

DANIEL SUTPHIN, M.D., FACS 7/17/2018

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1 IN THE UNITED STATES DISTRICT COURT FOR 2 THE DISTRICT OF SOUTH DAKOTA 3 4 TERRI BRUCE,) 5 Plaintiff,) 6 vs.) No. 17-5080 7 STATE OF SOUTH DAKOTA and) 8 LAURIE GILL, in her official) 9 capacity as Commissioner of) 10 of the South Dakota Bureau) 11 of Human Resources,) 12 Defendants.) 13 14 DEPOSITION OF DR. DANIEL SUTPHIN, M.D., FACS 15 TAKEN ON BEHALF OF THE PLAINTIFF 16 JULY 17, 2018 17 18 19 (Starting time of the deposition: 8:50 a.m.) 20 21 22 23 24 25	1 IN THE UNITED STATES DISTRICT COURT FOR 2 THE DISTRICT OF SOUTH DAKOTA 3 4 TERRI BRUCE,) 5 Plaintiff,) 6 vs.) No. 17-5080 7 STATE OF SOUTH DAKOTA and) 8 LAURIE GILL, in her official) 9 capacity as Commissioner of) 10 of the South Dakota Bureau) 11 of Human Resources,) 12 Defendants.) 13 14 15 Deposition of DR. DANIEL SUTPHIN, M.D., 16 FACS, produced, sworn and examined on the 17th 17 Day of July, 2018 between the hours of 9:00 a.m. 18 and 5:00 p.m. at the offices of Alaris Litigation 19 Services, 711 N. 11th Street, in the City of St. 20 Louis, State of Missouri, before Rebecca Brewer, 21 Registered Professional Reporter, Certified 22 Realtime Reporter, Missouri Certified Shorthand 23 Reporter, and Notary Public within and for the 24 State of Missouri. 25
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1 INDEX 2 PAGE 3 QUESTIONS BY: 4 Mr. Block 5 5 Mr. Johnson 226 6 Mr. Block 228 7 EXHIBITS 8 9 EXHIBIT DESCRIPTION PAGE 10 Exhibit 9 Expert Declaration of Daniel Sutphin 7 11 Exhibit 10 Web Page for CMDA 35 12 Exhibit 11 Transgender Identification CMDA Website 37 13 Exhibit 12 Standards of Care - WPATH 77 14 Exhibit 13 Newsweek Website 103 15 Exhibit 14 BBC Website 103 16 Exhibit 15 Rebuttal Report of Dr. Schecter 113 17 Exhibit 16 Original Complaint 160 18 (Original exhibits retained by the court reporter to 19 be copied and attached to the transcript.) 20 21 22 23 24 25	1 APPEARANCES 2 FOR THE PLAINTIFF: 3 Ms. Leslie Cooper 4 Mr. Joshua A. Block 5 American Civil Liberties Union Foundation 6 125 Broad Street, 18th Floor 7 New York, New York, 10004 8 Lcooper@aclu.org 9 Jblock@aclu.org 10 11 FOR THE DEFENDANT: 12 Mr. Jerry D. Johnson 13 Jerry Johnson Law Office 14 909 St. Joseph Street, Suite 800 15 Rapid City, South Dakota, 57701 16 Jdjbck@aol.com 17 18 19 20 21 Ms. Rebecca Brewer, RPR, CCR, CRR 22 Alaris Litigation Services 23 711 North Eleventh Street 24 St. Louis, Missouri, 63101 25 (314) 644-2191

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Page 5 1 IT IS HEREBY STIPULATED AND 2 AGREED by and between counsel for the Plaintiff 3 and counsel for the Defendant that this 4 deposition may be taken in shorthand by Rebecca 5 Brewer, RPR, CRR, CCR, Certified Court 6 Reporter, and Notary Public, and afterwards 7 transcribed into typewriting; and the signature 8 of the witness is not waived. 9 * * * * * 10 DR. DANIEL SUTPHIN, M.D., FACS, 11 Of lawful age, produced, sworn and 12 examined on behalf of the PLAINTIFF, deposes and 13 says: 14 EXAMINATION 15 QUESTIONS BY MR. BLOCK: 16 Q Good morning, Dr. Sutphin. 17 A Good morning. 18 Q My name is Josh Block. I'll be taking 19 your deposition today. I represent the plaintiff in 20 the case. Have you ever had your deposition taken 21 before? 22 A Yes. 23 Q How many times? 24 A Once. 25 Q Okay. So you -- you're a little bit	Page 7 1 give your full and truthful testimony today? 2 A No, sir. 3 Q Great. Let's begin. So, start by marking 4 as Exhibit A a document entitled Expert Declaration 5 of Daniel Sutphin. 6 MR. JOHNSON: Just a suggestion. It's 7 easier with Judge Viken if we just go 8 consecutive, so if we go 9, but it's your 9 deposition. 10 MR. BLOCK: Well, you know the judge, so 11 you if you want to go with 9, that's okay with 12 me. 13 MR. JOHNSON: Just throwing it out. We 14 haven't marked it yet. Otherwise, I wouldn't 15 have said anything. 16 MR. BLOCK: No, I haven't. All right. We 17 can mark it as Exhibit 9. 18 (Deposition Exhibit 9 marked.) 19 Q (By Mr. Block) Do you recognize that 20 document? 21 A Yes, sir. 22 Q Does it appear to be a copy of the expert 23 declaration you submitted in this case? 24 A If I may review quickly just to verify. 25 Yes, sir.
Page 6 1 experienced with how this goes, at least. I just 2 want to repeat some ground rules I'm sure you heard 3 before when you've had your deposition taken before. 4 So the first is, as you know, the court reporter's 5 typing down everything we say. So it's important 6 that when you answer my questions, you respond 7 verbally instead of nodding your head. 8 A Okay. 9 Q The second is to make sure to wait until 10 I'm done talking before you start speaking and I'll 11 wait until you're done talking before I start 12 speaking, so there's no cross talk and the reporter 13 can write everything down, okay? 14 A Understood. 15 Q Great. The third thing is, you know, it's 16 my job to ask you questions that you understand. 17 And so, if for any reason you're unclear with what 18 I'm asking, can we agree that you will say so and 19 let me know so I'll rephrase the question? 20 A Yes, sir. 21 Q Great. And so if you answer the question, 22 I'm going to assume that you understood it. Is that 23 okay? 24 A Yes. 25 Q Great. Is there any reason why you can't	Page 8 1 Q If you could turn to the -- after, 2 actually, the text of your declaration to the CV. 3 A Yes, sir. 4 Q Great. I just want to review some 5 elements of the CV with you. So, for education and 6 medical training, let's start at the bottom and go 7 to the top. So you received your undergraduate 8 degree at Carson-Newman College, is that right? 9 A Yes, sir. 10 Q Now, while attending Carson-Newman 11 College, did you study gender dysphoria at all? 12 A No, sir. 13 Q Did you study psychology or psychiatry at 14 all? 15 A Other than the mandatory requisites for a 16 liberal arts degree, no, sir. It was just pretty 17 focused and just kind of arts sciences, so I had a 18 minor in history. That was my relief from arts 19 sciences. 20 Q For -- so after you finished college, you 21 went to University of Tennessee College of Medicine 22 for your M.D., is that right? 23 A Yes, sir. 24 Q Now, while you attended there, did you 25 study gender dysphoria at all?

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1 A No. And to my recollection, it wasn't 2 really something on the radar screen. At that time, 3 even as it relates to my specialty, I had had no 4 exposure to plastic surgery at that time. 5 Q Did you study psychology or psychiatry? 6 A No, sir. 7 Q So following that, you had an internship 8 at University of Tennessee Medical Center, is that 9 right? 10 A Yes, sir. 11 Q And during your internship, did you study 12 gender dysphoria at all? 13 A No, sir. 14 Q Did you study psychology or psychiatry? 15 A No, sir. 16 Q So, following your internship, you had a 17 residency at University of Tennessee Medical Center. 18 During the residency, did you study gender dysphoria 19 at all? 20 A No, other than of my own accord just in 21 reading, it really -- and even to date, in most 22 programs isn't part of the curriculum, for better or 23 for worse. I think many would argue for worse that 24 it's not, but that's something that I think is 25 probably changing, but at the time that I went	1 and just in my personal life, my wife would often 2 accuse me of saying, You're the worst at dates, 3 including your own children's birthdays, so -- 4 Q Would you be able to place it in one of 5 your residencies? 6 A Probably wasn't in earnest until I was at 7 UCSF in San Francisco. 8 Q All right. So, for -- well, let's just 9 finish up till we get to there. So, for, you know, 10 you have three different residencies, University of 11 Tennessee, two in Knoxville, one in Chattanooga, is 12 that right? 13 A Correct. They were different specialties 14 as well. In general surgery, I don't know that one 15 would ever encounter gender dysphoric patients as a 16 focus of one's training, irrespective of your 17 geography in the country. There's just not that -- 18 other than perhaps within neurology, which is an 19 element of exposure that, depending upon the program 20 in general surgery that you attend, you may have 21 some exposure to it. For instance, at UT, we would 22 make a month in urology or gynecologic surgery. 23 Q So, did you have any exposure? 24 A No, sir. No, sir. 25 Q Okay. And, now, just so I'm just clear on
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1 through training, it really was not on the radar 2 screen. 3 Q So, you said as part of your own reading, 4 Did you do your own reading about gender dysphoria 5 during your residency? 6 A Not so much about gender dysphoria, but 7 about sex reassignment surgery, as it was referred 8 to at the time. 9 Q And what reading did you do? 10 A Just what was available through hard text, 11 which was quite limited. 12 Q And what prompted you to start that 13 reading? 14 A It's a fascinating problem from the 15 standpoint of what -- what motivates a person who 16 has otherwise physiologically healthy anatomy. What 17 drives them to want to do that? And, technically 18 speaking, the operation, some of them are amongst 19 the most complex in plastic surgery, so -- 20 Q And so, is this -- when would you estimate 21 you first, you know, began asking that question and 22 doing your reading on it? 23 A Oh, I honestly don't -- I don't -- I 24 couldn't put a date on it, really. So much has 25 happened in my professional life in the last decade	1 the record, I'll just ask the questions for each of 2 the different residencies, so I just have them 3 clear. So for the first residency in department of 4 surgery, just to confirm, you had no training in 5 gender dysphoria in treating gender dysphoria? 6 A Correct. 7 Q And you had no training on psychology or 8 psychiatry? 9 A Correct. If I may make one quick 10 correction. When you mentioned psychiatry, we did 11 do formal psychiatry rotations in med school. 12 Q Tell me about those. 13 A I don't recall the exact amount of time. 14 I just recall thinking, during the rotation, I'm -- 15 as many surgeons are, I like to be able to see 16 tangible results and I derive great satisfaction 17 from being able to offer somebody something that 18 provides them a cure, a resolution of something, 19 it's very tangible, and in observing the 20 psychiatrists that were our mentors, they expressed 21 many occasions that one of their primary 22 frustrations with their field of specialty, and it 23 overlaps in some degrees with the medical 24 disciplines like internal medicine, is that they 25 feel they treat chronic disease and never really

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1 achieve a cure, so to speak. I just didn't find 2 that very appealing. 3 Q What type of -- can you give some examples 4 of the types of diseases they expressed frustration 5 treating as chronic diseases? 6 A Schizophrenia, depression/severe 7 depression. Those are two that come to mind. 8 Q So, I had thought that treatment for 9 depression had been improving. What was your sort 10 of just understanding from interacting with them 11 about the difficulties in treating depression? 12 A Well, my -- and forgive me. That's a 13 question I really don't understand. My 14 understanding from the people that were training me 15 or my own observations? 16 Q Either one. 17 A Okay. It wasn't inherently appealing to 18 me to just provide medicine to someone. I also am a 19 person who enjoys using my hands, whether with art 20 or with surgery. And so that was an element that 21 was kind of obviously devoid from treatment for 22 those patients, but the other reality, to me, 23 simplistic as it may be in the background, is the 24 world is a rotten place. It's a hard place, 25 sometimes, for all of us. And it was hard to sort	1 A It's hard to say that to that man. It's 2 hard to tell him, when he says to you, with his son 3 sitting there, Really, I need you to tell me 4 honestly, Dr. Sutphin. What do you -- do I need 5 to -- I mean, will I be hear at Christmas? And I, 6 you know, with humility after recognizing, No. 1, we 7 don't know all the answers, though we might like to 8 as physicians, No. 2, based on what we do know, I 9 can't say that I think you will be, so I think you 10 need to get -- start getting your things together as 11 quickly as you can. 12 Q So, going back to psychiatry and 13 psychology. I, you know, I take it that -- 14 A I have no formal training, beyond just my 15 brief mandatory exposure for a couple months in med 16 school. 17 Q Based on what you were saying, is another 18 difference between psychiatry and, you know, 19 surgery, or other medical conditions, is that 20 there's not some sort of, you know, diagnostic test 21 that you can search for to confirm whether or not 22 someone's depressed? 23 A I don't -- I'm not familiar enough with 24 psychiatry to know. I know there's a battery of 25 questions for many disorders that are sufficient to
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1 through chemical imbalance versus people just trying 2 to cope with the reality of their existence. Two 3 weeks ago I talked to a patient who came in to see 4 me with a mass on his ear and he's a very -- he's 5 just enjoying life, a retired guy with his family, 6 and he was very concerned about the spot on his ear. 7 Looks benign enough to him but, as a professional, 8 the biopsy came back for something called Merkel 9 cell carcinoma and it's very -- it's a relatively 10 unusual tumor. And I said, I think we need to do 11 some imaging studies to see, because he also had 12 lymph node involvement, it felt to me, in his neck. 13 And, unfortunately, on the PET CT scan, his liver is 14 filled with metastasis in the scapula as well on the 15 contralateral, or other side. That is horrible and 16 he is depressed and unfortunately there's nothing we 17 can offer within the medical realm to help him. 18 Now, thank goodness that's not the case for 19 everybody who's feeling bummed out or blue, but 20 that's an example of the reality of -- and that's 21 one of the things that is both a blessing and a 22 curse about the surgical realm. It pairs away 23 quickly sentiment and discussion and moves to the 24 realm of reality, you know. 25 Q Right.	1 provide diagnosis for those who are professionals in 2 that realm, but it is -- it is true that those who 3 practice in the disciplines of psychiatry deal with 4 what we often would say in medicine is inorganic 5 disease or supratentorial, as opposed to disease 6 that may be readily diagnosed by putting a hand 7 there or visualizing with eyes or, you know, 8 perceivable as the reality, you know, if somebody 9 comes in with a ruptured AAA, aortic aneurysm, 10 that's not -- none of us are going to disagree about 11 that, you know, that's a condition that's grave and 12 readily apparent on a CT scan or discernible by 13 physical examination, in the worst case scenario. 14 Q And psychiatric conditions are generally 15 not discernible by physical examination or by some 16 objective verification? 17 A Being someone who's outside the 18 discipline, I can't say that. I think we -- any of 19 us, without even medical training, can observe a 20 person and say, that person doesn't seem well, you 21 know, if, for instance, we came to a meeting like 22 this today and you see a surgeon sitting across from 23 you and he's got his buttons the wrong way and half 24 of his face is shaved and his hair's a mess, you 25 would have valid concern that I'm not a physician,

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Page 17 1 but he doesn't seem well. Something's amiss for 2 him. That could be a myriad number of 3 possibilities. He may have just been up all night 4 with American Airlines flying all over the country 5 or he may really -- he may have an alcohol problem. 6 It could be any number of things, but just even 7 unprofessional observation will lead you to assume 8 that something's not exactly typical for a surgeon, 9 at least. 10 Q So, just going back to our boring list. 11 For the third residency, in the department of 12 plastic surgery and reconstructive surgery at 13 University of Tennessee, during that residency, did 14 you have any training in treating gender dysphoria? 15 A No, sir. 16 Q Did you have any training in psychology or 17 psychiatry? 18 A No, sir. 19 Q Okay. And so, finally, the fellowship at 20 UCSF, during that fellowship, did you have any 21 training in treating gender dysphoria? 22 A At that point, I did have some exposure to 23 gender dysphoric patients and that was really the 24 first occasion that professionally I'd encountered 25 with a patient in that condition. Even at that	Page 19 1 think, obviously, even as Dr. Schechter is testimony 2 of, I think he's working on developing a fellowship 3 for people within the discipline of microsurgery to 4 tend specifically to transgender patients. Just 5 wasn't that formal presence at that point. 6 Q So, do the procedures that are involved in 7 sex reassignment surgery follow within the rubric of 8 microsurgery? 9 A Some, yes, sir. 10 Q Which ones? 11 A Phalloplasty is probably the predominant 12 technique that would be best executed, utilizing my 13 microsurgical technique. 14 Q Does vaginoplasty? 15 A Depending on whether intestinal 16 transposition is utilized. 17 Q So, if no intestinal transposition, then 18 it doesn't fall within microsurgery? 19 A No, it does not. And even in most cases, 20 for intestinal transposition, there's not a need for 21 microsurgical technique unless, perhaps, there's a 22 vascular complication that requires utilizing -- 23 disrupting the native blood supply to the intestine. 24 Q And mastectomy doesn't fall within 25 microsurgery, does it?
Page 18 1 stage, just a few relatively short years ago, there 2 was no formal, well-organized program as UC. And as 3 is submitted in my declarations, I think that's an 4 area of need that's been recognized nationwide and 5 Dr. Delgado at Miami, who I don't know personally, 6 suggests that we really need dedicated fellowships, 7 that the current state of training in the United 8 States in plastic surgery, this is something that is 9 lacking. Given the location in San Francisco, by 10 default, I think, really, we were even sensing a 11 need at that point to be able to address those 12 patients other than, okay, well, yeah, we know some 13 procedures, we can execute procedures, but we still 14 don't really understand what's bringing to the table 15 here. And so that's kind of where I found myself 16 taking care of patients, not on a regular basis, but 17 occasionally we would see somebody at San Francisco 18 General would come in -- or I remember on one 19 occasion, at St. Mary's Hospital, taking care of a 20 patient who had undergone a metoidioplasty and was 21 having some complications with that. But it wasn't 22 a formalized component. Of course, at that 23 juncture, I was doing a dedicated fellowship in 24 microsurgery. And so, the curriculum was not 25 structured specific to transgender surgery and I	Page 20 1 A No, sir. 2 Q During this fellowship, did you have any 3 training in psychiatry or psychology? 4 A No. 5 Q You also said this was around the time 6 when you started doing your own reading on SRS, is 7 that right? 8 A Yes, sir. 9 Q And so, what sources did you begin to 10 read? 11 A The only sources that I could find at the 12 time were basically limited to our plastics 13 literature, occasionally urology literature. 14 Q Did you read only in medical journals or 15 did you read beyond that as well? 16 A Such as? Forgive me, I don't understand 17 the question. 18 Q Sorry. Were there other writings, from a 19 philosophical perspective or from a non-medical 20 perspective, on SRS that you read at that time? 21 A Only perhaps what was in the lay press. 22 Q So, going to the next section of your CV, 23 on work history, you know, maybe we can make this a 24 little bit -- go a little bit quicker by, you know, 25 asking you if, you know, during any of these

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Page 21 1 professional work history stints you ever treated 2 someone for gender dysphoria. 3 A I don't know if I treated them, if that 4 would be the primary diagnosis. I treated gender 5 dysphoric patients, yes, sir. 6 Q So, give me an example of what treatment 7 you gave for gender dysphoric patients. 8 A Male to female patients that had 9 complications with their breast implants or 10 infection. 11 Q Any other context? 12 A No. I did not treat a patient 13 specifically with gender dysphoria, but a spouse of 14 a patient. A lady came to see me about her consult 15 for her breast implants and, to my recollection, she 16 had a technique which is not commonly accepted 17 within well-credentialed plastic surgery. She had a 18 number of implants stacked in her breast to make 19 them inordinately large, basically. Her spouse was 20 a transgender female. 21 Q I'm sorry, by transgender female, do you 22 mean someone whose sex assigned at birth was female 23 or someone whose sex assigned at birth was male? 24 A Male. So I didn't treat that individual 25 specifically and, in fact, the patients or the	Page 23 1 A Oh, it was probably no more than 25 total. 2 Q And what sort of treatment did you provide 3 them? 4 A Again, most occasions it was dealing with 5 complications of the surgery. Many of them were, 6 thankfully, non-operative. The lady I alluded to 7 previously who developed bleeding and incisional 8 dehiscence after a metoidioplasty thankfully didn't 9 require surgery. There were other occasions where 10 we would take care of trans female patients who were 11 male at birth and had developed complications with 12 their implants. To that end, the question that you 13 mentioned earlier, is there any reason for failure 14 in that patient population? Not so much an anatomic 15 reason other than the male pectoralis implants are 16 usually more well developed, depending upon the 17 stage at which the patient underwent transformation. 18 And certainly that patient population, I don't ever 19 recall seeing an individual who had undergone 20 transition, pre-pubertal. So, they had a fully male 21 phenotype in terms of skeletal development and 22 muscular development. And if the implant's in a 23 submuscular position, certainly that could lead to 24 increased implant migration. The behavioral pattern 25 in terms of those people, in terms of S&M and
Page 22 1 patient who was coming to me for counsel, I think 2 ultimately decided to seek care elsewhere. I 3 expressed concern to her that, given the stretching 4 of her breast envelope, what she wanted to 5 accomplish wasn't going to be safely doable. She 6 had been multiply operated previous times, including 7 some surgeries outside the country, so -- 8 Q The complications that you did see and 9 treat for breast implants, were those complications 10 different from the type of complications that a 11 cisgender female would experience having breast 12 implants? 13 A No more related to the complication of the 14 implant itself; common complications like device 15 failure or infection around the device. 16 Q So the fact that the implant was -- as 17 part of -- was provided as part of gender transition 18 didn't make it more likely to result in a 19 complication than if it had been provided to a 20 cisgender woman? 21 A I don't know any reason why, per se, no. 22 Q Going back for one second to your 23 fellowship at UCSF. When you were there, about how 24 many gender dysphoric patients do you estimate you 25 interacted with?	Page 24 1 bondage, I would not say are typical for -- but who 2 can say that sexual proclivities of, I mean, across 3 the country, between male, female, cis, or 4 transgender, that's far beyond my expertise, but 5 that was something that may perhaps lead to 6 increased failure, but that would be a common issue, 7 whether a person's a biological male or female, if 8 you smash the implant repetitively, it's going to 9 rupture, you know, so no matter what your gender or 10 where the thing is located. So pretty elementary, 11 not microsurgical techniques. That may have 12 reflected the knowledge base of the surrounding 13 surgical community, even in an area like San 14 Francisco, which is keen, certainly, to be able to 15 provide this care to people that really reflects the 16 rapid growth, even in the last decade, so -- 17 Q Can you explain more about the rapid 18 growth that's happened in the past decade? 19 A Well, I can just share with observation in 20 terms of authors like Dr. Schechter, who are working 21 diligently to be able to bring a greater knowledge 22 base to various disciplines, I think he -- I can't 23 speak for him, but he would probably be the first to 24 say, not just plastics, but outside of plastic 25 surgery, disciplines like neurology as well.

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Page 25 1 Q Just want to be clear on understanding 2 what you're saying. Is it fair to say that, you 3 know, the medical community's familiarity with 4 treating gender dysphoria has increased dramatically 5 over the past decade? 6 A I have no objective proof of that, but my 7 subjective impression, at least there's a greater 8 awareness of it. The fact that it's not reflected 9 in any of my training, I don't believe, is 10 geographical. I think it's time specific. 11 Q And do you think that -- so the fact 12 that -- well, strike that. Before I move on from 13 your professional work history, I just want to make 14 sure that I'm not missing any other context in your 15 education or your professional work history in which 16 you've treated gender dysphoric patients. 17 A No, sir. 18 Q And during the fellowship, or in your 19 subsequent work history, were you ever involved in 20 performing or assisting to perform the transition 21 surgery as opposed -- 22 A No, sir. I was not. Really, my knowledge 23 has been self-directed, to try to learn more, how 24 can we better care for these people? They're human 25 just as you or I. And so, that's really been my	Page 27 1 companies, I would be in a very different place 2 right now. I have no concept of what insurance 3 companies do, don't do, or why they do what they do. 4 I continue to be amazed. I've had insurance 5 companies deny treatment for patients for many 6 different reasons and, if I understood why, there 7 would be a large plaque on my wall called the Nobel 8 Prize. 9 Q Has anyone, you know, in your training or 10 your work experience asked you to perform surgery 11 for gender transition? 12 A No, sir. No, sir. 13 Q And in your -- going down on your CV, for 14 your research presentations and publications, am I 15 right that none of your research listed on your CV 16 concerns treatment for gender dysphoria? 17 A Yes, sir. 18 Q And none of the research on your CV 19 concerns performance of transition-related 20 surgeries? 21 A Correct. 22 Q And none of the research on your CV 23 concerns psychological or psychiatric care? 24 A Correct. 25 Q And have you conducted any other research,
Page 26 1 own, self-directed. And I think that's true. I'm 2 not anything special in that regard. Every surgeon, 3 whether this is transgender surgery or whether this 4 is laparoscopic surgery, a neurosurgeon practicing 5 in 1989 or you're a vascular surgeon practicing in 6 the early '90s before endovascular therapy was 7 available, you're going to continually work to 8 critically analyze what's coming down the pipeline 9 of treatment so you can continue to provide good 10 care for people, whatever their background is, 11 whatever their orientation is, whatever their 12 sexuality is. 13 Q You continue to evaluate new material? 14 A Yes, sir. Absolutely. That's our duty 15 and obligation. We wouldn't be practicing good 16 medicine if we didn't. 17 Q And do you think that in deciding what 18 sort of procedures should be covered by insurance, 19 that an insurance company should be, you know, 20 looking at new material and reevaluating decisions 21 in light of new material? 22 MR. JOHNSON: Lack of foundation. 23 Q (By Mr. Block) You can go ahead and 24 answer. 25 A Well, if I could speak for insurance	Page 28 1 presentations, or publications not listed on your 2 CV? 3 A No, sir. I just received a request to be 4 a potential author, actually, for Merkel cell, 5 management of Merkel cell cancer, but I have not 6 embarked on that. But that would not be original 7 research. That would be a literature review and 8 synopsis of that. That's the only other thing 9 that's not on my CV right now. 10 Q What's the difference between original 11 research and literature review? 12 A In the context that I use it, I mean, for 13 instance, if you look at my CV, the research done 14 with botulinum toxins. That is the concept that's 15 nidus and whose caring to fruition began just with a 16 clinical question that I had as opposed to a 17 question where I'm gathering data from -- just to 18 offer my colleagues a synopsis of what exists in the 19 medical literature at the present, you know, what's 20 valid today may not be valid tomorrow, depending on 21 what we learn overnight. It's that kind of thing. 22 Q So, what do you think qualifies you to 23 provide expert testimony on the -- on 24 transition-related surgery and its medical 25 necessity?

