

**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.	:	
-----	X	

OPPOSITION TO DEFENDANTS’ MOTION IN LIMINE

This case is a challenge to HB 1570 (the “Healthcare Ban” or “Ban”), which prohibits gender-affirming medical care for adolescents with gender dysphoria. In defending the Ban, Defendants claim that the Legislature passed it to protect minors against ineffective and dangerous medical care. Defendants have expert witnesses who offer opinions in support of their characterization of the banned medical care, and lay witnesses who say they were harmed by receiving gender-affirming medical care.

The evidence at trial will show, among other things, that the Ban does not further the State’s claimed interest in protecting minors. The medical care that the law proscribes is safe and effective treatment for adolescents with gender dysphoria, and, to the contrary, the Ban jeopardizes the health of transgender adolescents by denying them healthcare that they need. In addition to establishing these facts at

trial, Plaintiffs' cross-examination of Defendants' expert witnesses will show that their opinions about gender-affirming medical care are based on something other than those experts' assessment of the scientific evidence—namely, their personal beliefs about gender transition and LGBT people. Plaintiffs also intend to cross-examine Defendants' lay witnesses to show that the harm they attribute to receiving gender-affirming medical care is grounded in their personal disapproval of being transgender, which is based on their religious beliefs. As an alternative basis to invalidate the Healthcare Ban, Plaintiffs' cross-examination of Defendants' witnesses will show that the Legislature enacted the law based on the impermissible purpose of disapproval of transgender people, which includes presenting testimony of the lead sponsor of the Ban about her own and other legislators' personal disapproval of being LGBT. This is proper cross-examination intended to elicit material information relevant to the Court's determination of the important constitutional rights at stake here.

Defendants now seek to insulate their witnesses from cross-examination and deny the Court this critical information by moving to bar Plaintiffs from eliciting testimony showing that some of Defendants' experts' opinions in this case are inextricably intertwined with their personal beliefs about LGBT people and the propriety of gender transition. Defendants also seek to conceal critical parts of their lay witnesses' stories—that the harms those witnesses perceived were not based on

the medical care they received—but rather that they came to believe that being transgender was at odds with their religious beliefs. Relatedly, Defendants seek to prevent Plaintiffs from presenting evidence that the Legislature, in passing the Ban, acted based on the impermissible purpose of disapproval of LGBT people. All of this testimony is highly relevant to and probative of the claims and defenses in this case, and is admissible as it is not being offered for any improper purpose.

In addition, Defendants seek to exclude the testimony of Defendants Amy Embry—Executive Director of the Arkansas Medical Board (“Board”) and the Board’s designated representative under Federal Rule of Civil Procedure 30(b)(6)—and Dr. Rhys Branman—a physician and Board member—claiming that their testimony constitutes impermissible lay opinion, is irrelevant, is speculative, and, with respect to Dr. Branman, is cumulative. Not so. Defendants point to nothing that would constitute impermissible lay opinion, and fail to justify their claims that Ms. Embry’s and Dr. Branman’s testimony is either irrelevant or speculative—an objection that, to the extent not raised in those witnesses’ depositions, Defendants waived.

Finally, Defendants’ request for a blanket exclusion of any evidence or witness not disclosed during discovery is premature and inconsistent with Eighth Circuit case law. *See Martinez v. Union Pac. R.R. Co.*, 82 F.3d 223, 227 (8th Cir. 1996).

ARGUMENT

I. THE EVIDENCE OF DEFENDANTS’ WITNESSES’ AND LEGISLATORS’ PERSONAL BELIEFS ABOUT LGBT PEOPLE, INCLUDING THOSE BASED ON RELIGIOUS BELIEFS, IS RELEVANT AND ADMISSIBLE.

Defendants seek to exclude any testimony about legislators’ and Defendants’ expert and lay witnesses’ personal disapproval of LGBT people, including transgender people, and gender transition. And they specifically seek to exclude any testimony about those topics that is based on witnesses’ religious beliefs. Defendants’ motion to bar relevant and admissible evidence should be denied.

A. The Evidence of Witnesses’ Personal Beliefs About LGBT People Is Relevant and Admissible.

Federal Rules of Evidence (“FRE”) 401 and 402 provide that “relevant evidence is admissible” at trial, and that “evidence is relevant if it has a tendency to make a fact more or less probable than it would be without the evidence and the fact is of consequence in determining the action.” Defendants’ absurd claim that “[t]estimony and evidence of any personal beliefs of a party or witness regarding individuals who are gay, lesbian, bisexual, or transgender” (*Brief in Support of Motion* in Limine, ECF 165 (“Brief in Support”) at 5) are irrelevant in this case challenging a law banning gender-affirming medical care for transgender minors should be denied.

Evidence showing that Defendants’ experts’ opinions are grounded in

personal beliefs about LGBT people rather than science is highly relevant to the Court's assessment of the reliability of that evidence. Plaintiffs intend to present evidence showing that for some of Defendants' experts, their scientific opinions are inextricably intertwined with their personal religious beliefs about LGBT people.

Similarly, evidence showing that Defendants' lay witnesses' asserted harms of undergoing gender-transition treatment—anecdotal evidence that would have no relevance to this case in the first instance—are based on their belief that being LGBT is wrong. Defendants' motion suggests that Defendants intend to call two lay witnesses who have detransitioned to support Defendants' assertion that medical transition results in serious harm, including “post-transition regret.”¹ Plaintiffs must be able to present evidence that their experience of harm is based not on anything problematic about this medical care or how it was provided but, rather, their personal disapproval of being transgender, which is based on their religious beliefs. The evidence Plaintiffs seek to introduce will show that both of these witnesses detransitioned after religious experiences and coming to believe that living

¹ (E.g., *Defendants' Combined Brief in Opposition to Plaintiffs' Motion for Preliminary Injunction; and Reply in Support of Defendants' Motion to Dismiss*, ECF 44 at 19–20 (“If adults like Mr. Burleigh . . . and Ms. Perry—all of whom could trace their gender dysphoria to a young age, and for whom their dysphoria persisted into adulthood—can find themselves regretting their gender-transition procedures and detransitioning years later, it seems all the more likely that adolescents, with their reduced capacity to consider long-term consequences, will often regret these procedures later in life.”).)

as a transgender person is inconsistent with their religious beliefs. Even if the anecdotal experience of two people could constitute evidence to support the harms Defendants claim, their experience of harm based on personal disapproval of being transgender does not.

Finally, evidence about legislators' personal disapproval of LGBT people is relevant to Plaintiffs' assertion that the Legislature acted based on disapproval of the class affected by the law, which violates any level of equal protection scrutiny. *See U.S. Dep't of Agric. v. Moreno*, 413 U.S. 528, 533–34 (1973); *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 441 (1985). Plaintiffs intend to present evidence that both chambers of the Legislature passed resolutions expressing their view that “gender reassignment medical treatments” are not “natural,” as well as statements from individual legislators expressing their disapproval of transgender people. (*Memorandum in Support of Plaintiffs' Motion for a Preliminary Injunction*, ECF 12 at 45 (citing HR 1018, 2021 Gen. Assemb., Reg. Sess. (Ark. 2021); SR 7, 2021 Gen. Assemb., Reg. Sess. (Ark. 2021)); *id* at 45 n.17 (citing S. Floor Debate, 2021 Gen. Assemb. 93rd Sess., Mar. 10, 2021 at 2:19:08, <https://sg001-harmony.sliq.net/00284/Harmony/en/PowerBrowser/PowerBrowserV2/20210310/-1/21305>; *id.* at 2:24:59).) Further, Plaintiffs intend to present testimony of the primary sponsor of the Healthcare Ban, Rep. Robin Lundstrum, showing that the Ban was part of a broader effort by the Legislature to

pass laws targeting transgender people and that she and other legislators were pursuing this legislative agenda based on personal religious beliefs about LGBT people and gender transition. There is no basis to deny Plaintiffs the opportunity to present evidence demonstrating an impermissible legislative purpose.²

B. Evidence of Religious Beliefs Is Admissible for Any Purpose Other Than Attacking or Supporting a Witness's Truthfulness.

1. *The Court Should Deny Defendants' Request to Bar Relevant Evidence Under FRE 610.*

Defendants seek to exclude “any statements, testimony, evidence, or argument regarding the religious affiliations, practices, beliefs, or customs of any party or witness” based on FRE 610, which says that “[e]vidence of a witness’s religious beliefs or opinions is not admissible to attack or support the witness’s credibility.” (Brief in Support at 2.) There is no legal basis for Defendants’ sweeping request to exclude relevant evidence at trial.

As Defendants acknowledge, FRE 610 only prohibits using evidence of

² Defendants’ claim that “there is absolutely no way in which the Defendants’ liability can be predicated on any witness’s views toward gay, lesbian, bisexual, or transgender individuals” (Brief in Support at 6), but that is not the relevant standard. Witnesses’ personal beliefs about LGBT people are highly relevant and probative of the claims and defenses in this case—specifically, whether the Defendants’ defense is grounded in medical science as they say.

Further, given the relevance of such evidence and testimony to Plaintiffs’ claims, there is no basis whatsoever for Defendants’ assertion that “[i]nquiries into the Defendants’ personal beliefs about individuals who are gay, lesbian, bisexual, or transgender . . . would be solely for the purposes of harassment and undue embarrassment.” (Brief in Support at 6.) This evidence has nothing to do with embarrassment and everything to do with Plaintiffs’ ability to prosecute their claims.

a witness's religious beliefs for the narrow purpose of attacking a witness's credibility, not for all purposes. (*See id.* at 2); Fed. R. Evid. 608 Advisory Committee's Notes to 1972 proposed rules. And, here, the term "credibility" refers to a witness's character for truthfulness or untruthfulness. Fed. R. Evid. 608 Advisory Committee's notes to 2003 amendments (FRE 610 "use[s] the term 'credibility' when the intent of [that] Rule[] is to regulate impeachment of a witness' character for truthfulness"). "[A]n inquiry for the purpose of showing interest or bias because of [religious beliefs] is not within the prohibition." Fed. R. Evid. 608 Advisory Committee's notes to 1972 proposed rules. Nor is an inquiry for the purpose of determining whether an expert witness's opinions are based on science, rather than his or her religious beliefs, contextualizing a lay witness's testimony, or assessing whether the legislature's stated purpose for enacting a law is pretextual.

Courts routinely admit evidence of a witness's religious beliefs when used for a purpose other than his or her character for truthfulness. *See, e.g.,* Wright & Miller, *Rule 610, Religious Beliefs or Opinions: Scope*, 28 Fed. Prac. & Proc. Evid. § 6153 (collecting cases and noting that "Rule 610 is inapplicable when such evidence is offered for any other purpose, even if it impacts credibility in some other way"). For example, in *Firemen's Fund Insurance Co. v. Thien*, a decision on which Defendants purport to rely, the Eighth Circuit held that evidence of church membership and close relationships with religious leaders was "properly admitted

for the purpose of showing that [witnesses] may have been biased in favor of [the defendant] through their religious affiliation with him.” 63 F.3d 754, 760–61 (8th Cir. 1995). Likewise, in *United States v. Miller*, the Sixth Circuit held that testimony concerning the “Supreme Mathematics” system employed by a religious group affiliated with the Nation of Islam was admissible because it “explain[ed] the context of a code” used by the defendants to order drugs, “a relevant fact at trial.” 562 F. App’x 272, 302–03 (6th Cir. 2014); *see also Scott v. Am. Baptist Seminary of the W.*, 902 F.2d 40, 40 (9th Cir. 1990) (evidence of religious beliefs admissible in sex discrimination case against seminary because evidence of “inflexibility in religious matters . . . was highly probative of [] reasons for finding [plaintiff] unfit for the ministry (in any denomination) and dismissing her from the Seminary”).³

Here, Plaintiffs are entitled to explore fully, among other things, whether Defendants’ expert witnesses’ opinions are based on something other than an assessment of the science—*i.e.*, personal religious beliefs; whether Defendants’ lay witnesses’ experience of harm from gender transition treatment was due to their

³ *See also United States v. Beasley*, 72 F.3d 1518, 1527 (11th Cir. 1996) (“evidence [of religious teachings] admitted was highly relevant to the jury’s understanding of the existence, motives, and objectives of the RICO conspiracy The evidence regarding the religion was relevant, because religious teachings were used to justify, rationalize, and promote crime.”); *United States v. Hoffman*, 806 F.2d 703, 708–10 (7th Cir. 1986) (admitting evidence of defendant’s affiliation with Reverend Sun Yung Moon because “evidence as to Hoffman’s religious affiliation established a possible motive for his sending the letter [threatening the life of President Reagan] which was probative of whether Hoffman intended the letter to constitute a ‘true threat.’”).

personal religious disapproval of being transgender; and whether the legislature's purpose in enacting the Healthcare Ban was improper.

Defendants' reliance on *Jackson v. Allstate Insurance Co.*, 785 F.3d 1193, 1202–03 (8th Cir. 2015), and *Firemen's Fund Insurance Co. v. Thien*, 63 F.3d 754, 760–61 (8th Cir. 1995), is misplaced. In *Jackson*, the Eighth Circuit considered whether “the district court erred by entering a pretrial order that excluded [the plaintiff's] character witnesses,” not the admissibility of evidence of a witness's religious beliefs. 785 F.3d at 1202–03. Nothing in *Jackson* supports Defendants' request to hamstring Plaintiffs at trial by barring any evidence of witnesses' religious beliefs regardless of the purpose for which it is offered.

Likewise, Defendants misstate the holding of *Thien* by claiming that it stands for the proposition that “[t]he Eighth Circuit has identified mere membership in a religion as a narrow circumstance in which religious views may be admissible under Rule 610 to show bias.” (Brief in Support at 4.) Far from creating a narrow exception to FRE 610, the Eighth Circuit held that evidence of witnesses' religious beliefs was “properly admitted for the purpose of showing that [those witnesses] may have been biased in favor of [the defendant] through their religious affiliation with him.” 63 F.3d at 761. To the extent the Court excluded any evidence of the witnesses' religious beliefs, it did so based on the narrow exception in FRE 610, explaining that it “fail[ed] to see the relevance of this issue [of the religion's tenet

against participation in civil litigation] to the instant case,” and that “[t]he reasons why [the witnesses] did not join the wrongful death action . . . do not add to a showing of bias, and appear to be an attempt to undermine [their] credibility.” *Id.* at 761.

2. *The Court Should Deny Defendants’ Request to Bar Relevant Evidence Under FRE 403.*

Defendants’ objection to the admission of “any testimony or other evidence of any religious views” based on FRE 403 is similarly meritless. (Brief in Support at 5.) Under FRE 403, courts “may exclude relevant evidence if its probative value is substantially outweighed by a danger of . . . unfair prejudice.” Here, contrary to Defendants’ claim that “[r]eligion does not provide any necessary context to the acts of the Defendants,” such evidence is probative of Plaintiffs’ claims and Defendants’ defenses, for the reasons described *supra*, Section I.B.1. Likewise, Plaintiffs do not seek to “predicate liability of any Defendant on another witnesses’ [sic] religious beliefs,” as Defendants claim. (Brief in Support at 5.) The issue is only whether the evidence is relevant, and it is. *See supra*, Section I.A.

Defendants do not even attempt to explain how the evidence they seek to keep the court from hearing could be unfairly prejudicial, as they must to justify its exclusion. The closest Defendants come is to suggest that inquiring into witnesses’ religious beliefs at trial could “paint the witnesses as religious extremists.” (Brief in Support at 5.) But that is not the purpose of Plaintiffs’

intended use of this evidence. As the Eighth Circuit has recognized, “evidence is not unfairly prejudicial merely because it hurts a party’s case.” *United States v. Emeron Taken Alive*, 262 F.3d 711, 714 (8th Cir. 2001) (citing *Cummings v. Malone*, 995 F.2d 817, 824 (8th Cir. 1993)).

Lastly, any risk of prejudice here is grossly overstated as the Court, not a jury, will consider the evidence and resolve Plaintiffs’ claims at trial. *See Gulf States Utils. Co. v. Ecodyne Corp.*, 635 F.2d 517, 519 (5th Cir. 1981) (noting that this provision of FRE 403 has “no logical application to bench trials”); *United States v. Kienlen*, 349 F. App’x 349, 351 (10th Cir. 2009) (“Other circuits have held, and we agree, that excluding evidence in a bench trial under ‘Rule 403’s weighing of probative value against prejudice [is] improper.’”); *United States v. Lim*, 57 F. App’x 701, 704 (7th Cir. 2003) (“Finally, we reject Lim’s Rule 403 claims, which are inapposite in a bench trial, where there is no risk of jury prejudice.”); *United States v. Hall*, 2000 WL 32010 (6th Cir. Jan. 4, 2000) (“In bench trials, the application of the unfair prejudice portion of Rule 403 has been seen as an unnecessary and ‘useless procedure.’”); *Schultz v. Butcher*, 24 F.3d 626, 632 (4th Cir. 1994) (In bench trials, “evidence should not be excluded under 403 on the ground that it is unfairly prejudicial.”).

3. *Defendants’ Request Cannot Be Justified Under FRE 404(a) and 611.*

Defendants’ request to bar relevant evidence of witnesses’ religious

beliefs cannot be justified under FRE 404(a), which prohibits using “[e]vidence of a person’s character or character trait . . . to prove that on a particular occasion the person acted in accordance with the character or trait,” or under FRE 611, which counsels courts to “protect witnesses from harassment or undue embarrassment.” FRE 404(a) does not apply because Plaintiffs seek to introduce evidence regarding witnesses’ religious beliefs for proper purposes, such as showing that Defendants’ experts’ opinions are based on something other than science; that Defendants’ lay witnesses’ claims of harm tied to gender-affirming medical care are based on religious disapproval of being transgender; and that the legislature acted based on the impermissible purpose of disapproval of transgender people. Thus, the Court should not credit Defendants’ claim based on FRE 611 that “[a]ny reference to religion is merely an attempt to embarrass, harass, and annoy parties and witnesses.” (Brief in Support at 5.)

II. THERE IS NO JUSTIFICATION FOR PRECLUDING TESTIMONY OF DEFENDANTS EMBRY AND BRANMAN.

Defendants seek to exclude the testimony of Defendants Amy Embry and Dr. Rhys Branman, claiming that their “interpretation of the [Healthcare Ban] and other laws, as well as their opinions on the interpretation of state agency actions and regulations” “do not meet the relevance and reliability standards under the Federal Rules of Evidence.” (Brief in Support at 7.) Defendants’ argument is three-fold: (1) Ms. Embry’s and Dr. Branman’s testimony is inadmissible because they

testified that “with respect to any legal issues, they would consult the attorney for the Board”; (2) “[t]here is no evidence [Ms. Embry or Dr. Branman] . . . had any involvement in the [Healthcare Ban], and therefore their personal views are irrelevant”; and (3) testimony about “how the Board as a whole, or another individual Board member, may act in the future” is “speculative.” (*Id.* at 8.) None of these arguments has merit.

First, without identifying any specific testimony, Defendants claim that the testimony of Ms. Embry and Dr. Branman constitutes impermissible lay opinion testimony based on “scientific, technical, or otherwise specialized knowledge.” Fed. R. Evid. 701(c). Statements that they would “consult the attorney for the Board” about any legal issues do not transform their testimony into impermissible legal opinion (*see* Brief in Support at 7–8), particularly given that ultimate decision-making authority rests with the Board. *See* HB 1570 § 3, ARK. CODE ANN. § 20-9-1504(a). Further, as Defendants with years of experience on the Board, both Ms. Embry and Dr. Branman have personal knowledge of the Board’s processes. *See, e.g., Burlington N. R.R. Co. v. Nebraska*, 802 F.2d 994, 1004–05 (8th Cir. 1986) (“Personal knowledge or perception acquired through review of records prepared in the ordinary course of business, or perceptions based on industry experience, is a sufficient foundation for lay opinion testimony.”). And as the Board’s Executive Director and designated representative under Federal Rule of Civil

Procedure 30(b)(6), Ms. Embry was required “to give complete, knowledgeable, and binding answers on its behalf” about “information known or reasonably available to the organization,” *Lee v. Nucor-Yamato Steel Co.*, 2008 WL 4014141, at *3 (E.D. Ark. Aug. 25, 2008) (quoting Fed. R. Civ. P. 30(b)(6)), including the Board’s beliefs with respect to the Healthcare Ban and the Board’s “understanding of its obligations and policies” if the Healthcare Ban goes into effect. *Hopman v. Union Pacific R.R.*, 2021 WL 2694236, at *14 (E. D. Ark. Jun. 30, 2021) (overruling objection to 30(b)(6) testimony about legal issues because “designated Rule 30(b)(6) witness [] may testify about [entity’s] understanding of its obligations and policies”). As Defendants are aware, “[a]n *adverse* party may use *for any purpose* the deposition of a party or anyone who, when deposed, was the party’s officer, director, managing agent, or designee under Rule 30(b)(6) or 31(a)(4).” *Hopman*, 2021 WL 2694236, at *14 (quoting Fed. R. Civ. P. 32(a)(3)) (emphasis in original); *Wal-Mart Stores, Inc. v. Cuker Interactive, LLC*, 2017 WL 1391457, at *4 (W.D. Ark. Apr. 6, 2017) (“[A] corporate witness does not necessarily have to be expert-qualified in order to offer lay opinion under Fed. R. Evid. 701” to testify about legal matters.).

Second, Ms. Embry’s and Dr. Branman’s personal views are relevant to understanding how the Board approaches enforcement, as well as the relationship between the legislature’s stated interest and the Healthcare Ban. As Ms. Embry testified, the Board members’ personal views inform the Board’s decisions, such as

whether to investigate complaints of “failing to comply with accepted medical practices.” (See Exhibit 1, *Deposition Transcript of Arkansas Medical Board: Amy Embry 30(b)(6) Representative* (“Embry Dep. Tr.”) at 82:4–10.) Thus, as a member of the Board charged with enforcing the Healthcare Ban, Dr. Branman’s personal views are highly relevant to assessing the harm that would result if the Healthcare Ban were to go into effect. (See, e.g., Exhibit 2, *Deposition Transcript of Dr. Rhys Branman* (“Branman Dep. Tr.”) at 110:4–112:6 (testifying that it would “violate [a] doctor’s ethical obligations to not seek an alternative provider for the treatment that has already been started”).) Likewise, Ms. Embry’s and Dr. Branman’s views on whether and how gender-affirming care is treated differently than other types of state-regulated medical care is highly relevant given that Plaintiffs assert an Equal Protection Claim. (See Exhibit 1, Embry Dep. Tr. at 116:13–21, 136:18–137:20.)

Third, as the entity responsible for enforcing the Healthcare Ban, the Board’s understanding of the statute, how it would approach enforcement, and whether there are any other policies, procedures, or regulations that would affect the Board’s enforcement are highly relevant to Plaintiffs’ claims. See HB 1570 § 3, ARK. CODE ANN. § 20-9-1504 (a) (“Any referral for or provision of gender transition procedures to an individual under eighteen (18) year[s] of age is unprofessional conduct and is subject to discipline by the appropriate licensing entity or disciplinary review board with competent jurisdiction in this state.”). And to the

extent Defendants seek to exclude relevant testimony as “speculative” or not based on personal knowledge (Brief in Support at 8), such objections are waived to the extent Defendants did not raise them at Ms. Embry’s or Dr. Branman’s depositions. Fed. R. Civ. P. 32(d)(3)(B)(ii); *see Sec. Nat. Bank of Sioux City, Iowa v. Abbott Lab’ys*, 299 F.R.D. 595, 601 (N.D. Iowa 2014), *rev’d on other grounds sub nom. Sec. Nat. Bank of Sioux City, IA v. Day*, 800 F.3d 936 (8th Cir. 2015) (“[F]orm objections refer to a category of objections, which includes objections to . . . lack of personal knowledge . . . [and] speculation . . .”).

III. THE PROBATIVE VALUE OF DEFENDANT DR. BRANMAN’S TESTIMONY IS NOT SUBSTANTIALLY OUTWEIGHED BY THE DANGER OF BEING NEEDLESSLY CUMULATIVE.

FRE 403 allows courts to “exclude relevant evidence if its probative value is substantially outweighed by a danger of . . . needlessly presenting cumulative evidence.” Defendants ask the Court to exclude the testimony of Dr. Branman because, they claim, “his testimony is cumulative, repetitive, unnecessary, and not admissible.” (Brief in Support at 9–10.) Defendants do not even attempt to explain how the testimony of Dr. Branman, which Plaintiffs pursued after Ms. Embry repeatedly responded to Plaintiffs’ questions at her deposition by directing Plaintiffs to the members of the Arkansas State Medical Board (*see, e.g.*, Exhibit 1, Embry Dep. Tr. at 82:4–10, 149:19–150:15, 152:17–153:14, 159:25–160:6, 162:25–163:12, 170:6–170:19, 173:16–173:25, 209:25–210:9), overlaps with

that of Ms. Embry, much less could be considered “needlessly cumulative.” Fed. R. Evid. 403; (*see also* Brief in Support at 10). Instead, Defendants claim that “Dr. Branman has no personal knowledge of the [Healthcare Ban]” (Brief in Support at 10), an objection that has no bearing on whether the probative value of Dr. Branman’s testimony, as a member of the entity responsible for enforcing the Healthcare Ban, is substantially outweighed by the danger of presenting cumulative evidence. Fed. R. Evid. 401, 402. Because Defendants come nowhere close to meeting the relevant standard under FRE 403, their motion to exclude Dr. Branman’s testimony should be denied.

IV. DEFENDANTS’ MOTION TO BAR TESTIMONY AND EVIDENCE NOT DISCLOSED DURING DISCOVERY IS PREMATURE.

Defendants’ request to exclude “witnesses and evidence at trial that [Plaintiffs] did not previously disclose to Defendants” (Brief in Support at 9) is premature. Defendants claim that they “will be unfairly prejudiced and surprised at trial if Plaintiffs are permitted to call witnesses and produce exhibits not identified” (Brief in Support at 9), but Defendants do not (and cannot) point to any specific witnesses or evidence that they seek to exclude on this basis.

Defendants cite *Admiral Theatre Corp. v. Douglas Theatre Co.*, 585 F.2d 877 (8th Cir. 1978), a factually distinguishable case, where the Eighth Circuit affirmed the district court’s evidentiary rulings in light of “the procedural history and factual setting of the case.” *Id.* at 896. Specifically, the Eighth Circuit noted

that “the district court excluded the exhibits because of noncompliance with its pretrial orders only after repeated[] warning[s]” and “modifying its orders to accommodate the plaintiffs’ requests for more time,” and refused to let a previously undisclosed witness testify, in part, “because he refused to let the defendants examine documents in his possession” before the day of his testimony. *Id.* at 897. *Admiral Theatre* in no way justifies Defendants’ premature request to exclude relevant evidence, and such a blanket exclusion is inconsistent with Eighth Circuit law. *See Martinez v. Union Pacific R.R. Co.*, 82 F.3d 223 (8th Cir. 1996) (explaining that “[t]he trial court traditionally has broad discretionary power to decide whether to allow the testimony of witnesses not listed prior to trial” and describing four-factor test for determining whether to exclude at trial previously undisclosed witnesses).

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court deny Defendants’ motion *in limine* in its entirety.

Dated: July 27, 2022

Leslie Cooper

Leslie Cooper
Chase Strangio*
American Civil Liberties Union
Foundation
125 Broad St.
New York, NY 10004
Telephone: (917) 345-1742

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

lcooper@aclu.org
cstrangio@aclu.org
Attorneys for the Plaintiffs

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*

Brean Walas, Ark. Bar No. 2006077
Walas Law Firm, PLLC
P.O. Box 4591
Bozeman, MT 59772
Telephone: (501) 246-1067
brean@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
armbrustere@sullcrom.com
holland@a@sullcrom.com
Attorneys for the Plaintiffs

Laura Kabler Oswell*
Sullivan & Cromwell LLP
1870 Embarcadero Road
Palo Alto, CA 94303
Telephone: (650) 461-5600
oswell@sullcrom.com
Attorney 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

1 IN THE UNITED STATES DISTRICT COURT
2 EASTERN DISTRICT OF ARKANSAS
3 CENTRAL DIVISION
4 CASE NO. 4:21-CV-00450-JM

5 -----X

6 DYLAN BRANDT, by and through his
7 Mother, JOANNA BRANDT, et al.,
8 Plaintiffs,

9 V.

10 LESLIE RUTLEDGE, et al.,
11 Defendants.

12 -----X

13

14

15 REMOTE/ORAL/WEB VIDEOCONFERENCE

16 VIDEOTAPED DEPOSITION OF AMY E. EMBRY

17 (Sitting in Little Rock, Arkansas)

18 May 10, 2022

19 10:00 a.m.

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22

23

24 Reported by:

25 Maureen Ratto, RPR, CCR

<p>1 * * *</p> <p>2</p> <p>3 Videotape deposition of Amy E.</p> <p>4 Embry, held virtually via Zoom</p> <p>5 Teleconference, hosted from Veritext</p> <p>6 Legal Solutions, pursuant to notice,</p> <p>7 before Maureen Ratto, Certified Court</p> <p>8 Reporter, License No. XI01165,</p> <p>9 Registered Professional Reporter,</p> <p>10 License No. 817125, and Notary Public.</p> <p>11</p> <p>12 * * *</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	<p>Page 2</p>	<p>1 A P P E A R A N C E S, continued:</p> <p>2</p> <p>3 Counsel for the Defendants:</p> <p>4 SENIOR ASSISTANT ATTORNEY</p> <p>5 GENERAL, PUBLIC PROTECTION DIVISION</p> <p>6 OFFICE OF ARKANSAS ATTORNEY GENERAL</p> <p>7 323 Center Street</p> <p>8 Little Rock, Arkansas 72201</p> <p>9 BY: AMANDA LAND, ESQ.</p> <p>10</p> <p>11 ALSO PRESENT:</p> <p>12 Randy Schoening, Legal Video Specialist</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	<p>Page 4</p>
<p>1 A P P E A R A N C E S:</p> <p>2</p> <p>3 Counsel for the Plaintiffs:</p> <p>4 SULLIVAN & CROMWELL, LLP</p> <p>5 125 Broad Street</p> <p>6 New York, New York 10004</p> <p>7 BY: JONATHAN G. LESTER, ESQ.</p> <p>8 DANIEL RICHARDSON, ESQ.</p> <p>9</p> <p>10 AMERICAN CIVIL LIBERTIES UNION</p> <p>11 125 Broad Street</p> <p>12 New York, New York 10004</p> <p>13 BY: LESLIE COOPER, ESQ.</p> <p>14</p> <p>15 AMERICAN CIVIL LIBERTIES UNION</p> <p>16 OF ARKANSAS</p> <p>17 904 West 2nd Street</p> <p>18 Little Rock, Arkansas 72201</p> <p>19 BY: GARY SULLIVAN, ESQ.</p> <p>20</p> <p>21 GILL RAGON OWEN, PA</p> <p>22 425 West Capitol Avenue</p> <p>23 Little Rock, Arkansas 72201</p> <p>24 BY: DRAKE MANN, ESQ.</p> <p>25 BETH ECHOLS, ESQ.</p>	<p>Page 3</p>	<p>1 VIDEOGRAPHER: We are on</p> <p>2 the audio and video record. It is</p> <p>3 10:05 a.m. The date is May 10th,</p> <p>4 2022.</p> <p>5 This is the videotape recorded</p> <p>6 deposition of Amy Embry, taken by</p> <p>7 counsel for the Plaintiff in the</p> <p>8 matter of Dylan Brandt, et al</p> <p>9 versus Leslie Rutledge et al, filed</p> <p>10 in the United States District Court</p> <p>11 Eastern, District of Arkansas,</p> <p>12 Central Division, Case No.</p> <p>13 4:21-CV-00450-JM.</p> <p>14 This deposition is being held</p> <p>15 at Gill Ragon & Owen, PA, 425 West</p> <p>16 Capitol, Suite 3800, Little Rock,</p> <p>17 Arkansas.</p> <p>18 My name is Randy Schoening</p> <p>19 from the firm of Veritext, I'm the</p> <p>20 videographer. The court reporter</p> <p>21 is Maureen Ratto, from the firm</p> <p>22 Veritext.</p> <p>23 Will counsel please introduce</p> <p>24 themselves for the record.</p> <p>25 MS. COOPER: Yes. Thank you.</p>	<p>Page 5</p>

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1 Leslie Cooper from the ACLU for
 2 Plaintiffs.
 3 MR. LESTER: John Lester from
 4 Sullivan & Cromwell for the
 5 Plaintiffs.
 6 MR. RICHARDSON: Daniel
 7 Richardson from Sullivan & Cromwell
 8 for the Plaintiffs.
 9 MR. SULLIVAN: Gary Sullivan,
 10 ACLU of Arkansas for the
 11 Plaintiffs, in person.
 12 MR. MANN: Drake Mann, Gill
 13 Ragon Owen for the Plaintiffs.
 14 MS. LAND: Amanda Land of the
 15 Arkansas Attorney General on behalf
 16 of the Defendants.
 17 VIDEOGRAPHER: Will the
 18 witness please be sworn?
 19 * * *
 20 A M Y E. E M B R Y, having been duly
 21 sworn by an authorized Notary of the
 22 State of Arkansas, testifies as
 23 follows:
 24 DIRECT EXAMINATION BY MS. COOPER:
 25 VIDEOGRAPHER: You may

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1 AMY E. EMBRY
 2 proceed.
 3 Q. Thanks so much. Good morning,
 4 Ms. Embry. I'm Leslie Cooper. I'm with
 5 the ACLU, counsel for Plaintiffs and I'll
 6 be taking your deposition today.
 7 Before we get started, can I
 8 just ask you to state your full name for
 9 the record?
 10 A. My name is Amy Elizabeth
 11 Embry.
 12 Q. Thank you. And have you ever
 13 had your deposition taken before?
 14 A. Yes.
 15 Q. Okay. How many times?
 16 A. Once.
 17 Q. Was that in your capacity as
 18 an employee of the Board?
 19 A. Yes.
 20 Q. Okay. Can you tell me what
 21 that case was about?
 22 A. It was a lawsuit basically for
 23 a license action or action against a
 24 license, I guess I should say.
 25 Q. So a medical provider

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1 AMY E. EMBRY
 2 challenging a decision concerning a
 3 licensing --
 4 A. Correct.
 5 Q. -- issue?
 6 A. Correct.
 7 Q. So you have been deposed once
 8 before, so what I'm about to say may
 9 sound familiar, but just to make sure so
 10 we get a clean record I'm going to go
 11 over some of the groundrules for
 12 deposition taking so the transcript is
 13 clear.
 14 First thing is, the best we
 15 can, to the best we can we should really
 16 try to avoid speaking over one another.
 17 So if you could give me a chance to
 18 finish my question, even if you
 19 anticipate what I'm asking, before
 20 answering it will prevent the court
 21 reporter from having to try to hear two
 22 things at once. Does that sound okay?
 23 A. Yes.
 24 Q. Okay. And I similarly will try
 25 to wait until you complete your answer to

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1 AMY E. EMBRY
 2 ask a new question.
 3 Also, unlike regular
 4 conversations, we have to always answer
 5 verbally. We can't nod or even say a-hum
 6 because that's kind of hard to understand
 7 in -- typed out what that means. So I'm
 8 just going to ask you to do your best to
 9 answer verbally each time. Okay?
 10 A. Okay.
 11 Q. It may be that I'll ask
 12 questions that you don't fully understand
 13 or are confusing. If that happens, just
 14 let me know that the question wasn't
 15 clear to you and I can try to ask the
 16 question in a different way to clarify
 17 it. So please make sure to do that if a
 18 question is not clear. Okay?
 19 A. Okay.
 20 Q. Because if you do answer a
 21 question we will assume that means you
 22 understood it. Okay?
 23 We will take breaks as we go
 24 through. I will take them periodically,
 25 but if you feel you need to break at any

<p style="text-align: right;">Page 10</p> <p>1 AMY E. EMBRY 2 time before I bring it up just let me 3 know and we can find a breaking point to 4 do that. We will just need to make sure 5 we get completed answers to any questions 6 pending and then I'll find a time to take 7 a break. So no problem if you need to 8 take a break. Okay? 9 A. Okay. 10 Q. Is there anything that would 11 prevent you from giving complete and 12 accurate testimony today? 13 A. No. 14 Q. Okay. Is there any material 15 you're consulting today in connection 16 with your deposition, any notes or 17 written materials? 18 A. I do not have any notes or 19 anything with me. 20 Q. Okay. Did you do anything to 21 prepare for your deposition today? 22 A. Just -- I reviewed the 23 documents received for the deposition, I 24 reviewed that, and spoke with Amanda 25 Land.</p>	<p style="text-align: right;">Page 12</p> <p>1 AMY E. EMBRY 2 ending time, but maybe an hour. 3 Q. When was that? 4 A. Yesterday. 5 Q. And just the one time? 6 A. Yes. 7 Q. Okay. Did you review any 8 documents with counsel? 9 MS. LAND: Objection. 10 MS. COOPER: I'm sorry. I 11 didn't hear. 12 MS. LAND: I made an 13 objection. 14 A. Again, it was the document 15 that I received for my deposition and 16 what I would be responsible for answering 17 today. 18 Q. And I probably should have 19 mentioned this before, that your counsel 20 may from time to time object to some of 21 my questions. Some of them may be 22 objections about the form of my question, 23 in which case she's making the record and 24 I can either correct the question or you 25 can -- or leave it as is and you can</p>
<p style="text-align: right;">Page 11</p> <p>1 AMY E. EMBRY 2 Q. And when you say the documents 3 received, what documents are you 4 referring to? 5 A. That was the document stating 6 that I was going to be deposed today. 7 Q. Okay. We'll look at that just 8 to confirm. I understand you to be 9 referring to the notice of your 10 deposition; is that your understanding? 11 A. Yes. 12 Q. And that included topics for 13 the deposition? 14 A. Yes. 15 Q. Okay. You didn't review 16 anything else? 17 A. No. 18 Q. Okay. And you said you met 19 with Ms. Land; is that correct? 20 A. Yes. 21 Q. And without sharing any 22 content of your conversation, how long 23 did you meet with her? 24 A. Maybe an hour, maybe an hour. 25 I didn't write down the beginning time or</p>	<p style="text-align: right;">Page 13</p> <p>1 AMY E. EMBRY 2 answer. Unless she makes a privilege 3 objection and instructs you not to 4 answer, otherwise you can continue 5 answering. Okay? 6 A. Okay. 7 Q. Have you spoken with anyone 8 besides Ms. Land about your deposition 9 today? 10 A. I spoke with higher-ups at the 11 Department of Health to let them know I 12 would be in a deposition today. I also 13 informed the Board that they were being 14 sued and that I would be deposed. 15 Q. Okay. And when you say you 16 informed the Board, I know that's a lot 17 of people, how did you inform them? 18 A. I believe it was at a meeting 19 and I just told them that we had received 20 documents that we were being sued because 21 of the legislation that was passed and 22 the question from them was; why are they 23 suing us? And I said I don't know. 24 Q. And when did this happen? 25 A. I believe the lawsuit was</p>

4 (Pages 10 - 13)

<p style="text-align: right;">Page 14</p> <p>1 AMY E. EMBRY 2 filed last fall, so I don't have a date, 3 a specific date, but it would have been 4 in the fall or shortly after the lawsuit 5 was filed. 6 Q. So that was a meeting you -- 7 that occurred some time shortly after the 8 lawsuit was filed in this case; is that 9 right? 10 A. It could be. And again, I have 11 to say this was months ago. So it may be 12 that I only spoke with one Board member. 13 I just don't recall. I do know that I did 14 tell a Board member that we're being 15 sued. 16 Q. Okay. Did you notify the Board 17 at any time in writing that they were 18 being sued? 19 A. Not to my knowledge. 20 Q. Okay. And did anybody else 21 notify the Board in writing, besides you, 22 that the Board was being sued? 23 A. No, just the documents that 24 came. 25 Q. Okay. And then so that was at</p>	<p style="text-align: right;">Page 16</p> <p>1 AMY E. EMBRY 2 Let's give it another minute before 3 we abandon Exhibit Share. 4 MR. SULLIVAN: I'm going to 5 try and reload the exhibit. I 6 apologize. 7 MS. COOPER: Thank you. 8 MR. RICHARDSON: If you reload 9 the folder named Marked Exhibits 10 you should see Exhibit 1, Notice of 11 30(b)(6) deposition. 12 VIDEOGRAPHER: This is the 13 court reporter, we're going to need 14 someone to share that to a screen 15 share because the witness is not 16 able, I mean, I'm not able to go 17 out of the feed into the share. So 18 can you actually share it on the 19 screen? 20 MS. COOPER: I think given 21 that tech issue that we didn't 22 realize would be an issue, we 23 should resort to the hardcopies. 24 Can we go off the record for just a 25 moment?</p>
<p style="text-align: right;">Page 15</p> <p>1 AMY E. EMBRY 2 least several months ago that 3 communication with at least one Board 4 member about being sued. But more 5 recently, since you've been notified 6 about your deposition, did you speak to 7 anyone in the Board about that? 8 A. No. 9 Q. Okay. And I'd like to mark as 10 Exhibit 1 the 30(b)(6) notice of the 11 Board. That will be posted on Exhibit 12 Share in a moment. 13 (Exhibit 1, 30(b)(6) notice 14 for Defendant Arkansas State 15 Medical Board was received and 16 marked on this date for 17 identification.) 18 MS. LAND: This is my first 19 time using Exhibit Share, so I'm 20 just making sure I find it as well. 21 Leslie, has it been uploaded to 22 Exhibit Share yet? I am not seeing 23 it. 24 MS. COOPER: I think it's 25 still uploading. Sorry about that.</p>	<p style="text-align: right;">Page 17</p> <p>1 AMY E. EMBRY 2 VIDEOGRAPHER: Yes. We are off 3 the record at 10:18 a.m. 4 (Discussion is held off the 5 record.) 6 VIDEOGRAPHER: We are back on 7 the record at 10:20 a.m. 8 Q. Thank you. Ms. Embry, you've 9 been shown a document that we'd like to 10 mark as as Exhibit 1. Do you recognize 11 this document? 12 A. Yes. 13 Q. Is this the Notice of 14 Deposition that you referred to earlier? 15 A. Yes. 16 Q. Okay. And you've reviewed this 17 entire document? 18 A. Yes. 19 Q. Okay. And do you understand 20 that you have been designated by the 21 Defendant Arkansas State Medical Board to 22 testify on its behalf concerning a number 23 of topics listed in this notice? 24 A. Yes. 25 Q. And are you prepared to</p>

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1 AMY E. EMBRY
 2 testify on behalf of the Board regarding
 3 the topics listed in this notice?
 4 A. Yes.
 5 Q. You can put that aside for
 6 now. Are you currently employed by the
 7 Arkansas State Medical Board?
 8 A. I am.
 9 Q. And if I say "the Board" will
 10 you understand that I mean the Arkansas
 11 State Board?
 12 A. Yes.
 13 Q. And are you currently the
 14 Executive Director of the Board?
 15 A. Yes.
 16 Q. Okay. Since when?
 17 A. 2018.
 18 Q. And did you hold any position
 19 with the Board before 2018?
 20 A. Yes.
 21 Q. What position was that?
 22 A. It was the Administrative
 23 Services Manager.
 24 Q. And what were your
 25 responsibilities in that position?

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1 AMY E. EMBRY
 2 A. I was responsible for the
 3 human resources, accounting, budget,
 4 general office management of the Board.
 5 Q. When did you start that
 6 position?
 7 A. 2014.
 8 Q. Prior to that did you hold any
 9 employment with the Board?
 10 A. No.
 11 Q. What did you do before that?
 12 A. I worked at the Department of
 13 Finance and Administration for the State
 14 of Arkansas.
 15 Q. Do you have any medical
 16 training?
 17 A. No.
 18 Q. Any training at all related to
 19 healthcare?
 20 A. No.
 21 Q. Can you tell me what your
 22 responsibilities are as the Executive
 23 Director of the Board?
 24 A. I manage the day-to-day
 25 functions of the Board, I have managers

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1 AMY E. EMBRY
 2 that manage certain sections, I also work
 3 closely with the Board for Board meetings
 4 and each section within the Board works
 5 with the Board in their own way. In a
 6 nutshell, that's what I do.
 7 Q. Now, you mention sections.
 8 Could you tell me what the sections are?
 9 A. We have a regulatory section,
 10 licensure, we have IT and we have a
 11 credentialing section.
 12 Q. And those are all of the
 13 sections?
 14 A. Yes.
 15 Q. And you have someone who is a
 16 manager for each of those sections; is
 17 that right?
 18 A. Yes.
 19 Q. And are there other employees
 20 of the Board besides you and those
 21 managers?
 22 A. Yes. Those --
 23 Q. I'm sorry.
 24 A. Those managers do have
 25 employees and we have right now I would

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1 AMY E. EMBRY
 2 say 25, between 25 and 30 total
 3 employees, including the managers and
 4 myself.
 5 Q. Okay. And can you tell me
 6 within the regulatory section who the
 7 employees are or what their positions are
 8 and what they do?
 9 A. There are three employees, one
 10 of those is a manager. The manager's
 11 name is Juli Carlson and she had two
 12 employees who are fairly new, one is
 13 Penny Henderson and the other is
 14 Elizabeth Jones.
 15 Q. And what are their jobs?
 16 A. They handle all the complaints
 17 that come in that need to be processed to
 18 the Board, they also handle any letters
 19 or communication from the Board to the
 20 licensees. They handle continuing medical
 21 education audits, any questions that come
 22 in as far as how to file a complaint.
 23 Q. And do I assume correctly that
 24 the licensing or licensure section has to
 25 do with doctors and other healthcare

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1 AMY E. EMBRY
2 providers getting their license to
3 practice in Arkansas; is that correct?
4 A. It is the healthcare providers
5 that we license, that is what they deal
6 with.
7 Q. But any complaints regarding
8 any licensed healthcare providers go to
9 the regulation section; is that right?
10 A. Correct.
11 Q. Or regulatory, is that what
12 you called it?
13 A. Yes, ma'am.
14 Q. Okay. Thank you. The employees
15 in the regulatory section, do any of
16 those employees have medical or
17 healthcare training?
18 A. Not to my knowledge.
19 Q. Okay. I want to ask you a few
20 questions about the current Board members
21 of the Board. You have at this point, I'm
22 going to count here. Maybe you can just
23 tell me how many because you probably
24 know it, how many Board members you have?
25 A. In all we have 14 Board

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1 AMY E. EMBRY
2 members.
3 Q. And of those Board members
4 that are currently on the Board, are all
5 -- have they all been on the Board since,
6 say, the beginning of 2021?
7 A. With the exception of one. I
8 would have to go back and check my
9 records to see when they came in. I only
10 know of one that was not on the Board as
11 of 2021.
12 Q. And who was that?
13 A. Dr. Brian McGee. He was just
14 appointed within the past two months.
15 Q. And any of the members who
16 were on the Board in January 2021, if you
17 look at that list of people, are any of
18 those members no longer on the Board?
19 A. Yes.
20 Q. Who is that?
21 A. You have Dr. Rutledge,
22 Dr. Staggs. Bear with me, I have to think
23 about this. I think that's it. We've lost
24 two.
25 Q. So you've lost two and you

Page 24

1 AMY E. EMBRY
2 gained one?
3 A. Correct.
4 Q. Okay.
5 MS. COOPER: Can we mark as
6 Exhibit 2, tab 2, please, the
7 Arkansas Medical Practices Act and
8 Regulations.
9 (Exhibit 2, Arkansas Medical
10 Practices Act and Regulations,
11 revised as of December 2, 2020 was
12 received and marked on this date
13 for identification.)
14 Q. Do you have that in front of
15 you, Ms. Embry?
16 MS. LAND: I'm showing her my
17 Exhibit Share.
18 MS. COOPER: I'm sorry. Is
19 there someone speaking that I can't
20 hear on the record?
21 MS. LAND: That was Amanda
22 Land. I asked if I could have a
23 copy because I don't believe you
24 are uploading these to --
25 MS. COOPER: Yeah. We can

Page 25

1 AMY E. EMBRY
2 upload to Exhibit Share
3 simultaneously. You're able to
4 review that, Amanda?
5 MS. LAND: I'm on Exhibit
6 Share. It seems to be working
7 because I can see the first exhibit
8 that you did upload, but if --
9 whether it's in paper or Exhibit
10 Share, I don't have a preference.
11 MS. COOPER: Okay. We will
12 upload all of the exhibits on
13 Exhibit Share for counsel to be
14 able to review while giving
15 hardcopies to the witness. Okay. So
16 we're in the process of uploading
17 Exhibit 2.
18 And Amanda, if you can let me
19 know when you're able to see that.
20 MS. LAND: It has popped up
21 for me.
22 MS. COOPER: Amanda, I can't
23 hear you so well. If you can speak
24 a little louder or adjust the mic.
25 MS. LAND: I can see the

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1 AMY E. EMBRY
 2 exhibit.
 3 MS. COOPER: Great. Thank you.
 4 Q. Ms. Embry, do you recognize
 5 the document placed in front of you
 6 that's been marked as Exhibit 2?
 7 A. Yes.
 8 Q. Okay. And that is the, for the
 9 record, the title page is Arkansas State
 10 Medical Board, Arkansas Medical Practices
 11 Act and Regulations; is that correct?
 12 A. Yes.
 13 Q. And is this set of -- is this
 14 act and set of regulations what governs
 15 the Board?
 16 A. Yes.
 17 Q. And I take it you've seen this
 18 document before?
 19 A. Yes.
 20 Q. Okay. If you can turn to
 21 Section 17-95-301?
 22 A. Let me go to the table of
 23 contents to get the page.
 24 Q. I believe it's 21. Is this the
 25 provision that dictates the membership of

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1 AMY E. EMBRY
 2 the Board?
 3 A. Yes.
 4 Q. And do I understand correctly
 5 that there are 14 members appointed by
 6 the Governor?
 7 A. Yes.
 8 Q. And 10 must be active medical
 9 practitioners?
 10 A. Yes.
 11 Q. And one must be a practicing
 12 physician; did I say that right? If you
 13 look at Subsection 3 --
 14 A. Yes. That is the one that --
 15 yes. There are physicians but this is the
 16 one that is appointed by that specific
 17 organization. That's what was throwing me
 18 on your question.
 19 Q. Understood. Thank you. So
 20 there are other physicians on the Board
 21 as well?
 22 A. Yes.
 23 Q. Okay. And I understand -- do I
 24 understand correctly that two members
 25 must not be medical providers; is that

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1 AMY E. EMBRY
 2 correct?
 3 A. Yes.
 4 Q. And one must be an osteopathic
 5 physician?
 6 A. Correct.
 7 Q. Now, I'd like to go through
 8 the current members of the Board and ask
 9 you to tell me what their designated
 10 position is on the Board? In other words,
 11 are they a medical practitioner, are they
 12 a non-medical provider, and what their
 13 area of practice is, if they are medical
 14 providers.
 15 So we can start with -- and if
 16 I read a name and that person is no
 17 longer on the Board just let me know.
 18 Sylvia Simon, is she still on the Board?
 19 A. Yes.
 20 Q. And what is her designated
 21 position on the Board?
 22 A. She is the Chairman of the
 23 Board, Chairperson of the Board.
 24 Q. And she is a physician?
 25 A. Yes.

