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

3 DYLAN BRANDT, et al.,

4 Plaintiffs,
v. No. 4:21CV00450 JM
5
November 29, 2022
6 Little Rock, Arkansas
8:03 AM
7 LESLIE RUTLEDGE, et al.,

8 Defendants.

9 **TRANSCRIPT OF BENCH TRIAL - VOLUME 6**
BEFORE THE HONORABLE JAMES M. MOODY, JR.,
10 UNITED STATES DISTRICT JUDGE

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24 Appearances continuing...

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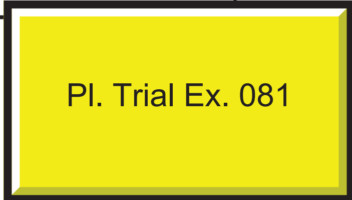

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1 (Proceedings continuing in open court at 8:03 AM.)
2 MR. JACOBS: I think just briefly before we get
3 started with Dr. Regnerus, the parties conferred in advance of
4 Thursday regarding closings, and I think we've both agreed that
5 if the Court's amenable to it, we would just not have closing
6 arguments and instead just submit proposed findings of fact and
7 conclusions of law at some point after the close of trial and
8 discuss schedule wise. We just wanted to raise that just for
9 scheduling purposes.
10 THE COURT: Suits me. What does that do to the
11 schedule?
12 MR. JACOBS: I don't think -- well, we'll still
13 finish on Thursday.
14 THE COURT: I guess that's what I'm asking.
15 MR. JACOBS: Yeah, we just won't have to stay any
16 later than we otherwise would to do arguments.
17 So Defendants would call Dr. Regnerus. Are we ready to
18 go?
19 THE COURT: Doctor, can you hear me?
20 THE WITNESS: I can. Can you hear me?
21 THE COURT: I can. Would you raise your right hand?
22 **DANIEL REGNERUS, DEFENDANTS' WITNESS, DULY SWORN**
23 THE COURT: I'm not sure what camera to look into,
24 so y'all are free to proceed.
25 DIRECT EXAMINATION

1 BY MR. JACOBS:
2 Q Dr. Regnerus, does it help if I have my video on, or my
3 screen on for you to look at?
4 A I think so.
5 Q Okay. I can turn it off if it's distracting. Can you
6 state and spell your name for the court reporter?
7 A My name is Mark Regnerus. Spelled M-a-r-k
8 R-e-g-n-e-r-u-s.
9 Q What is your profession?
10 A I'm a professor of sociology.
11 Q And how long have you been a sociologist?
12 A Like, I started training for it in 1994 and then employed
13 as a sociologist since 2001.
14 Q What is it that sociologists do?
15 A They study the influence of mostly structures on human
16 behavior and also development of those social structures and
17 how they influence the course of our lives and vice versa.
18 Q And do sociologists do that through performing research?
19 A We do.
20 Q Have you conducted research yourself?
21 A I have.
22 Q What are some of your research areas?
23 A I began as a sociologist for religion, and I still dabble
24 in that a little bit, but not that much. I primarily study
25 relationship behavior, romantic and sexual relationship

1 behavior, and to some extent, marital and decision making,
2 things like that.
3 Q Has your work been published?
4 A Yes.
5 Q As part of your work as a sociologist, are you familiar
6 with the principles of study design and methodology?
7 A Yes.
8 Q Does your expertise include critically evaluating
9 research?
10 A Yes, I do that sometimes in reviews for journalists.
11 Sometimes I do that when I'm teaching research methods. And
12 I've published at least one study, perhaps more, and some
13 essays critically evaluating research conclusions of methods of
14 others.
15 MR. JACOBS: Your Honor, similar with Dr. Levine, if
16 there's not going to be any voir dire of the witness, I think
17 we'll just rest on his CV and move on to the rest of the
18 questioning.
19 MR. RICHARDSON: Your Honor, Plaintiffs don't object
20 to Professor Regnerus's training in sociology, but based on his
21 reports in this case, we do have concerns first that he will
22 testify about matters outside of sociology and, second, that
23 his sociological opinions will be based on his assessment of
24 areas outside of his expertise like the quality of medical
25 evidence, so we would like to voir dire the witness.

1 THE COURT: Okay.
2 MR. RICHARDSON: Your Honor, would you prefer if I
3 come to the --
4 THE COURT: I don't have a preference if the doctor
5 can hear you wherever you are. You just need your mic right
6 there.
7 VOIR DIRE EXAMINATION
8 BY MR. RICHARDSON:
9 Q Professor Regnerus, my name is Dan Richardson, attorney
10 with the plaintiffs. Good morning or good evening where you
11 are. You only have degrees in sociology, correct?
12 A Yes, that's correct.
13 Q So you don't have any degrees in medicine?
14 A That's correct.
15 Q How about psychiatry?
16 A No.
17 Q And psychology?
18 A No.
19 Q Your academic training did not include training on how to
20 diagnose or treat medical conditions; is that right?
21 A That is correct.
22 Q And it did not include training on how to diagnose or
23 treat mental health conditions; is that right?
24 A That is correct.
25 Q Is it correct that you have no academic training at all

1 related to transgender healthcare or gender dysphoria?
2 A Not in terms of a diagnosis or medical and psychological
3 side. In terms of medical research, there's a fair amount of
4 medical research in this domain that well-trained social
5 scientists can evaluate. I do not evaluate things that are
6 outside my purview. I stick to statistics in this domain.
7 Q Understood, but just to clarify, do you have any academic
8 training related to transgender healthcare or gender dysphoria
9 specifically?
10 A No.
11 Q So while you were working toward your academic degrees as
12 I understand it, there were courses offered about gender but
13 you just didn't take them; is that right?
14 A That was not an interest of mine at the time, correct.
15 Q So you did not take courses in gender even when they were
16 offered to you?
17 A That was 20 years ago, but no.
18 Q Have you ever conducted a clinical trial in medicine?
19 THE COURT: Doctor, can you repeat your last answer?
20 THE WITNESS: I have not in medicine.
21 THE COURT: Doctor, from time to time I'm going to
22 ask you to repeat yourself because my court reporter is taking
23 down everything we say and she can catch some things and not
24 others so if you can just anticipate that.
25 THE WITNESS: No problem.

1 THE COURT: I might not be up in your grill as much
2 so you'll know why I'm doing that, but thank you.
3 THE WITNESS: Sure.
4 BY MR. RICHARDSON:
5 Q Professor, is it right that you've never submitted
6 research on the effectiveness of care for gender dysphoria to a
7 peer reviewed publication?
8 A That is correct.
9 Q Is it correct that you've never served as a peer reviewer
10 for any academic work involving gender dysphoria?
11 A That I cannot recall. If it was, it would be strictly to
12 the statistical side of things.
13 Q But you don't recall any piece specific to gender
14 dysphoria that you peer reviewed?
15 A Not specific.
16 Q Am I correct that you've authored one peer reviewed
17 publication that discusses transgender people or gender
18 dysphoria?
19 A In terms of peer reviewed publications, correct.
20 Q And that piece is called *Attitudes in the U.S. Toward*
21 *Hormonal and/or Surgical Intervention for Adolescents*
22 *Experiencing Gender Dysphoria.* Is that right?
23 A Correct.
24 Q That paper was a national survey of attitudes about
25 medical interventions to treat gender dysphoria, right?

1 A Yes.
2 Q So that paper did not address the effectiveness of
3 gender-affirming medical care?
4 A No.
5 Q And it does not address the safety of that care?
6 A No.
7 THE COURT: At some point we're getting past voir
8 dire into cross.
9 MR. RICHARDSON: I just want to ask another question
10 about that specific paper for qualifications, Your Honor.
11 THE COURT: Okay.
12 BY MR. RICHARDSON:
13 Q As part of that research, did you interview or talk with
14 any healthcare providers who treat transgender youth?
15 A Not that research.
16 Q And apart from that one paper, you don't have any other
17 peer reviewed scholarship related to transgender people or
18 gender dysphoria?
19 A Correct.
20 Q So, instead, your research I think you put it this
21 morning is focused on religion, relationship behavior, and
22 marriage?
23 A Yeah, I mean, sexual relationship behavior, basically.
24 Q Okay. It is not focused on gender dysphoria, right?
25 A Not specifically.

1 Q And it hasn't focused on transgender people?
2 A They have come up as participants in the surveys and
3 control variables, data analysis, but not as, like,
4 interviewees.
5 Q Your research is not focused on gender identity then
6 either, right?
7 A Only, again, as a measure and further discipline models.
8 Q You don't teach any classes related to gender identity,
9 right?
10 A I don't.
11 Q You don't teach any classes focused on gender dysphoria;
12 is that right?
13 A Correct.
14 Q Okay. You don't have any experience working in the
15 clinic that provides gender-affirming medical care; is that
16 correct?
17 A That is correct.
18 Q Okay. And clinicians don't contact you to consult about
19 the care they're providing, right?
20 A No, although I have fielded phone calls with frustrations
21 about such care, but not as a consultant.
22 Q So just to clarify, during those calls you were not asked
23 to provide views on how to provide gender-affirming medical
24 care?
25 A No.

1 Q And you haven't worked in a medical or mental health
2 clinical setting of any kind, correct?
3 A No.
4 Q So you would not know how clinics go about obtaining
5 informed consent?
6 A Only by their own description of it. It's not radically
7 different than how I obtain informed consent from participants
8 in my studies. Probably a lengthier process, but I'm well
9 acquainted with the informed consent process in general.
10 Q But you acknowledge that informed consent might be
11 different in the medical setting?
12 A Sure.
13 Q And what is your knowledge of informed consent in the
14 medical setting based on?
15 A Reading materials.
16 Q But no materials that you would have been peer reviewing
17 or publishing or teaching about, right?
18 A No, no, it's a part of the building of the report for
19 this case.
20 Q Okay. And have you ever been part of a group that
21 established or revised a medical standard?
22 A Medical standard, no.
23 Q Thank you, Professor.
24 Your Honor, based on the witness's testimony, we would
25 ask you to limit his testimony to exclude certain topics.

1 Those would be --
2 THE COURT: If he gets into those topics, I'll allow
3 you to object at that time and then I'll deal with them. I'm
4 going to let you keep track of what you think is appropriate or
5 not and I'll deal with it on a question by question basis if
6 that suits you.
7 MR. RICHARDSON: Understood. Thank you, Your Honor.
8 (Recess at 8:16 AM.)
9 REPORTER'S CERTIFICATE
10 I certify that the foregoing is a correct transcript of
11 proceedings in the above-entitled matter.
12
13 /s/ Karen Dellinger, RDR, CRR, CCR
---------------------------------- Date: December 4, 2022
14 United States Court Reporter
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1 (Proceedings continuing at 8:27 a.m.)
2 DIRECT EXAMINATION CONTINUED
3 BY MR. JACOBS:
4 Q. Can you hear me, Dr. Regnerus?
5 A. I can.
6 Q. Can you explain what the term "sociology of science" is?
7 A. It's when you take your methods and disciplinary tools you
8 have, and you train it on your own discipline and studying how
9 it operates.
10 COURT REPORTER: I am having trouble hearing.
11 THE COURT: Just do the best you can.
12 BY MR. JACOBS:
13 Q. I will just ask that question over if that works. So I
14 asked you if you could tell us what the term "sociology of
15 science" means.
16 A. Sociologists take the tools of their discipline,
17 methodological skills, etc. And they train it on the discipline
18 itself, the practice of sociological science. And it seeks to
19 evaluate how this works and does it accomplish what it claims to
20 set out to accomplish. Are there norms that seem distinctively
21 unscientific that are operative in the discipline. Instead of
22 training on sociology, on family or religion, we just turn it
23 around and say, well, what is it like to do sociology?
24 Q. What can sociology tell us? What kinds of questions can it
25 answer about the medical treatment of gender dysphoria?

1 A. We're not going to weigh in on treatment decisions per se.
2 But we could evaluate are they made evenly, what kind of
3 measures could they use and are measures comparable, especially
4 insofar as they are evaluating things that overlap with what
5 social scientists would collect. For example, Professor Turban
6 does survey research like I do survey research. So there's a
7 variety of us who can evaluate the kinds of measurements he uses
8 because they are similar to ours, the same thing with some of
9 the analytic models that are used in medicine. There's often
10 sociologists brought in as analysts for medical data, especially
11 when comparing outcomes.
12 One of my best friends from graduate school, we both got
13 Ph.D.s in sociology from the same university. And he goes off
14 to work in a medical center doing studies with doctors, and I go
15 off to an eastern university. The skill set is the key in what
16 we use it. We do not weigh in on things that we don't know
17 about. We stick to our comments.
18 Q. Are you familiar with the practice that some of the medical
19 field call gender-affirming treatments or gender-affirming care?
20 A. Insofar as I've read about them, I think I'm familiar with
21 some aspects of them. What I can tell, they can vary. But, in
22 general, I understand the term.
23 Q. What do you, in general, understand the term
24 "gender-affirming care" to encompass?
25 A. I have a little feedback, but I think I understand the

1 question. It is an approach that does give the patient a little
2 bit more authority in the process and purports to listen to the
3 patient and sort of lean in the direction performing the care
4 that they wish to receive if, in fact, they understand the
5 nature of their own condition. So a little bit fewer barriers
6 to care and a little bit less concern about other comorbidities
7 that may be occurring in terms as barriers to delivery of care.
8 MR. RICHARDSON: Objection, Your Honor.
9 THE COURT: Doctor, let me interrupt you. I'm not
10 sure you heard the question, or maybe the transcription is not
11 the same. But the question was: What do you, in general,
12 understand the term "gender-affirming care" to encompass?
13 Is that what you asked?
14 MR. JACOBS: That was my question. I was going to
15 sort of move on a little bit from that and just --
16 MR. RICHARDSON: Sorry, Your Honor. We would object
17 to Professor Regnerus's response to that question. It goes
18 outside of his expertise.
19 THE COURT: To what his understanding of
20 gender-affirming care is?
21 MR. RICHARDSON: Well, his response got into how that
22 care is provided and diagnosed.
23 THE COURT: I understand that his response was well
24 far afield of the question, and that's why I asked him if he had
25 heard the question. So Mr. Jacobs said he was going to move on

1 from that.
2 I'm going to put it back in your lap, Mr. Jacobs, and let
3 you proceed.
4 MR. JACOBS: Sure.
5 BY MR. JACOBS:
6 Q. Dr. Regnerus, do you understand gender-affirming care to
7 include medical and surgical interventions for some patients?
8 A. Yes.
9 Q. And do you understand that the medical and surgical aspects
10 of gender-affirming care are some of the treatments that are
11 prohibited for minors under the SAFE Act, the law at issue in
12 this lawsuit?
13 A. Yes.
14 Q. In the work you've done in this case, what is your
15 understanding of the gender-affirming model of care's prominence
16 with practitioners of gender-related medicine today in the
17 United States?
18 MR. RICHARDSON: Objection, Your Honor. It goes
19 beyond the witness's expertise.
20 THE COURT: I'm going to allow him to answer what his
21 understanding is, but he's probably going to have to lay a
22 foundation to go beyond what his understanding is.
23 Go ahead and answer the question, Doctor, if you can.
24 THE WITNESS: Would you repeat the question?
25 THE COURT: Repeat your question, Mr. Jacobs.

1 BY MR. JACOBS:
2 Q. The question is what is your understanding of the
3 gender-affirming model of care's prominence with practitioners
4 of gender-related medicine today in the United States?
5 THE COURT: Forgive me, but I'm not even sure I
6 understand the question.
7 MR. JACOBS: I'll reword it.
8 BY MR. JACOBS:
9 Q. Based on the work that you've done in this case, Dr.
10 Regnerus, is it your understanding that the gender-affirming
11 model of care is the more prominent approach to treating gender
12 affirming -- excuse me -- to treating gender dysphoria in minors
13 in the United States?
14 MR. RICHARDSON: Objection, Your Honor. Leading.
15 THE COURT: I'm going to allow the leading.
16 Answer the question, if you can, Doctor.
17 THE WITNESS: Yes. My understanding, given the
18 reading about the affirmative care and model, is that it's
19 increasingly common. But I have no absolute knowledge of that.
20 I know there's a significant debate about the affirmative care
21 model. It seems to be increasing in prominence.
22 BY MR. JACOBS:
23 Q. I want to shift gears a little bit. Can you explain, as a
24 sociologist, what you understand the term "ideology" to mean?
25 A. Ideology is sort of a belief system about the way something

1 works. It's easily sort of a grand system. But it's largely
2 restricted to beliefs and understanding of how something works
3 and what would one often do. It's an overarching belief system.
4 Q. Can you sort of offer us like a contrast of what you might
5 mean to say when a decision is based on ideology rather than
6 being based on science?
7 THE COURT: I'm not sure we need expert opinions on
8 the difference between ideology.
9 Doctor, is your definition of ideology any different than
10 the average lay person's definition of ideology?
11 THE WITNESS: Probably not.
12 THE COURT: Okay.
13 MR. JACOBS: I'll move on from that, Your Honor.
14 THE COURT: Thank you.
15 BY MR. JACOBS:
16 Q. Have you used your training as a sociologist and that
17 background to assess the relationship between ideology and the
18 evolving treatment of gender dysphoria in the United States?
19 A. Yes.
20 Q. I want to ask about some of your observations. Are you
21 familiar with the term "idealogical capture"?
22 A. I am.
23 Q. Could you describe your understanding of what that term
24 means?
25 A. Idealogical capture is a series of authority. Authority is

1 the successfully co-opting, particularly regarding professional
2 organizations, in order to serve the aims and ends of a
3 particular set of actors or, in this case, activists. So it's
4 basically the co-opting of authority of a larger professional
5 organization to serve the interests of a particular group.
6 Q. Have you observed the phenomenon of idealogical capture in
7 the course of assessing the treatment of gender dysphoria in the
8 United States?
9 MR. RICHARDSON: Objection, Your Honor. The witness
10 testified that he has no knowledge or background in
11 gender-affirming medical care for treatments for gender
12 dysphoria.
13 THE COURT: Lay a foundation for the answer to that
14 question, Mr. Jacobs. I need to know what he's basing his
15 answer on before I allow him to continue.
16 MR. JACOBS: Maybe I'll break it down into smaller
17 parts then, Your Honor.
18 THE COURT: Great.
19 MR. JACOBS: I'll do it that way.
20 BY MR. JACOBS:
21 Q. Is a part of what sociologists do to examine things like
22 the norms?
23 THE COURT: I guess I'm more interested in what he's
24 done as opposed to what sociologists do. What has he done in
25 preparation for that question I guess is what I'm trying to get

1 to.
2 MR. JACOBS: I guess I was trying to lay a foundation
3 for the foundation, if that makes sense.
4 THE COURT: Fair enough.
5 BY MR. JACOBS:
6 Q. Is a part of what sociologists in general do to assess
7 social norms?
8 Can you hear me, Dr. Regnerus?
9 A. No. I didn't catch that last part.
10 Q. Is it a part of what sociologists do -- excuse me. Is
11 assessing social norms part of what sociologists do?
12 A. Yes. That's central to sociology.
13 Q. And can that include things like language and terminology?
14 A. Right, right.
15 Q. Can you briefly describe what sociologists might analyze
16 about things like language and terminology when you are doing
17 work?
18 A. Right, right. In general or with regards to this case?
19 Q. In general, just a little primer, I guess.
20 A. Right. So we look at sort of language changes, a
21 terminology change over time, and what it means and why it
22 happens and what it might signal for the future. That's one
23 example. Norms, we look at how behavior has changed over time
24 and does it signal changes in attitudes, changes in dominant
25 patterns of expected behavior, that sort of thing.

1 Q. Going back to this notion of idealogical capture, might
2 that involve language or terminology becoming intertwined with
3 ideology? And, if so, can you explain how?
4 MR. RICHARDSON: Objection. Leading.
5 THE COURT: I'm going to allow it.
6 THE WITNESS: Do you want me to give an example in
7 this case?
8 BY MR. JACOBS:
9 Q. I was sort of asking as a general matter first if you can.
10 A. You are asking for what?
11 Q. Well, so let me ask in general. So what exactly am I to
12 mean for terminology to be intertwined with ideology from the
13 perspective of a sociologist?
14 A. How we even talk about something in sociology can sort of
15 reflect and also can change the course of the study of
16 something. So when we talk about religion, for example, you
17 know, if we use the term "religiosity," just kind of a technical
18 measurement term, we know what we mean by that. It doesn't mean
19 it percolates out into common parlance, but it can. So there
20 can be a two-way relationship between what we study, what
21 sociologists see and write down. And then it can turn around
22 and go out back and affect the people that we're studying, so
23 it's kind of a feedback mechanism.
24 Q. Have you observed this in the context of gender dysphoria
25 and the treatment of gender dysphoria?

1 MR. RICHARDSON: Objection, Your Honor. The witness
2 testified that he has no experience in gender dysphoria or the
3 treatment for gender dysphoria.
4 MR. JACOBS: Your Honor, the question is about
5 language.
6 THE COURT: Where are we going with this, Mr. Jacobs?
7 I'm trying to figure out whether or not, one, this witness has
8 done any specific research on authority capture or whatever.
9 And I'm assuming that where it's going is that these various
10 groups that promote transgender have been co-opting this
11 authority as opposed to the flip side of that, which are the
12 organizations that are not promoting transgender authority.
13 But I've yet to see what this witness has done to put
14 co-opting of authority or idealogical capture, what he's done to
15 put that in the transgender context. And you've given me your
16 primer, so thank you for that. I kind of knew that part. But
17 what I'm trying to do is find out what this witness has done to
18 study the relationship of idealogical capture as to this
19 question to transgender norms or whatever you want to put in
20 there. And have you seen it isn't enough for me to allow him to
21 answer the question. I need to know what he's done to answer
22 that question, because based on the voir dire, he hasn't done
23 much to associate the questions you are asking with transgender
24 in preparation of his testimony.
25 So that's what I was trying to get to is what has he done

1 with regard to transgender research or evaluation that can allow
2 him to answer that question, not like all of us in this room who
3 either read the paper or other has seen stuff like that. So I
4 need to know what his expertise is going to do to help me answer
5 my questions, and that's where I was headed with it.
6 MR. JACOBS: I think that was what I was intending to
7 get out with that question, Your Honor.
8 THE COURT: Well, I need to know what he has seen, not
9 has he seen it. So we've all seen stuff, but we're not all
10 allowed to testify in this case. So I need to know how his
11 experience or expertise is going to help me beyond the average
12 lay person if he's going to give his opinions on it. So keep
13 trying, I guess.
14 BY MR. JACOBS:
15 Q. So, Dr. Regnerus, do you have experience as a sociologist
16 examining norms of behavior and language and terminology?
17 That's my question.
18 A. For this case, in my expert witness report, yes.
19 MR. RICHARDSON: Objection, Your Honor. We
20 established that he had not done any work on gender dysphoria.
21 THE COURT: The question, as far as it went, was not
22 objectionable. I understand you might think that's not enough.
23 But he hasn't asked another question yet, so I'm going to
24 overrule that objection.
25 MR. RICHARDSON: Understood, Your Honor. I just

1 wanted to note that he said it was only in preparation for this
2 litigation.
3 BY MR. JACOBS:
4 Q. Just to clarify, outside of previously what you've done
5 prior to this litigation, setting aside the topic of gender
6 dysphoria, have you used your training as a sociologist to
7 assess things like social norms and language and terminology?
8 A. Yes, yes.
9 Q. What areas, you know, have you used the skill set in
10 throughout your career? What subject areas?
11 A. Right. Relationship behavior norms, how people talk about
12 each other, sociology, religion. I've written essays on some of
13 these subjects at hand based on observations of what's going on
14 broadly within the field as it can be discerned from journal
15 articles, from discussions of the field.
16 Q. What are the methods that you've used to do that only
17 applicable -- I'm sorry. Are the methods that you've used to do
18 that only applicable to those fields, or are they portable to
19 other fields?
20 A. I don't know. It's probably the sociology of science, how
21 people are asking questions, survey questions, interview
22 questions of the patterns and how people are interacting with
23 subjects, whether they are research subjects or patients.
24 Q. And specific to research and conducting research, is there
25 any relationship between ideology and how research is conducted?

1 A. Sure. I mean, the way we ask questions often reflects with
2 what we think is true about a particular process, which can be
3 disputed. Are you looking for examples?
4 Q. No, not just yet. And have you used the skill set to
5 analyze, for example, the language that has been used in the
6 debate and discussion concerning the treatment of gender
7 dysphoria in the United States?
8 MR. RICHARDSON: Objection, Your Honor. It goes
9 beyond the witness's expertise. He testified he's applied his
10 expertise to other topics, not gender dysphoria.
11 THE COURT: I'm going to let Mr. Jacobs finish his
12 question.
13 THE WITNESS: Yes.
14 THE COURT: Well, I'm not sure you didn't get
15 interrupted.
16 Would you restate your question, Mr. Jacobs?
17 BY MR. JACOBS:
18 Q. Dr. Regnerus, have you used your training as a sociologist
19 and the methods we've been discussing to analyze the language
20 that's been used in the debate and discussion surrounding
21 medical treatment of gender dysphoria?
22 A. I have.
23 Q. And what have been the results of that analysis?
24 THE COURT: Well, I need to know how he has done that
25 as opposed to going to the results.

1 BY MR. JACOBS:
2 Q. Dr. Regnerus, could you sort of explain your work and
3 methodology, how you've gone about conducting that analysis?
4 A. Right. This was done by evaluating, especially on medical
5 journals and medical research in this area, is talking about the
6 subject matter, how they analyze data, how they collect data,
7 the measures they use, how they ask questions. This is all
8 available in medical research that all of us can access.
9 THE COURT: Doctor, when you refer to "they," who are
10 you talking about?
11 THE WITNESS: Medical researchers and those who write
12 articles about medical research.
13 THE COURT: Medical researchers in general or medical
14 researchers that deal with transgender questions?
15 THE WITNESS: Right. In this case, Your Honor, I
16 evaluated the later.
17 THE COURT: That's all I wanted to know. Continue.
18 THE WITNESS: Yes, sir.
19 THE COURT: I said continue. I interrupted you for a
20 clarification. If you are done, that's fine. He can ask his
21 next question.
22 THE WITNESS: Sure.
23 THE COURT: But I didn't want to cut you off.
24 THE WITNESS: No. That's fine.
25 BY MR. JACOBS:

1 Q. Just to clarify, were you finished with your answer, Dr.
2 Regnerus?
3 A. I think I was. Mostly evaluation of existing published
4 research.
5 Q. What were your findings from your analysis?
6 A. So there's a variety of terms that are being used and
7 employed, not just in public parlance, but they can be, but are
8 actually used in data collection processes in a way that,
9 frankly, they didn't used to be.
10 So one of the more common examples is the term "assigned at
11 birth," right, in particular, sex assigned at birth. This is a
12 term that had its beginning probably within the last decade or
13 so. Some people may have been talking about it a little bit
14 before then. But it's a term that still doesn't exist on most
15 published social science and probably medical research, although
16 it is growing in frequency.
17 Obviously, there's some people who think, oh, this is a
18 perfectly fine way of asking about the sex of a person, right?
19 But it also indicates that there's a process going on here where
20 a physician or some particular authority comes alongside and
21 does the assigning of sex at the birth of the child, whereas a
22 very long time we used to understand sex is observed, right?
23 Sometimes it's observed in utero, when the doctor is getting a
24 pre -- an exam during pregnancy and says, "Oh, congratulations,
25 you are going to have a girl." But now we talk about this, and

1 we actually put surveys in front of people that says "what sex
2 were you assigned at birth?" I think most times people play
3 along with that. But, you know, it's certainly recognizing
4 there is a particular value embedded in how we ask about that
5 question that signals something has changed about how we
6 understand sex and how it is measured.
7 So I used to just ask, you know, are you male or female?
8 And in rare cases people would make an exception for intersex
9 conditions. Usually you capture the vast majority of the
10 population by asking about male, female. Now I see surveys
11 doing a two or three part question to just getting at what used
12 to be understood as dimorphic sex, male or female.
13 That's one example of one measure out of a variety of
14 measures in this domain that to me signal the ideological
15 capture of even like the method by which we document basic
16 things.
17 MR. RICHARDSON: Your Honor, we would object to that
18 portion of the answer that discussed medical research and the
19 terms used by medical scientists and practitioners.
20 THE COURT: Overruled.
21 BY MR. JACOBS:
22 Q. In the changing of language that you were just giving an
23 example of, how does that affect, or how might that affect how
24 research is conducted, the questions that are asked and the
25 results that are, you know, obtained from research?

1 A. Right, right. So there's certain pressure put on people to
2 -- scholars, I should say, researchers, to change how they ask
3 the questions like the one I just gave. That signals to
4 scholars, oh, do I change the way I ask about this question and
5 have for decades, or do I stay put and ask it in the way I wish
6 to? The whole thing creates tension, professional tension,
7 often. You will see guidance from organizations suggesting that
8 we change the way we ask about sex. So that's an example of the
9 sort of capture of authority. And then researchers have to
10 figure out what am I signaling when I change the way I ask a
11 question, right?
12 Another example is the use of the term "cisgender." I
13 remember when I first heard that 10, 15 years ago, I thought,
14 wow, that probably won't catch on. But to some extent it has,
15 but it's not in popular parlance. But it's certainly increasing
16 in frequency in researchers' parlance, certainly in legal
17 parlance too as far as I can tell. And, you know, it's not a
18 neutral term. It kind of indicates and portrays that some
19 situation, some social situation that's common to persons, has
20 changed and that there's a new way to talk about something, and
21 not just talk about something, but something has changed in the
22 social world which is better reflected than using the new term,
23 right, according to some. There's theological conflict over the
24 very words we use in this domain.
25 Another example, non-binary. When you are talking about

1 sexual dimorphism, male, female, then relatively recently we
2 sort of inserted the language around non-binary. This happens
3 outside of medical research as well. This is in social
4 research. So, you know, that's not really a question of sex, is
5 it, or is it? So it creates confusion for researchers about,
6 well, do I need to measure this? Do I need to add categories to
7 my list of sex categories, or do I create another question for
8 gender? So even kind of documenting basic, or at least ideas
9 that were long considered basic, take on this sort of
10 idealogical charge and meaning because we use new terms, right?
11 Q. I'm going to shift gears just a bit. As a sociologist,
12 have you studied or analyzed how groups and organizations debate
13 a known consensus on topics?
14 A. Uh-huh.
15 Q. I'm sorry. If you answered the question, I didn't hear
16 your answer.
17 THE COURT: He said: Uh-huh.
18 THE WITNESS: I didn't catch the last part of the
19 question. Sorry.
20 BY MR. JACOBS:
21 Q. As a sociologist, have you analyzed how groups and
22 organizations might debate issues and build consensus on topics?
23 A. Yes.
24 Q. For this case, have you analyzed the growing consensus
25 concerning gender-affirming care or gender-affirming treatments

1 for gender dysphoria in minors?
2 A. By my read of what's being said publicly within the field
3 and what's discernible in research print.
4 Q. Just to clarify, I think I asked have you done it, have you
5 done that, not how have you done that.
6 A. Yes.
7 Q. Yes. Okay. And this may repeat a little bit. But how
8 have you gone about doing that in this case?
9 A. That's what I was mentioning. By observing, reading fairly
10 widely about publicly discernible debates that are going on
11 within the medical community insofar as they are published,
12 either in long form or in research articles, letters to the
13 editor, letters of concern to journals, that sort of thing.
14 Q. Have you observed a change over time in the discourse
15 related to this consensus of prominence of gender-affirming
16 care?
17 MR. RICHARDSON: Objection, Your Honor. It goes
18 beyond the witness's expertise.
19 THE COURT: I'm going to allow him to testify that
20 based on what he's read, either old or new, how he thinks it's
21 becoming more prevalent or not is what I understand the question
22 to be. So I'm going to allow him to testify based on what he's
23 seen does he think it's more prevalent or not.
24 THE WITNESS: Yeah. There's certainly been a shift in
25 the debate as concerns what's called the Dutch protocol, which

1 by popular reading of it concerns being aware of and concerned
2 about --
3 THE COURT: Doctor, let me interrupt you. That's not
4 what I understood the question to be. I understood it to be do
5 you find it to be more widely discussed, or whatever you want to
6 say, based on your reading, not some analysis of the Dutch
7 study.
8 THE WITNESS: Right. I'm not particularly talking
9 about how the Dutch study works, just it has become less
10 prominent, and affirmative care seems to have been growing.
11 Yet, there's signs of debate and contest about what's the right
12 thing to do.
13 THE COURT: Doctor, let me interrupt you. That's a
14 different question. So what is your answer to whether or not
15 your review of the documentation seems to make this topic more
16 prevalent or not?
17 THE WITNESS: It does seem to be more debated.
18 BY MR. JACOBS:
19 Q. Have you analyzed the influence of professional medical
20 organizations in the United States on this debate?
21 A. I have analyzed their public statements, often published in
22 journals.
23 Q. Can you describe your observations on the role of those
24 organizations and the discussion and talk of consensus about
25 gender-affirming care?