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Page 29 1 A Just an evaluation, I guess, as a plastic 2 surgeon, many of the principles and techniques that 3 are being utilized, obviously, are inherently 4 derived from plastic surgery, whether they're local 5 regional flaps, whether they're surgical techniques. 6 And I think that based on my training, which is 7 excellent technical training, offers me the ability 8 to discuss, with clinical acumen within my 9 specialty, what these complications actually mean. 10 And what does it mean to have a 40 percent stricture 11 rate versus 10 percent and how does really affect 12 people's lives? Because whether they're male or 13 female or transgender or cisgender, if you can't 14 void properly, that's a life-altering thing. And 15 certainly, as I'm going to, you know, as a plastic 16 surgeon, looking toward the future, I have to, as I 17 alluded to earlier, I have to critically analyze 18 literature based on what -- what the literature says 19 to know whether it's something I need to get on 20 board with, so to speak, or whether it's something 21 that, really, I need to refrain from. And that's 22 just my own personal opinion, obviously. 23 Q So, do you think that anyone who has 24 completed plastic surgery fellowship would have 25 similar competence to be an expert on these issues?	Page 31 1 MR. JOHNSON: No, just -- 2 A I don't recall the specific date, quite 3 honestly. 4 Q (By Mr. Block) Okay. And before you were 5 retained as an expert in this case, had you spoken 6 to anyone about your concerns with SRS? 7 A No, sir. 8 Q Do you -- 9 A Patients? That's a question I don't know 10 that I fully understand. 11 Q Thanks for asking me to clarify. Had 12 you -- 13 A I mean, I've spoken to colleagues and 14 said, Hey, what do you think? I mean, this is a 15 pretty high complication rate, but -- 16 Q So, in what context did you speak to 17 colleagues about SRS? 18 A Just observation, phone conversations. 19 Given the practice location, I'm practicing in an 20 underserved area, so I would contact colleagues 21 about microsurgical cases and just chat over 22 whatever, you know, you don't see each other or talk 23 to each other professionally very often and you try 24 to catch up, what's going on. 25 Q So, if no one has asked you to perform
Page 30 1 A I think anyone who has completed 2 fellowship training with a microsurgical background 3 would be able to discuss, intelligently, some of the 4 risks and potential benefits of some of these 5 techniques, yes, sir. 6 Q Is there anything that distinguishes you 7 from anyone else who has completed a fellowship in 8 plastic surgery with a microsurgery background -- I 9 apologize if I didn't use the right term -- is there 10 anything that distinguishes you from anyone else who 11 has that credential in providing expert testimony on 12 this specific issue? 13 A You probably have to talk to my patients 14 to make that determination. But in an academic 15 sense, no, sir. No, sir. 16 Q So, without, you know, revealing the 17 substance of any conversations, when were you first 18 retained to be an expert in this case? 19 A I honestly don't remember the date. It 20 was in the calendar year 2018, to my recollection. 21 Earlier in the calendar year, probably before 22 spring. 23 Q Okay. So, we'll just refer to that as 24 early 2018. Is that -- 25 A May I ask?	Page 32 1 SRS, you know, what prompted you to, you know, pick 2 up the phone and have these conversations with 3 colleagues? 4 A It wasn't a conversation where I called 5 with that being the nidus. It was a conversation 6 where, what's happening, what's going on in your 7 world? I've got this patient who's, you know, an 8 88-year-old person who, I think, really needs a free 9 flap, what would you do? That sort of thing. It 10 wasn't a lengthy or extensive conversation. 11 Q Do you -- do you have any knowledge of 12 if -- I'll take that away. Have you spoken to any 13 of your colleagues about being an expert in this 14 case? 15 A No, sir. 16 Q Have you -- before you were retained as an 17 expert in this case, had you expressed any interest 18 to colleagues about providing expert testimony 19 regarding SRS? 20 A In 2016, when I was still in New Mexico, I 21 submitted that there was a call for opinion 22 regarding the -- there was an injunction issued in a 23 federal court, I think out of Texas, and there was a 24 call for opinion, public opinion. And there was a 25 gentleman by the name of Imbody, Jonathan Imbody,

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1 that I got an e-mail. I don't think it was directed 2 specifically to me, per se, just making a request, 3 as, you know, if anybody who has any background in 4 plastic surgery and is willing to make some comments 5 and provide testimony about your impressions. 6 Q How do you spell Imbody? 7 A I-M-B-O-D-Y. 8 Q And did he -- was he speaking on behalf of 9 any organization? 10 A I don't know. I don't know. 11 Q Are you familiar with the Christian 12 Medical and Dental Association? 13 A I am. Yes, sir. 14 Q What's the basis of your familiarity? 15 A I'm actually a member of CMDA. 16 Q And CMDA was one of the plaintiffs in that 17 case in Texas, is that right? 18 A I honestly don't know. 19 Q How long have you been a member of CMDA? 20 A Probably since 2000 in a student capacity. 21 Q And what is CMDA? 22 A Christian Medical Dental Association. 23 Q And what does it do? 24 A Well, it's basically an association of, I 25 would say, like-minded physicians and dentists who	1 A I've never been to one. 2 (Deposition Exhibit 10 marked.) 3 Q So, marking this as Exhibit No. 10. This 4 is a printout of the web page for CMDA. It 5 obviously looks different on paper than it does on 6 the computer screen, but does this appear -- have 7 you visited the website of CMDA at all? 8 A This looks like it would be legitimate. 9 My dad's in internet security, so he taught me you 10 can make anything look any way you want. He showed 11 me websites that are said to be Bank of America and 12 they're based in Russia, so -- 13 Q But there doesn't appear to be anything 14 wrong with this? 15 A No, sir. This doesn't appear to be a 16 misrepresentation of anything related to CMDA that 17 I'm aware of. 18 Q Okay. Great. And under "Our mission and 19 vision" at the bottom of the first page. 20 A Yes, sir. 21 Q It says, Our mission. And then it says, 22 Christian Medical and Dental Association motivates, 23 educates, and equips Christian healthcare 24 professionals to glorify God by -- and the first 25 bullet point is serving with professional excellence
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1 share a Christian faith. I don't fully know all the 2 capacity of CMDA. I know that they facilitate 3 various missions outreach around the world and 4 serving various areas that are underserved 5 throughout the world. I've never -- never 6 participated in that element, but I know it's a 7 strong element of the organization. 8 Q So, what's the substance of your 9 participation in the organization? 10 A Well, I'm a Christian and so, medicine is 11 a very demanding specialty. It's not a position 12 that you can just leave at home. And I think -- I 13 think all of us within medicine, having had friends 14 who come from various different world view 15 perspectives; atheist, Jewish, Mormon, Muslim, all 16 of us have to figure out how are we going to deal 17 with the realities that I was just relating earlier. 18 I'm sitting down with somebody and telling them 19 they're probably not going to be here in a few 20 months. And so I think whatever a person's -- 21 whatever their world view is, I think it's important 22 for them to find that fellowship. That's the basis 23 for my membership. 24 Q Are there annual or semi-annual meetings 25 that you attend?	1 as witnesses of Christ's love and compassion to all 2 peoples. And, second bullet point, Advancing 3 biblical principles of healthcare within the church 4 and to our culture? 5 A Yes, sir. 6 Q And do you agree with that mission 7 envision? Is that something that you try to adhere 8 to? 9 A Yes, sir. 10 Q And what's your understanding of biblical 11 principles of healthcare? 12 A Compassion, selflessness, and commitment 13 to excellence. 14 Q Anything else? 15 A For me as a Christian that ultimately 16 models Christ, love for us as humans. And I don't 17 see anything discordant with that with care of 18 transgender people. In fact, you know, if you read 19 through the New Testament, I think Paul was probably 20 the original guy to blow up binary definitions in 21 the Book of Galatians; with him there is no male nor 22 female, slave nor free man, there's no Jew or Greek. 23 And so I've never had any -- personally, I can't 24 speak for the whole organization, but for me 25 personally, I've never had any -- if you look at the

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1 life of Christ, he got himself in a lot of trouble 2 tending to people that were not espoused as and 3 worthy of care. And I can find no better example 4 than that. 5 (Deposition Exhibit 11 marked.) 6 Q Another document marked as Exhibit 11. 7 This is a PDF from CMDA's website entitled 8 Transgender Identification. Have you seen this CMDA 9 statement before? 10 A No, sir, I have not. 11 Q Okay. So I'll give you a minute to read 12 it and familiarize yourself with it. 13 A Okay. 14 Q Okay. So, is there anything in this 15 document that you disagree with? 16 A No, sir. 17 Q So, if we go to the very first page, the 18 second paragraph. 19 A Yes, sir. Biological? 20 Q No. Starting with "CMDA affirms." 21 A Okay. 22 Q CMDA affirms the obligation. Is that the 23 second paragraph? Did I say the first? So the 24 second paragraph on the first page; CMDA affirms the 25 obligation of Christian healthcare professionals to	1 have it? 2 A Yes, sir. 3 Q It says, CMDA believes that Christian 4 physicians should not engage in hormonal and 5 surgical interventions that alter natural sex 6 phenotypes as this contradicts the basic principles 7 of Christian medical ethics which regards medical 8 treatment as intended to heal and not to harm. Do 9 you agree with that statement? 10 A I think that Christian medical ethics 11 don't have a monopoly on the intent to heal or not 12 to harm. I think that's true for all of us. I 13 think all of us in this room would agree that our 14 goal is to strive to help anyone. I think -- I'm 15 going to have to speak as my own self, not just as 16 CMDA, though I'm a member of CMDA, that's a body. 17 As Daniel Sutphin, I would agree that it is -- in 18 one sense, sex reassignment surgeries are an 19 advocacy of what is natural. That is a biological 20 state the person is born into. And so whether I'm 21 Christian or not, I have to stop and say, why would 22 we -- not just why would the person, but why we, as 23 a culture, abandon -- seems a very debased valuation 24 of the body itself, physical human body, as opposed 25 to a body honoring this is -- this is a special
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1 care for patients struggling with gender identity, 2 with sensitivity and compassion. CMDA holds that 3 attempts to alter gender surgically or hormonally 4 for psychological indications, however, are 5 medically inappropriate, as they repudiate nature, 6 are unsupported by the witness of scripture, and are 7 inconsistent with Christian thinking on gender in 8 every prior age. Accordingly, CMDA opposes medical 9 assistance for gender transition on the following 10 grounds. Now, so, do you agree that attempts to 11 alter gender surgically or hormonally for 12 psychological indications are medically 13 inappropriate? 14 A I don't know. 15 Q Do you agree that they repudiate nature? 16 A Yes, I do. 17 Q Do you agree that they're inconsistent 18 with Christian thinking? 19 A Well, Christian thinking is a very 20 broad -- and as much as I believe that we are 21 created beings and that God does not make mistakes, 22 yes. 23 Q If you go to the third page, under the 24 heading of CMDA recommendations for Christian 25 healthcare professionals, Item 3, it says -- do you	1 structure. And as a surgeon, you know that it is. 2 And I often joke with patients, if you don't believe 3 there's a God, try reconstructing the hand. It's 4 really hard to do. It's a very complex structure 5 that whatever -- whatever one's religious beliefs, 6 you open the hood of a car, something intelligent 7 put that together. You open a human hand -- and I 8 don't practice hand surgery -- it's a pretty amazing 9 design. One millimeter off affects the tendon 10 excursion and flexion. So just from a natural 11 sense, I would have natural questions that is this a 12 valid option. And that's why I say I think we have 13 to first turn to -- we have to look at the medical 14 literature and say, What does it say? What facts 15 are there? Because if the fact is that something 16 helps someone, well, then you have to stop and 17 consider how do I need to adjust my thinking? Is my 18 thinking correct? There's only one God. I'm not 19 him. I don't pretend to know everything. I think 20 in scripture, the principle that I do support that 21 CMDA declares is that male and female, he made them. 22 And I'm a Christian as much as I believe that Jesus 23 Christ is who he said he was, who he claimed to be. 24 And he actually declared that himself while he was 25 on earth. So, some people would just say, well,

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1 it's a nice fairytale. I respect that. I can't 2 prove that. I can't at all. The New Testament 3 speaks to the truth of what I've seen in my own life 4 and what I've seen in the lives of those around me. 5 I don't -- I don't see any evidence at the present, 6 factual evidence, that tells me that I, as a plastic 7 surgeon, need to engage in this surgery in an effort 8 to save a person's life. And I feel a strong enough 9 sense of obligation to patients, honestly, even for 10 cisgender women, I don't offer cosmetic breast 11 surgery. I really focus my practice on what I would 12 say, I guess, is surgery that I know that what I'm 13 engaging in can produce a tangible -- a tangible 14 result for someone that will not just make them feel 15 better about themselves, that's very gratifying, but 16 restore what disease or nature has taken away, I 17 guess. 18 Q You spoke about how complicated the human 19 hand is. 20 A Yes, sir. 21 Q Do you believe in intelligent design? 22 A As defined how? I've heard a lot of 23 people define that in different ways. I believe 24 there is a creator and I believe, to me, my faith is 25 an active process where I look, you know, I sit down	1 MR. JOHNSON: You've answered it. 2 Q (By Mr. Block) I mean, do you believe that 3 humans developed through evolution? 4 A No. I believe we're created beings and 5 that the genome is something that is what our 6 physical manifestations are reflective of, that 7 that's something that allows for -- if that's what 8 you mean by Darwin's Natural Selection, allows 9 manifestations of what we commonly hear as survival 10 of the fittest. You know, if Josh and Daniel live 11 in the desert southwest and they're blue-eyed, 12 fair-skinned white guys, and they don't have any 13 protection, they're going to die pretty quick of 14 melanoma or other related skin cancers over time. 15 They're going to thrive and do better in an overcast 16 Northern European environment. 17 Q But you don't believe that's how human 18 beings, as a species, developed? 19 A I don't personally, no, sir. 20 Q One more question just on this document 21 from CMDA and on the same paragraph that we spoke 22 about last. So Paragraph 3. It says -- just 23 focusing on the first clause of that sentence -- 24 CMDA believes that Christian physicians should not 25 engage in hormonal and surgical interventions that
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1 with Josh Block, I talk with him, and Josh is a 2 smart guy and he's got some good ideas and he 3 arrived at those with good reason, somehow. So, 4 what -- how does what I, as Daniel David, think 5 about, how does that compare and where am I amiss? 6 Or where might Josh be, in my opinion? As it 7 relates to intelligent design, I believe in it as 8 much as I think, yes, it's easier for me as an 9 individual to have faith there is a God when I see 10 structures like this and when you operate on the 11 human eye and you know that when you sit as a human 12 and look at me, you can perceive two milliliters of 13 asymmetry in my upper lids, just in casual 14 observation. When you try to restore or correct 15 that, when you try and put it back together again, 16 you realize this is not -- this is pretty neat 17 stuff, so -- 18 Q Do you believe in Darwin's Theory of 19 Natural Selection? 20 A As defined as what? 21 Q Well, how -- do you have a definition of 22 it? 23 A I don't. I don't. I mean, I don't. 24 Q Okay. 25 A I've heard a lot of --	1 alter natural sex phenotypes. And just want to 2 confirm, you agree with that statement, is that 3 right? 4 A Based on what I've read to date, yes, sir. 5 Q So, going back to your contact with 6 Jonathan Imbody. Do you know if he was -- sent that 7 e-mail on behalf of CMDA? 8 A I don't. I'd have to -- I'd have to look 9 at the e-mail. 10 Q And what did you write in response to the 11 e-mail? 12 A I have no recollection, honestly, other 13 than I would be happy to provide whatever -- in 14 essence, what I said is I'd be happy to provide any 15 insights that I can, based on my technical expertise 16 in the realm of microsurgery and plastic surgery. 17 If I can help, let me know. 18 Q And so, after that, do you have any 19 subsequent contact with Jonathan Imbody? 20 A No, sir. 21 Q Did you have any contact with anyone from 22 Alliance Defending Freedom? 23 A No, sir. 24 Q Do you know what Alliance Defending 25 Freedom is?

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Page 45 1 A I do. 2 Q Have you -- have you had any contact with 3 Dr. Paul McHugh? 4 A No, sir. 5 Q Have you had any contact with Dr. Paul 6 Hruz? 7 A Not until having coffee yesterday. 8 Q When -- what time -- 9 A That was my own request. 10 Q What time yesterday did you have coffee 11 with him? 12 A What time? 7, 8:00, 8:30. We met 13 before -- actually, I walked with him over here. I 14 just wanted to see where the building was. He and 15 Jerry were meeting for coffee and I requested, via 16 text, if I could come down and join them. 17 Q Did you have any contact with him after 18 his deposition? 19 A No, sir. 20 Q Have you had any contact with Allan 21 Josephson? 22 A No, sir. 23 Q Have you had any contact with Ryan 24 Anderson? 25 A No, sir.	Page 47 1 MR. BLOCK: So, is now -- I don't need a 2 break, but if you need a break, now is a good 3 time. 4 MR. JOHNSON: Sure. 5 (Break Taken.) 6 Q (By Mr. Block) Just to close the loop on 7 the discussion with Jonathan Imbody. When you 8 replied to him, what research had you done up to 9 that point at the time that you wrote back to him? 10 A Research regarding? 11 Q Research regarding SRS and treatment for 12 gender dysphoria. 13 A Only what I had encountered in practice. 14 Just daily reading, casual observation. The 15 microsurgery techniques that I'm expert in are the 16 same whether a person's transgender or not. Now, 17 the applications, anatomically, are going to be 18 different, but -- 19 Q But you understood the purpose of 20 providing comments or testimony was to oppose 21 providing SRS to patients? 22 A The purpose in my understanding is to lend 23 candid assessment of what these techniques actually 24 mean. And in terms of -- I mean, you, for instance, 25 Josh, will know things about the legal process that
Page 46 1 Q Have you had any contact with Walter 2 Heyer? 3 A No, sir. 4 Q So, have you attended any meetings in 5 which the topic of providing, you know, either 6 testimony or scientific studies regarding SRS came 7 up? 8 A No, sir. I think, actually, I think 9 Dr. Schecter's encouraged it. That will hopefully 10 change, start with getting more information in our 11 meetings within the surgical disciplines, but not to 12 date, I have not. 13 Q So, between the time you responded to 14 Jonathan Imbody in 2016 and the time that you were 15 retained to be an expert in this case, did you have 16 any communications at all regarding being an expert 17 or providing testimony regarding SRS? 18 A No, sir. And to be clear, if I might, 19 real quick, Josh, the only thing that I recall about 20 my contact with Imbody is that the decision, if I 21 remember correctly, the injunction came in 2016. I 22 have no recollection specifically of when that 23 contact came, if it was there -- really, I do not 24 remember that specifically. So it may have been -- 25 it was not beyond early 2017, I would think.	Page 48 1 I might hear -- I might hear the terminology, but I 2 have no concept of what that actually translates to 3 in real life. Someone might hear the term 4 "phalloplasty." Okay. They're probably surgeons 5 and medical personnel who don't really understand 6 how technically that happens and so, that is my 7 purpose and intent; is to be able to speak candidly 8 about that and, also, where possible, to preserve 9 the opportunity for those of us who do not subscribe 10 to transition surgery, to be able to speak freely 11 about it to people. The literature shows clearly, 12 whatever side of the coin we wish to be on, there's 13 a very high complication rate for some of these 14 surgeries. And I don't know that that is clearly 15 and carefully discussed. Though it may be in 16 clinics like Dr. Schecter's, I certainly haven't 17 seen that in the media at large. 18 Q So, at the time that you wrote to Jonathan 19 Imbody, you had decided, at least for yourself, that 20 providing transition-related surgery was not 21 something that you thought was appropriate? 22 A In the sense of initiating it. If that 23 makes any -- if that -- is that clear to you? In 24 the sense of providing a transition surgery. For 25 instance, if a patient comes to me, male, female,

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1 some combination thereof, they're a human being of 2 equal value in God's sight, every bit as me, and 3 they need to be cared for with compassion, with love 4 and with respect. So if they come with a 5 complication, while I don't perform those surgeries, 6 I have a number of women who come to my practice to 7 address the complications of their breast implants. 8 I didn't put them in years ago but they come to me 9 and they have trouble and the same is true of those 10 transgender patients that I've cared for. 11 Q So, you spoke towards -- in answer to a 12 previous question, you talked about preserving the 13 freedom of people who disagree with providing those 14 surgeries? 15 A Right. 16 Q Now, what was your understanding of the 17 legal issue in the Texas case? 18 A I really don't have any understanding. 19 What I observed is conditions like what's happened, 20 for instance, at Bath Spa University in England, 21 where there is a psychiatrist who wants to bring 22 like a careful analysis of those patients who 23 actually want to go through reversal surgery. And 24 the university, after the initial proposition, not 25 because it's bad science, or because, as	1 reality, with biologic reality? If so, how can I 2 address that or even can I? And every surgeon's got 3 to address that freely and I get a sense that that 4 is something that we're -- though we want to give 5 people options, we're moving increasingly toward an 6 environment, at least that I can perceive, that 7 there is no room for objection to say, Hey, is this 8 really the best thing? That's -- and I think for 9 any of us who have ever traveled, thank God we're 10 not in Beijing or Moscow, thus it is decreed, thus 11 shall it be. Maybe it needs to be that way, but I 12 don't see the literature yet to support that. 13 Q You understand that the issue in this case 14 isn't whether any particular doctor has to perform 15 surgery, is that something you understand? 16 MR. JOHNSON: I'm going to object to that 17 as vague and indefinite. 18 Q (By Mr. Block) If you understand that, you 19 can answer. 20 A I would agree that is vague and 21 indefinite. It seems, based on what I've been able 22 to assess in the case, that the -- the scope is 23 moving continuously, even so recently as to 24 describing medical necessity from the question mark 25 at hand.
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1 Dr. Djordjevic, a urologist, said, we actually 2 really need to study these patients not because of 3 those reasons but because the university says, 4 basically, hey, due to the threat of political 5 fallout, we're just not even going to entertain this 6 and, to my mind's eye, that's a disservice no matter 7 what side of this coin we may be; Christian, 8 atheist, indifferent, or otherwise, these people 9 need help and it's really -- it's unprecedented in 10 terms of the nature of the surgery. We're removing 11 an otherwise physiologic organ to satisfy a concept 12 in the patient's mind, and if it does alleviate 13 that, okay, good. That's good to know. What are 14 the complications? What is it going to translate to 15 for them physically? And those people who choose to 16 go through that reversal is it because of those 17 physical complications or because they're 18 dissatisfied? And that would point to observations 19 by some of my psychiatric colleagues, though I'm not 20 a psychiatric professional, I, myself, casually 21 observe. Male, female, cis, trans, whatever it is, 22 as a surgeon, every time we have a patient come 23 before us that's seeking a surgery that's not cancer 24 related, and even if it is, is there an expectation 25 here from the patient that's discordant with	1 Q Well, so I want to focus, just briefly, on 2 the specific context of is insurance covering a 3 procedure. Now, there are -- do you recognize the 4 difference between the question of whether a doctor 5 should be forced to perform a procedure versus the 6 question of whether a doctor determines that a 7 procedure is medically necessary, should insurance 8 cover it? Do you recognize the difference between 9 those two questions? 10 A I think, in theory, there is a difference. 11 In reality, I think what the legal community can do 12 with the two is quite amazing and could cross the 13 line. 14 Q So, in -- 15 A Furthermore, if I may, even in the initial 16 complaint, I sense some of that language that 17 there's -- that Daniel's objection, for instance, or 18 anybody else who may object, is based solely on some 19 Draconian hatred of another human being rather than 20 an honest, candid, what's really going on here? And 21 as a person, when you put a knife on another 22 person's skin, that's a marriage for life. Like it 23 or not. And whether they know or whether they 24 don't, I can sit and talk to a patient, yes, we have 25 to at some point, as surgeons, come to an

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Page 53 1 understanding that this person really gets what 2 we're talking about. But, Josh, neither you nor I 3 can fully understand what it is like to live with a 4 urinary fistula. And we're trying to have a meeting 5 and, excuse me, I've got to wear Depends as a 6 38-year-old man because I wet myself. Even though I 7 may look as a man physically and you may perceive me 8 as a man physically and that may make me feel better 9 about myself, my life is permanently changed. And 10 who's going to fix that and how are we going to fix 11 that? How can we, as a medical community, devise 12 techniques that will provide people the ability to 13 address that? That's the reality of the world as a 14 surgeon. Now, I can go to meetings and I can go to 15 board rooms -- there's an old saying in surgery; 16 never confuse a meeting with reality. But in 17 reality, that's what -- when you deal with the 18 complications of these types of surgeries, I think 19 that's what I sense as being lost, even in the 20 language of the complaint, of, hey, let's have a 21 real candid discussion here. And is your objection 22 because you're just bigoted toward these people or 23 is your objection because you really have candid 24 concerns? Irrespective of your religious belief. 25 Irrespective of who you think Jesus Christ is or	Page 55 1 MR. JOHNSON: Excuse me. Unless you have 2 more circumstances, lack of foundation. 3 A If I may, if that physician, whether it's 4 me or Schecter or anybody else, can demonstrate a 5 tangible benefit over time, yes, sir. Yes, sir. 6 Q (By Mr. Block) Even though another 7 physician, looking at the same facts, might say 8 they're not convinced that it's medically necessary? 9 MR. JOHNSON: Same objection. 10 A I think in the context that you're 11 stating, it's superseding what I'm trying to 12 communicate and that is if we're talking about 13 altering normal anatomy, there needs to be a clear 14 and well-defined precedent that establishes this 15 actually -- what is our end point? Right now we 16 don't even have one, other than this makes people 17 feel better. If so, for how long? Because once we 18 pull the trigger on it, it's done. It's not a 19 matter of speculation anymore. And there's still -- 20 I don't know that the valid concerns about the 21 psychiatric component of it have been fully 22 addressed, and, furthermore, that's going to be, in 23 reality, a hard thing to do between the different 24 disciplines. 25 Q I just want to focus, aside from the fact
Page 54 1 isn't or whether he ever lived or existed or whether 2 you praise Allah or you praise the flying spaghetti 3 monster if I'm Pastafarian. You ever see that? 4 Q Um-hmm. 5 A Immaterial. Certainly what we believe 6 about those things are going to impact how we 7 perceive the human body and its plasticity and what 8 we should do with it. 9 Q Do you -- do you think that, for, you 10 know, a particular procedure, a medical condition, 11 two different surgeons could, you know, in good 12 faith have different views about whether 13 something -- 14 A Absolutely. 15 Q Let me -- 16 MR. JOHNSON: Let him finish. 17 A I'm sorry, my apologies. 18 Q (By Mr. Block) That two different 19 physicians in good faith have different views on 20 whether something is medically necessary? 21 A Yes, sir. Absolutely. 22 Q And in those circumstances, do you think 23 that an insurance company should not cover the 24 procedure if the physician who does think it's 25 medically necessary performs it?	Page 56 1 that this particular surgery changes characteristics 2 that someone is born with, on the topic of surgeries 3 in general, for other medical conditions. 4 A Yes, sir. 5 Q I just want to get your opinion on 6 whether -- when there's disagreement between 7 different informed medical professionals, should 8 that preclude an insurance company from covering 9 care that a particular medical professional believes 10 is medically necessary for their patient? 11 MR. JOHNSON: I object, complete lack of 12 foundation for that hypothetical. 13 Q (By Mr. Block) You can answer. 14 A I'll enter Jerry's objection. 15 MR. JOHNSON: That's an objection for the 16 record. You answer the best you can. 17 A Josh, I can only state that unless there 18 is a clear precedent of benefit, whoever it is, me, 19 anybody, I think going back to what I said early on, 20 surgery divides us under very quickly speculation 21 and leaves somebody somewhere going home with that, 22 and the effects, good or bad, good, bad, ugly, 23 indifferent, whatever they may be. So I think it's 24 especially important, whether we're talking about 25 this or any procedure, to really have a

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Page 57 1 well-established precedent that demonstrates, yes, 2 this is beneficial to people. 3 Q So, is there medical disagreement about 4 having, you know, preventative mastectomy to -- if 5 someone has a genetic predisposition to developing 6 breast cancer? 7 A There's a lot of -- I think from the 8 lawyer's perspective, you're asking a very 9 well-intentioned question. There's a lot of -- 10 there are even tests like Oncotype DX that try to 11 gage that percentage. You're saying in a case where 12 a patient has a high likelihood of developing breast 13 cancer with her certain genetic composition, that 14 it's warranted to counsel her that she may benefit 15 from mastectomy, is that correct? 16 Q From a preventative mastectomy. 17 A Yes, sir. Yes, sir. For instance, if 18 we -- if somebody comes to us and we say, We 19 perceive your likelihood of developing breast cancer 20 to be and, again, it's based on perception. We 21 don't have a crystal ball, but based on the best of 22 the literature that we have right now, we perceive 23 that by the time you get to age 55, if your family 24 history is XYZ and you test positive for certain 25 genes like the RCA, we anticipate the likelihood of	Page 59 1 course of action for treating a condition is surgery 2 or a different type of treatment? 3 A Every week in tumor board. 4 Q Okay. So, in that -- 5 A No, I see that the problem -- the reason 6 disagreement exists is not a -- none of us know with 7 certainty. For instance, we're probably all going 8 to get in a car and go back to the airport today. 9 In most cases, that's going to be fine. When my 10 sister was 18, it wasn't. She died in a car crash. 11 But for most of us, the benefit of getting to the 12 airport on time is worth the very small risk of 13 being killed in a car crash. So, all patients that 14 I see, I counsel in the same regard, whatever their 15 sexuality, whatever -- listen, what we're talking 16 about here, here's what we can say is the 17 anticipated benefit. But, the likelihood of -- you 18 know, if the likelihood of getting hit or killed in 19 a car crash, if we were living in Africa, I might 20 not feel so good about going to the airport in a 21 car. I might actually want to take a cart instead, 22 because the drivers are terrible in some of the 23 places I've worked. 24 Q Did you use the phrase "a tumor board 25 meeting"? Is that what you said?
Page 58 1 you developing breast cancer to be high enough that 2 you -- it would be reasonable to consider 3 mastectomy. 4 Q And would knowledgeable, you know, 5 surgeons in good faith, you know, disagree over 6 whether that mastectomy should be performed? 7 A I don't know of any who would. Maybe my 8 knowledge is not broad enough, but having trained 9 where I have, I've had the privilege of working with 10 some really top people and I don't know of anyone 11 that would argue that fact. I even have a colleague 12 who I trained with whose wife went through that 13 procedure, so -- 14 Q Are there -- are there any other 15 procedures that are performed for prophylactic 16 purposes that there's disagreement within the 17 surgical community about whether the cost of the 18 procedure outweigh the benefits? 19 A Not that I'm aware of. Prophylactic 20 purposes, no, sir. If there's any that you have in 21 mind that you can think of, I'd certainly be happy 22 to discuss them to the extent my expertise allows, 23 but I can't think of any. 24 Q Have you ever encountered a situation 25 where there's disagreement over whether the best	Page 60 1 A Yes. 2 Q A tumor board meeting, is that when 3 several different, you know, physicians, sort of 4 discuss what the best approach is for treating a 5 particular patient's tumor? 6 A Right. 7 Q Okay. Now, in those situations, is it 8 possible for two different tumor boards, looking at 9 the same tumor, to disagree over whether or not the 10 risks of surgery are outweighed by the benefits of 11 surgery for that tumor in that patient? 12 A It is. Generally speaking, the surgeon -- 13 the person who would be responsible for managing the 14 complications and creating them, inadvertently or 15 deliberately, let's say the tumor develops -- it's a 16 tumor in the axilla, and it envelopes the brachial 17 plexus or the brachial nerve, or the artery, the 18 surgeon's going to know better than anybody in the 19 room what that's going to mean in reality when you 20 get there and you have to try to cut around. So, 21 even if the oncologist says, well, that needs to 22 come out, it absolutely needs to come out. The 23 surgeon's going to be able to say, well, you know, I 24 agree, it would be nice to get it out, but the inner 25 position graft we're talking about is a

