NO. 22-1721

In The

United States Court Of Appeals

For The Fourth Circuit

MAXWELL KADEL; JASON FLECK; CONNOR THONEN-FLECK; JULIA MCKEOWN; MICHAEL D. BUNTING, JR.; C.B., by his next friends and parents; SAM SILVAINE; DANA CARAWAY,

Plaintiffs – Appellees,

v.

DALE FOLWELL, in his official capacity as State Treasurer of N.C.; DEE JONES, in her official capacity as executive Administrator of the N.C. State Health Plan for Teachers and State Employees,

Defendants – Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF NORTH CAROLINA AT GREENSBORO

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

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*,

Defendants.

Case No. 1:19-cv-00272-LCB-LPA

PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF MOTION TO EXCLUDE EXPERT TESTIMONY OF DR. PATRICK W. LAPPERT

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Plaintiffs respectfully submit this memorandum of law in support of their motion to exclude the expert testimony of Dr. Patrick W. Lappert.

INTRODUCTION[1]

Dr. Lappert holds himself out as being board-certified in both plastic surgery and general surgery. He is neither: his certification in plastic surgery lapsed in 2018, and he has not been board-certified in surgery since ***2002***. Moreover, in his entire career, Dr. Lappert has never performed a single surgical procedure to treat gender dysphoria—which is not surprising, since he considers those procedures to be "intentional mutilation" and "child abuse." Dr. Lappert has no reliable basis to opine about gender-affirming surgery, and his purported expert opinions about those procedures should be excluded.

And Dr. Lappert's opinions outside of surgery are even more ripe for exclusion. Straying far afield from his surgical experience, Dr. Lappert gives a smorgasbord of opinions that he is not qualified to provide, and for which he has no basis. For example, he criticizes how organizations like the World Professional Association for Transgender Health ("WPATH") and the Endocrine Society have developed guidelines for diagnosis and treatment of gender dysphoria, despite admitting that he does not know the first thing about how those guidelines were created. He speculates about whether puberty-blocking treatment is appropriate for adolescents, even though he is not an endocrinologist and he admits "that's not [his] area of expertise." He criticizes the process by which patients are

[1] Unless otherwise noted, all emphasis is added, and all citations, alterations, and ellipsis are omitted. Exhibits referenced herein are attached to the concurrently-filed Declaration of Dmitriy Tishyevich.

diagnosed with gender dysphoria, despite admitting that he has "very limited psychiatric / psychological knowledge," is not "a licensed mental healthcare provider of any kind," and is not qualified to make this diagnosis himself. And he also offers rank speculation about patients with gender dysphoria who "detransition" or experience "regret," even though he concedes he has no reliable data to quantify these phenomena. These and other of Dr. Lappert's many non-surgery opinions are both unreliable and irrelevant, and they should all be excluded accordingly.

Dr. Lappert's deposition also made clear that he is certainly not a dispassionate expert who will offer neutral "specialized knowledge" to "help the trier of fact to understand the evidence," as Rule 702 contemplates. Far from it. In addition to calling gender-affirming surgery "intentional mutilation," Dr. Lappert says that parents who talk to their children about gender identity issues are "sexualizing them" and "grooming" them for abuse. He accuses doctors who provide gender-affirming treatment of being part of a "Transgender Treatment Industry" cabal—a term that he concedes is certainly not "commonly used" in his professional field, and is instead "idiosyncratic" to his report. He has given inflammatory presentations on gender-affirming surgery, opining that performing these surgeries is a "moral violation" for physicians and that "changing a person's sex is a lie." He tours the country, urging state legislatures to outlaw gender-affirming treatment for minors. And he also thinks that states should "criminally prosecute doctors" that provide this critically-needed treatment—even though ***every*** reputable

medical organization in the country, including his own professional society, has said that such treatment is medically necessary and appropriate.

Even if Dr. Lappert's opinions were reliable under Rule 702 (and they are not), and even if they had any minimal probative value (and they do not), that value would be far outweighed by unfair prejudice and confusion of the issues under Rule 403. For these reasons, and as explained below, all of Dr. Lappert's opinions should be excluded.

LEGAL STANDARD

Federal Rule of Evidence 702 places "a special gatekeeping obligation" on the trial court to ensure that an expert's testimony is "relevant to the task at hand" and "rests on a reliable foundation." *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 597 (1993); *Sardis v. Overhead Door Corp.*, 10 F.4th 268, 281 (4th Cir. 2021). As the Fourth Circuit recently reaffirmed, "the importance of the gatekeeping function cannot be overstated." *Sardis*, 10 F.4th at 283.

"The proponent of the testimony must establish its admissibility by a preponderance of proof." *Mod. Auto. Network, LLC v. E. All. Ins. Co.*, 416 F. Supp. 3d 529, 537 (M.D.N.C. 2019). The first step is to determine if the expert is qualified to give the proffered opinion, which requires examining the expert's professional qualifications and "full range of experience and training." *Belk, Inc. v. Meyer Corp.*, U.S., 679 F.3d 146, 162 (4th Cir. 2012). If the expert is not qualified, the testimony should be excluded. *See SMD Software, Inc. v. EMove, Inc.*, 945 F. Supp. 2d 628, 639 (E.D.N.C. 2013).

Even if the expert is qualified, the court must consider the relevancy of the expert's testimony as "a precondition to admissibility." *Sardis*, 10 F.4th at 282. To be relevant, the testimony must have "a valid scientific connection to the pertinent inquiry." *Id.* at 281. "If an opinion is not relevant to a fact at issue, *Daubert* requires that it be excluded." *Id.*

The opinion must also be based on a reliable foundation, with the inquiry focusing on the expert's "principles and methodology" to assess whether it is "based on scientific, technical, or other specialized knowledge and not on belief or speculation." *Id.* at 281-82. In evaluating reliability, courts consider, among other things, whether: (1) the theory "can be and has been tested"; (2) has been "subjected to peer review and publication"; (3) "the known or potential rate of error"; and (4) "whether the technique is generally accepted in the scientific community." *Id.* at 281.

When an expert relies upon experience and training rather than a specific methodology, the application of the *Daubert* factors is more limited. *See Freeman v. Case Corp.*, 118 F.3d 1011, 1016 n.6 (4th Cir. 1997). In those cases, courts consider: "1) how the expert's experience leads to the conclusion reached; 2) why that experience is a sufficient basis for the opinion; and 3) how that experience is reliably applied to the facts of the case." *SAS Inst., Inc. v. World Programming Ltd.*, 125 F. Supp. 3d 579, 589 (E.D.N.C. 2015).

Finally, the Fourth Circuit has cautioned that although the trial court has "broad latitude" to determine reliability, it must still engage in the gatekeeping process and not simply "delegate the issue to the jury." *Sardis*, 10 F.4th at 281. Even rigorous cross-

examination is not a substitute for the court's gatekeeping role. *See Nease v. Ford Motor Co.*, 848 F.3d 219, 231 (4th Cir. 2017).

ARGUMENT

I. Dr. Lappert Is Not Qualified to Offer Any of His Purported Opinions.

An expert witness must have "knowledge, skill, experience, training, or education" that would assist the trier of fact. *Kopf v. Skyrm*, 993 F.2d 374, 377 (4th Cir. 1993). "[Q]ualifications alone do not suffice," however. *Clark v. Takata Corp.*, 192 F.3d 750, 759 n.5 (7th Cir. 1999); *Patel ex rel. Patel v. Menard, Inc.*, 2011 WL 4738339, at *1 (S.D. Ind. Oct. 6, 2011). Even "a supremely qualified expert cannot waltz into the courtroom and render opinions unless those opinions are based upon some recognized scientific method and are reliable and relevant." *Clark*, 192 F.3d at 759 n.5.

Moreover, "an expert's qualifications must be within the same technical area as the subject matter of the expert's testimony; in other words, a person with expertise may only testify as to matters within that person's expertise." *Martinez v. Sakurai Graphic Sys. Corp.*, 2007 WL 2570362, at *2 (N.D. Ill. Aug. 30, 2007); *Lebron v. Sec. of Fla. Dept. of Children and Families*, 772 F.3d 1352, 1369 (11th Cir. 2014).

Importantly, this qualification inquiry is subject-specific, because "[g]eneralized knowledge of a particular subject will not necessarily enable an expert to testify as to a specific subset of the general field of the expert's knowledge." *Martinez*, 2007 WL 2570362, at *2. "For example, no medical doctor is automatically an expert in every medical issue merely because he or she has graduated from medical school or has achieved

certification in a medical specialty." *O'Conner v. Commonwealth Edison Co.*, 807 F. Supp. 1376, 1390 (C.D. Ill. 1992), *aff'd*, 13 F.3d 1090 (7th Cir. 1994). Dr. Lappert fails these requirements, for reasons below.

A. Dr. Lappert Has Never Performed Gender-Affirming Surgery and Is Not Qualified to Opine on Such Procedures.

Dr. Lappert's report represents that he is "Board Certified in Surgery and Plastic Surgery." (Ex. 1 at 1.) This is not true. As he admitted, his "plastic surgery board certificate expired at the end of 2018." (Ex. 2 at 23.) His "board certification in surgery" expired "in 2002"; thus, he has not "been board-certified in surgery" for "over nineteen years." (*Id.* at 31-32.)

These are not trivial fibs, because physicians are not allowed to hold themselves out as board-certified unless they actually have a ***current*** board certificate. The American Board of Plastic Surgeons unequivocally prohibits such misrepresentations, stating that "when a physician misrepresents certification status," as Dr. Lappert did here, "ABPS may notify local credentialing bodies, licensing bodies, law enforcement agencies, and others." (*Id.* at 30; Ex. 3 at 3.) And the American Board of Surgery takes a similarly dim view of such misrepresentations, as Dr. Lappert also acknowledged. (Ex. 2 at 32 (agreeing it does not "surprise [him] that the [ABS] does not allow doctors to represent that they are board-certified in surgery unless they have a current board certificate.").)

Setting aside these misrepresentations about his credentials, Dr. Lappert is also not qualified to give expert opinions about gender-affirming surgery for a more basic reason: he has never even performed a single such procedure. He admitted that he has "never

performed facial feminization surgery" or "facial masculinization surgery" for any transgender patient. (*Id.* at 167.) The same is true for "transfeminine top surgery" and "chest reconstruction surgery." (*Id.* at 167.) He has also never "performed a vaginoplasty" nor "metoidioplasty." (*Id.* at 167-68.) In short, Dr. Lappert has "***never*** performed ***any kind*** of gender-affirming surgery in transgender patients." (*Id.* at 168; *id.* at 151 ("I have never treated a patient with gender dysphoria surgically.").) He was also emphatic that he would never perform such surgeries, because he personally does not "see them as beneficial" and thinks that they are "incorrect treatments." (*Id.* at 150.)

Dr. Lappert has not published any research on gender-affirming surgery either. He agreed that he has "not published any original research in peer-reviewed literature within the ***last 23 years***" at all—and of the six total articles that he did publish a quarter-century ago, not one was on gender-affirming surgeries for patients with gender dysphoria. (*Id.* at 129; *see id.* at 130-134.)

As a substitute for first-hand experience, Dr. Lappert cites a handful of studies in his report about supposed complications from gender-affirming surgery. But reading studies does not make one an expert. That is just the sort of "generalized knowledge of a particular subject" that courts have rejected as a qualification under Rule 702. *Martinez*, 2007 WL 2570362, at *2. As with the disqualified expert in *Lebron* who "reached his opinion . . . by relying on studies," reading literature is not enough. 772 F.3d at 1369.

It is also telling that the Code of Ethics of the American Society of Plastic Surgeons ("ASPS") prohibits members from giving this kind of unfounded testimony.[2] Section IV of that Code of Ethics says that "to help limit false, deceptive and/or misleading testimony, Members serving as expert witnesses ***must***: 1. Have ***recent and substantive experience*** (as defined in the Glossary of the Code) in the area in which they testify[.]" (Ex. 4 at 6.) The Glossary, in turn, defines "recent and substantive experience" to mean (among other requirements) that the member "has performed the specific procedure in question within three (3) years of the date of being retained as an expert witness." (*Id.* at 8.)

Dr. Lappert fails these requirements. Far from having actually performed any of the gender-affirming procedures that he criticizes in his report (*see* Ex. 1 at 29-39)—***ever***, let alone within the last three years—Dr. Lappert was emphatic that he would never perform such surgeries because he does not "see them as beneficial." (Ex. 2 at 150.) To be sure, the ASPS Code of Ethics is not a substitute for the Court's Rule 702 inquiry. But the fact that the ASPS prohibits members from providing these kinds of ill-informed expert opinions precisely to "help limit false, deceptive, and/or misleading [expert] testimony" from being offered in court (Ex. 4 at 6) should give the Court serious pause, to say the least, about allowing Dr. Lappert's testimony.

[2] Dr. Lappert resigned from ASPS around the time his board certification lapsed (Ex. 2 at 100-101), but he was a member from 1997 to 2017, and he agreed that ASPS is a "reputable organization" to which "93 or so percent of all plastic surgeons" in the country belong. (*Id.* at 102-103.)

B. Dr. Lappert Has No Basis to Offer Opinions on Topics Outside of Plastic Surgery.

Dr. Lappert also offers a grab-bag of opinions on topics far outside his field of plastic surgery—including endocrinology (*e.g.*, opining whether puberty-blocking agents and cross-sex hormones like testosterone are appropriate treatments for gender dysphoria), psychiatry (*e.g.*, criticizing how patients are diagnosed with gender dysphoria), and more.

Dr. Lappert has no qualifications or any other basis to give any of these opinions, and they all should be excluded. For example, he has no basis to opine about purported risks of puberty-blocking treatments, given that he agreed that he is "not an endocrinologist" and has "no specialized training or expertise in endocrinology." (Ex. 2 at 153, 204.) He also has "never prescribed any puberty-blocking drugs of any kind"; and indeed, he admitted: "I ***do not*** consider myself an expert in that area" and "that's not my area of expertise." (*Id.* at 201, 203.)

The same is true for Dr. Lappert's opinions on cross-sex hormone treatments—given that he admits that he has "never prescribed cross-sex hormones for treatment of gender dysphoria," and that he has "no firsthand experience with advising [his] patients about potential risks and benefits" of such treatment. (*Id.* at 214.) Here, again, Dr. Lappert conceded that he does not "hold [himself] out as an expert in endocrinology," and that he does not plan to offer "any expert opinions in endocrinology in this case because that's outside [his] scope of expertise." (*Id.* at 204.) All of his purported opinions related to endocrinology should be excluded accordingly.

Dr. Lappert also has no qualifications—or any other basis—to opine about diagnosis or treatment of mental conditions. He admits that he has "very limited psychiatric/psychological knowledge"; he is "not a psychiatrist" or "a licensed mental healthcare provider of any kind"; and in his "professional day-to-day practice," he "do[es] not diagnose mental health conditions of any kind." (*Id.* at 68, 153-54.)[3] Thus, as Dr. Lappert conceded, "for any patient that presents to [him] with a mental health condition," he would "send them to someone who is . . . trained in how to diagnose mental health conditions."). (*Id.* at 157.) And after all of these admissions, he also conceded that he "do[es] not hold [himself] out as an expert in ***diagnosing*** mental health conditions outside, potentially, of body dysmorphic disorder," and that he also does "not have special[ized] training or expertise in ***treating*** mental health conditions." (*Id.* at 75.)

In short, while Dr. Lappert does not even have the relevant expertise to opine about gender-affirming surgery, he certainly does not have the expertise to "waltz into the courtroom" and mislead a factfinder with purported expert testimony about endocrinology, psychiatry, or anything else. *See Clark*, 192 F.3d at 759 n.5. So at the very least, all of his opinions outside of plastic surgery should be excluded.

[3] Dr. Lappert said he feels qualified to identify a potential diagnosis of body dysmorphia, and to then "offer referral for psychiatric/psychological support and evaluation" to those patients. (Ex. 2 at 72.) Body dysmorphic disorder is a distinct condition from gender dysphoria, however, that "is primarily characterized by an excessive preoccupation with a perceived defect or flaw in appearance that others cannot see or would judge as slight in appearance." (Ex. 17 at 1; Ex. 2 at 71 ("They see a defect that you don't see.").)

II. Dr. Lappert's Opinions on Topics Outside of Gender-Affirming Surgery Do Not "Fit" the Disputed Issues, Are Unreliable, Or Both.

An expert's testimony should only be admitted if it is reliable. And "proffered evidence that has a greater potential to mislead than to enlighten should be excluded." *In re Lipitor (Atorvastatin Calcium) Mktg., Sales Pracs. & Prod. Liab. Litig. (No II) MDL 2502*, 892 F.3d 624, 632 (4th Cir. 2018).

Even if the testimony is reliable, the court must still "satisfy itself that the proffered testimony is relevant to the issue at hand, for that is a precondition to admissibility." *Sardis*, 10 F.4th at 282. "The test for relevance, or fit, considers whether expert testimony proffered in the case is sufficiently tied to the facts of the case that it will aid the jury in resolving a factual dispute." *Viva Healthcare Packaging USA Inc. v. CTL Packaging USA Inc.*, 197 F. Supp. 3d 837, 846 (W.D.N.C. 2016).

This case turns on whether Defendants' exclusion of coverage for gender-confirming health care treatments violates Plaintiffs' rights under the equal protection clause, Title VII, and Section 1557 of the Affordable Care Act. Many of Dr. Lappert's opinions are both unreliable and irrelevant to this inquiry, as described below.

A. Far from Being Generally Accepted, Dr. Lappert's Opinions Have Been Rejected by the Scientific Community.

General acceptance is a reliability factor, *Nease*, 848 F.3d at 229, and the fact that a particular theory "has been able to attract only minimal support within the community may properly be viewed with skepticism." *Daubert*, 509 U.S. at 594. Dr. Lappert asserts that gender-affirming surgical and hormonal treatments "have not been accepted by the relevant

scientific communities" (Ex. 1 at 40), but this is not true. In fact, it is Dr. Lappert's opinions that are on the scientific fringe, to say the least.

Another court found as much just last year in addressing a challenge to Arkansas' state-law ban on gender-affirming treatment for minors, where Dr. Lappert had offered virtually identical opinions to support that ban. *Brandt v. Rutledge*, 4:21-cv-450 (E.D. Ark.); Ex. 2 at 33-34; Ex. 5 (Lappert *Brandt* Declaration). In *Brandt*, Dr. Lappert asserted that "'[g]ender affirming' treatments are experimental," which he agreed was "basically the same opinion that [he] offered in this case." (Ex. 2 at 35.) Drs. Hruz and Levine had also submitted similar declarations in *Brandt* in support of the ban. (*See id.* at 33-34.)

The *Brandt* court preliminarily enjoined the ban on August 2, 2021 (Ex. 6), squarely rejecting these opinions. That court recognized that "the consensus recommendation of medical organizations is that the ***only*** effective treatment for . . . gender dysphoria is to provide gender-affirming care," citing briefs from organizations like the American Medical Association, American Academy of Pediatrics, and many more. (*Id.* at 6 n.3; Br. of Am. Med. Ass'n, et al. (ECF No. 131 (expressing same views in this case).) *Brandt* also found that "gender-affirming treatment is supported by medical evidence that has been subject to rigorous study," and that "***every*** major expert medical association recognizes that gender-affirming care for transgender minors may be medically appropriate and necessary to improve the physical and mental health of transgender people." (Ex. 6 at 7-8.)

As Dr. Lappert admitted, *Brandt*'s findings were "contrary to the opinions that [he] offered." (Ex. 2 at 39.) And as he also agreed, "every major expert medical association

disagrees with [him] because they've all taken [the] position that this treatment is in fact medically necessary." (*Id.* at 40; *see also id.* (agreeing the same is true regarding Drs. Hruz and Levine).) In fact, Dr. Lappert admits that there are at least "18 different professional medical organizations" that "take[] the view that's contrary to the opinions that [he] and Dr. Hruz and Dr. Levine are offering" here, testifying that "there's a consensus of consensus on this, exactly." (*Id.* at 42.)

That consensus also includes Dr. Lappert's own former association, the ASPS. While he says that gender-affirming surgery is experimental, the ASPS said the exact opposite in a February 2021 statement—stating that it "***firmly believes*** that plastic surgery services can help gender dysphoria patients align their bodies with whom they know themselves to be," and promising to "continue its efforts to advocate across state legislatures for full access to medically necessary transition care." (Ex. 8 at 3.) So as Dr. Lappert admitted, the ASPS also "does not agree with [his] opinions that gender-affirming surgery is experimental." (Ex. 2 at 112-13.)

And it is not just professional medical associations either. ***Every major insurer*** in the country also says that gender-affirming surgical and hormonal treatments are medically necessary, as Dr. Lappert also admitted. (Ex. 2 at 334-38 & Ex. 9 at 2 (BCBS North Carolina policy, stating that "[s]ervices for gender affirming surgery and hormone therapy may be considered medically necessary when the criteria below are met"); Ex. 2 at 427-28 & Ex. 10 at 1 (similar for Aetna); Ex. 2 at 430-33 & Ex. 11 (similar for Cigna); Ex. 2 at 434-39 & Ex. 12 (similar for UnitedHealthCare).)

In short, this overwhelming consensus confirms that far from being generally accepted, Dr. Lappert's opinions are fringe and unreliable.

B. Dr. Lappert's Critiques of WPATH, Endocrine Society Guidelines, DSM-V, and Other Organizations' Positions Are Unreliable.

Aware that his views are contrary to those of every major medical society and professional organization, Dr. Lappert tries to dismiss every single one of them as partisan—part of the same supposed "Transgender Treatment Industry" that he crusades against. For example, he contends that the "WPATH, APA, AAP," and "AMA" all supposedly rely on a "non-scientific" methodology, and that the guidelines and position statements issued by every one of those organizations are "political" and are "not the product of a reliable scientific method." (Ex. 1 at 10-11.)

These opinions are—again—not generally accepted, to put it mildly. Just recently, the Fourth Circuit confirmed that the WPATH guidelines in particular "represent the consensus approach of the medical and mental health community" and "have been recognized by various courts, including [the Fourth Circuit], as the authoritative standards of care." *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586, 595 (4th Cir. 2020). "There are ***no*** other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups," in fact. *Id.* at 595-596.

Dr. Lappert's deposition further confirmed that his critiques are baseless *ipse dixit* because he admitted that he has no idea how any of these standards of care were actually developed, and on what scientific basis. Take WPATH SOC Version 7 ("WPATH7"), for example. Dr. Lappert admits that he has "not been involved with the development" of

WPATH7; he does not "know what kind of scientific literature [review] the WPATH conducted as part of drafting" WPATH7; he does not know what kind of "peer review" or "outside experts" or "public comments" the WPATH may have relied on in developing WPATH7, or how many "different drafts" the WPATH7 went through, or "what may have gone on during [WPATH] meetings or conferences" to discuss the development of WPATH7. (Ex. 2 at 184-87.) And after these admissions, Dr. Lappert unsurprisingly conceded that he is "***not an expert*** in how Version 7 of the WPATH was developed." (*Id.* at 188.) The same is true for WPATH SOC Version 8. (*Id.* at 189 (agreeing he does not "hold [himself] out as an expert on how Version 8" is being developed).)

The same is also true with respect to Dr. Lappert's critiques of other standards of care and position statements:

- Endocrine Society Guidelines for Treatment of Gender Dysphoria: Dr. Lappert does not know when these guidelines "were initially published" or "last revised"; he was "not involved with the[ir] development"; he does not know "what kind of scientific literature review" went into that development; thus, he agrees he is "***not an expert*** in how the Endocrine Society developed the original 2009 guidelines" or "the 2017 updates" (Ex. 2 at 195-200);

- DSM-5: Dr. Lappert has "not been involved with the development of DSM-5"; does not know "what kind of scientific literature review was done" during that development; does not know what went on during "different meetings or conferences" to "discuss that development"; thus, he "do[es] ***not*** have expert firsthand knowledge of how the DSM-5 was developed" (*id.* at 190-93);

- AMA Position Statement on Gender-Affirming Treatment: Dr. Lappert "do[es] not know how the AMA came to issue this consensus statement" and has "no personal knowledge what scientific literature they reviewed"; thus, he has "***no idea*** . . . how the AMA came to reach this consensus statement" (*id.* at 47-48);

- American Academy of Pediatrics Position Statement on Gender-Affirming Treatment: has no "personal knowledge" of how the AAP adopted this statement (*id.* at 48).

In the end, Dr. Lappert agreed more broadly that he does "not have firsthand knowledge of how ***any*** of those organizations came to reach these positions," and that he "do[es] not know what scientific literature they relied on." (*Id.* at 49-50.) He should not be allowed to mislead a factfinder with these unfounded *ipse dixit* critiques. *See Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997).

C. Dr. Lappert's Opinions About the Need for Randomized Clinical Trials Are Unreliable.

A key component of Dr. Lappert's opinions is that surgical and hormone gender-affirming treatments are supposedly experimental because they are unsupported by results from randomized clinical trials ("RCTs"). (*See, e.g.*, Ex. 1 at 5 (arguing that "properly conducted [RCTs] and long-term treatment outcome studies" are necessary to make "experimental procedures actual, proven treatments"). But his deposition confirmed that these critiques are baseless because he agreed that: (1) it is common for surgeons to perform procedures unsupported by RCT results; and (2) in any event, it is not possible to conduct RCTs for hormonal or surgical gender-affirming treatments.

First, RCTs in surgery are exceedingly rare. The ASPS's Plastics and Reconstructive Surgery Journal—which Dr. Lappert agreed is the "premier peer-reviewed source for current information on reconstructive and cosmetic surgery" (Ex. 2 at 296)—confirms as much. As a 2019 study found, in 2018, "only ***2.1 percent*** of all publications" in the ASPS Journal "were level 1 [*i.e.*, RCT] evidence"; "in 2008 and 2013, those

percentages were ***0.3*** and ***1.7 percent*** respectively," as he also agreed. (*Id.* at 299, 302; Ex. 7 (Sugrue study)). Given this paucity of RCTs, Dr. Lappert unsurprisingly conceded that surgeons in the real world do not actually wait for RCT results before deciding that a particular procedure is non-experimental. (Ex. 2 at 294-95 (agreeing it is "not uncommon for plastic surgeons to perform procedures that are not supported by results from an RCT").) In fact, he ***himself*** does not even "think it's necessary for a surgical procedure to be supported by results from a[n] . . . RCT before it can be considered effective." (*Id.* at 285.) Rule 702 demands that experts apply "the same level of intellectual rigor [in the courtroom] that characterizes the practice of an expert in the relevant field." *Cooper*, 259 F.3d at 200. Here, though, Dr. Lappert tries to impose an impossible RCT-based standard that he concedes surgeons in the real world—including himself—do not actually apply.

Second, it is not possible to perform RCTs for gender-affirming surgery or hormonal treatment. Dr. Lappert conceded this too: he agreed "it is not possible to perform RCTs for some surgical procedures because you can't blind the patient or the investigator to what the procedure is" (meaning, it is impossible to do the surgery without the patient and the investigator knowing that it was done)—including for "phalloplasty," "metoidioplasty," and more generally for all types of what is "colloquially known as bottom surgery." (Ex. 2 at 315-16.) He also agreed the same is true for "puberty-blocking hormones," since they cause "observable physical effects"; thus, "it's not possible to do an RCT for puberty-blocking hormones" either. (*Id.* at 316-18.) And he also conceded that the same is true for

cross-sex hormones, because those also cause "physical effects" and thus "it's not possible to design a double-blind RCT" for those treatments. (*Id.* at 318-19.)

Given all this, Dr. Lappert should not be permitted to offer his misleading opinion that gender-affirming surgery and hormone treatments are experimental in the absence of RCT support.

D. Dr. Lappert's Speculation About "Detransitioners," "Regret" and "Social Contagion" Is Unreliable.

Dr. Lappert also opines that some patients will "drop out of transitioning or reverse the process" (so-called "detransitioners"); others will experience "regret" after surgery; and yet others supposedly develop gender dysphoria as a result of "social contagion" like "peer group, social media, [and] YouTube role modeling." (Ex. 1 at 21-22, 40.)

None of this passes *Daubert* muster. To start, none of these opinions are even remotely connected to Dr. Lappert's experience as a plastic surgeon, given that he studiously avoids performing gender-affirming surgical procedures due to his personal beliefs, and has "never treated a single patient for gender dysphoria." (Ex. 2 at 150-51; *SAS Inst., Inc.*, 125 F. Supp. 3d at 589 (when an expert relies on experience, he must show how his "experience leads to the conclusion reached" and "why that experience is a sufficient basis for the opinion").)

Next, Dr. Lappert's own report makes clear that these are all speculative hypotheses at best. For instance, he admits that the extent of "social contagion" is unknown, writing: "a currently unknown percentage and number of patients reporting gender dysphoria are being manipulated by . . . social contagion and social pressure processes." (Ex. 1 at 40

(underlining in original).) He also wrote the same thing about "desistance" and "regret," stating that these phenomena have "to my knowledge ***not been quantified or well-studied***." (*Id.* at 21 (emphasis in original).)

Dr. Lappert's deposition confirmed that these opinions are pure guesswork. He conceded that he is "not aware of any peer-reviewed studies that quantifies the number of people" affected by social contagion, and that "we don't know the numbers." (Ex. 2 at 367-38; *id.* at 373 ("At present, we're ***hypothesizing*** about the actual cause.").) The same was true for his "regret" opinions. (*Id.* at 329 (agreeing "there's no data available on the percentage of people" treated for "gender dysphoria who experience regret.").

But "the courtroom is not the place for scientific guesswork, even of the inspired sort." *Rosen v. Ciba-Geigy Corp.*, 78 F.3d 316, 319 (7th Cir. 1996); *accord, e.g.*, *Small v. WellDyne, Inc.*, 927 F.3d 169, 176-77 (4th Cir. 2019) (expert testimony "must not be based on belief or speculation"). Dr. Lappert's speculation about regret, de-transitioning, and social contagion should be excluded accordingly.

E. Dr. Lappert's Opinions About Risks Communicated to Plaintiffs Are Unreliable.

Dr. Lappert also purports to opine about what risks were or were not communicated to individual Plaintiffs before they started gender dysphoria treatment. (*See, e.g.*, Ex. 1 at 50 (for C.B., asserting there is no evidence that "the parents were counseled concerning" risks of "off-label use of puberty blocker"); *id.* (opining there was a "failure to obtain proper informed consent" for Plaintiff "CT-F").)

There is no basis for these opinions either. Dr. Lappert "did not meet with any of the plaintiffs" and has "never spoken" with any of them about what risks their doctors discussed. (Ex. 2 at 417-18.) He was "not present in any meetings that any of these plaintiffs may have had with their mental health professionals," or their "endocrinologists," or their "surgeons"; thus, outside of reviewing medical records, he has no idea "what was said or not said during those meetings." (*Id.* at 418-19.) With no reliable basis to say what was or was not communicated during these meetings, Dr. Lappert should not be permitted to create confusion with this speculation. *See, e.g.*, *Small*, 927 F.3d at 176-77.

III. Dr. Lappert's Opinions Are Based on His Personal Beliefs Rather than Science.

Reliability is a flexible inquiry, under which "courts must ensure that an expert's opinion is based on scientific, technical, or other specialized knowledge and not on belief or speculation." *Sardis*, 10 F.4th at 281. There is ample evidence that Dr. Lappert's opinions are so tainted by his strong personal views against gender-affirming care as to make those opinions unreliable. To be clear, Plaintiffs do not seek to impugn whatever moral or religious views Dr. Lappert may hold. But because those views plainly inform the opinions that he offers here—indeed, they seem to be the main driver of those opinions—they are something the Court should consider in assessing their reliability.

Dr. Lappert readily admits that he has "strong personal opinions on whether doctors should be providing gender-affirming treatment to minors." (Ex. 2 at 79.) That's putting it mildly. He has urged state legislatures in Utah, Arkansas, Alabama, and Texas (at least) to pass laws that would ban doctors from being able to provide this medical care for

adolescents. (*Id.* at 57, 61-62; *id.* at 54-55 (agreeing he has "actively lobbied to get these kinds of bans passed").) For example, he spoke in favor of the ban before the Alabama legislature and "publish[ed] an op-ed" that urged the legislature to protect what he called "gender-confused children." (Ex. 2 at 77, 64, 76 & Ex. 14.) He likewise threw his support behind a similar proposed ban in Utah—arguing to the legislature that "you can't change a person's sex," and that "all that is happening is that the patient is undergoing an intentional mutilation in order to create a counterfeit appearance of the other sex." (Ex. 13 at 5).

Dr. Lappert was unapologetic about these opinions at his deposition. He testified that he "absolutely" stands by them, and that he "absolutely" considers "gender reassignment surgery to be an intentional mutilation." (Ex. 2 at 60.) What's more, he also wants doctors who perform these gender-affirming surgeries to be "criminally prosecute[d]"—agreeing that he thinks "that's a good idea." (*Id.* at 52.)

And even though Dr. Lappert was understandably more careful in how he phrased his expert report—avoiding inflammatory language that he uses outside of litigation, like calling gender-affirming care "intentional mutilation"—sometimes the mask slips. For instance, his report accuses every single doctor and organization who oppose his views of being part of some made-up "Transgender Treatment Industry." That is obviously not "a commonly used term in the field of treatment and diagnosis of gender dysphoria," as he admitted; instead, it is "idiosyncratic" to his report. (*Id.* at 21-22.)

Dr. Lappert has also worked closely with the Alliance Defending Freedom ("ADF"), an organization he agreed has "moral objections" to gender-affirming healthcare. (*Id.* at

83, 82.) Among other things, he attended an ADF conference that discussed the "poverty of [experts] who are willing to testify" about these anti-gender-affirming treatments. (*Id.* at 90-91.) Attendees at that conference "were asked whether they would be willing as participate as expert witnesses"; not coincidentally, Dr. Lappert became an expert witness for the first time after attending that conference. (*Id.* at 91.)

Dr. Lappert's report also unapologetically misgenders individual Plaintiffs—"referring to [them] in a way that doesn't align with their gender"—because in Dr. Lappert's view, he is "obliged to honor objective biological realities" (*id.* at 447), which is to say that he does not believe that a person's birth-assigned sex can ever be changed. (*See also id.* at 448 ("I think it's essential that we stick to the biological reality that . . . biological sex is ***immutable***.").)

And then there are Dr. Lappert's many public interviews and presentations where he crusades against gender-affirming care. These include, for example, his views that the religious conception of "the human person" "defines the 'end' of medical and surgical care." (Ex. 2 at 459.) They also include his opinions that "changing a person's sex is a lie and also a moral violation for a physician," and that gender-affirming surgery is "diabolical in every sense of the word." (*Id.* at 464 & Ex. 16 at 1, 7; Ex. 2 at 465 (agreeing that he "hold[s] those views"). And finally, these also include his inflammatory views that parents who "discuss[] gender identity issues with children" are "sexualizing them" (Ex. 2 at 462), and that these conversations are "grooming a generation" for abuse. (*Id.* at 461 & Ex. 15 (Dr. Lappert's presentation titled "Transgender Surgery & Christian Anthropology") at 23;

see also Ex. 16 at 1, 2 (another interview with Dr. Lappert titled "Plastic surgeon: sex-change operation 'utterly unacceptable' and a form of 'child abuse'"; reporting that "regarding children, Lappert said, sexualizing them at a young age with these ideas is grooming them for later abuse.").)

These are obviously not neutral, well-reasoned scientific opinions by a dispassionate expert. It is moral opprobrium masquerading as science, and it should be excluded as such.

CONCLUSION

For the foregoing reasons, the Court should exclude Dr. Lappert's opinions in full.

Dated: February 2, 2022

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief is in compliance with Local Rule 7.3(d)(1) because the body of this brief, including headings and footnotes, does not exceed 6,250 words as indicated by Microsoft Word, the program used to prepare this document.

Dated: February 2, 2022

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CERTIFICATE OF SERVICE

I hereby certify that the foregoing document was filed electronically with the Clerk of Court using the CM/ECF system, which will send notification of such filing to all registered users.

Dated: February 2, 2022

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

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	Case No. 1:19-cv-00272-LCB-LPA

DECLARATION OF DMITRIY TISHYEVICH

Pursuant to 28 U.S.C.§ 1746, I, Dmitriy Tishyevich, do hereby declare as follows:

1. I am over 18 years of age.

2. I am a partner at the law firm McDermott Will & Emery LLP, and I serve as counsel of record for the Plaintiffs in the above-captioned matter.

3. I have personal knowledge of the facts stated herein, except those stated on information and belief, and if called upon, could and would testify competently to them.

4. I submit this declaration in support of Plaintiffs' Motion to Exclude Expert Testimony of Dr. Patrick Lappert.

5. Attached as **Exhibit 1** is a true and correct copy of Dr. Lappert's May 1, 2021 expert report submitted by Defendants in this matter. (Pages 47 to 55 of this report reference confidential medical information for individual Plaintiffs, are subject to the

concurrently-filed Plaintiffs' Motion to Seal, and have been redacted from this exhibit accordingly.)

6. Attached as **Exhibit 2** is a true and correct copy of the transcript of the September 30, 2021 deposition of Dr. Lappert in this matter.

7. Attached as **Exhibit 3** is a true and correct copy of a printout of the webpage "Guidelines for Stating Certification Status," published by the American Society of Plastic Surgeons, entered as Exhibit 2 at Dr. Lappert's deposition.

8. Attached as **Exhibit 4** is a true and correct copy of the Code of Ethics of the American Society of Plastic Surgeons, updated September 25, 2017, entered as Exhibit 10 at Dr. Lappert's deposition.

9. Attached as **Exhibit 5** is a true and correct copy of the Declaration of Dr. Patrick W. Lappert, filed on July 9, 2021 in *Brandt, et al. v. Rutledge, et al.*, E.D. Ark. (Case No. 4:12-cv-450-JM), entered as Exhibit 3 at Dr. Lappert's deposition.

10. Attached as **Exhibit 6** is a true and correct copy of the August 2, 2021 Supplemental Order from *Brandt, et al. v. Rutledge, et al.*, E.D. Ark. (Case No. 4:12-cv-450-JM), entered as Exhibit 4 at Dr. Lappert's deposition.

11. Attached as **Exhibit 7** is a true and correct copy of "Levels of Evidence in Plastic and Reconstructive Surgery Research: Have We Improved Over the Past 10 Years?," by Conor M. Sugrue, FRCS, et al., published in Plastic Reconstructive Surgery—Global Open in September 2019, entered as Exhibit 17 at Dr. Lappert's deposition.

12. Attached as **Exhibit 8** is a true and correct copy of a printout of the webpage "State Focus on Gender Affirmation Intensifies," published by the American Society of Plastic Surgeons on February 25, 2021, entered as Exhibit 7 at Dr. Lappert's deposition.

13. Attached as **Exhibit 9** is a true and correct copy of the Blue Cross Blue Shield of North Carolina Corporate Medical Policy, Gender Affirmation Surgery and Hormone Therapy, updated March 2021, entered as Exhibit 23 at Dr. Lappert's deposition.

14. Attached as **Exhibit 10** is a true and correct copy of a printout of the webpage "Gender Affirming Surgery—Medical Clinical Policy Bulletins," published by Aetna, updated January 2021, entered as Exhibit 30 at Dr. Lappert's deposition.

15. Attached as **Exhibit 11** is a true and correct copy of the Cigna Medical Coverage Policy, Treatment of Gender Dysphoria, updated May 2021, entered as Exhibit 31 at Dr. Lappert's deposition.

16. Attached as **Exhibit 12** is a true and correct copy of the United HealthCare Commercial Medical Policy, Gender Dysphoria Treatment, updated April 2021, entered as Exhibit 32 at Dr. Lappert's deposition.

17. Attached as **Exhibit 13** is a true and correct copy of a document titled "Transgender 'Transition' Procedures Performed on Minors, Answers to Questions and Information for Joint Interim Committee, Submitted by [Utah House of Representatives member] Rep. Rex. P. Shipp," dated June 10, 2021, entered as Exhibit 5 at Dr. Lappert's deposition.

18. Attached as **Exhibit 14** is a true and correct copy of a printout of a webpage titled "Alabama bill that would criminalize treatment for transgender minors headed to full Alabama Senate," published on www.rocketcitynow.com, dated February 14, 2021, entered as Exhibit 6 at Dr. Lappert's deposition.

19. Attached as **Exhibit 15** is a true and correct copy of a presentation by Dr. Lappert titled "Transgender Surgery & Christian Anthropology," entered as Exhibit 33 at Dr. Lappert's deposition.

20. Attached as **Exhibit 16** is a true and correct copy of a printout of a webpage titled "Plastic surgeon: Sex-change operation 'utterly unacceptable' and a form of 'child abuse,'" published on www.lifesitenews.com, entered as Exhibit 34 at Dr. Lappert's deposition.

21. Attached as **Exhibit 17** is a true and correct copy of an abstract from C.M. Elliott & S. Wilhelm, "Body Dysmorphic Disorder," in the Encyclopedia of Mental Health (2d ed., 2016), *available at* https://doi.org/10.1016/B978-0-12-397045-9.00081-1.

I declare under penalty of perjury that the foregoing is true and correct.

Dated this 2nd of February 2022.

/s/ Dmitriy Tishyevich
Dmitriy Tishyevich

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
Case No.: 1:19-cv-272-LCB-LPA

MAXWELL KADEL, et al.,	)
	)
Plaintiffs;	)
v.	)
	)
DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, et al,	)
	)
Defendants.	)

Declaration of
Patrick W. Lappert, MD
Board Certified in Surgery and Plastic Surgery
Decatur, AL 35603

Knowledge Training and Experience :

1. **Education and Training :** I received my Bachelor of Arts in Biological Sciences at the University of California, Santa Barbara, 1979. There I was engaged in research in cell membrane physiology with Dr. Philip C. Laris, studying stoichiometry of the sodium: potassium ATPase pump. I received my M.D., Doctor of Medicine degree at the Uniformed Services University of the Health Sciences, 1983 at Bethesda, Md. I served my General Surgery Residency at the Naval Hospital Oakland/ UC Davis East Bay Consortium, 1987-1991 and served as Chief Resident, Department of Surgery, Naval Hospital Oakland, 1990-1991. I also served a Plastic Surgery Residency at the University of Tennessee- Memphis, 1992-1994. My

professional background, experience, and publications are described in more detail in my curriculum vitae. An updated copy of my CV is attached as Exhibit A to this declaration.

2. **Board Certifications in Medicine :** I have been Board Certified in Surgery (American Board of Surgery, 1992), in Plastic Surgery (American Board of Plastic Surgery, 1997; American Board of Plastic Surgery, 2008).

3. **Medical Staff Appointments : I served as the** Staff General Surgeon at the Naval Hospital Oakland, CA 1991-1992 and as Associate Professor of Surgery, UC Davis-East Bay, 1991-1992. I also served as a Plastic and Reconstructive Surgeon, Naval Medical Center, Portsmouth, VA 1994-2002 and as Chairman, Department of Plastic and Reconstructive Surgery, Naval Hospital Portsmouth, VA 1996-2002. I later served as Clinical Assistant Professor, Department of Surgery, Uniformed Services University of the Health Sciences, 1995-2002 and as Founding Director, Pediatric Cleft Palate and Craniofacial Deformities Clinic, Naval Hospital Portsmouth, VA 1996-20002 also as the Founding Director, Wound Care Center, Naval Hospital Portsmouth, VA 1995-2002. I have also served as a Staff Plastic Surgeon in Nebraska, and Alabama.

4. **U.S. Surgeon General Service:** I served as a Specialty Leader, Plastic and Reconstructive Surgery, Office of the Surgeon General-USN, 1997-2002

5. **Faculty Appointments:** I served as Teaching Faculty at Eastern Virginia Medical School, Division of Plastic Surgery, 1995-2002

6. **Military Service :** I served as an Aviation Officer Candidate, Naval Aviation Schools Command, NAS Pensacola, 1978 and was Commissioned an Ensign, MC, USNR 1979 and Commissioned as a Lieutenant, MC, USN 1983 . I served as a Designated Naval Flight

Surgeon, Naval Aerospace Medical Institute, 1985 and was Assigned Marine Fighter/ Attack Squadron-451, serving as Flight Surgeon, and serving as Radar Intercept Officer in the Marine F-4S Phantom, accumulating 235 flight hours, and trained for qualification as an Air Combat Tactics Instructor. Deployed to the Western Pacific as UDP forward deployed fighter squadron in Korea, Japan, and the Philippines. I served in the US Navy for 24 years, served in the USMC for 3 years. I retired with the rank of Captain, USN in 2002

7. **Publications - Peer Reviewed Medical Journals** : Lappert PW. Peritoneal Fluid in Human Acute Pancreatitis. Surgery. 1987 Sep;102(3):553-4 ; Toth B, Lappert P. Modified Skin Incisions for Mastectomy: The Need for Plastic Surgical Input in Preoperative Planning. J Plastic and Reconstructive Surgery. 1991; 87 (6): 1048-53 ; Lappert P. Patch Esophagoplasty. J Plastic and Reconstructive Surgery. 1993; 91 (5): 967-8 ; Smoot E C III, Bowen D G, Lappert P, Ruiz J A. Delayed development of an ectopic frontal sinus mucocele after pediatric cranial trauma. *J Craniofacial Surg.* 1995;6(4):327–331 ; Lappert PW. Scarless Fetal Skin Repair: "Unborn Patients" and "Fetal Material". J Plastic and Reconstructive Surgery. 1996 Nov;98(6):1125 ; Lappert PW, Lee JW. Treatment of an isolated outer table frontal sinus fracture using endoscopic reduction and fixation. P!astic and Reconstructive Surgery 1998;102(5):1642-5.

8. **Publications - Medical Textbooks:** Wound Management in the Military. Lappert PW, Weiss DD, Eriksson E. Plastic Surgery: Indications, Operations, and Outcomes, Vol. 1; 53-63. Mosby. St. Louis, MO 2000

9. **Operations and Clinical Experience - Consultations and Discussions :** As a physician and surgeon, I have treated many thousands of patients in 7 states and 4 foreign

nations. My practice has included Primary Care, Family Medicine, Aerospace Medicine, General Surgery, Reconstructive Surgery for combat injured, cancer reconstructive surgeries including extensive experience with microvascular surgery, Pediatric Congenital Deformity, and the care of chronic wounds. I have practiced in rural medicine, urban trauma centers, military field hospitals, university teaching hospitals, and as a solo private practitioner. In my private practice I have had occasion to treat many self-identified transgender patients for skin pathologies related to their use of high dose sex steroids, laser therapies for management of facial hair both in transitioners and detransitioners. I have performed breast reversal surgeries for detransitioning patients. My practice is rated as "LGBTQ friendly" on social media. I have consulted with families with children who are experiencing gender discordance. I have given many presentations to professional meetings of educators and counselors on the subject of transgender, and the present state of the science and treatment. I have discussed the scientific issues relevant to the case with many physicians and experts over a number of years and also discussed related issues with parents and others.

10. **Retained as an Expert Witness - Compensation - Bases for Opinions**: I have been retained as an expert witness by John G. Knepper, JD for the defense in connection with the Kadal, et al. vs. Folwell, et al litigation. I have actual knowledge of the matters stated in this declaration. I am being compensated at an hourly rate for actual time devoted, at the rate of $400 per hour including report drafting, travel, testimony, and consultation. My compensation does not depend on the outcome of this litigation. I am paid in advance for all written opinions or testimony to avoid any conflict of interest. To formulate opinions in this case I have reviewed

many scientific publications, the plaintiff's medical records, the Complaint and Answer, and all expert witness declarations.