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1 AMY E. EMBRY
 2 Q. What is her practice area?
 3 A. I'm going to say family
 4 practice.
 5 Q. How about Brian Hyatt, is he
 6 still on the Board?
 7 A. Yes.
 8 Q. And what is his designated
 9 position?
 10 A. He is the vice-chair.
 11 Q. And he's a physician as well?
 12 A. Yes.
 13 Q. What is his area of practice?
 14 A. Psychiatry.
 15 Q. How about Veryl Hodges?
 16 A. Yes.
 17 Q. They're on the Board?
 18 A. Yes.
 19 Q. And what is their designated
 20 position?
 21 A. He is the secretary of the
 22 Board.
 23 Q. Is he a physician?
 24 A. Yes.
 25 Q. I see his title says DO, is

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1 AMY E. EMBRY
 2 that a doctor of osteopathy, am I saying
 3 that correctly?
 4 A. Yes.
 5 Q. Is John Scribber still on the
 6 Board?
 7 A. That's John Scribner.
 8 Q. Thank you. Is he still on the
 9 Board?
 10 A. Yes.
 11 Q. And what is his designated
 12 position on the Board?
 13 A. He is the treasurer.
 14 Q. And he's a physician?
 15 A. Yes.
 16 Q. What is his area of practice?
 17 A. Family practice.
 18 Q. Okay. Elizabeth Anderson, is
 19 she still on the Board?
 20 A. Yes.
 21 Q. Is she a physician?
 22 A. No.
 23 Q. So she's one of the designated
 24 non-physicians on the Board?
 25 A. Correct.

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1 AMY E. EMBRY
 2 Q. Okay. Does she have a title
 3 within the Board, such as secretary or
 4 treasurer?
 5 A. No.
 6 Q. Rhys Branman still on the
 7 Board?
 8 A. Yes.
 9 Q. And what is -- does he have a
 10 designated position or title?
 11 A. All the designated were the
 12 four officers we've already mentioned.
 13 Q. Okay. Is Rhys Branman a
 14 physician?
 15 A. Yes.
 16 Q. What is his area of practice?
 17 A. Plastic surgery.
 18 Q. Is Robert Breving still on the
 19 Board?
 20 A. Yes.
 21 Q. And he's a physician as well?
 22 A. Yes.
 23 Q. What area of practice?
 24 A. Surgery.
 25 Q. Is Edward Gardner still on the

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1 AMY E. EMBRY
 2 Board?
 3 A. Yes.
 4 Q. Is he a physician?
 5 A. Yes.
 6 Q. And his area of practice is?
 7 A. He's an ENT doctor, ENT
 8 physician.
 9 Q. Is Rodney Griffin still on the
 10 Board?
 11 A. Yes.
 12 Q. Is he a physician?
 13 A. Yes.
 14 Q. And is his area of practice?
 15 A. Family medicine, as far as I
 16 can recall.
 17 Q. Is Betty Guhman -- am I saying
 18 that right?
 19 A. Guhman.
 20 Q. Is Betty Guhman still on the
 21 Board?
 22 A. Yes.
 23 Q. Is she a physician?
 24 A. No.
 25 Q. Okay. Is Timothy Paden still

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1 AMY E. EMBRY
 2 on the Board?
 3 A. Yes.
 4 Q. Is he a physician?
 5 A. Yes.
 6 Q. What area of practice?
 7 A. Family medicine.
 8 Q. Is Don Philips still on the
 9 Board?
 10 A. Yes.
 11 Q. And he's a physician?
 12 A. Yes.
 13 Q. And what is his area of
 14 practice?
 15 A. OBGYN.
 16 Q. Okay. And I believe you said
 17 William Rutledge and David Staggs are no
 18 longer on the Board?
 19 A. That is correct.
 20 Q. Okay. Are they both
 21 physicians?
 22 A. Yes.
 23 Q. And can you tell me what their
 24 areas of practice are?
 25 A. Dr. Rutledge was a surgeon and

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1 AMY E. EMBRY
 2 Dr. Staggs was family practice.
 3 Q. Okay. Thank you. We were
 4 looking at the Arkansas Medical Practices
 5 Act. If we can go to Section 17-95-303(5)
 6 and I understand that Section 303(5) are
 7 the duties of the Board and it says, "The
 8 Arkansas State Medical Board shall:", and
 9 list a number of items. And number (5)
 10 says "have the authority to employ a
 11 Medical Director who shall hold a valid
 12 license to practice medicine in this
 13 State to evaluate medical issues and to
 14 assist in investigations pending before
 15 its Board." Did I read that right?
 16 A. Yes.
 17 Q. Does the Board employ a
 18 Medical Director?
 19 A. No.
 20 Q. No. Since you've been with the
 21 Board have they ever employed a Medical
 22 Director?
 23 A. No.
 24 Q. Do you know why that is?
 25 A. No, I do not.

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1 AMY E. EMBRY
 2 Q. Okay. Staying in that same
 3 part of the statute, Section 303, under
 4 subsection (7) it says, that the Medical
 5 Board shall "have the power and authority
 6 to employ one or more inspectors as may
 7 be necessary to carry out the provisions
 8 of the Arkansas Medical Practices Act."
 9 Does the Board employ
 10 inspectors?
 11 A. We employed one inspector.
 12 Q. Is that in the past?
 13 A. Yes.
 14 Q. When was that?
 15 A. Within the past year. I don't
 16 have exact dates.
 17 Q. But you don't currently have
 18 any employed inspectors?
 19 A. Not employed by the Board, no.
 20 Q. Do you work with inspectors
 21 who are not employed by the Board?
 22 A. Yes.
 23 Q. What is that arrangement? Can
 24 you explain that to me?
 25 A. It is in the Arkansas code

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1 AMY E. EMBRY
 2 that we are to use Pharmacy Services at
 3 the Arkansas Department of Health for
 4 inspections, investigations -- not
 5 inspections, investigations.
 6 Q. Is that only for
 7 investigations concerning issues relating
 8 to prescription of drugs?
 9 A. Yes, and other things, we use
 10 it also for others besides just the
 11 prescription of drugs.
 12 Q. So these are inspectors that
 13 are employed by Pharmacy Services at the
 14 Department of Health?
 15 A. Correct, but it's
 16 investigators not inspectors. I believe
 17 they're investigators.
 18 Q. So just I want to make sure I
 19 understand how this works. If there is a
 20 complaint against a physician, for
 21 example, and the Board feels the need to
 22 do an investigation it would work with an
 23 investigator from Pharmacy Services; is
 24 that right?
 25 A. Yes.

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1 AMY E. EMBRY
 2 Q. How many investigators do they
 3 have at Pharmacy Services that you work
 4 with?
 5 A. That I know of, we have worked
 6 with three.
 7 Q. But are there others there
 8 besides the ones you've worked with?
 9 A. That is my understanding but
 10 that's not my staff, so I can't answer
 11 truthfully on that.
 12 Q. Okay. You know of three; is
 13 that right?
 14 A. Yes. That is correct.
 15 Q. And what is the role of these
 16 investigators?
 17 I sort of tried to lay out
 18 what I understood but I'm sure that was
 19 not a full description.
 20 What do these investigators do
 21 when you work with them?
 22 A. Well, if the Board votes that
 23 there needs to be an investigation on a
 24 complaint that comes in a subpoena will
 25 be issued that I sign and those

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1 AMY E. EMBRY
 2 investigators serve that subpoena for
 3 whatever is listed in the subpoena.
 4 Q. Do they do anything else?
 5 A. They gather that information,
 6 they do -- they evaluate it and they
 7 present a report back to the Board
 8 offices to present to the Board members.
 9 Q. When you say they gather
 10 information, is that information that
 11 they gather documents that are requested
 12 by a subpoena that they then deliver; is
 13 that what you mean?
 14 A. That is correct.
 15 Q. That might be some of their
 16 medical records, that kind of thing?
 17 A. It could be, yes.
 18 Q. So the investigator serves the
 19 subpoena that asks for documents and then
 20 collects those materials and then writes
 21 a report about the materials; did I get
 22 that right?
 23 A. Yes, they take them back. They
 24 will look through them and try to gather
 25 what information they can, and then

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1 AMY E. EMBRY
 2 present a report to the Board office.
 3 Q. And who identifies the
 4 documents that are being requested in the
 5 subpoena? Is that an employee of the
 6 Board?
 7 A. I need you to clarify that
 8 question.
 9 Q. Sure. So you mention that the
 10 investigators from Pharmacy Services will
 11 serve the subpoena. Who writes the
 12 subpoena?
 13 A. The Board office does, staff
 14 at the office writes the subpoena.
 15 Q. Which staff? Let's say it's in
 16 -- presumably it's always in a regulatory
 17 context, right?
 18 A. Yes, regulatory section.
 19 Q. So that would be the manager
 20 or the other employees in the regulatory
 21 section would write that subpoena?
 22 A. Correct.
 23 Q. Presumably with counsel is
 24 that involved or no?
 25 A. Yes. It's a very generic

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1 AMY E. EMBRY
 2 subpoena listing exactly what we need,
 3 so...
 4 Q. And then the report is
 5 provided to those within the regulatory
 6 section when it's done?
 7 A. Yes.
 8 Q. And then what happens after
 9 that in the investigation process?
 10 A. It is prepared, that report is
 11 prepared to be presented to the Board
 12 members, it's discussed at the next
 13 meeting or if they feel they have enough
 14 information from that investigation to
 15 present it to the Board. If not, there
 16 may be other things that need to be done
 17 and then the Board discusses it and they
 18 make a decision on what needs to be done
 19 next.
 20 Q. Thank you. While we're in this
 21 part of the Arkansas Medical Practices
 22 Act, if you can look at 17-95-303
 23 subsection (9), bottom of the same page
 24 and it's again, "The Arkansas State
 25 Medical Board shall consider and give

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1 AMY E. EMBRY
 2 deference to data, studies consensus
 3 documents and conclusions issued by the
 4 Center For Disease Control and Prevention
 5 or the National Institute of Health
 6 whenever their data, studies consensus
 7 documents and conclusions are relevant to
 8 any decision made pursuant to the Board's
 9 powers and duties under the Arkansas
 10 Medical Practices Act."
 11 Is that something the Board
 12 does?
 13 A. I have not seen it in my
 14 tenure at Director. I don't know if a
 15 situation has come up that they have to
 16 do that. So during the time that I've
 17 been the Board Director, I can't say that
 18 I've seen that --
 19 Q. Okay.
 20 A. -- from these organizations
 21 listed in this section.
 22 Q. Okay. Have you seen data,
 23 studies, consensus documents or
 24 conclusions issued by other organizations
 25 that were considered by the Board in

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1 AMY E. EMBRY
2 making any decisions concerning
3 regulation of medical professionals?
4 A. I do not recall that. I would
5 have to go back and look at documents to
6 see.
7 Q. Okay. Is it fair to say the
8 Board is the State entity in Arkansas
9 charged with regulating the practice of
10 medicine; is that correct?
11 A. Yes.
12 Q. And what does that mean, to
13 regulate the practice of medicine to the
14 Board?
15 MS. LAND: Object to form. You
16 may answer.
17 A. Well, they put it in the code
18 that the State Medical Board is -- is --
19 let me start that over.
20 We are responsible for
21 regulating those healthcare professionals
22 that we license. If someone is practicing
23 medicine without a license it is usually
24 referred to our Board. So if someone has
25 another license with another healthcare

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1 AMY E. EMBRY
2 licensing board, but it does not fall
3 within their scope of practice what the
4 complaint is being made against that
5 individual, then it will probably be
6 referred to the Medical Board as
7 practicing medicine, this individual is
8 practicing medicine.
9 Q. And for those who are licensed
10 by the Board, those medical professionals
11 licensed by the Board, you said you're
12 responsible for regulating those
13 healthcare professionals. What do you
14 mean by "regulating" them?
15 A. Well, maybe that wasn't the
16 best term but we are responsible for
17 those individuals that are licensed by
18 us, but we work on a complaint basis.
19 So we have between 19 and 20
20 thousand liscensees at the Board right
21 now in various practice and various types
22 of licenses. And if a complaint comes in
23 every single complaint is reviewed by the
24 Board, every single complaint is reviewed
25 by the Board, and from there it is

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1 AMY E. EMBRY
2 determined what needs to be done. We do
3 get complaints that it may be, for
4 example, on a nurse, we do not regulate
5 nurses, we forward it onto the Nursing
6 Board.
7 Q. Thank you.
8 A. And we work on a complaint
9 basis.
10 MS. COOPER: Can we see tab 3
11 and mark that as Exhibit 3?
12 (Exhibit 3, printout of the
13 homepage of the Arkansas State
14 Medical Board website was received
15 and marked on this date for
16 identification.)
17 MS. COOPER: Amanda, if you
18 can let me know if that's available
19 to you.
20 MS. LAND: Yes, it is. I'll
21 let you know each time going
22 forward.
23 Q. Thank you. Ms. Embry, do you
24 recognize what's been marked as Exhibit
25 3?

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1 AMY E. EMBRY
2 A. Yes.
3 Q. And can you tell me what that
4 is?
5 A. This is -- it is the homepage
6 or a page from our website.
7 Q. So I'd like you to read along
8 with me the box to the section in the
9 middle that says, "The Medical Board's
10 mission is to protect the public" --
11 excuse me, I'll start that again. "The
12 Medical Board's mission is to protect the
13 public and act as their advocate by
14 effectively regulating the practices of
15 medical doctors, osteopathic medical
16 directors, physician assistants, medical
17 corporations, respiratory therapists,
18 occupational therapists, occupational
19 therapy assistants, radiology
20 practitioner assistants and radiologist
21 assistants." Did I read that right?
22 A. Yes, ma'am.
23 Q. Is this an accurate statement
24 of the Board's mission?
25 A. Yes.

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1 AMY E. EMBRY
 2 Q. And I understand the Board has
 3 authority to enact regulations to carry
 4 out the purposes and intentions of the
 5 Medical Practices Act; is that right?
 6 A. Yes.
 7 Q. So under what circumstances
 8 can the Board enact regulations?
 9 A. If it is in the law where it
 10 says that a licensing board shall or will
 11 promulgate a rule or if we are requested
 12 by the legislature to do so.
 13 Q. Okay. So I want to unpack that
 14 a little bit.
 15 So the first scenario is if a
 16 statute says the Board shall enact a
 17 regulation concerning a particular topic,
 18 you will -- the Board will enact a
 19 regulation; is that correct?
 20 A. Yes.
 21 Q. Okay. And then a separate
 22 scenario is if the legislature requests
 23 the Board to enact a regulation; did I
 24 understand that right?
 25 A. Yes.

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1 AMY E. EMBRY
 2 Q. And that's outside of the
 3 context of a statute?
 4 A. Yes. That is very rare.
 5 Q. Has that ever happened since
 6 you've been with the Board?
 7 A. Yes. It finished up when I
 8 became Director. It started with a
 9 previous Director and even though we were
 10 requested by the legislature to come up
 11 with a rule, the rule did not pass and it
 12 was not enacted.
 13 Q. What was the issue that the
 14 legislature asked you to come up with a
 15 rule about?
 16 A. It was basically about
 17 cosmetic procedures, as far as what was
 18 happening at medical spas, what can be
 19 considered the practice of medicine, what
 20 cannot be considered the practice of
 21 medicine.
 22 Q. And how was that communicated
 23 to the Board by the legislature that they
 24 wanted you to to come up with a
 25 regulation?

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1 AMY E. EMBRY
 2 A. They can either make a request
 3 to the Board, themselves, through
 4 attorneys, they can ask a Board member,
 5 say we're interested in a rule about
 6 this. But again, that is very rare and
 7 since I've been with the Board since 2014
 8 that's only happened once, which the rule
 9 did not pass.
 10 Q. Okay. And given that the
 11 legislature includes a lot of people,
 12 does it have to be that the legislature
 13 as a body has voted by majority vote to
 14 request that regulation or could an
 15 individual legislator ask the Board to
 16 enact a regulation?
 17 A. I can only speak to my
 18 understanding. I do not have any
 19 knowledge of how the legislature would
 20 handle that, but to my knowledge and my
 21 understanding is that anybody can ask.
 22 Q. Anybody within the
 23 legislature?
 24 A. Yes.
 25 Q. Can ask -- let me make sure I

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1 AMY E. EMBRY
 2 asked that question that's not broken up
 3 for the record.
 4 So anybody who is a member of
 5 the legislature can ask the Board to
 6 enact a regulation; that's your
 7 understanding?
 8 A. That is my understanding, but
 9 that would be a question for the
 10 legislature.
 11 Q. And in the example that you
 12 mention, the one time that happened since
 13 you've been with the Board, the cosmetic
 14 procedure issue, was that a single member
 15 of the Board asked for that or how did
 16 that come to you?
 17 A. That I do not know because I
 18 was not on the front end of that when it
 19 began, so I cannot answer to that.
 20 Q. Okay. Can anyone outside of
 21 the legislature, who is not a member of
 22 the legislature, ask the Board to enact a
 23 regulation on a topic?
 24 A. I suppose. I suppose. It has
 25 not happened but there is a whole process

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1 AMY E. EMBRY
 2 that the legislature must approve all the
 3 rules. So even if we draft a rule, it has
 4 to be approved by the legislature before
 5 it can be considered an active rule.
 6 Q. And that's true of all of the
 7 rules that have been passed by the Board
 8 so far?
 9 A. Correct. Correct.
 10 Q. And I believe there's
 11 something like 30-something rules; is
 12 that right?
 13 A. That's right.
 14 Q. They've all been approved by
 15 the legislature?
 16 A. Yes.
 17 Q. Okay. Has, to your knowledge,
 18 any other government official, outside of
 19 the legislature, let's say within the
 20 executive branch of government, ever
 21 asked the Board to enact a regulation?
 22 A. Not to my knowledge, not that
 23 I know of.
 24 Q. That would include the
 25 Governor's Office has never asked?

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1 AMY E. EMBRY
 2 A. Since I've been Director, I
 3 have not received that request.
 4 Q. And are you aware if that's
 5 ever happened before?
 6 A. I am not aware if it's
 7 happened before.
 8 Q. Okay. Can the Board enact a
 9 regulation on its own without being
 10 requested to do so by somebody else?
 11 A. It could but, again, it's
 12 usually never done. I don't know if it
 13 has been done.
 14 Q. So I looked through the
 15 regulations that you have and I see that
 16 there are lots of different topics about
 17 which the Board has passed regulations.
 18 I'm just going to list some and ask if
 19 you're familiar.
 20 I saw one about precautions
 21 concerning HIV. And this is not a test.
 22 Let me back it up. I'm happy to have you
 23 look through.
 24 Do I understand correctly that
 25 Regulation 16, which is in Exhibit 2 --

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1 AMY E. EMBRY
 2 A. That's correct.
 3 Q. -- is about precautions
 4 related to HIV and some other
 5 communicable diseases; is that correct?
 6 A. Yes.
 7 Q. And then I understand that
 8 Regulation 22 has some guidelines
 9 concerning laser surgery; is that
 10 correct?
 11 A. Yes.
 12 Q. And there are guidelines, or I
 13 should say regulations concerning
 14 abortion in Regulation 36?
 15 A. Yes.
 16 Q. And there is a Regulation 27
 17 concerns informed consent for gastric
 18 bypass surgeries; is that right?
 19 A. Yes.
 20 Q. And then Provision 21 relates
 21 to -- is a regulation concerning
 22 anorexiant drugs. Am I saying that right,
 23 anorexiant?
 24 A. Anorexiant.
 25 Q. Now, were you on the Board or

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1 AMY E. EMBRY
 2 not on the Board -- excuse me.
 3 Were you employed by the Board
 4 when any of those provisions were
 5 enacted?
 6 A. The ones that you mentioned?
 7 Q. Yes.
 8 A. No, I was not at the Board.
 9 Q. Okay. And do you know if all
 10 of these provisions were prompted by a
 11 statutory directive by the legislature?
 12 A. I would need to go back and
 13 research but nearly every rule is
 14 prompted by legislation.
 15 Q. But some are not?
 16 A. I would have to go back and
 17 read the history of each one. So I can't
 18 answer that honestly.
 19 Q. Okay. Can we look at
 20 Regulation 21 concerning anorexiant's?
 21 Would looking at this rule, or
 22 I should say regulation, provide you with
 23 the information about whether it was
 24 prompted by a statute?
 25 A. It may.

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1 AMY E. EMBRY
 2 Q. Okay.
 3 A. Again, I could not answer
 4 completely honestly without going back
 5 and looking how this began.
 6 Q. So from the regulation,
 7 itself, where it says at the end, if you
 8 look along with me, "history adopted
 9 March 13, 1998 amended August 6, 2015
 10 effective December 14, 2015", that
 11 doesn't tell you what prompted it?
 12 A. It would not tell me because I
 13 was not at the Board. If I was there I
 14 may remember.
 15 Q. Okay. If the Board had a
 16 concern about how medical care was being
 17 provided in a particular field, could the
 18 Board get together and put together a
 19 regulation?
 20 A. They could.
 21 Q. They could. But you don't know
 22 if they've ever done that?
 23 A. Not to my knowledge.
 24 Q. They have not done that, to
 25 your knowledge, is that what you're

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1 AMY E. EMBRY
 2 saying?
 3 A. I have no memory of them doing
 4 that in my time at the Board.
 5 Q. And do you know whether prior
 6 to your time at the Board that was ever
 7 done?
 8 A. I do not know.
 9 Q. I want to ask some of the
 10 process about enacting regulations. Who
 11 within the Board, or is it someone within
 12 the Board who drafts these regulations?
 13 A. They're usually drafted either
 14 by staff or with the assistance of an
 15 attorney.
 16 Q. And who decides on the
 17 content?
 18 A. The Board votes on the final
 19 draft. They approve what will be the rule
 20 that will begin -- that will be sent for
 21 the promulgation process.
 22 Q. So if it's a draft that
 23 relates to let's say -- I guess they're
 24 all within the regulatory context, right,
 25 all of these regulations? So if there's

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1 AMY E. EMBRY
 2 -- if somebody were to draft a regulation
 3 relating to orthopedics, for example,
 4 would the staff who are drafting that
 5 regulation look to expertise within the
 6 field of orthopedics to draft the
 7 regulation?
 8 A. Yes. That would be -- yes.
 9 MS. LAND: Objection to form
 10 on that previous question.
 11 Q. Okay. How would they -- how
 12 would they do that?
 13 A. They would work with the Board
 14 members and the Board members would have
 15 their input. The Board members would then
 16 say if they did not -- for example, if it
 17 was orthopedics, if there is an
 18 orthopedic society or association to get
 19 some expertise, if they did not have that
 20 expertise. And then changes would be made
 21 to that and then the Board would vote yay
 22 or nay on the draft.
 23 Q. If they were to reach out to
 24 an orthopedic society or an organization
 25 with expertise, would that mean to then

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1 AMY E. EMBRY
 2 speak with orthopedists who could offer
 3 expertise; is that what you mean?
 4 A. It could be, yes.
 5 Q. Could it also be to look at
 6 any best practices guidelines they have?
 7 A. Could be, yes.
 8 Q. Have any regulations been
 9 enacted by the Board since you've been
 10 employed by the Board?
 11 A. Yes.
 12 Q. Can you tell me which ones?
 13 A. I may not have been the
 14 Director, but these are the ones that
 15 were -- let me get back to the table of
 16 contents. It will be the ones towards the
 17 end. 39 was amended, 40 was created, 41,
 18 42, 43 and 44 and 45.
 19 Q. Thank you. So let's take, for
 20 example, Regulation 40, Arkansas Surgical
 21 Technologists. Did the Board reach out to
 22 any surgical professional groups in
 23 developing that regulation?
 24 A. Let me flip to that. I believe
 25 this was taken directly from the code,

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1 AMY E. EMBRY
 2 which is on our rules, it's just cut and
 3 paste and put in there what it is.
 4 Q. And by "code" do you mean
 5 Arkansas statutes?
 6 A. Yes.
 7 Q. Okay. And let's look at number
 8 43, Genetic Counselor Licensure, was that
 9 taken directly from the code?
 10 A. Yes.
 11 Q. All of it?
 12 A. To my knowledge, yes. Without
 13 having documents in front of me, to my
 14 knowledge yes.
 15 Q. Okay. Is it your understanding
 16 that all of the regulations are language
 17 from the legislature or -- let me ask it
 18 differently. Strike that.
 19 Does the Board ever develop
 20 language for regulations, itself?
 21 A. Yes.
 22 Q. And is there ever a case where
 23 the statute mandates a regulation and
 24 certain requirements but the Board may
 25 fill that out with additional details in

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1 AMY E. EMBRY
 2 the regulation?
 3 A. Yes.
 4 Q. And is that where the
 5 expertise of professional associations
 6 may come in; is that correct?
 7 A. Yes.
 8 Q. Okay. Which professional
 9 associations do you recall the Board
 10 having relied on?
 11 A. The ones that we work closest
 12 with, the ones that we have the most
 13 contact with and I would say, okay, the
 14 Medical Society, the Hospital
 15 Association, Physician Assistant, and
 16 these are all within Arkansas, these are
 17 all Arkansas organizations. Let's see who
 18 else? Occupational Therapy and
 19 Respiratory.
 20 Q. So when you say the Medical
 21 Society, is that an association called
 22 the Arkansas Medical Society, is that its
 23 name?
 24 A. Yes.
 25 Q. And is that a professional

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1 AMY E. EMBRY
 2 association of doctors within Arkansas?
 3 A. Yes, it is.
 4 Q. Okay. And when you mentioned,
 5 say, the Occupational Therapy, you said
 6 Occupational Therapy, is that an
 7 association, a professional association
 8 of occupational therapists in Arkansas?
 9 A. Yes, ma'am. I can't remember
 10 the exact name off the top of my head.
 11 Q. Okay. And when you've worked
 12 with these groups did they -- again, did
 13 members of those groups provide expertise
 14 as professionals within the field?
 15 A. Sometimes, yes.
 16 Q. And when you've worked with
 17 these groups did you ever review -- and
 18 by "you" I mean the Board -- best
 19 practices guidelines of those
 20 organizations?
 21 A. Yes.
 22 Q. And does the Board, when it
 23 enacts regulations, attempt to try to
 24 enact regulations that are consistent
 25 with best practices in a particular

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1 AMY E. EMBRY
 2 field?
 3 A. They do try, yes.
 4 Q. Are you familiar with the
 5 regulation about opioid prescriptions?
 6 A. Yes.
 7 Q. Was that a regulation that was
 8 passed based on a statutory mandate?
 9 A. That was before I was the
 10 Director. My understanding is that it was
 11 drafted and put through the promulgation
 12 process at the request of the legislature
 13 because of the opioid epidemic.
 14 Q. So your understanding is
 15 that's in that category of a request of
 16 the legislature but not a statutory
 17 provision?
 18 A. Correct.
 19 Q. That's correct?
 20 A. Yes. That's my understanding.
 21 Q. I may not have heard part of
 22 your answer. I understood you to say it
 23 was drafted at the request of the
 24 legislature because of a concern; is that
 25 what I heard?

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1 AMY E. EMBRY
 2 A. It was because of the opioid
 3 epidemic.
 4 Q. Okay. That was before your
 5 time on the Board; is that right?
 6 A. Yes. Before I was Director,
 7 yes.
 8 Q. You were employed at the Board
 9 at that time?
 10 A. Yes. But in my previous job I
 11 had nothing to do with the rules or
 12 anything.
 13 Q. Understood. Okay. Thank you.
 14 You mentioned that the
 15 legislature needs to approve any
 16 regulations that the Board enacts. Did I
 17 understand that correctly?
 18 A. Yes.
 19 Q. Has that always been a
 20 requirement since you're aware?
 21 A. Yes.
 22 Q. Since you've been employed by
 23 the Board?
 24 A. Yes.
 25 Q. And the process to get the

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1 AMY E. EMBRY
 2 legislature approval after you enact a
 3 regulation, or I guess you would call it
 4 a proposed regulation at that point, does
 5 it actually have to get voted on by the
 6 State Legislature?
 7 A. It must be voted on by
 8 committees and subcommittees.
 9 Q. So it's not the full
 10 legislature that has to approve it but
 11 the relevant committee; is that correct?
 12 A. That's my understanding, yes.
 13 Q. Is it a particular committee
 14 or subcommittee that generally has to
 15 approve your regulations?
 16 A. I do know it's -- it's the
 17 Rules Subcommittee and I'm sorry, I can't
 18 remember the name of the actual committee
 19 that it's the subcommittee of.
 20 Q. You mentioned various Arkansas
 21 professional medical or related
 22 organizations that the Board will
 23 sometimes look to for guidance in
 24 developing regulations. Does the Board
 25 ever look to national professional

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1 AMY E. EMBRY
 2 medical groups like the American Medical
 3 Association?
 4 A. Since I have been Director I
 5 think it's more for information, data
 6 collection, things of that nature.
 7 Q. And the Board will look to
 8 those national groups for information and
 9 data collection; is that correct?
 10 A. If needed, yes.
 11 Q. Can you tell me in what
 12 context?
 13 A. An example may be that if they
 14 need to know what the national average is
 15 for a particular prescription of a drug,
 16 the AMA, for example, may have that
 17 information. They would go to the website
 18 and see what information is there, so
 19 just basically on an informational scale.
 20 Q. Got it. And when the Board
 21 passes a regulation, that's by a majority
 22 vote; is that right?
 23 A. Yes.
 24 Q. So it's not a consensus
 25 requirement?

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1 AMY E. EMBRY
 2 A. No, but it does require a
 3 vote.
 4 Q. Is there a public comment
 5 period for regulations?
 6 A. Yes.
 7 Q. Is that before or after it
 8 goes to the legislature?
 9 A. Before.
 10 Q. So do I understand right, the
 11 Board will write the regulation, vote to
 12 approve it, then put it out for public
 13 comment or do I have that backwards?
 14 A. You are correct.
 15 Q. Okay. And then the Board
 16 considers the comments that were made by
 17 the public?
 18 A. Absolutely.
 19 Q. And potentially change the
 20 regulation as a result?
 21 A. Could be. Could be. That is an
 22 option.
 23 Q. And then they would have a
 24 perhaps a revised version that they would
 25 vote on again; is that right?

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1 AMY E. EMBRY
 2 A. That is correct.
 3 Q. And at that point it would get
 4 sent to the legislature for approval?
 5 A. At that point any changes that
 6 are made it has to go through the whole
 7 promulgation process again, so it would
 8 have the public comment period again and
 9 then begin the legislative process.
 10 Q. Okay. Has the legislature ever
 11 rejected a proposed regulation?
 12 A. Yes.
 13 Q. Do you know what about?
 14 A. It was the one we discussed
 15 earlier, the one about the cosmetic
 16 procedures. That's the only one that I
 17 know of.
 18 Q. Oh, I misunderstood. So the
 19 Board actually did adopt a regulation but
 20 the legislature rejected it; is that
 21 right?
 22 A. Correct.
 23 Q. Do you know why?
 24 A. During the committee meeting
 25 they thought the Medical Board did not

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1 AMY E. EMBRY
 2 have the authority to -- to regulate
 3 those procedures when they were not their
 4 licensees and it was also a scope of
 5 practice issue. So it was voted down in
 6 the legislature -- in the committee, in
 7 the committee.
 8 Q. And what do you mean by "a
 9 scope of practice issue"?
 10 A. Scope of practice basically
 11 means was it in the Board's scope to say
 12 this -- this person can or cannot do this
 13 procedure; was it in the law?
 14 Q. And by "the law" you mean the
 15 law that gives the Board authority to
 16 regulate various healthcare providers?
 17 A. Yes.
 18 Q. The Arkansas Medical Practices
 19 Act?
 20 A. Yes.
 21 Q. Okay. You mention the public
 22 comment period. Do public comments ever
 23 get submitted on proposed regulations by
 24 professional medical groups?
 25 A. Yes.

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1 AMY E. EMBRY
 2 Q. Would those be Arkansas
 3 professional medical groups or national
 4 groups or both?
 5 A. Usually they are Arkansas.
 6 Q. Would that include the same
 7 groups that you mentioned earlier, the
 8 Arkansas Medical Society and similar
 9 organizations for occupational therapists
 10 and physician assistants, I think you
 11 said?
 12 A. Yes.
 13 Q. Any others?
 14 A. Not that I can think of but
 15 public comments can come from anyone,
 16 anywhere on the planet.
 17 Q. Okay. And are those comments
 18 from the medical groups given weight by
 19 the Board in making a decision?
 20 A. Sometimes.
 21 Q. I want to talk a little bit
 22 about licensing.
 23 I understand the Board
 24 licenses certain kind of medical
 25 providers, correct?

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1 AMY E. EMBRY
 2 A. Yes.
 3 Q. And that includes medical
 4 doctors, right?
 5 A. Yes.
 6 Q. Where would I find the
 7 requirements for licensure of a medical
 8 doctor in Arkansas? Where are those
 9 contained?
 10 A. They're contained in the
 11 Medical Practices Act but they're also on
 12 our applications on our website.
 13 Q. Okay. But no other places
 14 besides that?
 15 A. Not that I'm aware of.
 16 Q. Okay.
 17 MS. COOPER: Can we look at
 18 tab 4 and post that, please, and
 19 mark that as Exhibit 4?
 20 (Exhibit 4, printout from the
 21 Medical Board re: Regulatory and
 22 Discipline was received and marked
 23 on this date for identification.)
 24 MS. LAND: I have it.
 25 MS. COOPER: Thank you.

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1 AMY E. EMBRY
 2 Q. Do you recognize this page?
 3 A. Yes.
 4 Q. Do I understand correctly this
 5 is from the Arkansas State Medical
 6 Board's website?
 7 A. Yes.
 8 Q. And if you'll read with me the
 9 box that says Regulatory/Discipline, it
 10 says, "The Arkansas State Medical Board's
 11 mission is to protect the health, safety
 12 and welfare of the people of the State of
 13 Arkansas with the goal that all citizens
 14 are provided with the highest quality
 15 healthcare. The Medical Board receives
 16 and reviews complaints against each type
 17 of medical profession it licenses. All
 18 complaints received are reviewed by the
 19 Medical Board to determine if there have
 20 been any violations of the Medical
 21 Practices Act. If the Medical Board
 22 determines that violations have occurred
 23 disciplinary actions are taken." Did I
 24 read that correctly?
 25 A. Yes.

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1 AMY E. EMBRY
 2 Q. Is this an accurate statement
 3 of the Board's mission concerning
 4 regulatory work?
 5 A. Yes.
 6 Q. Okay. I'd like to go back to
 7 what we marked as Exhibit 2, the Medical
 8 Practices Act and Regulations.
 9 Before I turn to a particular
 10 provision, I just have a more open
 11 general question.
 12 Can the Board, is it right,
 13 can investigate allegations of wrongdoing
 14 by doctors; is that correct?
 15 A. Yes.
 16 Q. And if you can turn to Section
 17 17-80-106. I understand this is the
 18 provision that says, "Investigations and
 19 inspections of alleged wrongdoing",
 20 correct?
 21 A. Yes.
 22 Q. If you look down to Section C
 23 it has some subsections there and if you
 24 would like to take the time to read (c),
 25 and then the (2), I have a question about

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1 AMY E. EMBRY
 2 that. So why don't you take a moment.
 3 (Deponent reviews the
 4 document.)
 5 A. Okay.
 6 Q. So do I understand correctly
 7 from this provision or perhaps somewhere
 8 else that the Board can investigate to
 9 determine if doctors are practicing their
 10 profession in a way as to endanger the
 11 general health and welfare of the public?
 12 A. Yes.
 13 Q. So if somebody brings a
 14 complaint that there is a doctor engaging
 15 in some conduct that they say is harmful,
 16 you would investigate that? You, the
 17 Board, will investigate that complaint?
 18 A. Yes.
 19 Q. You mentioned you're a
 20 complaint-based -- it's a complaint-based
 21 process. If it comes to the attention of
 22 the Board that a doctor is practicing in
 23 a way that is endangering the public, but
 24 nobody has brought a formal complaint,
 25 can the Board investigate?

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1 AMY E. EMBRY
 2 A. Yes.
 3 Q. Has that ever happened?
 4 A. Oh, yes.
 5 Q. Can you tell me about those
 6 times?
 7 A. Well, I don't -- I could not
 8 tell you specifically which ones without
 9 documents in front of me but other ways
 10 that we can be notified is if someone is
 11 arrested, if they make the news, if a
 12 Board member finds out about it, if it
 13 happens in front of a Board member.
 14 Q. And this is something that's
 15 happened -- when I say "this" let me
 16 rephrase that.
 17 Investigations that were done
 18 in the absence of a formal complaint, is
 19 that something that's happened since
 20 you've been with the Board?
 21 A. Yes.
 22 Q. Can you estimate how many
 23 times?
 24 A. If I had to guess, if I had to
 25 guess in the four years since I've been

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1 AMY E. EMBRY
 2 there, I would say a dozen, maybe a
 3 little less. But that's my best guess
 4 without documents in front of me.
 5 Q. Understood. And you said you
 6 gave some examples of potential ways an
 7 issue could come to the Board's attention
 8 and in one example you mention was if it
 9 made the news.
 10 Are there particular examples
 11 you can think of where something was in
 12 the news that prompted the Board to act?
 13 A. Usually what happens is if we
 14 hear on the news that a doctor or a
 15 licensee, it doesn't have to be a doctor,
 16 just one of our licensees is arrested, if
 17 they are actually arrested that sends up
 18 red flags. If they are just suspected but
 19 no arrest has been made, that still sends
 20 up red flags. But usually an arrest
 21 means they have something, some sort of
 22 proof that they could justify an arrest.
 23 And then we would usually have what's
 24 called a "called meeting", which means a
 25 meeting outside of our regular scheduled

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1 AMY E. EMBRY
 2 board meetings, if that individual is an
 3 immediate threat to the public, and we
 4 could -- the Board could decide; does
 5 this need to be an Emergency Order of
 6 Suspension or what needs to be done?
 7 Q. And just to understand this
 8 type of circumstance better, I imagine a
 9 doctor or other licensed provider could
 10 be arrested for something that has
 11 nothing to do with their practice of
 12 medicine, say, you know, really bad
 13 speeding violations, would that be
 14 something that would prompt the Board's
 15 attention and investigation?
 16 A. Every situation is different.
 17 They look at it; does it put the public
 18 in danger? Speeding is one thing, two
 19 DUIs is something else. So it just really
 20 depends. That's just examples, it's just
 21 an example. So every situation is
 22 different and the Board must address that
 23 situation and decide what needs to be
 24 done.
 25 Q. Have there been times when a

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1 AMY E. EMBRY
 2 licensee was arrested for something
 3 related to how they were providing care?
 4 A. Yes.
 5 Q. Can you give me examples?
 6 A. We had a physician who was
 7 arrested on suspicion of rape with
 8 patients and the Board took actions to
 9 protect the public.
 10 It was later, once it made it
 11 to court, they could not have any
 12 witnesses, no witnesses would testify, so
 13 all the charges were dropped but the
 14 Board had to take action to protect the
 15 public.
 16 Q. Any other examples of somebody
 17 arrested in relation to the practice of
 18 medicine?
 19 A. Not that I can recall. And
 20 again, if I had documents in front of me
 21 I may have more information.
 22 Q. Could it be a substance abuse
 23 issue, arrest for that would be something
 24 that could prompt the Board's attention?
 25 A. Yes, absolutely.

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1 AMY E. EMBRY
 2 Q. What if, for example, somebody
 3 was arrested for writing improper
 4 prescriptions, you know, for friends to
 5 get painkillers or something like that,
 6 would that be something that could prompt
 7 the Board's investigation?
 8 A. Yes.
 9 Q. And that would be whether or
 10 not somebody brought a formal complaint
 11 against the Board, is that right, against
 12 the doctor?
 13 A. Not necessarily. There does
 14 not have to be a formal complaint if
 15 there is an arrest or something that
 16 shows substance abuse or that could
 17 affect their ability to practice medicine
 18 safely.
 19 Q. Okay. Understood. I think I
 20 asked the question awkwardly.
 21 So there does not need to be a
 22 complaint for the Board to investigate?
 23 A. No.
 24 Q. Understood. Have there been
 25 any investigations of doctors or other

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1 AMY E. EMBRY
 2 licensees for providing care that is
 3 considered harmful to patients?
 4 A. Yes.
 5 Q. Can you tell me about those
 6 examples?
 7 A. We've had complaints, for
 8 example, most recently we've had
 9 complaints that a doctor was prescribing
 10 a drug to county inmates that they felt
 11 was inappropriate. And that's the most
 12 recent one.
 13 Q. What drug was that?
 14 A. Ivermectin.
 15 Q. So that was a formal complaint
 16 made to the Board?
 17 A. Several formal complaints made
 18 to the Board and it also made the news.
 19 Q. That's something that the
 20 Board was going to address and did
 21 address?
 22 A. Yes. They are currently
 23 addressing it and I can't say much more
 24 on open investigations.
 25 Q. So the investigation is open

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1 AMY E. EMBRY
 2 now?
 3 A. Yes.
 4 Q. How many complaints did the
 5 Board receive about that Ivermectin use
 6 in the jail?
 7 A. Written complaints, if I had
 8 to give a ballpark number, around ten.
 9 Q. And what about unwritten?
 10 A. Well, that would be from
 11 media, social media and I could not tell
 12 you how many there were. There were quite
 13 a few but I could not give you an exact
 14 number.
 15 Q. Has the Board received any
 16 complaints or otherwise chosen to
 17 investigate doctors that provided care
 18 that departed from accepted standards in
 19 the field?
 20 A. Yes.
 21 Q. Can you tell me some of those?
 22 A. I couldn't tell you exactly
 23 but it is very common to receive a
 24 complaint that the Board reviews in
 25 which, for example we'll use surgery,

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1 AMY E. EMBRY
 2 somebody writes a complaint that the
 3 surgery did not go well, that they're not
 4 healing well or they're suffering from
 5 that and it is very common when the Board
 6 reviews that complaint they may ask the
 7 surgeons on the Board; is this common?
 8 They will say; yes, this is a common
 9 occurrence in surgery; or no, it is not a
 10 common occurrence, and we need to do an
 11 investigation.
 12 Q. In the surgery example you
 13 gave, that's a real life example that has
 14 happened at least once that someone
 15 complained about a surgery that they felt
 16 went wrong; is that correct?
 17 A. Yes.
 18 Q. And then so the surgeons on
 19 the Board would be consulted about
 20 whether what was described is a common
 21 occurrence or not?
 22 A. That's just my example, but
 23 usually during the board meeting all the
 24 Board members review that complaint, but
 25 some of them may have, you know, may say;

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1 AMY E. EMBRY
 2 surgeons, what do you think about this,
 3 and get their expertise.
 4 Q. And then if there's concern
 5 that it may be inappropriate treatment,
 6 then it would be investigated?
 7 A. Usually, yes.
 8 Q. And when you say they may ask
 9 the surgeons about what do you think, is
 10 the question; is this conduct by the
 11 surgeon at issue consistent with accepted
 12 medical practice or something else? I
 13 just want to make sure I understand.
 14 A. Yes, it is usually accepted
 15 medical practice.
 16 Q. So failure to follow accepted
 17 medical practice could be a reason for
 18 investigation?
 19 A. Could be.
 20 Q. And to determine the accepted
 21 medical practice, does that involve
 22 looking to some of these medical
 23 professional groups that you talked
 24 about?
 25 A. That would be a question for a

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1 AMY E. EMBRY
 2 physician. I can't answer that as an
 3 unphysician, as far as use.
 4 Q. But for the Board to determine
 5 whether this is something that should be
 6 investigated for failing to comply with
 7 accepted medical practices, how do they
 8 determine that?
 9 A. There are 14 Board members, so
 10 each one determines that individually. I
 11 think what I was trying to get to is that
 12 if they ask the surgeons their expertise
 13 and the surgeon says; this never should
 14 have happened, they would have been
 15 taught in medical school, or something
 16 like that. So it could be from medical
 17 education, it could be from continuing
 18 education, it could be from
 19 certifications.
 20 Q. When you say "it could be from
 21 medical education" and these other
 22 things, what is the "it" you mean?
 23 A. Their decision.
 24 Q. Oh, what they might base it
 25 on?