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Page 61 1 ten-centimeter segment, the likelihood of thrombosis 2 for that is -- and we have may have gotten the tumor 3 out and checked the boxes and patted ourselves on 4 the back, but when the patient's arm -- when they 5 have a thrombosis and they end up losing the arm 6 anyways, those are the discussions that I think need 7 to be able to continually happen without -- 8 Q But different surgeons could look at the 9 same tumor and disagree about the -- 10 A They could. 11 Q -- chances of a positive outcome, is that 12 right? 13 A They could. But, generally speaking, in 14 conditions such as that, where we're talking about a 15 disease process that's organic, and this is 16 something that I do see happen with these 17 discussions, we move from the organic to the 18 inorganic disease process. 19 Q I'm just talking about organic diseases. 20 A An organic disease process, yes, sir. 21 Q So different surgeons could have different 22 opinions? 23 A They could, yes, sir. 24 Q And different surgeons could have 25 different opinions about whether they personally	Page 63 1 MR. JOHNSON: Same objection. 2 THE WITNESS: Sir? 3 MR. JOHNSON: I said same objection. Just 4 for the record. 5 THE WITNESS: Okay. 6 Q (By Mr. Block) So what opinion had you 7 already formed at the time that you agreed to be an 8 expert in this case? 9 A The opinion that I have formed both before 10 I agreed to be an expert and the opinion I have 11 right now -- 12 Q I want to just focus -- 13 A -- as we sit here this morning, is that I 14 have seen in the literature no tangible benefit to 15 this patient population that is sustained over time 16 that warrants incurring the risks associated with 17 the surgeries. I believe there is something 18 involved that we can't get to with a knife. And I 19 feel disingenuous, as a surgeon, to come and say to 20 a patient, I'm going to do this for you, it may make 21 you feel better, but I don't know that it's really 22 going to fix the problem. 23 Q So -- and when did you first form that 24 opinion? 25 A It's hard to say, Josh. I think it's
Page 62 1 feel that it is ethical or appropriate for them to 2 perform the surgery, depending on how they view the 3 risks and benefits? 4 A In theory, they could. In practice, it's 5 less common, I would say, certainly. There should 6 be a general consensus, usually. It's uncommon. I 7 mean, patients come to me for second opinions. If I 8 see any doubt in a patient, I always encourage them 9 to get a second opinion because you're usually going 10 to find if it's something that's a well-established 11 method of care, you're going to find a general 12 consensus, you know, if Dr. Block's a radiation 13 oncologist, he may want to give you an extra two 14 weeks, but Dr. Sutphin, who's also a 15 radi-oncologist, he's going to agree that you need 16 at least four weeks, maybe plus or minus an extra 17 two, depending upon how you handle it. There's 18 usually a pretty well-established consensus. 19 Q Okay. We can move on to a different line. 20 So when you agreed to serve as an expert in this 21 case, had you already formed an opinion regarding 22 whether transition-related surgery should be 23 covered by insurance? 24 A Yes. 25 Q And what was that opinion?	Page 64 1 really an evolution of what I observed while I was 2 in San Francisco, in combination with what I see 3 coming out in the literature, even this very month. 4 It's not included in my declarations, because it's 5 not in existence, but Dr. Schecter did a nice job, 6 as a guest editor in Clinics in Plastics putting 7 together a segment on transgender surgery. And I 8 think it's -- some of the articles are very well 9 done. Very well done. And they talk about some of 10 the complication rates, particularly for 11 phalloplasty, which is the tour de force. It's kind 12 of, to transgender surgery, what the DIP flap is to 13 breast surgery, which I've executed myself and that 14 is -- I couldn't offer DIP surgery to patients with 15 a complication rate known of 40 plus percent, no 16 matter what their background. 17 Q So, that information isn't being 18 suppressed by the scientific community, is it? 19 A I don't know. I don't think there was 20 anything suppressed in this month's clinics, but 21 there's sometimes, like the old song says, you don't 22 know what you don't know. 23 Q So the people -- anyone who reads that 24 journal or any -- or Dr. Schecter himself, you know, 25 is aware of those complication rates?

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Page 65 1 A I can't speak for Dr. Schecter. I would 2 presume, in his position, that yes, sir, he would be 3 better qualified than me to speak about his practice 4 and what he observes and obviously he's observed and 5 executed quite a bit. 6 Q So -- so I want to just pinpoint -- I 7 understand you have an opinion now and that 8 opinion's change and evolved, but I want to try to 9 just pinpoint, you know, what was in your head at a 10 specific moment in time. And so, going back to the 11 time that you first formed an opinion regarding 12 these surgeries, is it fair to say that you began 13 with a presumption that the surgeries were not 14 medically appropriate until sufficient evidence is 15 shown to you to show that they are medically 16 appropriate? 17 A I begin every surgery that way, Josh. 18 Yes. Yes. 19 Q So -- 20 A To me, to operate in any other way is 21 irresponsible. If I were to be doing experimental 22 surgery, I would stay at an academic center and, 23 instead, I've chosen to be in an underserved 24 relative obscurity. 25 Q I don't want to talk about your personal	Page 67 1 Q Do you regularly read journals of 2 psychiatry and sex therapy? 3 A No, sir. This sounds smart aleck, but 4 given the demands of my practice, I have to really 5 focus on my practice. 6 Q So why did you decide to read those for 7 this condition? 8 A Because it's relevant. It's relevant. 9 It's increasing relevant. It wasn't even discussed 10 ten years ago. And that's testimony based on the 11 fact that, as Delgado's noted, we actually need to 12 start fellowships because this is widely 13 unrecognized and this is not a prevalent and 14 well-discussed element of surgical training and this 15 population seems to be growing considerably. 16 Q But no one has come to you asking for 17 transition-related surgery as part of gender 18 transformation, right? 19 A No, sir. Just those patients who have 20 come seeking care with their complications. So if 21 I'm going to provide them safe care that's standard 22 of care, based on whatever we can surmise that might 23 be at this point, then I need to be able to read 24 what exists. So, I'm -- 25 Q So, based on that, you've read at least a
Page 66 1 opinion. I want to talk about it being medically 2 appropriate, as a general matter. 3 A Right. I've got a question, though, what 4 that means, because I -- contrary to where we want 5 to kind of force this argument in a binary 6 direction, you support it or you don't. No matter 7 what I do, I have to look critically at does the 8 evidence support it? If it does, then my thinking 9 is perhaps off. 10 Q So, when did you first begin to actually 11 review the scientific literature on it? 12 A Probably when I was in San Francisco. I 13 mean, there wasn't really much literature at the 14 time of my general or plastic surgery training other 15 than sporadic articles, NPRS. 16 Q So by the time that you agreed to be an 17 expert in this case, approximately how many articles 18 do you think you read? 19 A Oh, goodness, Josh, I don't know. At 20 least a hundred. At least a hundred articles. 21 Q And in what publications would those 22 articles have been? 23 A Predominately NPRS, also urologic 24 journals, and then journals of psychiatry and sex 25 therapy.	Page 68 1 hundred articles and journals regarding this 2 surgery, right? 3 MR. JOHNSON: That was up to the time he 4 was retained in this case? 5 Q (By Mr. Block) Yes, up until the time you 6 were retained in this case. 7 A Yes, sir. 8 Q And you also -- 9 A I haven't had a ticker, but I would -- 10 based on my usual reading habits and patterns, yes, 11 sir, I would surmise that -- 12 Q And you also read journals in psychiatry 13 and sex -- 14 A Articles. 15 Q You also read articles in psychiatry and 16 sex therapy for this condition, even though that's 17 not something you normally read as part of your 18 practice? 19 A Correct. If I may, there's always 20 overlap. We don't exist in boxes. Our minds are 21 attached to our bodies and what we do with our 22 bodies are attached to our minds. So perhaps more 23 than any other patient, but -- not perhaps more. 24 This is the only patient population with what is 25 happening in the mind is dictating what we're going

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Page 69 1 to do with the body, as it relates to altering 2 normal anatomic structures. Nowhere else in 3 medicine does this happen. I mean, if I came to you 4 and said -- and you're a surgeon -- Josh, my hand is 5 troubling me. I find tremendous, tremendous 6 distress in it. And you look at me and say, Daniel, 7 your hand is okay. What's -- no, no, you don't 8 understand. You may not understand what's going on 9 in my mind, but if I'm asking you to take my hand 10 off, you got to start looking at the overlap between 11 the two. Because that's an otherwise functional 12 organ that's healthy. And the patient's asking you 13 to take it off and put something in its place 14 without evidence of organic disease. That's 15 unprecedented. 16 Q And is it your understanding that 17 psychiatrists view that situation as the equivalent 18 of someone with gender dysphoria? 19 A Parallels have been drawn. I can't speak 20 for psychiatrists in the psychiatric profession at 21 large, but parallels have been drawn. 22 Q By psychiatrists? 23 A I would have to look and see whether the 24 authors -- the authors and their institutions are 25 listed, but it doesn't say their specific -- if	Page 71 1 A I think one of the key things would be to 2 determine whether this is something that actually 3 decreases a person's risk and the actual execution 4 of suicide. That's an important one. 5 Q So, suicide is one -- one rubric. So if 6 the research showed that over the long term, having 7 transition-related surgery decreased a transgender 8 person's risk of suicide, would that change your 9 opinion about the medical necessity providing the 10 surgery? 11 A It would certainly impact it. I think one 12 thing -- this is a much more complex issue than we 13 want to give it credit for. There are real 14 biological questions that are outside the domain of 15 the concept of gender. There are real questions, as 16 I allude to in my declarations, what happens to 17 intestinal mucosa when it's subjected to repetitive 18 insemination or trauma associated with a sex toy 19 over a 20-year period? Those are valid questions 20 that just aren't answered as of yet. What happens 21 in terms of intimal hyperplasia in vascular disease? 22 We're really going against the grain of what the 23 person physically, naturally, their chromosomes are 24 XX or XY. And what we're doing is, as a medical 25 community, is reversing the flow and so we don't
Page 70 1 they're in a division of psychiatry versus 2 psychology, I don't know. 3 Q So you can't -- so right now, you can't 4 speak to whether the psychiatric and psychological 5 community views those two situations as equivalent? 6 A I cannot speak as a psychiatrist, no, sir. 7 Q If the research for -- regarding surgery 8 for gender transition did show long-term tangible 9 benefits, would your -- would that change your 10 opinion on -- regarding the medical necessity of the 11 surgery? 12 A What benefits, specifically? 13 Q In alleviating the gender dysphoria. 14 A Well, that's -- that's a broad topic, 15 Josh. I mean, I've read some studies where part of 16 alleviating gender dysphoria, the patient 17 questionnaires talk about how you feel about how 18 your gender will smell. I'm not being crude. So, 19 to me, it's -- it's not moral for me to offer 20 somebody a procedure where the end point is the 21 patient is happier with the appearance of the 22 external genitals and how they smell. 23 Q So, I mean, is there any rubric by which 24 you think research could demonstrate long-term 25 benefits from transition-related surgery?	Page 72 1 really know how the body's going to tolerate that 2 yet. It's a very broad spectrum from risk of breast 3 cancer all the way down to psychosocial inorganic 4 disease like suicide risk. I mean, that's something 5 that is not just exclusive to the transgender 6 community, as unfortunately the high profile cases 7 of Anthony Bourdain and Kate Spade have demonstrated 8 recently. I mean, I've carried a friend of mine to 9 the grave in a casket after he shot himself in the 10 head. None of us ever saw that coming. So I think 11 it's going to be a hardened point to really analyze. 12 There's so many -- it's a multifactorial thing. And 13 I think it would really be a challenge to analyze 14 that, but it's certainly something that has to be 15 considered if that's the case. 16 Q So -- 17 A And I would applaud those surgeons and 18 clinicians who can help those patients in that way. 19 Q So even if it was proven to reduce 20 someone's risk of surgery -- sorry, even if surgery 21 was proven to reduce someone's risk of suicide, you 22 would still have other concerns -- 23 A Yes, sir. 24 Q -- besides that? 25 A Yes, sir.

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Page 73 1 Q And based on those other concerns, you 2 would still not support the surgery as being 3 medically necessary? 4 A Based on what I know today, yes, sir. 5 Q And if I hear you right, you can't think 6 right now of any study that could be structured to 7 provide you the proof that you would need to 8 indicate that the surgery is medically necessary? 9 MR. JOHNSON: Existing study or future? 10 THE WITNESS: Future study. 11 A Josh, it would take a lot of studies, 12 honestly. We'd have to look -- are we talking cis, 13 male, female? The patient populations and risks 14 with each are going to be different. You know, if 15 you and I start taking estrogens, our risk for DVT 16 based on what we know right now is going to be 17 higher. What is that risk over 25 years? And how 18 can we talk to patients about that? What do we do 19 around the time of surgery? When do we stop those 20 estrogens? Because when we stop them, depending on 21 whether you or I have undergone actual anatomic 22 castration, you know, it's -- it's -- it would 23 require multiple studies looking not just at 24 inorganic disease, like suicide risk, as an end 25 point, but also biologic realities.	Page 75 1 biologically and histologically capable of 2 accommodating intercourse as is vaginal tissue, so 3 whether male or female, even potential for disease 4 transmission, the lamina and the basal cellular 5 layer of the vagina is going to be very different 6 than intestinal mucosa. Very different. Intestinal 7 mucosa's much more friable. Much more friable. And 8 the anal complex, the musculature complex, the 9 sphincter of the anus is -- it's designed for exit 10 activity rather than receptive activity. 11 Q So do you think that anal sex contradicts 12 biological reality? 13 A Biological reality is you can put a penis 14 or anything in an anus. You can put a finger for 15 examination. You can put a sex toy in the anus or 16 you can put a bottle in the anus or any number of 17 things. Biologically, though, that can be traumatic 18 to the anus and the rectum. 19 Q Do you think it repudiates nature? 20 A What is nature? I mean -- 21 Q Well, I'm asking you. You agreed with the 22 statement in CMDA that having altering gender 23 surgically or hormonally repudiates nature. And I'm 24 asking the same question -- I'm asking the same 25 question about anal sex.
Page 74 1 Q In discussing the, you know, some 2 questions about the risks of trauma to -- is it 3 colon tissue that you were talking about? Colon 4 mucosa? Could you say what term you were referring 5 to there? 6 A Sure. Colonic mucosa is something that 7 is not stratified squamous epithelium, like the 8 vagina is. I mean, this is something that we -- 9 it's just a fact. 10 Q And so, you expressed concerns about like 11 trauma from like intercourse and insemination -- 12 A Correct. 13 Q -- with that type of tissue? 14 A I'm sorry? 15 Q You expressed concerns about trauma from 16 intercourse and insemination with that type of 17 tissue, is that right? 18 A Correct. 19 Q Do those same concerns apply to anal sex? 20 A Yes. 21 Q So, do you, you know, have any medical 22 opinions, you know, regarding sexual activity 23 between two men? 24 A Two men, a man and a woman, whoever is the 25 recipient of anal sex, the rectal vault is not	Page 76 1 A Nature in the sense of what we observe, 2 physically, in its natural state, not iatrogenically 3 altered, that's irrespective of CMDA's definition, 4 that's how I'm defining the anus, whether it is on a 5 male or female body, its primary function is to 6 control evacuation of excreta. And the mucosa, if 7 we look at it under a microscope, is at risk for 8 trauma compared to vaginal mucosa. And that's 9 something that taking care of homosexual men, or 10 females who engaged in anal receptive sex, as a 11 physician, you need to talk to those patients 12 candidly about that, whatever their preference is, 13 this is something you got to be aware of. 14 Q Would you use the phrase "repudiates 15 nature" to describe it? 16 A If we define formulates to function to 17 engage in anal sex seems contrary to the function of 18 the anus. 19 Q Do you -- do you have any objection to 20 counseling, you know, people who engage in anal sex 21 to use condoms? 22 A No, sir. 23 Q Do you have any religious objection to 24 counseling people who engage in vaginal intercourse 25 to use birth control?

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Page 77 1 A No, sir. 2 Q So, do you have any -- do you have any 3 medical views, you know, regarding sexual activity 4 that is not happening for procreative reason? 5 MR. JOHNSON: Object. Vague and 6 indifferent. 7 A Can you help me understand better what you 8 want me -- 9 Q (By Mr. Block) Sure. So, if the 10 purpose -- do you believe the purpose of sexual 11 organs is to facilitate reproduction? 12 A I think that's certainly one part of it. 13 Q What are other parts of it? 14 A To facilitate connection between two human 15 beings in an intimate relationship unlike any other. 16 Q And do you think it's possible -- all 17 right. We can let that go. Marking as Exhibit -- 18 are we on 12? 19 (Deposition Exhibit 12 marked.) 20 Q This is the standards of care issued by 21 the World Professional Association of Transgender 22 Health. Have you seen these before? 23 A Yes, sir. 24 Q When's the first time you saw them? 25 A Oh, honestly, I don't know, Josh. It's	Page 79 1 Q Well, doesn't WPATH tell them what they 2 should counsel them on? 3 A What WPATH says or any other body says and 4 what people actually do are very different. 5 Q So my question is: A surgeon who follows 6 the WPATH standards of care, you know, is it your 7 understanding that a surgeon following those 8 standards as they are supposed to be followed does 9 not provide patients with information about side 10 effects and risks and harmful consequences? 11 A I think they would do that no matter what 12 WPATH says or not. I think if we're going to 13 discuss what WPATH's recommending, I could have this 14 wrong, in terms of the actual cadence of the case in 15 question, but if I understand correctly, when 16 Mr. Bruce sought counsel with his surgeon, his 17 surgeon had already submitted for approval for his 18 procedure without the patient undergoing any prior 19 psychological assessment. I think that occurred in 20 a delayed fashion as opposed to in a manner that 21 I've -- I could be looking at the dates wrong in the 22 case, but the reality of what is recommended and 23 what people do are two different things. 24 Q I want to focus on what the standards 25 recommend. On the top of Page -- well, you know,
Page 78 1 been sometime in the last three years. 2 Q So, have you read them before responding 3 to the e-mail from Jonathan Imbody? 4 A I can't say with certainty. I believe so, 5 but I can't say with certainty. 6 Q Can you say with certainty whether you 7 read them before being retained as an expert in this 8 case? 9 A Yes. 10 Q And did you read the whole thing, cover to 11 cover? 12 A Yes, sir. 13 Q The whole thing? 14 A Yes, sir. 15 Q Did you read -- if you can turn to Page 16 54, where it has XI and the heading of surgery. 17 Before you agreed to be an expert in this case, you 18 read this whole section in particular? 19 A Yes, sir. 20 Q And, you know, is it your understanding 21 that surgeons who provide surgery in accordance with 22 the WPATH standards don't counsel their patients on, 23 you know, the potential harms and complication rates 24 of surgeries? 25 A I don't know what they counsel them on.	Page 80 1 Page 56 to 57 has a discussion of relationship of 2 surgeons of mental health professionals, 3 hormone-prescribing physicians, if applicable, and 4 patients' informed consent. Do you see that? 5 A Forgive me, Josh, what page is it? 6 Q 56. 7 A And the top? 8 Q Yeah. I'm looking at the bolded heading. 9 A Yes, sir, I'm sorry, I was looking at the 10 paragraphs. Okay. 11 Q Okay. And if you look at the last full 12 paragraph of that section, once a surgeon is 13 satisfied the criteria for specific surgeries have 14 been met, as outlined below, surgical treatment 15 should be considered and preoperative surgical 16 consultation should take place. During this 17 consultation, the procedure and postoperative course 18 should be extensively discussed with the patient. 19 Surgeons are responsible for discussing all of the 20 following with patients seeking surgical treatments 21 for gender dysphoria; the different surgical 22 techniques available, with referrals to colleagues 23 who provide alternative options, the advantages and 24 disadvantages of each technique, the limitations of 25 a procedure to achieve ideal results. Surgeons

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Page 81 1 should provide a full range of before and after 2 photographs of their own patients, including both 3 successful and unsuccessful outcomes, the inherent 4 risks and possible complications of the various 5 techniques. Surgeons should inform patients of 6 their own complication rates with each procedure. 7 And then going to the top of the paragraph on the 8 next page; These discussions are the core of the 9 informed consent process, which is both an ethical 10 and legal requirement for any surgical procedure, 11 ensuring the patients have a realistic expectation 12 of the outcomes, it's important in achieving a 13 result that will alleviate their gender dysphoria. 14 So, do you have any -- is there any information not 15 included here that you think a surgeon should be 16 discussing with a patient before performing 17 transition-related surgery? 18 A Presumably, the irreversible nature of the 19 surgery and the potential loss of ability to bear 20 children, if that's ever something that, I mean, 21 I've seen patients wax and wane on that idea. I 22 don't see those two items in there and they may be 23 implied, but I don't see them explicitly. 24 Q Are these -- is the description of the 25 informed consent process that's contained here	Page 83 1 same as 11. 2 Q You had read 11? 3 A Yes, sir. And 12. No. 13 and 14, I have 4 not read. No. 15, I'd only read the abstract. No. 5 16, the same thing. 6 Q You had only read the abstract? 7 A Yes, sir, I believe so. No. 17, I had not 8 read. No. 18, I don't know. I don't know whether I 9 read that. No. 19, I had read. No. 20, I had read. 10 No. 21, I had read before. No. 22, I had not read 11 before. No. 23, I had not read before. No. 24, I 12 had not read the entire article. I read the 13 abstract. No. 25, same thing; only the abstract, 14 not the entire article. No. 26, I had read. No. 15 27, I had read. 28, I had read. 29 and 30, I had 16 not read. And we're speaking in terms of a time 17 reference from when I was actually retained? 18 Q Yes. 19 A No. 31, I had read. No. 32, I had read. 20 No. 33, I had read. No. 34, I believe I had read 21 that, actually, when I was in San Francisco. I had 22 read that previously. No. 35, I had not read. And 23 No. 36, I had not read. And No. 37, I had read. 24 Q So, it's fair to say that the materials on 25 this list that you had not read at the time that you
Page 82 1 consistent with how the informed consent process 2 works for other types of surgeries? 3 A Barring those two significant items, yes, 4 sir. That are relevant and germane to this type of 5 surgery, depending upon which -- I mean, if we're 6 talking about forehead remodeling, that's different 7 than hysterectomy, obviously, with that 8 understanding, yes, sir. 9 Q So I want to turn back to your -- your 10 declaration and I want to go through the sources 11 cited there. 12 A Yes, sir. 13 Q So, that's the fourth or fifth to last 14 page. And to the best of your ability, I'd like you 15 to go through the list and tell me which of these 16 sources you had read before agreeing to be an expert 17 in this case. 18 A I will do this to the best of my ability. 19 No. 1, I have read. No. 2, I have read. No. 3, I 20 have read. I don't think No. 4 that I had read. I 21 don't believe I read that prior. No. 5, I have 22 read. No. 6, I believe I read. No. 7, I had not 23 read. No. 8, I had not read. No. 9, I had not read 24 in detail. I had read the abstract but not the 25 study itself. No. 10, I believe I had read. The	Page 84 1 agreed to be an expert didn't play any role in your 2 views regarding the medical necessity of 3 transition-related surgery at that time? So finding 4 what was in your head when you had an opinion 5 regarding transition-related surgery, when you 6 agreed to be an expert -- let me try to rephrase 7 that one more time. Okay? Trying to find the 8 foundation of your opinion at the moment in time 9 when you agreed to be an expert. So, just 10 logically, material that you had not yet read -- 11 A Correct. 12 Q -- could not have formed the basis of your 13 opinion? 14 A Yes, sir. 15 Q Could you say the answer again just for 16 the -- 17 A Yes, sir. 18 Q Okay. All right. So, in the course of 19 performing research in your capacity as an expert 20 for this case, you had already formed an opinion and 21 you then conducted research to find further support 22 for that opinion, is that right? 23 A I just conduct research to verify whether 24 my concern is valid or not. Some of these things, 25 actually, as testimony to the continuing evolution

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Page 85 1 of this topic, only emerged after -- and even this 2 month, July's Clinics in Plastic Surgery, guest 3 edited by Dr. Schechter, those things have only 4 emerged after this deposition begun. And some of 5 those things are not contradictory to my concerns. 6 Dr. Bill Kuzon, the director of the transgender 7 program at Michigan, expressed the same concern that 8 I have. And that is, as he said, and is quoted in 9 Plastic Surgery News, this is the only surgery that 10 I operate on someone for which I really have no 11 diagnosis. And he cautions and, rightly so, that we 12 dare not offer this surgery to anyone without a 13 formal perioperative psychiatric or psychological 14 assessment. 15 Q Which is what the WPATH standards require, 16 isn't that right? 17 A That's what they state, correct. But even 18 with that requisite, he still, very candidly, notes 19 that this really -- in my practice, which is vast 20 and varied, to be sure, this is the only patient 21 population that I operate on. And some surgeons are 22 going to be comfortable with that and some are not. 23 MR. JOHNSON: For the record, that's his 24 statement or yours? 25 THE WITNESS: That's his statement.	Page 87 1 for literature that demonstrated benefit for 2 transgender people who had had surgery? 3 A Yes, sir. 4 Q So you affirmatively sought to find the 5 literature that gave the strongest support in favor 6 of surgery? 7 A Yes, sir. I mean, please understand, 8 whatever perceptions may be, I don't have an agenda, 9 I want to help these people. And if I can find 10 something that supports helping them with surgery, 11 and like I said earlier, in a sustained tangibly 12 demonstrable way, well, then I need to call CMDA and 13 say, Hey, we can help these people. Let's take a 14 look at this. CMDA hasn't retained me, but to the 15 point that I was questioned earlier about their 16 statements which, again, I had not seen this until 17 today, that's our job as surgeons and physicians; is 18 to be fact finders. Let the facts fall where they 19 may. We have to do what's best for our patient and 20 be confident in our mind and that's to your point 21 earlier, Josh, surgeons may arrive at different 22 conclusions based on the same data or experience. 23 Q So, I just want to talk about the research 24 you did in your capacity as an expert. And I want 25 to know whether, in your capacity as an expert,
Page 86 1 Q (By Mr. Block) He said that some surgeons 2 will be comfortable with it and other 3 surgeons won't? 4 A No, that's my statement. My apologies. 5 Q And so -- and, yet, this doctor in 6 Michigan does not draw the conclusion that these 7 surgeries are therefore not medically necessary and 8 should not be covered by insurance, isn't that 9 right? 10 A I don't know what his conclusion is about 11 the medical necessity or the insurance part of it. 12 He obviously has no objection, personally, to 13 executing a surgery for a patient when he doesn't 14 have a diagnosis, based on -- based on his 15 statement. 16 Q He does or he does not have an objection 17 to providing surgery without a diagnosis? 18 A He does not appear to have an objection to 19 that based on the fact that he does perform -- and I 20 would say Dr. Schechter may know Dr. Kuzon personally 21 and the quality of his technique, but I can't 22 imagine, at Michigan, that he could chair and lead a 23 department if he were not a skillful surgeon. 24 Q When you were conducting research in your 25 capacity as an expert, did you affirmatively search	Page 88 1 you -- like, did you view your role there as doing a 2 comprehensive review of the literature and finding 3 the strongest evidence that supported surgery or -- 4 well, I'll let it at that. Did you view that as 5 what your role is? 6 A I don't know that my review is 7 comprehensive, but I certainly tried, yes, sir. And 8 the thing that I could find was subjective sensation 9 of improvement. And which, as some of these 10 resources that I cite note, there's really no good 11 scale specific for trans patients. And that's a 12 problem right now in terms of being able to qualify 13 the data, is what is our measurement. Are we using 14 centimeters? Are we using English? What are we 15 even using? None of us even know at this point. 16 Q But your view of the data indicates that 17 it does report a subjective sensation of 18 improvement, isn't that right? 19 A Many studies do, yes, sir. 20 Q Now, what have you -- 21 A I define no difference, though, in the 22 2016 CMS review that said, really, the quality of 23 data overall is low. And that's why we're leaving 24 this open for interpretation, is because we really 25 can't find any great data that supports this