1 THE COURT: Mr. Jacobs, I'm not sure -- again,
2 sometimes I know where people are going, and other times I
3 don't. I don't understand the question you are asking this
4 witness.
5 MR. JACOBS: It might have been a bad question.
6 THE COURT: No. Help me understand what the question
7 to the witness is. I mean, you asked him what the role of these
8 organizations was, and I'm not sure what organizations you were
9 talking about or how he would know what their role is any more
10 than you and I would.
11 MR. JACOBS: Let me perhaps rephrase this into
12 something more understandable.
13 THE COURT: I mean, if that's what you are asking him,
14 what organizations are you talking about, and what is their
15 role, I get that question. But I feel that you are headed
16 somewhere else with it maybe because I'm thinking that's too
17 simplistic.
18 MR. JACOBS: Well, I think that was sort of more of a
19 foundation question to get into more.
20 BY MR. JACOBS:
21 Q. So when I say American professional medical organizations,
22 Dr. Regnerus, what do you understand those organizations to be?
23 A. Like the American Academy of Pediatrics, the American
24 Medical Association, the American Psychological Association,
25 Endocrine Society.

1 Q. You don't have to list all of them. But those are the
2 types of organizations that you understand that term to mean?
3 A. Right.
4 Q. And in the course of your work analyzing the discussion and
5 debate concerning gender-affirming care, what have you seen as
6 the role of those professional organizations?
7 A. They seem to be -- they offer guidance. They offer
8 standards of care, suggestions, short of rules, so far as I can
9 tell, from the outside. And then, you know, I observe how
10 people react to that, for example, the American Academy of
11 Pediatrics stating their new guidance. I think it was in 2017.
12 And kind of some of its more popular concern about the American
13 Academy of Pediatrics had a lot of pediatricians in the United
14 States wondering where the new guidance came from and who wrote
15 it and what was the decision-making process by which that
16 guidance came to be.
17 Q. Have you observed a consensus among these professional
18 organizations in the United States specifically concerning
19 gender-affirming care?
20 A. On some of them they seem to endorse gender-affirming care.
21 At the same time, there is, you know, there's a lot of conflict
22 over whether the consensus was legitimate or settled too soon
23 and how in part the research consensus came to be, also how the
24 guidance came to be. So all of these domains, especially in
25 this area of health, seem to play out in the public sphere more,

1 say, than they would for, you know, oncology, for example.
2 Q. Are you familiar with the term Castro consensus?
3 A. I am.
4 Q. Could you explain what that means?
5 A. Right. A Castro consensus occurs when consensus is viewed
6 as a proxy for truth. It's not the same as the truth, but it's
7 a consensus means this is true. It depends on whether the
8 consensus was arrived at by independent evaluation, free
9 evaluation, free from any sort of strong norms or suggestions
10 like so that people can be free to sort of find where the data
11 lead. That's how we get to good consensus. Castro consensus is
12 when it looks likes it's not free, it's not independent, it's
13 the result of sort of a forced consensus. And that truth
14 becomes whatever the consensus says it is.
15 Q. Is it your opinion that this phenomenon has occurred in the
16 debate discussion about the treatment of gender dysphoria?
17 MR. RICHARDSON: Objection, Your Honor.
18 THE COURT: Sustained. You haven't laid any
19 foundation that he's done any studies on that this phenomenon
20 even exists in this field or how it's affected people's minds.
21 So, short of that, I'm going to sustain the objection.
22 BY MR. JACOBS:
23 Q. I'll back up. Is it part of your training and background
24 in sociology and the sociology of science to question consensus
25 and analyze whether a Castro consensus exists in a field?

1 A. We don't often label it as a Castro consensus, but the idea
2 is certainly present. In the area I worked in for some time,
3 the study of adult/child outcomes, the mothers and fathers who
4 had been in same sex relationships, which plaintiffs' attorneys
5 will remember, there was sort of a Castro consensus at work in
6 that field where even before lots of good data collection and
7 sort of random studies, actually representative studies had come
8 in, there was already kind of this consensus forming that there
9 was no differences between children who grew up in one kind of
10 household as opposed to another kind of household. There were
11 sociologists who analyzed at a macro level this data, including
12 that, yes, there's consensus here. I didn't really dispute that
13 there was a consensus. I disputed whether the consensus was
14 free and not sort of the result of wide agreement short of
15 rational science, so it felt like that was a proxy for truth.
16 And I thought it was false.
17 Q. So in that case, what sort of methods or approach did you
18 take going about to determine whether there was a legitimate
19 consensus that existed? What sorts of things did you do?
20 A. Well, I didn't undertake that. I observed it in the
21 language which social scientists used about that subject, the
22 study. And there was a well trafficked article probably eight
23 or nine years ago that talked about consensus in this and used
24 sort of the conclusions of a variety of studies to build the
25 idea that, ah, since these studies say this is the case, then we

1 have consensus. You know, the truth in this area should not be
2 built on consensus. It should be built on a wide variety of
3 studies using methods appropriate to the subject of study and
4 building complexity, not the race to complexity. I mean, I
5 think that's important for people to document basic associations
6 and then build in complexity. In that domain there was a rush
7 to complexities, which to me I thought they were hiding
8 something. They don't want to hide anything if they are trying
9 to generate a bona fide widely shared free agreement as a
10 consensus.
11 Q. So turning back to this case and gender-affirming care, how
12 did you go about analyzing the consensus and determining what
13 that was based on?
14 A. That's based on a read of the sort of widely popular
15 discussions of affirmative care and research around it and
16 discussions of support for it, concerns about it, concerns about
17 it outside of that research in a medical domain, concerns about
18 it within that research in a medical domain, to suggest that any
19 sign that there is wide agreement in this domain to me read as
20 if it was artificially created and that there was a lot more
21 dissent, obvious dissent, dissent playing out in the national
22 newspapers of the United States than sort of supporters of
23 affirmative care were letting on.
24 MR. RICHARDSON: Your Honor, we would object to that
25 answer. He testified that part of his opinion was based upon

1 his review of medical research, and earlier he testified he has
2 no relevant experience in medical research.
3 THE COURT: I'm going to allow it.
4 BY MR. JACOBS:
5 Q. Have you observed any trends over time in the discussion
6 regarding the consensus toward gender-affirming care?
7 A. Well, I just mentioned a little bit sort of this trend
8 towards disputes in domain being carried out in popular print.
9 It seems like there's far more of a power struggle going on, as
10 is apparent by reading about the field, than --
11 THE COURT: Doctor, who is the power struggle between?
12 THE WITNESS: So far as I can tell, it's different
13 wings of the affirmative care.
14 THE COURT: What do you mean by different wings of the
15 affirmative care?
16 THE WITNESS: Different doctors.
17 THE COURT: Who is -- let me finish my question. Who
18 is in opposition to the American Pediatric Association or the
19 Endocrine Society or whatever the number of groups that you were
20 referencing? I understand that you are saying they come to a
21 Castro consensus or whatever that word means. We've talked
22 earlier about language and short terms for things. And I
23 understand that, rather than give a paragraph explanation of
24 what the Castro consensus means, we just come to a short term or
25 a shorthand version of that word like cisgender instead of

1 explaining all of what that means.
2 But what I'm trying to do is, when you say there's a
3 conflict, I've heard you talk about who is in favor of it. Who
4 is opposing these groups based on your reading and research,
5 because, I mean, if there's conflict, I'm just trying to see who
6 is at war.
7 THE WITNESS: So the consensus, there are people who
8 think this kind of treatment should not be conducted on minors.
9 THE COURT: And who are those people that we're
10 talking about?
11 THE WITNESS: So there are people who have lost their
12 position or been demoted to talk about this. So, for example,
13 Ken Zucker is the Journal -- *Archives of Sexual Behavior Journal*
14 editor who was in charge, I believe, of the Toronto gender
15 clinic. And he was removed from his position because he was
16 advocating for too much caution for patients in treatment,
17 displaying concern for parents and families. That's just my
18 reading of it from the outside.
19 THE COURT: Right. I guess what I'm trying to figure
20 out --
21 THE WITNESS: He lost his job at the gender clinic for
22 that.
23 THE COURT: Doctor, if I can interrupt you for a
24 minute.
25 THE WITNESS: Yeah.

1 THE COURT: We've talked about societies and
2 organizations and whatnot. And maybe you were getting to it and
3 I interrupted you. But you are talking about an individual that
4 is opposing that. What I'm talking about is this a large group
5 that is in favor of this and a small group that's not, or are
6 these an equal debate, kind of like an election of a fifty-fifty
7 situation? And I'm trying to get a feel so I can understand
8 what your opinions are about this consensus. Who is opposing
9 these organizations that you say have rushed to judgment, as I
10 paraphrase your testimony?
11 THE WITNESS: Right. I'll say two things about this.
12 One is that there are people writing and complaining, including
13 pediatricians, and feeling like they are unable to voice their
14 concerns because this sort of Castro consensus is the dominant
15 paradigm and that if they don't go along with this treatment
16 path, if they object to it, they risk losing their job or losing
17 patients, etc. And they just feel like they don't have freedom
18 to object. And some will say, I'll redirect patients elsewhere.
19 But then, at a level above that, you have evidence from
20 Finland, Sweden and the United Kingdom about changing direction
21 a little bit on care. It's not my judgment about why exactly
22 they decided to do that, but there is significant concern about
23 a rush to treating adolescents, the ages at what adolescents are
24 treated with hormones or surgery and concern that it's all too
25 premature and that they are still a minor, not the age of

1 adulthood.
2 THE COURT: Doctor, I'm not so concerned with what the
3 opposition's positions are as I am identifying who the
4 opposition is.
5 THE WITNESS: Right. There are particular
6 organizations in Sweden, Finland, UK, that hold those --
7 THE COURT: And we've had testimony about all those
8 studies, so I'm familiar with that. But you gave an opinion
9 that there was conflict. And is your opinion about this
10 conflict limited to those foreign studies and these individuals
11 who have either been fired or perceived to have been silenced?
12 THE WITNESS: It's limited sort of an outside
13 observation of what's going on within this group and how
14 researchers are treated if they dissent. So one of the more
15 famous dissenting pieces of evidence is from Lisa Littman, which
16 you may have already heard about, and how it was an assessment
17 of this rapid onset gender dysphoria. And no sooner had that
18 article come out, all seemed fine. The Brown University, I
19 believe's, public health dean issues a statement saying this is
20 an interesting article. And all of a sudden they are beset with
21 criticism from the outside, and they are like deer in
22 headlights. What's wrong with this? Is there something wrong
23 with it? Did we miss something? The journal editors freak out
24 a little bit and put the article under re-review, which is a
25 very strange process.

1 THE COURT: Doctor, I understand that. Let me
2 interrupt you again, because my question is really more limited
3 to that. Are there any organizations in America, medical or
4 otherwise, that you are able to identify that oppose these views
5 of the American Pediatric Association, etc., that form your
6 opinions, because I'm trying to decide how much weight to give
7 what you are telling me.
8 THE WITNESS: Right. I believe it's called SEGM.
9 THE COURT: What is that?
10 THE WITNESS: I'm blanking exactly. I believe it's
11 the Society for Evidence in Gender Medicine, I believe. They
12 are a loose configuration of people -- I'm not quite sure how
13 many -- a fair number, who sort of contest openly the move
14 towards more affirming gender medicine. And they often write
15 op-eds or letters to the editor for journals. For example,
16 several of them wrote criticizing a very large and pretty good
17 study of Swedish data where the author concluded that surgery
18 had a positive effect on the downstream ten-year mental
19 health --
20 THE COURT: Doctor, I don't need to get into what they
21 are saying because I'm not sure you are qualified to comment on
22 that, at least based on what you told me your qualifications
23 are. I'm trying to dial down to what you are trying to tell me
24 and qualified to tell me that, as a sociologist, based on your
25 statistical review of the body of stuff, who is opposing who.

1 And I think you probably answered my question.
2 My next question is did you limit your opinions or the
3 basis of those opinions to this one organization you referred me
4 to or these various individuals in giving me your opinion that
5 there's conflict among the people in the know?
6 THE WITNESS: Right. So there's those conflicts.
7 There's the *60 Minutes* controversy that played out a year or two
8 ago, where there was open seeking to suppress the interviews
9 that were going on about affirmative gender medicine on *60*
10 *Minutes* about detransitioners in particular. There were
11 researchers, published medical scientists, who were trying to
12 get people to stop talking to Lesley Stahl. That's just an
13 example of how contrary assessments here are suppressed.
14 Pediatricians who object feel like they are silenced.
15 Another example is when Amazon, in response to criticism of
16 them, banned a book called *When Harry met Sally* by Ryan
17 Anderson, and I think they eventually brought it back. But
18 there was just this like, wow, banning books on things just
19 because people object. There's just a sense that's obvious from
20 the read of what is popularly available in this domain that an
21 aggressively affirmative care model, there are people who
22 dispute it but would feel like they can't publicly dispute it.
23 BY MR. JACOBS:
24 Q. I want to turn to a portion of, I guess, something you
25 mentioned when you were talking with Judge Moody. You mentioned

1 Lisa Littman's, I think, 2015 article. Was that the one you
2 were referencing?
3 A. The one in Public Library of Science?
4 Q. That's the one. I don't want to ask you to repeat the
5 discussion you had about what happened following that article.
6 But I guess in your work in sociology of science, was the
7 reception of Lisa Littman's article outside of the norm?
8 THE COURT: Mr. Jacobs -- let me interrupt you,
9 Doctor. Here's the problem I have with some of this. What
10 investigation or something did he do to find out about the
11 reception as opposed to I just looked at these things and saw
12 the reaction in the newspaper? For him to give me meaningful
13 testimony, he has to have done something to give me more than a
14 lay opinion about how he reads the tea leaves. So if we were
15 going to get there, that's fine. But it sounds to me like we
16 jumped straight to what was the reception that her article got.
17 BY MR. JACOBS:
18 Q. Okay. I'll back up for a moment. So we have the
19 information out there, could you briefly explain what that
20 paper, you know, was about, how the course of it being published
21 and the offense that occurred after it being published before I
22 ask you about your work analyzing that?
23 A. Okay. She examined sort of the surge in gender identity,
24 gender dysphoria among adolescents, especially adolescent girls,
25 if I'm not mistaken, and inquired of parents of those teenagers,

1 knowing that this gender dysphoria was happening among
2 adolescents who had not previously shown any sort of sign of
3 such dysphoria, which is distinctive from the Dutch protocol
4 talks about sort of people who had this since childhood and how
5 it tended to occur in groups of friends within particular
6 schools.
7 And the parents described to Dr. Littman sort of some of
8 the social characteristics of the kids. You know, I think there
9 was like one-third of the friendship groups in the study,
10 friendship groups of the kids, witnessed half or more of that
11 friendship group identifying as transgender in a fairly tight
12 time frame. And she said this is about 70 times as high as you
13 would expect to find.
14 Q. Sorry. I thought you were done. The timing on the
15 electronic transmission.
16 A. There's also sort of, you know, this idea of a social
17 aspect, almost a social contagion that kids who are being
18 diagnosed with gender dysphoria seem to signal that they were --
19 or parents would signal they were influenced by things they had
20 seen on the internet. That was part of the blow-back I think
21 that she got for this.
22 She's just describing this rapid onset gender dysphoria,
23 which, after it was published, quickly was denounced from
24 outside the academy first, and then the academy response, what
25 should we do here? And the editors decided to re-review the

1 study.
2 She issues sort of an update, but it's not really a
3 correction. And opponents of hers used that update as kind of
4 evidence like, oh, that she had done something wrong and that
5 there is no evidence for sort of a social side to gender
6 dysphoria. That was a fairly famous occurrence in this domain,
7 and you can read it. You can read the article itself. You can
8 read the response. But it was also playing out in a more widely
9 public academic debate about this.
10 And it's kind of highlighted how the administration of
11 Brown University, where she worked, wrestled with what are we
12 supposed to do about this? They were concerned about appearing
13 uncaring towards people with gender dysphoria. So it just
14 looked like they were critical of Dr. Littman, and they should
15 have been supportive of her academic freedom.
16 THE COURT: Mr. Jacobs, can you just tell me where you
17 are headed with this because all I'm hearing is that people are
18 forming opinions which are causing debate, and some people may
19 or may not be appropriately --
20 MR. JACOBS: I have a tie-up question on the Littman
21 stuff.
22 THE COURT: I would just like to know where we're
23 headed because he can't testify whether or not the criticism was
24 appropriate or not. All he is telling me is that there was a
25 report made and there was backflow and that that shows that

1 there was criticism of her opinions. I need to know what point
2 you are trying to make maybe in a broader sense so I can get
3 something out of this time we've invested with this witness.
4 MR. JACOBS: I think I'll get it out of this last
5 question.
6 THE COURT: Well, humor me and just tell me.
7 MR. JACOBS: What I'm going to ask, his training in
8 sociology of science, he knows how research methods are done,
9 how stuff is published, how critical reception works. I think
10 the point we're hoping to get at with this is in this particular
11 field, in this particular discussion about this article, is this
12 outside of the norm of how this usually works? Is there
13 something else going on that is different?
14 THE COURT: And assuming he can do that, what does it
15 have to do with the decision I have to make here today?
16 MR. JACOBS: I think part of what the claimed medical
17 consensus about this, as a part of the plaintiffs' case here, is
18 that all these organizations, that there's consensus about this.
19 And part of what I think Dr. Regnerus's analysis is, well, not
20 the medical side of the consensus, but what else is influencing
21 this? Is it coming from outside of the medical field? What are
22 the sociological factors surrounding the debate that might be
23 affecting this, might make something seem like a medical
24 consensus which is maybe something else?
25 THE COURT: Right. And I asked him that exact

1 question, and he said at least from the side that was opposing
2 it he didn't see any groups or factors trying to influence this
3 field of discussion. So I'm not sure who is arguing over it has
4 anything to do with the constitutionality of this particular
5 statute. I know you say that they think there's consensus, and
6 it's apparent to me that it's not because there's a lot of
7 people who have views about all of this, and they are not all
8 the same. And if he's there to tell me that, I get it. But I'm
9 not sure what we're doing here or what I'm supposed to take away
10 from it.
11 MR. JACOBS: So I think part of it is the premium that
12 the plaintiffs' case is placed on the consensus of, say, the
13 professional organizations themselves. That was in -- frankly,
14 Your Honor's preliminary injunction rulings referenced all of
15 this. If that is a thing that is important in the lawsuit, then
16 I think it's fair for us to be able to say, well, we have the
17 medical experts who are talking with the medical side. But as
18 far as the nonmedical influences on this consensus building
19 process --
20 THE COURT: But what nonmedical influences or people
21 has he discussed so far, because I asked him that specific
22 question. What other groups are part of this debate? And I got
23 a couple of individuals who had been criticized or whatever. If
24 the point you are trying to make is not everybody is on board
25 with the other organizations, I acknowledge that. And I don't

1 know that I need to know why, that some gentleman reads these
2 articles that really doesn't know much about the field and says
3 that there may or may not be some Castro consensus or there may.
4 What evidence has he got other than I look out there in the
5 world and see that there's discord about this situation?
6 MR. JACOBS: So I think the particular thing I was
7 getting at with the Littman article I hope to ask is he knows
8 how the science is usually done and how that's usually done and
9 to ask him if it was different reception-wise.
10 THE COURT: But what studies, other than just kind of
11 looking to see what's out there, has he done to evaluate that?
12 And I still haven't gotten any of that other than I watched *60*
13 *Minutes* and they were hard on somebody that wanted to talk about
14 desistance, or I read the articles and some were critical of
15 these situations, all of which you would expect in any
16 controversial treatment from cancer chemotherapy, abortion or
17 whatever. I'm just trying to find out what I'm supposed to take
18 away from this witness.
19 MR. JACOBS: The question that I'm hoping to ask about
20 the Littman article in particular focuses on he mentioned in his
21 answer that there was a criticism response outside of the
22 scientific academy about this. I'm hoping to ask the degree
23 that appears that influence had on the response to this
24 scientific article, if that's typical in how he sees things from
25 the sociology of science or if this is atypical. I think that

1 serves as an example of not just the lack of consensus but the
2 effect to which professional organizations and others and
3 activists are working to affect scientific debate. I think
4 that's part of our broader point with this.
5 THE COURT: I'm still not sure how that helps me
6 decide this case, whether or not it's atypical of a hot button
7 issue or not. But let's move on and see if you can make your
8 record on it.
9 BY MR. JACOBS:
10 Q. Dr. Regnerus, can you hear us and everything?
11 A. Yes.
12 Q. Going back to the Littman article, we were talking about
13 the reception. You mentioned that there was a response from
14 outside the academy. Can you elaborate on what you meant by
15 that?
16 A. So the immediate outcry upon publication of it was intense
17 and calling for her to be fired, for the article to be
18 retracted, even though it was largely something just basic
19 description and not making wild leaps and claims about how
20 gender dysphoria operates. It's just documenting what's going
21 on.
22 But since it seemed to be outside the purview or outside
23 these standard kind of model, she was peer reviewed. And they
24 called for a re-review of the study. I happen to know what
25 that's like. And it's driven by fear of basically people had

1 keyboards being hostile towards strangers. So it signals in
2 organizations, like universities are very sensitive to popular
3 outcry in this domain. So I think this is an example of the
4 very difficult way of contesting what seems to be this premature
5 consensus, so the price you pay for going against the grain. So
6 she managed to keep her job, although it was tarnished by this
7 experience. Other people weren't so lucky. Lisa Littman was
8 asked to step down from this job for contesting some of the
9 basics from affirmative care.
10 Q. If I could just stay on Littman for one more question. My
11 question is so, in general, retractions or clarifications of
12 academic papers, is that an uncommon phenomenon, or does that
13 happen?
14 A. It happens. They seldom make the news. Littman's case, it
15 sort of kind of shook the university research community world
16 for a time in part because it seemed based on nothing more than
17 her to basic findings, so it wasn't like people read it, like,
18 oh, that can't be true. It was just immediate outrage to
19 suggest that there could be social pressure that affects the
20 diagnoses of gender dysphoria.
21 Q. Okay. So I'm going to switch topics for a bit. Well, so
22 maybe not so different. Have you noticed any, I guess, trends
23 in the provision of gender-related care in the United States in
24 terms of the market for that care and how that care is provided
25 over time in terms of how it's delivered, things like that?

1 MR. RICHARDSON: Objection, Your Honor. The witness
2 testified he has no expertise in the provision of
3 gender-affirming care.
4 THE COURT: Sustained.
5 BY MR. JACOBS:
6 Q. So have you, as part of your work in this case, did you
7 review any sociological data about the rate at which minors
8 identify as transgender and how it's changed over time?
9 A. Uh-huh. I did.
10 Q. Generally speaking, what have those trends been?
11 A. Rapid growth so far as I can tell.
12 Q. Has there been a change in the statistics related to the
13 sex of those who are coming to identify as transgender in
14 childhood?
15 A. Right. Previously most diagnoses that were recorded were
16 of boys who were diagnosed with gender dysphoria. Then, over
17 time, up to present, that ratio of boys to girls has
18 flip-flopped. So natal girls are far more likely today to be
19 diagnosed with gender dysphoria than boys, which raises the
20 question of why.
21 And one of my concerns, and I raised it in my expert
22 report, was that there has just been insufficient attention to
23 the question of why. It's not as if I need to weigh in on why.
24 But the medical researchers ought to weigh in on why because
25 something significant is going on. There's a surge in cases,

1 and there's this flip-flop in sex ratio. And it just breathes
2 -- those of us who do research in this area -- that they were
3 largely ignoring the kind of big picture why, where is this
4 coming from, question. I think if this was occurring in, say,
5 cancer research or medical -- I'm sorry -- heart, cardiac
6 research, there's a condition -- I'm sorry?
7 Q. I don't think there was anything on our end.
8 A. Oh, sorry. If there's a cardiac or a cancer condition that
9 was increasing rapidly in frequency, I think we would want to
10 know where that may be coming from instead of sort of ignoring
11 it and then see a flip-flop in the sex ratios. It reads as if
12 the gender affirmative care industry is insufficiently concerned
13 about the developments in this domain. You know, it just raises
14 the basic question where did that come from, right, why the
15 flip-flop, why the surge. Littman writes about the surge to
16 some extent. There's a documentation of it but kind of no
17 sustained study of where it has come from.
18 Now, some people will say it's a function of long
19 suppressed gender dysphoria. The stigma diminishes about it.
20 More people can express it. But that's speculative. I'm just
21 struck by how little genuine research there is on these
22 fundamental questions.
23 MR. RICHARDSON: Your Honor, we would move to strike
24 Professor Regnerus's answer to that question. He is not
25 qualified to assess medical research or why medical research may

1 be happening. He is also not a mental health professional
2 qualified to testify about the causes of gender dysphoria.
3 THE COURT: I'm not going to strike it, but I'm well
4 aware of what he testified to and what he can't, and I'll take
5 that up.
6 Again, Mr. Jacobs, we know, or based on his reading there's
7 not a lot of research as to why the ratio between girls and boys
8 flipped. What am I supposed to take from that? That there's
9 more we need to know, agreed. That's what every expert has
10 testified to so far. Why did he just tell me again? What am I
11 supposed to get from that?
12 MR. JACOBS: I asked that question so I can ask my
13 next question, I guess.
14 THE COURT: What's your next question?
15 BY MR. JACOBS:
16 Q. My next question, specifically on the male/female ratio
17 flip, are you aware of any sociological data showing a similar
18 trend in adults? By that I mean are you aware of any
19 sociological data showing an increase of female relative to
20 males identifying as transgender in the adult population?
21 A. Not in the adult population, not that I'm aware of. Now,
22 if you are asking about sexual identity, we see a rise in female
23 bisexuality, a surge in that. I consider that different than
24 gender identity.
25 Q. I want to go back to -- let's switch topics a little bit.

1 There's been a lot of discussion in this case on research
2 concerning suicidality and suicidal ideation in transgender
3 minors. Have you reviewed that research in the course of your
4 work in this case?
5 A. I have.
6 Q. And I'm not asking you to give any medical opinions --
7 A. Right.
8 Q. -- about that research. But in terms of research design,
9 study design and statistical methodology, what are your
10 observations about what that research says?
11 A. Right. First, in the general discourse, popular discourse
12 about gender dysphoria, it seems quite associated with increase
13 in suicidality. So a lot of people are writing on this subject,
14 etc., connecting it to increasing suicidality. And, yet,
15 there's also research that comes alongside it and says, well,
16 you know, if we distinguish suicidality from actual suicides,
17 completed suicides, we see a much more narrow story validated,
18 whether it's the UK kids clinic, also the Amsterdam clinic,
19 documenting fairly small numbers of actually completed suicides
20 among gender clinic patients, which is just a very different
21 impression on this than when you read about suicidality, which,
22 again, back to the idea of ideological capture, if you make this
23 about suicidality rather than suicide, then we're talking about
24 very different measures of suicidality, like thinking about it.
25 We know from evidence in the sociology of suicide that

1 adolescents are far more apt to think about suicide than, say,
2 middle-aged adults, right, even though middle-aged adults in the
3 United States are extraordinarily more apt to actually carry out
4 a suicidal act, right? So there's this impression that gender
5 dysphoria is connected tightly with suicidality, right? But
6 what does it mean? What does it mean to sort of make up various
7 rules of suicidality? Is there actually an elevated risk of
8 completed suicides among transgender youth or youth with gender
9 dysphoria? I think it's far more related to attitudes about it,
10 possibly to attempts, but not completed suicides.
11 Suicide is by definition rare and noisy, meaning like it's
12 hard to establish causality based on what you know about
13 persons. So the white male suicide rate in the United States is
14 the highest. But we don't go out and think about, oh, something
15 about being white causes suicide or something about being male
16 causes suicide. We know there's more to it than this.
17 But there's a rush in the literature, as far as I can tell,
18 to sort of equate suicidality with gender dysphoria. And it
19 seems to be used as a motivation for, wow, we need to move
20 people towards treatment, less this risk of suicide plays out.
21 So in a popular discourse around gender dysphoria, there's
22 a strong connection made between the experience of gender
23 dysphoria and the risk of the person who experiences this, their
24 suicide. The phrase, you would rather -- would you rather have
25 a living child or -- a living son or a dead daughter? Again,

1 how often this terminology is actually used is unclear. But
2 there's this connection being made in the research that there's
3 a short leap between the experience of dysphoria and the risk of
4 suicide, which does seem to be not what the literature on
5 completed suicide finds.
6 Q. Dr. Regnerus, based on the review that you've done of the
7 literature in this area and observing the public discourse, what
8 are your conclusions on the openness of debate in this area and
9 the effects that the discourse have had on them?
10 A. Thanks. So I've done research in domains that are fairly
11 sensitive, the study of sexual behavior, etc. I mentioned an
12 earlier study. So I'm used to a bit of controversy when I see
13 it. And this reminds me of that previous experience, the
14 domain. There's not a whole lot of medical research domains
15 that get the attention that this one is getting. Now, I know
16 it's sensitive, etc. We're talking about teenagers, minors,
17 being able to consent to such treatment. It certainly involves
18 a measure of controversy that the average study does not.
19 Again, back to the idealogical capture authority, the
20 professional organizations appear to act as if like they know
21 exactly what they think ought to be the case. They change the
22 standards, etc. They have lowered the bar in some cases. WPATH
23 has made it sort of stage, not age. So you just get this
24 impression, what's going on in these professional organizations
25 and their influence on the field and the ways in which

1 clinicians can feel torn about what they ought to recommend for
2 children here, you see a field that is wrestling with very, very
3 significant issues. And to me it's not a field where you can
4 openly dissent or say, I'm not going to go in that direction of
5 treatment. I'm going to do this kind of practice. It seems to
6 funnel and channel clinicians towards one right way in some
7 ways.
8 MR. JACOBS: No further questions, Your Honor.
9 THE COURT: We're going to take a break until the
10 bottom of the hour. So I don't have to do the calculus on your
11 time frame and mine, we're going to go to the bottom of the
12 hour. Court will be in recess here until 10:30, and to the
13 bottom of the hour where you are, Doctor.
14 THE WITNESS: Thank you.
15 (Recess at 10:09 a.m.)
16 REPORTER'S CERTIFICATE
17 I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.
18
19 /s/Elaine Hinson, RMR, CRR, CCR Date: December 4, 2022.
United States Court Reporter
20
21
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25

1 (Proceedings continuing in open court at 10:34 AM.)
2 THE COURT: I would ask that you not replow the
3 ground that you've already done in voir dire because I already
4 know what those questions are going to be. So if you would not
5 be redundant in that regard, you have the floor.
6 MR. RICHARDSON: Understood. Thank you, Your Honor.
7 CROSS-EXAMINATION
8 BY MR. RICHARDSON:
9 Q Professor Regnerus, can you hear me all right?
10 A I can.
11 Q Thanks for staying on. I know it's late there. We'll
12 keep this pretty brief. You're aware that this trial began
13 last month and it's now resuming this week, right?
14 A Yes.
15 Q Have you reviewed any transcripts from the trial?
16 A I have not.
17 Q Have you spoken to anyone about the testimony that was
18 given during the first week of trial?
19 A I have not.
20 Q Are you a contributing editor for a publication called
21 *Public Discourse*?
22 A I am.
23 Q *Public Discourse* is not a peer reviewed academic journal.
24 Isn't that right?
25 A It's reviewed by a team of editors, it's not reviewed as

1 in sending it out for other people elsewhere to look at, no.
2 Q So it doesn't go through the process that something
3 published in a peer reviewed journal would go through to be
4 published on *Public Discourse*?
5 A Correct. It's also largely essays on different kinds of
6 topics.
7 Q Is *Public Discourse* run by the Witherspoon Institute?
8 A It is.
9 THE COURT: The what institute?
10 MR. RICHARDSON: Witherspoon Institute.
11 THE COURT: Thank you.
12 BY MR. RICHARDSON:
13 Q Sorry, your answer? I didn't hear your answer,
14 Professor.
15 A It is.
16 Q Is the Witherspoon Institute an independent research
17 center that works to enhance public understanding of the moral
18 foundations of free and democratic societies?
19 A It sounds like that when you're reading from it. I'm not
20 familiar with what exactly they state about themselves, so I'll
21 take your word for it.
22 Q Did the Witherspoon Institute provide funding for
23 something you published called the New Family Structure Study
24 or NFSS?
25 A They helped raise the money for it. They said it's

1 expensive and they asked around for funding to accomplish that
2 in conjunction with other organizations.
3 Q Did you previously --
4 A For data collection. Not for the publication of a study,
5 but for the data collection to which has been made public.
6 Q Understood. Did you previously testify as an expert
7 witness in a case called DeBoer against Snyder?
8 A I did.
9 Q That case was about a Michigan law prohibiting same sex
10 marriage, correct?
11 A I think it was tied to adoption, but yes, that was what
12 it was concerned with, yeah.
13 Q You testified as an expert on the side of the state in
14 that case, right?
15 A Yes.
16 Q Was your work on the New Family Structure Study discussed
17 by the district court in Deboer?
18 A By the district court? Federal district, that's what
19 you're talking about?
20 Q Was it discussed in the judge's opinion in the case?
21 A I think so.
22 Q I'd like to show you a passage from that opinion. We're
23 going to put this on the screen. Can you see that, Professor?
24 A Not yet.
25 Q This is going to be on page 766. You see the highlighted

1 passage there?
2 A I do.
3 Q Can you read with me, please? "The Court finds
4 Regnerus's testimony entirely unbelievable and not worthy of
5 serious consideration. The evidence adduced at trial
6 demonstrates that his 2012 study was hastily concocted at the
7 behest of a third party funder." Do you see that passage?
8 A I do.
9 Q Do you see a passage a little further down on the page
10 also highlighted?
11 A Not yet.
12 THE COURT: Do you have a question of him about that
13 other than --
14 MR. RICHARDSON: I do. I want to give both
15 passages.
16 BY MR. RICHARDSON:
17 Q Can you read with me, please? "The funder clearly wanted
18 a certain result and Regnerus obliged." Do you see that?
19 A I see it.
20 Q In those passages, is the funder the Court is referring
21 to the Witherspoon Institute?
22 A I'm presuming that's probably it although in the article
23 itself, I made clear who the funding organizations were. I
24 think I mentioned both the Witherspoon Institute and the
25 Bradley Foundation.

