**IN THE UNITED STATES DISTRICT COURT**
**EASTERN DISTRICT OF ARKANSAS**
**CENTRAL DIVISION**

| | | |
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| DYLAN BRANDT, et al., | : | |
| Plaintiff, | : | |
| v. | : | Case No. 4:21-CV-00450-JM |
| LESLIE RUTLEDGE, et al., | : | |
| Defendant. | : | |

**BRIEF IN SUPPORT OF MOTION TO EXCLUDE EXPERT TESTIMONY OF DR. PATRICK W. LAPPERT**

Plaintiffs challenge a law banning gender-affirming medical procedures to treat adolescents with gender dysphoria. They argue that the challenged law prohibits treatments that, based on scientific research and decades of clinical experience, are widely recognized in the medical community as safe and effective. Plaintiffs also allege that by cutting off patients' access to needed care, the challenged law would cause serious harms to the minor plaintiffs and transgender adolescents throughout Arkansas. *See, e.g.*, Mem. Supp. Pls.' Mot. Prelim. Inj. 40–43, 57–61, ECF No. 12. To defend the law, the State asserts an interest in protecting minors from what it contends are unnecessary, harmful, and experimental treatments that, they claim, lack evidence of effectiveness. *See, e.g.*, Defs.' Combined Br. Opp'n Pls.' Mot. Prelim. Inj. 1–2, 34, ECF No. 44. At trial, the Court will be tasked with resolving

factual disputes regarding medical treatments for adolescents with gender dysphoria, which will largely turn on expert testimony.

Defendants offer Dr. Patrick W. Lappert to provide expert testimony regarding the diagnosis and treatment of gender dysphoria. In his report and rebuttal report, he challenges the validity of the diagnosis of gender dysphoria and offers a range of opinions about the treatment of gender dysphoria, including his views about the proscribed hormonal treatments, assertions about the lack of psychological benefits of the prohibited hormonal and surgical treatments, and the claim that valid informed consent for such treatments cannot be obtained. But Dr. Lappert—a surgeon who has no training or experience related to the diagnosis or treatment of patients with gender dysphoria—lacks the qualifications necessary to offer opinions on these topics.[1]

Federal Rule of Evidence 702 requires that before a witness may offer expert testimony, they must be qualified as an expert in the subject matter of their testimony. Dr. Lappert fails to clear that hurdle, and his testimony regarding the diagnosis and treatment of gender dysphoria—apart from any opinions related to risks or complications from surgeries—should be excluded.

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[1] Plaintiffs are not challenging Dr. Lappert's qualifications to offer testimony about risks and complications associated with surgical treatments for gender dysphoria.

Earlier this month, a court in a case involving gender-affirming medical care rejected Dr. Lappert's testimony on these very topics, holding that "[Dr.] Lappert is not qualified to render opinions about the diagnosis of gender dysphoria, . . . the efficacy of puberty blocking medication or hormone treatments, the appropriate standard of informed consent for mental health professionals or endocrinologists, or any opinion on the non-surgical treatments obtained by Plaintiffs." *Kadel* v. *Folwell*, 2022 WL 2106270, at *13 (M.D.N.C. June 10, 2022). That conclusion was correct. As discussed below, Dr. Lappert lacks training and experience in the diagnosis or provision of care to patients with gender dysphoria. Indeed, at his deposition, Dr. Lappert agreed that he does not "claim to be an expert" in the diagnosis or treatment of gender dysphoria (Exhibit 4, Deposition of Patrick W. Lappert (*Brandt*), at 29:10–12; 46:11–13, May 6, 2022), and expressed that "it's not [his] area of care." (Exhibit 4, at 150:19–151:2.)

**BACKGROUND**

In his report and rebuttal report in this case, Dr. Lappert offers a number of opinions related to the diagnosis and treatment of gender dysphoria.

Dr. Lappert challenges the validity of the diagnosis of gender dysphoria, which is the psychiatric condition the proscribed treatments are provided to address. He asserts that "[t]ransgender is a subjective diagnosis made by the patient, that is not accessible to objective clinical, laboratory, or radiologic

confirmation by the treating physician." (Exhibit 2, Expert Report of Patrick W. Lappert, M.D. ("Report") ¶ 47; *see also id.* ¶ 30 (asserting that there is "no objective diagnostic test for transgender").) At his deposition, Dr. Lappert testified that he does not believe that gender dysphoria is an actual diagnosis, but rather, believes it is a symptom of body dysmorphic disorder (Exhibit 4, at 133:5–134:8), and believes being transgender can be a "delusion." (Exhibit 4, at 120:17–121:4; 222:4–222:18; 252:11–252:14.)

Dr. Lappert also offers a range of opinions related to the treatment of gender dysphoria. *First*, he offers opinions about hormonal therapies—puberty blockers and cross-sex hormone therapy—as treatments for gender dysphoria. Specifically, he opines that scientific research fails to show benefits of such treatment (Exhibit 3, Rebuttal Expert Report of Patrick W. Lappert, M.D. ("Rebuttal Report") ¶¶ 4a–c, 11, 12, 15), and he offers opinions about the reversibility of these hormonal treatments. (Exhibit 3, ¶¶ 13, 14.)

*Second*, Dr. Lappert offers opinions about what he claims are the lack of psychological benefits of gender-affirming surgery. (Exhibit 2, ¶¶ 30, 34–35, 50; Exhibit 3, ¶¶ 16–27; *see* Exhibit 3, ¶ 16 ("The plaintiffs' experts make the claim that surgical procedures performed on adolescents have been shown to improve mental health. Evidence does not support this claim.")).

*Third*, Dr. Lappert offers opinions about whether informed consent can

be validly obtained for gender-affirming medical care for adolescent patients. He asserts that it cannot, largely based on his opinions about the lack of validity of the gender dysphoria diagnosis and the lack of efficacy of the care. (Exhibit 2, ¶¶ 30, 35; Exhibit 3, ¶¶ 4b, 8–15.)

## LEGAL STANDARD

Federal Rule of Evidence 702 places a special "gatekeeping role" on district courts. *Daubert* v. *Merrell Dow Pharm., Inc.*, 509 U.S. 579, 597 (1993). To be admissible under Rule 702, expert testimony must satisfy three requirements: "First, evidence based on scientific, technical, or other specialized knowledge must be useful to the finder of fact in deciding the ultimate issue of fact"; "Second, the proposed witness must be qualified to assist the finder of fact"; "Third, 'the proposed evidence must be reliable or trustworthy in an evidentiary sense, so that, if the finder of fact accepts it as true, it provides the assistance the finder of fact requires." *Lauzon* v. *Senco Prods., Inc.*, 270 F.3d 681, 686 (8th Cir. 2001) (citing *Daubert*, 509 U.S. at 591). "The proponent of the expert testimony must be able to prove its admissibility by a preponderance of the evidence." *Id.* (citing *Daubert*, 509 U.S. at 592).

One of *Daubert's* most important functions is ensuring that witnesses do not speak on matters that go "beyond the expert's expertise." *Am. Auto. Ins. Co.* v. *Omega Flex, Inc.*, 783 F.3d 720, 724 (8th Cir. 2015) (citing *Weisgram* v. *Marley*

*Co.*, 169 F.3d 514, 520–521 (8th Cir. 1999)). When an expert "lack[s] the education, employment, or other practical personal experiences to testify as an expert" on a specific topic, their opinions should be excluded. *Wheeling Pittsburgh Steel Corp.* v. *Beelman River Terminals, Inc.*, 254 F.3d 706, 716 (8th Cir. 2001); *see also Khoury* v. *Philips Med. Sys.*, 614 F.3d 888, 893 (8th Cir. 2010) (holding that an expert witness cannot opine on topics for which he or she lacks any "training, education, or experience"). "[T]he trial judge must determine whether the testimony has a reliable basis in the knowledge and experience of the *relevant discipline*." *Smith* v. *Rasmussen*, 249 F.3d 755, 759 (8th Cir. 2001) (emphasis added) (quoting *Kumho Tire Co., Ltd.* v. *Carmichael*, 526 U.S. 137, 149 (1999)). Accordingly, courts must exclude testimony whenever the witness is "not well-versed in the particular discipline relevant to their testimony." *Id.*

**ARGUMENT**

Defendants seek to offer expert opinions from Dr. Lappert on the diagnosis and treatment of gender dysphoria, but Dr. Lappert is not qualified to opine on these topics because he lacks the necessary training or experience.

Dr. Lappert lacks training related to the diagnosis and treatment of gender dysphoria. He is not a psychologist or psychiatrist, or a mental health provider of any kind. (Exhibit 1, Deposition of Patrick W. Lappert (*Kadel*), at 65:22–68:20, 157:14–158:12, Sept. 30, 2021; Exhibit 4, at 133:25, 135:6–8 (Dr.

Lappert is "not testifying as a psychiatrist.").) Nor is he an endocrinologist. (Exhibit 4, at 62:15–17.) Dr. Lappert admitted that he is not qualified to provide care to patients seeking puberty blockers and hormone therapy to treat gender dysphoria. (Exhibit 4, at 300:7–9.) In fact, the only education or training he has ever received regarding gender dysphoria was a half-day weekend course. (Exhibit 4, at 135:9–24.) This is not sufficient training to qualify him as an expert on the diagnosis and treatment of gender dysphoria. *See Khoury*, 614 F.3d at 893.

Dr. Lappert also lacks experience in the diagnosis or treatment of gender dysphoria. He has never diagnosed someone with gender dysphoria because "it's not [his] area of care." (Exhibit 4, at 150:19–151:2.) And Dr. Lappert has never conducted or published research relating to gender dysphoria, the treatment of gender dysphoria, or any research about transgender people more generally. (Exhibit 4, at 138:3–10.) Of the six articles that he has published, none were about gender dysphoria. (*See generally* Exhibit 1, at 129–134.)

Dr. Lappert has no training or experience that would qualify him as an expert in the diagnosis or treatment of gender dysphoria, and he candidly admitted that he does not "claim to be an expert" on these subjects. (Exhibit 4, at 29:10–12; 46:11–13.)

The fact that Dr. Lappert is a physician does not qualify him to offer expert testimony on any medical question. In *Smith*, "an experienced, board-

certified general psychiatrist" was not deemed qualified to opine on "the effectiveness and necessity of sex reassignment surgery." 249 F.3d at 758. In excluding the expert's testimony on those topics, the district court cited the expert's lack of "expertise in the *specialized discipline of gender identity disorder*." *Id*. at 758–759 (emphasis added) (referring to a diagnosis that preceded gender dysphoria). The Eighth Circuit affirmed that ruling. *Id.*; *see also O'Conner* v. *Commonwealth Edison Co.*, 807 F. Supp. 1376, 1390 (C.D. Ill. 1992), *aff'd*, 13 F.3d 1090 (7th Cir. 1994) (noting that a "medical doctor" is not "automatically an expert in every medical issue merely because he or she has graduated from medical school or has achieved certification in a medical specialty").

Plaintiffs do not contest Dr. Lappert's qualifications to opine on risks or complications associated with surgeries. But being a plastic surgeon does not qualify him to testify about the validity of a psychiatric diagnosis. Nor does it qualify him to testify about the psychological benefits of hormonal or surgical treatments for this gender dysphoria, or offer any testimony about hormonal treatments.

In his report, Dr. Lappert lists as "credentials" the fact that he has "consulted with families with children who are experiencing gender discordance," and "given many presentations to professional meetings of educators and counselors on the subject of transgender medicine and the present state of the science and

treatment." (Exhibit 2, ¶ 7.) But the "consultations with families" he referred in his report to turned out to be conversations with three families from his parish, two of which took place in the parish library, in his capacity as the deacon of the parish. (Exhibit 4, at 151:10–153:12; 250:13–250:22; 302:23–303:23.) And his presentations on transgender medicine, which he titled "Transgender Christian Anthropology," were to religious audiences and included religious content. (Exhibit 4, at 32:16–34:9, 277:11–279:14.) They were not given to scientific or medical professional audiences. This is not experience in the diagnosis or treatment of gender dysphoria that satisfies the qualification requirements of Rule 702.[2] *See Khoury*, 614 F.3d at 893.

Dr. Lappert stated in his report that in "formulat[ing] the opinions expressed in this report, [he has] reviewed the medical literature." (Exhibit 2, ¶ 8.) His review of medical literature in a subject in which he has no training and in a field in which he has no experience is plainly insufficient to qualify him as an expert. *See Smith*, 249 F.3d at 759 (limiting the testimony of a doctor to testify on gender identity issues "because [the doctor's] testimony was based neither on his personal

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[2] Dr. Lappert's report also includes "perform[ing] breast reversal surgery for detransitioning patients" as a "credential. (Exhibit 2, ¶ 7.) The fact that Dr. Lappert has provided such surgery—at his deposition, he testified that he only had one such patient (Exhibit 4, at 38:16–38:20)—does not constitute experience in the diagnosis or treatment of gender dysphoria.

experience nor on his knowledge of the relevant discipline," and thus was "not well-versed in the particular discipline relevant to [the doctor's] testimony"); *see also Kadel*, 2022 WL 2106270, at *9 ("Merely reading literature in a scientific field does not qualify a witness—even an educated witness."). Because Dr. Lappert's opinions regarding the diagnosis and treatment of gender dysphoria are well outside his training and experience, they should be found inadmissible under Rule 702.

## CONCLUSION

Dr. Lappert lacks qualifications to offer expert opinions about the validity of the diagnosis of gender dysphoria and the treatment of adolescents with gender dysphoria, including his opinions about hormonal therapies to treat gender dysphoria, his opinion that there is a lack of psychological benefits of hormonal and surgical treatments, and his opinion that valid informed consent for such treatments cannot be obtained.

Dr. Lappert seeks to offer opinions on the same topics that he was precluded from testifying about in *Kadel*. 2022 WL 2106270, at *13. Nothing about this case warrants a different outcome, and Dr. Lappert's testimony regarding the diagnosis and treatment of gender dysphoria—with the exception of any opinions about the risks or complications related to surgeries—should be excluded.

Dated: June 22, 2022

*/s/ Leslie Cooper*

Leslie Cooper
Chase Strangio*
American Civil Liberties Union Foundation
125 Broad St.
New York, NY 10004
Telephone: (917) 345-1742
lcooper@aclu.org
cstrangio@aclu.org
*Attorneys for the Plaintiffs*

Beth Echols, Ark. Bar No. 2002203
Christopher Travis, Ark. Bar No. 97093
Drake Mann, Ark. Bar No. 87108
Gill Ragon Owen, P.A.
425 W. Capitol Avenue, Suite 3800
Little Rock, AR 72201
Telephone: (501) 376-3800
echols@gill-law.com
travis@gill-law.com
mann@gill-law.com
*On behalf of the Arkansas Civil Liberties Union Foundation, Inc.*
*Attorneys for the Plaintiffs*

Breean Walas, Ark. Bar No. 2006077
Walas Law Firm, PLLC
P.O. Box 4591
Bozeman, MT 59772
Telephone: (501) 246-1067
breean@walaslawfirm.com
*On behalf of the Arkansas Civil Liberties Union Foundation, Inc.*
*Attorneys for the Plaintiffs*

Sarah Everett, Ark. Bar No. 2017249
Gary Sullivan, Ark. Bar No. 92051
Arkansas Civil Liberties Union Foundation, Inc.
904 W. 2nd Street
Little Rock, AR 72201
Telephone: (501) 374-2842
sarah@acluarkansas.org
gary@acluarkansas.org
*Attorneys for the Plaintiffs*

Garrard R. Beeney*
Brandyn J. Rodgerson*
Emily T.L. Armbruster*
Alexander S. Holland*
Sullivan & Cromwell LLP
125 Broad Street
New York, NY 10004
Telephone: (212) 558-4000
beeneyg@sullcrom.com
rodgersonb@sullcrom.com

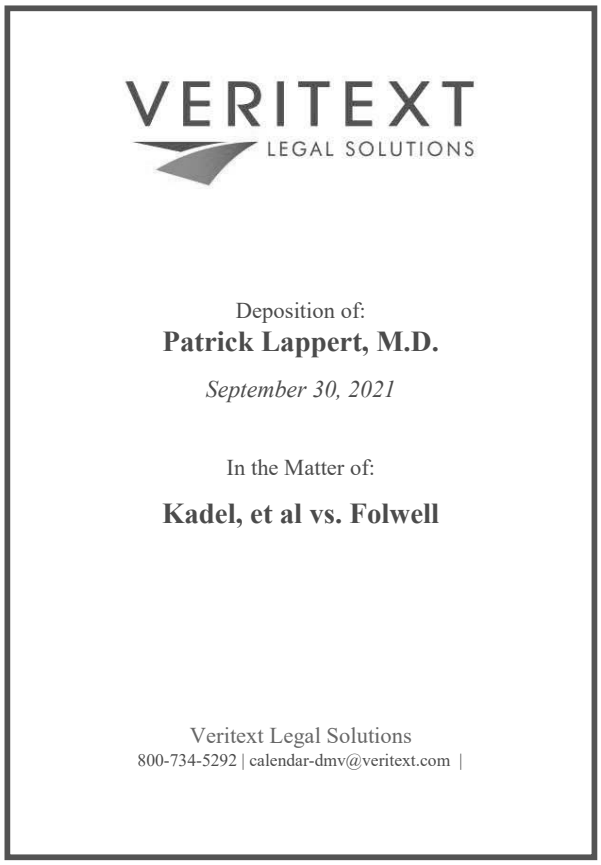
Laura Kabler Oswell*
Duncan C. Simpson LaGoy*
Sullivan & Cromwell LLP
1870 Embarcadero Road
Palo Alto, CA 94303
Telephone: (650) 461-5600
oswell@sullcrom.com
simpsond@sullcrom.com
*Attorneys for the Plaintiffs*

armbrustere@sullcrom.com
hollanda@sullcrom.com
*Attorneys for the Plaintiffs*

Daniel J. Richardson*
1700 New York Avenue NW
Suite 700
Washington, DC 20006
Telephone: 202-956-7500
richardsond@sullcrom.com
*Attorney for Plaintiffs*

**Admitted pro hac vice*

# Exhibit 1








IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

CIVIL ACTION NO.: 1:19-cv-272-LCB-LPA

MAXWELL KADEL, et al.
Plaintiffs

v.

DALE FOLWELL, et al.
Defendants

REMOTE VIDEOTAPED VIDEOCONFERENCE
DEPOSITION TESTIMONY OF:
PATRICK LAPPERT, M.D.
September 30, 2021







A P P E A R A N C E S

FOR THE PLAINTIFFS (via remote videoconference):

Dmitriy Tishyevich, Esq.
MCDERMOTT, WILL & EMERY
One Vanderbilt Avenue
New York, New York 10017
dtishyevich@mwe.com

Tara L. Borelli, Esq.
LAMBDA LEGAL DEFENSE AND EDUCATION FUND
158 West Ponce de Leon Avenue, Suite 105
Decatur, Georgia 30030
tborelli@lambdalegal.com

Omar Gonzalez-Pagan, Esq.
LAMBDA LEGAL DEFENSE AND EDUCATION FUND
120 Wall Street, 19th Floor
New York, New York 1005
ogonzalez-pagan@lambdalegal.com







FOR THE DEFENDANTS (via remote videoconference):

John G. Knepper, Esq.
LAW OFFICE OF JOHN G. KNEPPER LLC
1720 Carey Avenue, Suite 590
Cheyenne, Wyoming 82001
john@knepperllc.com

Kevin G. Williams, Esq.
BELL, DAVIS & PITT
100 North Cherry Street, Suite 600
Winston-Salem, North Carolina 27101
kwilliams@belldavispitt.com

ALSO PRESENT (via remote videoconference):

Andrew Baker, Videographer

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(Exhibits attached to transcript.)





I, Lane C. Butler, a Court Reporter and Notary Public, State of Alabama at Large, acting as Notary, certify that on this date, pursuant to the Federal Rules of Civil Procedure, there came before me via remote videoconference from Decatur, Alabama, commencing at approximately 8:30 a.m. Central, on the 30th day of September, 2021, PATRICK LAPPER, M.D., witness in the above cause, for oral examination, whereupon the following proceedings were had:

THE VIDEOGRAPHER: Good morning. We are going on the record at 8:31 a.m., Thursday, September 30th, 2021. This is Media Unit 1 of the videorecorded deposition of Dr. Patrick Lappert as taken by counsel for plaintiff in the matter of Kadel, et al. v. Folwell, et al., filed in the United States District Court for the Middle District of North





Carolina, Civil Action No. 1:19-cv-272-LCB-LPA.

This deposition is being recorded remote via Zoom located in Decatur, Alabama. My name is Andrew Baker from the firm Veritext Legal Solutions. I am the videographer. The court reporter is Lane Butler, also from Veritext Legal Solutions.

Will counsel now state their appearance and affiliations for the record. The court reporter will swear in the witness. Thank you. We may proceed.

MR. TISHYEVICH: This is Dmitriy Tishyevich from McDermott, Will & Emery, LLP, for plaintiffs.

MR. KNEPPER: My name is John Knepper. I represent three of the defendants in this matter: the North Carolina State Health Plan for Teachers and State Employees; Dale Folwell, the treasurer for the State of North Carolina; and Dee Jones, the executive





administrator of the North Carolina State Health Plan. I'll be defending Dr. Lappert's deposition.

PATRICK LAPPERT, M.D.,
having first been duly sworn,
was examined and testified as follows:

EXAMINATION BY MR. TISHYEVICH:

Q. Good morning, Doctor.

A. Good morning, sir.

Q. State your full name for the record.

A. Patrick Walter Lappert.

Q. Any reason you're not able to give complete and truthful testimony today?

A. There is no reason.

Q. You've been retained as an expert by defendants in this case; correct?

A. I have.

Q. You've prepared an expert

report; right?
A. I have.
Q. So, I've premarked Exhibit 1. Open that, and let me know when you have it.
(Exhibit 1 was marked for identification and is attached.)
A. Okay. I have it.
Q. This report contains all the opinions that you intend to offer in this case; correct?
A. It does.
Q. All right. Without telling me any conversations that you had with counsel, what did you do to prepare for your deposition today?
A. Well, I reviewed the -- the documents. I guess it's called the complaint. I reviewed the patient records. And then, I reviewed the literature, pertinent journal articles, publications, and had conversations with -- with counsel, Mr. Kadel [sic], and his





staff at various times.
Q. When you say "patient records," are you talking about the medical records for the individual plaintiffs?
A. Yes. The ones that were -- that were given to me to review.
Q. And when you say "the literature," are you referring to some of the studies that you cite in your report?
A. Yes.
Q. Have you reviewed any studies -- strike that.
In preparing for your deposition today, have you reviewed additional studies that are not cited in your report?
A. No. The report contains all of the studies that I -- that I reviewed that I consider pertinent. I glossed some but didn't see them as germane. So all the ones that were -- that were germane to my opinion are -- are in the -- in the document.





Q. Understood. And you mentioned that you met with or spoke with Mr. Knepper in preparing for today?
A. I have.
Q. Okay. Again, without disclosing any substance of the conversation, how many times did you speak or meet with him?
A. Three or four times, I think.
Q. And when did those conversations take place?
A. Well, as recently as yesterday evening and I think a couple of meetings back in May, I think it was. I'd have to look at my calendar, but.
Q. Last evening, you spoke -- strike that.
You know that Dr. Hruz was deposed yesterday; right?
A. I'd heard, yes.
Q. And so before yesterday, when was the last time that you spoke with Mr. Knepper to prepare for your deposition?





A. I want to say it's a couple of weeks ago. I'm not exactly sure.
Q. How long was the conversation with Mr. Knepper last night?
A. A little less than an hour.
Q. Did he provide you with copies of any of the exhibits that were used at Dr. Hruz's deposition?
A. No, he did not.
Q. Did he provide you with any -- any portions of that deposition transcript?
A. No.
Q. And then going in reverse chronological order, you mentioned you may have spoken a couple of weeks ago?
A. I think. I don't know exactly -- I don't know exactly when that was, Mr. Tishyevich. I want to say three weeks ago perhaps. I'm not exactly sure.
Q. Do you recall roughly how long that conversation was?
A. About the same duration. I

think it was perhaps an hour, perhaps an hour.

Q. Okay. All right. You -- in the course of -- strike that.

In the course of working on this case, have you ever communicated with Dr. Hruz?

A. Not directly. I've spoken with Dr. Hruz, but in the matter at hand, I have not spoken with him about it.

MR. TISHYEVICH: For the court reporter, that's H-R-U-Z. And I'll try and spell things as we go to make it a little easier.

Q. How about Dr. McHugh? M-C-H-U-G-H. Have you spoken with him in the course of working on this case?

A. I've never spoken directly to him, no.

Q. How about Dr. Levine? L-E-V-I-N-E.

A. I have not spoken with Dr. Levine.





Q. But you have met Dr. Hruz before working on this case; right?

A. Yes.

Q. And is the same true for Dr. Levine?

A. I've never met Dr. Levine.

Q. All right. About how many hours do you estimate you've spent working on your expert report?

A. Somewhere around maybe 60 hours. I could -- I could look for that number, but I'm going to estimate it at about 60 hours, something like that.

Q. You're aware that the individual plaintiffs in this case have been deposed; right?

A. Yes, I've heard.

Q. Were you provided with deposition transcripts or any portion of their testimony?

A. I have -- I have not seen those, no.

Q. Okay. You're aware that other





experts in this case have also already been deposed?

A. Yes.

Q. Have you been provided with deposition transcripts or any portion of their deposition testimony?

A. I -- I saw a transcript of Dr. McHugh's.

Q. Was that the only tran- -- strike that.

Was Dr. McHugh's transcript the only expert deposition transcript you've seen?

A. It's the only one I've read. I -- I think that -- yeah, I think it's the only one I read. Yes, sir.

Q. Okay. All right. So throughout your report, you use this term --

A. Could I amend that last answer?

Q. Of course.

A. I -- I did read portions of Dr. Brown's transcript, actually, some days back. My -- my apologies.





Q. No. And I should say that. If at any point in time in your deposition you want to go back and amend your answer, that is totally fine.

A. Thank you.

Q. Okay. So in your report, you use this term "transgender treatment industry." Right?

A. Yes.

Q. And you and Dr. Levine and Dr. McHugh all use this term in your reports. Were you aware of that?

A. Oh, I was aware that the -- no, I wasn't aware that they were using it, actually.

Q. Is it coincidental that the three of you are using this term?

A. I -- I think it's sort of becoming a common term lately. I don't know where it came from. I was trying to think about that. I don't know who originated it, but I've -- I don't know even if it was me that originated it,

actually, since I've been speaking about this subject for some time now. But it seemed like an apt term, so it doesn't surprise me that others are using it.

Q. You don't know who came up with that term?

A. I don't.

Q. It's possible that it was you?

A. It wouldn't surprise me.

Q. And you mentioned that it's becoming more commonly used. Is that right?

A. It seems to be. I don't know. I don't know how common it is, but it's kind of a small circle of people talking about these things.

Q. Are you aware of a single peer-reviewed scientific article that has used the term "transgender treatment industry"?

A. I am not.

Q. Do you know what PubMed is? P-U-B-M-E-D.





A. Yes.

Q. It's a search engine maintained by the National Institute of Health; right?

A. Yes. That's my understanding.

Q. It's a search engine for scientific articles, basically; right?

A. Yes.

Q. So I'll represent to you that I ran a search in PubMed for the phrase transgender treatment industry, in quotation marks, and came back with zero results for that phrase.

MR. KNEPPER: Objection to form.

Q. Do you find that surprising?

A. No.

Q. Okay. What does that lack of results tell you about whether this term is a commonly used term in this field?

MR. KNEPPER: Objection to form.

A. I wouldn't expect it to be a commonly used term, and it doesn't surprise me that you didn't find it.





Q. Yeah. "Transgender treatment industry" is not a commonly used term in the field of treatment and diagnosis of gender dysphoria; right?

MR. KNEPPER: Objection to form.

A. I would agree.

Q. Yeah. It's a term that, as far as I can tell, is fairly idiosyncratic to the opinions that you and the other defendant experts are using in this case. Does that sound right?

MR. KNEPPER: Objection to form.

A. That sounds right to me, yeah.

Q. Okay. Look at page 1 of your expert report, Exhibit 1.

A. All right.

Q. I see it says, "Declaration of Patrick Lappert, MD." You see that?

A. Yes.

Q. Under that, it says, "Board Certified in Surgery and Plastic Surgery." Do you see that?

A. I do.





Q. Let's talk about your certifications. Let's start with plastic surgery. You originally received your board certification in plastic surgery in 1997; correct?

A. That's correct.

Q. Then you got recertified in 2008; correct?

A. That's correct.

Q. That board certificate was only valid for ten years; correct?

A. Correct.

Q. And your plastic board -- strike that.

And your plastic surgery board certificate expired at the end of 2018; correct?

A. Correct.

Q. Well, why did you decide not to renew your board certificate past 2018?

A. Well, I'm a -- I'm a solo practitioner, and the main reason for maintaining that expensive certificate

was that many hospitals required it in order to have privileges. Several years ago, a lot of hospitals started dropping that requirement, so it didn't make sense for a surgeon who is within three years of retirement to expend all that money and time to maintain a certification that was no longer necessary for me in terms of maintaining my practice.

Q. Do you currently have admitting privileges at any hospital?

A. No.

Q. When was the last time you had admitting privileges in any hospital?

A. A year ago.

Q. What hospital was that?

A. Crestwood Hospital, Huntsville, Alabama.

Q. So within the last year at least, I take it you haven't performed any surgeries at a hospital. Right?

A. That's correct. A -- a year ago, I retired from active surgical





practice.

Q. Were you doing surgeries in 2019 after your plastic -- plastic surgery board certificate expired?

A. Yes.

Q. When -- just can we pin this down more? What -- what month do you think you stopped performing surgeries?

A. Let's see. This is November of 2021, so it would have been August of 2020.

Q. All right. You are not currently board-certified in plastic surgery; correct?

A. Correct.

Q. And you have not been board-certified in plastic surgery since 2018; correct?

A. Correct.

Q. For over two and a half years at this point; right?

A. Correct.

Q. So this page 1 of your report





says that you're board-certified in plastic surgery. Do you think it's appropriate for you to make that representation even though you don't have an active certification?

MR. KNEPPER: Objection, form.

A. Well, appropriate in terms of -- I don't understand the question.

Q. Let me be more specific.

A. Okay.

Q. Do you know what the Amer- -- I'll go back.

You know what the American Board of Plastic Surgery is; right?

A. Certainly.

Q. Do you know what the American Board of Plastic Surgery has to say about doctors who represent that they're board-certified when they don't have an active certification?

MR. KNEPPER: Objection, form.

A. They discourage it. I -- I suspect that the -- the document -- well,





I didn't prepare that -- that particular part of the document, although I signed it, certainly. But I see your point, yes.

Q. Okay. I'm going to introduce another exhibit. You'll see it in a minute. Let me know when you have it, Doctor.

(Exhibit 2 was marked for identification and is attached.)

A. I have it.

Q. This is a printout from the -- a web page from the American Board of Plastic Surgery. Go to page 2.

A. All right. I'm there.

Q. Middle of the page, it says in bold letters, "Guidelines for Stating Certification Status." Do you see that?

A. I do.

Q. Look at the third paragraph.

A. All right.

Q. It says, "ABPS does not mandate the specifics of how diplomates state

their certification, except to assert that diplomates should not state or imply that they are certified if their certification has expired."

Do you see that?

A. I do.

Q. All right. You understand that under this guidance from the ABPS, you are not supposed to be representing that you are board-certified in plastic surgery because you do not have a current certification; correct?

MR. KNEPPER: Objection, form.

A. Yes, I understand it.

Q. Let's look at what else it says. Towards the bottom of page 2, it says, "We ask that you follow these guidelines throughout your career to accurately state your ABPS certification." Do you see that?

A. I do.

Q. The first bullet says, "Diplomates of ABPS must accurately state







their certification status at all times." Do you see that?

A. I do.

Q. And you understand what this means; right?

A. I do.

MR. KNEPPER: Objection, form.

Q. Page 3, next bullet says, "Diplomates with expired time-limited certification or those whose certification is revoked may not claim Board certification by ABPS and must revise all descriptions of their qualifications accordingly." Right?

MR. KNEPPER: Objection to form.

A. Yes. Yes, I see that.

Q. And you understand what that means; right?

MR. KNEPPER: Objection to form.

A. I do.

Q. Your expert report is not in compliance with this guidance from the ABPS; correct?







MR. KNEPPER: Objection, form.

A. The -- the one line there under my name is not in compliance. That's correct.

Q. And the same is true of your CV; right?

A. Well, the CV states that I have been board-certified by the American Board of Surgery and have been board-certified by the ABPS in 1997 and 2008, yes. Have been.

Q. And look back at this page 3 from the ABPS. It says, "When a physician misrepresents certification status, ABPS may notify local credentialing bodies, licensing bodies, law enforcement agencies and others." Do you see that?

A. I do.

Q. All right. And you understand what this means; right?

MR. KNEPPER: Objection to form.

A. Yes.







Q. Okay. Are you going to update your expert report so that it comports with this guidance from the ABPS?

MR. KNEPPER: Objection to form.

A. Certainly.

Q. Okay. So that's plastic surgery. Let's talk about your board certification in surgery next. So, go back to your expert report, page 1.

A. Okay.

Q. You received your board certification in surgery in 1992; correct?

A. Was it '92 or '91? '92, yes, sir.

Q. And that certification expired in 2002; right?

A. Yes.

Q. And you had not renewed that after 2002; right?

A. Correct.

Q. You're not currently board-certified in surgery; correct?

A. Correct.
Q. You have not been board-certified in surgery since 2002; correct?
A. Since 2002, yes, sir.
Q. That's over nineteen years; right?
So, I showed you this guidance from the American Board of Plastic Surgery. How about the American Board of Surgery? What do you think they have to say about doctors who make these kind of representations?
MR. KNEPPER: Objection, form.
A. I'm sure it's probably the same.
Q. Yeah. Would it surprise you that the American Board of Surgery does not allow doctors to represent that they are board-certified in surgery unless they have a current board certificate?
MR. KNEPPER: Objection, form.
A. It would not surprise me, no.
Q. All right. You are currently







serving as an expert in another case, Brandt v. Rutledge. B-R-A-N-D-T. Correct?
A. Yes.
Q. That's a case pending in federal court in Arkansas; right?
A. Correct.
Q. In that case, you were retained by the defendants, by the State of Arkansas; right?
A. Yes.
Q. Dr. Hruz, who is one of the defendants -- strike that. Dr. Hruz, who is one of the experts in this case, is also serving as an expert for defendants in that Brandt case; right?
A. That's my understanding, yes.
Q. And the same is true for Dr. Levine; right?
A. I didn't know about Dr. Levine, but.
Q. And you submitted an expert declaration in that Brandt case in July







of this year; correct?
A. I believe that was when I submitted it, yes.
Q. All right. Let's look at it. And let me know when you get the exhibit, Doctor.
(Exhibit 3 was marked for identification and is attached.)
A. Here it is. Let's see. All right.
Q. All right. Page 1 says, "Declaration of Dr. Patrick Lappert." That's you; right?
A. Yes.
Q. Fair to say that there is at least some overlap between the opinions that you're offering in this case and the opinions that you're offering in that Brandt case; right?
MR. KNEPPER: Form.
A. Well, given that the subject matter is the same, I would expect some overlap, yes, sir.







Q. Go to page 5 of that declaration.
A. All right. I'm there.
Q. You say under Section II, "'Gender affirming' treatments are experimental." Right?
A. Yes.
Q. It's basically the same opinion that you offered in this case; right?
A. Yes, sir.
Q. Go to page 29 of your declaration. See there's a paragraph 63?
A. Yes, sir.
Q. And toward the end of that paragraph, you talk about the national reviews in England, Sweden, and Finland and other reviews like Cochrane, Griffin, and Carmichael. You see that?
A. Yes, sir.
Q. You relied -- you relied on all those studies for your opinions in this case as well; right?
A. I did.

Q. Okay. Go to page 38 of your declaration. Do you see that it's the section titled "Concluding Opinions" and it goes through the next --

A. Yes, sir.

Q. -- few pages?

We don't need to go through these individually, but you agree there's a lot of overlap between the opinions you're offering in that Brandt case and the opinions you're offering in this case; right?

MR. KNEPPER: Objection to form.

A. Yes.

Q. The Brandt case involves a challenge to an Arkansas law which bans doctors from providing various types of gender-affirming treatments to adolescents; correct?

A. Yes.

Q. Including puberty blockers and cross-sex hormones and gender-affirming surgery; correct?







A. Yes.

MR. KNEPPER: Objection.

Q. Have you kept up with what's going on in that case in Arkansas?

MR. KNEPPER: Objection, form.

A. I haven't heard anything perhaps in the last several weeks.

Q. Well, are you aware that in July of this year, the judge in that case held that the State is prohibited from enforcing the ban while the case is being decided?

A. I've heard that.

Q. All right. And as part of that order, the judge made some factual findings. Are you aware of that?

A. I'm not -- haven't read the details.

Q. All right. Let me show you.

A. Okay.

Q. Let me introduce one more exhibit.

(Exhibit 4 was marked for identification







and is attached.)

A. I have it now.

Q. Okay. So, this is a supplemental order from Judge Moody in Arkansas dated August 2nd, 2021. Do you see that?

A. I see that, yes.

Q. This first paragraph says, "After further consideration, the Court supplements the ruling made at the conclusion of the July 21, 2021 hearing to include the following findings." Do you see that?

A. I do.

Q. By the way, did you testify live at that July 2021 hearing?

A. No.

Q. Do you know if any of the other experts testified live at that hearing?

A. I don't know.

Q. Go to page 7.

A. All right.

Q. All right. Look at the last







paragraph.

A. Okay.

Q. The second sentence in that last paragraph says, "Gender-affirming treatment is supported by medical evidence that has been subject to rigorous study." Right? Do you see that?

A. That's what it says, yes, sir.

Q. And that finding by the Court in Arkansas is contrary to the opinions that you offered in that case; right?

A. Apparently so, yes.

Q. And it's also contrary to the opinions that Dr. Hruz and Dr. Levine offered in that case; right?

A. Yes.

MR. KNEPPER: Objection to form.

A. It appears to be, yes.

Q. And it's also contrary to the opinions that you and Dr. Hruz and Dr. Levine are offering in this case; right?

A. Yes.

Q. Look at the next sentence. It says, "Every major expert medical association recognizes that gender-affirming care for transgender minors may be medically appropriate and necessary to improve the physical and mental health of transgender people."

That's what it says; right?

A. That's what it says, yes, sir.

Q. That's also contrary to the opinions that you and Dr. Hruz and Dr. Levine are offering in both these cases; right?

A. Yes, it certainly is.

Q. In fact, according to this order, every major expert medical association disagrees with you because they've all taken a position that this treatment is in fact medically necessary; right?

MR. KNEPPER: Objection to form.

A. Apparently so, yes.

Q. All right. Look at page 6.







Look at the last paragraph. You see it says that -- the third sentence says, "The consensus recommendation of medical organizations is that the only effective treatment for individuals at risk of or suffering from gender dysphoria is to provide gender-affirming care." Do you see that?

A. I do.

Q. You see there's a Footnote 3?

A. Let me get my glasses on here. Footnote 3. I don't see Footnote 3. Let's see.

Q. The bottom of page 6.

A. I see it now, yes.

Q. Footnote 3 has a long list of medical organizations that all have taken the position that gender-affirming care is medically appropriate for individuals with gender dysphoria; right?

MR. KNEPPER: Objection to form.

A. Yeah, the consensus recommendations. Those are consensus







recommendations. And yes, I was aware that those were the positions taken by those organizations even before the judge's opinion.

Q. Yeah. By my count, Footnote 3 lists 18 different professional medical organizations, and as I read this footnote, every single one of them takes the view that's contrary to the opinions that you and Dr. Hruz and Dr. Levine are offering; right?

MR. KNEPPER: Objection to form.

A. Yes. There's a consensus of consensus on this, exactly, yes, sir.

Q. And you're not aware of a single professional medical organization that submitted anything in this Brandt case and said that they agree with the opinions that you and Dr. Hruz and Dr. Levine are offering; right?

A. Well, I'm aware of at least one professional organization that -- that disagrees with that, yeah, the







pediatric -- American Pediatric -- American Association of Pediatricians.

Q. Do you know if they submitted anything to the Court in this Brandt case to that effect?

A. I'm not aware. I don't know.

Q. Okay. Look back to your report, Exhibit 1.

A. Okay.

Q. And go to page 5.

A. Okay.

Q. See there's paragraph 11?

A. Yes.

Q. And you say that "Affirmation Treatments are Currently Experimental." And then you say, "are not generally accepted by the relevant scientific community." Right?

A. Yes, I say that, absolutely.

Q. Well, apparently, there's at least eighteen different professional medical organizations that all say that you and Dr. Hruz and Dr. Levine are wrong

and that these gender-affirming treatments are, in fact, medically appropriate; right?

A. Well, I --

MR. KNEPPER: Object.

A. I would say that part of the difficulty here is a misunderstanding about how those consensus opinions are arrived at. They're not arrived at scientifically. So minus a scientific opinion, those are -- those are consensus opinions.

For example, in plastic surgery, there was a controversy some years ago about the use of fat grafting in breast reconstruction, and there was a concern about whether it would promote malignant degeneration. The American Society of Plastic and Reconstructive Surgeons came out with a consensus statement essentially recommending against, if not outright forbidding, the use of fat grafting in breast reconstruction or





cosmetic surgery. But I was never polled. I was a member of the American Society of Plastic Surgery, but I was never polled.

These consensus statements do not poll the scientific or professional community. They're the work product of a -- of small committees where they perhaps will review scientific literature and come to an opinion within that relatively small group.

So I think the misunderstanding is that because, for example, the American Medical Association or the American Pediatric Society has a statement making this claim, it's not, by definition, supported by the membership of that -- that society. It is the work product of a committee, and it's -- and it doesn't -- it doesn't lay out the scientific basis for those opinions for the membership to review, as was the case in -- and it turns out that seven, eight





years later, the American Society of Plastic and Reconstructive Surgery rescinded their prohibition when the membership basically chimed in and said this is incorrect and this is our evidence, here's the science. And the American Society rescinded that consensus statement that they had made ten years earlier.

So I imagine that similar things are going on here. Committees generates consensus statements. The consensus statements are published. And one gets the impression that the entire membership supports the statement when that in fact is not the case. And when these consensus statements are published, they don't publish the supporting scientific literature. They merely make the statement. So I think this is the case here as well.

Q. You are not a member of the, let's say, American Medical Association;





right?

A. Not -- not any longer, no.

Q. And your -- I hear you speculating that there's a committee that came to this decision at the AMA; right?

MR. KNEPPER: Objection, form.

A. Well, if the AMA functions like the American Society of Plastic Surgery or other -- other professional bodies like that, professional organizations like that, I would expect that's how they make their consensus statements, yes.

Q. You personally do not know how the AMA came to issue this consensus statement, do you?

MR. KNEPPER: Objection.

A. I have no personal knowledge, no.

Q. You have no personal knowledge what scientific literature they reviewed in coming up with that consensus statement, do you?

A. That's the difficulty. Yes,

sir.
Q. Yeah.
A. Correct.
Q. You have no idea, in short, how the AMA came to reach this consensus statement; right?
MR. KNEPPER: Objection to form.
A. I have no personal knowledge of it, no.
Q. How about the American Pediatric Society? You're not a member of that; right?
A. No.
Q. You have no idea how the American Pediatric Society came to support this consensus statement; right?
A. Well, in that case, I do have friends who are members of the American Pediatric Society, I think it is. And they, in conversation, have told me that this is how the process works. I don't have personal -- personal knowledge of it, no.





Q. Are those friends on the committee at the APA that decided to adopt this consensus statement?
A. Not to my knowledge.
Q. So they also -- strike that.
How about the American Psychiatric Association? You're not a member of that --
A. No.
Q. -- right?
A. No.
Q. You have no idea on what basis they decided to support this consen- -- what you call consensus -- consensus statement about the necessity of treatment for gender dysphoria, do you?
A. No.
Q. So, Doctor, I hear you criticizing these organizations, but you do not have firsthand knowledge of how any of those organizations came to reach these positions, do you?
MR. KNEPPER: Objection to form.





A. No.
Q. And you do not know what scientific literature they relied on, do you?
A. No.
MR. KNEPPER: Objection to form.
A. Other than to say that I'm familiar with the current literature, and I -- and whenever these -- these consensus statements are supported with references to the scientific literature, that literature I have reviewed. That was part of the process of generating my expert testimony.
Q. I thought I just heard you say that these position statements are not typically supported by "Here's the study we relied on." Isn't that what you said?
A. Well, no. In the -- in the actual document that they publish, they make -- they make reference to things like that.
What I meant to say, I suppose,





is that -- that I've reviewed the current literature, particularly in the last three to five years, that's germane to the subject of gender affirmation in pediatric patients and adolescents, and I -- and I find that the science is weak, so --
Q. But because you have no firsthand knowledge of how any of these associations came out with these position statements, you do not know to what extent it may have taken that literature into account before adopting these position statements; right?
MR. KNEPPER: Objection.
A. I can only say that if they gave full force to the scientific literature that is used to support their position, I find the scientific literature weak, yeah.
Q. This Brandt case involves a state law that prohibits doctors in Arkansas from providing gender-affirming

medical treatment to anyone under eighteen; correct?

A. Yes.

Q. You yourself support these kind of state law bans; right?

MR. KNEPPER: Objection, form, scope.

A. I do support a control over these kinds of therapies, yes, I do.

Q. Well, not -- not just control, because Arkansas says it will criminally prosecute doctors that do it; right?

A. Right.

MR. KNEPPER: Objection to form, scope.

Q. And you think that's a good idea; right?

A. I do.

MR. KNEPPER: Objection to form, scope.

Q. You think that other states outside of Arkansas should be passing similar bans; right?





MR. KNEPPER: Objection, form, scope.

A. Actually, what I would prefer to see is the -- is the professional societies recommend against these sorts of things, yes. That would be my preference. I would rather that the State did not step in and manage the care of people who are suffering. I'd rather the State stayed out of it. But short of that, I suppose that's the -- the fallback position is to recourse through the law.

It would seem to me that professional organizations should be managing these issues, and practitioners ultimately should be responsible, as was found in the -- in the -- the case in Great Britain at the Tavistock Portman Institute when the Court came back and reviewed the find -- the ruling there and declared that primacy should be given to the decision-making of doctors rather





than the Courts stepping in as -- as managers of medical care.

And I feel the same way. I don't think that the State should have to do this. But -- given that -- given that things are moving at the pace they are.

Q. Are you aware that state legislators in Utah have proposed a similar ban as Arkansas for gender-affirming medical treatment for minors?

A. Yes.

MR. KNEPPER: Objection to form, scope.

Q. You had involvement with those legislative efforts in Utah, didn't you?

A. I think I made some recommendations to them. Yes, I did.

Q. Yeah. Because now I hear you saying you prefer the professional organizations handle it. But the fact is you have actively lobbied to get these kind of bans passed in other states,





haven't you?

A. Yes, I have.

MR. KNEPPER: Objection to form, scope.

A. Yes, I have.

Q. I'm going to introduce another exhibit. Let me know when you have it, Doctor.

(Exhibit 5 was marked for identification and is attached.)

A. I have it.

Q. Exhibit 5 is a document titled: "Transgender 'Transition' Procedures Performed on Minors. Answers to Questions and Information for Joint Interim Committee," dated June 10th, 2021. Do you see that?

A. I do.

Q. It says, "Submitted by Rep Rex P. Shipp," S-H-I-P-P. Do you know who that is?

A. I don't know him personally, but I -- I see he's a representative from

Utah apparently.
Q. Have you ever communicated with Mr. Shipp and his staff?
A. I may have and don't recall.
Q. Why do you say you may have?
A. I have a lot of correspondence with people who ask a lot of questions who are involved in this -- in this issue, and I don't have a great memory for names sometimes. But I know I was in communication at some level with people in Utah, but I don't recall exactly the nature of that conversation, or that interchange.
Q. Go to page 16.
A. Sixteen?
Q. One six.
A. One six. Okay.
Q. Toward the bottom of the page, it says, "We express appreciation to these noted professionals who contributed to this report." Do you see that?
A. I do.





Q. Go to page 17.
A. Okay.
Q. The bottom of the page says, "Patrick Lappert, M.D."
A. Yes.
Q. That's you; right?
A. Yes.
Q. So at some point earlier this year, you were providing information to the Utah State Legislature to support the potential enactment of a ban on gender-affirming healthcare for minors; right?
MR. KNEPPER: Objection, form.
A. Yes.
Q. Look at the fourth name from the bottom on page 17.
A. Fourth name -- I'm sorry?
Q. Fourth name from the bottom.
A. Paul Hruz. Yes.
Q. That's the same Dr. Hruz who's an expert in this case; right?
A. Yes.





Q. Go to page 18. The second name from the top is Stephen B. Levine M.D.; right?
A. Yes.
Q. Same Dr. Levine who is an expert in this case; right?
A. Yes. I think so, yes.
Q. And the next name is Paul McHugh, M.D.; right?
A. Yes.
Q. The same Dr. McHugh who is an expert in this case; right?
A. Yes.
Q. All four of you were providing information to the Utah State Legislature to support this potential ban; right?
MR. KNEPPER: Objection to form.
A. Yes.
Q. How did you get involved with providing this information to the Utah State Legislature?
A. I don't recall. My -- my suspicion is I may have been contacted by





e-mail or some other such thing. In fact, I'm fairly confident it was an e-mail request for assistance, probably.
Q. Do you remember who the e-mail was from?
A. I do not.
Q. Do you remember who at the Utah State Legislature or anyone affiliated with them you were communicating with in this respect?
A. I don't remember, no.
Q. All right. Let's see what you were telling the state legislature in this report. Go to page 5. See there's a section near the top titled "Sex reassignment surgeries"?
A. Yes.
Q. There's some language in quotes -- in quotes and italicized. Do you see that?
A. I do.
Q. And the first portion of the paragraph says: '"Sex reassignment

surgery' is a massive misrepresentation of what these operations actually do. You can't change a person's sex. All that is happening is that the patient is undergoing an intentional mutilation in order to create a counterfeit appearance of the other sex."

Do you see that?

A. I do.

Q. And underneath, it says, "Patrick Lappert, M.D." Right?

A. Yes.

Q. These are your words, Dr. Lappert; right?

A. Yes.

Q. You consider gender reassignment surgery to be an intentional mutilation; right?

A. I do. Absolutely.

MR. KNEPPER: Form.

Q. And calling gender reassignment surgery, quote, intentional mutilation, is that commonly accepted terminology in





this field, Doctor?

A. I expect not.

Q. And then you say that when a patient undergoes gender reassignment surgery, all that is happening is, quote, a counterfeit appearance of the other sex; right?

A. Yes.

Q. This phrase, "counterfeit appearance," do you think that's an appropriate term for a doctor to use?

A. Absolutely.

Q. And you stand by these words; right?

A. I do.

Q. All right. So, we've talked about Arkansas, we've talked about Utah. Now, I know there is currently a number of other states that are considering passing similar bans. Outside of Utah, have you done any work whatsoever in connection with these potential bans in other states?





MR. KNEPPER: Objection, form, scope.

A. I have.

Q. Which states?

A. Alabama, Texas.

Q. What else?

A. Texas. I don't know if there were any in the Northwest or not. I think that's all of them. I may be wrong, but I think that's all. Alabama and Texas I would just add to your list.

Q. Okay.

A. There may been something in Arizona. I'm not certain about Arizona as well, but --

Q. Now let me introduce another exhibit. Okay. Let me know when you get this one.

(Exhibit 6 was marked for identification and is attached.)

A. I've got it.

Q. All right. This article is titled, "Alabama bill that would





criminalize treatment for transgender minors headed to full Alabama Senate." You see that?

A. I do.

Q. Alabama, your home state, was considering a ban very similar to Arkansas just this year; correct?

A. Actually over the last couple of years.

Q. Okay. The first paragraph says, "The Alabama Senate Health Committee on Wednesday approved a bill that would outlaw puberty-blocking medications and gender-affirming care for minors, giving" -- "giving it a favorable report in an 11-2 vote." You see that?

A. I do.

Q. Then it says, "An Alabama House committee heard testimony in a public hearing on a companion bill, but the committee did not vote on the" -- "on the measure." You see that?

A. I do.

Q. You testified in support of this bill; right?
A. Yes, sir.
Q. Go to page 2.
A. Okay.
Q. Look at the second paragraph from the bottom.
A. Second from the bottom. Yes.
Q. It says, "Dr. Patrick Lappert, a Decatur plastic surgeon, spoke in favor of the bill."
That's you; right?
A. That's right.
Q. Go to page 3.
A. Okay.
Q. And look at the third paragraph. It says that you've "spoken against the use of medicine and surgery for transgender people as a Catholic deacon in his local diocese." See that?
A. Yes.
Q. You don't deny that you've spoken against the use of medical and





surgical treatment for transgender people in your position as a Catholic deacon; right?
A. That's correct, I do not.
Q. All right. Focus on the last sentence of this third paragraph. It says that when a committee member questioned your medical expertise on this issue, you said that you would not treat a person for gender dysphoria and would instead refer them to a qualified mental health professional. You see that?
A. Yes.
Q. At this hearing, someone on the committee was questioning your medical expertise to offer these opinions; right?
MR. KNEPPER: Objection, form.
A. I don't remember that detail, but I think so, yeah. I think the objection they raised was that I don't do these treatments, how could I know.
Q. You're not a psychiatrist; right?





A. No.
Q. You do not have specialized training or expertise in diagnosing mental health conditions; right?
A. I have limited -- limited training. Yes.
Q. And when you say "limited training," what does that mean?
A. Well, in the training of plastic surgeons, we are -- we are required -- because we offer aesthetic surgery, we get some training in issues, psychological/psychiatric issues relating to people who will seek to modify their bodies in order to achieve a sense of peace or a sense of improvement in their lives. And it's imperative that a plastic surgeon be able to recognize persons who are suffering from psychiatric problems because plastic surgery -- to offer them plastic surgery to modify their bodies is in the category of malpractice, not to mention that very





often, dissatisfied patients will -- will make life very difficult for the practitioner, if not threaten them with physical harm.
I would refer you to an article by -- although we haven't offered it up, -- a friend of mine, Dr. Mark Gorney, who was one of the -- one of the grand old men of plastic surgery, started the Physicians Company to manage physician liability and risk and had -- he discovered that there's an overrepresentation of -- of violence against physicians by aesthetic patients committing violence against plastic surgeons. That's just one of the motivators.
But nonetheless, the issue of body dysmorphic disorder is part of our training, persons who are seeking a remedy to their interior woundedness or their psychological disturbances by changing their outward opinion. And body

dysmorphic disorder is a well-characterized psychiatric diagnosis that impinges greatly upon plastic surgery precisely because aesthetic surgery -- even in its name, you can tell that aesthetic surgery is surgery aimed at the aesthetic, the feelings, esthesia, the feelings that a patient has about themselves, about their life. So it's incumbent upon plastic surgeons to know about these things, and so we get trained in those matters.

So again, I have very limited psychiatric/psychological knowledge, but I do know that that subset of patients should be referred for psychological help rather than offered surgery. Not to mention the fact that such patients can't even give informed consent because of their psychological disturbances.

Q. All right. You're talking about patients who have body dysmorphic disorder; right?





A. That's right.

Q. When did you last receive training in how to diagnose someone with body dysmorphic disorder?

A. I guess it's ongoing training when one's in the -- in the practice of plastic surgery. But I had originally in my residency and then on an ongoing basis I think at conferences through the years.

Formal training in it, I -- I don't recall beyond my residency. All I do is try to keep abreast of the literature.

Q. Yeah. So, let's take that in steps. Outside of -- when was your residency in plastic surgery, Doctor?

A. '92 to '94.

Q. Right. Past '94, you have not received formal training in how to diagnose someone with body dysmorphic disorder; right?

A. There may have been some CME credits at a conference in there





somewhere or remote learning. I don't recall.

Q. But sitting here, you can't recall any of those specifically; right?

A. I cannot, no.

Q. What are the diagnostic criteria for body dysmorphic disorder?

A. Well --

Q. Do you know that sitting here today?

A. Yes. So, a person with body dysmorphic disorder, the diagnostic criteria is the -- is the patient who presents with evidence of a psychological disturbance. In review of their history and physical examination, you may see evidence of a history of substance abuse, maybe evidence of some self-harm, evidence of social isolation in their intake forms, that sort of thing. That would raise the concern.

The second would be the person who attaches tremendous potential benefit





of, psychologically, the -- the quality of the -- sort of a transformative power of cosmetic surgery.

And then the third criteria would be that they -- they see something that you don't see. They see a defect that you don't see. And that's probably the key diagnostic criteria. For example, a man who presents seeking a modification to his nose who has evidence of living a life of social isolation who is adamant that by changing his -- the appearance of his nose, he will -- he will have a much better life. And hearing that, of course, the alarm bells go off and then examining the patient and seeing that there's no objectively definable deformity, only a normal variation that one would expect to see on a man's face.

Those are all red flags. And -- and based upon that, it is -- it is definitely the -- has been

historically the recommendation of the likes of Dr. Mark Gorney and other leaders in the American Society of Plastic Surgery to not offer surgery, but rather to offer referral for psychiatric/psychological support and evaluation.

Q. These diag- -- these diagnostic criteria that you mentioned, where do they come from?

A. They -- I think you can find much of that in the DSM book, if -- if -- if that's the route you want to go. You find it in the literature. There are -- there are references in the scientific literature about it dating back to I think the 1920s. I included some of those, I think, in my discussion, if not on this one, in the Arkansas case.

But -- but there have been papers published through the years that describe the condition and make recommendations about care, and again,





going all the way back even to textbooks in plastic surgery and -- and of course, the residency training that speaks about that as well.

Q. So for diagnosing someone with body dysmorphic disorder, you would rely on the DSM-5; right?

A. I wouldn't rely on it, no. No. I would rely on my -- my clinical experience more than anything else there.

Q. Well, you just rattled off three or four guidelines that I think I heard you say come from the DSM-5; right?

MR. KNEPPER: Objection, form.

A. Well, they're -- they don't come from the DSM-5 but are described in the DSM-5, yeah.

Q. So when I asked you --

A. And 4 -- actually, DSM-4 has a clearer description, I think, than DSM-5.

Q. So when I asked you what criteria you would use to diagnose someone with body dysmorphic disorder,





the source you went to was the DSM; right?

A. No. The source I went to was my training and the -- and the papers that relate to it. I think it's just been subsequently characterized in the DSM. And it's a ready -- it's a volume that's readily accessible to people. The language is readily accessible, so people who are seeking information about that, they can go there for it or they can go to the articles, if they like. Yes.

Q. Outside of whatever training you had on diagnosing someone with body dysmorphic disorder, you do not have specialist training or expertise in diagnosing other mental health conditions; fair?

MR. KNEPPER: Objection, form.

A. Let's see. Well, there's -- I guess there are subcategories of -- of body dysmorphic disorder, like recognizing the anorexic patient, of





course, who presents for body modification. That -- that's a fairly readily and obvious one.

But no, I'm not a -- I'm not formally trained in psychiatry or psychology.

Q. You do not have -- you do not hold yourself out as an expert in diagnosing mental health conditions outside, potentially, of body dysmorphic disorder; right?

A. Correct.

Q. You do not have specialist training or expertise in treating mental health conditions; right?

A. No.

Q. You would refer that person to a qualified mental health professional; right?

A. I would. I would.

Q. Because you yourself are not a qualified mental health professional; correct?

A. Correct.
Q. All right. You've also published an op-ed in May of this year supporting this Alabama ban; correct?
A. Yes.
Q. And you said that Alabama legislators should enact this ban because they have a duty to protect the vulnerable population of gender-confused children. Does that sound familiar?
A. Yes.
Q. So again, earlier you said you had a preference for professional societies dealing with this, but you're out there publishing op-eds calling on state legislatures to pass these bans; right?
MR. KNEPPER: Objection, form.
A. Right. Yes, sir.
Q. All right. How about Texas? Tell me what work you've done supporting this kind of a ban in Texas?
A. It's been similar. I've been in





communication with -- I can't remember if they're on the legislative side or on the justice side. I don't remember exactly where they fit into the -- the government of Texas, but I've corresponded with them and offered them information and advice.
Q. Was it similar information to what we've seen in that Utah packet?
A. I'm sorry, sir?
Q. Was it information similar to what we've seen in that Utah legislation packet?
MR. KNEPPER: Objection, form.
A. Right. The substance -- the substance of the issue at hand is the same wherever you find it. It's this contest between those who -- who promote gender-affirming care versus those who promote, in the case of children, for example, watchful waiting and psychological support and cognitive behavioral therapy and those things, yes. It's the same battle wherever you find it





because it's the same problem, the same science, the same language. All of it's the same.
Q. So earlier, we saw that in addition to you, Dr. Hruz and Dr. Levine and Dr. McHugh were also involved with those Utah legislative efforts; right?
MR. KNEPPER: Objection, form.
A. I -- I don't know their involvement in -- in Texas. I'm -- I'm not aware.
Q. Yeah. Do you know whether any of them have been involved with any of these efforts in any other state?
A. I don't. I don't know.
Q. Okay. Fair to say that you have some strong personal opinions on whether doctors should be providing gender-affirming treatment to minors?
MR. KNEPPER: Objection to form.
A. Very fair to -- very fair to say, yes.
MR. TISHYEVICH: Let's go off





the record.
THE VIDEOGRAPHER: This is the end of Media Unit 1. We are off the record at 9:33 a.m.
(Break taken.)
THE VIDEOGRAPHER: This is the beginning of Media Unit No. 4. We are on the record at 9:44 a.m.
Q. (By Mr. Tishyevich) Doctor, you're familiar with an organization called Alliance Defending Freedom, ADF; right?
A. Yes.
Q. How are you familiar with the ADF?
A. I was invited down there for a conference on the subject of transgender. I was an invited presenter, I should say. They asked me to come and speak from a plastic surgeon's perspective on how I view the current state of transgender medicine and surgery.
Q. Those were -- those were the

meetings in Arizona? Is that right?
MR. KNEPPER: Objection.
A. Yes.
Q. Who invited you?
A. I don't remember who the particular name was. I -- I don't recall who the -- the particular person, the one that sent me the invitation.
Q. Was it --
A. It may have been -- it may have been Gary McCaleb, I want to say. I'm not positive about that, though.
Q. You -- you anticipated my question.
A. Okay.
Q. To your knowledge, what's the view that the FDA takes on providing healthcare treatment to patients with gender dysphoria?
A. The position of the FDA?
Q. The ADF.
A. Oh, the ADF. They -- let's see. So, the sense I get is that the ADF takes







a -- the opinion that the present state of transgender medicine and surgery is not in the interest of the patients or the families.
Q. The ADF has moral objections to doctors performing this kind of surgery and treatment; right?
MR. KNEPPER: Objection, form, scope.
A. I would -- I would characterize the ADF's position as more than just a moral objection. It's both moral and objective scientific objections.
So the -- the -- the sense I got from that conference was that most of the invited speakers came to speak about -- for example, Dr. Hruz was there, and he spoke about endocrinology and the endocrinol- -- endocrinologic basis for sex/gender. And he spoke about the effects of -- the endocrinological effects, the objective changes that are caused by, for example, puberty-blocking







cross-sex hormones.
I was -- there was also another speaker there, I think, on the subject of -- from the family medicine perspective, the overall effects on the health of the child, developmental issues. There was a presenter on the objective psychological issues.
And then, I presented on the realities of the surgery. They wanted me to speak about the technical details of transgender surgery, kind of the evolution of the process of transitioning surgery, and the -- and to give them a summary of the state of the science on it.
So I would characterize the ADF as interested in both the moral -- the moral issues and the objective, and they impinge upon one another. Clearly, to do something that is not in the -- in the objective benefit of the patient is a moral problem.







Did I answer your question?
Q. That's helpful, yeah.
The ADF is not a professional scientific organization; right?
A. Not to my knowledge, no.
MR. KNEPPER: Objection to form, scope.
Q. They're a legal organization; right?
A. Yes. That's my understanding.
Q. ADF is engaged with bringing lawsuits that do things like challenge schools' rights to -- to have transgender persons on their teams; right?
MR. KNEPPER: Objection, form, scope.
A. I don't know the scope, the full scope of their efforts, but yeah, they're one of I guess several legal organizations that are -- that are approaching these matters, as are you, for example.
Q. All right. Let's talk about

these meetings in more detail. So, how many -- strike that.

You've been to two meetings organized by ADF?

A. That's my recoll- -- yeah, two meetings. I think that's right.

Q. All right. Let's start with the first one. This was in 2017?

A. That sounds about right, yeah.

Q. What --

A. I think it was 2017, yeah.

Q. What month roughly?

A. I don't remember now.

Q. Do you know how they came to invite you to that first meeting?

A. I do not.

Q. Before that meeting, you had not published anything about gender dysphoria, had you?

A. No.

Q. Before that meeting, you had not published anything about the risks of use of hormone blockers in minors; right?





A. No. I've given -- I gave some -- some -- I think they may have heard of me not through publications, but through public speaking.

Q. How long have you been doing public speaking on the issues related to gender dysphoria?

A. Since 2014.

Q. Let's start with the first meeting. So, Dr. Hruz was also present at that meeting?

A. Yes.

Q. Was Dr. Levine present at that meeting?

A. I don't think I've ever met Dr. Levine, so I don't -- he couldn't have been there because I would have remembered meeting him, and I don't remember ever having met him.

Q. How about Dr. McHugh?

A. No. I would have remembered him. He's a very famous person.

Q. How many people were present at





this first meeting?

A. Perhaps ten. I'm not certain.

Q. Outside of you and Dr. Hruz, who else do you remember being at that first meeting?

A. I remember meeting a Dr. Andre Van Mol. I believe he was at that meeting. There was a pediatric endocrinologist there by the name of Quentin Van Meter. I think he was there.

There was a -- there was an expert in scientific data and scientific data analysis, medical record data analysis from UC-San Francisco. I don't believe he was a physician. I think he was a -- had a doctorate in science. And he was a -- he was actually a detransitioner. So he was giving not only his knowledge of the medical literature, he was just an incredible resource and reference for medical literature. You could just about ask him anything. But he was also there, I





think, to speak from a personal perspective as well, being a detransitioner.

There was another detransitioner there who I don't remember their name, but they were there to speak. I think they were also an educator as well. I'm not positive about that.

So it's kind of vague for me, but I -- but definitely Paul Hruz stands out because we had a very good conversation there.

Q. What was the format? Were there presentations, a round table discussion? How did the conversations go?

A. There was some introductory remarks, and then -- and then each -- each sort of specialist gave a presentation. I think I gave an hour-long presentation. And there were others like mine on those other subjects we talked about.

Q. Did you use slides as part of

that presentation?
A. I usually do, yes, although I don't know what I've done with that slide deck. I don't keep them very long. They sort of morph all the time.
Q. Do you think you might have an electronic copy of that slide deck somewhere?
A. I don't.
Q. At a very high level, what was the -- what were you trying to convey through your presentation to that group? Let me ask it a different way. Were -- was your presentation broadly similar to the opinions that you're offering in this case and in the Brandt case?
MR. KNEPPER: Objection, form.
A. Well, by the -- by "broadly similar," do you mean the subject matter or the nature of my opinion or the evidence used to support my opinion?
Q. All right. Give me a high-level summary of what your presentation was at





that first meeting.
A. It was a --
MR. KNEPPER: Objection, form, scope.
A. -- a summary, a summary of the present state of transgender medicine and surgery, a review of the scientific literature used to support the treatments that are being offered, a review of the long-term outcomes of treatment that are being offered, with particular attention to the European literature, which is more reliable. I sort of -- I compared the American literature to the European literature because that's one of the great problems we're having in this issue. And it was already evident in 2017 that there was a great disparity between the American literature and the European literature in terms of the quality of the scientific evidence that's being used to support the interventions.
So that was -- really at the





heart of the presentation was what's the state of the science and where is the reliable science coming from and what is it -- what is it showing us, so. But they also -- the audience wanted to have an understanding of what these plastic surgery interventions were. So there was an extensive discussion of the particulars of the surgeries, the details about the surgeries, the typical outcomes of the surgeries, so.
Q. I want to -- strike that.
One of the topics of discussion at that meeting was about the need to have expert witnesses for litigation; right?
MR. KNEPPER: Objection, form, scope.
A. I remember -- I remember a fairly long discussion about the poverty of people who are willing to testify because of the risk that they take in testifying. That was a -- that was a





fairly long discussion. And the difficulty that that -- that people have in finding expert witnesses because of the risks they place themselves in, in testifying.
Q. And people at that meeting were asked whether they would be willing to participate as expert witnesses; right?
A. Yes.
Q. Before that meeting, you had never testified as an expert witness?
A. Before this moment, I never testified as an expert witness.
Q. Who made the introductory remarks at the beginning of this meeting?
MR. KNEPPER: Objection, form, scope.
A. I'm trying to remember. It was a -- it was an attorney whose first name is Jeff, and I'm trying to remember what his last name was. But he seemed to be the -- the -- kind of the emcee, if you will. Yeah, Jeff. I'll see if, in the

course of our conversation today, the name will pop in. This is the difficulty I have with remembering names. They'll just pop in at a moment's notice.

But it was -- yeah, it was an attorney who gave the overall scope of why -- why we were there, to discuss this issue, to see what -- what the -- what the science is showing to see where -- what the -- the moral aspects of good science versus bad science and issues like that, yeah.

Q. Aside from you and Dr. Hruz, do you recall anyone else expressing an interest at that conference about serving as an expert witness?

MR. KNEPPER: Objection, form, scope.

A. You mean someone expressing just generally about having expert witnesses?

Q. No. Other participants saying, "I might consider being an expert witness in one of these cases."







A. I don't recall. I don't, no.

Q. Okay. All right. So then there was a second meeting also in Arizona; right?

A. Right.

Q. And that was also in 2017?

A. I don't remember the date of that as well -- either, no.

Q. What was the purpose of that second meeting?

A. I think it was similar, although it may have been a little bit more refined. There was not as much discussion of the really foundational science as more a review, I think, of -- you know, I -- I guess it was similar in terms of format. I think there were more -- more people there who were speaking from personal experience.

So I think the most important thing I recall from that meeting was that -- that there was a mother -- actually, a couple of family members of persons who







experienced cross-sex self-identification who have gone through various -- various phases of transitioning. And they were giving sort of a personal experience, trying to describe to us what they went through as a family, what they went through with their children. And that's what -- so that was the difference between the first and the second meeting. I think it was more of a personal thing. It had the science as well, but I think it had more of a personal side to it as well.

Q. How many people do you think attended -- attended that second meeting?

A. I'm trying to think how full the room was. I think it was probably comparable maybe, a dozen perhaps. I'm not sure.

Q. Who do you remember being there by name?

A. I think that may have been when I met Dr. Cretella. I can't remember if







I met her at the first meeting or the second meeting.

Oh, also at that second meeting, there was a plastic surgeon. I can't remember his last name. I was -- I remember being very encouraged to meet another plastic surgeon who saw this as an issue. And I do remember that he had been the chairman -- this speaks to the issue of fear about testifying. He had been the chairman of a major plastic surgery department in a large Midwest university, had built that program for many years, had run one of the most successful residency training programs. And he had been fired because he had objections to the transgender services that the hospital administration -- or the university administration wanted to introduce. And I thought it was a very heartbreaking story to see that a man had lost his entire career over his professional opinion. I don't remember

his last name, but I do know that I met him at that second meeting.

Q. Do you remember his first name?

A. I don't.

Q. Do you remember which center he was affiliated with?

A. I believe he was from the Ohio State University. But I haven't seen or heard from him since. He has just disappeared. I tried to reach out to him, I recall, because, again, there's not a lot of plastic surgeons who are willing to speak on this matter. And -- but I haven't heard from him since.

Q. Did participants at the second meeting make presenta- -- make presentations as well?

MR. KNEPPER: Objection, form, scope.

A. I -- I don't -- yeah, I think it was more limited presentations, briefer, sort of reviews sort of thing. But it wasn't -- it didn't have the formality of





the first meeting, as I recall. Again, it's -- it's a little bit murky four years on.

Q. Yeah. I'm just asking for your best recollection. That's fine.

A. Sure. Okay.

Q. Do you remember giving a presentation at that second meeting?

A. I believe I did.

Q. How long do you think that meeting lasted, roughly?

MR. KNEPPER: Objection, form, scope.

A. Well, I remember it -- we went through a full morning, a light lunch, and perhaps into the very early afternoon.

Q. And you mentioned that there was some personal testimony from parents, families. What portion of the meeting was that, roughly?

A. What -- what portion?

MR. KNEPPER: Objection, form,





scope.

Q. What portion, yes.

A. I would be guessing that perhaps a third of the meeting was -- was that.

Q. Okay. After these meetings in 2017, have you continued to stay in touch with the ADF?

MR. KNEPPER: Objection, form, scope.

A. I think perhaps, you know, one or two e-mail exchanges, but nothing -- nothing substantive. I haven't really heard anything from them. I think I got a -- no. Well, I can't -- I can't recall anything other than maybe a thank-you e-mail or hope you're doing well kind of thing, but nothing substantive, no.

Q. How did you come to get involved with being an expert in this case?

A. I was contacted by Mr. Knepper.

Q. Okay.

A. Actually, I was contacted by his staff. He didn't call me himself, but





his -- someone on his staff called me and asked --

Q. I understand.

A. -- if I would be available. Yeah.

Q. How did you come to get involved with the Brandt case in Arkansas?

MR. KNEPPER: Objection, form, scope.

A. I think it may have been similar. I don't recall the particulars, but I -- someone on -- on the legal counsel side contacted me. I don't remember who it was.

Q. Okay. Let me shift gears a bit. You know what the American Society of Plastic Surgeons is; right?

A. Of course.

Q. Are you a current member?

A. No. I -- I let my membership lapse years ago, yeah.

Q. When --

A. About two years ago, I would

say. Maybe two years ago, yeah.
Q. Why did you decide to let your membership lapse?
A. Well, in order to be a member of the American Society of Plastic Surgeons, you have to be board-certified. And so since I declined continuing board certification for the reasons I explained to you, then my membership -- you know, over time, when my subscriptions and membership fees lapsed, so did my membership. And I think that would have been in 2019.
Q. I understand.
A. Yeah.
Q. Is it -- is an active board certification in plastic surgery a prerequisite to being in the American Society of Plastic Surgeons?
A. I seem to remember that when I -- back in the '90s after my residency, there's a -- there's a membership for -- for board-eligible. It's not the full





membership, but then when you get board-certified, then you get full membership and the rights to use the logo and all that sort of stuff, so. Yeah, as I recall. It's been a long time since I read the bylaws. That would have been back in '95, I think, that I read those things.
Q. Yeah. When did you first join the ASPS?
A. I think I joined as a student member when I was in my residency. I want to say it was probably like '92 or '93, somewhere in there.
Q. So you were in the ASPS roughly '92 --
A. I think, yeah.
Q. -- to 2017?
A. I think, yeah. As I recall -- again, it's a little bit murky, but as I recall, there's sort of a provisional membership for residents in training. You sort of get a discounted rate on all





of the expensive things, and the -- and access to the White Journal, as it's called. And then -- and then I -- as I recall, you don't get the full membership until you've been board-certified, which happened for me, as you know, in '97.
Q. Okay. But you were part of the ASPS for a long time; right?
A. Yes. Going to meetings.
Q. You consider the ASPS to be a reputable organization; right?
MR. KNEPPER: Objection, form.
A. Yeah. Well, for the most part, yeah. Certainly, the members, virtually most of the members I've ever known are reputable. And there are some things that the ASPS has done through the years that -- that I've had difficulty with and -- but they're certainly the organization in American plastic surgery.
Q. Yeah. I think one statistic I heard is 93 or so percent of all plastic surgeons are part of the ASPS.





A. Yeah.
Q. Right?
A. That -- that number wouldn't surprise -- I would have thought even higher, actually, but yeah.
Q. Do you think the ASPS would encourage its members to perform surgeries that are not medically necessary?
MR. KNEPPER: Objection, form.
A. Well, the -- as a -- as an organization, they don't encourage particular surgeries, but they may support them with their scientific presentations, their conferences, and that sort of thing.
For example, three or four years ago, I went to a meeting of the California Society of Plastic Surgery, which is -- I think it has sort of a subsidiary relationship with the ASPS. And at that conference, among other things -- I went there because that's one

of the -- the areas of the country where I trained and I had hoped to see some friends there. But -- but for example, in that conference I went to a lot of great presentations, but the last day was devoted almost entirely to transgender surgery.

And so if you're asking me do I -- how do I feel about that, well, I have great difficulty with a professional organization that would support or promote those sorts of interventions knowing what I know about the scientific underpinnings of those medical and surgical procedures. And I had many conversations at that conference on the subject with persons who were providing the services, and I didn't find their answers particularly satisfactory. So that would be an example.

I can't give you carte blanche that everything that the Society says and does is to my liking. I would say







probably most of what they say and do is very much to my liking. But on this matter, I have -- I have a great difficulty. And it's one of the reasons that I -- I -- yeah.

Q. It's one of -- one of the reasons that you what?

A. That I -- that I don't have a lot of heartache about stepping away from the ASPS.

Q. Do you think the AS- -- ASPS advocates in favor of surgical procedures that are not medically necessary?

A. I think that would be probably an overreaching statement. I wouldn't say that. I would say that perhaps they're mute on some of the -- some of the procedures that their members perform, and they certainly have their eyes and ears open for new things. And so when members come forward to make presentations about particular new therapies and new approaches, as they







should, the ASPS is open to those things. So for many years, transgender surgery has been in that category.

I remember when I was a -- even when I was a general surgeon and I was looking for residency programs to train in, I was considering UVA. And I saw that -- that Milton Edgerton, one of the great names in plastic surgery was at UVA doing transgender surgery, both at UVA and at Johns Hopkins. And I remember thinking, well, I'm -- I really need -- it struck me as an unusual operation, and I -- I started doing some research into it.

And I remember starting to think about the issue of transgender surgery back in the -- what would have been 1991, 1990, 1991. And -- and through the years, the ASPS has made room for that intervention, those therapies, in their conferences, in their dialogues, in their publications. And I've reviewed all that







stuff as it has come along. And I think now being twenty, nearly thirty years on since I first started looking at it and they're still just sort of at that stage of -- of putting it out there, although now they're offering more extensive training conferences on how to do those procedures, and they're now encouraging that it be included in residency programs, and so -- yeah.

Q. Do you know what position the ASPS takes on whether gender-affirming surgery is medically necessary?

A. I think that position has changed, and now they're -- they're speaking positively about it.

Q. Yeah. Your own professional organization, or at least your former organization, takes the position that gender-affirming surgery is medically necessary; right?

MR. KNEPPER: Objection, form.

A. Yeah. As I -- as I said before,

this is one of the reasons why I don't have a lot of heartache about having withdrawn my membership. Yeah.

Q. Now let me introduce another exhibit. Let me know when you have it, Doctor.

(Exhibit 7 was marked for identification and is attached.)