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Page 89 1 surgery, which is really unique and unprecedented in 2 other fields. 3 Q So what's your understanding of how the 4 success of other psychological treatments for 5 psychological conditions is measured? 6 A Boy, Josh, that's a -- that's a pretty 7 broad question and, not being a psychiatrist, I 8 can't really comment on it. All I can comment is, 9 within my discipline, where what I'm offering 10 somebody that bears considerable risk and, from my 11 world of microsurgery, that procedures we're talking 12 about do, then I really need to see strong data that 13 that would help a person. I can't speak to the 14 psychiatric element of it. 15 Q Okay. So, you can speak to how measuring 16 outcomes for surgery for gender dysphoria compares 17 to how outcomes are measured for other types of 18 surgeries, but you can't speak to how those measures 19 of outcomes compare to measurements of outcomes for 20 other conditions in the field of psychiatry, is that 21 right? 22 MR. BLOCK: Can you read that back? 23 (The requested portion of the record read back.) 24 MR. BLOCK: I'll just reword it. Thank 25 you for reading it back and demonstrating how bad	Page 91 1 Q But when it comes to treating psychiatric 2 conditions -- 3 A Correct. 4 Q -- you don't have any knowledge of whether 5 the efficacy of those treatments are measured on the 6 basis of a subjective sense of improvement, do you? 7 A I don't follow the psychiatric literature 8 otherwise. And I don't know of any other realm 9 within psychiatry where psychiatric disorders have 10 any overlap in their treatment with surgical 11 conditions. 12 Q So, understanding that, unlike many other 13 psychological psychiatric treatments, this treatment 14 is provided through surgery, I want to just focus on 15 how the field of psychiatry measures outcomes and 16 improvements. And you have no basis for offering an 17 opinion on whether the measurements being used for 18 gender dysphoria differ than the measurements being 19 used to judge improvement for other psychiatric 20 conditions? 21 A I'd have to see what conditions we're 22 talking about to determine whether I consider that a 23 valid measurement or not. 24 Q All right. So, sitting here today, you 25 have no basis to offer an opinion on that?
Page 90 1 it was. 2 Q (By Mr. Block) So, you know, you have no 3 basis for opining on how the field of psychiatry 4 measures outcomes for treatment of psychiatric 5 conditions, is that right? 6 A Any more than my medical background. I 7 would not consider myself expert in that. 8 Q And gender dysphoria is a psychiatric 9 condition, is that right? 10 A Gender dysphoria is, if it is a 11 psychiatric condition, then it is -- I think that 12 goes back to the definition of which playing field 13 are we on? Because, if it's a psychiatric 14 condition, we're referring to people in the true 15 sense as male or female and even in the medical 16 record, but we've even removed the term "disorder" 17 and listed it as simply "dysphoria." And I think 18 that's a disservice, because the experience that I 19 have with these patients, they do not -- it's not 20 just simply a sense of intense unease. There's true 21 distress. 22 Q So, just to clarify, you don't know 23 whether gender dysphoria is a psychiatric condition? 24 A I believe it is. And that's why I have 25 grave reservation about offering surgery for it.	Page 92 1 A I won't speculate on speculation. I would 2 have to see objective evidence or fact or 3 preexisting, well-defined psychiatric disorder and 4 how that's measured and what we're talking about 5 before I could be able to comment specifically. 6 Q Okay. So, the -- so, the testimony that 7 you have provided, you know, is not testimony that 8 opines on whether the proof being offered for the 9 efficacy of treating gender dysphoria with surgery 10 is any better or worse than the proof being offered 11 for how other psychiatric conditions are treated? 12 A Can you say that one more time? 13 Q Yeah. So, you expressed concern that 14 there's -- there's no tangible result that you can 15 see with your own hands to measure whether gender 16 dysphoria is treated through surgery, is that right? 17 A I expressed concern that there is no 18 well-documented well adhered to by WPATH or any 19 other organization, to my knowledge, standard by 20 which we, as a medical community, are measuring 21 these patients. 22 Q Okay. 23 A That's my -- 24 Q I want to focus on, you know, one 25 component of the opinion, which is that the

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Page 93 1 improvement is being measured by subjective 2 descriptions of improvement from the patients, is 3 that right? 4 A I think, Josh, if we're going to measure 5 subjective descriptions, we have to be able to tie 6 them to benefit, real benefit, to a patient. I 7 mean, you can come in and see me with a raging 8 abscess in your axilla, your armpit, that hurts 9 badly. And I can give you a steroid shot and you 10 can subjectively walk out and feel better, but I 11 haven't fixed the problem. And so, you can report 12 on a patient outcome questionnaire and you can get 13 online and go on and say, Dr. Sutphin is the bee's 14 knees. I went in, I feel better, I'm better, but I 15 don't -- I repeat, again, I don't know of any well 16 ascribed to standard by which we are measuring these 17 patients over a time, subjectively or otherwise. 18 Q How do you think -- when someone is 19 treated for depression, how do you think improvement 20 is measured by the psychiatric community? 21 A I would defer to the psychiatrists to -- I 22 don't know what the standard of care is for 23 subjective measurement in that regard. I don't know 24 that. 25 Q For all you know, it could be exactly the	Page 95 1 you have a basis for making that determination? 2 A I can make my own determinations 3 independently, but even the APA, there was 4 disagreement about that in 2012 when they shifted 5 their position from disorder to dysphoria. It's a 6 valid question. Because if somebody has a true 7 disorder, that's a different thing than dysphoria. 8 Dysphoria is a normal part of the human experience, 9 as we discussed earlier. I mean, that's part of our 10 life's experience. If we can still follow the 11 common English definitions of disorder and dysphoria 12 as Merriam Webster defines them. 13 Q You said depression is also part of the 14 normal human condition in life experiences, isn't 15 that right? 16 A Correct. 17 Q And, yet, the psychiatric community has 18 treatments for depression, isn't that right? 19 A I believe, yes, sir. 20 Q And -- 21 A How efficacious those are are open to 22 speculation. 23 Q How efficacious the treatments for 24 depression are are open to speculation? 25 A Yes, sir. And, again, the psychiatrists
Page 94 1 same as the standard for gender dysphoria? 2 A I don't believe that to be the case, based 3 on the subjective measures that I answered in the 4 literature that I've read, but it could be. 5 Q So when you talk about comparing risks for 6 rewards and benefits, since you're not a 7 psychiatrist, how can you quantify the value of 8 having improvements to the patient's mental health 9 and subjective sense of well-being, after undergoing 10 SRS? Who can you value that when comparing the 11 benefits with the risks? 12 A By observation. I have to form, as is 13 every surgeon, an opinion. And we're talking one 14 thing and saying another. We're saying that these 15 patients are not impaired but yet they are. So this 16 is a person who comes with a condition that is 17 distressing to the point that they want, in many 18 cases, an otherwise normal healthy part of their 19 body removed, amputated, or they need castration, 20 seek castration, I guess we have to define, first is 21 that well? Is that a well state? Because before I 22 could begin to qualify whether I think the risks of 23 complications are justified, we have to first come 24 to an agreement is that well or not. 25 Q As someone who is not a psychiatrist, do	Page 96 1 would be better qualified to comment on that. 2 Q Is alleviating mental distress a valid 3 goal of treatment, in your view? 4 A Absolutely. 5 Q So, if the evidence showed that surgery 6 for gender dysphoria was successful in alleviating a 7 patient's mental distress, why isn't that a 8 sufficient benefit to justify the surgery? 9 A Well, like we were talking earlier, what 10 is the cost? I'm not talking financially, either. 11 I'm speaking physiologically, what is the cost to 12 the patient? 13 Q Right. Well, is the cost -- do you think 14 the benefit of alleviating mental distress can ever 15 be a sufficient benefit to outweigh the cost in 16 providing a surgery for any condition? 17 A Potentially, yes. 18 Q Like what? 19 A I can't think of any other off the top of 20 my head. I don't know of any other condition where 21 we would operate to alleviate distress. 22 Q So sitting here, it seems that you're very 23 knowledgeable about, you know, how the physical 24 costs and benefits of a surgery operate, but you 25 don't have a significant knowledge base on how to

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Page 97 1 measure the psychiatric benefits of the surgery, is 2 that a fair statement? 3 A Which surgery we speaking of? 4 Q About SRS. You don't have a knowledge 5 base that allows you to -- to -- 6 A That's part of my concern. And it may be 7 that my knowledge base is deficient, but based on 8 what I can gather, and the evidence right now of 9 some of my colleagues at tertiary centers like 10 Dr. Hazen are that we don't have any good measures 11 of this right now. We've got to do a better job of 12 forming measurements for subjective success. We 13 don't even have any measures on how to counsel 14 patients. Let's say a female patient comes to me 15 and says, Well, I've done due diligence. I've 16 honored the WPATH guidelines. I've been through the 17 process. I've been on hormone therapy. I've lived 18 in a separate role for a year. I've done these 19 things and now I'd like metoidioplasty or 20 phalloplasty. Dr. Hazen points out, Well, you know 21 what? We don't even really have good data about how 22 to cancel those. And that is just one very specific 23 segment of this patient population. Very specific. 24 Q Is it possible that the amount of data we 25 have is, nevertheless, the same as the amount of	Page 99 1 as happened not that long ago, who they believe was 2 an absolutely great candidate for an immediate 3 breast reconstruction. The patient was -- had some 4 factors in their profile that, to my mind's eye, 5 made them not a good candidate and the patient was 6 not happy about it. She said, Can I get this 7 somewhere else? You may well and I'd be happy to 8 provide you a second opinion and referral, if you'd 9 like. The patient returned after having a 10 mastectomy and unfortunately experienced some 11 problems. And said, You know, thank you for being 12 straight up with me. 13 Q Do you know if insurance covered the 14 mastectomy that she had? 15 A Yes, she had breast cancer. 16 Q Going back to my previous question, the 17 question isn't whether surgery should be performed. 18 I'm focusing on assessing the mental health benefit 19 side of the scale. And my question is whether a 20 psychiatrist with experience treating gender 21 dysphoria would be better equipped than you to weigh 22 the mental health benefits of the procedure. 23 A May I ask a question? And this is 24 sincere. Are we speaking about me in a personal 25 sense or me as a surgeon? Is this individual
Page 98 1 data we have for treating other psychiatric 2 conditions? 3 A I don't know about other psychiatric 4 conditions, Josh. I've had to focus within the 5 realm of my -- those things touch. When I see 6 patients who come to me for various issues, I can't 7 exclude that inorganic element of their existence 8 nor do I seek to in this case. 9 Q So a psychiatrist with experience treating 10 gender dysphoria would be better qualified than you 11 to weigh the mental health benefits of SRS? Would 12 that be a fair statement? 13 A Their opinion would be important, so 14 long -- unless the psychiatrist wants to pick up the 15 knife and incur the responsibility for the 16 complications. It's a team approach. 17 Q Yeah, I'm discussing -- 18 A But I'm not operating in a vacuum. 19 That's, in essence, what I think is a danger and, 20 yes, as we brought these to the table, as these 21 state, we still have an obligation to speak about 22 complications, but we don't operate in vacuums. We 23 have to be able to form an opinion about whether 24 we're doing, irrespective of what anybody else -- I 25 mean, a referring physician may send me a patient,	Page 100 1 specific? 2 Q Individual specific. 3 A Depends on the psychiatrist. I would have 4 to form my opinion about who that individual is and 5 what their qualifications and what the testimony of 6 their practice is. 7 Q So if a clinician has worked with hundreds 8 of patients who were suicidal before having surgery 9 and then, after having surgery, reported no longer 10 being suicidal and having their severe distress be 11 resolved, is that relevant information to consider 12 in determining whether or not the surgeries are 13 valid medical treatments? 14 A Yes, sir. 15 Q And have you had any firsthand, you know, 16 interactions with patients who were in the midst of 17 being gender dysphoric? 18 A Yes, I have. 19 Q What interactions? 20 A Perioperative assessment for candidacy for 21 mastectomy, actually. 22 Q I thought that you hadn't played any role 23 in treating patients, you know -- 24 A I didn't perform her surgery. 25 Q Okay. So what did you do?

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Page 101 1 A I just assessed the patient. She was in 2 the clinic and presented to talk about the 3 complications of mastectomy. I was serving as a 4 fellow staffing a clinic for residents. So I come 5 in with the resident and I talk to her, just as I 6 would any other woman, about what the risks of 7 mastectomy are. I can't say what guidelines she had 8 been through or followed at that point. It was a 9 county hospital facility serving an indigent 10 population, so I couldn't tell you that any more 11 than the case in question, that she had gone through 12 a thorough vetting such as this, but I was off the 13 service. I don't know whether she ever had her 14 surgery. It was a consultation and I felt like we 15 had a good exchange. But yes, sir. 16 Q How many other consultations have you 17 provided over the course of your career with gender 18 dysphoria? 19 A No more than 25. I don't know a specific 20 number, Josh, but it's no more than 25. 21 Q Would you think that a clinician trained 22 in psychiatry would be better equipped than you to 23 measure whether someone's psychiatric distress was 24 resolved or alleviated through surgery? 25 A Perhaps. It's possible. It's possible.	Page 103 1 to get them marked as exhibits. 2 (Deposition Exhibits 13 and 14 marked.) 3 Q So having marked as 13 the Newsweek 4 website and marked as 14 the BBC website, could you 5 take a quick look and confirm that those are stories 6 you were citing to? 7 A Yes, sir. Okay. So that's the BBC, yes, 8 sir, I think that's the article that I read. Yes, 9 sir. These are the articles. 10 Q So, how did you come across these 11 articles? 12 A Just Googling. 13 Q Just Googling? 14 A Yes, sir. And to your point earlier, 15 Josh, I mean, really trying to look at this, the 16 internet is not a source of Christian thought by 17 default in any way, form, or fashion. And so, to 18 candidly assess this, I need to look at everything 19 and that's, quite honestly, I mean, like I cite 20 here, these news sources are not in any way, form, 21 or fashion Christian affiliated. And so to really 22 look at this from a candid perspective of those who 23 may have gone through this, what actually happens, 24 this is something that's pretty quiet and it's -- 25 yes, those are the sites.
Page 102 1 May I ask it on the basis of specialty or numbers of 2 experiences? 3 Q Well, both. Or either. How about on the 4 basis of specialty? 5 A Possibly. 6 Q And how about on the basis of numbers? 7 A Possibly as well. 8 Q And someone who had the training and the 9 numbers has an even greater possibility of being 10 better equipped to measure? 11 A I think there's value to both. 12 (Break Taken.) 13 Q Let's go to your -- we're back on the 14 record. Let's go to your declaration or your report 15 again. So if you can turn to Paragraph 22. 16 A Yes, sir. 17 Q You say, Point of regret in vacillation 18 regarding the surgical outcome of sex reassignment 19 surgery, as expressed by patients who have undergone 20 such surgery, has also even been described in media 21 outlets, such as Newsweek, the BBC, and 22 LGBTQnation.com and then for citations, you cite, in 23 your references, to 13, 14, and 35. 24 A Yes, sir. 25 Q If we look to Reference 13 and 14, I want	Page 104 1 Q What Google terms did you use? 2 A I honestly don't recall. 3 Q For the BBC article, you know, it's dated 4 August 1st, 2007. Isn't that right? 5 A I'd have to check. Yes, sir. 6 Q And if you look at this Newsweek article, 7 if you turn to the second page. 8 A Yes, sir. 9 Q It's repeating quotes that were given to a 10 British publication called The Telegraph, isn't that 11 right? 12 A The quotes by Dr. Djordjevic? 13 Q Yeah. 14 A It appears to be what they cite, yes, sir. 15 Q And then it sites to a BBC documentary on 16 the next page? 17 A Okay. 18 Q So -- and both articles discuss that 19 documentary and a person named Charles Kane, is that 20 right? 21 A He appears in both, that's correct. 22 Q So it doesn't seem to me to be a 23 representative sample of what, you know, you would 24 find on Google in America in 2018, Googling about 25 the condition, so I'm wondering if there's any

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Page 105 1 other, you know, qualifier or search term that led 2 you to, you know, these articles in particular. 3 A The only term I can think of is regret; is 4 there any regret? That's a valid question. If 5 we're changing a person's body irreversibly, any 6 candid mind is going to say, well, how many people 7 actually regret this? 8 Q Did you read the published peer-reviewed 9 literature on rates of regret? 10 A Yes, sir. 11 Q Why didn't you cite to that in your 12 report? 13 A The rate of regret, actually, is 14 relatively low. And that goes all the way back to 15 Dr. Meyer's study, which Dr. Schecter, I noticed, 16 said is outdated. That study, back in 1979, 17 actually commented on that. They really didn't find 18 that much regret amongst their patients. My purpose 19 was not to -- my purpose was to find out is there 20 regret, not necessarily that it's a small 21 proportion. I just want to read the experience of 22 those who may have had regret, because they should 23 have a voice. Now, they may be a very small 24 proportion, very small proportion, but one of the 25 severe limitations of this population is the	Page 107 1 would be the published peer-reviewed medical 2 literature instead of like articles found on Google. 3 A Oh, I agree. The problem, again, is the 4 lack of literature on this patient population. I 5 can tell you in this month's Plastics it appears to 6 me that one section entitled penile prosthesis has 7 been lifted from a transgender web page that was 8 first put up in 2013. And that's in a medical -- 9 that's supposed to be the so-called gold standard of 10 literature by which we're basing -- now, it may be 11 good information. I don't think that it comes from 12 the internet, ergo, it's patently wrong or invalid 13 is a legitimate statement, but -- 14 Q But wouldn't it be relevant in your report 15 to have acknowledged the rates of regret are 16 reported to be low? 17 A I don't know that it would be. This -- 18 what happens -- it's immaterial if the rate of 19 regret is low. For those who do have regret, what 20 do we then do? And do they exist? If we're talking 21 about a minority population and we're looking 22 critically at the whole gamut of the population, I 23 think it's a valid question. 24 Q But, your report is designed to talk 25 about, you know, the medical necessity of providing
Page 106 1 followup. I don't want to state things that you 2 already know. But followup is an issue. And when 3 you have occasions like that, such as Bath Spa 4 University, where we won't even allow a study to be 5 conducted to look at those patients who express 6 regret and go through with reversal of the surgery, 7 it's difficult to reference well-defined literature 8 because it's not even being given an opportunity to 9 be formed in academia. 10 Q But there is literature, aside from this 11 incident in the UK, there is published literature on 12 regret, right? 13 A There's literature that looks, to my 14 knowledge, at regret as an incidence and it is 15 generally low. 16 Q Wouldn't that be something to acknowledge 17 if the report was designed to have a evenhanded 18 assessment of the medical necessity of the care? 19 A Not in the sense of looking at 20 complications of it. 21 Q Well, your report has a paragraph talking 22 about regret. 23 A Correct. 24 Q And it would seem to me that a more 25 reliable source to cite regarding rates of regret	Page 108 1 this care in general and to the extent that regret 2 is talked about at all, it seems to me to be a 3 relevant fact when formulating, you know, policies 4 about whether procedure should or should not be 5 covered to acknowledge the rate of regret is low. 6 Do you disagree with that? 7 A If there's long-term followup data and 8 there's not, in many cases. 9 Q So you don't think that those studies 10 should even be, you know, cited to or in your 11 report? 12 A I would be happy to cite any study that 13 anyone wants to produce that cites that. Part of 14 the job of a surgeon, Josh, is to look critically at 15 the whole spectrum. And if we're going to talk 16 about why we shouldn't do a surgery, well, what are 17 the valid concerns? I don't, in any way, state or 18 imply that that's a large patient population. I 19 just say that these are -- this does happen. This 20 does occur. How often, I don't know. And one -- I 21 think one of the articles actually states that very 22 clearly. It comes of something as a surprise to 23 learn the medical profession does not yet know the 24 answer to this question. 25 MR. JOHNSON: For the record, reading from

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Page 109 1 Exhibit 13 -- 2 A My apologies. I'm actually reading, I 3 think -- yes, if these are both considered Exhibit 4 13, this is the BBC article, Exhibit 14, my 5 apologies. 6 Q (By Mr. Block) Is the fact that some 7 people regret the procedure a reason to deny the 8 procedure to everyone when the majority of people 9 don't regret it? 10 A No, no, Josh. The thing, though, is that 11 person's a real human being. Now, what do we do for 12 them? And to be a competent surgeon, we, as 13 surgeons, have to deal with this frequently. Other 14 colleagues that might delve into areas of treatment 15 that they really don't know how to manage the 16 complications for. So any -- any competent and 17 ethical, I would argue, surgeon is going to look at, 18 okay, what happens if and when things don't go like 19 we'd hoped, either physically or psychiatrically? 20 What happens when these people -- we don't even have 21 the answer of questions of how do we determine 22 whether this is a valid -- if the patient wants to 23 go detransition, what do we then do? How do we 24 assess them? There's no literature in the 25 psychiatry world that I'm aware of that states	Page 111 1 for everyone. It may work for many people but 2 regret does exist. 3 Q And do you think that the WPATH standards 4 of care say it's a panacea for everyone? 5 A Immaterial what they say. I respect the 6 WPATH, but I still have to function independently. 7 Q But you're rebutting this idea that it's a 8 panacea for everyone. And I'm asking whether the 9 proposal to provide coverage in accordance with the 10 WPATH standards of care means that it's a panacea 11 for everyone. 12 A I don't see anything in this document that 13 says it's a panacea nor do I see anything in this 14 document that says here's what we do when we find a 15 patient, here's what options we give our patients if 16 they express regret. I may have missed that, Josh, 17 but they don't exist. 18 Q This seems like an issue that you're 19 concerned about that isn't particularly germane to 20 the question of whether or not providing care to 21 patients who are diagnosed with gender dysphoria and 22 meet the WPATH standards of care should be provided 23 that surgery. It seems you're answering a separate 24 question about what should happen to a separate 25 group of patients who, you know, regret surgery.
Page 110 1 here's how we take these people through this 2 protocol. 3 Q Isn't that exactly what, you know, the 4 article by Dr. Jvorvicich is describing, is about? 5 A Where are you reading? 6 Q Sorry. On -- 7 A No, he's just observing the fact that, 8 hey, I'm seeing people who are coming back and they 9 can't get this anywhere else. And just FYI, this is 10 happening. Let's talk about this kind of thing. 11 Q And he suggests, you know, areas for study 12 for indicating what is -- what's more likely to lead 13 to regret, doesn't he? 14 A Yes, he makes -- he basically raises the 15 flag and says, hey, we need to look at this. And 16 this points, again, to my concern and my objection 17 is that to call this -- to speak about this like 18 it's well studied and to liken it to something like 19 an appendectomy is not really a valid -- there's 20 still many, many areas of this realm of care that 21 not just in surgery, but other elements of care that 22 just don't seem to be thought out to this point or 23 defined to this point. Not that they shouldn't be. 24 I would argue they should be. But at this juncture 25 and this statement I am saying this is not a panacea	Page 112 1 A Well, there's no way for us to have a 2 crystal ball to know, Josh. And when part of my 3 job, as a surgeon, when somebody comes to me about 4 any surgery, is to know to the best of my ability 5 every potential scenario and what happens in the 6 unlikely event that you develop a DVT, thank God 7 that's a low complication with XYZ surgery, what 8 happens, Dr. Sutphin, if that occurs? What happens 9 if I get a seroma? And what if I just have a breast 10 reduction surgery and I regret it? 11 Q Is that a reason, though, the fact that a 12 small percentage of people regret a surgery, is that 13 a reason to deny providing the surgery to everyone 14 else? 15 A I don't think that I posit it as such. 16 Q So does that mean no? 17 A No, no, it's just something that needs to 18 be acknowledged, I think. And I, in no way 19 intention, form or fashion, I don't believe I 20 indicate that in that statement. I just raise the 21 issue that this does exist because I haven't seen it 22 in the complaint. 23 Q Do you have any reason to quarrel with the 24 regret statistics that were cited in Dr. Schecter's 25 rebuttal report?

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Page 113 1 A Do you all have a copy of that with you 2 before I say yes or no? May I just review, please? 3 Q Yeah, sure. Well, let's mark it Exhibit 4 15; the rebuttal report of Dr. Schechter. 5 (Deposition Exhibit 15 marked.) 6 Q I believe his -- on Page 7 at the bottom, 7 he doesn't have the numbers, but in the last 8 sentence of that paragraph he says, All available 9 research indicates that reports of regret are 10 extremely low when gender confirming surgery is 11 provided in accordance with the WPATH standards. Do 12 you have any reason to dispute that? 13 A I haven't read -- it appears he cites the 14 Amsterdam cohort of gender dysphoria. And that's a 15 report, not plural reports, so I would have to read 16 the report, but I would -- 17 Q You haven't read anything to indicate that 18 regrets for people provided surgery in accordance 19 with the WPATH standards are not extremely low? 20 A No, sir. No, sir. 21 Q And, you know, at the time that you wrote 22 your report, did you have any understanding of 23 whether or not the patients discussed in the 24 Dr. Djordjevic article had been prescribed surgery 25 in accordance with the WPATH standards?	Page 115 1 discussing the study who regretted their surgeries 2 necessarily had their surgeries performed by a 3 competent surgeon in accordance with the WPATH 4 standards? 5 A Correct. Absolutely. I would have to 6 look at that paper again, Josh, to remember 7 specifically whether all of those patients had 8 been -- I think they came from geographically 9 diverse areas in Europe. I don't remember if there 10 was an American in that study or not. But you're 11 absolutely right. It's impossible to say whether 12 those surgeons were operating in accordance with the 13 standards now ascribed by WPATH or whether those 14 were even competent surgeons. It's difficult to say 15 given the nature of their surgeries. Most surgeons 16 will not, I don't believe, undertake a so-called 17 bottom surgery without having had some technical 18 training and knowhow. But that's speculation. 19 Q So, this article by Dr. Djordjevic has 20 nothing to say, one way or another, about rates of 21 regret among people who have had surgery in 22 accordance with the WPATH standards, is that right? 23 A No, no. I don't think that was the intent 24 of his article. And certainly not -- not the intent 25 of my -- you know, like I tell patients that I see,
Page 114 1 A Josh, looking -- I don't know 2 Dr. Djordjevic, his -- but I know, based on his 3 presence and the scope of his practice, I would 4 presume that he is a competent and technically safe 5 surgeon and to the same principles that we've been 6 talking about, he's not just going to operate on 7 anyone. Now, the WPATH standards are a body 8 constantly in evolution, so as the study 9 Dr. Schechter alludes to, the vast majority of that 10 study was conducted, a significant component, based 11 on the dates, 1975 through -- 1972, excuse me, 12 through 2015, I haven't been able to read and see 13 what is their followup rate. Did they get a 14 catchment of 50 percent of patients? Did even half 15 the people follow up? That's another problem in 16 reviewing this patient population; whether that 17 followup was due to suicide. Conversely, they could 18 have been so thrilled with their result they never 19 came back again. It's hard to know. 20 Q I'm just talking about the Dr. Djordjevic 21 study, is it your understanding he was the one that 22 performed the original surgeries for these patients? 23 A No, sir. 24 Q So the fact that he's a competent surgeon 25 in performing surgery doesn't mean the patients	Page 116 1 if the complication rate of flat necrosis is one 2 percent and I operate 100 people, it doesn't matter 3 to those -- that patient what happened with the 4 other 99. They've had a complication. And it 5 matters profoundly to them. And I need to know, as 6 a surgeon, how do I safely take them through that 7 process? Both the clinical and psychiatric element 8 of disappointment, discouragement, depression, how 9 do I help that patient through? And am I qualified 10 to do so by myself or do I need additional help to 11 do so? 12 Q And those concerns apply to all sorts of 13 surgery, is that right? 14 A Yes, sir. 15 Q Those concerns aren't unique to surgery 16 for gender dysphoria? 17 A No, sir. 18 MR. JOHNSON: Going to another area or can 19 we take a break for lunch? 20 MR. BLOCK: Just want to ask a few 21 questions about the things cited in the -- 22 MR. JOHNSON: Sure. 23 Q (By Mr. Block) So, in Paragraph 25 of your 24 report, you reference a Dr. Charles Ihlenfeld, is 25 that right?