11. **Affirmation Treatments are Currently *Experimental*** — as they have not been competently tested, not proven effective, are not generally accepted by the relevant scientific community, and have no documented error rates: Patients who experience a gender identity that is discordant with biological sex have an alarmingly high incidence of serious psychosocial morbidity including depression, anxiety, eating disorders, substance abuse, HIV infection, suicidality, and homelessness [Connolly, M. D., M. J. Zervos, C. J. Barone, C. C. Johnson, and 2nd C. L. Joseph. 2016. *"The Mental Health of Transgender Youth: Advances in Understanding.*" Journal of Adolescent Health 59:489–95. :10.1016/j.jadohealth.2016.06.012.] . While a need for effective treatment modalities is clear, ***there are currently significant deficiencies in our understanding the etiology of this condition, the risks and benefits of the current experimental (unproven, untested) medical interventions, and the long-term success of various affirmation experimental treatments in achieving the primary desired goal of reducing mental illness including reductions in suicide risk.*** ***M***ultiple recent studies and reviews including the recent national science summaries and guidelines from England-NICE, Sweden, Finland, the Cochrane Review, the British Royal College of Psychiatrists and others ***all document significant deficits in our current understanding of these complex disorders and signifigant defects in the existing science.*** As we strive to provide real, effective, and sustained treatment to patients who experience gender dysphoria within established ethical boundaries, it is essential that we properly and scientifically research the causes of gender dysphoria as well as conduct competent, properly conducted ***randomized clinical trials and long-term treatment***

outcome studies. These basic, foundational tasks — the tasks that make experimental procedures actual, proven treatments worthy of trust — have ***never been accomplished in the highly controversial field of the Transgender Treatment Industry***. Why? Suffering and vulnerable patients and their families continue to wait for this basic, foundational scientific work to be completed. Meanwhile, affirmation "treatments" must continue to be properly viewed as experimental.

The science and medical world have — in just the past few years — become increasingly aware of and deeply concerned about the glaring science and ethical defects of the Transgender Treatment Industry. For example, the very recently released 2020 Finland national science review and guidelines documented "***a lack of quality evidence*** to support the use of hormonal interventions in adolescents with gender dysphoria.". The new strict Finnish guidance prioritizes psychological therapy over treatment with hormones or surgery thus directly contradicting the non-science-based association protocols of WPATH]. The 2020 Finland national science review and guidelines also document the ongoing lack of scientific basis for the Transgender Treatment Industry stating "***Only limited research has been conducted on transgender identity and other gender identity conflicts, and comparative studies are very rare.***" In sum, the Finland National Science Review and Guidelines, like the new Sweden Review and Guidelines, and other reviews, and the collapse and recantation of the 2020 Branstrom long-term treatment outcome study claims under withering methodological criticisms, all appear contrary to the opinions of Drs Brown and Schechter and WPATH. See, e.g., https://genderreport.ca/finland-strict-guidelines-for-treating-gender-dysphoria/

Meanwhile, practitioners in this troubled field continue to offer defective research and politicized endorsements from politicized, union-like associations (WPATH, APA, ACP, etc) rather than competent, credible, valid and reliable, peer reviewed and published scientific evidence. As with the plaintiffs' experts in this case, they continue to refuse the serious defects and methodological limits of their data and experimental practices. 50 years of experimenting is enough! Its time for the Transgender Treatment Industry to come up with real, competently constructed scientific evidence that they are helping more people than they are hurting. As the recent recent national science reviews from England, Sweden, and Finland have all noted, its time to step back, slow down, and prudently investigate a range of approaches to vulnerable patients struggling with gender discordance issues.

12. **My Opinions regarding the Plaintiff's Expert Reports in this Case by Drs Schechter and Brown :**

As a physician and surgeon for decades, I have dedicated my life to helping the injured, the wounded, the sick, the vulnerable, and those in distress. As a physician and surgeon, I have a duty to carefully assess the available scientific research literature and determine what surgical procedures have been ***scientifically proven safe and effective for use on patients — and which procedures are still experimental***, potentially dangerous, and may well do more harm than good for patients. Such an assessment requires prudentialy reviewing scientific publications and being familiar with ***the ongoing methodological and scientific debates in the field***. In my opinion, the expert reports from Drs. Schechter and Brown in this case demonstrate little or no knowledge of the ongoing, raging scientific debates over the safety and effectiveness of "gender affirming" medical procedures. The reports of Drs. Schechter and Brown offer no disclosure and

demonstrate no awareness of the serious methodological defects and controversies exposing the lack of scientific foundations for the Transgender Treatment Industry (TTI). Over the past few years, scientific review after scientific review and multiple methodological exposes and national reviews in England, Sweden, Finland plus other reviews (e.g. Cochrane, Griffin, Carmichael, etc) have raised ***urgent warnings and serious questions about the quality and the integrity of the scientific foundation for this very controversial field.*** It it troubling that Drs Schechter and Brown appears to have financial and professional conflicts of interest as they appear to have admitted that much of their practices and income are derived from the experimental, unproven, potentially harmful methods and procedures of "affirmation" medical treatments. My review of the declarations of Drs Brown Schechter produced the following list of errors, omissions, and failures:

FAILURE TO DISCLOSE THE ONGOING CONTROVERSIES : Drs Schechter and Brown failed to properly disclose and discuss the international debates and controversies surrounding transgender affirmation methods and procedures. (See, the multiple journal articles, news reports, court cases, international reviews, etc cited below).

DEFECTIVE RESEARCH — Drs Schechter and Brown failed to properly disclose and discuss multiple peer-reviewed published exposes of significant methodological defects in research on transgender affirmation methods and procedures (e.g. the defective studies by Branstrom, Turban, and others discussed in detail below).

FAILURE TO DISCUSS CONTRARY STUDIES: Drs Schechter and Brown also failed to properly disclose and discuss recent scientific studies and reviews including the Cochrane Review, the Carmichael study, the Griffin review and the devastating scientific critiques of the

ill-fated and recanted Branstrom et al study including the many multiple, detailed, methodologically sophisticated letters to the editor.

TRANSGENDER, AFFIRMATION BREAST SURGERY IS EXPERIMENTAL and THUS NOT MEDICALLY NECESSARY: Drs Schechter and Brown failed to properly disclose and discuss the methodological and ethical controversies involving transgender breast surgery. The diagnostic process for such surgery is based soley on the patient's subjective report of dysphoria, but the medical necessity is based on the expectation that surgery will relieve the patient of the risk of, among other things, major depression, self-harm behaviors, and suicide. Competent , credible ressearch demonstrating such benefits does *not* yet exist. *None of the papers cited by Dr. Schechter (20, 21, 22, 23, 24, 25) address themselves to the question of medical necessity for either masculinizing surgery, or feminizing surgery.* They only address technical issues, management of complications, and subjective outcomes that employ precisely the same language that is used to assess cosmetic (not medically necessary) surgery of the breast. In summary, the medical necessity of transgender chest surgery is ***not supported by credible, competent, methodologically rigorous scientific evidence, and appears to be firmly in the category of cosmetic (not medically necessary) surgery.***

THE ENGLAND-SWEDEN-FINLAND-COCHRANE-CARMICHAEL-GRIFFIN-BRANSTROM (Retraction) — NATIONAL SCIENCE REVIEWS and/or GUIDELINES ALL APPARENTLY CONTRADICT WPATH and the other ASSOCIATION NON-SCIENCE ENDORSEMENTS BASED ON VOTING PROCESSES : Drs Schechter and Brown also failed to properly disclose and discuss the internationally reported national reviews from England (NICE), Sweden, and Finland. These new science-based guidelines recommend different

methods, approaches, foci, and treatments than the controversial, unproven WPATH model supported by Drs. Schechter and Brown in this case. Where is the concern of WPTAH and Drs. Schechter and Brown for the suffering, vulnerable patients who deserve properly tested, proven, reliable, and efficacious treatments?

EXPERIMENTAL, UNPROVEN TREATMENTS ARE NOT "MEDICALLY NECESSARY" : Drs Schechter and Brown also failed to properly disclose and discuss the opinion of the relevant scientific community that all Transgender Transition affirmation "treatments" remain — after 50 years — controversial, untested, unproven, and thus clearly still experimental — and thus *cannot be medically necessary* — given the state of current research. (See, national reviews of England, Sweden, Finland, the Cochrance Review, the Griffin review, the Carmichael study, the Branstrom (recanted) study and others as cited in detail below).

THE ASSOCIATION VOTES CITED BY DRS BROWN and SCHECHTER ARE NOT THE PRODUCT OF A RELIABLE SCIENTIFIC METHOD, NOT ACCEPTED BY THE RELEVANT SCIENTIFIC COMMUNITY, HAVE NO KNOWN ERROR RATSE. SUCH METHODS HAVE NOTABLY PRODUCED SOME HISTORIC, DISASTROUS RESULTS : — Drs Schechter and Brown also failed to disclose and properly discuss the methodological defects in the ***non-scientific, unreliable, consensus-seeking, "voting" methodology*** of "associations" (e.g. WPATH, APA, ES, AAP, etc) in contrast to reliable-valid scientific research undergoing peer reivew, publication, then public review? Where is their concern for the suffering, vulnerable patients who deserve properly tested, proven, reliable, and efficacious treatments?

Professional associations and similar organizations have a tainted history of supporting unproven, controversial notions that were later shown to be improper, unreliable, and/or unethical. For example, it has been widely reported by historians that the American Medical Association supported (by voting) eugenic proposals to "improve the quality of the human stock" by coercive sterilization of "defective and undesirable Americans" and selective breeding. During the 1890s the renowned surgeon Albert Ochsner was invited to speak about his vasectomy procedure to the meeting of the American Medical Association. He recommended vasectomies to prevent the reproduction of "criminals, chronic inebriates, imbeciles, perverts, and paupers." (See, Oshsner, AJ, Surgical treatment of habitual criminals. JAMA, 1899:32:867-868). Similar to the political-policy-voting support of associations such as WPATH and APA for the Transgender Treatment Industry methods, the AMA's policy support for eugenics was a political not a scientific process. The unproven, political, experimental "treatments" of this movement were focused on "terminating the bloodlines" of the "submerged lower ten percent of the population with 'defective germ-plasm'". (See, Black, E. War Against the Weak, New York, NY, 2003). With the political-policy-voting support of the AMA, a Model Eugenics Sterilization Law was proposed to authorize sterilization of those supported in institutions or maintained at public expense. The model law encompassed the "feebleminded, insane, criminalistic, epileptic, inebriate, diseased, blind, deaf, deformed, and dependent" — including "orphans, ne'er-do-wells, tramps, the homeless and paupers". Eighteen states passed laws based on the 1922 model legislation and ***sixty-four thousand people were forcibly sterilized.*** The lesson from the eugenics era is that associations can lend their weight and prestige to social movements believing that they are speaking from a foundation of science when

in fact they are articulating political or ideological concepts. Such pseudoscientific voting consensus processes are neither valid, reliable, nor evidence-based — whether they vote for experimental eugenics "treatments" or experimental transgender affirmation "treatments". Suffering patients deserve more than political posturing they deserved competent, scientifically validated, tested and proven, effective and safe treatments. We are all still waiting for the politicized Transgender Treatment Industry to provide competent scientific support for their controversial, experimental methods and theories.

A similar methodological critique is relevant to the understanding of WPATH, the American Academy of Pediatrics, the American Endocrine Society, the American Psychiatric Association, the American Psychological Association and similar groups as they declare supportive policies that are not based on credible, reliable-valid science. These policies often do not acknowledge the glaring scientific deficiencies of proposed guidelines Beyond such policy voting statements is the absence of controlled studies, the absence of prospective follow up studies and no discussion nor proof of the error rates of interventions. It might be useful to examine what has been called the "Transgender Treatment Industry" (TTI). The TTI generates considerable income for hospitals, clinicians, and pharmaceutical companies. Members of the TTI have a vested interest in believing that science has already justified their existence. As sterilization is the expected adult outcome of endocrine and surgical treatments of the procedures undertaken in youth prior, the TTI must have developed strong rationalizations to justify creating infertility. Will one day the medical profession look at support for transitioning youth in the same manner the eugenics movement is now regarded? (See, Hruz, PW, Mayer, LS, and McHugh, PR, "Growing Pains: Problems with Puberty Suppression in Treating Gender Dysphoria," The New

Atlantis, Number 52, Spring 2017 pp. 3 -36 ; See also, McHugh, P., Psychiatric Misadventures, The American Scholar, Vol. 62, No. 2 (Spring 1993), pp. 316-320

Why did Drs Brown and Schechter fail to report this issue? Where is their concern for the suffering, vulnerable patients who deserve properly tested, proven, reliable, and efficacious treatments?

ANECDOTAL PATIENT STORIES ARE NOT DATA: — Drs Schechter and Brown also ***failed*** to disclose and properly discuss that Anecdotal Data unverified patient reports without control groups, randomized trials, or other scientific protections for the integrity of the medical system — are NOT reliable science. Tragically, much of the Transgender Treatment Industry support seems to come from personal patient stories claiming the "transitioning treatments" helped them. ***This is unreliable Anecdotal Data*** and it is not credible, ***scientific*** information. For example, for hundreds of years physicians/barbers would use "bleeding and leeching" to remove "unhealthy blood" as a "treatment" for a range of disorders including fevers. Many people were killed by such untested, unproven procedures but the patients who survived offered wonderful marketing by naively and unscientifically claiming that "bleeding and leeching" cured them.

PATIENTS SHOULD NOT RUN THE HOSPITAL — Drs Schechter and Brown also *failed* to disclose and properly discuss that surgeons are not permitted to give patients whatever they ask for (see e.g. Body Identity Disorder patients in the grip of a delusion demanding amputations) without credible research demonstrating safety and effectiveness Much of the Transgender Treatment Industry support comes from personal patient stories (unreliable anecdotal evidence) claiming the "treatments" will help them. Such patient stories are

Anecdotal Data. Such data if well known to be highly unreliable unscientific information. For example, for hundreds of years physicians/barbers would use "bleeding and leeching" to remove "unhealthy blood" as a "treatment" for a wide range of illnesses. Many people were killed by such procedures (including reportedly George Washington) but the ones who survived often offered wonderful marketing by naively and unscientifically believing and claiming that "bleeding and leeching" cured them. If the patient died during bleeding the physician could say "if she had only come in sooner so we could take more of the bad blood out" and alternatively if the patient recovered from the fever the physician could claim a treatment success. This failure to understand or apply fundamental scientific principles used in clinical trial research doomed millions to death and injury by quackery. It appears that the Transgender Treatment Industry is following in this destructive, unscientific footsteps.

CONFIRMATION BIAS — A POTENTIALLY DEADLY ERROR: — Drs Schechter and Brown also ***failed*** to disclose and properly discuss the wide spread foundational error of Confirmation Bias in the Transgender Treatment Industry. Providers in this troubled field apply a uni-causal hypothesis for very complex psychological disturbances, in spite of the fact that gender dysphoria can appear in different ways at different stages of development, and that the demographics show exponential growth and a radical switch in demographics. Whereas gender dysphoria historically affected boys 80% of the time, now the majority of new patients are adolescent females. In the politically tainted process of the Transgender Treatment industry the dangerous error of Confirmation Bias is built in to the system and institutionalized because the process of competent diagnosis and treatment — ***seeking and testing scientifically validated alternative theories, methods, and treatments*** — is demonized as "conversion therapy" when

actually such treatments are scientifically proven methods for reducing anxiety, depression, suicidality (e.g. Cognitive Behavioral Therapy that would ***not challenge*** any of the patients' beliefs regarding gender orientation or identity). In fact, an alternative hypothesis for investigation is that the "affirmation" providers want the patient to suffer depression and anxiety ***such untreated suffering motivates vulnerable patients*** to undergo the often painful and damaging experimental "transitioning" process. Once again, Drs. Brown and Schechter's defective expert reports somehow ignored all of these key issues. Where is their concern for the suffering, vulnerable patients who deserve properly tested, proven, reliable, and efficacious treatments?

THE DSM IS A DICTIONARY, NOT RELIABLE, VALID, PROVEN, METHODOLOGICALLY COMPETENT SCIENCE: — Drs Schechter and Brown also ***failed*** to disclose and properly discuss the ***fundamentally unreliable, defective and dangerous mis-diagnostic processes*** at the heart of the Transgender Treatment Industry. Basing life changing surgeries that damage and destroy the natural functions of perfectly healthy organs on nothing more than the ***unverified self-reports (conversations) of often disturbed patients*** as part of untested, unproven, experimental "treatments" that are "supported" by a methodologically defective research base when competent reviews have called such research "low quality" evidence and noted the "lack of any randomized clinical trials" — should be properly investigated as unethical, misconduct and an abuse of a vulnerable patient population. In addition, the reliance upon the DSM category of "gender dysphoria". It is important for legal professionals to understand that the DSM was created using a consensual, political process of small committees using ***voting methodologies***. ***Voting by DSM committees is not a reliable-***

valid scientific, evidence-based process. In the DSM methodology, small groups of professionals, often with ideological agendas and potentially with financial conflicts of interest, would form committees and create diagnoses to be "voted" into the DSM. The field has increasingly come to see the DSM as controversial and unreliable and in need of significant reform or retirement as a diagnostic methodology. The serious defects and limitations of DSM methodology are now well known leading to calls for reform by the relevant scientific community. See, e.g., Lee, C., *The NIMH Withdraws Support for DSM-5: The latest development is a humiliating blow to the APA*. Psychology Today News Blog at https://www.psychologytoday.com/us/blog/side-effects/201305/the-nimh-withdraws-support-dsm-5 ["Just two weeks before DSM-5 is due to appear, the National Institute of Mental Health, the world's largest funding agency for research into mental health, has indicated that it is withdrawing support for the APA's manual. In a humiliating blow to the American Psychiatric Association, Thomas R. Insel, M.D., Director of the NIMH, made clear the agency would no longer fund research projects that rely exclusively on DSM criteria. Henceforth, the NIMH, which had thrown its weight and funding behind earlier editions of the manual, would be "re-orienting its research away from DSM categories." See, NIMH Director Thomas Insel: Transforming Diagnosis, April 29, 2013, See, https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2013/transforming-diagnosis.shtml The National Institute of Mental Health website documents the defects in DSM methodology. "Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the ***DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of***

fever. Indeed, symptom-based diagnosis, once common in other areas of medicine, ***has been largely replaced*** in the past half century as we have understood that ***symptoms alone rarely indicate the best choice of treatment. Patients with mental disorders deserve better***. NIMH has launched the Research Domain Criteria (RDoC) project to transform diagnosis by incorporating genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classification system."] In my opinion, these views are generally accepted by the relevant scientific community and sound the death knell for the diagnostic practices of the experimental Transgender Treatment Industry. In sum, the field has come to agree that the DSM was indeed based upon a less than optimal process.

DRS BROWN AND SCHECHTER DID NOT REPORT RISKS AND DANGERS TO "TRANSGENDER TREATMENTS" INCLUDING: — Drs Schechter and Brown also ***failed*** to disclose and properly discuss serious risks with their experimental "treatments":

Sterilization. Sex Reassignment Surgery (SRS) that removes testes, ovaries, or the uterus is ***inevitably sterilizing and irreversible***. While by no means all transgender adults elect SRS, many patients do ultimately feel compelled to take this serious step in their effort to "live fully as the opposite sex". More immediately, practitioners recognize that the administration of cross-sex hormones, which is often viewed as a less radical measure, and is now increasingly done to minors, creates a risk of irreversible sterility. 31 These risks have never been properly studied nor quantified in a systematic manner. As a result, even when treating a child, the MHP, patient, and parents must consider ***permanent loss of reproductive capacity (sterilization)*** *to be one of the major risks of starting down the road.* The risk that supporting social transition may put the child on a pathway that leads to intentional or unintentional permanent sterilization is

particularly concerning given ***the disproportionate representation of minority and other vulnerable groups*** among children reporting a transgender or gender-nonconforming identity. *See* C. Guss et al., *TGN Adolescent Care* at 4 ("a side effect [of cross-sex hormones] may be infertility") and 5 ("cross-sex hormones . . . may have irreversible effects"); Tishelman et al., *Serving TG Youth* at 8 (Cross-sex hormones are "irreversible interventions" with "significant ramifications for fertility").

Loss of sexual response. Puberty-blockers prevent maturation of the sexual organs and response. Some and perhaps many transgender individuals who transitioned as children and thus did not go through puberty consistent with their sex face significantly diminished sexual response as they enter adulthood, and are unable ever to experience orgasm. To my knowledge, data quantifying this impact has not been published. In the case of males, the cross-sex administration of estrogen limits penile genital function. Much has been written about the negative psychological and relational consequences of anorgasmia among non-transgender individuals that is ultimately applicable to the transgendered. (Levine, *Informed Consent,* at 6.) (Perelman and Watters, 2016) Delayed Ejaculation in Handbook of Clinical Sexuality for. Mental Health Professionals 3rd edition, New York, Routledge)

The long-term health risks of this major alteration of hormonal levels ***have not yet been quantified*** in terms of exact risk *thus appropriate, ethical, complete informed consent* ***is not yet possible*** *for such experimental "treatments".* However, a recent study found *greatly elevated levels of strokes and other acute cardiovascular events among male-to-female transgender individuals* taking estrogen. Those authors concluded, "it is critical to keep in mind that the risk for these cardiovascular events in this population must be weighed against the benefits of

hormone. *See* Tishelman et al., *Serving TG Youth* at 6-7 (Long-term effect of cross-sex hormones "is an area where ***we currently have little research to guide us***"). treatment." See, D. Getahun et al. (2018), *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, Annals of Internal Medicine at 8, DOI:10.7326/M17-2785.

Others similarly noted that administration of cross-sex hormones creates "an additional ***risk of thromboembolic events"—which is to say blood clots*** (Guss et al., *TGN Adolescent Care* at 5), ***which are associated with strokes, heart attack, and lung and liver failure.*** The young patient may feel, "I don't care if I die young, just as long I get to live as a woman." The mature adult may take a different view.

Health risks inherent in complex surgery. Complications of surgery exist for each procedure, and complications in surgery affecting the reproductive organs and urinary tract can have significant anatomical and functional complications for the patient's quality of life.

Disease and mortality generally. The MHP, the patient, and in the case of a child the parent, must also be aware of the wide sweep of strongly negative health outcomes among transgender individuals. ***Shortened life expectancy has been repeatedly documented*** in Sweden, US, and Denmark. See, Levine, Informed Consent, at 5 (citing T. van de Grift, G. Pigot et al. (2017), A Longitudinal Study of Motivations Before & Psychosexual Outcomes After Genital Gender-Confirming Surgery in Transmen, J. Sexual Medicine 14(12) 1621.).

Whatever the reason, transgender individuals including transgender youth certainly experience greatly increased rates of mental health problems. I have detailed this above with respect to adults living under a transgender identity. Indeed, Swedish researchers in a long- term study (up to 30 years since Sex Reassignment Surgery (SRS), with a median time since SRS of >

10 years) concluded that ***individuals who have SRS should have postoperative lifelong psychiatric care***. (Dhejne, Long Term, at 6-7.) With respect to youths a cohort study found that transgender youth had an elevated risk of depression (50.6% vs. 20.6%) and anxiety (26.7% vs. 10.0%); a higher risk of suicidal ideation (31.1% vs. 11.1%), suicide attempts (17.2% vs. 6.1%), and self-harm without lethal intent (16.7% vs. 4.4%) relative to the matched controls; and a significantly greater proportion of transgender youth accessed inpatient mental health care (22.8% vs. 11.1%) and outpatient mental health care (45.6% vs. 16.1%) services.

AFFIRMATION IGNORES MANY OTHER WAYS TO HELP THE SUFFERING— Drs Schechter and Brown also ***failed*** to disclose and properly discuss that the *diagnosis of "gender dysphoria" encompasses a diverse_and* ***controversial array of conditions***, with widely differing pathways and characteristics depending on age of onset, the complexities introduced by co-occurring mental illnesses, social contagion and other environmental factors, among other things. Data from one population (e.g. adults, those struggling with complex mental illnesses) should not naively be assumed to be easily applicable to others (e.g. children, those changed by social contagion) and other factors. The developmental and mental health patterns for of these groups are sufficiently different that data developed in connection with one of these populations ***cannot be assumed to be reliably applicable to another.*** See, K. Zucker (2018), The Myth of Persistence: Response to "A Critical Commentary on Follow-Up Studies & 'Desistance' Theories about Transgender & Gender Non-Conforming Children" by Temple Newhook et al., INT'L J. OF TRANSGENDERISM at 10, DOI: 10.1080/15532739.2018.1468293 ("Myth of Persistence").

NOT FDA APPROVED: — Drs Schechter and Brown also ***failed*** to disclose and properly discuss that the Food and Drug Administration has not approved the medications/ hormones used in the Transgender Treatment Industry for the treatment of gender dysphoria. The treatment research appears to document that such hormone treatments are of little if any benefit to patients and can cause severe damage to bone density and prevent normal psychological development during the key adolescent phase of life. (See, Carmichael, national science reviews of England-Sweden-Finland, and other publications cited in the Notes section of this declaration). Such off-label (not FDA approved) use of these powerful, permanently life-altering, medications is further evidence of the experimental nature of these scientifically unsupported treatments.

FAILURE TO DISCUSS THE FAILURE TO CONDUCT COMPETENT RESEARCH ON the ***UNKNOWN NUMBER AND PERCENTAGE of PATIENTS*** WHO DROP OUT OF TRANSITIONING OR REVERSE THE PROCESS (Detransitioners) : — Drs Schechter and Brown also ***failed*** to disclose and properly discuss — the phenomenon of desistance or regret experienced *later* than adolescence or young adulthood, or among older transgender individuals, has to my knowledge ***not been quantified or well-studied.*** However, it is a real phenomenon. I myself have worked with multiple individuals who have abandoned trans female identity after living in that identity for years, and who would describe their experiences as "regret". More dramatically, a surgical group prominently active in the SRS field has published a report on a series of seven male-to-female patients requesting surgery to transform their surgically constructed female genitalia back to their original male form. See Djordjevic ML, Bizic MR, Duisin D, Bouman MB, Buncamper M. Reversal Surgery in Regretful Male-to-Female

Transsexuals After Sex Reassignment Surgery. J Sex Med. 2016 Jun;13(6):1000-7. doi: 10.1016/j.jsxm.2016.02.173. Epub 2016 May 4. PMID: 27156012. An increasingly visible online community of young women who have desisted after claiming a male gender identity at some point during their teen years. Given the rapid increase in the number of girls presenting to gender clinics within the last few years, the phenomena of regret and desistance by young women deserves careful attention and study by MHPs. As reported by one author in 2021, *60,000 testimonies of personal de-transition can be found on the Internet*. See, Pablo Exposito-Campos. A typology of gender detransition and its implications for health care providers J Sex & Marital Therapy 2020 https:..doi.org/101080/0092623x.2020.1869126); See also, reportedly one Reddit subthread [See, https://www.reddit.com/r/detrans/new/] for detransitioners currently has more than 17,000 members, and a facility in Sweden, the Lundstrom Gender Clinic, provides trauma therapy for detransitioners. [See, The Trans Train and Teenage Girls (Swedish documentary with English subtitles) at https://www.youtube.com/watch?v=oDV-ZL6-Gu0]

NOT GENERALLY ACCEPTED — Drs Schechter and Brown also ***failed*** to honestly and properly disclose that the A) underlying defective science, B) unreliable diagnostic methods, C) confirmation bias riddled treatment selection procedures, and the still unproven-experimental treatments of the Transgender Treatment Industry have never been generally accepted by the relevant scientific community.

NO ERROR RATES — Drs Schechter and Brown also ***failed*** to honestly and properly disclose that the A) underlying defective science, B) unreliable diagnostic methods, C) confirmation bias riddled treatment selection procedures, and the still unproven-experimental

treatments of the Transgender Treatment Industry have no known error rates thus more patients could be injured than helped by such methods and procedures as recent studies demonstrate (See Branstrom critiques, Carmichael study, etc.)

FAILURES TO DISCLOSE INFORMED CONSENT ERRORS: In the present treatment paradigm that is supported by Dr. Schechter, and applied to self-identified transgender persons, the diagnosis is made by the patient, and affirmed by counselors, primary care providers, pediatricians, and psychological services providers. Confirmation of the diagnosis amounts to the use of questionnaires that often are identical to questionnaires found on line. The questions, and their answers use highly rehearsed language that is the same whether asked by the school nurse, or the licensed psychologist. They are based upon the affirmation model of the condition, and assumes that the condition is biologically determined, even though there is little to no scientific evidence to support this hypothesis. No alternative hypotheses of causation of the patient's condition are permitted.

By the time the patient presents to the transgender surgeon, they have been the subject of affirmation processes that include everything from social transitioning, to hormonal manipulation. The surgical services provider does not question the diagnosis, nor investigate the science upon which it is based. Essentially the surgeon is performing permanently life-altering surgical interventions to cure a psychological condition that was diagnosed by the patient, and sometimes the patient made the diagnosis before they even entered puberty. ***Since the abandonment of frontal lobotomies in 1967, there has been no other psychological condition for which surgery is performed***, and there is no other area of surgical care where the

diagnostician is the patient themselves, and the surgeon has no means of confirming or rejecting the diagnosis.

Valid surgical consent requires that the surgeon is ultimately responsible for the accuracy of the diagnosis. For example, if an endocrinologist refers a patient for thyroidectomy because they have diagnosed a malignant thyroid nodule, the operating surgeon is still obliged to ensure the validity of the diagnosis. He has to entertain alternative diagnoses. Is it a benign nodule? Can it be treated with non-surgical means at lower risk to the patient. What do the scans show? What do the hormone levels show? Having evaluated all the alternative possibilities in the differential diagnosis, the surgeon can then counsel the patient and their family on the options of care, the likelihood of cure, and proper informed consent can be obtained.

The Transgender Treatment Industry, employing the scientifically unsupported WPATH guidelines, co-authored by Dr. Schechter, essentially excuse the surgeon from any responsibility for the diagnostic process or its consequences if the diagnosis is incorrect.

The 7th edition of the WPATH guidelines only requires two letters written by psychologists, and a period of social transition. There is no action taken to verify the diagnosis on the part of the surgeon. The surgeon has no means by which to anticipate who might benefit or who might be harmed by surgery.

Transgender surgeons like Dr. Schechter have no means of evaluating the diagnostic error rate because there is no= body of reliable scientific evidence that can be used to counsel the patient about what their risk of transgender regret is. The ever growing population of de-transitioning patients suggests that the error rate may be considerable, and the future medico-legal consequences may be proportionate.

In sum, in my opinion the expert reports of Drs Brown and Schechter — are misleading, un-scientific, advocacy statements of two providers that appear deeply embedded — politically, ideologically, and financially — in the Transgender Treatment Industry. It is currently not clear whether the "treatment" efforts of that industry and providers like Drs Schechter and Brown are causing more harm than benefit to the vulnerable, suffering patients we should seek to help and support with treatments proven safe and effective by validated, competent scientific research. ***After 50 years of experimental, unproven, treatments in this area, the vulnerable, suffering patients are still waiting for scientifically validated treatments.***

13. Review of Dr. Brown's Opinions Regarding the Plaintiff's Medical Records and My Review of the Plaintiff's Medical Records:

Dr Brown's updated (2nd) report on the plaintiff's medical records continued his avoidance of the many controversies, methodological defects, ongoing debates, and incongruous findings of the Transgender Treatment Industry. Once again, he failed to mention the significant hazards involved with these experimental treatments and the published reviews documents documented the lack of benefits and harms of "transitioning" treatments. My own review of the plaintiff's medical records found a demonstration of the errors in the industry described below including :

— *lack of appropriate informed consent* including failure to disclose and discuss the "low quality" of evidence this industry is based upon and the lack of randomized trial research and the lack of long-term research indicating such experimental treatments are more helpful than harmful to most patients.

— *failure to carefully investigate the psychosocial alternative hypotheses regarding the etiology of the patient's disorder* (See, new treatment guidelines from Sweden and Finland seeking psychological evaluations over years prior to intrusive medical "treatments" leading to harm to otherwise healthy organs

— *failure to acknowledge that the "association" endorsements of these experimental treatments are based upon consensus-seeking (committee voting) and not evidence-seeking, scientific methodologies.*

and the other errors and failures to disclose as discussed above.

14. **Why I Do Not Engage in *Experimental* Treatments Lacking Reliable, Credible Scientific Support with Gender Dysphoric (Transgender) Patients — or Any Other Patients:** As multiple national science reviews and multiple peer reviewed science publications demonstrate, the relevant scientific community has never accepted the reliability, validity, safety or effectiveness of "gender affirmation" treatment procedures — including surgical procedures. Significant medical, ethical, and potential legal problems are created when health care providers employ experimental, unproven, treatment including surgical procedures. As multiple national science reviews (e.g. Sweden, Great Britain, Finland), a Cochrane Review and multiple other published reviews of this controversial research field have recently noted, current Transgender Treatment Industry procedures are only supported by "low quality" methodologically flawed, research lacking general acceptance and lacking any published error rates. (See, eg. the Branstrom, et al study with accompanying multiple exposes of the researchers' serious methodological errors and failures to report the data accurately). For example, the current assortment of "gender affirmation" surgical procedures lack credible,

reliable and valid scientific support as there are currently no published randomized trials, nor and competent long-term research studies demonstrating safety, efficacy, and scientific validity for these currently controversial, unproven, experimental treatment protocols. Due to this well-documented lack of scientific support and only low quality evidence of efficacy and safety, I will not personally engage in the delivery of experimental gender affirming medical interventions to patients of any age. I will not consider doing such invasive, potentially harmful surgical procedures — that can lead to life-long sterilization of vulnerable patients — until reliable-valid, credible scientific research supports such methods.

15. **The biological basis of sex** — Sex is not "assigned at birth" but permanently "assigned" at conception by DNA. Medical technology can be used to determine a fetus's sex ***before birth***. It is thus not scientifically correct to talk of doctors "assigning" the sex of a child at birth; almost anyone can accurately and reliably identify the sex of an infant by genital inspection with approx 99.9% accuracy. Every nucleated cell of an individual's body is chromosomally identifiably male or female—XY or XX. Claims that patients can — via hormonal and surgical treatments — obtain a "sex change" or a "gender transition" process are ***misleading and scientifically impossible***. In reality, the typical "transgender" Gender Discordant patient has normal healthy sex organs but struggles with Gender Discordant ***feelings and perceived identity — a psychiatric and not a medical problem.***

16. ARE PATIENTS and PARENTS UNETHICALLY MISINFORMED BY PROVIDERS WHO FAIL TO DISCUSS THE KNOWN RISKS AND DANGERS OF "TRANSITIONING" TREATMENTS AND THE INTERNATIONAL CONTROVERSIES IN

THIS FIELD? : Putting a patient of any age on a pathway towards life as a transgender person puts that individual at risk of a wide range of long-term or even life-long harms, including:

— sterilization (whether chemical or surgical) and associated regret and sense of loss;

— inability to experience orgasm (for trans women);

— physical health risks associated with exposure to elevated levels of cross-sex hormones;

— surgical complications and life-long after-care;

— alienation of family relationships;

— inability to form healthy romantic relationships and attract a desirable mate;

— elevated mental health risks including increased depression, suicidality, and completed suicide.

Given that Drs Schechter and Brown failed to inform this court of the defects, uncertainties and controversies surrounding the entire field of Transgender Treatments, it seems difficult to imagine that they are properly informing patients of these defects, uncertainties and controversies.

17. VIRTUALLY ALL TRANSGENDER PATIENTS ARE BORN WITH HEALTHY NORMAL SEX ORGANS AND NO KNOWN BRAIN OR GENETIC ABNORMALITIES and NO SCIENTIFICALLY VALIDATED REASON TO SURGICALLY DAMAGE THEIR HEALTHY ORGANS - Transgender surgery is currently experimental and thus not medically necessary, as it seeks goals and benefits that have not yet been scientifically tested, validated, and proven. The long-term research on transgender surgical outcomes FAILED to show benefits and

suggested injuries from these experimental procedures (See Branstrom et al. research cited and discussed in the notes section of this declaration).

Contrary to assertions and hopes that medicine and society can fulfill the aspiration of the trans individual to become "a complete man" or "a complete woman," ***this is not biologically attainable***. It is possible for some adolescents and adults to pass unnoticed as the opposite gender that they aspire to be—but with unknown levels of limitations, costs, and risks.

18. INDIVIDUAL PATIENTS and THE FIELD AS A WHOLE SHOULD CAREFULLY REVIEW AND CONSIDER THE POTENTIAL SURGICAL COMPLICATIONS and/or IATROGENIC INJURIES WITH EXPERIMENTAL TRANSGENDER SURGERY of UNKNOWN LONG-TERM SAFETY AND EFFECTIVENESS :

EXAMPLES OF SURGICAL RISKS: "Masculinizing" Female to "Male" - Complications:

"Transgender Procedures Metoidioplasty: Following hormonally induced clitoromegally, the clitoris is released so that it hangs dependently, mimicking a small phallus, the urethra is lengthened by the use of mucosal, and/ or cutaneous flaps and/or grafts so that the urinary stream emerges from the tip of the counterfeit phallus. Reported complications with varying degrees of frequency:

1. Urethral strictures producing varying degrees of urinary obstruction and retention. a. Requires re-operation to open or dilate the scar strictures, additional grafts, urinary diversion through the use of a bladder catheter through the lower abdominal skin (suprapubic catheter)

2. Urethral- cutaneous fistulae (urine leaking from holes in the neo-urethra caused by wound healing problems and obstruction as in 1. above) a. Requires re-operative procedures as in 1. a. above.

3. Recurrent lower urinary tract infections caused by 1, and 2 above.

4. Chronic cysto-cutaneous fistula (urine leaking from the bladder through the skin of the lower abdomen) caused by the need for suprapubic catheter to divert the urinary stream to protect the neo-urethra construct if chronic distal urinary obstruction results from original or subsequent re-operation.

5. **Life-long reproductive sterilization**, since metoidioplasty is often accompanied by previous or subsequent hysterectomy and oophorectomy.

Phalloplasty: The construction of a counterfeit "neo-phallus". Typically accomplished by the transplantation of a vascularized, sensate flap of skin and associated soft tissue from the non-dominant forearm (Sensate Radial Forearm Flap). Blood vessels and sensory nerves in the flap are connected to blood vessels and nerve in the area of the native genital structures. A highly technical procedure requiring microscopic assistance. ***Many published studies do NOT report complication rates***. *Overall,* ***the reported complication rate is above 50% for the most favored operation to construct counterfeit phallus*** *(1).* The most frequent complications involve stricture or leakage of urine, and occurs in approximately 40% of all patients (2, 3, 4), requiring surgical correction. Infectious complication rate of 9%, with associated complete flap loss in 2% of patients have been reported in a patient series by Leriche et al., as is cited in a comprehensive review of phalloplasty complications (5). One single center review of a 20 year experience shows that blockage of blood flow to the pseudo-phallus, requiring reoperation occurs 11% of

the time (6). This same review showed complete loss of the construct occurred in 3% of patients, and 17% of patients showed significant wound healing issues requiring re-operation and long term wound care. In a comprehensive review of the most common phalloplasty surgeries, published in Clinics of Plastic Surgery in 2018, the authors state, *"**Phalloplasty is known for its high rate of complication**"*. Their systematic review of the literature showed complete flap loss approaching 2%, partial loss of the flap in 5-7% of cases, opening of wounds (dehisence) in 11% of patients, and a high rate of blood clot formation in the patient's legs with risk of pulmonary embolization due to the long operative time, patient positioning for surgery, and the prolonged bed rest required (5). Similar complication rates have been reported in a review of 269 phalloplasties performed at a single center in Germany over a 22 year period. A review of patients whose phalloplasties included the use of prosthetic implants ***showed implant associated complication rate of 44%, including infection, extrusion, surgical replacement, and the need for surgical removal*** *(8).* There is also a high complication rate associated with the defect caused by harvesting the forearm tissue that is used in the construction of the counterfeit phallus. Kuran et al. in a 2019 article reviewing 940 radial forearm flap surgeries (730 of which were in transgender patients) showed an overall complication rate of 8%. **Infection in 16%, chronic pain in 10%,** loss of strength and sensation in the limb in 5%, contracture with loss of mobility requiring occupational therapy in 6.5%, and failure of the covering skin graft in 4.5%. (9) In addition to the cosmetic result, and the ability to urinate while standing, ***it would be expected that the transgender scientific literature would rigorously investigate the effects of these surgeries on erotic sensibility but they have not.*** *Human sexuality and gender identity discordance is at the heart of the justification for these very elaborate surgeries which carry high*

complication rates, however, ***a review of outcomes in this area shows the low quality of outcomes data, and thus the experimental nature of these operations.*** *In a 2019 literature review by Morrison et al. (10) the authors found that of 341 articles that had been published in peer reviewed journals, only 26 were found suitable for analysis.*

The authors summarize by saying, " Little data are available on genital sensibility outcomes after phalloplasty, and there are no standardized approaches for assessment of either sensibility or erogenous perception." They then conclude by confessing, " it is difficult to draw evidence-based conclusions." This is a remarkable finding given that the human genital apparatus has two basic functions, namely reproduction and erotic sensibility. We know that reproduction is irreversibly destroyed by these operations, and now we see that erotic sensibility is degraded if not destroyed as well. Having thus excluded the entirety of genital function, all that remains is a cosmetic result, which is not a scientifically quantifiable product. In summary, masculinizing female to "male" surgeries are highly complex procedures with a very high complication rate. The scientific literature in this area of medicine is largely of low quality, and evidences the experimental nature of these operations. The most scientifically rigorous long-term studies (11,) show that the stated goals of the surgeries, including decreased anxiety, decreased psychiatric hospitalization, decreased substance abuse, decreased self harm, and decreased suicide are not met. The long term cohort study from Sweden shows that persons who have completed all transition steps from female to "male", when compared with a population matched cohort, have a substance abuse rate that is 3.5 times higher, a psychiatric hospitalization rate that is 3.5 times higher, a rate of incarceration for violent crime that is 9.9 times higher, and a suicide rate that is 40 times higher than the control group. When the authors graphed these

findings over time, they show that any improvement in these markers begins to disappear within 6 to 8 years following completion of surgery. This largely explains the suggestion of improvement seen in the low quality data that is tainted by short follow-up, and self-selection bias. The best population based, cohort matched, longitudinal studies appear to show that all that is achieved by these surgeries is a cosmetic result, and reproductive sterilization.

COMPLICATIONS:

1. Complete loss of the microvascular flap. Typically caused by technical failure of the venous connection, may also result from clot formation in the blood vessels, or pressure of swelling that compresses the blood supply. a. Requires major re-operation to remove the dead flap, and placement or retention of urinary diversion with the use of a suprapubic bladder catheter.

2. Partial loss of the microvascular flap. Caused by transient or persistent insufficiency of blood flow, with similar etiologies as in 1 above. a. Requires re-operation to debride (remove) dead tissue, and chronic wound care involving daily dressing changes, wound care visits. b. Requires placement or retention of urinary diversion with suprapubic catheter to prevent urinary contamination of the chronic wound.

3. Urethro-cutaneous fistulae (urine leakage from the counterfeit phallus). Caused by wound healing problems within the construct that may result from inadequate blood flow, pressure, or distal urinary obstruction. a. Requires placement or long term retention of the suprapubic catheter, and surgical procedures to repair the wound openings.

4. Urethral strictures with associated urinary obstruction of varying degrees. a. Repeated urethral dilation and/ or catheterization, or re-operation to relieve chronic strictures, and will likely require urinary diversion as above.

5. Lower Urinary Tract Infections: resulting from any or the above complications of surgery. 6. Extrusion of erectile and or testicular prostheses. Cause by presence of bacteria on the implanted devices. Bacteria may have been introduced at time of surgical placement, or may result from above complications of partial flap loss or lower urinary tract infections that result from above complications.

7. Partial or complete loss of erotic sensibility. Native clitoris is typically placed at the base of the counterfeit phallus as part of the construct. Some degree of incidental surgical injury to sensory nerves is expected. Sensation from the shaft of the counterfeit phallus, provided by the surgical connection of the forearm nerve to the groin nerves, is considered successful if it provides any tactile sensation. It is not expected to produces the erotic provocation that the sensory apparatus of the native vagina produces.

8. Upper extremity complications. Common problems with the donor site can include: partial or complete loss of the skin grafts used to cover the exposed muscles and tendons that results from harvesting the forearm flap. Uncommon, but nonetheless possible, ischemic hand injury (inadequate blood flow to hand). a. Chronic wound care to achieve healing, and to protect exposed tendons. b. Scarring and tendon injuries from exposure may result in loss of range of motion. This is typically temporary, but may become permanent, depending on the age of the patient, and will require occupational therapy (OT). c. Chronic pain from harvest of the flap, or complications of healing as above.

9. Lifelong Reproductive Sterilization. These surgeries are typically preceded by or followed by hysterectomy and oophorectomy. An essential human function is being destroyed in order to produce a cosmetic result.'

Vaginoplasty - Complications :

Feminizing surgeries, performed on male persons, include the creation of external and internal structures that mimic the appearance and function of female genitalia. The most commonly performed surgery, called "inversion vaginoplasty" uses tissues from the patient's native genital structures to create neo-vaginal labia majora and minora, and a skin sleeve that is inverted into the pelvis to create a receptive passage capable of receptive copulation. In the process of this operation, the patient is castrated, the penis is opened, the erectile tissues removed, a portion of the glans is preserved while trying to preserve the erotic innervation so that it can be used to create a neo-clitoris, the skin of the penis is surgically closed and inverted into the pelvis, while preserving its native blood supply. The scrotal skin is used to construct the labia, and the urethra is shortened to an opening at the base of the neo-clitoris. Other vaginoplasty operations may involve the use of vascularized flaps from the thighs or abdomen to create the receptive neo-vaginal structure. Portions of the lower intestinal tract may be used to create the receptive sleeve of the neo-vagina. These operations are often used when prior surgeries have failed for a variety of reasons that will be presented below, or they may be a first choice if the patient has a poverty of genital tissue. Such poverty is a common result of prior use of puberty blockade and cross-sex hormones if the patient has been the subject of treatments that began in early adolescence.

As documented in the NOTES section of this declaration, The scientific literature offered in support of the efficacy, safety, and cost-effectiveness of these procedures is of low quality, and comprised almost entirely of case-series reports that lack controls, are of short duration, suffer from various biases including self-selection and confirmation bias. These problems are attested to by citations offered by Dr. Schechter in his expert testimony for the plaintiff. Dr. Schechter, in support of the efficacy of vaginoplasty surgery, cites a 2014 paper (20) which is typical. It reports outcomes on a consecutive case series of 254 male to "female" surgical patients. The data presented in support of the efficacy of surgery was in the form of a ***questionnaire*** that asked questions about satisfaction with the result (subjective data). The average follow up interval was 5 years, with the longest follow up in a single patient at 7 years (short follow-up), and ***only 46% of patients completed the questionnaire*** (self-selection bias). In another of Dr. Schechter's cited articles, the authors present a prospective study **of only 39 patients (a very small sample)**, who are given ***questionnaires*** about their quality of life (subjective data), and the final evaluation of outcomes is ***only 6 months post operation*** (very short follow up given that research shows deep regret often begins on average ***10 years after surgery***. Based upon such ***low quality data***, the authors conclude by claiming that their study result, "endorses sex reassignment surgery as a valuable option for these patients."