1 Q Is the study the Court is referring to in that passage
2 the New Family Structure Study or NFSS?
3 A The New Family Structure Study is the data. That's just
4 data. I think he's referring to the study with a much longer
5 name that appeared in the peer reviewed journal, *Social Science*
6 *Research*, June or July issue of 2012. You can call it the New
7 Family Structure Study, but that's the reference to the data
8 which has been used in multiple studies, used for studies of
9 other kinds of things, but he's referring rather to the
10 published study mid 2012.
11 Q Understood. Thank you. So is that published study
12 from 2012 the study you were referencing earlier today with
13 Mr. Jacobs when you talked about your work on the well-being of
14 children raised by same sex parents?
15 A Right.
16 Q Thank you. Are you familiar with the Alliance Defending
17 Freedom or ADF?
18 A I am.
19 Q Is ADF a legal organization committed to protecting god's
20 design for marriage and family?
21 A I'm going to have to take your word for it you're reading
22 off their website or something like that. As far as I know,
23 they are a religious freedom defense organization. They don't
24 seem to litigate much in terms of marriage or family these
25 days.

1 Q Okay. Did you attend a meeting hosted by ADF in Arizona?
2 A I think I know what you're referring to, so yes.
3 Q That meeting took place in 2017, correct?
4 A No. At a deposition, you asked and I told you I couldn't
5 remember exactly when. It was before COVID era and it was
6 after 2015.
7 Q And that meeting in Arizona was focused on sexuality and
8 gender identity, right?
9 A Probably yeah, I think. I know we talked about gender
10 identity. I don't remember what else was talked about.
11 Q During the meeting, there was a discussion about the lack
12 of experts willing to testify in cases involving transgender
13 issues. Is that right?
14 A Yeah, it was probably brought up. I don't recall. I
15 remember going around the room and they asked us what we were
16 working on. What exactly was said besides that, I have a vague
17 memory of the meeting itself.
18 Q Do you recall if meeting attendees were asked if they'd
19 be willing to serve as experts?
20 A You know, I don't even remember what I said at the
21 deposition. Maybe. It just doesn't -- it sounds like
22 something ADF would do, but I don't recall the question being
23 posed. Again, I'm not surprised if they asked it.
24 Q Okay. But if that discussion happened, you would have
25 been there for it?

1 A I think so unless it happened the last day and I left
2 early. Again, I have only the vaguest recollection of that
3 meeting.
4 Q Okay. Can I show you your deposition real quick? We'll
5 put it up on the screen for you.
6 A As I said, the deposition, I might have said yeah. They
7 probably asked.
8 Q Just to refresh your memory, we'll briefly pull it up.
9 A I'm not surprised if it was said. Pretty much the same
10 thing I just told you.
11 Q Yep. And then a little further down, do you see a
12 question: "Would you have been there for that? Your answer
13 was: For that discussion? Question: Was for that discussion.
14 And you said, If it happened, yes, because I think I stayed in
15 the balance of the time."
16 A Meaning to the end. Again, I remember one instance of
17 being in the room and people going around talking about what
18 they were doing. Besides that, I don't remember a whole lot
19 about the conference.
20 Q Paul Hruz was at the ADF meeting, right?
21 A I believe so.
22 Q And Patrick Lappert was at the ADF meeting, right?
23 A I think I said in the deposition I don't remember because
24 I really don't know who he is.
25 Q Just shifting gears a little bit. Research standards are

1 different in sociology, psychology, and medicine, correct?
2 A Research standards? Standards can be different, but the
3 demand for sort of high quality measurements and key values,
4 statistical models, these things are comparable, but you know,
5 they're concerned about particular things more than other
6 things.
7 Q Understood. I'd like to show you a passage of your
8 deposition again. Do you see the highlighted passage on the
9 screen?
10 A Yes.
11 Q "Question: Understood. So we've got research standards
12 that may differ between fields like social and psychology?
13 Answer: Correct. Question: And medical research? Answer:
14 Correct."
15 Are those the questions you were asked and the answers
16 you gave at your deposition?
17 A Yes.
18 Q Would it be fair to say that research methods also vary
19 across the different scientific fields?
20 A Yes.
21 Q So a study can be useful to a psychologist even though it
22 might not be given a lot of weight by a sociologist, correct?
23 A It could be criticized by a sociologist but for different
24 things.
25 Q But just to clarify, your answer was yes, that a study

1 could be useful to a psychologist even if not given weight by a
2 sociologist?
3 A Yes.
4 Q Healthcare providers might place weight on research that
5 would not be valuable to a sociologist. Isn't that right?
6 A Yeah, I suspect.
7 MR. RICHARDSON: Nothing further, Your Honor. We
8 pass the witness.
9 REDIRECT EXAMINATION
10 BY MR. JACOBS:
11 Q Dr. Regnerus, is it common in your experience for
12 academics to attend conferences with each other and perhaps
13 with academics from other disciplines?
14 A Yes.
15 Q Have you attended -- back up. If you had to guess, how
16 many of these sorts of conferences have you attended over your
17 career if you could ballpark it?
18 A In general, interdisciplinary in nature or?
19 Q Back up. In general. Interdisciplinary or not, in
20 general, about how many academic conferences would you say that
21 you've attended in the course of your career?
22 A I sent you a list of a variety of them, but for a while,
23 I was going to three a year, four a year. Some of them are
24 limited to sociology, some of them are interdisciplinary. Some
25 of them are sort of privately funded areas of interest, some of

1 them are marriage and sociological association, etc.
2 Q I think you testified that there could be some
3 differences in research methodologies between various fields.
4 Are there similarities?
5 A Sure. As I was inferring in my comment, measurement
6 issues are something that we all value, so when I said earlier
7 about assigned sex at birth, this becomes a measurement issue,
8 not just medical research, but in sociological research,
9 psychological research, and something that we all kind of take
10 to heart, maybe dispute, think through, but certainly
11 acknowledge the ramifications of, because measures in one field
12 would probably be used in other fields.
13 So, for example, I use a short form depression index
14 that, you know, a sociologist didn't create but a psychologist
15 did. I tend to like it. So we share a lot of things across
16 disciplines. We share model building techniques. So one of
17 the reasons I -- one of the topics I cover in the report is a
18 variety of the publications that have come out using methods,
19 survey research methods and analytic tools that are comparable
20 in medical research and in sociological research, standard
21 professional models, group comparisons, etc. So why I even get
22 into this is because I and other people looked at some of the
23 results that were coming from folks like Professor Turban who
24 shares a lot of not necessarily the same interests but a lot of
25 the sort of same survey research, data collection efforts,

1 analysis efforts.
2 So I can read Turban, a lot of people can read Turban and
3 evaluate the quality of a study like that, so don't have to
4 have an M.D. to understand there's measures, there's methods,
5 there's analyses, and that we can read them too.
6 Q You mentioned I think in your cross-examination maybe a
7 difference in P values between disciplines. Could you explain
8 what you meant by P value?
9 MR. RICHARDSON: Objection, Your Honor. That was
10 not raised on direct as best I can tell and goes beyond the
11 scope of cross.
12 BY MR. JACOBS:
13 Q Dr. Regnerus, did I hear you use the term "P value"
14 during your cross or did I mishear you?
15 THE COURT: I didn't hear anything about a P value,
16 but if he wants to limit his testimony shortly to tell me
17 generically what a P value is as opposed to a beta, I have no
18 objection to him rolling through that.
19 BY MR. JACOBS:
20 Q I guess the first question, Dr. Regnerus, did you mention
21 the term "P value" or did I mishear you?
22 A P value came up in some conversation, so I mean, if you
23 want me to mention it, it's just a measure of statistical -- a
24 way of detecting statistical significance of one particular
25 variable. We use it in sociology, we use it in medical

1 research, psychology, etc.
2 Q Do different disciplines look for higher or lower P
3 values in their published work?
4 A Right. Some disciplines with smaller samples will
5 consider a P value of less than .10 to be statistically
6 significant and worth talking about. If you look at big
7 demographic data sets and will want it to be P of less than
8 .001 meaning like the odds of it being random, randomly
9 different from zero are really low in that case, so the
10 standards of statistical significance can vary. Usually it
11 depends on the size of the data set, less than the discipline.
12 Q So I want to turn briefly to you mentioned the NFSS study
13 during your cross-examination. Are you aware of any criticism
14 of your collection of the underlying data for that study as
15 opposed to the conclusions that you may have reached from that
16 data?
17 A Well, at the beginning, they're a little bit like Lisa
18 Littman, I came under a fire storm for all aspects of it, but
19 over time, it became limited to modeling decisions and language
20 use. But no, eventually, like, the data were not a problem.
21 In fact, the data collection was -- I had a lot of advisers in
22 that including people who certainly would have disagreed with
23 me for my opinions in the *DeBoer v Snyder* case. The data is
24 out there, it's still publicly used, it's been used in analysis
25 of completely different kinds of research questions. So no,

1 people didn't really have a problem with the data.
2 MR. JACOBS: No further questions, Your Honor.
3 MR. RICHARDSON: Nothing more from us, Your Honor.
4 THE COURT: Thank you, Doctor. We'll let you
5 disconnect and be about your business.
6 THE WITNESS: All right. Thank you, Your Honor.
7 MR. JACOBS: We've got another witness if the
8 Court's ready for it or I don't know what time you were
9 planning to break for lunch today.
10 THE COURT: Probably 1:00, so let's get an hour into
11 it and we'll proceed from there.
12 MR. JACOBS: Defense will call Dr. Patrick Lappert.
13 **PATRICK LAPPERT, DEFENDANTS' WITNESS, DULY SWORN**
14 DIRECT EXAMINATION
15 BY MS. TEMPLIN:
16 Q Good morning, Dr. Lappert. Could you state your name and
17 spell it for the court reporter?
18 A Patrick Walter Lappert. L-a-p-p-e-r-t.
19 Q Dr. Lappert, what is your profession?
20 A I'm a physician surgeon.
21 Q What type of surgeon?
22 A Plastic and reconstructive surgery.
23 Q How long have you been a plastic surgeon?
24 A I did my training in 1992, so 30 years.
25 Q What do plastic surgeons do?

1 A Our business is about the restoration of form and
2 function primarily. That's what the term "reconstructive
3 surgery" is meant to convey. In cases of trauma, injury of any
4 kind, cancer, congenital deformity. That's our primary work.
5 We also do a lot of aesthetic surgery where form is primarily
6 the issue at hand and it's aimed at improving the subjective
7 life of the person who's seeking an improvement in their
8 appearance.
9 Q In addition to your practice as a surgeon, have you
10 published any articles or scholarship on plastic surgery?
11 A Yes, I have.
12 Q Have you published any on the procedures at issue in this
13 trial?
14 A Well, in the sense that one of the issues at hand is
15 surgery of the breast. So I published an article in
16 collaboration with Dr. Bryant Toth in San Francisco on the
17 subject of preoperative planning.
18 THE COURT: Can I get you to spell the name of that
19 other doctor?
20 THE WITNESS: Certainly. It's B-r-y-a-n-t T-o-t-h.
21 THE COURT: Thank you.
22 THE WITNESS: The article was about preoperative
23 planning in breast cancer surgery. The collaboration between
24 general surgeons, cancer surgeons, and the plastic
25 reconstructive surgeons seeking a better outcome.

1 BY MS. TEMPLIN:
2 Q Dr. Lappert, have you treated any transgender patients?
3 A I have.
4 Q Can you tell us a little bit about that?
5 A Well, in terms of general treatment consultation and
6 things like that in my office, we offer laser services so I
7 have several patients who come to me seeking laser hair removal
8 from their faces. That's sort of an ongoing part of the
9 practice lately. As far as surgical treatment, only one
10 patient, two surgeries. The explantation of breast implants
11 that were placed and then the gynecomastectomy to reverse the
12 effects of female hormones on his chest.
13 Q So to clarify, was that person detransitioning?
14 A That's correct.
15 Q And have you performed any gender transition procedures?
16 A I do not do that.
17 Q Do you have a CV?
18 A I do.
19 MS. TEMPLIN: Your Honor, may I approach the
20 witness?
21 THE COURT: You can. I've got it in the book as 4
22 under a defendants' stipulated exhibit, so I have the benefit
23 of it and it's in the record, but go ahead.
24 BY MS. TEMPLIN:
25 Q Dr. Lappert, is that your CV?

1 A It is.
2 MS. TEMPLIN: Your Honor, depending on whether the
3 plaintiffs wish to voir dire the witness, otherwise we would
4 seize questioning on his qualifications and rest on the CV.
5 MS. OSWELL: Your Honor, we do have voir dire
6 questions for this witness. As the Court knows, we have moved
7 to exclude this witness on testifying beyond the scope of his
8 expertise as a plastic surgeon. With the Court's permission,
9 we do have a few questions to establish the basis of our
10 objections.
11 THE COURT: Briefly.
12 VOIR DIRE EXAMINATION
13 BY MS. OSWELL:
14 Q Good morning, Dr. Lappert. My name is Laura Oswell. I'm
15 an attorney for the plaintiffs in this case.
16 Doctor, you're not a psychiatrist, correct?
17 A That's correct.
18 Q You're not a psychologist either, are you?
19 A That's correct.
20 Q You do not claim to be an expert in mental health?
21 A No, I don't.
22 Q And you're not an endocrinologist?
23 A I am not.
24 Q You're not an expert in endocrinology?
25 A I am not.

1 Q You don't claim to be an expert in pediatrics?
2 A I do not.
3 Q You don't hold yourself out to others as an expert in
4 medical ethics or bioethics, do you?
5 A I do not.
6 Q You don't claim to be an expert in the diagnosis of
7 gender dysphoria?
8 A Expertise, no. I'm familiar with the process of
9 diagnosis, but I'm not an expert.
10 Q You have never diagnosed any person with gender
11 dysphoria, have you?
12 A I have, but in the course of my practice, persons come to
13 me with issues relating to their appearance, but they ascribe
14 to their gender presentation so I have made that diagnosis and
15 excluded them from surgical intervention.
16 Q Could we quickly just take a look at your testimony in
17 this matter? You were deposed, Dr. Lappert, in this case on
18 May 6th of this year; is that correct?
19 A Correct.
20 Q We're going to take a quick look at your testimony. It
21 will be up on the screen just a moment here. Here we go.
22 Direct you to page 150, line 18. Question here is: "Have you
23 ever diagnosed someone of gender dysphoria? Answer: Are you
24 talking about like making a formal diagnosis and sending an
25 insurance document? Answer: No."

1 Did I read that correctly?
2 A You read it correctly, yes.
3 Q Thank you. You have not conducted or published research
4 on gender dysphoria or transgender people. Is that correct?
5 A That's correct.
6 Q You agree that gender dysphoria is not your area of care,
7 correct?
8 A Correct.
9 Q Your only education or training in gender dysphoria was
10 one weekend class at the California Society for Plastic
11 Surgery, wasn't it?
12 A Correct.
13 Q You do not claim to be an expert in the treatment of
14 gender dysphoria, do you?
15 A I do not.
16 Q And you only hold yourself out as an expert in plastic
17 and reconstructive surgery, correct?
18 A Correct.
19 Q Thank you.
20 Your Honor, I know in your order on our motion to
21 exclude, you asked us to take our objections question by
22 question. We would plan to do so in accordance with the
23 Court's instruction.
24 THE COURT: Thank you.
25 BY MS. TEMPLIN:

1 Q Dr. Lappert, in your experience, why might patients want
2 plastic surgery?
3 A Well, two broad categories. They might want plastic
4 surgery because of something they've suffered, as I say,
5 trauma, cancer care, congenital deformities, or they might want
6 plastic surgery as a means of improving their appearance,
7 seeking an improvement in their subjective life. That's what's
8 called aesthetic surgery.
9 Q The first category, do you have a term for that?
10 A It's called reconstructive surgery.
11 Q Are there different ethical considerations for
12 reconstructive and aesthetic surgery?
13 A There are.
14 Q Could you explain?
15 A Certainly. In the case of reconstructive surgery, you
16 have a patient who has a measurable objective deficit of some
17 kind that, as I said, they have either acquired from trauma,
18 from congenital deformity, from cancer care or among other
19 reasons. And that's something that's objectively visible,
20 quantifiable, loss of function, loss of form. So that differs
21 from aesthetic surgery where generally speaking the patient
22 presents with findings that are within the realm of normal.
23 But perhaps at the limit of normal say, for example, the
24 prominence of the ears or the size of the nose relative to the
25 size of the face. So that would be aesthetic surgery.

1 Now, the ethical difference between those two is that
2 with reconstructive surgery, the patient presents with a
3 deficit and very typically a deficit of function, say for
4 example, loss of a limb from trauma, they have a deficit of
5 function. And the aim of reconstruction there is to restore
6 function and form, and generally function takes precedence over
7 form most typically, although sometimes all you can offer is
8 the restoration of form.
9 Say, for example, the loss of an eye, I can't give them
10 back an eye, but I can give them a prosthetic eye so I restored
11 form, but I haven't restored function. But one of the
12 principles there is that when planning a reconstructive
13 operation, generally what we're doing is we're borrowing from
14 other areas of the body or even maybe proximate areas of the
15 body in order to restore the form and the function and what
16 that causes us to have to reflect on is what is called the
17 donor defect. So, for example, if I'm reconstructing the
18 perineum of somebody who had a bomb injury in the area around
19 the genitalia or the upper thigh, I might be using muscles from
20 the upper thigh to cover the defect and to have closure of the
21 wound while attempting to preserve function, but the patient
22 will be paying a price because I would borrow a muscle and skin
23 from one area of the body to reconstruct the injured part. So
24 that's what we call donor defect or the price the patient pays
25 for the reconstruction.

1 And one of the general principles is you try to give up
2 as little as humanly possible in getting the reconstruction.
3 But sometimes you do have slight deficit in function. For
4 example, if I reconstructed the breast of a woman and used the
5 muscle from her back, the latissimus dorsi muscle and rotated
6 it around to the chest and placed an implant there, she's going
7 to be paying a price in terms of strength of the upper limb in
8 order to have the restoration of form of the breast. That's
9 the donor morbidity, donor defect. And we have to weigh that
10 out. That contrasts very dramatically with aesthetic surgery
11 where what you're trying to obtain is form where that's a
12 circumstance where you would not want to surrender function for
13 the sake of a cosmetic result. So there's a very, very
14 important difference there.
15 You do not sacrifice function for the sake of a cosmetic
16 result. For example, if I was trying to beautify somebody's
17 nose, if I planned an operation in which she got perfect
18 appearance, the symmetry, the proportion, everything was
19 absolutely perfect, congruent even with her ethnicity,
20 everything perfect, but if she were not able to breathe through
21 that nose, that would be an abject failure. And so one doesn't
22 do that.
23 Q Just to clarify, I think you have used both the terms
24 "aesthetic" and "cosmetic". Are those synonyms or are there
25 slightly different meanings?

1 A Sort of slightly different. Cosmesis or cosmetic
2 addresses essentially the form and proportion and all of those
3 things that enter into it. For example, if I was
4 reconstructing a nose, I would want it to be a third of the
5 height of the face and a fifth of the width of the face and so
6 on. That's the cosmesis side of it.
7 But aesthetics addresses itself to how it affects the
8 subjective life of the patient, and that's generally why the
9 patient came to you in the first place. They're looking for an
10 improvement in their subjective life. Maybe because of
11 something that constantly calls attention to itself. Somebody
12 who is in the public light who's constantly being asked are you
13 getting enough sleep. She is perfectly rested, but she appears
14 tired all the time, that's an annoyance to somebody who's in a
15 profession where she's in the public light. So if I can make
16 her look rested, then I've done a great good for her. It's a
17 cosmetic process, but it's an aesthetic result.
18 Q When someone seeks reconstructive surgery, are there
19 criteria that you use to diagnose abnormalities?
20 A Well, that certainly includes the whole breadth of my
21 training as a physician and surgeon, so there are physical
22 criteria, there are functional criteria. And depending on what
23 is being reconstructed, one may predominate over the other.
24 For example, reconstructing a hand on a man can be a very
25 different process from reconstruction of a hand on a young

1 girl. In a man, if I'm reconstructing his helping hand, his
2 nondominant hand, cosmetic result isn't really a big concern
3 typically. What you're really looking for is a functional
4 restoration so that he can work. Those are sort of the issues
5 that enter into it.
6 Q Talking more specifically about the procedures here, why
7 might a transgender individual seek gender transition plastic
8 surgery?
9 MS. OSWELL: Objection, Your Honor. This goes
10 outside the scope of the expert's expertise.
11 THE COURT: I'm going to let the doctor testify
12 about what -- I'm not sure this is a question for --
13 MS. TEMPLIN: Your Honor, I can rephrase.
14 THE COURT: Let me finish, please. I'm not sure
15 this is a question that requires expert testimony. We all know
16 what the options are depending on the direction an individual's
17 taken about what surgeries are available. I'm not sure we need
18 him to tell us that because we've gone over it. So, Doctor, do
19 you agree with that? Or do you think that there's something
20 you have to offer that we don't already know? And I know you
21 don't know what we already know, but there's a limit to what
22 could be requested in a transgender surgery, and do you think
23 that's commonly known?
24 THE WITNESS: I think what all these surgeries have
25 in common is that the patient is seeking happiness.

1 THE COURT: Okay. Let's go to your next question.
2 BY MS. TEMPLIN:
3 Q Dr. Lappert, are those surgeries reconstructive or are
4 they aesthetic?
5 A Well, because the patient is typically -- I would say
6 typically, because the patient is presenting with normal
7 physical appearance and function and because the primary
8 motivation is in the subjective life of the patient, then that
9 meets all the criteria for aesthetic surgery.
10 Q Setting aside patients with gender dysphoria, do you ever
11 see patients who want aesthetic surgery to alter a body part
12 causing them significant mental distress?
13 A I do. It's a routine part of being an aesthetic surgeon.
14 Q Can you tell us a couple of those examples?
15 A A very common example is a man seeking rhinoplasty. In
16 fact, this is one of the ones that's most commonly discussed in
17 the world of plastic surgery because it's a risk event for the
18 surgeon, and let me explain. Men presenting for rhinoplasty
19 surgery or aesthetic surgery of the nose, first of all, it's a
20 common presentation, very often they're presenting because they
21 have a functional problem as well. The surgery is very
22 straightforward and generally what you're seeking is
23 restoration. Perhaps they were struck boxing or something, who
24 knows, but there's a slight form problem there and when you
25 correct the form problem, their function is restored.

1 But another subcategory of male rhinoplasty would be the
2 patient presenting seeking a purely cosmetic change in the
3 nose. And it's a common thing that when having the discussion
4 with the patient about their desires for the surgery, they will
5 point to things about their nose that they dislike, and this is
6 a common thing in cosmetic surgery. And while the patient is
7 presenting their complaint, I as a plastic surgeon am examining
8 their nose sort of sub rosa, if you will, so while they're
9 describing their nose, I'm looking at their nose trying to see
10 if I see what they see. And this is a very important part of
11 being a cosmetic surgeon is I have to be able to see what the
12 patient sees, because if I don't see what the patient sees,
13 there's no hope that I can get the patient what they're
14 seeking. And the result of happiness is what they all want.
15 But what will happen sometimes, it's not all that common,
16 but it's common enough that we talk about it in the world of
17 plastic surgery is that they'll be describing a defect that I
18 can't see, and while they're describing the defect, very often
19 they'll be describing the burden of sorrow that the defect
20 causes them. Very often they'll talk about maybe having been
21 to a prior consultation with another plastic surgeon who
22 himself perhaps tried an operation and didn't give them the
23 result they wanted. But what will happen is while they're
24 describing their condition and while I'm examining the patient
25 without actually laying hands on them, they'll often times

1 become very emotional and start talking about how this has
2 affected their life.
3 Perhaps they'll talk about how their level of isolation
4 that they experience or the lack of a social life or failure to
5 be promoted at work. Basically what you're dealing with here
6 is somebody who is ascribing their sorrows to their appearance.
7 This is something that as plastic surgeons this is an essential
8 part of our training as plastic surgeons because if you're
9 going to offer aesthetic surgery, you have to be able to ferret
10 out these patients who have an expectation of a result, an
11 expectation of a happiness that's not achievable through
12 cosmetic surgery.
13 And these patients also put the doctor at risk. Dr. Mark
14 Gorney, the founder of a company called The Physicians Company,
15 very familiar with insuring doctors against harm, he gave us a
16 lecture one time describing the surgeons at highest risk of
17 violent harm are plastic surgeons doing rhinoplasties on men,
18 murders. And it speaks to the profound level of subjective
19 investment that a patient may have in their appearance. And
20 his theory about this, and I think experience bears it out, is
21 that the patient is ascribing their sorrows to a physical
22 attribute because they don't want to look at the actual cause
23 of their sorrow. This is where my training taught me this in
24 plastic surgery. And as I said earlier, this is a common
25 experience in consultation with cosmetic surgery.

1 Q To clarify, how have you been trained to recognize signs
2 of mental distress or mental illness if a patient comes to you
3 asking for something?
4 A Well, so the common features that I see is the patient
5 will be describing a defect that I may not be able to see. The
6 other one is that the patient will be describing a level of
7 emotional harm caused by the defect that they see, a level of
8 sorrow. They'll be describing what started out as a simple
9 routine cosmetic consultation has now in the course of a
10 conversation developed into something profound in their life,
11 something that's a cause of their sense of isolation or a cause
12 of their sense of failure in life.
13 Or, for example, a common one is women seeking breast
14 enhancement and in the course of the consultation they'll be
15 talking about how they fear they're losing their partner and if
16 they had better looking breasts, that they wouldn't be losing
17 their partner. This is a real red flag for plastic surgeons
18 because essentially what the patient is hanging their life on
19 is what they perceive as the quality of your cosmetic surgery.
20 Q You've mentioned potential dangers to plastic surgeons in
21 those situations. Are there any other ethical reasons why a
22 plastic surgeon may be hesitant to treat patients for those
23 reasons?
24 A Well, the term that's applied to patients who present to
25 plastic surgeons seeking an unmeetable improvement in their

1 subjective life is called body dysmorphic disorder, and this is
2 well characterized. And you find it in the DSM-III, but you
3 also find it in textbooks of plastic surgery because this is
4 one of the very important areas of broad overlap between the
5 world of psychiatry, psychology, and plastic surgery because
6 aesthetic surgery, we're talking about the patient's feelings.
7 So body dysmorphic disorder is a very important diagnosis
8 for the plastic surgeon to make because to offer surgery to a
9 patient that they know to be presenting with body dysmorphic
10 disorder is considered misdiagnosis or failure to diagnose or
11 malpractice for offering surgery in that circumstance because
12 essentially you're offering the patient the hope in something
13 that's not founded.
14 Q So if you had a patient come to you who wanted plastic
15 surgery and you suspected had body dysmorphic disorder, would
16 you perform that surgery?
17 A I would not.
18 Q Why not?
19 A Because it's a disservice to the patient. It's a common
20 thing that the patients will, when they have such surgeries,
21 there's a period of happiness. This is a very common thing.
22 There's a period of happiness after the surgery, there's a time
23 of excitement, but then the excitement has worn away. They're
24 no longer hearing compliments from their friends, they're no
25 longer feeling the emotional support or the satisfaction,

1 because they've essentially sought a physical remedy for a
2 subjective problem. And, of course, that's an impossibility.
3 And that's really what's at the heart of body dysmorphic
4 disorder and the reason why you don't offer surgery to them
5 because essentially you're abusing the patient in doing it, and
6 the abuse is financial. The abuse is holding out a false hope,
7 and then the patient is left with essentially the same sorrow
8 and a bill for plastic surgery and their hopes have not been
9 realized.
10 Q Let me pivot just a little bit. What is your
11 understanding of informed consent?
12 A Informed consent is the process by which the patient is
13 helped to make a decision for or against a particular care. It
14 is a process of informing the patient about the reasons for
15 offering the procedure, what we call the indications as well as
16 the risks. And an important part of informed consent is
17 alternative treatments. So, for example, if I'm presenting a
18 consent form to a parent because the child has been diagnosed
19 with a hernia, I have to talk to the parent about the risks of
20 the hernia. I have to talk to the patient about the risks of
21 the surgery to correct the hernia. I have to discuss with them
22 alternative surgical methods for managing it, say for example,
23 endoscopic versus open and the use of mesh and all those sorts
24 of things.
25 There's usually differences of technique or methodology.

1 And then I have to talk to them about the alternative
2 treatments so that the parents can have an understanding. So
3 the discussion of risk is not only the risk of the surgery but
4 also the risk of not operating as well as the risks of the
5 various alternatives.
6 In that way, the parent in this case would have the
7 resources to make an informed decision. Generally it's frowned
8 upon to pressure the person, the parent, in a particular
9 direction other than to offer that this is a high risk surgery,
10 this is a low risk surgery, higher likelihood of success, that
11 sort of thing.
12 Q Does informed consent differ based on the evidence
13 available?
14 A Well, it does. So there are certain things that are
15 anecdotal on the part of the doctor. So, for example, I guess
16 one of the newer things that I offered in my practice was the
17 use of autologous fat for the management of problematic wounds.
18 This is novel stuff. And so all I can offer the patient in
19 that circumstance is my anecdotal experience. I can say I've
20 done this treatment on radiation burn wounds, I've had seven
21 patients and this has been my result. While it's certainly
22 encouraging, I could not stand in front of the patient and say
23 this has a 90 percent likelihood of success, because I don't
24 have that level of data.
25 All I have is anecdotal data, what we call level five

1 evidence, one practitioner, me, and my anecdotal experience.
2 Level five evidence is not something that I could walk into the
3 consultation room and say this is what we must do, because I
4 don't have that level of evidence. All I can say is my
5 experience tells me and I'm a plastic surgeon, I used to be
6 board certified, all that kind of stuff. But that's low level
7 evidence, as compared to walking in and talking to a patient,
8 having what we call level three evidence, longitudinal study
9 that shows, well, long term evidence shows us that patients who
10 get autologous fat grafting for radiation burn wounds have a
11 75 percent likelihood of healing those wounds within three
12 months. That's what the science shows us. That I could
13 present with a lot more confidence, level three evidence.
14 Q Let's return to the hypothetical of the patient who comes
15 with what you suspect might be body dysmorphic disorder and
16 wants a rhinoplasty. What is that patient's capacity for
17 informed consent?
18 A A person with body dysmorphic disorder?
19 Q Yes.
20 A Well, I guess --
21 THE COURT: Are you talking about in general or are
22 you talking about --
23 MS. TEMPLIN: For surgery.
24 THE COURT: You're asking what this person's
25 capacity for informed consent could be and it's a hypothetical

1 person. I'm not sure I follow the question.
2 BY MS. TEMPLIN:
3 Q Let me rephrase. If you had a patient in the
4 hypothetical that we discussed who was seeking plastic surgery
5 to cure something such as body dysmorphic disorder, would that
6 factor in to your understanding of whether that patient could
7 consent to that plastic surgery or not and how?
8 A Well, I would have to agree that being a hypothetical,
9 there's a whole broad range of possibilities here, and
10 depending on the seriousness of the surgery we're considering,
11 that would have a great effect. There are some persons who are
12 so emotionally invested in their appearance or seeking cosmetic
13 surgery that they'll speak of a desire to end their life, for
14 example, they'll say that this has got to go right or I'm going
15 to end my life. That would be absolutely exclusionary because
16 a person who is threatening suicide by definition is considered
17 incompetent to give consent regardless of what they're seeking.
18 So comparing that to somebody who has a trivial anxiety about
19 something and you just improve the appearance of their nose,
20 that would be a very different category and I would consider
21 them quite competent to give consent. So it really touches
22 upon how grave the matter is.
23 Q You mentioned also that the risks would factor into that
24 particular calculus just now. Will you explain that a little
25 bit further?