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Page 117 1 A Yes, sir. 2 Q Okay. How did you become aware of 3 Dr. Charles Ihlenfeld? 4 A I don't know. I presume through Googling 5 and researching. Dr. Benjamin's life was very 6 fascinating to me, Harry Benjamin, and I think 7 that's honestly how I first -- I thought, I wonder 8 whatever happened to that guy? You know, because 9 when you start off a practice and you're kind of 10 paired up with somebody, it's interesting that he 11 started, if I remember it, Ihlenfeld began either in 12 endocrinology or internal medicine, and I can't 13 remember which, and then decided to go into 14 psychiatry. And that kind of resonated with me. 15 What would make you abandon your primary specialty 16 in a quest to figure something out that you're 17 willing to go through the struggle of a whole new 18 training process? Why would you do that? I think 19 that's, you know, the best of my recollection how I 20 first came across Dr. Ihlenfeld. 21 Q Did you read any articles by Walt Heyer? 22 A I've read articles by Heyer, yes. 23 Q Is there any chance that is how you came 24 across Dr. Ihlenfeld? 25 A There's a chance but my -- before ever --	Page 119 1 remember what institution he graduated from, but 2 there was an announcement that he had married 3 whoever the gentleman, Mr. Packard, in 2008. 4 Q So you found that just independently 5 Googling Dr. Ihlenfeld, right? 6 A Yes, sir. And to my recollection, Josh, 7 it's a self-entered caption that, you know, if we go 8 on a Yale or UT site, we can say, Josh Block XYZ, 9 Daniel Sutphin XYZ. I think it was of his own 10 accord based on the presentation of it. 11 Q But do you generally look at the alumni 12 listings of doctors' publications or doctors who 13 publish? 14 A Sure. Absolutely. I want to know where 15 they came from, what are their credentials, where do 16 they train? That's extremely important to me. I 17 mean, there's value to me. It's, you know, it's a 18 privilege to speak with a guy who trained at Yale 19 Law School, you know, that's an accomplishment. So, 20 that's -- you know, I take that very seriously. 21 Q At the last sentence of the paragraph, you 22 say, Despite his caution regarding the limitations 23 of sex reassignment surgery, it's understood that 24 Dr. Ihlenfeld does not harbor, quote, sex 25 stereotypes, discomfort with gender non-conformity,
Page 118 1 to my recollection, I actually came across Mr. Heyer 2 subsequent to reading about Benjamin. 3 Q How did you come across Dr. Heyer? I 4 mean, how did you come across Walt Heyer? 5 A He came up in the regrets Google search, 6 which, obviously, he expresses considerable regret. 7 Q So you read his posts on the public 8 discourse website, is that right? 9 A I don't know. I've read some of his 10 posts, but in an effort to -- given his -- given his 11 experience, and if I understand correctly, he's a 12 Christian, given his experience, I felt it better 13 just to try and look, is there anybody outside -- 14 obviously Heyer feels very strongly. Is there 15 anybody who is not in any way, form, or fashion 16 expressing some of the sentiments that Heyer does, 17 as it relates to his concept of his personal faith, 18 is there anybody else who expresses any concern? 19 Q Is the fact that he, Dr. Ihlenfeld, 20 married a same sex partner, is that information that 21 you learned through Walt Heyer's writings? 22 A No, it is not. 23 Q How did you learn that information? 24 A It was actually a self-described blog, I 25 believe, or it was a alumni type affair that I don't	Page 120 1 and moral disapproval of people who are transgender, 2 close quote. And are you saying the reason why he 3 doesn't is because he is married to a same sex 4 partner? 5 A That's why I said "presumably" and "based 6 on his practice" and the fact that he began his 7 practice with Dr. Benjamin and cared for these 8 patients far more than I have in terms of sheer 9 numbers. That's why I cite that. 10 Q But you agree that the fact that someone 11 is gay doesn't necessarily mean that they might not 12 possess discomfort or moral disapproval with 13 transgender people, right? 14 A Sex stereotypes, discomfort with gender 15 non-conformity. Dr. Ihlenfeld, at the time he 16 married Bill Packard, was engaging in a gender 17 non-conforming relationship. So he's, in one sense, 18 very courageous, and based on the testimony of his 19 professional life, has no moral disapproval. These 20 are all the reasons that people like me are 21 disqualified, by virtue of my Christian faith, is 22 that, well, Daniel can't care about these people and 23 the only reason he won't take care of them is 24 because he's a backwards bigoted so-and-so, rather 25 than, actually, he's really looking critically at

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Page 121 1 the data and trying to determine what's really going 2 on to help these people. It would be very easy to 3 say, sure, let's move forward with the surgery 4 rather than -- rather than taking the time to sit 5 down and work through and do we even have a safe 6 environment to sit down and work through; how did 7 you arrive at this point? 8 Q To your knowledge, has Dr. Ihlenfeld 9 worked with this population since the early 1980s? 10 A That I don't know. 11 Q And is it possible that someone whose 12 experience is based on the state of the art as of 13 the early 1980s might have a view that differs from 14 someone whose experience is based on the state of 15 the art as of today? 16 A Sure. Absolutely. I think, though, what 17 Dr. Ihlenfeld observed is just what I recorded. 18 It's very true. And it resonates with me 19 professionally. Whatever we're doing for these 20 people surgically, we can build a penis on you and 21 we can cut the penis off and make a neo-vagina that, 22 for all intents and purposes, would fool anyone 23 externally, but the core of it, there's something 24 there that is difficult to define. It really is. 25 And I don't know that we're doing a good service to	Page 123 1 well yet and I don't think that we've been able to 2 describe how sustained is that benefit, whether it's 3 an inorganic benefit or whether it's any other form 4 of benefit. 5 Q Do you think that someone who's 6 transgender could, with the benefit of therapy, stop 7 being transgender or have their gender identity 8 aligned with the sex assigned to them at birth? 9 A Possibly. 10 Q On what basis do you believe that's a 11 possibility? 12 A Based on the description of -- I mean, 13 somebody even like Walter Heyer, obviously his -- we 14 could discredit him based on his faith. But he is 15 an individual who has made a number of transitions. 16 I don't know of anybody in the public sphere who's 17 been through more than he has. I could be wrong in 18 that. 19 Q Do you think that insurance should cover 20 therapy designed to help a transgender person align 21 their gender identity with the sex assigned to them 22 at birth? 23 MR. JOHNSON: Object to lack of 24 foundation. 25 Q (By Mr. Block) You can answer.
Page 122 1 people by just saying we now created a structure, 2 move through the structure, and there. 3 Q So what do you think should be provided to 4 people who are experiencing distress from gender 5 dysphoria? 6 A I don't know. I think it begins with a 7 psychiatric assessment. 8 Q And so the answer to the question is 9 something that is in the realm of psychiatry, is 10 that right? 11 A It begins "in the realm of." 12 Q And so, when you say you don't know, why 13 don't you know? 14 A I don't know that anyone does who's 15 candid. 16 Q Is there any form of treatment for people 17 with gender dysphoria that you think is medically 18 justified? 19 A I think that psychiatric consideration and 20 counseling is a starting point. And based on the 21 available data that we have, surgically speaking, I 22 conclude the same thing that I stated earlier. 23 Aside from my own personal faith, I don't see that 24 the risk associated with the surgery justifies the 25 benefit. I don't think we've qualified the benefit	Page 124 1 A I decline. 2 Q Well, no, no -- 3 MR. JOHNSON: I object. I'm lodging an 4 objection for the court to rule on, but unless I 5 say you don't answer, you have to answer. 6 THE WITNESS: All right. 7 Q (By Mr. Block) So, do you think that 8 insurance should cover psychological therapy 9 designed to help a transgender person align their 10 gender identity with the sex assigned to them at 11 birth? 12 A If I may, I want to be very clear, I think 13 the declaration that sex assignment, as it's being 14 used in these guidelines, is a total farce. 15 Q All right. So let's take out the issue of 16 the terminology of sex assigned at birth. Do you 17 think insurance should cover therapy designed to 18 help a transgender person have their gender identity 19 match up with their biological sex? 20 MR. JOHNSON: Same objection. 21 A I don't see any reason why there's not a 22 valid reason for that. 23 Q (By Mr. Block) So you think there's 24 adequate level of proof at this time for that to be 25 covered as a medically necessary service?

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Page 125 1 MR. JOHNSON: Same objection. Lack of 2 foundation. 3 A No, sir. I'd just say that I don't see 4 any reason why there's not. 5 Q (By Mr. Block) Are you aware of -- 6 A Unlike the surgery, I can see that there's 7 a high complication rate, ergo, I say, until we have 8 better data, I don't see a valid reason for us to 9 supporting this surgically. I don't know of any 10 complications, from sitting down and talking with 11 somebody, about how did you arrive at this, I mean, 12 and the patients that I've had the privilege of 13 doing so with, who have been candid about such, just 14 to listen to them, not because I have any agenda, I 15 just want to know, How do you arrive at this point 16 in your life? Tell me about your life. I'm 17 genuinely interested. 18 Q (By Mr. Block) I just want to get, for the 19 record, a clear answer to the question. You don't 20 see any reason why insurance should not cover it, is 21 that right? 22 MR. JOHNSON: Same objection. 23 Q (By Mr. Block) You don't see any reason 24 why insurance should not cover psychological therapy 25 designed to help a transgender person align their	Page 127 1 any reason why insurance should not cover 2 gender-affirming psychological therapy that helps 3 someone socially transition? 4 A I don't know. I don't have enough 5 experience with that element of non-operative -- the 6 non-operative patient population to know. I don't 7 know. I don't see, necessarily, any reason why 8 there's not. The only thing that I don't know is 9 what is the risk for that patient population if they 10 remain in that role that is not aligned with their 11 biological sex. I don't know that. In terms of 12 domestic violence, et cetera, the other variables 13 that have been variously talked about, I don't know. 14 I don't know that anyone does right now well. 15 Q Well, is your -- is your level of 16 confidence on gender-affirming psychological therapy 17 equal to your level of confidence in providing 18 psychological therapy to align someone's gender 19 identity with their biological sex? 20 A One more time. 21 Q We have two types of psychological therapy 22 and we're talking about do you think that either of 23 them should be considered, you know, medically 24 necessary treatment covered by insurance. And Jerry 25 objects to --
Page 126 1 gender identity with their biological sex? 2 MR. JOHNSON: Same objection. 3 A I don't. I think that's -- I don't know 4 of any risk associated with that. 5 Q (By Mr. Block) Are you -- have you read 6 any of the literature on -- on the psychological 7 harms from conversion therapy? 8 A No, sir. I'd certainly be -- whatever 9 literature would like to be put forth, I'd be happy 10 to read through it and suggest whether I think it's 11 valid or not. 12 Q And are you aware if there's any 13 literature demonstrating the efficacy of treatment 14 designed to help the transgender person align their 15 gender identity with their biological sex? 16 A I am not. That's exactly why I said I 17 don't see any reason why there's not a reason for 18 it. I'm not aware of any reason there's not. 19 Q Do you think that insurance should cover 20 psychological therapy designed to help a transgender 21 person live consistently with their gender identity 22 without any medical interventions? 23 MR. JOHNSON: Same objection. 24 A One more time. 25 Q (By Mr. Block) So, do you think there's	Page 128 1 MR. JOHNSON: Can I just have a standing 2 objection any time you ask what he feels should 3 be covered by insurance? Lack of foundation 4 objection. 5 MR. BLOCK: Okay. Perfect. 6 Q (By Mr. Block) So -- and so, and my 7 question is: Do you -- are your feelings or is your 8 medical view about the necessity of those two types 9 of therapies the same or do you think that one of 10 those therapies has a firmer foundation of being 11 medically necessary than the other? 12 A I don't have any evidence to support one 13 over the other. 14 Q Okay. So, just one more question. In 15 Paragraph 33 of your declaration, you cite to a 1997 16 study by Meyer, is that right? 17 A Yes, sir. 18 Q And in Dr. Schecter's report, you read 19 some criticisms that he had about that study, is 20 that right? 21 A Yes, sir. I think perhaps the intent of 22 my allegiance to this study was -- can you tell me 23 what page Dr. Schecter -- 24 Q Yeah, sure. 25 A I don't know that I did a good job of

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Page 129 1 clarifying what my purpose was in leading to that. 2 Q So that is Paragraph 25, Page 8 of 3 Dr. Schecter's rebuttal. 4 A Forgive me, Page -- Section 28? 5 Q Page 8, Paragraph 25. 6 A Okay. 7 Q Well, I'll just read the first -- 8 Dr. Schecter says, Sutphin's citation to a 1979 9 study by John Meyer shows his apparent unfamiliarity 10 with research in this area. The report is extremely 11 outdated by current standards and was even 12 criticized at the time of publication because of 13 serious methodological flaws. In 1980, Fleming, 14 Steinman, and Bachmann published a paper challenging 15 the report's findings citing methodological problems 16 as well as conceptual flaws in research, design, 17 score reporting, interpretation of data, and 18 conclusions. One striking example of the flaws 19 includes the author's assignment of a negative value 20 of minus one to a person who cohabited with a person 21 of, quote, the non-gendered appropriate sex, 22 unquote. Were you aware of these criticisms of the 23 Meyer study at the time that you wrote your report? 24 A No, sir. I was not. And to me, they're 25 not really -- my purpose in alluding to this was	Page 131 1 may both be or they may not be. It's just an 2 interesting observation that they both came to 3 this -- and if the context, if we look at the 4 context of the study that I allude to, it was where 5 I'm talking about time. In Dhejne's study, where, 6 really, that's the most comprehensive study, kudos 7 to her and to her team for that assessment. I mean, 8 I don't know where else in the world, other than 9 Sweden, where we have such registries and we can 10 access that data. 11 Q So, in her study, isn't it true that the 12 outcomes were very different for people who had had 13 surgery over 15 years ago and people who had had 14 surgery within the last 15 years? 15 A There's question about that. And it's 16 hard to say whether it was societal, exogenous from 17 the patient, or whether it's actually, you know, the 18 technical elements of surgery. 19 Q So before we get to the causes, I just 20 want to establish like the underlying data. Isn't 21 it right that for people who had had surgery in the 22 past 15 years, the mortality rates were actually the 23 same as the mortality rates of the population at 24 large? 25 A I'd have to look at that part of the study
Page 130 1 not -- the outcome was that, like we discussed 2 earlier, there was a very low rate of regret. But 3 what they did not see was that something that really 4 helped these individuals move forward in any 5 socioeconomic sense as measured at that time. Now, 6 I understand what Dr. Schecter's saying, but I think 7 if we take ourselves out of the current context, 8 Josh, if you and I are homosexual males in 2018, we 9 may both be highly educated professionals operating 10 in an environment that endorses and supports this. 11 But circa late '70s, when this study is going on, 12 early '70s, that's not going to be conducive to 13 forward mobility, so it would be, in my estimation, 14 a valid -- it's not a statement of judgment. It's a 15 statement of what you guys have worked to accomplish 16 in the ACLU in the last 25 years. So I don't know 17 that we can assign values or a judgment statement to 18 that. But no, sir, I have -- that was not the 19 purpose. That was just casual observation. I 20 wasn't relying on that study to make a case that 21 because John Meyer said in 1979 -- and that's why, 22 ergo, we should do this. It's just -- when we look 23 at data we have to -- just because it's old doesn't 24 necessarily mean it's invalid. And just because 25 it's new doesn't necessarily mean it's valid. They	Page 132 1 again, Josh. I think those patients, one of the 2 things that's interesting about Dhejne's study is 3 that it does provide a perspective over time and 4 certainly, as we get closer to that cutoff window, 5 it's a valid question. Well, maybe -- maybe that's 6 a reflexion of the quality of care, societal change, 7 and/or the fact that we're not capturing those 8 people who more recently had the surgery with the 9 same window of time as those who went for it in the 10 earlier part. Those are all valid considerations, I 11 think. 12 Q Those are all potential hypotheses that 13 could explain the difference? 14 A Yes, sir. 15 Q And if I understand you right, do you 16 believe that, to the extent that negative outcomes 17 with regard to suicidally or other socioeconomic 18 concerns persist after surgery that one potential 19 cause of that could be societal factors of 20 non-acceptance? 21 A Could be. It could be. And I think any 22 of us acknowledge that, but I also think -- you 23 know, the significance of Dhejne's study is the -- 24 to me, the volume and the time and the candor of the 25 department that's doing it. There's -- I can't

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Page 133 1 believe there's any agenda at Karolinska. They're 2 not known for such. But the thing that's interested 3 is Dhejne's conclusion at the end of this study is 4 that very similar to Ihlenfeld's observation years 5 ago and that is, whatever this does, there's still 6 something more than we can get to with a knife. So 7 that's my interest. If I'm going to subject 8 somebody to risk associated with these surgeries, 9 what else is there that we're missing or that we 10 don't have a handle on? Q I mean, do you -- the fact that a particular medical treatment isn't a panacea for everything that could be bothering the patient is not something unique to gender dysphoria, is it? A No, but some of the concerns that we have 16 for these people, like the amplified suicide rate, 17 also, those are unique to gender dysphoria. Q So, if -- A And they could be multifactorial, as we've 20 discussed. It could all just be a reflection of the 21 society's approach to these people, but based on my 22 interaction with the patients that I have interacted 23 with, it's not just societal issue. I've even 24 discussed with patients who have lived outside of 25 our country, and their desired role in gender after	Page 135 1 Q It's entirely possible, under the Swedish 2 study, that a transgender person who has, you know, 3 a likelihood of suicide at, you know, five times the 4 norm of the regular population, would actually have 5 had a likelihood of ten times the regular 6 population -- MR. JOHNSON: Finish your question. Q (By Mr. Block) Would likely have had -- 9 could have had a suicide rate at ten times the 10 regular population without surgery? MR. JOHNSON: I object. Speculation. A I would say that that is -- that is 13 speculation. It's an observation. Q (By Mr. Block) So if the data showed that 15 having surgery dramatically -- I'll take out 16 "dramatically." Start over. If the data showed 17 that having surgery decreased a transgender's 18 person's risk of suicidality, without curing it, 19 would that mean that the treatment shouldn't be 20 provided? A The treatment being any number of the 43 22 surgeries -- Q SRS. A Okay. Let me understand the question. If 25 SRS surgery helps diminish the suicide rate over
Page 134 1 undergoing penile amputation and vaginoplasty and 2 breast augmentation, and living in a married state, 3 how did it work? Tell me about it. Did you find 4 relief? Q Who are these people? A There's one patient that comes to mind. 7 And I don't know in terms of HIPAA what I'm allowed 8 to say or not say. Q Are you allowed to say in what context, 10 like which of your jobs or locations you came into 11 contact with that person? A Correct. Yes, sir. In New Mexico. Q Okay. If -- you agree with me that the 14 Swedish study did not measure the rate of suicide of 15 transgender people who had surgery as compared with 16 the rate of suicide of transgender people who did 17 not have surgery. A Forgive me, one more time. Q So -- A I'm starting to lose my -- Q Does the Swedish study -- you agree with 22 me the Swedish study doesn't measure the impact of 23 having surgery on suicide rates? A Correct. Its purpose is not to study the 25 efficacy of surgery.	Page 136 1 time, I think it would be something that would 2 require, morally, a consideration. Q So even though it doesn't fully resolve 4 whatever is bothering a patient, the fact that it 5 reduces the risk of suicide is still a valid 6 consideration? A Yes, sir. Q Okay. I think we can eat. 9 (Break Taken.) Q Welcome back. Some of these questions 11 we've, you know, covered before, but I want to take 12 another pass at a few of them, hopefully and just 13 condensing the questions and responses. So, what 14 would research need to show to convince you that SRS 15 is medically necessary treatment? A A sustained benefit and reproducible 17 benefit and suicide reduction without the level of 18 risk that's evident in the literature today. I also 19 don't know, again, due to the fact that hormone 20 therapy is requisite before people can get to 21 surgery now, at least if these recommendations are 22 followed, I would need to see prolonged evidence 23 that there's no significant harm that comes to 24 people from use of exogenous hormone therapy. Q So, if a patient is coming to you who is

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Page 137 1 already on hormone therapy and, you know, the 2 question is whether or not surgery is justifiable, 3 you would still want to consider the risk from the 4 hormone therapy in deciding whether or not the 5 surgery is medically justifiable? 6 A I think the two can't offer exclusive of 7 the other. You know, I have to look at the patient 8 as they are, irrespective of my own sentiments, the 9 person is now on hormone therapy and so I have to, 10 just even as a pragmatic question of care, if 11 they're going to have surgery, we need to actually 12 stop these hormones because of your risk of DVT in 13 the perioperative period is markedly increased. I 14 mean, that's even a recommendation in this month's 15 clinics. It has no literature, that I'm aware of, 16 that support the recommendation but that's the 17 sentiment of the authoring surgeon. And that's 18 Clinics in Plastic Surgery, for the record, that can 19 be reviewed by any of us at the table. Again, that 20 was not even published at the time when I submitted 21 my original declarations, but -- 22 Q So, you said -- in answer to my question, 23 you said you would need to see sustained and 24 reproducible benefit in reducing suicide without the 25 current level of risk. Does that mean that even if	Page 139 1 hematoma formation, seroma formation, nipple 2 necrosis, systemic risk of surgery, including DVT, 3 pulmonary embolism, complication related to 4 anesthesia, partial or total mastectomy, flap 5 necrosis, an unfavorable aesthetic outcome, and need 6 for additional surgery. 7 Q So those are all risks that apply to 8 mastectomy for either purpose of gender dysphoria or 9 for any other reason why a cisgender woman would 10 want a mastectomy, correct? 11 A Correct. 12 Q It's not unique to mastectomies performed 13 for transgender men? 14 A Those are risks inherent with that 15 procedure, yes. 16 Q We'd also previously talked about unknowns 17 from the simple fact that you are performing the 18 procedure on someone of a different chromosomal or 19 physical makeup when you're performing breast 20 implants for a trans woman as opposed to breast 21 implants for a cisgender woman. Are those risks 22 also present when it comes to mastectomies for a 23 trans man versus mastectomies for a cisgender woman? 24 A I'm not sure that I'm following. 25 Q Are there any other risks? Does the fact
Page 138 1 the literature did show a sustained and reproducible 2 benefit in suicide, you would still not be convinced 3 that SRS is medically necessary treatment because of 4 the current level of risk that exists? 5 A I think the balance of those two is the 6 art of medicine, SRS surgery or otherwise. That's 7 what we have to, as physicians, really counsel 8 patients and I just don't see that equation at 9 present being reasonable. 10 Q And under the category of level of risk, I 11 want to make sure I'm capturing everything that 12 falls within that category, so that includes 13 complications from the surgery itself, right? 14 A Yes, sir. 15 Q It includes potential, you know, long-term 16 consequences of the surgery itself in terms of 17 mental health? Why don't you tell me a list. Let's 18 do it that way. 19 A Well, which surgery we speaking about? 20 Q Let's talk about -- let's talk about 21 mastectomy for a trans man. 22 A Without any form of further surgery? 23 Q Yes. 24 A Okay. Mastectomy for a trans man, you 25 would like to know the risks of the surgery,	Page 140 1 that this is being performed for the purpose of 2 gender transition create any other long-term 3 unknowns about the safety of it? 4 A Yes, to my estimation. Because the 5 population is so fluid and not particularly well 6 defined and anybody who's expert in this field will 7 tell you, not every trans man has the same -- that's 8 candidly known, has the same desire or need for XYZ 9 surgeries, not every same trans woman. There's 10 tremendous fluidity between the two. And that's one 11 of the more challenging elements to me about care 12 for this; is how do we decide who's actually going 13 to do well with this surgery and, again, at the end 14 of the day is the issue of we're cutting off 15 perfectly healthy sexual organs. Those organs -- 16 we, as a society, assign those organs certain 17 inherent value due to their function, but as I 18 mentioned earlier, for those with body identity and 19 integrity disorder, there's really nothing different 20 about my hand than my testicles at the end of the 21 day, not anatomically not functionally, but in a 22 sense from a surgeon talking about taking off one 23 functional part of the body that is not diseased, I 24 just can't justify that in my mind, Josh, as a valid 25 and sound option.

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Page 141 1 Q So, regardless of what the science shows 2 in terms of benefit and regardless of what the 3 science showed in terms of tangible risks, you don't 4 see any way that it can justify performing surgery 5 to remove healthy tissue? 6 A Well, the problem is, it's speculative. 7 The science doesn't show it. It doesn't. 8 Q Yeah, but, you know, so as an expert, you 9 can engage in speculation, and I'm just want to know 10 if there's any test or if there's any studies that 11 can satisfy your request for proof or not. 12 A That would be -- those would be litmus 13 tests for the same thing we discussed. 14 Q Even after that, even after all those 15 litmus tests were met, you would still have 16 significant concerns about the fact that it's 17 being -- that an operation is being done to remove 18 healthy tissue? 19 A Personally, I would, but that would not 20 preclude, in the case at hand, the approval of 21 insurance companies saying, okay, let's march 22 forward with this, unhindered. Because we see 23 there's good, good evidence to support that. And it 24 would certainly make me question, well, maybe I need 25 to change my practice. I would still have a level	Page 143 1 who practiced the surgery daily, perhaps weekly, may 2 have a differing opinion, but I do not find that 3 personally, no, sir. 4 Q Do you think that doctors who perform SRS 5 right now are violating the standard of care that 6 applies in their field? 7 A I think there is no well-defined standard 8 of care. I think that's why we're having a 9 discussion. If there was an excellent standard of 10 care, I don't think that would be, really, a valid 11 discussion. I think it's something that we need to 12 work on. Because at the end of the day, ultimately 13 Dr. Schecter and Dr. Sutphin, I would presume to say 14 this for him, both have a sincere and genuine 15 interest in the person across from them as their 16 patient. They might have a different opinion about 17 how to go about it, but I don't think there's any 18 standard of care to say. 19 Q And it's not uncommon for doctors to have 20 different opinions about how to best treat a 21 patient, right? 22 A Not uncommon. 23 Q And even when doctors disagree about the 24 best interest for a patient, it's still proper for 25 insurance companies to cover procedures that a
Page 142 1 of discomfort and that's just an honest level of 2 discomfort. I mean, that's just -- gosh. And any 3 of us who are candid and you've got to reach a point 4 and obviously some of us as surgeons are completely 5 satisfied in our mind and to our understanding about 6 what they are about surgically is in the best 7 interest of the patient. I have no disparaging 8 remark for that individual. Within the scope of 9 their practice, they've achieved that station where 10 they feel confident in that. I just don't see that 11 personally myself. So I'd have to clarify if I'm in 12 the role of Daniel David Sutphin, personally, or if 13 we're talking about, as we were earlier alluding to, 14 insurance companies. 15 Q No, that was useful to clarify. Is it 16 your position that, based on the current state of 17 the science, no doctor would be justified in 18 performing SRS to treat gender dysphoria? 19 A I can't see that. I would have to talk to 20 the doctor and find out what their grounds -- I 21 don't see anything in the literature that supports 22 the risk of the surgery to my estimation. 23 Q So -- 24 A Incurring the risks that the patient will 25 go home and live with. Those such as Dr. Schecter,	Page 144 1 doctor determines to be in that patient's best 2 interest, right? 3 MR. JOHNSON: I still have my standing 4 objection. 5 A I think it's something that should be 6 considered and I think that's a statement of the CMS 7 paper; is we don't see anything, really, that 8 strongly supports a uniform declaration for this. 9 But we will trust the Schecters and we will trust 10 the Sutphins of the world to candidly take care of 11 these people and make recommendations. 12 Q So, why isn't that policy appropriate for 13 the state of South Dakota to have in its decisions 14 about what procedures to cover? 15 A I can't speak for the state of South 16 Dakota, but I can say that, to my estimation, if 17 you're talking about the very thing I mentioned in 18 my declarations, if you're talking about an 19 unprecedented surgery, it should require an 20 unprecedented level of support. A surgery that's 21 taking off physiologically healthy tissue, surgical 22 castration and amputation for dysphoria, is unlike 23 anything else in medicine. 24 Q So you think it should have an 25 unprecedented level of support to justify it?