In his expert testimony, Dr. Schechter, having defined gender dysphoria, then goes on to justify surgical treatment based upon "medical necessity". He states, "Gender dysphoria can lead to debilitating anxiety and depression, as well as serious incidents of self-harm, including self-mutilation, suicide attempts, and suicide. Yet with only a single exception, ***no measure was made of the effects of surgery*** on what is claimed to constitute the "medical necessity" for these

procedures. The long term research — the Branstrom study cited in detail in the Notes Section of this declaration showed NO benefits for transgender surgery and NO reduction in succeed and an ***increase*** in serious suicide attempts requiring hospitalization in patients ***receiving*** the surgery. ***These recent, long-term, published, peer reviewed, credible research findings are quite contrary to the claims of Dr Schechter and Dr Brown — as are the National Science Reviews in this area from England-NICE, Sweden, and Finland (see Notes section in this declaration).***

Scientific rigor would demand an examination of such outcomes as: rates of substance abuse, psychiatric hospitalization, self-harm, or suicide, and how they were changed by surgery. The only paper in Dr. Schechter's list of citations that asks these crucial questions concerning efficacy is a very comprehensive, long term, longitudinal population cohort study (11) ***which actually shows the opposite*** of what Dr. Schechter claims for these patient outcomes. When followed beyond 8 years post operatively, this paper shows patients receiving Dr Schechter's treatments have ***the same alarmingly high rates of hospitalization, substance abuse, self-harm, and completed suicide as persons who have had no medical or surgical intervention***. The fact that the citation is included by Dr. Schechter, but never discussed in his opinion regarding efficacy is troubling. In summary, on the issue of the safety and efficacy of these surgeries, the scientific support is very weak, ***while the scientific evidence rejecting the hypothesis of efficacy is quite strong.***

BREAST SURGERY - COMPLICATIONS:

Mastectomy/ Chest Masculinization, Breast Augmentation/ Chest Feminization

The surgical removal of the breasts, and the re-contouring of the chest through liposuction is a common procedure for women who seek to present as men. These operations are

performed in both men and women, for a variety of reasons, are very safe, and typically performed in the outpatient setting. It is important to understand that the only way of distinguishing cosmetic breast surgery from "medically indicated" surgery is based upon the diagnosis of underlying pathology. For example, breast reduction may be cosmetic, or it may be medically indicated. In both cases, the patient presents with a complaint that her breast are too big. The distinction between cosmetic breast reduction, and medically indicated breast reduction, is based upon the presenting symptoms of orthopedic problems caused by the weight of the breasts, but even then, the weight of the removed tissue is factored into the objective verification that the surgery was "medically necessary".

The same issues are at stake in breast enhancement for men seeking to present as women. Cross-sex hormones will have caused varying degrees of gynecomastia (breast enlargement in men). Surgical enhancement procedures are exactly the same in both men and women. Medically necessary surgery in women is based upon the diagnosis of an objective medical condition, such as Poland's syndrome (congenital absence of a breast), surgical absence of the breast following cancer care. In men, the objective diagnosis of gynecomastia might warrant surgery based upon medical necessity, but it would be a removal of tissue. A rare diagnosis of breast cancer in a man might warrant chest wall reconstruction after cancer care. On the other hand, cosmetic surgery of the breast is entirely about the subjective feelings of the patient, and that is all that we have in the case of the self-identified transgender patient.

In the case of transgender chest surgery, the diagnosis is based on the patient's subjective report of dysphoria, but the medical necessity is based on the expectation that surgery will relieve the patient of the risk of, among other things, major depression, self-harm behaviors, and

suicide. None of the papers cited by Dr. Schechter (20, 21, 22, 23, 24, 25)address themselves to the question of medical necessity for either masculinizing surgery, or feminizing surgery. They only address technical issues, management of complications, and subjective outcomes that employ precisely the same language that is used to assess cosmetic surgery of the breast. In summary, the medical necessity of transgender chest surgery is not supported by scientific evidence, and appears to be firmly in the category of cosmetic surgery.

19. **SUMMARY OF OPINIONS:**

— There are no currently no competently conducted, long-term, peer-reviewed published, reliable and valid, research studies documenting the number or percentage of patients receiving gender affirming medical interventions who are helped by such procedures.

— There are no long-term, peer-reviewed published, reliable and valid, research studies documenting the number or percentage of patients receiving gender affirming medical interventions who are injured or harmed by such procedures.

— There are no long-term, peer-reviewed published, reliable and valid, research studies documenting the reliability and validity of assessing gender identity by relying solely upon the expressed desires of a patient.

— There are no long-term, peer-reviewed published, reliable and valid, research studies documenting any valid and reliable biological, medical, surgical, radiological, psychological, or other objective assessment of gender identity or gender dysphoria.

— A currently unknown percentage and number of patients reporting gender dysphoria suffer from mental illness(es) that complicate and may distort their judgments and perceptions of gender identity.

— A currently unknown percentage and number of patients reporting gender dysphoria are being manipulated by a — peer group, social media, YouTube role modeling, and/or parental — social contagion and social pressure processes.

— Patients suffering from gender dysphoria or related issues have a right to be protected from experimental, potentially harmful treatments lacking reliable and valid, peer reviewed, published, long-term scientific evidence of safety and effectiveness.

— It would be a serious violation of licensing rules, ethical rules, and professional standards of care for a health care professional to provide gender transition or related procedures to any patient without first properly obtaining informed consent including informing the patient and/or guardian(s) of the lack of valid and reliable on the long-term risks and benefits of "affirmation" treatments.

— A large percentage of children (over 80% in some studies) who questioned their gender identity will, if left alone, develop an acceptance of their natal (biological) sex.

— Medical treatments may differ significantly by sex according to chromosomal assessment but not gender identity. Misinforming physicians of a patient's biological sex can have deleterious effects on treatment for medical conditions.

— NOT GENERALLY ACCEPTED: Affirmation medical treatments — hormones and surgery — for gender dysphoria and "transitioning" have not been accepted by the relevant scientific communities (biology, genetics, neonatolgy, medicine, psychology, etc).

— NO KNOWN NOR PUBLISHED ERROR RATES: Gender transition "Affirmation" medical assessments and treatments — hormones and surgery — for gender dysphoria and

"transitioning" have no known, peer reviewed and published error rates — the treatments and assessment methods lack demonstrated, reliable and valid error rates.

— ASSOCIATION GUIDELINES AND ENDORSEMENTS ARE NOT SCIENCE : Political activists, political activist physicians, and politically active medical organizations that operate by voting methodologies (e.g, WPATH, the American Medical Association, the American Academy of Pediatrics, the American Endocrine Society) are not the relevant scientific community, they are politically active professional organizations. These organizations operate via consensus-seeking methodology (voting) and political ideologies (e.g., Critical Theory) rather than evidence-based scientific methodologies.

— ETHICAL RESTRICTIONS ON EXPERTS - WILL THERE BE A PROPER INVESTIGATION OF MISINFORMATION? : Experts in legal cases have an ethical obligation to honestly, fairly, and accurately disclose and discuss the international controversies regarding the safety, effectiveness, reliability, and credibility of the Gender Transition Industry. It is astonishing that in their expert declarations, Drs Schechter and Brown ***failed*** to disclose and discuss the controversies, complex issues, debates, and contrary national science review recommendations in this field. Dr Brown even swore in his declaration that… "***Nor is there any uncertainty or dispute in the medical field regarding the medical necessity of this care.***" It is difficult to imagine a more inaccurate summary of the state of the embattled, experimental Transgender Treatment Industry. Will such mis-information be properly investigated by the relevant authorities?

20. DR LAPPERT's RESEARCH NOTES: To assist in my testimony in this case. I include my notes, references and citations documenting the depth and breadth of the serious

controversies in this field. Over the past few years, the glaring defects in the research foundations of the Transgender Treatment Industry have been exposed for all the world to see.

> **Controversy** - 2015 Dutch Study by *Vrouenraets et al, Early Medical Treatment of Children and Adolescents With Gender Dysphoria: An Empirical Ethical Study,* Journal of Adolescent Health 57 (2015) 367e373. *...no consensus exists whether to use these early medical interventions*.....Results: Seven themes give rise to different, and even *opposing, views on treatment*: (1) *the lack of an explanatory model for GD*; (2) *the unknown nature of GD (normal variation?, social construct?, or mental illness?)*; (3) the role of physiological puberty in developing gender identity; (4) *the role of comorbidity [with severe mental illnesses]* ; (5) unknown possible *physical or psychological effects of (refraining from) early medical interventions*; (6) *child competence and decision making authority [to give truly informed consent to be sterilized for experimental procedures?]*; and (7) *the role of social context ...how GD is perceived.* Strikingly, the guidelines are debated both for being too liberal and for being too limiting. Conclusions: As long as *debate* remains on these seven themes and *only limited long-term data are available, there will be* ***no consensus on treatment***. Therefore, more systematic interdisciplinary and (worldwide) multi-center research is required. It is striking that Drs. Brown and Schechter somehow both failed to properly report this ongoing international debate within their claimed filed of expertise.

> **2011 - Dhejne** et al. (**2011**), Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden, PLOS ONE 6(2) e16885 ("Long Term"); See also, R. K. Simonsen et al. (2016), Long-Term Follow-Up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity & Mortality, Nordic J. of Psychiatry 70(4). Swedish follow-up study of patients who underwent sex-reassignment surgery over a 30-year periodfound a ***suicide rate in the post-Sex Reassignment Surgery (SRS) population 19.1 times greater*** — after affirmation treatment — than that of the controls; both studies demonstrated elevated mortality rates from medical and psychiatric conditions.

> **2021-2020 Carmichael** P, Butler G, Masic U, et al. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. medRxiv 2020.12.01.20241653 ... Self-harm did NOT improve and "no changes in psychological function," meaning no improvement. (Also, "YSR [Youth Self Report] data at 36 months (n = 6) were not analyzed."... no significant effect on their psychological function, thoughts of self-harm, or body image, a study has found... children experienced reduced growth in height and bone strength by the time they finished their treatment at age 16. The findings, from a study of 44 children treated by the Gender Identity Development Service (GIDS) run by the Tavistock and Portman NHS Foundation Trust in London, have emerged as the trust prepares to appeal against a High Court ruling that led NHS England to pause referrals of under 16s for puberty blockers.

> **See, 2020 Bränström and Panchankis long term surgical results NO benefit (data**

suggests and suggests an increased risk of serious suicide attempts) ...See also See, Kalin, N.H., Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals After Gender-Affirming Surgeries: A Comment by the Editor on the Process by the Editor-in-Chief The American Journal of Psychiatry, Am J Psychiatry 2020; 177:7 64; doi: 10.1176/appi.ajp.2020.20060803; See also, Anckarsäter, H., (MD, Ph.D.) and Gillberg, C., (M.D., Ph.D.) Methodological Shortcomings Undercut Statement in Support of Gender-Affirming Surgery, Am J Psychiatry 2020; 177:764–765; doi: 10.1176/appi.ajp.2020.19111117 .

DEMOGRAPHICS... no biological explanation... The radical change in patient demographics from early onset in boys to teen girls with rapid onset— has been termed late-, adolescent-, or rapid-onset gender dysphoria — has now been seen in every gender clinic in the western world, and there has been a huge surge in the number of cases. "National College Health Assessment: ACHA-NCHA s://www.acha.org/NCHA/ACHA-NCHA_Data/Publications_and_Reports/NCHA/Data/Publications_and_Reports.aspx?hkey=d5fb767c-d15d-4efc-8c41-3546d92032c5 See, Kaltiala-Heino, Riittakerttu, Hannah Bergman, Marja Työläjärvi, and Louise Frisen. "Gender Dysphoria in Adolescence: Current Perspectives." Adolescent Health, Medicine and Therapeutics Volume9 (March 2018): 31–41. https://doi.org/10.2147/AHMT.S135432 See, Vries, Annelou L.C. de. "Challenges in Timing Puberty Suppression for Gender-Nonconforming Adolescents." Pediatrics 146, no. 4 (October 2020): e2020010611. https://doi.org/10.1542/peds.2020-010611. See, Zucker, Kenneth J. "Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues." Archives of Sexual Behavior 48, no. 7 (October 2019): 1983–92. https://doi.org/10.1007/s10508-019-01518-8.
and reportedly Australia.

2020 See National Review for Great Britain (NICE), Deborah Cohen and Hannah Barnes, Evidence for puberty blockers use very low, says NICE at https://www.bbc.com/news/health-56601386 ["The evidence for using puberty blocking drugs to treat young people struggling with their gender identity is "very low", an official review has found. The National Institute of Health and Care Excellence (NICE) said existing studies of the drugs were small and "subject to bias and confounding".;

See, Asscheman H, Giltay EJ, Megens JA, et al. A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *Eur J Endocrinol.* 2011;164:635-642. *"There is no evidence that transition reduces suicide when we look past 10 years, and there is some suggestion that suicide rates may actually increase after the transition honeymoon phase is over,"* says Malone, stressing the importance of providing proper evaluation and appropriate psychological treatment for any suicidal tendencies. (Supports the Branson conclusions after recantation and correction).

Sweden = Review of Gender dysphoria in children and adolescents: an inventory of the literature, SBU Policy Support no 307, 2019 www.sbu.se/en • registrator@sbu.se Contact SBU: Jan Adolfsson, Medical Advisor, Project Manager, jan.adolfsson@sbu.se,

English Proofreading: Project group and Jan Adolfsson, SBU [" No relevant randomized controlled (treatment outcome) trials in children and adolescents were found."] ; See, also e.g., FINLAND Issues Strict Guidelines for Treating Gender Dysphoria at https://genderreport.ca/finland-strict-guidelines-for-treating-gender-dysphoria/. In 2020, Finland reportedly became the first country in the world to issue new guidelines for this group of patients when it concluded similarly to the UK High Court that there is a lack of quality evidence to support the use of hormonal interventions in adolescents with gender dysphoria.... they also issued the guideline ordering "No surgical interventions are allowed for children under the age of 18".). As the ***methodological quality of the studies was already poor*** based on the type of study, thus no actual quality assessment or determination of the degree of evidence was performed."] ;

See, Cochrane Review (See, Haupt, C., Henke, M. et. al., Cochrane Database of Systematic Reviews Review - Intervention, Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women, 28 November 2020.)

See, Griffin, L., Clyde, K., Byng, R., Bewley, S., Sex, gender and gender identity: a re-evaluation of the evidence. BJPsych Bulletin (2020) doi:10.1192/bjb.2020.73, Cambridge University Press, 21 July 2020, the authors noted ***the hazardous error of mandating "affirmation treatments"*** — thus requiring the negligent practice of Confirmation Bias — rather than properly and carefully exploring alternative hypotheses — the standard, required ethical, medical standard of practice. ... As Griffin discussed, "Attempts to properly explore, formulate and treat coexisting mental illness in gender dysphoric populations, including that relating to childhood trauma, might be considered tantamount to 'conversion therapy'. Although mental illness is overrepresented in the trans population it is important to note that gender non-conformity itself is not a mental illness or disorder. ***As there is evidence that many psychiatric disorders persist despite positive affirmation and medical transition, it is puzzling why transition would come to be seen as a key goal rather than other outcomes, such as improved quality of life and reduced morbidity***. When the phenomena related to identity disorders and the evidence base are uncertain, it might be wiser for the profession to admit the uncertainties. Taking a supportive, exploratory (psychotherapy) approach with gender-questioning patients should not be considered conversion therapy."... In addition, Griffin et al wrote: "Transgender support groups have emphasized the risk of suicide. After controlling for coexisting mental health problems, studies show an increased risk of suicidal behaviour and self-harm in the transgender population, although ***underlying causality has not been convincingly demonstrated.***

See, Dyer, C., Puberty blockers do not alleviate negative thoughts in children with gender dysphoria, finds study BMJ 2021; 372 doi: https://doi.org/10.1136/bmj.n356 (Published 08 February 2021) Cite this as: BMJ 2021;372:n356 [Puberty blockers used to treat children aged 12 to 15 who have severe and persistent gender dysphoria had no significant effect on their psychological function, thoughts of self-harm, or body image, a study has found. However, as expected, the children experienced reduced growth in height and bone strength by the time they finished their treatment at age 16]

See, e.g., Wold, A. (M.D., Ph.D.) Gender-Corrective Surgery Promoting Mental Health in Persons With Gender Dysphoria Not Supported by Data Presented in Article, Am J Psychiatry 2020; 177:768; doi: 10.1176/appi.ajp.2020.19111170. [among the individuals examined in the Branstrom study, the risk of being hospitalized for a suicide attempt was 2.4 times HIGHER if they had undergone gender-corrective surgery than if they had not…. the data presented in the Branstrom article do not support the conclusion that surgery is beneficial to mental health in individuals with gender dysphoria."]
"Therefore, … the data in the article … ***OVERTURNS the authors' stated conclusions, suggesting that sex reassignment surgery is in fact associated with INCREASED mental health treatment*** See, Ring, A. (PhD) and Malone, W. , Confounding Effects on Mental Health Observations After Sex Reassignment Surgery, Am J Psychiatry 2020; 177:768–769; doi: 10.1176/appi.ajp.2020.19111169.

See, See, Van Mol, A., , Laidlaw, M. K., Grossman, M., McHugh, P. , Gender-Affirmation Surgery Conclusion Lacks Evidence, Am J Psychiatry 177:8, August 2020 ajp.psychiatryonline.org 765. "The study confirms the strong association between psychiatric morbidity and the experience of incongruity between gender identity and biological sex. However, the study does NOT demonstrate that either hormonal treatment or surgery has ANY effect on this morbidity. It seems that the main message of this article is that the incidence of mental health problems and suicide attempts is especially HIGH in the year AFTER the completion of gender-affirming surgery [It is telling that the authors some how ignored this most essential finding] …" See, Curtis, D. (M.D., Ph.D.), Study of Transgender Patients: Conclusions Are Not Supported by Findings, Am J Psychiatry 2020; 177:766; doi: 10.1176/appi.ajp.2020.19111131.

See, Malone, W. and Roman, S. , Calling Into Question Whether Gender-Affirming Surgery Relieves Psychological Distress, Am J Psychiatry 2020; 177:766–767; doi: 10.1176/appi.ajp.2020.19111149. "Bränström and Pachankis study on mental health treatment and suicide attempts … is misleading because the study design is flawed." "The authors first found what was already known … the rate of psychiatric morbidity is much higher in persons with gender dysphoria compared with the general population (both before AND after "transitioning"). The authors then explored if the risk for mental health treatment changes as a function of years since starting HORMONAL treatment. They find NO effect (odds ratio = 1.0), but they do find a trend toward INCREASED risk of suicide attempts as a function of years since starting [gender affirmation] HORMONAL treatment. They somehow failed to publish this essential finding.
See, Landén, M. (M.D., Ph.D.) The Effect of Gender-Affirming Treatment on Psychiatric Morbidity Is Still Undecided, Am J Psychiatry 2020; 177:767–768; doi: 10.1176/appi.ajp.2020.19111165. this conclusion is not supported by the data presented in the article.

See, Bränström, R. and Pachankis, J. , Toward Rigorous Methodologies for Strengthening Causal Inference in the Association Between Gender-Affirming Care and Transgender Individuals' Mental Health: Response to Letters, Am J Psychiatry 2020; 177:769–772; doi: 10.1176/appi.ajp.2020.20050599.

2020 - Sweden, following a national review of transgender science, published a new guideline that is NOT consistent with WPATH protocols nor the opinions of Drs Schechter and Brown in this case. [https://genderreport.ca/finland-strict-guidelines-

for-treating-gender-dysphoria/ The SWEDISH NATIONAL GUIDELINES appear quite contrary to the opinions of Drs Brown and Schechter and WPATH.

2020 - Finland following a review of transgender science, became the first country in the world to issue new guidelines for this group of patients when it concluded similarly to the UK High Court that *there is a lack of quality evidence to support the use of hormonal interventions in adolescents with gender dysphoria*. This new Finnish guidance *prioritizes psychological therapy over treatment with hormones or surgery* and suggests different care plans for early-onset vs late-onset childhood gender dysphoria. The 2020 Finland guidelines state "***Only limited research has been conducted on transgender identity and other gender identity conflicts,*** *and comparative studies are very rare*."] The Finland National Guidelines appear quite contrary to the opinions of Drs Brown and Schechter and WPATH.

See, https://genderreport.ca/finland-strict-guidelines-for-treating-gender-dysphoria/ Finland Clinical Guidelines and Conclusions Three reports were created by COHERE in Finland. The report "Medical treatment methods for dysphoria associated with variations in gender identity in minors – recommendation" clarifies the roles of different healthcare providers in a situation where a minor is uncertain about their gender identity. They also produced general recommendations for the treatment of transgender people, which applies to adults. And interestingly, a third and separate set of recommendations for the treatment of gender dysphoria related to non-binary people and people with gender identities other than opposite-sex gender identities. The summaries are available for download here:
Summary-transgender_enDownload
Summary_minors_enDownload
Summary_non-binary_enDownload

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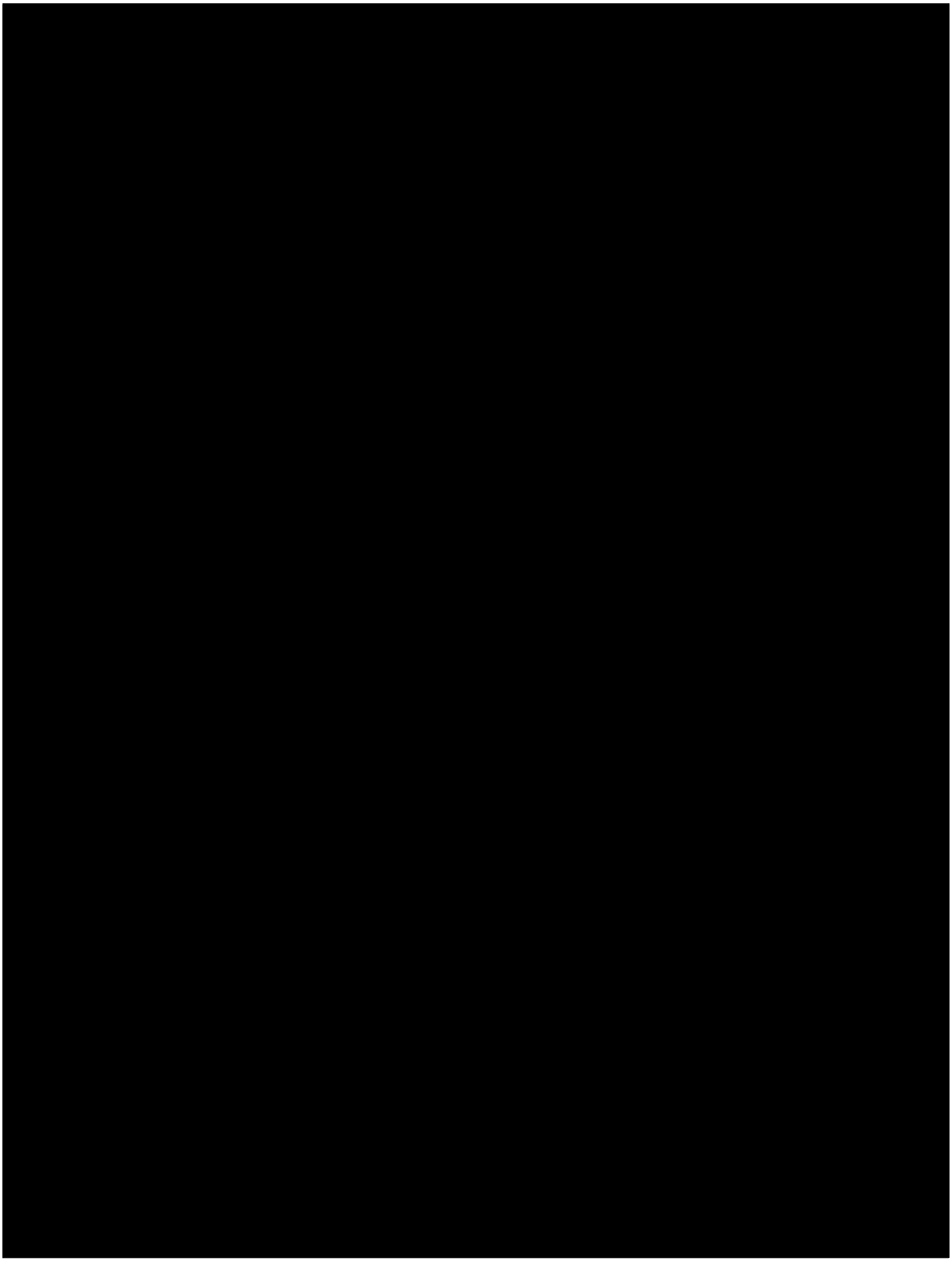
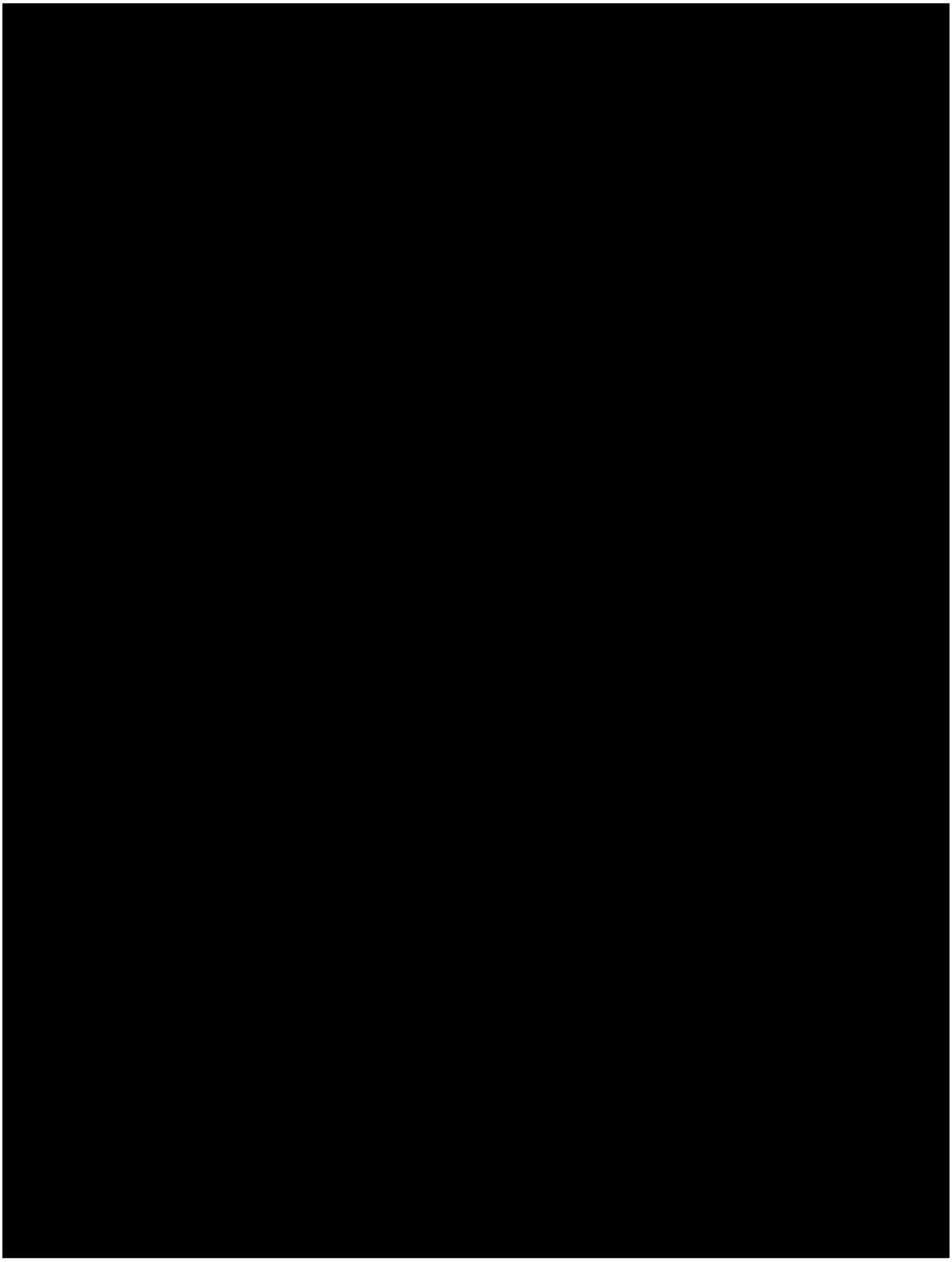
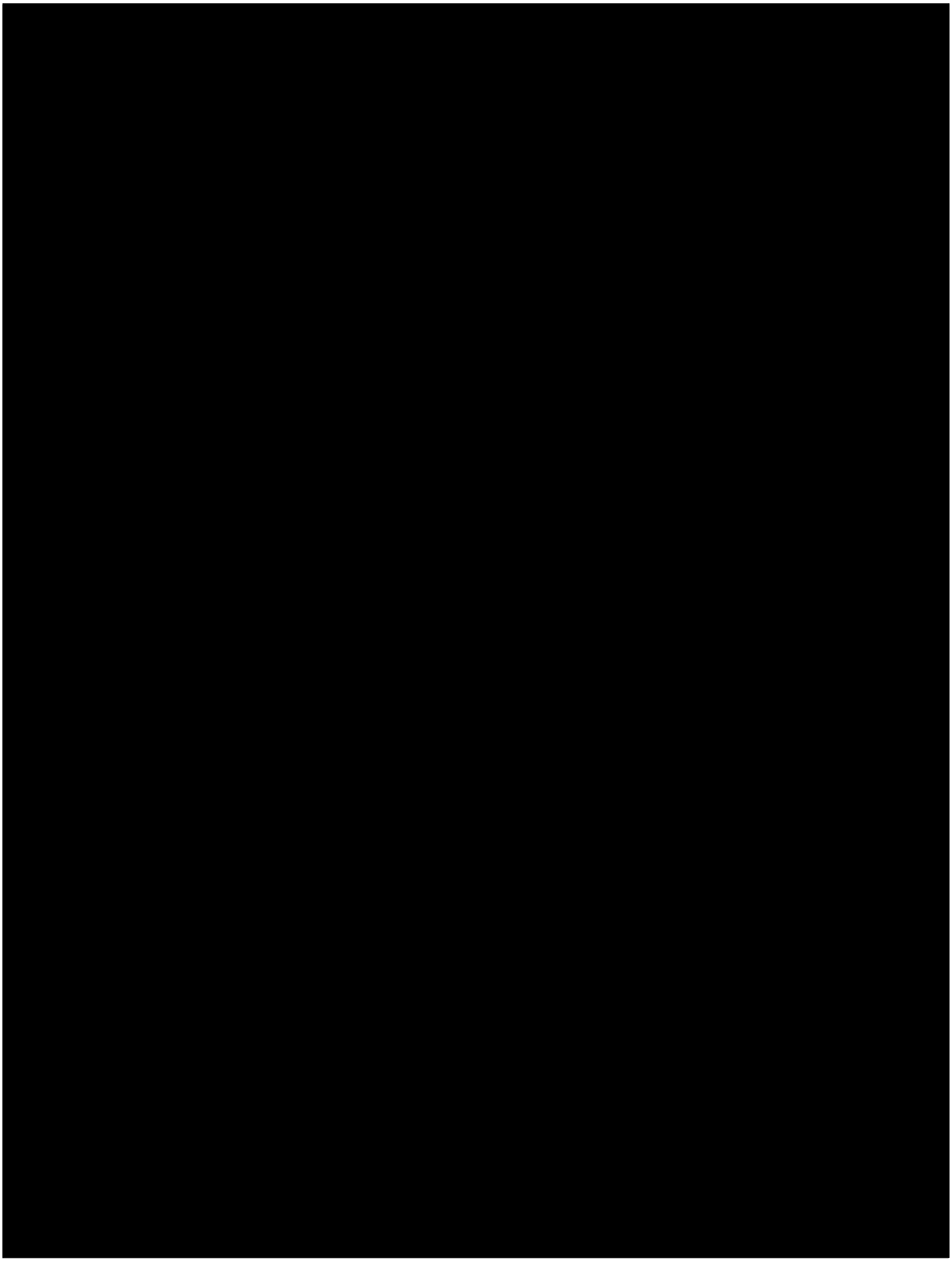
21. Expert Report Limitations: My opinions and hypotheses in this matter are — as in all expert witness reports — subject to the limitations of documentary and related evidence, the impossibility of absolute predictions, as well as the limitations of social, biological, and medical science. All opinions have been offered to a reasonable degree of medical certainty. I have not met with, nor personally interviewed, anyone in this case. As always, I have no expert opinions regarding the veracity of witnesses in this case. I have not yet reviewed all of the evidence in this case and my opinions are subject to change at any time as new information becomes available to me. Only the trier of fact can determine the credibility of witnesses and how scientific research may or may not be related to the specific facts of any particular case. In

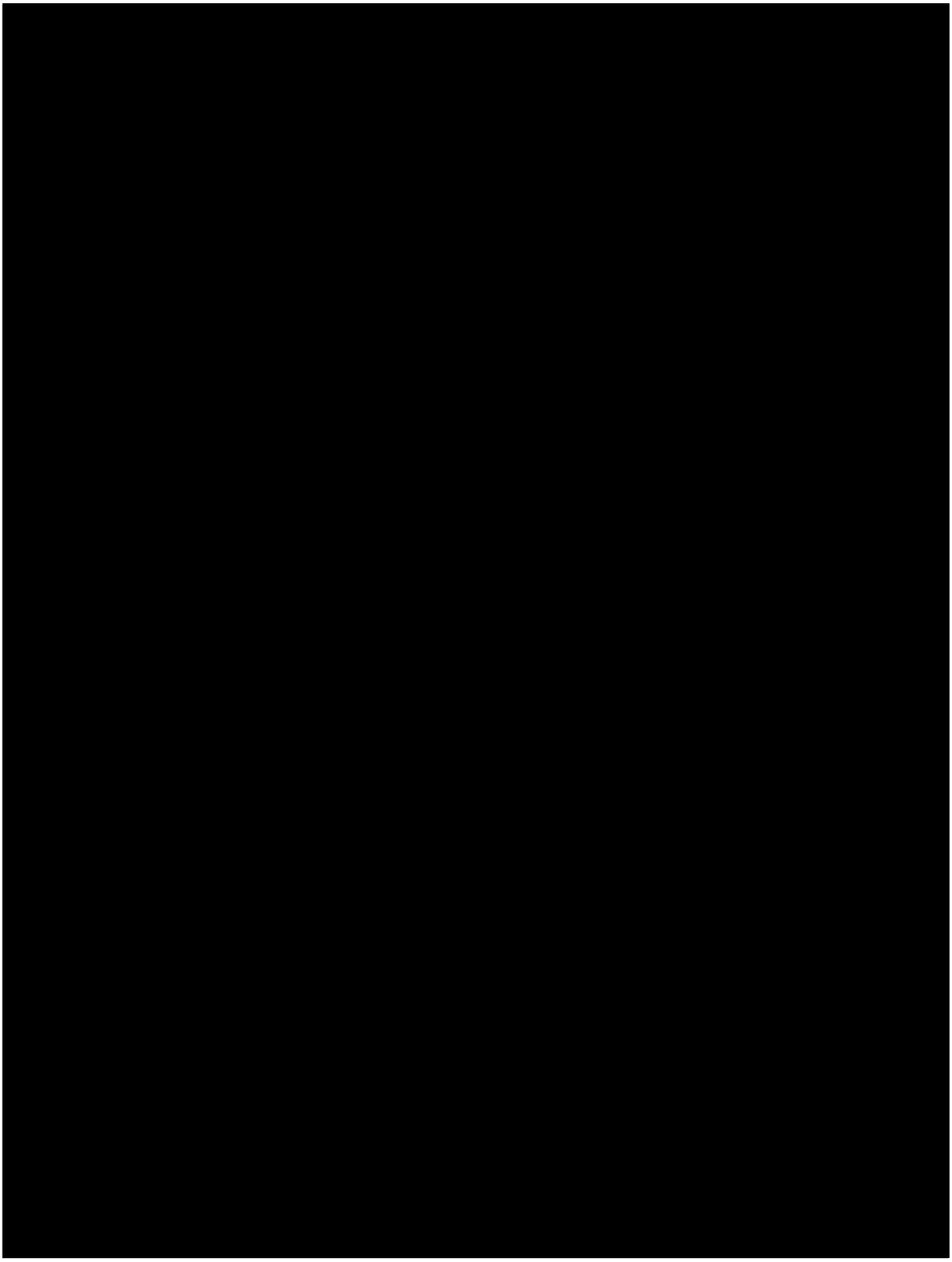
my opinion, a key role of an expert witness is to help the court, lawyers, parties, and the public understand and apply reliable scientific, technical, and investigative principles, hypotheses, methods, and information. I have transmitted this confidential expert report directly to attorney John G. Knepper, J.D. for distribution as consistent with the laws of the appropriate jurisdiction for this case.

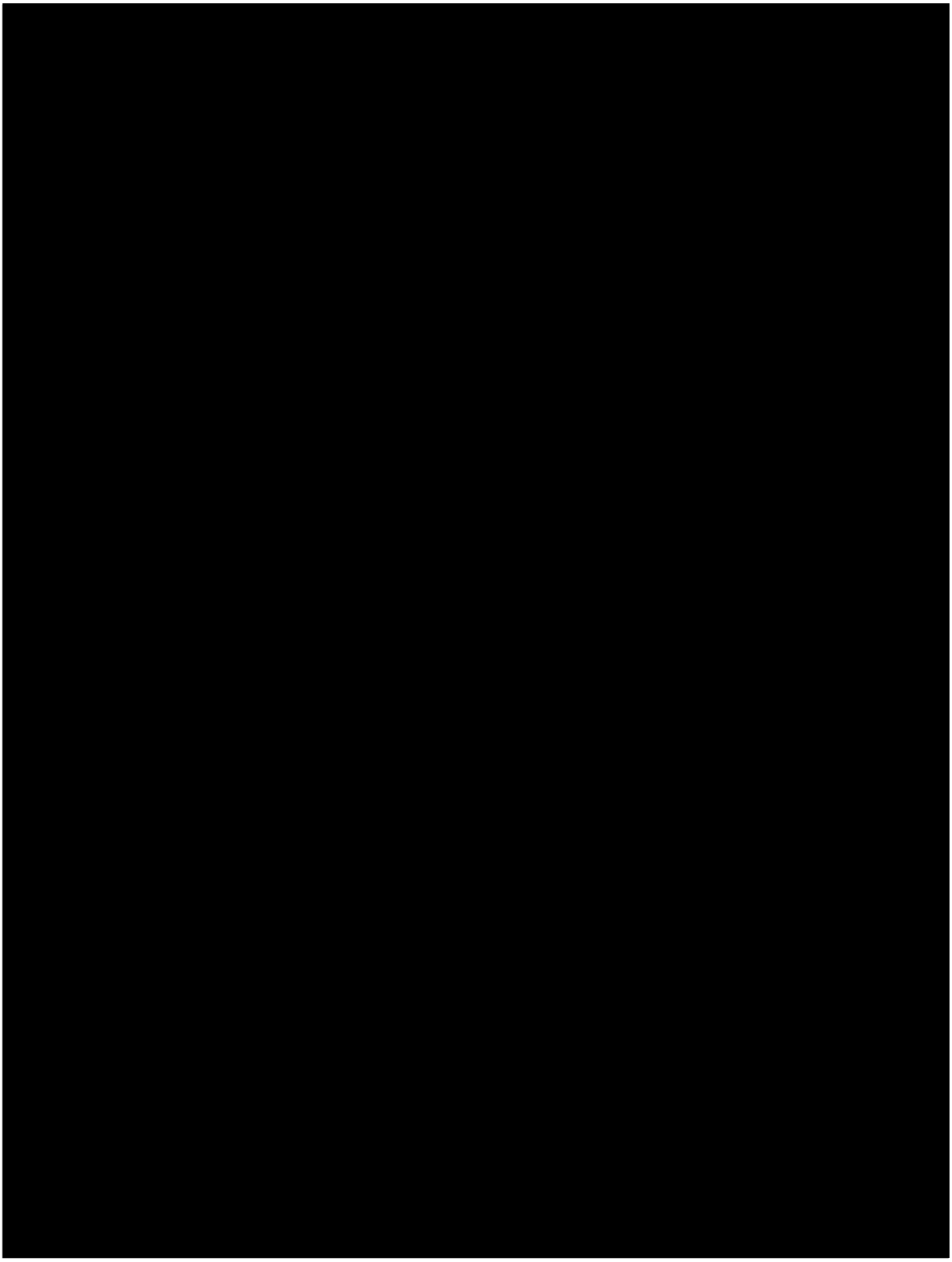
CONFIDENTIAL INFORMATION SECTION BELOW

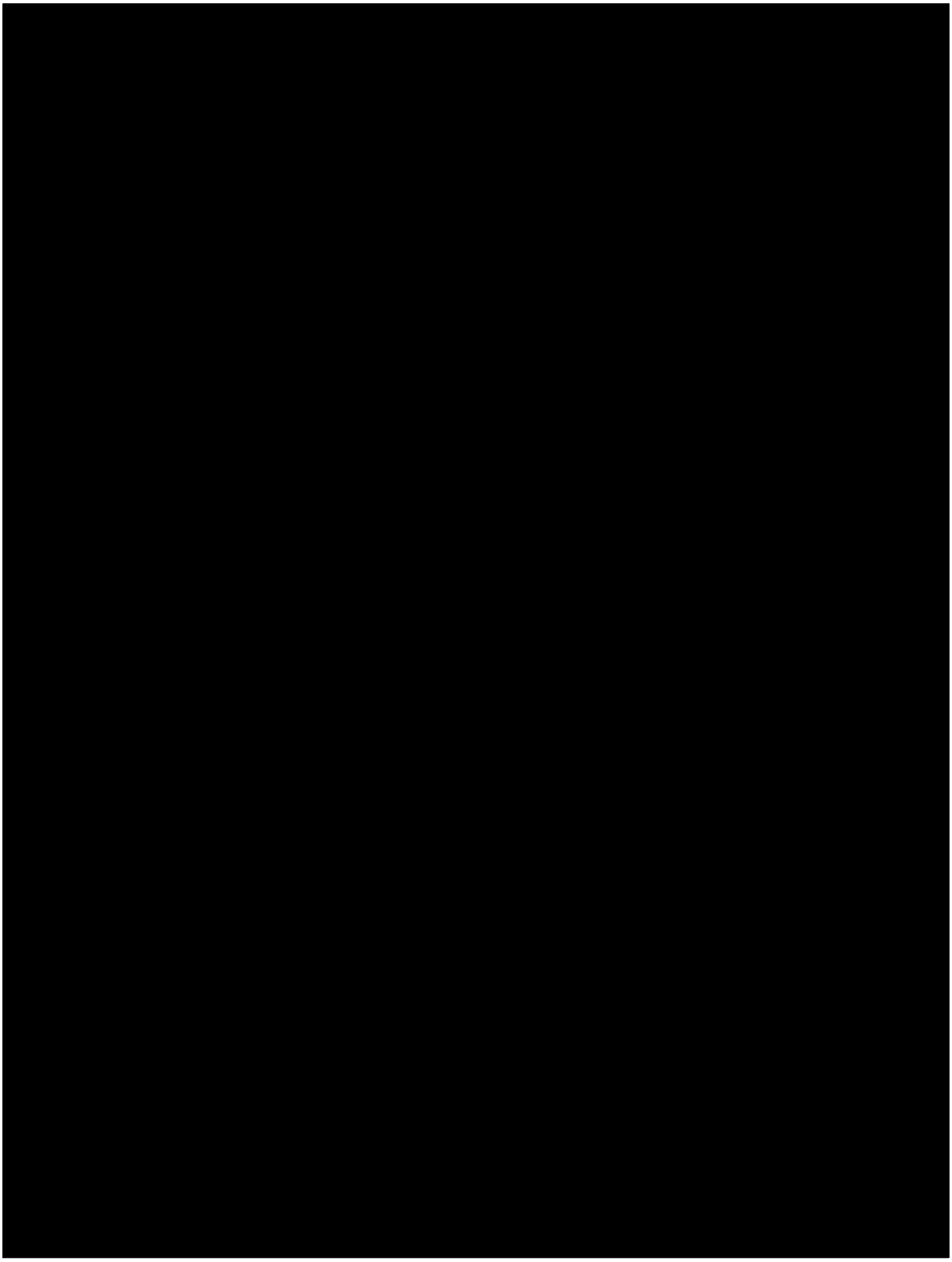


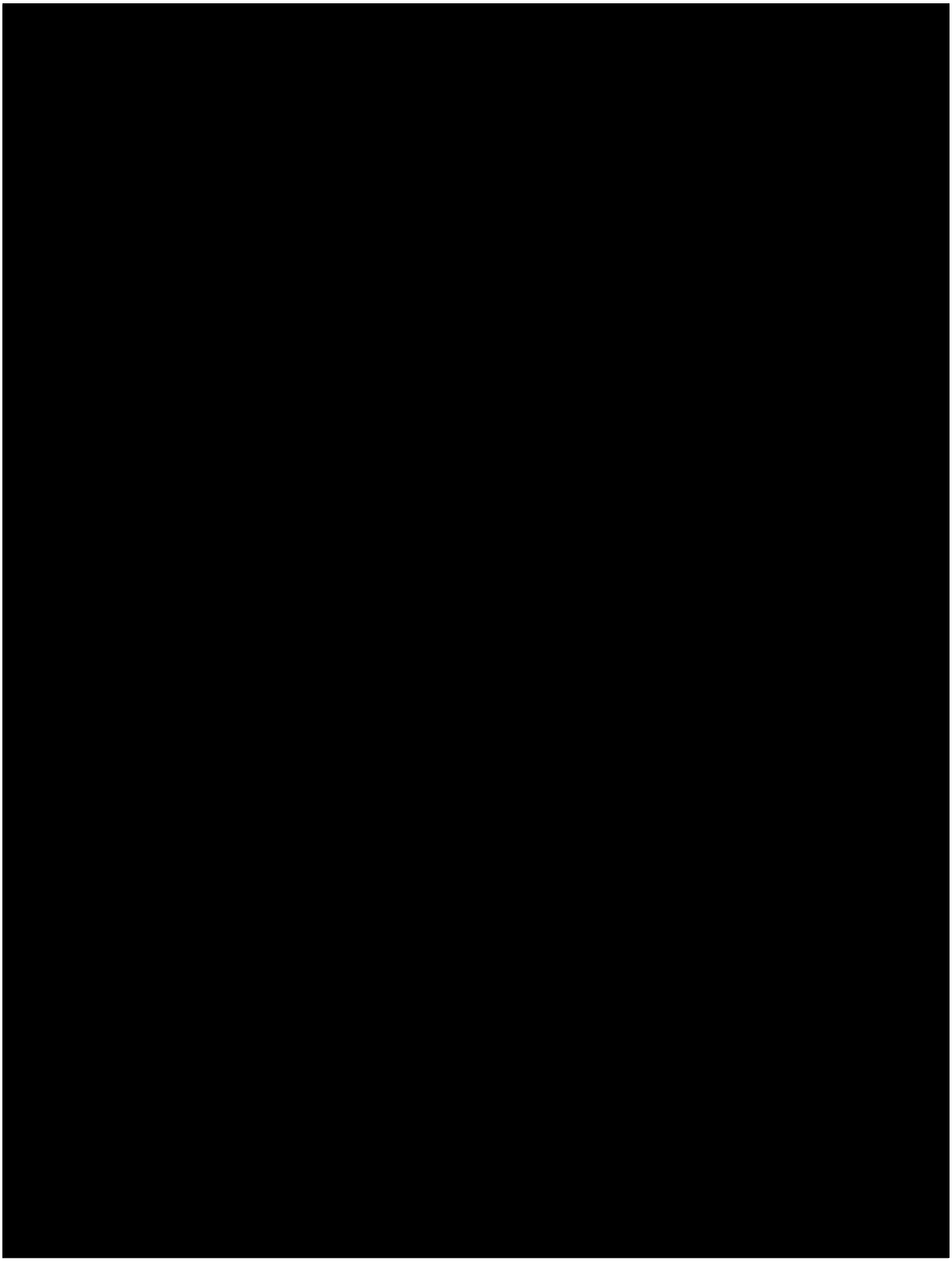


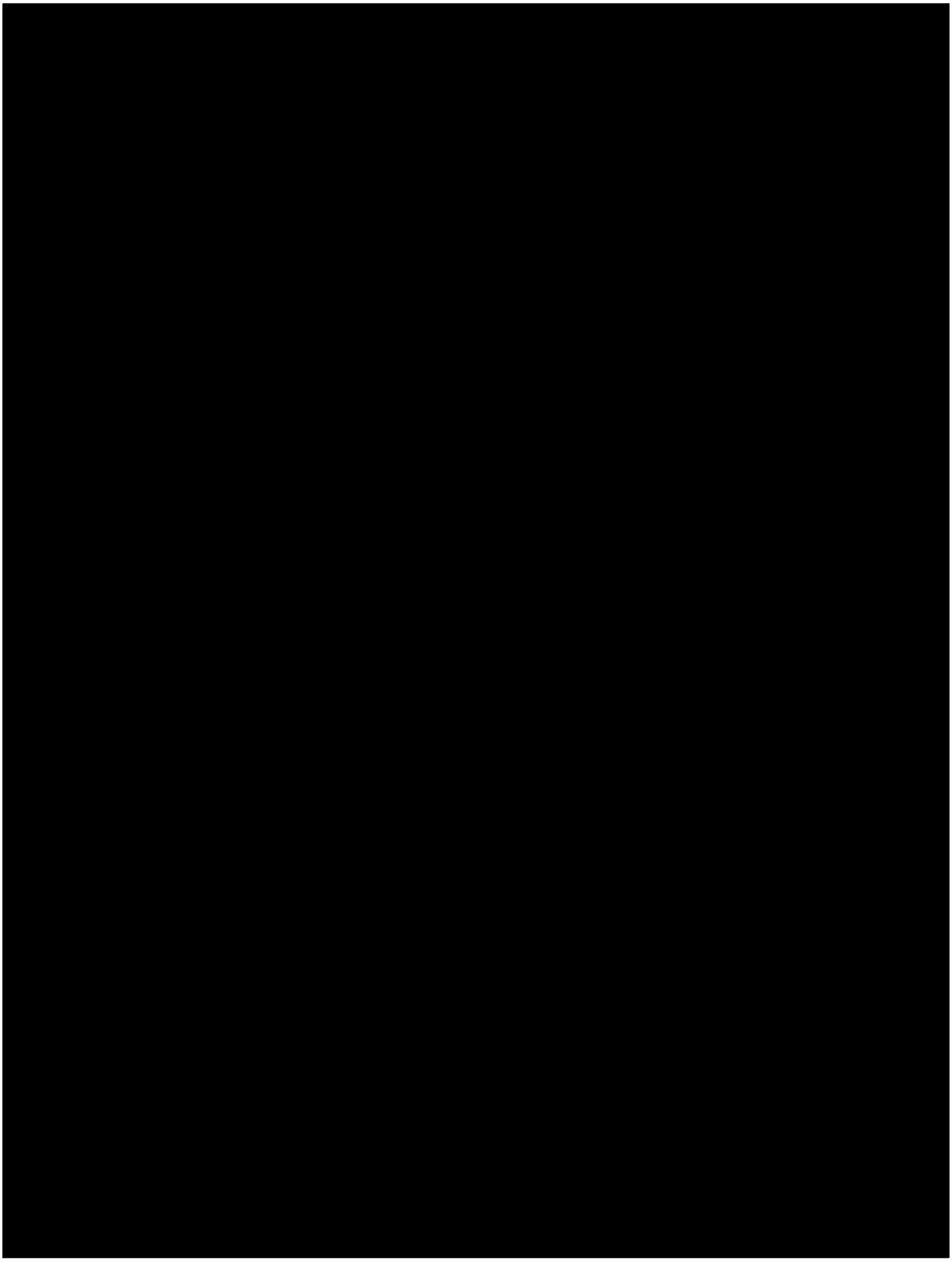












Pursuant to 28 U.S.C § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Date: _____

Signed: _____ **May 1, 2021**

Patrick W. Lappert, MD

EXHIBIT 2

Deposition of:

Patrick Lappert, M.D.