A. Okay. Okay. I've got it.

Q. The top of the page says, "American Society of Plastic Surgeons." Right?

A. Yes.

Q. You see this document is dated February 25, 2021; right?

A. Yes.

Q. This is after all the studies that you cite in your report; right?

A. Where does that say that? I'm sorry, you're at a particular paragraph?

Q. No. The date of this --

A. Oh, I see. Oh, the date is after this --





Q. Yeah.

A. Yes. Well, February 25th, yes, 2021.

Q. Yeah. This is -- this is dated after all of the studies that you cite in your report; correct?

A. I don't -- yeah, I don't remember off the top of my head any studies that were dated after. There may have been an April study in there, but okay.

Q. The first sentence says, "Policy around transgender care has recently gained considerable attention amid a growing trend of legislation carrying serious professional, financial or criminal penalties for the provision of gender affirmation care." You see that?

A. I do.

Q. Now, this reference to a growing trend of legislation, that's talking about legislation like the Arkansas ban and the Utah ban and the Alabama ban that





we talked about earlier; right?

A. Right.

MR. KNEPPER: Objection, form.

Q. Go to page 2. Look at the second paragraph. It says that "Less than three months into 2021, 11 pieces of legislation attempting to criminalize gender affirmation therapies have been introduced in 10 states." See that?

A. I do.

Q. And then there's a list of states; right?

A. Yes.

Q. So we talked about Utah and Alabama and Texas before. Looking at this list, does that refresh your recollection whether you've worked on these kind of legislative efforts in any other states?

A. I think -- I think, yeah, my answer has not changed. I think I've only been involved in Alabama, Texas, and Utah. I don't remember anything from





Oklahoma, New Hampshire, Montana, or Missouri or Mississippi. I don't recall any other states in that list, no.

Q. Okay. All right. Now let's look at what position the ASPS takes on whether gender-affirming treatment is medically necessary. Go to page 3. The first sentence says, "ASPS firmly believes that plastic surgery services can help gender dysphoria patients align their bodies with whom they know themselves to be and improve their overall mental health and well-being." Do you see that?

A. I do.

Q. The ASPS, your own professional organization, does not agree with your opinions that gender-affirming surgery is medically inappropriate; right?

MR. KNEPPER: Objection, form.

A. Let me just read that. Give me just a moment to look at that. Okay.

Yeah. This is a very --

language used by the other professional organizations, and essentially, the language takes the position that surgical intervention for a subjective problem is medically indicated. And that's the difficulty that I'm having here, is that in this document the ASPS does not -- does not provide medical scientific support. They essentially admit that the surgery is for help with a psychological problem of perception on the part of the patient. So essentially what -- what the ASPS firmly believes in is the use of surgery to manage a psychological problem. And -- and this is -- this is consonant with the -- with the -- the consensus opinions that were offered by the other professional organizations that you listed earlier.

Q. The AS- -- ASPS does not agree with your opinions that gender-affirming surgery is experimental; correct?

MR. KNEPPER: Objection, form.





A. They don't -- let's see, do they say anything about experimental in here? No, they don't. So yeah, I would agree.

Q. Do you agree? Yeah.

A. I would agree, yeah, sure.

Q. Look at the last sentence. It says, "ASPS will continue its efforts to advocate across state legislatures for full access to medically necessary transition care." Do you see that?

A. Yeah. I don't find that statement at all surprising. No.

Q. Yeah.

A. I do see that, yeah. Not surprising. This is legislative --

Q. The ASPS --

A. -- legislative advocacy by the ASPS.

Q. The ASPS considers transition care to be medically necessary; right?

MR. KNEPPER: Objection, form.

A. Again, that returns -- returns to that -- that inherent and





contradictory statement of medical necessity for a subjective condition. And the statement is consistent with what -- yeah. Exactly, yeah.

Q. It's fair to say that the opinions that you and Dr. Hruz and Dr. Levine are offering in this case are very different than the position that the ASPS has adopted on whether gender-affirming surgery is medically necessary; right?

MR. KNEPPER: Objection, form.

A. Absolutely correct.

Q. In fact, let me show you how strongly the ASPS feels about this issue. Let me introduce another exhibit. Okay. Let me know when you -- when you receive it.

MR. KNEPPER: Dmitriy, I -- I will tell you, it seems to be moving more slowly than normal. I don't know if you're seeing the same thing on your end.

MR. TISHYEVICH: I am.

A. So yeah, I have this document.





Again from the ASPS? Is that the one? February 25th?

Q. No. It should be -- it's a one-page document. I think it just says ASPS in your folder.

A. Exhibit 7?

MR. TISHYEVICH: Let me -- let's go off the record for a minute.

MR. KNEPPER: Sure.

THE VIDEOGRAPHER: We are off the record at 10:19 a.m.

(Break taken.)

THE VIDEOGRAPHER: We are back on the record at 10:21 a.m.

Q. (By Mr. Tishyevich) All right. Doctor, before the break, we were talking about the ASPS and the position they take on the medical necessity of gender-affirming surgery. You recall that?

A. Yes.

Q. All right. This is a document from the ASPS titled "2021 State Policy

Priorities." Do you see that?
(Exhibit 8 was marked for identification and is attached.)
A. Yes.
Q. Last sentence of the first paragraph says, "To ensure that our health care system is effective and efficient, ASPS will focus its state advocacy efforts on," and then there's a list. Do you see that?
A. Yes.
Q. And there's three sections: "Core Priorities," "High Priorities," and "Other Priorities." You see that?
A. Yes.
Q. Go to the "High Priorities" section.
A. Okay.
Q. The last bullet says, "Opposing attempts to criminalize gender confirmation." Do you see that?
A. I do.
Q. And you understand what this





bullet means; right?
A. I do.
MR. KNEPPER: Objection to form.
Q. One of the ASPS's high priorities for this year is to oppose legislation like the Arkansas ban and the Utah ban and the Alabama ban that you are supporting; right?
A. Apparently so, yes.
MR. KNEPPER: Objection, form, scope.
Q. The sense that I got from reading your report, Doctor, is that it's supposedly generally accepted that gender-affirming surgical treatment is experimental and should not be performed on anyone; right? That's what you think?
MR. KNEPPER: Objection, scope, form.
A. Right. My opinion -- my opinion in that matter is based on the -- on the world literature rather than advocacy statements by a professional





organization. That's right.
Q. You are suggesting, in fact, that doctors who do these surgeries should be investigated for unethical behavior and potential misconduct; right?
MR. KNEPPER: Objection, form.
A. I -- yes, I do.
Q. And you do not think it's relevant to mention that your own professional society takes a view that is contrary to the opinions that you're offering in this case; right?
A. I'm not sure I understood your question, sir.
Q. Yeah. When you talk about how these doctors should be investigated for misconduct, you don't think it's relevant that your own professional society takes a completely contrary view?
MR. KNEPPER: Objection, form.
A. Well, I think I would -- I would characterize my concern and -- and possibly recommendation of investigation,





I was discussing, I think, consent procedures and getting informed consent. I don't think -- yeah, so -- so I think the object- -- the concerns I raised had to do with the off-label use of drugs in irreversible treatments, the -- the problem of obtaining consent from emotionally compromised people who are threatening suicide. Those were the issues that I raised in terms of, you know, investigation kind of things, or examination would be a better term, examination of -- of how a physician/surgeon conducts their practice, so.
Q. Go -- go back to your report.
A. Okay.
Q. Go to page 15. You with me?
A. Yes, sir.
Q. Look at the second sentence in the bottom paragraph. You say, "Basing life changing surgeries that damage and destroy the natural functions of

perfectly healthy organs on nothing more than the unverified self-reports (conversations) of often disturbed patients as part of untested, unproven, experimental 'treatments' that are 'supported' by a methodo-" -- "methodologically defective research base when competent reviews have called such research 'low quality' evidence and noted the 'lack of any randomized clinical trials' -- should be properly investigated as unethical, misconduct and an abuse of a vulnerable patient population."

Right? That's your opinion?

A. Yes, sir. And I stand by that.

Q. You know that today there's thousands of plastic surgeons that are performing these surgeries; right?

MR. KNEPPER: Objection, form, scope.

A. I don't know the number of plastic surgeons who do these surgeries.





Q. Hundreds?

A. I'm -- I'm sure the number is large. I don't know what the number is. Yes.

Q. And you think all of those doctors are out there committing misconduct? Is that really what you think?

A. Well, I think that -- that their knowledge might affect their decision-making. So if somebody is going through a residency training program that -- that is teaching these things and they grow up in that world -- let me give you an example.

When I was a surgeon in training in general surgery, the -- the most coveted surgical experience would be, as a chief resident, to do ulcer surgery. At the time, we thought that ulcers were caused by neurologic problems affecting the stomach. And so some of the most complex abdominal surgeries were ulcer





surgeries, and some of the greatest names in general surgery were given to those operations. Subsequent to my residency training, perhaps five years later, it was found to be a medical condition treatable with antibiotics and antacids. Nobody does ulcer surgery any longer.

I would put -- I would put transgender surgery in the same category. Well-meaning persons who are interested in the care of people who are suffering, in this case, transgender persons who are suffering, well-meaning physicians and surgeons are offering them the best care that they've learned in their training. But I -- I would expect that when the science shows that to be not the case, that those same doctors will abandon it. And I think we're at the same stage now. We're at an inflection point in plastic surgery where in the last three years things have changed radically.

If you had asked that question





five, seven years ago, it would have been up for grabs. But things have changed radically with the flood of credible scientific evidence pouring in from Europe to now -- if -- if five years from now, having seen that information, surgeons persist in doing transgender surgery, then I would -- then I would have real issues with that, as I would with a -- with a general surgeon offering a Billroth II ulcer operation today when you could give the patient erythromycin and some -- and some Zantac. You see where I'm going.

So we're at a -- we're at a tipping point in the world of plastic surgery right now, and the last three years have changed everything, because the very, very well-supported -- see, the problem is quality of evidence. Plastic surgeons in America are operating with scientific evidence that even the American Society of Plastic Surgery

characterizes as level 5 evidence, basically, the -- the professional opinions based on personal experience. This is entry-level science for a particular therapy or a particular intervention.

To raise to level 4, you would have to have the same collected cases with -- with before and after tests of the patient. We haven't gotten to that level yet. There are no long-term longitudinal studies in the American literature. It's all in the European literature, and the bulk of it in the last three years.

So the question is a difficult one to answer. As simply as saying that all of these people are immoral, I'm not saying that at all. I'm saying that they're doing the best that they know how according to the training that they've received for people that they very much care for and are hoping to do good by.





But the -- but the world is changing rapidly now, and we've reached a stage now where it's such a controversy that this is -- this is -- this is why I've become so publicly vocal about it, because the controversy is now raging. It's no longer: "Maybe so. Milton Edgerton, interesting guy. You know, the surgery at UVA, the surgery at Johns Hopkins, let's get a look at that kind of thing." We've gone beyond that now, and just in the last three years.

So I -- the people who do these surgeries are not right out of residency training. These are people who have -- you know, who have been in the -- in the business for a number of years now, and they're relying on what they learned and doing the best that they can. But as I say, the science is changing everything, so.

MR. TISHYEVICH: With respect, I'm going to strike that answer as not





responsive.

Q. Here's the -- here's --

MR. KNEPPER: No.

Q. -- the question that I'd like you to answer.

MR. KNEPPER: Go ahead.

Q. Here's the question that I'd like you to answer. Is it your expert opinion that the surgeons that are today performing gender-affirming surgical procedures are committing or potentially committing misconduct, yes or no?

MR. KNEPPER: Objection, form, scope, asked and answered. Dmitriy, you asked him. He gave you a --

MR. TISHYEVICH: I don't need the speaking objections. I do not need the speaking objections.

Q. Answer my question, Doctor.

MR. KNEPPER: He gave you a thoughtful answer.

A. Okay. If you could ask me the question again, I want to be sure that





I -- I answer it as succinctly as I can.

Q. Is it your expert opinion that the surgeons that are performing gender-affirming surgical procedures today are potentially committing professional misconduct, yes or no?

MR. KNEPPER: Objection, form.

A. I would -- I would say, only to the extent that they're familiar with the more recent literature would make them sort of culpable, if you will. Not -- not being aware of that literature, I would not accuse them of such a thing.

Q. All right. Let me introduce another exhibit. Let me know when you get this one, Doctor, Exhibit 9.

(Exhibit 9 was marked for identification and is attached.)

A. All right. The first page of my -- well, that's the CV, I guess. My CV, yes.

Q. This is a copy of your CV; right?

A. Yeah. Yes.
Q. You prepared this?
A. Well, it was prepared for me by -- I gave -- I gave the factual input for it, but I didn't prepare it myself, let's say.
Q. Top of the page says, "Board Certified in Surgery and Plastic Surgery" again; right?
A. Right. Same mistake, yeah.
Q. We agree that's not consistent with guidance from the American Board of Surgery, American Plastic Board of Surgery; correct?
MR. KNEPPER: Objection, form.
A. Yes.
Q. Go to page 3, the bottom of the page. It says, "Publications - Peer Reviewed Medical Journals." You see that?
A. I do.
Q. And then through page 4, it lists six publications; right?







A. Right.
Q. In your professional career, you've published six articles in peer-reviewed medical journals; right?
A. Right.
Q. First one was in 1997; right?
A. '87. Yes.
Q. Most recent one was in 1998; correct?
A. Correct.
Q. That's 23 years ago; right?
A. Right.
Q. You have not published any original research in peer-reviewed literature within the last 23 years; correct?
A. Correct.
Q. All right. Let's go through these in reverse order. All right. Most recent one from '98 is titled "Treatment of an isolated outer table frontal sinus fracture using endoscopic reduction and fixation." Right?







A. Yes.
Q. That publication doesn't relate to gender-affirming surgery or to gender dysphoria; correct?
A. Tangentially, it would relate to it. And I would say this about it. It was one of the first, if not the first, paper demonstrating the use of endoscopic technique to operate on facial bones of the forehead and the use of internal fixation devices for modification or repair of the forehead. Those are the same techniques that are now used by transgender surgeons who are offering top surgery. For example, for feminization of a masculine brow ridge, they use endoscopic technique, which is described in this paper that came out 23 years ago and was written by myself and another Navy surgeon.
Q. Understood.
A. Yeah.
Q. The -- the patient in this







publication was not treated for face -- for gender dysphoria obviously; right?
A. No. She was a sweet pizza maker who had slipped in the kitchen and struck her head on a stainless steel table and had a -- had a displaced fracture of her forehead. But no, she was -- not to my knowledge. I don't know if she was or not, but to my knowledge, she was not.
Q. Next one going backwards is from 1996, and it's titled, "Scarless Fetal Skin Repair: 'Unborn Patients' and 'Fetal Material.'" Do you see that?
A. I do.
Q. All right. That doesn't relate to gender-affirming surgery or to gender dysphoria, I take it?
A. It -- it actually refers to all forms of surgery and particularly, ethical decision-making. So I would say that it's -- it's a -- it's a fairly broad paper that talks about how we treat other human persons. So transgender

surgery is all about how we treat other human persons. That's what that paper is about and how -- how some surgeons are likely -- or possibly physicians and surgeons could characterize someone as less than human, which is a -- which is a danger that transgender persons experience when they're seeking care. And so I would say that in a very tangential way, it does. It does impinge upon the field of transgender medicine precisely for the reason that transgender persons suffer oftentimes from being treated as -- as someone who is less than human.

Q. Aside from that very tangential angle, this paper does not specifically relate to gender-affirming surgery or gender dysphoria; correct?

A. No, it does not.

Q. And the next one before that is in 1995. Do you see that?

A. I do.





Q. You're listed as the third author in this one; right?

A. Yes, sir.

Q. Because you're not the lead author; right?

A. No. The attending surgeon is always the lead author, and I was a resident. I was a resident at that time, yeah.

Q. Understood. This one's titled "Delayed development of an ectopic frontal sinus mucocele after pediatric cranial trauma."

A. Mucocele, yes. Mucocele.

Q. Thank you. This publication doesn't relate to gender-affirming surgery or gender dysphoria; correct?

A. Not directly, no.

Q. Okay. Next one before that is titled "Patch Esophagoplasty"?

A. Very good.

Q. And that's repair or reconstruction of the esophagus; right?





A. Yes.

Q. Does this relate to gender-affirming surgery or gender dysphoria?

A. No.

Q. Next one before that is titled "Modified Skin Incisions for Mastectomy: The Need for Plastic Surgical Input in Preoperative Planning." Do you see that?

A. I do.

Q. And finally, your oldest publication is from 1987, titled "Peritoneal Fluid in Human Acute Pancreatitis." Do you see that?

A. Yes.

Q. Does that relate to gender-affirming surgery or gender dysphoria?

A. It does not. By the way, that -- that second to the last article, your pattern of questions, I wondered if you overlooked asking the same question on that paper.





Q. No. I want to ask you more specific questions about that one, so we'll spend --

A. Oh, okay.

Q. -- more time on that one.

A. Good. Good. Very good. All right.

Q. Don't worry.

A. Yeah. "Peritoneal Fluid in Acute Pancreatitis" was a research paper, animal model, and review of the literature. Yeah.

Q. Okay. You agree there's a difference between a scientific article that reports original research versus a letter to the editor that's published in a scientific journal?

MR. KNEPPER: Objection, form.

A. Yes.

Q. Some of your publications listed here are just letters to editors; right?

A. Yes.

Q. Why is it that your CV doesn't

identify those as letters as opposed to original research?

A. I didn't -- that didn't occur to me to do that. Do we generally list them separately? I don't know. I just put all my publications there.

Q. So we can look at them, but for example, the scarless fetal skin repair, that's a letter to the editor; right?

A. Right.

Q. And so is the 1993 publication on patch esophagoplasty; right?

A. Right.

Q. So out of the six publications that you list in your CV, at least two of them are letters to editors rather than original research; fair?

MR. KNEPPER: Objection, form.

A. Right. Yes.

Q. Okay. Let's talk about your experience treating transgender patients. You retired from the military in 2002; correct?





A. Correct.

Q. In 2002, the U.S. military certainly was not providing any gender-affirming treatment to anyone in the military; right?

A. That's correct.

Q. Or to veterans; right?

A. Correct.

Q. In fact, at that time, there was a policy not to provide gender-affirming treatment to active military or to veterans; correct?

MR. KNEPPER: Objection, form, scope.

A. Correct.

Q. So during your career in the military, you did not provide any gender-affirming treatment to any patients; correct?

A. Correct.

Q. All right. Let's focus on your practice after you left the military in 2002. You currently run the Lappert Skin





Care clinic; right?

A. That's correct.

Q. How long have you operated that clinic?

A. One year.

Q. Did you operate any clinics before opening this one?

A. Yes.

Q. What was that one?

A. That was my plastic surgery office called Lappert Plastic Surgery in Madison, Alabama. And before that, it was under the same name but located in Decatur, Alabama. And before that, it was in Scottsbluff, Nebraska, same name.

Q. How long did you run the Lappert Plastic Surgery clinic?

A. The Madison office was for 15 years. I'm sorry. The Madison office was for ten years. My -- my mistake. Ten years at the Madison office, five years at the Decatur office, and three years at the Scottsbluff office.





Q. So, let me just make sure I have my timing here. So you've had the Lappert Skin Care clinic for a year, since 2020?

A. Right.

Q. And then the Lappert Plastic Surgery ten years in Madison, so roughly 2010 to 2020?

A. That's right.

Q. And then five years before that in Decatur, 2005 --

A. Right.

Q. -- to 2010, roughly?

A. Right.

Q. And then --

A. Scottsbluff was from 2002 through two -- through 2005. That was where I went when I retired out of the Navy.

Q. Your -- your skin clinic currently does treatments like Botox, light therapy, laser hair removal; right?

A. Right. Laser tattoo removal,

injectables, just skin consultations for skin problems like rosacea, acne, that sort of thing. That's right.

Q. Were you performing similar treatments at the Lappert Plastic Surgery clinic?

A. Yes. All I've done is I've just suspend -- I just retired from active surgical practice. I had an operatory in my office in Madison as well as in Decatur previously, so I would do both hospital-based surgeries as well as clinic-based, office-based procedures.

Q. So for example, light therapy services, you've offered that for ten-plus years, I take it?

A. I believe we got that instrument in 2006.

Q. How about Botox? Have you been offering that for more than ten years?

A. Yes.

Q. Have you done forehead injections for more than ten years?





A. With Botox?

Q. Yes.

A. Yes.

Q. How about crow's feet? Is that the right term?

A. Yes.

Q. More than -- more than ten years?

A. Yes.

Q. When was the last time you've performed a surgical procedure?

A. Well, as I said, I retired from surgery in August of 2020, so it was -- I think I was doing some last procedures in that same month, perhaps July, somewhere in there.

Q. And in 2020, roughly how many surgical procedures do you think you've performed?

A. From January to July?

Q. Yes.

A. Let's see. Seven months. Perhaps -- I don't know. Maybe eighty,





something 80 to 100, I'm guessing. I don't know.

Q. And give me examples of common surgeries you would have performed in 2020.

A. Well, among the most common ones that we did in the -- in the office were autologous fat grafting for recon- -- for rejuvenation of the face, autologous fat grafting for breast augmentation, ultrasound -- I'm sorry -- laser lipoplasty for body contouring, and then many in-office surgical procedures for skin cancer and skin cancer reconstruction, particularly of the face and the extremities.

And then on the hospital side, I would be guessing how many, but it was common for me to do breast reductions and abdominoplasties, little local flap reconstructions in the hospital for younger patients who needed anesthesia, reconstruction -- little reconstructive





flaps for trauma or for cancer.

I had a working relationship with a dermatologist who did a lot of what's called Mohs surgery for removal of cancers. He would send me his patients if they -- if they were cancers that involved the face. I would do those reconstructive surgeries.

Yeah, that was probably -- I was definitely throttling back in my last year. I didn't take on a lot of complex cases, so.

Q. Okay.

A. Because I needed -- you need follow-up, and so limited.

Q. I understand. Let's go back to your report. Go to page 4.

A. Okay.

Q. Okay. Five lines down, you see the sentence starting with, "In my private practice"?

A. Yes.

Q. Okay. Let's break this down.

So you reference treated skin pathologies. What skin pathologies are you referring to here?

A. Skin can- -- well, surgically or medically, we're talking two different categories, but. So I'm consulted on -- on a lot of nonsurgical skin pathologies. But as far as surgical skin pathologies, that would include various forms of malignancy and then benign growths and things that are either aesthetically or -- aesthetically problematic or suspicious in appearance, so both proven cancers and things that are suspicious of cancers. So those would be the skin conditions. The medical --

Q. Yeah. Well --

A. -- skin conditions -- I'm sorry?

Q. Yeah. That's all right. I'm asking more specifically.

A. Okay.

Q. Because here, you write, "I've had occasion to treat many





self-identified transgender patients for skin pathologies related to their use of high dose sex steroids."

A. Yeah.

Q. So focusing specifically on that patient population.

A. Okay.

Q. So, what skin pathologies are you referring to here with respect to transgender patients?

A. Well, I've had a few patients who've come in evidencing, you know, acneiform conditions of the facial skin. And so helping people manage acne is a common thing that I do, and a variety of interventions including, you know, the light therapy, but more -- more properly, the use of medications and -- and sometimes laser therapy to manage scarring. But in those particular cases of the trans-identified people, it's mostly just ordinary management of acne. And it's usually the same patients who





come to see me about facial hair removal with laser. I have a couple of patients in that category, people who are transitioning and who are seeking laser removal of hair from their faces.

Q. And you said this is a few patients. How many transgender patients would you estimate you've treated for skin pathologies related to steroids?

A. Related to -- to sex steroids?

Q. Yes.

A. Oh, I don't know. Probably less than half a dozen.

Q. Okay. The acne you're referring to, it's essentially a side effect from the steroids; right?

A. It's a common side effect of -- of -- yeah. Particularly androgen is the most common.

Q. So this -- and so you're treating patients with gender dysphoria after they have already decided to follow a certain course of treatment and started





taking sex steroids; right?

A. Right. Yeah.

Q. Okay. And then you say you've done laser therapies for management of facial hair of also the transgender population?

A. That's right.

Q. Right?

A. That's right.

Q. And is that also in about half a dozen patients? Or what's you're estimate?

A. Yeah. It's not a huge number.

Q. Okay. And finally, you say you've done breast reversal surgeries for detransitioning patients. On how many patients have you performed -- strike that.

On how many detransitioning patients have you performed the surgery?

A. Two.

Q. Two. All right. It's not a commonly performed procedure for you;

fair?

MR. KNEPPER: Objection, form.

A. Yeah, no. They -- they started coming to me in that last year of practice, so. Yeah, that -- it's not a -- yeah, it's not a -- it was never a common procedure for me. I did a lot of, you know, implant removals and stuff through my years. It's the same operation. And I've done a lot of gynecomastectomy surgeries. That's also the same operation. But in terms of as it's applied to a trans- -- a transitioned person who wants to revert back to male presentation, very limited experience. But even though it's the same operation, I have only done it for two people.

Q. And you said both of those patients were in 2020?

A. I believe so, yeah. One of them may have been in 2019. I'm not positive about that.





Q. Before 2019 or 2020, you had never had a detransitioning patient come to you to obtain breast reversal surgery; fair?

A. I think that's correct, yeah. I'm just trying to think if there was any, but I can't -- I can't recall any other.

Q. Okay. Are you aware that modern gender affirmation programs typically have a multidisciplinary team of healthcare providers?

A. Yes.

MR. KNEPPER: Objection, form.

Q. And they usually involve mental health specialists; right?

A. Yes.

MR. KNEPPER: Objection, form.

Q. Endocrinologists?

A. Yes, that's my understanding.

Q. And oftentimes plastic surgeons if the patient wants to go that route; right?





A. Right. That's -- that's my understanding, yes.

Q. You personally have never been part of this kind of a multidisciplinary team for any patient with gender dysphoria; correct?

A. No. I have always -- I have always turned away personal -- for per- -- well, my understanding of those procedures has caused me to reject offering them to my patients because I don't see them as beneficial. So clearly, I wouldn't want to participate in a multidisciplinary team that's offering therapies that I consider to be incorrect treatments for a condition that deserves our care, so.

Q. All right.

A. If you want, I can give you a shorter answer. No.

Q. Yeah, let's -- you personally have never treated a single patient for gender dysphoria; correct?





A. I have never treated a patient with gender dysphoria surgically.

Q. Okay.

A. Other than the detransitioner. I -- I suspect they were still suffering from dysphoria even though they were detransitioning, but I didn't treat them with surgery to -- per se for that condition the way the transgender teams do. Yeah.

Q. When you were providing laser hair removal to trans women, is that providing gender-affirming care?

MR. KNEPPER: Objection, form.

A. I don't get into the affirmation side of the treatment. I'm simply providing a service to -- to people who -- who I want to have as friends. Believe it or not, it's true. I -- I don't turn anyone away whose -- whose request is -- is within the scope of what I consider moral practice of medicine and surgery, so.

Q. So earlier, I asked you, you personally have never treated a single patient for gender dysphoria, and I think you said not surgically. Let me ask more broadly. Not limited to surgery, you have never treated a single patient for their gender dysphoria symptoms; correct?

A. Well, I guess if -- if you were to look at laser facial hair removal and consider that in the -- in the spectrum of care, certainly that's -- that's -- that's clinic care that's probably improving the emotional life of the patient because they're seeking to present as women. So in that sense, I have, yeah.

Q. Nothing outside of laser hair removal?

A. No.

Q. You personally have never --

A. Well, and -- and acne. Because clearly, that's a problem. But in terms of their -- the trajectory of their







transition, acne doesn't enter into it. But certainly laser hair removal, yeah.

Q. You personally have never sat in any meetings between a provider and a patient where the doctor was trying to diagnose whether the patient has gender dysphoria; correct?

A. Correct.

Q. You have never sat in any meetings between a provider and a patient discussing their potential treatment options for gender dysphoria; correct?

A. No.

Q. All right. You're not an endocrinologist; right?

A. Correct.

Q. You're not a psychiatrist; right?

A. Correct.

Q. You're not a licensed mental healthcare provider of any kind; right?

A. Correct.

Q. In your professional day-to-day







practice, you do not diagnose mental health conditions of any kind; right?

MR. KNEPPER: Objection, form.

A. With the exception of what we discussed earlier about body dysmorphic disorder and gender -- gender identity as a subcategory of body dysmorphic disorder, no, I would say I don't.

Q. Okay. If some patient thinks that they may have depression or anxiety, you would expect that patient to go to a mental health professional, not to you; right?

A. That's my expectation. But again, many depressed people come to plastic surgeons seeking a remedy for their depression thinking that their appearance is the cause of their depression. And it's my duty as a plastic surgeon to recognize those patients and -- and send them to the psychologist, psychiatrist, rather than offering them surgical care, yeah, so.







Q. Yeah. I'm asking a slightly different question.

A. Okay.

Q. If a -- if a patient, for some reason, came to you and asked you to diagnose them with depression or anxiety, I assume you would refer them to a train -- trained mental health professional; right?

A. Yes.

Q. Because doctors should not be diagnosing patients with mental health conditions if they do not have training in how to diagnose mental health conditions; right?

MR. KNEPPER: Objection, form.

A. Well, I wouldn't say that, because for example, as a -- as a -- as a surgeon, as a plastic surgeon, we do have to make diagnoses outside of our specialty in order to get people to the right specialist. So to an extent, you have to make that diagnosis.

So for example, as a resident in training, I diagnosed an endocrinological disease and probably saved a woman's life because she was in a psych ward, and -- and -- and the doctors had a question about her -- a lump in her neck. She had been on the psych ward for weeks, and I diagnosed a hyperfunctioning thyroid nodule. I didn't confirm that diagnosis. I sent her to an endocrinologist. But I made the initial diagnosis of hyperfunctioning thyroid nodule, and -- and ultimately, I did her thyroidectomy. But that's an example.

You have to understand pathology outside your specialty because you don't know why the patient is going to present to you, and you have to be ready to start the process that gets them to the specialist, so you have to have a working knowledge of the problems.

Q. Yeah, that's exactly the point. Even for that one example, you still send







this patient to a trained endocrinologist to confirm the diagnosis; right?

A. Right. And then they sent them back to me to give them definitive care.

Q. Yeah. And that's what you would do for any patient that presents to you with a mental health condition; right? You would train -- you would send them to someone who is -- who is trained in how to diagnose mental health conditions; right?

MR. KNEPPER: Objection, form.

A. Yes.

Q. You're not trained in providing psychotherapy counseling; right?

A. Right.

Q. You've never provided counseling, psychotherapy counseling to children or adolescents with gender dysphoria; right?

A. Right.

Q. You've never provided psychotherapy counseling to adults who







have gender dysphoria; right?

A. Right.

Q. You do not have the professional training to provide psychotherapy counseling to adults who have gender dysphoria; right?

MR. KNEPPER: Objection, form.

A. Correct.

Q. Or to children or adolescents with gender dysphoria; right?

MR. KNEPPER: Objection, form.

A. Correct.

Q. Go to page -- back to your -- strike that.

Back to your report on page 4, in this paragraph 9, about six lines down, you say, "I have consulted with families with children who are experiencing gender discordance." Do you see that?

A. Yes.

Q. Describe these consultations for me at a high level.







A. Basically, it was families that wanted to understand what -- the nature of plastic surgery sort of in the future for their children. These were -- these were personal encounters rather than in the office, but fairly lengthy at times, talking to families about -- they wanted to understand what was being offered to their children. They wanted to understand the nature of -- or what the future would look like for their children. They wanted to get some idea of -- basically, they wanted to hear sort of a fuller explanation of the -- of the medical and surgical side of things. So I wasn't giving them psychiatric counseling, but basically offering them my experience as a plastic surgeon, wanting to know what the surgery's about, what the -- the hormone therapy that precedes the surgery's about, that sort of thing.

Q. How many of these consultations

have you done, would you estimate?
A. Perhaps five or six, maybe more. Maybe -- yeah, five or six would be a fair number, I think.
Q. Over what years?
A. Perhaps the last three.
Q. Do you know how these parents know to reach out to you for these consultations?
A. It's -- I think maybe some of them were -- having heard about my public presentations at various venues. People hear about this plastic surgeon in Decatur who's raising objections, I guess. I don't know the particular details about how a particular patient might have come to me. I just -- I just always make myself available when people are anxious for their children and they're looking for an understanding of what transgender is about.
Q. What's the typical advice that you give to parents of children or





adolescents who are considering starting puberty blockers?
A. Well, my advice on that score is based on the -- on the world literature, that the desistance rate for their child, if they don't give them puberty blockers, the likelihood is that by the time they reach mid-adolescence, they have an 80 percent likelihood of desisting in their cross-sex self-identification. And if you follow them into young adulthood, that percentage will be in the 90s.
But essentially, I recommend that they slow everything down, and I recommend against the use of puberty blockade because it's experimental and because the likelihood is very high -- in fact, if I had any medical procedure that gave me 90-plus percent success rate, I would consider that a great victory. So -- so that's -- that's what I speak to them about.
That -- that desistance data is





a very important thing for parents to understand. And very often, the patient -- the parents are experiencing tremendous pressure from the people they've seen in consultation, a tremendous pressure. And usually, the parents are very distressed about what they're hearing, particularly the -- the fear of suicide and self-harm.
Q. Yeah.
A. So --
Q. You encourage -- yeah, no, I got it. You encourage patients of children who -- or adolescents who experience gender dysphoria not to start them on puberty-blocking drugs; fair?
MR. KNEPPER: Objection, form.
A. Yeah, I discourage the use of puberty blockade for anything other than precocious puberty or other endocrinopathies.
Q. And you also discourage them from pursuing surgical procedures for





gender dysphoria; correct?
MR. KNEPPER: Objection, form.
A. Correct.
Q. When you do these consultations, do you talk just to the parents or to the children as well?
A. Both, yeah. I like to meet the children and -- and -- and get to know them, yeah.
Q. And do you convey the same message to the children? Don't start puberty blockers; don't start -- don't do any surgical procedures?
MR. KNEPPER: Objection.
A. I -- I generally don't -- I'm sorry. I generally don't speak about the details of therapy to children. I speak to their parents.
Q. How many children do you think you have consulted with specifically?
A. On this -- on this issue?
Q. Yes.
A. As I say, maybe six. I often --

well, yeah, I would say six is a good number.

Q. Do you know how many of them went on to start hormone-blocking therapy, if any?

A. I don't. I don't know the answer to that question. Yeah, I don't.

Q. Do you know how many of them, if any, went on to start cross-sex hormone therapy?

A. I don't know the answer to that question, no.

Q. You don't know how many of them went on to do any kind of surgical gender-affirming procedures?

A. No.

Q. You haven't done any follow-up with any of these families that you've consulted?

A. As I say, this was an informal thing, so. Yeah. So no, I -- I haven't followed up long-term. This has -- as I say, this has happened over the last







perhaps three years. And so the general course of events there is -- is typically longer than that, so. But I have not seen -- well, I have seen one -- one child twice, actually, with the parents. And actually -- okay. So -- so perhaps she would be an exception.

She was sort of headed in the direction of seeking puberty blockade. And then in our meetings, she has sort of given that up. She was under a lot of pressure at school, you know, being pressured by boys because she was starting to develop secondary sex characteristics, and she developed a tremendous anxiety about it. And someone had told her that -- that if she went through transition care, that that would be avoided. And I had a conversation with her parents, I had a conversation with her, and essentially just encouraged her to slow down and sort of examine her other options. And I think within about







seven months, she came back to me, and she's not even thinking along those lines any longer. In fact, now she's talking about what high school she wants to go to, so.

Q. Okay. So this is one child who was considering, or whose parents were considering starting puberty-blocking, but after consultation with you, decided not to; right?

A. I think that she -- yeah.

MR. KNEPPER: Objection to form.

MR. TISHYEVICH: Okay. All right off the record.

THE VIDEOGRAPHER: This is the end of Media Unit No. 2. We are off the record at 11:06 a.m.

(Break taken.)

THE VIDEOGRAPHER: This is the beginning of Media Unit No. 3. We are on the record at 11:16 a.m.

Q. (By Mr. Tishyevich) Doctor, you know what facial feminization surgery is;







right?

A. Yes, I do.

Q. You have never performed facial feminization surgery for any transgender patient; correct?

A. Correct.

Q. You know what facial masculinization surgery is?

A. Yes.

Q. You have never performed that for any transgender patient; correct?

A. Correct.

Q. Do you know what transfeminine top surgery is?

A. Yes.

Q. You have never performed that on a transgender patient?

A. No.

Q. How about a chest reconstruction surgery? Have you performed that on a transgender patient?

A. No.

Q. You have never performed a

vaginoplasty for a transgender patient?
A. No.
Q. You have never performed a metoidioplasty for any transgender patient?
A. No.
Q. You've never performed what's colloquially known as bottom surgery for any transgender patient; correct?
A. Correct.
Q. Fair to say you've never performed any kind of gender-affirming surgery in transgender patients; right?
A. Correct.
Q. And fair to say you don't have recent and substantive experience in performing gender-affirming -- -affirming surgery for transgender patients; correct?
MR. KNEPPER: Form.
A. I have -- I have substantive experience with all the actual -- the nature of the particular operations but





never performed for transgender patients to transition them, no. But the operations themselves as used in reconstruction, I have considerable experience with.
Q. We talked earlier about the American Society of Plastic Surgeons. You recall that?
A. I do.
Q. You know that the ASPS has a code of ethics?
A. Yes.
Q. And you know that members are required to comply with the code of ethics; right?
A. Yes.
Q. And I know you're not a member now, but you were a member of the ASPS for a considerable amount of time; right?
A. Yes.
Q. And I assume during that time, you followed the ASPS code of ethics; right?





A. To my knowledge, I never violated it. Yes.
Q. When was the last time you reviewed it?
A. I'm sorry, did I lose the sound here?
Q. When was the last time you reviewed the ASPS code of ethics?
A. Oh, gosh. Years ago. Years ago.
Q. Let me introduce an exhibit.
Let me ask you this first. Are you aware that the ASPS code of ethics had some specific rules for members who provide expert testimony?
A. Yes.
Q. Okay. You didn't review those provisions before you formed your expert opinions in this case?
A. No.
Q. Sitting here today, do you know if your opinions in this case are in compliance with what the ASPS code of





ethics says about members who provide expert testimony?
A. I'm not aware that I've violated them in any way, yeah.
Q. Let me introduce an exhibit. Okay. Let me know when you have it.
(Exhibit 10 was marked for identification and is attached.)
A. Okay.
Q. It's still opening on my end.
Okay. So, Exhibit 10 is the Code of Ethics of the American Society of Plastic Surgeons. You see that?
A. I do.
Q. The bottom left corner says, "Updated September 25, 2017." See that?
A. I do.
Q. That's when you were still an active member of the ASPS; right?
A. Yeah, that's right.
Q. Go to page 4.
A. I think I'm on page 4 here. They're not numbered. Oh, here we are,

yes.
Q. Or I'm sorry, page 6.
A. Page 6.
Q. Section IV.
A. Section IV, yes.
Q. Section IV is "Expert Testimony"; right?
A. Yes.
Q. I want to focus you on the last two sentences of this first paragraph. It says, "Members whose testimony, including testimony as to credentials or qualifications, is false, deceptive, or misleading may be subject to disciplinary action, including expulsion." You see that?
A. Yes.
Q. The next sentence says, "Further to help limit false, deceptive and/or mislead" -- "misleading testimony, Members serving as expert witnesses must," and then there's a list of requirements. You see that?





A. I do.
Q. Okay. So "must" means this is a mandatory rule, not an optional suggestion; right?
MR. KNEPPER: Objection, form.
A. I expect that's what it means, yes.
Q. All right. Let's look at these rules. Number 1 says that members serving as expert witnesses must "Have recent and substantive experience (as defined in the Glossary of the Code) in the area in which they testify, including, without limitation, experience in the relevant subspecialty or the particular procedure performed on the plaintiff."
Do you see that?
A. I do.
Q. All right. Without looking at the glossary, do you know, sitting here today, how the glossary defines "recent and substantive experience"?





A. I don't.
Q. Okay. Why don't we look at that definition together. Go to page 8.
A. Okay.
Q. See there's subsection F?
A. Yes.
Q. All right. Read that definition to yourself, and tell me when you're done.
A. Okay.
(Witness reviews document.)
A. Okay.
Q. To be able to provide expert testimony -- well, strike that.
Let me focus you on the very last part of this definition. Okay. To be able to provide expert testimony about a particular surgical procedure, the ASPS Code of Ethics requires a surgeon to have performed a specific procedure in question within three years of being retained as an expert witness; correct?
A. That's what it says, yes, sir.





MR. KNEPPER: Objection, form.
Q. All right. Now, as we've just discussed, you personally have not performed any kind of facial masculinization surgery in the last three years; correct?
MR. KNEPPER: Objection, form.
A. Correct.
Q. Any kind of facial feminization surgery; right?
A. Correct.
MR. KNEPPER: Objection, form.
Q. Vaginoplasty; right?
MR. KNEPPER: Objection, form.
A. Correct.
Q. Metoidioplasty; right?
MR. KNEPPER: Objection to form.
A. Correct.
Q. You personally have not performed any kind of gender-affirming surgical procedure on a transgender patient in the last three years; correct?
MR. KNEPPER: Objection, form.

A. I have never performed such procedures.

Q. All right. Well, given that you have not ever personally performed any kind of surgical procedures in the last three years, I take it you're not offering expert opinions on any of these surgeries because doing so would be inconsistent with the ASPS code of ethics; right?

MR. KNEPPER: Objection, form.

A. Well, so the ethics that informs my opinion here is I don't derive from the ASPS, nor am I subject to their -- their -- what's the word I'm looking for -- their sanctions, I guess, would be the correct word. The expert opinion I offer here is not on -- on complications of an operation that might enter into a litigation. In terms of the -- you know, I guess the -- the question at hand here is transition surgery, the bigger picture. I certainly make record of --







of the known complications as available in the literature. And in my testimony, I did a literature review on the complications of particular surgeries.

But I don't do these operations for a reason, and the reason I don't do these operations is ethical based on my knowledge of the science. I don't derive my ethical decision-making from the ASPS, and this is one of the reasons why, again, I have no heartburn about having withdrawn my membership. I have great issue with -- with the idea that a professional organization would encourage or sanction these operations given the world literature.

Q. Your opinion -- your -- strike that.

Your expert report does offer some opinion, or purports to offer some opinions about surgical risks of some of these gender-affirming surgical procedures, does it not?







A. Yes. Based on my -- my experience in microvascular surgery, on flap reconstruction of the perineum, for example, flap reconstruction of the chest or the -- or the genital area in treatment for traumatic injuries and things. So the operations themselves, I'm quite familiar with. I'm quite familiar with the complications that are peculiar to free flap or local flap reconstructions.

But as far as doing those operations for gender transitioning, I -- I don't do those operations. But the complications are the same: flap loss, flap necrosis, urinary fistulas. All of those things I have -- I have experience with in managing trauma, in managing cancer, in managing infectious destruction of the genital area. But I've never done the operation for transgender per se, correct.

Q. And because you've never done







any of those procedures on transgender patients, can we agree that offering those opinions is inconsistent with the ASPS Code of Ethics?

MR. KNEPPER: Objection, form.

A. I would not agree with that.

Q. Does it bother you that you might be in violation of the Code of Ethics by offering these opinions?

MR. KNEPPER: Objection.

A. No. Not in the least.

Q. Do you think that a judge might be troubled by the fact that your professional organization, former professional organization, says you shouldn't be allowed -- you shouldn't be offering these kind of opinions?

MR. KNEPPER: Objection, form.

A. Yeah, I find -- I find the -- the whole situation troubling, and I would hope that the judge would be troubled by it, yes.

Q. Okay. Yeah, no, I mean, I'm

asking a much more specific question. The judge is going to be asked to find whether your testimony is reliable. Do you think the judge might have some concerns if she -- if they were to conclude that the testimony you're offering in this case is not allowed under the code of ethics of the ASPS?

MR. KNEPPER: Objection, form.

A. I -- I -- I haven't thought about it.

Q. And you haven't thought about it because before today, you didn't know whether or not your testimony complies with the ASPS Code of Ethics; right?

MR. KNEPPER: Objection, form.

A. I was not -- I was not concerned with the ASPS Code of Ethics, for reasons we've discussed earlier.

Q. Did you know that -- did you know that the ASPS Code of Ethics prohibits members from offering expert testimony on topics in which they do not







have recent and substantive experience?

MR. KNEPPER: Objection, form.

A. Could you -- can you -- I want to make sure I answer your question and not something else. Could you offer me that question again, please?

Q. Before I showed you this code of ethics at your deposition today, were you aware that the ASPS Code of Ethics prohibits members from offering expert opinions on topics on which they do not have recent and substantive experience?

MR. KNEPPER: Objection, form.

A. Actually, I dreaded that such a -- such a fact would come to light. I have not read the -- the ethics code in recent years, as I said earlier. But I -- I have dreaded this evolution in the ethics of my former professional society, that they would consider transgender surgery the way they do.

I -- other -- aside from that, I was not concerned that I might be







violating the ethics of the society because in all my previous life, I have never violated the ethics of the society. And I don't -- at present, I don't consider my testimony to be a violation of this policy that we've read together.

Q. I understand. All right. Let's switch gears. You know what the WPATH is? The World Professional Association for Transgender Health?

A. Yes.

MR. TISHYEVICH: And for the court reporter, it's W-P-A-T-H, all capital.

Q. All right. You know that the WPATH publishes standards of care for the health of transgender people; right?

A. They have a publication that they call the standards of care, yes.

Q. And are you aware that they've been publishing those standards since 1979?

A. Yes.







Q. The latest publicly available standard of care is Version 7; correct?

A. Correct.

Q. And that was published in 2012; right?

A. That's right.

Q. All right. Before you wrote your report, did you sit down and review the Standards of Care, Version 7 that you're criticizing?

A. Yes, I did.

Q. All right. You yourself are not part of the WPATH; correct?

A. No, I am not.

Q. You've never been part of the WPATH; right?

A. I would never be part of the WPATH.

Q. You've never advised the WPATH in any capacity; right?

A. They've never asked my opinion. No.

Q. You've never advised the WPATH

in any capacity; correct?
A. I have not.
Q. You personally have not been involved with the development of WPATH's Standards of Care, Version 7; correct?
A. Correct.
Q. You don't know what year the WPATH started working on Version 7; right?
A. My understanding was it was in 2007, but I could be wrong. I think it was 2007. I think it was a five-year process, but I could be wrong on that.
Q. You don't know for sure?
A. I don't know for sure.
Q. You don't know how many different work groups at the WPATH were involved with working on Version 7; correct?
MR. KNEPPER: Objection, form.
A. In reading the -- the introduction to the document, the number nine pops into my mind, but I can't swear





to that.
Q. Okay. You don't know what kind of scientific literature the WPATH conducted as part of drafting Version 7; right?
A. As far as naming the particular papers that they may have reviewed, I can't do that for you because those are -- that happens in closed committee. I -- all I can say to you is my -- based upon my reading of the product and the verbiage that it's used, my suspicion is that it's pretty heavily weighted towards the American literature and -- and does not bring in particular document -- well, being that it was published in 2012, the big inflection point in 2011 probably wasn't available to the committee when they were writing that document.
So given that the document is already out of date and it's -- and the subsequent WPATH 8, no one knows when it's going to come out, yeah, it's --





it's almost -- it's almost irrelevant because of the change in the literature that happened since it was published, so. In particular, the 2011 article by Dhejne, Cecilia Dhejne, and -- and others that kind of changed the view of the scientific evidence.
So yeah, it's an out-of-date document by the standards of what are called standards of care. It's not a standards of care document. It's a -- it's a treatment guideline document is really what it is, and it's a poorly supported treatment guideline at that, so -- gosh, I wandered off.
Did I -- did I answer your question?
Q. Yeah, you anticipated my objection.
MR. TISHYEVICH: Which, again, I'll move to strike most of that as nonresponsive.
Q. Because here's my question. You





don't personally know what kind of scientific literature the WPATH conducted as part of drafting Version 7; correct?
MR. KNEPPER: Objection, form.
A. No. Again, a closed session, so I don't know what documents they used.
Q. You don't know what kind of outside experts the WPATH may have consulted in drafting Version 7; right?
A. No.
Q. You don't know what kind of peer review the WPATH may have conducted as part of developing Version 7; right?
MR. KNEPPER: Objection, form.
A. No.
Q. You don't know what kind of public comments the WPATH may have solicited as part of developing Version 7.
MR. KNEPPER: Objection, form.
Q. Right?
A. No.
Q. You don't know how many

different drafts the Version 7 went through before it was finalized; right?
A. No.
Q. You don't know how many different meetings or conferences the WPATH had to discuss the development of Version 7; right?
A. Correct.
Q. You have no idea what may have gone on during those meetings or conferences; correct?
MR. KNEPPER: Objection, form.
A. No. I was not a part of the conferences that produced the product.
Q. Yeah, you are not an expert in how Version 7 of the WPATH was developed; right?
A. Correct.
Q. And we can go through all these questions again individually for Version 8, but maybe we can shortcut this.
A. Well, no one knows what's in Version 8 except the people who are in





the committee. It's a -- it's a privileged document. There's no one in plastic surgery who knows it apart from the people who serve as members of the WPATH, so that would be the case.
Q. Okay.
A. It's a -- it -- yeah.
Q. So just so we have it on the record, you don't hold yourself out as an expert on how Version 8 of the WPATH Standards of Care are currently being developed; fair?
A. Fair.
Q. Okay. We talked earlier about the DSM; right?
A. Yes.
Q. In your day-to-day practice, you don't use the DSM-5; correct?
A. No.
Q. But you do know the DSM-5 is widely used by psychiatrists; correct?
A. Yes.
Q. The DSM-5 was published in 2013;





correct?
A. I don't know the publication date, but it sounds about right.
Q. Do you know that it was developed by the American Psychiatric Association?
A. Yes.
Q. You're not a member of the APA; right?
A. Correct.
Q. You personally have not been involved with the development of DSM-5; right?
A. No.
Q. You don't know how many different working groups were involved with developing the DSM-5; right?
MR. KNEPPER: Objection, form.
A. Correct.
Q. You don't know how many different members those working groups had; right?
MR. KNEPPER: Objection, form.





A. No.
Q. Or how they were selected; right?
MR. KNEPPER: Objection, form.
A. Correct.
Q. You don't know how many different authors contributed to the development of DSM-5; correct?
A. Correct.
MR. KNEPPER: Objection, form.
Q. You don't know what kind of scientific literature review was done by different work groups as part of developing the DSM-5; correct?
MR. KNEPPER: Objection, form.
A. Correct.
Q. You don't know what kind of public comments the APA may have solicited in developing the DSM-5; correct?
MR. KNEPPER: Objection, form.
A. Correct.
Q. You don't know how many

different drafts the DSM-5 went through before it was finalized; correct?

MR. KNEPPER: Objection, form.

A. Correct.

Q. You don't know how many different meetings or conferences or telephonic conferences the working groups had to discuss the development of the DSM-5; right?

MR. KNEPPER: Objection, form.

A. Right.

Q. You have no idea what was discussed during any of those meetings; right?

A. Right.

Q. Let me ask you specifically about the Sexual and Gender Identity Disorders Work Group. First of all, before today, did you know that the APA had a Sexual and Gender Identity Disorders Work Group as part of the development of the DSM-5?

MR. KNEPPER: Objection, form.





A. Yes.

Q. Do you know how many members were in that work group?

A. No.

Q. You don't know --

MR. KNEPPER: Objection.

Q. -- how those members were selected; right?

MR. KNEPPER: Objection to form.

A. Correct.

Q. You don't know their expertise; right?

A. Correct.

Q. You do not have expert firsthand knowledge of how the DSM-5 was developed; fair?

MR. KNEPPER: Objection, form.

A. Fair.

Q. Are you aware that the DSM-4 used the term "gender identity disorder" instead of "gender dysphoria"?

A. Yes.

Q. Do you know the reason for that





change?

A. From DSM-4 to DSM-5?

Q. Yes.

A. Yes.

Q. What's the reason?

A. In reading the literature and reading the reports of perhaps people who served on the committee, because I don't know how else you would be privy to this information, there was a desire on the part of the APA to de-pathologize the condition, and they wanted to use terminology that didn't sound like medical diagnoses. It was the opinion of the members of that committee that -- that transgenderism is only a diagnostic issue from the standpoint of the discomfort or the sorrow that the patient feels rather than any underlying pathology. So the -- the desire was to move those -- the diagnosis to change the language of diagnosis to de-pathologize it. But the problem that the committee





faces is that having done that, there's no mechanism for providing the services that they felt that the patients needed, so there had to be a diagnose -- a diagnostic code in order to get thirty-part -- third-party payers to pay. So it's a de-pathologize but maintain a diagnostic -- diagnostic code. That's my understanding of it.

Again, I wasn't there. But again, reading the writings of people who could only have gleaned it from having been present because it's closed session, that's my understanding.

Q. Understood. All right. Do you know what the Endo- -- Endocrine Society guidelines for treatment of gender-dysphoric or gender-incongruent persons are?

A. Do I know what they are?

Q. Yeah.

A. Yes.

Q. Do you know when they were

initially published?
A. No.
Q. Do you know when they were last revised?
A. I think it was just a couple of years ago, but I don't know the exact date.
Q. If I tell you it's 2017, does that sound right?
A. That wouldn't -- it wouldn't surprise me if that were true. I -- just within the last couple of years. I think theirs are current, and the expectation is that these standards of care or treatment guidelines will have a five-year revision. So given that they're current, they couldn't be any older than, say, 2017. So I suspect that -- yeah.
Q. All right. Did you review the latest available version of those Endocrine Society guidelines before forming your opinions in this case?





A. Yes. I have read them, yes.
Q. Okay. You yourself are not part of the Endocrine Society; right?
A. Correct.
Q. Have never been part of that society; right?
A. Correct.
Q. You've never advised the Endocrine Society in any capacity; correct?
A. Correct.
Q. You personally were not involved with the development of these original guidelines; correct?
A. That's correct.
Q. Not personally involved with the development of the updated guidelines in 2017; right?
A. Correct.
Q. Do you know how many people at the Endocrine Society were involved with those 2017 updates?
A. I do not know that number.





Q. And you don't know how they were selected to work on the 2017 updates; correct?
A. Correct.
Q. You personally don't know what kind of scientific literature review the Endocrine Society conducted in developing those updates; correct?
MR. KNEPPER: Objection to form.
A. Correct.
Q. You don't know what kind of outside experts they may have used; right?
A. What kind of outside experts? I would imagine they were all endocrinologists. Or are you asking did they have plastic surgeon input or --
Q. Do you know specifically whether the Endocrine Society used any outside experts in updating the -- in implementing the 2017 updates?
A. Well --
MR. KNEPPER: Objection, form.





A. I can only infer that they would, because such -- such statements, in order to be valid, demand review by outside parties to -- to obviate conflicts of interest, whether financial or professional. Those are all issues when generating standards of care, so of necessity, they would have had to have had outside experts to come in, yes.
Q. Okay. Do you know what kind of public comments the Endocrine Society may have solicited as part of developing the 2017 updates?
A. I don't.
MR. KNEPPER: Objection to form.
Q. You don't know how many different drafts there were of those 2017 updates before they were finalized; right?
A. No.
MR. KNEPPER: Objection to form.
A. No, I don't.
Q. Again, you haven't been to any

meetings or conferences or telephonic conferences where those 2017 updates were discussed, where the development of those 2017 updates was discussed; correct?

MR. KNEPPER: Objection to form.

A. Correct.

Q. You don't know what went on during those meetings or conferences; right?

MR. KNEPPER: Objection, form.

A. I do not.

Q. You -- you're not an expert in how the Endocrine Society developed the original 2009 guidelines for treating gender dysphoria; correct?

MR. KNEPPER: Objection to form.

A. That's not -- that's not my area of expertise. That's correct.

Q. Right. And you're also not an expert in how the Endocrine Society then developed the 2017 updates back to those guidelines; correct?

A. Correct.





Q. Okay. All right. Now let's talk about puberty-blocking agents. What puberty blocker drugs are you aware of by name?

A. Well, Lupron is probably the most widely used one. They're -- they're all gonadotropin-releasing hormone agonists. They come by a variety of trade names. But gonadotropin-releasing hormone is the genetic -- I'm sorry, the generic name for the drug that may appear under a variety of, you know, proprietary names, Lupron being the most commonly used.

Q. You've never prescribed Lupron; right?

A. No, I have never. No.

Q. You have never prescribed any puberty-blocking drugs of any kind; right?

A. No. That's not my area of expertise.

Q. Right. Have you ever looked at





the package -- strike that.

You know what a package insert is; right?

A. Yes.

Q. Have you ever looked at a package insert for Lupron?

A. Some time ago, but yes, I have.

Q. Okay. How recently do you think?

A. Gosh, it's probably more than four or five years ago. I think probably when I first started go -- you know, looking into this more carefully back in 2014. It was probably that long ago.

Q. Do you know what Vantas is? V-A-N-T-A-S.

A. Oh, I've read that somewhere before. Let's see. Is it -- it's the adverse events reporting -- is that what I -- I don't --

Q. It's a type of drug.

A. Oh.

Q. So no, that doesn't sound





familiar?

A. It does not sound familiar, no.

Q. How about Triptodur? T-R-I-P-T-O-D-U-R.

A. That sounds like a trade name I'm not familiar with.

Q. Okay. Fensolvil? F-E-N-S-O-L-V-I-L.

A. That sounds like a trade name I'm not familiar with.

Q. Trelstar? T-R-E-L-S-T-A-R.

A. Same.

Q. All right. You're not an expert in the different types of prescription drugs that are used as puberty-blocking agents; fair?

A. I do not consider myself an expert in that area, no. I rely on experts.

Q. All right. You know that puberty blockers are typically prescribed by endocrinologists; right?

A. Yes. Pediatricians and

endocrinologists, yes.
Q. Right. You have no specialized training or expertise in endocrinology; correct?
A. Correct.
Q. You don't hold yourself out as an expert in endocrinology; correct?
A. No, I do not.
Q. You're not planning on offering any expert opinions in endocrinology in this case because that's outside your scope of expertise; right?
A. Yes.
MR. KNEPPER: Objection to form.
Q. All right. Earlier, you said you have never prescribed puberty-blocking agents to anyone, so I take it you have no experience, no firsthand experience with advising your patients about potential risks and benefits of puberty blockers; right?
MR. KNEPPER: Objection, form.
A. Well, I have talked to patients





-- well, families, really, about the risks of puberty blockers in -- in early puberty and into adolescence. I have because I've reviewed the literature and I've spoken with experts in the area. And so, is that the question --
Q. Yeah.
A. -- you're asking, have I spoken to anybody? Yeah, I have. I -- I have, again, knowing that -- for example, that the drug Lupron, as an example, is -- is -- is not cleared by the FDA for application. It's an off-label use when using it in the diagnosed condition of gender dysphoria. So I know that it's an off-label application of the drug, and I know what the effects of the drug are. But nobody knows what the effects of the drug are on otherwise normal children, and that's pretty much all I'd relate to the families on the -- on that subject.
I don't offer myself as an endocrinologist, but I offer myself as a





concerned physician who has spoken with the specialists and read the package insert. Yes.
Q. You think off-label use is improper; right? That's the sense I got from reading your report.
MR. KNEPPER: Objection, form.
A. Off-label use in certain situations. So I use -- I use -- I have applied drugs' off-label use many times. But what the -- what the practitioner has to do is weigh the risk/benefit equation there and what is the expected goal and what are the likely risks.
For example, I used Botox long ago in the treatment of -- of hyperhidrosis before the company that produces it got FDA clearance to use it that way. The risk, very, very low risk; the potential benefit, very, very high. But in this case, we're talking about very significant risks for an unproven benefit. So that's an example of how you





have to weigh off-label use.
And the FDA understands that, and they don't go after off-label use unless there's significant risk. And even then, they might not yet spring into action. It's a pretty slow-moving organization.
Q. All right. We'll come back to that.
A. Okay.
Q. You never sat in on any appointment where an endocrinologist prescribed a puberty-blocking drug to a patient; correct?
A. I have never.
MR. KNEPPER: Objection, form.
Q. You personally don't know what endocrinologists typically tell their patients about risks and benefits of puberty blockers; right?
MR. KNEPPER: Objection, form.
A. Only what I have read in the record. For example, the plaintiffs'

records, I -- I -- I believe I have read that -- that kind of consultation, yeah. But I -- but I wasn't present in the room, if that's what your question is.

Q. Yeah. You don't know what was actually communicated to the patient; correct?

A. Only what was entered in the record, yeah, the medical record.

Q. And just as a more -- outside of these plaintiffs, as a more general matter, you don't personally know what endocrinologists tell their patients about potential risks and benefits of puberty blockers because you're not present on those prescribing decisions; right?

MR. KNEPPER: Objection, form.

A. Well, if -- I assume that they follow the same sort of process that every other medical professional does when getting consent for -- for therapies of various kinds. And so to offer





informed consent to a -- in this case, perhaps a family, parents, that informed consent would have to include -- in order to be valid, it would have to include the potential risks that are enumerated in the package insert. And then they would also, in certain cases, have to enumerate risks that may not be in the package insert but may be expected given the -- the particular case of their child or the particular patient.

So we all have to follow that same general standard, and so to that extent, I have some knowledge of what they would be saying. But the particular words or the particular things they may have emphasized, I have no -- no personal knowledge of.

Q. Your general expectation is that before a doctor prescribes the drugs, they will at least inform the patients of the risks as specifically enumerated in the drug labeling; right?





A. Among other things, yes.

Q. And the doctor may also go beyond the labeling and advise them of potential risks even though they're not specifically disclosed in the drug labeling; right?

A. Yes. Because there -- there are circumstances wherein the underlying conditions of the patient may -- may cause particular risks in particular areas, so that's right.

So there's the general precautions that are included in the package insert, but they usually tend to be exhaustive. They -- they list in the package inserts even remote possibilities, so. But most physicians can't drill down into those details with a patient. You don't want to overwhelm the patient and their family with those minute details. You want to talk about the major risks and then the risks that are peculiar to the patient because of





their underlying condition. And that's generally what everybody does.

Q. Yeah.

A. Although, again, I'm not present in every office on every occasion, but that's generally how we're trained to conduct a consent.

Q. Do you know -- are you aware that patients who are prescribed puberty-blocking agents are typically monitored through blood tests and lab work?

MR. KNEPPER: Objection, form.

A. It -- I don't -- I'm not familiar in all cases to what extent they're monitored. My hope is that they're being monitored. I would expect that they're being monitored.

Q. Yeah. And you don't have experience with monitoring patients who undergoing treatment with puberty blockers; right?

A. No.

Q. And you don't have experience with reviewing blood work, labs, what's normal, what's not, anything in that field; right?

MR. KNEPPER: Objection to form.

A. Oh, no, I am familiar with reviewing labs and interpreting laboratory data --

Q. Sorry.

A. -- as it pertains -- yeah.

Q. Sorry. Let me make -- make my question more specific. I'm still talking about patients who are treated with puberty-blocking agents.

A. Okay.

Q. For those patients in particular, you don't have experience with reviewing their blood work, labs to see -- to check their hormone levels and see if any adjustments are needed; right?

MR. KNEPPER: Objection, form.

A. No. I have some familiarity with the interpretation of hormone levels







in endocrinology. As a -- as a general surgeon and a critical care doctor, these issues were very important to me for a number of years. So I'm familiar with that, although I haven't monitored patients receiving puberty blockers or cross-sex hormones per se. So generally, I am familiar with -- with that and the ramifications of endocrinopathies, again, because I had considerable experience with management of critical care patients and -- yeah.

Q. Yeah. My question is more specific.

A. Okay.

Q. You personally have not monitored blood work from patients who are undergoing puberty-blocking agents; right?

A. Correct.

Q. Okay. And you mentioned cross-sex hormones. You know what those are; right?







A. Yes.

Q. For transgender women, estrogen is a hormone that's typically prescribed; right?

A. Yes.

Q. For transgender men, testosterone is the hormone that's typically prescribed; right?

A. Right.

Q. You've never prescribed cross-sex hormones for treatment of gender dysphoria to anyone; correct?

A. Correct.

Q. You have no firsthand experience with advising your patients about potential risks and benefits of cross-sex hormones when used for treatment of gender dysphoria; correct?

A. Correct.

Q. You personally don't know what doctors who do prescribe estrogen or testosterone to their patients for gender dysphoria tell those patients about the







risks and benefits of that treatment; correct?

MR. KNEPPER: Objection, form.

A. I would answer that question as we did earlier, that my expectation would be that they would cover the -- the risks and benefits of that -- of that particular therapy and that the exploration of potential risks would include the major points that are contained in the package insert and whatever particular risks that the patient may have because of their underlying conditions, medical conditions that may impinge upon them. That would be my expectation.

Q. Okay. So for testosterone and estrogen when used to treat gender dysphoria, you would generally expect doctors to at least give the warning about -- that's in the labeling and potentially give additional warnings outside of that as well; fair?

MR. KNEPPER: Objection to form.
A. That would be my -- that would be my expectation.
Q. All right. We started talking about off-label use, so let's circle back to that. So in your report, you criticize Dr. Brown and Dr. Schechter for not disclosing that the FDA has not approved these hormones for treatment of gender dysphoria. Do you recall that?
A. Yes. My testimony, yes, I do recall that.
Q. All right. Off-label use is when a doctor prescribes a drug outside of its FDA-approved indication; correct?
A. Correct.
Q. And we touched earlier on whether it's proper or improper to prescribe drugs on an off-label basis. There are circumstances where it is appropriate to prescribe a drug on an off-label basis; correct?
A. Yes.





Q. It's a case-by-case decision; right?
MR. KNEPPER: Objection, form.
A. Yes.
Q. It's a case-by-case decision that's made between the doctor and their patient; right?
MR. KNEPPER: Objection, form.
A. Right.
Q. You're not expressing the opinion that doctors should not be prescribing drugs on an off-label basis ever; right?
A. I'm expressing the opinion that -- that drugs that have massive potential side effects should not be off-label prescribed unless those risks warrant -- I mean, those risks are warranted given the underlying condition of the patient and that the patient is being treated as a -- as a -- as a trial or an experimental patient with ethics monitoring and all the rest of it that





attends.
The reason why off-label use is problematic is because it doesn't have a body of proven scientific evidence that the FDA has made use of in order to -- to warrant the use of the drug. So if you're going to go off label, again, the risks have to be low. If the condition you're treating makes -- makes the risks high, then that's where you have to get into ethics panels and experimental trials and things like that. I think that's at the heart of this issue.
We're dealing with a condition where the application of these drugs is not proven and the risks are very high, and that's where my concern lay.
Q. Do you think that off-label use of prescription drugs is, by definition, investigational?
A. To the extent that very often the -- the use of -- the off-label use of drugs begins on the basis of anecdotal





reports. So anecdotal reports, again, are categorized as level 5 evidence. And -- and so when those reports are published and -- and the risks are seen as low, then other physicians may begin the off-label use of those drugs.
But generally, one wants to progress to a more definitive scientific evidence, like level 4 evidence where there's a pre-application test, the use of the drug, and a post-application test, or level 3 where you're looking at longitudinal data to confirm not only the safety but the efficacy of the application of the drug.
In the case of the use of puberty blockade and cross-sex hormones, it doesn't exist beyond level 5 evidence even though the treatment has now been going on off-label for more than a decade, if not approaching twenty years.
Q. All right. You mentioned doctors are prescribing on an off-label

basis after there's case reports. It does happen that doctors prescribe drugs on an off-label basis based on nothing more than case reports; right?

A. That's how it always begins, yeah.

Q. Yeah. The FDA doesn't say that's not permissible, do they?

A. No, they don't.

Q. Okay.

A. I don't know. I don't know what the FDA -- if there's a published policy about that. I would suspect not, given the history in my lifetime of people off-label using, for example, asthma medications for the treatment of breast implant encapsulation, that kind of stuff. That's an example of a very benign drug being used off-label to treat a surgical condition of breast implant encapsulation. So that's my personal experience. I suspect there isn't an FDA policy that utterly prohibits it. I





would agree, yeah.

Q. Okay. The FDA is the federal agency that regulates prescription drugs; correct?

A. Food and drugs, yes.

Q. And they decide whether a particular drug can be marketed for a particular indication; correct?

A. Right.

MR. KNEPPER: Form.

Q. And one of the areas of oversight the FDA has is the safety of prescription drugs; right?

A. Right.

Q. Before forming your opinions in this case, did you investigate what position the FDA takes on off-label use of drugs?

A. No, I did not.

Q. Sitting here today, do you know what that position is?

A. I do not, no.

Q. Do you know whether the expert





opinions you're expressing about off-label use of drugs are consistent or inconsistent with what the -- what the FDA has said about off-label use?

MR. KNEPPER: Objection, form.

A. I remember when the controversy about the use of Singulair in breast implant capsules came up. That was discussed at an ASPS meeting and then some articles that came out. And I think I recall from those -- either the conference or the article that the FDA takes a permissive attitude where risk is low.

Q. You think the FDA only allows off-label use of prescription drugs when the risk is low?

A. I don't know that for a fact.

Q. All right.

A. I would -- I would hope. I would hope low risk/high benefit. So -- so again, it's an equation, it's not just a one-sided thing. So it isn't just the





risk but also the potential benefits. And the potential benefits have to be very high. The higher the risk is, the higher the benefit has to be. And that's kind of a general principle of the medical care. You know, before all else, do no harm. That's what informs all medical care, and I would hope that's what informs the FDA policy, whatever that may be.

Q. Okay. Well, let's look at the policy.

A. Okay.

Q. I'm going to introduce another exhibit. Okay. This is going to be Exhibit 11. Let me know when you have it.

(Exhibit 11 was marked for identification and is attached.)

A. Okay.

Q. Have you ever seen this document before?

A. I have not.

Q. Do you know what the Federal Register is?
A. It's a -- it's a federal list of regulations pertaining to things like this.
Q. Yeah. It's the official publication --
A. Federal code.
Q. -- of federal rules, proposed rules, and notices for federal agencies; right?
A. Yeah. Right.
Q. I see this is dated at the top November 18, 1994. See that?
A. Yes.
Q. Page 1, middle column, see it says, "Agency: Food and Drug Administration, HHS"?
A. Let's see. "Agency: Food and Drug Administration, HHS." Yes.
Q. It says, "Action." It says, "Notice; request for comments." Do you see that?





A. Yes.
Q. All right. Go to page 2.
A. Okay.
Q. In the column all the way to the right, you see there's a section II, and it's titled, "FDA Policy on Promotion of Unapproved Uses." Do you see that?
A. I do.
Q. All right. The first paragraph says, "Over a decade ago, the FDA Drug Bulletin informed the medical community that 'once a [drug] product had been approved for marketing, a physician may prescribe it for uses or in treatment regimens of patient populations that are not included in approved labeling.'" Do you see that?
A. I do.
Q. What do you understand that to mean?
A. That --
MR. KNEPPER: Objection.
A. I apply that to mean that --





that the -- that the FDA does not -- does not intend to weigh in on off-label use, you know, without restriction, I guess. The sense I get of it is that they're -- they're declining to prohibit the off-label use in -- in other patients at this time, I would -- I would guess. I suppose that if they started to see complications, they might weigh in. This has been the history, for example, with nausea medicines and things like that that created problems after use.
Q. At that time at least, the FDA was telling the medical community that doctors may prescribe drugs for uses outside of FDA-approved indications; correct?
A. Yes. I would say that --
MR. KNEPPER: Objection, form.
A. -- in 1994, the FDA declined to -- to -- I don't know what they've done subsequently. I -- but -- but in 1994, they -- they -- off-label use was not





prohibited.
Q. Well, actually --
A. They finally --
Q. Sorry, finish.
A. No, go ahead.
Q. Well, you see this actually says, "The publication further stated," and then there's a quote. And after the quote, there's a Footnote 4.
Before we get to that, do you see it says -- it cites to the FDA Drug Bulletin from 1982.
A. Right.
Q. Right?
A. Right.
Q. So that original guidance came from a 1982 FDA position; right?
A. Right.
MR. KNEPPER: Objection, form.
Q. And you say that you read this and you don't think that the FDA has taken a position, but let's see what else that quote says. You see the quoted

language starting with "The publication further stated"? Do you see that?

A. That starts with the word "unapproved"?

Q. Yeah. It says, "'unapproved' or, more precisely, 'unlabeled' uses may be appropriate and rational in certain circumstances, and may, in fact reflect approaches to drug therapy that have been extensively reported in medical literature." Do you see that?

A. I do.

Q. You understand what that means; right?

MR. KNEPPER: Objection to form.

A. Yes. Yes.

Q. Off-label use -- strike that.

The FDA has recognized as early as 1982 that off-label use may be based on medical literature, not published indications; right?

A. Right.

Q. And then it says, "Valid new







uses for drugs already on the market are often first discovered through serendipitous observations and therapeutic innovations, subsequently confirmed by well-planned and executed clinical investigations." Right?

A. Yeah. That's -- that's kind of a -- just a restating of what I related to you about, for example, the use of Botox and hyperhidrosis, as I have done. Yeah, I would totally agree with that.

Q. And then it says, "The agency and its representatives have restated this policy on numerous occasions." Do you see that?

A. I do.

Q. Do you understand that for decades, for three decades at least, the FDA has taken the position that physicians are allowed to prescribe drugs on an off-label basis?

MR. KNEPPER: Objection, form.

A. Yes.







Q. Your report doesn't acknowledge this longstanding position from the FDA, does it?

A. My report does not -- no, it does not.

Q. And I mean, I know I just heard you say, well, maybe this is from the '80s. Let me show you what the FDA says today.

A. Okay.

Q. I'm going to introduce another exhibit. This is Exhibit 12. Let me know when you get it.

(Exhibit 12 was marked for identification and is attached.)

A. Okay. All right. I've got it.

Q. All right. You see that this is a printout from fda.gov, the official website of the FDA; right?

A. Right.

Q. The title is "Understanding Unapproved Use of Approved Drugs 'Off Label.'" Right?







A. Right.

Q. Go to page 2.

A. Okay.

Q. Toward the bottom, it says in bold, "Why might an approved drug be used for an unapproved use?" Do you see that?

A. I do.

Q. Then it says, "From the FDA perspective, once the FDA approves a drug, healthcare providers generally may prescribe the drug for an unapproved use when they judge that it is medically appropriate for their patient." Do you see that?

A. I do.

Q. And then skipping one sentence, it says, "One reason is that there" may -- "might not be an approved drug to treat your disease or medical condition." Right?

A. Right.

Q. So the FDA -- the position that the FDA takes is off-label use may be

medically appropriate for patients; right?

A. Right.

Q. That's a position they've taken for thirty years plus; right?

A. Right.

MR. KNEPPER: Objection, form.

Q. All right. And we talked earlier about, you know, is off-label use experimental or investigational. Before forming those opinions, did you look to see what the FDA says on that point?

A. How the FDA classifies experimental or investigational?

Q. Do you know what position the FDA takes on whether off-label use is considered investigational?

A. I don't know what their official position is, no.

Q. All right. Let's look at that. All right. This is going to be Exhibit 13. Let me know when you have it.

(Exhibit 13 was marked for identification





and is attached.)

A. I have it.

Q. This is a guidance document from the FDA from 1998. Generally, are you aware that the FDA issues guidance documents?

A. Generally, yes, I am aware.

Q. Have you ever seen an FDA guidance document before today?

A. I've heard them referred to, but I've never read one, no.

Q. Okay. All right. Well, this one's titled "'Off-Label' and Investigational Use of Marketed Drugs, Biologics, and Medical Devices." You see that?

A. I do.

Q. Okay. All right. The first paragraph, second sentence says, "If physicians use a product for an indication not in the approved labeling, they have the responsibility to be well informed about the product, to base its





use on firm scientific rationale and on sound medical evidence, and to maintain records of the product's use and effects." You see that?

A. I do.

Q. All right. The next sentence says, "Use of a marketed product in this manner when the intent is the 'practice of medicine' does not require the submission of an Investigational New Drug Application, Investigational Device Exemption or review by an Institutional Review Board." Do you see that?

A. I do.

Q. I understand that what this is saying, according to the FDA, when a doctor prescribes a drug on an off-label basis, that is not necessarily an investigational use of that drug; right?

MR. KNEPPER: Objection, form.

A. I would disagree, because as it says there, when they're -- when they're prescribing in that manner, they have a





responsibility not only to be informed about the product but to do the recordkeeping of its effects, which is really the initial phase of investigation. So in a sense, they are -- they are part of the investigative process now because a new application of the medication has been proposed, and safety and efficacy have -- have to be documented in some measure.

So the FDA is giving you room to broaden the application of the drug, but they're also placing upon you the burden of documenting so that its effects and benefits can be characterized because that's being -- obviously, it's being investigated. That's the point of their wanting the recordkeeping, so --

Q. Do you know what the Institutional Review Board is?

A. Yes.

Q. Clinical trials have to be cleared by IR- -- IRBs; right?

A. Right.
Q. And this says you don't actually have to apply for approval by an IRB when you're prescribing a drug on an off-label basis; right?
MR. KNEPPER: Objection, form.
A. It says that it's not of necessity, so they're not making a blanket requirement. I would imagine that that might be modified in particular cases.
Q. Yeah. Because this is saying that when you're prescribing a drug on an off-label basis, that doesn't mean you're starting up a clinical trial; right?
A. It doesn't necessarily mean you're starting a clinical trial, that's right. It doesn't exclude the necessity for a clinical trial. It just says you're not necessarily starting a clinical trial.
Q. Yeah. And when this says -- when it says doctors should maintain







records of the product's use and effects, it's not telling them that they're enrolling their patients in a clinical trial by starting -- by prescribing a drug on an off-label basis; right?
MR. KNEPPER: Objection, form.
A. Right. But what it -- what it probably is inferring is that if they start seeing complications, then the further application of the drug in that circumstance might be required -- might require an IRB. So yeah. So it's -- what they're saying is it doesn't require an IRB of necessity. It does require recordkeeping. And I would expect that if they were to see complications, problems, lack of efficacy, that -- and the desire for its continued use might require an IRB. In fact, I would -- I would hope it would require an IRB. Yeah.
Q. Yeah. A clinical trial down the line is a "this might be nice to have,"







but it's not a requirement for a doctor to prescribe a drug on an off-label use basis. That's what this says; right?
MR. KNEPPER: Objection, form.
A. That's what that says, yeah.
Q. Yeah. You don't cite this guidance in your report obviously; right?
A. I don't think it's --
MR. KNEPPER: Objection, form.
A. I don't think it's germane to my report. No.
Q. All right. You've also offered opinions on whether it's proper to prescribe drugs on an off-label basis to children and adolescents; right?
A. I've only offered it in the case of this particular therapy. I haven't offered it generally, only in the case of puberty blockade and cross-sex hormones for the purposes of transitioning a child to the appearance of the other sex. That's all I've offered it as an opinion.
Q. All right. Do you know what the







American Pediatrics Association is?
A. Yes.
Q. Before forming your opinions, did you look to see what the APA says about off-label use of drugs in children and adolescents?
A. No.
Q. Sitting here today, you don't know the APA's position on this -- on this topic; correct?
MR. KNEPPER: Objection, form.
A. Correct.
Q. Let's look at that next. Okay. This is going to be Exhibit 14, and let me know when you have it.
(Exhibit 14 was marked for identification and is attached.)
A. Okay. I have it.
Q. You understand this is a policy statement from the APA?
A. I'm reading it now. I see that it is a policy statement from the American Academy of Pediatrics.