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1 AMY E. EMBRY
 2 A. A-hum.
 3 Q. I see. But would it be a
 4 violation of the Arkansas State Medical
 5 Practices Act for doctors to provide care
 6 that departs from accepted standards in
 7 the field?
 8 MS. LAND: Objection to form.
 9 A. Could you repeat the question?
 10 Q. Sure. Would it be a violation
 11 of the Arkansas Medical Practices Act for
 12 doctors to provide care in a way that
 13 departs from accepted standards in the
 14 field?
 15 A. Not necessarily. I think it
 16 would just depend on the situation.
 17 Q. But the accepted standards in
 18 the field are relevant to assessing
 19 whether there was a violation; is that
 20 right?
 21 A. If I had to answer on how the
 22 Board makes their decision, I would say
 23 yes, that is part of their consideration.
 24 MS. COOPER: Okay. I'm mindful
 25 of the time, we've been going for

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1 AMY E. EMBRY
 2 close to an hour and a half. Are
 3 folks, including the court
 4 reporter, okay going a few more
 5 minutes until a break to wrap up a
 6 line of questions?
 7 (Discussion is held off the
 8 record.)
 9 Q. Just to explore a little bit
 10 more this process the Board goes through
 11 when it's considering whether to
 12 investigate a complaint, and I should
 13 back up and ask, am I even describing
 14 that right, that there is a process that
 15 happens before a decision is made whether
 16 to investigate; is that correct?
 17 A. Yes. Yes.
 18 Q. So in the case of a complaint,
 19 a complaint is filed with the Board and I
 20 understand you spoke earlier about
 21 potentially hiring or not hiring, I guess
 22 working with investigators to collect
 23 subpoenaed information from the licensee
 24 and then issuing the report, but before
 25 you get to that stage does something

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1 AMY E. EMBRY
 2 happen at the Board before investigators
 3 are called to assist?
 4 A. Yes. And again, every
 5 situation is different, but we do have a
 6 process within the office that is
 7 followed before it's presented to the
 8 Board.
 9 Q. And what is that process
 10 before the investigation would be
 11 launched?
 12 A. Okay. So when a complaint
 13 comes in the complaint is processed, a
 14 letter is sent to the complainant saying
 15 we have received your complaint; a copy
 16 of that complaint is also sent to the
 17 licensee and that licensee needs to
 18 respond to that complaint.
 19 At that point when we receive
 20 that response both the complaint and the
 21 response from the licensee is presented
 22 to the Board and they determine if there
 23 has been a violation of the Medical
 24 Practices Act and then from there that is
 25 -- they determine; are we going to do an

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1 AMY E. EMBRY
 2 investigation; does the licensee need to
 3 come and talk to us more before we decide
 4 what we need to do? There could be a
 5 variety of situations of how this could
 6 work out.
 7 It could also be that the
 8 Board reads it, reads the response and
 9 they take it as information only, meaning
 10 that we understand we've received the
 11 complaint, we've reviewed the complaint,
 12 there has been no violation of the
 13 Medical Practices Act and that's the end.
 14 And then once it is concluded a letter is
 15 sent to the complainant and also the
 16 physician to let them know the outcome.
 17 Q. Thank you. Very helpful.
 18 So in the event that they
 19 determine there is a violation, that's
 20 when they would then investigate? Or do
 21 they need the investigation to determine
 22 if there is a violation?
 23 A. Again, it all depends on the
 24 complaint. There are some complaints that
 25 we receive that are so severe that we may

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1 AMY E. EMBRY
 2 call the Chairman of the Board saying; do
 3 you want us to start an investigation now
 4 to at least gather some medical records,
 5 description records, whatever they did?
 6 Or it could be that it's a standard
 7 complaint, it's presented to the Board
 8 and the Board says; yes, we need to open
 9 an investigation and we would like to see
 10 these medical records for these patients.
 11 And this is just an example, just to give
 12 you an idea, that they could say we want
 13 the medical records, we also want the
 14 PDMP report, which is the Prescription
 15 Drug Monitoring Program in Arkansas, for
 16 opioids and so forth and they can
 17 determine from there. So, again, it
 18 really depends on the complaint.
 19 Q. So there are some complaints
 20 where -- tell me if this is correct --
 21 that when the complaint and the response
 22 are presented to the Board, on the face
 23 of it the Board can determine that a
 24 violation has or has not occurred; is
 25 that correct?

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1 AMY E. EMBRY
 2 A. Yes.
 3 Q. Do they ever review, the Board
 4 ever review the complaint and response
 5 and determine they need an investigation
 6 to determine if a violation has occurred?
 7 A. Yes.
 8 Q. And then in terms of where
 9 they look to determine what constitutes a
 10 violation, would that be the provisions
 11 that we looked at -- actually, let me ask
 12 you generally because I don't want to
 13 limit your answer if there is more.
 14 Where does the Board look to
 15 determine what standards they're applying
 16 to determine what constitutes a violation
 17 of the Medical Practices Act by a doctor
 18 or other licensee?
 19 A. They look at the Medical
 20 Practices Act and the rules that are a
 21 part of it.
 22 MS. COOPER: Okay. I think
 23 this would be a good time to take a
 24 break. How is ten minutes.
 25 VIDEOGRAPHER: We are off the

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1 AMY E. EMBRY
 2 record at 11:36 a.m.
 3 (Recess is taken.)
 4 VIDEOGRAPHER: We are back on
 5 the record at 11:48 a.m.
 6 Q. Thank you. When we were
 7 speaking before we were talking about the
 8 process the Board follows when there is a
 9 complaint against a licensee and I just
 10 have a couple of additional questions
 11 about that.
 12 Is there ever a hearing
 13 involving a complaint against a licensee?
 14 A. A hearing occurs whenever
 15 there is any action against a licensee,
 16 against their license. Usually that's an
 17 Emergency Order of Suspension.
 18 Q. So if the Board decides to
 19 suspend a license there would be a
 20 hearing first?
 21 A. Yes -- no. Let me -- you can
 22 do an Emergency Order of Suspension if
 23 you feel there is an immediate threat to
 24 the public and then there will be a
 25 hearing at the next scheduled board

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1 AMY E. EMBRY
 2 meeting.
 3 Q. If the Board does not believe
 4 there is an immediate threat would there
 5 be a meeting before the suspended
 6 license?
 7 A. Yes.
 8 Q. So if there is an emergency
 9 suspension of the license it's followed
 10 up by a hearing to allow the person to
 11 contest it; is that correct?
 12 A. Correct.
 13 Q. So a licensee could have their
 14 license suspended without any hearing?
 15 A. Yes. If there is -- if there
 16 is a perceived threat to the public.
 17 Q. I'm sorry. Let me -- let me
 18 try to ask it differently.
 19 If there is a complaint about
 20 some wrongdoing by a licensee, and the
 21 Board determines that a violation has
 22 occurred, it would make that
 23 determination before there would be any
 24 hearing for the licensee?
 25 A. That is correct. Action can be

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1 AMY E. EMBRY
 2 taken on a license without a licensee
 3 being present, but they must be given a
 4 hearing and that is actually part of the
 5 administrative rules in Arkansas.
 6 Q. So they get a hearing if
 7 action is taken to rescind or suspend
 8 their license?
 9 A. Correct. Any action on a
 10 license, if they feel that it needs to be
 11 a revocation, which is very rare, and
 12 EOS, Emergency Order of Suspension is
 13 usually the most common done by our
 14 Board.
 15 Q. In that case there would be an
 16 emergency order of suspension but it
 17 would be followed up by a hearing?
 18 A. Correct.
 19 Q. But if it's not an emergency
 20 order of suspension, but the Board would
 21 like to suspend, would there be a hearing
 22 and then a decision whether to suspend?
 23 A. No, they can suspend at a
 24 meeting. For example, if a complaint
 25 comes in, they review that complaint,

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1 AMY E. EMBRY
 2 they vote that there has been a violation
 3 of the Medical Practices Act, they can
 4 suspend the license then.
 5 Q. And then there is no hearing?
 6 A. And then there is a hearing,
 7 the licensee is given notice that their
 8 hearing will be at the next board
 9 meeting.
 10 Q. And they give -- are given an
 11 opportunity to convince the Board to
 12 change their mind, is that the idea?
 13 A. Correct.
 14 Q. And when there is a hearing --
 15 so there's always a hearing when action
 16 is taken to suspend or revoke a license;
 17 is that correct?
 18 A. Yes.
 19 Q. Does the Board make a case at
 20 the hearing for why it is suspending the
 21 license?
 22 A. Yes. That falls on the
 23 attorneys.
 24 Q. The attorneys for the Board
 25 would do that?

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1 AMY E. EMBRY
 2 A. Correct.
 3 Q. Would the attorneys for the
 4 Board present experts?
 5 A. Yes, they could.
 6 Q. And those would be experts in
 7 the relevant field at issue?
 8 A. Usually, yes.
 9 Q. Okay. And how does the Board
 10 find those experts?
 11 A. There really is no official
 12 way that we find them. We could use
 13 recommendations of somebody in a
 14 particular field.
 15 For example, if a complaint
 16 was against an ENT doctor, we may ask our
 17 Board member who is an ENT; do you know
 18 of anybody that would be a good expert to
 19 review this.
 20 Q. So we've kind of been talking
 21 about this but I haven't asked this
 22 question; can the Board discipline a
 23 doctor who is licensed by the Board?
 24 A. Oh, absolutely, yes.
 25 Q. And under what circumstances

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1 AMY E. EMBRY
 2 can a Board discipline a doctor?
 3 A. It could be that they're -- I
 4 will give an example, that a complaint
 5 comes in and it's more about boundaries,
 6 that they feel they overstep their
 7 bounds, they've become too close to
 8 patients, they could have a relationship
 9 with the patient. It could be numerous
 10 things.
 11 So part of the discipline can
 12 be you need to take a boundaries course
 13 and you need to take that documentation
 14 to the Board and report back to the Board
 15 to let us know what's going on.
 16 Discipline, if there is substance abuse
 17 involved they could say; you need to meet
 18 with the Foundation, which is the
 19 organization that handles licensees in
 20 distress. So they can administer
 21 discipline that way. Very rarely do we
 22 issue a reprimand, but reprimands can be
 23 issued.
 24 Q. If we can go back to Exhibit
 25 2, the Medical Practices Act, and turn to

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1 AMY E. EMBRY
 2 Section 17-95-409, page 28.
 3 A. 28?
 4 Q. Got that? If you'll read with
 5 me (a)(1) says, "The Arkansas State
 6 Medical Board may revoke an existing
 7 license, impose penalties as listed in
 8 17-95-410 or refuse to issue a license in
 9 the event the holder or -- in the event
 10 that holder or complainant, as the case
 11 may be, has committed any of the acts or
 12 defenses defined in this section to be
 13 unprofessional conduct."
 14 My first question is, is this
 15 the provision that defines the scope of
 16 when the Board can discipline or the
 17 circumstances under which the Board can
 18 discipline a licensee?
 19 A. Well, this is when it may
 20 revoke. This says when it may revoke.
 21 Q. Well, it says -- I'm sorry. Go
 22 ahead.
 23 A. This section specifically
 24 relates to revocation and refusal to
 25 issue a license.

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1 AMY E. EMBRY
 2 Q. And they impose penalties as
 3 listed in Section 95-410, that's also
 4 limited to, I see denial, suspension or
 5 revocation. Okay.
 6 So these are -- Section
 7 17-95-409 are the circumstances under
 8 which a license may be revoked or not
 9 issued; is that correct?
 10 A. Correct.
 11 Q. And other types of discipline
 12 for other -- excuse me. Sorry. Strike
 13 that.
 14 You talked about other kinds
 15 of discipline, like requiring a doctor to
 16 take a particular kind of course about
 17 boundaries. Where in the act, if
 18 anywhere, are those kinds of discipline
 19 options enumerated?
 20 A. That's going to be in the
 21 code. I don't know exactly where in the
 22 code. I would have to do some research to
 23 find it.
 24 Q. Okay. Then let me ask a
 25 different way.

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1 AMY E. EMBRY
 2 So the Board has the ability
 3 to deny, suspend or revoke a license
 4 based on the grounds listed in Section
 5 17-95-409, correct?
 6 A. Yes.
 7 Q. And is it correct that the
 8 Board has the authority to take other
 9 action, like suspension of a license?
 10 A. Within this section, is that
 11 what you're asking?
 12 Q. Well, let me ask it
 13 differently.
 14 You've talked about suspension
 15 and emergency suspension. Is that
 16 something -- I'm sorry. Strike that. I
 17 read it wrong.
 18 Apart from denial, suspension
 19 and revocation, are there other types of
 20 discipline a Board can impose?
 21 A. Just off the top of my head,
 22 the ones I've already mentioned. Usually
 23 it is, you know, we want you to report
 24 back, check in, you need to take these
 25 courses just as a refresher. That's, off

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1 AMY E. EMBRY
 2 the top of my head, without having other
 3 things in front of me, that's what I can
 4 think of.
 5 Q. Thank you. And focusing then
 6 on suspension and revocation, it is
 7 correct then that 17-95-409 are all of
 8 the grounds for suspension or revocation
 9 or denial of license?
 10 A. In the code, yes. I'm going to
 11 have to read through each one of these
 12 individually. There may be other issues
 13 but I need to see if it's included in
 14 there.
 15 Q. Well, let's look at subsection
 16 (2) of 17-95-409. It says -- and
 17 actually, before we look at that, just
 18 because we've skipped around a little
 19 bit, going back to section (a)(1), it
 20 says, "The Arkansas State Medical Board
 21 may revoke an existing license, impose
 22 penalties as listed in Section 17-95-410
 23 or refuse to issue a license in the event
 24 that the holder or applicant, as the case
 25 may be, has committed any of the actions

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1 AMY E. EMBRY
 2 or offenses defined in this section to be
 3 unprofessional conduct." And if we look
 4 at subsection Unprofessional Conduct, as
 5 used in the Arkansas Medical Practices
 6 Act, what the citations mean, and it
 7 lists sections (A) through (S), correct?
 8 A. Yes.
 9 Q. So those are all practices or
 10 conduct deemed to be unprofessional
 11 conduct under the Act; is that correct?
 12 A. Correct.
 13 Q. And are there other places
 14 where conduct may be deemed
 15 unprofessional conduct, besides what's in
 16 this statute?
 17 A. To my knowledge, yes,
 18 everything is listed here.
 19 Q. Okay. I have a few questions
 20 about just a couple of these provisions.
 21 If you could look at
 22 subsection (G), "grossly negligent or
 23 ignorant malpractice", does the Board
 24 have a standard for determining grossly
 25 negligent or ignorant malpractice?

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1 AMY E. EMBRY
 2 A. They do have a definition of
 3 grossly negligent that they have as part
 4 of their Board packet when considering
 5 this. I do not have it in front of me,
 6 though.
 7 Q. When you say "part of their
 8 Board packet when considering this", what
 9 do you mean by that?
 10 A. We give them a list of
 11 definitions so they'll understand what
 12 suspension means; grossly negligent
 13 they'll understand that; if we say
 14 revoke, what does revoke mean. It's just
 15 a reference sheet, the reference sheets
 16 of commonly used words.
 17 Q. And does "grossly negligent"
 18 include departing from accepting
 19 standards of medical care?
 20 A. I would have to look at the
 21 definition that they use. Again, I don't
 22 have that with me.
 23 Q. Okay. Is it based on
 24 community standards of care?
 25 A. I do not know.

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1 AMY E. EMBRY
 2 Q. Okay. Can you give examples of
 3 some -- well, let me ask it differently.
 4 Since you've been with the
 5 Board has anyone faced discipline based
 6 on gross and ignorant -- grossly
 7 negligent or ignorant malpractice?
 8 A. Not that I can recall.
 9 Q. Could you look down to
 10 subsection (S), the last one, it says,
 11 "committing an ethical violation as
 12 determined by the Board by rule." Did I
 13 read that right?
 14 A. Yes.
 15 Q. Okay. So I understand from
 16 this the Board has authority under this
 17 provision to determine ethical violations
 18 or to enact rules to identify what are
 19 ethical violations; is that correct?
 20 A. Yes.
 21 Q. Has the Board done that?
 22 A. Yes.
 23 Q. Can you tell me where they've
 24 done that?
 25 A. It is Rule -- I don't want to

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1 AMY E. EMBRY
 2 say it wrong, I'm thinking it is 17 but I
 3 need to make sure.
 4 Q. Okay.
 5 A. No. It is Rule 32, Rule 32.
 6 Q. Do I understand from previous
 7 testimony that this was a rule that was
 8 enacted prior to you joining or becoming
 9 employed by the Board?
 10 A. That is correct.
 11 Q. Okay. Is this the only rule
 12 the Board has identifying ethical
 13 violations?
 14 A. To my knowledge, yes.
 15 Q. By the way, I see sometimes
 16 the terminology in these -- in the
 17 regulations calls it a regulation and
 18 sometimes it calls it a rule. Is there
 19 any difference?
 20 A. It was in 2019 the legislature
 21 said we had to change everything that
 22 says "regulation" to "rule", that was
 23 statewide, all agencies. So we are in the
 24 process of updating everything. So
 25 anything that says "regulation" would be

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1 AMY E. EMBRY
 2 changed to "rule". That is the only
 3 difference.
 4 Q. Okay. But the content won't be
 5 changed, just the name --
 6 A. Just the name.
 7 Q. -- that they would be all
 8 rules. Okay.
 9 Let's look at Regulation 32
 10 that I suppose will soon be referred to
 11 as Rule 32; is that correct?
 12 A. Yes.
 13 Q. It says, "Pursuant to Act 1178
 14 of the 87th General Assembly the Arkansas
 15 State Medical Board determines that the
 16 following conduct is an ethical
 17 violation." And in that regulation it
 18 lists subsections (a) through (e),
 19 correct?
 20 A. Yes.
 21 Q. So these are enumerated
 22 examples of -- strike that.
 23 The conduct listed in
 24 subsections (a) through (e) are the only
 25 things that are deemed unethical or

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1 AMY E. EMBRY
 2 ethical violations by the Board; is that
 3 correct?
 4 A. That is correct for this rule,
 5 yes.
 6 Q. Are there other rules that
 7 address ethical violations that the Board
 8 has promulgated?
 9 A. Not to my knowledge.
 10 Q. So to your knowledge, this is
 11 the universe of ethical violations for
 12 physicians?
 13 A. Yes.
 14 Q. Okay. If we can just fairly
 15 briefly go through them, subsection (a)
 16 is about improper sexual contact or
 17 relationship with patients; is that
 18 correct?
 19 A. Yes.
 20 Q. Section (b) is about physician
 21 disclosing confidential information about
 22 a patient, correct?
 23 A. Yes.
 24 Q. Section (c) is about failing
 25 to notify a patient that they have an

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1 AMY E. EMBRY
 2 ownership in a facility or service?
 3 A. Yes.
 4 Q. And (d) is sexual harassment
 5 by the physician; is that correct?
 6 A. Yes.
 7 Q. And (e) is a licensed
 8 physician grossly overutilizing or
 9 ordering or performing tests or
 10 procedures on a patient when that may
 11 result in harm to the patient; is that
 12 correct?
 13 A. Yes.
 14 Q. So that's the universe of
 15 ethical violations for physicians; is
 16 that correct?
 17 A. Yes.
 18 MS. COOPER: I'd like to mark
 19 as Exhibit -- sorry -- 5 what is
 20 tab 5.
 21 (Exhibit 5, Arkansas State
 22 House Bill 1718 was received and
 23 marked on this date for
 24 identification.)
 25 MS. LAND: It has pulled up on

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1 AMY E. EMBRY
 2 my screen.
 3 MS. COOPER: Thank you.
 4 Q. Just for the record, I'm going
 5 to say this is Section 20-6-201 of
 6 Arkansas Statutes.
 7 Are you familiar with this
 8 statute?
 9 A. I am. It's been a while since
 10 I've read it.
 11 Q. I would like to call your
 12 attention to a particular part of this
 13 statute but if you need to read more we
 14 can take time to do that.
 15 I'm going to, instead of
 16 taking your time, why don't I look for
 17 the relevant provision. Let's put that
 18 to the side and we'll come back to that.
 19 So we talked earlier about the
 20 provision in the Medical Practices Act
 21 about unprofessional conduct. And that
 22 one of the examples of unprofessional
 23 conduct was an ethical violation as
 24 determined by the Board by rule, correct?
 25 A. Could you repeat that?

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1 AMY E. EMBRY
 2 Q. Right. That one of the -- we
 3 talked earlier about the definition of
 4 unprofessional conduct with subsections
 5 (A) through (S) in the Arkansas Medical
 6 Practices Act; do you remember that?
 7 A. Yes.
 8 Q. And then one of those
 9 provisions for unprofessional conduct was
 10 defined as unethical conduct or
 11 violations as determined by the Board by
 12 rule; is that correct?
 13 A. Yes.
 14 Q. So what I'm trying to
 15 understand is if there were a complaint
 16 about a doctor engaging in conduct that
 17 was considered harmful by the complainant
 18 but it didn't fall under any of the
 19 categories in the unprofessional conduct
 20 statute (A) through (S), and wasn't
 21 considered an ethical violation under
 22 Regulation 32, is that something the
 23 Board could investigate and potentially
 24 address?
 25 MS. LAND: Objection to form.

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1 AMY E. EMBRY
 2 A. Yes. Yes, they could.
 3 Q. So anything that involves a
 4 complaint by someone in the public
 5 alleging that a doctor is engaging in
 6 harmful conduct could be investigated by
 7 the Board?
 8 A. Yes. It could be, yes.
 9 Q. And would the Board need to
 10 determine that the doctor violated any of
 11 those provisions that were defined as
 12 unprofessional conduct subsections (A)
 13 through (S) or an ethical violation under
 14 Regulation 32 to take action against a
 15 licensee?
 16 A. They would need to determine
 17 if there had been any violation in any
 18 part of the Medical Practices Act,
 19 whether it's in code or in the rule.
 20 Q. And to revoke -- let me ask it
 21 differently.
 22 To revoke or suspend a license
 23 would it have to be "unprofessional
 24 conduct" under the statute we discussed?
 25 A. I don't know if it's limited

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1 AMY E. EMBRY
 2 just to that, a revocation. I would have
 3 to do some research on that one.
 4 Q. Okay.
 5 A. But if -- I can't -- I can't
 6 answer truthfully to that.
 7 Q. I'm just trying to think of --
 8 for example, somebody says; I went to a
 9 surgeon and the surgeon did this
 10 treatment that left me disfigured, would
 11 that potentially be a basis to suspend a
 12 license?
 13 A. They would have to research,
 14 they would have to do an investigation,
 15 unless there was an immediate threat to
 16 the public.
 17 Q. If we can look at the Medical
 18 Practices Act, Exhibit 2, Section
 19 17-95-410. Can we look at subsection
 20 (e)(1), and when you have that let me
 21 know, it's on page 29.
 22 A. What subsection?
 23 Q. (e)(1).
 24 A. Okay.
 25 Q. So it says here, "At the

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1 AMY E. EMBRY
 2 conclusion of the hearing the Board shall
 3 first decide whether the accused is
 4 guilty of the charges against him or her
 5 and then decide on the appropriate
 6 disciplinary action; subsection (2), If
 7 the accused is not guilty the Board shall
 8 dismiss the charges; subsection (3), If
 9 the accused is found guilty the Board may
 10 do one or more of the following; (a)
 11 revoke his or her license; (b) suspend
 12 his or her license not to exceed one
 13 year; (c) issue a reprimand; (d) issue a
 14 probation allowing the licensee to
 15 continue practicing under terms and
 16 conditions found to be in the best
 17 interests of the accused and the general
 18 public; or (e) levy a fine up to \$1,000
 19 under the Arkansas Medical Practices Act
 20 and collect out-of-pocket costs of
 21 investigation incurred by the Board to
 22 conduct the disciplinary hearing."
 23 Those are all forms of
 24 discipline that the Board can impose if a
 25 doctor is found to be in violation of the

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1 AMY E. EMBRY
 2 Medical Practices Act?
 3 A. Yes.
 4 Q. Are there other discipline
 5 options besides those?
 6 A. As we discussed earlier, you
 7 know, if there's no action taken against
 8 the license they can say prescribing
 9 courses, they need you to meet with
 10 so-and-so or whatever. But if this is --
 11 if there is an actual -- an actual -- I'm
 12 sorry -- an actual action against the
 13 license.
 14 Q. Okay. And focusing in on
 15 subsection (3)(d) that we looked at it
 16 says, "The Board can impose a probation
 17 allowing the licensee to continue
 18 practicing under terms and conditions
 19 found to be in the best interests of the
 20 accused and the general public". Is what
 21 you just described an example of that,
 22 you know, a course on anything that you
 23 thought the doctor needed?
 24 A. Imposing a probation, I'm
 25 wondering if this can refer to what we

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1 AMY E. EMBRY
 2 call consent orders, meaning you're
 3 allowed to practice as long as you do A,
 4 B and C.
 5 Q. That's called a consent order?
 6 A. Yes. That's a legal document.
 7 As far as impose a probation, I'm
 8 thinking that's what that is.
 9 Q. And can you tell me examples
 10 of some of those? You called it a
 11 consent order?
 12 A. Yes.
 13 Q. What kinds of conditions are
 14 required? You can continue practicing if
 15 you do A, B or C, what kinds of
 16 conditions?
 17 A. Just some off the top of my
 18 head, if it is a substance abuse issue,
 19 they're allowed to practice as long as
 20 they're in compliance with their contract
 21 with the Arkansas Medical Foundation who
 22 monitors distressed physicians licensed
 23 by our Board. It could also be that they
 24 have to complete these courses in a
 25 certain timeframe and present it to the

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1 AMY E. EMBRY
 2 Board member, the Board as a whole, and
 3 -- I mean, that gives you some ideas,
 4 that there are certain stipulations that
 5 they must adhere to in order to continue
 6 practicing.
 7 Q. Is there something called a
 8 restricted license?
 9 A. No. We do not have a
 10 restricted license.
 11 Q. You just have the consent
 12 order that says you need to do X, Y or Z
 13 to continue practicing?
 14 A. Right.
 15 Q. But even with, say, issues
 16 concerning, you know, prescription of
 17 drugs improperly there couldn't be a
 18 consent order that says you can continue
 19 practicing but you can't prescribe drugs?
 20 Could that be something?
 21 A. Sure. It could be in the
 22 consent order, yes.
 23 Q. Has the Board ever done that?
 24 A. I can't recall. We've had a
 25 lot of consent orders, so I would have to

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1 AMY E. EMBRY
 2 look at that.
 3 Q. So one example you gave was
 4 involving substance abuse. Have there
 5 ever been consent orders that do relate
 6 to prescription practices?
 7 A. Yes.
 8 Q. What kinds of consent orders?
 9 A. It could be, for example, if
 10 the complaint was the physician or
 11 whomever was overprescribing, that part
 12 of the consent orders, if the Board chose
 13 to do so, they could say, you know,
 14 continue practicing but you must
 15 surrender your DEA license.
 16 Q. And what is a DEA license?
 17 A. Drug enforcement, so you can
 18 prescribe controlled substances.
 19 Q. So the doctor could continue
 20 practicing but couldn't prescribe
 21 controlled substances?
 22 A. Correct.
 23 Q. Is there ever monitoring as
 24 part of the consent order, monitoring by
 25 the Board?

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1 AMY E. EMBRY
 2 A. There is monitoring, but we
 3 would gather that information from other
 4 sections. For example, as I discussed
 5 earlier, the PDMP is the Prescription
 6 Drug Monitoring Program, we can request a
 7 report from that program to show what
 8 physician or licensee prescribed to
 9 whomever whenever. So we could use that
 10 as -- to give you an example.
 11 Q. And when the decision is made
 12 to impose discipline, whether suspension
 13 or revocation or something else, is that
 14 a majority vote by the Board?
 15 A. Yes.
 16 Q. If the Board learned that a
 17 doctor were using a treatment that is
 18 unsafe, could the Board issue a rule
 19 prohibiting the use of that treatment?
 20 A. They could. They could draft a
 21 rule and put it through the promulgation
 22 process.
 23 Q. Has it ever done that?
 24 A. Yes.
 25 Q. Tell me about that.

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1 AMY E. EMBRY
 2 A. It was discussed earlier, it
 3 was the rule about the cosmetic
 4 procedures and that's the one that I have
 5 since I have been at the Board that I
 6 know about.
 7 Q. And that was a rule to ban
 8 certain procedures across the board or
 9 prohibit them from being provided at all?
 10 A. It was to say who could
 11 provide those services, not prohibit.
 12 Q. So let me ask it differently.
 13 Has the Board ever promulgated
 14 a rule that prohibits anyone from
 15 performing a particular service or
 16 medical treatment?
 17 A. Not to my knowledge, no.
 18 Q. But it could if that came to
 19 its attention that there was a harmful
 20 treatment going around?
 21 A. Yes.
 22 Q. Has the Board ever considered
 23 prohibiting a treatment across the board?
 24 A. Not to my knowledge, no.
 25 Q. I want to switch gears away

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1 AMY E. EMBRY
 2 from the process, the Board's process.
 3 When the legislature passes
 4 laws concerning the regulation of
 5 medicine, is the Board consulted about
 6 legislation of that nature?
 7 A. Sometimes.
 8 Q. Can you tell me examples of
 9 when it has been consulted?
 10 A. Most recently they were
 11 considering licensing another healthcare
 12 provider and they consulted with the
 13 Board. They had a bill that was
 14 introduced and they said if we went
 15 forward with this bill what would need to
 16 be done. We went with them and went
 17 through that process.
 18 Q. I'm sorry. I may not have
 19 understood. You said "they" meaning the
 20 legislature were considering licensing a
 21 healthcare provider?
 22 A. Correct.
 23 Q. I didn't realize the
 24 legislature licenses healthcare
 25 providers. What do you mean by that?

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1 AMY E. EMBRY
 2 A. They put forward a bill to
 3 license naturopathic physicians.
 4 Q. I see. Not a particular
 5 provider but a category of providers?
 6 A. Correct. Correct.
 7 Q. So there was a bill to license
 8 -- I'm sorry, what did you call the
 9 category?
 10 A. Naturopathic.
 11 Q. Naturopathic physicians. And
 12 the legislature consulted with the Board
 13 about what sorts of issues the --
 14 A. They would say if we decided
 15 to license, how would your office handle
 16 this if we put it underneath your Board?
 17 And we told them when you're drafting the
 18 bill this is how our licensure process is
 19 set up now, so if you do move forward
 20 with this bill we would ask you to
 21 consider X, Y or Z.
 22 Q. Was the Board asked its view
 23 on whether that was a good idea to
 24 license naturopathic physicians?
 25 A. In that instance, no.

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1 AMY E. EMBRY
 2 Q. Are there any other examples
 3 where you think that the legislature
 4 consulted with the Board about a bill?
 5 A. There may have been. The one
 6 that I gave earlier, that's the one that
 7 actually required a sit-down meeting but
 8 it's very common for the legislature to
 9 ask for statistics or information before
 10 they draft a bill.
 11 It is -- to my knowledge, it
 12 is not required for the legislature to do
 13 that and it has not done on any -- any
 14 and all bills that would affect our
 15 licensees.
 16 Q. Since you've been with the
 17 Board or since you've been Executive
 18 Director, are there other examples
 19 besides the naturopathic physician
 20 licensing measure that the legislature
 21 consulted with the Board about?
 22 A. Let me think on that for a
 23 minute. There may have been. I just
 24 can't think of any off the top of my
 25 head. I just remember that one about the

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1 AMY E. EMBRY
 2 naturopaths, that stuck out in my mind.
 3 Q. And since you've been the
 4 Executive Director have there been any
 5 bills that actually were passed
 6 concerning the regulation of medicine?
 7 A. Yes.
 8 Q. Which ones?
 9 A. Well, I don't have the
 10 documents in front of me, but 2021 was a
 11 very active session and I do know that
 12 the Act 626 that we're here about today,
 13 that was passed, that would affect the
 14 Medical Practices Act. There was also,
 15 that affected the Board directly, is that
 16 they changed that physicians could renew
 17 for two years rather than one year, they
 18 put that into law.
 19 I don't have my list in front
 20 of me. That's a couple of them.
 21 Q. Did the legislature consult
 22 with the Board about the rule or bill
 23 about physicians renewing for two years?
 24 A. No.
 25 Q. And when you said before that,

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1 AMY E. EMBRY
 2 referring to the naturopathic physician
 3 bill, that the legislature consulted with
 4 the Board, who in the legislature did
 5 that?
 6 A. I don't have my notes in front
 7 of me but it was one representative and I
 8 believe one senator and I believe they
 9 were the sponsor and co-sponsors of the
 10 bill so they met -- it was during the
 11 pandemic, so it was via Zoom.
 12 Q. So is that something that has
 13 happened in other situations that the
 14 sponsors of a bill would consult with the
 15 Board about a bill?
 16 A. It could happen, yes, that
 17 could happen.
 18 Q. Have there been any
 19 significant bills concerning the
 20 regulation of medicine where the
 21 legislature did not consult with the
 22 Board?
 23 MS. LAND: Object to form.
 24 A. I would have to say yes. I
 25 don't know what they are, but at some

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1 AMY E. EMBRY
 2 point, yes.
 3 Q. That there are times that the
 4 legislature does not consult with the
 5 Board?
 6 A. Correct.
 7 Q. Is it typical that they do
 8 consult with the Board when it's a matter
 9 of medical regulation?
 10 A. In my opinion, I wouldn't say
 11 typical.
 12 Q. Sometimes yes, sometimes no?
 13 A. Correct.
 14 Q. And when they consult with the
 15 Board, who on the Board do they consult
 16 with?
 17 A. It would come through the
 18 office. So they could speak to me, they
 19 could speak to a member of my staff. They
 20 could also reach out because we're under
 21 the Department of Health, it may come
 22 through the Department of Health. It
 23 would be direct contact or it could be
 24 indirect contact.
 25 Q. So in the example you gave

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1 AMY E. EMBRY
 2 about the naturopathic physicians, did
 3 that come through you?
 4 A. Yes, it did, yes.
 5 Q. And you said it was the
 6 sponsors of the bill that reached out?
 7 A. From what I can recollect,
 8 without anything in front of me, yes.
 9 Q. And then do you then connect
 10 the legislators with members of the Board
 11 or do you just talk to them yourself?
 12 A. No. We do not do that at the
 13 Board. We do not connect them unless it's
 14 specifically requested by the legislator
 15 or Department of Health or anything like
 16 that, no.
 17 Q. So when the Board gave input
 18 to the legislature -- legislators, I
 19 should say, in what format did that come?
 20 A. For?
 21 Q. Let me ask it differently.
 22 I understood you to be saying
 23 that these legislators asked for the view
 24 of the Board with respect to some
 25 questions related to the bill. Were you

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1 AMY E. EMBRY
 2 the one who answered those questions to
 3 provide the information they were
 4 seeking?
 5 A. Yes. Because in that instance
 6 for the naturopathic it was specifically
 7 licensing questions and that would come
 8 from the Board staff.
 9 Q. So the Board staff would
 10 typically provide the information that
 11 the legislators are seeking regarding a
 12 bill?
 13 A. Yes.
 14 Q. It would not go to the Board
 15 members?
 16 A. Only if it is something that
 17 the Board needs to consider before
 18 returning that. For example, as I used in
 19 that example, the licensing practices,
 20 the Board would -- the licensing
 21 practices are what they are, the staff
 22 could answer that. But if they are
 23 asking; we want your input from a
 24 physician point of view, or something
 25 like that, we would either ask them to

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1 AMY E. EMBRY
 2 draft something that we would present to
 3 the Board or they could come and address
 4 the Board at the next board meeting.
 5 Q. And have legislators ever come
 6 to address the Board on questions about
 7 which they wanted input?
 8 A. I'm trying to recall. Since
 9 I've been Director, no.
 10 Q. But do you know if that's been
 11 done in the past?
 12 A. I'm not sure. I'm not sure.
 13 Q. And you said they could put,
 14 the legislators could put questions in
 15 writing for the Board; is that correct?
 16 A. Yes.
 17 Q. Has that ever been done?
 18 A. Not since I've been Director.
 19 Q. Before that?
 20 A. I don't know.
 21 Q. Okay. But I understand you to
 22 be saying that if it were a question
 23 about wanting input from the Board on a
 24 matter of practice of medicine, that you
 25 would take that to the Board, not answer

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1 AMY E. EMBRY
 2 it by staff alone?
 3 A. Correct.
 4 Q. Okay.
 5 A. The staff handles what the
 6 staff can handle. The rest goes to the
 7 Board.
 8 Q. Okay. We talked earlier about
 9 prescription of opioids and I'd like to
 10 look at Section 17-95-701 of the Medical
 11 Practices Act. And this is titled --
 12 subchapter (7) is titled Chronic
 13 Intractable -- Chronic Intractable Pain
 14 Treatment Act, correct?
 15 A. Yes.
 16 Q. And is this the provision of
 17 the Medical Practices Act that governs
 18 prescriptions for painkillers?
 19 A. Yes.
 20 Q. And I think you touched on it
 21 in the past. Has overprescription of
 22 opioids been a problem in Arkansas?
 23 A. Yes.
 24 Q. Has it caused harm to the
 25 public?

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1 AMY E. EMBRY
 2 A. Yes.
 3 Q. What kind of harms?
 4 A. Addiction.
 5 Q. And there have been complaints
 6 to the Board about doctors
 7 overprescribing opioids; is that correct?
 8 A. Yes.
 9 Q. Did the Board enact
 10 regulations to address overprescription
 11 of opioids?
 12 A. Yes, 2.8.
 13 Q. Okay. And that one is which
 14 one, I think we talked about it, but --
 15 A. It's Rule 2.8.
 16 Q. Thank you. You said 2.8?
 17 A. No. I'm wrong about that. I'm
 18 sorry.
 19 Q. I'm not finding it there.
 20 A. It is -- it's in Regulation 2,
 21 Regulation 2 has quite a bit to it, and
 22 if you look at 6 (a) and (b).
 23 Q. You said subsection 6 of
 24 Regulation 2?
 25 A. Correct.

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1 AMY E. EMBRY
 2 Q. "The treatment of pain with
 3 dangerous drugs and controlled substances
 4 is a legitimate medical practice when
 5 done in the usual course of medical
 6 practice", that provision? I'm reading
 7 just a portion of it just to make sure
 8 we're on the same page; is that correct?
 9 A. Yes.
 10 Q. And this regulation, was this
 11 all dictated by statute or did the Board
 12 develop any of this?
 13 A. This was before my time, but
 14 from what I understand, this was at the
 15 request of the legislature.
 16 Q. Not by a statute but
 17 legislators requesting it?
 18 A. Correct. That is my
 19 understanding.
 20 Q. If we can go back to
 21 subchapter 7 of the Medical Practices Act
 22 that's on page 34, and if we look at
 23 subsection (c)(1) it says, "In lieu of a
 24 finding of gross and ignorant malpractice
 25 the Board after a hearing may

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1 AMY E. EMBRY
 2 incrementally impose sanctions as
 3 follows: (a) monitor prescribing habits
 4 of the physician not to exceed six
 5 months; (b) require that the decision to
 6 voluntarily surrender his or her United
 7 States Drug Enforcement Agency license to
 8 the Board for a specified period of time
 9 not to exceed three months; (c) suspend
 10 the physician's license, stay the
 11 suspension and require monitoring of
 12 prescribing habits; (d) revoke the
 13 physician's license, stay revocation and
 14 require monitoring of the physician's
 15 prescribing habits for a specified time;
 16 and (e) revoke the physician's license
 17 for serious violations of statutes and
 18 regulations."
 19 Are these all steps the Board
 20 can take if a doctor is found to violate
 21 the provisions regarding prescription of
 22 pain medication?
 23 A. Yes.
 24 Q. And the Board has a Pain
 25 Management Review Committee to review

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1 AMY E. EMBRY
 2 complaints of overprescription of main
 3 medications; is that right?
 4 A. Yes.
 5 Q. And have doctors faced
 6 discipline due to improper prescription
 7 of opioids?
 8 A. Yes.
 9 Q. Can you say approximately how
 10 many, since you've been ED?
 11 A. Not truthfully. I honestly
 12 could not give an honest number on that.
 13 It has occurred.
 14 Q. Do you know if it's more than
 15 20?
 16 A. Since I've been Director, no,
 17 it's not more than 20.
 18 Q. Okay. But it's happened?
 19 A. Yes.
 20 Q. Did any of them have
 21 monitoring or surrender of DEA license as
 22 a discipline that was imposed?
 23 A. Describe "monitoring"?
 24 Q. Well, I'm just reading what it
 25 says there; "monitoring prescribing

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1 AMY E. EMBRY
 2 habits up to six months."
 3 A. Yes. They can be referred to
 4 the Pain Management Review Committee and
 5 it could be that we want an MP run every
 6 month for the next six months.
 7 Q. And some doctors have had
 8 their DEA license revoked or they've had
 9 to surrender it, I should say?
 10 A. We cannot revoke a DEA
 11 license.
 12 Q. But you can require them to
 13 surrender it as a condition to continuing
 14 to practice?
 15 A. Yes, if that's what the Board
 16 decides.
 17 Q. And has that happened?
 18 A. Yes.
 19 Q. Did these actions serve to
 20 protect the public from harmful conduct
 21 by these doctors?
 22 A. Yes.
 23 Q. Did the Board consider just
 24 prohibiting the use of opioids
 25 altogether, given the harm they were

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1 AMY E. EMBRY
 2 causing to the public?
 3 A. I do not know.
 4 Q. You do not know. Okay.
 5 That's never been proposed as
 6 a regulation by the Board?
 7 A. Not since I've been Director,
 8 no.
 9 Q. Do you know why they did not
 10 do that?
 11 A. I have no knowledge about
 12 that. This was before I was there.
 13 Q. Okay. Can we look at
 14 Regulation 27? This is the provision,
 15 "Informed consent for gastric bypass
 16 surgery." Okay?
 17 A. A-hum.
 18 Q. Do I understand correctly from
 19 this that the Board has established
 20 requirements for the informed consent
 21 process before a doctor can perform
 22 gastric bypass surgery?
 23 A. Yes.
 24 Q. And is this a regulation that
 25 was mandated by statute?

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1 AMY E. EMBRY
 2 A. Yes. Actually, by Act 1356.
 3 Q. Okay. And did the Board
 4 develop any part of the regulation or was
 5 it all specified by statute?
 6 A. I do not know. I would have to
 7 look at the document.
 8 Q. And in looking at this I see
 9 it says here, "Pursuant to Act 1356 of
 10 the 84th General Assembly of 2003 all
 11 physicians of the State prior to
 12 performing gastric bypass surgery, also
 13 known as open or laparoscopic Roux-en-Y,
 14 will have the patient signs an informed
 15 patient consent form acknowledging they
 16 have been told information about the
 17 various complications that can result
 18 from the surgery. The complications and
 19 information the patient must be informed
 20 of are as follows:" Did I read that
 21 correctly?
 22 A. Yes.
 23 Q. And then it lists (a) through
 24 (i) as complications that patients must
 25 be informed of, correct?

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1 AMY E. EMBRY
 2 A. It's actually A through M.
 3 Q. Oh, sorry. It is A through M.
 4 And then some of those provisions have
 5 subsections, correct?
 6 A. Yes.
 7 Q. Okay. So, for example,
 8 subsection I says, "The following
 9 surgical complications may arise", and it
 10 lists 33 potential complications,
 11 correct?
 12 A. Yes.
 13 Q. And then there are a series of
 14 nutritional complications, four of those,
 15 correct, under J?
 16 A. Yes.
 17 Q. And psychiatric complications
 18 under K include 4, psychiatric
 19 complication, correct?
 20 A. Yes.
 21 Q. And then L lists items 1
 22 through 22 as additional complications,
 23 correct?
 24 A. Yes.
 25 Q. And then M identifies

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1 AMY E. EMBRY
 2 pregnancy complications, correct?
 3 A. Yes.
 4 Q. And then going back to Section
 5 E says, "There is no guarantee of weight
 6 loss or long-term weight management as a
 7 result of getting surgery." Did I read
 8 that right?
 9 A. Yes.
 10 Q. Okay. And then F, a lifetime
 11 of followup medical care is required; is
 12 that correct?
 13 A. Yes.
 14 Q. So these are all provisions
 15 that doctors have to inform patients
 16 about, complications and risks that the
 17 doctors have to inform patients about
 18 before performing gastric bypass surgery,
 19 correct?
 20 A. Yes.
 21 Q. Now, how did the Board
 22 identify all of these complications?
 23 A. I do not know. I was not at
 24 the Board when this was created and
 25 promulgated. So I would have to look at

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1 AMY E. EMBRY
 2 that documentation.
 3 Q. Okay.
 4 A. But it is possible it came
 5 directly from the Act.
 6 Q. Okay. And do these provisions
 7 that lay out requirements for informed
 8 consent for gastric bypass protect the
 9 public from harm?
 10 A. My belief is yes.
 11 Q. And how is that?
 12 A. Well, it's information to the
 13 patient, they need to be made aware of
 14 these complications.
 15 Q. Did the Board ever discuss
 16 prohibiting gastric bypass surgery?
 17 A. I do not know.
 18 Q. Okay. Does the Board prohibit
 19 any -- I think I asked a version of this
 20 question before but I want to make sure I
 21 understand. Does the Board prohibit any
 22 medical treatment across the Board?
 23 A. No.
 24 Q. And has the Board ever
 25 considered, to your knowledge, a proposal

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1 AMY E. EMBRY
 2 to prohibit a particular medical
 3 treatment across the Board?
 4 A. Not to my knowledge, no.
 5 Q. Has any member of the Board
 6 proposed a regulation that would prohibit
 7 a particular medical treatment across the
 8 Board?
 9 A. Not since I've been the
 10 Director, no.
 11 Q. Okay. Are you aware of, as the
 12 Director of the Board, of any State
 13 statutes that prohibit a particular
 14 medical treatment?
 15 A. The only one that I am aware
 16 of is the one that we're here today to
 17 discuss, Act 626.
 18 Q. You're not aware of any
 19 others?
 20 A. No, I am not.
 21 Q. Now, is off-label use of drugs
 22 permitted in Arkansas?
 23 A. Yes.
 24 Q. Is it common?
 25 A. Yes. I would say so, yes.

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1 AMY E. EMBRY
 2 Q. And I understand that the
 3 State allows off-label use of
 4 hydroxychloroquine to treat COVID; is
 5 that correct?
 6 MS. LAND: Objection to
 7 relevance. You can answer.
 8 A. It does not prohibit it.
 9 MS. COOPER: Can we mark as
 10 Exhibit 6, tab 8?
 11 (Exhibit 6, Guidance For the
 12 Use of Hydroxychloroquine and
 13 Chloroquine For the Treatment of
 14 COVID 19 was received and marked on
 15 this date for identification.)
 16 MS. COOPER: Amanda, do you
 17 have it up?
 18 MS. LAND: Leslie, it is not
 19 loading for me.
 20 MR. RICHARDSON: One moment.
 21 That should be available to you
 22 now.
 23 MS. LAND: Yes, I have it.
 24 MS. COOPER: Great.
 25 Q. For the record, I'll just

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1 AMY E. EMBRY
 2 state that the document is called
 3 Guidance For the Use of
 4 Hydroxychloroquine and Chloroquine For
 5 the Treatment of COVID 19, dated July 29,
 6 2020 from the Arkansas Department of
 7 Health.
 8 Have you ever seen this
 9 before, Ms. Embry?
 10 A. Yes.
 11 Q. When did you see it?
 12 A. When it was released back in
 13 2020.
 14 Q. And why was this -- why did
 15 you see it? How did you come to see it?
 16 A. It was sent out by the
 17 Department of Health to all of its
 18 sub-agencies and sections. It was also on
 19 their website.
 20 Q. Did the Board have any role in
 21 the creation of this guidance?
 22 A. No.
 23 Q. That was done by the
 24 Department of Health?
 25 A. To my knowledge, yes.

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1 AMY E. EMBRY
 2 Q. And just stepping back, I
 3 understand that you're -- well, let me
 4 ask you differently.
 5 What is the relationship
 6 between the Arkansas State Medical Board
 7 and the Department of Health?
 8 A. We are within the Department
 9 of Health. The State Medical Board is an
 10 agency or subsection or whatever you want
 11 to call it of the Department of Health.
 12 Q. Okay. Thank you.
 13 And if we can just read along
 14 together, since it's pretty short, it
 15 says, "On June 15, 2020 the Food and Drug
 16 Administration, FDA, revoked the
 17 emergency use authorization, EUA, for the
 18 use of chloroquine, CQ, and
 19 hydroxychloroquine, HCQ, to treat COVID
 20 19 after concluding it was 'no longer
 21 reasonable to believe that oral
 22 formulations of HCQ and CQ may be
 23 effective in treating COVID 19, nor is it
 24 reasonable to believe that the known and
 25 potential benefits of these products

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1 AMY E. EMBRY
 2 outweigh their known and potential
 3 risks.' The latter included serious
 4 adverse events. Based on this
 5 information, the Arkansas Department of
 6 Health, ADH, updated its guidance related
 7 to HCQ and CQ indicating that their use
 8 for treatment of COVID 19 should be
 9 avoided in both outpatient and
 10 hospitalized settings, but could be
 11 administered prescribed and dispensed for
 12 FDA medical supervision of a patient's
 13 healthcare provider. Unapproved use,
 14 i.e., off-label use, of these medications
 15 is left to the discretion of individual
 16 clinicians and their patients. However,
 17 the ADH wants clinicians to be aware that
 18 coadministration of HCQ or CQ with
 19 remdesivir and MEUA, approved medication
 20 for treatment of COVID 19, is not
 21 recommended based on data showing an
 22 antagonistic effect of these medications
 23 on the antiviral activity of remdesivir."
 24 Did I read that reasonably
 25 okay?