September 30, 2021

In the Matter of:

Kadel, et al vs. Folwell

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

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

MAXWELL KADEL, et al.
Plaintiffs

v.

DALE FOLWELL, et al.
Defendants

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

A P P E A R A N C E S

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ALSO PRESENT (via remote videoconference):

Andrew Baker, Videographer

I N D E X

E X H I B I T S

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Systematic Reviews

(Exhibits attached to transcript.)

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

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

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

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

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

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

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

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

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

EXAMINATION BY MR. TISHYEVICH:

Q. Good morning, Doctor.

A. Good morning, sir.

Q. State your full name for the record.

A. Patrick Walter Lappert.

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

A. There is no reason.

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

A. I have.

Q. You've prepared an expert

report; right?

A. I have.

Q. So, I've premarked Exhibit 1. Open that, and let me know when you have it.

(Exhibit 1 was marked for identification and is attached.)

A. Okay. I have it.

Q. This report contains all the opinions that you intend to offer in this case; correct?

A. It does.

Q. All right. Without telling me any conversations that you had with counsel, what did you do to prepare for your deposition today?

A. Well, I reviewed the -- the documents. I guess it's called the complaint. I reviewed the patient records. And then, I reviewed the literature, pertinent journal articles, publications, and had conversations with -- with counsel, Mr. Kadel [sic], and his

staff at various times.

Q. When you say "patient records," are you talking about the medical records for the individual plaintiffs?

A. Yes. The ones that were -- that were given to me to review.

Q. And when you say "the literature," are you referring to some of the studies that you cite in your report?

A. Yes.

Q. Have you reviewed any studies -- strike that.

In preparing for your deposition today, have you reviewed additional studies that are not cited in your report?

A. No. The report contains all of the studies that I -- that I reviewed that I consider pertinent. I glossed some but didn't see them as germane. So all the ones that were -- that were germane to my opinion are -- are in the -- in the document.

Q. Understood. And you mentioned that you met with or spoke with Mr. Knepper in preparing for today?

A. I have.

Q. Okay. Again, without disclosing any substance of the conversation, how many times did you speak or meet with him?

A. Three or four times, I think.

Q. And when did those conversations take place?

A. Well, as recently as yesterday evening and I think a couple of meetings back in May, I think it was. I'd have to look at my calendar, but.

Q. Last evening, you spoke -- strike that.

You know that Dr. Hruz was deposed yesterday; right?

A. I'd heard, yes.

Q. And so before yesterday, when was the last time that you spoke with Mr. Knepper to prepare for your deposition?

A. I want to say it's a couple of weeks ago. I'm not exactly sure.

Q. How long was the conversation with Mr. Knepper last night?

A. A little less than an hour.

Q. Did he provide you with copies of any of the exhibits that were used at Dr. Hruz's deposition?

A. No, he did not.

Q. Did he provide you with any -- any portions of that deposition transcript?

A. No.

Q. And then going in reverse chronological order, you mentioned you may have spoken a couple of weeks ago?

A. I think. I don't know exactly -- I don't know exactly when that was, Mr. Tishyevich. I want to say three weeks ago perhaps. I'm not exactly sure.

Q. Do you recall roughly how long that conversation was?

A. About the same duration. I

think it was perhaps an hour, perhaps an hour.

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

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

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

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

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

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

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

A. I have not spoken with Dr. Levine.

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

A. Yes.

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

A. I've never met Dr. Levine.

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

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

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

A. Yes, I've heard.

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

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

Q. Okay. You're aware that other

experts in this case have also already been deposed?

A. Yes.

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

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

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

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

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

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

A. Could I amend that last answer?

Q. Of course.

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

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

A. Thank you.

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

A. Yes.

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

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

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

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

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

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

A. I don't.

Q. It's possible that it was you?

A. It wouldn't surprise me.

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

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

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

A. I am not.

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

A. Yes.
Q. It's a search engine maintained by the National Institute of Health; right?
A. Yes. That's my understanding.
Q. It's a search engine for scientific articles, basically; right?
A. Yes.
Q. So I'll represent to you that I ran a search in PubMed for the phrase transgender treatment industry, in quotation marks, and came back with zero results for that phrase.
MR. KNEPPER: Objection to form.
Q. Do you find that surprising?
A. No.
Q. Okay. What does that lack of results tell you about whether this term is a commonly used term in this field?
MR. KNEPPER: Objection to form.
A. I wouldn't expect it to be a commonly used term, and it doesn't surprise me that you didn't find it.

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

MR. KNEPPER: Objection to form.

A. I would agree.

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

MR. KNEPPER: Objection to form.

A. That sounds right to me, yeah.

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

A. All right.

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

A. Yes.

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

A. I do.

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

A. That's correct.

Q. Then you got recertified in 2008; correct?

A. That's correct.

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

A. Correct.

Q. And your plastic board -- strike that.

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

A. Correct.

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

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

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

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

A. No.

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

A. A year ago.

Q. What hospital was that?

A. Crestwood Hospital, Huntsville, Alabama.

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

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

practice.

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

A. Yes.

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

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

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

A. Correct.

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

A. Correct.

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

A. Correct.

Q. So this page 1 of your report

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

MR. KNEPPER: Objection, form.

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

Q. Let me be more specific.

A. Okay.

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

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

A. Certainly.

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

MR. KNEPPER: Objection, form.

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

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

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

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

A. I have it.

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

A. All right. I'm there.

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

A. I do.

Q. Look at the third paragraph.

A. All right.

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

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

Do you see that?

A. I do.

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

MR. KNEPPER: Objection, form.

A. Yes, I understand it.

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

A. I do.

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

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

A. I do.

Q. And you understand what this means; right?

A. I do.

MR. KNEPPER: Objection, form.

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

MR. KNEPPER: Objection to form.

A. Yes. Yes, I see that.

Q. And you understand what that means; right?

MR. KNEPPER: Objection to form.

A. I do.

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

MR. KNEPPER: Objection, form.

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

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

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

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

A. I do.

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

MR. KNEPPER: Objection to form.

A. Yes.

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

MR. KNEPPER: Objection to form.

A. Certainly.

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

A. Okay.

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

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

Q. And that certification expired in 2002; right?

A. Yes.

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

A. Correct.

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

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

serving as an expert in another case, Brandt v. Rutledge. B-R-A-N-D-T. Correct?

A. Yes.

Q. That's a case pending in federal court in Arkansas; right?

A. Correct.

Q. In that case, you were retained by the defendants, by the State of Arkansas; right?

A. Yes.

Q. Dr. Hruz, who is one of the defendants -- strike that. Dr. Hruz, who is one of the experts in this case, is also serving as an expert for defendants in that Brandt case; right?

A. That's my understanding, yes.

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

A. I didn't know about Dr. Levine, but.

Q. And you submitted an expert declaration in that Brandt case in July

of this year; correct?

A. I believe that was when I submitted it, yes.

Q. All right. Let's look at it. And let me know when you get the exhibit, Doctor.

(Exhibit 3 was marked for identification and is attached.)

A. Here it is. Let's see. All right.

Q. All right. Page 1 says, "Declaration of Dr. Patrick Lappert." That's you; right?

A. Yes.

Q. Fair to say that there is at least some overlap between the opinions that you're offering in this case and the opinions that you're offering in that Brandt case; right?

MR. KNEPPER: Form.

A. Well, given that the subject matter is the same, I would expect some overlap, yes, sir.

Q. Go to page 5 of that declaration.

A. All right. I'm there.

Q. You say under Section II, "'Gender affirming' treatments are experimental." Right?

A. Yes.

Q. It's basically the same opinion that you offered in this case; right?

A. Yes, sir.

Q. Go to page 29 of your declaration. See there's a paragraph 63?

A. Yes, sir.

Q. And toward the end of that paragraph, you talk about the national reviews in England, Sweden, and Finland and other reviews like Cochrane, Griffin, and Carmichael. You see that?

A. Yes, sir.

Q. You relied -- you relied on all those studies for your opinions in this case as well; right?

A. I did.

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

A. Yes, sir.

Q. -- few pages?

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

MR. KNEPPER: Objection to form.

A. Yes.

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

A. Yes.

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

A. Yes.
MR. KNEPPER: Objection.
Q. Have you kept up with what's going on in that case in Arkansas?
MR. KNEPPER: Objection, form.
A. I haven't heard anything perhaps in the last several weeks.
Q. Well, are you aware that in July of this year, the judge in that case held that the State is prohibited from enforcing the ban while the case is being decided?
A. I've heard that.
Q. All right. And as part of that order, the judge made some factual findings. Are you aware of that?
A. I'm not -- haven't read the details.
Q. All right. Let me show you.
A. Okay.
Q. Let me introduce one more exhibit.
(Exhibit 4 was marked for identification

and is attached.)

A. I have it now.

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

A. I see that, yes.

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

A. I do.

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

A. No.

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

A. I don't know.

Q. Go to page 7.

A. All right.

Q. All right. Look at the last

paragraph.

A. Okay.

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

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

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

A. Apparently so, yes.

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

A. Yes.

MR. KNEPPER: Objection to form.

A. It appears to be, yes.

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

A. Yes.

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

That's what it says; right?

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

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

A. Yes, it certainly is.

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

MR. KNEPPER: Objection to form.

A. Apparently so, yes.

Q. All right. Look at page 6.

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

A. I do.

Q. You see there's a Footnote 3?

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

Q. The bottom of page 6.

A. I see it now, yes.

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

MR. KNEPPER: Objection to form.

A. Yeah, the consensus recommendations. Those are consensus

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

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

MR. KNEPPER: Objection to form.

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

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

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

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

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

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

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

A. Okay.

Q. And go to page 5.

A. Okay.

Q. See there's paragraph 11?

A. Yes.

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

A. Yes, I say that, absolutely.

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

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

A. Well, I --

MR. KNEPPER: Object.

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

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

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

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

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

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

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

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

right?

A. Not -- not any longer, no.

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

MR. KNEPPER: Objection, form.

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

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

MR. KNEPPER: Objection.

A. I have no personal knowledge, no.

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

A. That's the difficulty. Yes,

sir.

Q. Yeah.

A. Correct.

Q. You have no idea, in short, how the AMA came to reach this consensus statement; right?

MR. KNEPPER: Objection to form.

A. I have no personal knowledge of it, no.

Q. How about the American Pediatric Society? You're not a member of that; right?

A. No.

Q. You have no idea how the American Pediatric Society came to support this consensus statement; right?

A. Well, in that case, I do have friends who are members of the American Pediatric Society, I think it is. And they, in conversation, have told me that this is how the process works. I don't have personal -- personal knowledge of it, no.

Q. Are those friends on the committee at the APA that decided to adopt this consensus statement?

A. Not to my knowledge.

Q. So they also -- strike that.

How about the American Psychiatric Association? You're not a member of that --

A. No.

Q. -- right?

A. No.

Q. You have no idea on what basis they decided to support this consen- -- what you call consensus -- consensus statement about the necessity of treatment for gender dysphoria, do you?

A. No.

Q. So, Doctor, I hear you criticizing these organizations, but you do not have firsthand knowledge of how any of those organizations came to reach these positions, do you?

MR. KNEPPER: Objection to form.

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

is that -- that I've reviewed the current literature, particularly in the last three to five years, that's germane to the subject of gender affirmation in pediatric patients and adolescents, and I -- and I find that the science is weak, so --

Q. But because you have no firsthand knowledge of how any of these associations came out with these position statements, you do not know to what extent it may have taken that literature into account before adopting these position statements; right?

MR. KNEPPER: Objection.

A. I can only say that if they gave full force to the scientific literature that is used to support their position, I find the scientific literature weak, yeah.

Q. This Brandt case involves a state law that prohibits doctors in Arkansas from providing gender-affirming

medical treatment to anyone under eighteen; correct?

A. Yes.

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

MR. KNEPPER: Objection, form, scope.

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

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

A. Right.

MR. KNEPPER: Objection to form, scope.

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

A. I do.

MR. KNEPPER: Objection to form, scope.

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

MR. KNEPPER: Objection, form, scope.

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

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

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

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

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

A. Yes.

MR. KNEPPER: Objection to form, scope.

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

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

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

haven't you?

A. Yes, I have.

MR. KNEPPER: Objection to form, scope.

A. Yes, I have.

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

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

A. I have it.

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

A. I do.

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

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

Utah apparently.

Q. Have you ever communicated with Mr. Shipp and his staff?

A. I may have and don't recall.

Q. Why do you say you may have?

A. I have a lot of correspondence with people who ask a lot of questions who are involved in this -- in this issue, and I don't have a great memory for names sometimes. But I know I was in communication at some level with people in Utah, but I don't recall exactly the nature of that conversation, or that interchange.

Q. Go to page 16.

A. Sixteen?

Q. One six.

A. One six. Okay.

Q. Toward the bottom of the page, it says, "We express appreciation to these noted professionals who contributed to this report." Do you see that?

A. I do.

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

Q. Go to page 18. The second name from the top is Stephen B. Levine M.D.; right?

A. Yes.

Q. Same Dr. Levine who is an expert in this case; right?

A. Yes. I think so, yes.

Q. And the next name is Paul McHugh, M.D.; right?

A. Yes.

Q. The same Dr. McHugh who is an expert in this case; right?

A. Yes.

Q. All four of you were providing information to the Utah State Legislature to support this potential ban; right?

MR. KNEPPER: Objection to form.

A. Yes.

Q. How did you get involved with providing this information to the Utah State Legislature?

A. I don't recall. My -- my suspicion is I may have been contacted by

e-mail or some other such thing. In fact, I'm fairly confident it was an e-mail request for assistance, probably.

Q. Do you remember who the e-mail was from?

A. I do not.

Q. Do you remember who at the Utah State Legislature or anyone affiliated with them you were communicating with in this respect?

A. I don't remember, no.

Q. All right. Let's see what you were telling the state legislature in this report. Go to page 5. See there's a section near the top titled "Sex reassignment surgeries"?

A. Yes.

Q. There's some language in quotes -- in quotes and italicized. Do you see that?

A. I do.

Q. And the first portion of the paragraph says: '"Sex reassignment

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

Do you see that?

A. I do.

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

A. Yes.

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

A. Yes.

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

A. I do. Absolutely.

MR. KNEPPER: Form.

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

this field, Doctor?

A. I expect not.

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

A. Yes.

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

A. Absolutely.

Q. And you stand by these words; right?

A. I do.

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

MR. KNEPPER: Objection, form, scope.

A. I have.

Q. Which states?

A. Alabama, Texas.

Q. What else?

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

Q. Okay.

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

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

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

A. I've got it.

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

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

A. I do.

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

A. Actually over the last couple of years.

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

A. I do.

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

A. I do.

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

surgical treatment for transgender people in your position as a Catholic deacon; right?

A. That's correct, I do not.

Q. All right. Focus on the last sentence of this third paragraph. It says that when a committee member questioned your medical expertise on this issue, you said that you would not treat a person for gender dysphoria and would instead refer them to a qualified mental health professional. You see that?

A. Yes.

Q. At this hearing, someone on the committee was questioning your medical expertise to offer these opinions; right?

MR. KNEPPER: Objection, form.

A. I don't remember that detail, but I think so, yeah. I think the objection they raised was that I don't do these treatments, how could I know.

Q. You're not a psychiatrist; right?

A. No.

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

A. I have limited -- limited training. Yes.

Q. And when you say "limited training," what does that mean?

A. Well, in the training of plastic surgeons, we are -- we are required -- because we offer aesthetic surgery, we get some training in issues, psychological/psychiatric issues relating to people who will seek to modify their bodies in order to achieve a sense of peace or a sense of improvement in their lives. And it's imperative that a plastic surgeon be able to recognize persons who are suffering from psychiatric problems because plastic surgery -- to offer them plastic surgery to modify their bodies is in the category of malpractice, not to mention that very

often, dissatisfied patients will -- will make life very difficult for the practitioner, if not threaten them with physical harm.

I would refer you to an article by -- although we haven't offered it up, -- a friend of mine, Dr. Mark Gorney, who was one of the -- one of the grand old men of plastic surgery, started the Physicians Company to manage physician liability and risk and had -- he discovered that there's an overrepresentation of -- of violence against physicians by aesthetic patients committing violence against plastic surgeons. That's just one of the motivators.

But nonetheless, the issue of body dysmorphic disorder is part of our training, persons who are seeking a remedy to their interior woundedness or their psychological disturbances by changing their outward opinion. And body

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

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

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

A. That's right.
Q. When did you last receive training in how to diagnose someone with body dysmorphic disorder?
A. I guess it's ongoing training when one's in the -- in the practice of plastic surgery. But I had originally in my residency and then on an ongoing basis I think at conferences through the years.
Formal training in it, I -- I don't recall beyond my residency. All I do is try to keep abreast of the literature.
Q. Yeah. So, let's take that in steps. Outside of -- when was your residency in plastic surgery, Doctor?
A. '92 to '94.
Q. Right. Past '94, you have not received formal training in how to diagnose someone with body dysmorphic disorder; right?
A. There may have been some CME credits at a conference in there

somewhere or remote learning. I don't recall.

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

A. I cannot, no.

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

A. Well --

Q. Do you know that sitting here today?

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

The second would be the person who attaches tremendous potential benefit

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

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

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

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

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

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

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

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

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

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

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

MR. KNEPPER: Objection, form.

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

Q. So when I asked you --

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

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

the source you went to was the DSM; right?

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

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

MR. KNEPPER: Objection, form.

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

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

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

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

A. Correct.

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

A. No.

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

A. I would. I would.

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

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

communication with -- I can't remember if they're on the legislative side or on the justice side. I don't remember exactly where they fit into the -- the government of Texas, but I've corresponded with them and offered them information and advice.

Q. Was it similar information to what we've seen in that Utah packet?

A. I'm sorry, sir?

Q. Was it information similar to what we've seen in that Utah legislation packet?

MR. KNEPPER: Objection, form.

A. Right. The substance -- the substance of the issue at hand is the same wherever you find it. It's this contest between those who -- who promote gender-affirming care versus those who promote, in the case of children, for example, watchful waiting and psychological support and cognitive behavioral therapy and those things, yes. It's the same battle wherever you find it

because it's the same problem, the same science, the same language. All of it's the same.

Q. So earlier, we saw that in addition to you, Dr. Hruz and Dr. Levine and Dr. McHugh were also involved with those Utah legislative efforts; right?

MR. KNEPPER: Objection, form.

A. I -- I don't know their involvement in -- in Texas. I'm -- I'm not aware.

Q. Yeah. Do you know whether any of them have been involved with any of these efforts in any other state?

A. I don't. I don't know.

Q. Okay. Fair to say that you have some strong personal opinions on whether doctors should be providing gender-affirming treatment to minors?

MR. KNEPPER: Objection to form.

A. Very fair to -- very fair to say, yes.

MR. TISHYEVICH: Let's go off

the record.

THE VIDEOGRAPHER: This is the end of Media Unit 1. We are off the record at 9:33 a.m.

(Break taken.)

THE VIDEOGRAPHER: This is the beginning of Media Unit No. 4. We are on the record at 9:44 a.m.

Q. (By Mr. Tishyevich) Doctor, you're familiar with an organization called Alliance Defending Freedom, ADF; right?

A. Yes.

Q. How are you familiar with the ADF?

A. I was invited down there for a conference on the subject of transgender. I was an invited presenter, I should say. They asked me to come and speak from a plastic surgeon's perspective on how I view the current state of transgender medicine and surgery.

Q. Those were -- those were the

meetings in Arizona? Is that right?

MR. KNEPPER: Objection.

A. Yes.

Q. Who invited you?

A. I don't remember who the particular name was. I -- I don't recall who the -- the particular person, the one that sent me the invitation.

Q. Was it --

A. It may have been -- it may have been Gary McCaleb, I want to say. I'm not positive about that, though.

Q. You -- you anticipated my question.

A. Okay.

Q. To your knowledge, what's the view that the FDA takes on providing healthcare treatment to patients with gender dysphoria?

A. The position of the FDA?

Q. The ADF.

A. Oh, the ADF. They -- let's see. So, the sense I get is that the ADF takes

a -- the opinion that the present state of transgender medicine and surgery is not in the interest of the patients or the families.

Q. The ADF has moral objections to doctors performing this kind of surgery and treatment; right?

MR. KNEPPER: Objection, form, scope.

A. I would -- I would characterize the ADF's position as more than just a moral objection. It's both moral and objective scientific objections.

So the -- the -- the sense I got from that conference was that most of the invited speakers came to speak about -- for example, Dr. Hruz was there, and he spoke about endocrinology and the endocrinol- -- endocrinologic basis for sex/gender. And he spoke about the effects of -- the endocrinological effects, the objective changes that are caused by, for example, puberty-blocking

cross-sex hormones.

I was -- there was also another speaker there, I think, on the subject of -- from the family medicine perspective, the overall effects on the health of the child, developmental issues. There was a presenter on the objective psychological issues.

And then, I presented on the realities of the surgery. They wanted me to speak about the technical details of transgender surgery, kind of the evolution of the process of transitioning surgery, and the -- and to give them a summary of the state of the science on it.

So I would characterize the ADF as interested in both the moral -- the moral issues and the objective, and they impinge upon one another. Clearly, to do something that is not in the -- in the objective benefit of the patient is a moral problem.

Did I answer your question?

Q. That's helpful, yeah.

The ADF is not a professional scientific organization; right?

A. Not to my knowledge, no.

MR. KNEPPER: Objection to form, scope.

Q. They're a legal organization; right?

A. Yes. That's my understanding.

Q. ADF is engaged with bringing lawsuits that do things like challenge schools' rights to -- to have transgender persons on their teams; right?

MR. KNEPPER: Objection, form, scope.

A. I don't know the scope, the full scope of their efforts, but yeah, they're one of I guess several legal organizations that are -- that are approaching these matters, as are you, for example.

Q. All right. Let's talk about

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

You've been to two meetings organized by ADF?

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

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

A. That sounds about right, yeah.

Q. What --

A. I think it was 2017, yeah.

Q. What month roughly?

A. I don't remember now.

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

A. I do not.

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

A. No.

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

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

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

A. Since 2014.

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

A. Yes.

Q. Was Dr. Levine present at that meeting?

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

Q. How about Dr. McHugh?

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

Q. How many people were present at

this first meeting?

A. Perhaps ten. I'm not certain.

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

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

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

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

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

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

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

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

Q. Did you use slides as part of

that presentation?

A. I usually do, yes, although I don't know what I've done with that slide deck. I don't keep them very long. They sort of morph all the time.

Q. Do you think you might have an electronic copy of that slide deck somewhere?

A. I don't.

Q. At a very high level, what was the -- what were you trying to convey through your presentation to that group? Let me ask it a different way. Were -- was your presentation broadly similar to the opinions that you're offering in this case and in the Brandt case?

MR. KNEPPER: Objection, form.

A. Well, by the -- by "broadly similar," do you mean the subject matter or the nature of my opinion or the evidence used to support my opinion?

Q. All right. Give me a high-level summary of what your presentation was at

that first meeting.

A. It was a --

MR. KNEPPER: Objection, form, scope.

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

So that was -- really at the

heart of the presentation was what's the state of the science and where is the reliable science coming from and what is it -- what is it showing us, so. But they also -- the audience wanted to have an understanding of what these plastic surgery interventions were. So there was an extensive discussion of the particulars of the surgeries, the details about the surgeries, the typical outcomes of the surgeries, so.

Q. I want to -- strike that.

One of the topics of discussion at that meeting was about the need to have expert witnesses for litigation; right?

MR. KNEPPER: Objection, form, scope.

A. I remember -- I remember a fairly long discussion about the poverty of people who are willing to testify because of the risk that they take in testifying. That was a -- that was a

fairly long discussion. And the difficulty that that -- that people have in finding expert witnesses because of the risks they place themselves in, in testifying.

Q. And people at that meeting were asked whether they would be willing to participate as expert witnesses; right?

A. Yes.

Q. Before that meeting, you had never testified as an expert witness?

A. Before this moment, I never testified as an expert witness.

Q. Who made the introductory remarks at the beginning of this meeting?

MR. KNEPPER: Objection, form, scope.

A. I'm trying to remember. It was a -- it was an attorney whose first name is Jeff, and I'm trying to remember what his last name was. But he seemed to be the -- the -- kind of the emcee, if you will. Yeah, Jeff. I'll see if, in the

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

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

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

MR. KNEPPER: Objection, form, scope.

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

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

A. I don't recall. I don't, no.
Q. Okay. All right. So then there was a second meeting also in Arizona; right?
A. Right.
Q. And that was also in 2017?
A. I don't remember the date of that as well -- either, no.
Q. What was the purpose of that second meeting?
A. I think it was similar, although it may have been a little bit more refined. There was not as much discussion of the really foundational science as more a review, I think, of -- you know, I -- I guess it was similar in terms of format. I think there were more -- more people there who were speaking from personal experience.
So I think the most important thing I recall from that meeting was that -- that there was a mother -- actually, a couple of family members of persons who

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

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

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

Q. Who do you remember being there by name?

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

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

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

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

Q. Do you remember his first name?

A. I don't.

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

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

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

MR. KNEPPER: Objection, form, scope.

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

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

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

A. Sure. Okay.

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

A. I believe I did.

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

MR. KNEPPER: Objection, form, scope.

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

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

A. What -- what portion?

MR. KNEPPER: Objection, form,

scope.

Q. What portion, yes.

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

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

MR. KNEPPER: Objection, form, scope.

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

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

A. I was contacted by Mr. Knepper.

Q. Okay.

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

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

Q. I understand.

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

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

MR. KNEPPER: Objection, form, scope.

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

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

A. Of course.

Q. Are you a current member?

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

Q. When --

A. About two years ago, I would

say. Maybe two years ago, yeah.

Q. Why did you decide to let your membership lapse?

A. Well, in order to be a member of the American Society of Plastic Surgeons, you have to be board-certified. And so since I declined continuing board certification for the reasons I explained to you, then my membership -- you know, over time, when my subscriptions and membership fees lapsed, so did my membership. And I think that would have been in 2019.

Q. I understand.

A. Yeah.

Q. Is it -- is an active board certification in plastic surgery a prerequisite to being in the American Society of Plastic Surgeons?

A. I seem to remember that when I -- back in the '90s after my residency, there's a -- there's a membership for -- for board-eligible. It's not the full

membership, but then when you get board-certified, then you get full membership and the rights to use the logo and all that sort of stuff, so. Yeah, as I recall. It's been a long time since I read the bylaws. That would have been back in '95, I think, that I read those things.

Q. Yeah. When did you first join the ASPS?

A. I think I joined as a student member when I was in my residency. I want to say it was probably like '92 or '93, somewhere in there.

Q. So you were in the ASPS roughly '92 --

A. I think, yeah.

Q. -- to 2017?

A. I think, yeah. As I recall -- again, it's a little bit murky, but as I recall, there's sort of a provisional membership for residents in training. You sort of get a discounted rate on all

of the expensive things, and the -- and access to the White Journal, as it's called. And then -- and then I -- as I recall, you don't get the full membership until you've been board-certified, which happened for me, as you know, in '97.

Q. Okay. But you were part of the ASPS for a long time; right?

A. Yes. Going to meetings.

Q. You consider the ASPS to be a reputable organization; right?

MR. KNEPPER: Objection, form.

A. Yeah. Well, for the most part, yeah. Certainly, the members, virtually most of the members I've ever known are reputable. And there are some things that the ASPS has done through the years that -- that I've had difficulty with and -- but they're certainly the organization in American plastic surgery.

Q. Yeah. I think one statistic I heard is 93 or so percent of all plastic surgeons are part of the ASPS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. KNEPPER: Objection, form.

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

Q. No. The date of this --

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

Q. Yeah.

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

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

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

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

A. I do.

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

we talked about earlier; right?

A. Right.

MR. KNEPPER: Objection, form.

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

A. I do.

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

A. Yes.

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

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

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

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

A. I do.

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

MR. KNEPPER: Objection, form.

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

Yeah. This is a very --

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

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

MR. KNEPPER: Objection, form.

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

Q. Do you agree? Yeah.

A. I would agree, yeah, sure.

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

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

Q. Yeah.

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

Q. The ASPS --

A. -- legislative advocacy by the ASPS.

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

MR. KNEPPER: Objection, form.

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

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

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

MR. KNEPPER: Objection, form.

A. Absolutely correct.

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

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

MR. TISHYEVICH: I am.

A. So yeah, I have this document.

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

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

A. Exhibit 7?

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

MR. KNEPPER: Sure.

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

(Break taken.)

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

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

A. Yes.

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

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

bullet means; right?

A. I do.

MR. KNEPPER: Objection to form.

Q. One of the ASPS's high priorities for this year is to oppose legislation like the Arkansas ban and the Utah ban and the Alabama ban that you are supporting; right?

A. Apparently so, yes.

MR. KNEPPER: Objection, form, scope.

Q. The sense that I got from reading your report, Doctor, is that it's supposedly generally accepted that gender-affirming surgical treatment is experimental and should not be performed on anyone; right? That's what you think?

MR. KNEPPER: Objection, scope, form.

A. Right. My opinion -- my opinion in that matter is based on the -- on the world literature rather than advocacy statements by a professional

organization. That's right.

Q. You are suggesting, in fact, that doctors who do these surgeries should be investigated for unethical behavior and potential misconduct; right?

MR. KNEPPER: Objection, form.

A. I -- yes, I do.

Q. And you do not think it's relevant to mention that your own professional society takes a view that is contrary to the opinions that you're offering in this case; right?

A. I'm not sure I understood your question, sir.

Q. Yeah. When you talk about how these doctors should be investigated for misconduct, you don't think it's relevant that your own professional society takes a completely contrary view?

MR. KNEPPER: Objection, form.

A. Well, I think I would -- I would characterize my concern and -- and possibly recommendation of investigation,

I was discussing, I think, consent procedures and getting informed consent. I don't think -- yeah, so -- so I think the object- -- the concerns I raised had to do with the off-label use of drugs in irreversible treatments, the -- the problem of obtaining consent from emotionally compromised people who are threatening suicide. Those were the issues that I raised in terms of, you know, investigation kind of things, or examination would be a better term, examination of -- of how a physician/surgeon conducts their practice, so.

Q. Go -- go back to your report.

A. Okay.

Q. Go to page 15. You with me?

A. Yes, sir.

Q. Look at the second sentence in the bottom paragraph. You say, "Basing life changing surgeries that damage and destroy the natural functions of

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

Right? That's your opinion?

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

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

MR. KNEPPER: Objection, form, scope.

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

Q. Hundreds?

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

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

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

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

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

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

If you had asked that question

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

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

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

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

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

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

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

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

responsive.

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

MR. KNEPPER: No.

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

MR. KNEPPER: Go ahead.

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

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

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

Q. Answer my question, Doctor.

MR. KNEPPER: He gave you a thoughtful answer.

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

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

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

MR. KNEPPER: Objection, form.

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

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

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

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

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

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

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

A. Yes.

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

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

Q. Understood.

A. Yeah.

Q. The -- the patient in this

publication was not treated for face -- for gender dysphoria obviously; right?

A. No. She was a sweet pizza maker who had slipped in the kitchen and struck her head on a stainless steel table and had a -- had a displaced fracture of her forehead. But no, she was -- not to my knowledge. I don't know if she was or not, but to my knowledge, she was not.

Q. Next one going backwards is from 1996, and it's titled, "Scarless Fetal Skin Repair: 'Unborn Patients' and 'Fetal Material.'" Do you see that?

A. I do.

Q. All right. That doesn't relate to gender-affirming surgery or to gender dysphoria, I take it?

A. It -- it actually refers to all forms of surgery and particularly, ethical decision-making. So I would say that it's -- it's a -- it's a fairly broad paper that talks about how we treat other human persons. So transgender

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

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

A. No, it does not.

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

A. I do.

Q. You're listed as the third author in this one; right?
A. Yes, sir.
Q. Because you're not the lead author; right?
A. No. The attending surgeon is always the lead author, and I was a resident. I was a resident at that time, yeah.
Q. Understood. This one's titled "Delayed development of an ectopic frontal sinus mucocele after pediatric cranial trauma."
A. Mucocele, yes. Mucocele.
Q. Thank you. This publication doesn't relate to gender-affirming surgery or gender dysphoria; correct?
A. Not directly, no.
Q. Okay. Next one before that is titled "Patch Esophagoplasty"?
A. Very good.
Q. And that's repair or reconstruction of the esophagus; right?

A. Yes.
Q. Does this relate to gender-affirming surgery or gender dysphoria?
A. No.
Q. Next one before that is titled "Modified Skin Incisions for Mastectomy: The Need for Plastic Surgical Input in Preoperative Planning." Do you see that?
A. I do.
Q. And finally, your oldest publication is from 1987, titled "Peritoneal Fluid in Human Acute Pancreatitis." Do you see that?
A. Yes.
Q. Does that relate to gender-affirming surgery or gender dysphoria?
A. It does not. By the way, that -- that second to the last article, your pattern of questions, I wondered if you overlooked asking the same question on that paper.

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

A. Oh, okay.

Q. -- more time on that one.

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

Q. Don't worry.

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

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

MR. KNEPPER: Objection, form.

A. Yes.

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

A. Yes.

Q. Why is it that your CV doesn't

identify those as letters as opposed to original research?

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

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

A. Right.

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

A. Right.

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

MR. KNEPPER: Objection, form.

A. Right. Yes.

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

A. Correct.
Q. In 2002, the U.S. military certainly was not providing any gender-affirming treatment to anyone in the military; right?
A. That's correct.
Q. Or to veterans; right?
A. Correct.
Q. In fact, at that time, there was a policy not to provide gender-affirming treatment to active military or to veterans; correct?
MR. KNEPPER: Objection, form, scope.
A. Correct.
Q. So during your career in the military, you did not provide any gender-affirming treatment to any patients; correct?
A. Correct.
Q. All right. Let's focus on your practice after you left the military in 2002. You currently run the Lappert Skin

Care clinic; right?

A. That's correct.

Q. How long have you operated that clinic?

A. One year.

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

A. Yes.

Q. What was that one?

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

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

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

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

A. Right.

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

A. That's right.

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

A. Right.

Q. -- to 2010, roughly?

A. Right.

Q. And then --

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

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

A. Right. Laser tattoo removal,

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

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

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

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

A. I believe we got that instrument in 2006.

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

A. Yes.

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

A. With Botox?
Q. Yes.
A. Yes.
Q. How about crow's feet? Is that the right term?
A. Yes.
Q. More than -- more than ten years?
A. Yes.
Q. When was the last time you've performed a surgical procedure?
A. Well, as I said, I retired from surgery in August of 2020, so it was -- I think I was doing some last procedures in that same month, perhaps July, somewhere in there.
Q. And in 2020, roughly how many surgical procedures do you think you've performed?
A. From January to July?
Q. Yes.
A. Let's see. Seven months. Perhaps -- I don't know. Maybe eighty,

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

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

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

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

flaps for trauma or for cancer.

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

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

Q. Okay.

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

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

A. Okay.

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

A. Yes.

Q. Okay. Let's break this down.

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

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

Q. Yeah. Well --

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

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

A. Okay.

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

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

A. Yeah.

Q. So focusing specifically on that patient population.

A. Okay.

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

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

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

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

A. Related to -- to sex steroids?

Q. Yes.

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

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

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

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

taking sex steroids; right?

A. Right. Yeah.

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

A. That's right.

Q. Right?

A. That's right.

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

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

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

On how many detransitioning patients have you performed the surgery?

A. Two.

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

fair?

MR. KNEPPER: Objection, form.

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

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

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

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

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

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

A. Yes.

MR. KNEPPER: Objection, form.

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

A. Yes.

MR. KNEPPER: Objection, form.

Q. Endocrinologists?

A. Yes, that's my understanding.

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

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

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

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

Q. All right.

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

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

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

Q. Okay.

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

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

MR. KNEPPER: Objection, form.

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

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

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

Q. Nothing outside of laser hair removal?

A. No.

Q. You personally have never --

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

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

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

A. Correct.

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

A. No.

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

A. Correct.

Q. You're not a psychiatrist; right?

A. Correct.

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

A. Correct.

Q. In your professional day-to-day

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

MR. KNEPPER: Objection, form.

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

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

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

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

A. Okay.

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

A. Yes.

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

MR. KNEPPER: Objection, form.

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

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

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

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

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

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

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

MR. KNEPPER: Objection, form.

A. Yes.

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

A. Right.

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

A. Right.

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

have gender dysphoria; right?

A. Right.

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

MR. KNEPPER: Objection, form.

A. Correct.

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

MR. KNEPPER: Objection, form.

A. Correct.

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

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

A. Yes.

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

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

Q. How many of these consultations

have you done, would you estimate?

A. Perhaps five or six, maybe more. Maybe -- yeah, five or six would be a fair number, I think.

Q. Over what years?

A. Perhaps the last three.

Q. Do you know how these parents know to reach out to you for these consultations?

A. It's -- I think maybe some of them were -- having heard about my public presentations at various venues. People hear about this plastic surgeon in Decatur who's raising objections, I guess. I don't know the particular details about how a particular patient might have come to me. I just -- I just always make myself available when people are anxious for their children and they're looking for an understanding of what transgender is about.

Q. What's the typical advice that you give to parents of children or

adolescents who are considering starting puberty blockers?

A. Well, my advice on that score is based on the -- on the world literature, that the desistance rate for their child, if they don't give them puberty blockers, the likelihood is that by the time they reach mid-adolescence, they have an 80 percent likelihood of desisting in their cross-sex self-identification. And if you follow them into young adulthood, that percentage will be in the 90s.

But essentially, I recommend that they slow everything down, and I recommend against the use of puberty blockade because it's experimental and because the likelihood is very high -- in fact, if I had any medical procedure that gave me 90-plus percent success rate, I would consider that a great victory. So -- so that's -- that's what I speak to them about.

That -- that desistance data is

a very important thing for parents to understand. And very often, the patient -- the parents are experiencing tremendous pressure from the people they've seen in consultation, a tremendous pressure. And usually, the parents are very distressed about what they're hearing, particularly the -- the fear of suicide and self-harm.

Q. Yeah.

A. So --

Q. You encourage -- yeah, no, I got it. You encourage patients of children who -- or adolescents who experience gender dysphoria not to start them on puberty-blocking drugs; fair?

MR. KNEPPER: Objection, form.

A. Yeah, I discourage the use of puberty blockade for anything other than precocious puberty or other endocrinopathies.

Q. And you also discourage them from pursuing surgical procedures for

gender dysphoria; correct?

MR. KNEPPER: Objection, form.

A. Correct.

Q. When you do these consultations, do you talk just to the parents or to the children as well?

A. Both, yeah. I like to meet the children and -- and -- and get to know them, yeah.

Q. And do you convey the same message to the children? Don't start puberty blockers; don't start -- don't do any surgical procedures?

MR. KNEPPER: Objection.

A. I -- I generally don't -- I'm sorry. I generally don't speak about the details of therapy to children. I speak to their parents.

Q. How many children do you think you have consulted with specifically?

A. On this -- on this issue?

Q. Yes.

A. As I say, maybe six. I often --

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

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

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

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

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

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

A. No.

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

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

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

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

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

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

A. I think that she -- yeah.

MR. KNEPPER: Objection to form.

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

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

(Break taken.)

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

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

right?

A. Yes, I do.

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

A. Correct.

Q. You know what facial masculinization surgery is?

A. Yes.

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

A. Correct.

Q. Do you know what transfeminine top surgery is?

A. Yes.

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

A. No.

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

A. No.

Q. You have never performed a

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

never performed for transgender patients to transition them, no. But the operations themselves as used in reconstruction, I have considerable experience with.

Q. We talked earlier about the American Society of Plastic Surgeons. You recall that?

A. I do.

Q. You know that the ASPS has a code of ethics?

A. Yes.

Q. And you know that members are required to comply with the code of ethics; right?

A. Yes.

Q. And I know you're not a member now, but you were a member of the ASPS for a considerable amount of time; right?

A. Yes.

Q. And I assume during that time, you followed the ASPS code of ethics; right?

A. To my knowledge, I never violated it. Yes.

Q. When was the last time you reviewed it?

A. I'm sorry, did I lose the sound here?

Q. When was the last time you reviewed the ASPS code of ethics?

A. Oh, gosh. Years ago. Years ago.

Q. Let me introduce an exhibit.

Let me ask you this first. Are you aware that the ASPS code of ethics had some specific rules for members who provide expert testimony?

A. Yes.

Q. Okay. You didn't review those provisions before you formed your expert opinions in this case?

A. No.

Q. Sitting here today, do you know if your opinions in this case are in compliance with what the ASPS code of

ethics says about members who provide expert testimony?

A. I'm not aware that I've violated them in any way, yeah.

Q. Let me introduce an exhibit. Okay. Let me know when you have it.

(Exhibit 10 was marked for identification and is attached.)

A. Okay.

Q. It's still opening on my end.

Okay. So, Exhibit 10 is the Code of Ethics of the American Society of Plastic Surgeons. You see that?

A. I do.

Q. The bottom left corner says, "Updated September 25, 2017." See that?

A. I do.

Q. That's when you were still an active member of the ASPS; right?

A. Yeah, that's right.

Q. Go to page 4.

A. I think I'm on page 4 here. They're not numbered. Oh, here we are,

yes.

Q. Or I'm sorry, page 6.

A. Page 6.

Q. Section IV.

A. Section IV, yes.

Q. Section IV is "Expert Testimony"; right?

A. Yes.

Q. I want to focus you on the last two sentences of this first paragraph. It says, "Members whose testimony, including testimony as to credentials or qualifications, is false, deceptive, or misleading may be subject to disciplinary action, including expulsion." You see that?

A. Yes.

Q. The next sentence says, "Further to help limit false, deceptive and/or mislead" -- "misleading testimony, Members serving as expert witnesses must," and then there's a list of requirements. You see that?

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

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

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

A. I have never performed such procedures.

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

MR. KNEPPER: Objection, form.

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

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

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

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

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

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

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

Q. And because you've never done

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

MR. KNEPPER: Objection, form.

A. I would not agree with that.

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

MR. KNEPPER: Objection.

A. No. Not in the least.

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

MR. KNEPPER: Objection, form.

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

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

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

MR. KNEPPER: Objection, form.

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

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

MR. KNEPPER: Objection, form.

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

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

have recent and substantive experience?

MR. KNEPPER: Objection, form.

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

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

MR. KNEPPER: Objection, form.

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

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

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

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

A. Yes.

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

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

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

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

A. Yes.

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

A. Correct.

Q. And that was published in 2012; right?

A. That's right.

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

A. Yes, I did.

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

A. No, I am not.

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

A. I would never be part of the WPATH.

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

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

Q. You've never advised the WPATH

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

to that.

Q. Okay. You don't know what kind of scientific literature the WPATH conducted as part of drafting Version 7; right?

A. As far as naming the particular papers that they may have reviewed, I can't do that for you because those are -- that happens in closed committee. I -- all I can say to you is my -- based upon my reading of the product and the verbiage that it's used, my suspicion is that it's pretty heavily weighted towards the American literature and -- and does not bring in particular document -- well, being that it was published in 2012, the big inflection point in 2011 probably wasn't available to the committee when they were writing that document.

So given that the document is already out of date and it's -- and the subsequent WPATH 8, no one knows when it's going to come out, yeah, it's --

it's almost -- it's almost irrelevant because of the change in the literature that happened since it was published, so. In particular, the 2011 article by Dhejne, Cecilia Dhejne, and -- and others that kind of changed the view of the scientific evidence.