Q. It's a policy statement entitled, "Off-Label Use of Drugs in Children." Right?
A. Yes. Yes.
Q. Look at the introduction section toward the bottom of the page.
A. Okay.
Q. It says that, "The purpose of this statement is to further define and discuss the status of off-label use of medic- -- medications in children." And then it talks about a publication of a 2002 statement. You see that?
A. Yes.
Q. All right. So the FDA -- APA has taken a position on off-label use of drugs in children since at least 2002; right?
MR. KNEPPER: Objection, form.
A. I'm reading it now. It appears to be that, yeah.
Q. All right. Look at the abstract towards the top.





A. Okay.
Q. Second sentence says, "However, off-label drug use remains an important public health issue for infants," childrens, and" -- "children, and adolescents, because an overwhelming number of drugs still have no information in the labeling for use in pediatrics." Do you see that?
A. I do.
Q. Okay. And then it says, "The purpose of off-label use is to benefit the individual patient." Right?
A. Yes.
Q. And then it says, "Practitioners use their professional judgment to determine these uses." Correct?
A. Yes.
Q. And then it says, "As such, the term 'off-label' does not imply an improper, illegal, contraindicated, or investigational use." Right?
A. That's what it says there, yes.





Q. Yeah. The APA also takes the position that off-label use does not imply investigational use; correct?
MR. KNEPPER: Objection to form.
A. It does not de facto imply off-label use, that's right, yeah. It does not imply, right.
Q. And it does not imply that off-label use is de facto improper or illegal or contraindicated; right?
A. Right.
MR. KNEPPER: Objection, form.
Q. All right. Go to page 2.
A. Okay.
Q. Look at the left column, the very bottom paragraph.
A. Okay.
Q. It says: "The absence of labeling for a specific age group or for a specific disorder does not necessarily mean that the drug's use is improper for that age or disorder. Rather, it only means that the evidence required by law





to allow inclusion in the label has not been approved by the FDA. Additionally, in no way does a lack of labeling signify that therapy is unsupported by clinical experience or data in children."
Do you see that?
A. I do.
Q. This is the APA recognizing that even in the absence of FDA approval for a particular indication, that use may still be supported by clinical experience and data; right?
MR. KNEPPER: Objection, form.
A. Yeah. I would -- I would say also that the APA recognizes that -- that there's a poverty of evidence. The poverty of evidence is one of the characteristics of off-label use. And that's -- that's what the nature of my expert opinion was about, that the poverty of evidence is what makes the off-label use an issue, and in this case, poverty of evidence for off-label use in

a situation where the harms -- potential harms are great. That's what the concern was, not -- obviously, I use -- I've off-label used drugs in my own practice, as I said before.

I don't have an objection without qualification that -- that the off-label use of drugs is somehow a crime. I'm saying that in this particular instance of this particular application, that the off-label use tells us that there's a poverty of scientific evidence to support its application that way. Clearly, there's anecdotal reports; otherwise, doctors wouldn't be using it. But there's a poverty of evidence, and what we're dealing with here is not a potential trivial complication but potentially permanently life-altering complications.

That was the issue that I was addressing in my concern about the off-label use, that there's a standard





of -- of caution that's required when you go off-label. And that caution isn't being demonstrated by the -- for the persons who are prescribing or applying these drugs in this way. That was my concern.

Q. All right. You think that before these drugs are to be prescribed, they should first be supported by results from clinical trials; right?

MR. KNEPPER: Objection, form.

A. That's the beginning.

Q. That's the beginning.

A. Yeah.

Q. The absolute minimum to prescribe these drugs; right?

MR. KNEPPER: Objection, form.

A. Well, no. No, I -- I didn't say that. As I said, it begins with anecdotal evidence, not clinical trials. So somebody somewhere sees an effect. As it said in that FDA document, it's oftentimes serendipitous. A clinician





will see an effect, and then -- and then they'll, based on that, they'll hopefully check out the potential risks to the patient and then begin that off-label use.

So it begins actually with anecdotal reports, maybe case collections, maybe a number of providers' case collections, maybe it's a -- it's a -- it's an institutional experience. But that leads to clinical trials and the IRB and all the rest of it. So that's just the beginning of it.

Q. It may be appropriate for a doctor to prescribe a drug on an off-label basis without having the results from a clinical trial; correct?

A. Yeah, I would -- I would hope that after thirty years of doing this, that we would beyond -- be beyond institutional or personal experience, that those trials would have already been done. This isn't -- we're not just at





the beginning of puberty blockade and cross-sex hormones. We're well into this now, to the point where the European literature is now vehemently rejecting that.

That's -- these things have changed. In the last three years, it's all changed. With respect to this off-label application of puberty blockade and cross-sex hormones, it's changed utterly. So these general statements about off-label use are important to understand, certainly, when you see a serendipitous result and you consider applying the drug. But we are so far beyond that at this point in the history of transgender therapy, this is where we're concerned. We're concerned with the continued off-label use, the continued absence of clinical trials. We should have been beyond that years ago. And this is what the European literature is now showing us, that the application

of those drugs by -- which is approved by the APA, is now being rejected by the medical services in Great Britain, in Sweden, in Finland, in Holland. And this is where we as American providers have to get.

Q. All right. We'll -- we'll definitely come back to those --

A. Okay.

Q. -- studies. I promise.

A. Okay.

Q. Let's finish this document first, though. All right. Go to page 3. All right.

A. Okay.

Q. Look at the left column.

A. Okay.

Q. It says: "Therapeutic decision-making should always be guided by the best available evidence and the importance of the benefit for the individual patient. Practitioners are in agreement regarding the importance of





practicing evidence-based medicine. However, for the pediatric population, gold standard clinical trials are often not available, so practitioners must rely on either less definitive information, such as expert opinion for the age group that they are treating, or use evidence from a different population to guide practice."

You see that?

A. I do. And I would agree with that, that particularly in pediatric patients, the clinical trial approach oftentimes is -- is not available because of the nature of the condition and so on. But in the -- in this case, there's a -- it's not an all or none, it's got to be clinical trials or -- or nothing.

There's longitudinal population-based studies, long-term results seen in a population that has matured through this therapy, and looking at, you know, cohort studies





longitudinally, cohort study, which is -- which is an alternative when -- when the clinical trial is not available to you for ethical reasons. Like you wouldn't do sham surgery on somebody. That would be ethically untenable. But you can look at population-based studies where you have a cohort to compare. And that's -- that's where we should be. That's where the European literature is now.

So I would agree with that statement that -- that the APA is making there, but I would qualify it by saying that there's an alternative available that brings you to a higher level of evidence that may in fact bring it to on-label use if they were to bother to do it.

Q. The APA recognizes that for the pediatric population in particular, results from clinical trials are often not available; right?

A. Right.





Q. And the answer in those situations is not to stop prescribing these drugs altogether; right?

MR. KNEPPER: Objection, form.

A. Yeah. The "altogether" would be the qualifier there because there are some circumstances where it would be -- I mean, it wouldn't be good to stop its prescription, but there would be others that you would have to examine more carefully because of the risk issue.

Q. Yeah. Instead, what the APA says is that when clinical trial results are not available, doctors have to rely on less definitive -- definitive information; right?

A. That's what -- that's all you have. That's right.

Q. Yeah. The APA says it may be appropriate for doctors to prescribe drugs to pediatric patients on an off-label basis even when that use is not supported by randomized clinical trials;

correct?
A. Right.
Q. Because the reality is that for a lot of conditions, in the pediatric population, there are no randomized clinical trial results available; right?
MR. KNEPPER: Objection, form.
A. Again, so you're holding out randomized clinical trial, or they're holding out randomized clinical trial as the only alternative to the lowest form of evidence. And I -- I agree that randomized clinical trial are not always available, and we have to have recourse to perhaps lesser but nonetheless more convincing forms of evidence to fall back on rather than falling back to the lowest form of evidence as is the case today with the application of these drugs.
Q. All right. Look at the last paragraph in the left column of this page.
A. Okay.





Q. It says: "In most situations, off-label use of medications is neither experimentation nor research. The administration of an approved drug for a use that is not approved by the FDA is not considered research and does not warrant special consent or review if it is deemed to be in the individual patient's best interest." Do you see that?
A. I do.
Q. If the physician deems an off-label use to be in the individual patient's best interest, that's not experimental use, according to the APA; right?
MR. KNEPPER: Object to the form.
A. Well, according to the -- according to the APA, in most situations.
Q. Yeah.
A. So in that statement, it acknowledges that there are some





situations where that would be considered. That's the implication in that statement. So "most" is the qualifier, implying that there are situations where it would be considered experimental.
Q. Okay.
A. And that's what we propose in our expert testimony, is that this is one of those situations. This is experimental use.
MR. TISHYEVICH: Now let's go off the record.
THE VIDEOGRAPHER: This is the end of Media Unit No. 3. We are off the record at 12:30 p.m.
(Break taken.)
THE VIDEOGRAPHER: This is the start of Media Unit No. 4. We are on the record at 1:21 p.m.
Q. (By Mr. Tishyevich) All right, Doctor. You know you're still under oath; right?





A. Yes.
Q. Before lunch, we were talking about off-label use of prescription drugs. Do you know how common or uncommon off-label use of prescription drugs is in the overall population?
A. I'm not familiar with that number, no.
Q. All right. You don't know if it's 5 percent or 10 percent or 50 percent of all drugs are prescribed off label; right?
A. I have no idea.
Q. How about pediatrics specifically? Do you know how common or uncommon off-label use is in the pediatric population?
A. I do not.
Q. Let me introduce an exhibit.
MR. KNEPPER: One second.
Dr. Lappert?
THE WITNESS: Yes.
MR. KNEPPER: Your camera has

moved accidentally, yeah.
THE WITNESS: It just allows me to look at the bottom of the other screen here so I can look at the exhibits.
MR. KNEPPER: Okay. I think just for the video recording, we want to make sure that the camera stays on your face.
THE WITNESS: I'll go like this, then.
MR. KNEPPER: Perfect.
Q. (By Mr. Tishyevich) So this is going to be Exhibit 15. Let me know when you have it.
(Exhibit 15 was marked for identification and is attached.)
A. All right. I have it.
Q. All right. This is a study from 2019 by Dr. Yackey, Y-A-C-K-E-Y, titled "Off-label Medication Prescribing Patterns in Pediatrics: An Update." Do you see that?
A. I do.





Q. All right. And the objective is "To describe the frequency of off-label drug use in 2014 as defined by the FDA-approved age ranges in patients 18 or under 18 years of age." Do you see that?
A. I do.
Q. All right. Look at "Methods." Do you see that section?
A. I do.
Q. It says, "This is a retrospective cohort study of an administrative database containing inpatient resource use data from January 1, 2014, to December 31, 2014." And do you see that?
A. I do.
Q. Look at the "Results" section.
A. Okay.
Q. The first sentence says, "At least 1 drug was prescribed off-label in 779,270 of 2,773,770 (28.1%) patient visits during the study period." Do you see that?





A. I do.
Q. And skipping a sentence, then it says: "Off-label usage of certain medications differed between care settings. Rates of off-label medication use were higher in observational (45.5%), inpatient (53.9%), and ambulatory (54.2%) settings." Do you see that?
A. I do.
Q. All right. The study concluded after reviewing 2.7 patient visits that overall, 28.1 percent of patients were prescribed an off-label -- prescribed a drug on an off-label basis; right?
A. Right.
Q. And depending on the setting, off-label prescriptions in the pediatrics context can be as high as 45 to 54 percent; right?
A. That's what the study shows.
Q. All right. The reality is that prescribing drugs to children and adolescents on an off-label basis is a





fairly common practice; right?
MR. KNEPPER: Objection to form.
A. It appears to be, yes.
Q. You did not know this before you formed your expert opinions?
A. I knew that it was more common in children than in adults, and I knew that it was, you know, fairly common, having -- having prescribed off-label myself to children, that it's -- it's probably fairly common. I didn't know the exact numbers, though, until now.
Q. Okay.
A. Again, my -- my expert opinion about this is not about does it happen. It's about the particular case of the transgendered person receiving an off-label use of a -- of a fairly problematic drug in light of the recently changing evidence about its efficacy. So the issue of off-label use that I presented was not about are drugs prescribed off-label. The issue was

these particular drugs in these particular patients off-label in light of the recent change in the world literature about the risk/benefits of doing those things. And the evidence now is that that whole position about puberty blockade and cross-sex hormones, it's falling apart in the last three years, and there's a -- there's a growing wave of evidence that says do not do this. And in fact, that's where the Court stepped in in Great Britain, and it's where the Karolinska Institute stepped in.

It's not that it's off-label use. It's that it's particularly problematic in the case of these drugs in these suffering patients. That's what my expert opinion was about. It was not about drug policy. It was about these patients, these problems, these drugs. And the fact is that when you off-label use, the responsibility falls much more





heavily on the provider. When the FDA approves it, the responsibility falls to the shoulders of the approving authority. But if you're going off-label, it's on you as the provider to be certain that you're doing good to the patient. And up until the last three years, the evidence wasn't there. Now it's there. The continued use of the drugs in this way has become very problematic, and that's -- that's what my expert opinion was about, not about drug policy, but about these drugs, these patients.

Q. Doctor, there's actually no question pending, so I'm going to ask that you stick with listening to my questions and then answering them instead of making speeches. Okay?

All right. You -- we talked earlier about the Botox injections that you've done; right?

A. Yes.

Q. You told me you've been doing





Botox injections in the forehead for over ten years; right?

A. Correct.

Q. You've told me that you've been doing Botox injections for crow's feet for over ten years; right?

A. Yes.

Q. Do you know when the FDA first approved Botox for the use of treating forehead wrinkles?

A. Let's see. I recall that it was when I was the chief of plastics at Portsmouth, Virginia, because we had been using it for dystonias and things like that in children. And it got approved for cosmetic use I'm going to say before we moved to the new hospital, so it had to have been around ninety- -- I want to say '97, somewhere in there. I'm just ballparking it here.

Q. So when you were using Botox to do forehead injections, you think that was an on-label FDA approved use for the





last ten years; right?

A. Yeah. When used in the corrugator and procerus muscles, that's the on-label use for cosmetic botulinum toxin.

Q. Let me introduce another exhibit. All right. This is going to be Exhibit 16, and let me know when you have it.

(Exhibit 16 was marked for identification and is attached.)

A. All right. I have it.

Q. Top right corner, you see it says, "Food and Drug Administration"?

A. Yes.

Q. Below that, do you see it says, "Supplement Approval"?

A. Yes.

Q. You know what this is?

A. It looks to be a -- a letter from the FDA to the Allergan corporation, to a particular Ph.D. there who is the director of regulatory affairs. And it's

a supplemental -- I guess it's an amendment. I haven't read it. Can I have a moment to read it?

Q. I'll -- I'll point you to it. Don't worry.

A. All right.

Q. Allergan is a manufacturer of Botox; right?

A. Allergan, yes, uh-huh.

Q. Go to page 3.

A. Okay.

Q. And you see there's a signature line, and under that, it says, "10/02/2017"?

A. Correct.

Q. You understand this was issued on October 2, 2017; right?

A. That's -- that's what the document appears to show, yeah.

Q. Go back to the first page.

A. Okay.

Q. First paragraph says, "Dear Dr. Richmond: Please refer to your







Supplemental Biologics License Application, dated and received December 2, 2016." Do you see that?

A. I do.

Q. The next paragraph says, "This Prior Approval supplemental biologics application proposes an additional indication for the temporary improvement in the appearance of moderate to severe forehead lines associated with frontalis muscle activity."

A. Right.

Q. Do you see that?

A. I do.

Q. All right. Then the next section says, "Approval & Labeling." Right?

A. Yes.

Q. It says, "We have completed our review of this supplemental application, as amended. It is approved, effective on the date of this letter, for use as recommended in the enclosed, agreed-upon







labeling text." Do you see that?

A. I do.

Q. All right. You understand that Botox was not an FDA-approved treatment for improvement in moderate to severe forehead lines until October 3, 2017 --

MR. KNEPPER: Objection --

Q. -- right?

MR. KNEPPER: -- to form.

A. The sense I get of your question is that you -- you're conflating the injection of corrugator and procerus muscles with the injection of the frontalis muscles. I consider all those muscle groups to be forehead muscles because they all animate the brow. The approval of Botox for the corrugator and frontalis -- I mean, corrugator and procerus muscle that goes way back is, I thought, what you were -- you were asking me about with ten years application to the forehead. So yeah. So I consider the -- the corrugator and procerus







muscles (indicating) forehead muscles. Maybe others would call them glabellar, but glabellar is the lesser-included category. So yeah.

So I was aware of the broadened application, and I was aware that for most of the time it's been on the market, it has been limited, the approval been limited to the corrugator and procerus. And the frontalis marginal radicularis was considered off-label use, as was its use in hyperhidrosis, like we talked about earlier. Yeah.

Q. You have prescribed Botox cosmetic -- or strike that.

You have used Botox for treatment of moderate to severe forehead lines associated with frontalis muscle activity before October 3, 2017; correct?

A. Yes.

MR. KNEPPER: Objection to form.

A. Absolutely.

Q. It's an off-label use; right?

A. As we've talked about before, yes, I've -- I've used it off-label.
Q. And do you know when Botox received this indication for treatment of crow lines?
A. I'm sorry. Of?
Q. Treatment of crow lines.
A. Crow lines?
Q. Yes.
A. Oh, crow's feet (indicating).
Q. Sorry, crow's feet.
A. Yeah. Yeah. I don't know -- I don't know the exact date of that. I just know that it's been broadened.
Q. All right. Before -- strike that.
Before you first started using Botox on an off-label basis, did you do a literature search to see if there was a randomized, double-blinded controlled trial to demonstrate that this forehead use was safe and effective?
A. No.







MR. KNEPPER: Objection, form.
Q. So you were using it without having any idea if there was randomized controlled clinical trials to demonstrate the safety and effectiveness of that use; correct?
MR. KNEPPER: Objection, form.
A. So the question is, was I using it in other than the on-label purposes before the approval was handed down by -- to the -- by the FDA?
Q. No. I already heard the answer to that question.
A. Oh, okay.
Q. I'm asking you a different question.
A. Okay.
Q. At the time you were using Botox on --
A. Oh.
Q. -- an off-label basis --
A. Right.
Q. -- you were doing that without







having results from a randomized controlled trial to demonstrate that this off-label use was safe and effective; correct?
A. Correct. Correct.
MR. KNEPPER: Objection, form.
Q. The same is true for respective cohort studies; right?
A. Correct.
Q. The same is true for case control studies; right?
MR. KNEPPER: Objection, form.
A. Right. And that's an example of what we were talking about earlier where a low-risk application begins with anecdotal experience, shared anecdotal experience, and -- and the literature that comes later leading to the controlled trial that the Allergan company may have done and it's then subsequently approved by the FDA. That's right. So this would fit into that category.







Q. All right. Let's talk more about randomized controlled trials outside of Botox. If I call them RCTs for short, you'll know what I'm referring to; right?
A. Yes.
Q. An RCT typically involves two groups, an experiment group and a control group; right?
A. Yes.
Q. RCTs are typically double-blinded; right?
A. Well, in most cases. But when you're talking about things where there's going to be an outward change in the patient, it's -- it's difficult to blind such studies. You're essentially just -- for example, you couldn't have a double-blinded study of a surgical procedure, or you couldn't have a double-blinded study of a -- of a medical intervention where there's outward change to the patient that would be evident to

both the experimenter and the subject. So yeah.

Q. Yeah. So -- yeah, we'll get to that in a minute. Let me ask just some more general questions first.

A. Okay.

Q. Because I want to figure out your experience with RCTs. You personally have never been the lead investigator for an RCT; correct?

A. That's correct.

Q. You personally -- strike that.

Have you ever been involved with an RCT?

A. Yes. When I was a resident at the University of California-San Francisco working on the neurosurgical trauma unit, we were doing a randomized controlled trial of the medical management of elevated intracranial pressure, and I was -- because I was part of the team, I was responsible for gathering data in the critical care unit







and -- and working with the investigators ensuring the integrity of the data. So I was not the lead investigator, obviously. I was just one of the participants as one of the treating physicians.

Q. The only time you worked on a randomized controlled trial was during your surgery res- -- general surgery residency; correct?

MR. KNEPPER: Objection, form.

A. I'm trying to think if there were other instances here. At UC-Davis -- I'm trying to think. Give me just a moment. I just want to --

Q. Sure.

A. -- make sure I'm not missing any more. I think that's the only one where it was a randomized blinded study. That's right, yeah.

Q. And that residency was '87 through '91?

A. That's right.

Q. Okay. You've never published







any articles in peer-reviewed journals about RCTs; correct?

A. That's correct.

Q. You've personally never designed an RCT; correct?

A. That's correct.

Q. You don't hold yourself out as an expert in RCT design; right?

MR. KNEPPER: Objection, form.

A. Well, I would qualify that answer by saying that part of my training involves me being able to understand and review published literature on the subject even though I'm not the investigator because of my training as a plastic and reconstructive surgeon, as a general surgeon. As just a physician in general, we're trained on how to interpret the validity or the veracity of the medical literature, including how to interpret the randomized controlled trial and -- and understand its validity, which is -- what I'm testifying about is not my







personal experience. It's my opinion of the validity of the scientific data. So I -- so it's not that I -- that I can't express an opinion on it. It's just that I haven't personally conducted one, but I have been trained on how to interpret them.

Q. I understand that distinction you're making.

A. Thank you.

Q. But when it comes to designing RCT, you're not an expert in that aspect of RCT?

MR. KNEPPER: Objection, form.

A. Well, again, part of the evaluation of a randomized controlled trial is to evaluate how the study was designed. That's one of the criteria used for understanding the validity of a published document like a RCT. So you always look at -- that's why it's such an essential part of a -- of a RCT publication is you look at the materials

and methods and you look at the study design, and that's where, really, your analysis begins if you're trying to interpret the data. Did they design the study properly? Does it have the power of discrimination of what they claim that it has? And then you look at the actual results, and it's on -- it's on your shoulders as the -- as the professional, whether you're a -- you know, a researcher or somebody who's seeking to apply it in his practice, you're responsible for interpreting the data quite apart from their interpretation of it.

So an example of that would be the Branström study, where they -- they -- they generated a good -- a reasonable study design, but they misinterpreted the data, and that's what caused the retraction of the Branström study, is that all the other people who were not RCT investigators, but they were





all physicians, endocrinologists, pediatricians, they looked at the data and said, "You've misinterpreted the study."

And that's really what we're talking about here. There are those who perform the study, and then there's us who have to live with it, and we have to be able to understand what they're -- what they're purporting to. So we have to interpret the data even before reading their conclusions.

Q. Do you know what the CONSORT criteria are? C-O-N-S-O-R-T.

A. I've read it sometime before. I can't -- I can't -- I can't quote it for you, but it's -- it's germane to the study design process? I'm not sure.

Q. Okay. Can you describe for me what the CONSORT criteria are in general terms?

A. I cannot.

Q. All right. How about cohort





studies? You've personally never designed a cohort study; correct?

A. No, I have not.

Q. You've personally never been an investigator in a cohort study; correct?

A. Well, so -- so, that experience at -- at UC-San Francisco was a -- well, so are you asking -- by cohort study, are you talking about like a retrospective study of a -- of a population cohort? Is that what you're asking me about?

Q. Prospective or retrospective, either -- either/or.

A. I haven't designed any of those studies, no.

Q. Okay. And outside the one experience in your residency, have you ever been involved with any prospective or retrospective cohort study?

A. No.

Q. And how about case-control studies? Have you ever personally designed a case-control study?





A. No, I have not.

Q. Have you ever been an investigator in a case-control study?

A. I'm just trying to think if the -- if the head trauma investigation would fit the category of a case control. It was a randomized study. It had its own internal controls. So I guess I've assisted in that investigation, but only as a -- as a provider and a -- and a data gatherer.

Q. Outside of that one experience, you have not been involved with any prospective or retrospective cohort study; right?

A. No.

Q. Or a case-control study? Excuse me.

Okay. Let's go back to your report, Exhibit 1, and go to page 13.

A. Okay. Okay.

Q. You see there's a header that says in capital letters, "Anecdotal

Patient Stories Are Not Data." Do you see that?

A. I do.

Q. And you write, "Drs Schechter and Brown also failed to disclose and properly discuss that Anecdotal Data unverified patient reports without control groups, randomized trials, or other scientific protections for the integrity of the medical system -- are not reliable science." Do you see that?

A. I do.

Q. And then you reference personal patient stories, and you say, "This is unreliable Anecdotal Data and it is not credible, scientific information." Do you see that.

A. I do.

Q. All right. You think that case reports are anecdotal evidence; right?

A. Yeah, they're --

MR. KNEPPER: Objection.

THE WITNESS: I'm sorry?





MR. KNEPPER: Objection, form.

Go ahead.

THE WITNESS: I'm sorry.

A. Yeah. And so anecdotal data is personal experience of a -- of a practitioner, for example. So -- so a surgeon reporting on five cases that he did would be considered anecdotal reporting, or case reports and things like that, yeah. That's anecdotal, personal experience, a personal exper- --

Q. And you think --

A. I'm sorry?

Q. Go ahead. Sorry.

A. Personal experience as distinct from more stringent scientific evidence like a longitudinal study or a cohort study or something like that. Or even -- even personal experience with pre- and posttreatment testing rises to a higher level than anecdotal. So you can base -- you can base scientific evidence on that next level, which would be anecdotal





experience elevated to the next level by pretreatment and posttreatment testing. This is -- this is from the guidance that the American Society of Plastic Surgery puts out.

So depending on the -- depending on the type of study, if it's a -- if it's a therapeutic study or a diagnostic study or a prognostic study, depending on what you're looking at, if -- if you -- if you take it to that next level with pre- and posttreatment testing with a validated scientific instrument, you know, a validated study even of subjective reporting from the psychiatric/psychological side of things, that has more validity than the anecdotal reports of a practitioner or even an institution.

Q. Do you think that a case report that doesn't have this before and after comparator that you describe is essentially worthless from the --





A. No.

Q. -- scientific perspective?

A. No, no. Not worthless. Not worthless, but it's what's considered in the -- in the -- in plastic surgery circles, certainly, it's considered the lowest form of evidence. So for a number of years now, the American Society of Plastic Surgery has insisted that publications -- if you're going to publish a case series, for example, that they have to be a sequential -- you can't pick the cases you're reporting on. It has to be a sequential series of patients, and you have to declare in the publication, in your -- in your article, the level of evidence that you're presenting.

So if -- if it's merely a -- case reports, that would be level 5 evidence. If you added to that a review of the literature with a -- you know, a definitive review of the literature

looking at the -- at where the weight of evidence lies, then you raise it to the next level. But we're -- we're now required when we're publishing in -- in the ASPS journal, for example, to state in the -- in the document level of evidence. So a case report is not zero scientific evidence. It's level 5 evidence. It's the lowest form of -- of evidence is what it is.

Q. You personally would not rely on a level 5 case report to decide if a surgical technique is effective?

A. It would be the beginning of my interest in a particular technique. As a surgeon, we tend to be very conservative, and we call upon our personal experience very much and certainly upon our training. So if somebody proposes something radically new and all they have to support it is level 5 evidence, generally -- there's a saying that I learned in training is never be the first





or -- first one to do a procedure or the last one to do a procedure.

And so, yeah, you know, surgeons tend to not jump in early on -- on low-quality evidence. We tend to be conservative about it. And I would number myself among them.

Q. All right. Let me ask the flip side.

A. Okay.

Q. Do you think it's necessary for a surgical procedure to be supported by results from a level 5 RCT before it can be considered effective?

A. No.

MR. KNEPPER: Objection to form.

A. That would -- that would be one of those circumstances where what is the risk to the patient and -- and what's the potential benefit to the patient. That's -- that's what kind of would drive my decision to act on a level 5 case report, offering something like that to





one of my patients.

Q. Do you think that a surgical procedure has to be supported by a level 2 controlled study before that surgical procedure can be considered nonexperimental?

A. Not necessarily. It would depend on what is -- what is -- what is at risk here. Certainly, we're much more willing to -- to proceed with -- with techniques and procedures that aren't hugely supported if there's great risk to the patient of not doing anything. So level of risk and what is at stake kind of drives that and -- and yeah.

Did I answer that question? Is that what you were asking?

Q. Yeah. It's basically a case-by-case decision; right?

MR. KNEPPER: Objection, form.

A. Well, I wouldn't say case by case. I would say, you know, you're relying on -- on -- on a lifetime of





experience possibly, and you're relying also on -- on conversations with your peers, your colleagues, what is their experience in the area and how much of a risk are you going to subject to the patient -- subject the patient to in order to achieve a result. The greater the risk, the greater the expectation of a defined scientifically supported outcome.

So in the case -- in the issue at hand here, great risk of doing, for example, a transition surgery, because you're talking about permanent sterilization, irreversible sterilization, or the removal of the breasts, permanent and irreversible loss of the breasts, that's a huge stake, a huge risk to the patient that the -- the expected outcomes have to be consummately much larger in order to justify something like that if you don't have scientific support. If you're at low levels of

scientific evidence, then clearly, you have an obligation to the patient not to -- not to try something risky if you don't have extensive and very valid scientific -- and that's where we are now. We're at very low-level evidence for these things. That's kind of why we're here today.

Q. I guess I'm asking a more specific question. You're not taking the position that in order to be considered nonexperimental, a particular surgical procedure has to be supported by at least level 1 or level 2 evidence; right?

MR. KNEPPER: Objection, form.

A. Oh, okay. So you're asking me the definition of experimental. Is that -- do I understand you correctly?

Q. Sure.

A. Yes. Am I saying that something is nonexperimental once it reaches level 2 evidence or higher and not before?

Q. Correct.





A. I'm not saying that, no.

Q. Okay. How about level 3? Are you taking the position -- strike that.

Are you expressing the opinion that a surgical procedure can only be considered not experimental if it reaches evidence level 3?

A. Well, it's getting closer. So when you're -- when you're at level 3, you're talking about a retrospective study with a cohort. And if we were talking about some simple technique of reconstructing, say, a wound on the face for cancer therapy, then I certainly wouldn't wait to try a new technique. If it promised to get a better result, I wouldn't wait until I got to level 3 evidence.

But if you're talking about a very drastic operation where I'm amputating healthy parts, then yeah, I'm going to want to go at least to level 3 before I consider that, because again,





you're talk about tremendous risk to the patient, permanently life-altering changes. You better have very strong evidence that you're doing the patient good because you're doing the patient a great harm by, you know, removing their, genitals, permanently sterilizing them, removing their breasts. So again, it's -- it's not a case by case, but let's -- let's say broad categories of -- of techniques or surgery.

If you're talking about something small like reconstructing a facial defect, then yeah, you don't need to get to level 3. But if you're talking about something large and permanently life-altering, then at least level 3.

Q. All right. We talked earlier a while ago about some of the surgical procedure you performed, and I think one of the things you mentioned was breast reductions.

A. Yes.





Q. Right?

A. Yes.

Q. You've done those; right?

A. I have done so many of those.

Q. All right. You've done breast reduction surgery without having the results from a randomized controlled clinical trial; right?

A. I believe the -- the bulk of the evidence in the therapeutic benefit of breast reduction is primarily given to us by a long-term longitudinal cohort study that we actually get from the insurance industry. Because when you do breast reduction surgery, one of the key issues in a breast reduction is, is it going to be efficacious in curing an orthopedic problem. So if you're talking about breast reduction surgery as a quote, unquote reconstructive procedure, then really, it's being applied to an orthopedic condition.

And the insurance companies have

a wealth of evidence about, for example, the weight of the specimen that has to be submitted in order to have a hope of relieving the orthopedic complaint of neck, back, and shoulder pain.

So -- and vir- -- and I can tell you categorically, because I'm very fastidious about this, that all of the breast reduction operations that I've ever done for the orthopedic condition of neck, back, and shoulder pain have met the criteria based upon this long-term longitudinal cohort study that the insurance companies have been running since back in the '80s at least.

Q. All right. Doctor, again, I need you to listen to my questions. I didn't ask about cohort studies. I asked about randomized clinical trial.

A. Oh.

Q. You have done -- you have done breast reductions without having results from a randomized controlled clinical





trial?

A. Oh, forgive me. I -- I misunderstood the question, then. No. The -- I have not, no. The industry -- the plastic surgery community does not rely on a randomized trial for the -- the operation to be merited. That's correct.

Q. Right. Nobody in this industry waits for results from a randomized controlled trial before determining that a particular surgical procedure is nonexperimental; right?

MR. KNEPPER: Objection, form.

A. Well, this gets back to what we were talking about before, what the -- what the level of evidence is, what's at risk, and what are the potential benefits. So in the case of breast reduction surgery, yes, we have not relied on randomized controlled trials because there was such an abundance of level 3 evidence to justify the procedure. And so -- and level 3





evidence is sufficient to answer the question, is this experimental or not? This procedure doesn't rise to the level of level 2 or level 1 in order to be justified. I believe there have been -- well, no, I can't say categorically, so I won't.

So yeah, to answer your question, breast reduction does not rely on randomized trials. It relies on level 3 evidence.

Q. All right. Let's take it out of the realm of breast reduction in particular.

A. Okay.

Q. It is not uncommon for plastic surgeons to perform procedures that are not supported by results from an RCT; correct?

MR. KNEPPER: Objection, form.

A. As a general principle, plastic surgeons are perhaps more innovative than other surgeons, so we're inclined to try





new techniques. And then, of course, you have to exercise some significant prudential judgment about what risk are you placing the patient in before you get experimental with them. Yeah. So yes, we -- we do that all -- we're innovators, as -- as a general principle.

Q. And as a general principle, plastic surgeons will often commonly perform procedures that are not supported by level 2 evidence; correct?

MR. KNEPPER: Objection, form.

A. Yes.

Q. And as innovators, plastic surgeons will often perform surgical procedures that are not level 3 evidence; right?

MR. KNEPPER: Objection, form.

A. Yeah. They -- if you're talking about small like technical improvements in -- in low-risk procedures, then yeah, we -- we do that very commonly.

Q. Okay. You know what the

Plastics and Reconstructive Surgery journal is; right?
A. Yes.
Q. It's the official publication of the ASPS; correct?
A. Correct.
Q. It's a peer-reviewed medical journal; right?
A. Correct.
Q. It's published monthly; right?
A. And plus supplements as well and online. Yes, sir.
Q. One purpose of that journal is to educate members about new surgical techniques; right?
A. Yes.
Q. Would you agree that the journal is the premier peer-reviewed source for current information on reconstructive and cosmetic surgery?
A. I would.
Q. All right. Are you -- I know that you're no longer a member. Are you







still subscribing to the journal?
A. No, I'm not. It's a -- it's for members that you get the journal, so yeah. That's what my subscription relied on, so -- all those years.
Q. I understand. So not -- you haven't had access to it since 2018?
A. Well, I -- no, I go online, and I'll pay for access to particular articles. So yeah. So it's not that I've lost contact with it, it's just that I do literature searches, and if an ASPS citation comes up, I'll pay to look at it.
Q. I understand. Sitting here today, what percent of publications in that journal do you think consist of results from RCTs?
MR. KNEPPER: Objection, scope, form.
A. Yeah, I'm -- I'm not sure I could hazard a guess even.
Q. Ballpark, do you think it's 10







percent? 50 percent?
A. Of their published articles that are randomized controlled trials?
Q. Yes.
MR. KNEPPER: Objection to form, scope.
A. Gosh, I'm going to guess it's probably somewhere -- probably less than 10 percent.
Q. How about cohort studies? If you had to estimate, what percentage of publications in that journal do you think consist of results from cohort studies?
MR. KNEPPER: Objection, form.
A. Again, just ballparking here after, you know, 35 years of reading that article -- that journal for 35 years, I would say that -- I don't -- I may be guessing, but 15 percent maybe are -- are cohorts that are usually single-center studies. There's a lot of those in the -- in the White Journal. There'll be a single-center cohort study of -- of







some operation or technique, and they'll usually report it as three or four surgeons at a single center reporting a -- a longitudinal cohort of, say, breast cancer reconstructions with implants versus breast reconstruction with autologous flaps and comparing satisfaction surveys and things like that. So I'm going to ballpark it at 15 percent, but I don't know. I don't know for a fact.
Q. Let me introduce an exhibit. So this will be Exhibit 17, and let me know when you get it.
(Exhibit 17 was marked for identification and is attached.)
A. Okay. All right. I have it.
Q. All right. This is a study from 2019 by Sugrue, S-U-G-R-U-E, titled "Levels of Evidence in Plastic and Reconstructive Surgery Research." See that?
A. I do.

Q. All right. See there's a "Summary" box on the first page?
A. Yes.
Q. The third sentence says, "The aim of this study is to determine if the quality of evidence in plastic surgery research has improved over the past 10 years. Systematic review of research published in Plastics and Reconstructive Surgery journal over the years, 10-year period (2008, 2013, 2018), was performed." Do you see that?
A. I do.
Q. Now, you understand what this study was trying to accomplish; right?
A. Yeah. They were measuring the level of success that the American Society of Plastic Surgery was having after having applied those criteria we talked about earlier, the -- this requirement of reporting levels of evidence, seeking the clarity on levels of evidence. And so I expect -- I





haven't read this -- this article before, but I guess that's what they're looking at, is how successful have we been as a professional society in publishing --
Q. Yeah.
A. -- these things.
Q. And this references the levels of evidence, LOE, metric; right?
A. Yes.
Q. And that's the same metric that you referenced earlier, levels 1 through 5; right?
A. Right. Well, the levels 1 through 5 that I referenced includes the -- sort of the subcategorizing, depending on if it's a therapeutic trial or a -- or a trial of risk or things like that. So the -- the document that the ASPS published some years ago includes risk studies and diagnostic studies, but they're all ranked 1 through 5. That's right.
Q. And you see a couple of





sentences down, it says 884 studies were included in the final analysis. You see that?
A. Yes, I do.
Q. Okay. Go to page 2.
A. Okay.
Q. You see there's a Table 1?
A. Yes, I do.
Q. Table 1 is "Percentage of Each Level of Evidence Published per Year." Do you see that?
A. I do.
Q. And there's columns for 2008, 2013, and 2018; right?
A. Yes.
Q. All right. Let's start with level 1, and that's randomized control trials or metaanalyses of those trials; right?
A. Right.
Q. In 2018, only 2.1 percent of all publications in the journal were level 1 evidence; right?





A. That's right.
Q. And in 2008 and 2013, those percentages were 0.3 and 1.7 percent respectively; correct?
A. Correct.
Q. Not very common for the journal to report on results of RCTs, according to this summary; right?
MR. KNEPPER: Objection, form.
A. Yeah. And it even goes along with what -- my ballpark earlier, so I'm surprised -- yes, it was less than 10 percent were -- were level 1 evidence and somewhere around -- yeah, so those numbers are consistent. But yeah.
And the other thing to note about it is that they appear to have been successful in choosing what they publish to support higher levels of evidence. So I guess they're to be commended for having done this, yeah.
Q. Okay. All right. Then level 2 are -- level 2 evidence includes

prospective cohort or comparative studies; right?

A. Yes.

Q. With controls; right?

A. Yeah. There's a level of randomization that -- that's there as well --

Q. Okay.

A. -- in those prospective studies. That's right.

Q. And for that level 2 evidence, only 13.6 percent of all publications in the journal in 2018 consisted of that evidence; right?

A. Yes. That's what it says there, yes.

Q. All right. Level of evidence 4 is case series with a pre- or posttest or only posttest; right?

A. Right.

Q. And in 2018, those amounted to 41.7 percent of all publications; right?

A. Right. It looks as though more







of those level 4 have been shifted up into level 3, given that the level 5 has declined. So it looks like they're pushing more of the level 4 up into level 5. Yeah.

Q. Yeah. Much of the research on which your field relies doesn't consist of results from RCTs or controlled cohort studies; right?

A. Well, I wouldn't --

MR. KNEPPER: Objection, form.

A. I wouldn't say that based on this. I would say that much of the published research in this journal is of that -- of what you described, relying on RCTs and so on.

This is a -- this is not a document about what the profession is doing. This is a document about what this journal is publishing. And what they're publishing is more papers of higher value, for which they're to be commended. So this says nothing about







what people are investigating. This says about -- this says something about what this journal is publishing.

Q. Well, this is the journal for the ASPS; right?

A. Right. With limited space for publication. So they're being, apparently, more selective about what they'll publish, that it's not just that well, this is the chief of plastic surgery at NYU, so we're going to publish his paper. It's the chief of plastic surgery has a level 2 case. Let's -- let's present -- let's publish that one. I think that's what this is telling us, that they're being more fastidious about what they publish, whereas before, they might have been more -- well, less selective, let's say.

Q. Have you ever been involved with selecting articles to be published in this journal?

A. I've never been involved in --







in journal publication staff or -- no, I have not.

Q. You don't know the process by which they select what article to publish; right?

MR. KNEPPER: Objection, form.

A. I have some idea, but I'm -- it's not my -- my area of professional expertise.

Q. Yeah.

A. I merely read the journal, and have for approaching forty years now.

Q. Look at Table 2.

A. Okay.

Q. And look at the column under 2018.

A. Yes.

Q. The first two rows, "Systematic review/meta analysis" and "Randomized control trials," account for 3.2 plus 3.8 percent of all publications of the journal in 2018. Correct?

A. Right.

MR. KNEPPER: Objection.

Q. Case series account for 26.3 percent; right?

A. Right.

Q. Okay. Go to page 3 of this exhibit.

A. Okay. I'm there.

Q. All right. First full paragraph, first sentence says, "Case series are the backbone of surgical research." Do you see that?

A. I do.

Q. You don't disagree that case series can be helpful scientific evidence; right?

A. No. As I -- as I testified before, this is the beginning of research. It always begins with perhaps a serendipitous discovery, then to case reports, then to case series, single -- single-provider case series or multiple providers in a -- in a -- an institution. But that's the beginning of surgical





research, yeah. That's how it always begins.

Q. Well, it's a beginning, but sometimes it's also the end; right? Because look at the third sentence. It says: "The absence of a control group justifiably ranks this design at the lower end of the evidence pyramid. Despite this, case series are vital. They may be the only feasible and ethical study methodology obtainable, as seen with craniofacial surgery." You see that?

A. Yeah. And to that -- to that particular point, so I've got extensive experience with craniofacial surgery, and -- and it's -- this is one of those procedures where the outward change to the child can't be blinded. You cannot blind the investigator because, obviously, he's doing the surgery, and you can't blind the patient or the family to it because the results are quite





obvious. And that's what they're saying here. And obviously, they're not saying that it's never useful or is never necessary. They're saying that in many cases, you don't need to rise to that level because you have evident benefit to the patient and the risk is not only manageable but -- but sufficiently low to warrant the application of a particular technique.

So that was certainly the case, for example, when we introduced external fixation devices for advancement of the mid face in certain congenital deformities. Nobody had done a randomized trial because you can't. You've got this hardware sitting on the patient's face. So -- but yet, the -- the luminaries in craniofacial surgery were able to demonstrate through a case series that this was a valid technique, and then the rest of us adopted it. So that's an example of how plastic surgery





works.

Now, if the patient was at risk of death because this technique was being applied or if the patient was at risk of permanent life-altering changes that couldn't be reversed, then yeah, you would have to proceed with much greater caution, and you may be looking at finding some way, longitudinal study-wise, to -- to quantify the benefit of using your technique over using established techniques.

Q. There are some areas in plastic surgery and reconstructive surgery where case series are basically as good as it gets in terms of scientific evidence; right?

MR. KNEPPER: Objection, form.

A. Yeah. I suppose in the newer -- at the newer end of techniques, that's all you got for now until the technique has been applied over a sufficiently long time that you can look at a retrospective

cohort.

So for example, in the case of gender transitioning surgery, the -- the -- the surgeons have been at it now for several decades. And we should be already at the level of level 3 evidence, but -- but we're not.

Q. Well, you --

A. So I wouldn't put that in the category of -- you're talking there about a high-risk procedure that has a long track record that can be examined. And -- and clearly, the examination of that technique in the last three years, give or take, has -- has shown us that that this is in the category of those operations that demand higher levels of evidence than a case series, whether it's single provider, single institution, or even single nation. You've got to -- you've got to look at the data now and -- and prove that you are doing something good for the patient.





And quite frankly, it hasn't been proven in the -- in the American literature. Certainly, WPATH hasn't proven that. But in the European literature, they're looking at it and saying, gosh, you know, the -- the Swedish study shows us that if you only follow patients for five years at the most, you're not even going to see the long-term effect of what you did to them. And if you look at them eight years and beyond, you'll see that you haven't solved the suicidality, the self-harm, the incarceration, psychiatric diagnosis admissions, and things like that.

So -- so yeah, as far as what we're talking about today, yeah, there's a whole spectrum of what's acceptable levels of evidence for a particular procedure. The higher the risk, the higher the level of evidence is demanded. And sometimes you have to wait to get to that level of evidence if you're dealing





with something potentially life-threatening.

Like certainly, the providers were fully justified in considering this because of the high suicide rate of transgender patients. Case series, totally valid reason given that the life of the patient is at risk here, totally valid to go with a case series as the evidence by which you're consenting the patient to surgery. But we're now beyond that. We're now beyond that. We're at -- we're now -- the ethics demands that we look at higher levels of evidence because of the long-term risk to the patient and the fact that the long-term evidence doesn't support the indication for surgery, which is lower suicide rate, lower self-harm, lower drug abuse. That's really what we're talking about here.

Q. I have some other questions. You agree that -- strike that.





Do you agree that it is not possible to perform RCTs for some surgical procedure because you can't blind the patient or the investigator to what the procedure is?

A. Absolutely agree, yeah.

Q. So, let's take phalloplasty; right?

A. Okay. Yeah.

Q. When a surgeon performs a phalloplasty on a patient, both the surgeon and the patient are going to know that the procedure was done; right?

A. Yes.

Q. It's not possible to have a RCT for phalloplasty because you can't blind the participant or the investigator; right?

A. Yeah. That's typical of most surgical interventions. The only exception to that would be intraabdominal or intrathoracic surgeries or even intracranial surgeries. And -- and

that's considered sham surgery, which is considered malpractice and ethical violation of professional standards. So you can pretty much rule out most all surgical procedures from the randomized control trial category. Correct.

Q. And we agree that the same would apply to metoidioplasty, for example; right?

A. Yes.

Q. To all types of, again, colloquially known as bottom surgery; right?

A. Correct.

Q. All right. Let's take puberty-blocking hormones.

A. Okay.

Q. When patients with gender dysphoria treatment start puberty-blocking hormones, they're not going to undergo puberty, basically; right?

A. Well, that's the intended use,





that's correct.

Q. So there's going to be observable physical effects of the hormones that will be apparent to the patient; right?

A. Yes. Within a year, that child is going to look much smaller than his peers. He's going to be developmentally delayed psychologically, neurophysiologically. His -- his movements are not going to be as -- his coordination is going to be less matured. His higher executive functions will be impaired. So it will be very obvious that this child is now different from his peers. So I would agree with you; you couldn't find a way to blind such a study because the evidence of effect is so obvious within the first year that everyone would know that they're taking the -- the puberty-blocking gonadotropin-releasing hormone agonist.

Q. We agree that -- we agree that





it's not possible to do an RCT for puberty-blocking hormones because of these apparent physical effects; right?

MR. KNEPPER: Objection, form.

A. I -- I would agree, yes.

Q. Okay. Let's take cross-sex hormones.

A. And the -- the last question you asked me, did you qualify that as you couldn't do a double-blinded study using puberty-blocking drugs in self-identified transgender children?

Q. Yes.

A. Yeah. Because if you're applying the drug to other conditions like precocious puberty, it -- it may be possible. It may be possible to -- I don't know. I'd have to think about that but -- okay. Sorry.

Q. Let's take cross-sex hormones.

A. Okay.

Q. When somebody -- someone is treated with estrogen or testosterone for





gender dysphoria, there are also going to be physical effects from those treatments; correct?

A. Yes. Given that sex hormones have such a profound effect on every body system, then it's going to be impossible to conceal the fact that the person is on sex hormones because every -- every function of the body is affected by sex hormone levels, particularly at the age of early adolescence.

Q. And given these visible physical effects, it's not possible to design a double-blind RCT for cross-sex hormones for gender dysphoria; correct?

A. It would probably be an invalid study, yes.

Q. All right. Let's go back to your -- actually, you know what? I'm going to move to a different area. It's been about an hour. Let's take a quick break.

MR. TISHYEVICH: Off the record.

THE VIDEOGRAPHER: This is the end of Media Unit No. 4. We are off the record at 2:16 p.m.

(Break taken.)

THE VIDEOGRAPHER: This is the beginning of Media Unit No. 5. We are on the record at 2:24 p.m.

Q. (By Mr. Tishyevich) Let's go back to your report, Exhibit 1.

A. Okay.

Q. Go to page 21.

A. Twenty-one. Okay.

Q. And you see there's a paragraph starting with, "Failure to discuss the failure to conduct"?

A. Yes.

Q. Okay. So in the second line, you reference the "unknown number and percentage of patients who drop out of transitioning or reverse the process parentheses (Detransitioners)."

A. Right.

Q. You see that?







A. I do.

Q. All right. You agree that the number and percentage of patients with gender dysphoria who drop out of transitioning or who reverse the process is currently unknown; right?

A. Well, it depends on if you're asking that question about the general population or in a particular study. So in particular studies, that number is known, but in the general population, it's an unknown.

Q. Yeah.

A. And the reason -- the reason it's unknown in the general population is because the people doing the research aren't following those patients. That's why we don't know.

Q. In the overall population, the number and percentage of patients who drop out of transitioning or reverse the process is unknown; agree?

A. Yeah. I would agree that's







unknown, yeah.

Q. All right. Given that, obviously, you're not offering any expert opinions on what that number or percentage is in the general population; right?

A. Yeah, I don't -- I don't think it's possible for anyone to break out the difference, for example, between somebody who isn't followed up because they've detransitioned or somebody who isn't followed up because they've taken their own life. We have no way of knowing because nobody's following up.

Q. All right. Look toward the bottom of this page 21. You cite a case series from I believe it's Djordjevic, D-J-O-R-D-J-E-V-I-C. Do you see that?

A. I do.

Q. And you say, "More dramatically, a surgical group prominently active in the SRS field has published a report on a series of seven male-to-female patients







requesting surgery to transform their surgically constructed female genitalia back to their original male form." Right?

A. I see that, yes.

Q. Okay. Now, this article was not an RCT, obviously; right?

A. Right, right.

Q. It was not a cohort study; right?

A. No. This would be a case -- a case series.

Q. Yeah. The lowest level of evidence; right?

A. No. Actually, the lowest level of evidence would be sort of single patient -- well, it's sort of somewhere between 4 and 5, I suppose. I'd have to look at the article again to see what the -- what the denominator is, but --

Q. Yeah. Well, generally, you think that anecdotal patient stories like these are not reliable scientific

information; right?

MR. KNEPPER: Objection, form.

A. No. They're the first clue to a problem or the first clue to a solution. That's exactly right. So that -- that sort of points to the controversial nature of these therapies, is that -- is that we don't have the answer. We can't explain why these detransitioners weren't predicted preoperatively because we don't have a test instrument to figure that out.

So when you see a series like this -- this is what we talked about earlier, about the -- the history of progression of levels of evidence. You start out with reports like this. This leads to further research. And I'm just trying to remember, when I read the article, where that study was done. I don't have it in front -- I'm just trying to remember what -- what country that was done in.







Q. Yeah. I'll -- I'll show it to you.

A. Okay.

Q. Hold on. Let me introduce it.

A. Thank you.

Q. You did read these -- this article in full before you cited it; right?

A. Yeah. That -- it was -- it was probably about seven months ago, but yes, I did.

Q. Sure.

THE COURT REPORTER: I didn't hear anything. So it's just --

THE WITNESS: Okay.

THE COURT REPORTER: We're losing it in Zoom. Thank you.

THE WITNESS: Forgive me. I'm sorry.

THE COURT REPORTER: No, that's okay. It's awkward.

Q. (By Mr. Tishyevich) Okay. This is going to be Exhibit 18, and let me







know when you have it.

(Exhibit 18 was marked for identification and is attached.)

A. Okay. Okay. Yeah, there it is. Yes. Yeah, right. Okay. It's coming back to me now. And this was published out of the -- Amsterdam. That's right. Okay. All right. Yeah.

Q. All right. Let me ask you -- strike that.

Bottom of the page, there's a section titled "Introduction." You see that?

A. The bottom of the first page?

Q. Yes.

A. Yes, I see that.

Q. Look at -- look to the column on the right.

A. Okay.

Q. The last sentence says, "In general, most researchers have reported their patients are extremely satisfied overall with their surgical outcomes,







with a low rate of complications." You see that?

(Witness reviews document.)

A. Right. I see -- I do see that, yes.

Q. Then it cites three footnotes, 5 through 7; right?

A. Right.

Q. You don't acknowledge this portion of the article in your report; right?

A. Well, it is in the discussion, I think. Well, actually, probably maybe in the summary of the -- of the medical evidence. The -- I would put this in the category of subjective reporting and short -- subjective reporting and short follow-up. Right. That's what --

Q. Well, you --

A. I'm sorry. Go ahead.

Q. No, no, go ahead.

A. So I think the reason I included this was to show that there are -- you

know, that there's a growing pool of patients who are returning for reversal surgery. I don't think I discussed in this part of my report -- yeah. I'm just talking about increasingly visible community and patient -- increasing number of patients requesting reversal surgery. And as an example of that, again, going to a single-center case collection as an example, early evidence, we're starting to see this now as numbers of patients who have surgically transitioned increases, the numbers of patients who regret is going to increase, particularly in light of what these authors speak about here.

Let me see if I -- yeah. So in the second sentence of the abstract in the introduction, it says, "However, misdiagnosed patients sometimes regret their decisions." And one of the reasons for including this article is the fact that misdiagnosis is not measured. The





world literature doesn't present error rates. This would be what I would consider an error rate, that an erroneous diagnosis was acted upon surgically, leading to this complication of regret and a -- and a desire for reversal. Yeah.

Q. Your expert testimony is that there's no data available on the percentage of people who have received treatment for gender dysphoria who experience regret?

A. Yeah. It's very, very low -- low-level evidence right now. It's basically we're in the -- we're in the case collection study, whereas actually in the -- well, that's not regret. But -- but perhaps in the category of misdiagnosis would be the -- the reports out of Sweden, certainly the -- yeah, so beginning with the Swede -- Swedish studies by Cecilia Dhejne and others that shows us a lack of efficacy. Whether or





not the patient presented for reversal is definitely an unknown number, definitely.

Q. All right. That study doesn't quantify anything about patient regret; right?

A. The Swedish study does not. It quantifies lack of -- of effect from the surgical interventions. Lack of benefit, I should say.

Q. Go to page -- PDF page 7 of this document and look at the Conclusions --

A. Okay.

Q. -- section.

A. All right. Let's see that page. Conclusions. Okay. I'm there.

Q. The first sentence says, "The vast majority of properly diagnosed transsexual patients are satisfied with their decision to undergo SRS, with only a few coming to regret it." Right?

A. Right. So this -- the other reason why this study is useful to our conversation is that this is the same





language and the same metrics that's used to describe the success of cosmetic surgery. They don't include in here, apart from the regret number that they're actually publishing here -- not number but the examples, I should say. They don't include in their -- in their conclusions any statement about objective quantifiable benefit from the surgery. They talk about subjective reporting.

So this is an example of a -- of a peer-reviewed journal article that measures the efficacy of this surgery based solely upon a satisfaction survey of patients who have returned for follow-up, so this would be an example of that. Yes, sir.

Q. Do you know what metric was used to measure satisfaction or nonsatisfaction in these studies?

A. I'd have to reread the -- the methods and materials here, but I would -- I would guess it was one of the

approved instruments for measuring satisfaction. There are a variety of test instruments used for -- in satisfaction surveys, particularly in the world of plastic surgery.

Let's see. They used the -- these are the kind of things I don't keep in my long-term memory here for a particular article. Okay.

(Witness reviews document.)

A. Okay. There's the outcomes measures. Forgive me for eating up your time.

Q. Let me -- let help you, Doctor. Go to page --

A. Okay. There it is.

Q. -- PDF page 5.

A. Yeah. Fif- -- yeah.

Q. Yeah.

A. Fifteen, right.

Q. Question on the page --

A. So there's a -- there's a test instrument there. Right.





Q. Yeah. There's a test instrument that measures things like erectile function, sexual desire, orgasmic function, intercourse satisfaction, and overall satisfaction; right?

A. Right.

Q. They don't just ask the patient, "Hey, are you happy with the surgery?" There's five criteria that are applied; right?

A. Right.

Q. This is an approved instrument for measuring this type of satisfaction for surgery; right?

MR. KNEPPER: Objection, form.

A. This is -- this is -- yeah, it's definitely a valuable instrument for measuring things, but none of them are the -- are the indication for surgery, which is things like reduced suicidality, reduced self-harm, reduced alcohol use, all of those other things which are -- which are the reason, the indication for





the operation. So you generally try to match the surgical procedure with the indication for the surgery.

They're measuring things that weren't involved in the indications for surgery. They didn't get, you know, reconstructive surgical approval so that they could achieve erections, for example. This was approved because of the risk of self-harm, suicide, those sorts of things. Yeah. But none of those are measured. They -- it is -- it is they do have objective measures, and this is one of the -- one of the values of this study. But I don't think they report the complication rate in this study, as I recall.

Q. This -- this study specifically did not purport to seek out anything about suicidality or mortality or other adverse outcomes of that nature; right?

A. Let's see. I'm trying to remember in their introduction.





(Witness reviews document.)

A. Yeah. I think their indications used language that was more consistent with -- with aesthetic, aesthetic surgery rather than the reconstructive language. So yeah.

(Witness reviews document.)

A. Yeah. So --

Q. Yeah. Here's --

A. Yeah, I would --

Q. Here's what I find interesting, Doctor.

A. Okay.

Q. Your report cites this one case series of seven patients to make the point that there's this regret occurring without even mentioning that there's multiple case series that say the vast majority of these patients end up being satisfied with this type of surgery?

A. No. I don't think --

Q. You don't think that's appropriate to mention?

A. No. I -- actually, what I present these examples to show, that -- that the literature in support of these surgeries is characterized by very short follow-up and subjective reporting. So this is an example of some objective reporting, mostly subjective reporting. And most of the articles, for example, that you just asked me about involve subjective reporting and short follow-up. That's right, yeah.

Q. All right.

A. And in this case, you also -- I'm -- I'm pleased that they reported that one, two, three, four, five, six, seven -- so nearly half of their patients had a surgical complication of a urethral fistula, and if you have a urethral fistula and you have a malleable prosthesis, probably they went on to remove the prosthesis as well. But that's -- I mean, I -- props for this -- this team that they reported their







complications.

Q. Where -- what page is the complications portion you're looking at?

A. That's on -- just before you get -- the last page before the -- the same page as the conclusions. There's a table at the top, and they have the seven patients, and you can see -- what's also interesting here, too, is -- is that if you look at the period after sex reassignment surgery, that the -- that the dissatisfaction level really kicks in when you're beyond eight years. Actually, if you look at even six years beyond.

Initially, there's no patients reporting dissatisfaction at anything less than five years, and so this is actually further evidence of the -- of the inadequacy of the -- the papers that are in the literature right now which have follow-ups that are typically two to three years. So none of these patients







would have been seen, with most of the literature that supports these techniques, as a way to, you know, avoid -- avoid dissatisfaction or -- or suicidality or drug use or anything else like that. So that's an interesting -- I hadn't noticed that before, but yeah.

Q. Yeah. Are you reading Table 1 to say that these complications like urethral fistula and stricture were from the original surgery?

A. Well, I'm -- I'm merely --

Q. Or is it from the reversal surgery that was being done later?

A. So they're talking here about flaps. They're talking about complications from the -- the -- the surgeries. Yeah. So this --

Q. Yeah. This is --

A. They're speaking about urethral fistulas and strictures are the main problem after total phalloplasty. So that's the construct of the counterfeit







phallus because of insufficient vascular supply. I also discuss that in my complications section. These are characteristic complications of these free flaps, radial forearm free flaps, and you see those complications here. And you even see them later in -- in the case, so. Some of them are step procedures. In fact, all of them are.

Q. All right. Let me -- let me show you another study.

A. Okay.

Q. Let me reintroduce this with an exhibit -- exhibit stamp. Give me a second. All right. I'm reintroducing this as Exhibit 20. Let me know when you have it.

(Exhibit 20 was marked for identification and is attached.)

A. I just got Exhibit 19. Is there another? There's a 20 to follow?

Q. It -- it should load momentarily. Yeah.

A. Oh, I'm sorry.
MR. KNEPPER: Are 19 and 20 the same, just one's missing the little stamp?
MR. TISHYEVICH: Correct.
THE WITNESS: Okay. I'll just go to 20, then, when it comes in.
Q. Okay. This is a study titled "The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets." Do you see that?
A. I do.
Q. And then it's by an author, let's say Wiepjes, W-I-E-P-J-E-S.
A. Yeah.
Q. Right?
A. I agree.
Q. Have you seen this study before?
A. I'm trying to gloss it to see if I've read this before. I -- I may have. Give me just a moment, if that's okay.
Q. Sure.





(Witness reviews document.)
A. Yeah, this looks familiar.
Q. I don't think I saw this in your report, but tell me if you remember otherwise.
(Witness reviews document.)
A. Yeah, no. I remember this being evidence of the growing population of self-reported transgender patients, and it's a retro- --
Q. Okay. Let me --
A. -- retrospective trial. Yeah.
Q. Yeah. Let's go through this.
A. Retrospective study, I should say.
Q. All right. You see the "Abstract" section on the first page?
A. I do.
Q. See the "Results" section?
A. I do.
Q. It says, "6,793 people (4,432 birth-assigned male, 2,361 birth-assigned female) visited our gender identity





clinic from 1972 through 2015." See that?
A. I do.
Q. All right. So you understand that as part of this study, the authors reviewed medical records of 6,793 people who visited this gender identity clinic from 1972 to 2015; right?
A. I do.
Q. All right. And you see the "Strengths and Limitations" section?
A. Yes, I do.
Q. And you understand that this Dutch gender identity clinic treats more than 95 percent of the transgender population in the Netherlands; right?
A. Right.
Q. Pretty comprehensive study; right?
MR. KNEPPER: Objection, form.
A. As of 2015, yes. So it's a 7-year-old study, and it's -- it's certainly large in numbers, that's for





sure. So it's a retrospective chart review of patients visiting the -- the center in the Netherlands, and it's -- it concludes in 2015.
Q. This is certainly a better study than that seven series case report that you cited in your report; right?
A. It's a different type of study. Yes, it is. Right.
Q. Yeah. This study reports on 6,793 people, whereas the case series on which you rely has seven what you call anecdotes; right?
A. I wouldn't say I relied on that study. I merely presented it as an example of -- of reporting on transgender regret. I didn't present it as a study that I relied all my opinions on. Certainly, there's other study types and other studies in the literature that -- that one might rely more heavily on.
Q. Well, let the --
A. A retro- -- a retrospective

chart review, for example, might be more useful.

Q. Yeah.

A. But not -- not definitive. And again, we've got to examine the fact that we're looking at old data here.

Q. Well, let's see what this 30-year retrospective review found. Look at the "Results" section.

A. Scroll down. Okay.

Q. Look at the last two sentences. "The percentage of people who underwent gonadectomy within 5 years after starting HT remained stable over time" --

A. Right.

Q. -- "(74.7% of transwomen and 83.8% of transmen). Only 0.6% of transwomen and 0.3% percent of transmen who underwent gonadectomy were identified as experiencing regret." Do you see that?

A. I do. And that has caused me to want to look back and see -- okay. So





they started with the 6,800, roughly, and they report on 6,000 -- 7,000 almost. Okay. And clinic. Okay. And increase.

So I'm just trying to see if they reported the average follow-up. They're reporting when they underwent gonadectomy after starting hormone therapy, but they don't report the length of follow-up, which is one of the key reporting points there, because regret, as we talked about earlier, is a -- tends to be a function of time postsurgically. So, let's just scroll down because it's been a long time since I looked at this article. Transwomen, transmen total underwent gonadectomy.

Yeah. As I recall, they don't report average follow-up time. Every five-year cohort. So they're looking -- they -- they did look at when they entered the system. Prevalence and treatment. Confidence interval.

Yeah, as I -- yes. So I think





that's -- this is coming back to me now. I think they didn't report the average follow-up or the -- let's see if I'm missing something here. Age for each year, so they did break them out in age that they -- they entered the -- the process, the years during which they entered the process, age groups. And yeah, I think that's -- that was one of the -- one of the issues.

And this is -- consonant with -- with a lot of the literature, is they don't report the follow-up interval. And that's what the Swedish study is showing us, that if -- if you don't have a handle on the length of follow-up after sex reassignment surgery, then you don't have a -- you don't have any way to fully understand the issue of lack of efficacy or regret.

If you're asking the questions is the surgery effective in correcting the most calamitous problems that a





transgender person has, which is suicidality, self-harm, and all those things that we talked about earlier, then you have to look at the interval postsurgery in order to have a full understanding of the efficacy of the procedure. And as I recall now, looking it over again, this study does not report on the follow-up period. The median age at first visit was younger, 25. Yeah. So they talk about age. They talk about the years in which they were cared for, but they don't talk about the length of the follow-up interval, so.

Q. All right. Let me move on --

A. Okay.

Q. -- to save time.

A. All right.

Q. Go to page 4 and where it says "Regret."

A. Okay.

Q. You with me?

A. I am.

Q. Third sentence says -- fourth sentence says, "Reasons for regret were divided into social regret, true regret, or feeling non-binary." You see that?

A. I do.

Q. And social regret -- strike that.

It says, "Transwomen who were classified as having social regret still identified as women, but reported reasons such as 'ignored by surroundings' or 'the loss of relatives is a large sacrifice' for returning to the male role." Do you see that?

A. I do.

Q. All right. So some of the persons who are being counted as experiencing regret in the study did not experience regret in the sense of they're realizing they're not transgender; right?

A. Realizing they're not transgender? I'm -- I'm trying to understand your question here. So you're





-- you're pointing me to the -- social regret, true regret, feeling non-binary is what's stated here.

"Transwomen who were classified as having social regret still identified as women, but reported reasons such as 'ignored by surroundings' or 'the loss of relatives is a large sacrifice' for returning to the male role."

Okay. Yeah. So -- so it's -- it's reporting without quantifying the reasons for regret and the -- basically all of them, subjective reporting again, so -- okay.

Q. Well -- well, let's go to page 6.

A. That's the next page, isn't it? Am I on the right page?

Q. On page 6, it has a large vertical table on the left side.

A. Okay. There we are.

Q. And you may want to rotate it so that you can see that table 6.





A. When I got -- let's see. There's a way to do that, isn't there?

THE COURT REPORTER: Yeah. If you put your cursor over the document, a black rectangle will come up at the bottom.

THE WITNESS: I see it now. Yes.

THE COURT REPORTER: There you go.

THE WITNESS: All right. There we are.

Q. Table 4 is titled "Characteristics of people with regret."

A. Okay.

Q. According to this table, out of 6,793 patients who received treatment, 14 of them reported regret of any type; right?

A. Okay.

Q. And all the way on the right, you see there's a "Reason for regret" column; right?





A. Right.

Q. And you're welcome to count it, but by my count, only 7 of those 14 reported, quote, unquote, true regret; right?

A. Yeah. And what's interesting about that is that those are the same criteria that were used to seek transgender surgery to solve their interior problems. So many patients will present for care because they feel socially isolated and because they have, you know, issues of -- well, for example, being non-binary and so on, those -- those -- like social acceptance and feeling non-binary is among the indications for the procedure. So it's interesting to note also that time after surgery, the regretters seem to favor -- postsurgical, you start to see them, what, maybe 50 to 90 months out and a lot of them, years -- ten years out. Yeah. So that -- that speaks to what we talked

about earlier, that you see these regrets and these problems beyond five years.

Q. All right. Whatever criticism you have of the methodology, what the study reports is -- are rates of regret that are below 1 percent; right?

MR. KNEPPER: Objection, form.

A. Yeah. Again, so as we talked about earlier, that's the problem with this study, is that -- is that the -- the denominator is a much larger number than these 14 patients, and they don't address the length of follow-up out of which they extracted these 14 patients. So it makes it difficult to interpret the study, and the claim that it's a small number is hard to support by their own evidence because they didn't follow them long enough. As their own data shows, you got to follow them longer to see the regret in most patients. And they don't tell us what that number is.

Q. Are you aware that there are







studies on patient regret outside of the treatment for gender dysphoria?

A. Am I aware of -- of transgender transition regret outside of --

Q. No. I'm going to ask -- I'm going to ask this again.

A. I'm sorry.

Q. Are you aware there are studies on rates of patient regret outside of surgical treatment for gender dysphoria?

A. Yes. Absolutely, yeah. So --

Q. Okay.

A. One of the -- one of the most important --

Q. Okay. Let me ask -- yeah, Doctor, let's -- this is going to be a long day. Just listen to my questions.

Did you do a literature search to find out what the average rates of patient regret are for other surgical procedures compared to surgical treatment for gender dysphoria?

A. I did not.







Q. Do you know if those rates are higher, lower, or about the same as the rates of regret for surgical treatment for gender dysphoria?

A. I would say there's no way of knowing because we don't have the -- the rate of regret in transgender regretters. We don't have that number, so there's no way to compare or to know which is the higher number.

Q. Okay.

A. Like we talked about earlier, we don't have this number.

Q. Well, this one study I just showed you showed a finding of 0.3 percent to 0.6 percent; right?

A. Right. And I -- and as I said, this is -- this is -- it's difficult to use this to compare to other regret cases because of the poor quality of this study. So I can't use this to compare it to the other studies on regret because this is not -- not useful to that end. I







mean, it's useful in seeing that 14 -- 14 regretters had these complications, 14 regretters had these -- these explanations for their regret.

And so it's kind of like a case collection, and retrospective reviews of -- of patient records are helpful in getting a sense of the size of the problem. Certainly, this study shows us that there's an increasing patient pool of people who self-identify as transgender. So in that regard, this publication is very useful. But in terms of comparing the regret rate based on this paper, I'd say this paper is useless.

Q. Okay. Open Exhibit 21.

(Exhibit 21 was marked for identification and is attached.)

A. Okay.

Q. Let me know when you have it.

A. Okay.

Q. All right. This is a

publication from 2017 by Wilson, W-I-L-S-O-N, titled "Regret in Surgical Decision Making: a Systematic Review of Patient and Physician Perspectives." See that?

A. I do.

Q. All right. Look at the abstract. You with me?

A. I'm -- I'm looking -- I'm just reading it now.

Q. The third sentence says, "We performed a systematic review of the literature focused on patient and physician regret in the surgical setting." See that?

A. I do.

Q. Now look at "Results." See that?

A. I'm there now, yes.

Q. It says, "Of 889 studies identified, 73 patient studies and 6 physician studies met inclusion criteria." Do you see that?





A. I'm reading it now, yes.

Q. I understand this is a systematic review of 73 patient studies and 6 physician studies on regret and surgical decision-making; right?

A. That's what it says here, yes.

Q. Then the third sentence of "Results" says, "Interestingly self-reported patient regret was relatively uncommon with an average prevalence across studies of 14.4%." Right?

A. Right.

Q. And then "Conclusion" says, "Self-reported decisional regret was present in about 1 in 7 surgical patients." You see that?

A. I do.

Q. All right. So according to this systematic review, one out of seven surgical patients, on average, report having decisional regret; correct?

MR. KNEPPER: Objection, form.





A. Right. So actually, I would go a little deeper than that. The first thing to note about this study -- and again, this is my first reading of it, so I'm on the fly here.

The first thing to note about it is that they looked at nearly 900 studies, of which only 73 qualified as having sufficient validity to include in their study. So this -- this speaks to a problem in the literature. I'd have to read lower to see what particular -- if they even examined what kind of surgeries were performed, because regret can happen for a number of reasons, including postsurgical complications and so on, types of surgery.

Q. We don't need --

A. Yeah.

Q. We don't need to dig into this too deeply. But, I mean, you don't dispute that regret is not uncommon for patients who have any kind of surgical





procedure; right?

MR. KNEPPER: Objection to form.

A. No. You know, there's -- there's -- it's such a life-changing event that the potential for regret is very high, so that's why you have to be careful in consenting the patient.

Q. Okay. Let me -- let's go back to your report.

A. Okay.

Q. Because I hear you criticizing all this evidence, and I want to see the stuff that you're relying on. Go to page 22.

A. All right.

Q. All right. About halfway down this paragraph, you say, "As reported by one author in 2021, 60,000 testimonies of personal de-transition can be found on the Internet."

A. Yeah, that's a typo. That's a typo. That should have been 16, not 60.

Q. Okay. Well, I think it's more

than that.
A. Okay.
Q. So we'll look at this in a second.
A. Sure, sure.
Q. And you cited this article from Pablo Exposito-Campos.
A. Yes.
Q. E-X-P-O-S-I-T-O, dash, C-A-M-P-O-S. Right? That's what you rely on; right?
A. Not relying. I'm basically just putting that out there as an example of a growing number of patients regretting transitioning, yeah.
Q. Well, no. What you say in your report is that according to this publication, you can find 60,000 -- or let's call it 16,000 testimonies of personal de-transition on the Internet; right? That's the point you're making?
A. Sixteen thousand, right. Yeah.
Q. Let's look at what that article





actually says.
A. Okay.
Q. Okay. This is going to be Exhibit 22. And let me know when you get it.
A. Doesn't seem to be coming through.
Q. Yeah, it may be stuck on my end. Okay. Just went through, so you should see it shortly.
(Exhibit 22 was marked for identification and is attached.)
A. There it is. Okay. Right.
Q. All right. This is the article that you're citing in your report; right?
A. Uh-huh.
Q. All right. So before we get there, you know that what this author was talking about was a Reddit website; right?
A. Yeah. That was -- that was their data source, yeah. Right.
Q. Reddit is not a peer-reviewed





publication, obviously; right?
A. Clearly.
MR. KNEPPER: Objection.
A. Yeah.
Q. Right?
A. Yes. It's not a peer-reviewed.
Q. It's a social website that anyone can access; right?
A. Right. Correct.
Q. Anyone can post -- can register an account on Reddit and post whatever they want; right?
A. Right.
Q. A post on Reddit is not something that you would consider reliable scientific evidence, I assume; right?
A. Yeah, no.
MR. KNEPPER: Objection, form.
A. I would -- I would put that as self-reporting anecdotal-level evidence, that's right. So it's -- it's not definitive, but it's suggestive of an





area in need of examination. And that's the reason I include it here, is not as definitive evidence of a particular level of problem but the -- the presence of a problem that needs to be addressed. So the substance of my testimony there where I call this study up is to show that there's a growing body of patients, as we talked about earlier, a growing body of patients who regret their transition and are seeking reversal. So that's what this is about.
It's not a quantification of the phenomenon. It's not a level 3 evidence of the phenomenon. It's a level 5, self-reported, anecdotal stuff that -- that is basically just calling us to look more carefully at what promises to be a controversial area of medical care. So this is just part -- part of the controversy is what we're looking at here. We're not looking at a definitive scientific document, so.

Q. It's not even level 5 because at least a case report that's published in a peer-reviewed journal has someone looking at that case report to figure out if it's a real thing; right?

A. Right.

MR. KNEPPER: Objection, form.

A. What we have here is a clinical psychologist who's looking at something going on online, and the clinical psychologist is -- is reporting this, that's right.

Q. Go to page 4 of this article.

A. One, two, three, four. Okay.

Q. See there's a second paragraph under "Further clarifications"?

A. Yes, I do.

Q. All right. And it references this Reddit/detrans subreddit; right?

A. Right.

Q. And it says it's "a subreddit for detransitioners to share their experiences with more than 16,000





members."

A. That's correct.

Q. Right?

A. Uh-huh.

Q. Then it says, "one can find several stories of people who call their transgender status into question." You see that?

A. Right.

Q. All right. This author is not saying that there's 16,000 separate testimonies of people tran- -- detransitioning on that subreddit; right?

A. I think the author is saying that there's a pool of 16,000 people among whom are evidence of regret or cessation of transition. That's what -- I think that's what the author's saying.

Q. Well, let's be more specific, because what he actually says is "one can find several stories." Right?

A. Right.

Q. There's a very big difference





between, quote, several stories and 16,000 stories of detransitioning; right?

A. I think what the author is saying is that -- that there are -- let's see. Subreddit -- detran- -- experiences -- more than 16- -- one can find several stories of a particular kind of transgender -- persons who call their transgender status into question after stopping transition.

So the several stories have to do with people who call their transgender status into question. Not people who regret the surgery, but these are people who regret the diagnosis. So he's talking about several stories of regretters of the diagnosis. It doesn't speak about regretters of the transition. He doesn't address that in that.

Q. All right. A bunch of posts on a social website is not scientifically reliable evidence to show the number of different people who actually





detransition; right, Doctor?

MR. KNEPPER: Form.

A. Yeah. As we said before, we have no way of -- at present, of knowing the number of people.

Q. Okay. Go back to your report.

A. Okay.

Q. Go to page 40.

A. All right. Okay.

Q. All right. Your first paragraph at the top of this page says, "A currently unknown percent-" -- "percentage and number of patients reporting gender dysphoria are being manipulated by a -- peer group, social media, YouTube role modeling, and/or parental -- social contagion and social pressure processes." Right?

A. That's right.

Q. I take it you're not aware of any peer-reviewed studies that quantifies the number of people with gender dysphoria that are being, quote, unquote,

manipulated by social contagion or social pressure; right?

A. Again, as I said before, we don't know the numbers because that's not -- it's not adequately reported in the literature. But what we do know is that the social -- Lisa Littman's article, for example, in 2017 shows us that there's a significant factor in this new demographic of self-reported transgender patients, the new demographic being adolescent to young adult females without prior history of gender dysphoria or gender discordance suddenly reporting transgender self-identification.

And -- and what it shows us, what Lisa -- Lisa Littman's publication from Brown University shows us is that underlying these outbreaks is peer group networks of people online, peer groups online, social media, a modeled speech, a rehearsed speech, and -- and these -- these sudden outbreaks of -- of





self-identified transgender patients.

So we know it's there, but we can't quantify it yet. It's just it's -- but it's -- we have at present no other explanation for why the demographic of self-reported transgender patients has suddenly shifted from virtually all young boys to 50 to 60 percent of the new cases being adolescent to young adult females. And that's -- that's what we're -- what we're talking about here. This just speaks to the controversial nature of this -- medical and surgical interventions is that we don't even understand the origin of that phenomenon. And -- and what that Littman article shows us is precisely these things: that there's an element of social contagion, that there's peer pressure, there's rehearsed speech, online networks that cause these outbreaks of these new kind of patients, adolescent young adult females who previously had no





self-reporting of trans- -- cross-sex self-identification.