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Page 145 1 A Yes, I think it requires a -- if we're 2 going to do something that is unlike anything else 3 in medical care, surgical care, specifically, I 4 think it does require that, yes, sir. 5 Q Is that a personal view; that it should 6 require an unprecedented level of support? Or is 7 there, you know, a medical principle that a more 8 unusual type of surgery should require an 9 unprecedented level of support? 10 A I think that's a medical principle. I 11 mean, if we're -- I'm not an astronaut, obviously, 12 but if we're going to send somebody to the moon, we 13 better do a lot of work, perhaps more so than when 14 we're just sending an inanimate object into orbit. 15 If we're doing something that is truly unique, it's 16 not assigning a value to it, it's just assigning a 17 fact that a candid mission, we're not sure we can do 18 it, absolutely, but what does it actually mean in 19 terms of benefit and risk? That's what, 20 objectively, no matter my assumptions of nature, 21 religion or otherwise, objectively, that's what it 22 boils down to. 23 Q So, when considering any surgery, you 24 always have to weigh the benefits versus the risks, 25 right?	Page 147 1 A These are very tangible changes. 2 Q But benefits is what I'm talking about. 3 The psychiatric benefits are not the sort of 4 tangible benefits that you usually see when you 5 perform surgery? 6 A I would request that we specify 7 specifically what benefits the state and/or Daniel 8 Sutphin should expect to see with these surgeries. 9 That's what concerns me. We're missing that. 10 There's not well defined. That's something that's 11 even acknowledged by authors on these papers that, 12 really, we don't have any good metrics to 13 assess whether we're doing it -- we're firing lots 14 of shots, but where's our target? What is our 15 target? 16 Q So it seems the metrics aren't the metrics 17 you typically look at when you assess the benefits 18 of surgery? Can you agree to that? 19 A Which surgery? 20 Q When you -- any surgery. The benefits 21 that are asserted for gender dysphoria are not the 22 types of benefits that, as a surgeon, you usually 23 are looking for and assessing for as the benefit 24 providing the surgery, right? 25 A I think, Josh, and I'm not trying to be
Page 146 1 A Yes, sir. 2 Q And here, for surgery for gender 3 dysphoria, the asserted benefits are mainly 4 psychological, isn't that right? 5 A That's part of the problem. I haven't 6 defined what the benefits are. As I alluded to 7 earlier, I've seen everything in papers from "I'm 8 satisfied with the way my genitals smell" to "I'm 9 satisfied with the way that they look." 10 Q You've referenced the genital smell thing 11 a couple times. What paper is it that talks about 12 that? 13 A It's in NPRS. I'll work to locate it and 14 send it to you. 15 Q So, if the goal of the -- if the asserted 16 benefit is that it relieves significant 17 psychological distress, that benefit is in the 18 domain of psychiatric care, isn't that right? 19 A It may begin there. But when the person 20 enters the OR, they're in the operative domain. 21 Q And I'm focusing on the benefits that 22 someone is supposed to get from the surgery. Those 23 aren't tangible benefits you can see -- those aren't 24 the sort of tangible changes that you typically look 25 at when you perform surgery, right?	Page 148 1 difficult, there's such a broad spectrum. Let's say 2 we're talking about facial contouring surgery versus 3 that that a child would undergo for micrognathia, 4 the child with micrognathia has a obvious, 5 noticeable defect that we all look at the child and 6 say, My goodness. A gender dysphoric patient is 7 aiming for something that is in their mind; a vision 8 of what they want to be. I'm not making a statement 9 whether that's good, bad, none of that. They have a 10 vision. And so what are we going to measure as 11 their level of satisfaction with that? I don't 12 know. And that's not even with the mastectomy 13 surgery and this -- I, as a surgeon, may see that 14 you're healing well, but the patient may see 15 something much different and obviously they're 16 already arriving the day of the surgery, I may say, 17 You are well formed and apparently healthy, but you 18 see something that is hideous, so much so -- and I 19 do mean the patient may say that; "this is hideous 20 to me," "I hate this." And may even use expletives 21 to describe it. I need this off. That represents, 22 to me, just as a casual observer, this is a serious 23 level of discord. Doesn't answer the question of 24 whether I may be able to help them or not. Even if 25 I perform a penectomy, for instance, how do I know

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Page 149 1 that what I'm about to do -- this is changing their 2 body permanently. For instance, in the last two 3 months, I performed a penectomy for a patient who 4 had severe lymphedema. His penis was over 5 40 centimeters long, hung past the level of his 6 knees. I don't remember the specimen weight, but it 7 was in pounds. Something like 8 to 12 pounds. I 8 can't recall the exact weight. But with that 9 surgery in mind, he had reached the point where the 10 tip of the penis had grown so large and heavy it was 11 necrosing. And giving all the other factors 12 involved in his case, he was at risk of developing a 13 severe infection of the penis that would spread to 14 his body. He already had that occur once and had 15 lost the scrotum. Going into that surgery, I know 16 the result of the surgery and he's not going to be a 17 good candidate for reconstruction of the penis, but 18 I know, on my end, as a surgeon, what I hope to be 19 able to accomplish. And talking to the patient, I 20 can talk to him and say -- and document that he 21 understands that the ability to maintain or achieve 22 an erection and/or penetrative intercourse after 23 this surgery is non-existent without reconstructive 24 measures. And, furthermore, given some of the 25 systemic problems that the patient has, including	Page 151 1 is basically operating at the behest of a 2 psychiatrist, based on patient desire, which is 3 obviously discordant with the reality of their body. 4 That's uncharted water. It's been done, absolutely. 5 But I just -- doing something and actually being 6 able to affect a change that justifies the risks 7 that come with certain procedures, I think, are two 8 different things. 9 Q So, from the perspective of a surgeon, 10 such as yourself, determining whether your surgery 11 has resulted in a psychological benefit is uncharted 12 waters, from the perspective of a surgeon like 13 yourself? 14 A No, sir. But determining so, when the 15 patient comes to me with obvious pathology and 16 disorder, and irrespective of our terminology, 17 dysphoria or disorder, I would argue that disorder 18 is a better term. I think the people who experience 19 this would tell us, I live with this every day. 20 This dominates my life. This is horrible. Help me. 21 That's not just dysphoria, in my estimation. That's 22 a true disorder. But dysphoria is something that, 23 to my estimation, and it's not an exclusive -- I 24 know, in his statements, Dr. Schecter commented 25 about the fact that I allude to patients who undergo
Page 150 1 obesity, diabetes, unmanaged, poorly managed, he's 2 going to be at very high risk for any future efforts 3 of reconstruction. If I see a transgender patient, 4 I'm just hanging my hat on the fact that whichever 5 psychologist or psychologist who saw the patient 6 previously has made a determination that, okay, but 7 ultimately -- and I have to make my own 8 determination. I think this patient understands 9 this. I do. I think they get it. 10 Q So the benefit is in the patient's mind 11 when it's performed for gender dysphoria, is that 12 right? 13 A As best I can tell, yes, sir. 14 Q And the field of medicine that is devoted 15 to determining whether someone's state of mind has 16 actually improved is psychiatry, right? 17 A Psychiatry is devoted to mental disorders, 18 yes, sir. 19 Q So, is it fair to say that a psychiatrist 20 is better equipped to assess whether a mental 21 benefit has actually been achieved than you are? 22 A I would say the same thing as I did 23 earlier; that it depends on the psychiatrist, but 24 even if they were better trained, this creates a 25 unique situation in all of medicine where a surgeon	Page 152 1 breast augmentation. Now, I can't note all the 2 motivation for every woman who undergoes that 3 procedure in the United States, but they're 4 punitive so dissatisfied with the state of their 5 body that is otherwise healthy that they're willing 6 to pay a surgeon and undergo a procedure with 7 associated risks to have a change with that. No one 8 objects to that. But no one expects for an 9 insurance company to cover that surgery in relief of 10 those patients' state. Now, Dr. Schecter wisely 11 notes, and I understand, the fact that the patient 12 who comes to us with gender -- what is now called 13 dysphoria -- is a different patient than a patient 14 that comes to us for breast augmentation. The 15 gender dysphoria patient, in my opinion, has a true 16 disorder. And at least those in my experience, 17 those who I had the privilege of caring for, have 18 more than just dysphoria. It's a true life-altering 19 disorder that dominates their thought process and 20 their existence. 21 Q As a surgeon, you don't have -- you don't 22 have frequent experience in determining whether a 23 patient's mental disorder has been successfully 24 cured? 25 A I don't. And I'm not satisfied, frankly,

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Page 153 1 based on the criterion that I've seen that the 2 psychiatry community does either. But if they had, 3 we wouldn't be having any discussion. It's a debate 4 that's been unfolding for years. 5 Q But in the context of any treatment for 6 any mental disorder, as a surgeon, you do not have 7 experience in assessing whether any mental disorder 8 has been successfully cured? 9 A I don't practice in that realm. My realm 10 is, and responsibility, is to verify that what I do 11 and to the extent that I'm called upon to do so, 12 that we as a surgical community do so in a safe and 13 reproducible manner with an outcome that is more 14 than just subjective. 15 Q And so -- and you think that it's not 16 enough for -- to justify performing surgery as 17 treatment for gender dysphoria, it's not enough for 18 the psychiatric community to show that it improves 19 mental health based on the same level of proof that 20 applies to other mental disorders? You think an 21 exceptionally higher standard of proof should be 22 used when the treatment is surgical? 23 MR. JOHNSON: Lack of foundation. 24 A I don't remember. I understand what 25 you're saying, but, for instance, if we're talking	Page 155 1 seems to me, is a different structure than those who 2 have encountered gender dysphoria, as we're calling 3 it today. And, again, I will respect the 4 terminology that's requested that we use, but I 5 disagree with it. And I don't think it does a good 6 service to these people. There may be those who are 7 more dysphoric, but there's truly a disordered 8 patient population that I don't think we're helping 9 by saying it's just dysphoric and it's not -- I 10 don't think it's a good thing for them. 11 Q Is it your understanding that the medical 12 community doesn't distinguish between people with 13 severe gender dysphoria and people with less severe 14 gender dysphoria? 15 A The medical community is very large and 16 nondescript. All I can say is what I see in these 17 guidelines and the American Psychiatric Association 18 in terms of terminology. And that's all I can 19 observe. 20 Q I mean, isn't -- don't WPATH and the 21 other -- let's talk about WPATH. Doesn't it say 22 that -- whether surgery is medically necessary to 23 alleviate a person's dysphoria depends on the 24 individual needs of the patient? 25 A I would have to look specifically at that
Page 154 1 about affecting permanent change on the body for no 2 other reason other than a psychiatric disorder, it's 3 a different circumstance than if somebody presents 4 to us with Stage 4 breast cancer. There's organic 5 demonstrable disease that, without relief of that 6 exophytic cancer on the person's breast, we're not 7 going to be able to save their life, but we can, at 8 least, enable them to experience a death with some 9 dignity and resolution of that physical pain. 10 Q You're not used to treating inorganic 11 disease as a surgeon? 12 A I wouldn't say that. Every person that 13 comes to me comes with some set of circumstances 14 that they may not wish to openly discuss. And 15 sometimes they do. And they extend beyond the realm 16 of organic disease process. A young woman who comes 17 to me at 35 who's been the butt of every joke from 18 seventh grade on because of the shape of her nose to 19 the point she really thought about suicide by the 20 time she was a senior in high school, there's other 21 stuff there. 22 Q Are you providing medical treatment for 23 that condition? 24 A No, sir. What I do ties into that 25 treatment. And that person's coping structure, it	Page 156 1 part. I know what the general sentiment is. I 2 would also say, as a surgeon, and I may have just 3 missed this, I don't know which surgeons actually 4 constitute the -- other than Dr. Schecter, I think 5 Djordjevic has also said on WPATH as well -- which 6 of those surgeons constitute the rendering body of 7 opinion for this. 8 Q Let's talk about the body of opinion. 9 You're aware that the American Medical Association 10 has issued a statement saying that surgical care for 11 gender dysphoria is medically necessary, right? 12 A Yes, sir. I'm not a member of the AMA 13 deliberately. Not for that reason, but I alluded to 14 the fact that the AMA is so far departed from many 15 American physicians that it's not thought to 16 represent, even a number of years ago, no more than 17 15 percent of us. 18 Q So, putting aside your views about those 19 statements, I just want to get on the record your 20 knowledge that the statements exist. So, you're 21 also aware that the American Psychiatric Association 22 has issued a statement saying that gender 23 dysphoria -- I mean, transition-related surgery is a 24 medically necessary treatment for gender dysphoria, 25 right?

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1 A Can you read the statement specifically?
 2 I don't know that I've seen that.
 3 Q All right. I mean, without using the
 4 exact word of the statement, are you aware that
 5 they -- have you read their statement in the past
 6 regarding transition-related care for gender
 7 dysphoria?
 8 A The statement that I recall -- and I
 9 haven't read that statement recently, Josh, but the
 10 statement that I recall is that it's considered a
 11 valid option in their estimation. But I don't
 12 recall, I could be wrong, this medically necessary
 13 term is getting utilized a lot. Medically necessary
 14 for what? If I say a breast reduction, for
 15 instance, is medically necessary, a woman who comes
 16 me with a J cup-sized breast has certain
 17 manifestations of her macromastia that we expect to
 18 alleviate with the surgery and many of those are
 19 sentiments of relief of physical pain and
 20 improvement in certain symptoms physically
 21 observable, like notching in the shoulders from bra
 22 straps, maceration of the skin on the under surface
 23 of the breasts.
 24 MR. JOHNSON: Can we take a quick break,
 25 Josh?

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1 MR. BLOCK: Yeah, could we just --
 2 MS. COOPER: No, can he finish the answer?
 3 MR. JOHNSON: I'm sorry, I thought he was
 4 done.
 5 A That really was -- I mean, just those
 6 symptoms are observable. Forgive me. I lost my
 7 train of thought.
 8 MR. BLOCK: It's okay. Okay. You can
 9 take a break.
 10 MR. JOHNSON: If you want, she can read
 11 your answer back. I thought you were done.
 12 (The requested portion of the record read back.)
 13 A And those are -- those are observable.
 14 (Break Taken.)
 15 Q (By Mr. Block) And I really don't want to
 16 belabor these questions on my end. Just want to
 17 establish the American Psychiatric Association, the
 18 American Psychological Association, and the American
 19 Medical Association have all issued statements
 20 recognizing treatment, surgical treatment, as an
 21 accepted protocol for treating gender dysphoria?
 22 A If I understand, I think it's an accepted
 23 option for me to -- the AMA, as I've stated, is an
 24 organization that has its own course very well. I
 25 don't subscribe, necessarily, to what the AMA says

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1 politically, socially, or in this case medically.
 2 Q So you disagree with the AMA's position on
 3 this issue?
 4 A In this instance, yes, sir.
 5 Q And you disagree with the American
 6 Psychological Association's position, right?
 7 A If I may finish real quick. The American
 8 Psychological Association is very well and fine, but
 9 as a surgeon, my decision to operate is not based
 10 off of the recommendations alone. The American
 11 Psychiatric Association, I appreciate that. But as
 12 they themselves acknowledge our quality of data is
 13 very low. This is our -- our consensus. We really
 14 don't have anything to support this. Now, all of us
 15 in life have to make a choice about who we going to
 16 listen to? How much credence do we put -- you know,
 17 if Josh is my lawyer and he tells me, Daniel, I need
 18 you to consider these things, I respect Josh's
 19 training, his background, and I, irrespective of our
 20 opinions, he's an expert in this. I need to hear
 21 what he's saying. The American Psychiatric
 22 Association, based on their most recent statement,
 23 unless there's been a new one that I'm unaware of,
 24 issued their declaration with a caveat that we
 25 really -- this is low quality data evidence. And,

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1 again, going back to the issue as the guy, who, at
 2 the end of the day, or gal, who's responsible for
 3 putting a knife on someone's skin, we've got to take
 4 that responsibility seriously.
 5 Q So -- so, just for the record, so, you
 6 disagree with the position of the American
 7 Psychiatric Association and the American
 8 Psychological Association and the American Medical
 9 Association on this issue?
 10 A Based on the data available right now.
 11 Q Is it possible for there to be a medical
 12 consensus that proves to be wrong?
 13 A Yes.
 14 Q So, it's possible for there to be a
 15 medical consensus on an issue and still have certain
 16 physicians and researchers disagree with that
 17 consensus, is that right?
 18 A Well, if I may understand your question
 19 correctly, Josh, what you're saying is: Is it
 20 possible to be wrong? Is it possible to have
 21 disagreement? Both are possible.
 22 Q So, if -- I want to turn to the complaint.
 23 (Deposition Exhibit 16 marked.)
 24 Q This is a copy of the original complaint
 25 as filed. And you reviewed this complaint as part

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Page 161 1 of the process of writing your declaration, right? 2 A Yes, sir. 3 Q So, I want to focus on the first paragraph 4 says, The State of South Dakota provides healthcare 5 coverage to state employees through the South Dakota 6 State Employee Healthcare Plan. Under the plan, all 7 state employees are, quote, entitled to medically 8 necessary services and supplies, if provided by or 9 under the direction of a physician, unquote. The 10 plan defines medically necessary as, quote, 11 healthcare services or supplies needed to prevent, 12 diagnose, or treat an illness, injury, condition, 13 disease, or its symptoms and that meet accepted 14 standards of medicine, unquote. Did I read that 15 right? 16 A Yes, sir. Based on the copy I'm looking 17 at. 18 Q Okay. So, is it your understanding that 19 it's possible to provide treatment for symptoms of a 20 disease without curing the underlying condition? 21 A Yes, sir. 22 Q And is that a legitimate form of medicine 23 to treat symptoms, even if it doesn't cure the 24 underlying condition? 25 A Yes, sir.	Page 163 1 whether insurance should cover surgical care for 2 gender dysphoria, would that be evidence of a 3 medical consensus on the issue? 4 MR. JOHNSON: Object. Lack of foundation. 5 A Possibly. It depends upon how the 6 organization goes about arriving on consensus. And, 7 unfortunately, in the case of many bodies, it may 8 just be, you know, we are the board, we have thus 9 decided, and thus shall it be. You know, us four 10 here today have made a decision without any 11 opportunity for consideration or critical assessment 12 and here's how it's going to be. 13 Q And is that your understanding of how the 14 American Medical Association and the American 15 Psychiatric Association or the American 16 Psychological Association operate? 17 A I don't know how they operate. 18 Q Is that your understanding of how the 19 American Society of Plastic Surgeons operated? 20 A The American Society of Plastics Surgeons, 21 I imagine, would call for opinion from members and 22 review -- form a consortium, a body, to review the 23 literature at hand. And make a determination. 24 That's speculation. I don't know. I do not sit on 25 the board, so I don't know the proceedings that
Page 162 1 Q And I want to focus on the phrase, "meet 2 accepted standard of medicine." What's your -- just 3 from -- not from the perspective of a lawyer, but 4 just from a perspective as a physician, what's your 5 understanding of what it means to meet accepted 6 standards of medicine? 7 A I think it depends on your specialty, 8 Josh, at least in the United States. The 9 organizations which participate in the governance of 10 standards and observation of them, such as the 11 American College of Surgeons, the American Society 12 of Plastic Surgeons, and the American Board of 13 Surgeons and the American Board of Plastic Surgery 14 are, in the surgical realm, those bodies that help 15 us define as surgeons what are the accepted 16 standards. And, to my knowledge, as of the time 17 that I submitted my declarations, there was no such 18 consensus statement from any of those bodies. And 19 that's why, in my declaration, I stated it's unknown 20 whether the plaintiffs or, I believe, Dr. Brown at 21 that time, had considered those valid sources of 22 consideration. They were not mentioned or alluded 23 to. 24 Q If there were a statement from the 25 American Society of Plastic Surgeons regarding	Page 164 1 would effect a formal statement. 2 Q If the American -- so, focusing on this 3 phrase, "meet accepted standards of practice" -- 4 A Forgive me, Josh, of medicine? 5 Q Sorry. Thank you. Meet accepted 6 standards of medicine. So focusing on the phrase, 7 "meet accepted standards of medicine," it's possible 8 for the accepted standards of medicine at any given 9 time to be wrong, isn't that right? 10 A Yes, sir. 11 Q And further research can reveal that the 12 accepted standards of medicine should be changed, is 13 that right? 14 A Yes, sir. 15 Q And, in fact, there's often additional 16 research that must be done on how to treat a 17 condition, even when accepted standards of medicine 18 are currently in place? 19 A Yes, sir. There's -- sometimes. I don't 20 know about often but, yes, sir, sometimes. 21 Q Is it possible that treatment for gender 22 dysphoria has -- let me rephrase that. Would it be 23 fair to say that you disagree with the conclusion of 24 the AMA, the American Psychiatric Association and 25 the American Psychological Association, that

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Page 165 1 surgical treatment for gender dysphoria meets 2 accepted standards of medicine? 3 A It would be fair to say, as I previously 4 stated, I appreciate the American Psychological 5 Association, but I do not base my care upon their 6 recommendations. I value the American Psychiatric 7 Association, but as of to date, their 8 recommendations are made on low quality evidence and 9 I would not ask anyone else to make a decision based 10 on low -- of this magnitude, based on low quality 11 evidence, any more than I would ask myself to do so. 12 In terms of the American Medical Association, I do 13 not have any comment about what their 14 recommendations are or not. I'm not a member and I 15 can't comment on them further, beyond what I've 16 already stated. 17 Q Do you believe that it's impossible for an 18 accepted standard of medicine to exist if there are 19 physicians who disagree with that standard? 20 A One more time; if it's impossible for a 21 standard to exist? 22 Q I want to separate out two issues. One, 23 is there currently -- is treatment for gender 24 dysphoria currently accepted by -- sorry. Is 25 surgical treatment for gender dysphoria currently	Page 167 1 Q (By Mr. Block) You have 11? That's even 2 better. 3 A Is that what we're all on? 4 Q Yeah. So, if you go to the first page 5 under heading of C; social. 6 A C, social. 7 Q And then Bullet Point 2. So this is on 8 the first page. It says, In our current social 9 context, there is a prevailing view that removing 10 traditional definitions and boundaries is a 11 requirement for self-actualization, thus, Christian 12 healthcare professionals find themselves in the 13 position of being at variance with evolving use of 14 gender identity in which patients seek validation by 15 the medical community of transsexual desires and 16 choices that may be socially approved, but which are 17 contrary to a Christian world view. And so, do you 18 agree that your -- the prevailing view today is that 19 transgender patients seeking to transition should be 20 validated by the medical community? 21 A Well, Josh, I think there's a popular 22 sentiment. It's well founded that none of us want 23 to hurt anybody. We don't want to keep anybody from 24 getting what they need. But popular sentiment is 25 not, at this point, supported by, based on what I
Page 166 1 accepted by the medical profession from the question 2 of whether or not it should be accepted by the 3 medical profession and -- 4 A Well, like I said, the medical profession 5 is a pretty large body, Josh. 6 MR. JOHNSON: Let him ask his question. 7 Q (By Mr. Block) So, in determining accepted 8 standards of medicine, you think that refers to sort 9 of a poll of general membership? Is that what you 10 think determines accepted standards of medicine for 11 the context of providing a certain treatment? 12 A I don't know that I understand the 13 question as it's couched. It seems very broad to 14 me. 15 Q Well, you know, let's go back to the CMDA 16 statement, if we could. 17 A If I may be clear, up to this date I have 18 never seen the CMDA statement and have never based 19 my guidelines or my decisions medically on this 20 statement. 21 Q Of course. Of course. 22 MR. JOHNSON: What's the number on that, 23 Josh? 24 MR. BLOCK: I think -- 25 THE WITNESS: I've got 11, Josh.	Page 168 1 have read, objective evidence. In terms of the 2 variance of Christian world view versus the 3 remainder of society, that's been the case for the 4 last 2000 years, going back to the statement I first 5 alluded to that Paul said in the Letter to the 6 Galatians; In Christ, there's no difference between 7 male or female, Jew or Greek, slave nor free man. 8 That was the most radical statement the world at the 9 time had heard and it wasn't a very popular thing to 10 ascribe to, based on any of those cultural members; 11 Jews, slaves, free men. And it certainly wasn't 12 popular based on the sentiment and value of women at 13 the time in the culture to say, Mr. Man, this lady 14 that you've been treating like trash and chattel for 15 the last ten years of your marriage is actually of 16 equal worth in the sight of God as you. Those were 17 radical ideas that were grossly at variance. So 18 that's a statement that, as we review, I -- that 19 doesn't seem anything new, based on the last 2,000 20 years of history, based on what my knowledge is. 21 But, again, in terms of the surgical societies, I 22 don't find any contradistinction in the opinion that 23 I've formed right now with the bodies at large which 24 govern this process; that is, survey the process of 25 the practice of medicine in the United States of

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Page 169 1 America, including the American College of Surgeons, 2 the American Board of General Surgery, and Plastic 3 Surgery and the ASPS. 4 Q Are you – none of those organizations 5 have issued a statement saying that surgical 6 treatment for gender dysphoria is not medically 7 necessary, have they? 8 A No, sir. Not that I'm aware of. 9 Q And – 10 A But neither, to my knowledge, have they 11 issued a statement saying that those who would not 12 engage in the practice or have reservation about the 13 same are practicing unsafe or unsound medicine. 14 Q Agree with that? And isn't it true 15 that – just want to find it – that the American 16 Society of – that the American Society of Plastic 17 Surgeons hosts seminars and classes on providing 18 surgery to treat gender dysphoria? 19 A Dr. Schecter, I think he's been active in 20 orchestrating some of those things, perhaps since -- 21 I do not know this date specifically, but perhaps 22 since 2015. 23 Q And isn't it true that he also provides 24 classes to the American College of Surgeons on 25 providing surgery to treat gender dysphoria?	Page 171 1 Q Yeah, Plastic Surgery Statistics Full 2 Report, 2016. So you view that website to be a 3 reliable source of information? 4 A I do. 5 Q And are you aware that the website 6 categorizes the surgical procedures as either 7 cosmetic or reconstructive? 8 A Yes, sir. 9 Q And what's the difference between cosmetic 10 surgery and reconstructive surgery, in your 11 understanding? 12 A Cosmetic surgery is something that is 13 performed to improve an already existing structure 14 to a greater degree of satisfaction in the patient's 15 estimation. Reconstructive surgery is something 16 done to reconstruct what disease or trauma has taken 17 away from the patient. 18 Q And is your understanding that 19 reconstructive surgery is regarded as medically 20 necessary? 21 A In many cases it's considered medically 22 necessary. 23 Q And are you aware that the website for the 24 American Society of Plastic Surgeons lists gender 25 confirmation surgeries as an example of
Page 170 1 A I believe he does. I've never attended 2 one and I applaud him for, as any honest clinician 3 would want to do, if he feels that he's found a 4 technique that is advantageous and helpful to the 5 patient population, that he's striving to promulgate 6 that. 7 Q And in order to be board certified, isn't 8 the topic of surgery to treat gender dysphoria one 9 of the topics that you can be questioned on at board 10 certification? 11 A You could be questioned on any topic. 12 Q Including providing surgery to treat 13 gender dysphoria? 14 A Correct. 15 Q The American Society of Plastic Surgery, 16 their website is plasticsurgery.org, isn't that 17 right? 18 A I believe so, Josh. I'd have to pull up 19 their web address. I don't pay that close attention 20 in my log. 21 Q Going to your declaration, you cite 22 Footnote 33, when you're citing the statistics about 23 plastic surgery, you cite to a document on 24 plasticsurgery.org. 25 A Is that the breast augmentation numbers?	Page 172 1 reconstructive procedures? 2 A I haven't seen that. I didn't see that it 3 was classified as reconstructive. I would be 4 interested to note who made the decision to classify 5 it as such because it doesn't -- to my estimation, 6 the definition I just provided you, it's like a 7 mastectomy, and it's very inconsistent with the 8 things that we've talked about previously. One of 9 the key movements in those who advocate for this is 10 to change language. What is blue is now orange and 11 what is orange is now blue. And the plain language 12 in understanding reconstructive surgery, it's a 13 restorative procedure. We might say it's 14 restorative in a sense that we're operating from the 15 patient's frame of reference, in their mind, they 16 say this is what I always should have been, but, in 17 fact, what we're doing is we are -- it's extirpative 18 procedures. We're taking away what's already 19 biologically present. 20 Q So you would disagree with any decision to 21 describe surgery for gender dysphoria as 22 reconstructive surgery? 23 A If I may finish, it depends on the 24 surgery. For instance, a mastectomy, a phalloplasty 25 would be considered reconstructive, though you're

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Page 173 1 really building something that's not really -- 2 you're not reconstructing it. You're building it 3 from a nascent, de novo state, which is, again, is 4 unprecedented in medicine. Let's say in a male 5 patient who loses his penis to an explosive device, 6 you're rebuilding what was there to begin with. In 7 a phalloplasty for a trans male, you're creating 8 something that never existed to begin with and I 9 think Dr. Schecter would agree if you don't 10 recognize that fact, you're headed for serious 11 complications. Of course, you recognize that fact 12 as a surgeon. There's different inherent risks and 13 complications that come with that statement. 14 Statement of fact. Not of value. Just of fact. 15 Q But you would label it -- I just want to 16 focus on whether the label "reconstructive surgery" 17 would apply to it. And it's your opinion the label 18 of reconstructive surgery should or should not apply 19 to phalloplasty? 20 A I almost think we should call it 21 neo-constructive surgery. It really -- and you'd 22 have to ask others who practice it like 23 Dr. Schecter, on a regular basis, whether they think 24 the level of expertise really rises to that. I 25 believe it does. It's -- even, for instance, if I	Page 175 1 cisgender men, what is your understanding of the 2 medical purpose of performing gynecomastia surgery? 3 A It can be done for different reasons. 4 Occasionally the patients that I've cared for and 5 that you read about in the literature do complain of 6 pain and discomfort, asymmetry and, social 7 embarrassment. But, more commonly, 8 insurance-related indications are progressive growth 9 without arrest and failure to subside objectively on 10 examination. 11 Q Is there any medical harm that would 12 result from not performing surgery? Let me rephrase 13 that. Is surgery indicated to, you know, prevent 14 some other medical harm from happening to the 15 patient? 16 A I would say, in most cases, no. Unless 17 there's a mass involved. And usually that could be 18 ascertained in terms of the diagnosis with less 19 invasive means, like corneal biopsy or something, if 20 there's a real concern for oncologic process, but in 21 most cases, if the chief indication is soreness and 22 discomfort, that's one of the presupposed goals of 23 the procedure; is to alleviate that. 24 Q To alleviate the physical soreness and 25 discomfort?
Page 174 1 do a deep flap for breast reconstruction, that's 2 reconstructive. I'm restoring the tissue to the 3 place that once upon was, trying to connect a 4 neo-urethra of a phallus, a neo-phallus to a native 5 urethra, and contend with the complication rates at 6 the pars fixa, which is the place where the native 7 female urethra terminates, is really -- I mean, it's 8 a tour de force. 9 Q If someone has a congenital abnormality, 10 like a growth that's then removed, does that mean 11 that it can be categorized as reconstructive surgery 12 because it's taking something off? 13 A Well, I wouldn't categorize it for that. 14 For instance, cleft lip, they may be born with that 15 deformity, but you're reconstructing the upper lip. 16 Our daughter, Kali, was born with a hemangioma that 17 progressed and sized to the point that by the time I 18 was a fellow at UC, actually, she required surgery. 19 She developed a mass that was probably a tangelo 20 size mass on her breast bud. And there was some 21 concern whether that would actually interfere with 22 her future breast development. The surgery that she 23 had was extirpative in nature. I would not describe 24 it as reconstructive, but -- 25 Q Okay. For gynecomastia in men, in	Page 176 1 A Yes, sir. 2 Q Is one of the goals to alleviate the 3 social discomfort? 4 A Can be. In cases there are -- there may 5 be a case where insurance does not approve the same 6 and the patient or the patient's guardian determines 7 that they would wish to pay for that out of pocket. 8 Q How do you measure whether someone's 9 physical discomfort has been improved from 10 gynecomastia surgery? 11 A A patient's sentiment, what they express, 12 and what I can appreciate on examination in terms of 13 palpation. 14 Q And how do you measure whether a patient's 15 social discomfort has improved as a result of 16 gynecomastia surgery? 17 A Primarily the patient. 18 Q Gynecomastia surgery has medical risks, 19 doesn't it? 20 A By medical, I presume you mean surgical 21 risks, yes, sir. 22 Q Is someone generally under general 23 anesthesia for that surgery? 24 A It varies. It varies. 25 Q And there are risks of complications from