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1 AMY E. EMBRY
 2 A. Yes.
 3 Q. Despite some of the big words.
 4 So you said you were familiar
 5 with this guidance, correct?
 6 A. Yes.
 7 Q. Was the Board consulted in any
 8 way about this guidance?
 9 A. This was nearly two years ago
 10 but my recollection right now is no, they
 11 were not consulted.
 12 Q. Okay. Did the Board have any
 13 conversations about this guidance?
 14 A. Not that I can recall. I would
 15 need to go back and look at meetings.
 16 It's been years.
 17 Q. Did you have any conversation
 18 with Board members or Board have about
 19 this guidance?
 20 A. No.
 21 Q. Did you hear any conversations
 22 from Board staff or Board members about
 23 it?
 24 A. No.
 25 Q. So I understand here that the

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1 AMY E. EMBRY
 2 Department of Health is allowing
 3 off-label use of hydroxychloroquine to
 4 treatment COVID despite the State's
 5 awareness of the lack of evidence of
 6 effectiveness plus serious risks of use,
 7 correct?
 8 A. Repeat that question.
 9 Q. Yes. I understand from here
 10 the State is -- the Department of Health
 11 is allowing the off-label use of
 12 hydroxychloroquine to treat COVID despite
 13 the State's awareness of the lack of
 14 evidence of effectiveness for this
 15 purpose and the serious risks of using
 16 it; is that correct?
 17 A. According to this document, it
 18 says it's allowing the decision to be
 19 left to the individual clinicians and
 20 their patients.
 21 Q. Okay. And this is not
 22 something the Board considered weighing
 23 in on?
 24 A. Not that I can recall.
 25 VIDEOGRAPHER: Is there a

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1 AMY E. EMBRY
 2 chance we can take a break? I've
 3 got to change a card and I'm
 4 getting pretty close.
 5 MS. COOPER: Sure. We can take
 6 a break now. How much time do you
 7 need?
 8 VIDEOGRAPHER: We are off the
 9 record at 12:56 p.m.
 10 (Recess is taken.)
 11 VIDEOGRAPHER: We are back on
 12 the record at 1:50 p.m.
 13 Q. Thank you. Welcome back.
 14 You mentioned earlier an issue
 15 with some doctors or a doctor at a jail
 16 prescribing Ivermectin for COVID. Did I
 17 say that right?
 18 A. Yes.
 19 Q. Okay. And I think you
 20 mentioned there were a number of
 21 complaints about that use of Ivermectin;
 22 is that right?
 23 A. Yes.
 24 Q. And was it all against the
 25 same doctor or multiple doctors?

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1 AMY E. EMBRY
 2 A. In that instance it was the
 3 same doctor.
 4 Q. And so I understand that there
 5 were multiple complaints against this
 6 doctor and am I right that there was a
 7 determination that no action was taken at
 8 some point by the Board with respect to
 9 the complaint against this doctor for
 10 prescribing Ivermectin for COVID?
 11 A. This one is still open, so I
 12 cannot say that nothing has been done.
 13 Q. Okay. So when you say "this
 14 one is still open" and maybe I may be
 15 misspeaking here, but if there is
 16 multiple complaints about one doctor,
 17 then they get joined together as one
 18 investigation or are they separate
 19 investigations?
 20 A. It could. It depends on the
 21 nature of the complaint as well.
 22 Q. And in this case with the
 23 doctor prescribing Ivermectin, is there
 24 one process only or have there been more
 25 than one process in investigating these

<p style="text-align: right;">Page 146</p> <p>1 AMY E. EMBRY 2 complaints? 3 A. I think we did group this one 4 into one investigation. 5 Q. So the Board never reached any 6 conclusion with respect to this -- any 7 complaint against this doctor? 8 A. It is still ongoing. 9 Q. And it never took a complaint 10 for "information only" at any stage? 11 A. They may have taken some for 12 "information only". 13 Q. When you say "some", some 14 complaints against this doctor? 15 A. Yes. So, for example, let's 16 say ten complaints were received. All ten 17 complaints would be presented to the 18 Board individually as separate 19 complaints. Some complaints may say we 20 need to look into this one further, we 21 need to do an investigation, whatever 22 they decide. There may be another 23 complaint to say, no, there was no 24 violation, from what we have found there 25 is no violation of the Medical Practices</p>	<p style="text-align: right;">Page 148</p> <p>1 AMY E. EMBRY 2 but maybe you can help me cut to the 3 chase here. 4 Was there ever one where the 5 Board heard the complaint, had a hearing 6 and determined that even though the 7 doctor was found to have prescribed 8 Ivermectin to treat COVID, that it was 9 not a violation of the Medical Practices 10 Act? 11 A. No. There has not been 12 anything like that. 13 Q. Okay. Has the Board considered 14 passing any regulation prohibiting the 15 use of Ivermectin for COVID? 16 A. No. 17 Q. It's not been proposed by 18 anybody? 19 A. I'm sorry. Could you repeat 20 that? 21 Q. It hasn't been proposed by 22 anybody? 23 A. Not to my knowledge. 24 Q. Okay. Is informed consent a 25 requirement for medical treatments</p>
<p style="text-align: right;">Page 147</p> <p>1 AMY E. EMBRY 2 Act and this one is closed. 3 Q. So with these Ivermectin 4 complaints, some of them have been 5 closed? 6 A. Yes. 7 Q. And was that based on a 8 determination in those complaints there 9 wasn't a violation of the Medical 10 Practices Act? 11 A. Yes. 12 Q. And does that mean in those 13 situations the Board determined that 14 Ivermectin had not been prescribed to 15 treat COVID in those cases? 16 A. It would depend on what that 17 particular complaint was. If it was a 18 complaint about Ivermectin and they took 19 it as no violation, then that's it but I 20 would have to go back and review every 21 single one of those to see if it was 22 specifically Ivermectin. 23 Q. Was there ever a complaint -- 24 and I know I could go review all the 25 board meetings and look at this myself,</p>	<p style="text-align: right;">Page 149</p> <p>1 AMY E. EMBRY 2 generally in Arkansas? 3 A. Could you repeat that? 4 Q. Let me repeat that. Are you 5 having trouble hearing me? 6 A. I think you were just breaking 7 up on that question. 8 Q. Okay. I'll repeat it. 9 Is informed consent a 10 requirement for medical treatment in 11 Arkansas? 12 A. I would have to check the code 13 but I do know we have some regulations 14 for informed consent, abortion, gastric 15 bypass and I do know on certain instances 16 you do have to have a consent form to 17 treat certain patients. For all of them, 18 I'm not sure about. 19 Q. Is the Board aware of the 20 Gender Spectrum Clinic at Arkansas 21 Children's Hospital? 22 A. I can't answer for all the 23 Board members, so I don't know if they're 24 aware of it or not. 25 Q. But the Board, itself, has the</p>

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1 AMY E. EMBRY
 2 Board had any information provided to the
 3 Board that made it aware of the Arkansas
 4 Children's Hospital Gender Spectrum
 5 Clinic?
 6 A. Not to my knowledge, no.
 7 Q. Did the Board ever have any
 8 discussions about the Gender Spectrum
 9 Clinic at Arkansas Children's Hospital?
 10 A. Not to my knowledge no.
 11 Q. Did any members of the Board
 12 have any discussion about the Gender
 13 Spectrum Clinic at Arkansas Children's
 14 Hospital?
 15 A. Not to my knowledge.
 16 Q. What about Board staff?
 17 A. No. Not to my knowledge, no.
 18 Q. So you've not been part of any
 19 conversations about the Gender Spectrum
 20 Clinic?
 21 A. No.
 22 Q. Do you know what I refer to
 23 when I refer to Gender Spectrum Clinic?
 24 A. No. I just figure it's a
 25 section of that hospital.

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1 AMY E. EMBRY
 2 Q. Has the Board ever received
 3 any complaints concerning
 4 gender-affirming medical care for minors?
 5 A. No.
 6 Q. And by the way, do you know
 7 what I mean by "gender-affirming medical
 8 care" or do you have an understanding of
 9 that term?
 10 A. Yes. It was the definition
 11 provided in the document to me.
 12 Q. Okay. And just to be clear, in
 13 case there is any confusion, by
 14 "gender-affirming medical care", I'm
 15 referring to medical interventions for
 16 adolescents with gender dysphoria,
 17 including hormone therapy or puberty
 18 blocker or surgery to treat their gender
 19 dysphoria. Are we having a common
 20 understanding there?
 21 A. Yes.
 22 Q. So I will use the term
 23 gender-affirming medical care as
 24 shorthand rather than say that every
 25 time, okay?

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1 AMY E. EMBRY
 2 A. Okay.
 3 Q. So going back to my question,
 4 has the Board ever received any
 5 complaints regarding doctors providing
 6 gender-affirming medical care?
 7 A. No.
 8 Q. Never? And that's including
 9 before the introduction of what became
 10 Act 626 and since?
 11 A. To my knowledge, it has never
 12 received a complaint regarding
 13 gender-affirming medical care.
 14 Q. And is that for minors or
 15 adults?
 16 A. Correct.
 17 Q. Has the Board ever had any
 18 discussions about gender-affirming
 19 medical care?
 20 A. Not to my knowledge, no.
 21 Q. Well, so does that -- you are
 22 testifying on behalf of the Board, and
 23 you have been designated by the Defendant
 24 Board to testify on this topic.
 25 So have you been prepared --

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1 AMY E. EMBRY
 2 can you answer on behalf of the Board
 3 that the Board has not had discussions
 4 about this topic, let's say, since you've
 5 been Executive Director?
 6 A. There has not been discussion
 7 at any of the board meetings. I cannot
 8 speak for every single Board member to
 9 see if they ever discussed it.
 10 Q. Are you aware of any
 11 conversations with any -- with or between
 12 any Board members concerning
 13 gender-affirming medical care?
 14 A. No.
 15 Q. And are you aware of any
 16 conversations that included any Board
 17 staff about gender-affirming medical
 18 care?
 19 A. No.
 20 Q. Okay. So when the bill that
 21 became Act 626 was being debated and
 22 ultimately passed, nobody at the Board
 23 staff or at board meetings discussed it
 24 at all?
 25 A. No.

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1 AMY E. EMBRY
 2 Q. Has the Board ever considered
 3 are passing a regulation concerning
 4 gender-affirming medical care?
 5 A. No. Not as I've been
 6 Director, no.
 7 Q. Did the Board ever see a need
 8 for a regulation concerning
 9 gender-affirming medical care?
 10 A. It was not communicated to me
 11 if they did.
 12 Q. And so I asked you about
 13 whether there were complaints about
 14 gender-affirming medical care and you
 15 said there weren't, but I understand from
 16 your testimony earlier sometimes things
 17 come to the Board's attention apart from
 18 complaints.
 19 Did any problems related to
 20 gender-affirming medical care for minors
 21 ever come to the Board's attention
 22 outside of complaints?
 23 MS. LAND: Object to form.
 24 A. No.
 25 Q. Okay.

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1 AMY E. EMBRY
 2 MS. COOPER: Beth, if you can
 3 take tab 9 and we'll have that
 4 marked as Exhibit 7? Thank you.
 5 (Exhibit 7, May 5, 2021 email
 6 re: Public Health Grand Rounds was
 7 received and marked on this date
 8 for identification.)
 9 MR. RICHARDSON: Exhibit 7 has
 10 been introduced.
 11 MS. LAND: I have it.
 12 MS. COOPER: Thank you.
 13 Q. Ms. Embry, you have Exhibit 7
 14 in front of you?
 15 A. Yes.
 16 Q. Have you seen this document
 17 before?
 18 A. I cannot recall seeing this
 19 specific one.
 20 Q. Have you seen any documents
 21 representing grand rounds regarding
 22 gender-affirming medical care?
 23 A. I have to grand rounds. I
 24 can't say that I have seen it for
 25 gender-affirming but I have seen grand

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1 AMY E. EMBRY
 2 rounds.
 3 Q. And just to be clear the
 4 document marked as Exhibit 7 is an email
 5 including a document that has in large
 6 text Public Health Grand Rounds,
 7 Announcing a Session on Gender-Affirming
 8 Care Services in Arkansas. I'm just
 9 stating that for the record, not as part
 10 of the question.
 11 So you were not aware of a
 12 grand rounds --public health grand rounds
 13 on gender-affirming care services in
 14 Arkansas?
 15 A. Well, I may have received this
 16 email but we receive these normally
 17 weekly, so I do not recall this one in
 18 particular.
 19 Q. And so sitting here now is the
 20 first time that you think you have been
 21 aware of this grand round?
 22 A. Correct.
 23 Q. Just so I understand the email
 24 at the top, it says from Matt Gilmore
 25 ADH, is that the Arkansas Department of

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1 AMY E. EMBRY
 2 Health?
 3 A. Yes.
 4 Q. And it's sent to Heather Owen
 5 cc: Sarah Morris. Who is Heather Owen?
 6 A. Heather Owen is an employee of
 7 the Board.
 8 Q. What is her position on the
 9 Board?
 10 A. She is one of the licensing
 11 managers.
 12 Q. Okay. And Sarah Morris?
 13 A. I have no idea who Sarah
 14 Morris is.
 15 Q. Okay. Below that there is a --
 16 it looks like it was forwarding an
 17 earlier email from Sarah Morris to ADH
 18 All. Is ADH All, do I take it, an email
 19 list of all ADH employees?
 20 A. Correct.
 21 Q. Okay. So you would have
 22 received this but you don't recall that
 23 particular grand rounds?
 24 A. Correct.
 25 Q. Okay. Did anyone at the Board

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1 AMY E. EMBRY
 2 discuss the fact that there was going to
 3 be a grand rounds on gender-affirming
 4 care in Arkansas?
 5 A. Not to my knowledge.
 6 Q. And just for the record, I'm
 7 noting that it's dated, the event was
 8 dated to occur May 6th, 2021.
 9 Does that help refresh your
 10 recollection about whether there was any
 11 conversation about this?
 12 A. There was no conversation with
 13 me about this.
 14 Q. And you're not aware of others
 15 discussing it?
 16 A. No.
 17 Q. Okay. When Act 626 was first
 18 introduced in the legislature as HB 1570,
 19 during that period when it was being
 20 considered, did anyone at the Board
 21 discuss the bill?
 22 A. No, not to my knowledge.
 23 Q. Okay so no official board
 24 meeting discussion of the bill?
 25 A. No.

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1 AMY E. EMBRY
 2 Q. And you're not aware of any
 3 conversations among the Board members
 4 about the bill?
 5 A. No.
 6 Q. And you're not aware -- well,
 7 let me ask you a different question.
 8 Are you aware of any
 9 conversation involving any Board staff or
 10 employees about the bill?
 11 A. No.
 12 Q. Sorry if I'm -- I'm finding it
 13 surprising that a bill that obviously had
 14 a lot of public attention involving
 15 medical regulation, nobody at the Board
 16 talked about it at all?
 17 MS. LAND: Object to form.
 18 Q. Is that right? Really, nobody
 19 discussed it?
 20 A. I found out about the bill it
 21 was either on social media or the news.
 22 Q. Back at the time it was being
 23 considered?
 24 A. Correct.
 25 Q. So just to be clear, you are

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1 AMY E. EMBRY
 2 not aware of any conversations had among
 3 any Board members or involving any Board
 4 members or any staff about this bill that
 5 became Act 626?
 6 A. No.
 7 Q. Now, we talked earlier about
 8 other areas of regulations by the Board
 9 that were -- where the regulations after
 10 statutes were passed on the particular
 11 topic like gastric bypass procedures.
 12 Is the Board expected to pass
 13 regulations relating to Act 626?
 14 A. I do not have the act in front
 15 of me, but I do not recall that act
 16 requiring any Licensing Board to
 17 promulgate a rule. If it is specifically
 18 in there that they will promulgate a rule
 19 then it will be promulgated.
 20 Q. But at this point so far has
 21 there been any discussion about a
 22 possibility of promulgating a rule?
 23 A. No.
 24 Q. Has any government official in
 25 the executive branch or the legislature

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1 AMY E. EMBRY
 2 communicated with the Board about Act
 3 626?
 4 A. No, not to my knowledge, no.
 5 Q. Okay. And when the bill was
 6 introduced and being considered did
 7 anyone from the legislature consult with
 8 the Board regarding this bill?
 9 A. No.
 10 Q. And just to be clear, "this
 11 bill" I'm referring to the bill that
 12 became Act 626.
 13 A. No. No one contacted, no.
 14 Q. So the Board's input was not
 15 sought by any member of the legislature?
 16 A. No.
 17 Q. Okay. And since the law Act
 18 626 was enacted has any government
 19 official communicated with the Board
 20 about enacting regulations regarding the
 21 Act?
 22 A. No.
 23 Q. So your understanding is that
 24 the Act 626 does not require any
 25 regulations or rules to be promulgated by

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1 AMY E. EMBRY
 2 the Board?
 3 A. Yes, from my recollection. I
 4 don't have it in front of me, I would
 5 have to read through it again, but I do
 6 not recall a requirement for rules in
 7 that Act.
 8 Q. So there is no plan on the
 9 part of the Board to pass a regulation
 10 relating to Act 626?
 11 A. No.
 12 Q. Has the Board consulted with
 13 any experts on the topic of
 14 gender-affirming medical care?
 15 A. No.
 16 Q. So prior to the introduction
 17 of HB 1570, the bill that became Act 626,
 18 was the Board ever approached by any
 19 government official or their
 20 representatives about enacting
 21 regulations concerning gender transition
 22 procedures?
 23 A. As long as I've been Director,
 24 no. Before that, I can't answer that.
 25 Q. And was the Board or any Board

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1 AMY E. EMBRY
 2 member or Board staff contacted by
 3 anybody from the Governor's Office
 4 related to HB 1570 or Act 626, which it
 5 later became?
 6 A. I was not, and I don't recall
 7 anybody else in the office, being
 8 contacted by the Governor's Office.
 9 Q. Are you aware of any Board
 10 member being contacted by anyone from the
 11 Governor's Office?
 12 A. I am not aware of anything.
 13 Q. So the way I had asked the
 14 questions before about legislators, is
 15 whether any of the legislators contacted
 16 the Board. Do you know if anybody from
 17 the Board contacted any legislators
 18 concerning HB 1570?
 19 A. Not to my knowledge, no.
 20 Q. Do you know if anybody from
 21 the Board staff contacted any legislator
 22 regarding Act 626 or HB 1570?
 23 A. Not to my knowledge.
 24 Q. Okay. Did anyone from the
 25 Board or the Board staff reach out to any

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1 AMY E. EMBRY
 2 government official, executive or
 3 legislative branches regarding HB 1570,
 4 which later became Act 626?
 5 A. Did you say executive
 6 branches?
 7 Q. Yes, from the executive or
 8 legislative branches.
 9 A. No.
 10 Q. Okay. Did the Board ever take
 11 a position on HB 1570?
 12 A. No.
 13 Q. Why not?
 14 A. The Board does not lobby.
 15 Q. Did the Board ever discuss the
 16 possibility of taking a position about
 17 the bill?
 18 A. No.
 19 Q. Was the Board ever asked its
 20 position by anyone?
 21 A. Not to my knowledge.
 22 Q. But it was asked by press
 23 reporters, right?
 24 A. I don't recall being contacted
 25 by the press on this.

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1 AMY E. EMBRY
 2 MS. COOPER: Okay. Can we,
 3 Beth, take tab 10 and let's mark
 4 that as Exhibit 8.
 5 (Exhibit 8, email dated May
 6 25, 2021, re: CNN Inquiry was
 7 received and marked on this date
 8 for identification.)
 9 MR. RICHARDSON: Exhibit 8 has
 10 been introduced.
 11 MS. LAND: I've got it pulled
 12 up.
 13 Q. I'll give you a moment to just
 14 take a look at that.
 15 A moment ago I asked whether
 16 the Board was ever asked its position on
 17 HB 1570 or after it became law Act 626.
 18 I'll ask a slightly different question
 19 now.
 20 Was the Board ever asked its
 21 view on the lawsuit challenging Act 626?
 22 A. Yes.
 23 Q. And so the exhibit marked
 24 Exhibit 8, which I have handed to you, is
 25 a -- I'll describe for the record, an

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1 AMY E. EMBRY
 2 email from Chance Pagan sent Tuesday, May
 3 25th, 2021 to Juli Carlson, cc: Ann
 4 Embry ASMB Regulatory/Disciplinary
 5 Department, subject: Forward CNN
 6 Inquiry. That's just for the record.
 7 Do you recognize this email?
 8 A. Yes, I do.
 9 Q. You were copied on it? You saw
 10 it at the time?
 11 A. I was. This was a year ago.
 12 Q. Okay. And is this -- I do read
 13 right that CNN was asking for comment
 14 from the Board on the ACLU lawsuit
 15 against Act 626?
 16 A. Yes.
 17 Q. And so tell me if I'm getting
 18 this right, it looks like the initial
 19 email is from someone named Jamiel Lynch
 20 from Warner Media at, according to their
 21 email address, to ASMB Support
 22 Department, copying Kodwyer,
 23 K-o-d-w-y-e-r, @HDLlaw.com, subject: CNN
 24 Interview.
 25 What is ASMB Support

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1 AMY E. EMBRY
 2 Department, do you know?
 3 A. That's just an email, email
 4 that can go to Support Department, which
 5 means more than one person has access to
 6 that email. Anything that they need
 7 assistance with they send it to that, and
 8 so one of three or four people will be
 9 able to help out.
 10 Q. Okay. So then it looks like
 11 someone named Chance Pagan listed as
 12 Systems Administrator sent this,
 13 forwarded this email to Juli Carlson and
 14 you; is that correct?
 15 A. Correct.
 16 Q. And who is Chance Pagan?
 17 A. He is in our IT department.
 18 Q. It says here in the email, "I
 19 believe this would be for you." I assume
 20 he meant Juli Carlson; is that correct?
 21 A. That's why he sent it to Juli
 22 and this was sent to the Support
 23 department, which goes to IT. He
 24 forwarded it onto the Regulatory
 25 department.

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1 AMY E. EMBRY
 2 Q. Thank you. Did you talk with
 3 Juli Carlson about this request?
 4 A. I'm sure I did but this was a
 5 year ago, and I don't remember. We would
 6 have responded but I'd have to go back
 7 and look at my emails and notes on this.
 8 Q. Did the Board take a position
 9 on the ACLU lawsuit?
 10 A. No. We would not have taken a
 11 position.
 12 Q. Did it make a statement?
 13 A. I can't remember. I would have
 14 to go back and look in my emails and look
 15 at in my notes.
 16 Q. Okay. Was the Board asked for
 17 comment or statements about Act 626 or
 18 the ACLU lawsuit challenging Act 626,
 19 apart from this CNN inquiry?
 20 A. It's possible. It is possible.
 21 Q. And what responses would the
 22 Board have made?
 23 A. I would have to go back and
 24 look at my notes but it would be a
 25 generic response.

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1 AMY E. EMBRY
 2 Q. A generic response to the
 3 effect of what?
 4 A. We would not take a stance in
 5 the lawsuit, it would be somewhere along
 6 the lines -- and again, this is not what
 7 the response would have said -- is that
 8 we would have followed the process; we
 9 have a lawsuit filed against us, we'll
 10 follow the process.
 11 Q. Are you aware that the
 12 Governor vetoed HB 1570 before it
 13 ultimately became law?
 14 A. I think I do recall that, yes.
 15 Q. And were you aware that --
 16 well, let me ask a different question.
 17 Have you seen the Governor's
 18 veto statement or heard him speak about
 19 his veto?
 20 A. No.
 21 Q. You never saw it?
 22 A. Not that I can recall.
 23 Q. Do you know why the Governor
 24 vetoed the law?
 25 A. No.

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1 AMY E. EMBRY
 2 Q. Does the Board have a view
 3 about the appropriate course of treatment
 4 for adolescents with gender dysphoria?
 5 A. No.
 6 Q. Does the Board recognize that
 7 gender-affirming hormones can be a help
 8 to some adolescents?
 9 A. Not to my knowledge.
 10 Q. "Not to my knowledge" that the
 11 Board knows, or the Board recognizes
 12 this, rather?
 13 A. You're going to have 14
 14 different Board members with 14 different
 15 opinions, so you can have 14 different
 16 answers.
 17 Q. Do you know the views of any
 18 individual Board member?
 19 A. No.
 20 Q. Is the Board taking the
 21 position in this case that no adolescent
 22 can benefit from gender-affirming hormone
 23 therapy?
 24 A. I don't feel I can answer that
 25 question. The Board has not discussed it,

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1 AMY E. EMBRY
 2 so I don't know the answer to that.
 3 Q. So the Board doesn't -- the
 4 Board doesn't have a position on that?
 5 A. No.
 6 Q. And is it also true the Board
 7 does not have -- does not take the
 8 position that gender-affirming medical
 9 treatments can never be helpful to
 10 alleviate gender dysphoria in
 11 adolescents?
 12 A. Can you repeat that?
 13 Q. I'm realizing that was a
 14 terrible question with a double negative.
 15 I'm going to rephrase it.
 16 Is it the Board's position
 17 that gender-affirming medical treatments
 18 can never alleviate gender dysphoria in
 19 adolescents?
 20 A. It's never been discussed, so
 21 they do not have an opinion on this at
 22 the Board.
 23 Q. Is it the Board's position
 24 that the risks of gender transition
 25 procedures always outweigh the benefits

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1 AMY E. EMBRY
 2 for every minor patient with gender
 3 dysphoria?
 4 A. Again, they haven't discussed
 5 this, so there is no position that I'm
 6 aware of.
 7 Q. Does the Board recognize that
 8 for adolescents who are currently
 9 receiving gender-affirming medical
 10 treatments that withdrawing that
 11 treatment from them could put them at
 12 risk of harm?
 13 A. Again, they haven't discussed
 14 this, so I do not know the Board's
 15 position on this.
 16 Q. So does the Board have a
 17 position on this?
 18 A. No, they have never discussed
 19 it.
 20 Q. So it's not just that you
 21 don't know the Board's position, is it
 22 your testimony that the Board doesn't
 23 have a position on this?
 24 A. They have not discussed
 25 anything to have a position on this. This

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1 AMY E. EMBRY
 2 issue has not come up. The Board did not
 3 know about the bill or anything until it
 4 hit the media, same as us.
 5 Q. So is it fair to assume that
 6 nobody from the Board lobbied legislators
 7 to support the bill?
 8 A. No.
 9 Q. Nobody lobbied -- nobody from
 10 the Board lobbied legislators one way or
 11 the other related to the bill?
 12 A. The Board does not lobby.
 13 Q. The Board doesn't lobby about
 14 any bills; is that right?
 15 A. That is correct.
 16 Q. So members of the Board, have
 17 they ever individually taken positions on
 18 any bill related to medical care?
 19 A. Not at the Board meeting.
 20 Q. But outside of the board
 21 meeting?
 22 A. I wouldn't know that.
 23 Q. Are you aware of any times
 24 that happened?
 25 A. No. I don't know, no.

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1 AMY E. EMBRY
 2 Q. In Arkansas do parents have to
 3 consent to medical treatment for their
 4 children, for their minor children?
 5 A. Usually yes. That's between
 6 the physician and the parent and the
 7 patient.
 8 Q. And what do you mean by it's
 9 "between the physician and the parent and
 10 the patient"?
 11 A. Well, any care on any patient,
 12 whether it's a minor or an adult, that is
 13 between the physician and the patient. If
 14 a minor is involved, then the parent is
 15 involved.
 16 Q. When you say any care between
 17 the patient and the physician and if it's
 18 a minor the parent, do you mean the
 19 decision about whether to undergo care?
 20 A. I would think it -- yes. Yes.
 21 Q. But I think you testified that
 22 generally parents do have to consent for
 23 medical treatment for their children, if
 24 they want them to have that care? Excuse
 25 me. Let me do that again because that was

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1 AMY E. EMBRY
 2 my fault. I spoke over you. I just want
 3 to get a clear record.
 4 Do you understand your
 5 testimony that in Arkansas generally
 6 before minors can have medical care their
 7 parents need to consent?
 8 A. Yes.
 9 Q. Okay. Are there exceptions
 10 where the minor could consent on their
 11 own without parents?
 12 A. I don't know.
 13 MS. COOPER: Beth, if we can
 14 take tab 12 and mark that as
 15 Exhibit 9.
 16 (Exhibit 9, copy of House Bill
 17 1570 was received and marked on
 18 this date for identification.)
 19 MS. LAND: Okay. It's pulled
 20 up for me.
 21 Q. For the record, I'm going to
 22 identify Exhibit 9 as House Bill 1570.
 23 Have you seen this bill
 24 before?
 25 A. Yes.

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1 AMY E. EMBRY
 2 Q. When did you see it for the
 3 first time?
 4 A. For the first time it would be
 5 after it was put on the news or social
 6 media, however I heard of it, I pulled it
 7 up.
 8 Q. Why did you -- sorry. Go
 9 ahead.
 10 A. I pulled it up on the
 11 legislative website.
 12 Q. Why did you do that?
 13 A. Because I knew that it would
 14 probably affect the Board in some form or
 15 fashion, so I was just looking at it.
 16 Q. Why did you think it would
 17 affect the Board in some form or fashion?
 18 A. Because it involved
 19 physicians.
 20 Q. And now that you've looked at
 21 it, does it involve the Board in some
 22 form or fashion?
 23 A. One section.
 24 Q. Which section is that?
 25 A. It's going to be from page 9

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1 AMY E. EMBRY
 2 line 27, and the Code is 20-9-1504, it's
 3 the enforcement. And it says, "Any
 4 referral for or provision of gender
 5 transition procedures to an individual
 6 under 18 years of age is unprofessional
 7 conduct and is subject to discipline by
 8 the appropriate licensing entity or
 9 Disciplinary Review Board with competent
 10 jurisdiction in this State."
 11 Q. And that's the one provision
 12 within HB 1570 that you understand to
 13 involve the Board --
 14 A. Yes.
 15 Q. -- is that right? Is that
 16 because the Board is the appropriate
 17 licensing entity at issue?
 18 A. Well, it is the appropriate --
 19 Q. Excuse me. I have to -- I
 20 asked my question terrible. I'll redo it.
 21 Is it because the Board is the
 22 appropriate licensing entity or
 23 Disciplinary Review Board with
 24 jurisdiction in this State?
 25 MS. LAND: I'll object to the

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1 AMY E. EMBRY
2 form. You can answer that.
3 A. It is the licensing entity for
4 some healthcare professionals in the
5 State of Arkansas.
6 Q. And is it also the
7 Disciplinary Review Board for some
8 healthcare professionals in Arkansas?
9 A. We've always just been called
10 a Licensing Board. I've never heard us
11 called a Disciplinary Review Board.
12 Q. Okay. So I have a few
13 questions about this provision, which is
14 20-9-1504, subsection (a).
15 As you read it says, "Any
16 referral for or provision of gender
17 transition procedures to an individual
18 under 18 years of age is unprofessional
19 conduct."
20 I'm trying to understand what
21 that means for your enforcement as you,
22 the Board, because there's a whole other
23 provision in the Medical Practices Act
24 laying out unprofessional conduct.
25 Is it your understanding that

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1 AMY E. EMBRY
2 this is an additional type of conduct
3 that now constitutes unprofessional
4 conduct, in addition to what we discussed
5 in the other statute defining that term?
6 A. Yes.
7 Q. Okay. So I believe that one
8 had subpoints A through S defining
9 unprofessional conduct, so this is just
10 one more?
11 A. Yes.
12 Q. Okay. And you testified that
13 the Board is the licensing entity for
14 some medical providers.
15 Is there any other entity that
16 enforces or that is a licensing entity or
17 Disciplinary Review Board that would be
18 relevant with respect to enforcing Act
19 626?
20 A. It depends on what healthcare
21 professionals would be providing these
22 services.
23 Q. Okay. So let's break that
24 down. That's helpful.
25 So for physicians who are

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1 AMY E. EMBRY
2 providing procedures that are prohibited
3 by HB 1570, the Board would be the
4 appropriate licensing entity; is that
5 correct?
6 A. Yes.
7 Q. Okay. Is there any other
8 entity in Arkansas that would be a
9 licensing entity for physicians?
10 A. No, not for physicians.
11 Q. Is there any other entity in
12 Arkansas that would be responsible for
13 discipline of physicians in Arkansas?
14 A. No.
15 Q. Does the Board have discretion
16 in deciding how to enforce Act 626,
17 should it take effect?
18 A. It would -- it would work, as
19 the same as any other enforcement, if the
20 complaint came, that they would read the
21 law and see what needs to be done because
22 that's just how it works on a complaint
23 basis.
24 Q. Well, I think you also said
25 while it's on a complaint basis, things

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1 AMY E. EMBRY
2 can come to the Board's attention apart
3 from complaints that the Board could then
4 act on; is that right?
5 A. Yes.
6 Q. Like if it's in the news, for
7 example, I think you said?
8 A. Correct.
9 Q. Okay. Has the Board been
10 provided any direction from any
11 government official or entity about how
12 to enforce Act 626 if it takes effect?
13 A. No.
14 Q. Has the Board had any
15 conversations or any Board members or
16 Board staff about how the Board would
17 enforce Act 626 should it take effect?
18 A. No.
19 Q. Are you aware that the law Act
20 626 was preliminarily enjoined by Federal
21 Court in Arkansas and is not currently in
22 effect?
23 A. Yes.
24 Q. Okay. And prior to that,
25 before the court ruled, I believe --

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1 AMY E. EMBRY
 2 well, let's find this. I'm going to just
 3 strike that and ask it differently.
 4 If the law were to take effect
 5 would there be a process the Board would
 6 need to undergo to determine how to
 7 enforce Act 626?
 8 A. No. It would go through the
 9 usual process of any complaint received,
 10 it would be addressed by the entire Board
 11 and they would determine if there has
 12 been a violation.
 13 Q. So if tomorrow Act 626 went
 14 into effect the Board would be ready to
 15 field any complaints should they arise?
 16 A. Yes.
 17 Q. Okay. It doesn't have anything
 18 it needs to do to get ready for that?
 19 A. No.
 20 Q. Okay. So if Act 626 took
 21 effect and a complaint came to the Board
 22 saying that there is a doctor who is
 23 providing gender-affirming medical care
 24 to an adolescent, what would happen? What
 25 would the Board do?

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1 AMY E. EMBRY
 2 A. It would be the same as any
 3 other complaint. The physician would be
 4 provided a copy of the complaint and
 5 asked to respond and once that is
 6 received by the complaint and the
 7 response is presented to the Board and
 8 then they will move forward from there;
 9 if there needs to be an investigation;
 10 does action need to be brought against
 11 the license; it could be a variety of
 12 situations, but the whole thing will go
 13 before the full Board and it will be
 14 discussed.
 15 Q. And so if they got a
 16 complaint, the Board got a complaint
 17 about this and the physician responded
 18 and admitted providing that care, would a
 19 violation be determined?
 20 A. I can't answer that question.
 21 That would go before the Board, they
 22 would look at all situations, all
 23 circumstances surrounding it. So I can't
 24 answer how the Board would vote.
 25 Q. So there could be

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1 AMY E. EMBRY
 2 circumstances under which it might not
 3 constitute a violation?
 4 A. No. I can't think of anything
 5 off the top of my head.
 6 Q. So the Board would not have
 7 any discretion not to find a violation if
 8 the person admitted to providing care
 9 prohibited by Act 626?
 10 A. Could you repeat?
 11 MS. LAND: Object to form.
 12 Q. Sure. Would the Board have no
 13 discretion, it would have to find a
 14 violation if a doctor admitted providing
 15 care prohibited by Act 626?
 16 A. That is possible, that is a
 17 possible outcome.
 18 Q. Possible? Let me ask the
 19 question differently because I'm not sure
 20 I understand your answer.
 21 Would the Board be required to
 22 make a finding of a violation of Act 626
 23 -- let me ask that differently. I didn't
 24 ask that right.
 25 Would the Board have to make a

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1 AMY E. EMBRY
 2 finding of unprofessional conduct as
 3 directed by Act 626 if a doctor admitted
 4 to providing prohibited care under the
 5 statute?
 6 A. Yes.
 7 Q. Okay. Would the doctor be
 8 subject to discipline by the Board?
 9 A. Yes.
 10 Q. And what would happen? What
 11 would be the discipline?
 12 A. That is strictly up to the
 13 Board. You are looking at different
 14 scenarios every single time. Every
 15 single case is different. It could be
 16 that they find that they may have to
 17 suspend the license, it could be that
 18 they say; okay, you need to go back and
 19 take these courses and make sure you
 20 understand the law. It just depends.
 21 Every situation is different.
 22 Q. Could the Board revoke the
 23 license of the doctor?
 24 A. If their legal counsel says
 25 they do have enough and that's what the

<p style="text-align: right;">Page 186</p> <p>1 AMY E. EMBRY 2 Board votes to do, yes, they can. 3 Q. When you say if their legal 4 counsel says they do have enough, if the 5 Board's legal counsel says they do have 6 enough, is that what you mean? 7 A. Correct. Yes. 8 Q. And have enough what? 9 A. Evidence to either suspend or 10 revoke a license. 11 Q. Would admission or proof of 12 providing gender-affirming medical care 13 to a minor be enough to suspend or revoke 14 a license? 15 A. That would actually be a 16 question for the Board's legal counsel, 17 not me. It is very common for the Board 18 to ask the legal counsel in the room; do 19 we have enough for a suspension or 20 revocation before they make any decision. 21 Q. But it's a possible outcome? 22 A. Yes. 23 Q. When we talked earlier about 24 the definition of unprofessional conduct 25 in 17-95-409 of the Medical Practices Act</p>	<p style="text-align: right;">Page 188</p> <p>1 AMY E. EMBRY 2 complaint is received. 3 Q. So you're saying even before 4 the need for a hearing, the Board could 5 potentially deem a doctor's defense or I 6 should say the doctor's statement that 7 withdrawing the care a patient could 8 cause harm to the patient as a defense to 9 a complaint of unprofessional conduct 10 based on Act 626? 11 MS. LAND: Object to form. 12 A. So I want to make sure I 13 understand your question. The original 14 question was, you can do all this without 15 a hearing. So if a complaint comes in on 16 a physician, they gather the complaint, 17 the response from the physician, the 18 Board reviews it, they can decide then 19 there's been no violation and it's done. 20 They can also decide we want to see this 21 doctor at the next board meeting. They 22 can also determine just from the response 23 or from the complaint; has there been a 24 violation that rises to the level of a 25 suspension or a revocation? If they do</p>
<p style="text-align: right;">Page 187</p> <p>1 AMY E. EMBRY 2 and they had subsection A through S as 3 conduct that's deemed unprofessional 4 conduct, were those all determined by the 5 legislature, those categories of 6 unprofessional conduct or the Board? 7 A. Let me go back to that 17-95 8 -- 9 Q. Actually, withdraw the 10 question. I answered it myself. I 11 withdraw it. 12 If there were a complaint 13 against a doctor for violating Act 626 14 and the doctor responded by saying 15 withdrawing treatment from a patient 16 would cause severe harm to the patient, 17 would that be a defense to the complaint 18 for unprofessional conduct based on 626? 19 A. Yes, it could be a defense. 20 Q. It could be a defense. And 21 there would be a hearing on that? 22 A. I hearing is usually held only 23 if a license is going to be -- action is 24 going to be taken against a license. A 25 hearing is not held just because a</p>	<p style="text-align: right;">Page 189</p> <p>1 AMY E. EMBRY 2 that, then the hearing will be at the 3 next meeting. 4 So I'm getting confused as far 5 as what you're asking as far as a hearing 6 and a defense because a hearing is only 7 held if action is brought against a 8 license. Asking a doctor to appear is not 9 an action against a license. Asking a 10 doctor to respond is not an action 11 against a license. So I'm confused as to 12 what you're asking. 13 Q. Thank you. That's helpful. 14 I'll break it down into smaller bits and 15 try to focus better. 16 If there is a complaint 17 against a doctor on the basis that the 18 doctor is providing gender-affirming 19 medical care and the doctor's response is 20 to say withdrawing treatment for this 21 particular patient would cause severe 22 harm to the patient, so I could not do 23 that, is it possible that the Board could 24 determine that the doctor's conduct was 25 not a violation?</p>

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1 AMY E. EMBRY
 2 A. It's possible. They could
 3 choose to do that.
 4 Q. So the Board would not be
 5 required to discipline a doctor for
 6 providing gender-affirming medical care
 7 in all cases?
 8 A. Again, it depends on the
 9 situation. They would have to look at all
 10 the evidence before them.
 11 If I had to speculate, if a
 12 complaint came in of this nature they
 13 would want to speak with the physician.
 14 So more than likely the physician would
 15 be likely to appear to discuss this.
 16 Q. And then if the Board were
 17 convinced that the doctor's concern about
 18 harm to patient in the event of
 19 withdrawing treatment was valid, the
 20 Board would not have to find a violation
 21 and discipline the doctor?
 22 A. That is possible.
 23 Q. Okay. One of the topics on our
 24 30(b)(6) deposition notice had to do with
 25 two doctor plaintiffs in this case and

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1 AMY E. EMBRY
 2 their -- let me pull up the notice. The
 3 medical license of Dr. Michelle Hutchison
 4 and the medical license of Dr. Katherine
 5 Stambough.
 6 Do those doctors have any
 7 pending complaints against them?
 8 A. No.
 9 Q. Have there been any complaints
 10 against either doctor?
 11 A. No.
 12 Q. Okay. Another topic on our
 13 notice was what the Board did to search
 14 for documents in response to our
 15 subpoena. I believe that was the last
 16 item on the list.
 17 Can you tell me what was done
 18 to search for documents?
 19 MS. LAND: I'm going to object
 20 to that question to the extent it
 21 elicits any attorney-client
 22 privilege information. So to the
 23 extent she can answer that without
 24 revealing any of that, I'll assert
 25 that objection.

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1 AMY E. EMBRY
 2 Q. Right. So without revealing
 3 any attorney-client communications, what
 4 was searched or how did the search
 5 happen?
 6 A. We received the request and
 7 then we gave it to our IT department and
 8 I don't have the original request in
 9 front of me but I think it was along the
 10 lines any information we had on HB 1570
 11 or 626. So we researched our entire
 12 email system for those terms.
 13 And then the second request
 14 came in and we did it again and because
 15 the Board hadn't any involvement with
 16 this legislation there was not anything
 17 in there.
 18 When the third request came it
 19 came with two or three pages of search
 20 terms or search items and that is when
 21 they put that through the system and all
 22 these documents came out, whether they
 23 were relevant to this act or not.
 24 Q. And when you say "through the
 25 system" does that mean all employees of

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1 AMY E. EMBRY
 2 the Board?
 3 A. Yes, the entire email system.
 4 Q. For Board employees, though;
 5 is that right?
 6 A. Yes.
 7 Q. Or is it beyond Board
 8 employee?
 9 A. No. It is only Board employee
 10 employees.
 11 Q. And what about Board members?
 12 A. No, we do not have email
 13 addresses for Board members.
 14 Q. So you didn't search files of
 15 any Board members?
 16 A. We don't have files on Board
 17 members as far as communications. They
 18 don't use any of our systems to
 19 communicate.
 20 Q. Okay. So the Board members
 21 don't have an official email that they
 22 use in their business as Board members?
 23 A. No.
 24 Q. They just use their personal
 25 email?

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1 AMY E. EMBRY
 2 A. Correct.
 3 Q. So when the Board members are
 4 conducting Board business is it ever done
 5 through email?
 6 A. No. Well, that is if we have
 7 to send out some attachments that were
 8 not part of the, you know, original Board
 9 package, things of that nature, or if we
 10 have to say; here is the Zoom link for
 11 the board meeting or something like that.
 12 Q. And in those cases you'll
 13 email to their personal email?
 14 A. Correct.
 15 Q. Or might it be their workplace
 16 email?
 17 A. It might it depends on what
 18 email address they choose to use.
 19 Q. For these Board members this
 20 is just a part-time activity for them, is
 21 that right, it's not their full-time?
 22 A. No. No. The majority of them
 23 are full-time physicians.
 24 Q. Okay. And when you talked
 25 about giving a packet to members of the

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1 AMY E. EMBRY
 2 Board, I assume that relates to different
 3 complaints against medical providers; is
 4 that right?
 5 A. Yes. It is what is provided
 6 that they review at every single board
 7 meeting. They are sent out on disks and
 8 they are loaded into their computer and
 9 into the Board system and that is
 10 everything that they will discuss or that
 11 any appearances for that board meeting.
 12 Q. So it's based on what's on the
 13 agenda at the next board meeting, they
 14 will get a packet of materials; is that
 15 right?
 16 A. Correct.
 17 Q. And that could be related to a
 18 complaint against a physician; is that
 19 right?
 20 A. Yes.
 21 Q. And that could include
 22 something related to a regulation being
 23 considered; is that right?
 24 A. A-hum.
 25 Q. And all of those kinds of

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1 AMY E. EMBRY
 2 materials are sent on a disk in the U.S.
 3 mail or how do they get them?
 4 A. No. They are sent FedEx with
 5 signature required.
 6 Q. Wow. Okay.
 7 MS. COOPER: Why don't we take
 8 a break, maybe about ten minutes.
 9 Okay?
 10 VIDEOGRAPHER: We are off the
 11 record at 2:53 p.m.
 12 (Recess is taken.)
 13 VIDEOGRAPHER: We are back on
 14 the record at 3:06 p.m.
 15 MS. COOPER: Thank you. I just
 16 want to put on the record that Beth
 17 Echols, who is on the Plaintiff's
 18 counsel team joined the deposition
 19 some time ago but we have not
 20 mentioned that until now.
 21 Beth, can you grab tab 5?
 22 Actually, I'm sorry, did we already
 23 mark tab 5? We did, didn't we?
 24 MR. RICHARDSON: We marked it
 25 as Exhibit 5.