1 A Well, for example, the risk of pinning someone's ears
2 back because their ears are prominent, that's about as low risk
3 surgery as I could imagine. There's no risk of function lost,
4 there's little or no risk of local problems even. So that
5 would be a very low risk procedure. On the other hand, doing
6 an operation that involves the transfer of large flaps of
7 tissue and the removal of natal tissues, there's a lot at risk
8 there. For example, in the case of transgender surgery, you're
9 talking about hazarding a fundamental human function, which is
10 capacity for sexual embrace and reproduction. That's a huge
11 thing to put in jeopardy compared to a cosmetic ear surgery.
12 Q You're not a psychiatrist, but as a plastic surgeon, are
13 you familiar with what gender dysphoria is?
14 A Yes, I am.
15 Q How are you familiar with that?
16 A I follow the literature. I've reviewed the DSM.
17 Q Are you familiar with the WPATH guidelines on treating
18 patients who are seeking gender reassignment surgery?
19 A I am.
20 Q What do those guidelines recommend?
21 A Well, first of all, they recommend affirmation. The
22 basic position of the WPATH documents is affirmation. They
23 have portions of their what they call the WPATH Standards of
24 Care that discuss psychological, psychiatric support, but
25 there's little to nothing in there about the process of

1 diagnosis, which is a very troubling thing. The diagnosis is
2 what the patient presents with. So the recommendation, the
3 default position of the WPATH documents is affirmation.
4 Q For specifically in the surgical context, what would that
5 mean?
6 MS. OSWELL: Your Honor, we object to this line of
7 questioning on the grounds that the witness is not an expert in
8 gender-affirming care and was not included in his expert
9 report.
10 THE COURT: Sustained.
11 BY MS. TEMPLIN:
12 Q Dr. Lappert, can you predict whether a transgender
13 patient would be satisfied with the outcome of cosmetic
14 surgery?
15 A I cannot.
16 Q Is there evidence on this?
17 MS. OSWELL: Objection, Your Honor. Again, outside
18 the scope of the testimony. The doctor has testified that he
19 has not performed any sort of gender-affirming care surgery.
20 MS. TEMPLIN: Your Honor, Dr. Lappert has also
21 testified that as a plastic surgeon, he has to take into
22 account his patient's goals and whether it would be effective
23 and whether that expertise -- we believe he has the expertise
24 to discuss that.
25 THE COURT: I'm going to limit it to his practice.

1 THE WITNESS: Could you repeat the question?
2 BY MS. TEMPLIN:
3 Q Yes. In your practice, can you predict whether a
4 transgender person who comes to you -- have you been able to
5 predict whether that person would be satisfied with --
6 THE COURT: He's already answered that question.
7 MS. TEMPLIN: Apologies.
8 BY MS. TEMPLIN:
9 Q In your review of the evidence as part of your practice,
10 what does the evidence show?
11 THE COURT: No, ma'am. I just said that he can
12 testify to what he has personally done in his practice, not
13 what the evidence shows. So he can testify to his actual
14 interaction with patients and what the outcomes were, but I'm
15 going to limit it to that.
16 MS. TEMPLIN: Can I ask him about certain studies
17 that may have been referred to in his expert report or is that
18 also outside the scope of permissible testimony, Your Honor?
19 THE COURT: I don't know what your question is so I
20 can't answer that question. I can tell you what I'm limiting
21 to you the question that's before the witness now. He can
22 answer to the extent that he has hands-on experience with that,
23 but your next question I'll just have to field as it comes.
24 BY MS. TEMPLIN:
25 Q Okay. I'll try that question then. Dr. Lappert, are you

1 familiar with a 2020 study conducted by Richard Bränström and
2 John Pachankis on the mental health outcomes among transgender
3 individuals after gender transition surgeries?
4 MS. OSWELL: Your Honor, we object to the
5 reference --
6 THE COURT: He can answer whether or not he's
7 familiar with it.
8 THE WITNESS: I have read the paper.
9 THE COURT: I'm just going to limit you to that.
10 What's your next question, ma'am?
11 MS. OSWELL: Your Honor, we have a further objection
12 here. This study was not included in Dr. Lappert's expert
13 report for purposes of this litigation, or in his rebuttal
14 report or in his deposition testimony and should be excluded on
15 that basis. And on the basis that it's outside his field of
16 expertise.
17 THE COURT: Is that true or can you point to me some
18 designation of this report in his expert designations?
19 MS. TEMPLIN: I don't have a reference to that.
20 THE COURT: Then it'll be sustained.
21 BY MS. TEMPLIN:
22 Q Are you familiar with the Centers for Medicare and
23 Medicaid Services' 2016 final decision memo on gender dysphoria
24 and gender reassignment surgery?
25 MS. OSWELL: Your Honor, we have the same

1 objections. This study was not included in Dr. Lappert's
2 expert report, rebuttal report, or his deposition testimony.
3 It is also outside his field of expertise.
4 THE COURT: Same question, ma'am. Is that true?
5 MS. TEMPLIN: I don't know if it's in his report.
6 We are asking because that report is relevant for plastic
7 surgeons, just his own practice and what type of procedures he
8 would offer.
9 THE COURT: Sustained.
10 MS. TEMPLIN: Okay.
11 BY MS. TEMPLIN:
12 Q Dr. Lappert, we've talked about mental health as
13 something that you consider before you perform aesthetic
14 surgeries. Are there any other criteria you consider before
15 operating?
16 A Well, I have to consider whether it's within my training
17 or within my capacity to a particular operation that may be
18 requested. I have to consider the particular circumstances of
19 the patient, perhaps their health, perhaps their medications,
20 whatever it may be that may be precluding them from surgery. I
21 have -- in the case of cosmetic surgery, I have to consider
22 what's the likelihood that I can satisfy what the patient's
23 desires are as we talked about before.
24 Q Do you consider the patient's age?
25 A Yes, I do.

1 Q Would you perform cosmetic or aesthetic surgery on a
2 minor generally?
3 A Only certain surgeries would I consider. Some yes and
4 some no.
5 Q Can you explain that?
6 A Well, for example, like otoplasty in a child who has a
7 deformity of the ear, prominent ear, for example, a child in
8 late grade school or middle school, this is a source of
9 tremendous grief sometimes to the child. And while it may seem
10 trivial, it can be a real burden to the child. So that would
11 be an example where a simple 20-minute operation with zero risk
12 can change the life of that child, and I would gladly offer
13 them that surgery. An example of a surgery I would not offer a
14 child would be breast augmentation in a 15-year-old girl, for
15 example. That's out of the question. I would not do that.
16 Q Why not?
17 A Because, first of all, the child does not have the
18 capacity to give informed consent. By legal definition,
19 they're not capable of it. For the parent to make that consent
20 for a cosmetic procedure like that, I would have trouble with
21 that. And generally speaking, the American Society of Plastic
22 Surgery looks askance at cosmetic breast augmentation in
23 adolescent females.
24 Q Dr. Lappert, is there a good -- so you've just testified
25 that you would not perform breast augmentation on a female who

1 just wants larger breasts. Would you take the same approach to
2 a transgender female who seeks transitioning surgery?
3 A Well, it's -- when you say transgender female, are you
4 saying a male --
5 Q Biological male --
6 A -- seeking to present as female? Yeah, I would put that
7 in the same category. It's a cosmetic breast surgery seeking a
8 subjective improvement in their life, yeah.
9 Q Let's talk about some of the surgeries that transgender
10 minors might seek. What are so-called top surgeries?
11 A Top surgeries include surgeries of the face and the neck
12 as well as surgeries of the breast. They might include
13 masculinizing of the face or feminizing of the face, feminizing
14 of the neck, or breast surgery, either breast augmentation or
15 mastectomy and chest masculinization.
16 Q What are bottom surgeries?
17 A Bottom surgeries are definitive surgeries on the
18 genitalia. They may include -- well, they typically include
19 castration, removal of the ovaries or removal of the testicles
20 and use of the natal genital tissues to create counterfeit
21 genitalia. In the case of females seeking to present as males,
22 they may include the transfer of tissues from remote parts of
23 the body to create a counterfeit phallus.
24 Q So starting with surgeries for a male transitioning and
25 seeking to present as female, have you ever performed facial

1 feminization surgery?
2 A No.
3 Q Are there similar procedures you've performed on
4 nontransgender individuals that would utilize the same
5 techniques?
6 A Yes.
7 Q What are those techniques?
8 A Well, for example, the reduction of a frontal boss, a
9 large bony ridge above the brow is a common procedure done on
10 women seeking a less masculine appearance around their eyes.
11 This is a common operation which is now typically done
12 endoscopically. A large hawkish nose sometimes gives a
13 masculine appearance to a face, and the patient may be seeking
14 a more feminine appearing nose. A very strong jaw, a box-like
15 jaw, lantern jaw on a woman often is a source of difficulty for
16 them, and a reduction of contour of the mandible, mandibular
17 re-contouring we call them. These are common procedures.
18 Q Would you classify these as aesthetic?
19 A Yes.
20 Q Have you ever performed breast augmentation?
21 A Countless times.
22 Q On a transgender individual?
23 A I have not.
24 Q But is it the same procedure for a transgender?
25 A Exactly the same operation.

1 Q How does that procedure work?
2 A Breast augmentation typically involves the use of a
3 prosthesis, and decisions about the type of prosthesis and the
4 placement of the prosthesis in the chest either behind the
5 muscle or behind the natal breast tissue, it's an outpatient
6 surgery typically done under very brief general anesthesia.
7 Recovery is a matter of weeks for full return to full function.
8 Q Why would a nontransgender person usually seek breast
9 augmentation?
10 A The most common patient is a woman in her 30s who's had
11 several children and she wants to restore her appearance having
12 breast fed her children. Maybe there's a little asymmetry in
13 the size of the breasts. This is probably the most common
14 reason for breast augmentation.
15 Q Are there reconstructive reasons for breast augmentation?
16 A Well, there are two different surgeries. Breast
17 reconstruction versus cosmetic surgery. What amounts to a
18 breast augmentation, I suppose if you had a congenital
19 asymmetry of the chest, for example, Poland syndrome where you
20 might have a very vestigial breast on one side and partial
21 absence of the muscle, that would be a reconstructive surgery,
22 which I suppose you could characterize as an augmentation of
23 one side, but it's really a reconstruction of a congenital
24 defect. So generally cosmetic augmentation is not considered a
25 reconstructive operation.

1 Q For the reconstructive augmentation for something like
2 Poland syndrome, are there diagnostic criteria that would need
3 to be met?
4 A Right. So Poland, because it's a reconstructive surgery,
5 the issues of diagnosis and submitting of the diagnosis to
6 insurance carriers is an important part of the process for the
7 patient, so the diagnostic criteria, for example, for Poland
8 syndrome is congenital absence or significant hypoplasia of the
9 breast with associated absence of the sternal head of the
10 pectoralis major muscle. If those two criteria are met, then
11 the diagnostic criteria are met, then you can submit that to
12 the insurance company and they will give you a prior
13 authorization and then surgical planning would proceed from
14 there with a variety of different options for the patient.
15 Q And just to clarify what you testified earlier, if a
16 teenage girl came in seeking a cosmetic breast augmentation,
17 would you perform that?
18 A I would not.
19 Q Does breast augmentation have any complications?
20 A Yes.
21 Q What are those?
22 A The most common complication in breast augmentation
23 surgery is what's called capsular contracture where the tissues
24 surrounding the implant will thicken and contract and cause a
25 deformity and the deformity can be severe enough to even casual

1 observation and then it can get to the point of pain. So
2 capsular contracture is the most common thing and it most
3 likely results from incidental infection with bacteria, maybe a
4 failure of technique during surgery, maybe a failure of
5 manufacture of the implant. Sometimes it can become so severe
6 that the implant has to be removed because of peri-implant
7 infections. So those are the two most common complications.
8 And then you have less common things like failure of the wound
9 closure. Typically not a problem.
10 Q Are there any special difficulties with performing breast
11 augmentation on a transgender individual?
12 MS. OSWELL: Objection, Your Honor. This is outside
13 the scope of the doctor's practice.
14 THE COURT: Sustained.
15 BY MS. TEMPLIN:
16 Q Have you ever performed a vaginoplasty?
17 A No.
18 Q Are there similar procedures you've performed on
19 nontransgender individuals that would utilize these techniques?
20 A Yes.
21 Q Can you explain?
22 A Perineal reconstruction and vaginal reconstruction
23 following cancer care and trauma. For example, in the
24 reconstruction, I had a patient who was one of the victims of
25 the bombing of the USS Cole when I was on active duty in the

1 Navy. The Navy ship Cole was bombed in the Gulf of Aden, two
2 of the victims came to us at Portsmouth, both of them had lower
3 limb trauma, one of them had blast injury to the perineum and
4 the vaginal area required reconstruction not only of the limb
5 but reconstruction of the vaginal introitus as well, required
6 the use of local flaps to reconstruct as well as mucosal
7 grafts.
8 Q Are there diagnostic criteria for when such
9 reconstructive surgery would be necessary?
10 A Certainly in her case, the diagnosis was quite evident,
11 the blast injury. And the more common one would be
12 reconstruction following cancer care. So cancer management
13 would involve the removal of the affected tissues and result in
14 an observable measurable deficit. And I use the term
15 "measurement" because you have to measure out the tissues that
16 you're going to transfer to reconstruct the vaginal canal.
17 Q Do these procedures have any potential complications?
18 A Donor morbidity like we talked about before, what is the
19 price the patient is going to pay for harvesting the tissue
20 from elsewhere on her body to reconstruct the injured part. It
21 may be as simple as just a skin graft, what amounts to a burn
22 wound on the thigh to restore the lining of the vagina using
23 her own thigh skin. That's a very low risk donor defect. If
24 I'm transferring, say, gracilis muscle from her thigh to reline
25 that area, then she has the potential risk of infection of her

1 leg compromising function of movement, those sort of things.
2 Q Have you ever performed a mastectomy?
3 A Yes, many times.
4 Q How is that procedure performed?
5 A Well, the goal of mastectomy typically is the management
6 of cancer. And over the years, the level of aggression in the
7 operation has decreased significantly, but generally the
8 operation involves making incisions across the chest to lift up
9 flaps of skin, the skin of the chest is lifted up off the
10 breast mound itself, the breast is removed sometimes with
11 associated lymph nodes. Typically the nipple is removed at the
12 same time, although not always. But if you're talking about
13 mastectomy, or complete removal of the breast, then the nipple
14 comes with it typically. And then the skin flaps are closed on
15 the chest and drains are placed to prevent fluid from
16 accumulating behind the skin flaps. The drains are typically
17 removed at a week. Sutures are typically removed about the
18 same time.
19 Q Why might a woman seek a mastectomy?
20 A Generally those decisions are guided by typically a tumor
21 board. In most hospitals if a patient is going to have a
22 mastectomy for cancer, it's sort of standard or it has been in
23 my lifetime of practice to discuss the cases with colleagues
24 because it's a multidisciplinary treatment for breast cancer,
25 it will involve oncologists who are going to be managing

1 chemotherapy and radiation oncologists. Decisions will be made
2 regarding the size of the tumor, the aggressiveness of the
3 cancer, the likelihood that lymph nodes are involved. There'll
4 be a collaborative decision made about what's the best course
5 of care. If the decision for mastectomy is made, then
6 generally speaking, the discussions are usually about what the
7 adjuvant care is going to be, will the patient be on
8 chemotherapy. The reason that's important is because it
9 affects how the reconstructive plan fits into this.
10 So if a patient is going to get radiation therapy, for
11 example, you don't put a breast prosthesis in there because
12 they're very likely to extrude it. A patient who is going to
13 be getting aggressive chemotherapy, very often you don't do
14 elegant reconstructive operations because you're putting the
15 tissue at risk, and then you make decisions about later
16 reconstruction. So it's a multifaceted, multidisciplinary
17 decision-making process and the patient is brought along in the
18 consent process in all of that.
19 Q To clarify, you just testified here that the mastectomy
20 would be reconstructive; is that correct?
21 A Actually the mastectomy is the destructive part of it,
22 right. The reconstruction comes later. But that's what my
23 article was about with Dr. Toth was that planning cycle making
24 the decision about when reconstruction is going to happen,
25 making decisions about how even the incision is made with the

1 hope of getting a better result afterwards.
2 Q Do mastectomies have potential complications?
3 A Yes, they do.
4 Q What are those?
5 A The most common complication of mastectomy is loss of
6 blood flow in the skin flaps that were elevated when the skin
7 flaps are lifted up to expose the breast mound, you're reducing
8 the blood supply to that skin, what we call simplifying the
9 blood supply to that skin. And when you close that skin, the
10 part that's most in jeopardy that's furthest from its blood
11 supply is the edge of the incision. So you can get what's
12 called marginal flap loss, failure of the wound to heal,
13 dehiscence of the wound where the wound actually falls apart,
14 chronic seroma, fluid accumulating behind the skin flaps, the
15 need for chronic drainage, the need for sclerosis. Even
16 sometimes the risk of a pneumothorax where the integrity of the
17 chest wall has been damaged by the operation.
18 Q Is a breast reduction a similar procedure?
19 A Well, no, it's not. It's a different operation entirely.
20 Breast reductions are operations where you're trying to
21 decrease the volume, the mass of the breast mound in order to
22 correct an orthopedic complaint. They're considered
23 reconstructive surgery because the patient has a functional
24 deficit when they present for breast reduction. The deficit
25 that the patient has is typically -- well, it's orthopedic in

1 the sense that they'll have chronic neck, back, and shoulder
2 pain that can be severe enough to affect their capacity for
3 work, even routine living sometimes.
4 So this is a very well studied problem and there's a lot
5 of actuarial data behind that that patients with large breasts
6 will have a very high likelihood of visits to the pain clinic,
7 visits to the orthopedic surgeon, to the back clinic getting
8 injections, and insurance companies are very cognizant of the
9 fact that they're paying a lot of money for the care of
10 somebody who has an objective orthopedic problem. And they
11 have linked it to the actual mass of the breasts so that they
12 can make predictions, actuarial predictions, that if a person
13 of certain stature, if you remove X amount of breast tissue
14 from them, they have a higher than 90 percent probability of
15 resolving their back pain.
16 So you have an orthopedic problem with an objective
17 criteria and you have actuarial data to show you that the
18 operation will serve the patient. So when I obtain consent
19 from that patient, I can say you have a greater than 90 percent
20 likelihood that your back pain is going to be resolved.
21 Q Is this procedure then reconstructive or aesthetic?
22 A It's reconstructive because there's a functional problem.
23 Q Are all breast reductions necessarily reconstructive?
24 A No.
25 Q Would you perform a breast reduction on a teenage girl

1 seeking one for cosmetic reasons because she didn't like the
2 size of her breasts?
3 A That gets problematic because I'm relying on the
4 patient's subjective reporting, but if the only subjective
5 complaint is just dissatisfaction with her appearance, I would
6 not only not do the operation, but I would strongly discourage
7 the parents from seeking another consultation.
8 Q Can breast reduction have any complications?
9 A Yes, they can, and that's the reason for rejecting that
10 patient. Among the goals of breast reduction is not only the
11 resolution of the orthopedic complaint of neck, back, and
12 shoulder pain, but the goal is to preserve function of the
13 breast, to preserve erotic sensibility in the nipple so that
14 they can have a hope of breast feeding as well. And the
15 preservation of the relationship between the nipple and the
16 breast tissue so that they can breast feed, so those are among
17 the goals. Sometimes that is what we would call the donor
18 defect where you do the very best you can and yet the patient
19 comes back with an insensate nipple. In fact, that's about a
20 10 percent likelihood of unilateral loss of nipple sensation.
21 There's a possibility that they'll come back, and because
22 of scarring in the breast or even loss of sensibility, they
23 will be unable to breast feed. That would be a potential
24 complication. Not so much a complication, but an adverse
25 outcome really. So that's one of the reasons for not offering

1 the operation to a teenage girl because she may not have the
2 capacity to decide that for herself yet.
3 Q Might a biological male get a surgery that resembles
4 breast reduction or mastectomy?
5 MS. OSWELL: Your Honor, again, we object. This is
6 outside the scope of Dr. Lappert's expertise.
7 MS. TEMPLIN: Your Honor, this is not about
8 transgender procedures. Let me ask more -- rephrase the
9 question.
10 THE COURT: Let me just ask the same question a
11 different way. If a male comes in for breast reduction, is
12 there any different analysis?
13 THE WITNESS: Yes, there is, Your Honor. It's one
14 of the common diagnosis, one of the common complaints that
15 patients come to a plastic surgeon with. It's what's called
16 gynecomastia. Gynecomastia is a common condition in males and
17 it has two possible causes. The most common cause of
18 gynecomastia in males is obesity where there's just a general
19 increase in subcutaneous fat, so the contour of the chest
20 appears to resemble a breast.
21 From the standpoint of reconstructive surgery, the
22 gynecomastia that's what we call glandular gynecomastia where
23 very typically it would be one side but sometimes both sides of
24 a male patient will have a female glandular tissue behind the
25 nipple and it's a mass, it's a lump that may resemble a breast

1 depending on the size of the patient, often times painful, but
2 it also has objective pathological diagnostic criteria, meaning
3 that in the first case of the obese patient, all I submit to
4 the laboratory is fat and so that would be considered a
5 cosmetic operation.
6 In the second case, what gets submitted to the pathology
7 lab is fiber glandular tissue which when examined under the
8 microscope appears to be female breast tissue. So that's why
9 the term "gynecomastia" is applied. Gynecomastia basically
10 meaning breasts like a woman. So they differ markedly. One of
11 them has a objective problem there, the other one is a cosmetic
12 issue.
13 BY MS. TEMPLIN:
14 Q I may be misremembering, but did you testify at the
15 beginning that you have performed breast reconstruction on a
16 transgender individual detransitioning?
17 A Right, I did a breast implant removal and then
18 gynecomastectomy.
19 Q Are there any complications -- in that experience, are
20 there any complications with the gynecomastectomy removal with
21 that particular patient?
22 A Well, gynecomastectomy, one of the most common
23 complications in gynecomastectomy is post operative bleeding.
24 The male chest has larger caliber blood vessels supplying the
25 skin and so there's a higher likelihood of incidental damage to

1 a blood vessel that causes what's called a hematoma seroma.
2 They have a higher need for post operative drainage, potential
3 for loss of sensibility in the nipple because of the way you
4 have to lift the nipple away from the chest wall.
5 Q Have you ever performed phalloplasty?
6 A Phalloplasty?
7 Q Yes.
8 A I have done phalloplasty reconstruction on trauma and
9 cancer patients.
10 Q What does that procedure entail?
11 A It's a broad range of procedures. Most common is what we
12 call local flap reconstruction where you're using skin and
13 sometimes muscle to transfer a viable tissue down to the
14 phallus to reconstruct the cylinder of flesh and reconstruct
15 the urethra that's within that as well. So it involves the use
16 of local flaps, vascularized flaps, and skin grafts in the
17 operation I've performed. More recently phalloplasty might be
18 what we would call a free tissue transfer where you actually
19 produce the phallus structure even in a remote location on the
20 patient's body I should say and then transfer the whole
21 construct to the genital area and attach blood vessels and
22 nerves.
23 I've never done that operation before, phallus
24 reconstruction. I've done that operation for other
25 reconstructions, but not in the case of a phalloplasty. But

1 that would be the more contemporary operation from being what
2 we call the prefabricated free flap.
3 Q Is this a reconstructive or aesthetic surgery?
4 A Phalloplasty can be either one depending on why it's
5 done. The example I gave you of reconstruction of a cancer
6 patient, I think that was a cancer patient, yeah, versus for
7 gender transitioning, that would be a different one.
8 Q Are there diagnostic criteria for a reconstructive
9 phalloplasty?
10 A Sure, surgical or traumatic absence of the phallus with
11 associated urethral injury.
12 Q Do these procedures have any complications?
13 A Any time you transfer soft tissue from one place to
14 another, you risk losing that soft tissue because of inadequate
15 blood supply, you have the donor defects that we talked about
16 depending on where you're harvesting the tissue from, the
17 patient may be paying a price for the removal of that tissue
18 from its native area and it's transferred down to the genital
19 area. So loss of the flap because of the loss of blood supply.
20 A very common one in phallus reconstruction is urethrocutaneous
21 fistula. You've reconstructed the urethra and that
22 reconstruction involves suture lines and those sutures can fail
23 for the reasons we described earlier, lack of blood supply, and
24 when the suture lines fail, you have urine leaking out anywhere
25 along the length of the construct.

1 The same processes can cause stricture scarring, and that
2 scarring of the reconstructed or constructed urethra will cause
3 urinary obstruction and that urinary obstruction can cause
4 problems higher up in the urogenital tract including
5 obstructive injury to the kidney.
6 MS. TEMPLIN: Your Honor, could I have a moment?
7 THE COURT: You may.
8 MS. TEMPLIN: One last question that I think I
9 forgot to ask earlier.
10 BY MS. TEMPLIN:
11 Q Just to clarify, would there ever be a purely aesthetic
12 reason to perform a total mastectomy?
13 A Well, mastectomy, because it involves the removal of the
14 breast tissue, it involves the destruction of a human function.
15 And so as we talked about earlier, that's one of the things
16 that is considered unacceptable in cosmetic surgery, the
17 destruction of function in pursuit of a cosmetic result. So it
18 violates one of the most fundamental principles of plastic
19 surgery. This is like plastic surgery 1A. So for that reason,
20 I would say no.
21 MS. TEMPLIN: We'll pass the witness.
22 THE COURT: We're going to break for lunch. We'll
23 be back at 1:00.
24 (Recess at 11:57 AM.)
25

1
2 REPORTER'S CERTIFICATE
3 I certify that the foregoing is a correct transcript of
4 proceedings in the above-entitled matter.
5
6 /s/ Karen Dellinger, RDR, CRR, CCR
---------------------------------- Date: December 4, 2022
7 United States Court Reporter
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1 (Proceedings commenced in open court at 12:50 p.m.)
2 THE COURT: Ready when you're ready.
3 CROSS-EXAMINATION
4 BY MS. OSWELL:
5 Q. Dr. Lappert, just a few questions for you.
6 The American Society of Plastic Surgeons considers
7 gender-affirming surgeries to be reconstructive not
8 cosmetic, correct?
9 A. Right.
10 Q. And changing topics, you attended two meetings in
11 Arizona on the subject of transgender organized by the
12 Alliance Defending Freedom. Is that correct?
13 A. That's correct.
14 Q. It's an organization otherwise known as ADF for
15 short.
16 A. I'm sorry?
17 Q. Refer to that organization as ADF for short.
18 A. That's correct.
19 Q. The first meeting you attended took place in 2017.
20 A. I think that's correct, yes.
21 Q. And ADF is not a professional scientific
22 organization, is it?
23 A. Not to my understanding. I don't know them real
24 well, but my understanding is they're advocacy --
25 Christian-based advocacy legal organization.

1 Q. Okay. And at that meeting in 2017, there was a
2 fairly long discussion about the lack of people who are
3 willing to testify and the difficulty of finding expert
4 witnesses on transgender issues, wasn't there?
5 A. I believe there was.
6 Q. And people at that meeting were asked whether they
7 would be willing to participate as expert witnesses,
8 weren't they?
9 A. Yes.
10 Q. Both you and Dr. Hruz attended that meeting, correct?
11 A. That's correct.
12 MS. OSWELL: Pass the witness, thank you.
13 REDIRECT EXAMINATION
14 BY MS. TEMPLIN:
15 Q. Just a couple follow-up questions, Dr. Lappert.
16 As you were just asked about, the association of
17 plastic surgeons classifies gender-transition surgery as
18 reconstructive.
19 Do you agree with that classification?
20 A. I do not. It's contrary to every other case that we
21 work on. It's an exceptional case, I should say.
22 Q. And is it common for you to attend professional
23 conferences with other people, other doctors, medical
24 professionals, to discuss medical issues?
25 A. Yes, it is.

1 MS. TEMPLIN: No further questions, Your Honor.
2 MS. OSWELL: No follow-up.
3 THE COURT: Free to go, Doctor.
4 THE WITNESS: Thank you.
5 THE COURT: As I said, I would have picked that
6 up before lunch had I known that's what was going to
7 happen.
8 THE WITNESS: I would have bought you lunch.
9 THE COURT: Well, it's not too late.
10 Call your next witness.
11 MR. JACOBS: Our next two witness are traveling
12 in, will be here tomorrow. So we don't have any further
13 witnesses for this afternoon, Your Honor. We anticipate
14 that we won't go, I wouldn't imagine, any later today than
15 we will tomorrow with the two witnesses that are on tap
16 for tomorrow.
17 THE COURT: Let me see if I understood you. You
18 think we'll be done by lunch tomorrow. Is that what you
19 meant to say?
20 MR. JACOBS: We think that's likely. Thursday
21 will be closer to a full day and then we'll be --
22 THE COURT: That's contrary to what I thought
23 you said that we'd be done by noon on Thursday. I'm
24 confused. Why are we missing a couple half days to go all
25 day on Thursday?

1 MR. JACOBS: On Thursday -- I apologize if I
2 misspoke. We have -- it could be closer to a full day. I
3 think we were discussing --
4 THE COURT: Why are we losing two half days?
5 MR. JACOBS: For travel.
6 THE COURT: You had all week. I'm trying to
7 figure out why you put them on Thursday when --
8 MR. JACOBS: For -- for Dr. Hruz, that was his
9 availability. That was the day.
10 THE COURT: About what the others -- the others
11 or other? I'm not sure.
12 MR. JACOBS: Yeah. Availability -- there is a
13 decent chance it will only be Dr. Hruz on Thursday. And
14 then it could be like shortly after lunch, but we're sort
15 of making decisions about sort of the last witness,
16 whether we're going to call a last witness or not.
17 THE COURT: Well, if you got local witnesses
18 that you're thinking about calling, you need to either
19 call them today or tomorrow because I'm not going to let
20 you wait and lose two half days. I gave you the whole
21 week. You acted like we were going to be going steady
22 through.
23 So I'm a little at a loss at -- at why we're looking
24 at a whole day Thursday with two half days or one --
25 excuse me. We're on Tuesday. We're talking about

1 Wednesday, Thursday, so a half day tomorrow.
2 MR. JACOBS: Could I just confirm one thing,
3 Your Honor?
4 THE COURT: Sure.
5 MR. JACOBS: Okay. We will -- we will confer
6 and the -- I think the -- the remaining witness for
7 Thursday we will -- that we had tagged for Thursday other
8 than Dr. Hruz, I think --
9 THE COURT: Who would that be?
10 MR. JACOBS: That would be Dr. Hyatt. So either
11 -- we haven't made a final decision as whether we're
12 calling Dr. Hyatt at this point.
13 THE COURT: Where is Dr. Hyatt?
14 MR. JACOBS: He is local? West Memphis area.
15 So I'll check on his availability. It may be a moot point
16 because we may decide not to call him, and then -- but I
17 don't want to inconvenience the Court.
18 I apologize if I -- you know, sliding around the
19 schedule. That wasn't clear. I can't remember what his
20 schedule other than Thursday looked like, so I would need
21 to confirm that.
22 THE COURT: My point is, he needs to be ready
23 tomorrow if he's local, there is no travel issues, because
24 it's usually my position, regardless of who I'm dealing
25 with, to call your next witness or rest, especially when

1 we're losing a half day today and half day tomorrow is
2 what you're telling me.
3 MR. JACOBS: I understand.
4 THE COURT: Let me know. Let the other side
5 know who you plan to call tomorrow if you would.
6 Court will be in recess.
7 (Proceedings adjourned at 1:06 p.m.)
8 * * * * *
9 REPORTER'S CERTIFICATE
10 I, Valarie D. Flora, FCRR, TX-CSR, AR-CCR, certify
11 that the foregoing is a correct transcript of proceedings
12 in the above-entitled matter.
13 Dated this the 6th day of December, 2022.
14 /s/ Valarie D. Flora, FCRR
15 -------------------------
16 United States Court Reporter
17
18
19
20
21
22
23
24
25

Case 1:07-cv-12325-DPW Document 318 Filed 04/18/19 Page 1 of 209

1 UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

2

3 ________________________________

4 KATHEENA SONEEYA,

5 Plaintiff, Civil Action
No. 07-12325-DPW

6 V.

April 8, 2019

7 THOMAS A. TURCO III, in his official
capacity as Commissioner of the

8 Massachusetts Department of Correction, 10:23 a.m.

9 Defendant.
____

10

11

12 TRANSCRIPT OF BENCH TRIAL DAY 1

13 BEFORE THE HONORABLE DOUGLAS P. WOODLOCK

14 UNITED STATES DISTRICT COURT

15 JOHN J. MOAKLEY U.S. COURTHOUSE

16 1 COURTHOUSE WAY

17 BOSTON, MA 02210

18

19

20

21

22 DEBRA M. JOYCE, RMR, CRR, FCRR
KELLY MORTELLITE, RMR, CRR
Official Court Reporters

23 John J. Moakley U.S. Courthouse
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24 Boston, MA 02210
joycedebra@gmail.com

25

Pl. Trial Ex. 082

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1 witness, ask me.