So yeah, it's an out-of-date document by the standards of what are called standards of care. It's not a standards of care document. It's a -- it's a treatment guideline document is really what it is, and it's a poorly supported treatment guideline at that, so -- gosh, I wandered off.

Did I -- did I answer your question?

Q. Yeah, you anticipated my objection.

MR. TISHYEVICH: Which, again, I'll move to strike most of that as nonresponsive.

Q. Because here's my question. You

don't personally know what kind of scientific literature the WPATH conducted as part of drafting Version 7; correct?

MR. KNEPPER: Objection, form.

A. No. Again, a closed session, so I don't know what documents they used.

Q. You don't know what kind of outside experts the WPATH may have consulted in drafting Version 7; right?

A. No.

Q. You don't know what kind of peer review the WPATH may have conducted as part of developing Version 7; right?

MR. KNEPPER: Objection, form.

A. No.

Q. You don't know what kind of public comments the WPATH may have solicited as part of developing Version 7.

MR. KNEPPER: Objection, form.

Q. Right?

A. No.

Q. You don't know how many

different drafts the Version 7 went through before it was finalized; right?

A. No.

Q. You don't know how many different meetings or conferences the WPATH had to discuss the development of Version 7; right?

A. Correct.

Q. You have no idea what may have gone on during those meetings or conferences; correct?

MR. KNEPPER: Objection, form.

A. No. I was not a part of the conferences that produced the product.

Q. Yeah, you are not an expert in how Version 7 of the WPATH was developed; right?

A. Correct.

Q. And we can go through all these questions again individually for Version 8, but maybe we can shortcut this.

A. Well, no one knows what's in Version 8 except the people who are in

the committee. It's a -- it's a privileged document. There's no one in plastic surgery who knows it apart from the people who serve as members of the WPATH, so that would be the case.

Q. Okay.

A. It's a -- it -- yeah.

Q. So just so we have it on the record, you don't hold yourself out as an expert on how Version 8 of the WPATH Standards of Care are currently being developed; fair?

A. Fair.

Q. Okay. We talked earlier about the DSM; right?

A. Yes.

Q. In your day-to-day practice, you don't use the DSM-5; correct?

A. No.

Q. But you do know the DSM-5 is widely used by psychiatrists; correct?

A. Yes.

Q. The DSM-5 was published in 2013;

correct?

A. I don't know the publication date, but it sounds about right.

Q. Do you know that it was developed by the American Psychiatric Association?

A. Yes.

Q. You're not a member of the APA; right?

A. Correct.

Q. You personally have not been involved with the development of DSM-5; right?

A. No.

Q. You don't know how many different working groups were involved with developing the DSM-5; right?

MR. KNEPPER: Objection, form.

A. Correct.

Q. You don't know how many different members those working groups had; right?

MR. KNEPPER: Objection, form.

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

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

MR. KNEPPER: Objection, form.

A. Correct.

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

MR. KNEPPER: Objection, form.

A. Right.

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

A. Right.

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

MR. KNEPPER: Objection, form.

A. Yes.
Q. Do you know how many members were in that work group?
A. No.
Q. You don't know --
MR. KNEPPER: Objection.
Q. -- how those members were selected; right?
MR. KNEPPER: Objection to form.
A. Correct.
Q. You don't know their expertise; right?
A. Correct.
Q. You do not have expert firsthand knowledge of how the DSM-5 was developed; fair?
MR. KNEPPER: Objection, form.
A. Fair.
Q. Are you aware that the DSM-4 used the term "gender identity disorder" instead of "gender dysphoria"?
A. Yes.
Q. Do you know the reason for that

change?

A. From DSM-4 to DSM-5?

Q. Yes.

A. Yes.

Q. What's the reason?

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

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

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

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

A. Do I know what they are?

Q. Yeah.

A. Yes.

Q. Do you know when they were

initially published?

A. No.

Q. Do you know when they were last revised?

A. I think it was just a couple of years ago, but I don't know the exact date.

Q. If I tell you it's 2017, does that sound right?

A. That wouldn't -- it wouldn't surprise me if that were true. I -- just within the last couple of years. I think theirs are current, and the expectation is that these standards of care or treatment guidelines will have a five-year revision. So given that they're current, they couldn't be any older than, say, 2017. So I suspect that -- yeah.

Q. All right. Did you review the latest available version of those Endocrine Society guidelines before forming your opinions in this case?

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

Q. And you don't know how they were selected to work on the 2017 updates; correct?

A. Correct.

Q. You personally don't know what kind of scientific literature review the Endocrine Society conducted in developing those updates; correct?

MR. KNEPPER: Objection to form.

A. Correct.

Q. You don't know what kind of outside experts they may have used; right?

A. What kind of outside experts? I would imagine they were all endocrinologists. Or are you asking did they have plastic surgeon input or --

Q. Do you know specifically whether the Endocrine Society used any outside experts in updating the -- in implementing the 2017 updates?

A. Well --

MR. KNEPPER: Objection, form.

A. I can only infer that they would, because such -- such statements, in order to be valid, demand review by outside parties to -- to obviate conflicts of interest, whether financial or professional. Those are all issues when generating standards of care, so of necessity, they would have had to have had outside experts to come in, yes.

Q. Okay. Do you know what kind of public comments the Endocrine Society may have solicited as part of developing the 2017 updates?

A. I don't.

MR. KNEPPER: Objection to form.

Q. You don't know how many different drafts there were of those 2017 updates before they were finalized; right?

A. No.

MR. KNEPPER: Objection to form.

A. No, I don't.

Q. Again, you haven't been to any

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

MR. KNEPPER: Objection to form.

A. Correct.

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

MR. KNEPPER: Objection, form.

A. I do not.

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

MR. KNEPPER: Objection to form.

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

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

A. Correct.

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

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

Q. You've never prescribed Lupron; right?

A. No, I have never. No.

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

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

Q. Right. Have you ever looked at

the package -- strike that.

You know what a package insert is; right?

A. Yes.

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

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

Q. Okay. How recently do you think?

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

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

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

Q. It's a type of drug.

A. Oh.

Q. So no, that doesn't sound

familiar?

A. It does not sound familiar, no.

Q. How about Triptodur?

T-R-I-P-T-O-D-U-R.

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

Q. Okay. Fensolvil?

F-E-N-S-O-L-V-I-L.

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

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

A. Same.

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

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

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

A. Yes. Pediatricians and

endocrinologists, yes.

Q. Right. You have no specialized training or expertise in endocrinology; correct?

A. Correct.

Q. You don't hold yourself out as an expert in endocrinology; correct?

A. No, I do not.

Q. You're not planning on offering any expert opinions in endocrinology in this case because that's outside your scope of expertise; right?

A. Yes.

MR. KNEPPER: Objection to form.

Q. All right. Earlier, you said you have never prescribed puberty-blocking agents to anyone, so I take it you have no experience, no firsthand experience with advising your patients about potential risks and benefits of puberty blockers; right?

MR. KNEPPER: Objection, form.

A. Well, I have talked to patients

-- well, families, really, about the risks of puberty blockers in -- in early puberty and into adolescence. I have because I've reviewed the literature and I've spoken with experts in the area. And so, is that the question --

Q. Yeah.

A. -- you're asking, have I spoken to anybody? Yeah, I have. I -- I have, again, knowing that -- for example, that the drug Lupron, as an example, is -- is -- is not cleared by the FDA for application. It's an off-label use when using it in the diagnosed condition of gender dysphoria. So I know that it's an off-label application of the drug, and I know what the effects of the drug are. But nobody knows what the effects of the drug are on otherwise normal children, and that's pretty much all I'd relate to the families on the -- on that subject.

I don't offer myself as an endocrinologist, but I offer myself as a

concerned physician who has spoken with the specialists and read the package insert. Yes.

Q. You think off-label use is improper; right? That's the sense I got from reading your report.

MR. KNEPPER: Objection, form.

A. Off-label use in certain situations. So I use -- I use -- I have applied drugs' off-label use many times. But what the -- what the practitioner has to do is weigh the risk/benefit equation there and what is the expected goal and what are the likely risks.

For example, I used Botox long ago in the treatment of -- of hyperhidrosis before the company that produces it got FDA clearance to use it that way. The risk, very, very low risk; the potential benefit, very, very high. But in this case, we're talking about very significant risks for an unproven benefit. So that's an example of how you

have to weigh off-label use.

And the FDA understands that, and they don't go after off-label use unless there's significant risk. And even then, they might not yet spring into action. It's a pretty slow-moving organization.

Q. All right. We'll come back to that.

A. Okay.

Q. You never sat in on any appointment where an endocrinologist prescribed a puberty-blocking drug to a patient; correct?

A. I have never.

MR. KNEPPER: Objection, form.

Q. You personally don't know what endocrinologists typically tell their patients about risks and benefits of puberty blockers; right?

MR. KNEPPER: Objection, form.

A. Only what I have read in the record. For example, the plaintiffs'

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

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

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

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

MR. KNEPPER: Objection, form.

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

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

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

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

A. Among other things, yes.
Q. And the doctor may also go beyond the labeling and advise them of potential risks even though they're not specifically disclosed in the drug labeling; right?
A. Yes. Because there -- there are circumstances wherein the underlying conditions of the patient may -- may cause particular risks in particular areas, so that's right.
So there's the general precautions that are included in the package insert, but they usually tend to be exhaustive. They -- they list in the package inserts even remote possibilities, so. But most physicians can't drill down into those details with a patient. You don't want to overwhelm the patient and their family with those minute details. You want to talk about the major risks and then the risks that are peculiar to the patient because of

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

Q. Yeah.

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

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

MR. KNEPPER: Objection, form.

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

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

A. No.

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

MR. KNEPPER: Objection to form.

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

Q. Sorry.

A. -- as it pertains -- yeah.

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

A. Okay.

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

MR. KNEPPER: Objection, form.

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

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

Q. Yeah. My question is more specific.

A. Okay.

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

A. Correct.

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

A. Yes.
Q. For transgender women, estrogen is a hormone that's typically prescribed; right?
A. Yes.
Q. For transgender men, testosterone is the hormone that's typically prescribed; right?
A. Right.
Q. You've never prescribed cross-sex hormones for treatment of gender dysphoria to anyone; correct?
A. Correct.
Q. You have no firsthand experience with advising your patients about potential risks and benefits of cross-sex hormones when used for treatment of gender dysphoria; correct?
A. Correct.
Q. You personally don't know what doctors who do prescribe estrogen or testosterone to their patients for gender dysphoria tell those patients about the

risks and benefits of that treatment; correct?

MR. KNEPPER: Objection, form.

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

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

MR. KNEPPER: Objection to form.

A. That would be my -- that would be my expectation.

Q. All right. We started talking about off-label use, so let's circle back to that. So in your report, you criticize Dr. Brown and Dr. Schechter for not disclosing that the FDA has not approved these hormones for treatment of gender dysphoria. Do you recall that?

A. Yes. My testimony, yes, I do recall that.

Q. All right. Off-label use is when a doctor prescribes a drug outside of its FDA-approved indication; correct?

A. Correct.

Q. And we touched earlier on whether it's proper or improper to prescribe drugs on an off-label basis. There are circumstances where it is appropriate to prescribe a drug on an off-label basis; correct?

A. Yes.

Q. It's a case-by-case decision; right?

MR. KNEPPER: Objection, form.

A. Yes.

Q. It's a case-by-case decision that's made between the doctor and their patient; right?

MR. KNEPPER: Objection, form.

A. Right.

Q. You're not expressing the opinion that doctors should not be prescribing drugs on an off-label basis ever; right?

A. I'm expressing the opinion that -- that drugs that have massive potential side effects should not be off-label prescribed unless those risks warrant -- I mean, those risks are warranted given the underlying condition of the patient and that the patient is being treated as a -- as a -- as a trial or an experimental patient with ethics monitoring and all the rest of it that

attends.

The reason why off-label use is problematic is because it doesn't have a body of proven scientific evidence that the FDA has made use of in order to -- to warrant the use of the drug. So if you're going to go off label, again, the risks have to be low. If the condition you're treating makes -- makes the risks high, then that's where you have to get into ethics panels and experimental trials and things like that. I think that's at the heart of this issue.

We're dealing with a condition where the application of these drugs is not proven and the risks are very high, and that's where my concern lay.

Q. Do you think that off-label use of prescription drugs is, by definition, investigational?

A. To the extent that very often the -- the use of -- the off-label use of drugs begins on the basis of anecdotal

reports. So anecdotal reports, again, are categorized as level 5 evidence. And -- and so when those reports are published and -- and the risks are seen as low, then other physicians may begin the off-label use of those drugs.

But generally, one wants to progress to a more definitive scientific evidence, like level 4 evidence where there's a pre-application test, the use of the drug, and a post-application test, or level 3 where you're looking at longitudinal data to confirm not only the safety but the efficacy of the application of the drug.

In the case of the use of puberty blockade and cross-sex hormones, it doesn't exist beyond level 5 evidence even though the treatment has now been going on off-label for more than a decade, if not approaching twenty years.

Q. All right. You mentioned doctors are prescribing on an off-label

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

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

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

A. No, they don't.

Q. Okay.

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

would agree, yeah.

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

A. Food and drugs, yes.

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

A. Right.

MR. KNEPPER: Form.

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

A. Right.

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

A. No, I did not.

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

A. I do not, no.

Q. Do you know whether the expert

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

MR. KNEPPER: Objection, form.

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

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

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

Q. All right.

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

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

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

A. Okay.

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

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

A. Okay.

Q. Have you ever seen this document before?

A. I have not.

Q. Do you know what the Federal Register is?

A. It's a -- it's a federal list of regulations pertaining to things like this.

Q. Yeah. It's the official publication --

A. Federal code.

Q. -- of federal rules, proposed rules, and notices for federal agencies; right?

A. Yeah. Right.

Q. I see this is dated at the top November 18, 1994. See that?

A. Yes.

Q. Page 1, middle column, see it says, "Agency: Food and Drug Administration, HHS"?

A. Let's see. "Agency: Food and Drug Administration, HHS." Yes.

Q. It says, "Action." It says, "Notice; request for comments." Do you see that?

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

that the -- that the FDA does not -- does not intend to weigh in on off-label use, you know, without restriction, I guess. The sense I get of it is that they're -- they're declining to prohibit the off-label use in -- in other patients at this time, I would -- I would guess. I suppose that if they started to see complications, they might weigh in. This has been the history, for example, with nausea medicines and things like that that created problems after use.

Q. At that time at least, the FDA was telling the medical community that doctors may prescribe drugs for uses outside of FDA-approved indications; correct?

A. Yes. I would say that --

MR. KNEPPER: Objection, form.

A. -- in 1994, the FDA declined to -- to -- I don't know what they've done subsequently. I -- but -- but in 1994, they -- they -- off-label use was not

prohibited.

Q. Well, actually --

A. They finally --

Q. Sorry, finish.

A. No, go ahead.

Q. Well, you see this actually says, "The publication further stated," and then there's a quote. And after the quote, there's a Footnote 4.

Before we get to that, do you see it says -- it cites to the FDA Drug Bulletin from 1982.

A. Right.

Q. Right?

A. Right.

Q. So that original guidance came from a 1982 FDA position; right?

A. Right.

MR. KNEPPER: Objection, form.

Q. And you say that you read this and you don't think that the FDA has taken a position, but let's see what else that quote says. You see the quoted

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

A. That starts with the word "unapproved"?

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

A. I do.

Q. You understand what that means; right?

MR. KNEPPER: Objection to form.

A. Yes. Yes.

Q. Off-label use -- strike that.

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

A. Right.

Q. And then it says, "Valid new

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

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

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

A. I do.

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

MR. KNEPPER: Objection, form.

A. Yes.

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

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

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

A. Okay.

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

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

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

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

A. Right.

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

A. Right.
Q. Go to page 2.
A. Okay.
Q. Toward the bottom, it says in bold, "Why might an approved drug be used for an unapproved use?" Do you see that?
A. I do.
Q. Then it says, "From the FDA perspective, once the FDA approves a drug, healthcare providers generally may prescribe the drug for an unapproved use when they judge that it is medically appropriate for their patient." Do you see that?
A. I do.
Q. And then skipping one sentence, it says, "One reason is that there" may -- "might not be an approved drug to treat your disease or medical condition." Right?
A. Right.
Q. So the FDA -- the position that the FDA takes is off-label use may be

medically appropriate for patients; right?

A. Right.

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

A. Right.

MR. KNEPPER: Objection, form.

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

A. How the FDA classifies experimental or investigational?

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

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

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

(Exhibit 13 was marked for identification

and is attached.)

A. I have it.

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

A. Generally, yes, I am aware.

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

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

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

A. I do.

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

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

A. I do.

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

A. I do.

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

MR. KNEPPER: Objection, form.

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

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

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

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

A. Yes.

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

A. Right.

Q. And this says you don't actually have to apply for approval by an IRB when you're prescribing a drug on an off-label basis; right?

MR. KNEPPER: Objection, form.

A. It says that it's not of necessity, so they're not making a blanket requirement. I would imagine that that might be modified in particular cases.

Q. Yeah. Because this is saying that when you're prescribing a drug on an off-label basis, that doesn't mean you're starting up a clinical trial; right?

A. It doesn't necessarily mean you're starting a clinical trial, that's right. It doesn't exclude the necessity for a clinical trial. It just says you're not necessarily starting a clinical trial.

Q. Yeah. And when this says -- when it says doctors should maintain

records of the product's use and effects, it's not telling them that they're enrolling their patients in a clinical trial by starting -- by prescribing a drug on an off-label basis; right?

MR. KNEPPER: Objection, form.

A. Right. But what it -- what it probably is inferring is that if they start seeing complications, then the further application of the drug in that circumstance might be required -- might require an IRB. So yeah. So it's -- what they're saying is it doesn't require an IRB of necessity. It does require recordkeeping. And I would expect that if they were to see complications, problems, lack of efficacy, that -- and the desire for its continued use might require an IRB. In fact, I would -- I would hope it would require an IRB. Yeah.

Q. Yeah. A clinical trial down the line is a "this might be nice to have,"

but it's not a requirement for a doctor to prescribe a drug on an off-label use basis. That's what this says; right?

MR. KNEPPER: Objection, form.

A. That's what that says, yeah.

Q. Yeah. You don't cite this guidance in your report obviously; right?

A. I don't think it's --

MR. KNEPPER: Objection, form.

A. I don't think it's germane to my report. No.

Q. All right. You've also offered opinions on whether it's proper to prescribe drugs on an off-label basis to children and adolescents; right?

A. I've only offered it in the case of this particular therapy. I haven't offered it generally, only in the case of puberty blockade and cross-sex hormones for the purposes of transitioning a child to the appearance of the other sex. That's all I've offered it as an opinion.

Q. All right. Do you know what the

American Pediatrics Association is?

A. Yes.

Q. Before forming your opinions, did you look to see what the APA says about off-label use of drugs in children and adolescents?

A. No.

Q. Sitting here today, you don't know the APA's position on this -- on this topic; correct?

MR. KNEPPER: Objection, form.

A. Correct.

Q. Let's look at that next. Okay. This is going to be Exhibit 14, and let me know when you have it.

(Exhibit 14 was marked for identification and is attached.)

A. Okay. I have it.

Q. You understand this is a policy statement from the APA?

A. I'm reading it now. I see that it is a policy statement from the American Academy of Pediatrics.

Q. It's a policy statement entitled, "Off-Label Use of Drugs in Children." Right?

A. Yes. Yes.

Q. Look at the introduction section toward the bottom of the page.

A. Okay.

Q. It says that, "The purpose of this statement is to further define and discuss the status of off-label use of medic- -- medications in children." And then it talks about a publication of a 2002 statement. You see that?

A. Yes.

Q. All right. So the FDA -- APA has taken a position on off-label use of drugs in children since at least 2002; right?

MR. KNEPPER: Objection, form.

A. I'm reading it now. It appears to be that, yeah.

Q. All right. Look at the abstract towards the top.

A. Okay.

Q. Second sentence says, "However, off-label drug use remains an important public health issue for infants," childrens, and" -- "children, and adolescents, because an overwhelming number of drugs still have no information in the labeling for use in pediatrics." Do you see that?

A. I do.

Q. Okay. And then it says, "The purpose of off-label use is to benefit the individual patient." Right?

A. Yes.

Q. And then it says, "Practitioners use their professional judgment to determine these uses." Correct?

A. Yes.

Q. And then it says, "As such, the term 'off-label' does not imply an improper, illegal, contraindicated, or investigational use." Right?

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

Q. Yeah. The APA also takes the position that off-label use does not imply investigational use; correct?

MR. KNEPPER: Objection to form.

A. It does not de facto imply off-label use, that's right, yeah. It does not imply, right.

Q. And it does not imply that off-label use is de facto improper or illegal or contraindicated; right?

A. Right.

MR. KNEPPER: Objection, form.

Q. All right. Go to page 2.

A. Okay.

Q. Look at the left column, the very bottom paragraph.

A. Okay.

Q. It says: "The absence of labeling for a specific age group or for a specific disorder does not necessarily mean that the drug's use is improper for that age or disorder. Rather, it only means that the evidence required by law

to allow inclusion in the label has not been approved by the FDA. Additionally, in no way does a lack of labeling signify that therapy is unsupported by clinical experience or data in children."

Do you see that?

A. I do.

Q. This is the APA recognizing that even in the absence of FDA approval for a particular indication, that use may still be supported by clinical experience and data; right?

MR. KNEPPER: Objection, form.

A. Yeah. I would -- I would say also that the APA recognizes that -- that there's a poverty of evidence. The poverty of evidence is one of the characteristics of off-label use. And that's -- that's what the nature of my expert opinion was about, that the poverty of evidence is what makes the off-label use an issue, and in this case, poverty of evidence for off-label use in

a situation where the harms -- potential harms are great. That's what the concern was, not -- obviously, I use -- I've off-label used drugs in my own practice, as I said before.

I don't have an objection without qualification that -- that the off-label use of drugs is somehow a crime. I'm saying that in this particular instance of this particular application, that the off-label use tells us that there's a poverty of scientific evidence to support its application that way. Clearly, there's anecdotal reports; otherwise, doctors wouldn't be using it. But there's a poverty of evidence, and what we're dealing with here is not a potential trivial complication but potentially permanently life-altering complications.

That was the issue that I was addressing in my concern about the off-label use, that there's a standard

of -- of caution that's required when you go off-label. And that caution isn't being demonstrated by the -- for the persons who are prescribing or applying these drugs in this way. That was my concern.

Q. All right. You think that before these drugs are to be prescribed, they should first be supported by results from clinical trials; right?

MR. KNEPPER: Objection, form.

A. That's the beginning.

Q. That's the beginning.

A. Yeah.

Q. The absolute minimum to prescribe these drugs; right?

MR. KNEPPER: Objection, form.

A. Well, no. No, I -- I didn't say that. As I said, it begins with anecdotal evidence, not clinical trials. So somebody somewhere sees an effect. As it said in that FDA document, it's oftentimes serendipitous. A clinician

will see an effect, and then -- and then they'll, based on that, they'll hopefully check out the potential risks to the patient and then begin that off-label use.

So it begins actually with anecdotal reports, maybe case collections, maybe a number of providers' case collections, maybe it's a -- it's a -- it's an institutional experience. But that leads to clinical trials and the IRB and all the rest of it. So that's just the beginning of it.

Q. It may be appropriate for a doctor to prescribe a drug on an off-label basis without having the results from a clinical trial; correct?

A. Yeah, I would -- I would hope that after thirty years of doing this, that we would beyond -- be beyond institutional or personal experience, that those trials would have already been done. This isn't -- we're not just at

the beginning of puberty blockade and cross-sex hormones. We're well into this now, to the point where the European literature is now vehemently rejecting that.

That's -- these things have changed. In the last three years, it's all changed. With respect to this off-label application of puberty blockade and cross-sex hormones, it's changed utterly. So these general statements about off-label use are important to understand, certainly, when you see a serendipitous result and you consider applying the drug. But we are so far beyond that at this point in the history of transgender therapy, this is where we're concerned. We're concerned with the continued off-label use, the continued absence of clinical trials. We should have been beyond that years ago. And this is what the European literature is now showing us, that the application

of those drugs by -- which is approved by the APA, is now being rejected by the medical services in Great Britain, in Sweden, in Finland, in Holland. And this is where we as American providers have to get.

Q. All right. We'll -- we'll definitely come back to those --

A. Okay.

Q. -- studies. I promise.

A. Okay.

Q. Let's finish this document first, though. All right. Go to page 3. All right.

A. Okay.

Q. Look at the left column.

A. Okay.

Q. It says: "Therapeutic decision-making should always be guided by the best available evidence and the importance of the benefit for the individual patient. Practitioners are in agreement regarding the importance of

practicing evidence-based medicine. However, for the pediatric population, gold standard clinical trials are often not available, so practitioners must rely on either less definitive information, such as expert opinion for the age group that they are treating, or use evidence from a different population to guide practice."

You see that?

A. I do. And I would agree with that, that particularly in pediatric patients, the clinical trial approach oftentimes is -- is not available because of the nature of the condition and so on. But in the -- in this case, there's a -- it's not an all or none, it's got to be clinical trials or -- or nothing.

There's longitudinal population-based studies, long-term results seen in a population that has matured through this therapy, and looking at, you know, cohort studies

longitudinally, cohort study, which is -- which is an alternative when -- when the clinical trial is not available to you for ethical reasons. Like you wouldn't do sham surgery on somebody. That would be ethically untenable. But you can look at population-based studies where you have a cohort to compare. And that's -- that's where we should be. That's where the European literature is now.

So I would agree with that statement that -- that the APA is making there, but I would qualify it by saying that there's an alternative available that brings you to a higher level of evidence that may in fact bring it to on-label use if they were to bother to do it.

Q. The APA recognizes that for the pediatric population in particular, results from clinical trials are often not available; right?

A. Right.

Q. And the answer in those situations is not to stop prescribing these drugs altogether; right?

MR. KNEPPER: Objection, form.

A. Yeah. The "altogether" would be the qualifier there because there are some circumstances where it would be -- I mean, it wouldn't be good to stop its prescription, but there would be others that you would have to examine more carefully because of the risk issue.

Q. Yeah. Instead, what the APA says is that when clinical trial results are not available, doctors have to rely on less definitive -- definitive information; right?

A. That's what -- that's all you have. That's right.

Q. Yeah. The APA says it may be appropriate for doctors to prescribe drugs to pediatric patients on an off-label basis even when that use is not supported by randomized clinical trials;

correct?

A. Right.

Q. Because the reality is that for a lot of conditions, in the pediatric population, there are no randomized clinical trial results available; right?

MR. KNEPPER: Objection, form.

A. Again, so you're holding out randomized clinical trial, or they're holding out randomized clinical trial as the only alternative to the lowest form of evidence. And I -- I agree that randomized clinical trial are not always available, and we have to have recourse to perhaps lesser but nonetheless more convincing forms of evidence to fall back on rather than falling back to the lowest form of evidence as is the case today with the application of these drugs.

Q. All right. Look at the last paragraph in the left column of this page.

A. Okay.

Q. It says: "In most situations, off-label use of medications is neither experimentation nor research. The administration of an approved drug for a use that is not approved by the FDA is not considered research and does not warrant special consent or review if it is deemed to be in the individual patient's best interest." Do you see that?

A. I do.

Q. If the physician deems an off-label use to be in the individual patient's best interest, that's not experimental use, according to the APA; right?

MR. KNEPPER: Object to the form.

A. Well, according to the -- according to the APA, in most situations.

Q. Yeah.

A. So in that statement, it acknowledges that there are some

situations where that would be considered. That's the implication in that statement. So "most" is the qualifier, implying that there are situations where it would be considered experimental.

Q. Okay.

A. And that's what we propose in our expert testimony, is that this is one of those situations. This is experimental use.

MR. TISHYEVICH: Now let's go off the record.

THE VIDEOGRAPHER: This is the end of Media Unit No. 3. We are off the record at 12:30 p.m.

(Break taken.)

THE VIDEOGRAPHER: This is the start of Media Unit No. 4. We are on the record at 1:21 p.m.

Q. (By Mr. Tishyevich) All right, Doctor. You know you're still under oath; right?

A. Yes.
Q. Before lunch, we were talking about off-label use of prescription drugs. Do you know how common or uncommon off-label use of prescription drugs is in the overall population?
A. I'm not familiar with that number, no.
Q. All right. You don't know if it's 5 percent or 10 percent or 50 percent of all drugs are prescribed off label; right?
A. I have no idea.
Q. How about pediatrics specifically? Do you know how common or uncommon off-label use is in the pediatric population?
A. I do not.
Q. Let me introduce an exhibit.
MR. KNEPPER: One second.
Dr. Lappert?
THE WITNESS: Yes.
MR. KNEPPER: Your camera has

moved accidentally, yeah.

THE WITNESS: It just allows me to look at the bottom of the other screen here so I can look at the exhibits.

MR. KNEPPER: Okay. I think just for the video recording, we want to make sure that the camera stays on your face.

THE WITNESS: I'll go like this, then.

MR. KNEPPER: Perfect.

Q. (By Mr. Tishyevich) So this is going to be Exhibit 15. Let me know when you have it.

(Exhibit 15 was marked for identification and is attached.)

A. All right. I have it.

Q. All right. This is a study from 2019 by Dr. Yackey, Y-A-C-K-E-Y, titled "Off-label Medication Prescribing Patterns in Pediatrics: An Update." Do you see that?

A. I do.

Q. All right. And the objective is "To describe the frequency of off-label drug use in 2014 as defined by the FDA-approved age ranges in patients 18 or under 18 years of age." Do you see that?

A. I do.

Q. All right. Look at "Methods." Do you see that section?

A. I do.

Q. It says, "This is a retrospective cohort study of an administrative database containing inpatient resource use data from January 1, 2014, to December 31, 2014." And do you see that?

A. I do.

Q. Look at the "Results" section.

A. Okay.

Q. The first sentence says, "At least 1 drug was prescribed off-label in 779,270 of 2,773,770 (28.1%) patient visits during the study period." Do you see that?

A. I do.

Q. And skipping a sentence, then it says: "Off-label usage of certain medications differed between care settings. Rates of off-label medication use were higher in observational (45.5%), inpatient (53.9%), and ambulatory (54.2%) settings." Do you see that?

A. I do.

Q. All right. The study concluded after reviewing 2.7 patient visits that overall, 28.1 percent of patients were prescribed an off-label -- prescribed a drug on an off-label basis; right?

A. Right.

Q. And depending on the setting, off-label prescriptions in the pediatrics context can be as high as 45 to 54 percent; right?

A. That's what the study shows.

Q. All right. The reality is that prescribing drugs to children and adolescents on an off-label basis is a

fairly common practice; right?

MR. KNEPPER: Objection to form.

A. It appears to be, yes.

Q. You did not know this before you formed your expert opinions?

A. I knew that it was more common in children than in adults, and I knew that it was, you know, fairly common, having -- having prescribed off-label myself to children, that it's -- it's probably fairly common. I didn't know the exact numbers, though, until now.

Q. Okay.

A. Again, my -- my expert opinion about this is not about does it happen. It's about the particular case of the transgendered person receiving an off-label use of a -- of a fairly problematic drug in light of the recently changing evidence about its efficacy. So the issue of off-label use that I presented was not about are drugs prescribed off-label. The issue was

these particular drugs in these particular patients off-label in light of the recent change in the world literature about the risk/benefits of doing those things. And the evidence now is that that whole position about puberty blockade and cross-sex hormones, it's falling apart in the last three years, and there's a -- there's a growing wave of evidence that says do not do this. And in fact, that's where the Court stepped in in Great Britain, and it's where the Karolinska Institute stepped in.

It's not that it's off-label use. It's that it's particularly problematic in the case of these drugs in these suffering patients. That's what my expert opinion was about. It was not about drug policy. It was about these patients, these problems, these drugs. And the fact is that when you off-label use, the responsibility falls much more

heavily on the provider. When the FDA approves it, the responsibility falls to the shoulders of the approving authority. But if you're going off-label, it's on you as the provider to be certain that you're doing good to the patient. And up until the last three years, the evidence wasn't there. Now it's there. The continued use of the drugs in this way has become very problematic, and that's -- that's what my expert opinion was about, not about drug policy, but about these drugs, these patients.

Q. Doctor, there's actually no question pending, so I'm going to ask that you stick with listening to my questions and then answering them instead of making speeches. Okay?

All right. You -- we talked earlier about the Botox injections that you've done; right?

A. Yes.

Q. You told me you've been doing

Botox injections in the forehead for over ten years; right?

A. Correct.

Q. You've told me that you've been doing Botox injections for crow's feet for over ten years; right?

A. Yes.

Q. Do you know when the FDA first approved Botox for the use of treating forehead wrinkles?

A. Let's see. I recall that it was when I was the chief of plastics at Portsmouth, Virginia, because we had been using it for dystonias and things like that in children. And it got approved for cosmetic use I'm going to say before we moved to the new hospital, so it had to have been around ninety- -- I want to say '97, somewhere in there. I'm just ballparking it here.

Q. So when you were using Botox to do forehead injections, you think that was an on-label FDA approved use for the

last ten years; right?

A. Yeah. When used in the corrugator and procerus muscles, that's the on-label use for cosmetic botulinum toxin.

Q. Let me introduce another exhibit. All right. This is going to be Exhibit 16, and let me know when you have it.

(Exhibit 16 was marked for identification and is attached.)

A. All right. I have it.

Q. Top right corner, you see it says, "Food and Drug Administration"?

A. Yes.

Q. Below that, do you see it says, "Supplement Approval"?

A. Yes.

Q. You know what this is?

A. It looks to be a -- a letter from the FDA to the Allergan corporation, to a particular Ph.D. there who is the director of regulatory affairs. And it's

a supplemental -- I guess it's an amendment. I haven't read it. Can I have a moment to read it?

Q. I'll -- I'll point you to it. Don't worry.

A. All right.

Q. Allergan is a manufacturer of Botox; right?

A. Allergan, yes, uh-huh.

Q. Go to page 3.

A. Okay.

Q. And you see there's a signature line, and under that, it says, "10/02/2017"?

A. Correct.

Q. You understand this was issued on October 2, 2017; right?

A. That's -- that's what the document appears to show, yeah.

Q. Go back to the first page.

A. Okay.

Q. First paragraph says, "Dear Dr. Richmond: Please refer to your

Supplemental Biologics License Application, dated and received December 2, 2016." Do you see that?

A. I do.

Q. The next paragraph says, "This Prior Approval supplemental biologics application proposes an additional indication for the temporary improvement in the appearance of moderate to severe forehead lines associated with frontalis muscle activity."

A. Right.

Q. Do you see that?

A. I do.

Q. All right. Then the next section says, "Approval & Labeling." Right?

A. Yes.

Q. It says, "We have completed our review of this supplemental application, as amended. It is approved, effective on the date of this letter, for use as recommended in the enclosed, agreed-upon

labeling text." Do you see that?

A. I do.

Q. All right. You understand that Botox was not an FDA-approved treatment for improvement in moderate to severe forehead lines until October 3, 2017 --

MR. KNEPPER: Objection --

Q. -- right?

MR. KNEPPER: -- to form.

A. The sense I get of your question is that you -- you're conflating the injection of corrugator and procerus muscles with the injection of the frontalis muscles. I consider all those muscle groups to be forehead muscles because they all animate the brow. The approval of Botox for the corrugator and frontalis -- I mean, corrugator and procerus muscle that goes way back is, I thought, what you were -- you were asking me about with ten years application to the forehead. So yeah. So I consider the -- the corrugator and procerus

muscles (indicating) forehead muscles. Maybe others would call them glabellar, but glabellar is the lesser-included category. So yeah.

So I was aware of the broadened application, and I was aware that for most of the time it's been on the market, it has been limited, the approval been limited to the corrugator and procerus. And the frontalis marginal radicularis was considered off-label use, as was its use in hyperhidrosis, like we talked about earlier. Yeah.

Q. You have prescribed Botox cosmetic -- or strike that.

You have used Botox for treatment of moderate to severe forehead lines associated with frontalis muscle activity before October 3, 2017; correct?

A. Yes.

MR. KNEPPER: Objection to form.

A. Absolutely.

Q. It's an off-label use; right?

A. As we've talked about before, yes, I've -- I've used it off-label.

Q. And do you know when Botox received this indication for treatment of crow lines?

A. I'm sorry. Of?

Q. Treatment of crow lines.

A. Crow lines?

Q. Yes.

A. Oh, crow's feet (indicating).

Q. Sorry, crow's feet.

A. Yeah. Yeah. I don't know -- I don't know the exact date of that. I just know that it's been broadened.

Q. All right. Before -- strike that.

Before you first started using Botox on an off-label basis, did you do a literature search to see if there was a randomized, double-blinded controlled trial to demonstrate that this forehead use was safe and effective?

A. No.

MR. KNEPPER: Objection, form.

Q. So you were using it without having any idea if there was randomized controlled clinical trials to demonstrate the safety and effectiveness of that use; correct?

MR. KNEPPER: Objection, form.

A. So the question is, was I using it in other than the on-label purposes before the approval was handed down by -- to the -- by the FDA?

Q. No. I already heard the answer to that question.

A. Oh, okay.

Q. I'm asking you a different question.

A. Okay.

Q. At the time you were using Botox on --

A. Oh.

Q. -- an off-label basis --

A. Right.

Q. -- you were doing that without

having results from a randomized controlled trial to demonstrate that this off-label use was safe and effective; correct?

A. Correct. Correct.

MR. KNEPPER: Objection, form.

Q. The same is true for respective cohort studies; right?

A. Correct.

Q. The same is true for case control studies; right?

MR. KNEPPER: Objection, form.

A. Right. And that's an example of what we were talking about earlier where a low-risk application begins with anecdotal experience, shared anecdotal experience, and -- and the literature that comes later leading to the controlled trial that the Allergan company may have done and it's then subsequently approved by the FDA. That's right. So this would fit into that category.

Q. All right. Let's talk more about randomized controlled trials outside of Botox. If I call them RCTs for short, you'll know what I'm referring to; right?

A. Yes.

Q. An RCT typically involves two groups, an experiment group and a control group; right?

A. Yes.

Q. RCTs are typically double-blinded; right?

A. Well, in most cases. But when you're talking about things where there's going to be an outward change in the patient, it's -- it's difficult to blind such studies. You're essentially just -- for example, you couldn't have a double-blinded study of a surgical procedure, or you couldn't have a double-blinded study of a -- of a medical intervention where there's outward change to the patient that would be evident to

both the experimenter and the subject. So yeah.

Q. Yeah. So -- yeah, we'll get to that in a minute. Let me ask just some more general questions first.

A. Okay.

Q. Because I want to figure out your experience with RCTs. You personally have never been the lead investigator for an RCT; correct?

A. That's correct.

Q. You personally -- strike that.

Have you ever been involved with an RCT?

A. Yes. When I was a resident at the University of California-San Francisco working on the neurosurgical trauma unit, we were doing a randomized controlled trial of the medical management of elevated intracranial pressure, and I was -- because I was part of the team, I was responsible for gathering data in the critical care unit

and -- and working with the investigators ensuring the integrity of the data. So I was not the lead investigator, obviously. I was just one of the participants as one of the treating physicians.

Q. The only time you worked on a randomized controlled trial was during your surgery res- -- general surgery residency; correct?

MR. KNEPPER: Objection, form.

A. I'm trying to think if there were other instances here. At UC-Davis -- I'm trying to think. Give me just a moment. I just want to --

Q. Sure.

A. -- make sure I'm not missing any more. I think that's the only one where it was a randomized blinded study. That's right, yeah.

Q. And that residency was '87 through '91?

A. That's right.

Q. Okay. You've never published

any articles in peer-reviewed journals about RCTs; correct?

A. That's correct.

Q. You've personally never designed an RCT; correct?

A. That's correct.

Q. You don't hold yourself out as an expert in RCT design; right?

MR. KNEPPER: Objection, form.

A. Well, I would qualify that answer by saying that part of my training involves me being able to understand and review published literature on the subject even though I'm not the investigator because of my training as a plastic and reconstructive surgeon, as a general surgeon. As just a physician in general, we're trained on how to interpret the validity or the veracity of the medical literature, including how to interpret the randomized controlled trial and -- and understand its validity, which is -- what I'm testifying about is not my

personal experience. It's my opinion of the validity of the scientific data. So I -- so it's not that I -- that I can't express an opinion on it. It's just that I haven't personally conducted one, but I have been trained on how to interpret them.

Q. I understand that distinction you're making.

A. Thank you.

Q. But when it comes to designing RCT, you're not an expert in that aspect of RCT?

MR. KNEPPER: Objection, form.

A. Well, again, part of the evaluation of a randomized controlled trial is to evaluate how the study was designed. That's one of the criteria used for understanding the validity of a published document like a RCT. So you always look at -- that's why it's such an essential part of a -- of a RCT publication is you look at the materials

and methods and you look at the study design, and that's where, really, your analysis begins if you're trying to interpret the data. Did they design the study properly? Does it have the power of discrimination of what they claim that it has? And then you look at the actual results, and it's on -- it's on your shoulders as the -- as the professional, whether you're a -- you know, a researcher or somebody who's seeking to apply it in his practice, you're responsible for interpreting the data quite apart from their interpretation of it.

So an example of that would be the Branström study, where they -- they -- they generated a good -- a reasonable study design, but they misinterpreted the data, and that's what caused the retraction of the Branström study, is that all the other people who were not RCT investigators, but they were

all physicians, endocrinologists, pediatricians, they looked at the data and said, "You've misinterpreted the study."

And that's really what we're talking about here. There are those who perform the study, and then there's us who have to live with it, and we have to be able to understand what they're -- what they're purporting to. So we have to interpret the data even before reading their conclusions.

Q. Do you know what the CONSORT criteria are? C-O-N-S-O-R-T.

A. I've read it sometime before. I can't -- I can't -- I can't quote it for you, but it's -- it's germane to the study design process? I'm not sure.

Q. Okay. Can you describe for me what the CONSORT criteria are in general terms?

A. I cannot.

Q. All right. How about cohort

studies? You've personally never designed a cohort study; correct?

A. No, I have not.

Q. You've personally never been an investigator in a cohort study; correct?

A. Well, so -- so, that experience at -- at UC-San Francisco was a -- well, so are you asking -- by cohort study, are you talking about like a retrospective study of a -- of a population cohort? Is that what you're asking me about?

Q. Prospective or retrospective, either -- either/or.

A. I haven't designed any of those studies, no.

Q. Okay. And outside the one experience in your residency, have you ever been involved with any prospective or retrospective cohort study?

A. No.

Q. And how about case-control studies? Have you ever personally designed a case-control study?

A. No, I have not.
Q. Have you ever been an investigator in a case-control study?
A. I'm just trying to think if the -- if the head trauma investigation would fit the category of a case control. It was a randomized study. It had its own internal controls. So I guess I've assisted in that investigation, but only as a -- as a provider and a -- and a data gatherer.
Q. Outside of that one experience, you have not been involved with any prospective or retrospective cohort study; right?
A. No.
Q. Or a case-control study? Excuse me.
Okay. Let's go back to your report, Exhibit 1, and go to page 13.
A. Okay. Okay.
Q. You see there's a header that says in capital letters, "Anecdotal

Patient Stories Are Not Data." Do you see that?

A. I do.

Q. And you write, "Drs Schechter and Brown also failed to disclose and properly discuss that Anecdotal Data unverified patient reports without control groups, randomized trials, or other scientific protections for the integrity of the medical system -- are not reliable science." Do you see that?

A. I do.

Q. And then you reference personal patient stories, and you say, "This is unreliable Anecdotal Data and it is not credible, scientific information." Do you see that.

A. I do.

Q. All right. You think that case reports are anecdotal evidence; right?

A. Yeah, they're --

MR. KNEPPER: Objection.

THE WITNESS: I'm sorry?

MR. KNEPPER: Objection, form.
Go ahead.
THE WITNESS: I'm sorry.
A. Yeah. And so anecdotal data is personal experience of a -- of a practitioner, for example. So -- so a surgeon reporting on five cases that he did would be considered anecdotal reporting, or case reports and things like that, yeah. That's anecdotal, personal experience, a personal exper- --
Q. And you think --
A. I'm sorry?
Q. Go ahead. Sorry.
A. Personal experience as distinct from more stringent scientific evidence like a longitudinal study or a cohort study or something like that. Or even -- even personal experience with pre- and posttreatment testing rises to a higher level than anecdotal. So you can base -- you can base scientific evidence on that next level, which would be anecdotal

experience elevated to the next level by pretreatment and posttreatment testing. This is -- this is from the guidance that the American Society of Plastic Surgery puts out.

So depending on the -- depending on the type of study, if it's a -- if it's a therapeutic study or a diagnostic study or a prognostic study, depending on what you're looking at, if -- if you -- if you take it to that next level with pre- and posttreatment testing with a validated scientific instrument, you know, a validated study even of subjective reporting from the psychiatric/psychological side of things, that has more validity than the anecdotal reports of a practitioner or even an institution.

Q. Do you think that a case report that doesn't have this before and after comparator that you describe is essentially worthless from the --

A. No.

Q. -- scientific perspective?

A. No, no. Not worthless. Not worthless, but it's what's considered in the -- in the -- in plastic surgery circles, certainly, it's considered the lowest form of evidence. So for a number of years now, the American Society of Plastic Surgery has insisted that publications -- if you're going to publish a case series, for example, that they have to be a sequential -- you can't pick the cases you're reporting on. It has to be a sequential series of patients, and you have to declare in the publication, in your -- in your article, the level of evidence that you're presenting.

So if -- if it's merely a -- case reports, that would be level 5 evidence. If you added to that a review of the literature with a -- you know, a definitive review of the literature

looking at the -- at where the weight of evidence lies, then you raise it to the next level. But we're -- we're now required when we're publishing in -- in the ASPS journal, for example, to state in the -- in the document level of evidence. So a case report is not zero scientific evidence. It's level 5 evidence. It's the lowest form of -- of evidence is what it is.

Q. You personally would not rely on a level 5 case report to decide if a surgical technique is effective?

A. It would be the beginning of my interest in a particular technique. As a surgeon, we tend to be very conservative, and we call upon our personal experience very much and certainly upon our training. So if somebody proposes something radically new and all they have to support it is level 5 evidence, generally -- there's a saying that I learned in training is never be the first

or -- first one to do a procedure or the last one to do a procedure.

And so, yeah, you know, surgeons tend to not jump in early on -- on low-quality evidence. We tend to be conservative about it. And I would number myself among them.

Q. All right. Let me ask the flip side.

A. Okay.

Q. Do you think it's necessary for a surgical procedure to be supported by results from a level 5 RCT before it can be considered effective?

A. No.

MR. KNEPPER: Objection to form.

A. That would -- that would be one of those circumstances where what is the risk to the patient and -- and what's the potential benefit to the patient. That's -- that's what kind of would drive my decision to act on a level 5 case report, offering something like that to

one of my patients.

Q. Do you think that a surgical procedure has to be supported by a level 2 controlled study before that surgical procedure can be considered nonexperimental?

A. Not necessarily. It would depend on what is -- what is -- what is at risk here. Certainly, we're much more willing to -- to proceed with -- with techniques and procedures that aren't hugely supported if there's great risk to the patient of not doing anything. So level of risk and what is at stake kind of drives that and -- and yeah.

Did I answer that question? Is that what you were asking?

Q. Yeah. It's basically a case-by-case decision; right?

MR. KNEPPER: Objection, form.