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1 AMY E. EMBRY
 2 Q. So let's turn to Exhibit 5.
 3 A. I'm afraid, Leslie, that the
 4 ones before 6 were not marked, so if you
 5 could identify them?
 6 Q. I'm sorry, yes. We'll do that
 7 after but it is the document that says on
 8 the top A Bill and it's House Bill 1718.
 9 Do you see that?
 10 A. Yes.
 11 Q. Okay. Ms. Embry, are you
 12 familiar with this law?
 13 A. I know of it. I've read it.
 14 Q. Well, I want to call your
 15 attention to a particular part of it and
 16 if you want to read more, that will be
 17 fine but I specifically want to point to
 18 the beginning where it says, it's called
 19 Subsector 2, Patient Right-to-Know Act
 20 and it says 20-6-201 is the title and if
 21 you look right below that 20-6-202
 22 Legislative Findings and Purpose. You
 23 got that?
 24 A. Yes.
 25 Q. And it says, "(a) the General

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1 AMY E. EMBRY
 2 assembly finds that; (1) is patients are
 3 entitled to continuity of care with their
 4 healthcare providers; (2) healthcare
 5 providers are prohibited legally and
 6 ethically from abandoning a patient
 7 before treatment has concluded." We can
 8 stop reading there.
 9 Does that refresh your
 10 recollection about this statute?
 11 A. Yes. This was done before I
 12 was Director.
 13 Q. Okay.
 14 A. So I would not have been as
 15 involved with this.
 16 Q. Okay. And so I wanted to ask
 17 you, focusing in on subsection (a)(2) it
 18 says, "Healthcare providers are
 19 prohibited legally and ethically from
 20 abandoning a patient before treatment has
 21 concluded."
 22 So is this another source of
 23 ethical obligations of doctors in
 24 Arkansas?
 25 A. Ethical I don't know, but it

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1 AMY E. EMBRY
 2 is an obligation that the Board would
 3 look at.
 4 Q. Okay. Well, I ask because it
 5 says, "The healthcare providers are
 6 prohibited legally and ethically from
 7 abandoning a patient."
 8 So is that your
 9 understanding, that it would be an
 10 ethical violation to abandon a patient
 11 before treatment has concluded?
 12 A. Yes.
 13 Q. Okay. And so under this
 14 provision if a doctor is treating a
 15 patient and has to stop care for any
 16 reason before treatment is concluded,
 17 they have -- is it an ethical obligation
 18 to help them find care from another
 19 doctor?
 20 A. Yes.
 21 Q. Is that right? I'm sorry?
 22 A. Yes.
 23 Q. Yes, okay. And can complaints
 24 be filed with the Board for doctors
 25 abandoning patients in violation of this

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1 AMY E. EMBRY
 2 section?
 3 A. Yes.
 4 Q. Has that ever happened?
 5 A. Yes.
 6 Q. Under your watch?
 7 A. Yes.
 8 Q. Can you tell me about those
 9 kinds of circumstances?
 10 A. It would be a letter of
 11 complaint saying that either they were
 12 fired or they were abandoned by the
 13 physician without providing another
 14 physician or a referral to another
 15 physician and it would go through the
 16 complaint process.
 17 Q. Have any doctors been
 18 disciplined for abandoning patients?
 19 A. I can't recall if they were
 20 disciplined. I know some were called
 21 before the Board to explain what
 22 happened, but without looking at
 23 documents, I can't recall if they were
 24 disciplined.
 25 Q. But under the Board's

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1 AMY E. EMBRY
 2 authority that could be something that
 3 would happen?
 4 A. Yes.
 5 Q. And just to be clear, the
 6 Board could discipline a doctor for
 7 abandoning a patient in violation of
 8 20-6-202?
 9 A. Yes, they could.
 10 Q. We talked about the ethical
 11 obligations for doctors contained in
 12 Regulation 32. And now we've talked about
 13 an ethical requirement in Section
 14 20-6-202.
 15 Are there other sources of
 16 ethical obligations for doctors in
 17 Arkansas besides those?
 18 A. Not that I'm aware of. You
 19 know, anything in the code that is law we
 20 adhere to that as well. Just because it's
 21 in the law doesn't necessarily mean there
 22 is a rule.
 23 Q. I'm sorry. I didn't hear you.
 24 A. So if there could be a law
 25 that we're not required to have a rule on

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1 AMY E. EMBRY
 2 that we must adhere to that law as well.
 3 Q. So if there were other
 4 statutes that identified ethical duties
 5 of doctors, that would be an ethical
 6 obligation of doctors even if there is no
 7 corresponding rule; is that what you're
 8 saying?
 9 A. Correct.
 10 Q. Are you aware of any besides
 11 this ethical obligation contained in
 12 Section 20-6-202?
 13 A. Without looking at all my
 14 documents, no, I can't answer that
 15 truthfully. I can't say that with all,
 16 through the Arkansas -- all Arkansas
 17 statutes there aren't any others. I can't
 18 say that honestly.
 19 Q. Okay. We talked a few minutes
 20 before the break about parents being
 21 required generally, I think you said, to
 22 provide informed consent for treatment of
 23 their minor children. Do you recall that?
 24 A. Yes.
 25 MS. LAND: I objected to the

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1 AMY E. EMBRY
 2 form of that previous question.
 3 MS. COOPER: Okay.
 4 Q. Is that correct, that as a
 5 general matter, minors cannot undergo
 6 medical treatment without their parents
 7 providing informed consent?
 8 A. As far as I know.
 9 Q. Well, okay. That's fine.
 10 Are there any other medical
 11 treatments, besides gender-affirming
 12 medical care for minors with gender
 13 dysphoria, that parents cannot provide
 14 informed consent for their children to
 15 undergo?
 16 A. I don't -- I don't think so.
 17 This is the only one that I saw that
 18 meets those parameters, but no.
 19 Q. Under what circumstances could
 20 the Board step in and ban a particular
 21 medical treatment?
 22 A. I don't know of any because
 23 they have not banned any medical
 24 treatment, so that would be new ground,
 25 new territory.

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1 AMY E. EMBRY
 2 Q. So because it's not something
 3 they've ever done you can't say under
 4 what circumstances they would do
 5 something like that; is that right?
 6 A. No.
 7 Q. Okay. And as the Board being
 8 the entity responsible for regulating the
 9 areas of medicine that you cover, when
 10 would banning a particular treatment be
 11 an appropriate regulation of the field of
 12 medicine?
 13 A. I don't know.
 14 Q. The Board doesn't have a view
 15 on that?
 16 A. No.
 17 Q. And when is it appropriate for
 18 the State entity that regulates medicine,
 19 the Board, to override patients and their
 20 doctors' decisions about medical care?
 21 MS. LAND: Objection, form.
 22 A. I do not know the answer to
 23 that question.
 24 Q. Does the Board have a view
 25 about when it's appropriate to override

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1 AMY E. EMBRY
 2 patients and their doctors' decisions
 3 about medical care?
 4 A. Not to my knowledge.
 5 MS. LAND: Objection to form.
 6 Q. Does the Board have any view
 7 about the type of -- excuse me. Let me
 8 rephrase that.
 9 Does the Board have a view
 10 about the level of evidence of
 11 effectiveness that is required before
 12 doctors should be permitted to provide a
 13 medical treatment?
 14 A. No. That has not been
 15 addressed since I've been the Director.
 16 Q. So am I right that the Board
 17 would not prohibit or restrict a
 18 particular medical treatment based on the
 19 level of scientific evidence that
 20 supports that treatment?
 21 A. They have not, I can say that.
 22 They have not prohibited any procedure. I
 23 can't say what would be done in the
 24 future.
 25 Q. Has it ever come up before the

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1 AMY E. EMBRY
 2 Board that a particular treatment is
 3 harmful because it's not supported by
 4 adequate scientific research
 5 demonstrating its effectiveness?
 6 A. Not to my knowledge.
 7 Q. So as the representative of
 8 the Board here, the Board is not aware of
 9 that ever coming up, that has not come
 10 up?
 11 A. Not to my knowledge.
 12 Q. Has there ever been any issue
 13 raised with the Board whether in the
 14 context of a complaint against a doctor
 15 or otherwise an investigation against a
 16 doctor or a proposed regulation about the
 17 appropriate amount of evidence that's
 18 required before medical treatment should
 19 be allowed?
 20 A. No.
 21 Q. Is it the Board's
 22 understanding that only -- sorry.
 23 Is it the Board's
 24 understanding that all medical treatment
 25 that is provided in Arkansas and allowed

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1 AMY E. EMBRY
 2 to be provided is supported by randomized
 3 control clinical trials?
 4 A. No.
 5 Q. Are there medical treatments
 6 that are permitted to be provided in
 7 Arkansas that are not supported by
 8 randomized controlled clinical trials?
 9 A. I do not know the answer to
 10 that.
 11 Q. We talked earlier about the
 12 complaints about Ivermectin being used
 13 for COVID and I think -- I don't think I
 14 asked this question, has anyone proposed,
 15 within the Board, to prohibit doctors
 16 from prescribing Ivermectin to treat
 17 COVID?
 18 A. No.
 19 MS. LAND: Objection to
 20 relevance.
 21 Q. Why not?
 22 A. You are asking me? Is that
 23 question toward me?
 24 Q. That's for you, Ms. Embry.
 25 So you said there have not

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1 AMY E. EMBRY
 2 been any proposals to prohibit the use of
 3 Ivermectin to treat COVID and I asked why
 4 not?
 5 A. Because it is off-label drug
 6 and what is prescribed between a patient
 7 and the physician is between the
 8 physician and the patient, as with any
 9 prescription.
 10 Q. So even if there are known
 11 risks for using Ivermectin for COVID and
 12 no evidence of its effectiveness, the
 13 Board leaves that decision to patients
 14 and their physicians?
 15 A. It is left between physicians
 16 and patients, yes.
 17 Q. And the Board is in agreement
 18 with that position, that that should be
 19 between the patients and their
 20 physicians?
 21 A. Yes.
 22 Q. Am I right that doctors can't
 23 provide treatment to patients in Arkansas
 24 without informing the patients of
 25 potential risks? I'm not talking about

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1 AMY E. EMBRY
 2 Ivermectin specifically, but in general.
 3 A. Do you mean as far as
 4 prescription or treatment in general?
 5 Q. We can break that down. Let's
 6 start with treatment in general. Is it
 7 correct that doctors can't provide
 8 medical treatments to patients without
 9 informing them of any potential risks?
 10 A. I believe so. I can't answer
 11 completely on that point.
 12 Q. Okay. What about with respect
 13 to use of prescriptions, that doctors --
 14 is it your understanding that doctors are
 15 required to inform patients of risks
 16 before prescribing drugs?
 17 A. I'm not -- I don't know of a
 18 requirement. I know it is usually done. I
 19 don't know of a requirement.
 20 Q. Is it the Board's position
 21 that there are some treatments patients
 22 should not be permitted to consent to
 23 after being fully informed of the risks?
 24 A. Could you repeat that?
 25 Q. Is it the Board's position

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1 AMY E. EMBRY
 2 that there are some medical treatments
 3 patients should not be permitted to
 4 consent to after being fully informed by
 5 their doctors of the risks of the
 6 treatment?
 7 A. I don't know. That would be a
 8 -- the Board members would have to decide
 9 that.
 10 Q. Okay. Imagine Act 626 didn't
 11 exist, no one ever thought about it and
 12 it was just -- imagine times before that
 13 law.
 14 If there was a doctor that was
 15 providing gender-affirming medical care
 16 to minors and was not following the
 17 accepted standards in that field, could
 18 that issue be addressed by the Board?
 19 A. If the complaint is filed,
 20 yes.
 21 Q. And would that also be true if
 22 it otherwise came to the Board's
 23 attention that that was happening?
 24 A. Yes.
 25 Q. If the Board had a broader

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1 AMY E. EMBRY
 2 concern about doctors overprescribing
 3 hormone therapy for adolescents with
 4 gender dysphoria, is that something the
 5 Board could step in and regulate?
 6 A. Regulate means to form a
 7 regulation?
 8 Q. Yes.
 9 A. They can create a rule if they
 10 choose to do so. It would go through the
 11 promulgation process. It does not mean
 12 that it would pass.
 13 Q. I'm just thinking about, we
 14 talked about the very detailed
 15 regulations about pain medications and
 16 regulation in place to govern how
 17 prescriptions can be provided, is that a
 18 fair description?
 19 A. Could you repeat that?
 20 Q. Yeah. I'll ask it clearer.
 21 We talked earlier about the
 22 regulations for pain medications. You
 23 remember that?
 24 A. Yes.
 25 Q. If there were an issue with,

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1 AMY E. EMBRY
 2 say, some doctors in the State providing
 3 gender-affirming medical care to minors
 4 and specifically overprescribing hormone
 5 therapy, similar to the way opioids have
 6 been overprescribed, would it be possible
 7 for the Board to enact a regulation to
 8 address that problem?
 9 A. Yes. If they found it
 10 necessary, yes.
 11 Q. And similarly, if the Board
 12 were to learn that some doctors in
 13 Arkansas who provide gender-affirming
 14 medical care to minors were not providing
 15 sufficient information in the informed
 16 consent process about the risks and
 17 benefits of these treatments, could the
 18 Board enact regulations to impose
 19 informed consent requirements?
 20 A. The Board can create a
 21 regulation on any subject they choose.
 22 Whether or not it passes the promulgation
 23 process is what determines if it goes
 24 into effect.
 25 Q. But I'm just thinking about,

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1 AMY E. EMBRY
 2 for example, the gastric bypass
 3 regulation that we talked about earlier
 4 that had, I don't know, dozens, dozens of
 5 risks that doctors are required to tell
 6 patients about before they can obtain
 7 informed consent for the procedure. If
 8 there was a concern about inadequate
 9 informed consent with gender-affirming
 10 medical care for minors, could the Board
 11 pass a regulation to spell out informed
 12 consent requirements in a similar way?
 13 A. Again, if they feel a need to,
 14 for which they have a concern, they can
 15 do that.
 16 MS. LAND: I'll object to the
 17 form of that previous question as
 18 well.
 19 Q. Okay. So that would include
 20 enacting a regulation like the gastric
 21 bypass informed consent regulation that
 22 would impose requirements for informed
 23 consent before obtaining -- before
 24 providing hormone therapy for minors?
 25 A. Yes. And I believe on that

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1 AMY E. EMBRY
 2 one, though, that that was through an Act
 3 that was required.
 4 Q. Thank you. But that is
 5 something the Board could do if it saw a
 6 need; is that right?
 7 A. Yes. It could -- it could
 8 attempt. Let me say that, it could
 9 attempt to promulgate a rule.
 10 Q. And I want to make sure I
 11 understand what you mean by that.
 12 Do you mean they could come up
 13 with a rule but there is no guarantee the
 14 legislature would approve it; is that
 15 what you mean?
 16 A. Correct. Right.
 17 Q. But assuming the legislature
 18 were onboard, they could pass a rule to
 19 establish informed consent requirements
 20 for hormone therapy for minors if they
 21 felt that that was something that was not
 22 being done properly by all doctors in
 23 Arkansas?
 24 A. If that's what the Board chose
 25 to create a rule on, yes, that's the

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1 AMY E. EMBRY
 2 process.
 3 Q. There is nothing about that
 4 type of regulation that couldn't be done?
 5 A. Well, we can't make a
 6 regulation that is against law. Right,
 7 but we can --
 8 Q. Understood. Assuming Act 626
 9 never existed, you would be able to do
 10 that?
 11 A. If that's what the Board voted
 12 to do.
 13 Q. Okay. And I think we touched
 14 on this before but I want to be sure, if
 15 the Board felt that gender-affirming
 16 medical care for adolescents were
 17 inherently harmful, it could enact a
 18 regulation to prohibit that care; is that
 19 right?
 20 A. I mean, if that was a concern
 21 and that's what the Board felt was
 22 necessary it would start the process, go
 23 through the appropriate channels to
 24 create a rule.
 25 Q. Right. And it could enact a

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1 AMY E. EMBRY
 2 rule and then it would just be a question
 3 of whether the legislature approved it;
 4 is that right?
 5 A. Yes. And I mean, there's
 6 various steps to this. I mean, it is a
 7 lengthy process. It takes at least months
 8 to get it done.
 9 Q. It takes how long?
 10 A. At least months. It could go
 11 into years.
 12 Q. Okay. But if they felt -- if
 13 the Board felt there was a problem and
 14 they needed -- let me rephrase that.
 15 If the Board felt that
 16 gender-affirming medical care for
 17 adolescents was inherently harmful it
 18 could -- if the Board agreed that was the
 19 case, they could pass a regulation
 20 banning that care that could take effect
 21 as long as the legislature approved it?
 22 MS. LAND: Object to form.
 23 THE WITNESS: Answer it?
 24 MS. LAND: Yes.
 25 A. Yes.

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1 AMY E. EMBRY
 2 Q. That issue of gender-affirming
 3 medical care for minors has never been
 4 raised as an issue at the Board; is that
 5 right?
 6 A. That is correct.
 7 MS. COOPER: I'd like to take
 8 tab 11. We haven't done that one
 9 yet, right? I'm checking with my
 10 team. Can we mark that as the next
 11 exhibit, which is --
 12 MR. RICHARDSON: This will be
 13 -- apologies, uploading -- this
 14 will be Exhibit 10.
 15 MS. COOPER: Exhibit 10. Thank
 16 you.
 17 (Exhibit 10, Opinion article
 18 in Washington Post dated April 8,
 19 2021 was received and marked on
 20 this date for identification.)
 21 MR. RICHARDSON: Exhibit 10
 22 has been produced.
 23 MS. LAND: I've got it.
 24 Q. So we've now marked Exhibit
 25 10, and just for identification, it's a

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1 AMY E. EMBRY
 2 document from the Washington Post opinion
 3 titled Why I Vetoed My Party's Bill
 4 Restricting Healthcare For Transgender
 5 Youth by Asa Hutchinson, dated April 8th,
 6 2021.
 7 We talked a few minutes a
 8 while back about the Governor's veto of
 9 HB 1570 before it became law and I can't
 10 remember if you said you've seen his veto
 11 statement or his reasons for his veto.
 12 Have you seen this before?
 13 A. No, I have not.
 14 Q. Could you -- why don't you
 15 take a minute to read this and I'll have
 16 a couple of questions.
 17 (Deponent reviews the
 18 document.)
 19 Q. Have you had a chance to read
 20 it? Okay.
 21 Just to make sure I'm covering
 22 all bases, did the Board have any
 23 discussions about the Governor's veto or
 24 his statement about the veto?
 25 A. No.

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1 AMY E. EMBRY
 2 Q. And the staff, the same?
 3 A. No. There may have been
 4 conversations; hey, did you see he vetoed
 5 it? But nothing as far as Board
 6 business.
 7 Q. So you were aware at the time
 8 that he vetoed HB 1570?
 9 A. Yes.
 10 Q. And that was something that
 11 was acknowledged among members of the
 12 Board staff?
 13 A. Yes.
 14 Q. Do you remember who?
 15 A. It was me and Juli Carlson.
 16 Q. That was back at the time?
 17 A. Yes.
 18 Q. Roughly around April 8th, '21?
 19 A. Thereabouts. I don't know the
 20 date.
 21 Q. Who brought it up; was it you
 22 or Juli Carlson?
 23 A. I don't recall and I know we
 24 both got it on our phone that's how we
 25 found out about it.

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1 AMY E. EMBRY
 2 Q. I didn't hear part of what you
 3 said.
 4 A. We saw it on social media or
 5 from a news station, social media and
 6 that's how we found out about it. That's
 7 what started the conversation, that's it.
 8 Q. And what did you say to one
 9 another about it?
 10 A. Nothing. It was not a long
 11 drawn out conversation. It was just;
 12 hey, the Governor vetoed this bill.
 13 Q. Okay. Did anybody -- did
 14 either you or Juli Carlson express
 15 agreement or disagreement with the
 16 Governor's decision?
 17 A. No.
 18 Q. Neither one?
 19 A. Not that I recall. This was
 20 well over a year ago, so not that I
 21 recall.
 22 Q. Okay. In part of the message
 23 the Governor talks about concerns about
 24 youth accessing treatment on the black
 25 market. Do you recall seeing that part?

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1 AMY E. EMBRY
 2 A. Yes.
 3 Q. Well, do you agree in general
 4 that it is harmful for people to access
 5 medical treatment on the black market?
 6 A. Are you asking as a personal
 7 opinion or as my opinion as Executive
 8 Director?
 9 Q. Let's start with the Board, as
 10 the Executive Director of the Board.
 11 A. Yes. It is dangerous to
 12 receive it on the black market.
 13 Q. Do you have a different
 14 personal opinion about it?
 15 MS. LAND: I'll object to any
 16 questions about her personal
 17 opinions, that would be outside the
 18 scope of the notice for her
 19 30(b)(6) witness.
 20 MS. COOPER: Okay.
 21 Q. Did you have a different
 22 personal opinion? You can answer, she
 23 objected.
 24 A. No. I don't have a different
 25 personal opinion.

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1 AMY E. EMBRY
 2 Q. Does the Board recognize, as
 3 the Governor mentioned, that the
 4 procedures banned by the Law 626 are
 5 considered best practice medical care for
 6 youth with gender dysphoria?
 7 A. I'm sorry. Repeat that
 8 question.
 9 Q. Yeah. Does the Board
 10 recognize, as the Governor does, that the
 11 gender transition procedures banned by
 12 Act 626 are part of best practice medical
 13 care for youth with gender dysphoria?
 14 A. The Board has never discussed
 15 that, so I don't know what their stand is
 16 on that.
 17 MS. LAND: Object to the form
 18 of that previous question.
 19 Q. And does the Board agree with
 20 the Governor that the decision about
 21 providing gender-affirming medical care
 22 to minors is best left to parents and
 23 doctors?
 24 A. Again, the Board has never
 25 discussed this, so I do not know the

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1 AMY E. EMBRY
 2 Board's stance.
 3 Q. Okay. And does that mean the
 4 Board doesn't have a stance, since you're
 5 testifying on behalf of the Board?
 6 A. I don't know how to answer
 7 that. They've never discussed it. It's
 8 never been brought up to discuss. So I
 9 don't -- as of right now they don't have
 10 a stance because it's not been discussed.
 11 It has not been an issue.
 12 Q. Understood. I want to go back
 13 to few more questions about the Board's
 14 enforcement of 626, if it should take
 15 effect and to understand a little bit
 16 more about that.
 17 You mentioned a little while
 18 ago we talked about Arkansas Stat
 19 20-6-202 which says, "Healthcare
 20 providers are legally and ethically
 21 prohibited from abandoning a patient
 22 before treatment has been concluded." Do
 23 you recall that?
 24 A. Yes.
 25 Q. So if doctors are currently

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1 AMY E. EMBRY
 2 treating adolescents with
 3 gender-affirming hormones, would the
 4 doctor be violating their ethical duty to
 5 discontinue treatment for a patient
 6 without referring them to an alternative
 7 provider?
 8 A. According to this law, yes.
 9 Q. And by "this law" you mean
 10 20-6-202?
 11 A. Yes.
 12 Q. Okay. So that would be
 13 unprofessional conduct on the part of a
 14 doctor to discontinue gender-affirming
 15 hormones without providing a referral to
 16 another doctor to continue that care; is
 17 that correct?
 18 A. Yes, that is my understanding.
 19 Q. So what is the Board to do if
 20 that situation arises and a complaint is
 21 filed or the Board otherwise comes to
 22 learn about a doctor who is providing
 23 care to a patient, an adolescent patient,
 24 specifically gender-affirming medical
 25 care, and was providing that care before

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1 AMY E. EMBRY
 2 Act 626 took effect and then after 626
 3 takes effect feels the doctor cannot
 4 discontinue that care because it would be
 5 abandoning their patient? So on the one
 6 hand, there's the issue of abandonment
 7 and on the other hand, Act 626 says the
 8 doctor can't provide that care; how are
 9 doctors supposed to navigate that
 10 conflict?
 11 MS. LAND: Objection to form.
 12 A. If that were to occur, then
 13 what would happen is the Board would let
 14 their legal counsel know there is a
 15 conflict of these two rules and we need
 16 to know how to proceed. That attorney may
 17 go further and it may require an AG
 18 opinion. When two laws conflict they have
 19 to ask for legal assistance.
 20 Q. Has the Board raised the
 21 concern about Act 626 putting it in this
 22 bind?
 23 A. No. The Board has not
 24 addressed Act 626 at all.
 25 Q. Okay. Does the Board have any

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1 AMY E. EMBRY
 2 concerns about the impact of enforcing
 3 Act 626 on adolescents who are receiving
 4 gender-affirming medical care?
 5 A. The Board has not addressed
 6 this. Nothing has been discussed at the
 7 Board level of Act 626, so nothing has
 8 been addressed.
 9 Q. So if the Board were put in
 10 that situation where Act 626 took effect,
 11 a complaint was brought to the Board
 12 because a doctor is continuing to provide
 13 care to a patient that they had been
 14 treating beforehand, I'm trying to
 15 understand, would the Board tell that
 16 doctor they have to stop providing that
 17 care?
 18 A. So are you asking if 626 was
 19 in effect and it conflicts with 20-6-202,
 20 the Board would ask for legal assistance
 21 on this; what do they need to do.
 22 Q. Does the Board view Act 626
 23 promoting the well being of minors?
 24 A. Again, the Board has not
 25 addressed Act 626 so this has not been

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1 AMY E. EMBRY
 2 discussed.
 3 Q. So the Board has no position?
 4 A. No position.
 5 Q. So then just to make sure I
 6 understand, does the Board not have any
 7 knowledge of ways Act 626 to benefit
 8 minors?
 9 A. It has not been provided by
 10 the Board Office to the Board members
 11 anything about Act 626.
 12 Q. So the -- what I'm trying to
 13 learn is whether the Board, itself, has
 14 any evidence or knowledge that Act 626
 15 would benefit minors in some way?
 16 A. To my knowledge, no.
 17 Q. Okay. Is the Board aware of
 18 any minors in Arkansas who have been
 19 harmed by gender-affirming medical care?
 20 A. The Board has not received any
 21 complaints and that's how they would
 22 learn about that. So, no.
 23 Q. So again, I can be confident
 24 that the Board will not be presenting any
 25 evidence based on its own experiences of

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1 AMY E. EMBRY
 2 any minors being harmed by
 3 gender-affirming medical care?
 4 A. We have not received any
 5 information or any complaints to that
 6 nature.
 7 MS. LAND: Objection to form
 8 on that previous question.
 9 Q. So I think you testified
 10 earlier that the Board is the State
 11 entity charged with regulating medicine
 12 in Arkansas with respect to the
 13 categories of medical professionals that
 14 you license; is that correct?
 15 A. Correct.
 16 Q. And that includes doctors; is
 17 that correct?
 18 A. I'm sorry? What was that?
 19 Q. And that includes doctors?
 20 A. Yes.
 21 Q. Is it the Board's view that
 22 Act -- sorry. Is it the Board's view
 23 that Act 626 is an appropriate regulation
 24 of medicine?
 25 A. The Board has not addressed

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1 AMY E. EMBRY
 2 Act 626.
 3 Q. So it has no view?
 4 A. It has no view.
 5 Q. Okay.
 6 MS. COOPER: Can we mark tab
 7 13 as Exhibit 11?
 8 (Exhibit, 11, email dated
 9 March 22, 2021, from Sarah Vestal
 10 to ASMB was received and marked on
 11 this date for identification.)
 12 MR. RICHARDSON: Exhibit 11
 13 has been introduced.
 14 MS. LAND: I've got it.
 15 Q. Okay. Thank you. Ms. Embry,
 16 have you seen Exhibit 11?
 17 A. Yes, I have.
 18 Q. For the record, I'll identify
 19 it as an email marked "Confidential" from
 20 Sarah Vestal sent Monday, 22 March, 2021.
 21 I understand this to be
 22 referencing a complaint against a surgeon
 23 based on the complainant being
 24 transgender; do I read that right?
 25 A. That is correct.

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1 AMY E. EMBRY
 2 Q. Okay. Now, we didn't get the
 3 complaint that this was about. Was there
 4 ever a complaint filed?
 5 A. I believe that I would have to
 6 go back and look at the files again. I
 7 do not have the files with me and we get
 8 an average of 400 complaints a year. So I
 9 would have to actually have documents to
 10 answer anything about this.
 11 However, when this came in I
 12 think this was the complaint because this
 13 was asking, it was not filing a complaint
 14 against a physician, no physician is
 15 named. It asks if there was a statute of
 16 limitations for filing an ethics
 17 complaint.
 18 Q. I see. So and this could
 19 satisfy your requirements for a
 20 complaint, they just have to notify the
 21 Board that they are making a complaint,
 22 there is no form they have to use?
 23 A. No, but it must be in writing.
 24 It can be email, it can be handwritten,
 25 U.S. mail, whatever, but it must be in

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1 AMY E. EMBRY
 2 writing and must include the doctor's
 3 name or licensee's name.
 4 Q. Okay. And what -- did this
 5 complaint get taken up by the Board?
 6 A. I would have to see if an
 7 actual complaint came in after this. This
 8 cannot be considered a complaint because
 9 it does not mention a licensee's name.
 10 This was specifically a question as to
 11 the statute of limitations for filing an
 12 ethics complaint.
 13 Q. So you don't know whether
 14 Sarah Vestal subsequently filed a
 15 complaint?
 16 A. She may have because I do
 17 remember this name but, again, it could
 18 be that I'm remembering her name from
 19 this document.
 20 Q. So sitting here now, you have
 21 no recollection of the outcome of that.
 22 Okay.
 23 Now, assuming what she alleged
 24 here is correct, understanding that we
 25 don't know, but would the refusal to

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1 AMY E. EMBRY
 2 treat a patient because they're
 3 transgender be something that would be an
 4 appropriate issue for the Board to
 5 address?
 6 A. Again, that depends on the
 7 situation. If it's a new patient, the
 8 doctor can refuse new patients. So I
 9 mean, you would have to get into more
 10 detail to determine if there had been a
 11 violation.
 12 Q. So if it was discrimination by
 13 a doctor based on any of the protected
 14 characteristics, that would not be
 15 something the Board would be involved
 16 with?
 17 A. If the investigation can be
 18 proven, then that is something the Board
 19 would take up.
 20 Q. Oh, sorry. Let me clarify my
 21 question.
 22 Assuming she were able to
 23 prove discrimination by her doctor
 24 because she's transgender, is that
 25 something the Board would -- could find

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1 AMY E. EMBRY
 2 in violation?
 3 A. Yes.
 4 MS. COOPER: Can we take a
 5 short break? Let's take ten minutes
 6 and I think we're getting close.
 7 VIDEOGRAPHER: We are off the
 8 record at 3:56 p.m.
 9 (Recess is taken.)
 10 VIDEOGRAPHER: We are back on
 11 the record at 4:15 p.m.
 12 Q. Ms. Embry, is Act 626 an
 13 appropriate regulation of medicine?
 14 A. I do not have an opinion on
 15 that.
 16 Q. And does that mean the Board
 17 doesn't have an opinion about that?
 18 A. The Board, that would be a
 19 question for the Board. Also, I'm not a
 20 physician.
 21 Q. Okay. Now, this is one of our
 22 topics on the notice about regulation of
 23 medicine and so -- and you're testifying
 24 on behalf of the Board and you should
 25 have been prepared on these. So I'm

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1 AMY E. EMBRY
 2 looking at the, you know, much of the
 3 notice is about regulating the medical
 4 profession. So is this -- is Act 626 an
 5 appropriate regulation of medicine?
 6 MS. LAND: I'll object to the
 7 form of that question and it is
 8 also vague. You can answer.
 9 A. I would need more detail, such
 10 as who drafted the legislation, who did
 11 they consult with, did they consult with
 12 anybody in the medical field? I don't
 13 have enough information as to how this
 14 was drafted to say if this is a good form
 15 of medicine.
 16 Q. And I hear you and I think
 17 that your answer is telling me maybe my
 18 question could have been clearer because
 19 I wasn't -- I wasn't asking about what
 20 medical experts would say about
 21 appropriate medical care for youth with
 22 gender dysphoria, so let me ask the
 23 question a little bit differently because
 24 I see how it was heard by you.
 25 Is prohibiting treatment that

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1 AMY E. EMBRY
 2 is -- well, let me just ask it this way;
 3 you're aware that gender-affirming
 4 medical care is recognized as best
 5 practices in the medical field by many
 6 professional medical professional
 7 associations?
 8 MS. LAND: Objection to form.
 9 A. Could you repeat that question
 10 again?
 11 Q. Are you aware that
 12 gender-affirming medical care is
 13 recognized as best practice in the -- for
 14 the treatment of gender dysphoria by many
 15 medical associations, medical
 16 professional associations?
 17 A. No, I was not aware of that.
 18 Q. Okay. Is prohibiting a
 19 particular medical treatment, blanket
 20 ban, typical of how medicine is -- the
 21 field of medicine is normally regulated?
 22 MS. LAND: Objection to form.
 23 A. It is not typical as to how
 24 Arkansas regulates medicine at the
 25 moment.

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1 AMY E. EMBRY
 2 Q. And I think you said earlier
 3 this is the only -- strike that.
 4 I believe you said earlier Act
 5 626 is the only ban on a particular
 6 medical treatment in Arkansas that you're
 7 aware of; is that correct?
 8 A. That I am aware of.
 9 Q. Okay. And that the Board is
 10 aware of; is that correct?
 11 A. Yes, it is.
 12 Q. Okay. So do you have any
 13 concerns about the government intruding
 14 on the medical decisions families make
 15 with their doctors?
 16 MS. LAND: Objection to form.
 17 A. I believe the Board would have
 18 concern with some of the issues in 626.
 19 If they were to address this issue they
 20 may have concerns.
 21 Q. And which concerns or what
 22 concerns?
 23 A. If I had to speculate to
 24 answer for 14 individuals, it would be
 25 about cutting off care to patients that

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1 AMY E. EMBRY
 2 are already undergoing treatment. It
 3 would also be a conflict with another
 4 law, as we've already discussed earlier.
 5 Q. And what is your basis for
 6 thinking that might be -- those may be
 7 concerns? And let's start with the
 8 cutting off care to patients already
 9 receiving treatment.
 10 A. That is strictly from
 11 witnessing the Board at board meetings.
 12 What is -- issues that may not be exactly
 13 like this but similar to it and how they
 14 have addressed those issues.
 15 Q. So are you speaking of other
 16 issues unrelated to gender-affirming
 17 medical care where there were concerns
 18 expressed by the Board about physicians
 19 cutting off care for patients; is that
 20 correct?
 21 A. Yes. It's called patient
 22 abandonment.
 23 Q. And the Board, some of the
 24 Board members have expressed concerns
 25 about when that happens, when patients

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1 AMY E. EMBRY
 2 are abandoned by doctors; is that right?
 3 A. Yes.
 4 Q. What concerns were raised by
 5 the Board members about that?
 6 A. Just, in general, just the
 7 fact that patient abandonment happened,
 8 that they abandoned a patient with
 9 nowhere else to go and a complaint was
 10 filed against the Board and they
 11 addressed it as would any other
 12 complaint.
 13 Q. Did the Board express concerns
 14 that that's harmful to patients when that
 15 happens?
 16 A. Yes. At times they have said
 17 it is harmful to the patient.
 18 Q. And why? Why did they say it
 19 was harmful?
 20 A. They did not give a reason
 21 why. When they spoke of that it was just
 22 a statement that it was harmful to
 23 patients when you abandon them.
 24 Q. Which Board member said that?
 25 A. Oh, there's been -- I don't

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1 AMY E. EMBRY
 2 know. I don't know, but there have been
 3 issues of patient abandonment that have
 4 been brought before the Board.
 5 Q. I'm sorry. I can't recall if I
 6 asked you this question. Do you have
 7 concerns about the government intruding
 8 on the medical decisions families make
 9 with their doctors?
 10 MS. LAND: Objection to form
 11 and to the scope of that question.
 12 You can answer.
 13 A. I do believe upon any
 14 legislation that comes before the Board
 15 if they discuss, if they do have concerns
 16 they do discuss it and they would ask
 17 their legal counsel what would be the
 18 best way to proceed.
 19 Q. And are you speaking -- I
 20 asked the question a little bit generally
 21 but I didn't probably ask it as
 22 specifically as I should have and that
 23 may help clarify your answer.
 24 Do you have concerns about,
 25 with respect to Act 626, the government

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1 AMY E. EMBRY
 2 intruding on the medical decisions
 3 families make with their doctors?
 4 MS. LAND: Objection to form
 5 and scope.
 6 A. There is a possibility, yes.
 7 It's all I can say on that is that there
 8 is a possibility. Until it is addressed
 9 by the Board, I can't give a definite
 10 answer.
 11 Q. And there is a possibility
 12 that you would have concerns or there is
 13 a possibility that if Act 626 takes
 14 effect that the government would be
 15 intruding on medical decisions families
 16 make with their doctors? I'm not sure I
 17 understood your answer.
 18 A. I would say yes to both.
 19 Q. So does that mean there is a
 20 possibility that the Board, if faced with
 21 complaints about doctors providing care
 22 that is prohibited by Act 626, that the
 23 Board may not enforce Act 626 and
 24 prohibit doctors from or discipline
 25 doctors for engaging in such care?

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1 AMY E. EMBRY
 2 A. Again, every situation is
 3 different, but if Act 626 went into
 4 effect, as your question is based on, if
 5 it were to go into effect, it would be in
 6 conflict with another law and the Board
 7 would need to ask for legal assistance on
 8 what to do.
 9 MS. LAND: I'll object to the
 10 form of that previous question.
 11 Q. And that conflict would only
 12 be, if I understand correctly, in the
 13 case of individuals who are already
 14 receiving care from a doctor; is that
 15 right?
 16 MS. LAND: Object to form.
 17 A. Yes. According to 20-6-202
 18 it's legally and ethically prohibited
 19 from abandoning a patient before
 20 treatment has been concluded. So that
 21 means they are already within treatment.
 22 Q. Right. So understanding that
 23 the Board would need to ask for legal
 24 advice from counsel about what to do in
 25 the event of a complaint that raises this

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1 AMY E. EMBRY
 2 conflict between two statutes, if you
 3 had, you know, putting aside patients who
 4 are already receiving care and just
 5 somebody who their doctor recommends or
 6 would recommend that they initiate care
 7 that would violate Act 626, do you have
 8 concerns about the government intruding
 9 into that decision made by families with
 10 their doctor?
 11 MS. LAND: Objection to form.
 12 A. I don't understand the
 13 question. I don't understand exactly --
 14 Q. Let me ask it differently.
 15 If Act 626 were in effect and
 16 a patient, minor patient and their parent
 17 saw a doctor and after assessment the
 18 doctor's recommendation would be
 19 gender-affirming medical treatment, and
 20 the parents and minor agree that that's
 21 in the best interests of that patient,
 22 but that Act 626 would not permit the
 23 child or minor to receive that care that
 24 the parent and doctor believe is in the
 25 child's best interests, do you have

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1 AMY E. EMBRY
 2 concerns about the law intruding into
 3 this medical decision that families make
 4 with their doctors?
 5 MS. LAND: Objection to form
 6 and scope.
 7 A. I would say that the Board, it
 8 is possible that they would have
 9 concerns. But, again, if it were in
 10 effect and it's in conflict with another
 11 law, they would not do anything until
 12 they advised their legal counsel.
 13 Q. And in your view it's possible
 14 the Board would have concerns even if
 15 there's an individual minor who is not
 16 currently receiving care but is --
 17 parents and doctors believe care would be
 18 in their best interest?
 19 A. It is possible, it is a
 20 possibility that the Board would voice
 21 concerns.
 22 Q. But you have not heard
 23 specific concerns voiced by anybody at
 24 this point?
 25 A. No.

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1 AMY E. EMBRY
 2 Q. Okay. Do you have concerns?
 3 MS. LAND: I'll object to the
 4 form of that question to the extent
 5 it's asking for any personal views
 6 that would be outside the scope of
 7 this notice. So I will object to
 8 any question that's going to elicit
 9 personal views of this witness.
 10 MS. COOPER: Okay.
 11 MS. LAND: And if we're going
 12 to continue to ask her personal
 13 views, that might need to be a
 14 discussion we need to have further.
 15 MS. COOPER: Yeah. I just have
 16 this question.
 17 Q. Do you remember the question?
 18 MS. LAND: You can answer.
 19 A. Okay. So I have concerns that
 20 the law that was passed, Act 626, is in
 21 violation of other laws. That is my
 22 concern.
 23 Q. And which other laws?
 24 A. The 20-6-202.
 25 Q. Any others?

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1 AMY E. EMBRY
 2 A. Not that I'm aware of right
 3 now.
 4 Q. Okay. So that's a concern
 5 about people who are currently receiving
 6 care not being able to have the doctor
 7 continue to provide or refer them for
 8 continuation of that care?
 9 A. Correct.
 10 Q. Okay. But not about the people
 11 who haven't started care yet, there are
 12 no concerns about that?
 13 A. I don't know -- at this point,
 14 no. If the law were enacted, then more
 15 research would need to be done.
 16 Q. And have you talked with any
 17 families who will be directly affected by
 18 Act 626 if it takes effect?
 19 A. Have I spoken to anyone? No.
 20 Q. Do you know any?
 21 A. No, I do not.
 22 Q. Okay. Do you know any
 23 transgender adolescents who are receiving
 24 gender-affirming medical care?
 25 A. The only ones that I am aware

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1 AMY E. EMBRY
 2 of are the ones that were listed in the
 3 lawsuit.
 4 Q. So you don't personally know
 5 or the Board doesn't have interaction
 6 with any minors who are receiving
 7 gender-affirming medical care?
 8 A. Not to my knowledge.
 9 MS. COOPER: Just a minute.
 10 That's all I've got.
 11 MS. LAND: I don't have any
 12 questions.
 13 VIDEOGRAPHER: We are off the
 14 record at 4:35 p.m.
 15 MS. LAND: We would like to
 16 read and sign.
 17 (The proceedings were
 18 adjourned at 4:35 p.m.)
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1 C E R T I F I C A T E
 2 I, MAUREEN M. RATTO, a
 3 Registered Professional Reporter, do
 4 hereby certify that prior to the
 5 commencement of the examination, AMY E.
 6 EMBRY was sworn by me to testify the
 7 truth, the whole truth and nothing but
 8 the truth.
 9 I DO FURTHER CERTIFY that the
 10 foregoing is a true and accurate
 11 transcript of the proceedings as taken
 12 stenographically by and before me at
 13 the time, place and on the date
 14 hereinbefore set forth.
 15 I DO FURTHER CERTIFY that I am
 16 neither a relative nor employee nor
 17 attorney nor counsel of any of the
 18 parties to this action, and that I am
 19 neither a relative nor employee of such
 20 attorney or counsel, and that I am not
 21 financially interested in this action.
 22
 23
 24 
 25 MAUREEN M. RATTO, RPR
 License No. 817125

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1 I N D E X
 2 WITNESS: AMY E. EMBRY 6
 3 DIRECT EXAMINATION BY MS. COOPER 6
 4
 5 E X H I B I T S
 6 Exhibit 1, 30(b)(6) notice for 15
 7 Defendant Arkansas State Medical
 8 Board
 9 Exhibit 2, Arkansas Medical 24
 10 Practices Act and Regulations,
 11 revised as of December 2, 2020
 12 Exhibit 3, printout of the 44
 13 homepage of the Arkansas State
 14 Medical Board website
 15 Exhibit 4, printout from the 69
 16 Medical Board re: Regulatory and
 17 Discipline
 18 Exhibit 5, Arkansas State House 105
 19 Bill 1718
 20 Exhibit 6, Guidance For the Use 138
 21 of Hydroxychloroquine and
 22 Chloroquine For the Treatment of
 23 COVID 19
 24 Exhibit 7, May 5, 2021 email re: 155
 25 Public Health Grand Rounds

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1 Exhibit 8, email dated May 25, 165
 2 2021, re: CNN Inquiry
 3 Exhibit 9, copy of House Bill 175
 4 1570
 5 Exhibit 10, Opinion article in 217
 6 Washington Post dated April 8,
 7 2021
 8 Exhibit 11, email dated March 229
 9 22, 2021, from Sarah Vestal to
 10 ASMB
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1 AMANDA LAND, ESQ.
 2 aland@arkansasag.gov
 3 May 24, 2022
 4 RE: BRANDT, et al. vs. RUTLEDGE, et al.
 5 5/10/2022, Amy E. Embry (#5219516)
 6 The above-referenced transcript is available for
 7 review.
 8 Within the applicable timeframe, the witness should
 9 read the testimony to verify its accuracy. If there are
 10 any changes, the witness should note those with the
 11 reason, on the attached Errata Sheet.
 12 The witness should sign the Acknowledgment of
 13 Deponent and Errata and return to the deposing attorney.
 14 Copies should be sent to all counsel, and to Veritext at
 15 erratas-cs@veritext.com.
 16
 17 Return completed errata within 30 days from
 18 receipt of testimony.
 19 If the witness fails to do so within the time
 20 allotted, the transcript may be used as if signed.
 21
 22 Yours,
 23 Veritext Legal Solutions
 24
 25

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1 BRANDT, et al. vs. RUTLEDGE, et al.
 2 5/10/2022 - Amy E. Embry (#5219516)
 3 ACKNOWLEDGEMENT OF DEPONENT
 4 I, Amy E. Embry, do hereby declare that I
 5 have read the foregoing transcript, I have made any
 6 corrections, additions, or changes I deemed necessary as
 7 noted above to be appended hereto, and that the same is
 8 a true, correct and complete transcript of the testimony
 9 given by me.
 10
 11 _____
 12 Amy E. Embry Date
 13 *If notary is required
 14 SUBSCRIBED AND SWORN TO BEFORE ME THIS
 15 _____ DAY OF _____, 20____.
 16
 17
 18 _____
 19 NOTARY PUBLIC
 20
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1 BRANDT, et al. vs. RUTLEDGE, et al.
 2 5/10/2022 - Amy E. Embry (#5219516)
 3 E R R A T A S H E E T
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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.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

Veritext Legal Solutions complies with all federal and State regulations with respect to the provision of court reporting services, and maintains its neutrality and independence regardless of relationship or the financial outcome of any litigation. Veritext requires adherence to the foregoing professional and ethical standards from all of its subcontractors in their independent contractor agreements.

Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at www.veritext.com.

EXHIBIT 2

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

DYLAN BRANDT, et al.,)
) Case No.
Plaintiffs,) 4:21-cv-00450-JM
)
vs.)
)
LESLIE RUTLEDGE, et al.,)
)
Defendants.)

-----X

VIDEOTAPED DEPOSITION OF
RHYS BRANMAN, M.D.

Friday, June 24, 2022
1:58 p.m.

Office of the Arkansas Attorney General
323 Center Street - Suite 200
Little Rock, Arkansas 72201

Stenographically Remotely Reported By:
Mayleen Ahmed, RMR, CRR, CRC, CSR/CCR

Page 2	<p>1 APPEARANCES</p> <p>2 Attorneys for Plaintiffs:</p> <p>3 SULLIVAN & CROMWELL LLP</p> <p>4 BY: DANIEL J. RICHARDSON, ESQ. [via Zoom]</p> <p>5 1700 New York Avenue NW</p> <p>6 Washington, D.C. 20006</p> <p>7 202.956.7500</p> <p>8 richardson@sullcrom.com</p> <p>9</p> <p>10 GILL RAGON OWEN, P.A.</p> <p>11 BY: BETH ECHOLS, ESQ.</p> <p>12 DRAKE MANN, ESQ.</p> <p>13 425 W. Capitol Avenue - Suite 3800</p> <p>14 Little Rock, Arkansas 72201</p> <p>15 501.376.3800</p> <p>16 echols@gill-law.com</p> <p>17 mann@gill-law.com</p> <p>18</p> <p>19 AMERICAN CIVIL LIBERTIES UNION FOUNDATION</p> <p>20 BY: LESLIE COOPER, ESQ. [via Zoom]</p> <p>21 125 Broad Street</p> <p>22 New York, New York 10004</p> <p>23 917.345.1742</p> <p>24 lcooper@aclu.org</p> <p>25</p>	Page 4
Page 3	<p>1 APPEARANCES (cont'd)</p> <p>2</p> <p>3 Attorneys for Defendants:</p> <p>4 ARKANSAS ATTORNEY GENERAL'S OFFICE</p> <p>5 BY: AMANDA LAND, ESQ.</p> <p>6 323 Center Street - Suite 200</p> <p>7 Little Rock, Arkansas 72201</p> <p>8 501.682.2007</p> <p>9 amanda.land@arkansasag.gov</p> <p>10</p> <p>11</p> <p>12 ALSO PRESENT:</p> <p>13 MICHAEL TSCHIEMER, videographer, Notary Public</p> <p>14</p> <p>15 ---o0o---</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	Page 5
	<p>1 INDEX</p> <p>2</p> <p>3 WITNESS: RHYS BRANMAN, M.D.</p> <p>4 EXAMINATION PAGE</p> <p>5 BY MR. RICHARDSON 8</p> <p>6</p> <p>7</p> <p>8 MOTIONS TO STRIKE: None</p> <p>9 INSTRUCTIONS NOT TO ANSWER: None</p> <p>10 DOCUMENT/INFORMATION REQUESTS: None</p> <p>11</p> <p>12</p> <p>13 ----- EXHIBITS -----</p> <p>14 (Previously marked)</p> <p>15 PLAINTIFFS'</p> <p>16 EXHIBIT PAGE</p> <p>17 Exhibit 2 Regulation No. 27 92</p> <p>18</p> <p>19 Exhibit 3 Little Rock Cosmetic Surgery 44</p> <p>20 Center web page</p> <p>21</p> <p>22 Exhibit 4 American Society of Plastic 57</p> <p>23 Surgeons - Gender Affirmation</p> <p>24 Surgeries</p> <p>25</p>	
	<p>1 ----- EXHIBITS (Cont'd) -----</p> <p>2 (Previously marked)</p> <p>3 PLAINTIFFS'</p> <p>4 EXHIBIT PAGE</p> <p>5 Exhibit 7 Guidance For the Use of 83</p> <p>6 Hydroxychloroquine and</p> <p>7 Chloroquine For the Treatment</p> <p>8 of COVID 19</p> <p>9</p> <p>10 Exhibit 8 Opinion piece, Governor 126</p> <p>11 Hutchison, Washington Post,</p> <p>12 April 8, 2021</p> <p>13</p> <p>14 Exhibit 9 H.B. 1570 105</p> <p>15</p> <p>16 ---o0o---</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	

Page 6

1 DEPOSITION OF RHYS BRANMAN, M.D. - June 24, 2022
 2 -----
 3 THE VIDEOGRAPHER: We are on the record
 4 at 1:58 p.m. This is the media unit one of the
 5 video-recorded deposition of Dr. Rhys Branman taken
 6 by counsel for plaintiff in the matter of Dylan
 7 Brandt et al., vs. Leslie Rutledge, et al., filed in
 8 the United States District Court, Eastern District
 9 of Arkansas, Central Division, Case
 10 No. 4:21-CV-00450JM.
 11 We are at the location of the Arkansas
 12 Attorney General's Office at 323 Center Street,
 13 Suite 200, in Little Rock, Arkansas, and there are
 14 also participants remotely via Zoom.
 15 My name is Mike Tschiemer representing
 16 Veritext, and I'm the videographer. The court
 17 reporter is Mayleen Ahmed, also from the firm of
 18 Veritext.
 19 I'm not related to any party in this
 20 action, nor am I financially interested in the
 21 outcome. If there are any objections to proceeding,
 22 please state them at the time of your appearance.
 23 Counsel and all present, including
 24 remotely, will now state their appearances and
 25 affiliations for the record, beginning with the

Page 7

1 noticing attorney.
 2 MR. RICHARDSON: This is Daniel
 3 Richardson with Sullivan & Cromwell LLP for the
 4 plaintiffs.
 5 MS. ECHOLS: Beth Echols, Gill Ragon
 6 Owen, for the plaintiffs.
 7 MR. MANN: Drake Mann, Gill Ragon Owen,
 8 for the plaintiffs.
 9 THE VIDEOGRAPHER: And remotely, anyone
 10 else?
 11 MR. RICHARDSON: It looks like my
 12 colleague Leslie Cooper may have joined. I'm not
 13 sure if she can hear us.
 14 MS. COOPER: Yes. This is -- are we
 15 announcing? I'm sorry. Leslie Cooper for
 16 plaintiffs.
 17 THE VIDEOGRAPHER: Madam reporter --
 18 Doctor, would you, please, raise your
 19 right hand to be sworn in.
 20 Do you swear that the testimony you're
 21 about to give will be the truth, the whole truth,
 22 and nothing but the truth?
 23 THE WITNESS: Yes, I do.
 24 THE VIDEOGRAPHER: Thank you. Please
 25 proceed.