MR. TISHYEVICH: This is not responsive to my question, and I move to strike it.

Q. Here's my question, Doctor. You are not aware of any peer-reviewed study that quantifies the number of people with gender dysphoria who are being manipulated by social contagion or social pressure; correct?

A. No. We're at the -- we're at the level of level 4/5 evidence now. Lisa Littman's article is a level 5, possibly 4. A level 5. So --

Q. It's not a -- you're also not aware of any peer-reviewed study that quantifies the percentage of people with gender dysphoria who are being manipulated by social contagion or social pressure; correct?

A. No. That's part of the -- part of the problem with the literature.





Exactly right.

Q. Yeah.

A. Exactly right.

Q. Given this lack of reliable studies, do you agree that this phenomenon of social contagion is currently hypothetical?

MR. KNEPPER: Objection, form.

A. I would not agree with that. It's not hypothetical.

Q. Do you -- did you read the response from Lisa -- from Littman to the criticisms to that article?

A. I did. And -- and I also noted that the -- the -- the organization under which she published that article put considerable pressure on her. But she can't retract her data. She can retract her conclusions, but she can't retract her data, and she can't retract the findings in the paper itself that show the rehearsed speech, that show the networks that are involved, that showed

the -- the character of the -- the rehearsed speech, like, you know, if you're talking to the psychologist, tell them you've been thinking about suicide; if you're talking to the endocrinologist, tell them you feel better now that you're started on T, that sort of stuff. So -- so it's not hypothetical, it's actual.

The -- the size of the phenomenon can only be compared to the change in the demographic. Why are 60 percent of patients fitting into that category suddenly, whereas before, only 20 percent of patients were females?

Q. Do you remember --

A. That's what --

Q. Okay. Do you remember the part of the correction from Ms. Littman where she said that this is a hypothesis-generating article?

A. Hypothesis as to -- as to mechanism of -- of action, and some of the hypotheses are what's listed there:







social network peer -- media -- I'm sorry -- peer pressure, social media, role modeling, social contagion. So she admits that is a -- it is not understood. She admits that those phenomena are there, but it -- at present, we're hypothesizing about the actual cause. And this speaks again to the controversial nature of even the diagnosis, much less the treatment.

Q. Go back to your report.

A. Okay.

Q. Page 40.

A. I'm there.

Q. Toward the bottom, you say, in capital letters, "Not Generally Accepted." You see that?

A. I do.

Q. And you say, "Affirmation medical treatments -- hormones and surgery -- for gender dysphoria and transitioning have not been accepted by the relevant scientific communities." Do







you see that?

A. I do.

Q. It's your expert opinion that it's generally accepted that puberty blockers are not medically necessary; right?

A. No.

MR. KNEPPER: Objection, form.

A. I would say puberty blockers in the setting of a self-identified transgender is not medically necessary, but puberty blockers are often medically necessary, just not in that particular patient population.

Q. Is it also your expert opinion that it's generally accepted that hormone treatment for gender dysphoria is not medically necessary?

A. Well, the scientific evidence now shows that it is -- is not useful. That's what I said --

Q. Answer my question. Is it your expert opinion that it's generally







accepted that hormone treatment for gender dysphoria is not medically necessary?

A. Yes.

Q. Is it also your expert opinion that it's generally accepted that gender-affirming surgery for gender dysphoria is not medically necessary?

A. Yes. I would say so, yeah. I can't put a number on it, but yeah.

Q. All right. Let me -- let me show you another document. Okay. Let me introduce this. Okay. This is going to be Exhibit 23. And let me know when you get it.

(Exhibit 23 was marked for identification and is attached.)

A. Okay. All right. I'm there.

Q. Okay. Top of the page says, "BlueCross BlueShield of North Carolina." Right?

A. Correct.

Q. You know what Blue Cross and

Blue Shield is; right?
A. Right.
Q. It's a healthcare insurer; right?
A. Yes.
Q. Are you aware that Blue Cross Blue Shield is the largest private insurer in the state of North Carolina?
A. I am now.
MR. KNEPPER: Objection, form.
Q. All right. This document is titled "Corporate Medical Policy," "Gender Affirmation Surgery and Hormone Therapy." Right?
A. Right.
Q. Do you know what this is?
A. Do I know what what is?
Q. Do you know what this document is?
A. It appears to be an insurance company document concerning the coverage of certain services. I would have to read it to know what it is specifically,







but I think it's probably a policy statement about what is covered and what is not covered and what the diagnostic criteria are.
Q. Yeah.
A. What the policy of the company is. Yeah. So, shall I read it or?
Q. I'll walk you through it.
A. Okay.
Q. You see it says "Last Review" near the top?
A. Right.
Q. It's 3/2021. That's March 2021; right?
A. Yes.
Q. All right. You understand this policy was a -- strike that.
In your report, you cite a number of articles that you say Dr. Brown and Dr. Schechter overlooked, like a bunch of 2020 articles; right?
A. Right.
Q. You understand this was







published -- updated after all those studies that you cited were published; right?
A. It appears to be.
Q. Okay. Go to page 7. You see it says "Scientific Background and Reference Sources"?
A. Right.
Q. You understand this section of the policy provides some of the scientific background on which the policy is based; right?
A. I see that, yes.
Q. And if you go to page -- the next page, page 8, you see there's a bunch of references to Specialty Matched Consultant Advisory Panel; right?
A. I see that, yeah.
Q. And there's some references to sen- -- Senior Medical Director reviews; right?
A. I see that, yeah, from 2016.
Q. Yeah. Well, if you keep







looking, there's a bunch from 2020; right?
A. I see medical director review in 2020. Yes, I do. I see that.
Q. And then including a medical director review in March 2021; right?
A. I see it. That's probably what generated this document. Am I right?
Q. Yeah. Good guess. Now, obviously --
A. That's why they pay me the big bucks. Sorry.
Q. Obviously, you had no involvement with the development of this policy from BlueCross BlueShield of North Carolina; right?
A. Correct.
Q. You have no idea how BlueCross BlueShield of North Carolina came to decide what gender affirmation surgeries or hormone therapy they're going to cover or not; right?
A. Wrong. I -- I have now some

idea of what they used because you've listed -- or they've listed the scientific background and reference sources for coming to their company policy. And what I would point you to is the fact that every one of the documents, the scientific documents that support their decision-making, I think the most recent one is 2014. You've got some that go back to the year 2000. So you've got 21-year-old DSM-4 characterizations. You've got 2001 Harry Benjamin Gender Dysphoria Association publications. The most recent thing is a -- is a -- well, that's actually an advisory panel. So the most recent medical article is the Cohen-Kettenis Hembree article from 2016. So what's used to support a March 2021 document is essentially six-year-old information. And as we talked about earlier, it hasn't -- it's changed a lot. It's changed a lot since then.

The fact that Blue Cross Blue





Shield is slow off the mark would be troublesome to the shareholders, I suppose. But as far as what I'm here to talk about, the scientific basis for this, the scientific basis is old data.

Q. Doctor, you don't know whether this is an exhaustive list of every scientific resource that Blue Cross Blue Shield considered in making the March 2021 update; right? You have no idea?

MR. KNEPPER: Objection, form.

A. I can only go by what they've disclosed.

Q. Right.

A. And what they've disclosed -- which I would assume they would be leading with their best information rather than their worst -- I would call that -- the scientific support of low quality because of the -- the better-quality data that's now available in the last three years.

Q. You don't know personally





whether Blue Cross Blue Shield considered any of the articles that you've cited when they're making this policy change in 2021; right? You don't know that?

A. I have no way of knowing how --

Q. Yeah.

A. -- that committee worked. I only -- I only assume that they would have put out their best scientific support rather than their weakest.

Q. Yeah. Bottom of this page, by the way, see there's a section that says, "Policy Implementation/Update Information"?

A. Yes, I see that.

Q. And it says, "7/19/11" --

A. Yeah.

Q. -- "New policy developed." Right?

A. Right.

Q. You understand that Blue Cross Blue Shield has had some form of this policy for gender affirmation surgery





since July 2011?

MR. KNEPPER: Objection, form.

A. I can see that they have had a policy, according to their own reporting, since July of 2011.

Q. All right. So, let's look at what Blue Cross Blue -- Blue Cross Blue Shield thinks about whether these procedures are medically necessary. Go to page 5.

A. Let's see. So we're at page 8. We're going up to page 5? Okay. Okay.

Q. Give me a second. Actually, let me start you on page 1. You see there's a description of -- let me know when you get there.

A. I'm there.

Q. Okay. Now, the beginning says, "Gender Dysphoria is the formal diagnosis used by professionals to describe persons who experience significant gender dysphoria (discontent with their biological sex and/or birth gender)."

Right?
A. Yes, I see that.
Q. All right. You understand what this policy is addressing; right?
A. Yeah. It's addressing a psychiatric classification, not medically classified as a medical illness. So they're -- yeah.
Q. Okay. Go to page 2.
A. Can you give me just a moment to reread that sentence for just a second.
(Witness reviews document.)
A. Okay. Yeah. So that's boilerplate. I'm sorry. Sorry for slowing you down here.
Q. That's fine. Go to page 2.
A. Okay.
Q. Top of the page says, "Policy." Right?
A. Correct.
Q. And it says, "Services for gender affirmation surgery and hormone therapy may be considered medically







necessary when the criteria below are met." You see that?
A. Right. So that's -- that's language that insurance companies use. If you're not in the category of medical necessity, there's no insurance coverage. So whether or not one could classify it as a medical diagnosis is not at issue. What's at issue is, is the insurance company going to cover this -- this benefit.
Q. Yeah. Because insurers typically are not in the business of covering services that are not medically necessary; right?
A. No. I wouldn't --
MR. KNEPPER: Objection, form.
A. -- characterize it that way.
THE WITNESS: I'm sorry.
A. I wouldn't characterize it that way. Insurance companies are in the business of -- certainly, they're in the business of -- of paying for covered







benefits. But that's the problem with the insurance industry, is their primary fiduciary duty is to their investors. And so the question of coverage has more to do with are we going to make an insurance policy that earns us money or are we going to be paying for something and not seeing the money. Okay? Does that make sense?
Q. Doctor, you --
A. I think that's what -- that's what this language here is talking about is -- is medical necessity is the language that's used when an insurance company will cover. They will not cover cosmetic surgery, but they're -- they're proposing to cover transgender surgery beginning by attempting to define it as a medical diagnosis. That's what's at stake here is.
Q. No. What -- what this policy says is that when certain criteria are met --







A. Right.
Q. -- gender affirmation surgery and hormone therapy may be considered medically necessary; right? That's what it says in black and white.
MR. KNEPPER: Objection, form.
A. Yeah, again, so medically necessary from the standpoint of an insurance company is if you meet these criteria, we'll pay for it; if you don't meet these criteria, we won't pay for it. That's -- that's --
Q. Right. And the difference is whether the surgery is considered to be medically necessary or not; right?
MR. KNEPPER: Objection, form.
A. Well, again, so medically necessary in this case is has the insurance company decided that they're going to cover this benefit. It says nothing about the scientific support for the efficacy of the procedure. They haven't said anything in that about it.

They've just called it medically necessary.

Q. All right. Let's -- let's go off the record.

A. Okay.

THE VIDEOGRAPHER: This is the end of Media Unit No. 5. We are off the record at 3:25 p.m.

(Break taken.)

THE VIDEOGRAPHER: This is the beginning of Media Unit No. 6. We are on the record at 3:36 p.m.

Q. (By Mr. Tishyevich) All right. I'm going to introduce another exhibit, Doctor.

A. Okay.

Q. It's being slow on my end. Bear with me. Okay. This will be Exhibit 24. Let me know when you have it.

(Exhibit 24 was marked for identification and is attached.)

A. I will. Okay. I've got it.

Q. Okay. You've seen this study







before; right?

A. Yes, I have.

Q. How do you pronounce the lead author's name?

A. That's the subject of great debate, but I think it's Dhejne or -- I think it's Dhejne, Cecilia Dhejne, but I -- I -- I'm not -- I'm not a Swissophone.

Q. I'll use Dhejne as well.

A. Okay.

MR. TISHYEVICH: And for the court reporter, it's D-H-E-J-N-E.

Q. Okay. This is a study from 2011; right?

A. Yes.

Q. And you cited this study in several places in your report --

A. I do.

Q. -- right?

And one of the points for which you cite this study is to say that Swedish patients who underwent







gender-affirming surgery had a 19.1 times greater suicide rate than the control group; right?

A. Yeah. The hazard ratio for -- well, for all reassigned persons is 19.1, and they further break out the -- that into subgroups of female-to-male and male-to-female.

Q. Yeah. And you understand how the control group in this study was defined; right?

A. Yes.

Q. The control group did not consist of patients with gender dysphoria who did not undergo gender-affirming surgery; correct?

A. Correct.

Q. The control group consisted of patients without gender dysphoria; right?

A. Yeah. That's kind of the point of the -- of the research, yes. That's right.

Q. Yeah. What this Dhejne study







compared was the suicide rate for patients who underwent gender-affirming surgery against the general Swedish population; right?

A. Right.

Q. And you know there's many studies that find that patients with gender dysphoria, as a population, have a higher risk of suicide compared to the general population; right?

A. Very much accepted fact, yes.

Q. Yeah. All right. We'll go to page 7.

A. Let's see here.

Q. You see there's a "Strengths and limitations of the study" section?

A. Two, three, four, five, six, seven. Yes, I'm there.

Q. All right. Look at the third full paragraph in that column.

A. Okay.

Q. All right. Second sentence says: "The caveat with this design is

that transsexual persons before sex reassignment might differ from healthy controls (although this bias can be statistically corrected for by adjusting for baseline differences). It is therefore important to note that the current study is only informative with respect to transsexual persons health after sex reassignment; no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism."

You see that?

A. Right. Yeah.

Q. Then it says: "In other words, the results should not be interpreted such as sex reassignment per se increases morbidity and mortality. Things might have been even worse without sex reassignment." Correct?

A. Yeah. It's -- the -- let's see. The -- yeah, so -- and I don't think I ever make the claim that the surgery





increases the risk of morbidity and mortality. Yeah, I -- I would agree with that.

Q. Yeah, no --

A. But I would -- I would also wonder on what basis they -- there's nothing to support that it might have been worse either. It's for the same reason.

Q. Yeah. This study does not support the conclusion that sex reassignment surgery by itself increases risk of suicide; correct?

A. That's what they -- they say, yes.

Q. And they also say that this study does not support the conclusion that surgical procedure for gender dysphoria by themselves increase risk of morbidities other than suicide; right?

A. Right.

Q. Okay. All right. Let me -- you mentioned that -- in your report the 2020





Finland guidelines. You recall that?

A. I do.

Q. Let me ask you a couple of questions on those.

A. Okay.

Q. So I'll introduce another exhibit. This will be Exhibit 25, and let me know when you get it.

(Exhibit 25 was marked for identification and is attached.)

A. Okay.

Q. Let me ask you before we get into this, look at page 46 of your report.

A. Okay.

Q. Near the top, there's a "2020 - Finland" reference. You see that?

A. I see that, yeah.

Q. You say, "This new Finnish guidance prioritizes psychological therapy over treatment with hormones or surgery and suggests different care plans for early-onset vs late-onset childhood





gender dysphoria." You see that?

A. I do.

Q. And then you say in the last sentence, "The Finland National Guidelines appear quite contrary to the opinions of Drs Brown and Schechter and WPATH." Do you see that?

A. I do.

Q. Is it your opinion that the WPATH guidelines recommend that children who experience gender dysphoria should transition to a different gender role?

MR. KNEPPER: Objection, form.

A. No. I would say that the WPATH guidelines essentially leaves us with affirmation care only, that it does -- it does, you know, recom- -- recommend all of the psychological support but all of it in support of transition. I would say that. Yeah.

Q. Yeah. The WPATH guidelines do not recommend that children with gender dysphoria automatically be put on puberty

blockers; right?
A. They don't make that recommendation, no. They don't state that recommendation, no.
Q. Yeah. Let's look at what they actually say.
A. Okay.
Q. I'm going to introduce one more exhibit.
A. So we're going to leave the Finland article for now and go to --
Q. Yeah. We'll come back to it. I want to show you the WPATH --
A. Okay.
Q. -- Standards of Care Version 7 first.
A. Uh-huh.
Q. All right. This will be Exhibit 26. Let me know when you have it.
(Exhibit 26 was marked for identification and is attached.)
A. Okay.
Q. This is a larger file, so this







may take an extra minute or so.
A. Okay. I've got it.
Q. Okay. These are the WPATH Standards of Care Version 7; right?
A. Yes.
Q. Turn to page 23.
A. Okay.
Q. All right. There's a section titled "Social Transition in Early Childhood." You see that?
A. I must be on the wrong page. Did you say page 23?
Q. It's PDF page 23, which is going to be page 17 in the standards.
A. Oh, I'm sorry. Okay. Let's go back, then. Page 17. Okay. I'm there. Right. "Social Transition in Early Childhood."
Q. All right. It says: "Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression







of their gender identity. For others, this could be motivated by other forces."
You see that?
A. I do.
Q. And then a couple of sentences down, it says: "This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood." You see that?
A. I do.
Q. All right. The WPATH Standards of Care Version 7 is not making any clinical recommendations encouraging children in early childhood to go through gender transition roles; correct?
A. Yeah, I would -- yes. I would add to that that they're also not offering any clinical guidance on how to distinguish who might or who might not be suitable for transition. Right.







Q. Do you know whether that's explored somewhere else in this Standards of Care Version 7?
A. Yeah. I think it's discussed.
Q. Okay.
A. But -- but it's -- but I -- yeah. So what's -- what's important, I think, in what you cite here is that the current evidence base is insufficient to predict the long-term outcome. Yes.
Q. Okay. Go to the next page.
A. Okay.
Q. Page 18, PDF page 24.
A. Okay.
Q. There's a section titled "Physical Interventions for Adolescents."
A. Right.
Q. Right?
A. Yes.
Q. You understand that adolescents are different than children; right?
MR. KNEPPER: Objection, form.
A. Well, yeah. So, adolescents are

treated in pediatric clinics, but they're different from prepubertal children, yes.

Q. Yeah. This section does not provide any clinical recommendations for hormone therapy in prepubescent children; right?

A. Let's see. I've just got to refresh my memory here on the verbiage.

(Witness reviews document.)

A. Yeah. So it -- it addresses the important issue of gender fluidity in adolescents, potential for shift to conformity and -- that may not persist. Yeah. Right.

Q. Okay. And this section also does not provide any clin- -- clinical recommendations for surgical intervention in prepubescent children; right?

A. This section doesn't address prepubescent children. It addresses adolescents.

Q. Yeah, exactly. And you don't know of any other section in these





Standards of Care Version 7 that provide those guidelines for prepubescent children; right?

A. No.

Q. Okay. Go to the next page, PDF page 25, page 19 in the document.

A. Okay.

Q. And you see there's a section that says, "Criteria for Puberty-Suppressing Hormones"?

A. Yes.

Q. It says, "In order for adolescents to receive puberty-suppressing hormones, the following minimum criteria must be met." You see that?

A. Yes.

Q. And then there's four items; right?

A. Yes.

Q. Number 4 says, "The adolescent has given informed consent and, particularly when the adolescent has not





reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescents throughout the treatment process."

You see that?

A. Yeah. That -- in fact, that was one of the most troubling things I read when I reviewed this whole document from the WPATH guidelines, is that -- yeah, that using those words in the same sentence, an adolescent giving informed consent, is a -- is a non sequitur because I -- I don't think -- in all my years of practice as a surgeon, which amounts to greater than 35, the idea of obtaining consent from an adolescent was never accepted by the surgical community or the medical community, to my understanding.

Q. Well, this also talks about getting informed consent from the parents or other caretakers or guardians; right?





A. Yeah. So in their role supporting the adolescent's decision. It doesn't say -- yeah. So the parents or other caregivers have consented in support. Right.

Q. Yeah. What the guidelines contemplate is that it's not just the adolescent that's going to give an informed consent, it's also the parents or other caretakers or guardians; right?

A. Yeah. But again, that's the problem I have with it, because that's -- the introductory sentence has -- has no meaning -- or the introductory part of the one sentence has no meaning. If the beginning point of the process is adolescent consent, that's -- that's not an ethical thing to do because --

Q. Yeah.

A. -- because an adolescent can't grasp -- they don't have enough executive function or development, particularly if they have been through a period of

puberty suppression before they begin the period of cross-sex hormones, that it's -- it's already quite evident that these patients, these children do not have enough -- and it's just known in society at large that adolescent children don't have the capacity for long-term reckoning of things like risk and outcomes and neither do they have the executive capacity in their brains to make an informed consent decision. So that part of it is meaningless to me. Yeah.

Q. Yeah. But you understand there's two components to this requirement; one is informed consent by the adolescent, and two is informed consent by parents or other caretakers or guardians. Right?

A. Yes.

Q. Okay.

A. That's what it says.

Q. All right. Let's now go back to the Finland guidelines. It's Exhibit 25.





A. Okay.

Q. And go to PDF page 9 which has Section 8, "Summary" -- "Summary of the Recommendations." Let me know when you get there.

A. Okay.

Q. All right. This page provides recommendations for treatment of minors with gender dysphoria in Finland; right?

A. Yes.

Q. All right. Look at number 2 at the bottom.

A. At the bottom. Okay. Okay.

Q. All right. So it starts with, "If a child is diagnosed prior to the onset of puberty with a persistent experience of identifying as the other sex and shows symptoms of gender-related anxiety, which increases in severity in puberty." You see that?

A. Yes, I do.

Q. All right. And then next sentence says, "Based on these





assessments, puberty suppression treatment may be initiated on a case-by-case basis after careful consideration and appropriate diagnostic examinations if the medical indications for the treatment are present and there are no contraindications."

Do you see that?

A. I do.

Q. All right. You understand that these Finland guidelines do not categorically prohibit the use of puberty-blocking agents in minors; correct?

MR. KNEPPER: Objection, form.

A. Right. They don't categorically, but what they do is they express uncertainty about the data that -- that's been used to support the use of those drugs in children.

Q. Yeah. But -- but despite that data, what the guidelines recognize is that puberty-blocking treatment may still





be initiated for some minor patients in certain circumstances.

A. Right.

Q. Right?

A. Agree.

MR. KNEPPER: Objection, form.

Q. All right. Let's go back to your report. Go to page 46.

A. I'm there.

Q. So in your discussion of these Finland guidelines, you cite something called -- it's a website, genderreport.ca.

A. Correct.

Q. Do you see that?

A. I do.

Q. And I saw at least two other references to this source in your report. All right. This is -- genderreport is not a peer-reviewed publication, Doctor; right?

A. No. It's a data collection site. Yeah.

Q. It's a data collection site?
A. I think that's what the -- so, let me just review what I wrote here.
(Witness reviews document.)
A. All right. Okay. Yeah. Okay. Yeah, no. I agree they're not peer-reviewed to my knowledge, no.
Q. It's a blog; right?
A. Right. It's on -- it's online, exactly.
Q. Blogs are not generally considered reliable scientific evidence, I take it. Right?
MR. KNEPPER: Objection, form.
A. No, they're not.
Q. Okay. Do you know who started this genderreport blog?
A. I do not.
Q. Do you know this person was a doctor?
A. I don't know the person, no.
Q. You don't know they're a scientist?





A. I'm sorry?
Q. You don't know whether they're a scientist; right?
A. I don't know.
Q. Did you know that this blog was started by a parent who was upset that her daughter was told in school that girls are not real and who filed a lawsuit about it?
MR. KNEPPER: Objection, form.
A. I did not know those details, no.
Q. Assuming that's true, do you think this is an unbiased, objective resource?
MR. KNEPPER: Objection to form.
A. I -- I don't know. I don't know the answer to that question.
Q. Do other experts in your field rely on blogs like this one to support their opinions?
MR. KNEPPER: Objection, form.
A. And I don't, and neither did I





rely on this as sole support for my opinion. This -- again, this is just evidence of -- of controversy that exists out in the literature, or that exists out in the -- in the greater world, I should say, in this case because this is not medical literature, but in the wider world.
Q. Well, as I read this, your page 46, you're -- you're citing this gender report for your analysis of the 2020 Finland guidelines.
MR. KNEPPER: Objection, form.
Q. Right?
A. I think I'm using the Finland guidelines as a standalone and just referencing this gender report as evidence of events in Finland rather than scientific support for the conclusions of the Finland review.
Q. Okay. Another article you cite is the Carmichael 2021 study.
A. Right.





Q. Let's look at that one. I'll introduce it as Exhibit 27. Let me know when you have that.
(Exhibit 27 was marked for identification and is attached.)
A. Okay. Okay. I have it.
Q. Okay. This is titled, "Short-Term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK."
A. Right.
Q. Right?
A. Yeah.
Q. All right. Look at the -- on page 1, you see there's an abstract?
A. Yes.
Q. Under "Methods," it says, "We undertook an uncontrolled prospective observational study." Right? Do you see that?
A. Right.
Q. All right. This is not a

randomly controlled clinical trial; right?

A. Right.

Q. Not a cohort study --

A. Right.

Q. -- right?

A. Right.

Q. There's no control group; right?

A. Correct.

Q. You don't mention any of that in your report even though you spend a lot of time discussing the limitations of other studies. Why is that?

MR. KNEPPER: Objection, form.

A. I -- we include this to one to show the raging controversy in the world of transgender medicine, and this is an example of that, the -- the evidence of uncertain result or no result, no change from baseline effect.

Let's see. Let me just review because I've reviewed so many of these articles lately.







(Witness reviews document.)

A. Right. Yeah. So -- yeah. So that's right. So they were unable to quantify benefit or harm from puberty suppression.

Q. Go to page 21. See there's a "Strength and Limitations" section?

A. I see it. Yes, I do.

Q. The second sentence says: "The study size and uncontrolled design were key limitations. The small sample size limited our ability to identify small changes in outcomes. This was an uncontrolled observational study and thus cannot infer causality." See that?

A. I do.

Q. Again, you don't acknowledge any of these limitations in your report; right?

MR. KNEPPER: Objection, form.

A. Right. I believe I made reference to this in terms of it's evidence of -- of controversy in the







literature, that they could not see a benefit from it. So again, at lower levels of evidence, evidence of benefit would suggest further study. This shows that further study is needed because, at the observational level, you don't see effect.

Q. All right. Another study -- not a study, a review that you cite is this Cochrane 2020 --

A. Yes.

Q. -- review; right?

A. Right.

MR. TISHYEVICH: And for the court reporter, that's C-O-C-H-R-A-N-E.

Q. I'm going to introduce that one next.

A. Okay.

Q. All right. I'm introducing this as Exhibit 28, and let me know when you get it.

(Exhibit 28 was marked for identification and is attached.)







A. I will. Okay.

Q. Okay. This is from the Cochrane Library. This is the review that you cite in your report; right?

A. Right.

Q. Go to page 2.

A. Okay.

Q. All right. You see there's the section titled, "Authors' Conclusions"?

A. Okay. Yes, I do.

Q. All right. Toward the end, do you see it says, "We will include non-controlled cohort studies in the next iteration of this review, as our review has shown that such studies provide the highest quality evidence currently available in the field." You see that?

A. Yes, I do.

Q. All right. So the Cochrane review is not saying they're just going to ignore all those studies going forward; right?

A. Right.

MR. KNEPPER: Objection, form.
Q. They rec- -- they recognize that those noncontrolled studies currently represent the best available evidence; right?
MR. KNEPPER: Objection, form.
A. Well, yeah. Before they say best available evidence, they speak about the level of the evidence now. And what's -- what's interesting about this Cochrane review, because it's a worldwide review of the literature on the subject of cross-sex hormones and hormone blockade in transwomen, is that they found over a thousand references, and by the time they got through qualifying those references for suitability, they got down to thirteen studies. And when they fully screened the text, they got down to a single study. And that's -- that's kind of characteristic of -- of the data used to support hormonal transitioning.





And so yeah, they -- they have to -- they have to backpedal in order to get any data because what they have in hand now is -- is not supportive of -- of the use of cross-sex hormones in transwomen, so.
Q. All right. Let me introduce another exhibit.
MR. TISHYEVICH: Can we go off the record?
THE VIDEOGRAPHER: We are off the record at 4:07 p.m.
(Break taken.)
THE VIDEOGRAPHER: We are back on the record at 4:20 p.m.
Q. (By Mr. Tishyevich) All right. Doctor, let me ask you about what experience you have with the individual plaintiffs in this case specifically.
You personally did not meet with any of the plaintiffs in this case; correct?
A. No. I did a review of their





charts and nothing more. Yeah.
Q. All right. You've personally never spoken with any of the plaintiffs; correct?
A. I have not.
Q. You obviously were not present in any meetings that any of these plaintiffs may have had with their mental health professionals; right?
A. I was not.
Q. And you don't know specifically what was said or not said during those meetings; correct?
A. The only information I have about those meetings was what's entered in the medical record that was given to me to review.
Q. Yeah. You were also not present in any meetings any of the plaintiffs may have had with their endocrinologists; right?
A. Correct.
Q. And outside of reading medical





records, you don't know what was said or not said during those meetings; correct?
A. Correct.
Q. And finally, for plaintiffs who had undergone surgical procedures, you were also not present in any meetings between these plaintiffs and their surgeons; correct?
A. Correct.
Q. And outside of medical records, again, you don't know what was said or not said during those meetings; correct?
A. Correct.
Q. Okay. You should see a new exhibit pop up, Exhibit 29.
A. Okay.
(Exhibit 29 was marked for identification and is attached.)
Q. And if you can go to PDF page 54.
A. PDF page 54. Okay.
Q. First of all, you understand what this document is; right?

A. I didn't get to see the header on it. I haven't seen this before, I don't think.
Q. Oh, feel free -- yeah, feel free to go back to the first page if you want to.
A. Okay.
(Witness reviews document.)
Q. All right. This is the --
A. Okay. Okay. So it's --
Q. Yeah.
A. -- a benefits booklet for the State health plan. Is that right?
Q. For North Carolina, right.
A. Yes. The teachers union -- teachers and employ- -- and State employees, right. Okay.
Q. You know what a benefit plan is; right?
A. Yes, uh-huh.
Q. At a high level, it sets out what the insurer is going to cover or not cover; right?





A. Correct.
Q. Among other things. Okay. And earlier, we talked about medical necessity. You recall that?
A. Yes.
Q. All right. Go to -- now go back to PDF page 54 of this plan.
A. Okay. I'm there.
Q. You see at the top, it says, "What is not Covered?" And it's a list of items?
A. Am I on the right page? I'm on -- on PDF page 54?
Q. Yeah.
A. That's the -- the -- oh, I'm sorry.
Q. Plan page 46, so that's --
A. Plan page 46. Let me back up real quickly here. Sorry. Okay. I'm there.
Q. At the top or near the top, it says, "What is not Covered?" You see that?





A. I do.
Q. There's a list of items alphabetically. See that?
A. Yes.
Q. And under M, it says, "Services or supplies deemed not medically necessary." "Medically necessary" is in bold; right?
A. Right.
Q. All right. Let's look at that definition. Go to PDF page 89, which is page 81 of the plan.
A. Okay.
Q. All right. At the bottom, you see there's a definition of "Medically Necessary (or Medical Necessity"; right?
A. Yes.
Q. And it says, "those covered services or supplies that are: a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under





this health benefit plan, not for experimental, investigational, or cosmetic purposes." Right?
A. Okay.
Q. I understand that as part of determining what the benefit plan is going to consider medically necessary, whether or not the treatment is experimental is one of the factors; right?
A. As would be defined -- so all of the definitions here are determined by the insurance provider. So they've defined these listed necessities as covered under their plan, yes.
Q. Yeah. So under this definition, if a treatment is experimental, it is likely not going to be covered under the plan; right?
A. Right. According to their definition, it doesn't appear they would cover experimental surgery or cosmetic surgery.

Q. Conversely, if a treatment is not experimental, it may be covered by the plan in some circumstances; right?
A. It would seem --
MR. KNEPPER: Objection, form.
Q. Yeah. And I showed you earlier a policy from BlueCross BlueShield of North Carolina from March 2021 that says that gender-affirming hormone and surgical treatment is considered medically necessary; right?
MR. KNEPPER: Objection, form.
A. Yeah, no. As we talked about before, these are definitions formulated by the insurance company to define coverage, not medical definitions in terms of medical care. This is strictly coverage by insurance. Yeah.
Q. Well, one of the factors that goes into that consideration is whether or not that treatment in question is experimental; right?
MR. KNEPPER: Objection, form.





A. Right. The plan excludes experimental or investigational or cosmetic procedures.
Q. Okay. All right. We're talking about BlueCross BlueShield of North Carolina. Let me ask you about another insurer, Aetna, A-E-T-N-A. You've heard of Aetna; right?
A. Yes.
Q. Are you aware that Aetna is one of the five largest health insurance -- insurers in the U.S.?
A. It would not surprise me to learn that.
MR. KNEPPER: Form.
Q. Do you have any idea whether Aetna considers gender-affirming surgery and hormone therapy to be medically necessary?
MR. KNEPPER: Objection, form, scope.
Q. Would it surprise you if Aetna --





THE COURT REPORTER: I'm sorry. I didn't hear the answer over the objection.
THE WITNESS: I haven't answered yet.
THE COURT REPORTER: Okay.
THE WITNESS: Sorry.
A. So as to the size of Aetna or the -- that they cover --
Q. Yeah, let me just ask -- I'll ask the question again.
A. Okay.
Q. Do you have any idea whether Aetna considers gender-affirming surgery and hormone therapy to be medically necessary?
MR. KNEPPER: Objection, form, scope.
A. I don't.
Q. Well, let me show you. I'm going to introduce another exhibit. Okay. This is going to be Exhibit 30. Let me know when you have it.





(Exhibit 30 was marked for identification and is attached.)
A. Okay. All right. I have it.
Q. All right. This is a policy from Aetna titled "Gender Affirming Surgery." You see that?
A. I do.
Q. You see there's a "Policy History" on the right?
A. Yes.
Q. Under "Last Review," it says January 12th, 2021; right?
A. Yes.
Q. So you understand this was revised within this year; right?
A. Yes.
Q. And under Policy, it says, "Aetna considers gender affirming surgery medically necessary when all of the following criteria are met." Right?
A. Right.
MR. KNEPPER: Form.
Q. All right. So according to this

policy, in Aetna's view, gender-affirming surgery is medically necessary, therefore nonexperimental; right?

MR. KNEPPER: Objection, form.

A. Yeah, Aetna's definition of what is medically necessary appears to allow for gender-affirming surgery.

Q. Okay. Go to page 3.

A. Okay.

Q. Look at the bottom of the page.

A. Okay.

Q. The second to the last paragraph says, "Aetna considers gonadotropin-releasing hormone medically necessary to suppress puberty in trans identified adolescents if they meet World Professional Association for Transgender Health (WPATH) criteria." Do you see that?

A. I do.

Q. Okay. According to Aetna, puberty-blocking hormones are medically necessary to suppress puberty in





trans-identified adolescents if they meet the WPATH criteria; right?

MR. KNEPPER: Objection, form.

A. That -- that's what it states there, yes.

Q. By the way, look at the next paragraph. See it says, "Aetna considers reversal of gender affirming surgery for gender dysphoria not medically necessary."

MR. KNEPPER: Objection.

Q. Do you see that?

A. I do.

Q. Okay. We talked about Blue Cross Blue Shield, talked about Aetna. Do you know what Cigna is?

A. Yeah. It's one of the largest health insurance providers.

Q. Do you know what position Cigna takes on whether gender dysphoria treatment is medically necessary?

MR. KNEPPER: Objection, form, scope.





A. I have not read their policies.

Q. You don't know; right?

A. Correct.

Q. Let me show you that policy.

A. Okay.

Q. All right. This is going to be Exhibit 31. Let me know when you have it.

(Exhibit 31 was marked for identification and is attached.)

A. Okay. Okay. I have it.

Q. All right. This is a Cigna medical coverage policy titled "Treatment of Gender Dysphoria." Do you see that?

A. Yes, I do.

Q. On the right top, it says "Effective Date," May 18th, 2021; right?

A. Yes.

Q. Also recently updated; right?

A. Yes.

Q. Go to page 2. Under "Coverage Policy," look at the third paragraph in bold. It says, "Medically necessary





treatment for an individual with gender dysphoria may include any of the following services, when services are available in the benefit plan." Do you see that?

A. I do.

Q. All right. And then there's five different bullets of different categories of services; right?

A. One, two, three, four, five. Yes.

Q. Number two is "Hormonal therapy, including but not limited to androgens, anti-androgens, Gn-" -- "GnRH analogues, estrogens, and progestins." Right?

A. Yes.

Q. That's a medically necessary benefit in Cigna's view; right?

MR. KNEPPER: Objection, form.

A. It is a -- medically necessary as defined by a insurance company for purposes of a policy.

Q. Yeah.

A. Yes.
Q. And the last bullet point says, "Gender reassignment and related surgery (see below)." Do you see that?
A. I do.
Q. According to this policy, in Cigna's view, gender reassignment and related surgery is a medically necessary service; right?
MR. KNEPPER: Objection, form.
A. Again, so -- so the insurance company makes a distinction between medically necessary, meaning things that they will cover, versus not medically necessary, meaning things they won't cover. It's not based on an actual medical diagnosis but a -- a managerial diagnosis, because if it's not medically necessary, it's not covered by insurance. So if they choose to cover it, they will call that medically necessary. And that's what they're detailing here, what they will cover and what they won't







cover.
Q. Okay.
A. And they call what they will cover medically necessary.
Q. Let me show you one last policy. Do you know -- strike that.
You know what UnitedHealthcare is; right?
A. Yes, I do.
Q. It's another health insurer; right?
A. Yes.
Q. They're the largest health insurer in the country; right?
A. I don't know that for a fact. I'll assume if you're telling me so.
Q. All right. Well, do you have any idea whether United considers gender-affirming surgery and hormone treatment to be medically necessary for gender dysphoria?
A. I have a dawning suspicion that they do.







Q. Yeah. I think you can probably tell where this is heading at this point; right?
A. Sure. The insurance industry likes these services.
Q. Let me introduce this next exhibit. This is going to be Exhibit 32. All right at the top it says, "United Healthcare." You see that?
(Exhibit 32 was marked for identification and is attached.)
A. I don't have it yet.
Q. Oh, I apologize.
A. That's okay.
Q. Let me know when.
A. Okay. Yes.
Q. All right. Top right says "United Healthcare" -- "Healthcare Commercial Medical Policy." Right?
A. Yes.
Q. Under that, it says, "Gender Dysphoria Treatment." Right?
A. Yes.







Q. See there's an effective date of April 1, 2021; right?
A. Yes.
Q. Also fairly recently updated; right?
A. Yes.
Q. Okay. And then you see there's a bunch of bullet points setting forth criteria for the services on page 1; right?
A. Yeah. Yes.
Q. Then go to page 2.
A. Okay.
Q. And the first full paragraph says, "When the above criteria are met, the following surgical procedures to treat Gender Dysphoria are medically necessary and covered as a proven benefit." Do you see that?
A. I do.
Q. Okay. So United also covers -- also considers this treatment to be medically necessary; right?

MR. KNEPPER: Objection to form.
A. Yeah, again, so the interesting thing about this that I'm just reading -- because, again, this is the first time I've seen this -- is that the same policy declares that the policy does not apply to individuals with objectively ambiguous genitalia or disorders of sexual development. So that's an example of the insurance company choosing what to call medically necessary based upon an insurance definition rather than a medical definition. Because under, you know, plastic surgical/general medical wisdom, ambiguous genitalia and disorders of sexual development are objective medical surgical -- well, medical conditions, at least, that would be covered -- would be considered medically necessary to treat, you know, because disorders of sexual development can include emergencies like adrenal hyperplasia. So that's a -- you've given





an example of how insurance companies make their own definitions for the sake of distinguishing what they will cover and what they will not cover.
Q. Go to page 9.
A. Okay.
Q. You see there's a section toward the bottom that says, "Benefit Considerations"?
A. Yes.
Q. Third paragraph says, "Unless otherwise specified, if a plan covers treatment for Gender Dysphoria, coverage includes psychotherapy, cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy." Do you see that?
A. I do.
Q. You understand that United considers not just surgery but all these other services, including cross-sex hormone therapy and puberty suppressing





medications, to be medic- -- medically necessary for the treatment of gender dysphoria; right?
MR. KNEPPER: Objection, form, scope.
A. Yeah, again, the same -- same issues of definition. So they -- they can define it any way they choose for the sake of the business of insuring people, yeah. So they -- they definitely have defined all of the services associated with gender dysphoria as covered benefits.
Q. And not just as covered benefits, as medically necessary; right?
A. Again --
MR. KNEPPER: Objection, form and scope.
A. Again, they use -- the use of the word "medically necessary" is defined by the insurance company to distinguish covered benefits from not covered benefits, and it's not based in medical





evidence of efficacy or anything else. It's just an internal definition for the sake of their business model.
Q. You think that insurers do not look at scientific literature in deciding whether or not to cover something?
MR. KNEPPER: Objection, form.
Q. Is that really what you think?
A. Your -- your first example that we've gone through is a -- is an example of the level of literature they've been using, and that example showed that the most recent paper that they used to support it was 2016. So in my mind, it's in doubt. I don't know for a fact what this particular policy used as references. All I have is what you've shown me on that particular policy. And the evidence there was they're not current in the -- in the literature. But they're still doing good business, apparently, because they continue even after reviewing.

Q. Okay. Go to page 10.
A. Okay. All right.
Q. See there's a section at the bottom that says, "Clinical Evidence"?
A. Yes.
Q. Do you know what that means?
A. Yes, I do.
Q. You see then the first thing that's said -- cited is a study from 2019 and the second thing is a study from 2019, the third thing is a study from 2019. You see that?
A. I do.
MR. KNEPPER: Objection, form.
Q. Do you under- -- do you understand what this section represents?
MR. KNEPPER: Objection, form.
A. Permit me to just look at the particular names and the particular cited articles, if I could.
(Witness reviews document.)
A. Sorry. I just wanted to see if there were any -- and then they go to --





okay. Okay. Could I ask you to ask your question again? I'm sorry to have to do that. I just wanted to see what you were referring to.
Q. Yeah. You understand that this "Clinical Evidence" section provides an overview of some of the scientific evidence on which United based its policy; right?
MR. KNEPPER: Objection, form.
A. Yes. They -- they have listed some of the scientific evidence available in the literature.
Q. Including studies as recently as 2019 --
A. Yes.
Q. -- right?
A. Right.
Q. And because you weren't involved with writing this policy or updating for United, you don't know what else they may have considered outside of this policy; right?





A. I have no way of knowing what they would have considered. That's right.
Q. Okay. All right. Let's shift gears a little bit. You've heard the term "Christian anthropology." Right?
A. Yes, I have.
Q. You've used that term yourself; right?
A. Yes, I have.
Q. The view that Christian anthropology takes is that the -- a person's sex assigned at birth is intrinsic and unchangeable; correct?
A. No.
MR. KNEPPER: Objection, form, scope.
A. I would not say that.
Q. What would you -- how would you describe it?
A. Well, your use of the term "sex assigned at birth" is not -- is not contained within Christian anthropology.





Q. Let me try this --
A. By the -- by the way, I don't -- I don't use definitions in Christian anthropology to confect my expert opinion. My opinion is based in the scientific literature, my review of that literature, and my 30-plus years' experience as a reconstructive surgeon.
Q. I understand. The view that Christian -- to use your words, the view that Christian anthropology takes is that a person's biologic sex is intrinsic and unchangeable; right?
A. Yes.
MR. KNEPPER: Objection, form, scope.
Q. You think that people with gender dysphoria should be welcomed, but they should be told that they're biological sex cannot be changed; right?
MR. KNEPPER: Objection, form, scope.
A. Yeah. So, persons who

self-identify as transgender are to be welcomed and are to be cared for because they suffer greatly, and they -- they deserve, in justice -- they deserve, out of justice, I should say, our -- our care and support. But that care and support must always be rooted in the truth of the nature of the human person, the nature of the biology that informs our understanding of that, because that has to drive our medical and surgical decision-making.

So that's why my -- my expert opinion is based in the objective scientific evidence. I don't make reference to my -- any faith statements when I'm -- when I'm developing my expert opinion on transgender medicine and surgery.

Q. In your expert report, you refer to plaintiff Julie -- Dr. Julie McKeown; right?

A. Could you walk me to where I





speak about her?

Q. Yeah. Go to -- go to page 54 of your report.

A. Fifty-four. Thank you.

MR. TISHYEVICH: And the spelling is M-C-K-E-O-W-N.

A. Fifty-four. Okay. I'm there.

Q. Give me a second. Yeah. This is -- this is you discussing one of the plaintiffs; right?

A. Yes. Yes. I'm on page 53, 54.

Q. Yeah. And the second full paragraph on page 54, you refer to Dr. McKeown as a he; right?

(Witness reviews document.)

A. Am I looking at the right -- oh, yes. Okay. I'm sorry. Right at the very beginning. Yes.

Q. Page 48 of your report, this is you discussing minor plaintiff CB; right?

A. Right.

Q. And you refer to minor plaintiff as a she; right?





A. Correct.

Q. Go to page 51.

A. Fifty-one?

Q. Five one.

A. Okay. All right.

Q. This is you talking about plaintiff Connor Thonen-Fleck; right?

A. Let me go to the preceding page because I've got to see where the names -- oh, I only used the initials. Yes. CT-F, yes.

Q. It's T-H-O-N-E-N, dash, F-L-E-C-K. And you refer to him as a she; right?

A. Yes.

Q. Now, you personally do not believe that a person's sex assigned at birth can ever be changed?

MR. KNEPPER: Objection.

Q. Sorry, let me -- let me use your terms. You personally do not believe that a person's biological sex can ever be changed; right?





MR. KNEPPER: Objection, form.

A. A person's biological sex can never be changed, yes.

Q. Do you know what the term "misgendering" is?

A. It's a -- it's a political term, yes. It's a political, cultural term, I should say. Political, cultural term.

Q. Misgendering means referring to a person in a way that doesn't align with their gender; right?

MR. KNEPPER: Objection, form.

A. In -- within their hearing, I could see a problem with that. But from the standpoint of offering medical evidence, I'm obliged to honor objective biological realities when I speak about an examination of their medical record.

There's so many things at stake relating to the sex of the patient that impinge upon the effects of drugs, the effects of time, the effects of hormones that I -- I cannot incorrectly report the

sex of the patient when I'm talking about objective medical care.

Now, speaking with the patients themselves, I wouldn't do that. As we talked about earlier, I have a number of transgender patients, and I don't misgender them. We're talking here about something that's not within their hearing or I assume they -- I assume that they wouldn't be reading this. We're speaking as a professional to a professional review of this stuff, among other experts. So I think it's essential that we stick to the biological reality that -- that biological sex is immutable.

Q. In your expert report, you are misgendering several of the individual plaintiffs in this case; correct?

MR. KNEPPER: Objection, form.

A. I would say incorrect, because misgendering is something that's done to the person themselves or is something that they're going to read or hear or





see. And that's an abuse of the person's right to their name, and I don't do that to people. I don't misgender people.

Q. Well, in this report at least, you are referring to several of these plaintiffs, including a minor, in a way that does not align with their gender; right?

A. I would be --

MR. KNEPPER: Objection, form.

A. Again, I would be concerned to not do that if it was going to be something they were going to read or hear. But this expert testimony, in my understanding, is for the Court and for the other experts to review, in which case, I insist upon the -- the prevailing necessity of sticking to objective truths when talking about medical opinions, scientific opinions.

Again, I -- I'm not in the habit of -- of offending people or using names that they haven't chosen, because, again,





I treat transgender patients and I don't subject them to that kind of abuse. But when reviewing medical and biological realities like this, I have to insist upon it because medical care is not served by incorrectly naming biological realities and confusing people. I can give you an example if you like.

Q. That's all right.

A. Of a --

Q. That's all right.

A. Okay.

Q. You've used the phrase before, "You can't heal an interior wound with external surgery." Right?

A. Yes, I have.

Q. Do you remember giving a presentation at the Gospel of Life conference in Denver in 2018?

A. Yes.

Q. And that presentation was titled "Transgender Surgery & Christian Anthropology." Right?





A. Yes.

Q. All right. Let me introduce an exhibit. This will be Exhibit 33. Let me know when you have it.

(Exhibit 33 was marked for identification and is attached.)

A. Okay. Yes, I have it.

Q. Go to page 2.

A. Okay.

Q. These are slides you prepared; right?

A. Yes.

Q. On the bottom left corner, there's a red logo for Courage International. You see that?

A. I do.

Q. Why did you include that logo in this presentation?

MR. KNEPPER: Objection, form, scope.

A. This was a presentation for the Archdiocese of Denver, the Catholic Archdiocese of Denver, and it was to an

audience of pastors, teachers, school administrators, and so on. And I was there representing my position in the Catholic apostolate of courage, and so making a presentation to a church group, I wanted them to understand the resource so that they could investigate it themselves if they wanted to. So I put that up there for their benefit.

Q. Well, some of the topics you covered also included your views on what the scientific evidence on these issues is; right?

A. Yeah. The -- the talk is a combination of both the scientific evidence and the historic Catholic teachings on the nature of the human person.

Q. For example, go to page -- go to page 87, for example.

A. Okay. Let me hustle down there. Boy, no wonder people get bored when I give this talk. It's so long; right?







Let's see. 87. Here we are. Is that -- let's see. This is -- I want to make sure I'm on the same page as you are. It's of the --

Q. It's titled "The Swedish Study" --

A. Yes.

Q. -- at the top.

A. Yes, yes.

Q. And go to the next page.

A. Okay. Yeah.

Q. You cite from the abstract on that study; right?

A. Yes. Well, I -- I'm not citing it. I'm showing them what this study looks like if they search for it online.

Q. So part of the talk was your recitation of what you think the scientific evidence on these issues shows; right?

MR. KNEPPER: Objection, form, scope.

A. Yeah, I was asked to talk on







this -- on -- on both subjects, as I said earlier, both the -- the teaching in human anthropology as well as the scientific evidence that's used to support these services of transgender medicine and surgery. That's right.

Q. Courage International is an organization that offers support for persons who experience same-sex attraction; right?

A. Yes.

MR. KNEPPER: Objection, form, scope.

Q. Courage International says that people should not act on same sex attraction and should strive for chastity instead; right?

MR. KNEPPER: Objection, form, scope.

A. Actually, it's broader than that. So, Courage addresses chastity as something that's required of everyone. But it -- it particularly addresses the







struggles that persons who experience same-sex attraction experience in trying to maintain the same chastity that all of us are called to. So it's not an exceptional case; it's a particular apostolate to a particular group of people.

Q. There's a chapter of Courage International in Birmingham, Alabama; right?

A. That's correct.

MR. KNEPPER: Objection, form, scope.

Q. And their website lists you as the main contact for that chapter; right?

A. I'm not only the contact, I'm the chaplain for that chapter.

Q. Okay. Go to page 3 of this presentation.

A. Okay.

Q. Let me know when you get there.

A. Okay. Two, three. Yes. The Challenge?

Q. It's titled "The Challenge"?
A. Yeah.
Q. The first bullet says, "'Male and female He created them.'" Right?
A. Right.
Q. That's a quote from Genesis; right?
A. Correct.
Q. The capitalized "He" refers to God; right?
A. Yes.
Q. And this bullet reflects the church's position that God has created each individual as either a man or a woman; right?
A. Well, actually, so this -- these slides serve as jumping-off points for a discussion that I have at each slide. In this case, the point of the discussion was to disabuse the audience of the idea that they can rely on scripture when addressing this problem because the majority of the people that are seeking







to serve do not speak in Biblical language. So the point of this slide is to -- is to encourage them to understand that they have to learn a new language in order to be able to speak effectively to people suffering from gender discordance and to speak to their families on this same issue. That's what this slide is about. It's not a -- it's not a declaration about what God has said. It's a -- it's an explanation of the problem they're going to have if they're going to seek to serve people who experience same-sex -- I'm sorry, who experience cross-sex identification.
Q. All right. You say, "'Male and female He created them' has been replaced by a confusion of exceptional cases." Right?
A. Yes.
Q. And by the phrase "confusion of exceptional cases," one of the things you're referring to are patients with







gender dysphoria; right?
MR. KNEPPER: Objection, form, scope.
A. Right. I'm referring to the -- the recently growing list of exceptional cases that is enumerated in the -- the acronyms of -- of this topic, LGBTQ add a plus and so on, which can be very confusing to people who are trying to help. And so I'm acknowledging that the -- the likelihood that they may be confused by those terms, and I'm also acknowledging the sources of those confusing terms. And the point of the slide, again, is to help them understand there's a language they need to learn and to not be daunted by the confusion that they may experience when they first look into this topic. Yeah. That's what this is.
Q. Go to slide 11. It's titled "Human Nature."
A. So slide 11, Human Nature, yes.







Okay.
Q. So the first two bullets say, "Why must we consider first the nature of the human person?" Then it says, "Defines the 'end' of medical and surgical care."
A. Yes.
Q. What does it mean that it "defines the 'end' of medical and surgical care"?
MR. KNEPPER: Objection, form, scope.
A. Okay. So that's a -- that's a term that dates back to Aristotelian philosophy. And what it has to do is what is the purpose or what is the ultimate arc of a particular thing. So the "end" meaning what are you seeking to accomplish, what is the final goal of that -- of that medical or surgical treatment.
So -- and the examples I use are you have to have an understanding, for

example, of normal blood pressure in order to know when to treat it and why normalizing blood pressure is important. Or we have to know that, you know, the human person has two legs, and if he has a poverty of legs, he has a poverty of human flourishing. And so in the one case, I might be treating with blood pressure medicine, and in the other case, I might be fitting him for a prosthesis. But the point is we have an objective understanding of the nature of the human person, which defines the goals of treatment, whether you're talking about orthopedics or transgender medicine.

Q. Yeah. You think this concept also applies to the concept of treatment for gender dysphoria; right?

A. It does. Yes, it does.

MR. KNEPPER: Objection, form, scope.

Q. All right. Go to slide 23.

A. Okay. Okay.





Q. The top left says, "Shaping the Conversation, & Grooming a Generation."

A. Right.

Q. You see that?

A. Right.

Q. What do you mean by "grooming a generation"?

A. Grooming is a -- is a process by which ideas are introduced that make subsequent actions possible, so that's what -- that's what grooming is, yeah.

Q. Grooming is sometimes used to refer to preparing to -- strike that.

Grooming is sometimes used as preparing children for sexual abuse. Isn't that true?

A. That's one of the --

MR. KNEPPER: Objection, form, scope.

A. That's one of the uses of grooming, yeah, but it's not exclusive use of grooming. Yeah. And I discuss this in this -- in this slide. Yes, I





do.

Q. And you think that discussing gender identity issues with children means sexualizing them; right?

A. Yes, I do. Absolutely, I do.

MR. KNEPPER: Objection, form, scope.

Q. And you think that discussing gender identity issues with children means grooming them for potential later sexual abuse; right?

MR. KNEPPER: Objection, form, scope.

A. No. No. What we're talking about here is grooming them for -- for future -- what's the word I would want to choose carefully? It's preparing them for these interventions is what it does. It lays the groundwork for it by sexualizing their thoughts in a way that's -- is not consonant with their best interest. That's what this slide is about, so --





Q. Let me introduce another exhibit.

A. Okay.

Q. This will be Exhibit 34.

(Exhibit 34 was marked for identification and is attached.)

A. Could I back up to that last one? Would that be all right?

Q. Sure.

A. Before we -- before we press on. One of the things I'm just recalling, the -- the -- the urgency of having that particular slide there is that when people take care of transgender persons, children in particular, we always -- but including adults. But -- but children and adults, one always has to be on the lookout for signs of sexual abuse because it's a very -- it's a very commonly reported comorbidity in persons who experience these self-identifications. It's not uncommon to discover that they've suffered some form of abuse that

may be sexual but not necessarily sexual. And so this is -- one of the things I talk about in that slide is -- is for the people who are care providers, counselors, school administrators, to be alert to that possibility.

So I'm sorry, we were going to move on to the next one.

Q. Do you have the next exhibit?

A. And that is Exhibit 34?

Q. Yeah.

A. Okay.

Q. All right. This is a printout from LifeSite, and the title is "Plastic surgeon: Sex-change operation 'utterly unacceptable' and a form of 'child abuse.'" Right?

A. Yes.

Q. And it says, "Dr. Patrick Lappert, a Catholic deacon in Alabama, says changing a person's sex is a lie and also a moral violation for a physician." Right?





A. Yes.

Q. And you hold those views --

A. I do.

Q. -- correct?

A. I do.

MR. KNEPPER: Objection, form, scope.

Q. Go to page 2.

A. Okay.

Q. This was published in September 2019; right?

A. Yes.

Q. This is reporting on you appearing on a broadcast of something called the "Relevant Radio's Trending With Timmerie."

A. Yes.

Q. Right?

A. Yes.

Q. You made that appearance; right?

A. On the radio, yes.

Q. Okay. Look -- look to the fifth paragraph on page 2.





A. Okay.

Q. It says, "He called it 'utterly unacceptable' on moral grounds for a plastic surgeon, because it disregards the surgeon's call to balance respect for both form and function of the body in his or her work."

A. Right.

Q. Right?

A. Yes, sir.

Q. You don't deny saying that; right?

A. Right. You should understand, though, that the use of the term "moral grounds" here is strictly from the standpoint of my training as a plastic surgeon. I'm not using this as a platform for a religious discussion. Speaking -- I'm speaking about form and function, which are both very crucial to an understanding of what plastic surgery means.

And again, that speaks to the





end of plastic surgery, which is -- when you're speaking about reconstructive surgery, it's the restoration of form and function. And these operations lack moral basis precisely because they destroy essential human functions for the sake of achieving a cosmetic result, which is morally unacceptable. And I say that without reference to any religious teaching. This is strictly my training as a plastic surgeon, morally unacceptable. And from the first moments of my training as a reconstructive surgeon, that was drilled into me, that if you're planning a reconstructive operation and it involves the movement of tissue on the patient's body, you never do something that's going to compromise or destroy an essential human function.

You may challenge that function a little bit, as you do, for example, in a radial forearm flap, the same flap that's used to recon- -- to construct a

phalloplasty. I've used that flap many times to reconstruct head and neck cancer defects, the same neurotized vascular flap. And I would never dream of using that flap, for example, if I was going to compromise hand function. So it obliges me to be careful, to make sure that when I raise the flap, I don't harm the blood supply to the hand. That's an example of that.

In the example of transgender surgery, by definition, you're destroying fertility for life, which is an immoral act in the eyes of plastic surgery as I learned it through 30-plus years of training.

Q. I understand. Let me just ask you about the next two paragraphs --

A. Okay.

Q. -- of this article.

A. Okay.

Q. Then it says: "Regarding children, Lappert said, sexualizing them







at a young age with these ideas is grooming them for later abuse. 'It's atrocious,' he said. 'And no one even knows how that's going to play out. There's no body of scientific evidence to even support the safety of doing that to children. But it's being done.'" Right?

MR. KNEPPER: Objection, form, scope.

A. Okay. So, let's go through that. So in this case -- we talked about multiple uses of the word "grooming." In this case, the abuse that they're -- it's grooming them for is the abuse we just finished discussing, what I consider to be the abuse of transgender medicine and surgery and what it does to the life of that child. So that's the abuse I'm referring to here. I'm not speaking about this in terms of sexual abuse, I'm speaking about in terms of medical/surgical abuse of a child. So if you get a child -- if you sexualize a







child's thinking and encourage them to believe, for example, if -- if -- if I -- and I don't want to take up your remaining time, but we can go into it in more detail if you wish. But the point I'm making here is this is grooming them for medical and surgical abuse.

Q. Okay.

MR. TISHYEVICH: We can go off the record.

THE VIDEOGRAPHER: This is the end of Media Unit 6. We are off the record at 5:07 p.m.

(Break taken.)

THE VIDEOGRAPHER: This is the beginning of Media Unit No. 7. We are on the record at 5:14 p.m.

Q. (By Mr. Tishyevich) Doctor, that's all the questions I have for you today. Thanks for your time.

A. Thank you. This was my first ever deposition, and you were very kind to me. Thank you for that.







Q. Okay.

MR. TISHYEVICH: All right. Mr. Knepper?

MR. KNEPPER: Yeah, I'm ready to go. I'm sorry. I actually had you turned down, because when I put you on mute, I could still hear Lane and Andrew. I thought I saw their lips moving.

THE COURT REPORTER: Yeah, he said he was finished asking questions.

MR. KNEPPER: Oh, I'm sorry. I didn't hear that. I'm sorry, Dmitriy. I apologize. I had -- you know, Lane and -- and Andrew were talking to one another, and so I was -- I had to turn down my speaker.

So I guess why don't we -- why don't we take a -- I've got 4:15. Why don't we take a 15-minute break, and then I'll see if I have anything on redirect, and we'll come back at I guess it would be 6:30 your time, Dmitriy?

MR. TISHYEVICH: Yeah.

MR. KNEPPER: Okay.
MR. TISHYEVICH: Sounds good.
THE VIDEOGRAPHER: We are off the record at 5:15.
(Break taken.)
THE VIDEOGRAPHER: We are back on the record at 5:29 p.m.

EXAMINATION BY MR. KNEPPER:
Q. Dr. Lappert, I wanted to ask you a couple of questions about your CV and your biography.
A. Okay.
Q. On your biography, you identify yourself as the Specialty Leader for Plastic and Reconstructive Surgery, the Office of the Surgeon General - United States Navy, from 1997 to 2002. Could you describe what that position involved?
A. Yeah. So I advised the Surgeon General, first of all, with regard to the selection of physicians for advanced training in plastic surgery. I also







advised the Office of the Surgeon General on policy matters pertaining to the movement of patients and the availability of services in the various treatment facilities. I also advised him on policy relating to coverage of particular medical problems versus sending them out into the community for care or declining care.
So part of it was resource management, part of it was personnel management, and part of it was financial management. And all the time, it required to review the state of the literature regarding reconstructive surgery for combat-injured and as well as medically retired personnel and other retired people.
Q. And I -- I note that also in your resumé is that from 1996 to 2002, you were the Chairman of the Department of Plastic and Reconstructive Surgery at Naval Hospital Portsmouth. Could you







describe that -- that facility and its role within the United States military?
A. Okay. Well, that -- as department head, I was -- I had a five -- five staff plastic surgeons working for me. I had I think seventeen hospital corpsmen working for me. And we provided services, reconstructive surgical services on a referral basis from -- essentially from the eastern Mediterranean all the way to Appalachia and from North Carolina -- I'm sorry, from -- from Maryland all the way down to Florida. So all persons requiring reconstructive surgery, including combat-injured or other, would be referred to us, people with congenital deformities, peop- -- you know, pediatric patients and -- and adults. And this was in a -- in the facility which at the time was the largest medical treatment facility in -- I think in the world, certainly in -- in the American purview.







I also -- I also established and ran congenital craniofacial deformity treatment. We ran a limb salvage treatment that involved a great deal of microvascular reconstructive surgery for wounds, cancer, that sort of thing. We also established the -- the wound care center for that facility, and that -- again, we served that large catchment area with advanced wound care services.
Q. Dr. Lappert, you served as a -- as a plastic and reconstructive surgeon for the United States Navy. Is that correct?
A. Correct.
Q. And you also served as a plastic and reconstructive surgeon in private practice. Is that correct?
A. Correct.
Q. Could you describe the -- or contrast or describe the similarities and differences in those two practices.
A. Certainly. Well, so both

practices involved both reconstructive surgery and aesthetic cosmetic surgery. But the difference is that in the military, because of the nature of the requirements, the experience level grows much more rapidly in the military than it does in the civilian world. So within the first couple of years of my practice as a reconstructive surgeon in the Navy, I was doing the most advanced reconstructive procedures, such as the mi- -- the neurotized microvascular flap operations that are often used, for example, in the phalloplasties of transgender surgery, or the perineal vaginal reconstruction for cancer, same operations that are used in the vaginoplasty for transgender self-identified persons. So a very advanced complexity.

In fact, when I sat for my boards, my oral boards, we had to present ten selected cases that the board







selected, and both of my examiners were startled at the level of complexity for a second-year person out of training, doing craniofacial surgery, free flap operations, massive limb salvage surgery. So that's the distinct difference, what you get in civilian versus what you get in the military. But both of them involved reconstructive as well as aesthetic cosmetic surgery.

Q. Sure. Now earlier, you were asked about whether you had performed certain procedures in the context of transgender surgery. Is that correct?

A. Yes, sir.

Q. And your answer was that you had not. Is that correct?

A. That's correct.

Q. Have you done those procedures in the context of your practice of plastic surgery?

A. I have.

Q. Could you describe that --







those -- those circumstances.

A. Well, as an example, a -- a very memorable case, a patient with what's called Fournier's gangrene, where essentially, they had a massive uncontrollable infection of the perineum that destroyed the scrotum, destroyed major portions of the penis, required what amounts to a reconstructive phalloplasty/scrotoplasty to reconstitute them after a long period of wound care. But the -- the operations to reconstruct the urethra is the same operation that's used to construct the urethra in a phalloplasty or construct the urethra in a metoidioplasty, same operations involving local flaps, mucosal grafts, tubularized flap operations. All of those are the same. Just the indication for the surgery is reconstructive rather than the surgeries for transgender.

Same thing with the vaginoplasty. Again, often --







oftentimes, reconstruction for radiation injuries secondary to management of vagineal -- vaginal perineal malignancies that require removal of large areas of soft tissue, again reconstruction of the -- the perineum, the external genitalia, the vaginal introitus, the vaginal canal, same operations using flaps, grafts to reconstruct as are used in the transgender surgery world.

Q. So, do you feel that your professional experience and qualifications allow you to comment on the -- the medical operations involved in surgery for a transgender individual?

A. Yes. I'm -- I'm very familiar with all of those operations.

Q. And -- and you've performed those operations?

A. Yes, I have.

Q. Okay. Just not in the context of gender transition?

A. That's correct.

Q. Okay. There was a -- there was a brief question, and -- and we didn't get back to it, about one of the articles on your CV on breast reconstruction. Is that -- is that correct?

A. Right. Yeah, that's one of my listed articles. That's right.

Q. Great. Did you want to -- did you want to say more about that article?

A. Yeah. So, that's -- was really my entrance into the breast reconstruction world. That actually started when I was still a general surgeon and I was collaborating with a plastic surgeon, and we examined the surgical planning for mastectomy in the setting of breast cancer or other causes and -- and the surgeon's role in designing those operations to get the best possible outcome. And it was actually a seminal article, up until recently was the most quoted article in the literature on breast reconstruction.





And that was actually the first article that spoke about conservation surgery in surgical planning for the treatment of breast malignancies or other breast problems.

Q. Dr. Lappert, you were asked questions about the policy or position statements of several professional organizations. Do you recall those questions?

A. I do.

Q. Did those exhibits or any of the questions change your opinion that affirmative hormonal treatment and surgery remains unproven and experimental?

A. It has not changed my opinion.

Q. You were asked questions about the evidence supporting the provision of hormonal therapy and surgical interventions for the treatment of gender dysphoria. Is that correct?

A. Yes.





Q. Were any of the questions or any of the studies that were presented to you, did they change your opinion that the existing medical evidence supporting those interventions is of very low quality and has methodological defects?

A. That did not change my opinion about those, no.

Q. And just to clarify, what is your opinion about the -- about the current state of the evidence supporting hormonal therapy for treatment of gender dysphoria?

A. My opinion is that all of these published studies that are used to support or to justify the use of puberty blockade, cross-sex hormones, or transgender -- gender-affirming surgery are of the lowest quality scientific evidence and are not sufficient to support care and interventions that have such far-reaching and lifelong effects on the patient.





Q. Are your opinions on that -- on that issue in this case based on anything other than your review of the scientific and medical literature and your training as a -- as a physician?

A. No, they're not.

Q. Dr. Lappert, you were asked about off-label use of Botox for certain muscle -- muscle groups. Is that correct?

A. Yes, I was.

Q. And you -- and you described -- and you stated that you've actually used Botox off label for treatment of those muscle groups before that was approved by the FDA. Is that correct?

A. That's correct.

Q. But you have also said that you believe that it is significant and -- and relevant to this case that the use of hormone and puberty blockers for treatment of gender dysphoria is off-label. Is that correct?

A. Yes.
Q. Could you disting- -- distinguish between why you hold the view that off-label uses of some pharmaceuticals is acceptable by a -- by a physician and when you consider that to be unacceptable by a physician?
A. Right. So, the off-label use of medications when there's a low risk to the patient or that the -- the possible adverse effect may be brief and that a favorable result is likely where risk is low, then that's justifiable to go off label with medications. But when you're -- when you're talking about significant risk to the patient and irreversible changes, that the off-label use places a tremendous burden on the practitioner to -- to have scientific evidence to support his decision to do that. And to not have sufficient evidence when doing that is a -- is a -- is a great difficulty in terms of consent and in terms of just general





medical/surgical decision-making.
So the distinction is the risk/benefit equation. How much risk are you placing the patient under, is it irreversible, and is the benefit so great that it's worth taking the risk.
Q. Sure. Just to follow up, and these are going to be my final questions, is it your view that there are no -- and does it continue to be your view that there are no -- currently no competent -- competently conducted long-term, peer-reviewed, reliable, and valid research studies documenting the number or percentage of patients who receive gender-affirming medical interventions who are helped by such procedures?
A. It's still my position that -- that the medical literature does not support those interventions of medical and surgical treatment for self-identified transgender persons.
Q. Is it still your view that there





are no published, reliable, and valid research studies that document a valid or reliable biological, medical, surgical, radiological, psychological, or other objective assessment of a -- of a patient's gender identity or gender dysphoria?
A. Yes. It's still my position that there are no tests that will confirm or refute the diagnosis of transgender, a diagnosis made by the patient. There's no way to test for that.
Q. All right. Is it still your view, after the evidence and the questions that you've been presented, that an unknown percentage of patients who present with gender dysphoria also suffer from mental illnesses that complicate and may distort their judgments and perceptions of gender identity?
A. Yes. The -- the world literature demonstrates a consistent and





significant level of comorbidities, including severe anxiety, major depression, self-harm. The patient is very likely to be on the autism spectrum. Suicidal ideation. And -- and the world literature supports that. So -- and those are -- those are serious issues, not only in terms of decision-making, but even on the question of consent and competence for consent.
Q. Just one -- one more thing I wanted to follow up with. Your testimony -- we didn't cover this, but I want to make sure that it's still your view that medical treatments may differ significantly by sex according to your chromosomal assessment but not based on your gender identity and that misinforming physicians of a patient's biological sex could have deleterious effects on treatment for medical conditions?
A. Yes, that's correct. And when

we discuss the issue of misgendering, that's what we were talking about. We were talking about placing the patient at risk. If you're having a -- a discussion or conversation about medical decision-making, you have to distinguish between biological male and female because you run -- there -- there are illnesses that predominate in females that don't exist in males; there are conditions that affect males that do not affect females, and you have to know that if you're going to offer care. But again, that hasn't been changed by -- by what I've seen or heard here today. That's still -- is still the case.

Q. Okay. And it's still your view that the use of hormones and surgery to treat gender dysphoria is not supported by the relevant scientific communities as discerned by your literature review and your training as a physician in reconstructive and plastic surgery?





A. Yes.

MR. KNEPPER: Those are my questions. I don't think I have anything else. Did you have follow-ups you wanted, Dmitriy?

MR. TISHYEVICH: Very, very briefly.

MR. KNEPPER: Okay.

EXAMINATION BY MR. TISHYEVICH:

Q. Doctor, you were just asked about your views on why it's okay to use Botox off-label but you have a different view of puberty blockers. Do you recall that?

A. I do.

Q. And one of your considerations is the risk/benefit profile of Botox; right?

A. Right.

Q. Do you know what a black box warning is, Doctor?

A. Yes.





Q. It's the strongest warning that the FDA can require; right?

A. That's -- that's right.

Q. And that warning is typically only used if studies indicate that the drug carries a significant risk of serious or even life-threatening adverse effects; right?

A. Yes.

Q. Do you know that Botox has a black box warning?

A. Yes, I do.

Q. It's for distant spread of toxin effect; right?

A. Yes.

Q. And the use of Botox has -- has resulted in reports of life-threatening injuries and death; right?

A. I'm even familiar with the case reports that reported that. Yes, sir.

Q. Okay. That's all I've got for you.

MR. KNEPPER: Okay. Thank you,





Dr. Lappert.

THE WITNESS: Thank you.

MR. KNEPPER: We're finished with your testimony.

Thank you, Dimitry. Thank you, Lane. Thank you, Andrew.

We can go off the record.

THE VIDEOGRAPHER: This is the end of Media Unit No. 7. We are off the record at 5:47 p.m. Thursday, September 30th, 2021, and this concludes today's testimony given by Dr. Patrick Lappert.

END OF DEPOSITION

(5:47 p.m.)

C E R T I F I C A T E

STATE OF ALABAMA )

COUNTY OF JEFFERSON )

I hereby certify that the above and foregoing proceeding was taken down by me by stenographic means, and that the content herein was produced in transcript form by computer aid under my supervision, and that the foregoing represents, to the best of my ability, a true and correct transcript of the proceedings occurring on said date at said time.

I further certify that I am neither of counsel nor of kin to the parties to the action; nor am I in anywise interested in the result of said case.

/s/ Lane C. Butler

LANE C. BUTLER, RPR, CRR, CCR

CCR# 418 -- Expires 9/30/22

Commissioner, State of Alabama

My Commission Expires: 2/11/25





John G. Knepper, Esquire

john@knepperllc.com

October 13, 2021

RE: Kadel, Et Al v. Folwell

9/30/2021, Patrick Lappert, M.D. (#4814384)

The above-referenced transcript is available for review.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason, on the attached Errata Sheet.

The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at erratas-cs@veritext.com

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If the witness fails to do so within the time allotted, the transcript may be used as if signed.

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Kadel, Et Al v. Folwell

Patrick Lappert, M.D. (#4814384)

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Patrick Lappert, M.D. Date





Kadel, Et Al v. Folwell

Patrick Lappert, M.D. (#4814384)

ACKNOWLEDGEMENT OF DEPONENT

I, Patrick Lappert, M.D., do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

_____ _____

Patrick Lappert, M.D. Date

*If notary is required

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_____ DAY OF _____, 20___.

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**(Doc. 209-3, Pages 498-575)**

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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# Exhibit 2

**IN THE UNITED STATES DISTRICT COURT**
**EASTERN DISTRICT OF ARKANSAS**
**CENTRAL DIVISION**

**DYLAN BRANDT, et al.,**

**PLAINTIFFS,**

**v.** **No. 4:21-CV-00450-JM**

**LESLIE RUTLEDGE, et al.,**

**DEFENDANTS.**

# EXPERT REPORT OF PATRICK W. LAPPERT, M.D.

Pursuant to 28 U.S.C. 1746, I declare:

## I. CREDENTIALS

1. I received my Bachelor of Arts in Biological Sciences at the University of California, Santa Barbara, 1979. There I was engaged in research in cell membrane physiology with Dr. Philip C. Laris, studying stoichiometry of the sodium: potassium ATPase pump. I received my Doctor of Medicine degree at the Uniformed Services University of the Health Sciences in 1983 at Bethesda, Maryland. I served my General Surgery Residency at the Naval Hospital Oakland/UC Davis East Bay Consortium, 1987-1991, and served as Chief Resident, Department of Surgery, Naval Hospital Oakland, 1990-1991. I also served a Plastic Surgery Residency at the University of Tennessee-Memphis, 1992-1994. My professional background, experience, and publications are described in more detail in my curriculum vitae, which is attached as Exhibit A to this declaration.

2. I have been Board Certified in Surgery (American Board of Surgery, 1992-2002), in Plastic Surgery (American Board of Plastic Surgery, 1997-2018).

3. I served as the Staff General Surgeon at the Naval Hospital in Oakland, California from 1991 to 1992, and as Associate Professor of Surgery, UC Davis-East Bay, from 1991 to 1992. I also served as a Plastic and Reconstructive Surgeon, Naval Medical Center, Portsmouth,

Virginia, from 1994 to 2002 and as Chairman of the Department of Plastic and Reconstructive Surgery at the Naval Hospital in Portsmouth, Virginia, from 1996 to 2002. I later served as Clinical Assistant Professor, Department of Surgery, Uniformed Services University of the Health Sciences from 1995 to 2002, and as the Founding Director of the Pediatric Cleft Palate and Craniofacial Deformities Clinic at the Naval Hospital in Portsmouth, Virginia, from 1996 to 2002, and also as the Founding Director of the Wound Care Center at the Naval Hospital Portsmouth, Virginia, 1995-2002. I have also served as a Staff Plastic Surgeon in Nebraska and Alabama.

4. I served as a Specialty Leader, Plastic and Reconstructive Surgery in the Office of the Surgeon General-USN from 1997 to 2002.

5. I served as Teaching Faculty at Eastern Virginia Medical School in the Division of Plastic Surgery from 1995 to 2002. I also served on the teaching faculty of the Via College of Osteopathic Medicine from 2017 to 2020. A list of my publications is included in my attached curriculum vitae.

6. I served as an Aviation Officer Candidate at the Naval Aviation Schools Command, NAS Pensacola, in 1978 and was Commissioned an Ensign, MC, USNR 1979, and Commissioned as a Lieutenant, MC, USN 1983. I served as a Designated Naval Flight Surgeon at the Naval Aerospace Medical Institute in 1985, and I was Assigned Marine Fighter/Attack Squadron-451, serving as Flight Surgeon, and serving as Radar Intercept Officer in the Marine F-4S Phantom, accumulating 235 flight hours, and trained for qualification as an Air Combat Tactics Instructor. I was deployed to the Western Pacific as UDP forward deployed fighter squadron in Korea, Japan, and the Philippines. I served in the US Navy for 24 years, and I served in the USMC for 3 years. I retired with the rank of Captain, USN in 2002.

7. As a physician and surgeon, I have treated many thousands of patients in seven states and four countries. My practice has included primary care; family medicine; aerospace medicine; general surgery; reconstructive surgery for people with combat injuries; cancer reconstructive surgeries, including extensive experience with microvascular surgery; pediatric congenital deformity; and the care of chronic wounds. I have practiced in rural medicine, urban trauma centers, military field hospitals, university teaching hospitals, and as a solo private practitioner. In my private practice, I have had occasion to treat many self-identified transgender patients for skin pathologies related to their use of high-dose sex steroids, laser therapies for management of facial hair both in transitioners and detransitioners. I have performed breast reversal surgeries for detransitioning patients. My practice is rated as "LGBTQ friendly" on social media. I have consulted with families with children who are experiencing gender discordance. I have given many presentations to professional meetings of educators and counselors on the subject of transgender medicine, and the present state of the science and treatment. I have discussed the scientific issues relevant to the case with many physicians and experts over a number of years and also discussed related issues with parents and others.

8. I have been retained as an expert witness by Defendants to testify in this lawsuit and am being compensated at the rate of $400 per hour, in addition to actual expenses incurred. My compensation does not depend on the outcome of this lawsuit. I have personal knowledge of the information in this expert report. To formulate the opinions expressed in this report, I have reviewed the medical literature as it pertains to the issues in question, as well as the documents of this case, and have discussed the subject of transgender medicine and surgery with professional colleagues from numerous specialties.