A. Well, I wouldn't say case by case. I would say, you know, you're relying on -- on -- on a lifetime of

experience possibly, and you're relying also on -- on conversations with your peers, your colleagues, what is their experience in the area and how much of a risk are you going to subject to the patient -- subject the patient to in order to achieve a result. The greater the risk, the greater the expectation of a defined scientifically supported outcome.

So in the case -- in the issue at hand here, great risk of doing, for example, a transition surgery, because you're talking about permanent sterilization, irreversible sterilization, or the removal of the breasts, permanent and irreversible loss of the breasts, that's a huge stake, a huge risk to the patient that the -- the expected outcomes have to be consummately much larger in order to justify something like that if you don't have scientific support. If you're at low levels of

scientific evidence, then clearly, you have an obligation to the patient not to -- not to try something risky if you don't have extensive and very valid scientific -- and that's where we are now. We're at very low-level evidence for these things. That's kind of why we're here today.

Q. I guess I'm asking a more specific question. You're not taking the position that in order to be considered nonexperimental, a particular surgical procedure has to be supported by at least level 1 or level 2 evidence; right?

MR. KNEPPER: Objection, form.

A. Oh, okay. So you're asking me the definition of experimental. Is that -- do I understand you correctly?

Q. Sure.

A. Yes. Am I saying that something is nonexperimental once it reaches level 2 evidence or higher and not before?

Q. Correct.

A. I'm not saying that, no.

Q. Okay. How about level 3? Are you taking the position -- strike that.

Are you expressing the opinion that a surgical procedure can only be considered not experimental if it reaches evidence level 3?

A. Well, it's getting closer. So when you're -- when you're at level 3, you're talking about a retrospective study with a cohort. And if we were talking about some simple technique of reconstructing, say, a wound on the face for cancer therapy, then I certainly wouldn't wait to try a new technique. If it promised to get a better result, I wouldn't wait until I got to level 3 evidence.

But if you're talking about a very drastic operation where I'm amputating healthy parts, then yeah, I'm going to want to go at least to level 3 before I consider that, because again,

you're talk about tremendous risk to the patient, permanently life-altering changes. You better have very strong evidence that you're doing the patient good because you're doing the patient a great harm by, you know, removing their, genitals, permanently sterilizing them, removing their breasts. So again, it's -- it's not a case by case, but let's -- let's say broad categories of -- of techniques or surgery.

If you're talking about something small like reconstructing a facial defect, then yeah, you don't need to get to level 3. But if you're talking about something large and permanently life-altering, then at least level 3.

Q. All right. We talked earlier a while ago about some of the surgical procedure you performed, and I think one of the things you mentioned was breast reductions.

A. Yes.

Q. Right?
A. Yes.
Q. You've done those; right?
A. I have done so many of those.
Q. All right. You've done breast reduction surgery without having the results from a randomized controlled clinical trial; right?
A. I believe the -- the bulk of the evidence in the therapeutic benefit of breast reduction is primarily given to us by a long-term longitudinal cohort study that we actually get from the insurance industry. Because when you do breast reduction surgery, one of the key issues in a breast reduction is, is it going to be efficacious in curing an orthopedic problem. So if you're talking about breast reduction surgery as a quote, unquote reconstructive procedure, then really, it's being applied to an orthopedic condition.
And the insurance companies have

a wealth of evidence about, for example, the weight of the specimen that has to be submitted in order to have a hope of relieving the orthopedic complaint of neck, back, and shoulder pain.

So -- and vir- -- and I can tell you categorically, because I'm very fastidious about this, that all of the breast reduction operations that I've ever done for the orthopedic condition of neck, back, and shoulder pain have met the criteria based upon this long-term longitudinal cohort study that the insurance companies have been running since back in the '80s at least.

Q. All right. Doctor, again, I need you to listen to my questions. I didn't ask about cohort studies. I asked about randomized clinical trial.

A. Oh.

Q. You have done -- you have done breast reductions without having results from a randomized controlled clinical

trial?

A. Oh, forgive me. I -- I misunderstood the question, then. No. The -- I have not, no. The industry -- the plastic surgery community does not rely on a randomized trial for the -- the operation to be merited. That's correct.

Q. Right. Nobody in this industry waits for results from a randomized controlled trial before determining that a particular surgical procedure is nonexperimental; right?

MR. KNEPPER: Objection, form.

A. Well, this gets back to what we were talking about before, what the -- what the level of evidence is, what's at risk, and what are the potential benefits. So in the case of breast reduction surgery, yes, we have not relied on randomized controlled trials because there was such an abundance of level 3 evidence to justify the procedure. And so -- and level 3

evidence is sufficient to answer the question, is this experimental or not? This procedure doesn't rise to the level of level 2 or level 1 in order to be justified. I believe there have been -- well, no, I can't say categorically, so I won't.

So yeah, to answer your question, breast reduction does not rely on randomized trials. It relies on level 3 evidence.

Q. All right. Let's take it out of the realm of breast reduction in particular.

A. Okay.

Q. It is not uncommon for plastic surgeons to perform procedures that are not supported by results from an RCT; correct?

MR. KNEPPER: Objection, form.

A. As a general principle, plastic surgeons are perhaps more innovative than other surgeons, so we're inclined to try

new techniques. And then, of course, you have to exercise some significant prudential judgment about what risk are you placing the patient in before you get experimental with them. Yeah. So yes, we -- we do that all -- we're innovators, as -- as a general principle.

Q. And as a general principle, plastic surgeons will often commonly perform procedures that are not supported by level 2 evidence; correct?

MR. KNEPPER: Objection, form.

A. Yes.

Q. And as innovators, plastic surgeons will often perform surgical procedures that are not level 3 evidence; right?

MR. KNEPPER: Objection, form.

A. Yeah. They -- if you're talking about small like technical improvements in -- in low-risk procedures, then yeah, we -- we do that very commonly.

Q. Okay. You know what the

Plastics and Reconstructive Surgery journal is; right?

A. Yes.

Q. It's the official publication of the ASPS; correct?

A. Correct.

Q. It's a peer-reviewed medical journal; right?

A. Correct.

Q. It's published monthly; right?

A. And plus supplements as well and online. Yes, sir.

Q. One purpose of that journal is to educate members about new surgical techniques; right?

A. Yes.

Q. Would you agree that the journal is the premier peer-reviewed source for current information on reconstructive and cosmetic surgery?

A. I would.

Q. All right. Are you -- I know that you're no longer a member. Are you

still subscribing to the journal?

A. No, I'm not. It's a -- it's for members that you get the journal, so yeah. That's what my subscription relied on, so -- all those years.

Q. I understand. So not -- you haven't had access to it since 2018?

A. Well, I -- no, I go online, and I'll pay for access to particular articles. So yeah. So it's not that I've lost contact with it, it's just that I do literature searches, and if an ASPS citation comes up, I'll pay to look at it.

Q. I understand. Sitting here today, what percent of publications in that journal do you think consist of results from RCTs?

MR. KNEPPER: Objection, scope, form.

A. Yeah, I'm -- I'm not sure I could hazard a guess even.

Q. Ballpark, do you think it's 10

percent? 50 percent?

A. Of their published articles that are randomized controlled trials?

Q. Yes.

MR. KNEPPER: Objection to form, scope.

A. Gosh, I'm going to guess it's probably somewhere -- probably less than 10 percent.

Q. How about cohort studies? If you had to estimate, what percentage of publications in that journal do you think consist of results from cohort studies?

MR. KNEPPER: Objection, form.

A. Again, just ballparking here after, you know, 35 years of reading that article -- that journal for 35 years, I would say that -- I don't -- I may be guessing, but 15 percent maybe are -- are cohorts that are usually single-center studies. There's a lot of those in the -- in the White Journal. There'll be a single-center cohort study of -- of

some operation or technique, and they'll usually report it as three or four surgeons at a single center reporting a -- a longitudinal cohort of, say, breast cancer reconstructions with implants versus breast reconstruction with autologous flaps and comparing satisfaction surveys and things like that. So I'm going to ballpark it at 15 percent, but I don't know. I don't know for a fact.

Q. Let me introduce an exhibit. So this will be Exhibit 17, and let me know when you get it.

(Exhibit 17 was marked for identification and is attached.)

A. Okay. All right. I have it.

Q. All right. This is a study from 2019 by Sugrue, S-U-G-R-U-E, titled "Levels of Evidence in Plastic and Reconstructive Surgery Research." See that?

A. I do.

Q. All right. See there's a "Summary" box on the first page?

A. Yes.

Q. The third sentence says, "The aim of this study is to determine if the quality of evidence in plastic surgery research has improved over the past 10 years. Systematic review of research published in Plastics and Reconstructive Surgery journal over the years, 10-year period (2008, 2013, 2018), was performed." Do you see that?

A. I do.

Q. Now, you understand what this study was trying to accomplish; right?

A. Yeah. They were measuring the level of success that the American Society of Plastic Surgery was having after having applied those criteria we talked about earlier, the -- this requirement of reporting levels of evidence, seeking the clarity on levels of evidence. And so I expect -- I

haven't read this -- this article before, but I guess that's what they're looking at, is how successful have we been as a professional society in publishing --

Q. Yeah.

A. -- these things.

Q. And this references the levels of evidence, LOE, metric; right?

A. Yes.

Q. And that's the same metric that you referenced earlier, levels 1 through 5; right?

A. Right. Well, the levels 1 through 5 that I referenced includes the -- sort of the subcategorizing, depending on if it's a therapeutic trial or a -- or a trial of risk or things like that. So the -- the document that the ASPS published some years ago includes risk studies and diagnostic studies, but they're all ranked 1 through 5. That's right.

Q. And you see a couple of

sentences down, it says 884 studies were included in the final analysis. You see that?

A. Yes, I do.

Q. Okay. Go to page 2.

A. Okay.

Q. You see there's a Table 1?

A. Yes, I do.

Q. Table 1 is "Percentage of Each Level of Evidence Published per Year." Do you see that?

A. I do.

Q. And there's columns for 2008, 2013, and 2018; right?

A. Yes.

Q. All right. Let's start with level 1, and that's randomized control trials or metaanalyses of those trials; right?

A. Right.

Q. In 2018, only 2.1 percent of all publications in the journal were level 1 evidence; right?

A. That's right.
Q. And in 2008 and 2013, those percentages were 0.3 and 1.7 percent respectively; correct?
A. Correct.
Q. Not very common for the journal to report on results of RCTs, according to this summary; right?
MR. KNEPPER: Objection, form.
A. Yeah. And it even goes along with what -- my ballpark earlier, so I'm surprised -- yes, it was less than 10 percent were -- were level 1 evidence and somewhere around -- yeah, so those numbers are consistent. But yeah.
And the other thing to note about it is that they appear to have been successful in choosing what they publish to support higher levels of evidence. So I guess they're to be commended for having done this, yeah.
Q. Okay. All right. Then level 2 are -- level 2 evidence includes

prospective cohort or comparative studies; right?

A. Yes.

Q. With controls; right?

A. Yeah. There's a level of randomization that -- that's there as well --

Q. Okay.

A. -- in those prospective studies. That's right.

Q. And for that level 2 evidence, only 13.6 percent of all publications in the journal in 2018 consisted of that evidence; right?

A. Yes. That's what it says there, yes.

Q. All right. Level of evidence 4 is case series with a pre- or posttest or only posttest; right?

A. Right.

Q. And in 2018, those amounted to 41.7 percent of all publications; right?

A. Right. It looks as though more

of those level 4 have been shifted up into level 3, given that the level 5 has declined. So it looks like they're pushing more of the level 4 up into level 5. Yeah.

Q. Yeah. Much of the research on which your field relies doesn't consist of results from RCTs or controlled cohort studies; right?

A. Well, I wouldn't --

MR. KNEPPER: Objection, form.

A. I wouldn't say that based on this. I would say that much of the published research in this journal is of that -- of what you described, relying on RCTs and so on.

This is a -- this is not a document about what the profession is doing. This is a document about what this journal is publishing. And what they're publishing is more papers of higher value, for which they're to be commended. So this says nothing about

what people are investigating. This says about -- this says something about what this journal is publishing.

Q. Well, this is the journal for the ASPS; right?

A. Right. With limited space for publication. So they're being, apparently, more selective about what they'll publish, that it's not just that well, this is the chief of plastic surgery at NYU, so we're going to publish his paper. It's the chief of plastic surgery has a level 2 case. Let's -- let's present -- let's publish that one. I think that's what this is telling us, that they're being more fastidious about what they publish, whereas before, they might have been more -- well, less selective, let's say.

Q. Have you ever been involved with selecting articles to be published in this journal?

A. I've never been involved in --

in journal publication staff or -- no, I have not.

Q. You don't know the process by which they select what article to publish; right?

MR. KNEPPER: Objection, form.

A. I have some idea, but I'm -- it's not my -- my area of professional expertise.

Q. Yeah.

A. I merely read the journal, and have for approaching forty years now.

Q. Look at Table 2.

A. Okay.

Q. And look at the column under 2018.

A. Yes.

Q. The first two rows, "Systematic review/meta analysis" and "Randomized control trials," account for 3.2 plus 3.8 percent of all publications of the journal in 2018. Correct?

A. Right.

MR. KNEPPER: Objection.

Q. Case series account for 26.3 percent; right?

A. Right.

Q. Okay. Go to page 3 of this exhibit.

A. Okay. I'm there.

Q. All right. First full paragraph, first sentence says, "Case series are the backbone of surgical research." Do you see that?

A. I do.

Q. You don't disagree that case series can be helpful scientific evidence; right?

A. No. As I -- as I testified before, this is the beginning of research. It always begins with perhaps a serendipitous discovery, then to case reports, then to case series, single -- single-provider case series or multiple providers in a -- in a -- an institution. But that's the beginning of surgical

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

Q. Well, it's a beginning, but sometimes it's also the end; right? Because look at the third sentence. It says: "The absence of a control group justifiably ranks this design at the lower end of the evidence pyramid. Despite this, case series are vital. They may be the only feasible and ethical study methodology obtainable, as seen with craniofacial surgery." You see that?

A. Yeah. And to that -- to that particular point, so I've got extensive experience with craniofacial surgery, and -- and it's -- this is one of those procedures where the outward change to the child can't be blinded. You cannot blind the investigator because, obviously, he's doing the surgery, and you can't blind the patient or the family to it because the results are quite

obvious. And that's what they're saying here. And obviously, they're not saying that it's never useful or is never necessary. They're saying that in many cases, you don't need to rise to that level because you have evident benefit to the patient and the risk is not only manageable but -- but sufficiently low to warrant the application of a particular technique.

So that was certainly the case, for example, when we introduced external fixation devices for advancement of the mid face in certain congenital deformities. Nobody had done a randomized trial because you can't. You've got this hardware sitting on the patient's face. So -- but yet, the -- the luminaries in craniofacial surgery were able to demonstrate through a case series that this was a valid technique, and then the rest of us adopted it. So that's an example of how plastic surgery

works.

Now, if the patient was at risk of death because this technique was being applied or if the patient was at risk of permanent life-altering changes that couldn't be reversed, then yeah, you would have to proceed with much greater caution, and you may be looking at finding some way, longitudinal study-wise, to -- to quantify the benefit of using your technique over using established techniques.

Q. There are some areas in plastic surgery and reconstructive surgery where case series are basically as good as it gets in terms of scientific evidence; right?

MR. KNEPPER: Objection, form.

A. Yeah. I suppose in the newer -- at the newer end of techniques, that's all you got for now until the technique has been applied over a sufficiently long time that you can look at a retrospective

cohort.

So for example, in the case of gender transitioning surgery, the -- the -- the surgeons have been at it now for several decades. And we should be already at the level of level 3 evidence, but -- but we're not.

Q. Well, you --

A. So I wouldn't put that in the category of -- you're talking there about a high-risk procedure that has a long track record that can be examined. And -- and clearly, the examination of that technique in the last three years, give or take, has -- has shown us that that this is in the category of those operations that demand higher levels of evidence than a case series, whether it's single provider, single institution, or even single nation. You've got to -- you've got to look at the data now and -- and prove that you are doing something good for the patient.

And quite frankly, it hasn't been proven in the -- in the American literature. Certainly, WPATH hasn't proven that. But in the European literature, they're looking at it and saying, gosh, you know, the -- the Swedish study shows us that if you only follow patients for five years at the most, you're not even going to see the long-term effect of what you did to them. And if you look at them eight years and beyond, you'll see that you haven't solved the suicidality, the self-harm, the incarceration, psychiatric diagnosis admissions, and things like that.

So -- so yeah, as far as what we're talking about today, yeah, there's a whole spectrum of what's acceptable levels of evidence for a particular procedure. The higher the risk, the higher the level of evidence is demanded. And sometimes you have to wait to get to that level of evidence if you're dealing

with something potentially life-threatening.

Like certainly, the providers were fully justified in considering this because of the high suicide rate of transgender patients. Case series, totally valid reason given that the life of the patient is at risk here, totally valid to go with a case series as the evidence by which you're consenting the patient to surgery. But we're now beyond that. We're now beyond that. We're at -- we're now -- the ethics demands that we look at higher levels of evidence because of the long-term risk to the patient and the fact that the long-term evidence doesn't support the indication for surgery, which is lower suicide rate, lower self-harm, lower drug abuse. That's really what we're talking about here.

Q. I have some other questions. You agree that -- strike that.

Do you agree that it is not possible to perform RCTs for some surgical procedure because you can't blind the patient or the investigator to what the procedure is?

A. Absolutely agree, yeah.

Q. So, let's take phalloplasty; right?

A. Okay. Yeah.

Q. When a surgeon performs a phalloplasty on a patient, both the surgeon and the patient are going to know that the procedure was done; right?

A. Yes.

Q. It's not possible to have a RCT for phalloplasty because you can't blind the participant or the investigator; right?

A. Yeah. That's typical of most surgical interventions. The only exception to that would be intraabdominal or intrathoracic surgeries or even intracranial surgeries. And -- and

that's considered sham surgery, which is considered malpractice and ethical violation of professional standards. So you can pretty much rule out most all surgical procedures from the randomized control trial category. Correct.

Q. And we agree that the same would apply to metoidioplasty, for example; right?

A. Yes.

Q. To all types of, again, colloquially known as bottom surgery; right?

A. Correct.

Q. All right. Let's take puberty-blocking hormones.

A. Okay.

Q. When patients with gender dysphoria treatment start puberty-blocking hormones, they're not going to undergo puberty, basically; right?

A. Well, that's the intended use,

that's correct.

Q. So there's going to be observable physical effects of the hormones that will be apparent to the patient; right?

A. Yes. Within a year, that child is going to look much smaller than his peers. He's going to be developmentally delayed psychologically, neurophysiologically. His -- his movements are not going to be as -- his coordination is going to be less matured. His higher executive functions will be impaired. So it will be very obvious that this child is now different from his peers. So I would agree with you; you couldn't find a way to blind such a study because the evidence of effect is so obvious within the first year that everyone would know that they're taking the -- the puberty-blocking gonadotropin-releasing hormone agonist.

Q. We agree that -- we agree that

it's not possible to do an RCT for puberty-blocking hormones because of these apparent physical effects; right?

MR. KNEPPER: Objection, form.

A. I -- I would agree, yes.

Q. Okay. Let's take cross-sex hormones.

A. And the -- the last question you asked me, did you qualify that as you couldn't do a double-blinded study using puberty-blocking drugs in self-identified transgender children?

Q. Yes.

A. Yeah. Because if you're applying the drug to other conditions like precocious puberty, it -- it may be possible. It may be possible to -- I don't know. I'd have to think about that but -- okay. Sorry.

Q. Let's take cross-sex hormones.

A. Okay.

Q. When somebody -- someone is treated with estrogen or testosterone for

gender dysphoria, there are also going to be physical effects from those treatments; correct?

A. Yes. Given that sex hormones have such a profound effect on every body system, then it's going to be impossible to conceal the fact that the person is on sex hormones because every -- every function of the body is affected by sex hormone levels, particularly at the age of early adolescence.

Q. And given these visible physical effects, it's not possible to design a double-blind RCT for cross-sex hormones for gender dysphoria; correct?

A. It would probably be an invalid study, yes.

Q. All right. Let's go back to your -- actually, you know what? I'm going to move to a different area. It's been about an hour. Let's take a quick break.

MR. TISHYEVICH: Off the record.

THE VIDEOGRAPHER: This is the end of Media Unit No. 4. We are off the record at 2:16 p.m.

(Break taken.)

THE VIDEOGRAPHER: This is the beginning of Media Unit No. 5. We are on the record at 2:24 p.m.

Q. (By Mr. Tishyevich) Let's go back to your report, Exhibit 1.

A. Okay.

Q. Go to page 21.

A. Twenty-one. Okay.

Q. And you see there's a paragraph starting with, "Failure to discuss the failure to conduct"?

A. Yes.

Q. Okay. So in the second line, you reference the "unknown number and percentage of patients who drop out of transitioning or reverse the process parentheses (Detransitioners)."

A. Right.

Q. You see that?

A. I do.

Q. All right. You agree that the number and percentage of patients with gender dysphoria who drop out of transitioning or who reverse the process is currently unknown; right?

A. Well, it depends on if you're asking that question about the general population or in a particular study. So in particular studies, that number is known, but in the general population, it's an unknown.

Q. Yeah.

A. And the reason -- the reason it's unknown in the general population is because the people doing the research aren't following those patients. That's why we don't know.

Q. In the overall population, the number and percentage of patients who drop out of transitioning or reverse the process is unknown; agree?

A. Yeah. I would agree that's

unknown, yeah.

Q. All right. Given that, obviously, you're not offering any expert opinions on what that number or percentage is in the general population; right?

A. Yeah, I don't -- I don't think it's possible for anyone to break out the difference, for example, between somebody who isn't followed up because they've detransitioned or somebody who isn't followed up because they've taken their own life. We have no way of knowing because nobody's following up.

Q. All right. Look toward the bottom of this page 21. You cite a case series from I believe it's Djordjevic, D-J-O-R-D-J-E-V-I-C. Do you see that?

A. I do.

Q. And you say, "More dramatically, a surgical group prominently active in the SRS field has published a report on a series of seven male-to-female patients

requesting surgery to transform their surgically constructed female genitalia back to their original male form." Right?

A. I see that, yes.

Q. Okay. Now, this article was not an RCT, obviously; right?

A. Right, right.

Q. It was not a cohort study; right?

A. No. This would be a case -- a case series.

Q. Yeah. The lowest level of evidence; right?

A. No. Actually, the lowest level of evidence would be sort of single patient -- well, it's sort of somewhere between 4 and 5, I suppose. I'd have to look at the article again to see what the -- what the denominator is, but --

Q. Yeah. Well, generally, you think that anecdotal patient stories like these are not reliable scientific

information; right?

MR. KNEPPER: Objection, form.

A. No. They're the first clue to a problem or the first clue to a solution. That's exactly right. So that -- that sort of points to the controversial nature of these therapies, is that -- is that we don't have the answer. We can't explain why these detransitioners weren't predicted preoperatively because we don't have a test instrument to figure that out.

So when you see a series like this -- this is what we talked about earlier, about the -- the history of progression of levels of evidence. You start out with reports like this. This leads to further research. And I'm just trying to remember, when I read the article, where that study was done. I don't have it in front -- I'm just trying to remember what -- what country that was done in.

Q. Yeah. I'll -- I'll show it to you.

A. Okay.

Q. Hold on. Let me introduce it.

A. Thank you.

Q. You did read these -- this article in full before you cited it; right?

A. Yeah. That -- it was -- it was probably about seven months ago, but yes, I did.

Q. Sure.

THE COURT REPORTER: I didn't hear anything. So it's just --

THE WITNESS: Okay.

THE COURT REPORTER: We're losing it in Zoom. Thank you.

THE WITNESS: Forgive me. I'm sorry.

THE COURT REPORTER: No, that's okay. It's awkward.

Q. (By Mr. Tishyevich) Okay. This is going to be Exhibit 18, and let me

know when you have it.
(Exhibit 18 was marked for identification and is attached.)
A. Okay. Okay. Yeah, there it is. Yes. Yeah, right. Okay. It's coming back to me now. And this was published out of the -- Amsterdam. That's right. Okay. All right. Yeah.
Q. All right. Let me ask you -- strike that.
Bottom of the page, there's a section titled "Introduction." You see that?
A. The bottom of the first page?
Q. Yes.
A. Yes, I see that.
Q. Look at -- look to the column on the right.
A. Okay.
Q. The last sentence says, "In general, most researchers have reported their patients are extremely satisfied overall with their surgical outcomes,

with a low rate of complications." You see that?

(Witness reviews document.)

A. Right. I see -- I do see that, yes.

Q. Then it cites three footnotes, 5 through 7; right?

A. Right.

Q. You don't acknowledge this portion of the article in your report; right?

A. Well, it is in the discussion, I think. Well, actually, probably maybe in the summary of the -- of the medical evidence. The -- I would put this in the category of subjective reporting and short -- subjective reporting and short follow-up. Right. That's what --

Q. Well, you --

A. I'm sorry. Go ahead.

Q. No, no, go ahead.

A. So I think the reason I included this was to show that there are -- you

know, that there's a growing pool of patients who are returning for reversal surgery. I don't think I discussed in this part of my report -- yeah. I'm just talking about increasingly visible community and patient -- increasing number of patients requesting reversal surgery. And as an example of that, again, going to a single-center case collection as an example, early evidence, we're starting to see this now as numbers of patients who have surgically transitioned increases, the numbers of patients who regret is going to increase, particularly in light of what these authors speak about here.

Let me see if I -- yeah. So in the second sentence of the abstract in the introduction, it says, "However, misdiagnosed patients sometimes regret their decisions." And one of the reasons for including this article is the fact that misdiagnosis is not measured. The

world literature doesn't present error rates. This would be what I would consider an error rate, that an erroneous diagnosis was acted upon surgically, leading to this complication of regret and a -- and a desire for reversal. Yeah.

Q. Your expert testimony is that there's no data available on the percentage of people who have received treatment for gender dysphoria who experience regret?

A. Yeah. It's very, very low -- low-level evidence right now. It's basically we're in the -- we're in the case collection study, whereas actually in the -- well, that's not regret. But -- but perhaps in the category of misdiagnosis would be the -- the reports out of Sweden, certainly the -- yeah, so beginning with the Swede -- Swedish studies by Cecilia Dhejne and others that shows us a lack of efficacy. Whether or

not the patient presented for reversal is definitely an unknown number, definitely.

Q. All right. That study doesn't quantify anything about patient regret; right?

A. The Swedish study does not. It quantifies lack of -- of effect from the surgical interventions. Lack of benefit, I should say.

Q. Go to page -- PDF page 7 of this document and look at the Conclusions --

A. Okay.

Q. -- section.

A. All right. Let's see that page. Conclusions. Okay. I'm there.

Q. The first sentence says, "The vast majority of properly diagnosed transsexual patients are satisfied with their decision to undergo SRS, with only a few coming to regret it." Right?

A. Right. So this -- the other reason why this study is useful to our conversation is that this is the same

language and the same metrics that's used to describe the success of cosmetic surgery. They don't include in here, apart from the regret number that they're actually publishing here -- not number but the examples, I should say. They don't include in their -- in their conclusions any statement about objective quantifiable benefit from the surgery. They talk about subjective reporting.

So this is an example of a -- of a peer-reviewed journal article that measures the efficacy of this surgery based solely upon a satisfaction survey of patients who have returned for follow-up, so this would be an example of that. Yes, sir.

Q. Do you know what metric was used to measure satisfaction or nonsatisfaction in these studies?

A. I'd have to reread the -- the methods and materials here, but I would -- I would guess it was one of the

approved instruments for measuring satisfaction. There are a variety of test instruments used for -- in satisfaction surveys, particularly in the world of plastic surgery.

Let's see. They used the -- these are the kind of things I don't keep in my long-term memory here for a particular article. Okay.

(Witness reviews document.)

A. Okay. There's the outcomes measures. Forgive me for eating up your time.

Q. Let me -- let help you, Doctor. Go to page --

A. Okay. There it is.

Q. -- PDF page 5.

A. Yeah. Fif- -- yeah.

Q. Yeah.

A. Fifteen, right.

Q. Question on the page --

A. So there's a -- there's a test instrument there. Right.

Q. Yeah. There's a test instrument that measures things like erectile function, sexual desire, orgasmic function, intercourse satisfaction, and overall satisfaction; right?

A. Right.

Q. They don't just ask the patient, "Hey, are you happy with the surgery?" There's five criteria that are applied; right?

A. Right.

Q. This is an approved instrument for measuring this type of satisfaction for surgery; right?

MR. KNEPPER: Objection, form.

A. This is -- this is -- yeah, it's definitely a valuable instrument for measuring things, but none of them are the -- are the indication for surgery, which is things like reduced suicidality, reduced self-harm, reduced alcohol use, all of those other things which are -- which are the reason, the indication for

the operation. So you generally try to match the surgical procedure with the indication for the surgery.

They're measuring things that weren't involved in the indications for surgery. They didn't get, you know, reconstructive surgical approval so that they could achieve erections, for example. This was approved because of the risk of self-harm, suicide, those sorts of things. Yeah. But none of those are measured. They -- it is -- it is they do have objective measures, and this is one of the -- one of the values of this study. But I don't think they report the complication rate in this study, as I recall.

Q. This -- this study specifically did not purport to seek out anything about suicidality or mortality or other adverse outcomes of that nature; right?

A. Let's see. I'm trying to remember in their introduction.

(Witness reviews document.)
A. Yeah. I think their indications used language that was more consistent with -- with aesthetic, aesthetic surgery rather than the reconstructive language. So yeah.
(Witness reviews document.)
A. Yeah. So --
Q. Yeah. Here's --
A. Yeah, I would --
Q. Here's what I find interesting, Doctor.
A. Okay.
Q. Your report cites this one case series of seven patients to make the point that there's this regret occurring without even mentioning that there's multiple case series that say the vast majority of these patients end up being satisfied with this type of surgery?
A. No. I don't think --
Q. You don't think that's appropriate to mention?

A. No. I -- actually, what I present these examples to show, that -- that the literature in support of these surgeries is characterized by very short follow-up and subjective reporting. So this is an example of some objective reporting, mostly subjective reporting. And most of the articles, for example, that you just asked me about involve subjective reporting and short follow-up. That's right, yeah.

Q. All right.

A. And in this case, you also -- I'm -- I'm pleased that they reported that one, two, three, four, five, six, seven -- so nearly half of their patients had a surgical complication of a urethral fistula, and if you have a urethral fistula and you have a malleable prosthesis, probably they went on to remove the prosthesis as well. But that's -- I mean, I -- props for this -- this team that they reported their

complications.

Q. Where -- what page is the complications portion you're looking at?

A. That's on -- just before you get -- the last page before the -- the same page as the conclusions. There's a table at the top, and they have the seven patients, and you can see -- what's also interesting here, too, is -- is that if you look at the period after sex reassignment surgery, that the -- that the dissatisfaction level really kicks in when you're beyond eight years. Actually, if you look at even six years beyond.

Initially, there's no patients reporting dissatisfaction at anything less than five years, and so this is actually further evidence of the -- of the inadequacy of the -- the papers that are in the literature right now which have follow-ups that are typically two to three years. So none of these patients

would have been seen, with most of the literature that supports these techniques, as a way to, you know, avoid -- avoid dissatisfaction or -- or suicidality or drug use or anything else like that. So that's an interesting -- I hadn't noticed that before, but yeah.

Q. Yeah. Are you reading Table 1 to say that these complications like urethral fistula and stricture were from the original surgery?

A. Well, I'm -- I'm merely --

Q. Or is it from the reversal surgery that was being done later?

A. So they're talking here about flaps. They're talking about complications from the -- the -- the surgeries. Yeah. So this --

Q. Yeah. This is --

A. They're speaking about urethral fistulas and strictures are the main problem after total phalloplasty. So that's the construct of the counterfeit

phallus because of insufficient vascular supply. I also discuss that in my complications section. These are characteristic complications of these free flaps, radial forearm free flaps, and you see those complications here. And you even see them later in -- in the case, so. Some of them are step procedures. In fact, all of them are.

Q. All right. Let me -- let me show you another study.

A. Okay.

Q. Let me reintroduce this with an exhibit -- exhibit stamp. Give me a second. All right. I'm reintroducing this as Exhibit 20. Let me know when you have it.

(Exhibit 20 was marked for identification and is attached.)

A. I just got Exhibit 19. Is there another? There's a 20 to follow?

Q. It -- it should load momentarily. Yeah.

A. Oh, I'm sorry.

MR. KNEPPER: Are 19 and 20 the same, just one's missing the little stamp?

MR. TISHYEVICH: Correct.

THE WITNESS: Okay. I'll just go to 20, then, when it comes in.

Q. Okay. This is a study titled "The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets." Do you see that?

A. I do.

Q. And then it's by an author, let's say Wiepjes, W-I-E-P-J-E-S.

A. Yeah.

Q. Right?

A. I agree.

Q. Have you seen this study before?

A. I'm trying to gloss it to see if I've read this before. I -- I may have. Give me just a moment, if that's okay.

Q. Sure.

(Witness reviews document.)
A. Yeah, this looks familiar.
Q. I don't think I saw this in your report, but tell me if you remember otherwise.
(Witness reviews document.)
A. Yeah, no. I remember this being evidence of the growing population of self-reported transgender patients, and it's a retro- --
Q. Okay. Let me --
A. -- retrospective trial. Yeah.
Q. Yeah. Let's go through this.
A. Retrospective study, I should say.
Q. All right. You see the "Abstract" section on the first page?
A. I do.
Q. See the "Results" section?
A. I do.
Q. It says, "6,793 people (4,432 birth-assigned male, 2,361 birth-assigned female) visited our gender identity

clinic from 1972 through 2015." See that?

A. I do.

Q. All right. So you understand that as part of this study, the authors reviewed medical records of 6,793 people who visited this gender identity clinic from 1972 to 2015; right?

A. I do.

Q. All right. And you see the "Strengths and Limitations" section?

A. Yes, I do.

Q. And you understand that this Dutch gender identity clinic treats more than 95 percent of the transgender population in the Netherlands; right?

A. Right.

Q. Pretty comprehensive study; right?

MR. KNEPPER: Objection, form.

A. As of 2015, yes. So it's a 7-year-old study, and it's -- it's certainly large in numbers, that's for

sure. So it's a retrospective chart review of patients visiting the -- the center in the Netherlands, and it's -- it concludes in 2015.

Q. This is certainly a better study than that seven series case report that you cited in your report; right?

A. It's a different type of study. Yes, it is. Right.

Q. Yeah. This study reports on 6,793 people, whereas the case series on which you rely has seven what you call anecdotes; right?

A. I wouldn't say I relied on that study. I merely presented it as an example of -- of reporting on transgender regret. I didn't present it as a study that I relied all my opinions on. Certainly, there's other study types and other studies in the literature that -- that one might rely more heavily on.

Q. Well, let the --

A. A retro- -- a retrospective

chart review, for example, might be more useful.

Q. Yeah.

A. But not -- not definitive. And again, we've got to examine the fact that we're looking at old data here.

Q. Well, let's see what this 30-year retrospective review found. Look at the "Results" section.

A. Scroll down. Okay.

Q. Look at the last two sentences. "The percentage of people who underwent gonadectomy within 5 years after starting HT remained stable over time" --

A. Right.

Q. -- "(74.7% of transwomen and 83.8% of transmen). Only 0.6% of transwomen and 0.3% percent of transmen who underwent gonadectomy were identified as experiencing regret." Do you see that?

A. I do. And that has caused me to want to look back and see -- okay. So

they started with the 6,800, roughly, and they report on 6,000 -- 7,000 almost. Okay. And clinic. Okay. And increase.

So I'm just trying to see if they reported the average follow-up. They're reporting when they underwent gonadectomy after starting hormone therapy, but they don't report the length of follow-up, which is one of the key reporting points there, because regret, as we talked about earlier, is a -- tends to be a function of time postsurgically. So, let's just scroll down because it's been a long time since I looked at this article. Transwomen, transmen total underwent gonadectomy.

Yeah. As I recall, they don't report average follow-up time. Every five-year cohort. So they're looking -- they -- they did look at when they entered the system. Prevalence and treatment. Confidence interval.

Yeah, as I -- yes. So I think

that's -- this is coming back to me now. I think they didn't report the average follow-up or the -- let's see if I'm missing something here. Age for each year, so they did break them out in age that they -- they entered the -- the process, the years during which they entered the process, age groups. And yeah, I think that's -- that was one of the -- one of the issues.

And this is -- consonant with -- with a lot of the literature, is they don't report the follow-up interval. And that's what the Swedish study is showing us, that if -- if you don't have a handle on the length of follow-up after sex reassignment surgery, then you don't have a -- you don't have any way to fully understand the issue of lack of efficacy or regret.

If you're asking the questions is the surgery effective in correcting the most calamitous problems that a

transgender person has, which is suicidality, self-harm, and all those things that we talked about earlier, then you have to look at the interval postsurgery in order to have a full understanding of the efficacy of the procedure. And as I recall now, looking it over again, this study does not report on the follow-up period. The median age at first visit was younger, 25. Yeah. So they talk about age. They talk about the years in which they were cared for, but they don't talk about the length of the follow-up interval, so.

Q. All right. Let me move on --

A. Okay.

Q. -- to save time.

A. All right.

Q. Go to page 4 and where it says "Regret."

A. Okay.

Q. You with me?

A. I am.

Q. Third sentence says -- fourth sentence says, "Reasons for regret were divided into social regret, true regret, or feeling non-binary." You see that?

A. I do.

Q. And social regret -- strike that.

It says, "Transwomen who were classified as having social regret still identified as women, but reported reasons such as 'ignored by surroundings' or 'the loss of relatives is a large sacrifice' for returning to the male role." Do you see that?

A. I do.

Q. All right. So some of the persons who are being counted as experiencing regret in the study did not experience regret in the sense of they're realizing they're not transgender; right?

A. Realizing they're not transgender? I'm -- I'm trying to understand your question here. So you're

-- you're pointing me to the -- social regret, true regret, feeling non-binary is what's stated here.

"Transwomen who were classified as having social regret still identified as women, but reported reasons such as 'ignored by surroundings' or 'the loss of relatives is a large sacrifice' for returning to the male role."

Okay. Yeah. So -- so it's -- it's reporting without quantifying the reasons for regret and the -- basically all of them, subjective reporting again, so -- okay.

Q. Well -- well, let's go to page 6.

A. That's the next page, isn't it? Am I on the right page?

Q. On page 6, it has a large vertical table on the left side.

A. Okay. There we are.

Q. And you may want to rotate it so that you can see that table 6.

A. When I got -- let's see. There's a way to do that, isn't there?

THE COURT REPORTER: Yeah. If you put your cursor over the document, a black rectangle will come up at the bottom.

THE WITNESS: I see it now. Yes.

THE COURT REPORTER: There you go.

THE WITNESS: All right. There we are.

Q. Table 4 is titled "Characteristics of people with regret."

A. Okay.

Q. According to this table, out of 6,793 patients who received treatment, 14 of them reported regret of any type; right?

A. Okay.

Q. And all the way on the right, you see there's a "Reason for regret" column; right?

A. Right.

Q. And you're welcome to count it, but by my count, only 7 of those 14 reported, quote, unquote, true regret; right?

A. Yeah. And what's interesting about that is that those are the same criteria that were used to seek transgender surgery to solve their interior problems. So many patients will present for care because they feel socially isolated and because they have, you know, issues of -- well, for example, being non-binary and so on, those -- those -- like social acceptance and feeling non-binary is among the indications for the procedure. So it's interesting to note also that time after surgery, the regretters seem to favor -- postsurgical, you start to see them, what, maybe 50 to 90 months out and a lot of them, years -- ten years out. Yeah. So that -- that speaks to what we talked

about earlier, that you see these regrets and these problems beyond five years.

Q. All right. Whatever criticism you have of the methodology, what the study reports is -- are rates of regret that are below 1 percent; right?

MR. KNEPPER: Objection, form.

A. Yeah. Again, so as we talked about earlier, that's the problem with this study, is that -- is that the -- the denominator is a much larger number than these 14 patients, and they don't address the length of follow-up out of which they extracted these 14 patients. So it makes it difficult to interpret the study, and the claim that it's a small number is hard to support by their own evidence because they didn't follow them long enough. As their own data shows, you got to follow them longer to see the regret in most patients. And they don't tell us what that number is.

Q. Are you aware that there are

studies on patient regret outside of the treatment for gender dysphoria?

A. Am I aware of -- of transgender transition regret outside of --

Q. No. I'm going to ask -- I'm going to ask this again.

A. I'm sorry.

Q. Are you aware there are studies on rates of patient regret outside of surgical treatment for gender dysphoria?

A. Yes. Absolutely, yeah. So --

Q. Okay.

A. One of the -- one of the most important --

Q. Okay. Let me ask -- yeah, Doctor, let's -- this is going to be a long day. Just listen to my questions.

Did you do a literature search to find out what the average rates of patient regret are for other surgical procedures compared to surgical treatment for gender dysphoria?

A. I did not.

Q. Do you know if those rates are higher, lower, or about the same as the rates of regret for surgical treatment for gender dysphoria?

A. I would say there's no way of knowing because we don't have the -- the rate of regret in transgender regretters. We don't have that number, so there's no way to compare or to know which is the higher number.

Q. Okay.

A. Like we talked about earlier, we don't have this number.

Q. Well, this one study I just showed you showed a finding of 0.3 percent to 0.6 percent; right?

A. Right. And I -- and as I said, this is -- this is -- it's difficult to use this to compare to other regret cases because of the poor quality of this study. So I can't use this to compare it to the other studies on regret because this is not -- not useful to that end. I

mean, it's useful in seeing that 14 -- 14 regretters had these complications, 14 regretters had these -- these explanations for their regret.

And so it's kind of like a case collection, and retrospective reviews of -- of patient records are helpful in getting a sense of the size of the problem. Certainly, this study shows us that there's an increasing patient pool of people who self-identify as transgender. So in that regard, this publication is very useful. But in terms of comparing the regret rate based on this paper, I'd say this paper is useless.

Q. Okay. Open Exhibit 21.

(Exhibit 21 was marked for identification and is attached.)

A. Okay.

Q. Let me know when you have it.

A. Okay.

Q. All right. This is a

publication from 2017 by Wilson, W-I-L-S-O-N, titled "Regret in Surgical Decision Making: a Systematic Review of Patient and Physician Perspectives." See that?

A. I do.

Q. All right. Look at the abstract. You with me?

A. I'm -- I'm looking -- I'm just reading it now.

Q. The third sentence says, "We performed a systematic review of the literature focused on patient and physician regret in the surgical setting." See that?

A. I do.

Q. Now look at "Results." See that?

A. I'm there now, yes.

Q. It says, "Of 889 studies identified, 73 patient studies and 6 physician studies met inclusion criteria." Do you see that?

A. I'm reading it now, yes.
Q. I understand this is a systematic review of 73 patient studies and 6 physician studies on regret and surgical decision-making; right?
A. That's what it says here, yes.
Q. Then the third sentence of "Results" says, "Interestingly self-reported patient regret was relatively uncommon with an average prevalence across studies of 14.4%." Right?
A. Right.
Q. And then "Conclusion" says, "Self-reported decisional regret was present in about 1 in 7 surgical patients." You see that?
A. I do.
Q. All right. So according to this systematic review, one out of seven surgical patients, on average, report having decisional regret; correct?
MR. KNEPPER: Objection, form.

A. Right. So actually, I would go a little deeper than that. The first thing to note about this study -- and again, this is my first reading of it, so I'm on the fly here.

The first thing to note about it is that they looked at nearly 900 studies, of which only 73 qualified as having sufficient validity to include in their study. So this -- this speaks to a problem in the literature. I'd have to read lower to see what particular -- if they even examined what kind of surgeries were performed, because regret can happen for a number of reasons, including postsurgical complications and so on, types of surgery.

Q. We don't need --

A. Yeah.

Q. We don't need to dig into this too deeply. But, I mean, you don't dispute that regret is not uncommon for patients who have any kind of surgical

procedure; right?

MR. KNEPPER: Objection to form.

A. No. You know, there's -- there's -- it's such a life-changing event that the potential for regret is very high, so that's why you have to be careful in consenting the patient.

Q. Okay. Let me -- let's go back to your report.

A. Okay.

Q. Because I hear you criticizing all this evidence, and I want to see the stuff that you're relying on. Go to page 22.

A. All right.

Q. All right. About halfway down this paragraph, you say, "As reported by one author in 2021, 60,000 testimonies of personal de-transition can be found on the Internet."

A. Yeah, that's a typo. That's a typo. That should have been 16, not 60.

Q. Okay. Well, I think it's more

than that.

A. Okay.

Q. So we'll look at this in a second.

A. Sure, sure.

Q. And you cited this article from Pablo Exposito-Campos.

A. Yes.

Q. E-X-P-O-S-I-T-O, dash, C-A-M-P-O-S. Right? That's what you rely on; right?

A. Not relying. I'm basically just putting that out there as an example of a growing number of patients regretting transitioning, yeah.

Q. Well, no. What you say in your report is that according to this publication, you can find 60,000 -- or let's call it 16,000 testimonies of personal de-transition on the Internet; right? That's the point you're making?

A. Sixteen thousand, right. Yeah.

Q. Let's look at what that article

actually says.

A. Okay.

Q. Okay. This is going to be Exhibit 22. And let me know when you get it.

A. Doesn't seem to be coming through.

Q. Yeah, it may be stuck on my end. Okay. Just went through, so you should see it shortly.

(Exhibit 22 was marked for identification and is attached.)

A. There it is. Okay. Right.

Q. All right. This is the article that you're citing in your report; right?

A. Uh-huh.

Q. All right. So before we get there, you know that what this author was talking about was a Reddit website; right?

A. Yeah. That was -- that was their data source, yeah. Right.

Q. Reddit is not a peer-reviewed

publication, obviously; right?
A. Clearly.
MR. KNEPPER: Objection.
A. Yeah.
Q. Right?
A. Yes. It's not a peer-reviewed.
Q. It's a social website that anyone can access; right?
A. Right. Correct.
Q. Anyone can post -- can register an account on Reddit and post whatever they want; right?
A. Right.
Q. A post on Reddit is not something that you would consider reliable scientific evidence, I assume; right?
A. Yeah, no.
MR. KNEPPER: Objection, form.
A. I would -- I would put that as self-reporting anecdotal-level evidence, that's right. So it's -- it's not definitive, but it's suggestive of an

area in need of examination. And that's the reason I include it here, is not as definitive evidence of a particular level of problem but the -- the presence of a problem that needs to be addressed. So the substance of my testimony there where I call this study up is to show that there's a growing body of patients, as we talked about earlier, a growing body of patients who regret their transition and are seeking reversal. So that's what this is about.

It's not a quantification of the phenomenon. It's not a level 3 evidence of the phenomenon. It's a level 5, self-reported, anecdotal stuff that -- that is basically just calling us to look more carefully at what promises to be a controversial area of medical care. So this is just part -- part of the controversy is what we're looking at here. We're not looking at a definitive scientific document, so.

Q. It's not even level 5 because at least a case report that's published in a peer-reviewed journal has someone looking at that case report to figure out if it's a real thing; right?

A. Right.

MR. KNEPPER: Objection, form.

A. What we have here is a clinical psychologist who's looking at something going on online, and the clinical psychologist is -- is reporting this, that's right.

Q. Go to page 4 of this article.

A. One, two, three, four. Okay.

Q. See there's a second paragraph under "Further clarifications"?

A. Yes, I do.

Q. All right. And it references this Reddit/detrans subreddit; right?

A. Right.

Q. And it says it's "a subreddit for detransitioners to share their experiences with more than 16,000

members."