Page 8

1 -----
 2 RHYS BRANMAN, M.D.
 3 having been duly sworn, testified as follows:
 4 -----
 5 EXAMINATION
 6 BY MR. RICHARDSON:
 7 Q. Good afternoon, Dr. Branman. Thank you
 8 for being here. I know you're very busy, so I
 9 appreciate it.
 10 Just, have you been deposed before, sir?
 11 A. Oh, yes. I believe once before.
 12 Q. Okay. So this may sound familiar, I
 13 just want to go over a few brief ground rules to
 14 help us structure the conversation today.
 15 First, the reporter needs to make an
 16 accurate record, and so anything that's nonverbal
 17 won't be picked up. So if you can respond to
 18 everything verbally instead of, you know, head nods
 19 or hand gestures, that would be great.
 20 To that end, it's also good if we don't
 21 speak over another, so I'll try to not speak over
 22 you, and I'd appreciate if you could try to do the
 23 same for me.
 24 Throughout the deposition today, your
 25 attorney may have objections to some of my

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1 questions. If that happens, that's just for the
 2 record; we can sort that out later, but you can go
 3 ahead and answer the question even if there's been
 4 an objection.
 5 I might show you a few documents today.
 6 My colleagues in the room have those documents with
 7 them, but if there's ever any confusion about what
 8 I'm referring to, just let me know, and I can -- I
 9 can clarify things.
 10 Also, I already know it's already late
 11 in the day, and these things can be a little tiring.
 12 So if you want to break at any point, just let me
 13 know. I'll plan to take a break, you know, after --
 14 after an hour, hour and a half or so, just so we can
 15 gain our bearings. But if you need more than that,
 16 just -- just feel free to let me know.
 17 Does all of that sound all right?
 18 A. I'm sorry?
 19 Q. Does all of that sound all right?
 20 A. Yes. That sounds fine.
 21 Q. So, first, what did you do to prepare
 22 for your testimony today?
 23 A. I spoke with my attorney briefly, and
 24 she informed me about what the general -- I guess
 25 the protocol is for a disposition -- for

<p style="text-align: right;">Page 10</p> <p>1 disposition -- deposition. I'm sorry. 2 Q. No problem. Gotcha. 3 So it was just -- just the one meeting 4 with the -- the attorney? 5 A. I had two meetings with the attorney. 6 Q. Okay. And -- 7 A. One -- 8 Q. -- both of those were brief? 9 A. They were basically, yeah, this is what 10 a deposition is, this is, you know -- 11 MS. LAND: I'll go ahead and do an 12 objection on the record as to any attorney-client 13 privileged communications. 14 MR. RICHARDSON: Gotcha. 15 MS. LAND: Just for good measure. 16 BY MR. RICHARDSON: 17 Q. Okay. So how did you first become aware 18 of this case? 19 A. I was informed by Amy Embry that I would 20 be deposed for a lawsuit that the Medical Board is 21 being sued. 22 Q. Okay. So you were not notified of the 23 case prior to being notified for this deposition? 24 A. No, I was not. 25 Q. Okay. Are you aware that you're a</p>	<p style="text-align: right;">Page 12</p> <p>1 went to college, after high school, or just the 2 health sciences part? 3 Q. I would say just the health sciences 4 part. 5 A. So I graduated high school and I went 6 to -- well, I'll just start. I went to college at 7 UC Irvine, and then graduated from there, and went 8 to dental school first at UC San Francisco. 9 I graduated from there in 1986, and then 10 was in the United States Navy as a general dentist 11 for approximately three years. 12 After that, I grad -- I left the United 13 States Navy, and I was accepted at Vanderbilt 14 Medical School. And I did a residency -- I did my 15 medical school training as well as residency in oral 16 and maxillofacial surgery. It was a combined 17 residency. 18 And then after that, I went to -- did a 19 fellowship, a one-year fellowship in general 20 cosmetic surgery. So that's my training. 21 Q. And was that -- 22 A. And that -- 23 Q. -- fellowship also in Vanderbilt? 24 A. No. That was here in Little Rock 25 Arkansas under Jim Billie, who is also a cosmetic</p>
<p style="text-align: right;">Page 11</p> <p>1 defendant in this case? 2 A. I was -- as a member of the Medical 3 Board, I guess so. I didn't know I was a defendant. 4 What do you mean by that? 5 Q. Well, just named as a defendant in -- in 6 the matter in your capacity as a member of the 7 Medical Board. 8 A. Yes, I was aware of that. 9 Q. Okay. And were you aware of that before 10 being notified of this deposition? 11 A. No, I was not. 12 Q. Okay. Gotcha. 13 Are you aware of the arguments being 14 asserted in court in this case on your behalf? 15 A. No, I'm not. 16 Q. Okay. So you had no -- no knowledge or 17 involvement with the case prior to being informed of 18 this deposition? 19 A. That would be correct. 20 Q. Okay. I'd like to just briefly ask you 21 about your medical training. 22 Can you just describe your -- your 23 academic training and medical training to become a 24 doctor? 25 A. Would you like me to start from when I</p>	<p style="text-align: right;">Page 13</p> <p>1 surgeon. 2 Q. Gotcha. 3 So it's -- first was what? A DDS, I 4 guess, is what that would be, the dental school 5 degree. Is that -- 6 A. So the dental school degree is a DDS. 7 Q. DDS. 8 A. And the medical school degree was an 9 M.D. 10 Q. Gotcha. 11 And the M.D. and the residency both at 12 Vanderbilt, the fellowship in Little Rock? 13 A. Yes. 14 Q. Okay. 15 A. Correct. 16 Q. Are you currently board-certified? 17 A. I'm board-certified in oral and 18 maxillofacial surgery, and I'm board-certified in 19 general cosmetic surgery. 20 Q. Okay. And are there separate 21 organizations that provide those certifications, or 22 is that all one? 23 A. Those are separate organizations. 24 Q. So is the first one the American Board 25 of Cosmetic Surgery; is that --</p>

<p style="text-align: right;">Page 14</p> <p>1 A. That would be the cosmetic surgery side, 2 and then the other is the American Board of Oral and 3 Maxillofacial Surgery. 4 Q. Gotcha. Thank you. 5 Are you currently licensed to practice 6 in Arkansas? 7 A. Yes. 8 Q. Are you licensed anywhere else besides 9 Arkansas? 10 A. Yes. 11 Q. Okay. And where would that be? 12 A. I'm licensed to practice dentistry and 13 medicine in California. 14 Q. And does that stem from your time after 15 you graduated UC San Francisco when you were -- 16 A. Yeah. I wanted to maintain those 17 licenses. So, yes, that's when I was in California. 18 Q. Gotcha. 19 So as a licensed doctor in Arkansas, are 20 you regulated by the Arkansas Medical Board? 21 A. Absolutely. 22 Q. Are there any other entities that -- 23 that regulate doctors in Arkansas besides the Board? 24 A. Well, for me personally, I'm regulated 25 by the Arkansas State Dental Board as well. I don't</p>	<p style="text-align: right;">Page 16</p> <p>1 now? 2 A. I had a partner back -- I guess we 3 separated around 2011, 2010. 4 Q. So since then, you've been the only 5 person practicing at that center? 6 A. Yes. 7 Q. Okay. And did you practice anywhere 8 else beforehand since obtaining -- since completing 9 your fellowship? 10 A. I had my own practice in Nashville, 11 Tennessee. 12 Q. So at that time, you would have been 13 licensed in Tennessee? 14 A. That is correct. 15 Q. And that has lapsed or -- 16 A. I'm not practicing there, so I let that 17 lapse. 18 Q. So at your current role at the Little 19 Rock Cosmetic Surgery Center, what sort of 20 treatments do you provide? 21 A. Presently, I provide cosmetic surgery 22 treatments, cosmetic injections. Those are the main 23 things. I get -- do you want me to tell you the 24 list of procedures that I perform? 25 Q. Well, just give me some examples.</p>
<p style="text-align: right;">Page 15</p> <p>1 know of any other boards that license physicians in 2 the State of Arkansas. 3 Q. Okay. And where do you currently 4 practice? 5 A. I practice in Little Rock, Arkansas. 6 Q. And is that with the Little Rock 7 Cosmetic Surgery Center? 8 A. That is correct. 9 Q. And do you provide any treatments 10 outside of the Little Rock Cosmetic Surgery Center? 11 A. Well, if -- sometimes I take patients 12 from there to a hospital to do a hospital surgery. 13 Q. Okay. That's the kind of thing where 14 you would need, like, admitting privileges to some 15 legal hospital to -- 16 A. That is correct. 17 Q. I understand. 18 And how long have you been with the 19 Little Rock Cosmetic Surgery Center? 20 A. Since 2002. 21 Q. And are there any other doctors that 22 practice as part of that center? 23 A. Not currently. 24 Q. Okay. So there -- there used to be 25 colleagues working there, and you're the only one</p>	<p style="text-align: right;">Page 17</p> <p>1 So on the cosmetic surgery side -- 2 A. Sure. 3 Q. -- would that include things like a 4 rhinoplasty or breast augmentation or -- 5 A. Yes. Those would be things like 6 rhinoplasty, breast augmentation, eyelid surgery. 7 Q. Okay. 8 A. Liposuction. 9 Q. And on the injection side, I mean, do 10 you use the term "cosmetic injections"; is that 11 right? 12 A. I guess so. On the injection side, I 13 would perform things like BOTOX®; cosmetic fillers, 14 hyaluronic acid-based fillers; occasionally, I'll 15 provide a silicone injection. I think those are the 16 main ones that I did. 17 Q. So focusing just on the surgery piece of 18 that, what does a surgical course of treatment 19 usually entail? 20 A. The surgical course of treatment entails 21 a patient contacting the office; they're then 22 scheduled for an appointment. Typically, they tell 23 a receptionist what they're interested in. 24 They're appointed for a consultation. 25 During the consultation, there is a review of their</p>

5 (Pages 14 - 17)

<p style="text-align: right;">Page 18</p> <p>1 medical history, and then we do an examination. We 2 discuss with them what their desires are, and we do 3 an examination to see if they are a candidate for 4 the procedure they're asking for. 5 Q. Okay. So it normally would work where 6 they -- they come in already with an idea of the 7 surgical treatment in mind, or do they come in with 8 a problem, and then you tell them what surgery would 9 -- would best help with the problem? 10 A. I've seen both. 11 Q. Okay. And once you start down a course 12 of treatment and the person is qualified for the 13 procedure, does that usually involve, you know, 14 multiple procedures? Are there prescription drugs? 15 Is there physical therapy? 16 I'm just curious what might be included 17 within a single patient's -- 18 MS. LAND: Object to form. 19 Q. -- care and -- 20 MS. LAND: You can answer. 21 A. Can you repeat the question, please? 22 I'm sorry. 23 Q. I'm just curious what would -- what 24 would be included in a patient's care regimen once 25 they've started treatment?</p>	<p style="text-align: right;">Page 20</p> <p>1 we give a patient, so I'm not -- I may not be 2 physically writing that prescription each time. 3 But, yes, we do provide -- I do 4 prescribe that myself. 5 Q. Okay. And are there any treatments that 6 you offer that require multiple surgeries or 7 multiple appointments to complete the treatment? 8 A. Some. Yeah, there are a few. 9 For example, if I feel -- if the patient 10 needs a mastopexy or a breast augment- -- or a 11 breast lift, sometimes -- and they want an 12 additional fullness in the upper pull of the breast, 13 and I don't feel that a combination of a mastopexy 14 and a breast implant would be a safe, reliable 15 procedure, then I would go ahead and do the lift 16 first, let them heal, and then come back in and do a 17 breast augmentation to get that final result that 18 they're looking for. 19 Q. Gotcha. 20 And would it ever be the case with 21 things like a -- you know, like a rhinoplasty, where 22 you might do one procedure and then have to do a 23 follow-up procedure? 24 A. Only if the results of the first 25 procedure were not to the patient's liking.</p>
<p style="text-align: right;">Page 19</p> <p>1 A. Their care regimen can be anything from 2 a simple surgery where they have a surgical 3 procedure and then we follow up with postoperative 4 follow-up really just to make sure they're healing 5 well. Some patients may undergo a brief period 6 where they have a topical medication for a short 7 period of time. And then we do a procedure. Some 8 patients undergo a weight loss; some weight loss 9 ahead of time, and then we do the procedure. 10 Q. Would it ever be the case that after the 11 procedure, you would need to prescribe medication to 12 the patient? 13 A. Well, most -- 14 MS. LAND: Object to form. 15 A. Most patients, will be prescribed an 16 antibiotic, a pain medication, and sometimes other 17 types of medication to prevent infection and to see 18 them through the immediate postoperative course. 19 Q. Okay. And do you prescribe those 20 medications yourself? 21 A. I'm sorry? 22 Q. Do you prescribe those medications 23 yourself? 24 A. Do I prescribe them myself? Yes. 25 Now, sometimes we have a set form that</p>	<p style="text-align: right;">Page 21</p> <p>1 Q. Okay. And has that happened before? 2 A. Yes. 3 Q. Are there any treatments that you used 4 to provide that you no longer provide? 5 A. Yes. 6 Q. And what are some of those? 7 A. One is buttocks augmentation. I don't 8 provide that. 9 Q. And what -- 10 A. I don't -- I'm sorry. Go ahead. 11 Q. What was your reason for no longer 12 providing that? 13 A. I didn't feel the procedure was safe. 14 And the way the procedure was performed to get the 15 results that the patients wanted, I just didn't feel 16 comfortable with that procedure. 17 Q. Were there any incidents that led you to 18 change your view on the safety of that procedure? 19 A. Just some journal articles that showed a 20 relatively high incidence of pulmonary embolism or 21 blood clots going to the lungs. 22 Q. Are you aware of other providers that 23 still offer the buttocks augmentation procedure? 24 A. Yes. 25 Q. Any in Arkansas?</p>

Page 22

1 A. Yes.

2 Q. And are there any other procedures that

3 fall into that category that you used to provide and

4 no longer provide?

5 A. Let's see. Hair transplants.

6 Q. And what was the reason for the shift

7 there?

8 A. I didn't feel that I could provide the

9 results that the patients wanted due to the fact

10 that I didn't have the team together that could

11 effectively pro- -- you know, do the procedure.

12 Q. Okay.

13 A. It's very -- it's a very highly

14 intensive team approach that I felt I just wasn't

15 set up for.

16 Q. Okay. And are there other providers in

17 Arkansas -- in Arkansas offering that treatment?

18 A. I believe so. I'm not sure about that.

19 Q. And are there --

20 A. I know there used to be.

21 Q. And are there providers outside of

22 Arkansas that offer that hair transplant treatment?

23 A. Yes. Many.

24 Q. Have you ever performed surgery for a

25 transgender person?

Page 23

1 MS. LAND: Objection to form and

2 relevance.

3 You can answer when I object.

4 A. Not that I'm aware of.

5 Q. Okay. So have you ever performed

6 surgery related to a transgender person's gender

7 transition?

8 MS. LAND: Object to form.

9 A. When -- can you please define "gender

10 transition"?

11 Q. Well. Any, any procedure that would

12 have helped the patient align their sex

13 characteristics with their gender identity.

14 A. Are we talking about genitalia in

15 particular, or are we talking about any part of the

16 person's body?

17 Q. Any part of the person's body?

18 A. There's one patient that I performed a

19 rhinoplasty on, and that patient presented

20 themselves as a female, but when -- but we were

21 unaware that the patient was male. And so we -- we

22 were -- we did the procedure. But -- and this was a

23 hump reduction on a rhinoplasty. And that's the

24 only procedure that I'm aware of.

25 Q. Okay. And did that patient say that

Page 24

1 they were seeking out that care as part of an

2 attempt to align their -- their physical appearance

3 with their gender identity, or is that something you

4 found out after the fact?

5 A. I found out after the fact. I was

6 unaware of what their intention was, if there even

7 was that intention.

8 Q. Okay. And are you -- would you be

9 willing to provide care to a transgender person?

10 MS. LAND: Object to form.

11 A. In regards to gender transformation or

12 in regards to any procedure?

13 Q. Well, any procedure.

14 A. Sure. I have -- I have no problem with

15 providing various types of treatment.

16 Q. Okay. And would you feel comfortable

17 providing care to a transgender person that was a

18 gender transition procedure?

19 A. That was or was not?

20 Q. That was.

21 A. I'm not really trained to do that, so

22 I'm not -- that's not what I actually do.

23 I feel that if someone wants to have a

24 procedure in order to do a gender transformation,

25 then I would want to refer them to someone who

Page 25

1 specializes in that area.

2 Q. What if a person just came in for a

3 procedure like a breast augmentation or a mastopexy,

4 one of the procedures you do provide, but stated

5 that that was the reason?

6 MS. LAND: Object to form, relevance,

7 and calls for speculation.

8 You can answer.

9 A. Are you referring to a breast

10 augmentation?

11 Q. Well, let's just take a mastectomy. Is

12 that a procedure you've provided before?

13 A. No.

14 Q. Okay. Well, let's -- let's do a -- have

15 you provided something called facial feminization

16 surgery at any point?

17 A. No.

18 Q. Okay. Well, let's say it was breast

19 augmentation then.

20 If someone said that, you know, they

21 wanted a breast augmentation as part of a gender

22 transition, is that the kind of thing you would

23 provide?

24 A. I don't provide that.

25 Q. Oh, so you don't provide breast

<p style="text-align: right;">Page 26</p> <p>1 augmentation procedures currently? 2 A. Oh, I provide breast augmentation 3 procedures, I don't provide breast augmentation for 4 gender transformation or for -- if I had a male 5 patient, I guess the term would be a cisgender male 6 who was requesting breast augmentation as part of a 7 gender transformation procedure, I don't provide 8 that because I'm not trained to do breast 9 augmentation on men. 10 Q. Okay. So this would be about your -- so 11 the fact that you don't provide this therapy based 12 on a lack of training on your part? 13 A. That would be correct. I've not trained 14 to do breast augmentation on men. 15 Q. Understood. 16 So just thinking about the cosmetic 17 surgery procedures you do provide, why do people 18 generally seek out those procedures? 19 MS. LAND: Object to form. 20 A. I think the reasons are -- as many as 21 the people that come in. 22 Q. So let's just focus on one kind of 23 procedure, like a rhinoplasty. What are some of the 24 reasons that people might seek a rhinoplasty? 25 MS. LAND: Object to form.</p>	<p style="text-align: right;">Page 28</p> <p>1 effective. 2 Q. Okay. But you're aware of patients who 3 have not been satisfied with the procedure or for 4 whom it wasn't effective? 5 A. Yes. Their end result did not meet the 6 patient's expectation. 7 Q. Okay. And how do you decide if the 8 treatments that you offer are safe? 9 A. These are procedures that have been 10 performed many times without undue complications. 11 Q. And are you aware of clinical studies 12 that relate to all of the procedures you provide? 13 A. Yes. I reviewed many clinical studies 14 that review the procedures that I provide. 15 Q. Can you say that there is -- there is a 16 study review for every procedure that you provide? 17 A. What type of study? 18 Q. Well, I mean, any clinical study, just 19 to start. 20 A. Are you talking about a review of the 21 procedure-type study, or are you talking about a 22 study that is a double-blind controlled study? 23 Q. Well, let's -- let's take them both, I 24 guess. In the first group, just a review of the 25 procedure kind of study?</p>
<p style="text-align: right;">Page 27</p> <p>1 A. Some of the reasons could be they don't 2 like the way their nose looks; some of the reasons 3 could be they can't function, they can't breathe 4 well; some of the reasons could be that they had an 5 accident and they had a traumatic injury and they 6 wanted to repair the nose back to the way it was. 7 Q. Okay. So it sounds like some people -- 8 there are people for whom it would be because they 9 don't like the appearance of their nose, others for 10 whom it might be the result of an accident or 11 something, some kind of trauma, and others for whom 12 they might be suffering with some kind of 13 respiratory kind of issue; is that -- 14 A. That's correct. 15 Q. -- a fair summary? 16 A. Yeah. 17 Q. Okay. And would you say that your 18 treatments are effective in alleviating those 19 concerns for patients? 20 MS. LAND: Object to form. 21 A. Yes. I believe they are effective. Can 22 I say they're effective 100 percent of the time? 23 No. 24 Q. Okay. 25 A. But the majority of times, they are</p>	<p style="text-align: right;">Page 29</p> <p>1 A. Yes. Yes. Everything I've performed, 2 there has been some form of study or review of those 3 procedures. 4 Q. Okay. And then for the second group, 5 has there been some kind of experimental trial for 6 all of -- all of the procedures you provide? 7 MS. LAND: Object to form. 8 A. "Experimental trial," I'm not sure that 9 that terminology applies. 10 I would say double-blind controlled 11 studies for -- to see if these procedures are 12 effective? Yes. In many of the procedures, I did. 13 Q. Okay. But you wouldn't say all? 14 A. I would not say all. 15 Q. Do the treatments you provide have 16 certain risks associated with them? 17 A. Yes. 18 Q. Can you just describe some of the risks? 19 MS. LAND: Objection to form and 20 vagueness. 21 A. Which procedures are you referring to, 22 or do you want just general risks and complications 23 that can occur? 24 Q. General risks would be fine. 25 A. Bleeding; swelling; infection; poor</p>

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1 outcome; complications involving -- in some large
 2 procedures, you could have a blood clot that travels
 3 to the heart or lung; death can occur from some
 4 procedures.
 5 Q. And earlier we talked about the reasons
 6 that patients might seek these procedures, and you
 7 said there's one category of patients for whom it
 8 might be that they -- they don't like their
 9 appearance in some way; is that correct?
 10 A. That is correct.
 11 Q. And for those patients, the benefit of
 12 the procedure would be their -- their, kind of --
 13 what? -- their well-being? their mental health?
 14 How would you characterize the benefits
 15 for those patients?
 16 A. I would say their well-being.
 17 Q. Okay. So it's --
 18 Sorry. Go ahead.
 19 A. No, but, yeah, most of the time it's
 20 their -- it's something they desire.
 21 Q. So is it fair to say that for some of
 22 these procedures, there are significant physical
 23 risks, like the ones you just described, and the
 24 benefits to the patient would be their sense of
 25 well-being?

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1 MS. LAND: Object to form.
 2 A. I believe the patient does have risks
 3 involved in the procedure, and they may be getting
 4 the procedure because they want to look better or
 5 feel better.
 6 Q. Okay. So just a thought. Would --
 7 would that be correct, then, that there are
 8 procedures for whom -- or for which the benefit is
 9 improved well-being but there are significant
 10 physical risks?
 11 MS. LAND: Object to form.
 12 A. Yes. That may be true.
 13 Q. Okay. Is the goal of many of the
 14 surgeries you provide to permanently address the
 15 underlying issues we talked about, like sense of
 16 well-being or alleviating the impact of trauma?
 17 A. I don't think that any of the procedures
 18 that I performed provide a permanent result, and
 19 patients are aware of that. That as they -- for
 20 example, you may -- for a facelift, the patient may
 21 get a temporary improvement, but then over time
 22 things may change and they may have to have another
 23 procedure.
 24 Q. But do some of the procedures that you
 25 offer have irreversible consequences for patients?

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1 A. Irreversible consequences?
 2 Q. Yes.
 3 A. Yes.
 4 Q. Okay. So if I -- it seems like there
 5 are -- there's some population of patients who might
 6 not be satisfied with a procedure that you perform,
 7 and those procedures might have irreversible
 8 consequences; is that correct?
 9 A. That would be correct.
 10 Q. Okay. And would you see the combination
 11 of those two things as a reason to ban the care that
 12 you provide?
 13 MS. LAND: Object to form and relevance.
 14 A. Can you please restate the question?
 15 Q. So we -- some of the procedures will
 16 have irreversible consequences, and there's some
 17 population of patients who receive those procedures
 18 who may not be satisfied with the outcome.
 19 Would that --
 20 A. Okay.
 21 Q. Would that -- would those two things be
 22 a reason to ban the care that you provide?
 23 MS. LAND: Restate objection to form and
 24 relevance, as well as calls for speculation.
 25 A. I wouldn't provide a procedure that I

Page 33

1 felt that would endanger the patients and not
 2 provide some improvement in their concern -- with
 3 their concerns.
 4 Q. I understand.
 5 I guess what I'm trying to get at is, we
 6 talked about the fact that the procedures could have
 7 irreversible consequences, and the fact that the
 8 procedures may not always be a hundred percent
 9 effective. And I'm just asking: If those things
 10 are both true, does that provide a reason to ban
 11 that kind of care?
 12 MS. LAND: Object to form.
 13 A. If a patient receives -- if the risks
 14 outweigh the benefits, then I don't feel that
 15 procedure is valid and should be performed; if the
 16 benefits outweigh the risk, then I perform the
 17 procedure.
 18 Q. Okay. So the procedures you perform,
 19 you think the benefits outweigh the risk, and those
 20 procedures should not be banned; is that correct?
 21 A. I believe the procedures that I do
 22 perform, the benefits outweigh the risks, that's
 23 correct.
 24 Q. And those procedures should not be
 25 banned, correct?

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1 A. Who would ban them?
 2 Q. The state.
 3 A. I just don't understand the question,
 4 really. It doesn't make -- I mean, please restate
 5 the question. I'm not really sure --
 6 Q. Would you --
 7 A. -- who is banning what and why.
 8 Q. Would you support a ban on any of the
 9 medical treatments that you currently provide?
 10 MS. LAND: Objection to form and
 11 relevance.
 12 A. Do I support a ban on the procedures
 13 that I provide? No, I do not support a ban on
 14 procedures that I provide.
 15 Q. Okay. And the reason is because, in
 16 your view, those procedures have benefits that
 17 outweigh the risks?
 18 MS. LAND: Object to form.
 19 A. I believe that the procedures I perform,
 20 the benefits outweigh the risk, that's correct.
 21 Q. And for some of the procedures you
 22 perform, patients will not be satisfied a hundred
 23 percent of the time?
 24 A. A hundred percent of -- let's see, let
 25 me put it this way. So the procedures I perform,

Page 35

1 100 percent of the patients, there will be a certain
 2 subset of that hundred percent that will not be
 3 satisfied, or completely satisfied, or a hundred
 4 percent satisfied of the procedure that I performed
 5 and would want maybe a revision.
 6 Q. Understood.
 7 And the procedures that you perform,
 8 some of them have irreversible consequences?
 9 A. The procedures that I perform, there
 10 are -- it's an irreversible change. Whether you
 11 want to characterize it as a "consequence," I'm not
 12 sure. Because a "consequence," I feel, has a
 13 negative connotation.
 14 Q. Understood.
 15 Okay. Do you obtain informed consent
 16 before beginning surgery?
 17 MS. LAND: Objection to form and
 18 relevance.
 19 A. I make every attempt to obtain informed
 20 consent --
 21 Q. Okay. And how does that --
 22 A. -- before any --
 23 Q. I'm sorry.
 24 A. Before surgery.
 25 Q. Go ahead.

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1 A. I'm sorry. Please. Go ahead.
 2 Q. And how does that usually look in your
 3 practice, the informed consent process?
 4 A. Typically, a patient comes in for a
 5 consultation, then once we agree on a procedure that
 6 we're going to perform, they return to the clinic
 7 for what we call a pre-operative appointment.
 8 And at that point, they review the
 9 pre-operative and postoperative care instructions,
 10 and they sign informed consents that deal with the
 11 actual procedure that they're going to have done.
 12 Q. Okay. And is part of that process,
 13 then, explaining the risks of the surgical
 14 procedure?
 15 A. Yes.
 16 Q. Okay. And does that process look the
 17 same for prescribing drugs? Do you obtain an
 18 informed consent before prescribing drugs?
 19 A. I do not.
 20 Q. And is that standard, to not obtain
 21 informed consent before prescribing?
 22 A. I believe it is. I mean, we prescribe
 23 antibiotics and pain medication; we make sure they
 24 have no allergies to those medications; we review
 25 their medical history to make sure there's no

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1 interactions or problems with their medical history
 2 and the list of medications they have.
 3 But we don't get a formal consent saying
 4 that -- accepting the prescription of, for example,
 5 an antibiotic or pain medication that we prescribe.
 6 Q. Okay. So just pivoting back to the
 7 surgical setting. Are you aware of providers who
 8 don't obtain informed consent before beginning
 9 surgeries?
 10 A. I'm not.
 11 Q. You have not heard of any instances, you
 12 know, in the state of that happening, before
 13 somebody provides surgery?
 14 A. I have not heard of that, where someone
 15 didn't provide surgery.
 16 Q. Oh, sorry. Where someone didn't --
 17 A. Where they --
 18 Q. -- provide --
 19 A. -- didn't provide --
 20 Yeah, yeah. Didn't -- I haven't -- I
 21 haven't -- not to my recollection. But I've seen it
 22 where someone did not provide informed consent.
 23 Although, I'm sure there are cases where
 24 patients felt that they were -- did not receive or
 25 did not give informed consent, although -- where the

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1 physician may have said they obtained informed
 2 consent. And so I think there may be a different --
 3 there may have been a different perception of what
 4 the physician obtained and what the patient felt
 5 they gave.
 6 Q. Okay. So in that context, then, the
 7 physician thought they had done the proper procedure
 8 to obtain informed consent, but the patient did not
 9 think they had given consent?
 10 A. Correct.
 11 Q. Okay. And is that based on any personal
 12 experiences you've heard of?
 13 A. Not that I can recall.
 14 Q. We talked a bit about this previously,
 15 that some of your procedures may require follow-up
 16 or additional treatments down the line.
 17 Would you say it's common to have the
 18 follow-up with patients after they've received
 19 surgery?
 20 A. Yes.
 21 Q. Okay. And do you sometimes see a single
 22 patient multiple times within a course of treatment?
 23 A. Yes.
 24 Q. Have you ever stopped seeing a patient
 25 midway through a course of treatment?

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1 MS. LAND: Objection to form and
 2 relevance.
 3 A. Now, when you say "stop," what do you
 4 mean by that?
 5 Q. So --
 6 A. That I refuse to see them or that I
 7 just -- we didn't see them anymore, or we just
 8 stopped making appointments for them to come in?
 9 Or I'm not sure what you're -- what you're saying.
 10 Q. Well, that's -- let me try to make it
 11 more concrete. I, obviously, know this stuff a lot
 12 less -- less than you do.
 13 So let's say there's someone who got a
 14 rhinoplasty, and -- I don't know if this would
 15 happen. But imagine you said, "I'd like to follow
 16 up in two weeks. We might need to do a second
 17 procedure. I just want to see how it's coming
 18 along." Something like that.
 19 A. Sure.
 20 Q. And then, at -- in any of those
 21 situations, something like that, did a follow-up
 22 appointment not happen?
 23 A. Yes.
 24 Q. Okay. And is that ever because you
 25 refuse to see the patient?

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1 A. No.
 2 Q. Okay. So why would that happen?
 3 A. Either the patient didn't come into the
 4 office for their follow-up appointment, and then we
 5 reached out to them to have them return for a
 6 follow-up appointment, and they still didn't come
 7 back.
 8 Q. Okay. But if the patient wanted to seek
 9 the follow-up care that you thought was important or
 10 necessary, in those situations, you have seen the
 11 patient and followed up?
 12 A. Yes.
 13 Q. Do you think in that situation it would
 14 have been ethical to not follow up with the patient?
 15 MS. LAND: Objection to form.
 16 A. Ethical to not follow-up --
 17 Q. Yes.
 18 A. -- or --
 19 Q. If they needed some kind of continuing
 20 care, would it be ethical to not -- to start them
 21 on treatment but not provide the full course of
 22 treatment?
 23 A. I think it's imperative to follow-up
 24 with patients when they desire to be seen.
 25 Q. Okay. And if you thought that follow-up

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1 care was medically important or necessary and a
 2 patient wanted that care, would it violate your
 3 ethical obligations to not follow up with that
 4 patient?
 5 MS. LAND: Object to form.
 6 A. Could you repeat the question?
 7 Q. So let's say that you thought additional
 8 treatment was medically necessary and --
 9 A. So --
 10 Q. -- the patient --
 11 Sorry. What was that, sir?
 12 A. No. So I have a patient, and I feel
 13 that they need medical treatment?
 14 Q. Yes. And they want to receive that
 15 treatment, and you provided the initial start of the
 16 treatment, would it be ethical to then not follow
 17 through and continue providing the care?
 18 A. It would be unethical for them not to
 19 have some type of care, whether it's me or another
 20 physician. For example, if they left the state and
 21 they needed to be seen by someone, I would try to
 22 refer them to somebody.
 23 Q. Okay. So you --
 24 A. If I -- if I knew someone where they
 25 were going.

<p style="text-align: right;">Page 42</p> <p>1 Q. So it would be -- your ethical 2 obligation would be to either treat the patient or 3 to refer them and try to find them care from 4 somebody else? 5 A. That -- I believe that would be what I 6 would want to do. 7 Q. Do you currently offer medical care to 8 adolescents? 9 A. Occasionally. 10 Q. Okay. And what sort of care would that 11 include? 12 A. Otoplasty. 13 Q. And forgive my ignorance, is that an ear 14 procedure? 15 A. Ear surgery on female, some female 16 rhinoplasties if they've started menses; and, 17 occasionally, I do a breast augmentation on a 18 18-year-old, 17-year-old, 18-year-old. 19 Q. So the breast augmentation procedures 20 are sometimes on people below the age of 18? 21 A. Yes. 17, or if they're turning 18, 22 something like that. 23 Q. Okay. Do you perform procedures to 24 alleviate gynecomastia? 25 A. Yes.</p>	<p style="text-align: right;">Page 44</p> <p>1 or psychological health? 2 MS. LAND: Objection to form. 3 A. I assume so. 4 MR. RICHARDSON: Beth or Drake, is it 5 possible to get Exhibit 3, please? 6 I'm not sure if they heard me. 7 MR. MANN: I did. 8 MR. RICHARDSON: All right. Thanks. 9 (Exhibit 3 introduced) 10 BY MR. RICHARDSON: 11 Q. Do you recognize that document, Doctor? 12 A. I don't but -- 13 Q. It should be a web page from the 14 cosmetic surgery center. Sorry if they got 15 mis-numbered or anything. 16 (Witness reviewing document.) 17 A. Okay. I'm looking at it. 18 Q. Is this the document that says "Public 19 Service Announcement" from Little Rock Cosmetic 20 Surgery Center dated August 26, 2019? 21 A. Yes. Yes. 22 Q. Okay. If you just turn to the -- the 23 second page. 24 A. Yes. 25 Q. It should be right at the top. There's</p>
<p style="text-align: right;">Page 43</p> <p>1 Q. And have you ever performed those 2 procedures on someone under 18? 3 MS. LAND: Objection to form and 4 relevance. 5 A. Yes. 6 Q. So it sounds like it could be otoplasty, 7 rhinoplasty, breast augmentation, or procedures to 8 alleviate gynecomastia? 9 A. Correct. 10 Q. Anything else besides those? 11 A. I'm trying to remember if I've ever done 12 liposuction. It's relatively uncommon, but that's a 13 possibility. Yes. Liposuction. 14 Q. And why is it that minors would seek 15 those surgeries? 16 MS. LAND: Object to form. 17 A. Children sometimes are teased at school 18 and made fun of, and it becomes an issue for them 19 that they'd like -- for example, if they have 20 enlarged ears, and so -- the same with the nose; or 21 they feel that they can't take their shirt off 22 during physical activities, and so they may want to 23 have some liposuction of their chest area. 24 Q. So it sounds like in all of those 25 examples, the benefit would be their -- their mental</p>	<p style="text-align: right;">Page 45</p> <p>1 that first paragraph there. 2 A. "Otoplasty"? 3 Q. Yes. If you could read with me. It 4 says: 5 "At Little Rock Cosmetic Surgery 6 Center, usually otoplasty and rhinoplasty are 7 performed on children under 18 after a 8 thorough consultation with the child and his 9 or her parents. One might also note that 10 research published on PubMed about the best 11 age to perform ear surgery has produced 12 surprising evidence that earlier is better 13 psychologically." 14 Do you see that? 15 A. Yes. 16 Q. And do you agree with that statement? 17 A. Yes. It should have actually said "as 18 well as surgery." So it's better "psychologically 19 and surgically." 20 Q. And that -- and surgically would be mean 21 it would also -- is that because it limits the risk? 22 Why would it be surgically? 23 A. I think the results are more 24 reproducible in a younger patient than they would be 25 in an adult.</p>

<p style="text-align: right;">Page 46</p> <p>1 Q. So I am not sure what you mean by 2 "reproducible" in that context. It's outside my 3 wheelhouse. I apologize. 4 A. Sure. So when we perform an otoplasty, 5 we're trying to, typically, set the ears back or 6 make them less prominent. In a younger adolescent, 7 the cartilage is much more -- it's softer and more 8 pliable than in an adult where it can be sometimes 9 very thick and nonpliable. When we -- when we do 10 the surgery, we actually bend the cartilage. 11 And in children, the cartilage bends 12 much more easily, and it's more likely to stay in 13 place than in an adult where the cartilage does not 14 bend as easily and may spring back. And therefore, 15 that's what I mean by "more reproducible." 16 Q. Okay. So will it have more, like, 17 permanence, it could even last longer? Is that the 18 idea? 19 A. Yes. 20 Q. Okay. So it sounds like -- I mean, 21 earlier we talked about a procedure like 22 rhinoplasty, and the different reasons that people 23 might seek that out, and there were folks who is 24 going to improve their well-being, folks who might 25 have some kind of physical issue that's ongoing,</p>	<p style="text-align: right;">Page 48</p> <p>1 A. I believe the risks are the same. 2 Q. And do you think the benefits can 3 outweigh the risks for these procedures for 4 adolescents? 5 MS. LAND: Objection to form. 6 A. I wouldn't perform the procedures if I 7 didn't think the benefits outweigh the risks. 8 Q. When you're dealing with minor patients, 9 that document I just read says you typically, you 10 know, consult the child and the parent. 11 A. Yes. 12 Q. How do you decide whether care is 13 appropriate for a minor patient? 14 MS. LAND: Object to form. 15 A. Discussions with the parents as well as 16 the child. I want to know what their goals are, 17 what their expectations are from the procedure. 18 Q. Okay. 19 A. And so I try to assess that and know 20 that they're -- you know, what I can provide is what 21 their desire is. 22 Q. Okay. Have you ever said no to an 23 adolescent patient? 24 A. Yes. 25 Q. And what was the reason for that?</p>
<p style="text-align: right;">Page 47</p> <p>1 like a breathing problem, and then folks that have 2 some kind of trauma. 3 A. Correct. 4 Q. For adolescents who are seeking 5 rhinoplasty, would there be adolescents in that 6 first group who -- 7 MS. LAND: Object to form. 8 A. Is there -- 9 Q. -- it affects their well-being? 10 A. Very small minority, typically. 11 Q. Okay. But there would be some patients 12 for whom the benefit of the cosmetic surgery is 13 their -- their well-being? 14 A. Yes. 15 Q. Their mental health. Sorry. To -- 16 A. The way they -- the way they appear to 17 themselves. 18 Q. Okay. And would it be true that 19 surgical treatments have risks for adolescents just 20 like they would for anybody else? 21 A. Yes. 22 Q. Would those risks be the same, or 23 would -- are there risks that are unique to 24 adolescents? 25 MS. LAND: Objection to form.</p>	<p style="text-align: right;">Page 49</p> <p>1 A. It was a patient that wanted to have 2 liposuction, and I felt that weigh loss would be 3 more appropriate. 4 Q. Anything else besides that incident that 5 comes to mind? 6 A. Yes. I had an adolescent patient who 7 had a minor -- they wanted a rhinoplasty, but I felt 8 that the change was so minor that the risks 9 outweighed the benefits. 10 Q. And you just -- you make that decision 11 on a patient-by-patient level then? 12 A. That is correct. 13 Q. Okay. Do you obtain informed consent 14 from adolescents before beginning a surgical 15 procedure? 16 MS. LAND: Objection to form. 17 A. I obtain it from their parents, but -- 18 since they cannot give informed consent. 19 Q. So in that case, then, the parent 20 provides the consent, but you meet with the minor as 21 well to talk through the procedure? 22 A. Yes. 23 Q. Okay. Have you ever worried that a 24 minor is not mature enough to agree to a procedure? 25 MS. LAND: Objection to form.</p>

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1 A. If I felt that they were not mature
 2 enough or did not understand the procedure that we
 3 were about to do, then I wouldn't perform the
 4 procedure.
 5 Q. Okay. But that hasn't happened, in your
 6 experience?
 7 A. I'm not -- I don't recall. I'm not
 8 sure. It may have, but I'm not -- I can't
 9 specifically think of an exact patient that I could
 10 pinpoint --
 11 Q. Got it.
 12 A. -- at this point.
 13 Q. You said that you talk to the minor
 14 about, you know, expectations, and making sure that
 15 they sort of know what the procedure is for and what
 16 might happen.
 17 Do you discuss risks as well during
 18 those conversations?
 19 MS. LAND: Object to form.
 20 A. I discuss the risks with their parents.
 21 Q. Okay. But not with the minor directly?
 22 A. We tell them about -- that they will
 23 have some discomfort, that they may have to get the
 24 procedure done. Again, they do review with the
 25 parents all the risks that are inherent into the --

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1 with the procedure itself.
 2 Q. And what's the -- we talked a little bit
 3 about some procedures you perform for 17 or 18.
 4 Do you know the youngest age you've ever
 5 performed of a surgical procedure?
 6 A. Six years old.
 7 Q. And what was that for?
 8 A. Otoplasty, an ear surgery.
 9 Q. And do you recall the reason that
 10 procedure was sought?
 11 A. Yes. I felt as -- if I recall, the
 12 patient was being verbally teased and bullied at
 13 school.
 14 Q. And, you know, obviously for a
 15 six-year-old patient, there is going to be a limited
 16 ability to talk with the patient directly. Was most
 17 of the conversation in that case with the parent?
 18 A. Most of the conversation is with the
 19 parent.
 20 Q. Did you talk to the child as well about
 21 the procedure?
 22 A. I talk to them as best I can in a way
 23 that they can understand.
 24 Q. And that was just about, like you said
 25 earlier, kind of expectations and, you know --

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1 A. Where -- what the ears would look like
 2 afterwards; what the recovery, what the healing
 3 process is; length of time; how they're going to
 4 have to wear maybe a bandage on their ears and have
 5 to keep it on, and --
 6 Q. Gotcha.
 7 A. -- cooperate with their parents.
 8 Q. Just shifting gears a little bit here.
 9 Are you a member of any professional
 10 organizations?
 11 A. I'm a member -- I don't know if I still
 12 am, American Medical Association; Arkansas State
 13 Medical Society; American Association of Oral
 14 Maxillofacial Surgery, American Board of Oral
 15 Maxillofacial Surgery, American Board of Cosmetic
 16 Surgery.
 17 I think that's a enough. I don't think
 18 I can afford to be a member of any more.
 19 Q. Okay. So, yeah, it sounds like -- okay,
 20 so there's the Arkansas State society, which is --
 21 it sounds like kind of --
 22 A. Medical society.
 23 Q. -- medical.
 24 Medical society, right?
 25 A. Yes.

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1 Q. And the others -- a couple of them are
 2 national organizations focused on oral and
 3 maxillofacial surgery? Sorry if I said that wrong.
 4 A. Yes, one is the Board, so the Board is
 5 the licensing body, it gives you your license, and
 6 one is just the association.
 7 Q. Okay. And then the one is the American
 8 Board of Cosmetic Surgery?
 9 A. That's the board that gives you your --
 10 Q. I got you.
 11 A. -- certification, right.
 12 Q. Okay. So thinking about a group like
 13 the American Society of Oral and Maxillofacial
 14 Surgery, what does a group like that typically do
 15 for its members?
 16 A. Provides resources for them in order
 17 to -- let's say, maybe it's practice management;
 18 maybe it's buying and selling of their practices;
 19 they provide lobbying activities as a -- for the
 20 whole group; they set policies, national policies
 21 for various reasons to do procedures and things like
 22 that.
 23 Q. So some of those national procedures,
 24 would those be based on, like, what kind of care is
 25 effective, how to safely provide it, things like

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1 that?

2 A. Yes. Yes.

3 Q. Okay. And do you typically find their

4 guidance -- like, do you credit their guidance or

5 pay attention to it?

6 MS. LAND: Object to form and relevance.

7 A. On the American Association of Oral and

8 Maxillofacial Surgery, do I -- do I listen to their

9 guidance? And -- at present, because I don't

10 practice oral and maxillofacial surgery, I don't

11 necessarily keep up to date with what their

12 guidance. Since I practice only cosmetic surgery,

13 I'm not up to date on what their guidance is, for

14 example, on wisdom teeth removal, and when -- when

15 not to do that; so...

16 Q. Okay. But the guidance put out on

17 something like wisdom teeth removal, would that

18 generally be, you know, developed by practitioners

19 in the field?

20 MS. LAND: Object to form.

21 A. Typically it's through studies that have

22 been performed. For example, if they do X procedure

23 and they added this one little part to that

24 procedure, was it effective? And then they publish

25 that, and they say, yes, this was effective or, no,

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1 it wasn't, and then that helps develop the guidance

2 overtime.

3 Q. Okay. All right. So does that

4 organization put out, like, practice guidelines?

5 A. I believe they do.

6 Q. Okay. And are there similar

7 organizations like that on the cosmetic surgery

8 side?

9 A. American Academy of Cosmetic Surgery.

10 Q. And are you a member of that

11 organization?

12 A. I'm not.

13 Q. Are you aware of the guidelines put out

14 by the American Academy of Cosmetic Surgery?

15 A. Not at this point since I'm not a member

16 of that society.

17 Q. Gotcha.

18 But you're aware that they do have those

19 guidelines?

20 A. Yes. I'm sure they have some sort of

21 guidelines.

22 Q. Okay. But it sound like you don't

23 currently rely upon guidelines on the cosmetic

24 surgery side from that organization?

25 A. Correct. I -- I tend to look at general

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1 plastic and reconstructive surgery.

2 Q. And is that just a peer-reviewed

3 academic journal like --

4 A. Yes.

5 Q. And is that journal put out by an

6 organization in the field?

7 A. It's put out by the American Association

8 of Plastic Surgeons.

9 Q. So you would rely on that journal but no

10 specific, like, standards of care or practice

11 guidelines?

12 MS. LAND: Object to form.

13 A. I think within the journal, they develop

14 practice guidelines. And so I look at those

15 guidelines within the journal itself.

16 Q. Okay. And that journal is the -- --

17 just, once again, the American Society of Plastic

18 Surgeons?

19 A. It's the --

20 Q. That's the journal?

21 A. I'm sorry?

22 Q. The American Society of Plastic --

23 A. The journal is -- the journal is the

24 American Journal of Plastic and Reconstructive

25 Surgery.

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1 Q. Okay. And it is put out by an

2 organization called the American Society of Plastic

3 Surgeons?

4 A. Surgeons, yes.

5 Q. Okay. I got it. Thank you.

6 A. Okay.

7 Q. And are you a member of that

8 organization, ASPS?