## II. ERRONEOUS USE OF THE WORD "RECONSTRUCTIVE" TO DESCRIBE GENDER AFFIRMATION SURGERIES

9. The transgender treatment industry uses the word "reconstructive" to characterize a group of surgical treatments that seek to alter the sexed appearance of the person.[1] It is important to understand that these procedures, because of the indications for surgery, the motivations for surgery, and the outcomes of surgery, are not reconstructive, but are to be properly understood to be cosmetic in nature.

10. Reconstructive surgeries are procedures that seek to establish or restore structures and their functioning that have been lost due to trauma, disease, in-utero developmental abnormalities, or surgical treatment for disease.[2] Such reconstructive surgeries must begin with the objective characterization of the defect, including abnormalities of form, and associated loss of function. This process of defining the defect begins with a thorough understanding of normal human form and function, and seeks to select, develop, and execute procedures that will restore both. In some cases function may be emphasized more than form, as when the mangled hand of a man is reconstructed. In other cases, reconstruction of form is all that is possible because as yet there are no techniques to restore function. An example of this is seen in the reconstruction of a

[1] *Gender Confirmation Surgery: Cosmetic or Reconstructive Procedure?*, Laungani & Brassard, Plastic & Reconstructive Surgery – Global Open: 2017 Jun; 5(6): p e1401. doi: 10.1097/GOX.0000000000001401. Members of the American Society of Plastic Surgery are encouraged to "interpret" for lay persons and other medical specialists that, although normal anatomy and function is being manipulated for a cosmetic result, the procedures should be labeled "reconstructive."

[2] The American Society of Plastic Surgery defines reconstructive surgery as: "Reconstructive surgery is performed to treat body parts affected aesthetically or functionally by congenital defects, developmental abnormalities or trauma." Am. Soc'y Plastic Surgery, *Reconstructive Procedures* (accessed Dec. 9, 2021), https://www.plasticsurgery.org/reconstructive-procedures.

woman's breast following cancer care. All that can be offered is the appearance of a breast; she will never be able to feed an infant through the reconstructed part.

11. This is to be contrasted with cosmetic, or aesthetic surgery in which the appearance of a structure is improved, but functional restoration is not addressed because no functional loss exists.[3] The object of the surgery is aesthetic, and there is no loss of form or function that needs to be reconstructed. It is aesthetic surgery because the motivation is aesthetic (subjective feelings about appearance).

12. As will be shown in the following discussion of specific surgical procedures, surgeries that are offered to self-identified transgender persons are not reconstructive because there is no defined loss of form and function being addressed by the surgeries. These patients are virtually all morphologically and functionally within the range of human normal.[4]

## III. CHEST MASCULINIZATION SURGERY

### A. Overview

13. Chest masculinization surgery is the cosmetic process by which a female chest is made to appear masculine.[5] It typically involves the removal of the breasts (mastectomy), the grafting of the nipples back onto the chest wall after reducing their size and changing their shape, and the use of liposuction techniques to contour the chest wall in an effort to make the muscles of the chest more visible. Suction drains are placed to prevent the accumulation of fluid under

[3] The American Society of Plastic Surgery defines cosmetic surgery as: "Cosmetic plastic surgery includes surgical and nonsurgical procedures that enhance and reshape structures of the body to improve appearance and confidence." Am. Soc'y Plastic Surgery, *Cosmetic Procedures* (accessed Dec. 9, 2021), https://www.plasticsurgery.org/cosmetic-procedures.

[4] *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 451 (5th ed. 2013) ("DSM-5") (defining "transgender").

[5] *Chest Masculinization Technique and Outcomes in 72 Double-incision Chest-contouring Procedures with Free Nipple Grafting*, Naides, et al., Plastic & Reconstructive Surgery – Global Open: 2021 Mar; 9(3): e3459. doi: 10.1097/GOX.0000000000003459.

the skin flaps that are raised in order to gain access to the breast mound. Pressure dressings are sutured on in order to hold the nipple grafts in position. Typically these dressings are removed after 5 days, and the drains removed after 7 to 10 days.

14. The surgery is done under general anesthesia, and lasts from 2 to 3 hours. Depending upon the health of the patient, the surgery may be outpatient, or require a brief hospitalization. The cost of the surgery is between $8,000 and $12,000. Those costs include post surgical care for 90 days, but do not include the fees for pre-operative consultation, laboratory costs such as blood work, pre-operative mammography, or pathology study of the removed breast tissue. Those costs may add $3-4,000 dollars.

**B. Expected Outcomes**

15. Because these are cosmetic surgeries, the outcomes of surgery are based on subjective reporting. The expectation that the patient typically has is that they will be able to present as male in appearance. Very often, the self-identified transgender person has been using compressive binders to conceal the presence of breast mounds. Very often the affected natal females will experience high levels of anxiety trying to hide their feminine appearance. Chest masculinization surgery obviates the need for concealing the patient's natal female contour, and simplifies the process by which they "pass" as male.

16. The scientific literature that is used to support chest masculinization in self-identified transgender young females who are seeking to present as males is of very low quality. These papers typically present small case collections from single centers, and suffer from self-selection bias, lack of control populations, and very short term follow-up. Additionally, all of the measures of outcome are subjective patient reporting which adds the problem of confirmation bias. The "satisfaction surveys" that are typically used are not proven instruments with known error rates, and cannot be used to compare outcomes with other studies. A startling example can be seen in a

recent publication from Dr. Johanna Olson Kennedy, who is in leadership at the gender clinic at University of Southern California. The paper[6] was published in JAMA Pediatrics in 2018, and purports to examine outcomes from chest masculinization in "transmasculine youth" by comparing to non-operated patients in the same clinic. Patients who had been operated on were enrolled through recruitment if they visited the clinic, by mailings, and by direct phone contact. The study included patients that ranged in age from 13 to 25 years old. Many of the post-operative patients could not be found by any of these methods. Of those that were contacted, over 26% refused to participate in the study. No mention is made of what happened to these patients. Were they lost to follow up because of poor outcomes of surgery? Were they hospitalized with depression or suicidal ideation? Had they committed suicide? The author does not ask. What is even more troubling is that the author describes the test instrument as having been designed in part by the adolescent patients themselves, and admits that the reliability of the test instrument is unproven. The fact that such an article was published in a leading peer-reviewed journal, by one of the national leaders in transgender services speaks to the very low quality of the literature used to support these interventions in children.

17. Dr. Anders Tolstrup undertook a comprehensive analysis of the state of the literature in transgender breast surgery in 2019.[7] He examined the world literature on the subject, and found 849 publications. Upon further review he found that of these, only 47 (5%) were suitable

[6] *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults Comparisons of Nonsurgical and Postsurgical Cohorts*, Olson Kennedy, et al., JAMA Pediatrics 2018; 172(5): 431-36. doi: 10.1001/jamapediatrics.2017.5440.

[7] *Outcome Measures in Gender-Confirming Chest Surgery: A Systematic Scoping Review*, Tolstrup, et al., Aesthetic Plastic Surgery 2020; 44(1): 219-28. doi: 10.1007/s00266-019-01523-1.

for inclusion in his scoping review. Of that small number only 60% addressed psychological outcomes, all of them patient reported. There were no papers reported by the author that addressed such questions as rates of psychiatric hospitalization, self-harm events such as drug and alcohol use, incarceration, or suicide.

**C. Common Reported Complications**

18. Mastectomy surgery is ordinarily performed for the diagnosis of breast cancer, or as a prophylactic procedure in women who have a strong family history and/or are positive for genetic markers of increased risk of breast cancer.[8] Because the operation involves the undermining of the chest wall skin (referred to as the raising of skin flaps) in order to expose the breast tissue for removal, there can be a risk of compromise to the blood supply of the skin. This would result in necrosis (death) of areas of the skin flaps (typically along the incised edges) that would result in wound healing problems, a need for debridement (removal of dead tissue), prolonged wound care, subsequent re-operation to close the wound or revise the resulting adverse scars. There can be problems with the accumulation of fluid (serum) under the skin flaps, even when drains are placed. This condition is called seroma, and may require repeated drainage, and result in an increased risk of post-operative wound infection. It is very common for patients to report broad areas of the chest wall skin that are permanently numb due to injury to the nerve supply of the skin.

19. Because mastectomy in the case of chest masculinization surgery almost always includes the removal of the nipples, and subsequent replacement in the form of free nipple grafts (a form of full-thickness skin grafting), the patient may experience partial or complete loss of the

[8] *Prophylactic mastectomy for the prevention of breast cancer: Review of the literature*, Alaofi, et al., Avicenna J. Med. 2018; 8(3): 67-77. doi: 10.4103/ajm.AJM_21_18.

grafts. This may require a period of wound care, debridement, and scar management. Even when the grafts are fully successful, there will be a complete loss of erotic sensibility from the nipple because the native connection to the fourth intercostal nerve will have been severed. This is the natural connection to those areas of the brain that are responsible for sexual arousal, a connection that cannot be recovered.

20. In summary, chest masculinization surgery results in the irreversible loss of the ability to breast feed because all breast tissue is removed. Furthermore, the surgery results in the irreversible loss of sexual arousability due to the loss of erotic sensibility from the nipple because the surgeries use free nipple graft techniques to achieve a masculine-appearing outcome. Thus, all breast function is permanently destroyed in order to achieve a cosmetic result. In light of this completely irreversible loss of function, it is particularly troubling that surgeons who perform these procedures are claiming to obtain informed consent from girls as young as 14, a group of patients who, in the eyes of virtually all states, do not have sufficient psychological maturity to even drive a car.

**D. Problems of Surgical Consent**

21. Whereas the typical patient undergoing mastectomy has historically been middle-aged, and already a mother, in the case of the transgender patient, they are typically young, nulliparous females even as young as 14 years old.[9] The purported justification for the surgery is the severe emotional distress of the patient, often including suicidal ideation, or even a history of suicide attempt. In all other areas of surgery, a patient who reports major depression, anxiety, suicidal ideation, or suicide attempt would be considered incompetent to give informed consent for

[9] *Behavioral Health Concerns and Eligibility Factors Among Adolescents and Young Adults Seeking Gender-Affirming Masculinizing Top Surgery*, Boskey, et al., LGBT Health 2020; 7(4). https://doi.org/10.1089/lgbt.2019.0213.

surgery. They would be referred for psychiatric care which, if successful in resolving the depression, anxiety and suicidal ideation, would remove the only claimed indication for the surgery in the first place.[10]

## IV. CHEST FEMINIZATION

22. Men who are seeking to present as women will often seek feminizing surgeries for the chest. After having been on supra-normal doses of estrogen hormones, these patients will experience varying degrees of breast enlargement.[11] For many, these hormonal effects will be sufficient, but a significant number will seek further enhancement. Most commonly this is done through prosthetic breast augmentation using implants of various constructions. These surgeries are virtually always outpatient procedures performed under general anesthesia supplemented with local anesthetics.[12] Several different incisions may be chosen from in order to gain access to the space behind the breast tissue, or behind the chest wall muscle (pectoral muscle). These are technically simple, but sometimes aesthetically challenging, surgeries. The surgeries are well tolerated, and most patients adapt to the presence of the implant within the first few weeks.

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[10] *See Cosmetic Surgery and Body Dysmorphic Disorder – An Update*, Higgins & Wysong, Int'l J. Womens' Dermatol. 2017; 4(1): 43-48. doi: 10.1016/j.ijwd.2017.09.007; *Body Dysmorphic Disorder*, Bjornsson, et al., Dialogues Clin. Neurosci. 2010; 12(2): 221-32. doi: 10.31887/DCNS.2010.12.2/abjornsson; *Body Dysmorphic Disorder and Cosmetic Surgery*, Crerand, et al., Plastic & Reconstructive Surgery. 2006; 118(7): p 167e-180e. doi: 10.1097/01.prs.0000242500.28431.24.

[11] *Breast Development in Transwomen After 1 Year of Cross-Sex Hormone Therapy: Results of a Prospective Multicenter Study*, de Blok, et al., J. Clinical Endocrinology & Metabolism 2018; 103(2): 532-38. https://doi.org/10.1210/jc.2017-01927.

[12] *Breast augmentation in male-to-female transgender patients: Technical considerations and outcomes*, Miller, et al., JPRAS Open 2019 Apr. 17; 21: 63-74. doi: 10.1016/j.jpra.2019.03.003. Note that in the analysis of outcomes this paper shows that patients who were not satisfied with the outcome of chest feminization had a high likelihood of having been physically or sexually abused, and a very high probability of having attempted suicide.

23. Complications in the early post operative period are few, and typically associated with incidental wound infection, or implant contamination. If the infection is not immediately controlled, it may lead to the need for implant removal until the infection is fully managed. Breast implants may develop dense fibrous capsules (most commonly caused by subclinical infection) resulting in deformity and/or pain. This problem may require re-operation in order to remove the capsule. Implant failure and the need to replace implants at some future time is always included in discussions with the patient pre-operatively as this happens with some frequency depending upon the type of implant chosen.

24. With chest feminization in self-identified transgender females and breast augmentation in natal females, there are some technical challenges that differ in terms of the likelihood of post-operative bleeding due to the generally larger caliber blood vessels that are encountered during surgery on the male chest, as well as the greater bulk of the pectoral muscle in men presenting more mechanical resistance to developing the "pocket" for the implant if it is being placed behind the muscle. Depending upon the desired final size, the use of a two-stage procedure where tissue expanders are used over a period of weeks to develop the pocket in men is reported. The surgery performed on transgender patients is purely cosmetic. Most of the time in females it is also cosmetic, although a significant percentage are performed for congenital deformities such as Poland syndrome wherein the female is born with a congenital absence of one breast, and absence of a portion of the pectoral muscle among other findings.[13] It is generally

[13] *Correcting Poland Syndrome with a Custom-Made Silicone Implant: Contribution of Three-Dimensional Computer-Aided Design Reconstruction*, Chavoin, et al., Plastic & Reconstructive Surgery 2018; 142(2): p 109e-119e. doi: 10.1097/PRS.0000000000004605.

considered a breach of medical ethics to offer purely cosmetic breast augmentation to adolescent females.[14]

## V. CHEST MASCULINIZATION NOT ANALOGOUS TO BREAST REDUCTION, MASTECTOMY FOR CANCER, OR GYNECOMASTECTOMY

25. The claim is made that chest masculinization in natal females is in the same moral and ethical category as breast reduction or mastectomy as cancer treatment in women, and gynecomastectomy in males. The claim is made that all of these surgeries involve the removal of normal breast tissue in order to relieve social stigma, improve the subjective sense of well-being in the patient, or decrease the risk of death. A careful examination of these three surgeries will show that there are startling differences with regard to diagnosis, pathology, and expected outcome; differences that show a very stark contrast.

### A. Breast Reduction

26. These are surgeries that reduce the size of the breast, while making every effort to preserve the function of the breast. While some techniques of breast reduction are used (free nipple graft) that result in functional loss, these are comparatively rare, and in every case techniques which preserve function are to be preferred, particularly when the patient is a nulliparous (childless) young adult.[15]

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[14] *Considerations in Breast Augmentation in the Adolescent Patient*, Jordan & Corcoran, Seminars in Plastic Surg. 2013; 27(1): 67-71. doi: 10.1055/s-0033-1343998.

[15] *See Reduction mammoplasty*, Purohit, Indian J. Plastic Surg. 2008; 41(Suppl): S64-S79 (listing eight essential elements of surgical planning in breast reduction, including preservation of function); *Impact of breast reduction surgery on breastfeeding: Systematic review of observational studies*, Kraut, et al., PLoS One 2017; 12(10): e0186591. https://doi.org/10.1371/journal.pone.0186591 (reviewing world literature regarding preservation of function in breast reduction).

27. While the surgery may be performed for strictly cosmetic reasons, for example to correct problems of symmetry, the majority of breast reductions are performed to resolve problems of neck, back, and shoulder pain that these patients suffer from. Patients who have a diagnosis of macromastia, or gigantomastia, are frequent visitors to their primary care doctors and pain management clinics because of the postural problems caused by enlarged breasts. They will frequently be referred to physical therapists, and chiropractic practitioners in an effort to resolve the chronic back and shoulder problems. When these non-surgical interventions fail to relieve the orthopedic problems, the patient will be referred to the plastic surgeon to be evaluated for breast reduction.[16]

28. Plastic surgical consultation for macromastia seeks to examine the likelihood that the presenting complaint of neck, back, and shoulder pain may be caused by the enlarged breasts. This assessment is based in an extensive body of actuarial data that demonstrates a very strong correlation between the measured size of the breast pre-operatively, the weight of the breast tissue removed during surgery, and the post operative resolution of neck, back, and shoulder pain. Thus, macromastia has very clear, objective diagnostic criteria. These diagnostic criteria have proven error rates that can be discussed with the patient pre-operatively. The patient can be told the actual likelihood that their suffering will be relieved by the surgery. Using pre-operative measurements, patients can even be given an estimate of the weight of the breast tissue to be removed, which provides them valid criteria to determine whether they can expect that the surgery will relieve them of the need for physical therapy, repeat x-rays, pain medications, and lost time from work.

[16] *Breast Reduction*, Sachs & Szymanski, STAT Pearls Aug.1, 2021, https://www.ncbi.nlm.nih.gov/books/NBK441974/ (discussing indications for referral to surgical services for breast reduction).

29. In summary, breast reduction surgery for women suffering from macromastia is based upon well-defined objective criteria. The success of the surgery in resolving the complaints of neck, back, and shoulder pain can be accurately predicted using pre-operative evaluation tests that have known error rates. Surgical informed consent is based in objectively verified predictors of outcome. In the vast majority of cases, the surgical procedure is designed to preserve breast function, which includes nipple sensation necessary for the release of brain hormones that stimulate milk production, as well as preserving the integral structural relationship between milk producing lobules, milk ducts, and the nipple so that functional breast feeding is preserved.

30. In contrast to breast reduction, chest masculinization surgery is not based in any objective criteria. The diagnosis is entirely subjective and is based in a sense of self that the patient experiences, but the clinician cannot observe or otherwise confirm. There is no objective diagnostic test for transgender.[17] Neither is there an objective measurement, with proven error rates, that can be used pre-operatively to predict who will benefit from the surgery.[18] Because of this lack of objective criteria, pre-operative informed consent is essentially nothing more than a discussion of potential complications, mixed with an unsupported optimism that there may be some benefit. Furthermore, whereas breast reduction makes every effort to preserve the human faculty of breast feeding, chest masculinization is guaranteed to permanently and irreversibly destroy that function.

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[17] *See Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*, Hruz, Linacre Quarterly 2020; 87(1): 34-42. doi: 10.1177/0024363919873762.

[18] The Endocrine Society states, for example, that the medical community "cannot predict the psychosexual outcome for any specific child." *Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, Hembree, et al., J. Clinical Endocrinology & Metabolism 2017; 102(11): 3869-3903. https://doi.org/ 10.1210/jc.2017-01658.

31. For these reasons, the attempt to characterize chest masculinization surgery in self-diagnosed transgender patients as "reconstructive surgery" is utterly false. Chest masculinization reconstructs nothing. It is surgery that seeks to change appearance based upon purely subjective grounds, which is by definition cosmetic surgery. Furthermore, these surgeries are an intentional mutilation, with the associated loss of a normal human function (breast feeding), for the sake of a cosmetic result, and thus violates one of the most fundamental principles of plastic surgery: "never sacrifice function for the sake of a cosmetic result."[19]

**B. Mastectomy to prevent future cancer**

32. Prophylactic mastectomy is likened to chest masculinization by proponents of transgender surgery. The claim is made that both surgeries remove normal breast tissue, both surgeries have the goal of decreasing anxiety (one is anxious about the risk of lethal cancer, the other is anxious about their sexed presentation), and that both dramatically decrease the risk of untimely death.

33. Prophylactic mastectomy has become more common in the era of advances in genetic testing. Genetic markers of inherited risk of breast cancer can be tested for in persons who have a family history of breast cancer. When the test demonstrates heritable mutations in those particular genes, a risk of future malignancy can be estimated based upon a large body of clinical evidence. Based upon the proven presence of these mutations, the patient can be counseled about the risk of long-term monitoring for breast cancer versus undergoing prophylactic mastectomy. In this way, a woman who is anxious and fearful about developing a potentially lethal cancer can

[19] Plastic surgeon and Nobel Laureate Joseph Murray discusses this, among other foundational ethical principles that have informed the specialty through the years in the first chapter of the textbook *Plastic Surgery: Indications, Operations, and Outcomes*, Achauer, et al., Mosby Press, St. Louis, MO, 2000.

understand the risk and make an informed decision about how she wishes to manage that risk. Prophylactic mastectomy in women with the gene mutations has been demonstrated to reduce the risk of breast cancer by over 90%. These numerical values for risk and benefit are based upon proven objective tests with known error rates.[20]

34. Although prophylactic mastectomy and chest masculinization both remove apparently normal breast tissue, that is where the similarity ends. Chest masculinization surgery is purported to decrease anxiety and death from suicide, but this claim is based upon the very optimistic interpretation of data from very short term studies that suffer from poor follow-up, severe self-selection bias, lack of long-term data, lack of valid study cohort population, and small sample size.[21] Long term, population based longitudinal studies from Sweden have shown that the aggregate risk of death in fully surgically transitioned subjects is 19 times higher as compared to age and sex matched controls. This is essentially the same risk of death from suicide that is observed in non-operated transgender patients.[22]

35. Additionally, there are no pre-operative tests that can be performed on self-identified transgender patients that can be used to estimate what potential benefit they might obtain (if any) from the irreversible destruction of their breasts, and the attendant permanent loss of the ability to breast feed. This means that pre-operative informed consent is without substance beyond a simple discussion of potential surgical complications. Those surgical risks cannot be weighed against the potential benefits of surgery since those benefits have not been proven.

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[20] *Bilateral Prophylactic Mastectomy Reduces Breast Cancer Risk in BRCA1 and BRCA2 Mutation Carriers: The PROSE Study Group*, Rebbeck, et al., J. of Clinical Oncology 2004; 22(6). doi: 10.1200/JCO.2004.04.188.

[21] *See supra* ¶¶ 16-17 (discussing dismal data quality used to support these interventions).

[22] *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, Dhejne, et al., PLoS One 2011; 6(2): e16885. https://doi.org/10.1371/journal.pone.0016885.

36. Another crucial point as regards consent for surgery is the fact that any person who is reporting persistent and severe suicidal ideation would not be considered psychologically competent to give consent to such life-changing surgery, whether prophylactic mastectomy or chest masculinization. Yet in the case of the chest masculinization, the threat of suicide is held out as the reason for offering surgery.[23]

**C. Gynecomastectomy**

37. Gynecomastectomy is surgery performed on natal males who develop breast tissue. It may require removal of tissue from both sides of the chest, but very often the problem only affects one side. It results in variable amounts of abnormal growth, often with associated pain and tenderness. The condition of gynecomastia is to be distinguished from the symmetrical appearance of breast like structures caused by obesity. Gynecomastia is the development of female-type fibroglandular breast masses in a male.[24]

38. The diagnosis has objective clinical features that help to make the diagnosis. These include: enlarging masses behind the nipples that appear during adolescence; masses that are discreet and clinically distinguishable from general fat distribution. The recent use of medications or drugs that are known to provoke the condition, the presence of liver or kidney diseases associated with gynecomastia may increase the likelihood of the diagnosis. The condition has known association with alterations in the ratio of androgen (male hormone) to estrogen (female hormones). Response to estrogen receptor blocking drugs (such as Tamoxifen), or aromatase inhibitor drugs would tend to confirm the diagnosis.

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[23] *Sex, gender and gender identity: a reevaluation of the evidence*, Griffin, et al., BJPsych Bulletin 2020; 45(5): 291-99. doi: 10.1192/bjb.2020.73.

[24] *Gynecomastia: Pathophysiology, Evaluation, and Management*, Johnson & Murad, Mayo Clinic Proceedings 2009; 84(11): 1010-15. doi: 10.1016/S0025-6196(11)60671-X.

39. Finally, the diagnosis is confirmed by tissue pathology that demonstrates the presence of proliferating glandular tissue that is consistent with female-type fibroglandular tissue which should not be present in the male.

40. Although gynecomastectomy surgery has a cosmetic result as one of its goals, it does so by removing objectively abnormal tissue. It does not destroy a normal human capacity (breast feeding) in an effort to achieve a cosmetic result.

## VI. THE ERRONEOUS CONFLATION OF TRANSGENDER WITH INTERSEX OR DISORDERS OF SEXUAL DIFFERENTIATION

41. One of the features of popular literature that is used to support transgender as a scientifically based medical diagnosis is the frequency with which it is muddled in with objective disorders of sexual differentiation (often referred to as intersex conditions, or the now out of use term "hermaphroditism").[25]

42. Disorders of Sexual Differentiation (DSD) are a collection of congenital disorders that result from discordance in chromosomal, gonadal, and phenotypic development. These conditions occur at a rate somewhere between 1:1000 and 1:4500 live births.[26] Some of these conditions occur because of problems of chromosomal assortment during the formation of gametes (sperm and ova), which results in abnormal sex chromosome count, as is seen in Kleinfelter Syndrome, or Turner Syndrome. Some result from mutations in genes which code for sex hormone receptors, such as children born with Androgen Insensitivity Syndrome. Other DSDs can result

[25] *See* DSM-5, *supra*, at 451 (distinguishing "intersex" and "transgender," among other terms).

[26] *How sexually dimorphic are we? Review and synthesis*, Blackless, et al., Am. J. Hum. Biol. 2000; 12(2): 151-66. doi: 10.1002/(SICI)1520-6300(200003/04)12:2<151::AID-AJHB1>3.0.CO;2-F; *Consequences of the ESPE/LWPES guidelines for diagnosis and treatment of disorders of sex development*, Hughes, et al., Best Practice & Research Clinical Endocrinology & Metabolism 2007; 21(3): 351-65. doi: 10.1016/j.beem.2007.06.003.

from inherited traits that result in abnormalities in hormone metabolism and the resulting abnormalities in levels of sex hormones producing ambiguities in the formation of the genital structures, as is seen in congenital adrenal hyperplasia (CAH).

43. Disorders of Sexual Differentiation are conditions that have objective diagnostic criteria. The diagnoses, which can frequently be made on the basis of clinical examination, can be confirmed by objective tests. For example, Kleinfelter Syndrome (46 x,x,y) can be suspected based upon a constellation of physical findings, such as breast development, a wide feminine pelvis, proportionally long legs relative to height, and female hair pattern in a person with male external genitalia.[27] If the physician obtains a karyotyping study (chromosome count), it will be found that they are men ('y' chromosome present that has coded for the differentiation of the gonad into testes), but these men have an extra 'x' chromosome which has varying deleterious effects on their masculine nature (infertility, underdeveloped genitalia, and varying degrees of intellectual impairment are some of the most prominent effects). Management of Kleinfelter syndrome generally does not include surgical interventions.

44. Among the most common causes of DSD is congenital adrenal hyperplasia ("CAH"), in which inherited abnormalities in hormone metabolism results in varying degrees of genital ambiguity. The overwhelming majority of these cases involve females (46, x,x) who have varying degrees of virilization of their genitalia. In over 95% of cases they are correctly identi-

[27] *Klinefelter Syndrome*, Dobs & Matsumoto, J. of Clinical Endocrinology & Metabolism 2009; 94(12): f2. https://doi.org/10.1210/jcem.94.12.9990.

fied as female by simple inspection. Early diagnosis is typical and crucial as a significant percentage will be at risk of severe and potentially lethal effects of hormone abnormality on regulation of salt levels in the blood, and associated inadequate fluid volumes.[28]

45. The virilizing effects of CAH are variable, and graded using the Prader scale (I-V). In addition to the cosmetic effects including overgrowth of the clitoris into a penis-sized structure, there are also important functional effects that include the absence of normal vaginal canal opening and urethral opening, having instead a common urogenital sinus where vaginal canal and urethra are joined higher in the pelvis causing problems with urinary tract infections, and retained menstrual blood among other problems if not surgically treated.

46. Surgical management includes the separation of the urethral canal from the vaginal canal, and the creation of a normal relation between the two. Skin from the overgrown clitoris is contributed to the creation of the vaginal introitus. In this procedure, the dimensions of the clitoris are reduced using techniques that preserve erotic sensation. The timing of these surgeries are debated when simple cosmesis is the only issue (as in Prader I-II), however when urologic problems as described above are at issue, most of the surgeries happen before the end of the second year of life.

47. As can be seen from these examples, there is no clinical scientific basis for placing transgender in the same category as DSDs. Transgender is a subjective diagnosis made by the patient, that is not accessible to objective clinical, laboratory, or radiologic confirmation by the treating physician. There is no objective pathology that can be characterized, and used as the ba-

[28] *Congenital Adrenal Hyperplasia*, Witchel, J. Pediatric & Adolescent Gynecology 2017; 30(5): 520-34. doi: 10.1016/j.jpag.2017.04.001.

sis for medical and surgical planning. The self-identified transgender person is genetically, hormonally, biochemically, and morphologically normal. The use of hormonal and surgical techniques to alter the physical appearance of the person is entirely driven by subjective, and self-reported desires which places these interventions, by definition, in the category of cosmetic interventions. Furthermore, the fact that the majority of these interventions result in the permanent loss of important human functions, places them in the category of unethical cosmetic interventions.

48. By contrast, DSDs are objectively diagnosable, either by inspection or genetic testing. And surgical treatment of DSDs, such as those surgeries performed to correct the serious urologic problems that can be caused by CAH, are performed to initiate normal functioning of affected organs, rather than disrupt functioning.

## VII. OVERALL CONCLUSION

49. So-called gender affirmation surgeries seek a cosmetic outcome at the expense of normal functioning. To destroy normal, functional breasts and genitalia in order to produce a non-functional counterfeit is a complete abrogation of one of the most fundamental principles of plastic and reconstructive surgery. If a patient came to the surgeon's office and made the subjective claim that, although they have brown eyes, they identify as blue-eyed, I would not remove their functioning eyes and replace them with glass eyes of a lovely blue. Yet this is precisely what gender affirmation surgeons are doing with these operations.

50. The claim that these surgeries "save lives by reducing the risk of suicide," is supported by the lowest quality of scientific evidence.[29] More reliable long-term, population based studies show the exact opposite.[30]

**I declare under penalty of perjury that the foregoing is true and correct.**

**Executed on December 10, 2021.**

Patrick W. Lappert, M.D.

[29] A Finnish medical institution, for example, recently determined that "reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions." Palveluvalikoima, *Recommendation of the Council for Choices in Health Care in Finland (PALKO / COHERE Finland)*, at 7 (2020), https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf. Therefore, it concluded that such claimed benefits are "not a valid justification for gender reassignment." *Id.*

[30] Dhejne, *supra*, *Long-Term Follow-Up*.

**Curriculum Vitae**

**Patrick W. Lappert, MD**
**Board Certified in Surgery and Plastic Surgery**
**Decatur, AL 35603**

**Education and Training :**

— Bachelor of Arts in Biological Sciences at the University of California, Santa Barbara, 1979. Research in cell membrane physiology with Dr. Philip C. Laris, studying stoichiometry of the sodium: potassium ATPase pump.

— M.D., Doctor of Medicine degree at the Uniformed Services University of the Health Sciences, 1983 at Bethesda, Md.

— General Surgery Residency at the Naval Hospital Oakland/ UC Davis East Bay Consortium, 1987-1991

— Chief Resident, Department of Surgery, Naval Hospital Oakland, 1990-1991.

— Plastic Surgery Residency at the University of Tennessee- Memphis, 1992-1994.

**Board Certifications in Medicine :**

— Board Certified in Surgery — American Board of Surgery, 1992, in

— Board Certified in Plastic Surgery — American Board of Plastic Surgery, 1997; American Board of Plastic Surgery, 2008.

**Medical Staff Appointments :**

Exhibit A

— Staff General Surgeon at the Naval Hospital Oakland, CA 1991-1992

— Associate Professor of Surgery, UC Davis-East Bay, 1991-1992.

— Plastic and Reconstructive Surgeon, Naval Medical Center, Portsmouth, VA 1994-2002

— Chairman, Department of Plastic and Reconstructive Surgery, Naval Hospital Portsmouth, VA 1996-2002.

— Clinical Assistant Professor, Department of Surgery, Uniformed Services University of the Health Sciences, 1995-2002

— Founding Director, Pediatric Cleft Palate and Craniofacial Deformities Clinic, Naval Hospital Portsmouth, VA 1996-20002

— Founding Director, Wound Care Center, Naval Hospital Portsmouth, VA 1995-2002.

— Staff Plastic Surgeon in Nebraska, and Alabama.

**U.S. Surgeon General Service:**

— Specialty Leader, Plastic and Reconstructive Surgery, Office of the Surgeon General-USN, 1997-2002

**Faculty Appointments:**

— Teaching Faculty at Eastern Virginia Medical School, Division of Plastic Surgery, 1995-2002

**Military Service :**

— Aviation Officer Candidate, Naval Aviation Schools Command, NAS Pensacola, 1978

— Commissioned an Ensign, MC, USNR 1979 and Commissioned as a Lieutenant, MC, USN 1983 .

— Designated Naval Flight Surgeon, Naval Aerospace Medical Institute, 1985

— Flight Surgeon, Marine Fighter/ Attack Squadron-451

— Radar Intercept Officer in the Marine F-4S Phantom, accumulating 235 flight hours, and trained for qualification as an Air Combat Tactics Instructor.

— Deployed to the Western Pacific as UDP forward deployed fighter squadron in Korea, Japan, and the Philippines.

— Service in the US Navy for 24 years

— Service in the US Marine Corp. for 3 years.

— Retired with the rank of Captain, USN in 2002

**Military Awards:**

— Navy Commendation Medal - For service with Marine Fighter/Attack Squadron - 451

— Meritorious Unit Citation- 3rd award

— Humanitarian Service Medal - For service in the aftermath of the Loma Prieta earthquake.

**Publications - Peer Reviewed Medical Journals** :

— Lappert PW. Peritoneal Fluid in Human Acute Pancreatitis. Surgery. 1987 Sep;102(3):553-4

— Toth B, Lappert P. Modified Skin Incisions for Mastectomy: The Need for Plastic Surgical Input in Preoperative Planning. J Plastic and Reconstructive Surgery. 1991; 87: 1048-53

— Lappert P. Patch Esophagoplasty. J Plastic and Reconstructive Surgery. 1993; 91 (5): 967-8

— Smoot E C III, Bowen D G, Lappert P, Ruiz J A. Delayed development of an ectopic frontal sinus mucocele after pediatric cranial trauma. *J Craniofacial Surg.* 1995;6(4):327–331.

— Lappert PW. Scarless Fetal Skin Repair: "Unborn Patients" and "Fetal Material". J Plastic and Reconstructive Surgery. 1996 Nov;98(6):1125

— Lappert PW, Lee JW. Treatment of an isolated outer table frontal sinus fracture using endoscopic reduction and fixation. P!astic and Reconstructive Surgery 1998;102(5):1642-5.

**Publications - Medical Textbooks:**

— Wound Management in the Military. Lappert PW, Weiss DD, Eriksson E. Plastic Surgery: Indications, Operations, and Outcomes, Vol. 1; 53-63. Mosby. St. Louis, MO 2000

**Operations and Clinical Experience - Consultations and Discussions :** As a physician and surgeon, I have treated many thousands of patients in 7 states and 4 foreign nations. My practice has included Primary Care, Family Medicine, Aerospace Medicine, General Surgery, Reconstructive Surgery for combat injured, cancer reconstructive surgeries including extensive experience with microvascular surgery, Pediatric Congenital Deformity, and the care of chronic wounds. I have practiced in rural medicine, urban trauma centers, military field hospitals, university teaching hospitals, and as a solo private practitioner. In my private practice I have had

occasion to treat many self-identified transgender patients for skin pathologies related to their use of high dose sex steroids, laser therapies for management of facial hair both in transitioners and detransitioners. I have performed breast reversal surgeries for detransitioning patients. My practice is rated as "LGBTQ friendly" on social media. I have consulted with families with children who are experiencing gender discordance. I have given many presentations to professional meetings of educators and counselors on the subject of transgender, and the present state of the science and treatment. I have discussed the scientific issues relevant to the case with many physicians and experts over a number of years and also discussed related issues with parents and others.

# Exhibit 3

**IN THE UNITED STATES DISTRICT COURT**
**EASTERN DISTRICT OF ARKANSAS**
**CENTRAL DIVISION**

**DYLAN BRANDT, et al.,**

**PLAINTIFFS,**

**v.** **No. 4:21-CV-00450-JM**

**LESLIE RUTLEDGE, et al.,**

**DEFENDANTS.**

**REBUTTAL EXPERT REPORT OF PATRICK W. LAPPERT, M.D.**

Pursuant to 28 U.S.C. 1746, I declare:

1. My name is Patrick W. Lappert, MD. I have been retained by counsel for the defendants as one expert in connection with the above captioned litigation.

2. The following is in rebuttal to the reports offered by plaintiffs' experts, and I offer it in conjunction with my expert report previously submitted.

3. Attached to my initial report (dated December 10, 2021) is a summary of my credentials and experience in my capacity as a physician and a plastic and reconstructive surgeon. I will limit this rebuttal to those issues raised by plaintiffs' experts that fall within my particular area of expertise, recognizing that the other issues will be addressed by defendants' experts in pediatric endocrinology, psychiatry, and the particular problems of evaluating the quality of scientific evidence in those fields of practice. This rebuttal will be limited to those questions raised by plaintiffs' experts that weren't already discussed in my previous report.

4. The following is a summary of the opinions contained in this limited rebuttal:

a. The assertion by plaintiffs' experts that H.B. 1570 bans treatment protocols that are well supported in the scientific literature is false. The putative support for these permanently life altering treatments is only an aggregation of strong opinions held

by some experts. These opinions are not themselves supported by valid scientific evidence. Furthermore, the recent trend world-wide of stepping back from hormonal manipulation and surgery in transgender adolescents in such places as Sweden, Great Britain, and Finland, demonstrates the growing controversy in the offering of these irreversible treatments to children. Characterizing these as universally accepted treatments is false.

b. The assertion by plaintiffs' experts that valid informed consent can be obtained when offering children puberty blockade, cross-sex hormones, and surgery to manage gender dysphoria is a claim that is not supported in the medical literature. Valid informed consent cannot be obtained because the long-term benefits of these interventions have not been demonstrated (to the contrary they have been shown to be ineffective in long-term, population-based studies), alternative treatment options are not offered in the affirmation care model, and historically valid alternative treatment models are presented as having been disproved by valid scientific study. Together these distortions place the parents and guardians in a position where they are unable to give *informed* consent.

c. The assertion that the hormonal and surgical treatment of transgender children provides long-term relief from self-harm and suicide is not supported by meaningful scientific evidence. As will be seen in this rebuttal, the medical publications chosen by plaintiffs' experts to support such irreversible treatments as mastectomy do not in fact support such a conclusion. Furthermore, the papers chosen by plaintiffs' experts demonstrate systematic problems in the way such articles are peer reviewed.

d. The assertion by plaintiffs' experts that complete removal of healthy beasts in self-identified transgender adolescents is medically and ethically equivalent to

gynecomastia surgery performed in male children with objective pathologies is not supported even by a fundamental understanding of the relationship between correct medical diagnosis and basic decision-making in surgical planning.

e. The assertion by plaintiffs' experts that surgical treatment for congenital disorders of sexual development (DSDs) is medically and ethically equivalent to the surgical destruction of normal genital organs and the creation of counterfeit genital structures is not supported by established principles of medical diagnosis and surgical planning. Comparing the highly complex problems of diagnosis and treatment of DSDs with a condition that has no objective basis for diagnosis, and only subjective dissatisfaction with sexed appearance, is false and misleading.

***Government Interest in Regulating Cosmetic Surgical Procedures in Children***

5. Historically, most gender-transition surgical procedures in minors are surgery of the breast. The breast surgeries offered are almost exclusively to females seeking to present as males, and involve the surgical removal of the breast, and cosmetic contouring of the chest wall. The indications for the surgery are entirely subjective, and based upon the patient's unhappiness with their appearance.[1] There is no objective medical indication for these procedures.[2] For this reason, they can be rightly categorized as cosmetic.

[1] *See Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*, Hruz, Linacre Quarterly 2020; 87(1): 34-42. doi: 10.1177/0024363919873762; *see also* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 452-53 (5th ed. 2013) (listing DSM-5's diagnostic criteria for gender dysphoria).

[2] For a discussion of WPATH's criteria for gender-transition surgery, see World Professional Association for Transgender Health. (2012). *Standards of care for the health of transsexual,transgender, and gender nonconforming people* [7th Version], at pp.58-64. https://www.wpath.org/publications/soc.

6. Cosmetic breast augmentation for anything other than congenital breast deformities (such as Poland Syndrome) in minors is not considered ethical professional conduct.[3] If an adolescent presented to a plastic surgeon and expressed a desire to have large breasts, the surgeon would be right to hesitate. Yet in the case of the self-identified transgender minor the complete removal of the breast with the attendant permanent loss of breastfeeding and erotic sensibility is to be seen as an exception. The state has a true and abiding interest in protecting minors from such harms.

7. While breast surgery has been the most common gender-transition surgery, genital surgery on self-identified transgender adolescents is reported in the literature.[4] Moreover, these recent papers suggest that any lower limit on age at which children might undergo these irreversible genital surgeries can be thought of as subject to individual clinical decisions. This approach of essentially ignoring age limits as set out in the WPATH Standards of Care for the sake of particular patients makes meaningless the very definition of a "standard of care." The words "standard of care" are used to describe conduct of care that is not subject to clinical judgement, and if ignored has a high likelihood of harm to the patient. Interestingly, the draft of version 8 of WPATH's Standards recommends lowering the age limit to 17 for many surgeries, including metoidioplasty, orchidectomy, vaginoplasty, and hysterectomy. Only phalloplasty is reserved for 18-year-olds. And even these age limits could give way if "there are significant, compelling rea-

[3] *Considerations in Breast Augmentation in the Adolescent Patient*, Jordan & Corcoran, Seminars in Plastic Surg. 2013; 27(1): 67-71. doi: 10.1055/s-0033-1343998.

[4] *E.g.*, *Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States*, Milrod & Karasic, J. Sex. Med. 2017; 14(4): 624-34. doi: 10.1016/j.jsxm.2017.02.007; *Transgender adolescents and genital-alignment surgery: Is age restriction justified?*, Horowicz, Clinical Ethics 2019; 14(2): 94-103. doi: 10.1177/1477750919845087.

sons to take an individualized approach, considering the factors unique to the adolescent treatment frame."[5] The proposed changes in version 8 likely explain why Dr. Karasic cites only "[t]he WPATH SOC 7" in his discussion of genital surgery in paragraph 30 of his report. Given that, "[f]or the upcoming WPATH Standards of Care, Version 8," Dr. Karasic is "the lead author on the Mental Health chapter," a fact he discusses in paragraph 8 of his report, it seems unlikely that he is unfamiliar with the lowered age limits in version 8's guidelines. His failure to bring this fact to the attention of the court is troubling, given that the central issue at hand is the age-based prohibition of these treatments.

***Informed Consent***

8. The protection of children in situations requiring informed consent is a crucial problem that the state has a historic and abiding interest in.[6]

9. In the particular situation of self-identified transgender children, it becomes a most significant problem, given that they are being submitted for permanently life-altering interventions. In my opinion as a plastic and reconstructive surgeon, the life-altering nature of hormonal and surgical interventions needs to be addressed from the moment of the child's entry into the gender-transition system, given the fact that the overwhelming majority of children who first begin puberty blockade, go onto the physically altering and permanent changes produced by cross sex hormones, and many ultimately also pursue surgery.[7]

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[5] World Professional Association for Transgender Health. (Dec. 2021). DRAFT Standards of Care [8th Version], chapter entitled *Adolescent* (final publication expected spring 2022).

[6] *Minors and Cosmetic Surgery; An argument for state intervention*, Diaz, DePaul Journal of Healthcare Law Oct. 2015, 14(2), art. 3.

[7] *E.g., Factors Associated with Gender-Affirming Surgery and Age of Hormone Therapy Initiation Among Transgender Adults*, Beckwith, et al., Transgender Health Dec. 2017, 2(1): 156-64. doi: 10.1089/trgh.2017.0028.

10. Informed consent has several requirement that need to be met if such consent is to be deemed valid.[8] These requirements include a thorough discussion of the details of the proposed procedure including risks, known complications, and some measure of the likelihood of a favorable outcome. The discussion must include alternative treatments, and their risks, known complications and their likelihood of a favorable outcome. In the case of the interventions associated with gender-transition medicine and surgery, the favorable outcomes should be evident over the lifetime of the patient, given that they are permanently sacrificing structures and capacities (breasts and breastfeeding, or genitals and fertility). Plaintiffs' experts do not offer evidence of such lifetime benefits.

11. For example, in paragraph 40 of Dr. Antommaria's report, he cites in support of pubertal suppression in transgender adolescents, a 2016 article that makes the claim of efficacy and safety for this intervention.[9] That broad claim is inconsistent with more recent work. A 2020 paper by Dr. Turban, who is also testifying for plaintiffs, begins with the words, "There are limited data regarding the mental health benefits of this treatment," referring to pubertal suppression in gender dysphoric patients.[10]

12. Dr. Karasic provides another example of the problems with plaintiffs' evidence. In paragraph 29 of his report, Dr. Karasic states that the child will only be offered cross-sex hormones "if and when medically indicated." This is a crucial issue because it speaks to the issue of the offering of alternative treatments during the process of obtaining informed consent. The

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[8] *See Informed consent for clinical treatment*, Hall, et al., Canadian Med. Ass'n J. 2021, 184(5): 533-40. doi: 10.1503/cmaj.112120.

[9] *Efficacy and Safety of Gonadoptropin-Releasing Hormone Agonist Treatment to Suppress Puberty in Gender Dysphoric Adolescents*, Schagen, et al., J. Sex. Med. 2016, 13(7): 1125-32. doi: 10.1016/j.jsxm.2016.05.004.

[10] *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, Turban, et al., Pediatrics 2020, 145(2): e20191725. doi: 10.1542/peds.2019-1725.

phrase "when medically indicated" implies that there are criteria for inclusion or exclusion from this treatment. Yet none of the criteria for inclusion that Dr. Karasic offers in his paragraphs 21-22 are medical in nature. They are all psychological, subjective criteria found in the Diagnostic and Statistical Manual. It would be assumed that those persons excluded from hormonal manipulation by these unspecified medical indications are being offered some alternative treatment for their gender dysphoria yet Dr. Karasic describes gender affirmation as the only treatment that can be offered, for example in paragraph 26.

13. This single track of care without alternative treatments is further revealed in the report of Dr. Adkins. In paragraph 30 of her report she states that any psychiatric, medical or social problems that could interfere with hormonal treatments are managed in order to make the stable enough to start hormone therapy. This is a remarkable admission on her part. It is to be remembered that among transgender adolescents there is a very high incidence of autism spectrum disorder (one study found over 30%), major depression disorders, and anxiety disorders (between about a quarter and a half).[11] Yet according to Dr. Adkins's report, these comorbid neuropsychiatric conditions are only managed so that gender-transition hormonal therapy can be started. The neuropsychiatric conditions are not evaluated as possibly causal of the gender confusion, rather they are managed as obstacles to the administration of drastic, and for the most part irreversible hormonal treatments.

14. Just as with Dr. Antommaria's report, Dr. Adkins describes puberty blockade as "fully reversible" in paragraph 24. But the very papers cited by the experts in support of these interventions report that the likelihood that children who start puberty blockade will continue on

[11] *A 2020 Review of Mental Health Comorbidity in Gender Dysphoric and Gender Non-Conforming People*, Paz-Otero, et al., J. Psychiatry Treatment & Rsch. 2021, 3(1): 44-55. doi: 10.36959/784/425.

to cross-sex hormones is virtually 100%.[12] So their point does not reflect the reality of gender transition, given that cross sex hormones result in a high probability of irreversible changes, particularly in females seeking to present as males.

15. Taken together, these issues make consent very questionable. Parents are told that there is an elevated risk of self harm and suicide unless the child is treated, they are not given any alternative therapies, and the one therapeutic track they are offered, the affirmation model, has no long term (greater than 5 to 7 years) data to support its effectiveness.[13] What is particularly troublesome in this case is that the little long term data that is available (*e.g.*, from the Swedish national database) shows that beyond 8-10 years following completion of medical and surgical transition, the suicide rate, substance abuse rate, incarceration rate, and psychiatric hospitalization rate return to the same alarmingly high levels seen in transgender persons who do not undergo gender transition.[14] The fact that these findings are not discussed by the plaintiffs' experts further calls into question the validity of the consent process as they describe it.

***Claimed Efficacy of Gender-Transition Surgery in Minors***

16. The plaintiffs' experts make the claim that surgical procedures performed on adolescents have been shown to improve mental health. Evidence does not support this claim. As I

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[12] *E.g., Puberty Suppression in Adolescents With Gender Identity Disorder: A Prospective Follow-Up Study*, DeVries, et al., J. of Sex. Med. 2011, 8(8): 2276-83. doi: 10.1111/j.1743-6109.2010.01943.x.

[13] For a discussion of the data problems, see paragraphs 16-17 in my initial report.

[14] *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, Dhejne, et al., PLoS ONE 2011, 6(2): e16885. doi: 10.1371/journal.pone.0016885. In this longitudinal, population based study, the data as presented by the authors shows that the long-term follow up (beyond 7 years) shows that fully medically and surgically transitioned patients have an aggregate risk of completed suicide that is 19.1 times higher than the risk for age- and sex-matched controls in the same population. In the case of natal females seeking to present as males, the risk is 40 times higher. (For these figures, see Table S1.) This places the risk of suicide in the same range as that reported for self-identified transgender persons who are not offered or are unable to receive transgender medical and surgical treatments.

will show below, all of the articles cited by plaintiffs' experts are of the lowest grade of medical evidence, and cannot be interpreted to show that mental health is improved in the long term.

17. Dr. Turban makes the claim in paragraph 16 of his report that "peer reviewed research" shows proven benefit from surgical removal of the breast ("chest masculinization") in females who identify as males. To support this assertion, Dr. Turban cites 3 articles. The first article from 2018 by Olson-Kennedy et al. I discussed in my original report, and will summarize it here for convenience.[15]

18. The study sought to demonstrate the efficacy of chest masculinization in transmasculine patients (females seeking to present as males) who were being treated at the gender clinic that the author leads. Patients were recruited from among children who happened to visit the clinic during the study period. This method resulted in an abundance of children who had not had the chest surgery, so the authors began a recruiting process using telephone and messaging of patients who had undergone chest surgery (including at least one patient age 13). The authors report that 26% of the post operative patients could not be found. Of the patients that were found, only 72% completed the survey. This means that roughly 50% of the post surgical patients were not evaluated, and the reasons for this shortfall were never examined.

19. To make matters even worse, the essentially meaningless claim of benefit is based upon the results of a questionnaire type test instrument described by the authors (and by Dr. Turban in paragraph 16 of his report) as a "novel measure." The details of the article demonstrate

[15] See paragraph 16 of my initial report, which discusses *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults Comparisons of Nonsurgical and Postsurgical Cohorts*, Olson Kennedy, et al., JAMA Pediatrics 2018, 172(5): 431-36. doi: 10.1001/jamapediatrics.2017.5440.

that this entirely unproven testing methodology was in part designed by the adolescent patients themselves.

20. For such glaring and fundamental methodological errors to be made by highly trained physicians who serve at one of America's premier academic centers, and who themselves are widely considered leaders in the world of transgender medicine is very troubling. For such an article to pass the peer review process of a leading journal of pediatrics and the AMA is perhaps more troubling because it spreads the errors more broadly. For that same article to be cited by a psychiatrist who is quoted almost daily in the lay press makes clear why these erroneous positions are so widely held.

21. A systematic examination of the quality of evidence cited in support of transgender chest surgery was conducted by Tolstrup, and reported in the journal Aesthetic Plastic Surgery.[16] This study examined the world literature, and found 849 articles concerning efficacy in peer reviewed medical journals. Of those, only 47 articles (5.5%) were found suitable for inclusion. Of those, only 29 articles addressed mental health (3.4% of all the articles). What is startling is that the mental health outcomes were judged only on the basis of patient subjective reporting with descriptors that varied so widely from article to article that results could not be compared. In summary, less than 4% of all the world literature on the efficacy of breast surgery in transgender patients even addresses the mental health outcomes, and out of that small pool of papers, none can be compared to each other to give some aggregated measure of efficacy.

[16] *Outcome Measures in Gender-Confirming Chest Surgery: A Systematic Scoping Review*, Tolstrup, et al., Aesthetic Plastic Surgery 2020, 44(1): 219-28. doi: 10.1007/s00266-019-01523-1.

22. It is out of that pool of unreliable literature that Dr. Turban drew his third citation in support of the efficacy of chest masculinization surgery in adolescent children. This 2021 article by Bustos et al. is itself a review of the literature.[17]

23. The measures of success were all limited to subjective reporting of "satisfaction," which is the kind of reporting one finds in the world of cosmetic surgery.[18] There were no psychological evaluations of self harming behaviors, no search for evidence of suicide, and no measures of other co-morbidities such as substance abuse, major depression or anxiety disorders.

24. Additionally, the studies were all limited by their short term follow-up period. Across the literature reviewed by Bustos et al., post surgical follow-up of the patients was so short, the authors report it in months rather than years, and present it in two groups of greater than one year, or less than one year. The largest studies that Bustos et al. considered followed their patients for a year or less. The longest follow up of 3 1/2 years was in a paper from Belgium that only reported 14 patients (out of the 1052 patients in the whole review = 1.3%), and the average follow up was approximately 1 year. Given that the world literature on long-term outcomes in fully transitioned transgender persons shows an alarming rise in self-harm and suicide beginning roughly seven years post operatively, the short follow up period in this report makes it useless in assessing long term efficacy.

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[17] *Transgender and Gender-nonbinary Patient Satisfaction after Transmasculine Chest Surgery*, Bustos, et al., Plastic & Reconstructive Surgery Global Open 2021, 9(3): e3479. doi: 10.1097/GOX.0000000000003479.

[18] The plastic surgery literature that seeks to quantify outcomes in the various techniques in breast cosmetic surgery will typically use metrics derived from test instruments called PROM (Patient Reported Outcomes Measure). BREAST-Q being the most widely used. It is a subjective measure that examines several areas of satisfaction, and is typical of the metrics used to assess any cosmetic procedure, given that the motivation for surgery is a cosmetic (and therefore subjective) result.

25. What is most troubling of all is that Dr. Turban cited this article in support of gender-transition breast surgery on adolescent patients. Examination of this review article reveals that, even though there were adolescent patients included in most of the evaluated studies (including patients as young as 13), none of the studies had mean age less than 24, and most were in the late 20s or into the 30s. How Dr. Turban could consider this literature review to be powerful in supporting the surgical removal of breasts from adolescent girls is troubling. For him to summarize this literature by claiming, in paragraph 16, that it "has shown improvements in mental health following gender-affirming chest surgery" based upon studies mainly of adults that didn't even address mental health is also very troubling.

26. The other study that Dr. Turban chose to cite in support of chest masculinization surgery for self-identified transgender girls was by Mehringer et al. from March 2021.[19] This study is a single center, single researcher study that reports outcomes on 30 patients. The patients, in order to qualify for the study needed to be patients of Dr. Mehringer, and be willing to be voice recorded in interviews. It is the subjective reporting by the patients concerning their distress at having breasts.

27. Roughly half the patients in Mehringer et al. (2021) had undergone surgery, but the authors do not report the post-operative interval. They did exclude patients that were within 90 days of surgery, but they do not report the length of follow up for any of the patients. This is a crucial error because, as was discussed above, the return of depression and suicidality begins to evidence itself beyond 5 to 7 years post surgery as is seen in the study by Dhejne et al. (2011).

[19] *Experience of Chest Dysphoria and Masculinizing Chest Surgery in Transmasculine Youth*, Mehringer, et al., Pediatrics 2021, 147(3): e2020013300. doi: 10.1542/peds.2020-013300.

Furthermore, this study is useless in determining efficacy of surgical treatment, because it provides no denominator for assessing outcome. We are not told how many children underwent chest masculinizing surgery at the Children's Hospital in Rochester, nor how many young women underwent mastectomy and were lost to follow up, were hospitalized for major depression, or were incarcerated for violent crime (which has a 10 fold higher risk in females taking high dose testosterone). For Dr. Turban to cite this "peer reviewed" article as demonstrating "proven benefit" for mastectomy is very troubling, and appears to intentionally ignore the fact that studies such as this, being essentially single-center, single researcher case collection methodology are in the lowest category of medical and scientific evidence.

***Treatment for Disorders of Sexual Development***

28. Without justification, plaintiffs' experts compare surgical interventions performed on self-identified transgender persons with procedures performed on patients with congenital disorders of sexual development (DSDs). DSDs are a collection of objective medical and anatomic anomalies that vary greatly in severity and consequence.[20] Ambiguities in the development of the genital structures can arise from chromosomal abnormalities, genetic mutations including those which affect the production and metabolism of sex hormones, and in-utero problems of morphological development. These DSDs can present with external structures that appear fairly normal, to structures that are difficult to characterize as either male or female. Some abnormalities are essentially cosmetic, others require early medical and surgical interventions due to metabolic effects of abnormal hormone levels, or risks of complication due to urologic abnormalities that risk upper urinary tract infection among other potential problems.[21]

[20] *Disorders of Sexual Development: Current Status and Progress in the Diagnostic Approach*, García-Acero, et al., Current Urology 2020, 13(4): 169-78. doi: 10.1159/000499274.

[21] My initial report provided a more detailed overview of this topic at paragraphs 41-48.

29. The surgical management of DSDs is a highly controversial area, including controversies about timing of interventions, delay to allow the patient to have a voice in decision making, the relationship to the development of gender expression, the issue of "gender assignment" in cases of unresolvable ambiguity, and castration in certain cases to manage hormonal issues in adolescence among other issues. An excellent 2016 article by Moriquand et al. discusses this very complex category, and demonstrates a broad heterogeneity of opinion concerning the best care for this very small population of patients.[22] What is now very broadly accepted in this highly specialized area of care is that purely cosmetic modification surgery is the most controversial of DSD categories with regard to timing and consent issues. Such surgery is controversial because it risks, among other things, the patient's erotic sensibility. It is also problematic with regard to consent, and should for these reasons be put off into adulthood, when the patient is competent, and can make the decision themselves.

30. Transgender patients, as compared with DSD patients, have no chromosomal abnormalities, no genetic mutations, and no morphological abnormalities that occurred in utero. They have no underlying abnormalities in sex hormone production or metabolism. Surgical interventions are offered solely on the basis of subjective report of dissatisfaction, and are therefore in the category of cosmetic (aesthetic) surgery. Thus if the comparison is made between gender-transition surgery and surgery for DSD, it would place gender-transition surgery in the category of cosmetic procedures which are the most controversial of DSD groups with regard to offering surgery precisely because of issues of loss of erotic sensibility, and issues of informed consent.

**I declare under penalty of perjury that the foregoing is true and correct.**

---

[22] *Surgery in Disorders of Sex Development (DSD) with a Gender Issue; If (Why), When, and How?*, Moriquand, et al., J. of Pediatric Urology 2016, 13(3):139-49. doi: 10.1016/j.jpurol.2016.04.001.

**Executed on February 11, 2021.**

Patrick W. Lappert, M.D.

# Exhibit 4

THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

---

DYLAN BRANDT, by and through his mother,
JOANNA BRANDT, et al.,
Plaintiffs,
vs. CASE NO.
4:21-CV-00450-JM
LESLIE RUTLEDGE, in her official
capacity as the Arkansas
Attorney General, et al.,
Defendants.

---

VIDEOTAPED/ORAL/VIDEO CONFERENCE
DEPOSITION OF PATRICK WALTER LAPPERT, M.D.
TAKEN ON BEHALF OF THE PLAINTIFFS
LITTLE ROCK, ARKANSAS
ON MAY 6, 2022

REPORTED BY: TRENA K. BLOYE, CSR

APPEARANCES

For the Plaintiffs:
SULLIVAN & CROMWELL, LLP
JONATHAN J. OSSIP
ALEXANDER HOLLAND
BRANDYN RODGERSON (Appearing via video conf.)
125 Broad Street
New York, New York 10004-2498
212-558-4000
ossipj@sullcrom.com

GILL RAGON OWEN
BETH ECHOLS
425 West Capitol Avenue
Suite 3800
Little Rock, Arkansas 72201
501-376-3800
echols@gill-law.com

ACLU OF ARKANSAS
GARY SULLIVAN
CHASE STRANGIO (Appearing via video conf.)
LESLIE COOPER (Appearing via video conf.)
904 West 2nd Street
Little Rock, Arkansas 72201

For the Defendants:
OFFICE OF THE ARKANSAS ATTORNEY GENERAL
AMANDA LAND
MICHAEL CANTRELL (Appearing via video conf.)
323 Center Street
Suite 200
Little Rock, Arkansas 72201



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STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED BY and between the parties hereto, through their respective attorneys, that the videotaped deposition of PATRICK LAPPERT, M.D., may be taken on behalf of the Plaintiffs on the 6th day of May, 2022, in Little Rock, Arkansas, by Trena K. Bloye, Certified Shorthand Reporter for the State of Oklahoma, by notice pursuant to the Federal Rules of Civil Procedure.

* * * * * *

VIDEO OPERATOR: Good morning. We are with going on the record at 9:04 a.m. on May 6, 2022. Please note that microphones are sensitive and may pick up whispering and private conversations. Please mute your phones at this time. Audio and video recording will continue to take place unless all parties agree to go off the record.

This is media unit 1 of the video recorded deposition of Patrick Lappert taken by counsel for Plaintiff in the matter of Dylan Brandt, et al. versus Leslie Rutledge, et al., filed in the United States District Court, Eastern District of Arkansas, Central Division, Case Number 4:21-CV-00450-JM. The location of the deposition is in the Arkansas Attorney General's Office at 323 Center Street, Suite 200, in Little Rock, Arkansas.

My name is Mike Tscheimer representing Veritext. The court reporter is Trena Bloye, also representing Veritext. I am not related to any party in this action, nor am I financially interested in the outcome. If there are any objections to proceeding, please state them at the time of your appearance.

Counsel and all present, including remotely, will now state their appearances and affiliations for the record beginning with the noticing



attorney.

MR. OSSIP: Jonathan Ossip from Sullivan & Cromwell for the Plaintiffs.

MR. HOLLAND: Alex Holland from Sullivan & Cromwell for the Plaintiffs.

MS. ECHOLS: Beth Echols with Gill Ragon Owen, the Plaintiffs.

MS. LAND: Amanda Land of the Arkansas Attorney General on behalf of the Defendants.

MR. CANTRELL: Michael Cantrell with the Arkansas Attorney General's Office for the Defendants.

MR. STRANGIO: Chase Strangio with the ACLU for the Plaintiffs.

MS. COOPER: Leslie Cooper with the ACLU for Plaintiffs.

MR. RODGERSON: Brandyn Rodgerson with Sullivan & Cromwell for the Plaintiffs.

PATRICK WALTER LAPPERT, M.D., after having been first duly sworn, deposes and says in reply to the questions propounded as follows, to wit:

EXAMINATION

BY MR. OSSIP:

Q Good morning, Dr. Lappert.

A Good morning.

Q Would you please state your full name for the



record?

A Patrick Walter Lappert.

Q All right. And I'm just going to go over some ground rules before we get started. Before I do that, Dr. Lappert, have you ever been deposed before?

A This is my second time.

Q Okay. And when was the first deposition?

A I think it was about eight or nine months ago.

Q Okay. And what case was that for?

A Folwell in North Carolina. It's a lawsuit against the state treasurer seeking a change in policy from the State of North Carolina concerning transgender medicine surgery for beneficiaries of their insurance program.

Q And were you appearing as an expert witness in that case?

A Yes, I was.

Q And I'll go over this in a second. So one thing is Trena is writing down everything that we say, so it's really important that we don't overlap in our answers and questions --

A Okay.

Q -- so that way she can get every word down.

A Sure.

Q And other than that, you said Folwell was the



name of the case? I'm sorry.

A Right.

Q Other than that, no other depositions?

A No.

Q All right. So most of my questions today are going to be asking for more detail about your expert opinions in this case. So I'll be asking questions, the court reporter is going to be writing it down. So, as I said, we should avoid speaking over each other. Similarly, all answers should be verbal, so no nods or also uh-huh is really hard to write that down, so yes or no for those.

My job is also to make sure that everything is very clear today. So if I ask a question and you ever find it unclear, please let me know and I'll try to clarify my question.

A Okay.

Q If you don't do that I'll assume that you understood my question, though. Fair enough?

A Sure.

Q All right. I also want to really make sure that you are comfortable. I personally like to take breaks every hour or hour-and-a-half or so. But we can take a break at any point before then if you like. My only rule is if I have asked you a question, I would

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like you to answer it before we take that break.
A Sure, certainly.
Q All right. And Amanda is also here representing the State. And she may object to a question that I ask. This is typically just a legal thing that we work out later. So unless she instructs you otherwise, you should still answer the question. Okay?
A Certainly.
Q All right. Any reason, such as medication, that you can't give truthful and accurate testimony today?
A No.
Q All right. So you have been retained by the Defendants as an expert witness in this case; is that correct?
A Correct.
Q And how did you prepare for your deposition today?
A Well, I began by reading the Complaint, I guess it's called, and then reading other expert testimony relating to that Complaint, and then reviewing the references and citations that were used in the Plaintiff's expert testimony or expert -- whatever you call it. It's testimony I guess. Reviewing those

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particular journal articles, sometimes publications of various kinds to see where the strength of the scientific support was for the plaintiffs and then reviewing that, and just keeping up with the current literature in the world of transgender medicine and surgeries.
Q You mentioned that you reviewed the other expert testimony. Do you recall which specific expert testimony you reviewed?
A So there was -- there was one by Dr. Turban, and I think even a rebuttal from Dr. Turban. There was one from Dr. Antommaria, and I think also his rebuttal. There was one from Dr. Deanna Adkins that I reviewed. I think that's -- those were the three.
Q Okay. Did you review any of the other defense expert reports?
A Let's see if I did or not. Because there is no other expert that speaks in terms of the surgical aspect of it, so I don't remember reading the defense expert testimony, although I might have. It's been a while. It's been almost a year now, so.
Q Okay. But not recently?
A Not recently.
Q And did you meet with anyone in preparation for your deposition?

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A Just the meetings with the attorney generals, Mike. We had phone conversations basically about what to expect.
Q Okay. And now I'm going to ask you just a couple of questions about that.
A Sure.
Q But just as a -- I'm not asking ever about the content of those conversations.
A Sure.
Q Just about when they occurred and sort of broader nature of those. So how many phone calls did you have with the attorney general's office in preparation for your deposition?
A Let's see. I had one with Mike Cantrell, I think it must have been some months ago. I do not recall when. And then I had one last night with Mike Cantrell and Amanda here.
Q So just to take those one by one, the first one it was just you and Mike Cantrell?
A As I recall, yes.
Q And then last night, you, Mike, and Amanda?
A Correct.
Q Starting with the one that was just with Mike Cantrell, how long was that phone conversation?
A I would estimate it somewhere around -- less

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than an hour.
Q Less than an hour?
A I'm estimating here from some time ago.
Q And approximately when was that?
A I would have to look on my calendar. I don't know off the top of my head.
Q Was it more than a month ago?
A Yes, it was, certainly.
Q Was it more than two months ago?
A Yes.
Q Was it more than six months ago?
A It's probably right around there if I had to take a wild guess.
Q Okay. So right around six months?
A Something like that.
Q And the one last night, nobody else on that call other than you, Mike and Amanda?
A Correct.
Q And how long was that phone conversation?
A Half an hour to an hour.
Q And other than those two phone conversations you had no other meetings or communications in preparation for this deposition?
A I had one other phone call with Amanda, actually, which I think was a week ago.

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Q And how long was that phone call?
A About a half an hour.
Q Okay. So you mentioned you reviewed the references and citations from Plaintiff's experts, and those were from the three --
A I believe that's correct, yeah. I don't think I went to any other sources for citations.
Q And I will just say for Trena's benefit, if you could let me finish the question.
A I'm sorry.
Q Oh, no. Everyone does it. It's so natural. So, and approximately how many references and citations did you review?
A Just ball parking, maybe a dozen of the ones that were cited by the expert witnesses for the plaintiff.
Q And no other references and citations in preparation for this deposition?
A Very often when you're reading a journal article they make citations in there that take you -- so you go down a rabbit hole sometimes when you are chasing down a particular argument or a particular piece of evidence. So the beginning point was the citations of your experts, and then at times it would lead me into other -- other citations and references to look down.

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Q So just the experts' articles and then maybe others that were cited in those?
A Right. That's generally how I go.
Q Any other documents you reviewed in preparation for today?
A The World Professional Association of Transgender Health, Standards of Care, Version 7; the Diagnostic And Statistical Manual, Version 5; the "Endocrine Society Consensus Statement," just review of that, mostly looking for process and -- yeah, that -- that was pretty much the bulk of my sources there.
Q So you mentioned the references and citations from the plaintiff's experts, I think you mentioned the Complaints, their reports, and then WPATH -- and sorry. If I say WPATH, you mean the World Professional Association for Transgender Health, you'll understand what I mean; right?
A Certainly.
Q So you reviewed the WPATH SOC 7, the DSM V, and the Endocrine Society guidelines. Is that fair to say?
A I think that's fair, yes.
Q All right. Anything else?
A Nothing that comes to mind.
Q All right.
A You know, I take that back, sir. Because I'm

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looking in the world of how transgender and plastic surgery intersect I did a lot of rereading of textbooks and sort of historic sources in the world of plastic and reconstructive surgery to get a better sense of the ethics of decisionmaking and consent, obtaining consent. I did do some additional reading in terms of the history of surgical -- medical-surgical consent, and then also reviewed the history of transgender surgery. So that's like old textbooks, we're going way back.
Q And were any of those textbooks or sources not cited in your expert report?
A Whenever I -- whenever I, uh, made a claim that I -- I think I cited every -- every particular authors and things like that within the textbook, if it was a textbook, if I recall.
Q Okay. How did you travel to the deposition today?
A I drove.
Q And drove from home?
A Yes, I did.
Q All right. And when did you do that?
A Yesterday. Well, yesterday afternoon.
Q And you spent the night here?
A I did.
Q And is the state paying for your travel and

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lodging?
A Yes, they are.
Q Okay. No one else paying for that; correct?
A No.
Q Doctor, what field do you claim to be an expert in?
A Plastic and reconstructive surgery.
Q Any others?
A Well, I have a prior board certification in general surgery with a lot of trauma, critical care training in there. I've also been trained in aerospace medicine. I don't claim expertise in those areas because it's been some years since I was in that field. But the journey from general surgery into plastic surgery is fairly seamless and there is a lot that goes on in the world of reconstructive surgery certainly where I use my general surgery training. But, yeah, that's my area of expertise.
Q All right. So but in terms of what field you're an expert in, only plastic and reconstructive surgery. Is that fair to say?
A I think that's fair.
Q And looking within plastic and reconstructive surgery, you have never performed any gender-affirming surgeries; is that correct?

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A It depends on how you couch that question because there's an area of transgender surgery or gender affirmation surgery that's called top surgery that primarily concerns itself with the facial features. And I have done, for example, rhinoplasty on a -- on a person who was very evidently transitioning, so feminizing of his nose. Not a real radical operation. But, yeah, the rest of my surgeries as pertains to transgender persons has been reversal surgeries.

Q Okay. So I want to take that feminizing of the nose for a second. So just to make sure I understand what you mean by that, this was someone that, I think you used the term natal or biological male into somebody who is transitioning to present and live as a woman. Is that fair to say?

A Right. Natal biological male transitioning. Although, at the time he was not very out about it, but there was -- there was evidence in his medical history that that's where he was headed. And I tried to get a better sense of it, but he's very private about it.

Q And you performed the surgery to feminize this individual's nose?

A Right. Had a very masculine hawk-like nose that we toned down a little for him. It was not a real radical operation, but he was certainly satisfied with

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the results.

Q Okay. And other than that, no other gender-affirming surgery?

A No gender-affirming surgery. I do, for example, in my office offer sort of adjunct procedures. Like, for example, I have a number of patients who come to me for laser hair removal from their faces. So that's a person who is already socially transitioned, i fact, two people who are socially transitioned who come to me regularly for hair laser hair removal. And --

Q Okay. And --

A I didn't mean to interrupt you.

Q No. Go ahead.

A Also I see a number of patients who I'm helping manage the sequela of their hormone therapy. So acne in their skin caused by androgen medications and things like that.

Q And when was this -- looking to the feminizing rhinoplasty when was that?

A I would guesstimate it somewhere around 2014 perhaps. That would be a guess.

Q 2014.

A This is a guess on my part, sir.

Q And where was that?

A In my office in Madison, Alabama.

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Q Was the patient referred to you for this procedure?

A No. Self referral.

Q Okay.

A Then I would add, of course, he didn't present himself as seeking transition. This was a clinical judgment only my part. And his request was so relatively minor it seemed to be within the scope of something simple I could offer him.

Q Okay. So you said he didn't present himself as seeking transition. What do you mean by that?

A Well, he was -- he presented himself as a man, and presented himself as a man seeking a change in the appearance of his nose. But one of the things you do as a plastic surgery, particularly in the case of a man seeking a change in the appearance of their nose, you have to have some sense for what's the motivation for seeking it, because sometimes people can be struggling with severe emotional problems and they see their appearance as the reason for they are emotional problems. And so a lot of what goes into the initial consultation has to kind of address itself to the motivation of the patient.

And he seemed to be well composed, his request was relatively minor, basically just taking the hump off

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the top of his nose, and he didn't seem to be heavily emotionally invested in it. So I didn't consider him to be in the category of body dysmorphic disorder, which is one of the things you have to be careful of, especially in men being seeking rhinoplasty. He didn't seem to meet those criteria. So he was a self referral for a cosmetic rhinoplasty.

But the discovery of his transgenderism actually came later because he returned after some months complaining that I hadn't done the right operation, and then it became evident that he had been seeking a much more feminine nose. So what started out as a consultation for just a very visible and simple improvement in a nose turned out to be really a desire for a radical change that he didn't voice at the time of that visit. But it came to light when he returned for his followup that he was really seeking to transition and this was sort of his first step. So I considered that on my part a failure to detect gender identity disorder.

Q And if you had been aware at the time that the purpose of his operation was a gender transition, would you have still provided the procedure?

A Well, it's not so much the purpose as it is the underlying problem that he has. So what would divert me

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from deciding to offer him surgery is not the -- his particular intention -- his voiced intention. It's not his voiced index, but it's the emotional aspect that underlies it. That's what would keep me from offering the surgery.

Q But just to go back to my question, though. If you had been aware at the time that his intention, I'll put it that way, was to transition, would you have still performed the procedure?

A Well, again, so the issue is not his intentions. And what it would have caused me to do is to probe more deeply to understand what his motivation was for the transition. Because even the DSM makes a distinction between gender identity disorder and simple gender dysphoria.

And so in his case, because of the anger he evidenced when he came back, it would make me incline more towards a significant diagnosis of gender identity disorder which I put in the category of body dysmorphic disorder, which is really the diagnosis.

So it's not that -- it's not that I would have declined surgery because he was seeking to transition, I would have declined surgery because it would have been pointing me to the more grave diagnosis of body dysmorphic disorder.

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Q Okay. So just let me take a few things from that and dig into this. So your understanding is that in the DSM there is a distinction between gender identity disorder and more simple gender dysphoria; is that correct?

A The problem is it's a moving target. So -- so it's a moving target. Since DSM IV it was gender identity disorder, and they made a distinction between that and body dysmorphic disorder. And then DSM III, all of it was body dysmorphic disorder.

So over time the distinction has been made. I don't agree with that parsing the way they do it, but what underlies the whole thing is a form of obsessive compulsive disorder.

Q So, Doctor, you have drawn a distinction between gender identity and gender dysphoria. What's the difference between those two things?

A It's a linguistic decision that the DSM writers made before the publication of DSM V in 2013. And, interestingly, that distinction characterizes the problem with DSM methodology.

So the change between DSM IV and DSM V including this distinction about gender dysphoria. Before that it was gender identity disorder. But the DSM V made that change in 2013. And the justification

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they gave for it was sort of a procedural one. But in that same week, or the week before the DSM V came out the National Institutes of Mental Health essentially withdrew from the DSM project. They no longer fund it. The largest funding agency.

It's causing me to stop and think. The largest funding agency for mental health --

Q Doctor, I hate to interrupt you, but so my question, however, was what distinction do you draw between those two things, not what the DSM draws.

What distinction do you draw when you use those two terms earlier?

A Gender dysphoria is a description of the subjective feeling of the patient. Gender identity disorder is perhaps a description of the underlying psychological disturbance and more characteristically body dysmorphic disorder. That's my distinction.

Q Do you know of any professional -- medical professional organizations that draw that distinction?

A Between body dysmorphic disorder and gender identity disorder and gender dysphoria?

Q Between gender identity disorder and gender dysphoria.

A Well, the -- the APA does.

Q And that's in which document?

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A DSM V.

Q So in the DSM V there's a distinction between gender identity disorder and gender dysphoria?

A Correct.

Q Okay. And you reviewed the DSM V in preparation for your deposition today?

A A couple of weeks ago, yeah.

Q And going back to the feminizing rhinoplasty that you performed, if it was, I think you said, simple gender dysphoria, then you would have proceeded with the operation if that had been your conclusion?

A In that patient? No, I would not have offered him surgery.

Q And why is that?

A So because the -- you mean if I hadn't known of the evident -- see, in retrospect, in retrospect I see him as seeking something unachievable, and so I would not have offered him surgery because it would have been a liability to him and me both. I don't know if that answers your question or not.

Q Sort of. What was the something unachievable that you concluded he was seeking?

A Well, one of the characteristics of body dysmorphic disorder is a degree of emotional investment in the physical problem. So the underlying -- the

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underlying problem is the patient has a profound psychological wound that he does not wish to look at, but living with the psychological wound he seeks an explanation for it. And so he will latch onto something about his physical appearance as an explanation for the underlying sorrow that he has. And that's what underlies body dysmorphic.

And so you can never -- you can never reach the depth of that psychological wound doing an operation. It's very characteristic. And one of the characteristics of body dysmorphic disorder is patients, they keep coming back and keep coming back for more surgeries --

Q Doctor, I'm sorry to interrupt. We only have seven hours today, so I really need you to answer the question that I ask.

A Okay.

Q Which is what is the something unachievable that this patient was seeking in your opinion?

A Happiness.

Q And happiness was unachievable for this person?

A That was my estimation, yeah, in retrospect.

Q Nothing else unachievable that they were seeking?

MS. LAND: Object to the form.

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Q (By Mr. Ossip) You can answer.

A Not that I -- not that I could perceive or that I recall right now. But that was at the heart of it. I could never give him the happiness he was seeking, because he was seeking it in the wrong place basically. That's what characterizes the problem.