A. That's correct.

Q. Right?

A. Uh-huh.

Q. Then it says, "one can find several stories of people who call their transgender status into question." You see that?

A. Right.

Q. All right. This author is not saying that there's 16,000 separate testimonies of people tran- -- detransitioning on that subreddit; right?

A. I think the author is saying that there's a pool of 16,000 people among whom are evidence of regret or cessation of transition. That's what -- I think that's what the author's saying.

Q. Well, let's be more specific, because what he actually says is "one can find several stories." Right?

A. Right.

Q. There's a very big difference

between, quote, several stories and 16,000 stories of detransitioning; right?

A. I think what the author is saying is that -- that there are -- let's see. Subreddit -- detran- -- experiences -- more than 16- -- one can find several stories of a particular kind of transgender -- persons who call their transgender status into question after stopping transition.

So the several stories have to do with people who call their transgender status into question. Not people who regret the surgery, but these are people who regret the diagnosis. So he's talking about several stories of regretters of the diagnosis. It doesn't speak about regretters of the transition. He doesn't address that in that.

Q. All right. A bunch of posts on a social website is not scientifically reliable evidence to show the number of different people who actually

detransition; right, Doctor?

MR. KNEPPER: Form.

A. Yeah. As we said before, we have no way of -- at present, of knowing the number of people.

Q. Okay. Go back to your report.

A. Okay.

Q. Go to page 40.

A. All right. Okay.

Q. All right. Your first paragraph at the top of this page says, "A currently unknown percent-" -- "percentage and number of patients reporting gender dysphoria are being manipulated by a -- peer group, social media, YouTube role modeling, and/or parental -- social contagion and social pressure processes." Right?

A. That's right.

Q. I take it you're not aware of any peer-reviewed studies that quantifies the number of people with gender dysphoria that are being, quote, unquote,

manipulated by social contagion or social pressure; right?

A. Again, as I said before, we don't know the numbers because that's not -- it's not adequately reported in the literature. But what we do know is that the social -- Lisa Littman's article, for example, in 2017 shows us that there's a significant factor in this new demographic of self-reported transgender patients, the new demographic being adolescent to young adult females without prior history of gender dysphoria or gender discordance suddenly reporting transgender self-identification.

And -- and what it shows us, what Lisa -- Lisa Littman's publication from Brown University shows us is that underlying these outbreaks is peer group networks of people online, peer groups online, social media, a modeled speech, a rehearsed speech, and -- and these -- these sudden outbreaks of -- of

self-identified transgender patients.

So we know it's there, but we can't quantify it yet. It's just it's -- but it's -- we have at present no other explanation for why the demographic of self-reported transgender patients has suddenly shifted from virtually all young boys to 50 to 60 percent of the new cases being adolescent to young adult females. And that's -- that's what we're -- what we're talking about here. This just speaks to the controversial nature of this -- medical and surgical interventions is that we don't even understand the origin of that phenomenon. And -- and what that Littman article shows us is precisely these things: that there's an element of social contagion, that there's peer pressure, there's rehearsed speech, online networks that cause these outbreaks of these new kind of patients, adolescent young adult females who previously had no

self-reporting of trans- -- cross-sex self-identification.

MR. TISHYEVICH: This is not responsive to my question, and I move to strike it.

Q. Here's my question, Doctor. You are not aware of any peer-reviewed study that quantifies the number of people with gender dysphoria who are being manipulated by social contagion or social pressure; correct?

A. No. We're at the -- we're at the level of level 4/5 evidence now. Lisa Littman's article is a level 5, possibly 4. A level 5. So --

Q. It's not a -- you're also not aware of any peer-reviewed study that quantifies the percentage of people with gender dysphoria who are being manipulated by social contagion or social pressure; correct?

A. No. That's part of the -- part of the problem with the literature.

Exactly right.

Q. Yeah.

A. Exactly right.

Q. Given this lack of reliable studies, do you agree that this phenomenon of social contagion is currently hypothetical?

MR. KNEPPER: Objection, form.

A. I would not agree with that. It's not hypothetical.

Q. Do you -- did you read the response from Lisa -- from Littman to the criticisms to that article?

A. I did. And -- and I also noted that the -- the -- the organization under which she published that article put considerable pressure on her. But she can't retract her data. She can retract her conclusions, but she can't retract her data, and she can't retract the findings in the paper itself that show the rehearsed speech, that show the networks that are involved, that showed

the -- the character of the -- the rehearsed speech, like, you know, if you're talking to the psychologist, tell them you've been thinking about suicide; if you're talking to the endocrinologist, tell them you feel better now that you're started on T, that sort of stuff. So -- so it's not hypothetical, it's actual.

The -- the size of the phenomenon can only be compared to the change in the demographic. Why are 60 percent of patients fitting into that category suddenly, whereas before, only 20 percent of patients were females?

Q. Do you remember --

A. That's what --

Q. Okay. Do you remember the part of the correction from Ms. Littman where she said that this is a hypothesis-generating article?

A. Hypothesis as to -- as to mechanism of -- of action, and some of the hypotheses are what's listed there:

social network peer -- media -- I'm sorry -- peer pressure, social media, role modeling, social contagion. So she admits that is a -- it is not understood. She admits that those phenomena are there, but it -- at present, we're hypothesizing about the actual cause. And this speaks again to the controversial nature of even the diagnosis, much less the treatment.

Q. Go back to your report.

A. Okay.

Q. Page 40.

A. I'm there.

Q. Toward the bottom, you say, in capital letters, "Not Generally Accepted." You see that?

A. I do.

Q. And you say, "Affirmation medical treatments -- hormones and surgery -- for gender dysphoria and transitioning have not been accepted by the relevant scientific communities." Do

you see that?

A. I do.

Q. It's your expert opinion that it's generally accepted that puberty blockers are not medically necessary; right?

A. No.

MR. KNEPPER: Objection, form.

A. I would say puberty blockers in the setting of a self-identified transgender is not medically necessary, but puberty blockers are often medically necessary, just not in that particular patient population.

Q. Is it also your expert opinion that it's generally accepted that hormone treatment for gender dysphoria is not medically necessary?

A. Well, the scientific evidence now shows that it is -- is not useful. That's what I said --

Q. Answer my question. Is it your expert opinion that it's generally

accepted that hormone treatment for gender dysphoria is not medically necessary?

A. Yes.

Q. Is it also your expert opinion that it's generally accepted that gender-affirming surgery for gender dysphoria is not medically necessary?

A. Yes. I would say so, yeah. I can't put a number on it, but yeah.

Q. All right. Let me -- let me show you another document. Okay. Let me introduce this. Okay. This is going to be Exhibit 23. And let me know when you get it.

(Exhibit 23 was marked for identification and is attached.)

A. Okay. All right. I'm there.

Q. Okay. Top of the page says, "BlueCross BlueShield of North Carolina." Right?

A. Correct.

Q. You know what Blue Cross and

Blue Shield is; right?

A. Right.

Q. It's a healthcare insurer; right?

A. Yes.

Q. Are you aware that Blue Cross Blue Shield is the largest private insurer in the state of North Carolina?

A. I am now.

MR. KNEPPER: Objection, form.

Q. All right. This document is titled "Corporate Medical Policy," "Gender Affirmation Surgery and Hormone Therapy." Right?

A. Right.

Q. Do you know what this is?

A. Do I know what what is?

Q. Do you know what this document is?

A. It appears to be an insurance company document concerning the coverage of certain services. I would have to read it to know what it is specifically,

but I think it's probably a policy statement about what is covered and what is not covered and what the diagnostic criteria are.

Q. Yeah.

A. What the policy of the company is. Yeah. So, shall I read it or?

Q. I'll walk you through it.

A. Okay.

Q. You see it says "Last Review" near the top?

A. Right.

Q. It's 3/2021. That's March 2021; right?

A. Yes.

Q. All right. You understand this policy was a -- strike that.

In your report, you cite a number of articles that you say Dr. Brown and Dr. Schechter overlooked, like a bunch of 2020 articles; right?

A. Right.

Q. You understand this was

published -- updated after all those studies that you cited were published; right?

A. It appears to be.

Q. Okay. Go to page 7. You see it says "Scientific Background and Reference Sources"?

A. Right.

Q. You understand this section of the policy provides some of the scientific background on which the policy is based; right?

A. I see that, yes.

Q. And if you go to page -- the next page, page 8, you see there's a bunch of references to Specialty Matched Consultant Advisory Panel; right?

A. I see that, yeah.

Q. And there's some references to sen- -- Senior Medical Director reviews; right?

A. I see that, yeah, from 2016.

Q. Yeah. Well, if you keep

looking, there's a bunch from 2020; right?

A. I see medical director review in 2020. Yes, I do. I see that.

Q. And then including a medical director review in March 2021; right?

A. I see it. That's probably what generated this document. Am I right?

Q. Yeah. Good guess. Now, obviously --

A. That's why they pay me the big bucks. Sorry.

Q. Obviously, you had no involvement with the development of this policy from BlueCross BlueShield of North Carolina; right?

A. Correct.

Q. You have no idea how BlueCross BlueShield of North Carolina came to decide what gender affirmation surgeries or hormone therapy they're going to cover or not; right?

A. Wrong. I -- I have now some

idea of what they used because you've listed -- or they've listed the scientific background and reference sources for coming to their company policy. And what I would point you to is the fact that every one of the documents, the scientific documents that support their decision-making, I think the most recent one is 2014. You've got some that go back to the year 2000. So you've got 21-year-old DSM-4 characterizations. You've got 2001 Harry Benjamin Gender Dysphoria Association publications. The most recent thing is a -- is a -- well, that's actually an advisory panel. So the most recent medical article is the Cohen-Kettenis Hembree article from 2016. So what's used to support a March 2021 document is essentially six-year-old information. And as we talked about earlier, it hasn't -- it's changed a lot. It's changed a lot since then.

The fact that Blue Cross Blue

Shield is slow off the mark would be troublesome to the shareholders, I suppose. But as far as what I'm here to talk about, the scientific basis for this, the scientific basis is old data.

Q. Doctor, you don't know whether this is an exhaustive list of every scientific resource that Blue Cross Blue Shield considered in making the March 2021 update; right? You have no idea?

MR. KNEPPER: Objection, form.

A. I can only go by what they've disclosed.

Q. Right.

A. And what they've disclosed -- which I would assume they would be leading with their best information rather than their worst -- I would call that -- the scientific support of low quality because of the -- the better-quality data that's now available in the last three years.

Q. You don't know personally

whether Blue Cross Blue Shield considered any of the articles that you've cited when they're making this policy change in 2021; right? You don't know that?

A. I have no way of knowing how --

Q. Yeah.

A. -- that committee worked. I only -- I only assume that they would have put out their best scientific support rather than their weakest.

Q. Yeah. Bottom of this page, by the way, see there's a section that says, "Policy Implementation/Update Information"?

A. Yes, I see that.

Q. And it says, "7/19/11" --

A. Yeah.

Q. -- "New policy developed." Right?

A. Right.

Q. You understand that Blue Cross Blue Shield has had some form of this policy for gender affirmation surgery

since July 2011?

MR. KNEPPER: Objection, form.

A. I can see that they have had a policy, according to their own reporting, since July of 2011.

Q. All right. So, let's look at what Blue Cross Blue -- Blue Cross Blue Shield thinks about whether these procedures are medically necessary. Go to page 5.

A. Let's see. So we're at page 8. We're going up to page 5? Okay. Okay.

Q. Give me a second. Actually, let me start you on page 1. You see there's a description of -- let me know when you get there.

A. I'm there.

Q. Okay. Now, the beginning says, "Gender Dysphoria is the formal diagnosis used by professionals to describe persons who experience significant gender dysphoria (discontent with their biological sex and/or birth gender)."

Right?

A. Yes, I see that.

Q. All right. You understand what this policy is addressing; right?

A. Yeah. It's addressing a psychiatric classification, not medically classified as a medical illness. So they're -- yeah.

Q. Okay. Go to page 2.

A. Can you give me just a moment to reread that sentence for just a second.

(Witness reviews document.)

A. Okay. Yeah. So that's boilerplate. I'm sorry. Sorry for slowing you down here.

Q. That's fine. Go to page 2.

A. Okay.

Q. Top of the page says, "Policy." Right?

A. Correct.

Q. And it says, "Services for gender affirmation surgery and hormone therapy may be considered medically

necessary when the criteria below are met." You see that?

A. Right. So that's -- that's language that insurance companies use. If you're not in the category of medical necessity, there's no insurance coverage. So whether or not one could classify it as a medical diagnosis is not at issue. What's at issue is, is the insurance company going to cover this -- this benefit.

Q. Yeah. Because insurers typically are not in the business of covering services that are not medically necessary; right?

A. No. I wouldn't --

MR. KNEPPER: Objection, form.

A. -- characterize it that way.

THE WITNESS: I'm sorry.

A. I wouldn't characterize it that way. Insurance companies are in the business of -- certainly, they're in the business of -- of paying for covered

benefits. But that's the problem with the insurance industry, is their primary fiduciary duty is to their investors. And so the question of coverage has more to do with are we going to make an insurance policy that earns us money or are we going to be paying for something and not seeing the money. Okay? Does that make sense?

Q. Doctor, you --

A. I think that's what -- that's what this language here is talking about is -- is medical necessity is the language that's used when an insurance company will cover. They will not cover cosmetic surgery, but they're -- they're proposing to cover transgender surgery beginning by attempting to define it as a medical diagnosis. That's what's at stake here is.

Q. No. What -- what this policy says is that when certain criteria are met --

A. Right.
Q. -- gender affirmation surgery and hormone therapy may be considered medically necessary; right? That's what it says in black and white.
MR. KNEPPER: Objection, form.
A. Yeah, again, so medically necessary from the standpoint of an insurance company is if you meet these criteria, we'll pay for it; if you don't meet these criteria, we won't pay for it. That's -- that's --
Q. Right. And the difference is whether the surgery is considered to be medically necessary or not; right?
MR. KNEPPER: Objection, form.
A. Well, again, so medically necessary in this case is has the insurance company decided that they're going to cover this benefit. It says nothing about the scientific support for the efficacy of the procedure. They haven't said anything in that about it.

They've just called it medically necessary.

Q. All right. Let's -- let's go off the record.

A. Okay.

THE VIDEOGRAPHER: This is the end of Media Unit No. 5. We are off the record at 3:25 p.m.

(Break taken.)

THE VIDEOGRAPHER: This is the beginning of Media Unit No. 6. We are on the record at 3:36 p.m.

Q. (By Mr. Tishyevich) All right. I'm going to introduce another exhibit, Doctor.

A. Okay.

Q. It's being slow on my end. Bear with me. Okay. This will be Exhibit 24. Let me know when you have it.

(Exhibit 24 was marked for identification and is attached.)

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

Q. Okay. You've seen this study

before; right?
A. Yes, I have.
Q. How do you pronounce the lead author's name?
A. That's the subject of great debate, but I think it's Dhejne or -- I think it's Dhejne, Cecilia Dhejne, but I -- I -- I'm not -- I'm not a Swissophone.
Q. I'll use Dhejne as well.
A. Okay.
MR. TISHYEVICH: And for the court reporter, it's D-H-E-J-N-E.
Q. Okay. This is a study from 2011; right?
A. Yes.
Q. And you cited this study in several places in your report --
A. I do.
Q. -- right?
And one of the points for which you cite this study is to say that Swedish patients who underwent

gender-affirming surgery had a 19.1 times greater suicide rate than the control group; right?

A. Yeah. The hazard ratio for -- well, for all reassigned persons is 19.1, and they further break out the -- that into subgroups of female-to-male and male-to-female.

Q. Yeah. And you understand how the control group in this study was defined; right?

A. Yes.

Q. The control group did not consist of patients with gender dysphoria who did not undergo gender-affirming surgery; correct?

A. Correct.

Q. The control group consisted of patients without gender dysphoria; right?

A. Yeah. That's kind of the point of the -- of the research, yes. That's right.

Q. Yeah. What this Dhejne study

compared was the suicide rate for patients who underwent gender-affirming surgery against the general Swedish population; right?

A. Right.

Q. And you know there's many studies that find that patients with gender dysphoria, as a population, have a higher risk of suicide compared to the general population; right?

A. Very much accepted fact, yes.

Q. Yeah. All right. We'll go to page 7.

A. Let's see here.

Q. You see there's a "Strengths and limitations of the study" section?

A. Two, three, four, five, six, seven. Yes, I'm there.

Q. All right. Look at the third full paragraph in that column.

A. Okay.

Q. All right. Second sentence says: "The caveat with this design is

that transsexual persons before sex reassignment might differ from healthy controls (although this bias can be statistically corrected for by adjusting for baseline differences). It is therefore important to note that the current study is only informative with respect to transsexual persons health after sex reassignment; no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism."

You see that?

A. Right. Yeah.

Q. Then it says: "In other words, the results should not be interpreted such as sex reassignment per se increases morbidity and mortality. Things might have been even worse without sex reassignment." Correct?

A. Yeah. It's -- the -- let's see. The -- yeah, so -- and I don't think I ever make the claim that the surgery

increases the risk of morbidity and mortality. Yeah, I -- I would agree with that.

Q. Yeah, no --

A. But I would -- I would also wonder on what basis they -- there's nothing to support that it might have been worse either. It's for the same reason.

Q. Yeah. This study does not support the conclusion that sex reassignment surgery by itself increases risk of suicide; correct?

A. That's what they -- they say, yes.

Q. And they also say that this study does not support the conclusion that surgical procedure for gender dysphoria by themselves increase risk of morbidities other than suicide; right?

A. Right.

Q. Okay. All right. Let me -- you mentioned that -- in your report the 2020

Finland guidelines. You recall that?

A. I do.

Q. Let me ask you a couple of questions on those.

A. Okay.

Q. So I'll introduce another exhibit. This will be Exhibit 25, and let me know when you get it.

(Exhibit 25 was marked for identification and is attached.)

A. Okay.

Q. Let me ask you before we get into this, look at page 46 of your report.

A. Okay.

Q. Near the top, there's a "2020 - Finland" reference. You see that?

A. I see that, yeah.

Q. You say, "This new Finnish guidance prioritizes psychological therapy over treatment with hormones or surgery and suggests different care plans for early-onset vs late-onset childhood

gender dysphoria." You see that?

A. I do.

Q. And then you say in the last sentence, "The Finland National Guidelines appear quite contrary to the opinions of Drs Brown and Schechter and WPATH." Do you see that?

A. I do.

Q. Is it your opinion that the WPATH guidelines recommend that children who experience gender dysphoria should transition to a different gender role?

MR. KNEPPER: Objection, form.

A. No. I would say that the WPATH guidelines essentially leaves us with affirmation care only, that it does -- it does, you know, recom- -- recommend all of the psychological support but all of it in support of transition. I would say that. Yeah.

Q. Yeah. The WPATH guidelines do not recommend that children with gender dysphoria automatically be put on puberty

blockers; right?

A. They don't make that recommendation, no. They don't state that recommendation, no.

Q. Yeah. Let's look at what they actually say.

A. Okay.

Q. I'm going to introduce one more exhibit.

A. So we're going to leave the Finland article for now and go to --

Q. Yeah. We'll come back to it. I want to show you the WPATH --

A. Okay.

Q. -- Standards of Care Version 7 first.

A. Uh-huh.

Q. All right. This will be Exhibit 26. Let me know when you have it.

(Exhibit 26 was marked for identification and is attached.)

A. Okay.

Q. This is a larger file, so this

may take an extra minute or so.

A. Okay. I've got it.

Q. Okay. These are the WPATH Standards of Care Version 7; right?

A. Yes.

Q. Turn to page 23.

A. Okay.

Q. All right. There's a section titled "Social Transition in Early Childhood." You see that?

A. I must be on the wrong page. Did you say page 23?

Q. It's PDF page 23, which is going to be page 17 in the standards.

A. Oh, I'm sorry. Okay. Let's go back, then. Page 17. Okay. I'm there. Right. "Social Transition in Early Childhood."

Q. All right. It says: "Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression

of their gender identity. For others, this could be motivated by other forces."

You see that?

A. I do.

Q. And then a couple of sentences down, it says: "This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood." You see that?

A. I do.

Q. All right. The WPATH Standards of Care Version 7 is not making any clinical recommendations encouraging children in early childhood to go through gender transition roles; correct?

A. Yeah, I would -- yes. I would add to that that they're also not offering any clinical guidance on how to distinguish who might or who might not be suitable for transition. Right.

Q. Do you know whether that's explored somewhere else in this Standards of Care Version 7?

A. Yeah. I think it's discussed.

Q. Okay.

A. But -- but it's -- but I -- yeah. So what's -- what's important, I think, in what you cite here is that the current evidence base is insufficient to predict the long-term outcome. Yes.

Q. Okay. Go to the next page.

A. Okay.

Q. Page 18, PDF page 24.

A. Okay.

Q. There's a section titled "Physical Interventions for Adolescents."

A. Right.

Q. Right?

A. Yes.

Q. You understand that adolescents are different than children; right?

MR. KNEPPER: Objection, form.

A. Well, yeah. So, adolescents are

treated in pediatric clinics, but they're different from prepubertal children, yes.

Q. Yeah. This section does not provide any clinical recommendations for hormone therapy in prepubescent children; right?

A. Let's see. I've just got to refresh my memory here on the verbiage.

(Witness reviews document.)

A. Yeah. So it -- it addresses the important issue of gender fluidity in adolescents, potential for shift to conformity and -- that may not persist. Yeah. Right.

Q. Okay. And this section also does not provide any clin- -- clinical recommendations for surgical intervention in prepubescent children; right?

A. This section doesn't address prepubescent children. It addresses adolescents.

Q. Yeah, exactly. And you don't know of any other section in these

Standards of Care Version 7 that provide those guidelines for prepubescent children; right?

A. No.

Q. Okay. Go to the next page, PDF page 25, page 19 in the document.

A. Okay.

Q. And you see there's a section that says, "Criteria for Puberty-Suppressing Hormones"?

A. Yes.

Q. It says, "In order for adolescents to receive puberty-suppressing hormones, the following minimum criteria must be met." You see that?

A. Yes.

Q. And then there's four items; right?

A. Yes.

Q. Number 4 says, "The adolescent has given informed consent and, particularly when the adolescent has not

reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescents throughout the treatment process."

You see that?

A. Yeah. That -- in fact, that was one of the most troubling things I read when I reviewed this whole document from the WPATH guidelines, is that -- yeah, that using those words in the same sentence, an adolescent giving informed consent, is a -- is a non sequitur because I -- I don't think -- in all my years of practice as a surgeon, which amounts to greater than 35, the idea of obtaining consent from an adolescent was never accepted by the surgical community or the medical community, to my understanding.

Q. Well, this also talks about getting informed consent from the parents or other caretakers or guardians; right?

A. Yeah. So in their role supporting the adolescent's decision. It doesn't say -- yeah. So the parents or other caregivers have consented in support. Right.

Q. Yeah. What the guidelines contemplate is that it's not just the adolescent that's going to give an informed consent, it's also the parents or other caretakers or guardians; right?

A. Yeah. But again, that's the problem I have with it, because that's -- the introductory sentence has -- has no meaning -- or the introductory part of the one sentence has no meaning. If the beginning point of the process is adolescent consent, that's -- that's not an ethical thing to do because --

Q. Yeah.

A. -- because an adolescent can't grasp -- they don't have enough executive function or development, particularly if they have been through a period of

puberty suppression before they begin the period of cross-sex hormones, that it's -- it's already quite evident that these patients, these children do not have enough -- and it's just known in society at large that adolescent children don't have the capacity for long-term reckoning of things like risk and outcomes and neither do they have the executive capacity in their brains to make an informed consent decision. So that part of it is meaningless to me. Yeah.

Q. Yeah. But you understand there's two components to this requirement; one is informed consent by the adolescent, and two is informed consent by parents or other caretakers or guardians. Right?

A. Yes.

Q. Okay.

A. That's what it says.

Q. All right. Let's now go back to the Finland guidelines. It's Exhibit 25.

A. Okay.
Q. And go to PDF page 9 which has Section 8, "Summary" -- "Summary of the Recommendations." Let me know when you get there.
A. Okay.
Q. All right. This page provides recommendations for treatment of minors with gender dysphoria in Finland; right?
A. Yes.
Q. All right. Look at number 2 at the bottom.
A. At the bottom. Okay. Okay.
Q. All right. So it starts with, "If a child is diagnosed prior to the onset of puberty with a persistent experience of identifying as the other sex and shows symptoms of gender-related anxiety, which increases in severity in puberty." You see that?
A. Yes, I do.
Q. All right. And then next sentence says, "Based on these

assessments, puberty suppression treatment may be initiated on a case-by-case basis after careful consideration and appropriate diagnostic examinations if the medical indications for the treatment are present and there are no contraindications."

Do you see that?

A. I do.

Q. All right. You understand that these Finland guidelines do not categorically prohibit the use of puberty-blocking agents in minors; correct?

MR. KNEPPER: Objection, form.

A. Right. They don't categorically, but what they do is they express uncertainty about the data that -- that's been used to support the use of those drugs in children.

Q. Yeah. But -- but despite that data, what the guidelines recognize is that puberty-blocking treatment may still

be initiated for some minor patients in certain circumstances.

A. Right.

Q. Right?

A. Agree.

MR. KNEPPER: Objection, form.

Q. All right. Let's go back to your report. Go to page 46.

A. I'm there.

Q. So in your discussion of these Finland guidelines, you cite something called -- it's a website, genderreport.ca.

A. Correct.

Q. Do you see that?

A. I do.

Q. And I saw at least two other references to this source in your report. All right. This is -- genderreport is not a peer-reviewed publication, Doctor; right?

A. No. It's a data collection site. Yeah.

Q. It's a data collection site?
A. I think that's what the -- so, let me just review what I wrote here.
(Witness reviews document.)
A. All right. Okay. Yeah. Okay. Yeah, no. I agree they're not peer-reviewed to my knowledge, no.
Q. It's a blog; right?
A. Right. It's on -- it's online, exactly.
Q. Blogs are not generally considered reliable scientific evidence, I take it. Right?
MR. KNEPPER: Objection, form.
A. No, they're not.
Q. Okay. Do you know who started this genderreport blog?
A. I do not.
Q. Do you know this person was a doctor?
A. I don't know the person, no.
Q. You don't know they're a scientist?

A. I'm sorry?
Q. You don't know whether they're a scientist; right?
A. I don't know.
Q. Did you know that this blog was started by a parent who was upset that her daughter was told in school that girls are not real and who filed a lawsuit about it?
MR. KNEPPER: Objection, form.
A. I did not know those details, no.
Q. Assuming that's true, do you think this is an unbiased, objective resource?
MR. KNEPPER: Objection to form.
A. I -- I don't know. I don't know the answer to that question.
Q. Do other experts in your field rely on blogs like this one to support their opinions?
MR. KNEPPER: Objection, form.
A. And I don't, and neither did I

rely on this as sole support for my opinion. This -- again, this is just evidence of -- of controversy that exists out in the literature, or that exists out in the -- in the greater world, I should say, in this case because this is not medical literature, but in the wider world.

Q. Well, as I read this, your page 46, you're -- you're citing this gender report for your analysis of the 2020 Finland guidelines.

MR. KNEPPER: Objection, form.

Q. Right?

A. I think I'm using the Finland guidelines as a standalone and just referencing this gender report as evidence of events in Finland rather than scientific support for the conclusions of the Finland review.

Q. Okay. Another article you cite is the Carmichael 2021 study.

A. Right.

Q. Let's look at that one. I'll introduce it as Exhibit 27. Let me know when you have that.

(Exhibit 27 was marked for identification and is attached.)

A. Okay. Okay. I have it.

Q. Okay. This is titled, "Short-Term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK."

A. Right.

Q. Right?

A. Yeah.

Q. All right. Look at the -- on page 1, you see there's an abstract?

A. Yes.

Q. Under "Methods," it says, "We undertook an uncontrolled prospective observational study." Right? Do you see that?

A. Right.

Q. All right. This is not a

randomly controlled clinical trial; right?

A. Right.

Q. Not a cohort study --

A. Right.

Q. -- right?

A. Right.

Q. There's no control group; right?

A. Correct.

Q. You don't mention any of that in your report even though you spend a lot of time discussing the limitations of other studies. Why is that?

MR. KNEPPER: Objection, form.

A. I -- we include this to one to show the raging controversy in the world of transgender medicine, and this is an example of that, the -- the evidence of uncertain result or no result, no change from baseline effect.

Let's see. Let me just review because I've reviewed so many of these articles lately.

(Witness reviews document.)

A. Right. Yeah. So -- yeah. So that's right. So they were unable to quantify benefit or harm from puberty suppression.

Q. Go to page 21. See there's a "Strength and Limitations" section?

A. I see it. Yes, I do.

Q. The second sentence says: "The study size and uncontrolled design were key limitations. The small sample size limited our ability to identify small changes in outcomes. This was an uncontrolled observational study and thus cannot infer causality." See that?

A. I do.

Q. Again, you don't acknowledge any of these limitations in your report; right?

MR. KNEPPER: Objection, form.

A. Right. I believe I made reference to this in terms of it's evidence of -- of controversy in the

literature, that they could not see a benefit from it. So again, at lower levels of evidence, evidence of benefit would suggest further study. This shows that further study is needed because, at the observational level, you don't see effect.

Q. All right. Another study -- not a study, a review that you cite is this Cochrane 2020 --

A. Yes.

Q. -- review; right?

A. Right.

MR. TISHYEVICH: And for the court reporter, that's C-O-C-H-R-A-N-E.

Q. I'm going to introduce that one next.

A. Okay.

Q. All right. I'm introducing this as Exhibit 28, and let me know when you get it.

(Exhibit 28 was marked for identification and is attached.)

A. I will. Okay.
Q. Okay. This is from the Cochrane Library. This is the review that you cite in your report; right?
A. Right.
Q. Go to page 2.
A. Okay.
Q. All right. You see there's the section titled, "Authors' Conclusions"?
A. Okay. Yes, I do.
Q. All right. Toward the end, do you see it says, "We will include non-controlled cohort studies in the next iteration of this review, as our review has shown that such studies provide the highest quality evidence currently available in the field." You see that?
A. Yes, I do.
Q. All right. So the Cochrane review is not saying they're just going to ignore all those studies going forward; right?
A. Right.

MR. KNEPPER: Objection, form.

Q. They rec- -- they recognize that those noncontrolled studies currently represent the best available evidence; right?

MR. KNEPPER: Objection, form.

A. Well, yeah. Before they say best available evidence, they speak about the level of the evidence now. And what's -- what's interesting about this Cochrane review, because it's a worldwide review of the literature on the subject of cross-sex hormones and hormone blockade in transwomen, is that they found over a thousand references, and by the time they got through qualifying those references for suitability, they got down to thirteen studies. And when they fully screened the text, they got down to a single study. And that's -- that's kind of characteristic of -- of the data used to support hormonal transitioning.

And so yeah, they -- they have to -- they have to backpedal in order to get any data because what they have in hand now is -- is not supportive of -- of the use of cross-sex hormones in transwomen, so.

Q. All right. Let me introduce another exhibit.

MR. TISHYEVICH: Can we go off the record?

THE VIDEOGRAPHER: We are off the record at 4:07 p.m.

(Break taken.)

THE VIDEOGRAPHER: We are back on the record at 4:20 p.m.

Q. (By Mr. Tishyevich) All right. Doctor, let me ask you about what experience you have with the individual plaintiffs in this case specifically.

You personally did not meet with any of the plaintiffs in this case; correct?

A. No. I did a review of their

charts and nothing more. Yeah.

Q. All right. You've personally never spoken with any of the plaintiffs; correct?

A. I have not.

Q. You obviously were not present in any meetings that any of these plaintiffs may have had with their mental health professionals; right?

A. I was not.

Q. And you don't know specifically what was said or not said during those meetings; correct?

A. The only information I have about those meetings was what's entered in the medical record that was given to me to review.

Q. Yeah. You were also not present in any meetings any of the plaintiffs may have had with their endocrinologists; right?

A. Correct.

Q. And outside of reading medical

records, you don't know what was said or not said during those meetings; correct?

A. Correct.

Q. And finally, for plaintiffs who had undergone surgical procedures, you were also not present in any meetings between these plaintiffs and their surgeons; correct?

A. Correct.

Q. And outside of medical records, again, you don't know what was said or not said during those meetings; correct?

A. Correct.

Q. Okay. You should see a new exhibit pop up, Exhibit 29.

A. Okay.

(Exhibit 29 was marked for identification and is attached.)

Q. And if you can go to PDF page 54.

A. PDF page 54. Okay.

Q. First of all, you understand what this document is; right?

A. I didn't get to see the header on it. I haven't seen this before, I don't think.

Q. Oh, feel free -- yeah, feel free to go back to the first page if you want to.

A. Okay.

(Witness reviews document.)

Q. All right. This is the --

A. Okay. Okay. So it's --

Q. Yeah.

A. -- a benefits booklet for the State health plan. Is that right?

Q. For North Carolina, right.

A. Yes. The teachers union -- teachers and employ- -- and State employees, right. Okay.

Q. You know what a benefit plan is; right?

A. Yes, uh-huh.

Q. At a high level, it sets out what the insurer is going to cover or not cover; right?

A. Correct.
Q. Among other things. Okay. And earlier, we talked about medical necessity. You recall that?
A. Yes.
Q. All right. Go to -- now go back to PDF page 54 of this plan.
A. Okay. I'm there.
Q. You see at the top, it says, "What is not Covered?" And it's a list of items?
A. Am I on the right page? I'm on -- on PDF page 54?
Q. Yeah.
A. That's the -- the -- oh, I'm sorry.
Q. Plan page 46, so that's --
A. Plan page 46. Let me back up real quickly here. Sorry. Okay. I'm there.
Q. At the top or near the top, it says, "What is not Covered?" You see that?

A. I do.
Q. There's a list of items alphabetically. See that?
A. Yes.
Q. And under M, it says, "Services or supplies deemed not medically necessary." "Medically necessary" is in bold; right?
A. Right.
Q. All right. Let's look at that definition. Go to PDF page 89, which is page 81 of the plan.
A. Okay.
Q. All right. At the bottom, you see there's a definition of "Medically Necessary (or Medical Necessity"; right?
A. Yes.
Q. And it says, "those covered services or supplies that are: a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under

this health benefit plan, not for experimental, investigational, or cosmetic purposes." Right?

A. Okay.

Q. I understand that as part of determining what the benefit plan is going to consider medically necessary, whether or not the treatment is experimental is one of the factors; right?

A. As would be defined -- so all of the definitions here are determined by the insurance provider. So they've defined these listed necessities as covered under their plan, yes.

Q. Yeah. So under this definition, if a treatment is experimental, it is likely not going to be covered under the plan; right?

A. Right. According to their definition, it doesn't appear they would cover experimental surgery or cosmetic surgery.

Q. Conversely, if a treatment is not experimental, it may be covered by the plan in some circumstances; right?

A. It would seem --

MR. KNEPPER: Objection, form.

Q. Yeah. And I showed you earlier a policy from BlueCross BlueShield of North Carolina from March 2021 that says that gender-affirming hormone and surgical treatment is considered medically necessary; right?

MR. KNEPPER: Objection, form.

A. Yeah, no. As we talked about before, these are definitions formulated by the insurance company to define coverage, not medical definitions in terms of medical care. This is strictly coverage by insurance. Yeah.

Q. Well, one of the factors that goes into that consideration is whether or not that treatment in question is experimental; right?

MR. KNEPPER: Objection, form.

A. Right. The plan excludes experimental or investigational or cosmetic procedures.

Q. Okay. All right. We're talking about BlueCross BlueShield of North Carolina. Let me ask you about another insurer, Aetna, A-E-T-N-A. You've heard of Aetna; right?

A. Yes.

Q. Are you aware that Aetna is one of the five largest health insurance -- insurers in the U.S.?

A. It would not surprise me to learn that.

MR. KNEPPER: Form.

Q. Do you have any idea whether Aetna considers gender-affirming surgery and hormone therapy to be medically necessary?

MR. KNEPPER: Objection, form, scope.

Q. Would it surprise you if Aetna --

THE COURT REPORTER: I'm sorry. I didn't hear the answer over the objection.

THE WITNESS: I haven't answered yet.

THE COURT REPORTER: Okay.

THE WITNESS: Sorry.

A. So as to the size of Aetna or the -- that they cover --

Q. Yeah, let me just ask -- I'll ask the question again.

A. Okay.

Q. Do you have any idea whether Aetna considers gender-affirming surgery and hormone therapy to be medically necessary?

MR. KNEPPER: Objection, form, scope.

A. I don't.

Q. Well, let me show you. I'm going to introduce another exhibit. Okay. This is going to be Exhibit 30. Let me know when you have it.

(Exhibit 30 was marked for identification and is attached.)

A. Okay. All right. I have it.

Q. All right. This is a policy from Aetna titled "Gender Affirming Surgery." You see that?

A. I do.

Q. You see there's a "Policy History" on the right?

A. Yes.

Q. Under "Last Review," it says January 12th, 2021; right?

A. Yes.

Q. So you understand this was revised within this year; right?

A. Yes.

Q. And under Policy, it says, "Aetna considers gender affirming surgery medically necessary when all of the following criteria are met." Right?

A. Right.

MR. KNEPPER: Form.

Q. All right. So according to this

policy, in Aetna's view, gender-affirming surgery is medically necessary, therefore nonexperimental; right?

MR. KNEPPER: Objection, form.

A. Yeah, Aetna's definition of what is medically necessary appears to allow for gender-affirming surgery.

Q. Okay. Go to page 3.

A. Okay.

Q. Look at the bottom of the page.

A. Okay.

Q. The second to the last paragraph says, "Aetna considers gonadotropin-releasing hormone medically necessary to suppress puberty in trans identified adolescents if they meet World Professional Association for Transgender Health (WPATH) criteria." Do you see that?

A. I do.

Q. Okay. According to Aetna, puberty-blocking hormones are medically necessary to suppress puberty in

trans-identified adolescents if they meet the WPATH criteria; right?

MR. KNEPPER: Objection, form.

A. That -- that's what it states there, yes.

Q. By the way, look at the next paragraph. See it says, "Aetna considers reversal of gender affirming surgery for gender dysphoria not medically necessary."

MR. KNEPPER: Objection.

Q. Do you see that?

A. I do.

Q. Okay. We talked about Blue Cross Blue Shield, talked about Aetna. Do you know what Cigna is?

A. Yeah. It's one of the largest health insurance providers.

Q. Do you know what position Cigna takes on whether gender dysphoria treatment is medically necessary?

MR. KNEPPER: Objection, form, scope.

A. I have not read their policies.
Q. You don't know; right?
A. Correct.
Q. Let me show you that policy.
A. Okay.
Q. All right. This is going to be Exhibit 31. Let me know when you have it.
(Exhibit 31 was marked for identification and is attached.)
A. Okay. Okay. I have it.
Q. All right. This is a Cigna medical coverage policy titled "Treatment of Gender Dysphoria." Do you see that?
A. Yes, I do.
Q. On the right top, it says "Effective Date," May 18th, 2021; right?
A. Yes.
Q. Also recently updated; right?
A. Yes.
Q. Go to page 2. Under "Coverage Policy," look at the third paragraph in bold. It says, "Medically necessary

treatment for an individual with gender dysphoria may include any of the following services, when services are available in the benefit plan." Do you see that?

A. I do.

Q. All right. And then there's five different bullets of different categories of services; right?

A. One, two, three, four, five. Yes.

Q. Number two is "Hormonal therapy, including but not limited to androgens, anti-androgens, Gn-" -- "GnRH analogues, estrogens, and progestins." Right?

A. Yes.

Q. That's a medically necessary benefit in Cigna's view; right?

MR. KNEPPER: Objection, form.

A. It is a -- medically necessary as defined by a insurance company for purposes of a policy.

Q. Yeah.

A. Yes.
Q. And the last bullet point says, "Gender reassignment and related surgery (see below)." Do you see that?
A. I do.
Q. According to this policy, in Cigna's view, gender reassignment and related surgery is a medically necessary service; right?
MR. KNEPPER: Objection, form.
A. Again, so -- so the insurance company makes a distinction between medically necessary, meaning things that they will cover, versus not medically necessary, meaning things they won't cover. It's not based on an actual medical diagnosis but a -- a managerial diagnosis, because if it's not medically necessary, it's not covered by insurance. So if they choose to cover it, they will call that medically necessary. And that's what they're detailing here, what they will cover and what they won't

cover.

Q. Okay.

A. And they call what they will cover medically necessary.

Q. Let me show you one last policy. Do you know -- strike that.

You know what UnitedHealthcare is; right?

A. Yes, I do.

Q. It's another health insurer; right?

A. Yes.

Q. They're the largest health insurer in the country; right?

A. I don't know that for a fact. I'll assume if you're telling me so.

Q. All right. Well, do you have any idea whether United considers gender-affirming surgery and hormone treatment to be medically necessary for gender dysphoria?

A. I have a dawning suspicion that they do.

Q. Yeah. I think you can probably tell where this is heading at this point; right?

A. Sure. The insurance industry likes these services.

Q. Let me introduce this next exhibit. This is going to be Exhibit 32. All right at the top it says, "United Healthcare." You see that?

(Exhibit 32 was marked for identification and is attached.)

A. I don't have it yet.

Q. Oh, I apologize.

A. That's okay.

Q. Let me know when.

A. Okay. Yes.

Q. All right. Top right says "United Healthcare" -- "Healthcare Commercial Medical Policy." Right?

A. Yes.

Q. Under that, it says, "Gender Dysphoria Treatment." Right?

A. Yes.

Q. See there's an effective date of April 1, 2021; right?

A. Yes.

Q. Also fairly recently updated; right?

A. Yes.

Q. Okay. And then you see there's a bunch of bullet points setting forth criteria for the services on page 1; right?

A. Yeah. Yes.

Q. Then go to page 2.

A. Okay.

Q. And the first full paragraph says, "When the above criteria are met, the following surgical procedures to treat Gender Dysphoria are medically necessary and covered as a proven benefit." Do you see that?

A. I do.

Q. Okay. So United also covers -- also considers this treatment to be medically necessary; right?

MR. KNEPPER: Objection to form.

A. Yeah, again, so the interesting thing about this that I'm just reading -- because, again, this is the first time I've seen this -- is that the same policy declares that the policy does not apply to individuals with objectively ambiguous genitalia or disorders of sexual development. So that's an example of the insurance company choosing what to call medically necessary based upon an insurance definition rather than a medical definition. Because under, you know, plastic surgical/general medical wisdom, ambiguous genitalia and disorders of sexual development are objective medical surgical -- well, medical conditions, at least, that would be covered -- would be considered medically necessary to treat, you know, because disorders of sexual development can include emergencies like adrenal hyperplasia. So that's a -- you've given

an example of how insurance companies make their own definitions for the sake of distinguishing what they will cover and what they will not cover.

Q. Go to page 9.

A. Okay.

Q. You see there's a section toward the bottom that says, "Benefit Considerations"?

A. Yes.

Q. Third paragraph says, "Unless otherwise specified, if a plan covers treatment for Gender Dysphoria, coverage includes psychotherapy, cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy." Do you see that?

A. I do.

Q. You understand that United considers not just surgery but all these other services, including cross-sex hormone therapy and puberty suppressing

medications, to be medic- -- medically necessary for the treatment of gender dysphoria; right?

MR. KNEPPER: Objection, form, scope.

A. Yeah, again, the same -- same issues of definition. So they -- they can define it any way they choose for the sake of the business of insuring people, yeah. So they -- they definitely have defined all of the services associated with gender dysphoria as covered benefits.

Q. And not just as covered benefits, as medically necessary; right?

A. Again --

MR. KNEPPER: Objection, form and scope.

A. Again, they use -- the use of the word "medically necessary" is defined by the insurance company to distinguish covered benefits from not covered benefits, and it's not based in medical

evidence of efficacy or anything else. It's just an internal definition for the sake of their business model.

Q. You think that insurers do not look at scientific literature in deciding whether or not to cover something?

MR. KNEPPER: Objection, form.

Q. Is that really what you think?

A. Your -- your first example that we've gone through is a -- is an example of the level of literature they've been using, and that example showed that the most recent paper that they used to support it was 2016. So in my mind, it's in doubt. I don't know for a fact what this particular policy used as references. All I have is what you've shown me on that particular policy. And the evidence there was they're not current in the -- in the literature. But they're still doing good business, apparently, because they continue even after reviewing.

Q. Okay. Go to page 10.
A. Okay. All right.
Q. See there's a section at the bottom that says, "Clinical Evidence"?
A. Yes.
Q. Do you know what that means?
A. Yes, I do.
Q. You see then the first thing that's said -- cited is a study from 2019 and the second thing is a study from 2019, the third thing is a study from 2019. You see that?
A. I do.
MR. KNEPPER: Objection, form.
Q. Do you under- -- do you understand what this section represents?
MR. KNEPPER: Objection, form.
A. Permit me to just look at the particular names and the particular cited articles, if I could.
(Witness reviews document.)
A. Sorry. I just wanted to see if there were any -- and then they go to --

okay. Okay. Could I ask you to ask your question again? I'm sorry to have to do that. I just wanted to see what you were referring to.

Q. Yeah. You understand that this "Clinical Evidence" section provides an overview of some of the scientific evidence on which United based its policy; right?

MR. KNEPPER: Objection, form.

A. Yes. They -- they have listed some of the scientific evidence available in the literature.

Q. Including studies as recently as 2019 --

A. Yes.

Q. -- right?

A. Right.

Q. And because you weren't involved with writing this policy or updating for United, you don't know what else they may have considered outside of this policy; right?

A. I have no way of knowing what they would have considered. That's right.

Q. Okay. All right. Let's shift gears a little bit. You've heard the term "Christian anthropology." Right?

A. Yes, I have.

Q. You've used that term yourself; right?

A. Yes, I have.

Q. The view that Christian anthropology takes is that the -- a person's sex assigned at birth is intrinsic and unchangeable; correct?

A. No.

MR. KNEPPER: Objection, form, scope.

A. I would not say that.

Q. What would you -- how would you describe it?

A. Well, your use of the term "sex assigned at birth" is not -- is not contained within Christian anthropology.

Q. Let me try this --

A. By the -- by the way, I don't -- I don't use definitions in Christian anthropology to confect my expert opinion. My opinion is based in the scientific literature, my review of that literature, and my 30-plus years' experience as a reconstructive surgeon.

Q. I understand. The view that Christian -- to use your words, the view that Christian anthropology takes is that a person's biologic sex is intrinsic and unchangeable; right?

A. Yes.

MR. KNEPPER: Objection, form, scope.

Q. You think that people with gender dysphoria should be welcomed, but they should be told that they're biological sex cannot be changed; right?

MR. KNEPPER: Objection, form, scope.

A. Yeah. So, persons who

self-identify as transgender are to be welcomed and are to be cared for because they suffer greatly, and they -- they deserve, in justice -- they deserve, out of justice, I should say, our -- our care and support. But that care and support must always be rooted in the truth of the nature of the human person, the nature of the biology that informs our understanding of that, because that has to drive our medical and surgical decision-making.

So that's why my -- my expert opinion is based in the objective scientific evidence. I don't make reference to my -- any faith statements when I'm -- when I'm developing my expert opinion on transgender medicine and surgery.

Q. In your expert report, you refer to plaintiff Julie -- Dr. Julie McKeown; right?

A. Could you walk me to where I

speak about her?

Q. Yeah. Go to -- go to page 54 of your report.

A. Fifty-four. Thank you.

MR. TISHYEVICH: And the spelling is M-C-K-E-O-W-N.