2 MS. HANCOCK: Okay. Apologies, your Honor.

3 BY MS. HANCOCK:

4 Q. So two versions were released since 1999, correct?

5 A. Correct.

6 Q. And one in 2001, as you just testified, right?

7 A. Right.

8 Q. And another one in 2011; is that right?

9 A. Yes.

10 Q. And as you understand it, there's going to be an eighth

11 version coming out soon, correct?

12 A. Yes.

13 Q. And you're not involved in drafting that version, correct?

14 A. I am not.

15 Q. And you requested to participate in drafting that version,

16 correct?

17 A. I'm not sure that's correct.

18 Q. You did not ask to be involved in drafting that version?

19 A. I think -- I think I actually might have, now that you

20 bring it up, but I was told I had to be a member of WPATH.

21 Q. Now, you've worked as a consultant for the DOC since

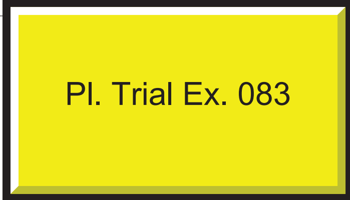
22 around 2007 or 2008. Does that sound right?

23 A. That sounds right.

24 Q. And you're not technically engaged by the DOC, though,

25 right?

1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE WESTERN DISTRICT OF WEST VIRGINIA
3 CHARLESTON DIVISION
4
5 ______________________________
B.P.J. by her next friend and)
6 mother, HEATHER JACKSON,)
)
7 Plaintiff,)
)
8 vs.) No. 2:21-cv-00316
)
9 WEST VIRGINIA STATE BOARD OF)
EDUCATION, HARRISON COUNTY)
10 BOARD OF EDUCATION, WEST)
VIRGINIA SECONDARY SCHOOL)
11 ACTIVITIES COMMISSION, W.)
CLAYTON BURCH in his official)
12 capacity as State)
Superintendent, DORA STUTLER,)
13 in her official capacity as)
Harrison County)
14 Superintendent, and THE STATE)
OF WEST VIRGINIA,)
15)
Defendants,)
16)
LAINEY ARMISTEAD,)
17)
Defendant-Intervenor.)
18 ______________________________)
19 VIDEOTAPED DEPOSITION OF
STEPHEN LEVINE
20 Wednesday, March 30, 2022
Volume I
21
22
23 Reported by:
ALEXIS KAGAY
24 CSR No. 13795
Job No. 5122884
25 PAGES 1 - 289



1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE WESTERN DISTRICT OF WEST VIRGINIA
3 CHARLESTON DIVISION
4
5 ________________________________
)
6 B.P.J. by her next friend and)
mother, HEATHER JACKSON,)
7)
Plaintiff,)
8) No. 2:21-cv-00316
vs.)
9)
WEST VIRGINIA STATE BOARD OF)
10 EDUCATION, HARRISON COUNTY)
BOARD OF EDUCATION, WEST)
11 VIRGINIA SECONDARY SCHOOL)
ACTIVITIES COMMISSION, W.)
12 CLAYTON BURCH in his official)
capacity as State)
13 Superintendent, DORA STUTLER,)
in her official capacity as)
14 Harrison County)
Superintendent, and THE STATE)
15 OF WEST VIRGINIA,)
)
16 Defendants,)
)
17 LAINEY ARMISTEAD,)
)
18 Defendant-Intervenor.)
________________________________)
19
20 Remote videotaped deposition of
21 STEPHEN LEVINE, Volume I, taken on behalf of Plaintiff,
22 with all participants appearing remotely, beginning at
23 9:09 a.m. and ending at 5:46 p.m. on Wednesday,
24 March 30, 2022, before ALEXIS KAGAY, Certified
25 Shorthand Reporter No. 13795.

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15 Also Present:
16 MITCH REISBORD - VERITEXT CONCIERGE
17
18 Videographer:
19 KIMBERLEE DECKER
20
21
22
23
24
25

1 Q Why don't you give me your estimate of how
2 many prepubertal children you've ever seen as patients,
3 and then we can ask more questions.
4 A I would say a handful. Six.
5 Q And how many of those -- of those 11:15:35
6 approximately six did you see more than one time?
7 A I can't recall one.
8 Q And then I'll ask the same question about
9 adolescents, which I'll mean minors from puberty
10 through being a minor. 11:16:00
11 How many adolescent patients have you had in
12 your career, approximately?
13 A 50.
14 Q And how many of those have you seen more than
15 once? 11:16:14
16 A Most.
17 Q And were most of those, of the adolescent
18 patients you've seen, late adolescence?
19 A No.
20 Q Turning back to your CV, you list yourself -- 11:16:27
21 you're listed as a clinical professor at Case Western
22 Reserve University School of Medicine; correct?
23 A Yes.
24 Q Do you work at Case Western Reserve University
25 School of Medicine full-time? 11:16:51

1 three months because I'm part of a committee to plan
2 the curriculum on sexuality and gender.
3 Speaking of education, the university --
4 other -- other institutions also asked me to teach
5 about this subject. And on August -- on April 7th, I'm 12:07:39
6 going to Akron to teach -- or virtually I'm going to
7 teach a three -- a two-and-a-half-hour seminar.
8 And I forgot to mention to you before, and I'd
9 like you to hear this, that when you were questioning
10 me about my credentials or not having a certificate 12:07:57
11 about -- in child psychiatry, you should know, I forgot
12 to tell you that Cleveland Clinic, department of child
13 psychiatry, and the University Hospitals, the
14 department of child psychiatry, sends residents to be
15 with me as part of their training in child development 12:08:18
16 and child clinical issues, child and adolescent
17 clinical issues.
18 So I think -- I just forgot to mention that.
19 Q Are you familiar with the University
20 Hospitals' LGBTQ and gender care program? 12:08:48
21 A I'm aware that it exists, yes.
22 Q Have you ever talked to any clinicians in that
23 practice?
24 A No one has ever talked to me in that practice.
25 The only time I have interaction with them is when -- 12:09:00

1 if I present grand rounds, some of those people ask me
2 a question. But they've never consulted me whatsoever
3 in the formation of their clinic and in the ongoing
4 work of their clinic.
5 Although, Cleveland Clinic has a very similar 12:09:20
6 program, and they have called me up and -- for some
7 advice sometimes.
8 But my -- my, quote, own University Hospitals'
9 place I don't really think has any people from child
10 psychiatry in it, but I'm not sure because they have 12:09:38
11 kept me away.
12 Q What do you mean they have kept you away?
13 A Just what I explained. They have never
14 communicated with me. It is -- you know, other people
15 know me as being published in this area. You know, I 12:09:54
16 think I've written 20 articles on this -- you know, I
17 have 20 or so publications in this area. You would
18 think that they would invite me or consult with me or
19 ask me questions, but I think they recognized that they
20 are part of what is called affirmative care and what I 12:10:18
21 would say, rapidly affirmative care, and -- and they
22 sense that I'm not so interested in rapid, that -- that
23 I believe that -- that I have long believed that people
24 who have this kind of dilemma need some patient time in
25 talking about this matter. 12:10:45

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1 IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
2 NORTHERN DIVISION
3
4 REV. PAUL A. EKNES-TUCKER, *
et al., *
5 *
Plaintiffs, * 2:22-cv-00184-LCB
6 * May 6, 2022
vs. * Montgomery, Alabama
7 * 9:00 a.m.
KAY IVEY, in her official *
8 capacity as Governor of the *
State of Alabama, et al., *
9 Defendant. *
****
10
11
12 TRANSCRIPT OF PRELIMINARY INJUNCTION HEARING
VOLUME II
13 BEFORE THE HONORABLE LILES C. BURKE
UNITED STATES DISTRICT JUDGE
14
15
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22
Proceedings recorded by OFFICIAL COURT REPORTER, Qualified
23 pursuant to 28 U.S.C. 753(a) & Guide to Judiciary Policies
and Procedures Vol. VI, Chapter III, D.2. Transcript
24 produced by computerized stenotype.
25

Pl. Trial Ex. 084

Case 2:22-cv-00184-LCB-CWB Document 105 Filed 05/08/22 Page 2 of 210

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Case 2:22-cv-00184-LCB-CWB Document 105 Filed 05/08/22 Page 3 of 210

1 COURTROOM DEPUTY: Deena Harris
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3 COURT REPORTER: Christina K. Decker, RMR, CRR
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Case 2:22-cv-00184-LCB-CWB Document 105 Filed 05/08/22 Page 4 of 210

1 **I N D E X**

2

3 ARMAND ANTOMMARIA 213
DIRECT EXAMINATION 213
4 BY MR. POWERS
CROSS-EXAMINATION 225
5 BY MR. BOWDRE

6

JAMES CANTOR, MD 253
7 DIRECT EXAMINATION 253
BY MR. DAVIS
8 CROSS-EXAMINATION 305
BY MS. EAGAN
9 REDIRECT EXAMINATION 332
BY MR. DAVIS
10

11 SYDNEY WRIGHT 337
DIRECT EXAMINATION 338
12 BY MR. DAVIS
CROSS-EXAMINATION 355
13 BY MR. DOSS
REDIRECT EXAMINATION 362
14 BY MR. DAVIS

15

16

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1 BY MS. EAGAN:
2 Q Good afternoon, Dr. Cantor.
3 A Good afternoon.
4 Q Dr. Cantor, you are an adult clinical psychologist,
13:29:15 5 correct?
6 A Yes.
7 Q You are not a medical doctor?
8 A Correct.
9 Q Your private practice -- in your private practice in
13:29:22 10 Toronto, the average age of your patients is 30 to 35 years
11 old?
12 A Average, that would be about right, yes.
13 Q You've not ever provided clinical care to transgender
14 prepubertal children?
13:29:39 15 A Correct.
16 Q You have not provided care to a transgender adolescent
17 under the age of 16?
18 A Correct.
19 Q The extent of your experience, Dr. Cantor, working with
13:29:52 20 transgender adolescents consists of counseling six to eight
21 transgender patients between the ages of 16 and 18; isn't that
22 correct?
23 A Yes.
24 Q So your clinical experience with gender dysphoria really
13:30:09 25 lies in the counseling of adult patients?

1 A Correct.
2 Q And you acknowledge that gender dysphoria in children does
3 not represent the same phenomenon as adult gender dysphoria,
4 correct?
13:30:24 5 A Correct.
6 Q And, in fact, to use your words, they differ in every
7 known regard, from sexual interest patterns to responses to
8 treatments?
9 A Correct.
13:30:36 10 Q Dr. Cantor, you have never diagnosed a child or an
11 adolescent with gender dysphoria?
12 A Correct.
13 Q Never treated a child or an adolescent for gender
14 dysphoria?
13:30:48 15 A Correct.
16 Q You have no experience personally with monitoring patients
17 who are undergoing puberty-blocking treatment?
18 A Correct.
19 Q You don't know what type of monitoring is typically done
13:31:04 20 or not done on those types of patients; isn't that fair?
21 A No.
22 Q No, that's not fair?
23 A Well, you -- I personally didn't do it, but I am aware of
24 the procedures that are done.
13:31:15 25 Q Okay. But you have no experience with that?

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1 A That's correct.
2 Q Similarly, you have never monitored -- or you have not
3 monitored an adolescent or teenage patient on hormone therapy?
4 A Correct. Until -- well, I wouldn't be monitoring the
13:31:34 5 status in any case, so, yes, that's correct.
6 Q I am going to switch to UAB Children's, the gender clinic
7 here in Alabama.
8 Have you ever spoken to a child or adolescent who was
9 treated at the gender clinic here in Alabama?
13:32:00 10 A No.
11 Q Have you ever spoken to any former patients of the clinic?
12 A No.
13 Q You weren't here yesterday to hear Dr. Ladinsky talk about
14 the treatment protocols they have at children's UAB, were you?
13:32:12 15 A Correct.
16 Q You weren't here to listen to the results of treatments
17 provided to adolescent patients at UAB's Children's in the
18 gender clinic; fair?
19 A Yes. They have never published them.
13:32:27 20 Q And you weren't here to hear them?
21 A Correct.
22 Q Dr. Cantor, you have no personal knowledge of the
23 assessment or the treatment methodologies that are used here in
24 Alabama at UAB Children's Hospital, correct?
13:32:42 25 A Correct. Correct.

1 regarding the efficacy of puberty blockers and hormone
2 treatments, okay?
3 A Yep.
4 Q As I understand your report and your testimony today, one
13:34:36 5 of the criticisms you have of some of those studies is that it
6 relies on participant's self-assessment I believe is the
7 language that you used.
8 Essentially, it is based upon what socially transitioned
9 youth and their family is reporting about their mental health
13:34:53 10 in these studies?
11 A I would say that's incomplete. My criticisms would be
12 relying on such subjective accounts entirely for all the
13 decision making rather than using it as one part of the
14 decision making.
13:35:08 15 Q In other words, basing your study based upon what the
16 participants in the study tell you how they're feeling at
17 different points in the study?
18 A Being limited to that is a problem, yes.
19 Q And I believe the way that you phrased it, you said,
13:35:22 20 subjective self-reports about how one is doing may not be
21 reflecting reality objectively.
22 A Correct.
23 Q But, Dr. Cantor, self-reports about how one is doing may
24 reflect reality, fair?
13:35:38 25 A That's correct.

Case 2:22-cv-00184-LCB-CWB Document 105 Filed 05/08/22 Page 105 of 210

1 Q So when somebody says, I am doing well, my mental state is
2 better, that very well may be the case?
3 A May be the case, yes.
4 Q Another complaint that you have, I believe, is what you
13:35:58 5 call confounded data. And I believe you referred to the de
6 Vries study for that?
7 A The two de Vries's studies, yes. As a matter of fact,
8 it's all but two of all papers in that set of literature.
9 Q And by confounded data, the way that I am understanding
13:36:13 10 it, what you're saying is that you are not able to tell because
11 the data is, quote, confounded, whether one's improved mental
12 health for a minor who has socially transitioned, whether that
13 came from the actual medical services, whether it came from the
14 psychotherapy, or whether it came from the combination of both?
13:36:34 15 A Correct.
16 Q But one thing, Doctor, that you do have to admit is when
17 adolescents with gender dysphoria have transitioned through a
18 combination of medical services and psychotherapy, you have to
19 admit that based upon the studies, their mental health
13:36:55 20 improved, correct?
21 A No. There were several studies that showed no improvement
22 even though -- even though they were receiving both. I've
23 listed them in my report.
24 Q Can you direct me to where in your report those are,
13:37:11 25 please, sir?

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1 So there -- again, I would have to go through and check to
2 be sure that it's not zero. It would be fair to say that there
3 might have been a study which found such a thing. But the
4 majority of studies are finding either no improvements or
13:39:17 5 deteriorations, or it's a situation that we call a failure to
6 replicate.
7 Q Sir, I am a little bit confused, because I want to go to
8 two of your studies that you have actually talked about today,
9 the Costa study and the Achille study.
13:39:33 10 Now, as I understand your testimony today, in those
11 studies, there was -- the studies reported that there was an
12 improvement in mental state for adolescents who were treated
13 with medication and psychological treatment in transition that
14 there was an improvement, but in those, you said you can't tell
13:39:58 15 whether it's from the medication or from the psychological
16 treatment?
17 A No. The Costa study and the Achille study associated the
18 improvement specifically with the psychotherapy and ruled out
19 that the effects were due to the medical interventions.
13:40:13 20 Q Okay. Well, let's pull those studies, Doctor, and let's
21 look at those.
22 If you could, there should be a notebook up there that has
23 plaintiffs' exhibits in it. Is that one plaintiff, sir?
24 If you could please, sir, turn to Plaintiffs' Exhibit 34.
13:40:55 25 A Yes.

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1 Q All right. Plaintiffs' Exhibit 34, is this the -- do you
2 say Costa or Costa?
3 A I'm sorry?
4 Q Do you say Costa?
13:41:05 5 A My guess is Costa. I have never met the person.
6 Q All right. Exhibit 34 that you have in front of you, is
7 that the Costa study?
8 A Yes, it is.
9 Q All right. So, Doctor, I first want to focus in on --
13:41:18 10 well, let me ask this: This study was aimed at assessing
11 gender dysphoric adolescents' global functioning after
12 psychological support and after puberty suppression, correct?
13 A Yes.
14 Q Bear with me. I am going to take this out so I can put it
13:41:42 15 up on the Elmo, sir.
16 All right, sir. I am going to direct your attention to
17 results that I have highlighted on my copy. Okay? According
18 to the abstract here, the results?
19 A Yes.
13:42:18 20 Q At baseline, gender dysphoric adolescents showed poor
21 functioning with -- it defines the mean scores. So baseline
22 means at the start of the study, correct?
23 A Usually it does. I would have to check that that's
24 exactly how they used the term.
13:42:35 25 Q All right. We will get to the details of that in a

1 minute.
2 Okay. Gender dysphoric adolescents' global functioning
3 improved significantly after six months after psychological
4 support. And then it goes on to say, Moreover, gender
13:42:49 5 dysphoric adolescents receiving also puberty suppression had
6 significantly better psychosocial functioning after 12 months
7 of puberty suppression compared to when they had received only
8 psychological support.
9 Did I read that right, sir?
13:43:07 10 A Yes.
11 Q Do you remember the methodology that was used for this
12 study, sir?
13 A Roughly.
14 Q Pardon?
13:43:14 15 A Yes. Roughly.
16 Q Sorry. I meant to -- all right. And do you recall that
17 the methodology was everybody started at baseline. For the
18 first six months all of the adolescents received psychological
19 counseling. And then for the next 12 months beyond that, one
13:43:36 20 group received puberty blockers, and one group just continued
21 to receive psychological counseling. Do you recall that?
22 A Yes.
23 Q All right. And then I am going to direct you, sir, to
24 page 2211 of the -- if you look at the blue writing on the top,
13:44:12 25 it's page 6 of 9.

Case 2:22-cv-00184-LCB-CWB Document 105 Filed 05/08/22 Page 110 of 210

1 A Yes.
2 Q All right. And I am going to direct you, sir, to on the
3 CGAS on follow-up?
4 A Yes.
13:44:32 5 Q All right. And I am going to start at the second
6 paragraph where it says delayed eligible. Do you see where I
7 am talking about?
8 A Yes.
9 Q This is talking about there were three follow-ups, right,
13:44:43 10 at 6 months, at 12 months, and at 18 months for this study; is
11 that correct?
12 A That sounds familiar to me, yes.
13 Q And let's read through that together.
14 Delayed eligible gender dysphoric adolescents, who
13:44:55 15 received only -- and gender delayed, GD adolescents, is your
16 recollection that those were adolescents who were eligible to
17 receive puberty blockers, but they delayed them for six months
18 so that they had everybody at a -- doing psychological study?
19 Do you remember this is the group that gets the puberty
13:45:17 20 blockers?
21 A Yes, that sounds correct.
22 Q Okay. The delayed eligible gender dysphoric adolescents
23 who received only psychological support for the entire duration
24 of the study -- excuse me -- I take that back.
13:45:29 25 This was actually the group that just got the

Case 2:22-cv-00184-LCB-CWB Document 105 Filed 05/08/22 Page 111 of 210

1 psychological -- had significantly better psychosocial
2 functioning after six months of psychological support, okay?
3 However, despite scoring better at the following
4 evaluations, they did not show any further significant
13:45:47 5 improvement in their psychosocial functioning.
6 Did I read that right?
7 A Yes.
8 Q Also, the delayed eligible group continued to score lower
9 than a sample of children adolescents without observed
13:46:04 10 psychological psychiatric symptoms even after 18 months of
11 being in psychological support.
12 So what that's saying is after 18 months, they were still
13 below a group that did not have psychological therapy or
14 issues, correct?
13:46:20 15 A Yes.
16 Q On the contrary, the immediately eligible group, who at
17 baseline had a higher, but not significantly different
18 psychosocial functioning than the delayed eligible group, did
19 not show any significant improvement after six months of
13:46:40 20 psychological support. However -- and this is the key --
21 immediately eligible adolescents had a significantly higher
22 psychosocial functioning after 12 months of puberty suppression
23 compared to when they had received only psychological support.
24 Did I read that correctly?
13:47:03 25 A Yes.

1 Q Then you see at the top of this, there is a chart. And
2 when you look at this chart, the bottom is actually the three
3 different check-ins. Time zero is baseline, when the study
4 started, right?
13:47:18 5 A Yes.
6 Q Time one is the six-month check-in, correct?
7 A Yes.
8 Q And during that six months, both groups are getting just
9 psychotherapy, correct?
13:47:31 10 A Yes, I believe so.
11 Q The rest -- and just to orient us.
12 The red group, the red line is the group of adolescents
13 who only got psychotherapy or psychotherapy through the entire
14 18-month study, right?
13:47:46 15 A Yes.
16 Q The green line that you see that goes up -- goes up and
17 keeps going up, that is the line of adolescents who receive
18 puberty blockers; fair?
19 A Yes.
13:47:59 20 Q And so, Doctor, to get to the ultimate conclusion of this
21 study that you say shows that puberty blockers don't work or
22 don't give any improvement in mental condition over
23 psychotherapy, the conclusion, this study confirms the
24 effectiveness of puberty suppression for gender dysphoric
13:48:37 25 adolescents. Recently, a long-term follow-up evaluation of

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1 puberty suppression among gender dysphoric adolescents after
2 that CSHT, which is hormone therapy and GRS, which is puberty
3 blockers, has demonstrated that gender dysphoric adolescents
4 are able to maintain a good functioning into their adult years.
13:49:00 5 This present study, together with this previous research,
6 indicate that both psychological support and puberty
7 suppression enable young gender dysphoric individuals to reach
8 a psychosocial functioning comparable with their peers.
9 Did I read that conclusion correctly?
13:49:17 10 A Yes.
11 THE COURT: Ms. Eagan, when you reach a comfortable
12 spot, let's take a post-lunch break.
13 MS. EAGAN: Perfect. We're good, Judge. We can go
14 ahead and break now.
13:49:35 15 THE COURT: Okay. I will see you in 15 minutes.
16 (Recess.)
17 THE COURT: Go ahead, Ms. Eagan.
18 MS. EAGAN: Thank you, Your Honor.
19 BY MS. EAGAN:
14:09:00 20 Q Dr. Cantor, my understanding from paragraph 63 of your
21 declaration is that the other study that you point to in
22 support of your assertion that testing revealed that puberty
23 blockers did not improve mental health any more than mental
24 health does on its own is the Achille study you mentioned
14:09:29 25 earlier today; is that right?

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1 A Yes.
2 Q If you, please, sir, could turn to Plaintiffs' Exhibit 42
3 in that binder in front of you, and this would be the
4 plaintiffs' exhibits that we were looking at earlier.
14:09:42 5 A Yep. Got it.
6 Q All right. Is Plaintiffs' Exhibit 42 the Achille study
7 that we just mentioned?
8 A Yes.
9 Q All right.
14:09:59 10 MS. EAGAN: Your Honor, do you mind if I take this off
11 of this?
12 THE COURT: That's fine.
13 BY MS. EAGAN:
14 Q All right. I am going to -- so this is Plaintiffs'
14:10:15 15 Exhibit 42.
16 And the Achille study, again, was -- in this case if we
17 look at the abstract, the background of the study or the
18 purpose of the study was to examine the associations of
19 endocrine intervention puberty suppression and/or cross-sex
14:10:35 20 hormones therapy with depression and quality of life scores
21 over time in transgender youths.
22 That was the purpose of the study, correct?
23 A Yes.
24 Q And looking down to the results section, between 2013 and
14:10:56 25 2018 -- so this went over a five-year period, right?

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1 A Yes.
2 Q And there were 50 participants in the study, correct?
3 A That sounds right, yes.
4 Q All right. And that they received endocrine intervention
14:11:17 5 both -- some were in the form of puberty blockers, and some
6 were in the form of cross-sex hormones, but endocrine -- and
7 over that time period and completed three waves of
8 questionnaires.
9 Is that your recollection of this study?
14:11:30 10 A Yes, roughly.
11 Q Okay. And when that was -- with those treatments, mean
12 depression scores and suicidal ideation decreased over time,
13 which means their depression was -- went down, or they got
14 better. Suicidal ideation went down, which is improvement,
14:11:50 15 correct?
16 A Yes.
17 Q While mean quality of life scores improved over time.
18 And then it goes on to say, When controlling for
19 psychiatric medications and engagement in counseling,
14:12:03 20 regression analysis suggested improvement with endocrine
21 intervention. And then it goes on to say that this reached
22 significance in male to female participants. And the male to
23 female participants, those are ones that were receiving hormone
24 therapy, correct?
14:12:23 25 A I believe they were both receiving hormone therapy. It

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1 was not significant in one group, and so they're just reporting
2 the successful in the other and not reporting the nonsuccessful
3 group.
4 Q Well, let's talk about that. Let me pull up paragraph 63
14:12:39 5 of your declaration.
6 When you're discussing this study, here is what you said.
7 You said that upon follow-up, some incremental improvements
8 were noted; however, after -- so, in other words, upon
9 follow-up, they saw improvements.
14:13:07 10 But after statistically adjusting for psychiatric
11 medication and engagement and counseling, quote, most
12 predictors did not reach statistical significance.
13 And that's your basis -- that statement is your basis to
14 say there was not a statistical significance of difference
14:13:26 15 between just counseling versus with meds; is that right?
16 A I'm sorry. Could you say that part again?
17 Q The language that you seize onto, to say that puberty
18 blockers did not improve mental health more than mental
19 healthcare did on its own --
14:13:43 20 A Right.
21 Q -- was the statement in the study that most predictors did
22 not reach statistical significance.
23 A Well, I wouldn't say that I derived that just from that
24 sentence. It's just easier to convey that idea to readers by
14:13:56 25 using the sentence. My evaluation of the study is by those

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1 statistics directly.
2 Q All right. Let's go to the language in the study that
3 they talk about, the regression analysis that you were just
4 referencing there.
14:14:11 5 Okay. And this is here in the regression analysis.
6 Let me first say this: The mean changes over time. And
7 it does say, Mean depression scores decreased. Quality of life
8 improved, but did not reach statistical significance.
9 But then when you go on to the regression analysis, here
14:14:39 10 is what it says. It says, Given our modest sample size --
11 which in this case was 50 people, right?
12 A Yes.
13 Q Given our modest sample size, particularly when stratified
14 by gender, most predictors did not reach statistical
14:14:57 15 significance.
16 So one of the contributing factors to that, of course, was
17 the size of the number of participants, correct?
18 A Yes. In statistics, that's a truism. The precision of
19 the statistics is the direct -- direct result of the sample
14:15:20 20 size.
21 Q Okay. And then it goes on to say, That being said, effect
22 sizes values were notably large in many models. In the male to
23 female participants, only puberty suppression reached a
24 significance level. And it gives the number in one of the
14:15:43 25 sample -- one of the tests, and associations with the two other

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1 scores approached significance.
2 And then it goes on to say, For female to male
3 participants, only cross-sex hormone therapy approached
4 statistical significance.
14:15:57 5 All right. Statistical significance are not -- on all
6 planes, the numbers improved, correct?
7 A No. That's -- the very meaning of determining --
8 factoring in whether something is statistically significant or
9 not.
14:16:15 10 Q Ultimately, the writers of this study stated, if you look
11 at the next paragraph -- or look on the discussion part if you
12 want -- can you see the screen up here?
13 A Oh, I have the same thing on this screen.
14 Q Oh. You have got one. Okay, good.
14:16:31 15 Our results suggest that endocrine intervention is
16 associated with improved mental health among transgender youth.
17 Did I read that right?
18 A Yes. Those are their words.
19 Q Doctor, to be clear, you agree that the U.S.-based medical
14:17:15 20 association guidelines and position statements are in support
21 for the use of medical treatment combined with mental health
22 treatment for adolescents with gender dysphoria, correct?
23 A I don't think I would phrase it quite that strongly. Most
24 of the associations are using relatively vague terms. And it's
14:17:35 25 not clear when they're talking about adults or children, when

1 Q And the Dutch approach is also, I believe, what you call
2 that watchful waiting approach?
3 A No.
4 Q Okay. The Dutch approach is what is accepted -- I have
14:19:24 5 already said what you said.
6 The Dutch approach says social transition can happen at
7 age 12, puberty blockers may be prescribed at age 12, hormones
8 at age 16, and then resolve other mental health issues before
9 transition. That's the Dutch method?
14:19:43 10 A Yes.
11 Q Do you know how that approach aligns with protocols that
12 are utilized at UAB Children's in Alabama?
13 A I don't know.
14 Q In any event, what you say is internationally the most
14:20:03 15 widely-respected and utilized method for treatment of children
16 who present with gender dysphoria, you would agree that that
17 approach would be a felony in Alabama with this new law,
18 correct?
19 A Yes. It's true that the Alabama law didn't leave an
14:20:26 20 exception for research purposes.
21 Q Okay. So let's talk about the European countries that you
22 mentioned very briefly, the UK, Finland, Sweden and France.
23 When you look at those four European countries, Doctor,
24 not one of them has enacted a ban to puberty blockers and
14:20:46 25 hormone treatments as Alabama has done here, correct?

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1 A No.
2 Q That's not correct?
3 A Correct. That is not correct.
4 Q UK has not fully banned puberty blockers and hormone
14:21:00 5 treatments in youth 18 and younger?
6 A That's correct.
7 Q Finland has not banned -- let me ask it this way: Has
8 Finland banned blockers and hormone treatments in youth ages 18
9 and under for gender dysphoria?
14:21:16 10 A Yes, I believe it has.
11 Q It has?
12 A I believe so.
13 Q A blanket ban? Should I refer you to paragraph 131 of
14 your declaration, sir?
14:21:47 15 A Hang on. That's just where I am now.
16 Q Okay.
17 A Oh, yes, they did leave an exception for hormones. The
18 total ban was on surgery.
19 Q Thank you, sir.
14:22:05 20 Sweden, has Sweden put an absolute ban on puberty
21 blockers?
22 A Yes.
23 Q And bear with me. Have they put a ban on puberty blockers
24 and hormone treatments in youth ages 18 and under for gender
14:22:23 25 dysphoria in Sweden?

1 A 18 and under?
2 Q Yes, sir.
3 A No. They allowed exceptions for 16 year olds -- 16 year
4 olds within research circumstances.
14:22:32 5 Q Has France banned the use of puberty blockers and hormone
6 treatments for adolescents ages 18 and under?
7 A No.
8 Q Can you point me to a single country, Doctor, in Europe
9 that has put a blanket ban on the use of puberty blockers or
14:22:50 10 hormone treatments for youth ages 18 and under for gender
11 dysphoria?
12 A Blanket ban in the way you're describing it, no.
13 THE COURT: How about any country?
14 THE WITNESS: No, not that I know of.
14:23:04 15 BY MS. EAGAN:
16 Q I want to turn very briefly to the subject of -- I will
17 use your word desistance.
18 If you turn to paragraph 36 of your declaration.
19 A Yes.
14:23:36 20 Q In that -- you state, Among prepubescent children who feel
21 gender dysphoric, the majority cease to want to be the other
22 gender over the course of puberty ranging from 61 to 80 percent
23 desistance across the large prospective studies.
24 I know that's a point that you also raised earlier today.
14:23:59 25 So I want to ask this question: Of those that number, do

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1 you know, Doctor, what percentage of those kids cease to want
2 to be the other gender -- that's using your words -- before or
3 as they enter puberty, in other words, before they actually get
4 into puberty? Do you know how many of those desisters are in
14:24:27 5 that window?
6 A I must not be understanding your question, because it
7 makes me want to say the same number that's in the report, 61
8 to 88 percent. What's different from what I said and what
9 you're asking?
14:24:39 10 Q The 61 to 88 percent, is that children that realign with
11 their birth sex before -- or as they're entering into puberty,
12 that's that number?
13 A Yes.
14 Q Okay. All right. So I want to focus on a different
14:25:01 15 category of youth. Let me ask you this: The medications in
16 the United States, puberty blockers and hormone treatments
17 cannot be given to kids for gender dysphoria until after
18 they've actually entered into puberty, correct?
19 A Very many clinics are doing it as close to the beginning
14:25:23 20 as soon as puberty starts as they are able.
21 Q But it's once they have entered puberty?
22 A Yes.
23 Q So let me ask you about that category of youth.
24 And that is adolescents who have entered into puberty,
14:25:38 25 okay, and who have been -- have suffered from gender dysphoria

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1 persistently, consistently, and insistently in childhood
2 leading up to puberty, okay?
3 A Okay.
4 Q Do you have any data regarding what percentage of those
14:25:58 5 individuals desist after they enter into puberty?
6 A No. I don't think that level of follow-up has yet been
7 conducted.
8 Q And, Doctor, in fact, it's your belief that the
9 majority -- that while the majority of prepubescent kids cease
14:26:35 10 to feel trans, you know, to puberty or during puberty, in other
11 words, as they enter into puberty, the majority of kids who
12 continue to feel trans after puberty rarely cease?
13 A That does seem to be the case, yes.
14 Q Okay. Doctor, are you being paid to be here to testify
14:27:10 15 today?
16 A Yes.
17 Q What's your rate?
18 A 400 an hour.
19 Q Who is paying your fees?
14:27:14 20 A The Alabama state -- State of Alabama.
21 Q Okay. Dr. Cantor, have you attempted to recruit parents
22 in Alabama whose children have gender dysphoria and were
23 prescribed or referred to gender-affirmative treatments, have
24 you tried to recruit them to give a witness statement in this
14:27:38 25 case that they believe the treatments are harmful?