Q And do you believe this individual had body dysmorphic disorder?

A Right.

Q And also gender identity disorder?

A I only learned that in retrospect.

Q Okay.

A Yeah.

Q But at the time you performed the procedure you didn't believe he had either of those things?

A No. I wouldn't have offered him the surgery because it would have been unethical for me to do so.

Q And do you believe this individual had gender dysphoria?

A In retrospect I do now, yeah.

Q So both gender dysphoria and gender identity disorder?

A Yeah. I don't make a huge distinction between those two things. One describes the subjective feeling the patient has and the other one is more of a clinical

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diagnosis of a psychological disturbance.

Q And you would agree with the DSM V's distinction between those two things?

A I don't agree with DSM V on a lot things and that's among them.

Q Okay. But the DSM V does distinguish --

A Yes, it does.

Q And you also mentioned -- you also mentioned two reversal surgeries I believe you called them.

A That's right.

Q And what were -- what were those?

A Removal of breast implants from a 20-something-year-old man who had been in Thailand and got a top and bottom surgery in one visit and then returned to the states, and within a year was suicidal again. He had a sudden sort of awakening and I got a call out of the blue from a pastor in Kansas City. It was a: I understand you're a plastic surgeon who has an understanding of transgender. Can I send this patient to you?

And he was down on his luck guy, had no money, so he came and we removed his breast implants. And, yeah, it was kind of an interesting story there. So, yeah, we got a removal of breast implants and then a subsequent gynecomastectomy for the effects of hormonal

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therapy on the patient, yeah.

Q So you did one -- just to clarify, you did one breast implant removal?

A Correct.

Q And no others?

A Correct.

Q And then one gynecomastectomy?

A Correct.

Q Okay. We'll come back to that.

Do you claim to be an expert in the treatment of gender dysphoria?

A No.

Q What about healthcare for transgender people?

A Well, I mean, I've been doing healthcare for people my whole life, so I guess it would depend on what it is you're asking for. If it's, you know, trauma or surgical disease of one kind or another, certainly. And, obviously, those things we talking about earlier that I already offer in my office.

But as far as things specific to gender transitioning, I don't offer those services.

Q And you don't claim to be an expert in those?

A No.

Q And in terms of healthcare for transgender people, nothing outside of plastic and reconstructive

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surgery that you have previously discussed here?
A Right. Although, I guess I would characterize it this way that all of the surgeries that are involved in transitioning, whether you're talking about the top surgeries or the genital surgeries involve procedures that I'm fully versed in and have done many times, though I have never applied those specific procedures to, say for example, creating an artificial phallus. I have used the same flap operation for head and neck reconstruction, limb salvage, that sort of things.
So the technology, the techniques, the processes are the same. It's just the application I do not do that surgery in that particular area.
Q So just to pin down on that, though.
A Okay.
Q Those -- but, again, you have never used those techniques to perform any sort of gender-affirming surgery; correct?
A That's correct.
Q Okay. Do you claim to be an expert in mental health?
A No.
Q What about the treatment of minors, by which I mean patients under the age of 18?
A Lots of experience taking care of minors.

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Q Do you claim to be an expert in that?
A Well, in certain areas of the care of minors. So I have expertise, for example, in cranial facial reconstruction of congenital deformities. I have experience with reconstruction of congenital deformities of children's hands, congenital deformities of abdominal wall in children, that sort of thing, cleft pallet.
Q You're not a pediatrician, though; correct?
A No.
Q And you don't claim to be an expert in pediatrics?
A I'm not a pediatricianist.
Q And you mentioned -- and going back to the breast implant removal you said was a reversal surgery, when was that?
A Let's see. It would have been before the pandemic. It was 2017 or 2018, somewhere in there. This is a guess on my part.
Q And what about the gynecomastectomy?
A In the same year, about seven -- seven months later.
Q And you said that the breast implant was referred to you; is that correct?
A From a -- from a priest in Kansas City. It wasn't a professional referral from a doctor. It was a

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priest trying to help a man in distress.
Q And how did the priest in Kansas City come to refer a patient to you?
A This young man just wandered into this church. He had -- he had been suicidal the day before, he had the pistol in his mouth, and he had this revelatory event. This is his medical history, it's in his chart. And rather than take his own life he had the sense that there is a God, and he walked out into the street and went to a church, walked in and talked to a priest who happened to hear me give a presentation two years previously in Denver on the subject of the care of transgender persons who are in distress, and he called me up and sent this young man to me. And, uh, yeah, it's a miraculous thing really.
Q So the priest in Kansas City heard your presentation in Denver and that's how that priest came to know you?
A That's right, that's right.
Q And what year was presentation in Denver?
A I'm going to say 2015, if I have to guess, 2015, 2016, somewhere in there.
Q And was that at a conference?
A Actually it was sponsored by a seminary out there, St. John Vianney Seminary. And it was a

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conference for educators and pastors on the subject of care of persons who experience transgender and gender dysphoria, those sorts of things.
Q And who was the sponsor of that presentation?
A I would have to look. I know it was held at the seminary, the St. John Vianney Seminary. It might have been the archdiocese of Denver. I'm not sure about that.
Q And did your presentation have a name of that or a title that you gave that presentation under?
A I think it was Catholic Anthropology and Transgender Medicine or something like that.
Q And is that a presentation that you have given in other settings?
A Yes. Well, similar settings, similar settings, other diocese. Word gets out and other bishops and priests want to hear the talk.
Q And how many times have you given that presentation?
A I would just be wildly estimating somewhere in the 40, 50 times over the last seven years, yeah. It's a very highly demanded. Everyone wants to understand transgender.
Q And all of those are at diocese?
A I'm trying to think if there are any

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exceptions. I think that would be -- diocese in schools, chancery education, priest retreats, that sort of thing, yeah.
Q So all of them in connection with the Catholic church?
A I think so. Well, not -- I wouldn't be absolute about that. Again, I have given the talk so many times. I'm trying to think if there is any other -- if it occurs to me can I come back with that.
Q You can always, if you have any change you can always come back to that.
A Okay. Thank you.
Q Okay. Sorry. Give me one second.
A So I had it backwards.
Q Oh, is that missing --
A No, no. I had it backwards. It was Transgender Christian Anthropology.
MR. OSSIP: Actually, I'm sorry. In the thickness of this some pages got ripped off. I don't know if you can move the sticker or something.
COURT REPORTER: I might be able to.
MR. OSSIP: Sorry about that. First technical mishap of the day.
COURT REPORTER: There we go.
MR. OSSIP: Awesome. All right. Crisis

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averted.
(Plaintiffs' Exhibit 1 was marked for identification and made a part of the record.)
Q All right, Doctor. The court reporter is now handing you another document that has been marked Exhibit 1.
A Okay.
Q Can you flip to the second page. It should be inside of that.
A Right. And that's the title, that's the title of the talk.
Q And is that the presentation that you gave?
A Let's see. So this -- I'd have to -- so November -- oh, this is when you copied it or was that when I sent it out? 2018. This might have been from another Denver conference.
Again, what I'll do, I have a basic talk for audiences that we talk -- I just described to you that I will modify based on, like, local questions or demand, the nature of the audience, sometimes I will take slides out and put slides in. But this is kind of a general talk here. Yeah, this is probably the one that I gave at Denver.
Q Okay.

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A Or something very close to it I would say.
Q But roughly the same --
A Roughly, yes, sir.
Q And that is the one that you gave in Denver; correct?
A Again, I don't know if this is exactly the one I gave in Denver. It looks like one I might have given in Denver. Like I said, I modify it. I was just trying to see if there was a date stamp on it. But if it was --
Q Well, do you see the day it says -- in that bottom corner it says Monday, November 5, 2018.
A Right. So if that's the date that I -- this is probably a talk that I put into a pdf format that I sent back to the organizer for distribution to the audience. So if that's the date, this may be a different talk given in the Denver.
Q So if you --
A Oh, there it is. That's it's. That's the image right there.
Q Well, yeah, for the benefit of the record, can you flip all the way to the back then. I'm sorry. It's a little unwieldy one.
A Right. Okay.
Q And do you see the Gospel of Life Conference,

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2018?
A Correct, yes.
Q Yeah, go ahead.
A So this would have been a subsequent conference in Denver obviously invited back, because I know I gave the presentation at St. John Vianney Seminary before I went and presented at this conference, probably by a year or maybe more, two years, something like that.
Q Okay.
A But, yeah, that's an example how I modify the talk for the particular audience.
Q Okay. All right. And that was -- and who was the host of this conference?
A The Augustan Institute it looks like, FOCUS, which is I guess the Fellowship of Catholic University Students. And then the Gospel of Life, it's the Human Life Apostolate at the Archdiocese of Denver, something like that.
Q And all of these organizations are affiliated with the Catholic Church in some way?
A Yeah, all the names I see here, yeah.
Q Okay. We can put that to the side for now.
A Okay.
Q And so -- okay. So that was -- I'm just trying to remember how we got to that and it was because of the

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priest in Kansas City?
A Exactly, exactly. The miracle of Kansas City.
Q Right. So then looking to the gynecomastectomy, how did that patient come to be in your care?
A Same patient.
Q Oh, okay. So there is only one patient, just two procedures?
A Correct.
Q Okay. And one was the implant removal --
A Correct.
Q -- and the other was the gynecomastectomy?
A Correct.
Q Gynecomastectomy. Excuse me.
A Very good.
Q Okay. And no other reversal surgeries?
A Correct.
Q So only one patient in your career has presented for a reversal; correct?
A Correct.
Q Okay. And both those procedures were in the 2017 to 2018 time period?
A Yeah. They were within six or seven months of each other. We took out his implants and just gave him time to resolve to see how much glandular tissue he had

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developed, because I had no way of judging that.
All of his transitioning had been done outside of my view so I didn't know how much was native -- or I should say hormonally induced breast tissue and how much of it was implant.
Q And let's see. Were both those procedures conducted in your office?
A Yes, they were.
Q Okay. So those were both in an outpatient setting?
A Right.
Q Okay. And going back to the feminizing rhinoplasty -- oops, I'm so sorry.
Did you conduct any follow-up after that second visit from that patient?
A I saw him back probably three or four times trying to sort out his anxiety really. Because rhinoplasty surgery, you don't actually see the final result for about 12 months, so followup with rhinoplasty has never been complete until it's been a year. And at a year you take your post-operative photos, so I would have seen him at intervals in that year.
Q And so when you say you're trying to work out his anxiety, what do you mean by that?
A Well, he was very characteristic of body

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dysmorphic patients because he came back after his surgery and in the first three months was thrilled, ecstatic about his result and talked about how all his friends agreed this was the best thing ever and he was thrilled. And then suddenly -- and this is kind of characteristic -- somewhere between about three months and six or seven months he came back in massive distress and despair and saying that I hadn't done the right operation.
And that's -- the moment those words came out of his mouth I knew that I had failed to detect what was really underlying his -- his desire for surgical modification.
Q So as of the last visit do you know what this individual's gender identity was?
A How he viewed himself?
Q How this individual --
A He was still not out. He was still not out.
Q Well, I want to draw a distinction. Did this person identify as a man or a woman or non-binary?
A Yeah, all right. So this is -- this is my clinical assessment of what's going on there. So he always presented himself as a man, but in the course of his repeated visits to me he was becoming more and more feminine in his presentation, yeah. So did he come with

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a diagnosis from a licensed social worker saying transgender, no; or pediatrician referral, transgender, no, none of those things. This is a clinical judgment on my part.
Q But this person, this individual always used male pronouns during your conversations with him?
A Yeah. I mean, it was always a man, yeah.
Q Okay. And never claimed to be transgender and never claimed to be seeking a gender transition?
A Right.
Q You just had assessed that this may be his intention?
A Correct. Well, yeah, it was becoming more evident as he came to me through that year something else was going on in his life.
Q And when you said you were -- I think you said that you were assisting with anxiety. Were you treating this patient for anxiety?
A No. It's more of the doctor-patient relationship in trying to get him to sort of kind of take a breath and draw back a little bit and let the postoperative process one its course before judging the result.
Q Did you diagnosis this patient with anxiety?
A No, it's not a psychiatric diagnosis. It's a

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characteristic of post-surgical patients that they will often experience anxiety about the result, whether it's reconstructive -- less so with reconstructive surgery, but certainly is the case with aesthetics patients, that at times they will have a period of anxiety that you have to help them weather.

Q And so did you ever refer this patient to mental health care?

A No.

Q All right. Changing topics a little bit, have you ever been approached to work as an expert witness in any other lawsuit?

A Yes, I have.

Q Which lawsuit or lawsuits?

A So I told you about Folwell in North Carolina. And I was contacted also by the Attorney General's Office, the State of Alabama. That's brand new. I haven't gotten a good look at that yet.

And then as far as lawsuits, I think Florida is in the process of asking for my help.

Q Okay. So you said you've been approached, aside from -- sorry, Doctor.

A There's also a case in Cincinnati, which is a private matter, that is a couple of years old. I haven't seen or heard from them in quite some time.

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Q What do you mean by a private matter?

A I think it's a lawsuit -- as I recall it's a lawsuit. I'd have to review. But it's not a -- it's not a litigation about a law or anything like that. It's a -- it's about a bad result I think. Or it might have actually been a child custody, yeah, injury to the family due to loss of custody of their child over a transgender issue. That's what I think it was. Again, I'm -- I'd have to pull that file up, but that's...

Q And you appeared as an expert witness in that case?

A I have not appeared, no. They just asked for expert -- what do you call it. Expert report, I guess. But I haven't been deposed, I have not appeared.

Q Well, did you submit an expert report in that case?

A Yes, as I recall I did.

Q And you were never deposed you said?

A No.

Q And what issues were you asked to opine on in that case?

A I think they were interested in my understanding of the progression of how the transitioning process works, the scientific evidence that's used in support of affirmation care. They wanted

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to understand affirmation care as it applies to adolescent children, what the expectations would be as far as the course of care for the child, that sort of thing.

Q So you were appearing in that case as an expert in affirmation care?

A I did not appear in that case. I -- again, I would have to refresh my memory on how they approached me. But as I it they were contacting me to explain from a surgeon's perspective how -- and -- well, essentially, how children enter into that process of transitioning and wind up in a surgical consultation, for example, top surgery.

Q Okay.

A It was a fairly limited question as I remember it.

Q But you submitted an expert report --

A I believe so, yes.

Q I'm sorry. Can you -- if you let me finish the question. And you signed that expert report and submitted it to the court?

A I would have -- I would have to refresh my memory on the extent of my participation in that case.

Q And when was that -- what was the timeline for your involvement in that case?

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A It would have been before the -- perhaps 2018, somewhere in there.

Q Sometime around 2018 is when the report was submitted?

A I think. I think so, somewhere in there.

Q And do you know -- well, and you said Cincinnati; is that correct?

A Right.

Q Do you know what court that was in?

A I do not.

Q Do you know if it was in state or federal court?

A I don't.

Q And you mentioned it was -- you think it was a child custody case?

A As I recall it, yes.

Q Okay. And were you retained by one of the parties in that case to serve as an expert?

A I'm trying to remember the attorney. Right, yes. So it was the attorney for the family. And I would have to -- I would have to dig around in my files to find the details.

Q Do you know if the court accepted your report in that case?

A I do not, no.

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Q Okay. And so you said you were asked to -- well, sorry, strike that.
Was the extent of your opinions in that case limited to surgery?
A So, uh, again, I would have to review the -- what I sent to the attorney. But it had a lot to do with how the diagnosis is made that leads to the transition process and how the -- kind of the decisionmaking steps that would lead a child along that process, possibly culminating in mastectomy.
Q But you don't claim to be an expert in the diagnosis of gender dysphoria; correct?
A No.
MS. LAND: Object to form.
Q (By Mr. Ossip) Okay. Then you also mentioned the Folwell case. That was in North Carolina; correct?
A Correct.
Q And you were retained by the state treasurer during that case?
A Correct.
Q And what issues were you asked to opine on there?
A The same.
Q Okay. The same as the Cincinnati case?
A The same as this case.

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Q Same as this case. Okay. And you were actually retained; correct?
A Yes.
Q And did you submit an expert report in that case?
A I did.
Q How many reports?
A I'm trying to remember if we had a rebuttal on that one. I think it was just the -- my initial -- there may have been a rebuttal report as well, yeah.
Q Okay. So an initial and possibly a rebuttal?
A Correct.
Q But you're not sure right now?
A Not off the top of my head.
Q And you testified in that case?
A Yes, I was.
Q Did you testify at any hearings in that case?
A I have not.
Q And have you testified at trials in that case?
A I have not.
Q Okay. Do you know if the court has accepted you as an expert in that case?
A I think it's being debated right now.
Q And by "being debated," you mean whether or not your testimony should be admitted as expert testimony?

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A Correct. The last communication I had with the attorney was that the plaintiff's attorneys had moved to have me removed from the expert list.
Q Okay. And that -- as far as you're aware that motion has not been decided; correct?
A I have not heard a decision in it.
Q Okay. And you mentioned Alabama. Well, actually, let's go back to -- I'm sorry.
When did you submit your expert report in that case?
A Again, I'm going to guess it's going to be about a year ago. I think it was at the -- I think it's in the first part of 2021.
Q So when were you -- so Alabama. When -- when -- sorry. Strike that.
You were retained by the state in Alabama; correct?
A Well, we're in the process of that. I have not been officially yet, no, sir.
Q So you have not even signed an engagement with the state; correct?
A I filled out some forms. But there is some processes they keep emailing me about having to do with payment and things they haven't ironed out yet. So, yeah, it's one of these governmental paper chases going

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on. I don't know what -- it's a fairly recent thing, because as of the date that the law passed, I think 20 minutes later they called me.
Q So 20 minutes after the law was passed, the state called you?
A Correct.
Q And who from the state contacted you?
A I don't remember.
Q Was it someone from the state attorney general's office?
A As I recall that, yeah. The particular person, I don't remember. But I believe it was the attorney general's office, yeah.
Q So had a lawsuit even been filed yet at that point?
A No. That's what happened. The lawsuit got filed immediately. And they immediately said, Okay, well, let's get our experts in.
Q Well, you said -- okay. Sorry.
You said 20 minutes after the law was passed they contacted you. But is that because within that same 20 minutes the lawsuit was filed?
A Correct.
Q Okay. So all very fast it sounds like.
A Yes. Everybody had it sort of loaded in the

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fax machines, I guess.
Q Okay.
A Just waiting to push the button.
Q Just lawyers and doctors still use fax machines; right? Let's see.
Okay. But you have not actually been retained yet in that case; correct?
A It's not official yet, no.
Q And you have not prepared a report for that case; correct?
A I -- I did write a report for them, but it was just sent as a draft. There's nothing that's been -- I just sort of sent them a draft of information for them to look over while we're working through the administrative processes. But it has not been reviewed, hasn't been edited, hasn't been finalized, nothing.
Q But you prepared this draft and you were not yet engaged by the state; correct?
A Yeah, I guess that's correct. I'm not sure. I guess what hasn't been completed yet is the -- I don't know. I don't understand the paperwork. I guess it would be more correct to say they have engaged me because they asked for the document, so they must have decided I'm worthy of it.
Q But have you come to an agreement as to your

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fees in the case?
A They asked me what my fees were and I told them and they didn't raise a fuss about it so -- and then they asked me for the report.
Q Got it. But you're still working on the paperwork?
A Yeah. I don't know what's left to be done. Perhaps it's all done.
Q You haven't been deposed in that case, have you?
A No.
Q What about a hearing?
A Nothing.
Q So you have not appeared at a hearing?
A Well, I appeared at legislative hearings.
Q Okay.
A But not at any proceedings relative to the lawsuit that's been filed.
Q Okay. We'll come back to that. But nothing related to the lawsuit; correct?
A Right.
Q Okay.
A Correct.
Q And then you mentioned Florida. Who contacted you about Florida?

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A The office of -- I forget what they call themselves. The office that manages the state Medicaid program.
Q Okay. I'm from Florida, but would not be able to tell you what that is. So the office that manages the state Medicaid, that's who contacted you?
A Right.
Q And when was this?
A A couple of weeks ago.
Q And is this about a lawsuit in Florida?
A No.
Q For what purpose did they contact you?
A In anticipation, I guess, of what was going be to the fallout when the state of Florida determines that Medicaid funds should not be used for the transitioning, surgical or medical, of children. That was the question they were asking me about.
Q So it's your understanding that this determination hasn't been made yet?
A Right.
Q And that if it will be made they anticipate a lawsuit and want to hire you as an expert?
MS. LAND: Objection to form.
A That's my understanding.
Q (By Mr. Ossip) All right. So you haven't --

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well, strike that.
Have you signed an engagement with the state in Florida?
A That's one of those other ones that's in process. Everything is happening so quickly right now and they all sort of blur together, you know.
Q Got it. Have you prepared a report in that case yet?
A I have not. It's not a case to my understanding. They just asked me a lot of questions.
Q But you have not sent them a draft report or anything?
A No.
Q Okay. All right. So you mentioned the child custody case in Cincinnati, the Folwell case in North Carolina, and then these preliminary cases in Alabama and Florida. No other appearances as an expert other than this case; correct?
A Right.
Q Okay. Has a court ever accepted your testimony as an expert?
A No, not yet. As I say, the first case is the Folwell case and that's what's being contested right now.
Q Understood. So, okay. So that was all

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lawsuits. Let's put that all to the side. Outside of litigation have you ever served as an expert regarding the treatment of gender dysphoria?
A No.
Q What about for surgical procedures related to gender dysphoria?
A As directly applied to the treatment of gender dysphoria?
Q Yes.
A No, I have not.
Q So you mentioned that you testified at a legislative hearing in Alabama; correct?
A Several times.
Q Okay. At several different hearings?
A Right. So it's a bicameral legislature and there were parallel bills in the house and the senate and they had the hearings on one side. It was the health and whatever it is department or -- committee rather. These terminologies. And the other one was the judiciary. So I had to testify in front of both over the course of two years, repeat visits for bills that have failed to move and things like that.
Q And when was the first such hearing?
A So the most recent iteration was early 2022. And it's a short legislative session so it occurs in the

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early part of the year. So previous to this year, 2022, would have been the same process in 2021, I believe it was.
Q So --
A Testifying twice on the same day, once in 2021 and then 2022 again. I think those are the dates. You're obviously are gleaning that I have difficulty remembering dates.
Q No. We're just going for your best recollection sitting hearing today.
A Certainly.
Q So but again, in 2021, we think, two times on the same day, though; correct?
A Yes.
Q And then the same thing in 2022?
A That's right.
Q Okay. And how did you -- looking back to that first time in 2021, how did you come to testify at those hearings?
A An advocacy group, I think it's the Eagle Forum, in Alabama had contacted me. I don't remember how I came to their attention. But they sent me a draft of the bills that they were trying to get sponsorship or they had sponsorship for. And they asked me what I thought and would I be willing to testify to the

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responsible committees that were reviewing the bills and I said I would.
Q And do you recall who from the Eagle Forum contacted you?
A Margaret Clark or Eunie Smith, one of those dear women. They are just precious little people.
Q And so it sounds like you knew them before they contacted you.
A No, no, I had never met them before.
Q But you met them both after that?
A On the day I went down there.
Q And is that the only meeting you have had with them?
A So I made two trips down there. And the first time there was -- it was a more drawn-out process because they wanted me to accompany them touring around the capital building, so it was a drawn-out process. The second time it was very brief, I met them in the hallway, we walked into the hearing room, bye. That was pretty much it.
Q And both of those women are members of the Eagle Forum; correct?
A It's my understanding, yes.
Q Okay. And is it your understanding that the Eagle Forum had prepared the draft of the bill?

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A I don't know who wrote it. I know who were the sponsors of it, but I don't know who actually crafted the thing. I know that Eagle Forum has a legal, obviously a very active legal department. They may have crafted it. I don't know who.
Q And who did you understand the sponsors of the bill to be?
A Shay Shellnutt, and he's on the house side. And then on the senate side -- oh, gosh. It will probably wake me up at two in the morning when I remember his name.
Q That's okay.
A I'll call you.
Q Sounds good. But did you -- those sponsors, did you meet with them in preparation for your testimony?
A It was a brief. Glad you're here, need some coffee, see you there kind of meeting, yeah. Nothing substantive, yeah.
Q So just on that day, though.
A Yes, sir.
Q Okay. Have you testified in any other state legislatures about this issue?
A No.
Q So only in Alabama?

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A Correct.
Q Did you ever submit any report to any other legislatures?
A I don't think I did. I think my first contact with Arkansas -- again, I'm working from poor memory. My first contact with Arkansas was after the law had been passed, so I don't think I offered anything to any legislatures besides Alabama.
Q One second. I'm sorry, Doctor. Let me put this another way. Did you ever make any recommendations to any other state legislatures?
A I don't remember if I did or not. I don't -- there may have been somebody from Texas that I had a phone conversation with, or maybe sent some -- a letter in brief or something like that to, but I -- I don't have a clear memory of that. I've had contact with people from Texas, but I don't think it was ever anything particularly formal.
Q Any other states other than Texas and Alabama?
A Not to my knowledge. Not to my recollection, I should say.
(Plaintiffs' Exhibit 2 was marked for identification and made a part of the record.)
Q All right. So you have just been handed what's

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been marked by the court reporter as Exhibit 2. And if you open up and you look at that inside cover --
A Right.
Q -- have you seen this document before?
A I have probably seen it in digital form, yeah, when I -- when I signed it.
Q Okay. And that's your transcripts from the deposition that we were discussing earlier in the North Carolina case; correct?
A It sure looks like it.
Q And that's Kadel versus Folwell?
A Have I been mispronouncing it? Is it Kadel or Kadell (phonetic)? Yeah.
Q All right. Bear with me one second. And could you turn with me to page 54? And that's using the page numbers in the top right corners.
A Page 54.
Q Correct. And do you see the line numbers on the left side of the page?
A I do.
Q And if you go down to line 15 you see, Question, "You had involvement in those legislative efforts in Utah, didn't you?"
Answer, "I think I made some recommendations to them, yes, I did."

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Does that refresh your recollection sitting here?
A It does, but it doesn't bring to mind exactly what they had asked me about. But, yeah. Okay.
Q Do you know if there was any report submitted to the legislature in Utah?
A I don't know what -- what they produced. Let's see. I'm thinking that this was another one of those telephonic, Do you have a minute, Doc, can I ask you some questions, that kind of thing. I don't remember having any other relationship with the State of Utah and I'm pretty sure I did not submit any report to them, but, yeah.
Q So if somebody submitted a report that had your name on it in that legislature, you would have never seen it; correct?
A Gosh, again I'm struggling here.
MS. LAND: Object to the form.
A I'm struggle here. I don't know what they -- what Utah has done. I haven't had any contact with anyone from Utah in a long, long time, if any.
Q (By Mr. Ossip) Okay. So you may have had a phone conversation with them?
A That's my -- that's about the only thing I can offer you is it must have been a phone conversation,

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because I don't have a file that says "Utah" on it.
Q And do you know who you would have had --
A No.
Q Well, sorry. Strike that.
And in Texas who did you have a conversation with?
A Let's see. I think I spoke with a woman in the attorney general's office who we had a very long phone conversation as she was just basically picking my brain to get an understanding of the issue at hand of gender transitioning children and was just looking for my perspective on the details, so it was a long conversation about that. That conversation must have been over a year ago.
Q And was that phone conversation limited to discussions of surgery?
A Diagnosis of -- how the diagnosis is made by other providers and referral is then made and the absence of confirmation of diagnosis by the surgeon, the experimental nature of the interventions, those sorts of things.
Q And which interventions are you referring to?
A She wanted to know about all of it, so everything from social transitioning to top surgery in children.

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Q Do you claim to be an expert in social transitioning?
A No.
Q What about endocrinology?
A Well, I have to -- as a -- with my background in general surgery and plastic and reconstructive surgery I have to understand endocrinology. So, for example, when I was a general surgeon, if I was going to do a thyroidectomy I would have to understand what the endocrinopathy was about and the confidence I might have in the diagnosis. So the diagnostic side of endocrinology I had to understand. I had to understand the metabolic side of endocrinology before embarking on surgery for endocrinopathic diseases, so --
Q But, Doctor, sitting here today you don't claim to be an expert in endocrinology; correct?
A I wouldn't offer myself as an expert.
MS. LAND: Object to form.
Q (By Mr. Ossip) Okay. And so you spoke with somebody from the attorney general's office. Was that about legislation that was pending in Texas?
A No. And I didn't find this out until after a second conversation was the reason they were seeking an understanding of transgender medicine and surgery was because they were trying to determine if, under existing

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law, family law, if transgender medicine and surgery would fall under the category of child abuse. I think that's what they ultimately did. So the phone conversation was about understanding the process, understanding what transitioning is about.
Q And in that conversation -- well, let me take a step back. I'm sorry.
So you mentioned one conversation, a long phone call with somebody from the attorney general's office. Were there any other conversations with Texas?
A No.
Q Just one long phone call with the AG?
A Right.
Q And in the course of that phone call did you opine that providing gender-affirming medical care is child abuse?
MS. LAND: Object to form.
A I think the way I present it -- first of all, I generally don't like to use the term child abuse when talking in a sort of public forum about things like this because it's a terrible thing to visit upon the parents of a child who is suffering with this, so I tend to avoid the use of that term.
The -- what I -- as I recall the conversation, they wanted to know the details and the expected

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outcomes of transitioning --
Q (By Mr. Ossip) So, Doctor --
A -- and possible complications.
Q So, Doctor, we've really got to stick to my questions because we only have seven hours and I don't want to have to run over our time and ask to come back for a second day. Okay?
So looking at the question yes or no. In the course of that phone conversation did you opine that you thought that providing gender-affirming medical care was child abuse?
A It's my recollection I did not.
Q You did not during that phone call? Okay.
Bear with me one second, Doctor. Okay. So we mentioned Texas, Utah, Alabama. Any other states you have discussed this issue with government officials?
A Not that I can recall.
Q Could you turn to page 62 of that -- of the transcript? And if you go down to line 13.
A Line 13.
Q Correct. It says, "There may have been something in Arizona." Do you see that?
A I do.
Q Does that refresh your recollection at all?
A Not at all.

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Q So you still -- you don't know, sitting here today, whether you did or did not speak to anyone in Arizona?
A I do not know that.
Q But you may have?
A Well, apparently back a year ago I thought I might have. But there seems to be as much uncertainty a year ago as there is today.
Q But, well, so sitting here today again you don't know one way or another; correct?
A Correct.
Q All right. How did you come to be retained as an expert in this case?
A I think it was an email from Mr. Cantrell, if I had to take a guess, from the attorney general's office. I think it was an email asking if I would be -- if I could offer any help.
Q And Mr. Cantrell just emailed you out of the blue?
A That's my recollection.
Q Okay. Nobody put you in contact with him; correct?
A I did not reach out to him, no.
Q And nobody that you're aware of connected the two of you?

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A Not that I'm aware of.
Q Okay. And if I refer to something as the Arkansas law you'll understand that I mean Arkansas's Act 626, which is also known as the SAFE Act. Is that fair?
A That's fair.
Q Okay. And you mentioned you were only contacted after that law was passed; correct?
A That's my recollection of it. I don't remember any contact before it was passed. I remember -- my recollection is that I remember hearing about it in the news before I heard anything about it from...
Q And when you say you heard about it in the news, you heard about the law's passage?
A That's my recollection, that I heard that first before I heard from the attorney general.
Q But you did not advocate for the passage of that law; correct?
A None.
Q And you had no interaction with the legislature?
A No.
Q Did you lobby in any way for this law?
A No.
MS. LAND: Object to form.

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Q (By Mr. Ossip) Okay. And no one from the state contacted you about the law before it was passed; correct?
A Not that I remember.
Q Okay. All right. And you never submitted any testimony supporting the law when it was in the legislature?
MS. LAND: Objection, asked and answered. Object to form.
Q (By Mr. Ossip) You can answer.
A Not that I remember.
Q All right. Do you recall when you got that email from Mike?
A It had to have been over a year ago I think, or maybe right around a year ago.
Q Do you recall if that was before or after this lawsuit was filed?
A I do not know that, no.
Q Okay. Did you know Mike Cantrell before he emailed you?
A No.
Q Did you know anyone else in the Arkansas Attorney General's Office?
A No.
Q And when were you actually retained by the

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state to act as an expert in this case?
A I think it was sometime over a year ago.
Q But after that initial email?
A Right. So the email led to, I guess, an exchange of emails. And as I remember it then the formal process began for getting my help.
Q And did you sign an agreement to serve as an expert in this case?
A I believe I did, yes.
Q And who signed that agreement?
A Besides me?
Q Correct.
A I do not know.
Q Okay. You're not aware of anyone other than the state having signed that agreement?
A I don't -- I don't remember it. I saw some official signature there, but I don't remember who that might have been.
Q What did the lawyers for the state ask you to do in this matter?
A To review the -- to review the Complaint, to review mostly the expert witnesses, and to offer an expert opinion on the evidence, my perspective on the value of the evidence.
Q Any particular issues they asked you to provide

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your expert opinion on?
A The initial request was just for a general overview. The subsequent one related to the rebuttal asked me to focus more specifically on the surgical issues.
Q Okay. So when you say the rebuttal, what do you mean by that?
A After I submitted my expert report there was a time, a couple of months that passed, and then they sent me the rebuttals by the three -- the three rebuttals that we spoke about earlier.
Q The plaintiffs' experts you mean?
A Correct, yeah.
Q Okay. Did counsel for the state provide you with any other materials to consider?
A None, no.
Q So just the three plaintiff expert reports?
A Yeah, that's my recollection of it. There was the Complaint and then their expert reports and then I got copies of the rebuttal.
Q And when was all this?
A Well, the -- the initial documents would have been sometime, I guess, shy of a year ago. And then the rebuttals probably came in six months later, because the whole cycle of me writing my opinion on my expert

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report, and then the -- them reviewing them, the rebuttals coming back.
Q Okay. Were you ever instructed to express a particular opinion in this case?
A No.
Q How did you reach your opinions in this case?
A Well, the -- my opinions on transgender, the issue of transgender medicine surgeries has been a -- has been an evolving process since I was a resident in training. But more recently in this particular case, again, as we talked about, the review of the citations that the expert -- the plaintiffs' experts submitted, review of their merits, review of the of associated citations, review of the WPATH Standards of Care, DSM, all of those things together, that's what formed my opinions, plus my -- my background in plastic and reconstructive surgery, issues related to the ethics of consent, the issues related to the ethics of surgical decisionmaking.
Q Did anyone instruct you to review or include any particular sources in your opinions?
A No.
Q Who determined the scope of the matters covered in your report?
MS. LAND: Objection. Form.

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A I did.
Q (By Mr. Ossip) No one else?
A No one.
MR. OSSIP: All right. Let's take a break here. I'm told we only have ten minutes left on this tape.
VIDEO OPERATOR: All right. This will end video part 1 and we are going off the record at 10:25 a.m.
(A break was had.)
VIDEO OPERATOR: We are back on the record at 10:41 a.m. This will begin media part 2. Please proceed.
Q (By Mr. Ossip) All right. Thank you. And welcome back, Doctor. So earlier we were talking about your phone conversation with the attorney general's office in Texas. In that discussion did you recommend anything to them?
A I don't remember making any recommendations. I remember it as a sort of information-seeking phone conversation from their office, more of a conversation what might be possible areas to look.
Q So it's your testimony that you made no recommendations during that phone call?
MS. LAND: Objection; form.

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A That's my recollection of that conversation. Again, it's over a year ago.
Q (By Mr. Ossip) Did you tell -- during that phone conversation did you opine that gender-affirming medical care is always harmful to minors?
MS. LAND: Objection to form.
A I don't remember ever giving that opinion. Ask me the question again. I might not have understood it correctly.
Q (By Mr. Ossip) Yeah. During that phone conversation did you opine that gender-affirming medical care is always harmful to minors?
A Transgender-affirming medical care. That's my opinion, yes, it is.
Q Do you support Texas's decision to investigate parents for child abuse if they provide what you just described as transgender-affirming medical care to their children?
A I don't support that at all.
Q So you don't support that Texas did?
MS. LAND: Object to the form.
A I don't support the idea that parents should be prosecuted for following the advice of physicians.
Q (By Mr. Ossip) Well, do you support -- strike that. Do you believe that children should be removed

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from the custody of their parents if their parents are offering -- or are providing their children with gender-affirming medical care?
MS. LAND: Objection; form.
A I generally do not -- I generally do not -- I mean, it has to be some pretty severe issue to remove a child from their parents. And most of what's happening in this area that we're talking about today does not rise to that level at all.
Q (By Mr. Ossip) Okay. And I know that you said before you don't like use using the term child abuse in public settings. But do you believe it is child abuse to provide gender-affirming medical care to minors?
A I believe it's abusive to the child and the family.
Q And in that case the abuser would be the doctors providing the care?
A Right.
Q Did Texas ask you to be an expert?
A No.
Q Do you believe that doctors should be charged with child abuse for providing gender-affirming medical care to minors?
A I wouldn't necessarily use the term child abuse because we have other similar laws that -- doctors don't

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get charged for child abuse if he prescribes anabolic steroids to a young athlete. Technically it isn't abuse to the body of that child. But generally it's not called child abuse. It's called, you know, misprescribing and pill rolling and various other things that doctors do. This is kind of in that category. It's medical malpractice, not child abuse.

Q So you believe it's medical malpractice to provide gender-affirming medical care to minors?

A I do.

MS. LAND: Objection to form.

Q (By Mr. Ossip) All right. We'll come back to that. Let's move on.

Did you work with anyone else in preparing your reports or testimony in this case?

A No.

Q Did you work with the state?

A No.

Q So every word of your report was written by you?

A Yeah, the whole thing was written by me. It went through, I guess, an editing process in terms of spelling and punctuation kind of issues like that and it came back as a -- as a -- in the format of a legal brief, which I then signed and submitted, yeah. But I

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composed the whole thing.

Q Okay. So, and the editing process you mean that counsel for the state was editing; correct?

A Right. Yeah, punctuation and spelling and paragraph numbering and things like that.

Q Did anyone other than counsel for the state edit your report?

A No.

Q Did you have any research assistance in preparing your report?

A None.

Q How are you compensated in this case?

A Hourly and travel.

Q And you have listed your hourly rate in your report; correct?

A Yes, I did. I think it's on the first page.

Q Okay. And that is still the rate that you receive?

A Correct.

Q How much have you billed to date in this case?

A Somewhere around $17,000.

Q And, now, best estimate what's the total amount of time you've spent on this case, whether you have billed for it or not?

A I don't know, 50, 70 hours. I'm -- that's --

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that's a -- I don't know where that number came from, but -- it might actually be more than that. You know, when --

Q So definitely more than 50 hours?

A I guess. I don't know. I'm so lax about that that, you know, I'll find myself reading about something and I didn't mark my little log and I'm two hours into some paper somewhere. I try to be punctual about timekeeping, but --

Q So do you expect to receive any additional compensation in connection with your reports?

A None.

Q Okay. All right. So now I'm going to do a brief name association exercise so bear with me. But I'm just going to ask if you know who the following people are. So the first one is Dr. Steven Levine.

A Right. I don't know him personally but he's a psychiatrist I believe, pediatrics psychologist or psychiatrist. Is that right?

Q Just going from what you know.

A Oh, okay.

Q And do you know if Dr. Levine is an expert for the state in this case?

A I think he might be, yeah.

Q But you're not sure?

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A Not right -- sitting here right now, no.

Q Okay. And you've never met Dr. Levine?

A I don't think I have.

Q What about Dr. Paul Hruz?

A Right, I know Dr. Hruz.

Q And where do you know Dr. Hruz from?

A I first met him at an ADF conference. We were both presenters. He came and gave an hour-long talk on pediatric endocrinology, and I gave a similar talk on plastic surgery and transgender.

Q Okay. And --

A And I've seen -- you know, we're now friends.

Q Before that conference you did not know him?

A No.

Q Okay. And by ADF, do you mean the Alliance Defending Freedom?

A Correct.

Q Sorry. Just trying to make things go a little faster today. Okay.

When did you first become familiar with ADF?

A Wow, that was some years ago. And essentially what it was -- I didn't know who they were, but I got an invitation to come down and give a presentation. And so it was, you know, down in Arizona and the first time I had met or heard of any of it was walking into their

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building and meeting an attorney named Jeff -- I'll think of his last name. Jeff something. And going into a large conference room and giving my presentation.
Q And that was at the ADF headquarters building?
A It must be. It was a lovely place and it was in Arizona. I think --
Q Do you know where in Arizona?
A Phoenix? I don't know. It all kind of looks the same down there to me.
Q I think Arizona is beautiful.
A No, it is beautiful. It's all developed about the same time so it's hard to judge Phoenix from Tucson sometimes.
Q Sure. And when was that conference?
A Again, it may be in 2016 or '17, just a wild guess there.
Q Okay. And you said you -- you didn't know ADF before you got that invitation.
A No.
Q Do you know who or -- strike that.
Do you know how ADF came to invite you to this conference?
A I don't know who they talked to. Again, since I give the talk so frequently in various venues around the country, somebody might have heard of it or maybe

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seen a recording of it.
Q Okay. That's helpful. So just to get the timeline right, this is after you started giving the presentation we discussed earlier?
A I suspect it was, because that's really kind of when a larger public audience was asking for the talk.
Q Okay.
A Again, the first several times I gave it was in very small groups of priests and religious educators and things like that.
Q And before that conference you had never met Dr. Hruz; correct?
A That was the first time I met him, yes.
Q And what did you discuss at the conference?
A Well, so the conference was organized kind of as a -- as an information gathering visit. There was a variety of speakers. Paul Hruz talked about endocrinology. I talked about plastic surgery.
There was a presentation on pediatrics. There was a presentation on psychology, psychiatry. There was a presentation on -- there might have been a presentation on law, but I'm not positive about that. Yeah.
Oh, there were a couple of people there who were -- that lived the experience of transgender. There

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was a young man named Hasci Horvath who works for the University of San Francisco, he manages their medical information processes and the guy is a genius remembering papers and authors and years and findings. But he had the lived experience of transitioning himself, and so he talked about his experience.
Q And you mentioned people with the lived experience and being transgender. Was there anybody else other than Hasci Horvath?
A There was a trans female there from Asia. And I'm trying to remember her name. But I believe she was residing in Thailand, but was an author, ran a -- some web blog or something about it. Again, the lived experience, fully transitioned transgender female.
Q And by that you mean that she identified as a woman?
A Oh, in every respect, yeah, fully. And had been living as a trans female for probably 25 years, had undergone surgery in the late 80s or 90s somewhere in the southwest. Might have been a transgender surgeon in Colorado or Arizona that had done her surgeries. Yeah, definitely.
Q Do you know who Mark Regnarus is?
A I have heard his name and I think I have read some articles by him.

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Q Do you know if Mark Regnarus was at that ADF conference in Arizona?
A I don't know. I don't think -- I don't know. It doesn't ring a bell.
Q But he could have been there?
A I don't know.
Q You wouldn't disagree if somebody else said he was there; correct?
A I wouldn't have any basis for disagreeing.
Q What about Dr. Levine?
A I know there was a psychiatry, psychology presentation, but I can't remember who it was. So if you were to tell me that Dr. Levine was at that conference I wouldn't argue with you about it. But we didn't -- I didn't talk with him individually. Maybe that's the reason I don't remember. I don't know.
Q And how many people total were present at that conference?
A A ballpark guess, maybe a dozen.
Q And how many of those gave presentations?
A I think everybody there was there to give a presentation.
Q And I think you had mentioned you were invited by an attorney. Did the attorney give a presentation?
A I think just sort of an introduction. Hi,

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welcome aboard, this is the issue we're looking at, this is kind of the conflicts in the greater society that we're seeing, if you need anything, I'm here kind of thing, yeah.

I do not remember him -- he might have given another presentation. Gosh, it was so long ago. He might have given another presentation on the law. He might have been the one who gave that presentation. It might have been another attorney that was there by the name of Gary McCaleb.

Q And if Gary McCaleb was there, do you know if he gave a presentation?

A I think he did. I think he gave a presentation, yeah.

Q Okay.

A I'm almost confident he did, because he brought to light the fact that he was a Navy veteran and I've got 24 years in the Navy. I think we had a conversation over lunch about that.

Q At that meeting were you asked to serve as an expert witness in cases about transgender issues?

A No.

Q You were never asked?

A No one asked me.

Q Okay. Was the group -- was the entire

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conference asked?

MS. LAND: Objection to form.

A That -- I mean, that might have been what Gary McCaleb was talking about or maybe the attorney Jeff, I will remember his name, talking about maybe some sense that they had that there might be future legal issues and that you might be called upon to give your expert opinion, but there was no invitation to give a particular -- you know, to a particular case or a particular legal issue. It was probably more like, you know, being a witness in a -- a very complicated public issue is. I think that's what it was about.

Q (By Mr. Ossip) Was one of the topics at that conference the difficulty in identifying expert witnesses who are willing to testify in these cases?

A I -- not to my recollection, no. There -- I know there was a lot of commiserating about how few people there are willing to speak publically against transgender medicine and surgery. I know that was a case, because one of the people that was there -- yeah, okay.

So one of the people that was there at that conference was a plastic surgeon himself who had lost his job -- he was the chief of plastic surgery.

Q I just want to keep it to answering my

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questions.

A Well, but to your question about whether --

Q My question is yes or no. At that conference was it discussed -- was one of the topics of discussion the difficulty in identifying expert witnesses who are willing to testify in this case?

MS. LAND: Objection to form.

Q (By Mr. Ossip) In these cases. Excuse me.

A It was not a matter of formal presentation. Again, it was just a private discussion between people who were there.

Q And were people at that meeting asked whether they would be willing to participate as expert witnesses?

A I don't remember that question.

Q Okay. Can you turn to page 90 of the transcript in front of you?

A Certainly.

Q Do you see on line 19 where it starts, "I remember." "I remember a fairly long discussion about the poverty of people who are going to testify because of the risk they take in testifying."

Was that your testimony in the Kadel case?

A Right. And that speaks to what I was starting to relate to you in my answer. I think that was a

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conversation among the people who attended the conference. I don't think it was as a formal presentation. I think that was a conversation we were having.

Q And can you turn to page 91?

A Certainly.

Q And do you see, Question, and people -- this is on line 6.

Question, "And people at that meeting were asked whether they would be willing to participate as expert witnesses; right?"

Answer, "Yes."

Was that your testimony?

A I guess it was.

Q And do you see where you said, "Before that meeting you had never testified as an expert witness?"

Answer, "Before this moment I never testified as an expert witness."

Was that by "this moment," you mean in Kadel; correct?

A Correct.

Q And again, you never testified in any other cases; correct?

A No.

Q No hearings as an expert witness?

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A Other than the legislative hearings we talked about earlier.
Q But no court hearings.
A Correct.
Q Correct?
A Correct.
Q Okay. At that conference did you offer to be an expert witness in cases involving transgender issues?
A I don't remember. Evidently my recollection of that event is not as strong as I --
Q Do you know if anyone else offered to be an expert witness in transgender issues?
A I don't remember.
Q You don't remember whether Paul Hruz did?
A I remember a willingness on his part, but I don't remember him saying that he would or anything like that. Again, I don't remember the question being asked.
Q But he expressed a willingness?
A We all expressed a willingness, yes.
Q Including you?
A Oh, yes, absolutely, absolutely. It wasn't -- I don't remember it being asked of us, but in our conversations we all expressed a willingness to offer our expert opinions on the issue.
Q Did anyone present not express a willingness?

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A I don't remember.
Q Did the ADF play any roll in your becoming an expert witness in this case?
A No.
Q Okay. So you mentioned there was a conference in either 2016 or 2017 and that was in Arizona possibly. Have you attended any other of ADF conferences?
A So there was two visits to ADF. And the -- they are all sort of muddled together as to who was there which time. I started to tell you about the other plastic surgeon. I was trying to remember if I met him on the first visit down or the second visit down. And, yeah, so...
Q Well, so there were two visits. Do you recall when the second visit was?
A I don't. It had to have been at least a year after that first one I would think.
Q At least one year after?
A I'd guess, yes. It seems some time had elapsed since we were there before.
Q Outside of those two conferences have you had any other contact with ADF?
A An occasional email, I think, from Gary McCaleb sending a link to an article, some scientific publications, that sort of stuff. Just sort of chatter

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in an email string. That's about it.
Q And all additional communications is with emails with Gary McCaleb?
A Yeah. That's -- it's been onesies, twosies over the last couple of years. I can't remember the last time I got anything from him actually.
Q Okay. But, well, outside of those two conferences have you had any contact with anyone associated with ADF other than Gary McCaleb?
A That's the only ones I can remember.
Q And did ADF play any role in your becoming an expert witness in any other case?
A No, I don't think so.
Q What about before your testimony in the legislature in Alabama?
A No.
Q What about your conversations with any other state?
A Not to my knowledge, no.
Q Okay. Is the ADF a scientific organization?
MS. LAND: Objection to form.
A My understanding is that they are a legal -- they certainly have a very strong Christian bent, evangelical kind of thing. But I think they are primarily a legal organization.

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Q (By Mr. Ossip) And so you said they had a strong evangelical bent. Would you describe them as a religious organization?
MS. LAND: Objection to form.
A No. I only say that because there is very few offices that you go into that have a chapel. Right?
Q (By Mr. Ossip) Okay. So when you walked in there was a chapel?
A Right, exactly.
Q Okay. That would make sense. And do you know if they describe themselves as a ministry?
A I don't know. I don't know.
Q Would it surprise you?
A I know that one of the founders is a fellow named Bill Bright, and he has -- he definitely speaks ministerially, but I don't know if they officially describe themselves as a ministry.
Q Got it. Okay. Okay. Perfect.
All right. Let's go back to the names. So next person, do you know who Dr. Roger Hiatt is?
A Hum. I've read the name somewhere. I couldn't -- I couldn't tell you where.
Q But you've never met Dr. Roger Hiatt; correct?
A I don't believe I have.
Q And you're not familiar with Dr. Hiatt's work?

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A If I was to maybe see his work I'd go, "Oh, yeah, I remember reading this." But I have a very hard time linking names with particular documents.
Q I see. But right off the top of your head, you don't know?
A I don't know.
Q And I think actually I want to go back to professor Mark Regnarus. Have you met professor Regnarus?
A I mean, if he was at that conference I probably met him, but I don't remember meeting him.
Q Got it. But -- well, let me put it another way. So putting aside the conference, never met him outside the conference?
A Not that I remember.
Q Okay. And are you familiar with professor Regnarus' work?
A I remember reading some things that he's written, but I couldn't tell you exactly what. But if you were to put it in front of me I would probably raise my eyebrows and go, "I remember reading this."
Q And what about Dr. Hruz, are you familiar with his work?
A I read a lot of the things he's written, yes, I do.

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Q Okay. And before that ADF conference have you -- did you -- strike that.
Before the ADF conference had you ever read any of Dr. Hruz's work?
A No.
Q Okay. Are you familiar with someone named Christine Cryer?
A It does not come to mind.
Q What about Billy Burleigh?
A Billy Burleigh. Have I seen that name as an online -- is it one of these influencer people? I'm not sure. It's one of those remote things. I'm not sure.
Q So may have seen that name on the internet somewhere?
A Perhaps, yeah. Maybe that's where I remember it from.
Q But never met Billy Burleigh?
A I don't remember meeting Billy Burleigh.
Q And Billy Burleigh wasn't at that ADF conference to the best of your knowledge?
A Now you have got me thinking that the person from Thailand might have had that name. I don't know. That was too long ago for me.
Q But you're not sure?
A I'm not sure.

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Q Could you have been, could have not been?
A I'm not sure.
Q What about Walt Heyer?
A I know Walter Heyer very well.
Q Where do you know Walter Heyer from?
A Where did I first meet Walter? I don't remember where I first met him. It may have been at one of those ADF conferences actually. But, yeah, wonderful person.
Q And what did Walt Heyer present on the ADF conference?
A His lived experience. And I can't remember if it was the first one or the second conference that he was there.
Q So it could have been different presenters between the two conferences?
A Oh, there were. Well, there was sort of a mix and match. Like I intimated before, there was a plastic surgeon and I had never met another plastic surgeon that spoke publically on the issue. He may have been at the second meeting. There was Hasci Horvath that presented at one of them. There was Walt Heyer that presented at one of them. I don't know which, first or second.
Q Have you interacted with Walt Heyer outside of the ADF conference?

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A Yes, I have.
Q How so?
A Let's see. Walter was at one of the times we testified at the Alabama legislature, he was there for one of those.
Q Okay. And that was on one of those two --
A Right.
Q -- double committee days?
A Correct, yes. And there was a little social gathering at somebody's restaurant that had been sort of -- was catering a little visit there.
Q And that was after the testimony?
A Yeah, that was in the evening.
Q And who was at that social gathering?
A Walter and myself and some people from Eagle Forum and some legislators that were there. I don't remember who else.
Q And would those legislators have included the sponsors of the bill?
A That would make sense, you know.
Q Okay. And what about Laura Perry?
A Laura Perry? I don't remember. That may be the -- that may be the woman from Thailand. The mystery woman from Thailand. It's so long ago.
Q Okay. But, well, unlike Walt Heyer though --

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well, let me put it another way. Are you aware of any contact with anyone named Laura Perry outside of, perhaps, the ADF conference?
A I don't remember. I don't remember any such contact.
Q Okay. And just going back to Walt Heyer, so you mentioned you might have seen him at ADF.
A No. I definitely saw him at ADF.
Q Oh, definitely saw him at ADF.
A Yeah. I just couldn't remember whether it was the first or second conference.
Q Okay. That helps. And then at one of the two dual committee meetings. Any other interactions with Walt Heyer?
A I may have seen -- well, it wouldn't surprise me to remember that he was at some other presentation on the subject to some other group, possibly even one of the Catholic presentations I have done. He gets a lot of requests because of his sex change regret website and people are always visiting him with invitations. I know we have crossed paths multiple times. I can't remember the circumstances of all them.
Q You mentioned a website. Do you know what that website addresses?
A Walter Heyer's?

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Q Correct?
A Sexchangeregret.com I think it is, yes, .com.
Q And have you visited that website?
A Once or twice, mostly just to find contact information to get ahold of Walt.
Q Got it. And so aside from meetings or conferences do you stay in touch with Walt?
A I mean, we're not in regular communications. Just the occasional email, I hear we're going to be in Montgomery, look forward to seeing you there. Let me drive your car. He loves my car.
Q But just social then?
A Right. Well, I mean, as social as -- the topic that brought us together always comes up.
Q Do you discuss research with Walt?
A With Walt it's mostly discussions of the suffering he encountered all the time and we commiserate about that because I encounter suffering in my own practice and he encounters it in his contact with people who are struggling with their identity.
Q How often do you -- well, strike that. Actually, I think we can move on.
MR. OSSIP: Can I get three?
(Plaintiffs' Exhibit 3 was marked for identification and made a part of the record.)
Q (By Mr. Ossip) The court reporter is handing you Exhibit 3. Take a look at that and see if you recognize that document.
A It appears to be my expert report --
Q All right.
A -- in this Arkansas case.
Q All right. And do you stand by this report as written?
A Yeah, the several times I have read it I didn't find any -- any discrepancies. I'm much more careful about that because there was a discrepancy in my report that I didn't catch and so -- I become a lot more guarded when lawyers ask that question.
Q Got it. I'm not trying to play gotcha.
A No. It always calls to my own fallibility so I always go slowly here. Yeah, this looks like it.
Q You mentioned there was a discrepancy with your report. Which report are you referring to?
A Kadel.
Q Oh, your report in the Kadel case?
A Yeah. They jumped on a discrepancy that was there that I didn't catch that I should have caught.
Q Understood. But you believe that discrepancy, if any, was corrected in this case?

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A Oh, there was no such discrepancy in this case.
Q Okay.
A It had to do with the way they titled the thing that was not correct.
Q I see. Can you elaborate on that, please?
A Right. So whenever I present my credentials --
Q Um-hum.
A -- I always -- among the things I talk about in addition to my education is my board certification. So board certified in general surgery, board certified in plastic and reconstructive surgery, recertified in plastic and reconstructive surgery, and I always include the dates.
I let my plastic surgery board certification lapse in the year I retired from surgery. And so -- but I'm -- the way they titled the document was board certified in plastic surgery. He jumped all over that, he said, "You're not board certified in plastic surgery, are you?" I said, "Well, no. I have been board certified in plastic surgery twice and I just let it lapse because I'm retired."
Q Got it. And so when you present your certifications you always put an end date on those?
A I always put the end date on it and I always speak of it in the past tense.

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Q Okay. And so in your -- everywhere it appears in your report you put an end date; correct?
A I certainly strive to do that, yes, I do.
Q Okay. Any -- and so you stand by every word of this report, then, just to be clear for the record.
A Yes.
Q Okay. That was my one gotcha. All right. Including the attachments, if any?
A So the attachments would include what?
Q I believe it's just your CV.
A Okay. Yeah, I stand by that.
Q Okay. Anything that you would like to amend or correct?
A Not that I -- not that I found the several times I've read it.
Q When did you first become familiar with the research that you've cited on the treatment for gender dysphoria?
A Which particular citation?
Q Well, let me put it another way. When did you first start reviewing research related to the treatment of gender dysphoria?
A Oh, well, I remember reading some publications by a surgeon at, I think it was at UVA, which in the 90s when I was in training was one of the few places

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offering transgender surgery. I remember reading some report. I remember reading the original publications by Sir Harold Gillies in the post-second world war. So it goes -- this is a running thing that I've been doing, along with a lot of other topics in plastic surgery that I kind of keep a tab on.

But in earnest I would say 2014 when I started digging into it much more aggressively.

Q And what prompted that much more aggressive digging?
A I was at a -- I was at a courage Conference at Villa Nova University, and there was a breakout session for ordained clergy, of which I am, I'm an ordained deacon in the Roman Catholic church. And I went to a breakout session.

And during the course of the breakout session a priest there opined that one day the Roman Catholic church will catch up to the science and we will accept human sexuality as existing on a broad spectrum. And I asked him if he had any access to the particular science that would support that position, he did not. And then I opined from my experience what I knew, you know, based on what we discussed earlier.

And at the conclusion of that the organizer of the conference said, you know, this is an important

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topic, deacon Lappert, would you mind putting together a talk on transgender medicine and surgery, so that started a much more -- a much deeper dive into the literature.
Q And was that -- well, let me put it another way. Would you consider that the origin of the presentation we discussed earlier?
A The first iteration of this presentation was a presentation to a clergy retreat day about seven months after that courage conference.
Q And who organized that clergy retreat day?
A The diocese in Birmingham, Alabama.
Q And is that the diocese for which you are a deacon?
A That's correct.
Q And what is Courage?
A Courage is a Catholic apostolate that serves persons who experience same sex attraction who are seeking to live a chaste life.
Q And are you affiliated with Courage in any way?
A I'm a chaplain for Courage and I am on the board of directors.
Q Okay. And what do you do as a chaplain for Courage?
A Lately not much because COVID really took the

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wind out of the sails. But generally what a chaplain does is we run meetings. The meetings are generally arranged like AA meetings, similar kind of a setup, but it's informed by Catholic prayer life and Catholic theology. We meet anonymously like AA. I sort of referee the meeting, I guide it in prayer, we kind of establish friendship, a community, and bear one another's burdens in the struggle for chastity.
Q And what do you know by chastity in this context?
A The chastity is living an authentic life and loving other people the way Jesus Christ would love them.
Q And with respect to persons with same sex attraction, what does that mean?
A It means the same thing as it means for anybody. In terms of what chastity asks of us, it doesn't matter if you're same-sex attracted, heterosexual, it doesn't make any difference. Chastity is chastity. It expresses itself differently whether you're married or single or a priest. But chastity is a form of authentic love. So it asks of me the same thing it would ask of somebody who is experiencing same-sex attraction all their life. It is the same demand.
Q And what is that demand?

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A Well, the demand is that the love of others rather than the use of others. And to live an integral life means to understand the role that sexual expression has in that life.
Q Well, let me put a -- so just -- but any same-sex sexual encounter would be the use of another in that context; correct?
A Well, but it's not peculiar to same-sex attracted persons.
Q Well, when is sex not the use of another?
A When it's --
MS. LAND: Objection to form.
A Well, that's going to be a difficult one. That's going to be a difficult one because it's kind of an individual thing --
Q (By Mr. Ossip) I see.
A -- that may be fleeting. I think the point of the -- the point of me defining chastity that way is to recognize that what -- the love we're called to when I said that we're called to love as Jesus loved, it's to love sacrificially, self-sacrificing the love and to help people to develop that capacity.
What chaste love is something we learn in preadolescence and adolescence and it's something we carry with us through our whole life assuming that it

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hasn't been wounded somehow.
Q But to just put an even finer point on it, having same-sex sexual encounters would not be chaste; correct?
MS. LAND: Objection, form.
A Well, it would -- yeah, that's right, by definition. Just as having sex outside of marriage would not be chaste. Just as having, you know, marital or sexual relations with a sibling. Right? There is all kinds of forms of abuse, but it's -- and they are not all of equal importance, but they are all not chaste.
Q (By Mr. Ossip) I see. And so is a same-sex sexual encounter is abuse then?
MS. LAND: Objection to form.
A No. You mischaracterize my word. Abuse is a form of non-chastity, but there are other kinds of non-chastity. Your question was about chastity. So, uh --
Q So you said -- I'm just going to read back what you said.
A Okay.
Q You said, Just as having, you now, the marital sexual relations -- well, you said -- I asked the question, "Just putting a finer point on it, having

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same-sex sexual encounters would not be chaste; correct?"
And then you answered, "Well, it would, yeah, that's right by definition, just as having sex outside of marriage would not be chaste. Just as having, you know, marital sexual relations with a sibling. Right? These are all kinds of forms of abuse."
A Oh, I'm sorry. So the last example was a form of abuse. But all of the examples were a form of non-chastity.
Q Okay.
A I guess that's the correct way to put it. Thank you.
Q Okay. And when did you become a chaplain for Courage.
A In -- let's see. Sometime in 2014 I believe. I think it was in 2014.
Q Was that before or after that conference?
A Which conference?
Q Oh, sorry. Was that before or after the conference at Villa Nova?
A No. I had become a chaplain before the -- I mean, I'm sorry. Wait a minute. That's tough. So I was ordained in 2013. The Villa Nova conference I think was in the summer of 2014, and I think I had already

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become -- no, it might have been the following year. Sorry.
I think when I went to Villa Nova I was already a chaplain. It may have happened after I was at Villa Nova that I became a chaplain. In fact, I can be certain about that.
Q That it happened after the --
A I think so, yeah.
Q Okay. How did you come to be invited to the Villa Nova conference?
A I -- let's see. I met Father Paul Check at a retreat at Casa Maria in Birmingham in 2014. And Father Paul Check invited me up to Villa Nova. At the time Father Paul Check was the executive director of Courage and he was the retreat master, and we met and had a lot of things in common and he was kind of inviting me into the work based on that meeting at that retreat.
Q And that retreat in Birmingham, was that affiliated with Courage also?
A Yeah. That was a regional retreat. The Southeast Retreat that happens every spring around -- well, the week before Easter, yeah.
Q And you attended that in your capacity as a deacon of the --
A I had just been ordained.

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Q Okay.
A I had just been ordained. And one of the -- of the women religious there said, Hey, Dr. Lappert, you're a doctor and a deacon now. I have a brother who is a doctor and a deacon. I'd like you to come down and meet him.
Q And that just happened to be at this --
A Correct, correct.
Q Okay. Serendipity. All right. And when did you join the board of directors of Courage?
A Let's see. Probably about five years, maybe four years ago. I think they are three-year terms and I'm just -- it's my second term.
Q And does the board have any other name other than board of directors?
A No, that's it.
Q Okay. And how many directors are on the board.
A Well, so I'm a non-voting member. There are two of us. And then there -- and it's -- the priests that are on the board that are voting members, I think there is four of them. And then there is a -- so somewhere around seven?
Q Okay. And so going back to our discussion of chastity, a same-sex sexual relationship within a same-sex marriage could not be chaste also; correct?

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A Right.
Q Okay. And why is that?
A Because of the nature of sexual relations in same sex acts. So -- so in the eyes of the church sacramental marriage is a different thing from the public civic, civil sort of thing. So the civil relationship under law is not determinative of that, you know.
Q So it's because a same-sex marriage would not qualify as a sacramental marriage under the law of the church; correct?
A Yeah, it's not -- it can't, yeah, exactly.
Q And so that's why it's not chaste?
A I believe that's why.
Q Any other reason?
A I think that's the heart of it there, yeah.
Q Okay. So if canon law were changed to permit same-sex marriages in the eyes of the church, those same-sex marriages would then be chaste; correct?
MS. LAND: Objection to the form, relevance.
A Well, my understanding of canon law is that it cannot violate essential church teachings. So your hypothetical is unimaginable because it's not constant with what the church teaches about marital relations.

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The sacrificial relationship between a man and woman, that is a life-giving event. So because of the fact that same-sex sexual relations are not life giving -- that's my understanding of it anyway.
Q (By Mr. Ossip) And those teachings couldn't change?
A I don't think so. I'm not a canon lawyer, but that's my understanding of it. So if you're asking me a hypothetical, that would be my hypothetical answer.
Q Well, and let me ask another hypothetical then. If there is essential teachings -- excuse me -- were changed such that a same-sex marriage is permitted within the eyes of the church, would then that relationship be chaste?
A Right. I mean, if there was some way, but what you're proposing is also an impossibility, because that particular teaching is based on immutable things, the nature of the human person as the church understands it.
MR. OSSIP: Can I get four?
(Plaintiffs' Exhibit 4 was marked for identification and made a part of the record.)
Q All right. Court reporter has handed you what's been marked Exhibit 4. Do you recognize this document?

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A It looks like my rebuttal to the expert.
Q All right. And do you stand by that as written?
A I do.
Q Okay. Any inaccuracies you would like to correct?
A Not that I have found.
Q And have you changed your opinions since you signed these reports?
A Not substantively, no.
Q What about non-substantively?
A Well, I mean, some of the things have changed, like the determination -- I believe I talk about it in here, the determination by the Swedish medical board has become much more final in terms of suspending, offering transgender medicine and surgery to adolescents, you know, minors. So where I think when I wrote this it wasn't as -- it was -- looks like they are headed in that direction. Now since then it's definitely they have ceased.
Q But your opinion hasn't changed?
A It has not, no.
Q Just the evidence?
A Right.
Q Okay. Do you intend to provide any opinions in

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this case other than what you said in your reports?
A No.
Q All right. You also submitted a declaration opposing the Plaintiff's motion for a preliminary injunction in this case; correct?
A I don't know what that means.
Q Okay. Well, let me help you out.
A Okay.
Q Probably should have started with the document.
(Plaintiffs' Exhibit 5 was marked for identification and made a part of the record.)
Q All right. So take a look at that, what's been marked --
A I'm trying to see how that --
Q Exhibit 5.
A Okay. So this is what -- so I have actually written three different things. Okay. Whew.
Q But you do recognize that document now?
A Yeah. I mean, all the content of it looks like my words, absolutely. So obviously I had something -- this was the first and then this is the second and this is the rebuttal. Okay.
Q And you stand by that document as well; correct?

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A Uh, yes.
Q Okay. All right. And you wrote all -- looking at all three of these documents, you wrote every word yourself; correct?
A Right, yeah. No, nobody has written anything for me.
Q You physically typed every word?
A Yeah.
Q All right.
A I get no help.
Q And what do you -- okay. Well, if we look at that, the Declaration, that's Exhibit 5, which you were just handed.
A Okay.
Q And if we can go to paragraph 11, which they are numbered on the left side.
A I see that.
Q And you look, this is the second sentence of paragraph 11, and you say, "All opinions are offered to a reasonable degree of medical certainty." Do you see that?
A I do.
Q And what do you mean by a reasonable degree of medical certainty?
A Well, the fact that I cannot -- I cannot make

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a -- any -- any -- well, some of it, I cannot make a statement of absolute certainty in some instances there as to, you know, like probability of complications or likelihood of favorable or unfavorable outcomes. That's kind of generally what you're talking about when you talk about scientific medical evidence, is that it's contingent upon the quality of your data, contingent upon the quality of your interpretation of the data, contingent upon some things that are not necessarily within my control. So reasonable degree of medical certainty.
Q Okay. Well, is everything you say in your reports to a reasonable degree of medical certainty?
MS. LAND: Objection to form.
A I think so, yeah.
Q (By Mr. Ossip) Okay. And in your declaration also?
A I think so. I try to be reasonable.
Q But, well, so when you define that, you put that in terms of uncertainty; correct?
A Right. I -- I point to the fact that depending on the evidence -- the source of the data, depending on the quality of the scientific data you are getting it will affect the level of certainty. So we find that is certainly the case with offering surgery to -- to

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parents and children, you have to -- you cannot speak with -- in 100 percent anything. You have to be able to present to them what's the likelihoods.
Q So let's look just to the opinions that you've offered in this case.
A Okay. All right.
Q To what degree of certainty do you offer those opinions?
A Reasonable.
Q And how certain is that?
A Gosh, I guess certain enough for me to write it down and have citations and support it with reasoned arguments and scientific evidence wherever I can find it.
Q But you didn't have anything in particular in mind in terms of certainty level?
MS. LAND: Objection to form.
A With respect to the overall -- this overall document, no. I can only -- I can only speak specifically in specific cases of particular citations.
Q (By Mr. Ossip) Okay.
A So if you're asking me if I cite a particular document to support a particular opinion, then I can offer you some level of certainty. But in the generality of this document I can only say reasonable.

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Q Okay. Do you still perform surgery?
A I retired a year ago.
Q Okay. And is that the last time you performed surgery?
A Right.
Q One year ago from today?
A More or less, yeah.
Q Okay. And I'm just going to ask you a few procedures and ask if you ever performed them. Okay, Doctor?
A Okay.
Q Have you ever performed a mastectomy?
A Many times.
Q Breast reduction?
A Many times.
Q Gynecomastectomy?
A Many times.
Q Chest masculinization?
A Never.
Q Breast augmentation?
A Many times.
Q Chest feminization?
A Never.
Q And for all the ones that you said you performed many times, do you believe you are qualified

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to perform those procedures?
A Very much so.
Q What about for chest masculinization?
A It's the same operation. It's the -- they only differ in terms of the subject. So for example a chest --
Q Sorry. I just want to keep us on track.
MS. LAND: No. Hold on, objection. You're not letting him explain his answer. And you have cut him off a couple of times and you're using his testimony from a previous case and you're also using that to follow up on some of the answers that you're cutting off, so I'm going to you object to you cutting him off.
MR. OSSIP: I'm going to object to the speaking objection and ask you to answer the question, which is are you qualified to perform chest masculinization. Yes or no, Doctor.
THE WITNESS: Yes.
Q (By Mr. Ossip) Okay. Are you qualified to perform chest feminization? Yes or no.
A Yes.
Q All right. You would agree that all of the procedures we just discussed are very safe; correct?
A Yeah. In terms of surgical risk, yes. Yes,

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absolutely.
Q Okay. Do you consider yourself an expert in medical ethics?
A I would consider myself very experienced in medical ethics.
Q Do you hold yourself out as an expert in medical ethics?
A I do not.
Q What about bioethics?
A I do not.
MR. OSSIP: Okay. Should we take a break here?
VIDEO OPERATOR: All right. This will end media part 2. We're off the record at 11:36 a.m.
(A break was had.)
VIDEO OPERATOR: We are back on the record at 11:52 a.m. This will begin media part 3. Please proceed.
Q (By Mr. Ossip) All right. Welcome back again, Doctor.
A Thank you.
Q Doctor, how do you define the term transgender?
A So transgender is a condition, human condition where there is dissonance between biological sex, the objective biological sex and the subjective perception

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of gender.
Q And that's what you mean when you say "transgender" in your report; correct?
A Yes.
Q All right. And your opinions in this case are only offered in connection with that definition of the term transgender; correct?
A I think so.
Q You use the term "gender confused" or "gender confusion" interchangeably with the word "transgender"; is that correct?
A Well, in the case of children I do, yeah. It's a different situation in adults. But the -- it's -- it was -- the matter we're talking about here is the experience in children, preadolescent and adolescent children. So because it's such a changeable thing and has evidenced changed over time, then, yeah, I use it primarily when I'm talking about children, gender confusion.
Q But you don't use that term in connection with adults?
A Generally, no. Generally in adults there is no confusion anymore. The dysphoria may persist, obviously, but the confusion is usually fairly settled by the time they are adults.

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Q And what do you mean by the confusion is settled?
A Well, they don't think about if they are male or female any longer. They have made a determination for themselves that they are -- now, it doesn't mean it's not going to change. It just means that they are not confused about it. There is clarity somehow in their lives that they have hit on something.
Q So, well, let me -- so is it your opinion that all children who experience gender dysphoria are gender confused?
A Hum, that's a challenging question there. Part of the problem in children -- and I have talked to, you know, quite a few children about it. They are sort of typically in a stage of formulating their story, formulating their words and so that can be very -- so typically they are confused, but some of them are more clear, perhaps, than others. It's not a black or white thing.
Generally in adolescence there is some level of confusion whether they are transgender or not. They are confused about themselves, confused about where they are headed in life, and certainly sexual matters confusion is a common thing, less common as adults.
Q And so it's your opinion that there is sort of

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a spectrum where confusion tends to be reduced as a person ages; is that correct?
A Generally, yeah. It's not a certainty, but generally there is less confusion as time goes on.
Q So it is not your -- well, let me put it this way. You'd agree it's not the case that anyone who claims to be transgender is actually just confused about their gender?
A No, I wouldn't make a blanket statement that all persons who are a transgender are confused.
Q Okay. Is it possible to have a gender identity that differs from a person's sex assigned at birth?
A All right. I'm going to take issue with that term because that doesn't make sense to me. Sex assigned at birth is something -- are you talking about the biological sex as determined at birth?
Q Let me use your -- let me put it this way. If I use the term biological sex, you'll understand that to be the same way that other people might say sex assigned at birth; correct?
A Sure.
Q Okay. So let's say biological sex then. Is it possible to have a gender identity that differs from biological sex?
A Yes.

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Q Okay. Have you -- is it your opinion that being transgender is a delusion.
MS. LAND: Object to form.
A So the historic understanding of transgender is being a subset of obsessive compulsive disorder. And up until -- as we talked about earlier, up until recently it was -- it was out of that category of body dysmorphic disorder. What -- what historically the understanding of that is that what underlies the obsessive -- as with other obsessive compulsive conditions there is a delusional that that keeps intruding into the life of a person that causes them to interpret things incorrectly and seeks explanation.
So -- so for example, the anorexic --
Q Well, let's stay with transgender individuals.
A Sure.
Q So is it your opinion that being transgender is a delusion?
A Well, it goes by degrees. It goes by degrees. So sometimes the content of the delusion is trivial and other times it's suppressive. But there is a -- there is an incorrect thought that underlies the whole thing having to do with how they perceive their body.
Q And what is the incorrect thought?
A That they are, quote/unquote, living in the

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wrong body. When people use those terms, that they are living in the wrong body, that's a delusional thought.
Q And that's in all cases?
A As far as I can tell, yeah.
Q So it is your opinion that anyone who identifies as transgender is delusional?
A Well, no, because in -- historically that would have been the case. But the new demographic in transgender is -- is not so much animated by delusion, it's animated by a rehearsed story which they come to believe. Okay. So --
Q Okay. Well -- sorry. Go ahead, Doctor. I didn't mean to interrupt.
A So -- so whereas in the earlier demographic of boy -- prepubertal boy cross-sex identification, if that persisted into adulthood you would typically find that behind that is a misperception of a lived event in childhood, you know, like some trauma, some fear, some personal fear that causes this repetitious explanation in their mind that the reason they are unhappy is because they are the wrong sex presentation.
Just as in the anorexic, the reason I'm unhappy is I'm fat. Or the reason I'm unhappy is because I didn't wash my hands. There is an intrusive thought that causes them to ruminate over something that isn't

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the case.
Q And but isn't the case -- let me put that another way. That's because you believe it's impossible to have a gender that differs from your biological sex; correct?
A No, it's not impossible. As we talked about earlier, it happens all the time. What I'm saying is that what informs that is a misunderstanding of themselves and their life.
Q But you would agree that a gender transition is impossible?
A A sex transition is impossible. Gender is a subjective world, and depending on, you know, the person, the success of a subjective perception can vary greatly. I mean, some people are totally -- they transition and they are totally sold. Other people transition and it hasn't answered the mail and they continue to suffer.
Q So can we -- this is Exhibit 5, which is your Declaration.
A That's what I have in front of me.
Q Can you go to paragraph 42?
A Okay.
Q So if you look at the sentence that starts at the very bottom of page 20 where it says, "Claims that

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patients can" --
A Right.
Q So you say, "Claims that patients can be a hormonal and surgical treatments obtain a sex chain or gender transition process are misleading and scientifically impossible." Do you agree with that?
A Yes, right, exactly. So when I put the words "gender transition" in quotations, the concept itself is a term of usage. So what is being addressed in these -- in these interventions is sex change. And that's -- that's used by the people interchangeably with gender transition. They are two different things.
Q Okay. Well, let's -- what is the treatment goal for any transgender identified person?
A Happiness.
Q And is it your opinion that in order to achieve that happiness they should stop being transgender?
A No. I'm -- well, so happiness can be a fleeting thing and we certainly see that in the arc of the typical transgender person as they go through transition. It's a kind of a roller coaster for them. And every time they enter into a new process of affirmation there is a tremendous encouragement and so there is a tremendous happiness there.
To offer a child an affirming message and an

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explanation for their anxiety is a tremendously uplifting thing for a child, but eventually that will run out and they will move on to the next thing. So happiness is present and then happiness is gone and then happiness comes back at the next step.
So in the case of a child being offered a puberty blockade or something may be a source of tremendous happiness for them. Parents may be relieved and very happy that their child is responding in a positive way, but then you get to the limit of what puberty blockade does for the child and happiness is gone again, and you move on to the next step.
So at every step the goal is happiness, but looking at final trajectory, that is what we're debating here, yeah.
Q So looking -- no. That's a good point. So looking at the final trajectory, though, it's your opinion that happiness will only be achieved in the final trajectory if a person stops identifying as transgender?
MS. LAND: Objection to form.
A No. So for example -- that's not necessarily the case. It's not necessarily the case. So for example, the woman that I met from Thailand, perfectly happy, she hadn't desisted, she hadn't regretted --

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maybe she had regretted. She didn't voice it to me, but certainly had issue with doing these things to children. So she had -- I mean, she's a living example of somebody who doesn't regret, who is perfectly happy having a transition. I don't know the circumstances of her childhood, I don't know any of these things. I can just hold her up as an example of a success.
Q (By Mr. Ossip) So looking -- so let's -- if you can go to paragraph 12 of the declaration.
A The --
Q The one that's in front of you.
A Exhibit 5, paragraph 12. Okay.
Q Um, do you see where you say -- this is the third sentence in -- "Patients who experience a gender identity that is discordant with biological sex have an alarmingly high incidence of serious psychosocial morbidity, including depression, anxiety, eating disorders, substance abuse, HIV infection, suicidality and homelessness." Do you see that?
A I do.
Q Do you believe that the best way to prevent these issues is for a transgender person to no longer be transgender?
MS. LAND: Object to the form.
A I would say that the best treatment is to -- is

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to address the underlying despair that the person has and find the source of that despair and do everything in my power to lovingly bring them back into contact with, you know, the fullness of life.