9 A. I am not.

10 Q. Are you aware of ASPS's material on

11 gender-affirming surgery?

12 A. I am not.

13 MR. RICHARDSON: Beth, can I get

14 Exhibit 4, please?

15 It should just be a one-pager.

16 A. Gender-affirmation surgeries?

17 Q. Yes.

18 A. This one?

19 (Exhibit 4 introduced)

20 BY MR. RICHARDSON:

21 Q. Okay. Does that document say "Gender

22 Affirmation Surgeries" at the heading?

23 A. It does.

24 Q. And "American Society of Plastic

25 Surgeons" on the top banner?

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1 A. Yes, it does.
 2 Q. Do you see the words right above the
 3 heading where it says "reconstructive procedures"?

4 A. Yes.
 5 Q. Okay. What do you take it -- take the
 6 word "reconstructive" to mean in that context?

7 A. I consider reconstructive procedures as
 8 procedures that are -- wow, it's pretty self-evident
 9 the word "reconstructive," as opposed to "cosmetic."

10 Q. Okay.
 11 A. Reconstructive are those procedures that
 12 may necessarily need to be done; for example,
 13 trauma, burns. Things like that.

14 Q. I think -- I mean, I'm just going to try
 15 to read the definition on the website, and you can
 16 tell me if it sounds right.

17 "Reconstructive surgery is performed to
 18 treat body parts affected esthetically or
 19 functionally by congenital defects,
 20 developmental abnormalities, or trauma."

21 Does that sound accurate?
 22 MS. LAND: Object to form.

23 A. I don't agree with the "aesthetic" side.
 24 I think that's -- I don't think that's -- I just
 25 don't agree with that.

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1 Q. And why is that?
 2 A. Because I don't consider that as a
 3 reconstructive procedure. I consider that as a
 4 cosmetic or aesthetic procedure.

5 Q. So from this document, it looks like the
 6 ASPS would consider gender-affirmation surgeries to
 7 be reconstructive procedures. Does that appear to
 8 be accurate?

9 A. With looking at this page?
 10 Q. Yes.
 11 A. Yes. It appears that under the title of
 12 "Reconstructive Procedures," they have the title
 13 "Gender Affirmation Surgeries." And so I guess I
 14 could make the assumption that that's a -- a gender
 15 affirmation surgery is a reconstructive procedure.

16 Q. Okay.
 17 A. By looking at this page.
 18 Q. And do you agree with that
 19 characterization?

20 MS. LAND: Objection to form and
 21 relevance.
 22 A. Do I agree that gender affirmation
 23 surgeries are reconstructive procedures?
 24 Q. Yes.
 25 A. Is that the question?

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1 Q. Yes.
 2 A. I'm more of the opinion they're
 3 aesthetic procedures, but I guess not according to
 4 the American Society of Plastic Surgeons.

5 Q. Do you disagree with the ASPS on that
 6 point?
 7 A. I disagree.
 8 Q. Okay. And what's the basis for that
 9 disagreement?

10 A. Because I think that it's more of an
 11 aesthetic type of procedure as opposed to
 12 reconstruction, reconstructing.

13 I guess if you're doing -- if you're
 14 doing genital surgery, there could be forms of
 15 reconstruction in that, but some of the procedures,
 16 I feel, are aesthetic. So it may be just a
 17 combination of both things.

18 I don't think it's -- the more I look at
 19 it, the more I think, well, maybe it's some are
 20 reconstructive, some are aesthetic. I don't think
 21 you can really pin it down to one or the other.

22 Q. Just so I understand the category, so it
 23 would be reconstructive -- can you just explain, so
 24 the general surgeries would be reconstructive, and
 25 why is that?

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1 A. Because you may be forming a new organ
 2 or forming something that isn't there. You're
 3 reconstruct- -- you know, how do I explain that?

4 For example, let me give you a different
 5 example. So let's say -- something that I maybe
 6 understand a little bit better since I don't do, you
 7 know, transformation surgery.

8 Let's say someone loses their ear. They
 9 don't have an ear or they only have part of an ear.
 10 You reconstruct that ear by maybe taking cartilage
 11 from the other ear, forming it into the shape of the
 12 ear, and then covering it with skin. That's a
 13 reconstructive surgery.

14 Q. Okay.
 15 A. As opposed to an aesthetic surgery of
 16 that ear that's already there but may be more
 17 prominent, and you're setting that back in an
 18 aesthetic manner.

19 So one you're almost, like, forming
 20 something new that isn't there, it's been lost
 21 through trauma; another one you're esthetically --
 22 the ear is there, but now it's being set back and
 23 just changed only in its aesthetic appearance.
 24 Q. Okay. Follow up with that example.
 25 So say somebody was in that situation

<p style="text-align: right;">Page 62</p> <p>1 where they were, you know, missing an ear because of 2 a congenital defect, would the surgery be 3 reconstructive in that setting? 4 A. Yes. 5 Q. Okay. And so applying that, it sounds 6 like applying that framework to distinguish cosmetic 7 and reconstructive, you think that some of the 8 things on this list could be reconstructive -- could 9 be reconstructive, some could be cosmetic? 10 MS. LAND: Object to form. Asked and 11 answered. 12 You can answer. 13 A. Are you asking if some could be 14 reconstructive and some could be aesthetic, or 15 you're just asking if some could be reconstructive? 16 Q. Well, I thought -- I thought it was kind 17 of a two-category piece, where it was they're either 18 cosmetic or reconstructive. But if I'm wrong -- 19 A. I think -- 20 Q. -- just tell me. 21 A. Yeah. I think -- I think you have 22 reconstruction of the male genitalia, the female 23 genitalia. I think that could be considered 24 reconstructive. Some of the chest surgery could 25 potentially be reconstructive or could be just</p>	<p style="text-align: right;">Page 64</p> <p>1 candidates piece, is that based off, like, reviewing 2 their application, or were there interviews as well? 3 I'm just curious what -- what goes into that. 4 A. Sure. Their -- they had to meet certain 5 criteria before they can make an application. The 6 application was then reviewed, and then they were 7 given either a -- they were given both a written 8 exam; and if they passed that, they were given an 9 oral exam. And so I was part of the oral 10 examination, so I would -- 11 Q. Okay. 12 A. I would orally examine them. 13 Q. Okay. And did -- did any of this focus 14 on professional ethics? 15 A. I believe the questions, there are 16 questions on ethics. I believe the oral exam maybe 17 not specifically, but it dealt with ethics on how 18 you would -- what you would do for a patient in a 19 certain circumstance. And so I think ethics plays a 20 role in that. 21 Q. Okay. And did you help develop 22 questions on the written exam related to ethics at 23 any point? 24 A. I did not specifically do any ethics 25 questions on the written exam.</p>
<p style="text-align: right;">Page 63</p> <p>1 aesthetic. 2 So I think you really have -- I don't 3 think you can really pin it down to one or the 4 other. I think there really is a combination of 5 both going on. I think it's -- you know, where you 6 draw that line between reconstruction and aesthetic? 7 It's hard. I think it may be something that the 8 individual surgeon does. 9 Q. So are you currently affiliated with -- 10 I think you mentioned a separate group called the 11 American Board of Cosmetic surgery? 12 A. Yes. 13 Q. Okay. And are you -- are you currently 14 a board examiner? 15 A. I'm not. I used to be. 16 Q. Okay. And what did that role entail? 17 A. It entailed developing questions for the 18 board; it involved reviewing board questions; it 19 also involved examining candidates. 20 Q. Okay. So part of this is like 21 developing a kind of standardized test? Is that -- 22 A. Yes. There's a standardized test that 23 was developed and reviewed each year, and then 24 administered to the candidates. 25 Q. Okay. And then the evaluating the</p>	<p style="text-align: right;">Page 65</p> <p>1 Q. Did you do questions -- I think you just 2 said some questions might implicate, you know, how 3 to work with the patient, or they might implicate 4 ethical questions, but they're not purely ethics 5 questions; is that right? 6 A. Yes. 7 Q. Okay. And did you work on those kinds 8 of issues? 9 A. Yes. 10 Q. Would any of that work have focused on 11 issues like patient abandonment? 12 A. Yes. 13 Q. Okay. And can you just describe sort of 14 what the ethical obligations are with respect to 15 patient abandonment? 16 A. It would involve seeing a patient when 17 they needed to be seen. Let's say you performed a 18 procedure and then that patient was having problems, 19 and in what timely manner you went to see that 20 patient. 21 It was that type of questions and how 22 quickly they saw -- how quickly they identified the 23 problem and then went to see the patient. I think 24 that was the primary focus. 25 Q. Okay. And would it have also covered</p>

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1 anything involving informed consent?
 2 A. I'm not sure about the informed consent
 3 side. I don't recall if any questions specifically
 4 asked if the candidate gave or got -- received
 5 informed consent.
 6 Q. Okay.
 7 A. I almost feel that it was assumed that
 8 everybody received informed consent.
 9 Q. Okay. And on the patient abandonment
 10 issue, would that have come up at all during the
 11 oral examination too?
 12 A. I'm sorry. That's what I was --
 13 Q. That's all. I didn't -- that was the
 14 question.
 15 A. I was referring to the oral exam, that
 16 it was inferred that they were receiving the care in
 17 a timely manner. And so that's what I was referring
 18 to in terms of "patient abandonment."
 19 Q. Understood. Okay.
 20 MR. RICHARDSON: Do you want to take a
 21 five-minute break, or are you good to keep going on?
 22 THE WITNESS: Sure. Five-minute break.
 23 MR. RICHARDSON: Okay. Is that all
 24 right with you, Amanda?
 25 MS. LAND: Yeah, that's great.

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1 THE VIDEOGRAPHER: Okay. This will end
 2 media part one, and we are off the record at
 3 3:11 p.m.
 4 (Recess taken.)
 5 THE VIDEOGRAPHER: We are back on the
 6 record at 3:23 p.m. This will begin media part two.
 7 Please proceed.
 8 MR. RICHARDSON: Thanks.
 9 BY MR. RICHARDSON:
 10 Q. Dr. Branman, we spoke a little earlier
 11 about the procedures you currently provide for
 12 adolescents. One of them that you mentioned, I
 13 believe, was breast augmentation?
 14 A. Yes.
 15 Q. And I think you said sometimes a patient
 16 might be 17 when they receive that procedure; is
 17 that correct?
 18 A. I believe there's been one I performed
 19 breast augmentation on who was 17. Maybe she
 20 was 18. I can't remember exactly.
 21 Q. Okay.
 22 A. It's -- it may have been a month
 23 later --
 24 Q. Yeah.
 25 A. -- she turned 18 or something like that.

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1 Q. Gotcha.
 2 So what would be the conditions under
 3 which somebody around that age would seek breast
 4 augmentation?
 5 A. Personal. They wanted to look better in
 6 clothes. They felt better about themselves.
 7 They -- some, some women have absolutely no breast
 8 tissue. I mean, literally, no breast tissue, and so
 9 they want to have some breast tissue.
 10 Q. So it would typically be a sense of
 11 well-being and a mental health benefit?
 12 MS. LAND: Object to form.
 13 A. I believe they would feel better about
 14 themselves.
 15 Q. And would that have been the reason that
 16 the person who came in when they might have been 17
 17 would have sought care?
 18 A. I -- as -- probably, but I don't know a
 19 hundred percent. I'd have to refer to my notes.
 20 Q. Okay. Are there other reasons that
 21 people seek breast augmentation?
 22 A. Yes. Some people want to return their
 23 breast back to where they were after having
 24 children. You lose breast volume after you have
 25 children, typically. Not everybody, but a large

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1 proportion of the patients do. And that's a very
 2 common reason to have breast augmentation.
 3 Q. Anything else besides the two reasons we
 4 discussed?
 5 A. Sometimes they want to have -- and we
 6 mentioned this before -- in combination with a lift,
 7 where they want to add some extra volume to the
 8 upper part of the breast. They feel they just want
 9 to look better in clothes. Sometimes it fills their
 10 clothes out better.
 11 Q. And in terms of that reason about after
 12 having children?
 13 A. Yeah.
 14 Q. Do you know if that reason would have
 15 applied to the person who came in when they were 17?
 16 A. I don't believe it did.
 17 Q. Are you currently a member of the
 18 Arkansas State Medical Board?
 19 A. I'm currently a member of the Arkansas
 20 State Medical Board.
 21 Q. When did you join the Board?
 22 A. I believe it was 2018. I was appointed.
 23 Q. Appointed by the Governor?
 24 A. By the Governor, yes.
 25 Q. And how do you become a member of the

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1 Board?

2 A. You're typically appointed. I -- I had

3 some -- made some inquiries about wanting to be part

4 of the Board. And the chairman at the time, I asked

5 him. I was interested in it. I thought it would be

6 something interesting to do, some way -- a way of

7 giving back to the community. So I made inquiries,

8 and then I was appointed.

9 Q. Gotcha.

10 I mean, is there like an application

11 that you submit to be considered?

12 A. I believe there was an application that

13 I submitted to the Governor's office.

14 Q. Okay. And is part of the process of

15 being selected your expertise in a certain field?

16 A. Not necessarily. It's helpful, but I

17 don't think that's the primary reason.

18 Q. Any other criteria that you're aware of?

19 A. Not that I'm aware of.

20 Q. Are Board members typically involved in

21 crafting new regulation?

22 A. Not typically.

23 Q. Have you been in the past?

24 A. I have. I've tried -- I've attempted

25 to. It didn't work out very well.

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1 Q. Okay. Do you mind describing that

2 experience?

3 A. Sure. We were seeing -- the Medical

4 Board was seeing issues with nonphysicians providing

5 aesthetic procedures, and so we wanted to see if we

6 could -- and, basically, maybe you might have an RN

7 providing some type of surgical procedure or

8 nonsurgical procedure that really should have been

9 performed by a physician or a physician assistant or

10 under the supervision of a physician.

11 And so we were -- we tried to set up

12 some, you know, regulations that would be good to

13 the legislature to kind of combat that so we didn't

14 see -- I mean, the primary focus really was that the

15 physician should be trained in the procedure that

16 they're supervised in.

17 So if they're supervising a nurse doing

18 it, well, that physician should be able to do that

19 procedure. They should be trained in it. I mean,

20 how -- I don't understand how you can supervise

21 somebody if you don't have any training in that

22 procedure.

23 So we wrote some rules and regs, but we

24 could only submit them to the legislature. The

25 legislature is the one that actually, you know,

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1 okays it and agrees upon it and changes it, and all

2 that kind of stuff.

3 We just -- I just made the suggestions,

4 put that, and we just got sort of handedly turned

5 down; so...

6 Q. And the legislature, you all, when you

7 write rules, they have to get approved by the

8 legislature?

9 A. Yes, sir.

10 Q. Okay. And these were -- so I

11 understand, these were like -- these were clinics

12 providing --

13 A. BOTOX@.

14 Q. -- plastic surgery or --

15 A. Fillers. Yeah, lasers and BOTOX@.

16 And -- and what they would have is they would have a

17 nurse there doing the procedures, but the physician

18 was a medical director, but that medical director

19 was living, you know, 200 miles away.

20 Q. Okay.

21 A. Or -- and not really -- it was a -- not

22 really supervising the procedures that were being

23 performed, and the physician didn't know how to do

24 these procedures as well.

25 Q. Okay.

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1 A. And so we were trying to say, "Hey, you

2 know, come on, this is -- this isn't -- this isn't

3 right." And then -- see, but the consequence was

4 that some people were being hurt by the procedures.

5 Q. Yeah.

6 A. For example, a filler or BOTOX@, you

7 know, it's not an innocuous. It's an injection of

8 medication, and there can be consequences from that,

9 and some of those consequences can be permanent.

10 And so if you don't know how to, you know, handle

11 the complication or you're not even in the area to

12 be able to handle the complication, I find that a

13 problem, problematic.

14 Q. And it sounds like the -- it sounds like

15 the procedures at issue here are procedures that you

16 provide, like that you have some expertise in?

17 A. Yes. Some of them were, yes. Some of

18 them were. Some are lasers that I don't necessarily

19 provide. Some are.

20 Q. Okay. And this is --

21 A. But this was -- this was an issue that

22 sort of had been brewing for a while, and so I got

23 chosen to draft up some rules and regs that dealt

24 with that since I had more experience than anybody

25 else on the Board.

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1 Q. Gotcha. Okay.
 2 So that would have been after you joined
 3 in 2018, this practice --
 4 A. Right -- yeah. Yes. That was after I
 5 joined.
 6 Q. Okay. So you had kind of extensive
 7 involvement here, it sounds like, because -- because
 8 you were selected, and because you have some
 9 expertise in this?
 10 MS. LAND: Object to form.
 11 A. Yes.
 12 Q. In some of the procedures? Okay.
 13 A. Some experience, yes.
 14 Q. Okay. And it sounds like that would not
 15 be common for board members to be involved in a
 16 rulemaking like that; is that -- is that what you
 17 said at the beginning?
 18 A. Typically not. I don't -- I don't --
 19 typically, the legislature will, you know, develop
 20 the rules and regs, or somebody else will.
 21 Various -- I don't know. I mean, the Medical Board
 22 doesn't typically do that.
 23 Q. Okay. And for this process, did -- once
 24 you were selected to kind of take this on, did you
 25 work with the legislature in developing the rule?

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1 A. We worked with many different people.
 2 We were trying to work with the legislature, the
 3 Governor's office, worked with the -- many
 4 physicians that provided these procedures in the
 5 community. And so we really -- we reached out for
 6 input from everybody, as many people as we could.
 7 Q. Okay.
 8 A. And we also worked -- you know, we tried
 9 to work with the nursing board too because they were
 10 involved as well. So we really tried to develop
 11 something that would work with everybody.
 12 Q. Okay. And I think you said earlier
 13 these -- that the procedures that were being
 14 provided here, they -- they can have serious
 15 consequences for patients, they can have permanent
 16 consequences for patients; is that correct?
 17 A. That is correct.
 18 Q. And was that explained to the
 19 legislature as part of your submission of the rule?
 20 A. Yes.
 21 Q. And the legislature decided not to --
 22 not to adopt the rule?
 23 A. It went to the rules committee, and
 24 it -- that's where it sort of never left.
 25 Q. Okay.

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1 A. I don't know -- I really -- I really
 2 don't know how all that works. But it just sort of
 3 went there and they weren't appreciative of it.
 4 Q. But you did have discussions with the
 5 legislature during the process of developing the
 6 rules?
 7 A. Yes. Various, various individuals in
 8 the legislature. Not the legislative body itself,
 9 but, you know, we would talk to various people, and
 10 what their -- and ask them what their thoughts were
 11 and ask for their input.
 12 Q. Gotcha. Okay.
 13 And has that been -- in your experience
 14 on the Board, has that sort of communication or
 15 collaboration been normal between the Board and the
 16 legislature?
 17 A. Not until -- yeah, not really. It
 18 usually works the other way, the legislature
 19 develops rules and regulations, and then they ask
 20 the Board to implement it. And that's how it
 21 typically works.
 22 Q. Okay. And when the legislature is
 23 developing the rules in that sort of scenario, are
 24 they often reaching out to the Arkansas -- the State
 25 Medical Board?

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1 A. Not as much as I would expect. I think
 2 they spend -- they develop the rules and
 3 regulations, and then we implement them. We ask
 4 them -- you know, we -- we read them and implement,
 5 implement what they've -- what they've ruled or
 6 whatever it is.
 7 Q. Okay. I got you.
 8 A. Sorry.
 9 Q. No. Okay.
 10 A. I mean, it usually works where the
 11 legislature, they write the rules and regs; they
 12 give them to us and they say, "Okay, here it is."
 13 Let's do it."
 14 Q. And it sounds like there's some --
 15 sometimes they may consult with you during the
 16 process, but you said often not; is that --
 17 A. Yeah. Or they may -- there may be some
 18 back-and-forth between medical society, I think.
 19 You know, 'cause we don't -- we're really just --
 20 for the most part, we're just, you know, following
 21 the rules and regs --
 22 Q. Okay.
 23 A. -- that the legislature developed.
 24 Q. And so pivoting over to, like, the other
 25 functions that the Board has. Is it common for the

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1 Board to investigate ethics complaints?
 2 A. Yes.
 3 Q. Okay. So how does that process
 4 typically work?
 5 A. Well, we receive a complaint, and then
 6 we ask for an answer, for the physician to answer
 7 the complaint. Let's say it's, like you had
 8 mentioned something before, "The doctor abandoned
 9 me, told me I wasn't a patient anymore and stopped
 10 treating me." That's the example I think you used.
 11 Q. Yeah.
 12 A. And so then we look at what the
 13 complaint says, what the doctor said, and then we
 14 make a ruling on that depending on -- it can be a
 15 number of things. It can be we just take the
 16 situation for information; we could ask the
 17 physician to come before the Board and explain the
 18 situation; we can inquire for more information.
 19 And so I think that's -- those are some
 20 of the things. I mean, if it's an egregious thing
 21 or something that's terrible, we may refer it to the
 22 Attorney General's office.
 23 So these are kind of -- things like
 24 that. Or we may suspend. I mean, in really bad
 25 situations, we'll -- we'll order an emergency order

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1 of suspension and suspend the license.
 2 Q. Okay. So at the beginning, there's a
 3 complaint. Is that typically from a patient?
 4 A. Typically it is. Typically it's from a
 5 patient.
 6 Q. And then at that point, there's some
 7 decision about what action to take. Is that -- is
 8 the staff usually the one making some kind of
 9 recommendation?
 10 A. No, no. The staff just presents the
 11 information, and then the Board reviews it and then
 12 makes a recommendation.
 13 Q. And is there a hearing for every
 14 complaint?
 15 A. At the Board hearing, we review all the
 16 complaints. Unless it's an emergency situation,
 17 then we may do it outside the regular scheduled
 18 Board meeting.
 19 Q. Gotcha.
 20 And in terms of the physician answering,
 21 do they -- do they come before the Board to sort of
 22 voice their side of things at these meetings?
 23 A. Sometimes they do. Sometimes they just
 24 write a letter. I guess I don't know if the right
 25 term would be "letter of rebuttal" or -- just a

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1 letter answering the claims of the patient.
 2 Q. Okay. In terms of deciding, you know,
 3 what actions to take, what -- what are you as a
 4 Board member consulting?
 5 A. I'm sorry. Say that again?
 6 Q. When you're deciding what action to
 7 take, you know, whether to suspend a license or
 8 refer somebody to the AG's office, what is that
 9 based on?
 10 MS. LAND: Object to form.
 11 A. It's based on the complaint itself; the
 12 history of the physician, for example, if
 13 they've had multiple complaints of the same type
 14 thing; the seriousness of the complaint. Those are
 15 some of the reasons --
 16 Q. In each of --
 17 A. -- that we would look at.
 18 Q. In each of these cases, do you need to
 19 determine that the person violated either the
 20 Arkansas Medical Practices Act or regulations to
 21 take action?
 22 A. Yes. There has to be a violation of the
 23 Arkansas Medical Practices Act.
 24 Q. And it sounds like these are kind of a
 25 recurring part of the Board meetings then; these are

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1 the investigations and disciplinary actions, right?
 2 A. It's a very common part of the Board
 3 meetings.
 4 Q. Okay. So you personally been involved
 5 in these investigations, then, correct?
 6 A. When you say "investigations," are you
 7 saying the evaluation of these complaints?
 8 Q. Yes. That's correct.
 9 A. Yes.
 10 Q. Do you have a rough sense for how many
 11 times?
 12 A. How many complaints I've reviewed?
 13 Q. Yes.
 14 A. Hundreds. I can't give you an exact
 15 number, but we may review 50 to 100 per Board
 16 meeting. So that's...
 17 Q. And the Board meets every month or two;
 18 is that right?
 19 A. Usually every couple of months, or there
 20 may be a little bit more space. But typically.
 21 Q. Were you involved in the investigation
 22 of a jail doctor regarding -- regarding the use of
 23 ivermectin to treat COVID-19?
 24 A. Yes.
 25 Q. Okay. Can you just describe the

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1 complaint as you remember it?
 2 A. As I remember it, there was a physician
 3 that was in the jail, and there was a complaint by
 4 the -- his patients, that they had received
 5 ivermectin without their consent.
 6 Q. And did the Board take action against
 7 that physician?
 8 A. What we did is we requested and
 9 subpoenaed the consent forms of the physician, as I
 10 recall, to find out if the claims of his patients
 11 were correct or not, and we received the consent
 12 forms that had been signed by the patients. And,
 13 therefore, the case at that point was closed.
 14 Q. During that process, after receiving
 15 that complaint, did the Board ever consider pursuing
 16 a regulation to ban the use of ivermectin to treat
 17 COVID?
 18 A. No.
 19 Q. Did the Board ever discuss the
 20 possibility of such a regulation?
 21 A. Not that I recall. Uh-uh.
 22 Q. Did the Board ever discuss the use of
 23 hydroxychloroquine to treat COVID?
 24 A. I don't recall.
 25 Q. Are you aware of the Arkansas

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1 Department of Health's statement on the use of
 2 hydroxychloroquine to treat COVID?
 3 A. I'm not.
 4 MR. RICHARDSON: Beth, can we get
 5 Exhibit 7, please.
 6 THE WITNESS: Sure.
 7 MS. ECHOLS: Yes.
 8 MR. RICHARDSON: It should be just the
 9 one-page press release.
 10 THE WITNESS: Sure.
 11 (Exhibit 7 introduced)
 12 BY MR. RICHARDSON:
 13 Q. Okay. Does this document say "Guidance
 14 For the Use of Hydroxychloroquine and Chloroquine
 15 For the Treatment of COVID 19"?
 16 A. Yes, it does.
 17 Q. Okay. The last part of -- the last
 18 sentence of the first paragraph, if you can just
 19 read with me here:
 20 "Based on this information, the
 21 Arkansas Department of Health updated its
 22 guidance related to hydroxychloroquine and
 23 chloroquine, indicating that their use for
 24 treatment of COVID-19 should be avoided in
 25 both outpatient and hospitalized settings."

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1 A. Okay.
 2 Q. Do you agree that hydroxychloroquine has
 3 not been demonstrated to be effective for treating
 4 COVID?
 5 A. I haven't done enough research on that.
 6 Q. Okay. Do you have any reason to doubt
 7 the conclusion of the Arkansas Department of Health?
 8 A. I think their conclusion is that it
 9 should be avoided, and that is their -- that's their
 10 conclusion. So I don't know if there's anything to
 11 doubt that.
 12 Q. So you have no reason to doubt their
 13 conclusion that it should be avoided?
 14 A. I believe that the Arkansas Department
 15 of Health has done their due diligence in order to
 16 come up with this statement.
 17 Q. Okay. And would you -- would you agree,
 18 then, or have no reason to doubt their conclusion
 19 that hydroxychloroquine to treat COVID might pose
 20 certain risks?
 21 A. I'm sorry. Can you repeat that
 22 question?
 23 Q. Would you have any reason to doubt their
 24 conclusion that the use of hydroxychloroquine to
 25 treat COVID poses certain risks?

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1 MS. LAND: Objection. Form. Asked and
 2 answered.
 3 A. I assume that there are -- as I said,
 4 there are potential risks for those medications.
 5 Q. Okay. Would you support a regulation
 6 that banned doctors from prescribing ivermectin or
 7 hydroxychloroquine to treat COVID-19?
 8 A. I believe that would be under -- that
 9 could be against the Medical Practices Act.
 10 Q. How is that, sir?
 11 A. Well, the Medical Practices Act gives
 12 broad leeway to the -- to physicians and what they
 13 feel is appropriate in their treatment of patients.
 14 Q. So you think a regulation banning a
 15 treatment with high risks would violate the Act
 16 itself?
 17 MS. LAND: Objection to form.
 18 A. I don't feel it would be within the
 19 spirit of the Act.
 20 Q. And why is that?
 21 A. Because physicians have broad
 22 prescriptive ability and treatment ability in the
 23 State of Arkansas.
 24 Q. And you mean by that, they have the
 25 ability to determine appropriate treatment for

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1 patients?
 2 A. That is correct.
 3 Q. So it sounds like, based on your view of
 4 the Arkansas state medical -- the Arkansas Medical
 5 Practices Act, that the standard practice, then, is
 6 that doctors, in consultation with their patients,
 7 determine appropriate treatments in each case; would
 8 that be fair?
 9 MS. LAND: Object to form.
 10 A. I believe the doctor-patient
 11 relationship allows for them to come to a mutually
 12 agreeable treatment.
 13 Q. Even for treatments that pose serious
 14 risk?
 15 MS. LAND: Object to form.
 16 A. I think many treatments that are
 17 prescribed by physicians as well as surgical
 18 procedures, you know, have risk involved with them.
 19 Q. And those treatments would fall within,
 20 I think you called it, the broad prescriptive
 21 discretion of the Board? I guess, you know, the
 22 practice of doctors to be able to decide on a course
 23 of treatment with their patients?
 24 A. I'm sorry. Can you please repeat that
 25 one?

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1 Q. Even those treatments with serious risks
 2 would be the source of treatment that, in Arkansas,
 3 doctors can prescribe in consultation with their
 4 patients?
 5 MS. LAND: Object to form.
 6 A. I think Arkansas shouldn't be sort of
 7 put to the side. I think that occurs in all states
 8 in the United States of America.
 9 Q. So you think it's the normal practice
 10 nationwide, then, that doctors and patients can
 11 decide on individual courses of treatment even when
 12 there are serious risks?
 13 MS. LAND: Object to --
 14 A. Yes.
 15 MS. LAND: -- form.
 16 A. Yes. I believe that's true.
 17 Q. And earlier we had talked about how you
 18 handle situations where a patient is a minor.
 19 And you said that, in that case, you
 20 would talk to the minor and then also extensively
 21 talk to the parent and obtain informed consent from
 22 the parent, correct?
 23 A. That's correct.
 24 Q. Okay. So in Arkansas, or nationally, is
 25 it -- is it true, then, that when the -- when the

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1 patient is a minor, there's also broad prescriptive
 2 authority for doctors to make decisions about
 3 treatment with serious risks as long as they're
 4 consulting the parent and the child?
 5 MS. LAND: Object to form.
 6 A. I believe that to be true.
 7 Q. And in Arkansas, then, there's this --
 8 there's this broad prescriptive authority for
 9 doctors, and then the Board provides oversight to
 10 ensure doctors are providing care ethically and
 11 safely; is that correct?
 12 A. That is correct.
 13 Q. Do you think that system that combines
 14 broad prescriptive authority with Board oversight is
 15 effective?
 16 A. I'm sorry. Could you repeat the
 17 question?
 18 Q. Do you think that system that Arkansas
 19 has, where there's broad prescriptive authority for
 20 doctors, combined with Board oversight, is
 21 effective?
 22 A. Did you say --
 23 MS. LAND: Object to form.
 24 A. -- "poor oversight"?
 25 Q. No. "Board oversight." I'm sorry.

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1 A. Oh, "Board"?
 2 Q. My bad.
 3 A. Because I was going to object to "poor
 4 oversight."
 5 Yes, Board oversight, yes, I believe
 6 that that does work.
 7 Q. Okay.
 8 MS. LAND: Hey, Dan, let me interrupt
 9 you for just one minute.
 10 MR. RICHARDSON: Oh, sure.
 11 MS. LAND: I need to ask if any of you
 12 parked in our garage.
 13 (Discussion off the stenographic
 14 record.)
 15 BY MR. RICHARDSON:
 16 Q. So we were talking about the
 17 effectiveness of Arkansas's systems where, you know,
 18 doctors have broad authority to determine
 19 appropriate treatment, and then the Board provides
 20 oversight.
 21 Do you think that the Board
 22 investigations of ethics complaints are effective in
 23 ensuring that medical care is provided appropriately
 24 in the state?
 25 A. Yes, I believe generally so. Uh-hmm.

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1 Q. And do you think the ethical obligations
 2 placed on Arkansas doctors are generally effective
 3 in regulating the profession of medicine in the
 4 state?
 5 A. Yes.
 6 Q. Are there any medical treatments that
 7 Arkansas does not allow patients and doctors to
 8 pursue?
 9 A. I'm not aware. I'm not sure. I'm not
 10 sure about the abortion procedures. I just --
 11 that's one thing I haven't really kept up with, and
 12 I don't know what the reading is on legislative, you
 13 know, agenda. I know there's been recent changes.
 14 Q. Okay. But outside of the abortion
 15 context, is there anything that -- any treatments
 16 you're aware of Arkansas does not allow doctors to
 17 pursue with patients?
 18 A. I'm sorry. You just went -- you just
 19 went crazy on me in terms of the Zoom. I'm sorry.
 20 Q. Okay. Can you hear me now?
 21 A. Yes. I can hear you now.
 22 Q. Outside of the abortion context, are
 23 there any medical treatments that Arkansas does not
 24 allow patients and their doctors to pursue?
 25 A. Not that I'm aware of. I'm not -- I'm

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1 not sure.
 2 Q. Okay. To your knowledge, has the Board
 3 itself ever banned any type of medical care?
 4 A. Not -- not since I've been a member.
 5 Q. Okay. And based on your prior response,
 6 is it your view that a ban on medical care would
 7 conflict with the Arkansas Medical Practices Act?
 8 A. I believe so. I think that, like I
 9 said, physicians do have broad prescriptive and
 10 treatment authority under their medical licenses.
 11 Q. And has the -- to your knowledge, has
 12 the Board ever considered banning a type of medical
 13 care?
 14 A. Not since I've been a member.
 15 Q. Are you aware of specific regulations
 16 under the Arkansas Medical Practices Act related to
 17 opioids?
 18 A. Yes. I'm generally aware.
 19 Q. Okay. And is it your view that those
 20 regulations address the risk of overprescribing?
 21 A. Yes.
 22 Q. And are you aware of regulations in the
 23 Arkansas Medical Practices Act related to gastric
 24 bypass surgery?
 25 A. That I'm not aware of.

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1 MR. RICHARDSON: Beth, can we get
 2 Exhibit 2, please.
 3 (Exhibit 2 introduced)
 4 BY MR. RICHARDSON:
 5 Q. This one is, unfortunately, long, but
 6 page 9 has the gastric bypass rule.
 7 A. Okay.
 8 Q. I got to get there myself.
 9 So this is Regulation No. 27. Do you
 10 see that?
 11 A. I do.
 12 Q. Okay. And that first paragraph says,
 13 "The complications of information the patient must
 14 be informed of are as follows," and then there's a
 15 very long list of potential risks. Those include
 16 complications, nutritional -- nutritional
 17 complications, psychiatric complications.
 18 Do you see those columns there?
 19 A. Yes.
 20 Q. Okay. So do you take it that the aim of
 21 Regulation 27 is to make sure that patients are
 22 adequately informed of the risks of gastric bypass
 23 procedures?
 24 A. Yes. That's -- yes, that's what it
 25 appears to say and -- uh-hmm. Yes.

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1 Q. So it sounds like there are regulations
 2 that address the risk of overprescribing in the
 3 opioid contest -- context, and the risk of, you
 4 know, severe undisclosed risks that need informed
 5 consent in the gastric bypass context; is that
 6 correct?
 7 MS. LAND: Object. Object to form.
 8 A. That is correct.
 9 Q. Okay. And has the Board ever considered
 10 banning either opioid prescriptions or gastric
 11 bypass procedures as a way to address those
 12 concerns?
 13 A. They have not considered banning those
 14 procedures as it is --
 15 Q. And why do you think that is?
 16 A. Because gastric bypass surgery is an
 17 effective procedure, and there's no reason to ban
 18 it.
 19 Q. Despite the serious risks listed in
 20 Regulation 27?
 21 A. Despite the seriousness. It would be
 22 the same as banning open heart surgery.
 23 And I -- I'm not aware of the impetus
 24 for this regulation; so...
 25 Q. Understood.

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1 We talked a little bit earlier about the
 2 legislature's contact with the Board when they're
 3 creating new regulations --
 4 A. Yes.
 5 Q. -- to be implemented by the Board.
 6 A. Yes.
 7 Q. Does the legislature ever contact the
 8 Board when it's considering new laws regulating the
 9 profession of medicine?
 10 A. Typically not. They tend to -- they
 11 tend to contact the medical society, and sometimes
 12 they don't contact the medical society either.
 13 Q. And this is the Arkansas State medical
 14 society --
 15 A. Yes.
 16 Q. -- that you mentioned earlier?
 17 Okay. And why do you think they would
 18 reach out to the society?
 19 MS. LAND: Object to form.
 20 A. The -- I guess I would assume -- they
 21 tell me I should never assume anything. But I
 22 assume that since the medical society represents the
 23 physicians in the state, they would want to know how
 24 they viewed whatever regulation they were proposing
 25 Q. But it sounds like it's less common for

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1 them to reach out to the Board directly then?
 2 A. They don't typically reach out to the
 3 Board.
 4 Q. Okay.
 5 A. They basically tell the Board what
 6 they've done, and then we do what they want us to
 7 do.
 8 Q. Are you aware of any time when they
 9 reached out to the Board in the process of
 10 developing a law as opposed to just to tell you all
 11 what to do?
 12 A. I'm not aware of a time when that's
 13 occurred.
 14 Q. Okay.
 15 A. Or I was not privy to that information.
 16 Q. Do you think, as a general matter, the
 17 legislature should talk with the Board in those
 18 situations?
 19 MS. LAND: Object to form.
 20 A. In an ideal world, I would speculate
 21 that the legislature, the Medical Board, the Medical
 22 Society would all work harmoniously together.
 23 Q. Including by talking about new laws and
 24 regs before they go into effect?
 25 A. Yes. It would be nice if that did

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1 occur.
 2 Q. Do other state agencies ever consult
 3 with the Board or Board members?
 4 A. The DEA occasionally will inform us of
 5 physicians who are on the DEA radar, so to speak, or
 6 law enforcement occasionally contacts the Board.
 7 Q. That's the federal DEA?
 8 A. Yes. I'm trying to think who else. The
 9 Health Department.
 10 Q. Okay. And why would the other
 11 components of the Health Department be reaching out?
 12 A. Well, we're under the umbrella of the
 13 Health Department. We're a part of the -- actually,
 14 part of the Health Department, so they may be
 15 reaching out to us in terms of budgets and financing
 16 and, you know, things of that nature;
 17 administrative-type things.
 18 Q. Okay. But nothing about the regulation
 19 of the practice of medicine?
 20 A. No. I haven't seen any of that.
 21 Q. Do any of the professional organizations
 22 that we talked about, or others, ever consult with
 23 the Board or Board members?
 24 A. Occasionally they may ask us -- when a
 25 new regulation comes down, they may ask to speak to

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1 the regulation at a society meeting.
 2 Q. And in that capacity, the Board would
 3 be explaining what the regulation does and how to
 4 comply?
 5 A. Yes.
 6 Q. Does the Board ever have contact with
 7 the Governor's office?
 8 A. Rarely. I'm trying to think if there's
 9 been a situation where they've directly work with
 10 the Governor's office. When I was trying to, you
 11 know, write those rules and regs., we sent them to
 12 the Governor's office for their input.
 13 Q. And this is the reg. about BOTOX®
 14 procedures and the other procedures that were
 15 being --
 16 A. Yes.
 17 Q. -- not supervised?
 18 A. Right.
 19 Q. And was the Governor's office supportive
 20 of the rule?
 21 A. They gave us their input on the rule.
 22 Q. And I know that's the one that you were
 23 most involved in. Do you think that the Board has
 24 developed rules in the past, does the Governor's
 25 office usually provide input?

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1 A. I can't speak to that. I don't know
 2 'cause this is the only one I was involved in.
 3 Q. All right. Is there anyone else who
 4 ever consults with the Board that we haven't
 5 discussed?
 6 MS. LAND: Object to form.
 7 A. Consults with the Board? Yes. The
 8 Board of Pharmacy and the -- we've -- there's been
 9 some new regulations where we consult with the
 10 Board of Pharmacy in terms of developing protocols
 11 for pharmacists to treat certain conditions, and so
 12 we have consulted with them.
 13 Q. Okay. And these are new regulations of
 14 the Board -- of the State Medical Board?
 15 A. These -- these are new regulations that
 16 involve pharmacy -- pharmacists being able to
 17 prescribe medications and diagnose certain
 18 conditions.
 19 Q. And anything else come to mind in terms
 20 of people reaching out to the Board for your
 21 expertise?
 22 A. Nothing right off the bat. I can't --
 23 I'm not -- I'm drawing a blank on other.
 24 Q. Are you familiar with a medical
 25 diagnosis called "gender dysphoria"?

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1 A. I am not.
 2 Q. Have you heard that term before?
 3 A. I have not.
 4 Q. Have you heard of a term called "gender
 5 identity disorder"?
 6 A. I have heard that.
 7 Q. And what do you understand that to be?
 8 A. An individual who, I guess if they're --
 9 to use the correct terminology, a cisgender male,
 10 maybe they feel that they really should be female or
 11 something of that nature, vice versa.
 12 Q. Okay. So are you familiar with medical
 13 treatments that are used to treat gender dysphoria?
 14 A. I am not.
 15 Q. Have you heard of puberty blockers
 16 before?
 17 A. I've heard the term, but I've never
 18 prescribed them, and I'm not familiar with their
 19 usage or exactly which ones that people use.
 20 Q. Okay. So you're not aware that puberty
 21 blockers are sometimes used to treat gender
 22 dysphoria?
 23 MS. LAND: Object to form.
 24 A. I'm not. I'm completely unfamiliar with
 25 those treatments.

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1 Q. Okay. Have you ever heard the term
 2 "cross-sex hormone therapy"?
 3 A. No. I don't believe I have.
 4 Q. How about gender-affirming hormone
 5 therapy?
 6 A. It sounds the same as the other, but I
 7 have not utilized those terms nor, you know, looked
 8 into providing them.
 9 Q. Okay. Are you aware that surgeries to
 10 align a patient's sex characteristics with their
 11 gender identity are sometimes used?
 12 A. Are sometimes what?
 13 Q. Are sometimes provided, those procedures
 14 are provided.
 15 A. I assume so, that those are provided.
 16 Q. We looked at the document from the ASPS
 17 which refers to -- I think the term is "gender-
 18 affirming surgeries."
 19 Did you -- on that list, did you see
 20 procedures like a mastectomy? I think it's
 21 Exhibit 4.
 22 (Witness reviewing document.)
 23 A. I don't see the term "mastectomy."
 24 There's --
 25 Q. I'm sorry. Go ahead.

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1 A. Is it under gender-affirmation
 2 surgeries?
 3 Q. Well, there is the description that says
 4 "transmasculine top surgery" --
 5 A. Yes.
 6 Q. -- which talks about removing breast
 7 tissue.
 8 A. That's --
 9 Q. Is that --
 10 A. That's -- that may or may not be a
 11 mastectomy. It doesn't --
 12 Q. Okay.
 13 A. Removing breast tissue doesn't
 14 necessarily mean a mastectomy.
 15 Q. Okay. Sorry for my ignorance on that.
 16 So what would a mastectomy be then?
 17 A. Total removal of the breast tissue.
 18 Q. Total. Okay.
 19 A. Where you could re- -- some of it would
 20 be a partial mastectomy.
 21 Q. Gotcha.
 22 A. But essentially.
 23 Q. So are you aware of the term "gender-
 24 affirming medical care"?
 25 A. I've heard the term.

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1 Q. Okay. And what do you understand it to
 2 be?
 3 A. Medical care that helps someone with
 4 their gender identification. I mean, that's how I
 5 would describe it.
 6 Q. You sort of touched on that with that
 7 answer. But -- but do you know why patients would
 8 seek gender-affirming medical care?
 9 A. Probably because they feel that they are
 10 of the incorrect gender that they are.
 11 Q. Do you know any people that have sought
 12 gender-affirming medical care?
 13 A. I do not.
 14 Q. Do you know any transgender people at
 15 all?
 16 A. On a personal basis?
 17 Q. Personal or professional, or any other
 18 basis.
 19 A. I do not.
 20 Q. So you wouldn't know anyone who has
 21 received gender-affirming medical care before?
 22 A. I'm not aware of that.
 23 Q. Okay. Has the Arkansas State Medical
 24 Board ever promulgated a rule respecting gender-
 25 affirming medical care?

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1 MS. LAND: Object to form.
 2 A. I'm not aware of that.
 3 Q. Okay. Has the Board ever discussed
 4 gender-affirming medical care?
 5 A. I'm not aware of any discussions about
 6 that either.
 7 Q. Has the Board ever received a complaint
 8 about a provider based on gender-affirming medical
 9 care?
 10 A. Not that I'm aware of.
 11 Q. Okay. So has the Board ever discussed
 12 any concerns about gender-affirming medical care in
 13 any context?
 14 A. Not that I'm aware of.
 15 Q. Okay. And have you had conversations
 16 with other Board members, whether or not during
 17 Board meetings, about gender-affirming medical care?
 18 A. I have not.
 19 Q. And are you aware of any discussions
 20 among Board members about that care that you may not
 21 have been a part of?
 22 A. I'm not. I don't -- I don't have any
 23 awareness of that.
 24 Q. How about in any conversations among
 25 Board staff involving that care?

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1 A. No. I've not been aware of any
 2 conversations with Board staff.
 3 Q. Are you aware of doctors at Arkansas who
 4 provide gender-affirming medical care?
 5 A. I'm not aware of any doctors that
 6 provide that care.
 7 Q. Are you aware if that care is provided
 8 in the state of Arkansas?
 9 A. I'm not aware of that.
 10 Q. Are you aware of a law called H.B. 1570?
 11 A. Please repeat that. I'm sorry.
 12 Q. A law called H.B. 1570.
 13 A. I am not.
 14 Q. It's the law at issue in this case --
 15 A. Okay.
 16 Q. -- which bans gender transition
 17 procedures for anybody under the age of 18.
 18 Have you heard the term "Act 626"?
 19 A. I have not.
 20 Q. Okay. That's another name for the same
 21 law. So when I say "Act 626" or "H.B. 1570," I'm
 22 referring to the law at issue in the case.
 23 A. Okay.
 24 Q. Okay. So what do you know about the law
 25 at issue in this case?

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1 A. I'm -- I don't know anything about the
 2 law. Sorry.
 3 Q. Okay.
 4 MR. RICHARDSON: Beth, can we get
 5 Exhibit 9, please.
 6 THE WITNESS: Thank you.
 7 (Exhibit 9 introduced)
 8 BY MR. RICHARDSON:
 9 Q. This is a copy, and the relevant text is
 10 on page 8, I believe.
 11 A. Page 8?
 12 Q. Page 8, yes, sir.
 13 A. Okay.
 14 Q. Okay. Do you see maybe the second
 15 paragraph there, "20-9-1502"?
 16 A. "20-9-1502."
 17 Yes, I see it.
 18 Q. And then there's a subpart (a) right
 19 below that.
 20 A. Yes. I see that.
 21 Q. It says:
 22 "A physician or other health care
 23 professional shall not provide gender
 24 transition procedures to any individual under
 25 18 years of age."

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1 A. Okay.

2 Q. Do you see that? Okay.

3 So you were not aware of this law before

4 today?

5 A. I have not been aware of this law until

6 today.

7 Q. Did you -- were you aware of any of the

8 reporting around a ban on health care for

9 transgender adolescents?

10 MS. LAND: Object to form.

11 A. I was not privy to any -- like news

12 reporting?

13 Q. Yes. Just any news reporting at the

14 time.

15 A. I really haven't seen anything on that.

16 I guess I've been working too much.

17 Q. So you would not have heard about

18 anything to do with -- would the phrase "a safe act"

19 sound familiar to you?

20 A. No.

21 Q. Okay. Do you recall at any point in

22 2021 or before that, anybody from the legislature

23 reaching out to you to talk about gender-affirming

24 medical care?

25 A. Nope. I never heard anything about

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1 that.

2 Q. Okay. And nobody from the Governor's

3 office on that topic?

4 A. Never received anything from the

5 Governor's office.

6 Q. Are you aware that Governor Hutchison

7 vetoed the law H.B. 1570?

8 A. I'm not aware of that.

9 Q. Okay. Do you know why you're a

10 defendant in this lawsuit?

11 A. I absolutely do not know why I'm a

12 defendant in this lawsuit.

13 Q. Do you know why the Board is a

14 defendant?

15 A. I don't. I have no idea. It's sort of

16 befuddling.

17 Q. Okay. Would the --

18 A. I'm not sure what -- can you tell me?

19 Q. Would -- does the Board have to enforce

20 the laws and regulations about the regulation of

21 medicine in Arkansas?