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1 A No.
2 Q Do you tweet?
3 A Yes.
4 MS. EAGAN: Your Honor, may I approach?
14:27:49 5 THE COURT: Yes.
6 BY MS. EAGAN:
7 Q Doctor, I've marked as Plaintiffs' Exhibit 45 a tweet
8 Dr. James Cantor retweeted. And it's -- let me say this: Is
9 this a tweet that you actually did?
14:28:40 10 A No. I --
11 Q You retweeted?
12 A Retweeted, exactly.
13 Q From a group called Genspect, or what's -- I don't tweet.
14 Would you call that a group? I guess it's a group called
14:28:56 15 Genspect?
16 A It's there is a group called Genspect, and this is their
17 Twitter account.
18 Q All right. And then you retweeted it?
19 A Yes.
14:29:03 20 Q And it says, Urgent. Attention. Alabama parents, if your
21 child experienced gender dysphoria and was prescribed or
22 referred to gender-affirmative treatments and you believe these
23 treatments are harmful, please direct message, e-mail us at
24 once. We are looking for witness statements. Can be anon.
14:29:26 25 By anon, I guess that means anonymous, correct?

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1 A That would be my reading, yes.
2 Q All right. Doctor, have you seen a sworn statement under
3 penalty of perjury for any Alabama parent whose kid received
4 puberty blockers or hormones and the parent said the
14:29:50 5 medications hurt their kid more than they helped them?
6 A I'm sorry. Did you ask have I seen such a statement?
7 Q Yes, sir.
8 A Not that I recall.
9 MS. EAGAN: Nothing further.
14:30:05 10 THE COURT: Any redirect?
11 MR. DAVIS: Short.
12 THE COURT: Ms. Eagan, did you intend to offer that
13 into evidence or no?
14 MS. EAGAN: Oh, yes. Thank you, Judge. I offer
14:30:37 15 Plaintiffs' Exhibit 45.
16 THE COURT: It will be admitted.
17 REDIRECT EXAMINATION
18 BY MR. DAVIS:
19 Q Dr. Cantor?
14:30:51 20 A Hi.
21 Q Is it true as a clinician you are not treating anyone who
22 has presented with gender dysphoria as an adult or as a child?
23 A I treat adults with gender dysphoria, not children.
24 Q You are not treating them while they are adolescents or
14:31:09 25 children, you are not currently treating someone who is like

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1 CERTIFICATE
2
3
4 I certify that the foregoing is a correct
5 transcript from the record of proceedings in the
6 above-entitled matter.
7
8
9
10
11 [signature] 05-08-2022
12 Christina K. Decker, RMR, CRR Date
13 Federal Official Court Reporter
14 ACCR#: 255
15
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IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

CASE NO. 4:20-cv-00020-MW/MAF

JAMI CLAIRE, KATHRYN LANE and
AHMIR MURPHY,

Plaintiffs,

vs.

FLORIDA DEPARTMENT OF
MANAGEMENT SERVICES, et al,

Defendants.

ZOOMED DEPOSITION OF STEPHEN B. LEVINE, M.D.

Monday, December 21, 2020

9:30 a.m. - 2:51 p.m.

Via Zoom

Tallahassee, Florida 32308

STENOGRAPHICALLY REPORTED BY:

SANDRA L. NARGIZ
RPR, CM, CRR, CRC, FPR, CCR-GA

Job No. 166551

Pl. Trial Ex. 085

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2 WITNESS PAGE
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4 Cross Examination by Ms. Coles 171
5
6
7
8 (STENOGRAPHER'S NOTE: Exhibits were received premarked electronically; only Exhibits 1, 2, 3, 7,
9 10, 11 and 13 were referred to in deposition.)
10
11 INDEX OF EXHIBITS
12

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1 **right?**

2 A No, that is. I think -- we'll quibble

3 over the word only. If you use the word

4 predominantly, I would say they are predominantly

5 taking care of. They are a specialty clinic for the

6 transgender.

7 **Q So predominantly treating transgender**

8 **people, but not 100 percent?**

9 A That's my guess.

10 **Q Okay. What sorts of treatments do you**

11 **provide for your patients with gender dysphoria?**

12 A Psychiatric evaluation of the patient and

13 the family, the parents and the other siblings;

14 psychotherapy to further the process of

15 understanding this whole phenomenon; recommendations

16 for hormones and occasionally recommendations for --

17 depending on the biologic sex of the patient, for

18 genital or breast surgery.

19 **Q How many patients have you recommended**

20 **hormone therapy for?**

21 A You mean over 47 years?

22 **Q Let's start with the 47 years, yeah.**

23 A I don't know. Can I give you a gross

24 estimate?

25 **Q Sure.**

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1 to be directed to the surgeon.

2 Q Okay. If a surgeon told you I require a
3 letter for this facial feminization surgery, are
4 there circumstances under which you could see
5 yourself providing a letter, not of recommendation
6 but of authorization, for a person to receive this
7 surgery from the surgeon?

8 A I could see myself under certain
9 circumstances, if I understood the patient's motives
10 and had a lot of time to discover and discuss this,
11 the history and alternative approaches and wondering
12 about the psychology of wanting this, I could see
13 theoretically.
14 That's what I do, you know, as a
15 psychiatrist; I am trying to investigate the meaning
16 of the wish and the solution that the patient is
17 hoping for, the problem the patient is hoping this
18 would be a solution for.
19 And so I want to be able to consider this
20 and have a respectful, mutual, slow dialogue that is
21 slow, meaning multiple sessions, to consider the
22 nuances of this because, you know, all of us have a
23 self-concept of how handsome we are or pretty we
24 are, and most everyone wants to get a little more
25 handsome and a little more pretty and we are -- we

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1 **Q Okay.**
2 A I believe that if a surgeon is going to do
3 this, he ought to know what I think -- what I know
4 about the person's history and the person's
5 intellectual capacities and the prices they paid for
6 their gender dysphoria already.
7 For example, the loss of a family and no
8 relations to children, or the inability to have a
9 relationship, an intimate relationship with other
10 people. I believe the surgeon needs to have an
11 understanding of the person.
12 I don't have an understanding whatsoever
13 of the techniques of surgery. You see? I am just a
14 psychiatrist. And the psychiatrist -- and the
15 surgeon has very little understanding of how a
16 person got to be in his office. And I believe that
17 the letters of recommendation should capture the
18 humanness of this person and the desperation of this
19 person and the justification that the person uses
20 and the hopes they have for this surgery. But
21 that's Levine, you know.
22 **Q I want to show you the WPATH Centers of**
23 **Care section that discusses letters. This is**
24 **Exhibit 7 which we are going to put on the screen.**
25

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1 (Exhibit 7 was marked for identification.)
2 BY MR. TILLEY:
3 **Q Let's go to page 27. It looks like the**
4 **document page 27, it's .pdf page 33, Bates stamp**
5 **PL 0450524.**
6 **You see, Dr. Levine --**
7 MS. COLES: Can you read that, Dr. Levine?
8 It looks a little small on my computer.
9 THE WITNESS: I can read it. It says
10 referral for surgery.
11 MS. COLES: Okay. Just making sure.
12 BY MR. TILLEY:
13 **Q At the bottom, I am going to start there**
14 **and then we'll go on to the following page. At the**
15 **bottom it says, The recommended content of the**
16 **referral letters for surgery is as follows: 1, the**
17 **client's general identifying characteristics -- now**
18 **we are continuing on to the next page -- number 2,**
19 **results of the client's psychosocial assessment,**
20 **including any diagnoses.**
21 **And then it goes on to 3, 4, 5, and 6.**
22 **Dr. Levine, can you just review those if**
23 **you can read it and then let me know if you agree**
24 **with those statements.**
25 (Short pause.)

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1 A I don't disagree with the statements, but
2 each of those statements, of course, need to be
3 operationalized by the letter writer. For example,
4 the first one, identifying characteristics,
5 oftentimes identifying characteristics would be like
6 this is a 63-year-old Caucasian veterinarian. But
7 there are many other identifying characteristics
8 that might be included.
9 So you can interpret these things with
10 terse statements or elaborate statements. I favor
11 elaborate statements. For example, I would like to
12 say a divorced father of four, or a roller derby
13 official. I would like to identify him as much as a
14 person as possible. But in the history of medicine,
15 race, age, and nourishment passes for identifying
16 information.
17 So the results of the psychosocial
18 assessment, including any diagnosis. Psychosocial
19 assessment would be the processes in his life
20 history, including any current or past diagnoses,
21 you see. So substance abuse might be a very
22 important part of number 2.; and the duration. So
23 if I am writing a letter, if I am one of two people
24 who have been hired to write a letter for genital
25 surgery, and I might have had three visits with the

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1 not inquiring about your medical history and your
2 psychiatric history. But it may be psychologically
3 beneficial to you and an M.D. may recommend that you
4 do that. And that recommendation would be based on
5 his or her knowledge that you are likely to suffer
6 from seasonal affective disorder, and the treatment
7 is bright lights and sunshine. And sunshine would
8 be far superior because of its luminescence, the
9 number of lumens exposed, than bright lights.
10 BY MR. TILLEY:
11 Q Let's go back just briefly to WPATH. And
12 I know you mentioned you have a more conservative
13 approach. So let me ask you this.
14 Is it fair to say that if you personally
15 believed that you would authorize hormones or
16 surgery for someone with gender dysphoria, someone
17 following the WPATH Standards of Care would also
18 believe that?
19 A Yes.
20 Q Okay. Let's talk about insurance for a
21 little bit. If you recommended that -- if you
22 authorized some form of treatment for gender
23 dysphoria, whether it be hormones or some form of
24 surgery, would you expect that that treatment would
25 be covered by your patient's insurance?

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1 You see?

2 So I am saying, please, let me talk to you

3 about human beings here and how important having

4 ongoing lifelong relations with one's children are

5 and being a grandfather or grandmother, and being

6 connected to a family of origin. I am not talking

7 about categorical bans. I am talking about being

8 smart.

9 BY MR. TILLEY:

10 Q Are you aware that this case concerns an

11 insurance exclusion that is categorical at

12 preventing --

13 MS. COLES: Form.

14 BY MR. TILLEY:

15 Q -- hormones and surgery as a treatment for

16 gender dysphoria?

17 MS. COLES: Form.

18 A I am aware that your plaintiffs are suing

19 to get coverage for -- that is not provided by their

20 particular insurance. I am aware of that.

21 BY MR. TILLEY:

22 Q Do you think that exclusion is

23 appropriate?

24 MS. COLES: Form.

25 A I've already answered that question, I

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1 believe.

2 BY MR. TILLEY:

3 **Q What is the answer?**

4 A That it's a political decision that varies

5 from state to state, and it belongs to the process

6 of political science and the courts and not doctors.

7 **Q And if you yourself were treating them and**

8 **determined that they understood the risks and you**

9 **thought the treatment would be psychologically**

10 **beneficial and provided letters of authorization to**

11 **them, you would want that treatment to be covered by**

12 **insurance; is that correct?**

13 MS. COLES: Form.

14 A I am an agent of the patient, I want

15 what's best for the patient, and especially if the

16 patient couldn't otherwise afford it, I would wish

17 for my patient to have it, yes.

18 BY MR. TILLEY:

19 **Q I know you said you are not about**

20 **categorical bans, but let me ask you about minors**

21 **again.**

22 **Would you support a categorical ban on**

23 **access to puberty blockers to treat gender**

24 **dysphoria?**

25 MS. COLES: Form.

1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
3 HUNTINGTON DIVISION
4 ---
5 Christopher Fain, individually and on behalf of all
6 others similarly situated, et al.,
7 Plaintiffs,
8 vs. CIVIL ACTION NO. 3:20-cv-00740
9 William Crouch, et al.,
10 Defendants.
11 ---
12
13
14 REMOTE VIDEOTAPED DEPOSITION OF DR. STEPHEN LEVINE
15
16
17
18 DATE: April 27, 2022
19 TIME: 8:00 a.m. CST
20 PLACE: Veritext Virtual Videoconference
21
22
23
24 REPORTED BY: KELLEY E. ZILLES, RPR (Via Videoconference)
25 JOB NUMBER: 5176996

Pl. Trial Ex. 086

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1 of your career, right?
2 A. Yes.
3 Q. Okay. You listed 23 separate pharmaceutical
4 company grants to study various pro-sexual medications,
5 right?
6 A. Yes.
7 Q. Were any of these 23 grants related to the
8 treatment of gender dysphoria in transgender people?
9 A. No.
10 Q. And were any of the grants related to the
11 treatment, any kind of treatment of prepubertal children
12 with gender dysphoria?
13 A. No.
14 Q. Or adolescents with gender dysphoria?
15 A. No.
16 Q. You also list in that same section in your
17 report, Dr. Levine, that you received a U.S. National
18 Institute of Health grant for the study of sexual
19 consequences of systemic lupus erythematosus and that
20 you were a co-principle investigator. Does that ring a
21 bell, is that accurate?
22 A. It is accurate.
23 Q. Okay. And did this grant have to do with the
24 study of anything related to gender dysphoria?
25 A. No.

1 A. Only to the extent that the grant helped us to
2 set up the Center For Marital & Sexual Health. The
3 Center For Marital & Sexual Health had a program called
4 the Case Western Reserve Gender Identity Clinic, and so
5 this was, this was not a grant for research, this was a
6 grant for the establishment, the administrative
7 establishment of our center that dealt with many sexual,
8 all sexual things including trans phenomenon. We didn't
9 in those days call it so much trans phenomenon, but we
10 called it gender identity problems.
11 Q. Right. So one of the grants was used to start
12 the Center for Marital & Sexual Health, but those five
13 separate grants were not for the study or, or direct
14 treatment under the Sihler Mental Health Foundation?
15 A. That's correct.
16 Q. Okay. But the Center For Marital & Sexual
17 Health, as a clinician there you saw a wide range of
18 patients there, right?
19 A. Yes.
20 Q. With a variety of problems related to sexuality
21 or sexual well-being?
22 A. Yes.
23 Q. Okay. And did you treat any children with
24 gender dysphoria at the Center For Marital & Sexual
25 Health?

1 A. If I can clarify your question, by you do you
2 mean me personally or do you mean under me as the
3 supervisor of people who did that?
4 Q. Let's start with you personally.
5 A. Yes, I have only on a rare occasion personally
6 treated or directly or indirectly treated a child. My
7 center, however, over the years has, has seen children
8 and, and I've been involved in the, the treatment as a
9 supervisor of those children.
10 Q. Okay. So you've reviewed their cases by way of
11 your supervision of clinicians at the center, but not
12 individually?
13 A. That's right.
14 Q. Okay. And is that the same for any adolescents
15 with gender dysphoria who were seen at the center? In
16 the early years I'm talking about now, not in recent
17 times.
18 A. Well, in the early years I occasionally saw
19 personally an older teenager, older adolescent, but in
20 the early years you must understand most of the patients
21 were adults.
22 Q. Okay. So to your knowledge, Dr. Levine, have
23 you received any grants to study the treatment -- I'm
24 sorry, excuse me. Have you received any grants to study
25 treatment for adults with gender dysphoria?

1 April 27, 2022. We're going back on the record at
2 10:36 a.m.
3 BY MR. CHARLES:
4 Q. Okay. Dr. Levine, talking about your writing
5 credentials, you've testified previously that you were
6 involved in drafting portions of the WPATH standards of
7 care Version 5, right?
8 A. Yes, I was the chairman of that group.
9 Q. And besides that, have you developed -- let me
10 back up. Have you helped to develop treatment
11 guidelines for the treatment of children or adolescents
12 with gender identity issues?
13 A. If you mean have I been part of a national or
14 international group that tried to, to publish, that
15 published guidelines about the treatment of these
16 individuals, the answer is no. But in my November of
17 2021 article I gave, I offered my opinions about what
18 the evaluation of adolescents and children ought to
19 consist of. In that sense I'm hoping that would
20 influence the guidelines of those committees who might
21 function in the future.
22 Q. I see. When we spoke in September of 2021 for
23 the Kadel vs. Folwell deposition, you said that you were
24 working with SEGM to develop some treatment guidelines.
25 What, what happened to those?

1 Q. Yes, Exhibit 01.
2 A. Would you give me the pages again.
3 Q. Sure, Page 2, Paragraph 3, so that will be the
4 top of Page 2, the paragraph does begin on Page 1.
5 A. Yeah.
6 Q. Okay. So in that paragraph your report states
7 that, "During this era an occasional child was seen."
8 By this era do you mean from around 1974 to 1993?
9 A. Yes.
10 Q. Okay. And by occasional do you mean infrequent?
11 A. Infrequent is a good word.
12 Q. So is it fair to say during that period your
13 clinic did not see many children with gender dysphoria?
14 A. It's fair to say that.
15 Q. And in your deposition on March 30th you
16 estimated that over the course of your career you've
17 probably only seen regularly six prepubertal children,
18 right?
19 A. It's an estimate, yes.
20 Q. And around 50 adolescents, give or take?
21 A. Give or take an unknown number, yeah, ten, 12,
22 five.
23 Q. Sorry, so you --
24 A. I've had extensive experience talking to
25 adolescents over the course of my career, adolescents

1 A. Page 51.
2 Q. Okay. Can you please scroll to Page 55.
3 A. I'm there.
4 Q. Okay. So at line 13 on Page 55, "Question,
5 okay, and I'm sorry, just by recent, when was the last
6 time you wrote a letter of authorization for a gender
7 affirming surgery for an adult? Answer, probably
8 12 months ago." So have you written a letter of
9 authorization for a gender affirming surgery in the last
10 seven months, Dr. Levine?
11 A. I think the last letter -- you, I need to, I
12 need to help you qualify your question. I have in the
13 last seven months given my, my approval to several
14 letters for bilateral mastectomies for members in Mass
15 at Framingham, the correctional institution in
16 Massachusetts. I don't know if that would number two or
17 three, but since September the 10th I believe at least
18 two and possibly three letters. I haven't personally
19 written the letter, but I am the consultant to a group
20 of team that approves such surgeries, and so the answer
21 to the question is yes.
22 Q. Okay. Thank you. And to your recollection,
23 any, any such letter outside the, outside of that
24 context?
25 A. Since September the 10th?

1 Q. That's correct, yes.
2 A. Yes, I think the answer is that, no, but I
3 believe at our center someone else has written one
4 letter for bilateral mastectomies.
5 Q. Okay. Thank you. Dr. Levine, are you familiar
6 with the, the exclusion for gender affirming surgical
7 care in the West Virginia Medicaid Program that's at
8 issue in this case?
9 MR. DAVID: Objection to form.
10 Q. You can answer.
11 A. I'm vaguely familiar that surgical care is
12 excluded currently, but endocrine care is not excluded.
13 Q. Have you reviewed any documents that, that show
14 that exclusion or was that information just communicated
15 to you by counsel?
16 A. Verbally communicated.
17 Q. Okay. And so you're aware that there are
18 categorical exclusions, which means that the exclusions
19 prohibit surgical care related to the treatment of
20 gender dysphoria regardless of a West Virginia Medicaid
21 member's need for it or appropriateness for such
22 intervention?
23 MR. DAVID: Objection to form.
24 Q. Let me simplify my question.
25 A. Thank you.

1 Q. The categorical, the exclusion does not
2 investigate or contemplate whether someone receiving
3 West Virginia Medicaid needs or is an appropriate
4 candidate for such intervention, it just prohibits it,
5 period?
6 MR. DAVID: Objection to form.
7 A. The categorical exclusion would include surgery
8 for teenagers and surgery for adults, so it would cover
9 removing the breasts or removing the scrotum of a
10 15-year-old who feels like --
11 Q. Not my question, Dr. Levine. Let me, let me
12 rephrase again. The, the West Virginia Medicaid Program
13 and the exclusion it maintains, which excludes surgical
14 care for members for whom it is appropriate, it, it just
15 excludes it, you're, you're aware it just excludes it,
16 there's no, there's no conditional considerations or any
17 investigation done into the member's health at all, it
18 just, there's no coverage for that care, you understand
19 that?
20 A. I, I --
21 MR. DAVID: Objection to form.
22 A. I think that's what categorical means, so I
23 think the answer is I understand that at the moment,
24 yes.
25 Q. Okay. But you don't view your testimony here in

1 your expert report as being in support of that exclusion
2 or whether it should exist, right?
3 A. Yeah, it's my understanding that, that the
4 lawyers who hired me wanted me to testify to the state
5 of science in this field, and, and so I have not been
6 involved with the legal questions, per se, or giving an
7 opinion about those matters. As I sort of indicated to
8 you before, I don't really feel that the, my expertise
9 extends to how the insurance industry works and how
10 governments and legislatives works and so forth. So I,
11 I think the answer to the question is that I'm not
12 considering myself to be expert on the question that
13 you're asking me.
14 Q. Right. So you're, you, you are an expert about
15 what your testimony is about though, right, and you're
16 saying your testimony is not about whether or not that
17 exclusion should exist?
18 A. Yes, I'm not offering an opinion about pro or
19 con about that question.
20 Q. I see. Because you're, you're, as you say,
21 you're not a politician or a law maker?
22 A. Or an insurance expert.
23 Q. Right. Or a public health expert, right?
24 A. Well, I'm a little more ambivalent about public
25 health matters, yeah. I'm not as, I'm not, I really

1 think that public health is the issue here and so I, I
2 don't want to say I'm not an expert. I'm not an expert
3 in public health, but I do have opinions about the
4 long-term public health of people who are prematurely
5 having their bodies changed because I do think this has
6 public health implications for the future of each of
7 these, these adolescence children and young adults.
8 Q. Understood.
9 A. And adults as well.
10 Q. And you, generally speaking, don't advocate to
11 deny all forms of medical intervention to people with
12 gender dysphoria though, right?
13 A. That's right.
14 Q. Okay. I'm going to introduce another exhibit,
15 Dr. Levine, give me just a moment.
16 (Exhibit 6 marked for identification.)
17 Q. Okay. It should be now or shortly visible, you
18 might need to refresh.
19 A. I now have Exhibit 6 here.
20 Q. Okay.
21 MR. CHARLES: So I'm showing Dr. Levine
22 what has been marked as SL06.
23 Q. Dr. Levine, this is a short document, please
24 just take a minute and scroll through it.
25 A. Okay, I, I've scrolled.

1 (A break was taken at 11:33 a.m.)
2 VIDEO TECHNICIAN: We're going back on the
3 record at 12:34 p.m.
4 MR. CHARLES: Okay. So I'm showing Dr.
5 Levine what has been marked as SL09, an article from
6 Society for Evidence Based Gender Medicine entitled,
7 "One year since Finland broke with WPATH standards of
8 care."
9 BY MR. CHARLES:
10 Q. Dr. Levine, do you see the date of publication
11 in the left corner of that first page?
12 A. July 2nd.
13 Q. And, and the year is 2021, right?
14 A. Yes.
15 Q. So looking at the first paragraph there, I'm
16 just going to read that, "A year ago the Finnish Health
17 Authority (PALKO/COHERE) deviated from WPATH standards
18 of care 7 by issuing new guidelines that state that
19 psychotherapy rather than puberty blockers and cross sex
20 hormones should be a first line treatment for gender
21 dysphoric youth. This change occurred following a
22 systematic evidence review which found a body of
23 evidence for pediatric transition inconclusive."
24 And then the next paragraph, the first sentence,
25 "Although pediatric medical transition is still allowed

1 in Finland, the guidelines urge caution given the
2 unclear nature of the benefits and the interventions,
3 largely reserving puberty blockers and cross sex
4 hormones for minors with early onset gender dysphoria
5 and no co-occurring mental health conditions." Did I
6 read that correctly?
7 A. Yes, you did.
8 Q. Okay. So as this article states, medical
9 interventions are still available in Finland for youth
10 experiencing gender dysphoria, right?
11 A. On a case-by-case basis I think.
12 Q. And --
13 A. I should say on a case-by-case basis and two
14 research centers as opposed to in any practitioner's
15 office throughout the country.
16 Q. Right. But it's, it's not been completely
17 prohibited is what I'm asking?
18 A. Oh, it's been, it's been, the brakes have been
19 put on.
20 Q. But it's not been completely prohibited is what
21 I'm asking?
22 A. That's what you and I have agreed on, yes.
23 Q. So it's not been completely prohibited, right?
24 A. Right.
25 Q. So then in the third paragraph beginning with,

1 "The qualifying criteria for gender reassignment of
2 youth articulated in the 2020 Finnish treatment
3 guidelines are consistent with the original Dutch
4 protocol, but represent a significant tightening of the
5 more recent practices promoted by WPATH." So the
6 article describes it as a tightening of the standards
7 which WPATH allows for, right?
8 A. Yes.
9 Q. So you, you've talked about in your report an
10 idea of rapid affirmation treatment where you allege
11 that diagnoses of gender dysphoria are being made in an
12 hour and then, and then prescriptions provided for
13 medical interventions, right?
14 A. Yes.
15 Q. Do you have, or I should say, your evidence for
16 that is anecdotal in nature, right?
17 A. My evidence for that is what has been told to me
18 by parents, what has been told to me by patients and
19 what this, what the third paragraph of this document
20 says.
21 Q. Right. So --
22 A. So I don't really think the answer is simply
23 anecdotal, it's based upon a considerable consistent
24 range of, of experiences, both of my personal
25 experiences, of my patient's personal experiences, and

1 paragraph -- actually, hang on a second. Dr. Levine,
2 let's go ahead and go to Page 26 of your report,
3 Exhibit 1.
4 A. Okay. Let me, I have to scroll back. Did you
5 say page or Paragraph 26?
6 Q. That would be Page 26.
7 A. Okay, I'm on Page 26.
8 Q. Okay. Okay. So, Dr. Levine, you've testified
9 previously that you generally provide care along some of
10 the same guidelines as WPATH, right?
11 A. In a general way, sure.
12 Q. And the difference from your view is that you
13 require psychotherapy for some not necessarily
14 predetermined length of time for patients that you see
15 before you will authorize any kind of like medical
16 intervention, right?
17 A. I don't want to answer that question right or
18 wrong because embedded in the question is the word
19 psychotherapy and I don't know what you understand by
20 psychotherapy, I mean, you're a lawyer and I'm a
21 practitioner of psychotherapy. And I think when a
22 lawyer uses psychotherapy it is a certain concept about
23 I'm trying to achieve a certain aim, you see. And in
24 the context of the question that you've asked, you could
25 substitute an extended period of time with the patient

1 working with patients.
2 Q. Okay. So back to my question. On some, on some
3 level that that is, that universe of care that you are
4 providing, which again, I think I'm still going to call
5 it psychotherapy, but I understand your explanation that
6 it is, that encompasses a lot that you do in your, in
7 your clinical practice, but again, the difference for
8 you between the Levine way, if we can shorthand, and
9 WPATH is that you cultivate, you engage in that process
10 as a requirement before you will authorize any kind of
11 medical intervention for a patient for the treatment of
12 gender dysphoria?
13 A. That's true.
14 Q. Okay. Thank you. But even still as a part of
15 your practice as we discussed earlier, you still
16 occasionally write letters of authorization for medical
17 interventions, like endocrine treatments or surgical
18 interventions?
19 A. Yes.
20 Q. Okay. Okay. Let's go back to your report,
21 please, to Page 35.
22 A. I am there.
23 Q. Okay. And looking at Paragraph 70, let's start
24 with Paragraph 70. I take that back, let's go with
25 Paragraph 71 at the bottom of the page, "In recent years

1 WPATH has fully adopted some mix of the medical and
2 rights paradigm discussed above. It has downgraded the
3 role of counseling or psychotherapy as a requirement for
4 these life-changing processes. WPATH no longer
5 considers pre-operative psychotherapy to be a
6 requirement. It is important to WPATH if the person has
7 gender dysphoria, the pathway to the true, the
8 development of this state is not. Cited Levine,
9 Reflections, at 240. Two separate evaluations, one from
10 Canada and one from the UK reviewed WPATH's guidelines
11 and found them untrustworthy."
12 So for that footnote 113 you've cited the Dahlen
13 study which we talked about and then there's also a
14 citation here that says, "See also," and then there's a,
15 a Web address, do you see that, the very last line?
16 A. Yeah, yeah, right.
17 Q. It says, "Gender report, CA"?
18 A. Yeah.
19 (Exhibit 13 marked for identification.)
20 Q. Okay. There should be another exhibit there for
21 you, Exhibit 13. Just let me know when you can see
22 that.
23 A. Okay. Okay.
24 Q. Okay.
25 A. Yeah, okay.

1 Q. Have you, have you seen this article before
2 either on the Internet or printed out perhaps?
3 A. The reason I cited it is that I had read it
4 before.
5 Q. Okay. And this is not a peer reviewed journal,
6 is it?
7 A. This is a journalist, but if you look very
8 carefully at the, its length and its content, it's very
9 impressive.
10 Q. Okay. Is this the review from Canada that you
11 were talking about in that sentence --
12 A. Yes, yes, it is.
13 Q. Okay. But it's, it's not a systematic review
14 like the one from the UK?
15 A. It's not systematic in that it wasn't done by a
16 community of scientists, a committee of scientists.
17 Q. Okay. And the --
18 A. It is systematic and it is a review, but it's
19 one person's review.
20 Q. Right. So it's more, we were discussing the
21 difference between systematic reviews earlier today,
22 it's a, it's, it's not a scientific committee that's
23 done in a, in a formal way that we were discussing, it's
24 more akin to that latter one person reviewing things
25 kind of --

1 A. It's an investigative report by a journalist.
2 Q. Right. And you see in the first page, Dr.
3 Levine, it says, "The following investigative report was
4 developed by @LisaMacRichards (a pseudonym)"?
5 A. Yeah, okay, right.
6 Q. Okay.
7 A. I see I'm wrong, she wasn't the journalist.
8 Q. So we, you don't know who this author is, right?
9 A. Well, her real identity?
10 Q. Correct, yeah.
11 A. No, I don't know who Lisa Mac Richards really
12 is.
13 Q. Okay. So it's hard to know if she's an actual
14 person?
15 A. If she's an actual person, is that what you
16 said?
17 Q. What I mean to say is, because she's using a
18 pseudonym, you can't confirm her identity is what she
19 represents it is, right?
20 A. Well, she says it's a pseudonym, so I presume
21 the rest of the paragraph is correct, that she works at
22 a Canadian hospital and holds a master's of science
23 degree and, yeah.
24 Q. But what I mean is there's no way to confirm
25 that because we don't know what her name is?

1 A. It could be written by a man, I don't know, it
2 could be written by a committee, I have no idea.
3 Q. Okay. Okay. So going back to what we were
4 talking about just a few minutes ago, Dr. Levine, about
5 your approach versus WPATH. You, you've said before,
6 not, not necessarily today, but you've testified in
7 other depositions that your approach has the limitation
8 that there's not any scientific evidence or long-term
9 studies to support it, right?
10 A. I think in particular what I said is that, that
11 the status of the outcome, the outcome status and the
12 methodologic status of psychotherapy as a first line
13 approach to the trans adolescent has, does not have a
14 firm evidence base just as trans affirmative care does
15 not have a firm evidence base.
16 So oftentimes that's, that's, I get a question
17 just like you ask, you just posed sort of implying that
18 there's no evidence that my, my recommendations have a
19 scientific proven basis to it. And that is correct,
20 except that all other psychiatric difficulties are
21 treated with, in our society both European and American
22 and Asian societies by a psychotherapeutic extended
23 evaluation and treatment approach before, with or
24 without psychiatric medications, you see.
25 And so we are trying to make a, you, some people

1 centers have cropped up that are providing affirming
2 care in one hour, again, we talked about the 35 parents
3 you had talked to, you've mentioned a couple of patients
4 you've talked to, but you don't have, or I should say
5 what evidence can you provide me today that is, is
6 scientific peer reviewed published data showing that
7 this is actually what's happening in these clinics?
8 A. Well, if I look at Exhibit 6. Do you know what
9 the, the first name for this center was and the name of
10 so many of the 50 or so centers are? And it has the
11 term gender affirming care, the clinic, you see. If you
12 look at all of the materials in Exhibit 6, it's about
13 support and affirmation, it's not about investigation,
14 it's not about psychotherapy. And, and you see, gender
15 affirming care has been taken over, it's been taking
16 over the world's sensibilities without any scientific,
17 first demonstrating its efficacy with scientifically
18 respectable methods.
19 Q. I understand that, Dr. Levine, but that's not my
20 question. My question is, what evidence can you point
21 to that these kinds of interactions are happening in
22 clinics? Is your basis that the, are you basing that on
23 the way these centers are named?
24 A. I'm basing it on what they're named and I'm
25 looking at the document that you are, are talking about.