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Page 177 1 the surgery, is that right? 2 A Correct. 3 Q But the surgery isn't life saving, is it? 4 A Not that we're aware of, no, sir. 5 Q So, do you believe that the benefits of 6 the surgery are -- outweigh the risks to make it 7 medically justified? 8 A That depend on the case and the severity 9 of the deformity and the patient's symptoms that 10 you're describing. 11 Q So, could you explain what would make it 12 medically justified? 13 A If the patient complains of physical pain, 14 and I can appreciate, on examination, a mass in the 15 retroareolar position of the man's chest wall that I 16 don't believe is going to be amenable to observation 17 alone, then if he complains the pain associated with 18 it is sufficient to warrant acceptance of the risks 19 associated with the procedure, then I would consider 20 it reasonable. 21 Q Isn't -- doesn't the surgery remove 22 organically healthy tissue? 23 A It's abnormal tissue. 24 Q But it's organically healthy? 25 A No, sir. There's no -- if -- I think	Page 179 1 yes, sir, in the vast majority of cases, it's benign 2 tissue. And by no means would I tell a patient, oh, 3 if you came to me and said, Josh, I think you're 4 going to be all right, you know, we can't say that 5 with absolute certainty until it's under microscope, 6 but I think it's going to be okay. But if it's 7 causing you discomfort, it's causing you pain, are 8 you willing to accept the risks of the surgery? 9 Then that -- yes, sir, that would be how I would 10 approach gynecomastia, depending upon the patient's 11 age. 12 Q And one of the purposes of the surgery is 13 to bring the person's body into align with the 14 typical male phenotype? 15 A One of the purposes of the surgery would 16 be to alleviate pain and the other purpose would be 17 to verify no physiologic abnormality, and a third 18 benefit, I would think, would be that it would bring 19 the patient's body into alignment with what already 20 exists in his body. Not to create something or 21 disrupt the state of the body otherwise. 22 Q But that's an entirely appropriate medical 23 consideration; to bring a person's physical body 24 into alignment with his typical male phenotype? 25 A Yes, sir, what already exists, yes.
Page 178 1 we're thinking the same thing, Josh, but we're 2 coming from different vocabularies. There's no 3 oncologic disease process. There's no infection. 4 But it is abnormal hypertrophied tissue. In some 5 cases, the actual etiology of which cannot be 6 excluded or confirmed as benign until it's under a 7 microscope. 8 Q Well, but the surgery is performed -- 9 A It's not normal for males to have breasts, 10 biological males. 11 Q Yeah, no, I'm getting to that. I'm 12 getting to that. But the surgery, you know, can be 13 medically necessary, even when it's known that the 14 tissue is benign, right? 15 A Yes, sir. It can be appropriate. Even 16 when the tissue is thought to be benign, yes. 17 Q But it is -- it is not -- but the tissue 18 does not conform to the type of tissue that males 19 usually have in their chest, is that right? 20 A I don't know that the tissue "conform" is 21 the right word, but it is not typical physiologic 22 phenotype and it does lead to question, though, in 23 the vast majority of cases, it is only benign 24 disease, the only way to exclude that with certainty 25 is to examine the specimen under the microscope, but	Page 180 1 Q Okay. If there's no -- can surgery for 2 gynecomastia be medically necessary, even when there 3 is no physical pain? 4 A This is one case, at least in my 5 experience, Josh, that there is a lot of variability 6 from insurance companies and policies. Some 7 policies have exclusions that others don't have. 8 Even with pain, some policies require progressive 9 growth that does not subside over time. It can 10 vary. 11 Q And how about your own personal belief? 12 Do you provide surgery for gynecomastia even if 13 there's not physical pain? 14 A If I have any objective concern that there 15 may be occult disease, then yes, sir. And even if I 16 don't operate the patient initially, I see them back 17 in followup to verify that my findings at the time I 18 see them initially are consistent over time and/or 19 resolving. And if that behaves in a manner 20 atypical, then irrespective of just the symptoms of 21 physical pain, I would make a recommendation that 22 they undergo at least tissue biopsy and/or imaging 23 studies like ultrasound. 24 Q If there's no indication, if there's no -- 25 nothing to indicate that the tissue is not benign

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Page 181 1 and the patient is not suffering physical 2 discomfort, just has abnormal growth and extreme 3 social discomfort from it, would you provide the 4 surgery in those circumstances? 5 MR. JOHNSON: You said is not benign? 6 A Nothing to indicate the tissue is not 7 benign. 8 Q (By Mr. Block) So there's no concern about 9 performing a biopsy, the only concerns are that this 10 is abnormal growth that does not subside and the 11 person is suffering social distress from it, would 12 you perform the surgery in those circumstances? 13 A If I may, I'm going to repeat what my 14 brain is picking up. I have a patient who doesn't 15 appear to have any pain. I have very low concern 16 that there's any pathologic mass suspicious for 17 oncologic process, however, the growth is persisted 18 and the only concern at this point is stigma, is 19 that correct? 20 Q Well, social distress and anxiety. 21 A Yes, that would be a reasonable thing. 22 His insurance may not cover it, but I would offer 23 that. 24 Q Because of the stigma? 25 A Yes. Yes. To the point in terms of a	Page 183 1 terminology. 2 Q I just want to confirm that, you know, a 3 distinguishing thing between those two surgeries 4 that's important to you is that for gynecomastia for 5 a man, the tissue is physiologically abnormal, and 6 for mastectomy for a transgender man, the tissue is 7 physiologically normal? 8 A Yes, sir. 9 Q And you're more concerned about tissue 10 that is physiologically normal than you would be 11 about removing tissue that is physiologically 12 abnormal? 13 A Correct. That represents an abnormal 14 developmental state, which gynecomastia does. 15 Q Do you think that having gender dysphoria 16 is a normal state? 17 A That's an interesting question, Josh. I 18 think those that I have observed with what I would 19 describe as a real disorder, no, I don't think it's 20 a normal state, but as opposed to one that can be 21 appreciated physically on examination, that I have a 22 high degree of confidence that I can address with a 23 scalpel, it's something that I would be altering the 24 patient's native biological state to achieve 25 something that I don't know that I can address. And
Page 182 1 patient like Mr. Bruce, what stigma has the patient 2 had by having breasts alone? I don't know. Those 3 begin to become more complex issues. Furthermore, 4 I've never examined Mr. Bruce and I can't comment on 5 the breast size and considerations associated with 6 that, but most gynecomastia patients as, again, as 7 also noted this month and I think very well noted in 8 the article dealing with the same in Clinics about 9 male to female and female to female chest surgery, 10 there are important differences that need to be 11 recognized between the two surgeries and they're not 12 the same surgeries at all. 13 Q Understood. So, is it fair to say, in 14 your view, a major distinction between performing 15 surgery for gynecomastia to alleviate distress from 16 social stigma and performing surgery to treat gender 17 dysphoria is that when you're performing 18 gynecomastia on a man, you're removing abnormal 19 tissue, but when you're performing 20 transition-related surgery, you are removing tissue 21 that is normal for that person? 22 A It's physiologic. We would presume, 23 unless there's a disease state that we know of to be 24 present, the fact that those two are technically 25 different procedures is reflected in CPT	Page 184 1 my colleagues, again, if they have been able to 2 produce evidence that they're highly confident, very 3 good, but I just not -- I have not seen that data 4 reproduced over time. 5 Q You've spoken a lot about phalloplasty in 6 particular. Are you aware that some insurance 7 companies cover vaginoplasty and chest surgery but 8 do not cover phalloplasty? Are you aware that some 9 insurance companies make that distinction? 10 A I never cease to be amazed at the 11 distinctions insurance companies make, yes, sir. 12 Q Phalloplasty is a much more complicated 13 surgery to perform than those other surgeries I 14 mentioned, right? 15 A I would agree. And if I may submit, my 16 judgment is not how complex it is. If it's 17 something that's going to help the patient and bears 18 a sufficiently minimal level of risk to achieve a 19 result, that's where we get into the, you know, 20 economics of medicine. It may be something that it 21 should not be, in my estimation, excluded based on 22 the complexity alone. 23 Q And phalloplasty is a much more expensive 24 a surgery than chest surgery or vaginoplasty, right? 25 A Yes, sir.

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Page 185 1 Q And phalloplasty has a higher rate of 2 complications than chest surgery or vaginoplasty, is 3 that right? 4 A Yes, sir. 5 Q Was that a yes? 6 A Yes. Yes, sir. 7 Q So -- 8 A To my understanding, considerably more so. 9 Q So, if an insurance policy didn't cover 10 phalloplasty but did cover chest surgery and 11 vaginoplasty, would that address at least some of 12 the concerns that you raised in your declaration 13 with surgery to treat gender dysphoria? 14 A Actually, to the contrary. I think it 15 would be somewhat illogical. If these surgeries 16 help people, why are we making our decision -- we 17 may have to make our decisions based solely on 18 economics, but given the fluidity of the patient 19 population and the dynamic state of the same and the 20 fact that we don't have any good parameters to say 21 Patient A, in 90 percent of patients, it's like if 22 you look at that old Meyer study. I think maybe 23 40 percent of them went on to complete surgery that 24 didn't have surgery initially. What surgeries did 25 they complete? I don't know. I don't know how	Page 187 1 Right now we don't even have any outcomes data, so 2 if we're going to talk about a urethral stricture 3 rate of 40 percent, what are we shooting for in this 4 whole process? And what are we offering people to 5 expect in terms of benefit on the other end of the 6 spectrum? 7 Q Is there more data on vaginoplasty than 8 there is on phalloplasty? 9 A My general sense is that yes, because the 10 number of phalloplasties, in terms of sheer numbers, 11 is greater for vaginoplasty. 12 Q And are you aware that many trans men 13 choose not to have any surgical procedure other than 14 chest surgery? 15 A Yes, sir. The thing that I think is a 16 problem is if we're really seeking to help these 17 people and they get to that point in their process, 18 oh, sorry, we can't do that now, and because that, 19 for some individuals -- and it's not necessarily 20 logical, there is no sequence, at least that I'm 21 aware of, that says, you know, you do this, you get 22 that. There's a high degree of variability. And I 23 think if we're going to offer that, why would we cut 24 that person, especially if it's so tied to their 25 well-being, from a psychiatric standpoint, why would
Page 186 1 we're going make those decisions and it would be 2 hard, in my estimation, to say, well, you're 3 approved for this but not for that. Based on what? 4 Complexity. That's not a valid reason for telling a 5 patient if we know we can help them. 6 Q In assessing the risks and the benefits, 7 isn't the risk of complications for a particular 8 surgery a relevant factor? 9 A It is a relevant factor. 10 Q So if the risks of complications for 11 phalloplasty are higher than the risks of 12 complications for vaginoplasty and chest surgery, 13 that would be one factor that counts against 14 covering phalloplasty when compared to chest and 15 vaginoplasty, right? 16 A Can you condense that one more time? 17 Q Sorry. So, there are three factors I 18 think I've talked about that are different with 19 phalloplasty. One is cost. One is risk of 20 complications. And the third is complexity. And 21 you said that you don't think complexity would be a 22 reason not to cover phalloplasty if you're covering 23 the other surgeries? 24 A Nor, necessarily, would the complication 25 profile, if it is deemed acceptable for the outcome.	Page 188 1 we cut them off at the chest surgery alone? 2 Q So if you think that if any form of 3 transition-related surgery is offered then the 4 insurance company would need to cover all forms of 5 transition-related surgery? 6 A Yes. Because the logic is we're seeking 7 to offer them help to the full extent possible. If 8 you come to me as your surgeon, you're expecting for 9 me to do the best thing for you, no matter what's 10 convenient or cost effective for me. I may be able 11 to parse your surgery into five different surgeries, 12 but if I do a significant number of them together, 13 then it gives you, in some cases, a better benefit 14 in terms of operative exposure, et cetera. So 15 that's what kind of the patient is trusting the 16 physician to offer him or her and our moral 17 obligation to the patient, I think. 18 Q Yeah, I want to go back to what it means 19 to meet accepted standards of medicine. In your 20 opinion, how is one to determine whether a 21 particular treatment meets accepted standards of 22 medicine? 23 A Josh, I think we begin with general 24 recommendations that are submitted as widely 25 accepted and reasonably safe. And then we, as

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Page 189 1 individuals, have to put those principles into 2 practice and determine whether we can execute them 3 independently or, for instance, whether if someone 4 comes to me seeking a phalloplasty, for instance, I 5 don't have the technical resources available in 6 terms of micro assistant help, I need to refer the 7 patient to Dr. Schechter. 8 Q When you referred to general standards, 9 were you referring -- when you were referring to 10 general recommendations, were you referring to 11 recommendations from organizations like the AMA and 12 the American Psychiatric Association? 13 A Again, the relevant recommendations, in my 14 professional world, would come predominantly from 15 those surgical societies. 16 Q But in determining what the field of 17 psychiatry views as accepted standards of medicine, 18 the recommendations of the American Psychiatric 19 Association and the American Psychological 20 Association would be the relevant recommendations 21 they would be looking to, is that right? 22 A I view -- I don't know what they -- who 23 "they" are in this case that we're alluding to, but 24 in my case -- and in the case I would submit of 25 plastic surgeons, it would be unprecedented that we	Page 191 1 organizations that you think is wrong? 2 A Well, yes, sir. I mean, I would hope you 3 all, as lawyers, feel the same way about the bar. I 4 mean, George Washington, I believe, if we read the 5 history right, was probably bled to death by his 6 physicians. That was the standard of the day; 7 bloodletting to get the evil humours out, so to 8 speak, by the best physicians, presumably, of the 9 day. 10 Q But at that time -- 11 A Medical knowledge is ever changing. That 12 we can be sure. 13 Q So, but at that time, George Washington 14 bloodletting met accepted standards of care as they 15 existed at that time, right? 16 A Putatively, yes, sir. 17 Q Yeah, if you're -- if the American Plastic 18 Surgery Association or the American College of 19 Surgeons said that surgical care for gender 20 dysphoria is medically necessary based on the 21 current science, would you recognize those 22 statements as evidence that the procedure meets 23 prevailing accepted standards of medicine, even if 24 you disagree with that conclusion? 25 A The standard would then be in place
Page 190 1 should operate at the behest of -- solely at the 2 behest of another clinician. That converts the 3 surgeon, in essence, into an automaton who is 4 responding in kind to the order for surgery. 5 Q So, if -- even if the American Plastic 6 Surgery Association and the American College of 7 Surgeons issued statements saying our general 8 recommendation is that surgery to treat gender 9 dysphoria is medically necessary, you would still 10 disagree with that conclusion, right? 11 A I'd have to see what the statement's made 12 on. What is the basis for it? 13 Q The basis being the current science that 14 exists right now. 15 A If the recommendation was made on the 16 current science, the current literature that we have 17 at our disposal, I question the recommendation. 18 Q You would think that recommendation is 19 wrong, right? 20 A I would not ascribe to it. 21 Q And -- 22 A Based on the state of the current 23 literature, please verify that. 24 Q Right. And it's possible for there to be 25 a recommendation that's accepted by these medical	Page 192 1 whether I think it is a valid standard or not, the 2 standard would then be in place, yes, sir. 3 MR. BLOCK: Okay. Thanks. I need just a 4 minute. It's okay to do a break or I can just 5 look through my papers for 30 seconds? 6 MR. JOHNSON: We'll take a break. 7 (Break Taken.) 8 Q (By Mr. Block) So, back on the record. 9 You had mentioned, in response to your previous 10 question, the CMS coverage decision that said 11 there's no nationwide rule, we'll leave it to 12 doctors to determine if it's medically necessary for 13 the individual patient. And my question is: Is 14 that a decision you support? Do you favor a rule 15 that doesn't have a national determination but 16 leaves it to individual doctors? 17 MR. JOHNSON: For the record, is that the 18 2016 decision? 19 MR. BLOCK: Yes. 20 A Well, Josh, maybe I'm just simplistic in 21 my way of thinking, but it doesn't really matter 22 what I favor or don't. In terms of just the 23 objective evidence, it seems there's not a 24 concordance to give us direction, one way or the 25 other. So, in that regard, I think those that

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Page 193 1 reviewed what they had to work with at the time were 2 not unreasonable. 3 Q (By Mr. Block) So, was it reasonable for 4 them to say that it is an option? Was it reasonable 5 for CMS to say that surgery for gender dysphoria is 6 an option for individual doctors to pursue based on 7 their determination of medical necessity? 8 A I don't think it's -- I don't think it's 9 unreasonable. 10 Q Now, you're aware that Medicare, before 11 2014, had a rule that prohibited surgery, regardless 12 of the individual views of a treating doctor, right? 13 MR. JOHNSON: Excuse me, I think you're 14 misstating the studies. There's an '89, 2014, 15 2016. Maybe I'm misunderstanding your question. 16 Q (By Mr. Block) Yeah, before 2014, so 17 you're aware that in the past, until the 2014 18 decision, Medicare had a blanket rule saying it 19 wouldn't cover surgery to treat gender dysphoria 20 under any circumstances, right? 21 A Yes. 22 Q And the rule adopted in 2016 is different 23 from a blanket ban on coverage, right? 24 A Correct. 25 Q And do you have a preference between CMS's	Page 195 1 standards? 2 A Well, I think -- I can't speak for the 3 thought process of those who reviewed the 4 literature, but I think what they're trying to do 5 with candor is really recognize the fact that we 6 don't have the answers that we need quite yet, but 7 we're willing to consider. And that's what all of 8 us, I think, really, must strive to do; is let's 9 consider, let's be candid, let's really look at this 10 and see what can we do to help these people. 11 Q And would you describe that as the 12 accepted standard right now? 13 A What's that, Josh? 14 Q The attitude of there's still more 15 information we need, we don't have all the answers, 16 but we're willing to consider providing the surgery 17 on an individualized basis, would you say that's the 18 prevailing accepted standard right now? 19 A Within what circle? 20 Q Within just accepted standards of 21 medicine. 22 A I mean, I think the American Psychiatric 23 Association has made their declarations, to my 24 opinion, based on subjective sentiment themselves 25 without good objective data, as they candidly note.
Page 194 1 current rule and a rule that simply prohibits 2 coverage across the board? 3 A I think it's in situations from a 4 physician perspective, I think in situations it's 5 more ideal to have a latitude to work with. I think 6 from third party payer perspectives, it's more ideal 7 to have blanket statements one way or the other 8 because it becomes very challenging to sort that 9 group. 10 Q Is the fact that CMS has -- is the fact 11 that CMS provides -- let me rephrase it again. Do 12 you think that CMS would provide coverage for a 13 condition if it did not meet accepted standards of 14 medicine? 15 MR. JOHNSON: I'm going to object. Lack 16 of foundation. Speculation. 17 A I think CMS, in all candor, is an 18 organization that can be very difficult to 19 understand what basis, logical or illogical, exists 20 for their support of one procedure over another, if 21 at all. 22 Q (By Mr. Block) So, do you think that CMS's 23 decision to provide coverage on an individualized 24 basis is at least evidenced in favor of the 25 conclusion that the procedure meets accepted	Page 196 1 I think in terms of CMS, that's why I'm asking, what 2 body are we talking about? I mean, all of us, I 3 think, I would hope, within medicine, really, are 4 taking that approach of let's look at this, let's 5 see, but I don't think that the statement that -- to 6 raise objections, to raise questions, is illogical 7 and unfounded and, you know, I have it, because I 8 just read it this weekend. I just took it with me. 9 I just got clinics before I came. I mean, we can 10 sit here, all of us, and look at just two of the 11 papers that, you know, came out of clinics in terms 12 of complication rates and say, Yikes. Okay. Well, 13 what -- you know, even if this is fantastic and does 14 alleviate dysphoria, part of our job as surgeons is 15 to think to the next step. What are we going to do 16 now? You know, that's kind of our job and we 17 probably all do that in different ways. But, my 18 statement is -- 19 Q What I'm getting at is just trying to make 20 sure that we're talking about the same thing when we 21 talk about what it means for something to meet 22 accepted standards of medicine. And I hear you to 23 be interpreting that phrase as has it been proven 24 definitively to be effective in a way that outweighs 25 the risks?

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1 A If I may, if I said proven, what I -- my
2 thought was that I said has it been demonstrated,
3 reproducibly demonstrated. It's difficult to prove
4 anything in medicine and I recognize that. I fully
5 recognize that point.

6 **Q So, my question is whether the phrase**
7 **"accepted standards of medicine" could, instead,**
8 **refer to the fact that the research is still out,**
9 **but given what we know, we're going to say it's an**
10 **acceptable option for doctors to pursue in their own**
11 **professional judgment? Is that another plausible**
12 **definition of accepted standards of medicine?**

13 A Repeat that one more time.

14 **Q Yeah.**

15 A Please.

16 **Q So, the definition I'm suggesting is that**
17 **something could meet accepted -- the meeting**
18 **accepted standards of medicine could mean that even**
19 **though more research needs to be done, it is an**
20 **acceptable option for doctors to pursue in their own**
21 **judgment?**

22 A It's -- it's not outside the pale of
23 popular sentiment to pursue, correct.

24 **Q Okay.**

25 A There's a difference in that, and as the

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1 high degree of complications, but to achieve the
2 benefit for those people that they see in their
3 patient population, they believe it reasonable and
4 thus feel it indicated and appropriate to discuss
5 within the body at large.

6 **Q And those physician's treatment decisions**
7 **are not outside the bounds of accepted medical**
8 **opinion?**

9 A Medical opinion is ever changing, Josh. I
10 would say that those decisions are not inherently
11 ill-intended. I think, you know, I have confidence
12 that a physician like Dr. Schecter is working for
13 the good of his patient. As you alluded to earlier
14 in the corrective surgery of Dr. Djordjevic, who can
15 say what was going on? You can get online and read
16 any blog and hear that common complaint from
17 patients that I feel like I just got hustled. And
18 that nobody really took time to talk with me about
19 this and what the implications were. Those are --
20 whether those are true or not, I can't say. But my
21 impression, as it relates to plastic surgery, is
22 that there are a select number of physicians,
23 including Dr. Schecter, who have found that they can
24 reproduce some things. Now, I don't know
25 Dr. Schecter would be better qualified, certainly

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1 American Psychiatric Association has candidly
2 demonstrated, one must interpret medical -- there's
3 a difference in medical sentiment and popular
4 opinion, even professional opinion, and standards of
5 care. And it is not obviously necessary for us to
6 have, according to some societies,
7 well-substantiated quality evidence to make a
8 recommendation. Now, different specialties and
9 different individuals than specialties are going to
10 have different comfort levels with those
11 recommendations. But, as surgeons, the effects of
12 what we do are tangible and lasting and often
13 irreversible, so it bears that we consider those
14 things, in my opinion, even greater degree of
15 scrutiny than perhaps other disciplines may.

16 **Q Do you think that the medical community**
17 **has been too lenient on -- in accepting surgery for**
18 **gender dysphoria as an appropriate treatment option?**

19 A I don't get that impression. I don't get
20 that impression, no, sir.

21 **Q And why is that?**

22 A My impression is that there are a number
23 of surgeons who have been willing to assist patients
24 in this regard, have found in their own experience
25 that they can execute the surgery, albeit with a

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1 than I am, to talk about the results of his
2 practice, his complication rates over time, and what
3 he sees as a tangible benefit for these people.
4 But -- and I don't think any candid surgeon would
5 ever discourage a colleague who is striving to do
6 something in the patient's best interest from doing
7 so.

8 **Q But, so it's possible for you to disagree**
9 **with the decision and still have that decision be**
10 **within the bounds of accepted standards of medicine,**
11 **right?**

12 A That's possible, yes, sir, for any of us,
13 any physician in practice.

14 **Q So, do you think the work of Dr. Schecter**
15 **is within the bounds of accepted standards of**
16 **medicine as it currently exists?**

17 A Which works specifically?

18 **Q Providing surgery to treat gender**
19 **dysphoria.**

20 A I think it's in as much as he has
21 satisfied himself that his complication rate -- and
22 I say this because I don't know this. Every surgeon
23 has to look at his own practice and say, okay, for
24 what I'm providing these people and what they're
25 emerging from this with, I'm satisfied that the good

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Page 201 1 outweighs the adverse effects. I don't know that. 2 I would presume, based on what I know of 3 Dr. Schechter, that he's operating under that 4 principle. 5 Q So does that mean that he's meeting 6 accepted standards of medicine? 7 A There's no standards to meet. As we 8 discussed, the ASP -- we don't have any standards. 9 We being the surgical bodies do not have standards 10 as of to date. That may all change, but -- but we 11 don't have any right now, so I don't -- it's 12 impossible for me to say whether he's meeting 13 standards when there really aren't any to speak of 14 in this regard. 15 Q So, if -- so, this brings up a good 16 question. If a surgical body has not issued an 17 authoritative statement on a particular procedure, 18 the fact that someone -- it's still possible -- let 19 me start again. In the situation where the medical 20 body has not issued an authoritative statement on a 21 procedure, how do you determine whether or not a 22 physician that chooses to perform that procedure is 23 meeting accepted standards of medicine? 24 A Well, I can't really think of any 25 occasions where -- within my practice there's	Page 203 1 and what you're getting at, probably the more 2 germane body would be the American Board of Plastic 3 Surgery. 4 Q Okay. To your knowledge, does the 5 American Board of Plastic Surgery include surgery 6 for gender dysphoria as a topic on which people can 7 be tested on for certification? 8 A I would surmise that it presently may be. 9 Q And to the best of your knowledge and 10 experience, does the American Board of Plastic 11 Surgery test people on procedures that don't meet 12 accepted standards of medicine? 13 A In as much as that, yes, they would select 14 to screen out candidates who are practicing cases or 15 in a manner that doesn't meet the standards, yes, 16 those cases may be presented. Their presentation 17 does not, de facto, make them such a case but they 18 can presented. That's speculative. 19 Q But if -- does the fact that -- taking 20 the -- does the fact that the American Board of 21 Plastic Surgery tests people on their knowledge and 22 ability to perform surgery for treating gender 23 dysphoria indicate that that surgery is accepted or 24 that that surgery meets accepted standards of 25 medicine?
Page 202 1 anybody that is practicing something that is -- that 2 doesn't have some relevant recommendation associated 3 with it. 4 Q You think gender dysphoria doesn't have a 5 recommendation associated with it, is that right? 6 A Not from a surgical society. There's one 7 from -- obviously from WPATH. 8 Q But, is every other surgery that -- that 9 you -- that a trained plastic surgeon performs 10 governed by a particular statement from the American 11 Society of Plastic Surgeons? 12 A I don't know. I don't know. I don't -- 13 based on the -- my practice, there's nothing that is 14 novel or outside the scope of what is commonly 15 assessed within the purvey of any completion of any 16 ACGME approved process or that would enable a 17 surgeon to complete board certification without 18 knowledge and expertise within those domains of 19 medicine, plastic surgical medicine, I should say. 20 Q But -- 21 A I haven't referenced the ASPS reference in 22 that regard. It's more of a society web page, and I 23 mentioned in my declaration only in as much that 24 it's a relevant body within the world of plastic 25 surgery for what I think you're discussing, Josh,	Page 204 1 A Well, this is a case where I would not be 2 qualified to answer because I've not been through 3 the board certification process in a few years. I'm 4 active on CME and actually cede my CME requirements 5 considerably, but I have not seen any -- any CME 6 requisites that require for ongoing certification, 7 knowledge, or competency in that regard. 8 Q Okay. So, changing topics, so we've been 9 discussing your medical opinion on performing SRS, 10 but you mentioned you also have -- have an opinion 11 based on your faith regarding SRS, is that right? 12 A Well, I have an opinion on everything 13 based on my faith, yes, sir, it informs my every 14 decision. 15 Q So, aside from -- aside from your medical 16 view, what is your faith view about providing SRS? 17 A Josh, my faith view is that the human body 18 is a reflection of a creator. It is not something 19 to be truffled with lightly. Or as if it is 20 something simply a composite clay to be molded to 21 the scope, extent, and nature of myself or anyone 22 else. That is not to say that we can't improve upon 23 disease states and that is not to say that if a 24 disease state is present that, by alteration of the 25 body, that we cannot offer alleviation of pain or

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Page 205 1 distress, that there's not a valid reason for doing 2 so. 3 Q Just to be clear, performing SRS to treat 4 gender dysphoria does not fall into that category 5 under your faith view? 6 A Which category? 7 Q You know, you said that the human body, 8 you know, should not be altered, you know, just 9 based on people's desires. That does not mean, 10 however, that, you know, we can't perform surgery 11 to, you know, address disease? I just want to 12 confirm that that "does not mean" caveat, you know, 13 doesn't include gender dysphoria as an acceptable -- 14 SRS to treat gender dysphoria as an acceptable 15 treatment that's compatible with your faith view? 16 A If I may say, I don't think it's wise. 17 I'm not saying we can't. What the rest of the world 18 does and even within our societies, we're going to 19 have disagreement on things. It's very different to 20 say I don't believe this is wise and to say we 21 can't. That's a different matter entirely from 22 saying I don't think this is wise because I don't 23 see what I've already discussed over time a 24 substantive objective reproducible benefit. 25 Q But even if a substantive reproducible	Page 207 1 achieve that state whereby they are qualified to 2 meet that. Even though there's no doubt, though, if 3 you give that person an injection of so much 4 Propofol, they will not suffer, that is 5 incontrovertible, they will be gone. But it doesn't 6 give me a level of comfort that what we did as 7 physicians was the best thing for them, if that 8 makes any sense. 9 Q It makes complete sense. And you think 10 that someone's -- is it fair to say that you agree 11 that someone's faith-based views on a procedure 12 should be distinct from their medical views on 13 whether it meets accepted standards of care? 14 A I think the honest person is going to look 15 candidly, as I mentioned earlier, I believe, the 16 only thing that I'm really certain of, I believe 17 there is a God and I am not him. So my views may or 18 may not matter, ultimately. What I seek to do is 19 align my views with my understanding of faith and 20 God and also of the practice of medicine in accord 21 with standard of care, based on the best of our 22 field, no matter what their religious belief is. 23 Q You look to medical sources and 24 peer-reviewed medical journals when -- when 25 determining whether something meets medical
Page 206 1 objective benefit did exist, you would still, just 2 as a personal matter, have a faith-based objection 3 to performing SRS? 4 A I would have great trepidation, yes, sir. 5 I would have great trepidation about that. 6 Q So, would performing SRS conflict with 7 your religious beliefs? 8 A At the present time, performing a nascent 9 sex reassignment surgery, yes. 10 Q Would performing SIS conflict with your 11 religious beliefs if data existed proving 12 substantive objective, positive, easily reproducible 13 effects, would performing the surgery, nevertheless, 14 conflict with your religious beliefs? 15 A It would. And that's not to deny its 16 efficacy. 17 Q Understood. 18 A Let's say, for instance, with euthanasia, 19 that's a tough problem, I've watched people suffer 20 with that. My religious belief is -- and I've -- I 21 do think about this more than I care to -- is such 22 that I believe that decision is beyond the scope of 23 my wisdom and judgment and I have yet to meet 24 another human being who, despite their intellectual 25 prowess and academic credentials, has been able to	Page 208 1 standards of care? 2 A I do. And I don't know why there's an 3 inherent contradiction between a person's faith and 4 the execution of their faith and the practice of 5 medicine at a level that's extraordinary or standard 6 of care. 7 Q Would you view the National Catholic 8 Bioethics Quarterly as a publication that you would 9 look to to determine whether a particular procedure 10 meets accepted medical standards of care? 11 A I would not. I might not be in 12 disagreement. I don't know that publication. But 13 if my personal religious beliefs are under review, 14 there are a number -- I don't find a number of 15 tenants of the Catholic component of Christianity 16 with what I read in the New Testament. So I don't 17 know that I would even look to that for even 18 religious matters. But, again, there might be some 19 common threads that I might share -- I've never 20 read -- I'm not familiar with that publication. 21 Q In determining, you know, an answer to a 22 medical question, you would generally rely on 23 peer-reviewed publications, is that right? 24 A Yes, sir. 25 Q And peer-reviewed publications in medical

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1 journals, is that right?