A. Fifty-four. Okay. I'm there.

Q. Give me a second. Yeah. This is -- this is you discussing one of the plaintiffs; right?

A. Yes. Yes. I'm on page 53, 54.

Q. Yeah. And the second full paragraph on page 54, you refer to Dr. McKeown as a he; right?

(Witness reviews document.)

A. Am I looking at the right -- oh, yes. Okay. I'm sorry. Right at the very beginning. Yes.

Q. Page 48 of your report, this is you discussing minor plaintiff CB; right?

A. Right.

Q. And you refer to minor plaintiff as a she; right?

A. Correct.
Q. Go to page 51.
A. Fifty-one?
Q. Five one.
A. Okay. All right.
Q. This is you talking about plaintiff Connor Thonen-Fleck; right?
A. Let me go to the preceding page because I've got to see where the names -- oh, I only used the initials. Yes. CT-F, yes.
Q. It's T-H-O-N-E-N, dash, F-L-E-C-K. And you refer to him as a she; right?
A. Yes.
Q. Now, you personally do not believe that a person's sex assigned at birth can ever be changed?
MR. KNEPPER: Objection.
Q. Sorry, let me -- let me use your terms. You personally do not believe that a person's biological sex can ever be changed; right?

MR. KNEPPER: Objection, form.

A. A person's biological sex can never be changed, yes.

Q. Do you know what the term "misgendering" is?

A. It's a -- it's a political term, yes. It's a political, cultural term, I should say. Political, cultural term.

Q. Misgendering means referring to a person in a way that doesn't align with their gender; right?

MR. KNEPPER: Objection, form.

A. In -- within their hearing, I could see a problem with that. But from the standpoint of offering medical evidence, I'm obliged to honor objective biological realities when I speak about an examination of their medical record.

There's so many things at stake relating to the sex of the patient that impinge upon the effects of drugs, the effects of time, the effects of hormones that I -- I cannot incorrectly report the

sex of the patient when I'm talking about objective medical care.

Now, speaking with the patients themselves, I wouldn't do that. As we talked about earlier, I have a number of transgender patients, and I don't misgender them. We're talking here about something that's not within their hearing or I assume they -- I assume that they wouldn't be reading this. We're speaking as a professional to a professional review of this stuff, among other experts. So I think it's essential that we stick to the biological reality that -- that biological sex is immutable.

Q. In your expert report, you are misgendering several of the individual plaintiffs in this case; correct?

MR. KNEPPER: Objection, form.

A. I would say incorrect, because misgendering is something that's done to the person themselves or is something that they're going to read or hear or

see. And that's an abuse of the person's right to their name, and I don't do that to people. I don't misgender people.

Q. Well, in this report at least, you are referring to several of these plaintiffs, including a minor, in a way that does not align with their gender; right?

A. I would be --

MR. KNEPPER: Objection, form.

A. Again, I would be concerned to not do that if it was going to be something they were going to read or hear. But this expert testimony, in my understanding, is for the Court and for the other experts to review, in which case, I insist upon the -- the prevailing necessity of sticking to objective truths when talking about medical opinions, scientific opinions.

Again, I -- I'm not in the habit of -- of offending people or using names that they haven't chosen, because, again,

I treat transgender patients and I don't subject them to that kind of abuse. But when reviewing medical and biological realities like this, I have to insist upon it because medical care is not served by incorrectly naming biological realities and confusing people. I can give you an example if you like.

Q. That's all right.

A. Of a --

Q. That's all right.

A. Okay.

Q. You've used the phrase before, "You can't heal an interior wound with external surgery." Right?

A. Yes, I have.

Q. Do you remember giving a presentation at the Gospel of Life conference in Denver in 2018?

A. Yes.

Q. And that presentation was titled "Transgender Surgery & Christian Anthropology." Right?

A. Yes.
Q. All right. Let me introduce an exhibit. This will be Exhibit 33. Let me know when you have it.
(Exhibit 33 was marked for identification and is attached.)
A. Okay. Yes, I have it.
Q. Go to page 2.
A. Okay.
Q. These are slides you prepared; right?
A. Yes.
Q. On the bottom left corner, there's a red logo for Courage International. You see that?
A. I do.
Q. Why did you include that logo in this presentation?
MR. KNEPPER: Objection, form, scope.
A. This was a presentation for the Archdiocese of Denver, the Catholic Archdiocese of Denver, and it was to an

audience of pastors, teachers, school administrators, and so on. And I was there representing my position in the Catholic apostolate of courage, and so making a presentation to a church group, I wanted them to understand the resource so that they could investigate it themselves if they wanted to. So I put that up there for their benefit.

Q. Well, some of the topics you covered also included your views on what the scientific evidence on these issues is; right?

A. Yeah. The -- the talk is a combination of both the scientific evidence and the historic Catholic teachings on the nature of the human person.

Q. For example, go to page -- go to page 87, for example.

A. Okay. Let me hustle down there. Boy, no wonder people get bored when I give this talk. It's so long; right?

Let's see. 87. Here we are. Is that -- let's see. This is -- I want to make sure I'm on the same page as you are. It's of the --

Q. It's titled "The Swedish Study" --

A. Yes.

Q. -- at the top.

A. Yes, yes.

Q. And go to the next page.

A. Okay. Yeah.

Q. You cite from the abstract on that study; right?

A. Yes. Well, I -- I'm not citing it. I'm showing them what this study looks like if they search for it online.

Q. So part of the talk was your recitation of what you think the scientific evidence on these issues shows; right?

MR. KNEPPER: Objection, form, scope.

A. Yeah, I was asked to talk on

this -- on -- on both subjects, as I said earlier, both the -- the teaching in human anthropology as well as the scientific evidence that's used to support these services of transgender medicine and surgery. That's right.

Q. Courage International is an organization that offers support for persons who experience same-sex attraction; right?

A. Yes.

MR. KNEPPER: Objection, form, scope.

Q. Courage International says that people should not act on same sex attraction and should strive for chastity instead; right?

MR. KNEPPER: Objection, form, scope.

A. Actually, it's broader than that. So, Courage addresses chastity as something that's required of everyone. But it -- it particularly addresses the

struggles that persons who experience same-sex attraction experience in trying to maintain the same chastity that all of us are called to. So it's not an exceptional case; it's a particular apostolate to a particular group of people.

Q. There's a chapter of Courage International in Birmingham, Alabama; right?

A. That's correct.

MR. KNEPPER: Objection, form, scope.

Q. And their website lists you as the main contact for that chapter; right?

A. I'm not only the contact, I'm the chaplain for that chapter.

Q. Okay. Go to page 3 of this presentation.

A. Okay.

Q. Let me know when you get there.

A. Okay. Two, three. Yes. The Challenge?

Q. It's titled "The Challenge"?
A. Yeah.
Q. The first bullet says, "'Male and female He created them.'" Right?
A. Right.
Q. That's a quote from Genesis; right?
A. Correct.
Q. The capitalized "He" refers to God; right?
A. Yes.
Q. And this bullet reflects the church's position that God has created each individual as either a man or a woman; right?
A. Well, actually, so this -- these slides serve as jumping-off points for a discussion that I have at each slide. In this case, the point of the discussion was to disabuse the audience of the idea that they can rely on scripture when addressing this problem because the majority of the people that are seeking

to serve do not speak in Biblical language. So the point of this slide is to -- is to encourage them to understand that they have to learn a new language in order to be able to speak effectively to people suffering from gender discordance and to speak to their families on this same issue. That's what this slide is about. It's not a -- it's not a declaration about what God has said. It's a -- it's an explanation of the problem they're going to have if they're going to seek to serve people who experience same-sex -- I'm sorry, who experience cross-sex identification.

Q. All right. You say, "'Male and female He created them' has been replaced by a confusion of exceptional cases." Right?

A. Yes.

Q. And by the phrase "confusion of exceptional cases," one of the things you're referring to are patients with

gender dysphoria; right?

MR. KNEPPER: Objection, form, scope.

A. Right. I'm referring to the -- the recently growing list of exceptional cases that is enumerated in the -- the acronyms of -- of this topic, LGBTQ add a plus and so on, which can be very confusing to people who are trying to help. And so I'm acknowledging that the -- the likelihood that they may be confused by those terms, and I'm also acknowledging the sources of those confusing terms. And the point of the slide, again, is to help them understand there's a language they need to learn and to not be daunted by the confusion that they may experience when they first look into this topic. Yeah. That's what this is.

Q. Go to slide 11. It's titled "Human Nature."

A. So slide 11, Human Nature, yes.

Okay.

Q. So the first two bullets say, "Why must we consider first the nature of the human person?" Then it says, "Defines the 'end' of medical and surgical care."

A. Yes.

Q. What does it mean that it "defines the 'end' of medical and surgical care"?

MR. KNEPPER: Objection, form, scope.

A. Okay. So that's a -- that's a term that dates back to Aristotelian philosophy. And what it has to do is what is the purpose or what is the ultimate arc of a particular thing. So the "end" meaning what are you seeking to accomplish, what is the final goal of that -- of that medical or surgical treatment.

So -- and the examples I use are you have to have an understanding, for

example, of normal blood pressure in order to know when to treat it and why normalizing blood pressure is important. Or we have to know that, you know, the human person has two legs, and if he has a poverty of legs, he has a poverty of human flourishing. And so in the one case, I might be treating with blood pressure medicine, and in the other case, I might be fitting him for a prosthesis. But the point is we have an objective understanding of the nature of the human person, which defines the goals of treatment, whether you're talking about orthopedics or transgender medicine.

Q. Yeah. You think this concept also applies to the concept of treatment for gender dysphoria; right?

A. It does. Yes, it does.

MR. KNEPPER: Objection, form, scope.

Q. All right. Go to slide 23.

A. Okay. Okay.

Q. The top left says, "Shaping the Conversation, & Grooming a Generation."

A. Right.

Q. You see that?

A. Right.

Q. What do you mean by "grooming a generation"?

A. Grooming is a -- is a process by which ideas are introduced that make subsequent actions possible, so that's what -- that's what grooming is, yeah.

Q. Grooming is sometimes used to refer to preparing to -- strike that.

Grooming is sometimes used as preparing children for sexual abuse. Isn't that true?

A. That's one of the --

MR. KNEPPER: Objection, form, scope.

A. That's one of the uses of grooming, yeah, but it's not exclusive use of grooming. Yeah. And I discuss this in this -- in this slide. Yes, I

do.

Q. And you think that discussing gender identity issues with children means sexualizing them; right?

A. Yes, I do. Absolutely, I do.

MR. KNEPPER: Objection, form, scope.

Q. And you think that discussing gender identity issues with children means grooming them for potential later sexual abuse; right?

MR. KNEPPER: Objection, form, scope.

A. No. No. What we're talking about here is grooming them for -- for future -- what's the word I would want to choose carefully? It's preparing them for these interventions is what it does. It lays the groundwork for it by sexualizing their thoughts in a way that's -- is not consonant with their best interest. That's what this slide is about, so --

Q. Let me introduce another exhibit.

A. Okay.

Q. This will be Exhibit 34.

(Exhibit 34 was marked for identification and is attached.)

A. Could I back up to that last one? Would that be all right?

Q. Sure.

A. Before we -- before we press on. One of the things I'm just recalling, the -- the -- the urgency of having that particular slide there is that when people take care of transgender persons, children in particular, we always -- but including adults. But -- but children and adults, one always has to be on the lookout for signs of sexual abuse because it's a very -- it's a very commonly reported comorbidity in persons who experience these self-identifications. It's not uncommon to discover that they've suffered some form of abuse that

may be sexual but not necessarily sexual. And so this is -- one of the things I talk about in that slide is -- is for the people who are care providers, counselors, school administrators, to be alert to that possibility.

So I'm sorry, we were going to move on to the next one.

Q. Do you have the next exhibit?

A. And that is Exhibit 34?

Q. Yeah.

A. Okay.

Q. All right. This is a printout from LifeSite, and the title is "Plastic surgeon: Sex-change operation 'utterly unacceptable' and a form of 'child abuse.'" Right?

A. Yes.

Q. And it says, "Dr. Patrick Lappert, a Catholic deacon in Alabama, says changing a person's sex is a lie and also a moral violation for a physician." Right?

A. Yes.
Q. And you hold those views --
A. I do.
Q. -- correct?
A. I do.
MR. KNEPPER: Objection, form, scope.
Q. Go to page 2.
A. Okay.
Q. This was published in September 2019; right?
A. Yes.
Q. This is reporting on you appearing on a broadcast of something called the "Relevant Radio's Trending With Timmerie."
A. Yes.
Q. Right?
A. Yes.
Q. You made that appearance; right?
A. On the radio, yes.
Q. Okay. Look -- look to the fifth paragraph on page 2.

A. Okay.

Q. It says, "He called it 'utterly unacceptable' on moral grounds for a plastic surgeon, because it disregards the surgeon's call to balance respect for both form and function of the body in his or her work."

A. Right.

Q. Right?

A. Yes, sir.

Q. You don't deny saying that; right?

A. Right. You should understand, though, that the use of the term "moral grounds" here is strictly from the standpoint of my training as a plastic surgeon. I'm not using this as a platform for a religious discussion. Speaking -- I'm speaking about form and function, which are both very crucial to an understanding of what plastic surgery means.

And again, that speaks to the

end of plastic surgery, which is -- when you're speaking about reconstructive surgery, it's the restoration of form and function. And these operations lack moral basis precisely because they destroy essential human functions for the sake of achieving a cosmetic result, which is morally unacceptable. And I say that without reference to any religious teaching. This is strictly my training as a plastic surgeon, morally unacceptable. And from the first moments of my training as a reconstructive surgeon, that was drilled into me, that if you're planning a reconstructive operation and it involves the movement of tissue on the patient's body, you never do something that's going to compromise or destroy an essential human function.

You may challenge that function a little bit, as you do, for example, in a radial forearm flap, the same flap that's used to recon- -- to construct a

phalloplasty. I've used that flap many times to reconstruct head and neck cancer defects, the same neurotized vascular flap. And I would never dream of using that flap, for example, if I was going to compromise hand function. So it obliges me to be careful, to make sure that when I raise the flap, I don't harm the blood supply to the hand. That's an example of that.

In the example of transgender surgery, by definition, you're destroying fertility for life, which is an immoral act in the eyes of plastic surgery as I learned it through 30-plus years of training.

Q. I understand. Let me just ask you about the next two paragraphs --

A. Okay.

Q. -- of this article.

A. Okay.

Q. Then it says: "Regarding children, Lappert said, sexualizing them

at a young age with these ideas is grooming them for later abuse. 'It's atrocious,' he said. 'And no one even knows how that's going to play out. There's no body of scientific evidence to even support the safety of doing that to children. But it's being done.'" Right?

MR. KNEPPER: Objection, form, scope.

A. Okay. So, let's go through that. So in this case -- we talked about multiple uses of the word "grooming." In this case, the abuse that they're -- it's grooming them for is the abuse we just finished discussing, what I consider to be the abuse of transgender medicine and surgery and what it does to the life of that child. So that's the abuse I'm referring to here. I'm not speaking about this in terms of sexual abuse, I'm speaking about in terms of medical/surgical abuse of a child. So if you get a child -- if you sexualize a

child's thinking and encourage them to believe, for example, if -- if -- if I -- and I don't want to take up your remaining time, but we can go into it in more detail if you wish. But the point I'm making here is this is grooming them for medical and surgical abuse.

Q. Okay.

MR. TISHYEVICH: We can go off the record.

THE VIDEOGRAPHER: This is the end of Media Unit 6. We are off the record at 5:07 p.m.

(Break taken.)

THE VIDEOGRAPHER: This is the beginning of Media Unit No. 7. We are on the record at 5:14 p.m.

Q. (By Mr. Tishyevich) Doctor, that's all the questions I have for you today. Thanks for your time.

A. Thank you. This was my first ever deposition, and you were very kind to me. Thank you for that.

Q. Okay.

MR. TISHYEVICH: All right. Mr. Knepper?

MR. KNEPPER: Yeah, I'm ready to go. I'm sorry. I actually had you turned down, because when I put you on mute, I could still hear Lane and Andrew. I thought I saw their lips moving.

THE COURT REPORTER: Yeah, he said he was finished asking questions.

MR. KNEPPER: Oh, I'm sorry. I didn't hear that. I'm sorry, Dmitriy. I apologize. I had -- you know, Lane and -- and Andrew were talking to one another, and so I was -- I had to turn down my speaker.

So I guess why don't we -- why don't we take a -- I've got 4:15. Why don't we take a 15-minute break, and then I'll see if I have anything on redirect, and we'll come back at I guess it would be 6:30 your time, Dmitriy?

MR. TISHYEVICH: Yeah.

MR. KNEPPER: Okay.

MR. TISHYEVICH: Sounds good.

THE VIDEOGRAPHER: We are off the record at 5:15.

(Break taken.)

THE VIDEOGRAPHER: We are back on the record at 5:29 p.m.

EXAMINATION BY MR. KNEPPER:

Q. Dr. Lappert, I wanted to ask you a couple of questions about your CV and your biography.

A. Okay.

Q. On your biography, you identify yourself as the Specialty Leader for Plastic and Reconstructive Surgery, the Office of the Surgeon General - United States Navy, from 1997 to 2002. Could you describe what that position involved?

A. Yeah. So I advised the Surgeon General, first of all, with regard to the selection of physicians for advanced training in plastic surgery. I also

advised the Office of the Surgeon General on policy matters pertaining to the movement of patients and the availability of services in the various treatment facilities. I also advised him on policy relating to coverage of particular medical problems versus sending them out into the community for care or declining care.

So part of it was resource management, part of it was personnel management, and part of it was financial management. And all the time, it required to review the state of the literature regarding reconstructive surgery for combat-injured and as well as medically retired personnel and other retired people.

Q. And I -- I note that also in your resumé is that from 1996 to 2002, you were the Chairman of the Department of Plastic and Reconstructive Surgery at Naval Hospital Portsmouth. Could you

describe that -- that facility and its role within the United States military?

A. Okay. Well, that -- as department head, I was -- I had a five -- five staff plastic surgeons working for me. I had I think seventeen hospital corpsmen working for me. And we provided services, reconstructive surgical services on a referral basis from -- essentially from the eastern Mediterranean all the way to Appalachia and from North Carolina -- I'm sorry, from -- from Maryland all the way down to Florida. So all persons requiring reconstructive surgery, including combat-injured or other, would be referred to us, people with congenital deformities, peop- -- you know, pediatric patients and -- and adults. And this was in a -- in the facility which at the time was the largest medical treatment facility in -- I think in the world, certainly in -- in the American purview.

I also -- I also established and ran congenital craniofacial deformity treatment. We ran a limb salvage treatment that involved a great deal of microvascular reconstructive surgery for wounds, cancer, that sort of thing. We also established the -- the wound care center for that facility, and that -- again, we served that large catchment area with advanced wound care services.

Q. Dr. Lappert, you served as a -- as a plastic and reconstructive surgeon for the United States Navy. Is that correct?

A. Correct.

Q. And you also served as a plastic and reconstructive surgeon in private practice. Is that correct?

A. Correct.

Q. Could you describe the -- or contrast or describe the similarities and differences in those two practices.

A. Certainly. Well, so both

practices involved both reconstructive surgery and aesthetic cosmetic surgery. But the difference is that in the military, because of the nature of the requirements, the experience level grows much more rapidly in the military than it does in the civilian world. So within the first couple of years of my practice as a reconstructive surgeon in the Navy, I was doing the most advanced reconstructive procedures, such as the mi- -- the neurotized microvascular flap operations that are often used, for example, in the phalloplasties of transgender surgery, or the perineal vaginal reconstruction for cancer, same operations that are used in the vaginoplasty for transgender self-identified persons. So a very advanced complexity.

In fact, when I sat for my boards, my oral boards, we had to present ten selected cases that the board

selected, and both of my examiners were startled at the level of complexity for a second-year person out of training, doing craniofacial surgery, free flap operations, massive limb salvage surgery. So that's the distinct difference, what you get in civilian versus what you get in the military. But both of them involved reconstructive as well as aesthetic cosmetic surgery.

Q. Sure. Now earlier, you were asked about whether you had performed certain procedures in the context of transgender surgery. Is that correct?

A. Yes, sir.

Q. And your answer was that you had not. Is that correct?

A. That's correct.

Q. Have you done those procedures in the context of your practice of plastic surgery?

A. I have.

Q. Could you describe that --

those -- those circumstances.

A. Well, as an example, a -- a very memorable case, a patient with what's called Fournier's gangrene, where essentially, they had a massive uncontrollable infection of the perineum that destroyed the scrotum, destroyed major portions of the penis, required what amounts to a reconstructive phalloplasty/scrotoplasty to reconstitute them after a long period of wound care. But the -- the operations to reconstruct the urethra is the same operation that's used to construct the urethra in a phalloplasty or construct the urethra in a metoidioplasty, same operations involving local flaps, mucosal grafts, tubularized flap operations. All of those are the same. Just the indication for the surgery is reconstructive rather than the surgeries for transgender.

Same thing with the vaginoplasty. Again, often --

oftentimes, reconstruction for radiation injuries secondary to management of vagineal -- vaginal perineal malignancies that require removal of large areas of soft tissue, again reconstruction of the -- the perineum, the external genitalia, the vaginal introitus, the vaginal canal, same operations using flaps, grafts to reconstruct as are used in the transgender surgery world.

Q. So, do you feel that your professional experience and qualifications allow you to comment on the -- the medical operations involved in surgery for a transgender individual?

A. Yes. I'm -- I'm very familiar with all of those operations.

Q. And -- and you've performed those operations?

A. Yes, I have.

Q. Okay. Just not in the context of gender transition?

A. That's correct.

Q. Okay. There was a -- there was a brief question, and -- and we didn't get back to it, about one of the articles on your CV on breast reconstruction. Is that -- is that correct?

A. Right. Yeah, that's one of my listed articles. That's right.

Q. Great. Did you want to -- did you want to say more about that article?

A. Yeah. So, that's -- was really my entrance into the breast reconstruction world. That actually started when I was still a general surgeon and I was collaborating with a plastic surgeon, and we examined the surgical planning for mastectomy in the setting of breast cancer or other causes and -- and the surgeon's role in designing those operations to get the best possible outcome. And it was actually a seminal article, up until recently was the most quoted article in the literature on breast reconstruction.

And that was actually the first article that spoke about conservation surgery in surgical planning for the treatment of breast malignancies or other breast problems.

Q. Dr. Lappert, you were asked questions about the policy or position statements of several professional organizations. Do you recall those questions?

A. I do.

Q. Did those exhibits or any of the questions change your opinion that affirmative hormonal treatment and surgery remains unproven and experimental?

A. It has not changed my opinion.

Q. You were asked questions about the evidence supporting the provision of hormonal therapy and surgical interventions for the treatment of gender dysphoria. Is that correct?

A. Yes.

Q. Were any of the questions or any of the studies that were presented to you, did they change your opinion that the existing medical evidence supporting those interventions is of very low quality and has methodological defects?

A. That did not change my opinion about those, no.

Q. And just to clarify, what is your opinion about the -- about the current state of the evidence supporting hormonal therapy for treatment of gender dysphoria?

A. My opinion is that all of these published studies that are used to support or to justify the use of puberty blockade, cross-sex hormones, or transgender -- gender-affirming surgery are of the lowest quality scientific evidence and are not sufficient to support care and interventions that have such far-reaching and lifelong effects on the patient.

Q. Are your opinions on that -- on that issue in this case based on anything other than your review of the scientific and medical literature and your training as a -- as a physician?

A. No, they're not.

Q. Dr. Lappert, you were asked about off-label use of Botox for certain muscle -- muscle groups. Is that correct?

A. Yes, I was.

Q. And you -- and you described -- and you stated that you've actually used Botox off label for treatment of those muscle groups before that was approved by the FDA. Is that correct?

A. That's correct.

Q. But you have also said that you believe that it is significant and -- and relevant to this case that the use of hormone and puberty blockers for treatment of gender dysphoria is off-label. Is that correct?

A. Yes.

Q. Could you disting- -- distinguish between why you hold the view that off-label uses of some pharmaceuticals is acceptable by a -- by a physician and when you consider that to be unacceptable by a physician?

A. Right. So, the off-label use of medications when there's a low risk to the patient or that the -- the possible adverse effect may be brief and that a favorable result is likely where risk is low, then that's justifiable to go off label with medications. But when you're -- when you're talking about significant risk to the patient and irreversible changes, that the off-label use places a tremendous burden on the practitioner to -- to have scientific evidence to support his decision to do that. And to not have sufficient evidence when doing that is a -- is a -- is a great difficulty in terms of consent and in terms of just general

medical/surgical decision-making.

So the distinction is the risk/benefit equation. How much risk are you placing the patient under, is it irreversible, and is the benefit so great that it's worth taking the risk.

Q. Sure. Just to follow up, and these are going to be my final questions, is it your view that there are no -- and does it continue to be your view that there are no -- currently no competent -- competently conducted long-term, peer-reviewed, reliable, and valid research studies documenting the number or percentage of patients who receive gender-affirming medical interventions who are helped by such procedures?

A. It's still my position that -- that the medical literature does not support those interventions of medical and surgical treatment for self-identified transgender persons.

Q. Is it still your view that there

are no published, reliable, and valid research studies that document a valid or reliable biological, medical, surgical, radiological, psychological, or other objective assessment of a -- of a patient's gender identity or gender dysphoria?

A. Yes. It's still my position that there are no tests that will confirm or refute the diagnosis of transgender, a diagnosis made by the patient. There's no way to test for that.

Q. All right. Is it still your view, after the evidence and the questions that you've been presented, that an unknown percentage of patients who present with gender dysphoria also suffer from mental illnesses that complicate and may distort their judgments and perceptions of gender identity?

A. Yes. The -- the world literature demonstrates a consistent and

significant level of comorbidities, including severe anxiety, major depression, self-harm. The patient is very likely to be on the autism spectrum. Suicidal ideation. And -- and the world literature supports that. So -- and those are -- those are serious issues, not only in terms of decision-making, but even on the question of consent and competence for consent.

Q. Just one -- one more thing I wanted to follow up with. Your testimony -- we didn't cover this, but I want to make sure that it's still your view that medical treatments may differ significantly by sex according to your chromosomal assessment but not based on your gender identity and that misinforming physicians of a patient's biological sex could have deleterious effects on treatment for medical conditions?

A. Yes, that's correct. And when

we discuss the issue of misgendering, that's what we were talking about. We were talking about placing the patient at risk. If you're having a -- a discussion or conversation about medical decision-making, you have to distinguish between biological male and female because you run -- there -- there are illnesses that predominate in females that don't exist in males; there are conditions that affect males that do not affect females, and you have to know that if you're going to offer care. But again, that hasn't been changed by -- by what I've seen or heard here today. That's still -- is still the case.

Q. Okay. And it's still your view that the use of hormones and surgery to treat gender dysphoria is not supported by the relevant scientific communities as discerned by your literature review and your training as a physician in reconstructive and plastic surgery?

A. Yes.

MR. KNEPPER: Those are my questions. I don't think I have anything else. Did you have follow-ups you wanted, Dmitriy?

MR. TISHYEVICH: Very, very briefly.

MR. KNEPPER: Okay.

EXAMINATION BY MR. TISHYEVICH:

Q. Doctor, you were just asked about your views on why it's okay to use Botox off-label but you have a different view of puberty blockers. Do you recall that?

A. I do.

Q. And one of your considerations is the risk/benefit profile of Botox; right?

A. Right.

Q. Do you know what a black box warning is, Doctor?

A. Yes.

Q. It's the strongest warning that the FDA can require; right?

A. That's -- that's right.

Q. And that warning is typically only used if studies indicate that the drug carries a significant risk of serious or even life-threatening adverse effects; right?

A. Yes.

Q. Do you know that Botox has a black box warning?

A. Yes, I do.

Q. It's for distant spread of toxin effect; right?

A. Yes.

Q. And the use of Botox has -- has resulted in reports of life-threatening injuries and death; right?

A. I'm even familiar with the case reports that reported that. Yes, sir.

Q. Okay. That's all I've got for you.

MR. KNEPPER: Okay. Thank you,

Dr. Lappert.

THE WITNESS: Thank you.

MR. KNEPPER: We're finished with your testimony.

Thank you, Dimitry. Thank you, Lane. Thank you, Andrew.

We can go off the record.

THE VIDEOGRAPHER: This is the end of Media Unit No. 7. We are off the record at 5:47 p.m. Thursday, September 30th, 2021, and this concludes today's testimony given by Dr. Patrick Lappert.

END OF DEPOSITION

(5:47 p.m.)

C E R T I F I C A T E

STATE OF ALABAMA)
COUNTY OF JEFFERSON)

I hereby certify that the above and foregoing proceeding was taken down by me by stenographic means, and that the content herein was produced in transcript form by computer aid under my supervision, and that the foregoing represents, to the best of my ability, a true and correct transcript of the proceedings occurring on said date at said time.

I further certify that I am neither of counsel nor of kin to the parties to the action; nor am I in anywise interested in the result of said case.

/s/ Lane C. Butler
LANE C. BUTLER, RPR, CRR, CCR
CCR# 418 -- Expires 9/30/22
Commissioner, State of Alabama
My Commission Expires: 2/11/25

John G. Knepper, Esquire
john@knepperllc.com

October 13, 2021

RE: Kadel, Et Al v. Folwell
9/30/2021, Patrick Lappert, M.D. (#4814384)

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The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at erratas-cs@veritext.com

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Kadel, Et Al v. Folwell

Patrick Lappert, M.D. (#4814384)

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Patrick Lappert, M.D. Date

Kadel, Et Al v. Folwell

Patrick Lappert, M.D. (#4814384)

ACKNOWLEDGEMENT OF DEPONENT

I, Patrick Lappert, M.D., do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

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Federal Rules of Civil Procedure

Rule 30

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(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.

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ABPS does not mandate the specifics of how diplomates state their certification, except to assert that diplomates should not state or imply that they are certified if their certification has expired. If you have multiple certifications by ABMS member boards and allow one of them to lapse, you should revise your public materials (letterhead, business cards, advertisements, websites, etc.) to reflect those certifications that are currently valid.

We ask that you follow these guidelines throughout your career to accurately state your ABPS certification.

- Diplomates of ABPS must accurately state their certification status at all times. This includes descriptions in Curriculum Vitae, advertisements, publications, directories, letterhead and websites.

- Diplomates with expired time-limited certification or those whose certification is revoked may not claim Board certification by ABPS and must revise all descriptions of their qualifications accordingly.

When a physician misrepresents certification status, ABPS may notify local credentialing bodies, licensing bodies, law enforcement agencies and others.

Note: The Board does not allow the use of its trademarked logo on diplomate or candidate websites or for any other commerical purposes.

Examples of accurate statements of certification:

Once you have successfully passed your initial certification examination or renewed your certification through the Continuous Certification program, you may represent that you are “ABPS Board Certified in Plastic Surgery (with a sub-specialty certification in Hand Surgery – if applicable)" or a “Diplomate of the American Board of Plastic Surgery”:

- **John Doe, M.D., ABPS Board Certified in Plastic Surgery**

or

- **John Doe, M.D., a Diplomate of the American Board of Plastic Surgery**

Important: Please be sure to correctly state your certification status in your Medical Licensing Board Profile. In addition, pay close attention to your group practice listings. A blanket statement that everyone in a group is Board certified may be misleading if multiple specialties are listed and some group members are certified in certain specialties and others are not currently certified. ABPS expects that certifications will be listed individually or stated in a way that is not misleading. Aside from accuracy and ABPS requirements, inaccurate statements of certification may create embarrassment or legal issues. ABPS understands that maintaining currency in stating the certification status of groups of physicians may not be easy. We encourage you to work with your colleagues to be sure the certifications you represent to the public are current and accurate.

Refer to the Board's **Advertising Policy**.

Feel free to contact ABPS whenever you have a question about stating your certification.

Call the Board Office at 215-587-9322, or send an e-mail to info@abplasticsurgery.org.

Seven Penn Center
1635 Market Street, Suite 400
Philadelphia, PA 19103-2204

Tech Support

EXHIBIT 4

CODE OF ETHICS OF THE AMERICAN SOCIETY OF PLASTIC SURGEONS

(PLEASE NOTE: All complaints regarding possible ethical misconduct must be in writing and sent to:
EthicsComplaints@plasticsurgery.org or
ASPS Ethics Committee, 444 East Algonquin Road, Arlington Heights, IL 60005.)

PREAMBLE

As stated in its Bylaws, the American Society of Plastic Surgeons (ASPS) is organized:

To benefit humanity by advancing the art and science of plastic and reconstructive surgery; to promote the highest standard of professional skill and competence among plastic surgeons; to promote the exchange of information among plastic surgeons; to promote the highest standard of personal and professional conduct among plastic surgeons and other Members; to provide the public with information about the scientific progress in plastic and reconstructive surgery; to promote the purpose and effectiveness of plastic surgeons as is consistent with the public interest.

Membership in ASPS is granted to those surgeons who are competent practitioners of the art and science of plastic surgery. Competence in plastic surgery involves attainment and maintenance of high standards of medical and ethical conduct. Medical competence is fostered by successful completion of the examinations of the American Board of Plastic Surgery, The Royal College of Physicians and Surgeons in Canada and/or the Corporation Professionelle des Médecins du Québec. Ethical competence is fostered by the adoption and enforcement of a Code of Ethics, adherence to which is prerequisite for admission to and maintenance of membership in ASPS. Members are expected to act in accord with the General and Specific Principles of the Code of Ethics of ASPS in all their contacts with patients, peers and the general public. Further, Members are individually responsible and accountable for their actions and words, as well as the use of their names, by any individual or entity. Members shall be subject to disciplinary action, including expulsion, for violation of any of the General or Specific Principles of this Code.

Section 1: General Principles

I. The principal objective of the medical profession is to render services to humanity with full respect for human dignity. Members should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

II. Members should strive continually to improve medical knowledge and skill, and make available to their patients and colleagues the benefits of their professional achievements. Members have an affirmative duty to disclose new medical advances to patients and colleagues.

III. Members should practice a method of healing founded on a scientific basis, and should not voluntarily associate professionally with anyone who violates this principle.

IV. Members should observe all laws, uphold the dignity and honor of the profession, and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow Members of the profession.

V. Members may choose whom to serve. In emergency situations, however, Members should render service to the best of their ability. Having undertaken the care of a patient, a Member may not neglect the patient; and until the patient has been discharged, a Member may discontinue services only after giving adequate notice.

VI. Members should provide services under the terms and conditions which permit the free and complete exercise of sound medical judgment and skill.

VII. A Member should seek consultation upon request, in doubtful or difficult cases or whenever it appears that the quality of medical service may be enhanced thereby.

VIII. A Member may not reveal a patient's confidence, any observed characteristics of the patient, or any information obtained from the patient in a professional capacity, without such patient's consent or unless required to do so by law or unless it becomes necessary in order to protect the welfare of the patient or of the community.

IX. The honored ideals of the medical profession imply that the responsibilities of the Member extend not only to the patient, but also to society. Activities, which have the purpose of improving both the health and well-being of the patient and the community, deserve the interest and participation of the Member.

X. To assist the public in obtaining medical services, Members are permitted to make known their services through advertising. Advertising, however, entails the risk that the Member may employ practices that are false, fraudulent, deceptive, or misleading. Regulation is, therefore, necessary and in the public interest. Subsection II of the Specific Principles permits public dissemination of truthful information about medical services, while prohibiting false, fraudulent, deceptive or misleading communications, and restricting direct solicitation.

XI. In their public and private communications with or concerning patients and colleagues made in a professional capacity or environment, Members shall strive to use accurate and respectful language and images.

Section 2: Specific Principles

I. Each Member may be subject to disciplinary action, including expulsion, if:

A. The member's right to practice medicine is limited, suspended, terminated, or otherwise affected in any state, province, or country for violation of a medical practice act or other statute or governmental regulation or the Member is disciplined by any medical licensing authority.

B. The Member fails to inform ASPS that the member's right to practice medicine has been limited, suspended, terminated, or otherwise affected in any state, province, or country for violation of a medical practice act, other statute or governmental regulation or, the Member has been disciplined by any medical licensing authority.

C. The Member is convicted of (or pleads guilty to) a felony or any crime relating to or arising out of the practice of medicine or involving moral turpitude.

D. The Member engages in sexual misconduct in the practice of medicine.

E. The Member is involved in improper financial dealings including, but not limited to:

1. Dividing a fee for medical service with another person licensed to practice medicine who is not a partner or associate of his or hers, unless

(a) The patient consents to employment of the other person licensed to practice medicine under a full disclosure that a division of fees will be made; and

(b) A division is made in proportion to the services actually performed and responsibility assigned to each; and

(c) The total fee charged by all persons licensed to practice medicine is not increased solely by reason of provision for the division of fees.

2. Payment and/or acceptance of rebates or referral fees to or from any person, including agents and employees of the member, in exchange for the referral of patients. Nothing in this Principle shall be construed to prohibit a Member from participating in a referral service, in which the member's paid participation is disclosed, where permitted by state law.

3. Charging exorbitant fees, particularly of a non-contractual nature (e.g., emergency care). Fees, whether for professional fees or associated with the use facilities owned in whole or in part by the Member, are exorbitant when they are wholly disproportionate to the services rendered and care provided. The reasonableness of fees depends upon the novelty and difficulty of the procedures involved; the skill required to provide proper care; the time and labor required; the fee charged for similar services by similarly situated peers; and whether or not the patient had agreed in advance to the fee. Members are responsible for ensuring the reasonableness and appropriateness of fees charged to patients and payors on such Member's behalf either directly or through third party billing services.

4. Except in instances of emergencies or urgent and life threatening disease or injury, nothing in this Principle shall be construed to prohibit a Member from requiring prepayment of professional fees for all elective surgical operations.

5. Nothing contained in this provision shall be construed to limit price competition among Members.

F. The Member uses, participates in or promotes the use of any form of public communication (as defined in Glossary to the Code) or private communication (as defined in the Glossary to the Code) containing a false, fraudulent, deceptive, or misleading statement or claim, including a statement or claim which:

1. Contains a misrepresentation of fact, or fails to state any fact that is necessary to make the statement not deceptive or misleading, when considered as a whole.

2. Omits facts or information of which the public ought to reasonably be informed before selecting a qualified plastic surgeon.

3. Contains photographs, images, or facsimiles of persons that falsely or deceptively portray a physical or medical condition, injury, disease, including obesity, or recovery of relief therefrom.

4. Contains photographs, images, or facsimiles of persons who have received the services advertised, but who have experienced results that are not typical of the results obtained by the average patient, without clearly and noticeably disclosing that fact.

5. Contains photographs, images, or facsimiles of persons before and after receiving services, which use different light, poses, or photographic techniques to misrepresent the results achieved by the individual.

6. Contains a testimonial or endorsement pertaining to the quality of the member's medical care if the experience of the endorser does not represent the typical experience of other patients or if, due to the infrequency and/or complexity of such care, results in other cases cannot be predicted with any degree of accuracy.

7. Contains a testimonial or endorsement pertaining to the quality of the member's medical care or the member's qualifications if the endorser has been compensated by the Member or a third party retained by the Member for making such testimonial or endorsement.

8. Is intended or is likely to create false or unjustified expectations of favorable results.

9. Contains a representation or statement of opinion as to the superior quality of professional services which is not susceptible to verification by the public or contains a statement representing that the Member possesses skills or provides services superior to those of other physicians with similar training unless such representation can be factually substantiated.

10. Appeals primarily to layperson's fears, anxieties, or emotional vulnerabilities.

11. Contains, in reference to any matter material to a patient's decision to utilize a member's services, a representation of fact or implication that is likely to cause an ordinary prudent person to misunderstand or be deceived, or fails to contain reasonable warnings or disclosures necessary to make a representation or implication not deceptive.

12. Contains a guarantee that satisfaction or a cure will result from the performance of the member's services.

13. States or implies that a Member is a board-certified specialist unless the Member is certified by a board recognized by the American Board of Medical Specialties, The

Royal College of Physicians and Surgeons in Canada and/or the Corporation Professionelle des Médecins du Québec.

14. Is not identified as a paid advertisement or solicitation unless it is apparent from the context that it is a paid advertisement or solicitation.

15. Is intended or is likely to attract patients by use of exaggerated claims.

G. The Member performs an unjustified surgical operation or a surgical operation that is not calculated to improve or benefit the patient.

H. The Member performs a surgical operation or operations (except on patients whose chances of recovery would be prejudiced by removal to another hospital) under circumstances in which the responsibility for diagnosis or care of the patient is delegated to another who is not qualified to undertake it.

I. The Member participates in a charity raffle, fund raising event, contest or other promotion in which the prize is any procedure, or an integral component of a procedure (e.g. breast implants), as defined in the Glossary to the Code.

J. The Member seeks or obtains a patent for any invention or discovery of a method or process for performing a surgical procedure or employs trade secrets, confidentiality agreements or other methods to limit the availability of medical procedures and the dissemination of medical knowledge.

K. The Member engages in unprofessional conduct in violation of the General Principles of the Code.

II. Advertising

A. Subject to the limitations of Section 2, I, F, a Member may advertise, including advertising through public communications media (as defined in the Glossary of the Code).

B. A Member shall not compensate or give anything of value directly or indirectly to a representative of the press, radio, television, or other public communication media in anticipation of or return for recommending the member's services. A Member shall approve all advertisements before dissemination or transmission, and shall retain a copy or record of all such advertisements in their entirety for one year after its dissemination. A Member shall be held personally responsible for any violation of the Code of Ethics incurred by a public relations, advertising or similar firm which he or she retains, or any entity that advertises on the member's behalf.

C. A Member may use photographs of models in his or her advertisements or other promotional materials. If photographs of models who have not received the services advertised are displayed in a manner that would suggest the model received the services advertised, the advertisement or other promotional material shall clearly and conspicuously state that the model has not received the advertised services.

III. Solicitation

A. A Member shall refrain from engaging in systematic verbal solicitation (as defined in the Glossary of the Code) of patients in person, by telephone, or through agents.

B. A Member shall not initiate contact with a prospective patient knowing that the physical, emotional, or mental state or degree of education of the person solicited is such that the person could not exercise reasonable judgment in employing a member.

C. A Member who has given unsolicited, in-person advice to a layperson that the individual should have medical or health care shall not accept employment resulting from that advice if:

1. The advice embodies or implies a statement or claim that is false, fraudulent, deceptive or misleading within the meaning of Article I, Section F.

2. The advice involves the use by the Member of undue influence, coercion, duress, harassment, intimidation, unwarranted promises of benefits, over-persuasion, overreaching, or pressure for immediate response.

3. The Member has been given notice that the individual non-patient does not want to receive a communication from the member.

IV. Expert Testimony

It is in the public interest that medical expert testimony be readily available, objective and unbiased. Members have an obligation to testify as expert witnesses when appropriate. However, Members may not accept compensation contingent upon the outcome of the litigation, nor agree to testify in any case where the Member has a conflict of interest (including, without limitation, where the Member is or has been the treating physician for the patient at issue or where the physician has a personal or professional relationship with the patient or plaintiff in the case). Members whose testimony, including testimony as to credentials or qualifications, is false, deceptive, or misleading may be subject to disciplinary action, including expulsion. Further to help limit false, deceptive and/or misleading testimony, Members serving as expert witnesses must:

1. Have recent and substantive experience (as defined in the Glossary of the Code) in the area in which they testify, including, without limitation, experience in the relevant subspecialty or the particular procedure performed on the plaintiff;

2. Thoroughly review the medical facts and testify to their content fairly, honestly, and impartially;

3. Be familiar with the standards of practice prevailing at the time of the occurrence,

4. Provide evidence-based testimony regarding the standard of care, citing peer-reviewed plastic surgery literature where possible and identifying personal opinion as such;

5. Demonstrate (or be prepared to demonstrate) a causal relationship between an alleged substandard practice and a medical outcome;

6. Neither condemn performance that clearly falls within the standard of care in the community nor endorse or condone performance that clearly falls outside of such standard of care; and

7. Not testify that a maloccurence is malpractice.

V. Conflicts of Interest

A Member's clinical judgment and practice must not be affected by economic interest in, commitment to, or benefit from professionally related commercial enterprises or other actual or potential conflicts of interest. Disclosure of professionally-related commercial interests and any other interests that may influence clinical decision-making is required in communications to patients, the public, and colleagues. When a Member's interest conflicts so greatly with the patient's interest as to be incompatible, the Member should make alternative arrangements for the care of the patient.

In the context of Member ownership interest in a commercial venture, the Member has an obligation to disclose the ownership interest to the patient or referring colleagues prior to utilization; the Member's activities must be in strict conformance with the law; and the patient should have free choice to use the Member's facility or therapy or to seek the needed services elsewhere.

VI. Enforcement

Any Member charged with a violation of any ethical standard set forth herein may be subject to disciplinary measures, including censure, suspension or expulsion, as described in Article XXII of the Society's Bylaws.

VII. Glossary

For purposes of this Code and unless the context otherwise requires,

A. "Electronic Media" includes websites, social media forums, blogs, video streams, discussion boards, digital platforms and any means of communication over the internet or similar virtual technology or networks.

B. "Private communication" includes any information, written or otherwise, that is disseminated by a Member and not made known to the general public or nor intended to be made known to the general public at the time it was made.

C. "Procedure" for the purposes of Section 2, Article I(I) of the Code, is defined as a medical service that requires an incision. Examples of services that require an incision include, but are not limited to, facelift, breast augmentation, blepharoplasty and liposuction. Examples of medical services that would not be considered procedures for purposes of Section 2, Article I(I) include, but are not limited to, injections (botulinum toxin, hyaluronic acid), microdermabrasion and other skin surface treatments.

D. "Public communication" includes any information transmitted orally, in writing, or through Electronic Media, the primary purpose of which is to communicate with the public, or a segment thereof.

E. "Public communications media" includes, but is not limited to, Electronic Media, television, radio, recorded video or motion picture, telephone, written correspondence, electronic mail/e-mail (other than those which are which are Private Communications), print (i.e. newspaper, magazine, book), marketing materials and branding (i.e. directory, business card, professional announcement card, office sign, letterhead, telephone directory listing or professional notice).

F. "Recent and substantive experience" means that the Member is familiar with the practice of plastic surgery and the particular procedure performed at the time of the occurrence that is the subject of legal action, was engaged in the practice of plastic surgery for a period of not less than three (3) years prior to the date of the occurrence and has performed the specific procedure in question within three (3) years of the date of being retained as an expert witness.

G. "Solicitation" is a communication to a specific individual to attract him or her as a patient.

STATEMENT OF PRINCIPLE OF INFORMED CONSENT

The American Society of Plastic Surgeons recognizes the Member-patient relationship as one of shared decision-making. Through a process of communication and dialogue the Member provides information that allows a patient and/or the patient's authorized representative to make individual choices about his or her medical treatment.

Shared decision-making is at the heart of the doctor-patient relationship and is based on the ethical principles of respect for individual autonomy and dignity.

The process by which Members and patients make decisions together is informed consent. For any surgical operation or treatment, relevant information must be provided, discussed, and understood by the patient and/or the patient's authorized representative. Relevant information for proper informed consent for any procedure may include, but is not limited to:

- Nature of the surgery or treatment
- Indications for the operation
- Expected benefits
- Consequences and side effects of the operation
- Potential risks and adverse outcomes with their probability and severity
- Alternatives to the procedure being considered, and their benefits, risks, and consequences
- Outcome anticipated
- Whether the operation or treatment is experimental or being applied in a manner not approved by the relevant regulatory authorities (e.g. an off-label use or without approval of an Institutional Review Board)

The patient and/or the patient's legally authorized representative(s) should sign a written consent form before any surgical procedures are performed.

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