22 A. Yes. The Board is involved in -- so,

23 for example, a regulation like this, we would be

24 involved in enforcing that regulation.

25 Q. All right. So, in your view, the Board

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1 would have to enforce H.B. 1570 if it went into

2 effect?

3 A. Yes. If it went into effect and it

4 stated that a physician can or cannot do something,

5 then we would be involved in enforcement on that.

6 Q. Okay. And what would that enforcement

7 action look like?

8 MS. LAND: Object to form.

9 A. We would have to write rules or

10 regulations involving that, and it would probably

11 look something like, if we received a complaint that

12 a physician was performing a certain procedure that

13 was prohibitive, that we would have to investigate.

14 Q. Okay.

15 A. That's how I think that would play.

16 Q. Okay. And has the Board had any

17 discussions about what that enforcement might look

18 like?

19 A. We have not.

20 Q. So just to take your hypo- there.

21 Let's say the law goes into effect and a

22 complaint is brought to the Board that there is a

23 doctor providing the care prohibited by the statute

24 to a minor, would the Board have to find the

25 violation of the law and take action?

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1 MS. LAND: Object to form.

2 A. The Board would be required to

3 investigate the situation.

4 Q. Okay.

5 A. And so they would investigate and find

6 out if there's, you know, substance to the

7 complaint, and if, in fact, a violation had actually

8 occurred. So there would be an investigation and a

9 hearing.

10 Q. Okay. And if the investigation -- if it

11 turned out that, you know, a doctor did provide,

12 let's say, cross-sex hormone therapy prohibited by

13 the statute, if the investigation reached that

14 conclusion --

15 A. Yeah.

16 Q. -- would the Board have to take action

17 against the doctor?

18 MS. LAND: Object to form.

19 A. There was -- if -- if at that point

20 there was a violation of the Medical Practices Act,

21 the Board would have to take some type of action.

22 Q. Okay. Would it have any discretion not

23 to act in that situation?

24 A. If the Board determined there's a

25 violation of the Medical Practices Act, it does have

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1 the discretion to decide what that -- what the
 2 penalty would be. Some type of action would have to
 3 be taken.
 4 Q. Would you feel comfortable in that
 5 situation, disciplining doctors who provide gender-
 6 affirming medical care to adolescents?
 7 MS. LAND: Objection to form and
 8 relevance.
 9 A. If there was a violation of the Medical
 10 Practices Act, I would have to act upon that
 11 irregardless of what the procedure was and who the
 12 physician was.
 13 Q. Okay. And would you feel comfortable
 14 with having to do that?
 15 MS. LAND: Objection to form and
 16 relevance. Asked and answered.
 17 You can answer.
 18 A. I took an oath to uphold the Medical
 19 Practices Act, and so I would have to act within
 20 those requirements.
 21 Q. Okay. What if in that situation a
 22 doctor asserted, in defense, that discontinuing the
 23 patient's care would harm the patient?
 24 MS. LAND: Object to form, and calls for
 25 speculation.

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1 A. If that situation were to occur and the
 2 patient -- or the physician felt that the patient
 3 was not going to receive the care that they needed
 4 and they were in a situation of abandoning the
 5 patient, we would recommend for them to seek to have
 6 that -- you know, counsel that patient on seeking
 7 care somewhere else, because it was a violation of
 8 the Medical Practices Act and the laws of the State
 9 of Arkansas.
 10 Q. And would it -- would it violate the
 11 doctor's ethical obligations not to seek an
 12 alternative provider?
 13 MS. LAND: Object to form.
 14 A. Say that one more time? Would it
 15 violate what?
 16 Q. Would it violate the doctor's ethical
 17 obligations to not seek an alternative provider for
 18 the treatment that has already been started?
 19 A. Yeah.
 20 MS. LAND: Object to form.
 21 A. I believe that if a physician started
 22 the treatment, but then they were not allowed to
 23 continue the treatment due to changes in the laws in
 24 the state which they reside, I think it would be
 25 incumbent upon them to try to have that patient be

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1 seen by another physician in another state where
 2 they could continue the treatment.
 3 Q. And is that typically done by a
 4 referral?
 5 A. That would be done by a referral type --
 6 typically.
 7 Q. Okay. Can you -- can you look back in
 8 the same page we were just looking at, page 8.
 9 A. Sure.
 10 Q. So do you see the "B" right under the
 11 part we read --
 12 A. Yes.
 13 Q. -- where it says:
 14 "A physician or other health care
 15 profession shall not refer any individual
 16 under 18 years of age to any health care
 17 professional for gender transition
 18 procedures."
 19 A. Sure.
 20 Q. So in that situation, it sounds like --
 21 earlier we talked about the ethical obligations of
 22 doctors require them to either continue providing
 23 treatment or to refer them for treatment, correct?
 24 MS. LAND: I'll object to that question.
 25 He's testified that he hasn't read this Act, and so

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1 he hasn't been given the opportunity to read the Act
 2 and the full exhibit in its entirety. So I'm --
 3 MR. RICHARDSON: My question is --
 4 MS. LAND: -- going to object.
 5 MR. RICHARDSON: Thanks. But my
 6 question was about the ethical obligations we
 7 discussed earlier.
 8 MS. LAND: You were also referring to
 9 subsection (b) of the exhibit that you provided him,
 10 and it's approximately -- well, it's nine -- ten
 11 pages, and he hasn't had the opportunity to review
 12 that.
 13 MR. RICHARDSON: My question didn't
 14 discuss the Act.
 15 BY MR. RICHARDSON:
 16 Q. My question was: Would it violate the
 17 ethical obligations of a doctor who has started
 18 providing care to a patient to not either continue
 19 the treatment or refer the patient to receive the
 20 treatment from somebody else?
 21 MS. LAND: You can answer.
 22 A. Sure. Reading this, I feel that --
 23 well, first of all, I'd like to say that I think
 24 part (b) refers to an initial referral, not a
 25 continuing treatment.

<p style="text-align: right;">Page 114</p> <p>1 Secondly, I think that the ethics that 2 you take as a physician is that if you start a 3 treatment, irregardless of what that treatment is, 4 and it requires continuing that treatment, then that 5 patient should be referred. 6 Now, whether that -- my thoughts violate 7 that law? You know, I don't know. There appears 8 that there could be a conflict there. It just 9 depends how you read that. 10 Q. Okay. So leaving this law to the side, 11 is it correct that the ethical obligations of 12 doctors, in your view, once they started treatment 13 are either to continue providing treatment or ensure 14 that the treatment is provided by somebody else? 15 MS. LAND: Object to form. 16 A. I believe that if a treatment needs to 17 be continued and the physician cannot provide that 18 treatment, that the physicians should do whatever 19 they can to refer that patient to get more -- that 20 -- to continue that treatment. 21 Q. Okay. Thanks. 22 And before I ask about the law, I just 23 want to give you an opportunity to read it if you 24 like. So if you want to take that time to read the 25 statute, that's fine by me.</p>	<p style="text-align: right;">Page 116</p> <p>1 way. 2 Again, you said that you would have 3 enforce H.B. 1570 as a Board if it went into effect, 4 correct? 5 A. That would be correct. We would have to 6 develop rules that fell in line with the legislative 7 bill. 8 Q. So, let's imagine a situation again 9 where a doctor -- you said that if you investigated 10 and found a violation of H.B. 1570, you would have 11 to take some kind of action? 12 A. Correct. 13 Q. So imagine a doctor asserts, in defense, 14 their ethical obligation to not abandon a patient, 15 would the Board have to take action against the 16 doctor in that situation? 17 MS. LAND: Object to form, and calls for 18 speculation. 19 A. Yeah. I would have to -- you know, I 20 guess you would have to query the entire Board. I 21 can't speak for all the Board members; there's a 22 large number of them. And so I can't speculate to 23 what the Board would actually do. 24 Q. Okay. What do you think would be an 25 appropriate response?</p>
<p style="text-align: right;">Page 115</p> <p>1 A. It could take a little bit. 2 Q. No worries. 3 (Witness reviewing document.) 4 THE VIDEOGRAPHER: Mr. Richardson, this 5 is the videographer. Can we take a comfort break 6 while the doctor is reading this document? 7 MR. RICHARDSON: That's just fine with 8 me. Do you want to take five from the tape? 9 THE VIDEOGRAPHER: Yes. I'd like to go 10 ahead and change the media. 11 So this will end media part 2, and we 12 are going off the record at 4:31 p.m. 13 (Recess taken.) 14 THE VIDEOGRAPHER: We are back on the 15 record at 4:37 p.m. This will begin media part 3. 16 Please proceed. 17 BY MR. RICHARDSON: 18 Q. Did you have a chance to read H.B. 1570? 19 A. Yes, I did. 20 Q. Okay. I'd just like to return, then, to 21 -- we were discussing the ethical obligations of 22 doctors regarding abandonment. 23 A. Yes. 24 Q. And the obligation to either provide 25 care or ensure that care can be provided in some</p>	<p style="text-align: right;">Page 117</p> <p>1 A. I don't know. I can't speculate on 2 that. I would just have to -- that I would have to 3 kind of think about. I'm not -- I'm not sure if I 4 could really come up with an answer right now. 5 Q. Okay. And now that you've read 6 sections (a) and (b) on page 8 that we had talked 7 about -- 8 Do you see those sections? 9 A. Yes. I'm turning to them right now. 10 Q. Okay. 11 -- do you read those sections to be in 12 conflict with the ethical obligations regarding 13 abandonment? 14 MS. LAND: I'll object to the form on 15 that, and I'll also object to the questioning over 16 this Bill. 17 He's not an attorney, and he can't 18 testify as to the effect or the substance of the law 19 or the meaning of the law. So it would be calling 20 for speculation and irrelevant testimony. 21 You can -- 22 THE WITNESS: So I -- 23 MS. LAND: -- answer. 24 You can answer. 25 THE WITNESS: All right. I'm just</p>

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1 rereading it.
 2 (Witness reviewing document.)
 3 THE WITNESS: And the question was
 4 again? I'm sorry.
 5 BY MR. RICHARDSON:
 6 Q. Do you think that sections (a) and (b)
 7 conflict with the ethical obligations of doctors
 8 regarding not abandoning patients?
 9 MS. LAND: Restate my objections.
 10 A. I guess it depends on how you read this.
 11 Q. If the law were --
 12 A. If --
 13 Q. -- interpreted as --
 14 A. If this -- yeah, if you're interpreting
 15 the law as -- and I'm referring to section (b), as a
 16 referral to any health care professional within the
 17 state of Arkansas, then I guess they wouldn't be in
 18 conflict.
 19 I guess if it's all health care
 20 professionals in general, I don't know if the state
 21 of Arkansas has jurisdiction over all health care
 22 individuals in Arkansas -- I mean, in the United
 23 States.
 24 So I think there are some legalistic
 25 parts of this that I really can't speak to, and I

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1 would probably have to consult our attorney, our
 2 Board attorney for clarification.
 3 Q. Okay. Let's leave the legal disputes to
 4 the side and just say: If the law did prevent a
 5 doctor from referring a patient to any medical
 6 provider to receive that care, would it conflict
 7 with the ethical obligations to not abandon the
 8 patient?
 9 MS. LAND: Object to form.
 10 A. Well, I think you're asking me to
 11 speculate on something that doesn't exist.
 12 Q. Well, the question was if a doctor was
 13 prevented from referring a patient for care during a
 14 continuing course of treatment --
 15 A. I just --
 16 Q. -- wouldn't --
 17 A. I just -- I just don't see how any law
 18 could actually do that.
 19 Q. Well, just imagine with me that -- that
 20 one did, and that the doctor was -- a doctor is
 21 prohibited from referring patients to receive care,
 22 but that doctor's -- but that patient's course of
 23 treatment is not complete.
 24 A. Well, I think that --
 25 MS. LAND: Object to form.

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1 A. I think that would be -- the physician
 2 would feel like it's their duty to refer so that
 3 patient could have the treatment that they require.
 4 I just -- that's -- that's all I can say about that.
 5 Q. So the physician would have an ethical
 6 duty to refer the patient in those circumstances?
 7 MS. LAND: Object to form. Calls for
 8 speculation.
 9 A. I just would think that -- I mean, I'll
 10 speculate. But, ethically and morally, a physician
 11 would want their patient to receive the care that
 12 that physician started.
 13 Q. So a -- once again, without getting
 14 into, you know, what -- how to read this law. If a
 15 law prevented a doctor from doing that, would there
 16 be a conflict between the ethical obligations you
 17 described and the legal requirement of that law?
 18 MS. LAND: Object to form.
 19 A. It appears that there would be a
 20 conflict. Whether that's a legal conflict or a
 21 moral conflict would have to do with what the --
 22 would -- you'd have to consult an attorney, I would
 23 assume. I don't know.
 24 Q. When we were talking about the general
 25 practice of medicine in Arkansas earlier --

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1 A. Yes.
 2 Q. -- you talked about the fact that
 3 doctors and patients should be able to agree on the
 4 treatment that the doctor thinks is appropriate; is
 5 that correct?
 6 A. Yes. I did make that statement.
 7 Q. Okay. Do you have concerns about the
 8 law you just read prohibiting patients from
 9 receiving care that the minor, the parent, and the
 10 doctor all think is appropriate?
 11 MS. LAND: Object to form, as well as
 12 for vagueness, and as well as my previous objections
 13 that he's only just had the opportunity to read this
 14 law, and he's not an attorney.
 15 A. Can you restate the question one more
 16 time, please? Thank you.
 17 Q. So do you have concerns about a law that
 18 prevents doctors, patients and parents, in the case
 19 of a minor, from receiving care that -- from the
 20 minor receiving care that the doctor, patient, and
 21 minor all think is appropriate?
 22 MS. LAND: Object to form. And restate
 23 my previous objections.
 24 A. It's a great question. That's a hard
 25 one to answer. I think within the ethics of

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1 medicine and treatment care, I think the
 2 relationship between a physician and their patient
 3 is very important in that, to a certain extent, it
 4 should be allowed when it's beneficial to the
 5 patient and agreed upon between the physician and
 6 the patient.
 7 Q. So does that mean you would have
 8 concerns about a law that prevented doctors and
 9 patients from making decisions about the patient's
 10 treatment?
 11 MS. LAND: Object to form. Asked and
 12 answered.
 13 A. As long as the treatments were ethical
 14 and supported by medical science, I don't see a -- I
 15 see that the physician should be allowed to treat
 16 the patient to what they felt was appropriate.
 17 Q. And that could include treatments that
 18 might have serious risks?
 19 A. All treatments. I mean, many treatments
 20 have serious risks. So, yes, it would include
 21 treatments that have serious risks.
 22 Q. Having read the law just now, do you
 23 think that a law that banned gender transition
 24 procedures for minors is an appropriate regulation
 25 of medicine?

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1 MS. LAND: Objection to form.
 2 A. I don't know. I can't -- I haven't
 3 looked into that procedure enough to really make an
 4 informed statement on that.
 5 Q. So what would be -- when do you think it
 6 would be appropriate to ban the care that a doctor
 7 and patient can -- agree is best for the patient?
 8 MS. LAND: Object to form.
 9 A. I think when there's no scientific
 10 evidence that the treatment actually is beneficial
 11 whatsoever, and that, I would -- and that is
 12 potentially very harmful where the risks way
 13 outweigh the benefits of the treatment.
 14 Q. When you say no support whatsoever, what
 15 do you mean by that? What would constitute
 16 sufficient support to allow a medical treatment, in
 17 your view?
 18 MS. LAND: Object to form. Vague.
 19 Overbroad. And calls for speculation.
 20 A. Can you repeat the question one more
 21 time?
 22 Q. Well, you said -- yeah. You said you
 23 don't think it would be appropriate to ban care
 24 unless there was no medical support whatsoever, I
 25 believe is the term you used.

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1 A. Sure.
 2 Q. So I'm just curious what you mean; what
 3 that line is that you're drawing.
 4 A. If there is no -- there is absolutely no
 5 indication or no -- even on -- I would say many
 6 treatments are used in an off-label manner.
 7 For example, some anti-inflammatories,
 8 some herbs are used off-label. I think they don't
 9 necessarily show -- the science doesn't necessarily
 10 show it for that procedure, but similar procedure,
 11 or similar treatment and the illnesses, and so there
 12 may be some benefit.
 13 And so I think that those types of
 14 things should be allowed to a certain extent as long
 15 as they're not causing any harm.
 16 Q. So that -- just to clarify: You do not
 17 think that off-label uses of medicine or treatment
 18 should be banned?
 19 MS. LAND: Object to form and relevance.
 20 A. No, I do not. I think off-label uses
 21 are very common in the medical field and should --
 22 and if used under the guidance of physicians, I
 23 think should be allowed.
 24 Q. Taking you back again to the law you
 25 just read.

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1 Do you think that it puts doctors and
 2 the patient -- in the position of having to deny
 3 care to their patients?
 4 MS. LAND: Objection to form. And I
 5 restate my previous objections about him having just
 6 read this law, and that he's not an attorney, and
 7 not qualified to speculate on its effect or what the
 8 law says or means.
 9 A. Part A says that the physician or health
 10 care professional shall not provide gender
 11 transition procedures; they're just not allowing
 12 them to provide it. I don't know if that really
 13 means denying them. I think it just means they're
 14 not allowed to provide it. So I don't know. If
 15 there's a fine line between that, that's where the
 16 attorneys would come in.
 17 Q. Okay. But if that passage you just read
 18 were -- if it did prevent doctors from providing
 19 treatment to their patients --
 20 A. Yes.
 21 Q. -- assume that's what it means.
 22 A. It would -- it would prevent them from
 23 providing that procedure, but not preventing the
 24 patient from receiving it. It sounds like the
 25 patient could receive it from somewhere else that

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1 was allowed.

2 Q. And would you have concerns about a law

3 that banned physicians from providing treatments to

4 their patients?

5 MS. LAND: Objection to form. Asked and

6 answered.

7 A. As a personal, or as a Medical Board

8 member or --

9 Q. How about both?

10 A. As a Medical Board member, I'm bound to

11 the rules and regulations that are set by the

12 legislature.

13 Personally, as long as there's no harm

14 being done, I think physicians and their patients

15 should be allowed to provide the procedures, you

16 know -- you know, allowed to participate in the

17 procedures that will help the patient.

18 Q. Are you aware that Governor Hutchison

19 vetoed H.B. 1570?

20 MS. LAND: Objection to form. Asked and

21 answered.

22 A. I'm not aware of that.

23 MR. RICHARDSON: Beth, can we get

24 Exhibit 8, please.

25 (Exhibit 8 introduced)

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1 BY MR. RICHARDSON:

2 Q. Do you see it's an opinion piece by

3 Governor Hutchison published in the Washington Post

4 on April 8, 2021?

5 A. Yes.

6 Q. Okay. Do you see the part, second

7 paragraph from the bottom of the first page, it

8 says:

9 "It is undisputed that the number of

10 minors who struggle with gender incongruity

11 or gender dysphoria is extremely small, but

12 they too deserve the guiding hand of their

13 parents and the counseling of medical

14 specialists in making the best decisions for

15 their individual needs."

16 Do you see that?

17 A. I see it.

18 Q. Do you agree with that statement?

19 MS. LAND: Object to form.

20 A. I think I already spoke to that. That I

21 think that parents, their children, do deserve the

22 counsel of medical specialists.

23 Q. If you turn to the second page. You'll

24 see, this is the last sentence of that second

25 paragraph, it says:

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1 "Their concern is that denying best

2 practices medical care to transgender youth

3 can lead to significant harm to the young

4 person from suicidal tendencies and social

5 isolation, to increased drug use. Given

6 these risks, we have to ask whether the State

7 action helps or unjustifiably interferes."

8 Do you see that?

9 A. I see it.

10 Q. Do you share the Governor's concern,

11 that denying gender-affirming medical care to

12 adolescents could lead to the harms identified

13 there?

14 MS. LAND: Objection to form. And he

15 has not had the opportunity to read this document in

16 its entirety.

17 Q. We can take a minute, if you like.

18 (Witness reviewing document.)

19 A. Yes.

20 Q. Do you see the passage I was just

21 referring to that talks about significant harm to

22 the young person, from suicidal tendencies and

23 social isolation to increased drug use?

24 A. Let's see. Was that on --

25 Q. Bottom of this paragraph on the second

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1 page.

2 (Witness reviewing document.)

3 Q. The last two sentences of the first

4 paragraph.

5 A. On the second page? Yes.

6 Q. On the second page, yes.

7 Do you share the Governor's concern,

8 that denying gender-affirming medical care to

9 adolescents could lead to the harms that he

10 identifies?

11 MS. LAND: Object to form.

12 A. I'm sure that it possibly could lead to

13 that.

14 Q. And would you have concerns about

15 denying care that led to those risks?

16 MS. LAND: Object to form.

17 A. I would have concerns.

18 Q. Do you see a little further down the

19 sentence, the paragraph that starts "instead"?

20 A. Yes.

21 Q. Okay. The last sentence there is:

22 "The young people who are currently

23 under a doctor's care will be left without

24 treatment when this law goes into effect."

25 A. Yes. I believe that that's possible.

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1 Q. Okay. And do you share the Governor's
 2 concern about that?
 3 A. Yes, I do.
 4 Q. What do you think the harms could be in
 5 that kind of situation?
 6 MS. LAND: Object to form. That calls
 7 for speculation. And he's already testified he does
 8 not practice in that area.
 9 A. Besides them not receiving the treatment
 10 and not being able to continue their gender
 11 transformation, beyond that, I mean, we just spoke
 12 about the possible significant harm in terms of, you
 13 know, possible suicide or other issues.
 14 Q. Do you think, in general, it's harmful
 15 for patients who are receiving a continuing course
 16 of treatment, to not complete that treatment?
 17 MS. LAND: Object to form.
 18 A. Typically, I think it can be harmful,
 19 yes.
 20 Q. Okay. And do you think that's true for
 21 patients being treated for gender dysphoria?
 22 MS. LAND: Object to form. And restate
 23 my objections as to his qualification to testify
 24 about that.
 25 A. Yeah. I don't perform those procedures.

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1 I could only assume that if they weren't receiving
 2 continuous treatments, that there could be problems
 3 associated with that.
 4 Q. Do you have any reason to think that
 5 gender dysphoria would be different from other
 6 procedures where that's true?
 7 MS. LAND: Object to form. Calls for
 8 speculation.
 9 A. In terms of hormonal treatments, it may
 10 be very similar to other treatments that people
 11 received. On the surgery side, which is what I'm
 12 more familiar with, I'm not so sure.
 13 Q. Okay. So earlier -- and I think this
 14 was Exhibit 3, we had talked about the work you do,
 15 rhinoplasties and otoplasties, for minors in some
 16 instances.
 17 A. Yes.
 18 Q. And I believe one of the things that you
 19 said was that the research shows that the procedures
 20 can be better at younger ages for the patient?
 21 A. For otoplasty, yes.
 22 Q. For otoplasty.
 23 Do you have concerns about denying care
 24 to a minor in a situation where their -- their
 25 condition might worsen without receiving the care?

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1 MS. LAND: Objection to form.
 2 A. Sure. For example, diabetes. If a
 3 patient has diabetes, and they're a minor, and they
 4 need insulin, I think that would be very
 5 detrimental; the patient can die.
 6 Q. Do you think there are any patients in
 7 your practice who would have been harmed by having
 8 to wait until adulthood to receive a treatment?
 9 A. That's up for opinion. I think in the
 10 opinion of the parents and the child, for example,
 11 with the otoplasty, that they could have been
 12 emotionally harmed.
 13 Q. By having to wait?
 14 A. By having to wait, yes.
 15 Q. And there's also research you cited
 16 showing that it's effective -- it's more effective
 17 at younger ages?
 18 A. The procedure, the procedure itself is
 19 easier to perform at younger ages on otoplasty, yes.
 20 Q. Okay. So in that situation, then, there
 21 could also be harms by the procedure being less
 22 effective if you waited, correct?
 23 A. That is possible.
 24 Q. Okay. Do you have concerns about
 25 adolescents who are experiencing gender dysphoria

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1 from not being -- those adolescents not being able
 2 to get the care while they're minors?
 3 MS. LAND: Object to form, vague, and
 4 overbroad.
 5 A. I hadn't really thought about that.
 6 Q. Well, would you think a minor could be
 7 harmed by having to wait until adulthood to receive
 8 gender-affirming medical care?
 9 MS. LAND: Object to form. Calls for
 10 speculation. He's already testified he doesn't
 11 practice in that area.
 12 A. I'm not familiar. I'm not sure.
 13 Q. Earlier we talked a little bit about the
 14 different clinical studies that support the care
 15 that you provide in your clinic.
 16 A. Yes.
 17 Q. And I think you said that there are
 18 clinical studies for the different treatments, but
 19 maybe not, you know, full experimental trials for
 20 those treatments. Is that accurate?
 21 A. That is correct.
 22 Q. Okay. Do you think that all types of
 23 care not supported by full experimental trials
 24 should be banned?
 25 MS. LAND: Object to form, vague and

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1 overbroad.
 2 A. Do I feel that any procedure that
 3 doesn't have a clinical trial backing it up should
 4 be banned?
 5 Q. Yes.
 6 A. No.
 7 Q. Is there any particular level of
 8 evidentiary support that you think a treatment
 9 should have before a medical regulator allows a
 10 doctor and a patient to agree on using that
 11 treatment?
 12 MS. LAND: Object to form.
 13 A. Can you restate that one more time?
 14 Sorry.
 15 Q. Sure. Is there any, like, particular
 16 level of support or evidence that you think a
 17 treatment needs before it should be permitted to be
 18 used by a doctor when treating that patient?
 19 MS. LAND: Object to form. Overbroad.
 20 A. God, that's a good one. At a minimum, I
 21 think the procedure should have history behind it.
 22 But the history of the procedure actually does work
 23 and has benefit to it; so...
 24 Q. So just some clinical experience with
 25 the procedure?

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1 A. Yes. There should be some clinical --
 2 and I'm talking about surgery primarily. But that
 3 the clinical results of the procedure should, like I
 4 said in the past, outweigh the complications.
 5 Q. And earlier we talked about a specific
 6 treatment that I think you said that you had stopped
 7 providing because, in your view, the costs were
 8 outweighing the benefits. I think that was buttocks
 9 implantation. Is that right?
 10 A. Similar to that. I think the way I
 11 wanted to perform the procedure was not meeting the
 12 patient's expectations, and the way I could have
 13 performed the procedure, I felt, was too risky.
 14 Q. Okay. So the way that you felt was too
 15 risky, you said other providers offer that option?
 16 A. Yes.
 17 Q. Would you support banning that option
 18 because of the risks?
 19 MS. LAND: Object to form.
 20 A. No. But I think the physician should
 21 look at the totality of the evidence to perform that
 22 procedure and inform the patient of those potential
 23 risks.
 24 Q. Okay.
 25 A. So the patient and the physician

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1 together can make an informed decision.
 2 Q. Okay. Are you aware of innovative
 3 treatments that doctors are permitted to provide to
 4 patients even though they've not been subjected to
 5 medical research yet?
 6 MS. LAND: Objection. Objection to
 7 form. Overbroad.
 8 A. I'm sure there's some form of lasers out
 9 there that are undergoing clinical trials as
 10 physicians are using them, so they may be occurring
 11 simultaneously.
 12 Q. And earlier you -- we had talked a
 13 little bit about how not every single one of the
 14 procedures you provide is going to have a randomized
 15 controlled trial showing effectiveness for that
 16 outcome.
 17 A. Correct.
 18 Q. Is that unusual in medicine, to offer
 19 treatments that lack randomized controlled trials
 20 showing support?
 21 MS. LAND: Object to form. Vague and
 22 overbroad.
 23 A. I think there are surg- -- on the
 24 surgical side, you tend to see more procedures that
 25 aren't being performed under a randomized control

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1 scenario. On the medicine side, where you're
 2 providing medications, you tend to see more
 3 randomized controlled studies that provide or prove
 4 the effectiveness of those medications.
 5 And that maybe have to do with the FDA
 6 and their requirements for medications to reach
 7 market as opposed to the surgical procedures. I
 8 think there is a division there.
 9 Q. Okay. So on the surgical side, then,
 10 would it be fair to say that performing procedures
 11 that lack randomized controlled trials showing
 12 effectiveness for that use is -- is not unusual?
 13 A. It's not unusual. It's very difficult
 14 to do a randomized controlled procedure -- you know,
 15 trial for a surgical procedure 'cause you can't do
 16 half the face and blinded for the other half, or
 17 something like that.
 18 Now, you can do -- it's just -- it's a
 19 harder thing to do to -- to do that kind of -- you
 20 can't do a sham operation on someone. I mean,
 21 it's -- it's difficult to, you know, physically do
 22 that type of study.
 23 Q. Gotcha.
 24 Earlier we had talked a little bit about
 25 the regulations that the Board already implements or

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1 oversees involving opioids and over-prescription.
 2 A. Yeah.
 3 Q. If the Board has concerns about doctors
 4 overprescribing a medication without following
 5 appropriate protocol, can the Board address that
 6 problem through its current regulatory powers?
 7 A. Yes. They have to be -- that physician
 8 has to be identified. There has to be some form of
 9 a complaint. We don't just broadly check
 10 physicians, you know, prescribing and see if they're
 11 complying with various rules and regulations.
 12 But we -- when we receive a complaint,
 13 we do review that in terms of what are standard, you
 14 know, protocols for prescribing various medications.
 15 Q. Okay. And if there --
 16 A. But typically, typically opioids tends
 17 to be the main one; so...
 18 Q. Okay. And if it was a problem where a
 19 broad class of treatment was being overprescribed,
 20 you know, as with the opioid crisis, could the Board
 21 pursue a regulation to address that concern?
 22 A. I don't know if they could speak to a
 23 regulation, but there may be -- they may speak to
 24 discussing the prescription -- the prescribing by
 25 the physician. There isn't various regulations for

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1 every drug class, if that's what you mean.
 2 Q. But could the Board recommend
 3 regulations on a new drug class if there was a
 4 problem?
 5 A. If we were seeing a large problem where
 6 many patients were affected, then we could
 7 definitely make some recommendations to the
 8 legislature.
 9 Q. Okay.
 10 A. Sure. I mean, I try to do that; so...
 11 Q. And, similar, for the gastric bypass
 12 regulation on informed consent, if the Board had
 13 concerns about doctors failing to adequately inform
 14 patients of risks, could it enact or recommend a
 15 regulation to address those concerns?
 16 A. I think it already exists in the Medical
 17 Practices Act.
 18 Q. For gastric bypass. Could it, for
 19 another treatment that had a similar problem?
 20 MS. LAND: Object to form.
 21 A. Typically, if the Medical Board saw
 22 multiple complaints about a single procedure, they
 23 could make recommendations to the legislature and
 24 say, "Hey, we're seeing this, you know, what do you
 25 think guys think about it?"

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1 Q. Okay. And if they had individual
 2 instances of a doctor failing to -- failing to
 3 obtain informed consent, they could -- the Board
 4 could handle that through the ethics process?
 5 A. Yes.
 6 Q. As someone practicing cosmetic surgery,
 7 what tends to happen when doctors have differing
 8 views about the effectiveness of a particular
 9 cosmetic surgery procedure?
 10 MS. LAND: Objection to form and
 11 relevance.
 12 A. What happens when different doctors have
 13 different opinions?
 14 Q. Yes. Let's say like --
 15 A. A procedure, let's say? Yeah.
 16 Well, it's -- that happens all the time.
 17 I don't know if anything really happens. I don't --
 18 I don't know what you mean.
 19 I mean, let's say I want to do a
 20 procedure one way and another doctor wants to do it
 21 the other way, and we don't agree on how it should
 22 be done; is that kind of the question you're asking?
 23 Q. Yes. That's one variation on it, yeah.
 24 A. Well, nothing happens unless the way I'm
 25 doing it is -- is getting terrible results, and the

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1 other way the doctor is doing it is getting great
 2 results, then you may have an issue. But --
 3 Q. But doctors and patients make --
 4 A. -- I think --
 5 Q. -- the decision --
 6 A. I'm sorry? What did you say?
 7 Q. But the doctors and patients can make
 8 the decisions about which avenue they want to go if
 9 there's a disagreement?
 10 MS. LAND: Object to form.
 11 A. Yes. The doctor and the patient can
 12 decide on which avenue, which way to go.
 13 Q. Okay.
 14 A. Yeah. Basically.
 15 Q. Okay. To make it more concrete, let's
 16 say there's a procedure like the buttons
 17 implantation procedure we talked about --
 18 A. Sure.
 19 Q. -- where, let's say, somebody in
 20 Arkansas wanted to get the treatment that you find
 21 to be too risky, what -- what happens when doctors
 22 disagree about the propriety of a procedure like
 23 that?
 24 A. I -- for example, the patient came to me
 25 and said, "Hey, I would like to do buttocks

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1 augmentation, or a fat transfer to the buttocks."
 2 I would say, "I don't perform that
 3 procedure."
 4 And the patient goes, "Well,
 5 Dr. Branman, why don't you perform that procedure?"
 6 And I would say, "In my hands, I don't
 7 get the results that I want, and I feel that it's
 8 too risky. There are other physicians that do that,
 9 if you'd like to seek them out, but I don't perform
 10 that particular procedure."
 11 Q. Okay.
 12 A. And that would be the conversation.
 13 Q. So in your experience, when providers
 14 disagree about issues like that, has there ever been
 15 a ban on the treatment --
 16 MS. LAND: Object to form.
 17 Q. -- based on that disagreement?
 18 A. There's never been a ban, that I know
 19 of, from doctors disagreeing about a procedure.
 20 Q. Okay.
 21 A. Unless the procedure that's being done
 22 is creating many, many complications, then it
 23 becomes a different issue.
 24 Q. Are you aware of procedures like that
 25 that have been banned because of the complications?

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1 A. The only procedure that I'm aware of was
 2 large-volume liposuction. And it wasn't -- and I
 3 think in Florida, it was banned, that you could only
 4 take a certain amount of fat at a time, and then
 5 recommendations were made.
 6 So liposuction was one of those
 7 procedures where too many patients were dying
 8 because they were getting too much fat taken out at
 9 one time, and then the State of Florida put rules
 10 and regulations banning the amount of liposuction
 11 that could be performed.
 12 And then regulations were formed
 13 throughout the American Society of Plastic Surgery,
 14 and, you know, recommendations were made as to how
 15 much volume is appropriate at a time to take when
 16 performing the liposuction procedure.
 17 Q. Okay. So it sounds like even in
 18 Florida, then, they did not ban liposuction, they
 19 just regulated amounts?
 20 A. Correct. They modified; they modified
 21 what you could do during that procedure.
 22 Q. Okay. Any other examples come to mind
 23 where care was banned in your field?
 24 A. No, I don't think so. Nothing that
 25 really comes to mind right off the bat.

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1 MR. RICHARDSON: I just saw the time,
 2 Amanda. Do you want to take a minute because it's
 3 after 6:00?
 4 MS. LAND: Yeah. Any time it's -- I
 5 mean, if this is a good spot.
 6 MR. RICHARDSON: Okay. Yeah, I thought
 7 you need to get keys or something. I just want to
 8 make sure I'm --
 9 MS. LAND: Just by 6:00. Like 5:55, I
 10 can go down there too.
 11 MR. RICHARDSON: Oh, sorry. It's 6:00
 12 Eastern. I'm in the wrong time zone.
 13 THE WITNESS: No. You're -- you're an
 14 hour ahead of us.
 15 MS. LAND: We still have an hour.
 16 THE WITNESS: You only got about, you
 17 know, 50 minutes and then we're out of here.
 18 BY MR. RICHARDSON:
 19 Q. I just want to circle back briefly. We
 20 talked about breast augmentation procedures a little
 21 bit.
 22 A. Yes.
 23 Q. Have you ever had patients who regretted
 24 getting a breast augmentation procedure?
 25 A. Not many. But I've had a few.

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1 Q. Okay. So there's a few who just, you
 2 know, wish they had never gotten the procedure in
 3 the first place; this wasn't -- wasn't the outcome
 4 they wanted?
 5 A. It wasn't for them. Correct.
 6 Q. Okay. Have you ever had patients who
 7 came back to have implants removed?
 8 A. Yes, I have.
 9 Q. Okay. Is that common or --
 10 A. Not really.
 11 Q. Okay. And is the reason -- is the
 12 reason in that case that they are just dis --
 13 dissatisfied with the implant, or some other reason?
 14 A. Multiple reasons. Should I enumerate
 15 them?
 16 Q. If you don't mind.
 17 A. Sure. Like we touched on before, they
 18 just felt like it wasn't for them; some of them have
 19 them removed because they -- and then replaced with
 20 a larger implant, they felt they wanted to go
 21 bigger; others felt that, with recent studies that
 22 show that there's a possible risk of certain
 23 systemic illnesses with -- although they've never
 24 been proven, but they've read somewhere that
 25 implants can cause certain illnesses, they want them

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1 removed; some have complications with the implants,
 2 and they want them removed; others just feel that,
 3 you know, they've had them 20 or 30 years and they
 4 don't feel like having large breasts anymore, and
 5 they want them smaller.
 6 And so those are the many reasons that
 7 women typically want to have breast implants
 8 removed.
 9 Q. And do you explain the risks of the
 10 issues that might lead to someone regretting a
 11 breast augmentation at the time that it's provided?
 12 A. Do I discuss the risks of wanting them
 13 removed; is that what --
 14 Q. Well, the risk that -- the things that
 15 might lead someone who wants them removed could come
 16 to pass?
 17 A. I discuss the risks and complications of
 18 the procedure; I discuss that the implant is not a
 19 lifetime implant and may not -- and may need to be
 20 removed in the future or changed. So yes, I do
 21 discuss that.
 22 Q. In the field of cosmetic surgery,
 23 generally, is the -- is the rate of regret for
 24 breast augmentation higher than other cosmetic
 25 surgery procedures?

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1 A. No. I think it's relatively lower than
 2 most cosmetic surgery procedures.
 3 Q. Okay. So would you say that cosmetic
 4 surgery procedures, in general, like there's going
 5 to be some population that regrets the procedure?
 6 A. Sure. I think there's always some
 7 percentage. Whatever procedure you do, the patient
 8 may decide that that procedure was not for them. We
 9 try to limit that by discussing the procedure with
 10 them and what it will do for them.
 11 Q. Do you know other doctors in Arkansas
 12 who provide breast augmentation surgery?
 13 A. Yes.
 14 Q. Okay. Do you know any others who
 15 provide that surgery to minors?
 16 A. You know, I don't know what their
 17 patient population is, but I think -- I'm not sure.
 18 Probably. But I can't speak to that.
 19 Q. Okay. So it wouldn't surprise you if
 20 they -- if they did?
 21 A. Did breast augmentation on minors?
 22 Q. Yes.
 23 A. It wouldn't surprise me if someone -- if
 24 they did 18-year-olds or maybe almost-18-year-olds,
 25 sure.

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1 Q. Okay. Gotcha.
 2 MR. RICHARDSON: All right. Amanda, do
 3 you want to take five? We can...
 4 MS. LAND: Sure. We'll just take this
 5 time to go get keys if that works for you.
 6 MR. RICHARDSON: Perfect for me.
 7 MS. LAND: Okay.
 8 THE VIDEOGRAPHER: All right. We're off
 9 the record at 5:19 p.m.
 10 (Recess taken.)
 11 THE VIDEOGRAPHER: We're back on the
 12 record at 5:35 p.m. Please proceed.
 13 BY MR. RICHARDSON:
 14 Q. Thank, Dr. Branman. We're on the finish
 15 line here.
 16 A. We were just talking about a marathon;
 17 so...
 18 Q. Hopefully not that long today.
 19 But we talked a bit earlier about sort
 20 of the way that medicine and the regulation of
 21 medicine typically works in Arkansas.
 22 And I think you said that the general
 23 rule is that doctors have this broad prescriptive
 24 authority to determine treatments with their
 25 patients, and that that authority is subject to

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1 oversight by the Board.
 2 A. Yes. And probably the legislature as
 3 well.
 4 Q. And I think you said that, in general,
 5 you think that system is effective in terms of
 6 making sure that care is adequately provided and
 7 it's safe; is that correct?
 8 A. I believe it's effective.
 9 Q. Okay. So kind of, if it -- if it were
 10 up to you, would you support a law that bans doctors
 11 from providing gender-affirming medical care that an
 12 adolescent, their parent, and the doctor all agree
 13 is appropriate for the patient?
 14 MS. LAND: Object to form. Relevance,
 15 and outside the scope.
 16 A. If it were up to me personally?
 17 Q. Yes, sir.
 18 A. Would I specifically oppose -- I'm
 19 sorry. Say it one more time? Would I be for --
 20 Q. Would you support a law banning care
 21 when the doctor, the adolescent patient, and their
 22 parent all agree that the gender-affirming medical
 23 care would be effective?
 24 MS. LAND: Restate my objections.
 25 A. Would I support a ban? Would I

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1 personally agree with that? I would not agree with
 2 it. But if I was a member of the Medical Board and
 3 it was a legislative rule and reg, then there's --
 4 I -- there's nothing I can do.
 5 I mean, I have to -- I have to carry out
 6 the rules and regulations that have been handed down
 7 to me by the legislation.
 8 Q. Understood.
 9 And when you say you personally don't
 10 agree with it, do you mind just explaining why.
 11 MS. LAND: Restate my objections.
 12 A. I believe, like I said before, that a
 13 known beneficial treatment that is being provided by
 14 a physician or by -- by a physician in consultation
 15 with the patient, I think that harm -- that has no
 16 harm to it. I think it's -- I think it should be
 17 allowed.
 18 MR. RICHARDSON: Well, that is it for
 19 me, Amanda. I'm not sure if you want to do any
 20 cross. We can take a break if you'd like.
 21 MS. LAND: No. No questions.
 22 THE VIDEOGRAPHER: This will conclude
 23 the deposition, and we are off the record.
 24 Let me just state this concludes -- one
 25 moment -- the deposition of Dr. Rhys Branman. Total

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1 number of media used was three, and will be retained
 2 by Veritext.
 3 And we are off the record at 5:38 p.m.
 4 THE REPORTER: Counsel, if I can just
 5 get who is ordering a copy of the transcript, if you
 6 need a rough draft, any expedited delivery needs.
 7 MS. LAND: We would like a copy, and we
 8 would also like to review and sign as well.
 9 THE REPORTER: Regular delivery, or do
 10 you need any expedited delivery?
 11 MS. LAND: I think regular delivery.
 12 THE REPORTER: Do you need a rough draft
 13 today?
 14 MS. LAND: No rough draft.
 15 THE REPORTER: And Mr. Richardson?
 16 MR. RICHARDSON: I'll take a rough
 17 draft. I don't think we need expedite.
 18 THE REPORTER: And then as far as the
 19 exhibits that were shown to the witness today, were
 20 those marked today? Were they previously marked?
 21 Would you like for us, Veritext, take possession of
 22 them, make them part of the record?
 23 MR. RICHARDSON: I believe I previously
 24 sent the file over.
 25 (Deposition concluded at 5:39 p.m.)

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REPORTER'S CERTIFICATE

1
 2
 3 I, MAYLEEN AHMED, the undersigned, a
 Registered Merit Reporter, Certified Realtime
 4 Shorthand Reporter and Notary Public, do hereby
 certify:
 5
 6 That the witness, RHYS BRANMAN, M.D.,
 before examination was duly sworn by a Notary Public
 in the State of Arkansas.
 7
 8 That the foregoing deposition was taken
 remotely stenographically by me on June 24, 2022,
 and thereafter was transcribed by me, and that the
 9 deposition is a full, true, and complete transcript.
 10 That, in accordance with FRCP 30(e),
 before completion of the proceedings, review of the
 11 transcript was requested and signature was reserved
 by the witness.
 12
 13 I further certify that I am not a
 relative or employee of any attorney or counsel or
 any party to this action, and that I am not
 14 financially interested in the said action or the
 outcome thereof.
 15
 16 In WITNESS WHEREOF, I have hereunto set
 my hand this 30th day of June 2022.
 17
 18 
 19
 20 MAYLEEN AHMED, RMR, CRR, CRC
 Washington CCR No. 3402 - Exp 12/29/22
 Oregon CSR No: 17-0447 - Exp 12/31/23
 Texas CSR No: 9428 - Exp 7/31/22
 California CSR No: 14380 - Exp 12/31/22
 New York Notary Public
 21
 22
 23
 24
 25

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NOTARIAL CERTIFICATE

1
 2 NAME OF CASE: Brandt v Rutledge, et al.
 DATE OF DEPOSITION: June 24, 2022
 3 NAME OF WITNESS: RHYS BRANMAN, M.D.
 LOCATION: Little Rock, Arkansas
 4
 5
 6 I, MICHAEL TSCHIEMER, a Notary Public
 7 within and for the State of Arkansas, do hereby
 8 certify that the witness, RHYS BRANMAN, M.D., before
 9 examination was duly sworn by me, and that the
 10 foregoing deposition transcript is the official
 transcription of record.
 11
 12 I further certify that I am not a
 13 relative or employee of any attorney or counsel or
 14 any party to this action, and that I am not
 15 financially interested in the said action or the
 16 outcome thereof.
 17 In WITNESS WHEREOF, I have hereunto set
 18 my hand this 30th day of June, 2022.
 19
 20 
 21
 22 MICHAEL TSCHIEMER
 23 Notary Public, State of Arkansas
 24
 25

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1 AMANDA LAND, ESQ.
 2 amanda.land@arkansasag.gov
 3 July 8, 2022
 4 RE: BRANDT, et al. vs. RUTLEDGE, et al.
 5 6/24/2022, Rhys Branman (#5286217)
 6 The above-referenced transcript is available for
 7 review.
 8 Within the applicable timeframe, the witness should
 9 read the testimony to verify its accuracy. If there are
 10 any changes, the witness should note those with the
 11 reason, on the attached Errata Sheet.
 12 The witness should sign the Acknowledgment of
 13 Deponent and Errata and return to the deposing attorney.
 14 Copies should be sent to all counsel, and to Veritext at
 15 erratas-cs@veritext.com.
 16
 17 Return completed errata within 30 days from
 18 receipt of testimony.
 19 If the witness fails to do so within the time
 20 allotted, the transcript may be used as if signed.
 21
 22 Yours,
 23 Veritext Legal Solutions
 24
 25

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1 BRANDT, et al. vs. RUTLEDGE, et al.
 2 6/24/2022 - Rhys Branman (#5286217)
 3 ACKNOWLEDGEMENT OF DEPONENT
 4 I, Rhys Branman, do hereby declare that I
 5 have read the foregoing transcript, I have made any
 6 corrections, additions, or changes I deemed necessary as
 7 noted above to be appended hereto, and that the same is
 8 a true, correct and complete transcript of the testimony
 9 given by me.
 10
 11 _____
 12 Rhys Branman Date
 13 *If notary is required
 14 SUBSCRIBED AND SWORN TO BEFORE ME THIS
 15 _____ DAY OF _____, 20____.
 16
 17
 18 _____
 19 NOTARY PUBLIC
 20
 21
 22
 23
 24
 25

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1 BRANDT, et al. vs. RUTLEDGE, et al.
 2 6/24/2022 - Rhys Branman (#5286217)
 3 E R R A T A S H E E T
 4 PAGE ___ LINE ___ CHANGE _____
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 6 REASON _____
 7 PAGE ___ LINE ___ CHANGE _____
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 9 REASON _____
 10 PAGE ___ LINE ___ CHANGE _____
 11 _____
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 13 PAGE ___ LINE ___ CHANGE _____
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 16 PAGE ___ LINE ___ CHANGE _____
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 18 REASON _____
 19 PAGE ___ LINE ___ CHANGE _____
 20 _____
 21 REASON _____
 22 _____
 23 _____
 24 Rhys Branman Date
 25

Page 156

1 BRANDT, et al. vs. RUTLEDGE, et al.
 2 6/24/2022 - Rhys Branman (#5286217)
 3 ACKNOWLEDGEMENT OF DEPONENT
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 12 Rhys Branman Date
 13 *If notary is required
 14 SUBSCRIBED AND SWORN TO BEFORE ME THIS
 15 _____ DAY OF _____, 20____.
 16
 17
 18 _____
 19 NOTARY PUBLIC
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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.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

Veritext Legal Solutions complies with all federal and State regulations with respect to the provision of court reporting services, and maintains its neutrality and independence regardless of relationship or the financial outcome of any litigation. Veritext requires adherence to the foregoing professional and ethical standards from all of its subcontractors in their independent contractor agreements.

Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at www.veritext.com.