So in every example, regardless of, you know, the particular case, if you take the time you'll probably find a wound and you'll find the source of the anxiety and the sorrow. That's where the happiness lies. And that's kind of what's at stake here.

So to just say no longer thinking of themselves as transgender does not solve that problem. What solves that problem is, you know, out of an abundance of charity helping that person to find their way to understand how they were wounded, how they came to be this way and find a way out of the sorrow, not just simply renounce transgender. That's not -- neither the solution nor the explanation. What's at -- what's at stake here is a person who is wounded and grieving. So --

Q (By Mr. Ossip) Okay. And do you believe it's morally wrong for a biological male to socially transition and live as a woman?

A Morally wrong?

Q Yes.

A No.

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Q And same for a biological woman to socially transition and live as a man?

A You know, I don't see that as a moral issue, except in certain circumstances in the eyes of the church, for example, where it creates scandal in the heart of a child. But, no, generally not. If they were using it to mislead somebody into a relationship that the person wasn't aware of, that would be immoral. But to live as the -- in the cross sex self-identity, that's not immoral.

Q And does that go against the teachings of the church.

A What does?

Q Living -- being a biological male, as you have said, and socially transitioning to live as a woman?

A I don't believe it does go against the teachings of the church, no.

Q Okay. And what about if someone went -- well, take a step back. What if someone went beyond social transition and took cross-sex hormones. Still not immoral?

A No, it is in the eyes of the church.

Q So that is immoral?

A Well, any form of mutilation is a -- is a crime against your person, and that is immoral, yeah.

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Q And that includes the use of cross-sex hormones?

A Right.

Q What about the use of puberty blockers?

A Same.

Q And can you explain, how is that a mutilation?

A Well, so it happens by degrees but the effects of puberty blockade radically alter the life course of the child, which will -- is demonstrated to show longstanding issues with osteoporosis, stunted growth, failure of psychosexual development, long-term medical issues, and a near certainty of transitioning to cross-sex hormones.

So whenever you talk about puberty blockade you've got to talk about cross-sex hormones, because the actual clinical experience is that essentially 100 percent of children who are started on a puberty blockade go into cross-sex hormones, which means sterilization of the child, which is a form of mutilation, a destruction of a human capacity, a human function destroyed. Whether or not you do it with a blade it's the same, same story.

Q Is use of the term mutilation to describe the use of puberty blockade --

A That's my own.

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Q And do you know if that's a commonly used term?

A In terms of endocrine management? No, I'm happy to claim that as my own.

Q Okay. And same for -- sorry. Go ahead.

A The reason being, most of the people who speak about this don't speak about it from the perspective -- first of all, when I present these opinions I don't use the teachings of the church to formulate those opinions. This is strictly on the merits of the science and the medical ethics. So, yeah, none of what I have in -- in my report is driven by Catholic church teaching. It's driven entirely by the science, my experience in medicine, surgery, and the citations offered by the plaintiffs' experts.

Q So you don't use the term "mutilation" in anything you filed in this case?

A No, not in terms of the hormonal manipulation, only in terms of the surgery.

Q Okay. Sorry.

A You see where I'm going with that?

Q So you do use -- you do use the phrase mutilation to refer to the surgery; correct?

A Yes, I do.

Q Okay. And is that commonly used within the medical profession to refer to these procedures?

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A I doubt it.
Q Okay.
A I doubt it, for the reason we talked about earlier, the poverty of surgeons willing to speak out against this.
Q And that's because -- okay. Well, strike that.
A I know why.
Q Do you think that any doctor that provides gender-affirming medical care is acting unethically?
A I wouldn't make that --
MS. LAND: Objection, asked and answered and form.
Q (By Mr. Ossip) You can answer.
A I wouldn't make that blanket statement, no. No, because I have been responsible for the training of surgical residents, medical residents, pediatrician residents and things like that, and they are very heavily influenced by their learning environment and if they experience is that this is normal, it's such a bewildering new world to them that they may step out into practice before they realize they are doing something. They might ask questions in the terms of ethics.
So what we would call culpability is a pretty variable thing. But to see a senior surgeon, who should

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know better, yeah, I'm going to have a problem with that.
Q And when should a senior surgeon know better?
A Yeah, pretty early on. Pretty early on.
Q Well, can you explain that a little bit more? What -- what would a surgeon encounter that would lead that surgeon to know better?
A Well, in the case of surgeons offering transgender surgery, what I would hope is that a familiarization with the world literature on that subject would show them that gender-affirmation surgery does not solve the suicide problem, does not solve the hospitalization problem, does not solve the substance abuse problem, does not solve the psychiatric problems. And armed with that information he might stop and ask himself, Am I doing something that's for the good of the patient or not, or am I just here living a good life, doing lots of surgeries?
Yeah. So familiarization with the world literature would talk him out of it. Even in his own experience, recognizing his own patients coming back, am I doing them good? A junior surgeon might not see that because he didn't have enough experience.
Q So any senior surgeon who performs gender-affirming surgeries would be acting unethically

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in your view?
A I consider it unethical. But, again, culpability is the question here. What did you know and when did you know it. Yeah, and it's a -- it's a new territory in the American world. It's old territory in Europe. But in the American experience of transgender and surgery this is a new territory because they haven't been doing it long enough.
Q Okay. And what about referrals for gender-affirming medical care? Is a doctor that refers a patient for gender-affirming medical care also acting unethically?
A Again, if they knew the likelihood of a good outcome versus the likelihood of an injury to the patient, then, yeah, they should know it's unethical.
Q Dr. Lappert, what is gender dysphoria?
A Gender dysphoria is unhappiness experienced by a person who feels that their gender is discordant with their biological sex. So it's a description of a subjective unhappiness over an underlying condition of discordance between their gender, their subjectively perceived gender, and their objectively determined sex.
Q And do you believe that gender dysphoria is a legitimate diagnosis?
A I think -- it's not -- I don't -- I don't view

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it as much as a diagnosis of a description of a condition. It doesn't -- yeah, I wouldn't put it in the category of diagnostic certainty. Let's put it that way.
Q So you would disagree with the DSM V's inclusion of gender dysphoria?
A Not its inclusion, but its splitting it away. Essentially, they took one of the characteristics of body -- or gender identity disorder, they carved that one -- that one finding away and made it a separate diagnosis in an effort to depathologize what the original diagnosis was. Gender identity disorder I would consider a diagnosis.
Q I see.
A Gender dysphoria is a trait of gender dysphoric people.
Q And can -- what is necessary to move from gender dysphoria into the realm of gender identity disorder?
A Well, gender dysphoria is one of the -- one of the symptoms. Gender dysphoria is a symptom more than a diagnosis. I guess that would be the best way to characterize it. That's my opinion.
Q Okay.
A Not speaking as a psychiatrist here. I'm

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speaking as a plastic surgeon with experience of people who have body dysmorphic disorder. I would say gender dysphoria is a symptom of the bigger issue, which is body dysmorphic disorder.

Q And is that because you believe that gender identity disorder is a subcategory of body dysmorphic disorder?

A I do.

Q And do you believe that gender identity disorder is a form of obsessive compulsive disorder?

A I do.

Q And what about gender dysphoria?

A It's a symptom.

Q Okay. A symptom of an underlying condition that is, itself, a form of obsessive compulsive disorder?

A Right. And by degrees. Okay. So obsessive is not an on/off switch. Levels of obsession, levels of compulsion, levels of willingness to seek remedy vary greatly. For some people it's just a recurrent thought that they harbor in their thoughts. Maybe they privately cross dress and that solves the issue for them and they don't even identify as transgender.

But they have this interior wound that's an obsessive thought that keeps presenting itself and they

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manage it in private with a behavior. That's the compulsive behavior, maybe as simple as secretive cross dressing. Maybe that's not enough and they want to present themselves publically in that persona to convince themselves that's a source of their problem. And so it's a great spectrum of presentation. But in my mind -- again, I'm not testifying as a psychiatrist. But in my experience as a plastic surgeon, uh -- yeah.

Q And have you received any education or training related to gender dysphoria?

A No. Well, I'm sorry. I did attend a course at the California Society Of Plastic Surgery. It was a weekend, half day thing on the subject of gender dysphoria. I got to hear the luminaries of surgery and medicine and transgender for a whole day there, brought me up to speed.

Q Was that a -- okay. Well, and -- and when was that?

A I want to say 2017, guessing. Guessing somewhere around there. California Society of Plastic Surgery.

Q Other than that no education or training related to gender dysphoria?

A No.

Q Treatment of gender dysphoria?

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A Again, I'm not -- well, since it's a symptom I guess every time I talk to somebody who is gender dysphoric and I help them manage their anxiety, I guess I do treat people with -- you know, the man who comes to see me for facial laser hair removal, he and I commiserate just about as often as he comes in and we talk about things and I get to kind of a gauge of his anxiety and how happy he is in his transition process.

Q And, um --

A So technically I suppose that's treatment as a physician.

Q And this individual that sees you for the laser hair removal, do they identify as a man or a woman?

A Oh, very much a woman.

Q And you're using man for what reason?

A Because --

MS. LAND: Object to the form.

A Because we're in a private conversation about something. I would never do that to his face. But I'm using this as an example of a man who is transitioning -- virtually fully transitioned already. When I speak with him it's female because that's the life he's living.

But when I speak to others about him as an example, I have to speak about the reality. Because if

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the reality of male didn't exist, the reality of transgender wouldn't exist, so we have to establish that.

Q Okay. And how many -- how many patients transitioning from male to female do you perform laser hair removal on?

A Oh, it's a minority of patients. One to two here and there. I run a very small office now.

Q Well, you mentioned one individual. More than five?

A No. Less than five.

Q Okay. More than one?

A Yes.

Q So somewhere between one and five?

A Yeah, probably two or three.

Q Two or three total?

A Yeah.

Q Okay.

A It's kind of a running total. People come and they go, you know. New patients present.

Q But throughout the entire course of your career, two or three total?

A Oh, in terms of laser hair removal, that's --

Q For an transgender person.

A Yeah. I don't know. Maybe something less than

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a dozen I guess. I mean, I've had that laser since 2005.
Q Okay. Have you ever conducted any research related to gender dysphoria?
A No.
Q Treatment of gender dysphoria?
A No.
Q What about research regarding transgender people more generally?
A No. I'm not an academic.
Q So you mentioned that you've -- you talked about a few transgender patients for whom you have provided treatment. Starting with the feminizing rhinoplasty, how old is that patient?
A I'm going to say mid -- late 20s probably. Maybe early 30s at the -- at the oldest.
Q Okay. And for the laser hair removal, none of those were minors; correct?
A No.
Q Okay.
A I do laser hair removal on minors, but not self-identified transgender minors.
Q And why not?
A I just haven't had any.
Q Would you perform it? Would you perform laser

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hair removal on a self-identified transgender minor if they presented to you?
A It would be a very unlikely event. Because the use of puberty blockade, generally you are only having to do laser hair removal on people who have gone through puberty who are seeking to present as females.
Q Was it your understanding that all transgender minors use puberty blockers?
A No, they don't.
Q And so let's say one presented to you who was not using puberty blockers. Would you perform laser hair removal on that minor?
A So for a boy who is under 18 who maybe was started on cross-sex hormones, the odds are they are not going to have facial hair. That's just really unlikely and I haven't seen any.
Would I do laser hair removal on a boy? I would consider it if it would afford me an opportunity to develop a doctor-patient relationship with them and see if I could help them in some other way.
Q And what do you mean by "some other way"?
A Again, if the person looks distressed, I have the inclination to help people who are distressed. So if a child is distressed over something -- and you know --

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Q And how would -- I'm sorry, Doctor. I didn't mean to interrupt.
A Oh, that's probably it.
Q And I -- well, how would you help?
A I guess just having a conversation, an adult conversation with somebody who is struggling in life. Like I said, it's like the pastoral side of me as the deacon. I don't have recourse to theological language in that circumstance because I'm there as a doctor. But it's my inclination to just want to help people out.
Q To provide them advice?
A Or maybe a discussion so they can have their own insight into their own life.
Q Have you read the SAFE Act?
A That's the Arkansas -- I have. It's been -- it's been some months since I last read it.
Q Okay. Yeah, let's go to that.
(Plaintiffs' Exhibit 6 was marked for identification and made a part of the record.)
Q So the court reporter is handing you what's been marked as Exhibit 6. Do you recognize that document?
A Yes, I do.
Q And is that the SAFE Act?

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A Appears to be.
Q All right. Bear with me one second. So if you look at the bottom. I don't think it's on the first page, but you can see some page numbers?
A Okay.
Q And we want to go to page 6.
A Okay.
Q And then there is line numbers on the left side. There's a lot of numbers on this. But if you see the line No. 10, and then if you look to the right of that you see 6(A) in parentheses. Do you see that?
A I see.
Q And then it says "Gender transition procedures." Do you see that?
A I see that.
Q And that defines gender transition procedures under the SAFE Act; correct?
A Appears, yes.
Q And do you understand this to refer to medical interventions to align a person's body with a gender that does not match their natal sex?
A If you can give me a moment to reread it because it's been some months since I read it.
Q Take your time.
(The witness reviewed the document.)

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Q Okay. And so do you understand this to refer to medical interventions to align a person's body with a gender that does not match their natal sex?
A Yes, that appears to be.
Q All right. And it's the same, when you use the phrase gender-affirming medical care, that's the same thing; correct?
MS. LAND: Object to form.
A This is -- the larger included term would be services. But so surgical versus medical? Is that your question.
Q (By Mr. Ossip) Well, earlier we spoke about gender-affirming medical care --
A Okay.
Q -- to mean surgical or otherwise.
A Okay. Fine.
Q And you'd agree that's the same thing what's called gender transition procedures under the SAFE Act?
A I would agree.
Q Have you ever provided gender transition procedures to patients?
A Well, as we talked about earlier in the adults getting laser hair removal that would be under the category of gender transition procedure, quote/unquote, top, an adult, yeah.

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Q Yeah. And -- okay. Any others?
A Other than the reversion that we talked about, the desistant, the regretter?
Q Well, that would not be a --
A Oh, that's right. That wouldn't fit this category. Okay, yeah. So no others.
Q Okay. Do you believe that the provision of gender transition procedures is tyrannical?
MS. LAND: Object to the form.
A I have never heard the term "tyrannical" applied to the provision of services.
Q (By Mr. Ossip) Well, let me ask it another way. Do you believe it's a form of tyranny over our own bodies?
MS. LAND: Object to the form.
A Oh, oh. You're asking a theological question.
Q (By Mr. Ossip) I'm just asking if you believe that.
A Right. So that's actually -- you must have got that from one of my presentations in one of my public conferences. So that's actually sort of a paraphrase of Pope Francis when he talks about the ecology of the body.
And he likens the abuse of the environment, environmental abuse and ecological problems, he likens

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transgender medicine and surgery to that, only the ecology is the ecology of the body. And he likens that tyranny to the tyranny of, you know, the industrial destruction of the environment. I think that's probably where that came from. I might have paraphrased Pope Francis in that. I don't think I ever coined that term myself.
I generally don't speak of this as tyranny. I speak of it more as medical malpractice.
Q Have you spoken of it as tyranny before, though?
A It might have been at a Catholic conference quoting Pope Francis.
Q And how many times do you think you have referred to it as tyranny?
A It must be very few because, like I said, I don't do that.
Q And I think before -- and how many times have you referred to gender transition procedures provided to minors as child abuse?
A I can't tell you how many times.
Q But you have done some.
A Never addressed to the parents that way. So I would never do it at a conference where parents are present. So, for example, I gave a presentation in -- I

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don't know where that was. It was a Courage conference but it was a breakout session for parents and I would never speak of it as abuse there, because, again, the parents are as much victims as the child.
Q Do you think that gender transition procedures are evil?
MS. LAND: Object to form.
A Okay. So evil meaning something bad visited upon a person physically like, yeah, like, being stricken with a disease or something like that or some harm comes to a person, yeah. When persons are harmed, that's generally evil. If they are harmed by accident or incident then that's not evil. But if they are harmed intentionally, that's evil.
Sometimes the intention behind it is ill-informed and so that goes to the culpability of the agent that harmed them. But generally speaking the harm itself could be called an evil because it harms the person, yeah.
Q And gender transition procedures harm the person is your opinion?
A Yes, it is.
Q Okay. And is it your opinion that the provision of gender transition procedures increase the risk of suicide?

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A I don't know that for a fact. What I do know is that it doesn't solve the problem of suicide.
Q And what's your source for that belief?
A The best source for that is the 2011 article by Dhejne out of Sweden that is a longitudinal 30-year study of transgender persons and outcomes and has a cohort that is a valid and valuable cohort of patients so that you can compare and see the merits of the particular intervention. And it shows us that fully transitioned persons in adulthood, when you get beyond about seventh or the eight year, have a 17-fold higher likelihood of suicide than age-sex matched controls, whether the sex matching is trans sex or biological sex, the result is the same.
And that persons transitioning to male, presenting as male have a 40-fold higher likelihood of successful suicide compared with age-sex matched controls. And it's a very difficult study to refute. Even if sometimes the authors will come back and restate their conclusions, the data -- they can't take the data back. The data clearly shows that.
Q And this is just for the court reporter. This article written by Cecilia Dhejne, and that's D-h-e-j-n-e. Correct?
A Is that the right pronunciation?

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Q Yes.
A We all debate it. Denah (phonetic)?
Q I believe so.
A Okay. Okay. Thank you.
Q But don't quote me on that either. And that is the study, though; correct?
A The 2011 study, exactly. I think it was in PLoS.
Q Okay. And PLoS 1; correct?
A Correct.
Q Okay. And any other sources that you rely on for the belief that the provision of gender transition procedures does not affect the risk of suicide?
A That's the most compelling one. The other studies that are -- that are coming forward now are out of Finland that directly address the issue of suicidality and anxiety in children as well as -- so Finland has taken the same step back. The Public Health Service in Great Brittain at the Tavistock Portman Institute, they have essentially determined, as the Swedes, that the provision of puberty blockade and cross-sex hormones to -- and certainly mastectomy surgery to minors has to be offered on a case-by-case basis and tightly controlled by a major review board.
So the fact that they are not seeing -- they

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were -- they were early adopters in those countries. They are well ahead of us. So if they are seeing the long-term results, that's the other reason.
Q So okay. Let's take that -- let's take a step back there. You mentioned studies in Finland; correct?
A Right.
Q Which studies are those?
A Gosh. I have to look that up here. You have to give me a minute here. Let's see. It would probably be in this one.
Q Well, let me put it another way, Doctor. Would those studies be cited in your report?
A Right. I cite them in the Declaration that's Exhibit 5 under paragraph 13 that makes reference to the NICE study in England that affected the policy at the Tavistock Portman Institute, the study in Sweden. There is a similar study that I have to hunt around with to give you the reference. I can send it along to you if you like. The Cochrane Review, British Royal College of Psychiatrists. That's all listed there. And let's see if I annotated that for you.
Q That's okay. I think the thing I want to figure out is nothing other than what's cited in your report, though; correct?
A No, I don't have any other outside sources that

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come to mind, yeah.
Q Okay. And do you believe that gender transition procedures affect brain development?
A Puberty blockade is known to affect brain development.
Q And what -- do you have a source for that belief?
A Well, my consultation with endocrinology people, people who are reading the writings of, for example Paul Hruz, who is very knowledgeable of the endocrinology on brain development, just general human development.
So what is known about that is -- and in fact, one of the most recent sources, this is excellent, is Dr. Marci Bowers in California who is one of the most accomplished transgender surgeons, who she will tell you in public that, I have done 2000 births and I've done 2000 gender transitions, surgical transitions. And she's publically stated in a conference that you can find online that children that have received puberty blockade by the time she is taking care of them as adults, almost universally none of them are capable of orgasm. That developmental step in their psychosexual development never happened because of a poverty of testosterone in early adolescence, and so they get to

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physical maturity through the process of cross-sex hormones, but when they arrive at adulthood they are incapable of orgasm, they are incapable of the effects of that on sexual intimacy.

It's also known that higher executive functioning is interfered, the development of higher executive functioning is interfered with. And, again, I would have to, again, cast around for that citation, but I can send it along to you if you like.

Q But nothing other than those consultations with endocrinologists; correct?

A Well, and the public testimony of Marci Bowers.

Q Okay.

A Yeah, who -- as she tells you, has tremendous breadth of experience of transgender persons in transition, surgically transitioning them. In fact, I think she's the one involved with the care of Jazz Jennings.

Q Have you ever diagnosed someone of a gender dysphoria?

A Are you talking about, like, making a formal diagnosis and sending an insurance document? No.

Q I'm just asking if you have ever diagnosed someone with gender dysphoria?

A Yeah, probably. I mean, you know, it doesn't

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enter into the medical record because it's not my area of care.

Q Okay.

A So I don't officially diagnosis people with gender dysphoric.

Q But you have never referred anyone for treatment for gender dysphoria?

A No.

Q What about gender identity disorder?

A Well, no, I take that back. Because I have had parents bring children to me who are experiencing gender dysphoria and I have suggested psychiatrists or psychologists they might speak with, I suppose, or how to find one. So not a formal referral, but a recommendation perhaps.

Q And which psychiatrist or psychologist did you recommend?

A I think I just gave them guidance about how to suss one out.

Q So you mentioned that parents would come to you with their children who they believe are experiencing gender dysphoria; is that correct?

A Both -- maybe all three times recently it's been after mass a mother comes to me and says, Could you come talk to my son, could you talk to my daughter.

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Yeah. So not in my capacity as a physician, but certainly with my knowledge as a physician, but in my pastoral capacity.

Q And did you speak with the parents, the children, or both?

A Both.

Q Okay. Separately or together?

A Both.

Q Both? What did you tell the parents?

A It's mostly a conversation about understanding and mostly helping them manage their guilt that they might have about the suffering of their child, helping to recognize that children suffer from things that oftentimes have no explanation, try reassurance to the parent that, you know, that there is hope for happiness for their child, health and happiness for their child. That's mostly the conversation. Like I said, it's mostly a pastoral thing.

Q And did you recommend any course of action with respect to the treatment of their child?

A Most of the time I talk to parents what I -- the thing I most recommend is to not be judgmental, do not be angry, maintain a loving relationship, give them confidence that they can bring their sorrows to you, because if they can't bring them to you they are going

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to suffer even more. That's mostly what I recommend.

Q But nothing about the treatment of their gender dysphoria or lack thereof?

A Generally those -- in fact, all of the ones that I -- that come to mind right now have not yet risen to the level where they are being recommended for treatment or anything like that. It's just a child struggling and sorrowing, withdrawing from friends and things like that.

Q And this was all in a religious capacity; correct?

A Yeah, as the deacon of the parish.

Q Who do you think should make the decisions regarding a minor's healthcare?

A The parents.

Q What about doctors?

A Well, clearly the doctor has to present the option, so he has to make a decision about what is the best course, what are the options, because that's what consent is all about.

Q What about the government?

A The government should only have to step in if something bad is happening.

Q What about in other aspects of a child's life, who should make those decisions?

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MS. LAND: Objection to the form.
A I don't understand your question.
Q (By Mr. Ossip) Well, you said that with regard to decisions about a child's medical care, the parent should make those decisions; correct?
A Yes.
Q What about decisions about other aspects of a child's life?
A Could you give me an example? Maybe that would help me.
Q Are you familiar with a bill that's entitled Parental Rights In Education that was passed in Florida earlier this year?
A Yeah.
Q Okay. Some people have called this the Don't Say Gay bill; correct?
A Some people call it that, yeah.
Q Yeah. Did you lobby in support of that legislation?
MS. LAND: Objection; form.
A I think I sent a letter or I did a public -- somebody interviewed me. I can't remember. Maybe it was a video. Oh, no, that was an interview that was video recorded about the legislation. Yeah, that's what it was. So it was -- let me see if I can remember

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who -- who it was.
Some, some media people video recorded me on -- on the subject. Yeah, I think that's what it was. I didn't lobby in terms of the legislation as I remember it.
Q (By Mr. Ossip) But you spoke in favor of the bill; correct?
A Right.
Q And that's because, at least in part, you believe parents know what's best for their children; correct?
A As a general rule, yeah.
Q Right.
A That's the default position I should say.
Q Do you believe that the parents of the minor plaintiffs in this case know what's best for their children?
MS. LAND: Objection; form.
A So that's a different question. That's a different question. The one question is to who has primary responsibility for the decisionmaking, which is the parents. And then the second question addresses itself to what do the parents know to be in the best interest of their child.
If a child is being -- if the parents are being

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misinformed about the best course of care and it's known by outside agencies then those outside agencies need to step in. So, yeah.
So for example, if a -- if a family brings their child to the pediatric endocrinologist and they have determined that the best course for their child is to have some hormonal support so they can be stronger and be more competitive in sports because they have a lot of emotional attachment to success in sports, if the doctor said, Yeah, that's the best course of events and the doctor didn't attempt to talk the parents out of it, then the parents would not culpable for that. The doctor would be culpable.
Because to give steroids to a high school athlete is evil and there are laws against that. And so the government at that point steps in and maybe has questions about the licensing of that endocrinologist if they were actually misleading parents and selling them anabolic steroids. The difference here is just which particular hormone you are using and when you're talking about transgender, but it's the same problem.
Parents have primacy, but parents can be misinformed by either misinformed doctors or doctors who are intentionally misleading. The default is that the doctor is misinformed as well.

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Q (By Mr. Ossip) And whenever that happens you think that the state should take that decision away from the parents and give it to the government; correct?
MS. LAND: Objection; form.
A Yeah. So that -- I wouldn't say whenever, but there are circumstances where the gravity is so significant that the state has a duty of protection. You know, the -- the Jehovah's Witness child who is bleeding out who gets a transfusion, the state knows it's a life and death thing, sometimes the state steps in. If there is a known harm that is grave and the parents are being misinformed then the state does have a duty to protect.
Q (By Mr. Ossip) Well, in what circumstances should the state prohibit a form of medical care?
A When the state understand there to be a known harm that outweighs any potential good. And it would have to be severely outweighs potential good, yeah.
Q And in any such case, the state should ban that care?
A I can't think of any exception.
Q You think that providing gender transition procedures is unethical in all cases; correct?
A Um, well, I mean, we've talked about laser hair removal that would be a gender transition procedure that

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I don't consider unethical.
Q And why is laser hair removal ethical in the case of use as a gender transition procedure?
A Well, because it's in the category of things that are sort of trivial but helpful. You know, I mean, I do laser hair removal for a variety of reasons.
So, for example, girls with polycystic ovary disease, they will have a condition of hirsutism by varying degrees. Obviously that's not unethical.
But to your question, in the case of a person who is -- who is transitioning, it's a minor thing. Men without beards is a common thing even without lasers. It's not a defining characteristic.
Q So if you're talking about laser hair removal from a biological male who is transitioning to live as a female, the reason why it's ethical is because there are biological males who do not have beards?
A Right.
Q Okay.
A Yeah. It's -- it's not a defining feature of masculinity or femininity for example.
Q Can women with polycystic ovary disease bear children?
A Sometimes. It depends on how well it's managed and the severity of the condition. But, yeah, the

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masculizing hormones can have an effect on fertility. And depending on how manageable their particular condition is, it may be a decisive thing. It may be something that, with management, can be overcome.
Q Okay. So we talked about why it's ethical to perform laser hair removal. Is, so -- let me take a step back.
Any other forms of gender transition procedures that you believe are ethical?
A Well, so if a person were to come to me seeking a -- a simple, very simple, like a tip rhinoplasty or something that I could do that would be within the -- you know, the range of normal, which all cosmetic surgeries are, all cosmetic surgeries are within the range of normal and aim themself at solving a subjective perception by the patient that will make them happy. So if somebody just happens to be transitioning and they want to tip rhinoplasty, I don't see any reason not to do that.
Q And what do you mean by a "range of normal"?
A Range of normal, there is a tremendous amount of overlap between the -- sort of the Gaussian curve of any particular trait that's called masculine and any particular trait that's called feminine. And their area of overlap sometimes is very broad and sometimes it's

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very narrow. Facial hair is a one of those things. It's a very ethnic thing, it's very a racial thing.
Q Okay. I think I understand. So just help me out for a second. So when you say the range of normal you mean if you are performing a procedure on, let's say, a biological male, right, you think it's ethical so long as it's within that Gaussian curve for a biological male; correct?
A Let me see if I understand how you phrase that. So -- so really the question is to transition to do -- transition procedures on defining characteristics. So, for example, genitalia is a very narrow thing, presence or absence pretty much.
There are the very small tails, which are disorders of sexual differentiation or disorders of sexual development, which is a very freited area of conversation. So in the case of those features, there's virtually no overlap, genitalia.
In the case of breasts for example, breasts there are some overlap, but there are defining pathologies that cause the overlap. Okay? So for example, in the case of breast reduction, size of breasts as a reason for surgery, gynecomastia versus macromastia, there is really no overlap there, although they have the same characteristic, too much breast

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tissue.
Q Okay. But just to go back to my question, the reason why it's ethical is because it's within that curve of what is normal for a biological male; correct?
A Yeah. It's a small non-risk procedure that's within the range of normal.
Q And why does the range of normal affect the ethics of the procedure?
A Well, because it -- the person could be presenting for it without you knowing that their motivation is transitioning. You know, so, for example -- well, let me answer your question directly, then.
How does it being in the range of normal affect the ethics of the decision?
Q Well, you have said that it does; correct? I'm just asking why.
A It affects the -- the ethics, I guess, of my own personal decisionmaking in the matter, whether or not I would perform a procedure, you know.
Q Okay.
A I'm not here testifying as an ethicist. I'm not an ethicist, a biomedical ethicist. I'm not expertise (sic.) in that either.
Q Okay. So all of the testimony about whether it

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is or is not ethical, that's not your expert opinion then; correct?
MS. LAND: Object to the form.
A No. The particular case of me doing laser hair removal on a transgender female is what I'm addressing there.
Q (By Mr. Ossip) Okay.
A It's a -- yeah.
Q Are you part of any organization that opposes the transgender procedures?
A Organization? I'm not a member of really any organizations, other than being, you know, a member of -- well, none -- certainly my membership in church has nothing to do with opposing -- so I would say no.
Q So it's your -- so Courage does not oppose the provision of gender transition procedures?
A Courage doesn't take a position on it.
Q Okay. What about the church as a whole?
A The church has been alarmingly mute on the subject. There have been -- there are documents in the church. For example, the catechism of the Catholic church speaks specifically about genital mutilation, so the church speaks very loudly in that regard. The separation of the unitive from the procreative aspects of human sexuality, the church speaks very loudly about

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that. But it's not a public declaration. You would have to go looking for it.
Q Okay.
A Yeah.
Q And you're not a member of ADF; correct?
A No, I'm not.
Q Okay. Do you agree with Finland's approach to gender transition procedures for minors?
A Let's see. I often conflate Sweden with Finland, the Scandinavian countries. My recollection is they have moved it into the category of subject to intensive review before offering, and that I would certainly agree with.
Q And so you agree that minors can still obtain gender transition procedures under that model; correct?
A Well, so I would want to be present in the room when they are going through that review. And I can't think of a circumstance where that would be the best choice for any child. But I would defer to the experience of the Fins and their large medical care system and their database and how they interpret it.
But any move in that direction I would certainly welcome. But if there -- if there's gonna be a let's potentially review this case, I would love to be in the room and hear on what basis they would be

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offering puberty blockade, cross-sex hormones, transition surgery.
Q But you would defer to the Fins on that; correct?
A At this point that's all I could offer, yeah.
Q Okay. And what about Sweden, do you agree with their approach?
A I agree with the direction in which they are taking it, that's right. And they are definitely, they have put the brakes on the medical-surgical transitioning of minors subject to institutional review and rare events.
Q And what about the UK? What's your understanding of their approach?
A So the UK, that was driven by a decision of the Crown Court in the case of Kyra Bell who sought damages for her hormonal and surgical transitioning and won her case. And as a result of that case the public health service put the brakes on the Tavistock Portman Institute's affecting the transgender services to minors.
They walked it back and then sort of walked it forward again, and that's sort of a moving target right now. But it seems to be the direction they are going, and let's put the brakes on this until further review.

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What that review has yielded, I haven't checked in on in the last couple of months. But my understanding is there is significant change at Tavistock Portman.
Q And do you agree with their approach?
A Of review of results? Absolutely I do. And I look forward to the day when American medical systems do the same thing.
Q Well, do you agree the UK's approach to the treatment of transgender -- or of minors with gender dysphoria?
A Well, as I say, I don't know what they're present, most recent decision is. But their historic treatment of transgender minors I disagree with wholeheartedly.
Q Okay. Do you think that doctors should be able to provide minors with gender transition procedures in the context of clinical research?
A Well, the clinical research has to be driven by the levels of evidence and the risks to the patient. So levels of evidence that -- that -- that drive clinical research can be fairly low-level evidence, like level 4 or level 5 evidence were you've got anecdotal reports or case collections, retrospective reviews, literature reviews that suggest a possible course of treatment that

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can lead to a clinical trial.
But in order to make it to clinical trial it has to be a circumstance where there isn't a high likelihood of harm, because if you are going to randomize people into a clinical trial, both arms have to be demonstrated safe or hold out a promise of efficacy.
And so if you can't demonstrate that then you probably will not get through the institutional review board that will allow you to experiment on a child.
So -- so in cases where the potential harm is small and the potential benefit is great, then certainly it can come to that. But from where I sit I don't see that as a likely circumstance, just because the permanence. The permanent effects of sterilization and irreversible genital surgery and irreversible mastectomy, that's a very grave matter and you can't take it back.
It's a different matter if you're testing the efficacy of asthma medication and you've got some experience with one or the other. Yeah, clinical trial.
Q What about laser hair removal? We talked about that before; right?
A Right.
Q Clinical trial?

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A Does that require clinical trial?
Q Well, do you think that doctors should be able to provide minors with laser hair removal as part of gender transition procedures in the context of clinical research?
A I don't know of any circumstance where laser hair removal is necessary in a child other than children who have -- and I've treated them -- children who have hirsutism secondary to endocrinopathy. If they have a pathological endocrinological condition, that doesn't even require a clinical trial. Because laser is known to be efficacious, the condition is demonstrable, it's an objective condition, it's cause can be demonstrated and the result can be anticipated.
Q Let's go back to my question, though. Is there any circumstance in which you think doctors should be able to provide what's -- what we've agreed as being called gender transition procedures to minors in the context of clinical research?
A I cannot think of a circumstance where it would be indicated -- where it would happen. I can't think of a circumstance where anything that is ethically plausible would rise to the level of a clinical trial.
Q What about in any other research context?
A Children enrolled in a research prospective

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study?
Q Yes.
A Right. Whether the risk of harm is small, where the risk of harm is small and the likelihood of benefit is significant.
Q So you'd agree that should be permitted?
A Oh, absolutely. It's permitted all the time.
Q So just to go back a second. Do you think that clinical trials should never be done in the case of gender-affirming medical care for minors because the care is always harmful?
MS. LAND: Objection; form.
A Well, let me take them in order. So known harms of puberty blockade, yeah, that would be a disqualifier. Known harms of cross-sex hormones in high dosages, that would be a known harm. Irreversible mastectomy, known harm. Genital surgery -- well, children don't yet get genital surgery under standard of care. They would. All known harms, grave matter. So knowing that I wouldn't subject any of those treatments to clinical trial.
Q (By Mr. Ossip) So, I mean, I think earlier your said the question was whether or not the benefits outweigh the harms; correct?
A Right.

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Q So it's not just a question of the harm; right? It's also a question of the benefit?
A Absolutely.
Q And I understood that your testimony -- well, let me take a step back.
Is it your testimony in this case that there is insufficient evidence as to the benefits of gender transition procedures?
A That's precisely what's at stake here.
Q And how would one develop that evidence?
A So if you cannot do a clinical trial -- clinical trials would be level 2 to level 1 evidence. So a clinical trial level 2 would be a non-blinded study, for example. Level 1 would be like multi-center randomized placebo controlled, let's go for it. You can't do that with these techniques, these particular issues.
Q Got it.
A So the best you can get to is a level 3, which would be like a longitudinal population-based study of outcomes, which is precisely what the Dhejne study, it's pronounced the Dhejne study, the 2011 Swedish study, that's precisely what that evidence shows us.
It's a gigantic study population in an LGBT-affirming society where every level, every incident,

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every moment of care in that medical system is recorded in the same language, whether that person is going to a hospital, clinic, a transgender clinic, a pediatric clinic, a school nurse, a prison hospital, a psychiatric hospital.

Everybody goes in the same database so you can query that database and say, I have a transgender person here who is suffering from alcoholism. What is their relative risk of alcoholism compared to age-sex matched controls. So that's a level 3 evidence, which may be the highest you can get to. But it shows us very dramatically what the potential benefit is long term. That's a 30-year study.

Q And so would you support doctors being able to provide gender transition procedures to minors in the context of a level 3 study?

A So a level 3 study is -- is a study of -- study of an existing database. So it's not -- it's not necessarily a prospective study. Right? Because what happens is you already have the study population. They are the patients that have been historically cared for, and what you are comparing them to is the age sex-match cohort.

Q Okay. Well, here is where I'm confused, Doctor.

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A Okay.

Q So you're saying that we need more evidence, we need to conduct more research; correct?

A That -- that -- without that evidence it's unethical to proceed.

Q All right. How would one generate that research?

A Well, a literature search will show you. So, for example -- here is a good example. It can be a literature review that gets you to better levels of evidence, or it can be a literature review that shows you that the level of evidence you have is even worse.

So the Dhejne study that we talked about, that's level 3 evidence and it points away from offering the services because of long-term result. It definitely demonstrates, by the way, that short-term it's a benefit to the patient. You look at their study and it will show you that fully transitioned patients will experience essentially the same levels of hospitalization, same levels of suicide, same levels of self-harm, alcoholism, violate crime, whatever, as the general population age sex-match controls, benefit, search to eight years.

And then the bottom starts to fall out, because they typically have fallen out of the affirmation loop

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and the interior wound is still there, and their suicidality returns because it hasn't addressed -- the problem itself hasn't been addressed by the care that they have received.

So that shows us in a level 3 study that long-term what we are interpret -- what the American medical community is interpreting as benefit is really a short-term phenomenon. And this is why it's excusable when experts will cite a paper and say, Well, we've got a followup of three-and-a-half years out of University of Southern California of top surgery.

Well, yeah that's a benefit because the child is still experiencing affirmation messages and the child still has a hope of improvement, but that doesn't mean long term. And remember, we're talking about irreversible things here so we have to talk about the entire arc of their life.

Q So you mentioned that they have fallen out of the affirmation loop.

A Right.

Q Was that in -- was that terminology in the Dhejne study?

A I don't believe it was, no.

Q All right. Where did you get that from?

A My knowledge of the way that transgender care

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works. So you know, reading -- for example, if you read in the American literature, it's rare that you find anyone reporting followups beyond -- in the surgical side you're lucky if you find followups beyond the third year.

Q Well, just that idea of them falling out of the affirmation loop, is that supposition on your part?

A Well, it's evidenced by what the reports are of the patient care in the -- in the collected cases, in the single-center studies, multi-center studies, surgical care of transgender persons. The fact that I don't find followups that extend beyond third year tells me they are falling out of that loop.

Q So it's the absence of evidence?

A Evidence you would expect in a body of scientific literature that purports to show long-term benefit.

Q So going back to clinical trials.

A Okay.

Q Should clinical trials regarding the provision of gender transition procedures for minors be banned?

MS. LAND: Object to form, vague.

A Well, um, let's say that -- that suddenly there's level 3 evidence of benefit. Let's say -- I mean, this is all supposition on my part. I don't rule

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it out because I'm open to following the science here. I can only -- I can only speak to the level of the science as I know it. Okay? But if there were -- if --

Q (By Mr. Ossip) Sorry. Go ahead, Doctor.

A That's okay. If there were a circumstance where the science was to suddenly present through level 3 evidence of a -- of a tremendous benefit then that would change the risk/benefit equation.

All surgical consent, which any trial like this would have to have, is a risk/benefit equation. In the case of the risk is so high the benefits through a level 3 study would have to demonstrate tremendous benefit.

Q But let me put it another way. Should the government ban those clinical trials?

A I think the government already does. I mean, ethics review boards for clinical trials, I'd have to step back. Because, again, I'm not an academic. Probably Dr. Hruz can answer that question better because he's routinely academic clinical trials.

But I think when you're talking about a lifetime risk of objective harm, infertility, loss of capacity for orgasm, loss for sexual intimacy and inability to breastfeed and all of those things, that's a gigantic body of harms.

And so I think this -- anyone bringing such a

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proposal for a prospective study -- I don't think even proponents of transgender see a prospective clinical trial as doable because you couldn't blind the treatment arm.

Q Well, what about a prospective longitudinal study?

A Well, we're living in that right now. We are living in that study right now, because we have a population -- the problem is that our database is not -- so what you're proposing here would actually be a proper database to manage what is already going on. We're living in a longitudinal trial right now.

Q And we're living in a longitudinal -- a prospective longitudinal trial -- I mean, let's put that aside.

We're living in a longitudinal trial because minors are being provided gender-affirming medical care; correct?

A Correct. Correct. And the take-home message there is experimentation. The long-term effects of puberty blockade in gender dysphoric children is not known, that is not known. It's not a known quantity. The reversibility of it is not a fallacy. It is not known.

The long-term effects of cross-sex hormones

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long term is not known, other than the known pathologies of hypertension, hypertriglyceridemia, all those other things that are known. But in terms of children being transitioned through puberty block and cross-sex hormone, that's an experiment.

Q And you support additional research then?

A I always have my eyes and ears open for meaningful research. And what I'm looking for in the American literature is when they are actually going to be examining their data long term, and to date that hasn't happened.

Q Earlier we were talking about chest masculinization.

A Okay.

Q Would you agree that that procedure is the same as a mastectomy?

A Yes, it's the same operation.

Q Okay. And it's safe; correct?

A It's a safe operation. The risk in a woman is different than the risk in a man. The risk of postoperative hematoma in a -- in a chest masculinization as it is for gynecomastectomy in a man is higher than it is in a woman getting a breast reduction. So there is minor differences in surgical risk, but all of those risks are small.

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Q And it's the same risk, then, as postoperative hematoma as it is for a gynecomastectomy; correct?

A Well, so I would expect a slightly higher risk in the chaste masculinization because part of the technique is -- involves the placement of the incisions, because the incisions are routinely inframammary, a lower crease of the breast. The reach up high on a male chest is more likely to cause accidentally vascular injury. So it wouldn't surprise me to learn that the risk is a little bit higher in a -- I'm sorry -- we're talking about masculinization versus breast reduction.

Q Correct.

A Forgive me. I was on the wrong sheet of music here. Risk is -- actually probably for hematoma in the masculinization is probably less than it is for a breast reduction.

Q So lower risk?

A Lower risk, yeah.

Q Okay.

A It's a small risk either way. It's maybe the 3 to 5 percent range. But it's probably lower risk in the mastectomy because of the dissection plain and the fact that you have to cut through the mass of the breast, which is rich in blood supply, so.

MR. OSSIP: All right. I think we can

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stop for lunch now maybe.
VIDEO OPERATOR: All right. This will end media part 3. We are off the record at 1:08 p.m.
(A break was had.)
VIDEO OPERATOR: We are back on the record at 2:16 p.m. This will begin media part 4. Please proceed.
Q (By Mr. Ossip) All right. Welcome back, Doctor.
A Thank you.
Q Doctor, do you believe that minors should be prohibited from participating in randomized clinical trials concerning treatment for gender dysphoria?
A No.
Q And do you believe that minors should be prohibited from participating in long-term treatment outcome studies with adolescents with gender dysphoria?
A No. We have to do that.
Q And anything that prevents those would be counterproductive; correct?
A Well, as -- as we talked about before, what could prevent it is the risk/benefit analysis before you embark on a clinical trial. What might prevent a clinical trial is that the risk to the child is so great that it's not ethical to subject them to it. But as a

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general principle I would say we have to find a way to find out, to come up with answers to that.
We talked about one of them being an examination of the longitudinal study data. But if there is a way to formulate a prospective clinical trial that wouldn't put the children at risk, that would make theoretical sense to me because it's higher-level evidence.
Q I guess I'm still struggling with this. So you're saying that we need prospective longitudinal studies assessing these treatments because they are higher-level evidence; correct?
A I'm saying that the higher level of evidence, the better it is for all of us. But some of those techniques of research are inaccessible right now because of risk of harm to the child. So we may only be able, right now, to settle with level 3 evidence.
Q And level 3 evidence still requires a group of a patient population receiving the intervention; correct?
A Right, yeah. That's the whole idea is that you have a cohort and you have the study group. And that study group is happening right now, like we talked about earlier, that we're living in a prospective trial.
The problem with the prospective trial that we

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are living in is the data gathering is very slip-shot.
Q Yeah.
A Whereas in Sweden it's not because of the centralized database.
Q Right.
A So the thing I fear is that the quality of level 3 evidence is going to be poor because of the poor data gathering.
Q But you agree that a prohibition of the intervention would make a level 3 trial -- or a level 3 study impossible; correct?
A Any -- any study that's prohibited for ethical reasons puts it out of reach. So, for example, if I proposed a clinical trial to subject people to, uh, frigid temperatures, that could potentially kill them in order to find out, you know, what the limits of human hypothermia are, that would be an unethical thing and that data wouldn't be accessible to me. That data is accessible to me because they did that research on my family members who are incarcerated in Auschwitz.
Q Yeah.
A So that's unethical data gathering.
Q And so you talked about unethical data gathering. And the same answer -- your answer would be the same if it was legally prohibited; correct?

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A Right. So it's a question of is the specialty policing itself or does it need intervention. If a specialty is policing itself, the state doesn't need to intervene. If the ethics boards that are governing research are preventing the research then the state doesn't have to intervene. Sometimes the state does have to intervene. You know, there was longitudinal stuff going on with lobotomy. Eventually, no lobotomies, please.
Q And is that because the state prohibited lobotomies?
A I think at some point in certain jurisdictions the state did enter in. But, ultimately, the people doing it, because enough data had flowed in that's the results, the long-term results were becoming evident that the specialty policed itself, the neurosurgeons policed themselves out of it.
Q And that was because the procedures were being conducted and the data was collected; correct?
A Right, yeah. The evidence -- you've got to have the evidence there, yeah.
Q Okay. So earlier we talked about the SAFE Act; correct?
A Okay.
Q Would you support an exception to the SAFE

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Act where -- and we agree that the SAFE Act prohibits gender transition procedures; correct?
A Yes.
Q Would you agree to an exception for gender transition procedures for minors in clinical trials?
MS. LAND: Object to form.
A I'm trying to think of a circumstances where that might happen. I mean, it's definitely a worthy thought because, as you pointed out it's good to know in a safe way. I suppose if -- if a particular question is being asked that could be answered through a clinical trial that didn't put the child at risk I guess that would be a reasonable thing.
So, for example, the effect of social transitioning, the data on that is very poor. You know, social transitioning of children through the affirmation model, the data of outcomes is very poor in that regard and so that would be a low risk to the child, and I don't know -- I would have to defer to the psychiatrists, the child psychiatrists to make an estimation of that risk. But I could imagine there might be a circumstance where you could test social transitioning versus not social transitioning.
Q (By Mr. Ossip) Well, you would agree that all medical interventions involve risk to the patient;

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correct?
A Some level of risk, yeah.
Q And so --
A In some cases trivial.
Q And so you said that a clinical trial would be permitted if it didn't put the child at risk. Under what circumstances could a clinical trial not put a child at risk?
A I suppose I could be more accurate and say: If the risk was so small compared to the potential benefits, as we talked about before, the risk/benefit equation of clinical trials. So if -- if you can come up with a study model that puts the child -- every time you introduce a child to a new medication you run the risks of, say, adverse reaction, or any time you subject the child to, you know, any modality of care whether you're talking about managing fever. Tylenol has risks. The risks are so small that they are acceptable within the confines of a monitored clinical trial.
Q Just early today we were discussing levels of evidence, and you have used the terms level 1, level 2, level 3, level 4, level 5; correct?
A Um-hum.
Q And are those the levels of evidence that the American Society of Plastic Surgery uses to

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categorize --
A That's the one that I use, yeah, that's right.
Q Okay. And do you recall testifying about those levels of evidence in your deposition for the Kadel case?
A I believe that question came up, yeah.
Q And when you use those levels here, you mean those the same way you used them there; correct?
A I try to stick to that -- that model, uh-huh, yeah.
Q Perfect. I just figured that was easier than going through all --
A Sure, yeah. And so -- yeah.
Q Perfect.
A I think the question that came up in the Kadel case is what is meant by low-quality evidence.
Q And you'd agree that when clinical trials are unavailable, doctors have to rely on less definitive information in making treatment recommendations; correct?
A Right.
MS. LAND: Object to form.
Q (By Mr. Ossip) So we talked about -- you said if the question about whether or not research should be permitted on a particular intervention, talking about a

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minor, is whether the risk was small compared to the benefit; right?
A Right. I mean, that's one of the factors that Anderson took, what's the likelihood?
Q Okay. I want to just move away -- I know we talked about clinical trials. But let's -- let's include any level 1, 2, or 3 evidence. Okay? Are you with me?
A I am.
Q Okay. So looking at those types of research are -- is the use of puberty blockers for the -- as a gender transition procedure as defined in the SAFE Act, would that research be permissible?
A In terms of what we have been discussing about that -- that risk/benefit thing?
Q Yes.
A I would put puberty blockade in the high risk category, a very high risk category. And in order to justify the use of those in a clinical trial I would have to have level 4, at least, evidence -- certainly level 3 would be preferable -- of a long-term benefit to the child. Right?
So if I have -- if I have a level 3 study that shows me long-term benefits, significant, like for example if you took the alarmingly high suicide rate

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that you see among transgender persons and you were able to demonstrate, you know, that you nearly knock that off the books, that would be a significant benefit. Or psychiatric major depression, substance abuse, if you could demonstrate a major objective benefit then it would be worth having a conversation about that. And again, I would have to defer to the pediatric endocrinologists and the psychiatrists to make that adjudication. But that's the kind of circumstance.

Q So I think this is going back to my confusion.

A Okay.

Q I think you said in order to do this study you would need either level 3, level 4 evidence to show that safety and efficacy of the intervention.

A Yeah. If you're trying to get to a level 2 result, you've got to have everything below that kind of supporting --

Q Okay. So let's talk about the lower levels, then.

A Okay.

Q So you would oppose a prohibition of collecting that research for puberty blockades then; correct?

A Right. Well, so what you're -- when you're talking about level 4 and level 5 evidence you're talking about -- in the case of level 5, for example,

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you're talking about anecdotal case reports.

Q Um-hum.

A In the case of a level 4 you're talking about of large case collections, retrospective study of literature, you know, analysis of multiple-collected case reports and things like that.

I'm pretty sure that pediatric endocrinologists right now cannot present you with better than short-term level 4 evidence of a benefit. And that's the problem with the puberty blockers because the consequences are not short-term.

Q So you would support research into long-term, level 4 research into long-term benefits of puberty blockers; correct?

A No. I would probably defer to a -- a longitudinal population based retrospective review because that doesn't put any new children at risk. Right? What you're looking at is what do we have so far? We've been doing this now for a decade. We've been doing puberty blockade and cross-sex hormones for a decade. We should have at least, in some patients, a ten-year followup. But what we're really looking at is even longer term than that. At eight to ten years you're starting to see fall-off.

But in terms of the consequences of hormonal

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blockade, we've arrived at that stage when the likes of Marci Bowers, transgender surgeon, is starting to report adverse long-term consequences of puberty blockade. So that's one of the data points you're going to have to weigh against.

Can a child that is entering puberty at age 11 understand what you're talking to them about like when you say, you know, "Like seven years from now you're not going to be capable of an orgasm." Well, they have never even experienced that so they have no way of judging that. "You're going to be infertile." They don't understand what that means.

And so -- but we're getting to the point now where what you really want to do is a historic population-based longitudinal evaluation of the results to date. And I think we're reaching that point in the American literature. Sweden is already there. That's why they are reporting what they're reporting now.

Q And that's just the Dhejne study; correct?

A Well, there is the decision by the Karolinska Institute, they are looking at their own internal review of their processes and their outcomes.

The Karolinska Institute in Stockholm has now -- has now shut down puberty blockade and cross-sex hormones because they are reaching the point where they

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are seeing the effects of long-term effects on children. So we're at that point now.

So I wouldn't say let's do research at level 4 and, you know, case collections or case report. I let's look at what we have so far and what is it showing us? And that's a longitudinal population-based retrospective review or examination of the data.

The risks we have right now is the data collection is so slip-shot compared to Sweden and Finland and the UK.

Q So earlier we were talking the about the levels of evidence, you know, through 1 through 5 and you said that -- or you'd agree that level 5 evidence is anecdotal reports and expert opinions; correct?

A Right.

Q Okay.

A Consensus statements I think is in that kind of group too. Sometimes consensus statements rises to the level of level 4.

Q And --

A Um-hum.

Q So I want to direct you to your rebuttal report, which is --

A Okay.

Q -- marked as Exhibit 4.

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A Okay.
Q And we're going to go to paragraph 16.
A Level 3, level 4. Paragraph 16? Okay.
Q So going on to the -- it's the last two words of page 8; right?
A "As I."
Q And then going on to the next page you say, "As I will show below all of the articles cited by plaintiffs' experts are of the lowest grade of medical evidence." Correct?
A Correct.
Q Do you mean by that that all of the articles cited by plaintiffs' experts are a level 5 evidence?
A No. Four, five. Four and five.
Q So not the lowest grade.
A No, no. The level 4 for sure, which is low-grade evidence. It's -- it's referred to in much of the literature as being, let's see, low quality. What are the words O'Connell (phonetic) used? Low quality. It's a very low quality or poor to low quality. There's a lot of different words people will use. There is no precision particularly in those words. It's better to speak of level 4, level 5.
Q But it's not the lowest grade.
A No, it's not. Level 4 for sure.

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Q Okay. So let's just flip back to paragraph 4. This is paragraph 4C. It's on page 2.
A Okay.
Q Do you see where you say, "The papers chosen by plaintiffs' experts demonstrate systemic problems in the way such articles are peer reviewed."
A Yeah.
Q What do you mean by that?
A Well, let's take for example one of the -- one of the papers cited by the plaintiffs' experts, a paper I think the lead author was Olson-Kennedy. It was out of USC, University of Southern California, their gender clinic. And it was an examination of top surgery in trans males.
And I discuss that -- let's see. Yeah, so I discuss that in paragraph 7 -- beginning at 17 and continuing on, 18. It basically looks at how is the data collected. So articles can be very low quality for a number of reasons.
The first point is -- is how you gather the data, how the patients are selected. The second point is how you interpret the data. And then -- and then the third is conclusions you have drawn.
Q And, Doctor, I'm specifically asking about how the articles were peer-reviewed. Do you know how they

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were peer-reviewed?
A Right, yeah. So that particular article appeared in Peds JAMA. And the peer review process in Peds JAMA is probably like it is in most professional journals. They have a board of reviewers who get assigned articles to review and -- prior to acceptance for publication. So JAMA and its various outlets, like JAMA Peds is one of those peer-reviewed journals.
Q So you would agree that the peer -- or it's your understanding that the peer review process in JAMA Pediatrics is the same as in most other medical journals; correct?
A The process is generally the same. The particular players, obviously, vary and the editorial policies probably vary.
Q Okay.
A But the process of peer review is where a peer who is working in the same field and maybe even more than one peer, it might get reviewed by more than one process, will evaluate your process, evaluate your -- your data, the validity, the conclusions drawn.
Does your study have the power to make the judgment because of it's got a big enough study population looking at a variable that, you know, may be broadly varying or narrowly varying. There's a lot of

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criteria, but that's the process. And it will get accepted for publication on the basis of that review process.
Q Okay. And JAMA Pediatrics is peer-reviewed; correct?
A As far as I know, yes, it is.
Q Yeah. Do you think that watchful waiting is a scientifically proven treatment model for gender dysphoria?
A It's -- it's -- I would call it a historically proven model. I would have to delve into the details. But when someone like -- gosh, his name just escaped me. Zucker.
Dr. Zucker from Toronto publishes data that shows the desistance rate, meaning children who cease cross-sex self-identification in puberty and young adulthood, that desistance data was arrived at using the watchful waiting model. So you have a comparison group right there that you could compare to your affirmation care model that we're living with right now. It's already in the medical literature. Zucker lost his job because he reported it.
But what does it show us? Watchful waiting isn't a passive process, it isn't a no care process. Watchful waiting is recognizing that the effects of

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maturation are going to affect mental and emotional maturation, recognizing that individual treatment by a child psychologist can help a child to understand what kind of fear, anxiety they are trying to manage, can keep them in contact with reality, which is what's called cognitive behavioral therapy. And but the most important element in that is family therapy, family dynamics.

That's what the watchful waiting model is, family therapy, behavioral cognitive therapy, sometimes the use of medications to control the anxiety, not very often, and then recognizing that puberty is going to mature their brains and that's why better than 80 percent of children abandon cross-sex self-identification in adolescents and 92 percent in young adulthood. So that's watchful waiting and it has a track record.

Q And what scientific literature supports the use of watchful waiting for adolescents?

A Zucker, among others. And I would go to him and I would read his citations. Yeah.

Q And what about for adults?

MS. LAND: Objection; form.

A Well, when you reach adulthood watchful waiting is not even on the table. See, watchful waiting

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essentially is the diagnostic process in a sense that separate out the children who desisted from the ones who would have persisted.

And so if you have somebody who is in young adulthood who is persistent then -- now, that's a group you might want to study carefully with alternative therapies. Right? Because now you have established the diagnosis.

If I have a desistance rate of 80 percent, but if I start them an affirmation care and I have a persistence rate of 100 percent, something is wrong here. I've misdiagnosed 80 percent of my patients. And so that's the reason why these prospective trials become a risky proposition, because you haven't determined even who has the diagnosis.

Q And by starting them on affirmation care, do you mean to include social transition in that?

A Well, in some measure it does. That's sort of the entry point. But in earnest it begins with puberty blockade.

Q And right now you believe that puberty blockers and cross-sex hormones are too harmful to minors with gender dysphoria to permit clinical trials for those treatments?

A That's my opinion.

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Q Do you believe that any patient who reports anxiety is incompetent to give informed consent for surgery?

A No.

Q What about depression?

A I would have to look at that carefully. You know, situational depression is a very different thing from a -- a chronic and severe depression, depressed state.

So I can -- I've often taken care of patients who are depressed over their diagnosis of breast cancer, for example. It's a very depressing thing to find out, but that's a situational depression that I can help the patient through even just as a plastic surgeon who can offer her the hope that she's going to be reconstructed and things like that.

Very different from a patient who is coming to me seeking a remedy for depression by getting aesthetic surgery. That's a completely different -- completely different person.

So to get a consent form in the cancer patient, I don't see any problem with that. To obtain consent for managing depression in a cosmetic aesthetic patient, I've got a real problem with that.

Q Well, let's move way from aesthetic; right?

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I'm talking about surgery in general, in all areas of surgery.

A Okay.

Q Do you believe that a patient with depression is incompetent to give informed consent for surgery?

A Given the qualifiers I just gave you, I would not make a blanket statement that's it's an absolute gold standard disqualifier. It's not.

Q Okay.

A It's a situational thing.

Q What about patients experiencing suicidal ideation?

A That's a problem.

Q So never competent to give --

A No.

Q -- informed consent?

A That speaks of a profound psychological disturbance. Anyone who is seriously considering ending their life is dealing with a level of anxiety, and perhaps even a misperception of the world they are living in that I would consider renders them incompetent to give informed consent.

Q In any context?

A I can't think of an exception. I can't think -- you might present me with an exception and I

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might say ah-ha, but I can't think of one.
Q And is that a generally accepted view in the medical profession?
A Pretty confident in that.
Q And what about a suicide attempt?
A Well, I would have to look into how remote that is. Is it a recent, is this an ongoing problem?
And also, the other thing you have to consider in that decisionmaking is what are you proposing with the surgery? So if a person is suicidal because they -- you know, they have got a gangrenous leg, well, I could maybe make a case that part of what's animating their suicidality is the fact that they are walking around with this stinking leg and that they would have a very high likelihood of a better disposition if I did the amputation. Right? Very, very important to kind of categorize what you are submitting them for.
If you're -- if you're proposing an elective operation, an elective operation and the person is recently suicidal, I would not off them a consent form. I would offer them a referral for psychiatric evaluation to see if they are -- if they are -- if their suicidality is being adequately managed.
If the reason for surgery is an elective procedure to obviate suicidality, well, if I can manage

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the suicidality then I don't have the indication for the surgery, so I wouldn't give them the consent form then because they no longer want it. They wanted the surgery to manage suicidality. If the suicidality is managed, why even offer them the surgery?
Q All right. But so just going back for a second, so you'd agree that -- again, that patients who report anxiety are competent to give informed consent for surgery; correct?
MS. LAND: Object to form.
A Right. Depending on the particulars of their anxiety. But as a general principle anxiety is not sufficient to render somebody incompetent.
Q (By Mr. Ossip) Okay.
A Right.
Q Can informed consent be obtained in cases where the long-term benefits of an intervention have not been demonstrated?
A Yes, I think so. I think so. You know, balancing that against immediate risk of harm. So if you're talking about a low risk of immediate harm, lacking long-term data on benefit, yeah, I guess that would be reasonable, um-hum; certainly in the case of something that's an immediate danger that you're using surgery to obviate, then absolutely.

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Q And let's see. Does informed consent require an objective measurement with known error rates that could be used before the procedure to predict who will benefit from it?
A That is sort of an ideal circumstance. But it's generally what we aim for. So, for example, when you're -- when you're talking about cancer surgery, you know, a known danger, if I was going to, you know, accept a patient for it -- say, for example, somebody is referred to me for a thyroidectomy because the endocrinologist has diagnosed a thyroid cancer, well, I'm going to want to see the evidence. If the evidence is just, "Well, I felt a lump, it's going to be cancer," I would go, "Well, that has very high known error rates and I'm not going to accept that as evidence for a thyroidectomy."
If he comes back and says, "Well, I've got an ultrasound and the ultrasound shows an echoic lesion in the right lobe," I will say, "Well, that's interesting, low probability of cancer," I still won't offer surgery because the error rate is too high. You've got a pathology report, I'll go, "Excellent," and I'll look at that slides. Do you see the difference?
Q Well, let's just go back to my question. So you would agree that informed consent does not require

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an objective measurement with known error rates that can be used before the procedure to determine who could benefit from it?
A It's not a sine qua non, right.
Q Not a requirement? To avoid Latin.
A Well, okay. I'm just trying to stay with you here. Having tests that -- with known error rates is a very important and indispensable thing when you're talking about a life-changing operation. Like a thyroidectomy is a life-changing operation and I'm going to want to have known error rates. If it's an unknown error rate what you have used to diagnose something where I'm going to do an operation that's life changing, that's unacceptable.
Q So any thyroidectomy that was performed in a time when there was not a known error rate, that was -- then informed consent for that procedure was impossible?
A Well, no. You're in a circumstance there where to the best of your ability. Some even with my own training era, a general surgery (sic.) in the 80s the diagnostic specificity has gotten better.
Take an appendectomy for example. When I was a junior resident in general surgery, if you weren't -- if you weren't taking -- if 20 percent of your appendectomies weren't normal, normal appendix removed,

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the chief of surgery would say you're not doing enough appies, because he's afraid of somebody rupturing their appendix and you not attending to it.

So but now the likelihood of a negative appendectomy is some number approaching zero.

Q Well, just again, just to get --

A You do the best you can.

Q I want to avoid the longer tangential examples. Okay, Doctor?

So just again, you're saying the question is to the best of your ability; correct?

A What's the best level of evidence you can get.

Q Okay. And that's sufficient to get informed consent?

A Right. The less uncertainty, the better. An error rate speaks to uncertainty.

Q And have you ever performed a procedure that lacked an objective measurement with known error rates to determine who would benefit from the procedure?

A I'm not a trailblazer in surgery. I generally go with what I have been trained up in in areas that has proven results and things like that. I'm trying to think if I have ever done anything experimental. I'm not that kind of surgeon.

Q Well, you -- we'll come back to that.

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Is it always a breach of medical ethics to perform a purely cosmetic procedure on someone under the age of 18?

A The -- you know, in my training for board certification, the American Society of Plastic Surgery, one of the things they would review is things like that, doing, like, for example a breast augmentation on an adolescent high school age female. If I presented a case like that for my board certification I probably would have been dismissed for it.

Q Well, my question is yes or no. Is it always a breach of medical ethics to perform purely cosmetic procedures on someone under 18?

MS. LAND: Object to form.

A So there we would have to get into the definition of cosmetic, because we're getting to the fine details here. So if cosmetic, you know, you could grade asymmetry of the breast in Poland syndrome to be cosmetic, but that would be a fairly heartless approach to a girl suffering from Poland syndrome.

So technically I'm not solving a functional deformity, but it's an objective deformity. She's not within the range of normal for a female. It could be considered cosmetic, but that would not be problematic because it's a reconstructive operation.

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But on the other hand, if a girl comes in who has a minor asymmetry in their breast, and that's a common thing, and she wants to have large breast implants put in, I would say no.

Q (By Mr. Ossip) So okay. I think I'm understanding. So the question of whether that would be ethical would be whether or not you are moving someone from outside the range of normal for their biological sex to somewhere inside the range of normal for their biological sex?

A That's a good way to put it, yeah, it is. That's reasonable, um-hum, I think.

Q All right. Do cosmetic surgeries ever sacrifice function?

A If a cosmetic operation puts in jeopardy a human function I would -- I would expect or hope that it only happened accidentally or through some misadventure, either preoperatively, intraoperatively, or postoperatively. To sacrifice function for a cosmetic result is one of those bedrock plastic surgery ethos. We sacrifice function all the time for a reconstructive procedure. But to sacrifice it for a purely cosmetic procedure would be -- it better be accidental.

Q Well, that's a good -- let's dig into that a little bit.

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A Okay.

Q So you said it better be accidental. So that gets to the intention of the physician; correct?

A Right, or his knowledge, his competence.

Q Is it ethical to perform a cosmetic surgery that carries a risk of sacrificing function?

A No. All operations have some risk. And so, for example, every time I do a rhinoplasty there is a potential risk that they are going to have a perforation of their septum if there is some accidental misadventure in the course of raising the flaps. And I explain that to the patient and every rhinoplasty surgeon does.

So your risk of septal perforation is somewhere around 3 to 4 percent. That's an acceptable risk because the management of it is certainly within reach of an office procedure most of the time.

So it's not uncommon that there is some measurable risk, but the risk ought to be very low and it ought to typically happen through a misadventure, like I'm raising the flap and I accidentally pierce that flap.

Q And how much risk of a functional loss is acceptable for a cosmetic procedure?

A It better be in the low single digits, you know.

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Q So, like, we talked about Poland syndrome. So let's -- and breast augmentation. Is it -- it's -- is it your testimony that's never ethical for someone under the age of 18 except for patients with a congenital breast deformity to receive a breast augmentation?

MS. LAND: Object to form.

A Well, okay. I can think of an example where it might be acceptable, but there again you're sort of skirting outside the range of normal. So a girl with what's called pectus excavatum where the chest is sunk in because of a developmental process, to conceal that pectus excavatum using autologous fat grafting augmentation rather than an implant would be a very reasonable thing to do for her.

But there again, you're still -- even though the defect would be close to within the range of normal and even if pectus excavatum is not an uncommon thing, I think it would be very reasonable to offer a girl who is in her high school years, who has done most of her skeletal growth already at that point to maybe offer -- she might be 16, 17, at that point I think it would be reasonable.

On the other hand, an otherwise normal, healthy girl who comes in who just wants bigger breasts, I think that's problematic.

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Q (By Mr. Ossip) And do you think that's unethical just looking at that particular case?

A I don't want to judge my colleagues, but I would consider it myself to be unethical if I was to do that.

Q Okay.

A I would judge myself to be unethical in doing that.

Q But is that a generally accepted view in the medical profession?

A I remember hearing it more than once when I was in training.

Q But are surgeons subject to discipline for performing such augmentations?

A They are subject to discipline following discovery. And a lot of these things go undetected I suppose. But, yeah, surgeons are at times disciplined. It's not a very common thing in the world of plastic surgery, but it happens.

Q But just to be clear, you're saying that physicians who conduct or perform a purely cosmetic breast augmentation on a minor are subject to professional discipline?

A Not as a general rule, no, not as a -- I think because it goes undiscovered virtually.

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Q Well, let's take a case where it is discovered; right?

A Okay. Okay.

Q Is such a physician subject to professional discipline?

A Probably at least review of the case and to see if it's a trend. Right? For example, if I was doing breast augmentations on minor females in the local hospital and I had an extrusion of an implant, because she's active and she doesn't pay attention to postoperative orders and forgot to take her antibiotic -- I don't know -- the implant extrudes and has to be removed because of infectious complication, that's going to appear in the morbidity report. And if the morbidity report comes up and goes, "Oh, Dr. Lappert did a breast augmentation that suffered complications in a 16-year-old girl, is this a trend?" And if that medical board at that hospital reviews my operative records and say, "Oh, look, he does these surgeries all the time," then that might get examination.

Q So let's go to your rebuttal report.

A Okay.

Q So that's --

A Is it 5? No. That's --

Q That is 4.

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A Four. Okay. That's right.

Q And I want to go to paragraph 6.

A Paragraph 6. Okay.

Q So let me know when you are there.

A I'm there.

Q So do you see that first sentence, you say, "Cosmetic breast augmentation for anything other than congenital breast deformities, such as Poland syndrome, in minors is not considered ethical professional conduct."

A Again, that's -- that's where my training has taught me. And then I have a reference for you. Reference 3, from the seminars and plastic surgery.

Q Right. And that's that Jordan and Corkrine article?

A Right, right, right.

Q And does that article say it's unethical to perform purely cosmetic breast augmentations?

A No. It raises it as a question. It doesn't declare it so, but it raises it as an ethical question worthy of examination, yeah.

Q Okay. Are breast reductions ever performed for strictly cosmetic reasons?

A Yes.

Q And does this sacrifice function for the sake

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of a cosmetic result?
A It hopefully does not.
Q But it risks it?
A Right, yeah, there is always risks. So if you want to hear it, I can expound; if not --
Q That's okay. I just want to keep it moving.
A Sure.
Q But you would agree that a purely cosmetic breast reduction can be ethical?
A Oh, absolutely. I do them all the time. I did them all the time.
Right. The distinction between a cosmetic and a reconstructive breast reduction has to do with did the patient present with orthopedic problems and what is the way the specimen you submit. So those are subjective criteria that span between cosmetic and.
Q Do you consider gender affirming surgeries to be cosmetic or reconstructive?
A They're -- I call them aesthetic rather than cosmetic.
Q What's the distinction between aesthetic and cosmetic?
A So cosmetic just speaks to the fact that you're changing the form. Right? Aesthetics speaks to the fact that you're changing the form affects the

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subjective life of the patient, and that's an important distinction to make because it helps you address risk.
So an aesthetic operation for somebody who has, like, a daily problem with explaining why they look tired. Maybe they're a bank teller and everybody is always, "You're not getting enough sleep, hon."
Well, I can solve the tired-looking face with an aesthetic operation. I can make their face look rested and that solves an objective problem that they are suffering every day. That's a very important thing to offer people. And I always make that distinction when talking about risk with patients because they're not doing it for nothing. They are doing it for objective reality, which is their subjective life.
If I put them at great risk to do that, now we've got an important conversation to have. If I can do it with little to no risk then that's a chip shot conversation.
Q And cosmetic surgeries don't involve that --
MS. LAND: Object to form.
Q -- objective benefit?
A No. Cosmetic surgery -- I make the distinction because of the way people understand cosmetics. Cosmesis is just about the change in appearance. Aesthetics is about the result of the change.

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And what we're -- the most important conversation we're having, especially when you're talking about trans children, is the subjective effect of surgery.
Q (By Mr. Ossip) So I guess are all cosmetic surgeries aesthetic?
A Right.
Q But not all aesthetic surgeries are cosmetic?
A Okay. An aesthetic operation involves a cosmetic change. The term "aesthetics" just calls to mind the fact of the motivation for the operation and the expected result of the operation. Cosmesis is just the physical change. Aesthetics is the more inclusive category. So aesthetics includes cosmetic procedures, but speaks to the subjective result of those cosmetic procedures. Does that help?
Q Maybe. But again are there any aesthetic procedures that are not cosmetic?
A Aesthetic procedures. I can't think of it because aesthetics is about the perception of the physical reality. Whether you're talking about the aesthetics of this room, the aesthetics of that painting or the aesthetics of somebody's nose.
Q So the answer is no; right?
MS. LAND: Object to form.

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A Yeah.
Q (By Mr. Ossip) Okay. And do you know if the -- but either way, you don't consider gender-affirming surgeries to be reconstructive; correct?
A No, it's not, absolutely reconstructive surgery.
Q Do you know in the American Society of Plastic Surgeons considers gender-affirming surgeries to be reconstructive?
A Yeah, they do.
Q They do?
A Yeah.
Q So let's talk for a second about facial feminization surgery.
A Okay.
Q Is there any loss of function there?
A There is a risk of loss of function, but no expected loss of function.
Q And that would put it in the realm of ethical then; correct?
A Right. In terms of just surgical risk and how it applies to ethics. And putting aside the entire question of body dysmorphic disorder. We'll just put that aside. Surgical risk and how surgical risk affects ethical decisionmaking. Surgical risk low, not

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ethically contraindicated.
Q Okay. Sorry. Bear with me one second, Doctor.
A Okay.
MR. OSSIP: Maybe now is a good time to take a break.
VIDEO OPERATOR: Okay. This will end media part 4 and we're off the record at 3:00 p.m.
(A break was had.)
VIDEO OPERATOR: We are back on the record at 3:20 p.m. This will begin media part 5. Please proceed.
Q (By Mr. Ossip) All right. Welcome back again Doctor.
A Thank you.
Q So, Doctor, earlier we were talking about a study by someone named Zucker; is that correct?
A Well, a series of papers on the subject, yeah.
Q Okay. And is it your understanding that Zucker found that patients who had gender dysphoria after the onset of puberty were likely to desist?
A No. What -- I -- let me see if I can remember the details. He's the one who fairly consistently reported the numbers of desistance in the 80 percent range, actually it was some spread between 60 and 80 percent, but roughly 80 percent.

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And he was talking about desistance in -- during adolescence, not at the onset of adolescence, but during adolescence. And as I recall the interpretation of that was that the effects of sex hormones on brain maturation and -- and perhaps more importantly the physical changes of puberty, confirmed in the mind of the child that their biological sex is -- has a reality that's comfortable for them now.
Q So the answer is, just to go back to the first word, no; correct?
A You were asking me if it desists at the onset of adolescence, and I'm saying it happens sometime during adolescence or, indeed, on adulthood.
Q My question was: Do you think that Zucker found patients who had gender dysphoria after the onset of puberty were likely to desist? Yes or no?
MS. LAND: Object to form.
A Oh, no, Zucker didn't address that.
Q (By Mr. Ossip) Okay.
A Zucker didn't address onset after puberty. That's a whole different diagnosis.
Q And did Zucker address onset prior to puberty that continued after puberty?
A Right. So those would be the persisters and that's what he found, that somewhere around 20 percent

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would persist into late adolescence and young adulthood.
Q Okay. Do the plaintiffs' experts all have significant financial and professional conflicts of interest in this case?
MS. LAND: Object to form.
A I'm not privy to their financial interests.
Q (By Mr. Ossip) Okay. So if you have previously signed a statement under oath that said that, that would be false; correct?
A Okay. So the -- when you have someone who, say an expert who 90-plus percent of their patient load is transgender persons, I think it would be safe to say that there is a financial element. Is it an overriding interest? I -- that might be subject to interpretation. But it seems that most of the plaintiffs' experts devote much of their professional life to persons with this condition and, therefore, their income is derived from the care of persons with that diagnosis.
Q Just to be clear, we have talked about a couple of experts; correct?
A Right.
Q So let's talk about Dr. Adkins.
A Okay.
Q Does Dr. Adkins have a significant financial and professional conflict of interest in this case?

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A She as a financial interest, I would imagine, in terms of continuing to offer the services she offers.
Q But not necessarily a conflict of interest?
A No. Not necessarily, no. But there is a suggestion of an issue there if --
Q What about Dr. Antommaria?
A I don't know what percentage of his patients are transgender. But as I recall it's a significant portion of his patients.
Q Where did you come to learn that?
A I don't know if I read his -- I don't know. That was so long ago that I read that stuff.
Q But you would have no way of knowing whether or not Dr. Antommaria has a significant conflict of interest; correct?
A I don't know the degree of his conflict of interest.
MS. LAND: Object to form.
Q (By Mr. Ossip) Do you know whether he has a conflict of interest at all?
A I would suspect that there was -- there may be a conflict of interest if decisions about doing these surgeries, if it -- if it becomes something that is not legal for him to do, let's say. Let's take a case example.

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A law passes that you can't do transition hormonal therapy then that would have a significant impact on his practice I would imagine.
Q And what's your understanding of Dr. Antommaria's practice?
A He's a psychiatrist; right? Pediatric psychiatrist.
Q What does it mean to divide the human person from our own bodies?
A So that's an anthropological concept of what you define as the essence of being a human person. So if you define the human person as a spirit being that occupies a body then that speaks of a division between the subjective life of the person and their embodied self, and that's a difficult issue because it goes against everything I ever learned about the human person as a physician.
I don't know of any human person apart from their body, I don't -- and the consequences of their body existing in the world. The fact that they have a voice, the fact that they do things.
So -- so when a child is given this idea that their essential self is a spirit that is in the wrong body, that's a -- that's a psychological division that's being created in the life of that child. In my

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experience it's not natural for a child to speak that way. A child -- it's not natural. In my experience the child is given language like that.
Q And -- well, when you say in your experience, what do you mean by that?
A Taking care of children for 30 years.
Q In what capacity?
A As a pediatric surgeon and cleft craniofacial care and, you know, trauma situations and coming into my clinic with minor birth defects and, you know, I mean, in my -- in my practice of plastic surgery a significant proportion are children, or were children until a year ago.
And I'm in the habit of not only taking the history from the parents, but trying to get a sense that the child has of what they're experiencing, so I always talk directly to the child in the presence of the parents to get a sense for how they're understanding their circumstance. And it is my experience that children don't speak about their bodies as being something separate.
Q So I just -- one thing I want to get back to. You said a big proportion of your practice as a plastic surgeon up until a year ago was children; correct?
A Yeah.