1 friendly especially designed specialty clinic. Those
2 clinics exist to take care of trans people, to give them
3 hormones and to get them surgery, that exists.
4 Q. But what you're describing --
5 A. It exists to do psychotherapy.
6 Q. Okay. And what you described, Dr. Levine, is
7 the basis for your, for this opinion, right?
8 A. The basis for my opinion is my collective
9 experience of dealing, watching, participating in the
10 evolution of the study of transsexual care over, over
11 since 1974.
12 Q. Okay. So your report states that you were
13 involved with WPATH before it was called WPATH, when it
14 was called the Harry Benjamin --
15 A. Can I help you?
16 Q. Yes. Harry Benjamin?
17 A. International Gender Dysphoria Association.
18 Q. Thank you. And you were involved around 1999
19 when the 6th version of the standards of care was
20 released, right, we talked about that?
21 A. Yes.
22 Q. Okay. And it's, it's true that you helped to
23 draft portions of that version, right?
24 A. Actually, my report misstates me as the
25 co-chair. If I remember correctly, I was the chairman.

1 Q. The chairman of that committee, okay. Thank
2 you.
3 A. And most, with very little exception I had a
4 significant editorial role in creating every sentence in
5 that 21-page document.
6 Q. Okay. And you've testified in other depositions
7 that even though the, there have been changes made to
8 the standards of care in subsequent versions, you still
9 continue to see your work reflected in those versions,
10 right?
11 A. Yes, my language.
12 Q. Yes, mm-hmm.
13 A. Yeah, my language, right. In fact, the next
14 version which came out I think three years later or two
15 years later I think was pretty much word for word except
16 for a requirement for one letter for endocrine treatment
17 rather than two, which is what my committee of eight
18 people recommended.
19 Q. Okay. And you've testified before that even
20 Version 7, which is, you know, one more, obviously one
21 more removed from Version 6, that that, as you read it
22 much of the language you had actually still, it was
23 still reflecting your language in that version even,
24 even though it's a much longer document?
25 A. Well, yeah, I think the introduction section

1 about what guidelines were and, and the problems of
2 cross culture, cross country rules affecting the laws
3 are different and the, that we wanted this to be a
4 information guide for, for patients and parents and
5 wives and husbands and so forth.
6 I think, you know, once, once we got, I mean, I
7 don't have it in front of me and I'm not sure I could
8 recognize every sentence I wrote anyway, but, but they
9 did, they did continue to use some of my sentences, some
10 of my concepts. It was my concept that there is a
11 difference between readiness criteria and eligibility
12 criteria, that was one of my contributions
13 Q. Thank you. And, and I think also you testified
14 in the Soneeya trial that you had asked to be involved
15 in helping to write standards of care 8 but were told
16 that you, in order to do so you had to be a WPATH
17 member, right?
18 A. Yes.
19 Q. And looking back at your report -- actually,
20 give me just a minute here. Actually, Dr. Levine,
21 let's --
22 MR. CHARLES: Sorry, Kelley and Kraig, can
23 we go off the record real quick.
24 VIDEO TECHNICIAN: We're going off the
25 record at 2:26 p.m.

1 be trans boys or trans males.
2 The historic pattern throughout most of the
3 world was 3.5 to 4 biologic males who wanted to be women
4 to biologic females who wanted to be men dominated
5 dramatically for decades in the '70s and the '80s and
6 the '90s and the early 2000s. But since 2005 there's
7 been a growing incidence of request for services and
8 particularly request for services from girls assigned at
9 birth who wanted to be males.
10 Some of us have come to in recent years call
11 this delayed or pubertal or rapid onset of gender
12 dysphoria, meaning it's a pubertal phenomenon because
13 there was no evidence prior to that except in the
14 retrospective subjective histories given by these kids
15 that they had any indication, parents and themselves,
16 had no behavioral indications that they were trans
17 identified or even sort of leaning in that direction.
18 Q. I understand that, Dr. Levine, and I'm not
19 talking necessarily about the, the increase in
20 referrals, I'm talking about this phenomenon that you
21 referenced called rapid onset gender dysphoria. So not
22 just adolescent onset gender dysphoria, which I
23 understand you're saying has somewhat increased since
24 2005, but rapid onset gender dysphoria. And I'm
25 specifically asking what peer reviewed studies, what

1 papers and what research would you refer me to or is
2 referenced in your report as evidence that this
3 hypothesis actually exists or that there's any
4 scientific study to support it?
5 A. No. 1, this is not a hypothesis, this is a
6 demonstrated fact.
7 Q. Okay. Based on what, Dr. Levine, that's what
8 I'm asking, what are the peer reviewed studies?
9 A. If you look up the presentations of Kenneth
10 Zucker, if you look at papers, I can't give you the
11 authors at the moment from Europe, this has been
12 documented by DiAngelo I believe in Australia, by
13 Clayton in Australia.
14 It seems to me there is no disagreements about
15 this except I've heard the cynical response that what
16 rapid onset gender dysphoria really means is that the
17 parents have suddenly discovered that their kids have
18 been transgender, meaning to deny the parental reports
19 that the children were not cross gender identified prior
20 to that, even though the kids say, well, I was never
21 comfortable with being a boy or a girl.
22 Q. Okay. So you, for this contention in your
23 report you cite one thing and that is Midgen A.
24 Hutchinson and her study is entitled, "In support of
25 research into rapid onset gender dysphoria." So that

1 was published in 2020 and I don't, I'm not seeing here
2 any of the other --
3 A. One, one of the reasons you're not seeing it is
4 that I assume that everyone understands that this is
5 true.
6 Q. Well, Dr. Levine, this is an expert report and
7 you have to include all of your expert opinions, and
8 you're also required under Rule 26 to disclose all of
9 the data and research that you considered for those
10 opinions. That's the purpose of our deposition today is
11 for me to understand and to have you put on the record
12 what you relied on to establish your opinions, so that's
13 what I'm trying to get at. And, and I understand what
14 you're saying that from your vantage point as a
15 clinician outside of the legal sphere that there are
16 things you think are givens, but we can't operate like
17 that unfortunately. So I need to, I need to understand,
18 and all I see here is the Midgen A. Hutchinson study
19 that's asking for support of, that's offering that she
20 wants to support research into this phenomenon, not that
21 the phenomenon has been evidenced to exist. Does that
22 make sense?
23 A. Yes. May I comment on that?
24 Q. On Hutchinson, yeah. Let me pull it up
25 actually.

1 makes reference to it as well. This is not to be
2 denied.
3 So if you're questioning whether, whether this
4 is really true, I think you're just simply wrong, but
5 you're not, you may not be questioning that. I'm wrong
6 and I didn't document adequately that sentence and I
7 apologize, I stand corrected.
8 Q. Okay. So let's turn in your report, Dr. Levine,
9 here to the following sentence which says, "There is
10 also no chapter on detransition despite the evidence
11 that a growing number of young people regret transition
12 and wish to reverse it," do you see that, are you still
13 on Page 38 there?
14 A. I do.
15 Q. Okay. So for this sentence here you have
16 provided a couple of citations. The first is an article
17 by Vanderbussche I believe, if I'm pronouncing it
18 correctly, and then a second article by Littman. So
19 let's, let's take each of those in turn. And I'll just
20 introduce the Vanderbussche exhibit, give me just a
21 moment.
22 (Exhibit 14 marked for identification.)
23 A. Is it up now?
24 Q. Let me know when you can see it.
25 A. This will be 14?

1 Q. Yes, correct.
2 A. Okay. All right, I see it.
3 MR. CHARLES: So this is, for the record
4 I'm showing Dr. Levine what has been marked as
5 Vanderbussche article entitled, "Detransition related
6 needs and support: A cross-sectional online survey, by
7 Elie" -- oh, excuse me, it's Elie Vandenbussche, not
8 Vanderbussche.
9 Q. And, and you've seen this article before, Dr.
10 Levine?
11 A. Yes.
12 Q. Okay. Scroll please to the, the first page of
13 text. Let me know if you can see that or if you need a
14 minute to zoom in.
15 A. You mean, "Introduction"?
16 Q. Yes, it has, it's the page that has introduction
17 on it, yes.
18 A. Okay.
19 Q. So from the abstract, the first sentence, the
20 abstract is in a, set off in a blue box there at the
21 top?
22 A. Yes, yes.
23 Q. It says, "The aim of this study is to analyze
24 the specific needs of detransitioners from online
25 detrans communities and discover to what extent they are

1 being met. For this purpose a cross-sectional online
2 survey was conducted and gathered a sample of 237 male
3 and female detransitioners. The results showed
4 important psychological means in relation to gender
5 dysphoria, co-morbid conditions, feelings of regret and
6 internalized homophobic and sexist prejudices. It also
7 found that many detransitioners need medical support
8 notably in relation to stopping/changing hormone
9 therapy, surgery/treatment complications and reversal
10 interventions." So the aim of this study as outlined
11 here in the abstract is to analyze the specific needs of
12 detransitioners, right?
13 A. Yes.
14 Q. Okay. Not to demonstrate that there is a
15 growing number of young people who regret transition or
16 wish to reverse it, right?
17 A. It's true. But you see, you're, you're taking
18 the reference out of that sentence and missing the first
19 phrase of that sentence. This sentence that you're
20 drawing attention to is that WPATH's standards of care
21 draft did not have any section on the phenomenon of
22 detransition.
23 Detransition exists and detransition is a
24 reflection of those adolescents or people, or adults who
25 have at one time in their lives thought that they needed

1 this care and then after they lived following the care
2 they decided that their problems have not been solved
3 and they decided to return to the gender expression --
4 Q. I understand that, Dr. Levine, and I'm not
5 actually contesting the assertion in your, in your
6 report that detransition exists at all.
7 A. All right.
8 Q. What I'm asking about is your assertion in the
9 latter half of that sentence that says that there is a
10 growing number of young people who regret transition and
11 wish to reverse it. Again, I'm just trying to
12 understand what you're saying here and on what basis you
13 are making those assertions.
14 So I'm not asserting whether or not
15 detransitioning exists, my question is, this study did
16 not look at how many detransitioners are there now as
17 opposed to any other time in history, it was not a
18 qualitative or quantitative analysis. It was a study
19 according to the abstract here, and I'm just asking you
20 to confirm that, about the specific needs of
21 detransitioners, both psychological, medical, other
22 kinds of support, right? So that's what I'm saying is
23 this study is not, the aim is not to quantify the number
24 of, whether the number of detransitioners is growing or
25 shrinking or staying the same, right?

1 A. Yes, I can answer to your question, correct.
2 Q. Okay.
3 A. But it doesn't mean that -- I think you're
4 missing the point. And, and by, by having me say yes,
5 that it doesn't quantify the incidents of detransition,
6 it's missing the point.
7 Q. I understand that, Dr. Levine. But if your
8 point was, if your point in your report was detransition
9 is a thing and here are the psychological supports that
10 these people need, that's what you should have written,
11 but that's not what you wrote. You wrote that a growing
12 number of young people regret transition and wish to
13 reverse it.
14 So my question to you about the article you rely
15 on for that contention is, this article doesn't say
16 that, this article is not a study of the growing numbers
17 or small or diminishing numbers or staying the same
18 numbers of people who detransitioned. That's what I'm
19 asking you to confirm.
20 A. What I am confirming is that this particular
21 paper talks about 237 people who have detransitioned and
22 that WPATH has no serious discussion of detransition,
23 there's no chapter on this, on this phenomenon which is
24 extremely relevant to the care of transgender people,
25 especially transgender young people.

1 The reason I cited this is 237, and the reason,
2 the next thing, Littman is another additional 100
3 people. And if you, if you read closely some of the
4 references in this particular article, there is
5 Exposito-Campos' article talking about subreddit and the
6 number of people who were discussing detransition.
7 So what I'm saying if WPATH is responsible for,
8 for providing a scientific basis for affirmative care,
9 they must talk about the error rate as represented by
10 detransitioned people. And four years ago we had no
11 idea about the, the rate of detransitioned people and
12 today we have two studies that have been published from
13 the UK that begin to give us a rate of detransition.
14 And so to me you are making the wrong point and
15 that I have not been in error. You just have
16 misunderstood the difference of why I cited these
17 particular papers. These particular papers just
18 demonstrate that detransition is a real problem and, and
19 it is a moral and ethical and scientific problem. And
20 that WPATH if it's going to deal with the science of
21 transition, it has to deal with the error rates and what
22 happens to people who detransition, you see. And so I
23 don't, I don't have nothing more to say about that, I
24 just think your point is quite irrelevant.
25 Q. Okay. Well, I'm going to continue to ask you

1 about evidence that you cite in your report that you use
2 as support for assertions you're making, so I'm just
3 going to flag that for you now. And again, this --
4 let's actually, let me, let me just ask one more time.
5 This study does not speak to the numbers of people who
6 have detransitioned now as opposed to any other time in
7 history, right?
8 A. As far as I remember this paper, the answer to
9 your question is right.
10 Q. Sorry, the answer to my question is -- okay,
11 right, okay. So let's actually now that you mention it,
12 let me just pull up really quickly the Littman study
13 that you mentioned.
14 (Exhibit 15 marked for identification.)
15 Q. This will be Exhibit 15.
16 A. Okay.
17 Q. Okay.
18 MR. CHARLES: So for the record, I'm
19 showing Dr. Levine what has been marked as SL15,
20 "Individuals treated for gender dysphoria with medical
21 and/or surgical transition who subsequently
22 detransitioned, a survey of 100 detransitioners by Lisa
23 Littman, received," well, published online 19 October
24 '21.
25 Q. Okay. So looking at the abstract again, the

1 first sentence, "The study's purpose was to describe a
2 population of individuals who experienced gender
3 dysphoria, chose to undergo medical and/or surgical
4 transition, and then detransitioned by discontinuing
5 medications, having surgery to reverse the effects of
6 transition, or both. Recruitment" -- oh, wait, let me
7 stop there, just a second. And then the last sentence
8 of the abstract -- oh, wait, hang on. So then actually
9 if you'll look please to page -- okay, go to two pages
10 down, Dr. Levine, it's going to be numbered Page 3355 in
11 the upper right-hand corner.
12 A. Okay, I'm on the page.
13 Q. Okay. In the left-hand corner the paragraph
14 starts on that page with, "Individuals," but I'm going
15 to start reading from the second to last sentence. It
16 begins, "This study does not describe the population of
17 individuals who undergo medical or surgical transition
18 without issue, nor is it designed to assess the
19 prevalence of detransition as an outcome of transition.
20 Instead, the goal was to identify detransition reasons
21 and narratives in order to inform clinical care and
22 future research."
23 So again, my question here, Dr. Levine, is this
24 study by design and by the admission of Lisa Littman is
25 not about assessing the prevalence of detransition or

1 whether or not the numbers of detransitioners are
2 growing, right?
3 MR. DAVID: Objection to form.
4 A. You know, I, I don't know if I should just
5 repeat what I said before. Detransition is a
6 phenomenon, science is only now beginning to get, we
7 have two studies that were published within the last I
8 think four months or five months.
9 Q. Okay. So, Dr. Levine, are you refusing to
10 answer my question because --
11 A. Not at all, I'm answering your question, I'm
12 answering.
13 Q. No, you're not.
14 A. Well, then ask me the question again. I'm
15 sorry, I apologize. You want to confine me to an answer
16 and so, so set me up for the answer you want, please.
17 Q. Okay. What I'm asking is, this sentence by the
18 admission of the author was not designed to assess the
19 prevalence of detransition?
20 A. That's true.
21 Q. Okay. Instead the purpose of this study was to
22 identify detransition reasons and narratives in order to
23 inform clinical care and future research, right?
24 A. Correct.
25 Q. Okay. Thank you. Okay. Let's, I'm going to

1 A. This is --
2 Q. Well, let me just ask you, Dr. Levine, you don't
3 speak Finnish, do you?
4 A. I'm an American, which means I have one
5 language.
6 Q. Okay. Okay.
7 A. I only speak English.
8 Q. Okay. Are you saying you have read a
9 translation of this document at some point?
10 A. Yes.
11 Q. And do you know if it was an official
12 translation, a certified official translation?
13 A. I don't know if it was a certified one. I think
14 I, I accessed it through SEGM.
15 Q. Okay. All right. Let's go, let's go back to
16 your report, Exhibit 1.
17 A. God, I'm having the same damn problem again.
18 All right. Exhibit 1, I'm going to get there. All
19 right, here I am.
20 Q. Okay. And you, you said earlier that the UK was
21 also changing some of their guidelines with regard to
22 medical interventions for the treatment of gender
23 dysphoria, right?
24 A. Yes.
25 Q. Give me just a second here. But the UK has also

1 not completely banned all medical interventions, right,
2 they're just adjusting them?
3 A. That's correct, you're correct.
4 Q. And then are you aware of the Cass review?
5 A. Yes.
6 Q. That the UK is doing?
7 A. Yes.
8 Q. Okay. And, and as a part of that review you're
9 aware that the, that the national, what do they call it,
10 the National Health Service acknowledges that some
11 children do experience gender dysphoria and will need
12 clinical support and interventions?
13 A. Yes.
14 Q. Okay.
15 A. That's the clinical perception around many
16 people, yeah.
17 Q. Okay. All right. Let's take a look, hopefully
18 you still have it up, Page 51 of your report,
19 Paragraph 103.
20 A. Getting there. Okay, I'm here.
21 Q. Okay. So in Paragraph 103 you're talking about
22 a review by Professor, excuse me, Professor Carl
23 Heneghan, the editor of the British Medical Journal.
24 And the citation provided to that review is at the end
25 of the paragraph, do you see that, footnote 165?

1 (Exhibit 23 marked for identification.)
2 Q. Okay. Dr. Levine, you talk in your report,
3 let's see here, it's going to be Page 42 of your report
4 about, "That many professionals are unfamiliar with
5 these 11 research studies indicating a high natural
6 resolution rate of gender dysphoria," I think that's
7 supposed to say gender dysphoria in children, but it
8 just says, "gender dysphoria children by late
9 adolescence," do you see that?
10 A. I don't see it, but I don't think I want to go
11 to the report.
12 Q. Okay.
13 A. It just takes time.
14 Q. Okay. That's fine. I'll just represent to you
15 that's where I'm reading that from. And your citation
16 is to this study here, or this article rather by James
17 M. Cantor.
18 MR. CHARLES: And for the record, I'm
19 showing Dr. Levine what has been marked as SL23,
20 "Transgender and gender diverse children and
21 adolescents: Fact checking of AAP policy."
22 Q. And the 11 studies you mentioned, Dr. Levine,
23 are included by Mr. -- I'm sorry, I don't know if it's
24 Dr. Cantor, is it Dr. Cantor, do you know?
25 A. Yeah, I definitely know, it's Dr. Cantor.

1 Q. Okay. Thank you. The 11 studies are referenced
2 by Dr. Cantor in this article in an appendix, but let me
3 point you to the sentence where he says that. So
4 it's --
5 A. I have the appendix in front of me.
6 Q. Okay, perfect. Let's just look at that. Okay.
7 So looking at that list of studies, the, the, how do I
8 say this, the, the oldest study is listed first, so
9 that's a study by P.S. Lebovitz published in 1972, do
10 you see that?
11 A. Yes.
12 Q. Okay. And then the second study by B. Zuger?
13 A. Yes.
14 Q. Published in 1978. A study by J. Money and A.
15 Russo published in 1979?
16 A. I see all those.
17 Q. Okay. I just, I'm just confirming the dates of
18 publication. So C.W. Davenport was published in 1986;
19 R. Green was published in 1987; it looks like R.J.
20 Kosky was published in 1987; Cohen-Kettenis and M.
21 Wallien was published in 2008; Drummond, et al. was
22 published in 2008; Singh, unpublished doctoral
23 dissertation was published in 2012; and lastly the
24 Steensma, et al. was published in 2013, right?
25 A. That's, although you didn't ask, I should tell

1 you that the Singh, et al. article, this 2012, has been
2 published now that it's, there's more years, it was
3 published in Frontiers of Psychiatry in April 2021.
4 Q. Okay.
5 A. And so, you know, that's --
6 Q. I'll, I'll, thank you for that, I'll turn to
7 that in a minute. So I just want to confirm, these
8 studies were all published, with the exception of
9 Steensma, they were all published before 2013, right?
10 A. Yes, these were follow-up studies, these are
11 long-term follow-up studies.
12 Q. And the datasets, none of the data that was
13 collected in any of these studies was collected after
14 2013, right?
15 A. Even after the DSM-V criteria.
16 Q. None of them, none of the data was collected
17 after 2013, right?
18 A. None of the original.
19 Q. Which, which data of any of these studies was
20 collected after 2013?
21 A. Oh, I see what you mean.
22 Q. Yeah.
23 A. I see. All right.
24 Q. I, I agree with you they are follow-up studies,
25 they, they follow youth sometimes as far back as the

1 late '60s all the way through as I understand it the
2 latest was corrected in 2011. So I just, I'm confirming
3 that that's your understanding of the scope of the
4 follow-up studies as well?
5 A. Yeah, I confirm.
6 Q. Okay. And the, let me, the Singh dissertation
7 which was later published in the Frontiers of
8 Psychiatry, that did not include any data that was
9 collected after 2013, right?
10 A. I don't remember one way or the other.
11 Q. Okay. Let's, I'll just, we'll just take a look
12 really quickly.
13 (Exhibit 24 marked for identification.)
14 Q. Okay. That should be available to you, Dr.
15 Levine --
16 A. Okay.
17 Q. -- as a new exhibit, it will be Exhibit 24.
18 A. The Singh article.
19 Q. That's correct, yeah, from Frontiers of
20 Psychiatry.
21 A. Oh, good.
22 Q. Okay. And you can see that now?
23 A. I do.
24 Q. Okay. So then just looking at the first page.
25 A. The abstract or the instruction?

1 Q. It's, I don't see a label abstract, but I'm
2 assuming that's what it is, just that intro paragraph on
3 the first page.
4 A. Mm-hmm.
5 Q. Okay. So I'm assuming, Dr. Singh, et al. is
6 writing this. And, let's see, we've got, okay. So,
7 "This study reports follow-up data on the largest sample
8 to date of boys clinic-referred for gender dysphoria
9 (n=139) with regards to gender identity and sexual
10 orientation. In childhood, the boys were assessed at a
11 mean age of 7.49 years with a range of 3.33-12.99 at a
12 mean year of 1989 and followed up at a mean age of 20.58
13 years with a range of 13.07-39.15 at a mean year of
14 2002." Do you see that, have I read that correctly?
15 A. You did.
16 Q. Okay. Let's go to page -- give me just a minute
17 here.
18 MR. CHARLES: Kraig, let me go off the
19 record real quickly.
20 VIDEO TECHNICIAN: Okay. One moment,
21 please. We're going off the record at 5:04 p.m.
22 (A break was taken at 4:04 p.m.)
23 VIDEO TECHNICIAN: We're going back on the
24 record at 5:08 p.m.
25 BY MR. CHARLES:

1 Q. Okay. So, Dr. Levine, back to the Singh
2 article. And if you would, please, scroll to Page 4,
3 and you're looking for the heading, "Method."
4 A. I'm there.
5 Q. Okay. So there in the first paragraph, "The
6 participants were 139 boys ('birth-assigned males') who
7 in childhood had been referred to and then assessed in
8 the Gender Identity Service, Child, Youth and Family
9 Program at the Centre for Addiction and Mental Health
10 (CAMH) in Toronto, Ontario between 1975 and 2009 (mean
11 year of assessment, 1989) and were adolescents or adults
12 at follow-up (mean year at follow-up, 2002)"
13 Continuing on there to the second paragraph,
14 "Participants entered the follow-up study through two
15 methods of recruitment. The majority of participants
16 (77%) were recruited for research follow-up. There were
17 two main waves of participant recruitment through
18 research contact, from 1986 to 1993 (n=32), and then
19 from 2009 to 2011 (n=71)."
20 So just, I just wanted to confirm with you
21 that's the, that's the same dataset that Dr. Singh, then
22 Ph.D. candidate Dr. Singh, presented in the dissertation
23 as well. So there, there was a, a follow-up collection
24 period from 2009 to 2011, but nothing beyond 2011, is
25 that, that's your understanding there of that, of those

1 sentences?
2 A. So isn't it -- let's see. During the period of
3 data collection 32 patients recontacted service for
4 clinical reasons and they were informed about the
5 opportunity to participate in a follow-up site. Okay.
6 So some were purely research, they agreed to
7 participate, and some asked for various services from
8 CAMH again.
9 Q. Right. And that collection in total, both the
10 initial contacts that was either patient initiated or
11 follow-up research requested, that all happened before,
12 collectively before 2013?
13 A. Yep.
14 Q. Okay. And let's take a look at one more article
15 here.
16 (Exhibit 25 marked for identification.)
17 Q. This should be available, Dr. Levine, if you
18 refresh your screen.
19 A. Are we done with the Cantor article?
20 Q. Oh, yes, you can put that to the side. Thank
21 you.
22 A. Okay. Okay.
23 Q. And do you see what's been marked as SL25?
24 A. Yes.
25 Q. Okay. And this article is entitled, "Gender

1 dysphoria in childhood, Jiska Ristori and Thomas D.
2 Steensma, published 2015." Oh, sorry, published, yes,
3 published online January 2016, accepted October 2015.
4 You cite this and the Singh article we just looked at in
5 your report for the, for the proposition that, "The
6 majority of children," and you put in parentheses,
7 "between 61 and 98 percent of them who identifies
8 transgender will reidentify with their sex before
9 reaching maturity absent interventions." So I just
10 wanted to locate that in context, in the context of your
11 report. So let's take a look at this article. Okay.
12 So if you would scroll to page, it's the third page of
13 this article, but it's numbered Page 15.
14 A. Okay, I'm on Page 15.
15 Q. Okay. And you'll see that the, this study is
16 listing the follow-up studies it's referencing in the
17 Table 1 at the bottom right-hand corner, do you see
18 that?
19 A. Yes.
20 Q. Okay. And do you see any overlap between the
21 studies cited in Dr. Cantor's article and this table
22 here in terms of on the left-hand side the, the names of
23 the authors and the year of publication?
24 A. Well, the Bakwin, was the Bakwin article in
25 Cantor?

1 Q. Now that you mention it, I don't think it was.
2 A. Yes.
3 Q. Okay.
4 A. And, and what about the Davenport?
5 Q. Yeah, Davenport was there, that was the
6 follow-up study of ten boys.
7 A. Yeah, I see. Of course Green was, yeah, and the
8 girls weren't in there because, yeah, all right.
9 Q. Okay. So is, is it your understanding that this
10 study is also looking at that, again that historical
11 dataset that begins back in the late '60s, early '70s
12 and continues through at the latest point 2011, right,
13 for the follow-up?
14 A. I'm going to trust you on that.
15 Q. Okay. Okay.
16 MR. CHARLES: Kraig, can we go off the
17 record.
18 VIDEO TECHNICIAN: Yeah, one moment please.
19 We're going off the record at 5:15 p.m.
20 (A break was taken at 4:15 p.m.)
21 VIDEO TECHNICIAN: We're going back on the
22 record at 5:25 p.m.
23 EXAMINATION
24 BY MR. DAVID:
25 Q. Dr. Levine, I'm going to be as brief as I

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

2 ~~~~~~~~~~~~~~~~~~~~

3 MAXWELL KADEL, et al.,

4

5 Plaintiffs,

6

vs. Case No. 1:19-cv-272-LCB-LPA

7

8 DALE FOLWELL, in his official
capacity as State Treasurer of

9 North Carolina, et al.,

10

Defendants.

11

12 ~~~~~~~~~~~~~~~~~~~~

13 Video Deposition of
STEPHEN B. LEVINE, M.D.

14

15 September 10, 2021
9:05 a.m.

16

17 Taken at:
Veritext Legal Solutions

18 1100 Superior Avenue
Cleveland, Ohio

19

20 Tracy Morse, RPR

21

22

23

24

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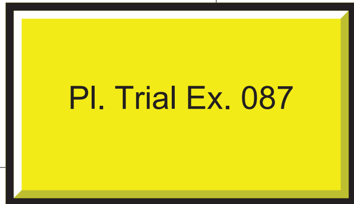

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10 EXHIBIT CUSTODY

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14

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Exhibit 2	12/21/2020 Zoom Deposition of Stephen Levine, M.D.	56
Exhibit 3	Typewritten Three-Page Document Entitled, "Special Programs,"	62
Exhibit 4	1/1/2019-12/31/2019 North Carolina State Health Plan Benefits Booklet, Bates Numbers PLAN DEF0001785-0001900	78
Exhibit 5	Lesbian Gay Bisexual Transgender Center Document Entitled, "Transgender Resources"	89
Exhibit 6	4/8/19 Soneeya v. Turco Trial Transcript, Day 1	104
Exhibit 7	"Correction: Parent Reports of adolescents And young adults Perceived to show signs Of a rapid onset of Gender dysphoria," Article	116
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Exhibit 10	"Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland)," Article	140
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Exhibit 12	"Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," Article	154
Exhibit 13	2017 "On Gender Dysphoria," Booklet From Department of Clinical Neuroscience, Karolinska Institutet	156
Exhibit 14	"Long-Term Follow-Up of Individuals Undergoing Sex-Reassignment Surgery: Somatic Morbidity and Cause of Death," Article	161
Exhibit 15	5/15/2017 Telephonic Deposition of Stephen Levine, M.D.	170
Exhibit 17	"A Typology of Gender Detransition and Its Implications for Healthcare Providers," Article	196
Exhibit 18	DSM-5: Frequently Asked Questions	202
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Exhibit 21	"Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance In Children and Adolescents," Article	223

1 Q. Okay. And so then were there any
2 external grants to research and publish about
3 the treatment of children or adolescents --
4 A. No.
5 Q. -- with gender dysphoria?
6 Okay. Is that a, "No," when I included
7 the, "Gender dysphoria," as well?
8 A. That is a, no.
9 Q. Okay. Thank you. Okay. So on
10 page 3 of your report -- actually, I'm sorry.
11 It's going to be the bottom of page 4 and to
12 the top of page 5. Your report lists your
13 experience as an expert witness, which we
14 talked about a little bit earlier. I just --
15 I'm wondering if you would confirm this is not
16 an exhaustive list of your experience as an
17 expert witness either via deposition or report.
18 A. I wouldn't want to testify that
19 this is absolutely complete, given the fact
20 that I don't keep a list compiled. This is
21 kind of compiled retrospectively from memory
22 and documents. And so this is the best I could
23 have done on April of 2021 --
24 Q. Understood. Thank you. So --
25 A. -- you might find something else.