2 A In combination with the reality of what I
3 see.

4 Q And is there a distinction, in your mind,
5 between a publication that is peer-reviewed and a
6 publication on medical issues that is not
7 peer-reviewed?

8 A Well, the principle of peer review is an
9 excellent one. And I think if the integrity of the
10 process is maintained, peer-reviewed literature is
11 ideally stronger than non-reviewed literature, yes,
12 sir.

13 Q Does your personal faith view inform your
14 medical decision making?

15 A I believe that it does. I believe that
16 based on -- I mean, as my practice is testament to,
17 I think if you're homosexual, heterosexual,
18 bisexual, transsexual patients, and I see no
19 conflict with what the life of Jesus Christ is in
20 the care of these people. I don't -- I guess there
21 should be a conflict based on the question, but I
22 don't perceive a conflict. I don't. I would hope
23 it would inform my practice.

24 Q And does your faith view inform what
25 surgical treatments you consider to be medically

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1 appropriate?

2 A What do you mean by medically appropriate,
3 Josh? For instance, an 18-year-old girl may show up
4 to my clinic seeking breast augmentation. And she
5 may have with her a 55-year-old male who says that
6 he's paying for the surgery. She's a cis female,
7 not interested in gender transition. My viewpoint,
8 based on my faith, is that I have no business
9 executing that surgery. Can it be safely executed?
10 Oh, yes, to the tune of 300,000 of them a year, but
11 many people say, Well, you're being paternalistic,
12 who are you? It's her body. It is her body. But
13 once I put an incision on it, I start a process
14 that's irreversible. There's ample number of
15 surgeons who may perform that surgery for her and
16 Lord knows, based on what insurance reimburses us
17 for some procedures, it would be very attractive to
18 do that as opposed to the type of work that I do.
19 But to answer your question, my faith informs, yes,
20 sir, my practice, my life, my marriage, how I
21 conduct myself in this deposition, you know, how I
22 conduct myself with the janitor at midnight when I'm
23 walking down the hall in the hospital. I mean, if
24 it didn't, I wouldn't think it a faith worth having.
25 I'd throw it in the trash can.

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1 Q I want to turn to the rebuttal report of
2 Dr. Schecter, which I think we already marked as an
3 exhibit. And have you reviewed that rebuttal report
4 before today?

5 A I have reviewed it. In all candor, I
6 reviewed it on the tarmac at O'Hare on my iPhone,
7 so -- and through a series of untoward events in the
8 time since it's been forwarded to me, I have not
9 been able to print it off, so I'm looking at it in
10 print for the first time.

11 Q Is there anything about his rebuttal
12 report that you disagreed with?

13 MR. JOHNSON: Object to that. Vague and
14 indefinite.

15 A The report, as I understand this, is a
16 review of Dr. Schecter's credentials, which are
17 certainly impressive, other than his rebuttal of my
18 comments about the Meyer paper and my drawing a
19 conclusion.

20 MR. JOHNSON: Go through the report.

21 A I would state even Point 23, Page 6, that
22 even with proper observation of WPATH guidelines,
23 that's quite a presumption to say that those will,
24 de facto, obviate any potential for patients to go
25 through surgery that may have not been good

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1 candidates to do so. There's tremendous variability
2 in the quality and credentialing process, as I
3 understand it, of psychology, to say nothing of
4 psychiatry. I think in Point 22 --

5 Q 22?

6 A Yes, sir. Dr. Schecter and I obviously
7 see very differently. He has reached a point in his
8 practice where he feels that he has no objection to
9 remove physiologically healthy tissue in pursuit of
10 a goal that he obviously has achieved a level of
11 confidence that he can obviate with his surgery. I
12 haven't seen that based on my experience and
13 observations.

14 Q So do you, in your experience, are you
15 willing to perform surgery on physiologically
16 healthy tissue in order to prevent disease?

17 A With reasonable likelihood of development
18 of disease. I think in Point 19, I think my -- my
19 intention in reviewing breast augmentation is
20 different in the sense the point I'm making in that
21 is: Are we talking about a disorder or are we
22 talking about dysphoria? Because there's lots of
23 women who are dysphoric about the state of their
24 body and no one expects that to be covered under
25 insurance. If we're talking about a true mental

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Page 213 1 disorder that we can alleviate by surgery, general 2 consensus, that's unprecedented and may well be the 3 case. But if it is so, and that's my observation, 4 just Daniel Sutphin, in taking care of these people, 5 if there is mental discord and distress there, there 6 is more than just simple dysphoria. And to couch it 7 in terms that we may think are less discriminatory 8 or emotionally harmful to the patient, I don't do 9 the patient a service if I don't call what's 10 happening what it is and I can do that in a 11 respectful manner and in a manner sensitive and 12 that's my obligation as a surgeon to do so, but I 13 don't help them if I ignore the process. And by not 14 calling it as such, I think it creates a lot of 15 confusion in terms of diagnosis. 16 Q So your view is that some transgender 17 people have a level of dysphoria that is low enough 18 that it's comparable to the displeasure that a 19 cisgender person might have with their physical 20 body? 21 A Not only me, but it's even observed in 22 this month's Clinics; that, really, that's actually 23 going to be an issue in the future with insurances 24 because there are people who are really not even 25 dysphoric but are seeking these surgeries and now	Page 215 1 talking about is a real disorder. That's, perhaps, 2 a valid point, if the other criteria that we 3 discussed about, at least to my opinion, are 4 satisfied. Obviously, based on Point 20, 5 Dr. Schecter does not believe the definition of 6 reconstructive and cosmetic surgery. He does not 7 ascribe to that definition of surgery that I do, 8 that I stated earlier. I made no statement in Point 9 24, whatsoever, regarding the frequency of regret. 10 My only point is to illustrate it does occur. And I 11 did not raise it as such as a statement, gender 12 reassignment surgery should not be performed because 13 there is a large percentage of regret, it's just for 14 consideration, a candid point for consideration. We 15 discussed the Point No. 25. And I do understand 16 Dr. Schecter's -- and how he would perceive that. 17 That's not my point in illustrating that. It's just 18 a casual observation in the sense that I stated 19 earlier. And Point 26, the research, which is 20 research as well as my own clinical expertise, I 21 would say that based on the volume of his practice 22 he does have considerable expertise, show that 23 surgical procedures for gender dysphoria are safe 24 and effective. I would argue that there are so many 25 procedures. Are we talking were trans men, trans
Page 214 1 what do we do? 2 Q But you agree that there are at least some 3 transgender people who have dysphoria that is much 4 more severe so that it qualifies, in your view, as 5 rising to the level of a mental disorder, is that 6 right? 7 A It appears to me to be much more severe 8 than dysphoria. 9 Q And you agree that that set of people are 10 not comparable to a cisgender person who wants 11 surgery because they're uncomfortable with their 12 body? 13 A I don't see the degree of distress in that 14 patient population, no, sir. 15 Q Just want to make sure that the -- I think 16 I understand what you're saying, but you're saying 17 you don't see -- when you said that you don't see 18 that degree of distress in the patient population, 19 you were referring to cisgender women, right? 20 A Correct. And so, that's part of the 21 illustration in Point 19. That, to me, further 22 underscores, from a state perspective, if what we're 23 talking about is dysphoria, I don't know how we 24 would expect the state to pay for -- or a third 25 party to pay or cover a procedure if what we're	Page 216 1 women, what -- that's a very broad statement. I 2 don't know of any other procedure that I would offer 3 reproducibly knowing that the complication rate of 4 something is 40 percent and call that safe. 5 Q Well -- 6 A I would say it's a procedure fraught with 7 complications and, in fact, one of -- one of our 8 colleagues notes that. Even going so far as to 9 describe a procedure like phalloplasty is a hydra 10 with multiple tentacles of potential pitfalls, so -- 11 Q Let's confine the statement in this 12 paragraph to vaginoplasty and chest surgery. 13 MR. JOHNSON: Excuse me, paragraph what? 14 MR. BLOCK: 26. 15 MR. JOHNSON: 26? 16 MR. BLOCK: Yes. 17 A I think it would be better to say "can be 18 executed safely and effectively." They are not, by 19 default, safe and effective. If they were, we 20 wouldn't be talking about fellowships for them. 21 Q (By Mr. Block) But they can be executed 22 safely and effectively? 23 A In the hands of people like Dr. Schecter, 24 yes, sir, I would presume, again, I haven't seen his 25 own personal literature, but I would presume that,

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Page 217 1 given his practice, that he finds the same to be 2 true. I don't know what he's referencing when he 3 describes the medical community. I'm not sure what 4 he's talking about with these analogous procedures. 5 Presumably any such procedure like mastectomy for a 6 cis woman, to the point that I made earlier, I'm not 7 sure that just because we can execute it safely 8 doesn't mean we necessarily should. 9 Q Do you agree that the surgical techniques 10 used for these surgeries are adapted from surgical 11 techniques that are performed on cisgender patients? 12 A Some, not all. For instance, vaginoplasty 13 with penile inversion is truly novel. Very 14 creative, I might add. And just like a plastic 15 surgeon to come up with. I disagree with 16 Dr. Schecter's statement in Point 28, no matter what 17 the ascribed gender of the patient; assigned, 18 perceived, otherwise, there's still the reality of 19 biology and if ignore that we do that to the peril 20 of the patient and to the peril of the medical 21 record. I don't understand Dr. Schecter's use of a 22 subcutaneous mastectomy unless he's performing it 23 for a female patient. That code is, by default, 24 performed for a female patient. The code that was 25 submitted for this case was that for gynecomastia	Page 219 1 obese at 53 of age, you're going to be much more 2 concerned about an occult breast cancer in that than 3 if you're getting a little bit of gynecomastia. 4 Much, much different scenario. 5 Q In your practice, have you ever submitted 6 authorization requests for a procedure and used the 7 wrong code by accident? 8 A I would imagine I have, but I never 9 ascribed a letter that ascribes a condition and, 10 based on my interpretation of the language used in 11 the letter seeking approval. There's a big 12 difference in gynecomastia refractory to weight loss 13 and natal female breasts. I don't perceive 14 Dr. Schecter would make that comment in any of his 15 cases. In Section 29, looking specifically at 16 complication rates from chest surgeries. Two recent 17 studies reveal a complication rate among transgender 18 men between 11 and 12 percent in comparison to the 19 complication rate of 43 percent for cisgender women 20 undergoing breast reduction in a 2005 surgery -- or 21 study, excuse me. To the point that I just made, 22 the female breast is different, is a different 23 construct altogether, the biological female breast. 24 And Dr. Schecter, in his discussion here, doesn't go 25 on to reveal what -- we can say major complications,
Page 218 1 and, Josh, those are two very different things. 2 Very, very different. And that's something that, no 3 matter what side of this coin a person is on, we all 4 recognize that there's certain principles you have 5 to acknowledge the IMF. You have to acknowledge the 6 blood supply to the nipple. You have to be aware of 7 the fact that the female nipple is going to be wide 8 and effaced in most cases at this point in a women's 9 life, so I don't -- I think candor is vital, 10 whatever we do and decide, I think we've got to be 11 candid about are we doing a mastectomy, which is the 12 code Dr. Schecter would assign, versus the code that 13 was utilized in this case, which was -- 14 Q So the code Dr. Schecter would assign is 15 consistent with your view of what the proper code 16 would be? 17 A Yes, sir. Yes, sir. And my apologies if 18 I wasn't clear on that. The code that I understand 19 was used in the case was not this code. 20 Q Understood. 21 A And it was not -- it was presented as 22 gynecomastia, not as the reality of a natal female 23 breast. Irrespective of where you come down on the 24 argument, the pathologist needs to know that when he 25 or she gets the specimen, because a woman who's	Page 220 1 moderate complications. I, at this point, have not 2 read this study to know, and No. 5, analysis of 3 breast reduction complications, but it is -- a 4 breast reduction is not the same surgery at all to 5 that of a mastectomy, subcutaneous mastectomy. If 6 I'm understanding the patient population, are we 7 talking about transgender men meaning natal females 8 who are transitioning to men? 9 Q Yeah, if you look at Footnote 4, female to 10 male transgender chest reconstruction, so these are 11 natal females having chest surgery. 12 A To answer this more intelligently, I would 13 have to see what is the age. For instance, even in 14 cis women, we notice a -- once a woman gets past the 15 age of 45, her risk of wound healing complications, 16 infection, tends to go up considerably. We think 17 that's likely tied to hormonal-related changes in 18 the breast parenchyma. At that station of life more 19 women may begin to experience menopause. And we, in 20 light fashion, speculate that some of that change is 21 due to change in vascularity of the breast, again, 22 I'd have to look more in depth at that. Those are 23 my comments. 24 MR. BLOCK: Thank you. Just give me a 25 moment. So we can go off the record.

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Page 221 1 (Break Taken.) 2 Q (By Mr. Block) Back on the record. I 3 don't have any other questions. Is there anything 4 that you felt you were unable to say in the course 5 of this deposition that you want to say? 6 A I've never met Dr. Schecter, don't know 7 him. His name's come up, given his prevalence in 8 some of these discussions, I think it's important to 9 distinguish to the point that I made earlier, even 10 though we can execute a surgery today, part of our 11 obligation of surgeons is to really follow up over 12 time. And that holds for any procedure, whether 13 it's the DIEP flap and abdominal site morbidity. 14 When you see patients who have had the surgery come 15 back in ten years later with abdominal bulge, pain, 16 and even hernia defects, that's not going to show up 17 in the initial literature and that's why, again, 18 I -- I don't see anything in the literature right 19 now that talks about a sustainable long-term benefit 20 to this surgery that will justify a real standard of 21 care transition. I don't -- personally, I don't 22 think that's possible until we can demonstrate, 23 though Dr. Schecter and his comments notes it's safe 24 and effective, what exactly is safe and effective? 25 For the first three months? Effective for making	Page 223 1 wouldn't grow back? 2 A If I knew the likelihood of growth is it's 3 going to grow back, I'm not doing a service to the 4 patient to operate on them in the first place unless 5 they're tripping over it, so to speak. Now, I can 6 go ahead and do the surgery and go for it, but if I 7 know that it's going to be back, if so, when, what 8 is the implication? What are the risks of surgery 9 of doing that procedure? And it's -- that's the one 10 really good thing about this scenario that we're 11 talking about in terms of sex reassignment, gender 12 confirmation surgery, is the -- it's not just in the 13 realm of the theoretical papers like Djordjevic and 14 in this month's Clinics. When you look at that, you 15 don't have to be a professional, you can be a laymen 16 and say, wow, this is the real deal. How do we 17 really know that this is really what's going on and 18 if we're putting these people through these 19 surgeries, boy, what do we have to show for it for 20 them, like 10, 15, 30 years down the road? 21 Q What treatment should someone with severe 22 gender dysphoria have, in your opinion? 23 A I don't know, Josh. If I did, I'd 24 certainly be one of the first people out there 25 trying to provide it for them. Like I said earlier,
Page 222 1 the person feel subjectively better? Again, that's 2 why I really find studies like Dhejne's useful 3 because that's something that we can all look at and 4 isn't under the subjective purvey of one surgeon or 5 a team of surgeons or a group of patients who are so 6 distraught by this condition they're willing to 7 accept significant complications to alleviate. My 8 position remains as such as what I've stated. 9 Q And is 15 years usually a good followup 10 period? 11 A I think it's a great start. I think it's 12 a great start. 13 Q And one more question. Is -- are there 14 procedures that -- that view as medically 15 appropriate to treat symptoms in the short-term even 16 if they aren't ultimately a care for the condition? 17 A None that I can think of with the 18 magnitude of what we're talking about here today. 19 Q Anything on a smaller magnitude? 20 A No, sir. I mean, not from a surgical 21 perspective, no, sir. 22 Q So if there's like a growth that is likely 23 to come back, you know, after a period of time, 24 is -- but would the practice be not to perform 25 surgery to remove the growth if you weren't sure it	Page 224 1 there would be a nice prize on my wall. I don't 2 know. And I'm fully not satisfied that any of us 3 really do. 4 Q And so, in your opinion, there's no 5 medical treatment that could be, you know, 6 responsibly offered to them that's consistent with 7 accepted standards of care? 8 A I think if somebody's willing to ignore 9 the fact that we don't have long-terms outcomes 10 data, I haven't seen a patient in that level of 11 distress yet that I feel comfortable offering. I'm 12 not an endocrinologist but, you know, if you were my 13 brother and this is something you're looking for, 14 obviously, and I actually work with an individual 15 whose natal sex sister, female, has now undergone 16 transition to a male, if you were contemplating 17 this, I would have grave concerns about, gosh, it 18 might make you feel better, but what is -- what is 19 20, 30 years of estrogen going to do for your body? 20 What's it going to do? And we've not even discussed 21 things like bone structure. Those -- those are 22 valid questions. And I don't think we have sound 23 answers and I think the question of responsibility 24 lies with if we're willing to disregard that or set 25 that aside, that we just don't have those outcome,

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Page 225 1 and we don't know -- perhaps we can use the word 2 responsible. If we're just ignoring those and 3 pretending like that data exists, it doesn't, and I 4 don't think that's responsible for us to say as a 5 medical community at large. I don't. I don't think 6 that's, you know, when you -- when you become a 7 physician, you need something more than speculation 8 and sentiment. You need -- whether those -- those 9 data exist or they don't, you're trusting a 10 physician to tell you that. 11 Q Well, I mean, you agree that low quality 12 data exists, right? 13 A Subjective data. It seems to me, based on 14 what I've read thus far, it's impression. And 15 impression is not without value. But impression, in 16 my mind, is not grounds enough to substantiate 17 incurring the risk to people in executing in real 18 life the procedures that are occurring. 19 Q And you agree that someone's clinical 20 experience in working with patients and seeing 21 improvement over the long term is also a form of 22 data? 23 A Yes, sir. 24 MR. BLOCK: I don't have anything else. 25 MR. JOHNSON: I've got a few.	Page 227 1 Q Sure. In your report, you referred to the 2 2016 CMS study or decision? 3 A Yes, sir. 4 Q Okay. That's one that talked about the 5 Swedish study, correct? 6 A Yes, sir. 7 Q Okay. Did -- from your reading of the CMS 8 2016 decision, did CMS look at the literature to try 9 to determine the long-term outcomes of patients that 10 have SRS surgery? 11 A No, sir. I don't know that they could 12 find any good data on that. 13 Q But they looked at whatever literature it 14 was they looked at? 15 A Correct. What was existed at the time. I 16 don't think that they weren't looking. I just know 17 they couldn't find it. 18 Q Did they say they looked at the Swedish 19 studies? 20 A Yes. 21 Q And they looked at other studies, correct? 22 A I would say, in my impression, Dhejne's 23 study was probably the best quality. 24 Q Did they say they didn't find high quality 25 evidence of studies that allow them to reach a
Page 226 1 EXAMINATION 2 BY MR. JOHNSON: 3 Q Listening to your testimony, appears you 4 looked at Dr. Schecter's education and training and 5 experience? 6 A I have looked at his education and 7 training. 8 Q And you believe he's a fine and skilled 9 surgeon? 10 A I believe he has sound credentials. 11 Q Okay. And I think you've testified, based 12 upon his credentials, he should be able to do a 13 skilled and good vaginoplasty or phalloplasty? 14 A I can only comment that he has sound 15 credentials. I have not seen any of his patients. 16 I've not been able to subjectively measure the 17 results of his -- 18 Q Well, assume he can do it skillfully and 19 if he reports that the patient tells him that the 20 dysphoria has been helped -- strike that. You have 21 no indication he's not a skilled physician? 22 A Correct. 23 Q Okay. And that he could do many forms of 24 SRS surgery? 25 A Based on what he has put forth, correct.	Page 228 1 conclusion on the long-term outcomes of the surgery? 2 A My understanding of the CMS paper was that 3 there was not. 4 Q Strong evidence? 5 A Strong evidence. 6 Q Did they suggest more robust studies in 7 the future? 8 A Yes, sir. Which, I think, incidentally, 9 is the same position that I would posit, put 10 forward. 11 Q Did you do a search beyond CMS to try and 12 find other studies? 13 A Yes, sir. 14 Q And I think your testimony's been that you 15 agree with CMS, there's just not sufficient, strong 16 studies on long-term outcomes? 17 A Not in my opinion. 18 MR. JOHNSON: Thank you. 19 EXAMINATION 20 BY MR. BLOCK: 21 Q In your opinion, are there sufficient 22 studies to demonstrate harm from transition-related 23 surgery? 24 A Yes, sir. What kind of harm are we 25 talking about? I mean, any complication is harm.

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Page 229 1 We can talk about whether we think it's justifiable 2 or not, but yes, sir. 3 Q In your opinion, is there a basis to 4 include that having transition-related surgery can 5 increase someone's risk of suicidality? 6 A I don't know of any data. Dhejne's study, 7 for instance, doesn't -- doesn't address that. It 8 only observes the fact that there is a markedly -- 9 there's a marked increase in suicide for those 10 individuals that have undergone sexual reassignment, 11 but it doesn't comment on whether that incident may 12 have been higher without sex reassignment surgery. 13 It underscores the very concern that I have and that 14 is there's something that we're missing that even 15 though these people may initially feel better, we're 16 not getting to the heart of the matter. And I'm not 17 sure, to answer your earlier question, Josh, I'm 18 just not sure that any of us know. That's not to 19 say we shouldn't do anything. But surgery requires, 20 I mean, that much more caution because the impacts 21 are so profound and tangible for people's lives. 22 Q Is it fair to say that CMS concluded that 23 there wasn't sufficient data to justify prohibiting 24 coverage for transition-related surgery? 25 A Well, I guess, depending on how we couch	Page 231 1 A That point is understood. I would also 2 submit that that's no way for us to do surgery. 3 Let's do it because we don't see enough -- we might 4 be able to do it because we're not seeing enough. 5 Let's see if we can -- I don't -- I don't see that 6 as a really valid option for surgery. If we're 7 going to subject another human being to the risk of 8 something, we need to emerge with that, with a high 9 degree of confidence that we can execute it with a 10 reasonably low level of complication, and I can't 11 know what those reviewers -- why they made the 12 decision as they did. 13 MR. BLOCK: Okay. That's it on my end. 14 MR. JOHNSON: No more from me. No mas. 15 He'll read and sign. 16 17 (Ending time of the deposition: 4:41 p.m.) 18 19 20 21 22 23 24 25
Page 230 1 the term, there was not data to support it. And in 2 one sense they left all of us in a conundrum because 3 it leaves us in this matters of verbiage. There's 4 no data at this point for them to issue a statement 5 saying, hey, we find that this is well supported, 6 move forward. 7 Q But they had the option of concluding that 8 surgery should never be covered, right? 9 A They had the option and they -- again, to 10 my estimation, on one hand, they said we don't find 11 the data, but yet, why they didn't issue a statement 12 saying we just -- we're not going to offer it, 13 because we don't -- obviously, they are not basing 14 their decision solely on data either. 15 Q Well, so it's not fair to say that they 16 didn't see enough data demonstrating significant 17 risk of harm to justify having a blanket prohibition 18 on coverage? 19 A They didn't issue it. Yes, sir. 20 Q So, the data was not conclusive enough for 21 them to determine either way? 22 MR. JOHNSON: Well, excuse me, I'm going 23 to object; asking this witness to testify to the 24 state of mind of thought processes of people that 25 wrote that decision.	Page 232 1 STATE OF MISSOURI) 2)SS 3 CITY OF ST. LOUIS) 4 I, Rebecca Brewer, Registered Professional 5 Reporter, Certified Real-time Reporter, and 6 Notary Public in and for the State of Missouri do 7 hereby certify that the witness whose testimony 8 appears in the foregoing deposition was duly 9 sworn by me; that the testimony of the said 10 witness was taken by me to the best of my ability 11 and thereafter reduced to typewriting under my 12 direction; that I am neither counsel for, related 13 to, nor employed by any of the parties to the 14 action in which this deposition was taken, and 15 further that I am not relative or employee of any 16 attorney or counsel employed by the parties 17 thereto, nor financially or otherwise interested 18 in the outcome of the action. 19 _____ RPR, MO-CCR, 20 Notary Public within and for the State of Missouri 21 22 My Commission expires April 7, 2021 23 24 25

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Page 233	Page 235
1 Mr. Jerry Johnson	1 WITNESS ERRATA SHEET
2 Jerry Johnson Law Office	2 Witness Name: DR. DANIEL SUTPHIN, M.D., FACS
3 909 St. Joseph Street, Suite 800	3 Case Name: BRUCE VS. STATE OF SOUTH DAKOTA
4 Rapid City, South Dakota, 57701	4
5 Jdjbjck@aol.com	5 Date Taken: JULY 17, 2018
6 In Re: BRUCE vs. STATE OF SOUTH DAKOTA.	6 Page #____ Line#____
7 Dear Mr. Johnson:	7 Should Read: _____
8 Please find enclosed your copy of the deposition of DR.	8 Reason for Change: _____
9 DANIEL SUTPHIN, M.D., FACS taken on JULY 17, 2018 in the	9 Page #____ Line#____
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24	24 _____
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1 State of)
2 County of)
3 I, DR. DANIEL SUTPHIN, M.D., FACS, do hereby
4 certify:
5 That I have read the foregoing
6 deposition;
7 That I have made such changes in
8 form and/or substance to the within deposition
9 as might be necessary to render the same true
10 and correct;
11 That having made such changes
12 thereon, I hereby subscribe my name to the
13 deposition.
14 I declare under penalty of
15 perjury that the foregoing is true and correct.
16
17 _____
18 DR. DANIEL SUTPHIN, M.D., FACS
19 Executed this _____ day
20 of _____ 2018, at _____.
21 Notary public:
22 My Commission Expires:
23
24 Signature page to: DR. DANIEL SUTPHIN, M.D., FACS
25 BRUCE VS. STATE OF SOUTH DAKOTA

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