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Q What proportion?
A Probably somewhere between 15 and 20 percent.
Q Okay.
A Years before that it was much larger. I directed a congenital deformities clinic at the Portsmouth Naval Hospital and had a very large enrollment of children with birth defects.
Q So you talked about there being -- well, let me ask it another way. So why is it a problem to divide the human person from our own bodies?
MS. LAND: Object to the form.
A Well, in terms of the issue in question it may predispose decisionmaking that would incline the person to treat their bodies as a separate object of domination, if you will, or an object of care. So speaking of your body the way you speak of a shirt. Right? I'm going to have the collars narrowed. I'm going to have my breasts removed, that kind of thing, objectifying their own body when, in fact, their body is part of their subjective life in important ways, which is where this problem comes from. It's a misinterpretation of what they're body is telling them about who they are.
Q And by "this problem," you mean transgender?
A Right. Gender dysphoria, gender identity

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issues, gender incongruence. Why does a child feel separated from their body in a way where they view their body as the enemy to their happiness. That's a very important thing.
Q And all of those things come from a misinterpretation?
A Yeah. Clearly, yeah.
Q And is that a medical issue?
A It's a psychological issue.
Q And what is the treatment for that psychological issues?
A Well, so to view your own body as the source of your problems apart from some objective -- is the analog to that would be like the anorexic girl. And anorexia predominates in adolescent females.
For them to view their unhappiness is caused by a misperception of their own body. So the anorexic misperceives a skeletal body as being obese, so that's where the misperception, misapprehension is. Why? Because she would rather not look at the internal wound that is causing her to feel unsafe or unloved, and so she sees something that's not there.
And that's directly applicable to the child that looks at their body and sees something that's not objectively there. They see a body that's an enemy to

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their happiness and they see their own genitalia, for example, as not really a part of themselves, so that's a misperception.

Q In both cases it's a delusion?

A Well, by degrees. By degrees it's a delusion. So in the case of the anorexic, delusion has three criteria. One of them is it's a fixed firm belief. And that's, interestingly, one of the diagnostic criteria in DSM by diagnosing gender dysphoria in the child is the fixity of the belief. Persistent, insistent, and consistent is what they say.

Well, persistence in a belief does not make it true, and that's the problem with the delusion. So it's not -- it's not amenable to logical argumentation is the other criteria. So they are insistent on it, it's not amenable to logical argumentation. And the third thing is it's an impossibility. Those are the diagnostic criteria for delusion.

Transgender, gender dysphoria that rises to the level of seeking surgical intervention in the case of the historic demographic. Meaning boys who persisted into young adulthood, right, now you've gotten to the point where it's persistent, right? It's a consistent thing. They have lived it since childhood. It's not amenable to objective argumentation, and it's an

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impossibility as surely as an anorexic girl is obese.

What's the impossibility? Well, it's impossible that a boy with a Y chromosome in every somatic cell of their body is, in fact, a girl. There's no basis for making that claim. It's a subjective claim based on a misperception of their body. So it meets all the criteria.

Now, contrast that with the late-onset gender dysphoric female, rapid-onset gender dysphoria, you're going to have a hard time demonstrating delusional thinking there. What you're more than likely encountering is a persistence in a social -- what's the term that's used.

The social contagion model is the term that's been applied to it, where it's a -- it's a shared belief among groups of people. You don't generally find this happening, isolated case. You will find three cases in middle school. You will find a group of women in college age who suddenly are cross-sex identifying or agender or non-gender or something like that.

Yeah, and so if you look into that you'll typically find an event of injury or something has happened. But what -- a delusion doesn't lie behind that.

And that speaks to a very important thing. The

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fact that you have two completely different mechanisms at work, one onset prepubertal, one onset in adolescence, young adulthood, one associated with delusional thinking, the other one not associated with delusional thinking. How could you possibly claim that it's the same process? And how could you possibly claim that it has the same cure? It makes so sense.

And the other thing you cannot claim is that it's biological caused, because you're proposing some massive mutation in the human genome that would cause a 5,000 percent increase in this diagnosis in seven years.

Q So you -- so you would --

A Sorry.

Q It's your -- it's your belief that what you're calling early onset and late-onset gender dysphoria have different cures?

A Well, I have a hard time imagining that -- that problems with completely different origins and completely different demographics are likely to have the same cure.

Q And what do you think the cure is for early onset gender dysphoria?

A Well, historically, you get an 80-plus percent cure rate, which under any other circumstance would be considered like trip to Stockholm for the Nobel Prize

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cure rate. 80 percent in a -- in a period of years, and over 90 percent, that's -- that's the cure is -- and it may get better with time. Maybe we find another therapy. But right now watchful waiting, family tear, the things we talked about.

Q And by "cure" in that context, you mean desisting from a transgender identity?

A Right. The child achieves happiness without requiring -- the child achieves that happiness that is sought for them without requiring a lifetime of medications or permanently altering surgeries. You've reached a resolution of the anxiety, a resolution of the dysphoria without subjecting the child to surgery and a lifetime of medicine. That's a win.

Q Okay. And what is the cure for late-onset gender dysphoria?

A Well, I don't think it's been studied adequately because the diagnostic category was only proposed by Lisa Littman back in 19 -- I mean, 20 -- is it 2019, 2018, somewhere around in there. I'm not sure. I'll have to check on the dates. So this is a recently recognized group, although other clinicians have reported there is a shifting demographic, especially the people looking at the sudden burgeoning of the diagnosis, they recognize that whereas in the past only

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20 percent of new diagnoses were female, now greater than 60 percent were female.

Lisa Littman proposed this is a different phenomenon, rapid-onset gender dysphoria, social contagion model.

Q So you would support research into -- sorry. Strike that.

You would support research assessing potential cures of late-onset gender dysphoria?

A Right. Well, so that research would have to begin with a look into the causes of the problem, causes of the problem looking for common factors, because that would direct your research in terms of remedy.

Q Okay.

A So, I mean, a tumor is a tumor, but a tumor caused by cancer is a very different creature from a tumor caused by a blow to the leg. And so the first thing is what's caused the tumor. What caused the gender dysphoria.

Q All right. Is gender dysphoria that persists for 20 years a delusion?

A Depends on if it's the child onset one versus the adolescent and adult onset one. The likelihood of it being animated by a delusional thought -- it's not a blanket major delusion versus trivial delusion or

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trivial misunderstanding. But there is some misperceived event likely in the early onset, or as I don't know in the adult onset. I don't see evidence for a delusion. And it may come to light, but I never read an article that --

Q So even if it persisted for 20 years that would not, in your mind, rise to the level of delusional thought?

A In the case of a female with rapid-onset gender dysphoria, late-onset gender dysphoria?

Q What you're calling late-onset gender dysphoria.

A Okay. That's the category. Ask me the question again, please.

Q If that persists for 20 years --

A Okay.

Q -- would that rise to the level of delusional thinking?

A No. I could see where -- I could see where a subtle habit of life and a comfort in the life chosen would be -- would have resolved the unhappiness in some measure and I wouldn't even categorize it as a dysphoria at that point because they have arrived at some reconciliation of the way they are living their life and they are at peace about their life. Problem solved.

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Q But it would -- I guess I'm confused. But --

A You mean if they -- I'm sorry.

Q So but for somebody who had early onset gender dysphoria and that persists for the same length of time, that is delusional thinking.

A It's vastly more likely that there is a delusional thought that animates that that's driving a compulsive behavior. You know, that's a very high likelihood. I'm using historical, you know, what's been reported in the literature, again, going to when I was in residency.

Q And going back to the phrase "dividing the human person from our own bodies," is that a religious issue?

MS. LAND: Object to form.

A No. I consider that to be an anthropology medicine issues. I don't recall ever attending a lecture, reading a paper, reading a textbook in medicine and surgery that ever described the human person as a spirit creature that occupies a body. Never heard it. Never heard it. So I don't have to turn to my religious education. This is fundamental to what it means to be a doctor in the western world.

Q (By Mr. Ossip) But is that limited to the western world?

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A Different -- different cultures have a different view of the human person. And I cannot speak to that. I can only speak to the -- to the world view that gave us science and medicine.

Q So this is a cultural view?

MS. LAND: Object to form.

A I think it's a scientifically based world. I think those two become inseparable, because it's the culture that gave rise to the science. The scientific revolution didn't happen just anywhere. It happened in a particular place at a particular time. And that happens to be the western world; in fact, you know, after the 12th century, western European world. That's where the science and the medicine that we're speaking about today came from. So what gave rise to all these wonderful medical advancements and technologies is the child of that culture.

So I wouldn't separate it from that culture, but I also wouldn't ascribe everything to that culture, because there is scientific evidence that now supports what we're doing. Now what we're doing is scientifically based, but it's animated by a culture that's willing to accept the fact that the world presents itself up to us in a predictable way, and if you come back tomorrow and make the measurement on that

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child you're going to get the same number. That's a decidedly western view of the world.
Q And that's an exclusively western view of the world?
A Not anymore.
Q And that's because -- well, strike that.
Is it -- well, should a person have control over their own body and its appearance?
A Yeah. That's --
Q Yes?
A Yes.
Q Is it a mistake for people to view their own bodies as something that they can do things to in order to provoke happiness in themselves?
A No. It's a reality.
(Plaintiffs' Exhibit 7 was marked for identification and made a part of the record.)
Q All right. So the court reporter has just handed you something that's been marked Exhibit 7. Have you seen this document before?
A Yeah. I'm trying to remember where it was published. Oh, Life Site. Okay. Now I remember.
Q And this article quotes you extensively; correct?

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A It does, yeah.
Q All right.
A I think it's the result of a phone interview.
Q So there are -- unfortunately there are not page numbers on this, but if you -- there is some headings, if you see in bold.
A Okay. Sure.
Q And I want you to flip to it's the second-to-last page. And there's a heading, it says "Regarding Objective Truth." It's in the second-to-last page.
A Oh, I'm sorry. I was on -- okay. "Rejecting Objective Truth." Yes, okay.
Q And so do you see that where you say, "One of the mistakes that people are making in temporary life is viewing themselves as some sort of spirit creature and their body is something they own or something they possess. They view their own body as something they can do things to in order to provoke happiness in themselves." Do you see that?
A I do.
Q And that second sentence, you don't believe that that's a mistake?
A It's not a categorical one. So that operates by degree. So for example, coloring your hair is a

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relatively trivial thing to do that provokes happiness. Right? Amputating your genitals, of course, would be in a whole other category. But they're animated by the same kind of idea.
In the one case it isn't a separation from themselves. It's just a coloring of their hair. But to view their bodies as being a source of sorrow or something to be worked over, like body modification, making your face look like a reptile, that would be -- and there are plastic surgeons that will do that for you and don't get censured for it. But it's -- it exists on a spectrum.
And if the society generally views the human body as a pallet on which you can exercise dominion then it's an easier sell that you can modify a child's body to make them happy if they are anxious. That's the point I'm making.
Q And you're not denying that you gave this quote for this article; correct?
A The quote, "They view their own bodies as something they can do" -- sometimes I misquote it, but let me read that.
(The witness reviewed the document.)
A Yeah. No. I stand by that.
Q Okay. And do you know whether your interview

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for this article is recorded?
A Gosh, I don't remember how it was done. Gosh, that was like three years ago almost.
Q It wouldn't surprise you if it were, though; correct?
A No, it wouldn't surprise me.
Q Okay.
A Sometimes people catch me after presentations and say, "Would you mind," you know, and it may have been something like that. And I know that Life Site, for example, is a Catholic media effort and it's very likely that somebody from Life Site might have come to one of my talks at a Catholic church and asked to interview me, asked me a bunch of questions.
Q Do gender transition procedures pervert our sense of human sexuality?
MS. LAND: Object to the form.
A Yeah, they -- they pervert and distort. I would stand by that, yes they do.
Q In what way?
A Well, okay. So the viewing of human sexual relations as a recreational process in which you can use a person to achieve a satisfaction I think perverts the sexual faculty. Because human sexual faculty, again, the division in the person comes up again. The human

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sexual union has two aspects that up until the 1960s were never separated. The unitive effect. The bonding of two people together in the act of love, and it's procreative consequences.

To utterly separate all those things to where now it's -- it has -- you've destroyed even the unitive aspect, putting aside the fact that you've rendered the person sterile, you have even perverted, if not utterly destroyed the unitive aspect with such things as the effect of puberty blockade on orgasm for example or the effect of loss of sensibility following the construction of artifical vagina and the moving of the glands to the clitoris position.

You degrade the unitive of functioning in doing those things. There is no surgeon that's so good that that's going to be perfectly preserved. Some achieve very near perfection. But the lion share of people having this surgery will report a loss of sensation, in addition to their utter loss of fertility.

So what that speaks to is a willingness to do that puts a value on sexual relations that's out of proportion to its meaning. If you're willing to destroy a human function in pursuit of a sexual life that may or may not be achievable that's -- that suggests to me -- by perversion I don't mean like "you pervert."

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Perversion means a distortion or a twisting. Not pervert like a legal definition. It is perverting truth.

Q And is that a medical opinion?

A That's my opinion.

Q And is that -- and part of that opinion is that is interferes with what you view as natural human reproductive capacity; correct?

A Well, that's one of its features. One of its features, yeah.

Q Is there anything wrong with assisted reproductive technology?

A I have ethical problems with it. I have personal contact with it, but I have ethical problems with it.

Q What are those ethical problems?

A The fact that the human person is turned into a commodity. That fact that it's associated with a marketing process that encourages people to believe they have a right to another person. This is rife in the world of transgender surgery because of the consultation that people undergo before their transition surgery. They are encouraged or given the option of reproductive -- what's called fertility preservation. It doesn't actually preserve fertility. It preserves

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gametes for future proxy pregnancies or something like that.

So first thing is it turns the child into a commodity. The second thing is it encourages people to believe they have a right to a child.

Q And you believe a person does not have a right to a child?

A No person has a right to another person. That's the language of slavery.

Q And so someone who claims, "I have the right to have a child," is using the language of slavery?

MS. LAND: Object to form and relevance.

A I think there's skirting along that, but because they haven't given thought to what they just said. Again, the way that the fertility doctors market their services is with the idea of entitlement. And a lot of plastic surgeons do precisely the same thing. A lot of people selling all kinds of things sell entitlement to the service or entitlement to the benefit.

But it's a very different thing when you're thinking of yourself as entitled to another human person. We get comfortable with the idea of entitlement and we forget to think about the fact that we're talking about another human person. So people inadvertently

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will slip into the language of slavery not knowing what they have said.

Q And so -- well, let me -- just to clarify, you do not agree that people have the right to bear children, then?

MS. LAND: Object to form.

A Okay. So they have a right not to be interfered with in doing that. So, for example, if you were like a public hygiene person in some expanded government and you came to my house and said, You are forbidden to have intimacy with your wife because there's too many people living in Little Rock, that would be an unjustice. So in that sense I have a right to that. I have a right not only to conjugal life, but to the consequences of conjugal life. That's quite a different thing from saying I have the right to do extraordinary things in order to acquire another person.

The child in the first example is a natural consequence of my right, conjugal life. Right? Natural consequence of what I am entitled to.

But I could not make the claim, you know, if my wife is childless or if we were childless to walk into a government agency and say, "I have a right to a child. Make it happen."

Q (By Mr. Ossip) So let's take another -- sorry.

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Give me one second, Doctor.
So let's take an example of a child who has testicular cancer --
A Okay.
Q -- and needs to have his testicles removed. Would it be inappropriate for a doctor to offer fertility preservation to that child?
A No. I think it's reasonable thing. That might put him in the category of artificial insemination of his future wife in the case of a boy with testicular cancer.
And I have to put on a different hat here. Now I'm speaking to you as a physician. If you walked up to me at a Catholic church and said, What do you think about this, I would say, You should start talking to that boy now about his life as an adoptive father, because in the Catholic teaching it's a different thing. So I'm speaking here as a medical witness and so it doesn't enter into the conversation.
Q But your previous answer was also as a medical witness?
A Well, that's a different category because you're talking about in vitro fertilization and the child being treated as a commodity that's for sale. Different thing.

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Q Oh, I see. So in vitro fertilization, you're drawing a distinction between in vitro fertilization and artificial insemination; correct?
A Yeah. And, again, speaking now in terms of the medical ethics now, yeah, it's a very different thing. It's a very different thing to have massive industrial process of producing human life, much of it being put in frozen storage and no one knowing what to do with those children, that's a very different ethical question than a trial of artificial insemination from a husband's own sperm.
Q And the same would be true for preserved ovo?
A Well, that's a different problem because if you -- if you're doing ovo preservation -- well, okay. A particular example.
So a woman you preserve ovo who is going to get, say, cancer therapy, and it's going to render her ovaries non-functional, if she still has a functioning womb and is receiving hormonal support you could conceivably do in vitro for her or, you know, implantation.
But you would still be relying on this -- so there are particular circumstances. Are you putting children into cold storage or is the woman willing to accept multiple embryos. In the case of embryo -- ovo

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preservation, it's not as morally fraught because you have just ova sitting there. But in the case of in vitro fertilization you have nase of humanity sitting in that freezer.
Q So going back to the testicular cancer example. So, you know, we're talking about fertility preservation. If the doctor in that case says, "Although you're having this surgery, you have the right to have a child and so we can preserve your sperm for that," is that the language of slavery?
MS. LAND: Object to form and relevance.
A Well, so I would wonder why the doctor needed to say you have the right to a child. Because, really, the discussion is if you want to have a hope of having a child then we ought to preserve sperm.
Q (By Mr. Ossip) But using that phrase, "you have a right to have a child" in this context --
A I would avoid using that language because, again, it encourages people to think of other human beings as their right. There is no such right. It's better to speak of preserving your hope of having children than to speak of your right to have a child.
Q And what about same-sex couples? Do you think that same-sex couples should be allowed to adopt?
MS. LAND: Object to form and relevance.

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A I don't want offer an opinion on that. That's a -- I'm not here as an expert on adoption law.
But one of the issues with adoption -- and I have five adopted children and so I have been through adoption processes a lot. And one of the things we have to be careful about is viewing the child only in terms of what they are doing for us as adoptive parents and, rather, viewing it as a responsibility to the child and what's best for the child.
So adoption is in the service of the child, not in the service of the couple. The couple benefits from it, but the adoption isn't in service of the couple. The adoption is in service for the child and what is best for the child.
Well, my opinion is that children generally do better with a mother and a father. I'm not here to outlaw adoption. In fact, I traveled in China with a same-sex couple and we both adopted children from China. I wasn't wagging my finger at them, but I was wondering the whole time if the child would suffer for having two mothers and not a father there, knowing what my father meant to me. And knowing also what fathers mean to a lot of people who come to me who are having difficulties. So that would be what I would say about that. Do I suggest that adoption should by same-sex

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couples should be outlawed? No such thing.
Q So earlier we talked about Courage.
A Okay.
Q So what is Courage's approach to individual with gender incongruence?
MS. LAND: Object to form, asked and answered.
A Well, Courage's approach to person's with gender incongruence is to punt them off to me, because the COURAGE apostolate doesn't aim itself at that population. It just happens that there are not many resources in the Catholic church to help families or persons struggling with gender dysphoria, gender identity issues.
And so they oftentimes will call Courage and then, basically, the Courage office puts them in touch with me. And mostly it's just long conversations trying to reassure parents because -- yeah. Generally the children themselves are not interested in anything different, so we don't go looking for them and -- and drag them off into some conversion therapy or something like that.
Q I guess let me ask you another question. Do you know whether Courage opposes gender transition procedures?

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MS. LAND: Objection; form.
A I don't think they have an official statement on that. It wouldn't surprise me if they did. But I don't think -- see, the Courage Apostolate is aimed at persons who experience same-sex attraction. And the Encourage Apostolate to the families and loved ones of persons who experience same-sex attraction.
Q (By Mr. Ossip) And is Encourage related to Courage?
A Right, it's an outgrowth. Encourage is an outgrowth of Courage.
Q And what's your connection with Encourage?
A I don't have -- I don't have Encourage group in Alabama. They are two separately running things. They sort of run in parallel and typically don't involve the same people?
Q So some people are Encourage chaplains but not Courage chaplains?
A Yeah. It's probably more common that they are both, given the poverty of clerics in the church right now. But I haven't established an Encourage chapter in Alabama, only a Courage one. And as I confessed earlier, the pandemic hammered it severely.
(Plaintiff's Exhibit 8 was marked for identification and made a part of the

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record.)
Q The court reporter is handing you what I believe has been marked Exhibit 8.
A Right.
Q And from the cover, do you recognize this document?
A Sure do.
Q And have you read this document before?
A I have.
Q All right. And this is, I'll represent, an excerpt from the Courage handbook -- or the Handbook For Courage and Encourage Chaplains.
A All right.
Q If you open it up you will see there is page 81.
A I see that.
Q And do you see, it's on the second column on the right side, there's a quote that starts: Everyone, man and woman, should acknowledge and accept his, in brackets, or her, close brackets, sexual identity. Do you see that?
A I do.
Q What does that mean?
A Well, in reading that and I remember reading this, that -- that I -- that's a somewhat poorly

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constructed sentence. If they had sent it to me for review I might have worded it differently. So I think what they are getting at is acceptance of gender, what we are calling in this conversation gender identity is what they are -- what they are speaking to here. So what it -- what it addresses is the desire that everyone should be gender congruent, if you will, with their biological sex.
Q All right. And is that -- do you see where -- it's missing a close quote, but do you see where that starts with an open quote before "Everyone"?
A Okay. Yeah, okay. Everyone, man and woman, should acknowledge and accept his or her sexual identity.
Q And after that there is a footnote 91.
A Right.
Q And that's citing to catechism No. 2333; correct?
A Number 369 is that I've got. Oh, 2333. You're right.
Q Okay.
A Okay.
Q And that was the sentence you were referring to earlier; correct?
A Right.

Q Okay. And then do you see where it says, Each person's moral obligation is to respond to his or her sexual identity by accepting and cooperating with the plan of God."
A I do.
Q And that means living with a gender identity that is congruent with one's biological sex.
MS. LAND: Objection; form.
A I think that's what the writers intended, yeah. That's not -- those are not my words, but I think that -- I tend to agree with you that that's probably what the writers of the catechism intended, yeah.
Q Okay. And do you agree with that?
A Let me reread it now because I will be chided for disagreeing with church teaching. (Reading)
Okay. So what that -- my understanding of that sentence is that the Catholic church views each individual person as a special creation of God that has a sexual identity and that that sexual identity is part of the order that God has designed for that person and that, you know, a person's moral duty is to be congruent with God's design for your life. So to act against God is a moral problem. And I think that's what that's saying is there is a moral obligation because it speaks to the nature of your creation, that your nature is



evidence of God's plan.
That's one of the breakthroughs in the 12th, 13th century that western civilization said that the world teaches you what God's plan is, so study -- it's the world of science -- and you will understand God. That's what -- I think that's what that sentence is saying.
Q And the moral duty in that context is to identify with and live as the gender that corresponds with one's biological sex?
A Okay. First and foremost, your moral duty is to your conscience. So the way the church teaches is your conscience is the first arbiter of your decisionmaking, but your conscience needs to be an informed conscience. So if your conscience is telling you to do something that is not in agreement with what the church is teaching, then it is your moral obligation to inform your conscience.
So you need to prayerfully examine what the church is proposing in its anthropology here and ask yourself, What am I doing wrong? And some people are never able to make that hurdle because they cannot be convinced that the -- what the church is proposing and so they live contrary to that. And sometimes their ignorance is culpable, sometimes their ignorance is



excusable.
Q But in any case, part of that moral duty, assuming your conscience is informed, is to identify and live as the gender that corresponds with your biological sex?
MS. LAND: Object to form and relevance.
Q (By Mr. Ossip) You can answer.
A To kind of sum up what this is embodied in here, what the church teaches, is that to inform your conscience with the truth gives you an obligation to the truth. It's a moral obligation to the truth.
Because in the eyes of the church and in the eyes of the faith, the truth isn't just a book full of propositions, like the DSM III. The truth is a person. And so -- and so to willfully ignore the truth is to turn your back on the person of Jesus Christ.
So that's why -- I didn't expect to have a theological conversation with people on the subject, but that's the heart of the teaching right there. You have an obligation, a moral obligation to your conscience, you have an obligation to inform your conscience with the truth, and then, having learned the truth, you have an obligation to live that truth.
Q Okay.
A Because recognizing the truth without action is



an empty -- empty thing.
Q And the truth here is biological sex?
A The nature, your nature. So that's, again, where the -- what the church teaches is that nature -- your human nature is a singularity. It's essential to the teachings of the church and it's essential, historically, to the teachings of medicine. It's that it's a singularity. Body and soul together comprise a single human nature. Human nature is not the soul lover here and the body over there. And the separation of those two, in fact, is diagnosable. It's called death.
Q So one's biological sex and, therefore, sexual identity is part of the order that God has designed for a person; correct?
MS. LAND: Objection; form, relevance, asked and answered.
A All right. So that -- that speaks to a very important point here and I'm glad you raised it. That is there are events in a person's life that will alter that ideal that you just laid out there, that under ideal circumstances perfect congruence, body and soul, sexual manifestation of sexual biology, and the gender identity of the person, the ideal circumstance.
But there are accidents of life in both arenas. You can have problems on the developmental side and you

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can have problems on the psychological developmental side that -- that lead to problems that may be insurmountable, either biologically medically or psychologically culturally. Yeah.

Q (By Mr. Ossip) But it is a problem?

A Gender incongruence is a problem.

MS. LAND: Objection.

A That's why we have a whole medical community that's devoted to resolving that problem.

Q (By Mr. Ossip) And what is gender incongruence?

A Where your perception of your sex differs from your biological sex.

Q So earlier we talked about your consultation with families with children who were experiencing gender discordance; correct?

A Right. In my pastoral role as a deacon, yeah.

Q And was that -- so that was all in your role as a deacon; right?

A Right. The couple of kids I've seen have been, again, families approaching me after mass concerned about their suffering child, can you talk to them kind of thing.

Q And was any of that part of your work with Courage?

A No. That's just my work in my parish.

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Q Okay. Doctor, you won't engage in the -- well, what gender transition procedures will you provide, Doctor?

A So are you asking -- I'm just trying to think if there is a difference in your question from the one you asked me earlier where we talked about laser hair removal.

Q So I think you said you would provide that as part of a gender transition; correct?

A Yeah, sure.

Q Any others that you would provide?

A I can't think of any. I would not do breast surgery, I would not do genital surgery.

Q And why would you not do breast surgery?

A Because I consider them morally and ethically culpable.

Q How so?

A My examination of the operations, my examination of the medical evidence, my examination of the -- my understanding of the nature of the suffering and its causes would essentially exclude me from ever offering such procedures. I have to confess to some guilt every time my transfemale comes in for facial hair removal. I have pangs of guilt that I'm offering and billing for the service, but I still go in there every

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time and talk to her and we're friends. But, yeah, I mean, I still struggle with that one, I have to confess.

Q Yeah. And -- well, I guess let's explore that. Why do you struggle with that?

A Because I never -- again, my obligations to the truth -- I'm trying to cultivate and maintain a friendship in doing it. I'm not trying to transition the person. I'm trying to keep them as a friend. And, yeah -- so, yeah, that's -- I think that's about the whole of it, yeah.

I struggle with it because you don't want to affirm somebody in a delusional thought that's contrary to the truth. And as we talked about earlier, I have a moral obligation to the truth because he's a person.

Q And this applies to patients of any age; correct?

A Right.

Q And earlier we talked about what you have called the poverty of evidence supporting these procedures; correct?

A Yeah.

Q So let's say one day reliable and valid scientific research supports gender transition procedures, would you provide the care then?

A That would be like a Copernicus moment in my

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world. I would have to step back and totally reexamination what I have learned as a physician and surgeon. I would have to -- I would have to examine the validity of the scientific claim. I would solicit the opinions of trusted professionals and let them examine the scientific evidence and together commiserate over that.

But if it's compelling evidence then I would have to reexamine my world view. I would happily do that. Not happily. I would willingly do it, but not happily.

Q Willingly reexamine your world view?

A Yeah, exactly, about how I view the human person even because it's contrary to so much of what I learned from medicine and surgery that -- and my life experience. I would have to reexamine a lot of things.

Q But what about -- so you talked about reexamining your world view. But what about providing those procedures?

A Well, so I would have to have confidence in the evidence before I would provide those procedures.

Q But let's say you did have confidence in the evidence, would you provide the procedures?

A Yeah. My practice of medicine and surgery, I like to think, has been historically scientifically

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driven. So if there is strong science that's in favor of doing something that's for the good of a person, I'm an early adopter on things like that.
Q Bear with me one second, Doctor. I apologize.
A Sure.
Q Earlier we spoke about -- well, strike that.
Are you familiar with the Gospel of Life Conference?
A I think that's the name they had for the one in Denver. Is that the Denver conference, this -- isn't that what that was?
Q I'm asking you, Doctor.
A There it is right there. I just refreshed my memory with Exhibit 1 there.
Q That was in the Denver, then?
A That's the Denver conference. Not the one at the seminary. This was at a separate location that happened some time later.
Q Do you know if that conference was recorded?
A Hum. There may have been some Franciscans there recording it. I'm not positive about that.
Q Do you know if that recording was released as a podcast?
A I don't know that. Oh, wait a minute. The Denver conference podcast. There was a -- it might have

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been -- it might have been released as a YouTube video, actually. In fact, I think it was because that's the conference where they didn't make a provision for me to have a monitor and I had to keep looking around at the screen to look at my slides and it was very annoying.
So I think yes, it was put out there on YouTube or one of those media platforms.
Q And have you ever described identifying as transgender as being evil?
MS. LAND: Object to the form, asked and answered.
A I doubt that I've ever said that. I -- I -- I wouldn't be surprised to hear that I characterize people who encourage children to think that way as doing evil to the child.
Q Okay.
A Yeah. I'm not saying anyone is fundamentally evil. I'm saying they've done an evil thing, as sure as somebody who hits a child with a car. They have done an evil to them whether they have done it culpably or not.
MR. OSSIP: So we're -- and actually, do you want to -- is it marked?
MR. HOLLAND: Um-hum.
Q (By Ms. Land) Okay. So we're going to play you some audio, Dr. Lappert.

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A Um-hum.
Q And I'm going to represent this was taken from a website that purports to present a recording of the Gospel of Life 2018 Conference. Okay?
A Okay.
(A discussion was had off the record.)
MR. OSSIP: We did not bring our speakers. And this will be pretty quick.
THE WITNESS: This is the audio part?
MR. OSSIP: Yeah. There is nothing to see.
THE WITNESS: Okay.
(The audio recording was played, which was later marked as Plaintiffs' Exhibit A.)
Q (By Mr. Ossip) So, Doctor, that was you speaking; correct?
A Yes, it was.
Q Okay.
A I was addressing a church group. I think it is a parish in Denver suburbs and I was addressing religious educators and -- yeah, religious sisters and various --
MR. OSSIP: And can we go off the record for 10 seconds? I'm sorry.

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VIDEO OPERATOR: We are off the record at 4:18 p.m.
(A discussion was had off the record.)
VIDEO OPERATOR: We are back on the record at 4:18 p.m. Please proceed.
Q (By Mr. Ossip) All right. And I'll just represent that this recording has been marked as recording A for the purposes of this deposition. And so -- oh, no.
Is being transgender a diabolical attack on the image of God and the world?
MS. LAND: Objection to form and relevance.
A No. The -- the encouragement of children to think that way about themselves, I suspect it is. But I'm here as a medical expert, not as a theologian.
Q (By Mr. Ossip) Well, do you believe that the transgender delusion is an attack on your understanding of who Jesus Christ is and what it means to be incarnate?
A I do.
MS. LAND: Objection to form and relevance.
Q (By Mr. Ossip) You do? And what the transgender delusion in this context?

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A That the human person is somehow divided and that the body has no meaning apart -- that the essential meaning of a human person is a spiritual one.
Which, if you're asking me as a Catholic deacon to expound on theology, that's a heresy, yeah. And to cause children to suffer through this ordeal when it can be avoided, if you're asking me is this a spiritual warfare, you know, I sometimes speculate publically about whether it is or not.
Q What do you mean by "spiritual warfare"?
A Things unseen at work in the world.
Q You mean the forces of the devil?
MS. LAND: Objection to the form.
A Well, that's a fairly medieval way to speak about things like that. I wouldn't have used those words.
Q (By Mr. Ossip) What words would you have used?
A That there is -- there is a spiritual, almost like a contagion that causes people to suffer and that the more people harm each other the more that is abroad in the world, yeah.
Q And so is the transgender delusion also contrary to western thought?
A Because it's a -- it's a division of the human person, their single nature into two separate and

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unseparable (sic.) things by separating them, then, yes, it is contrary to the western tradition.
Q And that -- that is also your medical opinion as well, correct, Doctor?
A Because the medical opinion derives from the western tradition. All the things we've been talking about here are the product of western medicine, our understanding of the sexes, you know, the biological basis of sex is a -- is a western contribution, all of it.
Q Doctor, did you do an interview for a radio show and podcast called "Tactics Radio"?
A That's that squirrely young man in Montgomery I think. I think I might have, yeah.
Q Sounds right to me.
A He was a bit of a squirrel. I'm sorry. I shouldn't have said that publically.
Q Let's see. So we're just going to play you another recording again. This is just to confirm that this was you on the video.
MR. HOLLAND: This one has video.
MR. OSSIP: You can see him again.
MR. HOLLAND: Yeah, and the squirrely man.
(The video played.)

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Q (By Mr. Ossip) And that was you on that recording?
A Yes, it was.
Q And do you stand by all that?
A I do.
MR. OSSIP: And I'll represent that this has been marked as recording B for the purposes of this deposition.
(Plaintiffs' Exhibit B was marked for identification and made a part of the record.)
MR. OSSIP: Do you want to take a break here?
THE WITNESS: I'm ready to go whenever you are. So if you need a break, take it by all means.
MR. OSSIP: All right. Let's take a five-minute break.
VIDEO OPERATOR: This will end media part 5. We are off the record at 4:24 p.m.
(A break was had.)
VIDEO OPERATOR: We are back on the record at 4:41 p.m. This will begin media part 6. Please proceed.
Q (By Mr. Ossip) Okay. Thank you. All right. Dr. Lappert, we're going to play you one more

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recording right now. The question is just whether this is you speaking in the recording.
(The video was played and was later marked Plaintiffs' Exhibit D.)
Q (By Mr. Ossip) And, Dr. Lappert, what was you speaking; correct?
A Absolutely.
Q And you stand by everything you said in that?
A I certainly do, yes.
Q And that's a recording that's been marked D for the purposes of this deposition.
MS. LAND: I think you may have skipped one.
MR. OSSIP: Yeah. That's okay.
MS. LAND: Okay.
Q (By Mr. Ossip) Doctor, would you analogize transgender surgery to a medical procedure that creates a monster?
A No. Well, that's a -- that's a term I suppose -- it wouldn't surprise me if I had at one point in some flight of ideas there. But monster in the sense of a fabrication, an attempt at fabricating a human person that's not natural, I suppose.
Q So it wouldn't surprise you if you said that?
A I would not, no. Yeah, using that shelly use

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of the word monster. I'm not saying that transgender persons are monsters. I'm not saying that people who suffer with transgender or gender identity or gender dysphoria are monsters. I'm saying that the process is monstrous.

Q And by the process, you mean --

A The -- the willful destruction of the natural structure of the person and the creation of counterfeits.

Q And that's gender transition procedures?

A Surgeries, yeah.

Q What about hormone replacement therapy?

A Not in the same category.

Q We're going to play another recording now. This one has been marked as E for the purposes of this deposition.

(The video played and was later marked as Plaintiff's Exhibit E.)

Q (By Mr. Ossip) Doctor, that was you speaking; correct?

A Yes. I was using my pedagogical Jewish exaggeration.

Q And, Doctor, you're not currently Jewish; correct?

A I'm more Jewish now than I ever was.

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Q How so?

A Because I'm a Catholic, which is a completed Jew.

Q What do you mean by that?

A That all the promises that were made to the people of God in the Old Testament were fulfilled in the life of Jesus Christ.

Q Doctor, do you think that discussing gender identity issues sexualizes children?

A Yes.

Q Do you think it grooms them for sexual abuse by older people?

A Yes.

Q Do you recall being asked about that in your deposition for the Kadel case?

A I don't remember, no.

Q All right. So I'd like to direct you to page 462 of the transcript from Kadel.

A Oh, Kadel? I'm sorry. 462?

Q Yeah. And that's Exhibit 2 for the record.

A Okay.

Q And do you see starting on line 8, you say --

A Yes.

Q It says, Question, "And you think that discussing gender identity issues with children means

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grooming them for potential later sexual abuse; right?"

Answer, "No."

A Let me see where the questions were coming from first. Give me just a moment.

Q Um-hum.

A Okay.

Q And so --

A One moment, please. I'm sorry. Right. So the questions that were being asked by Mr. Nepper looks like they were seeking a distinction between grooming that leads to further treatment versus grooming that leads to sexualization, and so I agreed with that distinction.

And then -- and then he asked the question directly, "And you think that discussing gender identity issues with children means grooming them for potential later sexual abuse; right?"

And my no answer was directed to I think the question at hand, which was the use of the word grooming in connection with leading to further treatment.

Let's see -- no, no. We're talking about here -- for future -- preparing them for these interventions. Right? It lays the groundwork whereby sexualizing their thoughts in a way that's not consummate with their best interest. Right.

Q Doctor, let's take a step back. So you were

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specifically talking about -- let's see. I think you were specifically talking about your presentation to the Denver conference; correct?

A I think that's what that was about because I'm talking about a slide or something here. I didn't get a chance to review the whole thing. Let's see. Slide.

Yeah, so that's the slide he's talking -- the questions about the slides, slide 23. So I would agree that most likely from that Denver conference, which we saw was recorded. And so I think the question he was asking is grooming for preparation for future -- for future treatment events, you know, grooming -- like for example, social transitioning. It's my opinion social transitioning, a child, grooms them for puberty blockade because it encourages them to believe that -- that the manifestations of puberty is a disagreeable event.

Q Well, Doctor --

A Yeah.

Q -- so, but again the question was -- let me put it this way.

A Okay.

Q So looking at just that question alone, you would disagree with the answer being no; correct?

A As it's in Nepper?

Q Just where it stays -- well, let me ask it

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another way. But you do think that discussing gender identity issues with children means grooming them for potential later sexual abuse; correct?

MS. LAND: Objection; form.

A Okay. So on 461, question 12?

Q (By Mr. Ossip) This is 462 starting on line 8.

A I'm sorry. (Reading.)

We're talking here about grooming them for future --

Q But you would agree that the answer to that question is yes; correct?

A Gosh, I'm lost now. So yes would mean that I think all grooming is oriented toward sexual abuse.

Q No. Well, all right. We can move on, Doctor. I think you have given your answer.

You discussed -- during that deposition in Kadel you also discussed that Life Site article; correct?

A I don't remember, but...

COURT REPORTER: What article?

MR. OSSIP: Life Site.

THE WITNESS: Yeah, that was Exhibit 7. I don't remember discussing it in that deposition.

VIDEO OPERATOR: Doctor, let me get you to raise your mic up.

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THE WITNESS: I'm sorry.

VIDEO OPERATOR: Thanks.

THE WITNESS: Um-hum.

Q (By Mr. Ossip) Well, if you go to that article, so that's --

A Okay.

Q -- Exhibit 7 and you go to the second page.

A Okay.

Q Do you see in the middle of that page where it says, "Regarding children, Lappert said, sexualizing them at a young age with these ideas is grooming them for later abuse."

By that did you mean sexual abuse?

A No. We're talking about the abuse of medicine and surgery there.

Q And you did not mean sexual abuse when you gave that quote; correct?

A I don't think it was about sexual abuse, because that's sort of a distant effect I suppose. But, no, I think we're talking here about the abuse of transgender medicine and surgery which results in injury to the child. So, yeah.

Q All right. And you're -- earlier we talked about your interview for this article. And this interview was recorded; correct?

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A The Life Site? I don't remember it, but I'm suspecting that it was recorded at some conference where I gave a presentation. Some reporter asked if they could ask me some questions. I don't remember where it was recorded, though.

Q If you look up a little bit do you see where it says, "Appearing on a recent broadcast of Relevant Radios, Trending With Timmerie"?

A Right, I do.

Q And is that the source for the quotes for this article?

A It sounds like it. I don't know if it was just the reporter listening to that broadcast and then writing this article or if she actually talked to me or interviewed me.

Q Okay. So I'm going to play you a part of that, that podcast now.

A Okay.

Q And this has been marked as recording F for the purposes of this deposition.

(The video played and was later marked Plaintiffs' Exhibit F.)

Q (By Mr. Ossip) And, Doctor, that was you on the recording; correct?

A Yes, it was.

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Q And you'd agree that there you were talking about sexual abuse; correct?

A Yeah. So on the one hand we're talking about the medical and surgical abuse, the grooming process that leads to that. Both of them are originating from sexualizing children. But in this case we're talking about a different kind of abuse, in this case sexual abuse.

Any time a child's mind is turned toward sexual things and encouraged to think of themselves as a sexual creature it makes them relatively easy prey.

Q So changing topics a little bit, Doctor, have you ever had a malpractice lawsuit filed against you?

A One that was dismissed before it ever went anywhere.

Q So you never were deposed for that?

A No, no.

Q All right. And what was the topic of that lawsuit?

A The -- the woman had a breast -- I did a breast cancer reconstruction on her. This is in Scotts Bluff, Nebraska. And she had I think it was an anesthetic complication. And I was named in that suit just because I was the surgeon. And ultimately she dropped the suit because there was no evidence that she was mistreated.

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Q All right. And you're not an anesthesiologist; correct?
A No. I'm a plastic surgeon. Cute.
Q And that's the -- and that's the only lawsuit; right, Doctor?
A Yeah, no. That's the only one I've ever.
Q Okay. And that was dismissed against you; correct?
A Correct.
Q Okay. So earlier you said that, "Gender transition procedures pervert and distort our sense of human sexuality." And you said that "this is because it separates out the reproductive aspect of sex." Correct?
A That's one of the things. It's not because, a sole cause, but it's one of the aspects of the -- yeah.
Q Yeah. And is that a medical opinion?
A Well, it's more of a medical moral opinion that's informed by my understanding of the human person, yeah. Could I find a journal article to support me in that? I'm sure I couldn't.
Q But it's a medical moral opinion; correct?
A Yes, it is, yeah.
Q And also earlier you said that church teachings say that sexualized entity is part of the order that God has designed for a person and that to act against God's

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plan as a moral problem; correct?
MS. LAND: Object to form.
A That's the church teaching on it, yeah.
Q (By Mr. Ossip) And do you agree with that?
A Yeah.
Q You also said that you would not do -- or, well, I believe you said that based on the evidence as it stands now you would not do breast regenital (sic.) surgery for gender transition because you do not think it would be ethical for patients of any age; correct?
A Right.
Q And would you support a law prohibiting such treatments even for adults?
A No.
Q Why not?
A Because when you are talking about adults, you are in the arena of people who can make those decisions who have a long-term view of their own lives. And, yeah, they have higher executive functioning, they can give consent. You can counsel them about infertility and it may not matter a wit to them.
They might not have any sexual life at all but are merely seeking to live a social life as a fully transitioned person and sex doesn't even enter into the question.

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In fact, the majority of older transgender persons don't have a sex life, per se. They have a life. And so, yeah, so it's a very different thing in adults.
Q But you would still consider it an intentional mutilation?
A Yeah, I would.
Q But one that should not be illegal?
A Right.
Q Okay.
A Sort of like other body modification surgery. It's a --
Q And you don't think that other body modification surgery should be illegal?
A No. But in children it should, because permanently life altering, inability to obtain informed consent.
Q But you have said that you personally wouldn't do gender transition procedures on adults; correct?
A I will not, no.
Q And why is that?
A Because I -- I wouldn't be doing them any good. My best understanding of the evidence tells me that it would be mutilation to no effect. So I do mutilating surgeries for people, I did up until a year ago. For

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example, an amputation of a finger because it interferes with the function of the hand. That's a willing mutilation, but I have improved the function of their hand. They're willing to accept the defect because the function is so radically improved. So that's an intentional mutilation that's fully morally acceptable.
But to take a fully functioning structure and destroy it for the sake of an aesthetic result in my opinion is not an acceptable approach to plastic surgery.
Q And is that -- well -- and so it's your belief that the surgeries are never appropriate, then?
A I cannot think, off the top of my head, of a transgender genital operation that is ever appropriate, no.
Q What about top surgery?
A Yeah. You would have to come up with an exceptional scenario for me to justify doing a mastectomy for no reason.
Q What about facial feminization surgery?
A So now we're sort of creeping into that less risk to the patient, less lifelong what we call donor defect. I might consider it, but there again, I would probably be having a lot of pastoral visits with them trying to understand why they are seeking this as a

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remedy to their difficulties.
Q And do you frequently have pastoral visits with your surgical patients?
A I can't tell you how many times I've talked people out of cosmetic surgery. Talk women out of breast augmentations all the time. Talk men out of facial surgery all the time, yeah.
Q And what's the nature -- well, how do you talk them out of it?
A Well, it kind of depends on the strength and the understanding that the person brings to the visit. Very often I recognize that I don't have enough of a friendly relationship with the person to where they would take such advice. So I'm not free to offer advice under those circumstances, but sometimes it's as simple as saying that I don't have the skills they are looking for.
Q And is that true?
A Largely. I suppose the fact that I haven't done a whole training program on penile inversion vaginoplasty, I've never been trained in that. So I would -- I would honestly say no, I'm not capable of that surgery. Or somebody who is seeking some radical change to their face, I don't do radical face surgeries other than reconstructions. So I would be perfectly

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truthful in saying "I don't have the skills to do what you're asking."
Q Okay. So why do you call those pastoral visits?
A Because I'm seeking to establish an emotional bond with the patient and try to understand what their sorrow is, what the origin of their sorrow is, what's going on in their life.
Can I give you an example? Woman comes to me seeking a breast augmentation, very common presentation. The examination would support doing a breast augmentation. But in getting into the reason for her visit, suddenly she's talking to me about how her husband is ignoring her, her husband doesn't have any interest in her. "If I have a breast augmentation it will save my marriage."
For me to affirm her in the idea that a breast augmentation is going to save her marriage would be an injustice, so I talk her out of it.
Q Do you ever incorporate religious content into this?
A I don't have to.
Q Do you ever?
A Sometimes I do with people I know from my parish who have problems like this and are happy to

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speak to me using the language of religion. But I generally don't run my practice using the language of religion, nor do I give opinions, medical opinions based on my religion. It's a separate thing.
Q So earlier we talked about Courage. I just want to go back to that one more time.
A Sure.
Q Does Courage provide any services -- well, strike that.
What is Courage's approach to individuals with gender discordance?
MS. LAND: Objection; asked and answered.
A So --
MS. LAND: And form.
A The only thing that would speak to that would be what you -- what you read earlier out of the Courage handbook is the recognition that there's an underlying reality. But Courage doesn't offer any interventions, nor any referrals, nor anything else, persons with transgender or gender identity issues or gender dysphoria.
Q (By Mr. Ossip) Does Courage have members experiencing gender identity issues?
A Let's see. I'm trying to think through everybody I know in Courage. It's such a huge group.

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No. It's almost entirely -- well, okay.
So Encourage does. Family members of persons experiencing gender dysphoria, the Encourage side does. But generally speaking people who are in the world of transitioning have no interest whatsoever in what Courage has to offer.
Q Okay.
A And we don't go seeking them or drag them off to some conversion. It's strictly supporting the family members who are struggling with it.
Q So earlier we talked about the presentation that you give on I believe it is transgenderism and Christian anthropology; is that correct?
A Correct.
Q And you mentioned you gave that about 40 to 50 times?
A I'm just ball -- I'm just guessing, you know.
Q Yeah.
A Virtually exclusively to church groups.
Q And in that presentation you talk about the medical issues related to gender transition treatments; correct?
A That's right.
Q Including those for minors?
A Yeah. So the discussion we have about minors,

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I -- you know, that sort of varies from one talk to another. The surgeries for minors is usually a discussion of top surgery, which is pretty much limited to a very small group of people. The majority of transgender stuff done with children is medical.

Q But your -- but that presentation goes beyond surgery; correct?

A Right. We discuss everything. Social transition, medical transition, and surgical transition in adults primarily. I discuss the range of surgeries that are offered to adults who are having affirmation care, affirmation surgery. So I get into the details of that because I find that the public has a great misunderstanding about what plastic surgeons are capable of, so I want the audience to understand what's actually happening and being presented as an actual sex change, which turns out to be typically a counterfeit front with complications.

Q You also discuss religious content in presentation; correct?

A To religious groups I do. Yes, I do.

Q So it's a mix of both; correct?

MS. LAND: Object to form.

A My presentations are a mix of both?

Q (By Mr. Ossip) Yeah.

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A Yeah. I would say the lion share of my presentations are to church groups, the only ones that have shown interest.

Q Okay.

A I haven't been invited by the American Society of Plastic Surgery to give a presentation on the moral problems of transgender surgery.

Q Were any other --

A Probably not going to happen, though. I have not.

Q And no other medical organization; correct?

A I'm trying to remember. Christian Medical and Dental Association. No, I haven't presented to them either, no.

Q Okay. Have you ever tried to help someone with gender dysphoria become comfortable with their biological sex?

A In terms of a therapeutic relationship with them.

Q In any way?

A Well, so for the example we have of the children, the one or two children that I have talked to in the parish library, it's been more -- and none of it has resolved by the way -- it's been more a conversation about seeking the origin of their anxiety.

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So, for example, in the one child that first comes to mind, she's undergoing a lot of anxiety over the fact that her father is sort of out of the picture because he devotes all of his time to taking care of her special needs sister. And it's possible that she's misinterpreting family dynamics there and thinking that her father is ignoring her because of her appearance. I don't know.

But that's an example of what I do. I don't try to change anybody's sexual identity. I try to understand what is the cause of their dysphoria.

Q And so it's only been one or two children that you have spoken to about this?

A Again, that's sort of a running total, but right now there is one or two, yeah.

Q How many total children with gender dysphoria have you spoken to in your lifetime?

A In my capacity as a doctor or in my capacity as a deacon?

Q In both.

A Well, as a doctor, maybe one or two. I don't know.

Q And that's in both capacities?

A No. In the deacon arena children, you know, the late-onset gender dysphoria thing, there's been

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three or four girls in the last two years alone, yeah.

Q Any other people you have spoken to in your capacity as a deacon?

A I don't think so.

Q And how many times did you meet with each of these people in your capacity as a deacon?

A Well, let's see. One of them I have met with three times. One of them I only got to meet one time. One of them maybe twice, three times maybe.

Q Okay. All right. So just changing topics a little bit again, have you ever been subject to any kind of professional discipline?

A No.

Q Nothing about a state medical board?

A Never.

Q No professional society?

A Never.

Q What about military discipline?

A Never.

Q No administrative actions?

A Never.

Q Summary proceedings?

A Never.

Q Okay. So you mentioned a couple instances of testimony. Have you ever been in court for any other

reason?
A Gosh, I remember trying to fight a traffic ticket in suburban Maryland one time.
Q Let's put aside traffic tickets. Any other reason you have ever been in court?
A No, no.
Q And earlier we talked about a child custody case.
A Right.
Q And you said you were testifying for the family; is that correct?
A Again, I would have to pull the -- my notes out and review them. But as I remember the situation it was a -- it is a family with a young girl in her mid teens who suddenly began identifying as a boy who was brought to the attention of the transgender clinic at the -- I believe it's the Cincinnati Children's Hospital. I would have to review my notes.
But in the course of receiving care at the Cincinnati Gender Clinic the parents resisted hormonal transitioning. And the clinic assisted the child, as I understand it the clinic assisted the child in seeking custody -- being transferred to the child's grandmother, I think it was, so that the grandmother could be the decisionmaker because the grandmother was all on board,



and so the parents lost custody of the child.
And as I -- again, I would have to review the notes. But as I recall the -- they were asking my opinion about the likelihood that that transitioning was going to resolve her problems. I think we had a discussion or presentation. Again, I would have to review the notes, but, again, that was the question they were asking.
Q And did you ever testify in that case?
A No.
Q And how old was the child in that case?
A I think when I was first contacted the child was in her mid to late teens. And I think the resolution of that was the child aged out of the whole process. And I don't know if she was an emancipated minor or and I think the litigation there is harms caused by to the family by the gender clinic.
Q So the family sued the gender clinic?
A I think that's what the situation is, yeah.
Q All right. So we're going to play you another portion of what's been marked as recording D for the purposes of this deposition.
(The video played and was later marked as Plaintiffs' Exhibit D.)
Q (By Mr. Ossip) And so that was you on a



recording?
A Yes, it was.
Q And you said on there that you had to give testimony in that case; correct?
A Well, I guess I misspoke. It was, I guess, an expert opinion.
Q So you submitted an expert report in that case?
A I think that's what happened in that case was an expert opinion submitted to the lawyers.
Q Okay.
A And I seem to have conflated it with another case in the news. It may have been in Texas where a father lost custody of his son who is in that age range of eight years old or nine years old.
Q Did you 2012 in that Texas case?
A No, no.
MR. OSSIP: Okay. All right. I think let's take another break.
VIDEO OPERATOR: Okay. We're off the record at 5:17 p.m.
(A break was had.)
VIDEO OPERATOR: We are back on the record at 5:30 p.m. Please proceed.
MR. OSSIP: Thanks, Mike. And thank you, Doctor.



Q (By Mr. Ossip) So, Doctor, you mentioned meeting with some of the children in your parish with gender dysphoria up to three times; is that correct?
A I think that's the most times I've met with any one of them.
Q And some of them you met with fewer times?
A Yeah. I can think of one right off the top of my head.
Q That you met with one time?
A Right.
Q And did you provide psychotherapy to these children?
A No.
Q Did you provide any other form of counselling?
A No, other than pastoral kind of discussion of what it means to suffer and how to bear suffering and what the possible meaning their suffering might have in their life. That's pretty much what that's about.
Q Did you share any of your understanding of the medical science of gender transition procedures?
A With the children, no.
Q What about with the parents?
A I might have answered pointed questions about is -- you know, is hormone therapy going to be good for my child kind of questions, but nothing beyond that.

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Those visits were pretty much pastoral in nature, yeah.
Q And how did you answer that question?
A That I would -- as I recall telling the mother that they should put off making any such decision.
Q And by that you mean not using --
A Not rushing to any decisions about hormone therapy.
Q And by that you mean not providing hormone therapy; correct?
A Right. Like if anybody is offering hormone therapy, delay.
Q Delay until when?
A Until you know more. Because my opinion at that point is if they know more they will be less likely to do it. I think I recommended them to read some articles, to -- let's see. There is some resources online.
I think I might have referred one of them to Erin Brewer's website because she's -- she's a person who lived that transgender experience as a child. I might have referred them to Walter Heyer's website for the parents to look at so they can understand kind of the arc of what happens to children when they are experiencing this kind of gender anxiety.
Q What articles did you refer them to?

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A It may have been something Walter Heyer may have written. It's been a while since that visit. That was over a year-and-a-half ago.
Q And was that all to the parents?
A Right.
Q You never provided any articles to the children?
A No.
Q Didn't refer them to any websites?
A No.
Q Looking to the children, did you -- during your conversations did you ever discuss Catholic teaching about gender transition?
A No.
Q What about with the parents?
A So the discussion with the parents may have been more difficult because they are a Spanish speaking family. The child speaks perfect English. The parents struggle with it and I would have a very hard time making any such conversation in Spanish.
Q Well, my question was with the parents did you discuss Catholic teaching about gender transition?
A I don't think so.
Q And you mentioned they were Spanish speaking. That applies to all three of the children we are

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discussing, the parents of all three of the children.
A Well, certainly the one -- let's see. The girl that I have seen about three times, yeah, her father speaks no English. Mother struggles with English. But she speaks perfect English. So my conversations with the parents would be mostly my broken Spanish to recommend sources of information like Walter Heyer and such like that.
Q Looking to the children, did you engage in prayer with them to help address their gender dysphoria?
A Well, did I try to pray them out of their dysphoria? No. Any time I meet with a child in the library or anywhere else, at the school or at the church, every such meeting always begins and ends with prayer. But as far as me praying over them to relieve that, that's not how I work.
Q What about with the parents?
A Similar thing, begin and end with prayer.
Q So earlier we talked about your presentations to church groups.
A Um-hum.
Q And those include a mixture of medical information and religious content; right?
A Right. The goal in those presentations almost always is for them to be conversant in the language and

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understand the medical issues so that they can speak intelligently to their friends, their peers, other people, and not be disturbed or surprised or angered or revulsed when they meet a person who is struggling with gender identity.
One of the problems in the Christian world, and like this guy on the radio, one of the problems in that world is a tendency for them to speak in words of revulsion and confusion and misunderstanding.
So when I talk to groups like that the very first thing I explain to them is that they have to be so conversant in things that nothing will repel them and they will never respond with anger or disgust, because if you do, you cannot make a friend. If you cannot make a friend, you cannot help anybody. So that's the beginning of very talk, so.
Q And you mentioned earlier that part of the reason why you continue to provide laser hair removal to your patient is so you can continue your friendship; is that correct?
A Right.
Q And why do you want to continue that friendship?
A I think because I have a hope that -- that they will value my opinion and see something in my life that

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they can trust.
Q And what opinion is it that you hope they will value?
A That I value them as a person and that I don't reject them as a person and that they may one day ask themselves, Why do I believe what I believe?
Q And what is it that you believe?
A I believe that the human person is a singular nature. I believe that we are binary in our construction, that that binary is ordered towards a unity that is a life giving unity and that informs my life as a physician and as a deacon.
Q And the reason why you're hoping that they ask themselves why you believe what you believe is because you hope that they will adopt that belief too; correct?
MS. LAND: Object to form, relevance.
A Well, I mean, I would -- I would love it if they did because I think that's where human happiness lies. But I also want them to trust me as a friend because what's very common and very likely in the -- in the life arc of persons who have this difficulty is you have a nearly 50/50 chance of experiencing some very dark time in their life when the transition is over and no one is interested any longer and they are alone and sorrowing, I don't want them to feel alone. I don't

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want them to feel as if there is nothing further to be done, I don't want them to kill themselves.
Q (By Mr. Ossip) So you mentioned going back to the parents of children that you had conversations with in your capacity as a deacon. You mentioned helping them find, was it a psychiatrist for their child?
A Psychological counselor. Usually children who are having these experiences are better served by family counseling. And so one of the things that's probably most necessary in a child having that experience -- and, I mean, the girl we were speaking about earlier, it's written all over her dynamic is there is a real conflict between her and her father and the way the mother mediates in that whole issue and how it alienates her daughter.
So for example her, I suggested some family counseling I think I found them a family counselor in Huntsville. But yeah, that's how it sits right now.
Q And how did you find that family counselor?
A I did a Google search looking for family counselors that would be convenient, who spoke Spanish. Because they need to be Spanish speakers to take care of that family.
Q Any other qualifications in that search?
A I generally will look for counselors that

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don't -- well, what was my search criteria there? In the family counseling side that's pretty much it. That's pretty much it. If they are a legitimate and qualified family counselor who can speak, and their kid is Spanish, that was enough for me.
Q And what makes them legitimate or qualified?
A Well, they have got the credentials of counseling, licensed social worker, counselor, family counselor. I don't fully understand the credentialing process on the counseling side of things. But I would hope that people who advertise themselves as family counselors are qualified to do this.
Q So you're just looking for whether they advertise themselves as a family counselor?
A Yeah. I don't remember exactly what I saw on that particular website, but my guess is there must have been some credential thing that they present. Most providers put their credentials on it.
Q Okay. And you mentioned three families. Did you assist all three of them in finding a family counselor?
A Well, so one of them was beyond family counseling because in this circumstance it was a young man who was at the very early stages of beginning a social transition and had not had any contact yet with

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any medical providers, but was absolutely resolute that this was the right thing to do. And that was kind of a heartbreaking visit.
He was even -- you know, that was -- so there was nothing I could offer, because there is nothing you can offer to somebody who is not interested in what you're offering. And he's beyond family counseling because he is already ignoring his parents and not in -- under their purview, no longer living at home. Basically, I think he was in his first semester of college.
Q So this was not a minor then?
A Seventeen years old. Seventeen, maybe going on 18, but 17.
Q And was in college?
A Just going off to college or might have been down there for a semester. It was one of those. A kid I recognized from around the parish.
Q And this 17-year-old began a social transition?
A Yeah, he was, he was. In his manner and his clothing and I think he had -- wore makeup, he wore a sort of a blousy-looking shirt. You can still call it a shirt, but it looked kind of blousy. I think he was wearing fingernails, wearing some facial makeup and definitely crafting his mannerisms to present himself as

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a more feminine side.
Q Do you classify this as late-onset gender dysphoria?
A In his case it would have been because I had never saw any sign of it. He was --yeah, it had to be late teens, obviously. This was -- the parents never said anything until he came back, I think, from his first semester in college as I recall. This was a while back.
Q And you said he wouldn't listen to his parents; correct?
A You could tell in the dynamic there that he was sort of wanting for his parents to be on his side. But, obviously, the reason they brought him to me was for him to hear the other side in terms of, you know, what's the outlook for you if you -- if you do hormonal transition, what's the outlook for you if you do gender transition.
Q And why was it heartbreaking?
A Because there is nothing I could offer. Here is a room full of people suffering and nothing I can offer.
Q Why was it obvious that that was the reason they brought him to you?
A Told me. They said, Doctor, I understand you know something about trans. My son is -- all of a

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sudden he's -- he's saying he's a woman. So I never turn away anybody who is in distress and so I said, Just plan to come by my office together and maybe we can talk, so they did. They showed up and we spent about an hour talking about things, but it went nowhere.
Q Did he want to be there?
A I think he wanted to be reconciled with his parents. I don't think he wanted to be there. I think his parents insisted that he come. And he, out of love for his parents, came. But I don't think he was there to listen to anything. He was just there out of love for his parents.
Q And you didn't refer him to any sort of care; correct?
A No.
Q Going back to the family counselor, did they -- do you know whether that family counselor supports gender-affirming care?
A I do not know.
Q Do you know whether they oppose gender-affirming care?
A No.
Q You never looked into it?
A It was not a criteria for me. It seemed to me that in her case the disorder in the family dynamics

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spoke for themselves quite apart from anything else going on in her life.
Q And so -- I'm sorry to jump around a little bit.
A No. That's okay.
Q For the 17-year-old, what did you tell them about hormone therapy?
A Well, what I usually -- since he would not have been a candidate for puberty blockade, he would have been right into cross-sex hormones I talked about the side effects and consequences of high dose estrogen in a man. We talked about hypertriglyceridemia, hypertension, metabolic syndrome, weight gain. We talked about life-long dependency on it. We talked about all of those issues and that it had some likelihood of leading on to surgery if he was still unhappy after receiving cross-sex hormones.
Q And did you include any discussion of Catholic teaching in that discussion?
A I don't think we did, because I didn't -- the vibe -- as I recall the vibe I was getting from that young man was he was not there to listen to church teachings. I think he was just there out of obedience to his parents and he was in a doctor's office. This was outside the parish. So he was sitting in an

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examination chair and we were having a conversation.
Q So, okay. Interesting. So but this was somebody that you knew through the church that brought their child to your physician's office for this discussion?
A Yeah. She approached me not as deacon Lappert, but Dr. Lappert, you know.
Q Was your goal to get him to -- strike that.
Was your goal to deter him from medical transition?
A I didn't have any expectation of that. I didn't have any expectation that the advice I was going to offer him was going to change the course of his life.
Q Well, putting aside your expectation, what was your objective?
A I think in that first visit it's to try to understand what's happened in his life that he all of a sudden and out of the blue would have such a change of heart about his life.
Q But you went through all the side effects of hormone therapy.
A Right, because towards the end of it he was pretty much talking about the fact that he is transitioning and so I just cautioned him, cautionary words about high-dose sex steroids.

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Q And why did you caution?
A Because I'm concerned about what's going to happen to his body if he takes high-dose sex steroids.
Q Because you didn't want him to take them?
MS. LAND: Object to form.
A Right, for medical reasons. Not, per se, for the transgender transition, but the fact -- basically cautioning him -- giving him the side of the conversation that he probably wasn't hearing, which is the consequences of high-dose sex steroids. I think he hadn't heard that. He seemed to be surprised in hearing it, but I don't think it had any effect.
Q So you mention going back or taking a step back, you mentioned a variety of discussions with children and families from your parish about gender dysphoria; correct?
A Right.
Q How many of those were at the church and how many were in your physician's office?
A The only one was in my physician's office was the one we just discussed.
Q All the rest were in the library?
A I'm pretty sure, yeah.
Q Okay.
A And all of those were basically deacon Lappert

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talking to parishioner child.
Q But the one in your office was Dr. Lappert.
A As I recall she specifically had approached me as Dr. Lappert.
Q And was that --
A I think that's the reason I asked to meet them at the office, because --
Q Was that consultation within the scope of your experience as a plastic surgeon?
A No. I was there just because of my knowledge of the subject and the parents just wanted me to talk. It was not a plastic surgical consultation. It wasn't a transitioning consultation. It was a visit with the hope of that child hearing some of the -- some of the difficulties he's going to encounter if he embarks on transitioning. So I --
Q Well, I mean, you said it was a medical visit; correct?
A That's what we talked about. That's all I had the chance to talk about.
Q And what type of medical visit was it?
A Just general visit to a doctor who knows about transgender medicine.
Q And you -- sorry. Go ahead, Doctor.
A No. Go ahead.

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Q And you consider yourself a doctor who knows about transgender medicine?
A I spend a lot of time studying and reading on it, yes, I have.
Q And that was since 2014; correct?
A Right.
Q And you feel qualified to provide care to patients seeking transgender medicine?
A No. But I -- I consider myself adequately qualified sort of at the primary care level to discuss medical risks with a family and a patient in the same way that I would discuss, you know, the risk of malignancy in a woman who has a family history of breast cancer. I'm not an oncologist, but I know enough about it that if I have concerns I can refer them to somebody I might trust.
So it's sort of at the primary care level, and that's kind of what that visit was. It was, sadly, not a very effective visit.
Q So that was a primary care visit; correct?
A Right, yeah, simple visit.
Q How many primary care visits do you typically do in a year?
A I do quite a few of them actually, because I run a skin care consultation service and I provide skin

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care services. And people will present with odd little things they don't know what to make of them. And, yeah, I've got quite an extensive experience in dermatology and I can read the difference between a malignancy and mole and a harbinger of some visceral disease.
So I'm an easy visit to somebody they know. And if I say, you need to see an endocrinologist, you need to see a dermatologist, you need to see somebody else I will make the referral for them.
Q And how many of those primary care visits involve patients presenting who are seeking gender transition?
A Some number approaching zero probably. I mean, these are just the patients we've talked about here. I don't have a practice in offering advice to transgender -- or gender dysphoric patients. I don't advertise it as a service. I don't present myself as an expert in that regard. I do express myself as a physician who has knowledge of the subject who can offer some guidance on it, but that's about the extent of it.
Q And you felt qualified to, in a medical capacity, have that visit with that patient; is that correct?
A Absolutely.
Q Do you consider that child a patient?

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A Not anymore, no.
Q But you did at that time?
A Anybody who comes to me I consider a patient. Whether or not that relationship develops, I always assume it's the beginning of a doctor-patient relationship.
Q Does that include the people who came to you at the church?
A Well, if they approach me as a deacon, no, I don't present myself as their doctor. I present myself as their deacon.
Q But you, nevertheless, discuss, for example, the medical consequences of hormone therapy?
MS. LAND: Object to form.
A The conversations I have had in the parish library have not been with children who were anywhere close to being offered hormonal therapy.
Q (By Mr. Ossip) But you've discussed it with their parents?
A No. Again, the Spanish speaking parents, I'm not conversant, fluent enough in Spanish to even have that discussion.
Q So you mentioned three families; correct?
A Three families, yeah.
Q So one we already discussed and that was you

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recommending they see a family counselor; correct?
A Right.
Q And the second one was the 17-year-old in your office, you didn't provide any recommendation at all.
A Well, I suppose you could -- it wasn't recommendation so much as caution.
Q But you didn't refer to any other provider?
A No.
Q And what about the third family, did you refer them to any other provider?
A I'm trying to remember. I know there is another child that I've seen a couple of years back. I would be hard-pressed to offer detailed information about that child.
I just remember having a conversation. I remember her being in eighth grade. And I remember her basically being sort of the doorstep of things because all of a sudden out of the blue she didn't want to wear girls clothes, cut her hair short, wanted to change her name. And I -- it was maybe one or two conversations in the parish library. Again, trying to plumb what happened in her life that would cause her to start thinking this way.
Q And did you have a conversation with the child's parents?

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A I believe the parents were in the room for that one.
Q Okay. Did you refer this child to any other --
A No, I didn't.
Q -- provider?
A I didn't refer her.
Q All right. And talking about the 17-year-old who was in your office, did you bill for that office visit?
A No, no.
Q Why not?
A Because of its informality and the fact that I don't -- I do lots of gratis visits for parishioners. It's just what I do.
Q Okay. But that was the only gratis visit for a person that involved gender transition?
A Right.
MR. OSSIP: Where are we at on time, Mike?
VIDEO OPERATOR: Let's see. Thirty-eight minutes.
MR. OSSIP: Okay.
Q (By Mr. Ossip) Doctor, would you describe your view on gender transition procedures as mainstream within the medical profession?

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A I would consider them common. That's hard to judge mainstream because of the silence that's out there. Mostly what you hear is that things like consensus statement of the Endocrine Society would have you believe that all endocrinologists believe it. Or consensus statement from the Pediatric Society that all pediatricians agree with this. And my experience is they don't all agree with it, but I just don't know how many of them agree with it.
Q But you have no idea one way or another?
A I have no idea.
Q And you have no idea how many doctors in the medical profession agree with you?
A I have no idea.
MR. OSSIP: All right. I think let's just take one more break now.
THE WITNESS: Sure.
VIDEO OPERATOR: Okay. We're off the record at 5:54 p.m.
(A break was had.)
VIDEO OPERATOR: We are back on the record at 6:02 p.m. Please proceed.
Q (By Mr. Ossip) All right. Give me one second, Doctor.
Doctor, have you ever recorded a podcast called

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"Transgenderism, a Surgeon's Perspective"?
A So that's not a podcast. That's a Light House Media CD. So, yes.
Q But it's a talk; correct?
A Correct.
Q Okay. I'm just gonna -- we're gonna play a minute of this. This has been marked as C, recording C for the purposes of this deposition.
(Audio recording was played and later marked as Plaintiffs' Exhibit C.)
MR. OSSIP: And that's your voice in this recording; correct, Doctor?
A Yes, it is.
Q And that's that Light House talk; is that correct?
A I believe that's correct, yeah.
Q All right. Doctor, do you have -- well, you have religious beliefs concerning gender transition. Is that fair to say?
A Yes, I do.
Q And what are those beliefs?
A That the human person is a single nature, that the mutilation of genitalia or otherwise bodily mutilation is a -- is a, from the religious perspective, is a sin against your bodily integrity. That pretty

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much would cover transgender.
Q And when does something rise to the level of mutilation?
A Well, so the intentional destruction of a structure like the breasts I would put in the category of mutilation. The intentional destruction of the native genitalia I would put in the category of mutilation. But the church considers mutilation including things like the division of the vas deferens in a vasectomy, are the tying of the fallopian tubes the church considers to be a mutilation.
Q What about facial feminization surgery?
A I don't believe anybody would consider that a mutilation.
Q Why not?
A Because you're not destroying function. You're just changing aesthetic contours. It's not a functional surgery. But the others are problematic because they destroy a function.
Q And do you think that -- that such a mutilation is a sin?
MS. LAND: Object to form and relevance.
A All right. So, again, I always make the distinction, I don't present the sin side of things when I'm talking about medical issues. But when religious

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issues come in, I do. When I offer an expert opinion like the one I've offered here I don't bring my religion into it. But in terms as a Catholic do I think that mutilation is a sin, yes.
MR. OSSIP: Sorry, just give me one second, Doctor. I apologize.
Sorry. Can we go off the record for one second?
VIDEO OPERATOR: Off the record at 6:06 p.m.
(A pause was had.)
VIDEO OPERATOR: We're back on the record at 6:07 p.m. Please proceed.
Q (By Mr. Ossip) Doctor, is it your view that performing gender transition procedures is against Catholic truth about the nature of a person?
MS. LAND: Object to form and relevance.
A Do I believe that gender transition procedures, surgeries are against -- I'm sorry.
Q (By Mr. Ossip) Yeah. Is it your view that performing gender transition procedures is against Catholic truth about the nature of a person?
A Yes.
Q Okay. In what way?
A Because it ignores the reality of the single

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nature of the human person.
Q And again, that reality of the single nature of a human person, that's not limited to Catholic teaching; correct?
A No. That's natural law. So the thing to understand about Catholic teaching when you're talking about these issues is that the foundation of all of it is natural law and that the -- the Catholic truth is basically just a -- the story of its perfection in eternity basically.
So you have to -- you have to understand and accept the nature of the human person if you're going to propose that that nature is going to be perfected by the grace of God. That's why it's an important issue in the Catholic church.
Q And what you're describing is natural law is also a predicate to the practice of medicine in our view?
A Very important predicate, exactly. Because if you get the natural truths, everything from body temperature to heart rate wrong, you're not going to treat them correctly.
Q And how does one determine natural law?
A Well, it's evident. One studies nature. So you study the nature of the human person and it includes

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things like taking their pulse and taking their temperature and doing all those things that medicine has been involved in for the last thousand years and you come to an understanding of it, just as -- and that understanding changes with time.

Particularly in the area of reproduction, it's changed a lot in the last 100 years. But, yeah, you -- it's the study of the nature of the human person. That's what science is about, the study of nature, philosophy of nature, the philosophical sciences.

Q Well, is natural law a predicate to science or is science a predicate to natural law?

MS. LAND: Object to form.

A I'm not sure I understand what you mean by predicate.

Q (By Mr. Ossip) Well, do you use science to determine natural law or does natural law determine the course of science?

A You use the scientific method to study natural law, but the scientific method itself is based on the idea of natural law, because that revolution that happened in the 12th and 13th century was the recognition of the fact that what you measure today will be the same tomorrow and that you can come to understand things because of their repeatability, their constancy.

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Which in the -- in the Catholic world view is speaking to the unchanging nature of God. Right? No shadow of turning in him.

So -- so that was the foundation of science. So science is based on the study of the natural world. And the recognition of the scientific method begins with recognizing that the natural world is regular, orderly, logical, repeatable, all of those things. So it's a both/and I think is the more correct way to look at that philosophically.

Q And that there is unchangeable truths?

A There are unchanging truths, yeah.

Q And that includes biological sex?

A Yes.

Q And that includes gender?

A No. Gender seems to be a very fluid thing because the subjective life of a person is a very fluid thing. Gender is in the category of the person's subjectivity. And the real Christian story is the subjectivity of the human person is where all the trouble comes from. Right, yeah.

So, yeah, the unchanging things, obviously in the absence of disease or harm or things like that, then changing things are the observable, the measurable, those sorts of things. And diagnoses that lead to surgery and medical care rely on that, obviously, very heavily.

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And so the natural law, for example, spills over into the truth, the -- actually, the scientific objective truths of the human body and how the body responds to influences of medications and hormones and trauma and all those other things.

Q And -- okay. I think -- I'm just going to check my notes. Give me one second, Doctor.

A Sure.

Q Let me ask one more actually.

Doctor, are you familiar with something called the GRADE approach?

A The what approach?

Q The -- well, are you familiar with Grading of Recommendations, Assessment, Development and Evaluation?

A Oh, I see. That's a -- I've never heard those terms. I used SOAP approach when I was learning diagnostic and evaluation or the HPI approach. But I -- is that GRADE approach, is that a psychiatric process?

Q I'm just asking, are you familiar with the GRADE approach?

A I've never heard it.

MR. OSSIP: Okay. All right. I think that's all I have. Thank you, Doctor, for your time and

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for hanging out with us today.

THE WITNESS: Sure.

MR. OSSIP: And with that I'll pass the witness.

EXAMINATION

BY MS. LAND:

Q Dr. Lappert, did any of the questions asked by Mr. Ossip change your opinions that you have previously given in this case?

A No.

Q A lot has been asked of you of your religious views today. Are any of the opinions that you gave as an expert in this case based upon any of the religious views you have testified to today?

A No.

MR. OSSIP: Objection to form.

A No. My expert opinion and my testimony today is informed by my knowledge of the science and my experience as a physician-surgeon.

Q (By Ms. Land) Were any of the recordings played for you today, specifically recordings, A, B, D, E, F and C, in which you heard yourself speaking given in your capacity as a medical doctor?

A They were given in my capacity as deacon and surgeon together, yes, so.

Q Were you giving any of those recordings -- or excuse me.

Were you speaking in any of those recordings in your capacity of giving consultation to any patients?

A No.

MR. OSSIP: Objection to form.

MS. LAND: No further questions.

MR. OSSIP: Can you give us one minute, please?

VIDEO OPERATOR: You want to go off the record?

MR. OSSIP: Yeah.

VIDEO OPERATOR: Okay. We're off the record at 6:16 p.m.

(A pause was had.)

VIDEO OPERATOR: We're back on the record at 6:16 p.m. Please proceed.

MR. OSSIP: All right, Doctor. I just want to once again, thank you for your time with us and I have no more questions for you.

THE WITNESS: Thank you.

VIDEO OPERATOR: Okay. This concludes today's testimony given by Dr. Patrick Lappert. The total number of media used was six, which will be retained by Veritext. And we are going off the record



at 6:16 p.m.

(A discussion was had off the record.)

MS. LAND: Okay. I would just like us to go on the record on behalf of Dr. Lappert and say that we would like to review and sign.

(Deposition concluded.)



C E R T I F I C A T E

I, Trena K. Bloye, Certified Shorthand Reporter within and for the state of Oklahoma, certify that PATRICK WALTER LAPPERT, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, in the case aforesaid; that the witness chooses to read and sign the deposition; that the above and foregoing videotaped deposition was taken by me in shorthand and thereafter transcribed; that the same was taken on May 6, 2022, at 9:04 a.m., at the Arkansas Attorney General's Office, 323 Center Street, Suite 200, Little Rock, Arkansas, that I am not an attorney for, nor a relative of any of said parties or otherwise interested in the event of said action.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal this 18th day of May, 2022.

Trena K. Bloye, CSR
State of Oklahoma CSR No. 1522



AMANDA LAND, ESQ.
aland@arkansasag.gov
May 20, 2022
RE: BRANDT, et al. vs. RUTLEDGE, et al.
5/6/2022, Patrick W. Lappert (#5163564)

The above-referenced transcript is available for review.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason, on the attached Errata Sheet.

The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at erratas-cs@veritext.com.

Return completed errata within 30 days from receipt of testimony.

If the witness fails to do so within the time allotted, the transcript may be used as if signed.

Yours,
Veritext Legal Solutions

BRANDT, et al. vs. RUTLEDGE, et al.
5/6/2022 - Patrick W. Lappert (#5163564)

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Patrick W. Lappert Date



BRANDT, et al. vs. RUTLEDGE, et al.
5/6/2022 - Patrick W. Lappert (#5163564)

ACKNOWLEDGEMENT OF DEPONENT

I, Patrick W. Lappert, do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

_____ _____
Patrick W. Lappert Date
*If notary is required

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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