1 two, two and a half years ago.
2 Q. Oh, okay. And what kind of
3 treatment -- I should say, have you referred
4 any of those adolescent patients for additional
5 treatment, besides psychotherapy, for the
6 treatment of gender dysphoria?
7 A. Yes.
8 Q. And what kinds of treatment have
9 you referred them for?
10 A. For endocrine treatment.
11 Q. Okay. And approximately what
12 percentage of those adolescent patients have
13 you referred for endocrine treatment?
14 A. Give me the timeframe of that
15 question, please.
16 Q. Sure. So you said a few moments
17 ago, in the last five years, you saw maybe,
18 asterisk, 12 to 15 adolescent individually
19 yourself. Of those 12 to 15, what would be the
20 approximate percentage you referred for
21 endocrine treatment?
22 A. I'm hesitating to answer the
23 question, because some of those children have
24 been taking testosterone or estrogen
25 surreptitiously from their parents. And while

1 where the number of adults has diminished and
2 the number of adolescents has increased
3 dramatically.
4 Q. Okay. Thank you. So as a part of
5 your private practice, do you write letters of
6 authorization for endocrine treatments?
7 A. Yes.
8 Q. And do you write letters of
9 authorization for gender affirming surgeries?
10 A. I have. I have not recently,
11 because most of my patients are 13 or 15 or 16,
12 you know.
13 Q. Okay. And I'm sorry. Just by,
14 "Recent," when was the last time you wrote a
15 letter of authorization for a gender affirming
16 surgery for an adult?
17 A. Probably twelve months ago.
18 Q. Okay. And over the course of your
19 career focusing on your treatment of adults
20 experiencing gender identity issues, for what
21 percentage of those patients would you estimate
22 you wrote a letter of authorization for gender
23 affirming surgery for?
24 MR. KNEPPER: Objection, form.
25 A. Again, I would like to put an

1 asterisk to whatever I answer this question as.
2 I have not kept track of those figures. I have
3 written -- I've written or cosigned letters for
4 hormone treatments and for gender confirming
5 surgeries for many people. There were more
6 people in the '70s and '80s than in recent
7 decades. In part as a reflection of my own
8 evolution of understanding of these problems
9 and in part it's a reflection of the demography
10 of patients who are coming to see me. I really
11 would not like to answer that question, only
12 because I don't know if the word, "Fifteen," or
13 the word, "Twenty-five," or the word,
14 "Thirty-five," is more accurate --
15 Q. Understood.
16 A. -- but I can tell you, I have
17 written letters, especially in the early years,
18 for the things that you're making reference to.
19 - - - - -
20 (Thereupon, Deposition Exhibit 2,
21 12/21/2020 Zoom Deposition of
22 Stephen B. Levine, M.D., was marked
23 for purposes of identification.)
24 - - - - -
25 Q. Okay. For the record, I'm showing

1 patient be able to afford it?
2 MR. KNEPPER: Objection, form.
3 A. May I say, of course?
4 Q. You may. You may say anything you
5 would like.
6 A. Of course.
7 Q. Thank you. Well, anything you
8 would like within reason.
9 If you make a letter of authorization for
10 a patient for the treatment of gender dysphoria
11 specifically related to a surgical treatment,
12 do you think it is good that they be able to
13 access that treatment that you've authorized?
14 MR. KNEPPER: Objection, form.
15 A. Not to be cagey, I want to talk
16 about one word you just used in that sentence.
17 I need you to understand that historically in
18 our clinic for those 47 years, our clinics
19 for 47 years, we are not in the business and we
20 have never been in the business of recommending
21 surgery or recommending hormones. We recommend
22 a continued evaluation so that we -- the person
23 can make up their mind how to proceed.
24 It is not our knowledge base to know
25 who's going to do better and who's going to do

1 worse and who is not going to have any
2 difference at all with hormones or with
3 surgery. So what we do is we say, we will
4 write a letter of support for endocrine
5 treatment or for hormones if this is what you
6 want. And we say what our concerns are. We
7 tell the endocrinologist and we tell the
8 surgeon what our concerns are and that we
9 see -- we have reservations about this, and
10 these are our reservations, but the patient has
11 decided this is what he or she wants to do.
12 And so we write a letter of support, but
13 I don't -- every time you use the word,
14 "Recommendation," there's part of me that wants
15 to say, no, we do not recommend. We have never
16 recommended. We have not had the knowledge
17 base. We have not had the clinical experience
18 and the knowledge base to say, I'm a doctor. I
19 know this field. This is what I recommend to
20 make you better. We do not talk that way. We
21 do not think that way. And so I may want to
22 always put an asterisk to any sentence that you
23 use the word, "Recommend." I need you to
24 understand that that's where I'm coming from.
25 MR. CHARLES: Thank you,

1 concept of agency and being a doctor, I think
2 is different than the implication of your
3 question.
4 Q. Is the worrisomeness for a
5 patient's future health, is that a reason to
6 deny all medical care for gender dysphoria?
7 A. Absolutely not.
8 Q. Dr. Levine, I'd like to return back
9 to, I believe it's Exhibit 2, the Claire
10 deposition. And please, if you would turn to
11 page 156.
12 A. I'm sorry. 150 what?
13 Q. Page 156. And beginning at line 10
14 on page 156, Dr. Levine, I'll read it, if
15 you'll just follow along, please.
16 Question: "Are you aware that this case
17 concerns an insurance exclusion that is
18 categorical at preventing" --
19 Skipping to line 15.
20 "-- hormones and surgery as a treatment
21 for gender dysphoria?"
22 Answer: "I am aware that your plaintiffs
23 are suing to get coverage for -- that is not
24 provided by their particular insurance. I am
25 aware of that."

1 demonstrate their efficacy. This is the
2 problem.
3 This is the essence of the problem. This
4 is, I think the essence of my testimony with
5 you today. It's not whether I personally as a
6 doctor would like this patient to have
7 insurance to cover their hormones. It's about,
8 is this the right thing to do for this person
9 and can I help the person see clearly what the
10 dangers are and what the benefits are. That's
11 the issue for a doctor, for Stephen Levine as a
12 doctor. I hope that's a cogent answer --
13 Q. It is --
14 A. -- to your question.
15 Q. -- it is cogent. Thank you.
16 Given all of that, is that -- so you just
17 explained, testified that there are
18 complications, some lack of -- and I'm
19 summarizing here, so I will confirm that this
20 is an accurate summary of what you just shared,
21 but I can't possibly repeat all of that. Given
22 all of those concerns that you have, is that a
23 reason to deny all medical interventions to
24 people with gender dysphoria?
25 MR. KNEPPER: Objection, form.

1 A. No, but that's not -- that's a
2 separate question about insurance.
3 Q. Yes, it is a separate question. So
4 now I'm asking: Are those concerns you raised
5 justifications in your mind for denying medical
6 interventions to all people with gender
7 dysphoria?
8 MR. KNEPPER: Objection, form.
9 A. You know, I'm not advocating
10 denying endocrine treatment or surgical
11 treatment. I'm just saying that we as a
12 medical profession need to walk the walk that
13 we talk. We say as a principle of ethics that
14 our interventions should be based upon the best
15 current knowledge, it should be based on
16 science. It should not be based on politics.
17 It should not be based on fashion. It should
18 not be based on civil rights considerations.
19 They should be based on the kinds of studies
20 that I just described to you with predetermined
21 outcome majors that are agreed upon --
22 Q. Sorry?
23 A. -- period.
24 Q. I was --
25 A. I forgot to put the period.

1 Q. That's okay. Did you just say,
2 Dr. Levine, you're not an expert in health
3 insurance?
4 A. I am not an expert in health
5 insurance.
6 Q. Okay. Or what insurance should or
7 should not cover?
8 A. Yes.
9 Q. Do you recall what the insurance
10 billing code typically is for psychotherapy for
11 gender dysphoria? I know it's been a long time
12 since you've accepted commercial insurance, so
13 I'm not sure if the billing codes are the same,
14 but do you recall --
15 A. The billing code is 90837.
16 Q. Okay. Is there a code that you're
17 familiar with that is F64.0?
18 A. That's not a billing -- that's
19 diagnostic code --
20 Q. Thank you.
21 A. -- there's a separate code for
22 diagnosis and a separate code for procedure.
23 Q. I see. So F64.0 is a diagnostic
24 code?
25 A. Yes.

1 VIDEOGRAPHER: Off the record 11:26.
2 (Recess taken.)
3 VIDEOGRAPHER: On the record 11:31.
4 BY MR. CHARLES:
5 Q. Okay. Dr. Levine, in your report,
6 you stated that you had not met with any of the
7 plaintiffs in this case, correct?
8 A. Yes.
9 Q. Okay. And you have not interviewed
10 any of the plaintiffs in this case, correct?
11 A. Correct.
12 Q. And so you are not offering any
13 opinions about the plaintiffs in this case,
14 correct?
15 A. Correct.
16 Q. Okay. And that would include the
17 veracity of their experiences of gender
18 dysphoria, correct?
19 A. Yes, correct.
20 Q. And that would not include the
21 accuracy of their gender dysphoria diagnoses,
22 correct?
23 A. Correct.
24 Q. Okay. You're not offering any
25 opinions about their mental health histories?

1 methodology and are capable of critically
2 reviewing the literature. So your statement is
3 true on the most superficial level, but is
4 totally incorrect when it comes to scientific
5 standards of care for issuing guidelines for
6 the medical profession. So I don't know how to
7 answer the question. On the surface, the
8 answer is, yes. And underneath the surface,
9 the answer is, no.
10 Q. So the International Journal For
11 Transgender Health is still a peer-reviewed
12 source, though, right?
13 A. It's peer reviewed by people who
14 make their living supporting transgender care.
15 Q. But it's still peer reviewed,
16 right?
17 A. It's peer reviewed --
18 Q. And as for your --
19 A. -- I think it's peer reviewed.
20 Q. Okay. Understood. And as for your
21 more conservative approach, can you cite to any
22 studies or research that resulted in better
23 outcomes than people who adhere strictly to the
24 WPATH standards of care version 7?
25 A. No. This is part of the problem in

1 evaluation leading to a therapeutic process, it
2 seems prudent, given the fact that we are
3 changing people's bodies, especially teenagers'
4 bodies, and they are not of developmental
5 sophistication yet that court systems or at
6 least one court system thinks they're certainly
7 too young to make these life-altering
8 decisions. So people in SEGM are biased in the
9 direction of being conservative and providing
10 psychotherapeutic evaluations of the child, of
11 the teenager and of their parents, of their
12 family systems to see if we can find a way to
13 help them be informed about what is going --
14 what they think they want to do in their
15 future.
16 Q. And so when you provide letters of
17 authorization for hormones or for surgery, do
18 you do so in accordance with the WPATH
19 standards of care?
20 A. Yes. That is the standard, to
21 provide a letter of recommendation.
22 Q. Okay. So turning back to your
23 report, Dr. Levine. You can go ahead and put
24 away the trial transcript there.
25 A. I'm sorry. Did you say, "Turning

1 hours and hours of their time getting counseled
2 or participating with the virtual trans
3 community. That's a hypothesis.
4 Q. So no scientific citation?
5 A. When we use the word, "Scientific,"
6 in the best sense, yes, the answer to your
7 question is, no scientific.
8 Q. Okay. No studies of citations you
9 can point to today to support that hypothesis?
10 A. Oh, I think Lisa Littman's studies
11 are in the literature and/or in press that
12 documents this.
13 - - - - -
14 (Thereupon, Deposition Exhibit 7,
15 "Correction: Parent reports of
16 adolescents and young adults
17 perceived to show signs of a rapid
18 onset of gender dysphoria," Article,
19 was marked for purposes of
20 identification.)
21 - - - - -
22 Q. Okay. For the record, please note
23 I'm showing to Dr. Levine what has been marked
24 as Exhibit 7. "Correction: Parent reports of
25 adolescents and young adults perceived to show

1 signs of a rapid onset of gender dysphoria," by
2 Lisa Littman published March 19, 2019. Have
3 you seen this material before, Dr. Levine?
4 A. I've seen of it. I don't think
5 I've read it.
6 Q. Okay. Were you aware that the Lisa
7 Littman article had to be withdrawn, corrected
8 and republished?
9 A. Yes.
10 Q. Okay. And were you aware that the
11 initial article was based on a survey of
12 parents --
13 A. Yes.
14 Q. -- of purportedly transgender
15 children and the parents were recorded -- I'm
16 sorry. Let me start over. Were you aware that
17 the Littman article was based on a survey of
18 parents who were recruited through some parent
19 groups?
20 MR. KNEPPER: Objection, form.
21 A. I knew it was a survey of parents.
22 Q. Okay. And did you know there were
23 no report-outs from the young adults of those
24 parents in the article?
25 A. It was a report of parents'

1 transitioning. However, it is...important to
2 note that there are other survey items where
3 the parent would have direct access to
4 information about their child and that those
5 answers reflect items that can be directly
6 observed." Did I read that correctly?
7 A. Yes, you did.
8 Q. All right. Your report also cites
9 as support for the social contagion hypothesis
10 to an article from Medscape.com written by
11 Becky Mccall and Lisa Nainggolan as support for
12 the social contagion theory. Is that correct?
13 I'm sorry. It's not going to be on this
14 article, Doctor.
15 A. I don't know that article.
16 Q. Okay.
17 A. You haven't asked me a question
18 about this. Did I misunderstand something?
19 Q. No, no. Sorry. We're just --
20 A. You haven't asked my opinions about
21 that, yeah.
22 - - - - -
23 (Thereupon, Deposition Exhibit 8,
24 "Transgender Teens: Is the Tide
25 Starting To Turn?" Article, was

1 marked for purposes of
2 identification.)
3 - - - - -
4 Q. Yeah. So, for the record, I'm
5 showing Dr. Levine what has been marked as
6 Exhibit 8. "Transgender Teens: Is the Tide
7 Starting To Turn?" by Becky McCall and Lisa
8 Nainggolan, April 26, 2021. Dr. Levine, you
9 said you have not reviewed this article before?
10 A. Which one are you referring to?
11 Q. I'm sorry. That one to your left.
12 A. This?
13 Q. Yes. Take your time.
14 A. Have I reviewed it, no. You know,
15 I've seen the picture of Keira Bell. I've seen
16 news reports of this in the past, but they were
17 just news reports, yeah.
18 Q. Do you know if either of the
19 authors of this article is a scientist?
20 A. I have no idea.
21 Q. Okay. Or a psychiatrist?
22 A. (Indicating.)
23 Q. I'm sorry. Could you make your
24 responses verbal? I'm forgetting.
25 A. I have no idea.

1 Q. Okay. Thank you. Have either of
2 them ever treated transgender children or
3 adolescents?
4 A. I would have no idea.
5 Q. Okay. To your knowledge, is the
6 information provided on Medscape.CA subject to
7 peer review?
8 A. I don't know how Medscape works.
9 I've heard there have been retractions, but I
10 don't know how their peer reviewed is made.
11 Perhaps people write in that, This is
12 ridiculous what you've been teaching or what
13 you've been saying, but whether they're peer
14 reviewed or not, I have no idea.
15 Q. So you probably -- I'm sorry. So
16 do you know if this article has been published
17 in a peer-reviewed journal to your knowledge?
18 A. "Transgender teens: Is the
19 Tides" -- that article?
20 Q. Yes.
21 A. I don't know. I don't know this
22 article. I don't know where it's from.
23 Q. Okay. So your report includes a
24 quotation from this article. "The vast
25 majority of youth now presenting with gender

1 multi-continental set of observations from
2 Europe, from Australia, from North America --
3 Q. Okay.
4 A. -- it almost doesn't even need
5 citations it's so clinically apparent.
6 Q. Okay. But there's no citation in
7 your report?
8 A. In my report, yes.
9 Q. Okay. So on page 18, going back to
10 your report, at the bottom of page 18, you use
11 a term, "Transgender Treatment Industry." Is
12 this the first time you have used this term?
13 A. In this report?
14 Q. No.
15 A. You mean, did I ever use it in
16 another report?
17 Q. Yeah, yeah.
18 A. I'm not sure. If this is -- if
19 it's not the first, it might be the second.
20 Q. And where did the term originate?
21 A. I think it -- the term originated
22 from Dwight Eisenhower at the end of his --
23 when he was leaving the presidency in 1952, he
24 warned the people about the military industrial
25 complex and that there was a very comfortable

1 A. No. Their gender dysphoria may be
2 a product, you see, of these other things. For
3 example, if you have someone who has been
4 sexually abused by her stepfather and becomes a
5 trans person in adolescents, we want to talk
6 about the sexual abuse and the process between
7 that person and what fears for the present and
8 the future that has caused the child. And
9 we're not attacking their trans identity.
10 We're trying to help them understand where they
11 came from and what they're coping with and why
12 they're so fearful or so distressed by their
13 body changing.
14 Q. And their gender dysphoria could be
15 separate and apart from that traumatic
16 experience?
17 A. Theoretically it could be, yes.
18 Q. And if it persisted sufficiently
19 enough, you would consider a letter of
20 authorization for --
21 A. Yes.
22 Q. -- hormones?
23 A. Yes.
24 MR. KNEPPER: Objection, form.
25 Q. Okay. If you would, please, turn

1 A. That is correct. And may I add
2 that it's very, very difficult to understand.
3 The natural question would be, how do you
4 compare the general population with the trans
5 people who did not have surgery with the trans
6 people who did have surgery.
7 Q. Thank you, Dr. Levine. That's not
8 my question, though. I just wanted to confirm
9 that was not the control group. You mentioned
10 this study later in your report, page 66
11 beginning at paragraph 74. Do you see that?
12 A. Um-hum.
13 Q. Okay. And basically that -- well,
14 here, let me point you exactly. The sentence
15 starts with, "Similarly," about halfway down
16 the page, third sentence of that paragraph.
17 A. Um-hum.
18 Q. And, as you mentioned, you cite the
19 Dhejne study and I believe -- or I should ask:
20 Is the Denmark study you're referencing the
21 study directly after it --
22 A. The Simonsen study.
23 Q. -- the Simonsen study?
24 A. Yes.
25 Q. Okay. So beginning with the Dhejne

1 study, do you think because that study showed
2 that some people committed suicide after gender
3 affirming surgery that no patient should be
4 able to access gender affirming surgery?
5 MR. KNEPPER: Objection, form.
6 A. That would be illogical.
7 Q. Okay. Dr. Levine, I understand you
8 said that would be illogical, but just to be
9 clear. You're not recommending -- sorry. I'm
10 not using that word. You're not saying that
11 the fact that some people commit suicide
12 following gender affirming surgery means that
13 there should be a ban on access to that
14 surgery. Is that right?
15 A. Not for that reason, no.
16 MR. KNEPPER: Objection, form.
17 Q. Not for that reason. Okay. Are
18 you recommending that there would be bans on
19 gender affirming surgery for any reason?
20 A. I think there are -- you know, I
21 think most prudent people in this field, just
22 to use the example of what you read out loud
23 about the Finland study, a case-by-case basis.
24 That's how doctor need to decide things, but
25 there are many, many reasons to be cautious

1 fashion and to be very hesitant about going
2 forward.
3 Q. But you're not recommending total
4 bans on gender affirming surgery?
5 A. I'm not recommending total bans.
6 I'm aware of the individual circumstances of
7 individual people's lives and their commitment
8 to transgender living. And I don't want to be
9 draconian about this. I want to be
10 compassionate about this.
11 Q. I understand. I appreciate that.
12 I just want to make sure I'm understanding you
13 correctly.
14 - - - - -
15 (Thereupon, Deposition Exhibit 12,
16 "Long-Term Follow-Up of Transsexual
17 Persons Undergoing Sex Reassignment
18 Surgery: Cohort Study in Sweden,"
19 Article, was marked for purposes of
20 identification.)
21 - - - - -
22 Q. So for the record, I'm presenting
23 to Dr. Levine what has been marked as
24 Exhibit 12. "Long-Term Follow-Up of
25 Transsexual Persons Undergoing Sex Reassignment

1 For the 22nd time today, did I read that
2 correctly?
3 A. It's the 23rd time.
4 Q. Oh, okay.
5 A. Yes.
6 Q. I was hoping you weren't counting,
7 but, okay. Did you testify earlier today that
8 the limitation of the Dhejne study is that the
9 controls were not transgender persons who had
10 not undergone gender affirming surgery?
11 A. Yes.
12 MR. KNEPPER: Objection, form.
13 Q. Okay. You can set that aside,
14 Dr. Levine.
15 - - - - -
16 (Thereupon, Deposition Exhibit 13,
17 2017 "On Gender Dysphoria," Booklet
18 From Department of Clinical
19 Neuroscience, Karolinska Institutet,
20 Stockholm, Sweden, was marked for
21 purposes of identification.)
22 - - - - -
23 Q. For the record, Dr. Levine has an
24 exhibit that has been marked as Exhibit 13.
25 "On Gender Dysphoria," by Cecilia Dhejne from

1 ideation in transgender people.
2 A. Well, you know about the
3 Branstrom-Pachankis study and the criticism of
4 the study --
5 Q. But I'm not talking about the
6 study.
7 A. -- and part of the study
8 demonstrated that it increased suicidal
9 ideation and attempts in the first two and a
10 half years after surgery, especially in the
11 first year --
12 Q. Right. Is your testimony --
13 A. -- so I'm not testifying that. I
14 thought you were asking me about this, which I
15 need to comment on, because this is not an
16 accurate depiction of my statement in the
17 reference. (Indicating.)
18 Q. Well, that's not what I'm asking
19 about, Dr. Levine.
20 A. Well, you're reading this and I'm
21 misquoted here. So I don't want you to imply
22 that she is accurately representing my views,
23 because I did not say that gender affirming
24 treatment in general should be stopped. I've
25 never said that. This is an article about

1 at different times have reported that in the
2 large majority of patients, absent a
3 substantial intervention such as social
4 transition and/or hormone therapy, gender
5 dysphoria does not," continue, "through
6 puberty."
7 So there are some children who persist in
8 their asserted gender identity through puberty,
9 correct?
10 MR. KNEPPER: Objection, form.
11 A. Correct.
12 Q. And some who persist in wanting to
13 transition via medical treatments?
14 MR. KNEPPER: Objection, form.
15 A. Yes. Some of the children have
16 learned about medical treatments somewhere
17 along the line and they feel instantly that
18 this is for them.
19 Q. And then looking at paragraph 56,
20 which is on page 41, so just the very next page
21 on the bottom, the second sentence in that
22 paragraph. "I observe an increasingly vocal
23 online community of young women who have
24 reclaimed a female identity after claiming a
25 male...identity at some point during their teen

1 years."
2 But there are some patients who assert a
3 male gender identity in their teen years and
4 continue to assert it into adulthood, correct?
5 A. Yes.
6 MR. KNEPPER: Objection, form.
7 Q. Okay. Can social transition be
8 used to treat gender dysphoria in adults? Not
9 looking at your report, now, Dr. Levine.
10 Sorry. Can social transition treat gender
11 dysphoria in adults?
12 A. Yes. As a matter of fact, that
13 used to be the recommendation in the '70s
14 and '80s, prior to taking hormones, was to try
15 living, what was sometimes called the real-life
16 experience or the real-life test for one year.
17 And then if when you confront the new issues of
18 confronting you in your new neo gender, if you
19 still want to do that, then we'll come back and
20 we'll think about using hormones to facilitate
21 your transition. But in the 7th edition of the
22 standards of care that was removed. There's no
23 real-life experience, real-life test anymore.
24 If persons want it, they should have it.
25 Patient autonomy was valued far greater than

1 transgender people is individual based, right?
2 A. Well, it's both --
3 MR. KNEPPER: Objection, form.
4 A. -- yes, that's partially true. And
5 ideally that's true, but it's obviously not
6 entirely true. It's why we're here, is it's
7 categorically based.
8 Q. Let me rephrase that. You design
9 treatment for your patients based on what that
10 patient in front of you, what they need, what
11 they want, what you determine -- sorry. Not
12 what you determine, but what you might
13 authorize?
14 MR. KNEPPER: Objection, form.
15 A. What the patient and I discern
16 together.
17 Q. Thank you. Okay. Let's jump to,
18 again, still in your report, page 68.
19 A. We've left 40 and 41? 68.
20 Q. Okay. Looking at the bottom of
21 page 68, Dr. Levine, paragraph 78. It states,
22 "Similarly, the American Psychological
23 Association has stated because approach" --
24 A. Sorry.
25 Q. I apologize.

1 Gender Nonconforming People (2015)."
2 So is that lack of consensus that you
3 discuss a justification to categorically ban
4 social transition for children as a treatment
5 for gender dysphoria?
6 MR. KNEPPER: Objection, form.
7 A. By, "Children," you mean 6 and 7
8 year olds?
9 Q. Those for whom medical intervention
10 is not indicated.
11 A. Is that a reason to ban it?
12 Q. Correct, social transition.
13 MR. KNEPPER: Objection, form.
14 A. The reason to -- so let me qualify
15 that. There's a, yes, answer, there's a reason
16 to ban it. And the reason to ban it is both a
17 developmental and an ethical reason. There
18 have been eleven studies of these cross-gender
19 identity children who are not socially
20 transitioned and the vast majority of them
21 de-transition by the time they're mid
22 adolescents or older adolescents. They become
23 homosexual individuals usually or bisexual
24 individuals, but they are cis gender.
25 So if we take a 6-year-old child and

1 her peers or his peers and I don't think this
2 is a prudent idea.
3 And if you wanted me to suggest a ban on
4 anything, it would be a ban on using puberty
5 blocking hormones, especially when the
6 evaluation of those children are focused on the
7 gender dysphoria of the child and not on the
8 background of the child and not on what's going
9 on. So I think that's an answer to your
10 question.
11 If we're going to use these drugs, if
12 we're going to use social transformation of
13 children, if we're going to use puberty
14 blocking hormones, it should only be used in a
15 carefully designed protocol. And follow up has
16 to be guaranteed so in one year and in two
17 years and in three years and before we start
18 giving cross-gender hormones we have data --
19 Q. Sorry.
20 A. -- so the answer to your question
21 is, I would consider banning puberty blocking
22 hormones even for children who have been
23 cross-gender identified for four years to give
24 them a chance to desist, which is exactly what
25 the Dutch protocol did, by the way.

1 Q. Sorry. So you just said you would
2 ban -- you would recommend a ban on --
3 A. If --
4 MR. KNEPPER: Objection, form.
5 A. -- look, I'm a doctor. I'm not a
6 policy maker --
7 Q. I understand, yes.
8 A. -- if you ask me my political
9 opinion about, should we ban this, is that a
10 reasonable thing, I think there's a very strong
11 argument for banning puberty blocking hormones.
12 Q. Okay. And, right. So you're here
13 as an expert offering an expert opinion. So
14 are you separating that from -- like are you
15 saying your political views that you would
16 advocate for bans or are you saying your expert
17 opinion you're offering in this case is you
18 would recommend ban?
19 MR. KNEPPER: Objection, form.
20 A. I would recommend ban. To what
21 extent it's from my politics or from my being a
22 parent or from my being a doctor, I don't know.
23 I would recommend we not use puberty blocking
24 hormones.
25 Q. In Claire, in this case that we

1 Answer: "Where we had a healthy mother
2 and father, an intact family who was
3 psychologically informed and who has -- where a
4 child has come out of toddlerhood acting
5 consistently in a gender atypical fashion, and
6 where the parents are not homophobic..."
7 Question: "The parents are not what kind
8 of people?"
9 Answer: "Homophobic."
10 For the 27th time, did I read that
11 correctly? Did I read that correctly?
12 A. Yes.
13 MR. CHARLES: Okay. All right.
14 Let's go ahead and take a break for a few
15 minutes.
16 VIDEOGRAPHER: Off the record 3:20.
17 (Recess taken.)
18 VIDEOGRAPHER: On the record 3:38.
19 BY MR. CHARLES:
20 Q. So, Dr. Levine, before the break,
21 you were talking about 6 and 7 year olds and
22 you mentioned there were eleven studies. Can
23 you identify which eleven studies from your
24 report you're referring to?
25 A. Cantor, the reference Cantor lists

1 the eleven studies and these eleven studies
2 have been done over probably thirty years.
3 Q. Okay. So Cantor was one review of
4 eleven studies?
5 A. Cantor was a review of the eleven
6 studies. I can't list to you the eleven
7 individual studies. The latest one is written
8 by Singh, S-i-n-g-h. It was published in April
9 of 2021, in the Frontiers of Psychiatry. And
10 that perhaps is the most comprehensive of them.
11 And that's the one that confirms -- that's a
12 study of boys and it confirmed that 12.2, I
13 think percentage of them persisted over a
14 thirteen-year period.
15 Q. So that was one -- that was the
16 Singh study that came out. Is that same study
17 mentioned in the Cantor review?
18 A. (Nodding.)
19 Q. Okay. And you said that
20 established that 12.2 percent of prepubertal
21 boys persisted into adolescents? Okay.
22 A. Yes. This harkens back to the
23 ethical issue that I talked about before. You
24 know, if you know that 88 percent of them are
25 going to persist -- desist, why in the world

1 identified 60,000 case reports world wide on
2 the Internet. See Exposito-Campos..." --
3 A. That is an error, by the way.
4 Q. Sorry. Which part of that is an
5 error?
6 A. That, "60,000," is my error. It
7 should say, "16,000."
8 - - - - -
9 (Thereupon, Deposition Exhibit 17,
10 "A Typology of Gender Detransition
11 and Its Implications for Healthcare
12 Providers," Article, was marked for
13 purposes of identification.)
14 - - - - -
15 Q. Okay. So for the record, I'm
16 showing Dr. Levine what has been marked as
17 Exhibit 17. "A Typology of Gender Detransition
18 and Its Implications for Healthcare Providers,"
19 Pablo Exposito-Campos, 2021. Okay. Have you
20 seen this study before, Dr. Levine?
21 A. Yes.
22 Q. Okay. So on page 1 of this report,
23 about halfway through the very first paragraph
24 in the introduction beginning with, "As a
25 consequence." Do you see that there?

1 important to note that this typology does not
2 suggest two clear-cut categories, for a
3 secondary detransition can lead to a primary
4 detransition" -- oh, sorry. Let me start over.
5 Sorry.
6 Okay. Let me start from a different
7 place, Dr. Levine. The second sentence.
8 "In r/detrans" --
9 And there's an HTTP address --
10 A. Okay.
11 Q. Okay. You see that.
12 -- "a subreddit for detransitioners to
13 share their experiences with more than 16,000
14 members, one can find several stories of people
15 who call their transgender status into question
16 after stopping transitioning due to medical
17 complications or feeling dissatisfied with
18 their treatment results"?
19 Do you know what a, "Subreddit," is,
20 Dr. Levine?
21 A. I believe it's just a division of a
22 larger website where people, you know, with
23 similar interests.
24 Q. Okay. Do you understand this
25 sentence to be suggesting that all 16,000 of

1 those members have offered a story of
2 detransition?
3 MR. KNEPPER: Objection, form.
4 A. I think -- I think it may be true
5 that either they have offered a personal story
6 or they're fascinated because of their own
7 considerations of that story. They're thinking
8 about it themselves, which would be in keeping
9 with the idea that even people who have
10 transitioned begin to doubt whether they made a
11 wise decision and they're considering
12 detransition. I'm not so sure it means that
13 all 16,000. I would have no way of
14 ascertaining that. You know, in my worry, I
15 would lean towards most of them are seriously
16 considering or have detransitioned. And in my
17 skepticism, I would say I'm not sure whether
18 it's 15,000 or 12,000 or 8,000.
19 Q. But you have no way to confirm
20 that --
21 A. I have no way.
22 Q. -- if it's all of them or a few of
23 them or three of them?
24 A. You're absolutely right. I have no
25 way of confirming that.

1 where hormones are safe and surgery is a good
2 thing to do. If a person said that, you know,
3 skeptically, I think that would disappoint
4 certain patients, but how it was said and when
5 it was said in response to what would either
6 determine whether the person is engaged with
7 the mental health professional or leaves the
8 mental health professional. You know, all
9 mental health professionals are not created
10 equal.
11 Q. So it sounds like you're saying it
12 could do harm to that patient?
13 MR. KNEPPER: Objection, form.
14 A. No, I'm not saying that. I'm
15 saying it could be disappointing to that
16 person. What that person did with the
17 disappointment may prove harmful just because
18 of that person or it may prove in fact
19 beneficial.
20 Q. Are you satisfied -- let's orient
21 this question around the patients you've seen
22 in the last 12 months. Are you satisfied that
23 those patients -- actually, sorry. Let me
24 start over. Are you satisfied that the
25 patients you have seen historically for whom

1 you provide letters of authorization for
2 hormones give sufficiently informed consent?
3 MR. KNEPPER: Objection, form.
4 A. From my point of view, I did what I
5 could to reach the standard of having the
6 person internalize and think about, digest,
7 dream about and come back and talk to me about
8 it. That's all I can do. I can't guarantee
9 that if I do what I do that it's going to
10 change your mind or help you steer your ship in
11 a slightly different angle --
12 Q. So --
13 A. -- so I would not write a letter of
14 recommendation if I didn't feel like I did my
15 part. And if the person indicated that they
16 couldn't pay attention to me, I wouldn't write
17 the letter.
18 MR. CHARLES: Understood.
19 Okay. John, finished.
20 MR. KNEPPER: You're finished?
21 MR. CHARLES: I mean, barring --
22 MR. KNEPPER: Barring --
23 MR. CHARLES: We can't tell the
24 future.
25 MR. KNEPPER: I wasn't ready for

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1 UNITED STATES DISTRICT COURT
FOR THE
2 MIDDLE DISTRICT OF FLORIDA
3
DREW ADAMS, a minor,)
4)
Plaintiff,)
5)
vs.)Civil Action
6)No.3:17-cv-00739-TJC-JBT
THE SCHOOL BOARD OF ST.)
7 JOHNS COUNTY, FLORIDA,)
)
8 Defendant.)
9
10
11
12 TELEPHONIC DEPOSITION OF KIM G. HUTTON
13 Taken on behalf of Defendant
14 December 5, 2017
15 (Starting time of the deposition: 3:00 p.m.)
16
17
18
19
20
21
22
23
24
25

Pl. Trial Ex. 088

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1 I N D E X O F E X A M I N A T I O N

2

3 Page

4 Questions by Mr. Harmon 5

5 Questions by Mr. Gonzalez-Pagan 49

6

7 (No exhibits were marked.)

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Case 4:22-cv-00325-RH-MAF Document 136-12 Filed 04/07/23 Page 3 of 15

1 UNITED STATES DISTRICT COURT
FOR THE
2 MIDDLE DISTRICT OF FLORIDA
3
DREW ADAMS, a minor,)
4)
Plaintiff,)
5)
vs.)Civil Action
6)No.3:17-cv-00739-TJC-JBT
THE SCHOOL BOARD OF ST.)
7 JOHNS COUNTY, FLORIDA,)
)
8 Defendants.)
9
10 TELEPHONIC DEPOSITION OF WITNESS, KIM G.
11 HUTTON, produced, sworn, and examined on the 5th day
12 of December, 2017, between the hours of nine o'clock
13 in the forenoon and six o'clock in the evening of that
14 day, at the offices of Veritext Legal Solutions, 515
15 Olive Street, Suite 300, St. Louis, Missouri before
16 BRENDA ORSBORN, a Certified Court Reporter within and
17 for the State of Missouri, in a certain cause now
18 pending in the United States District Court for the
19 Middle District of Florida, wherein Drew Adams, a
20 minor, is the Plaintiff and The School Board of St.
21 Johns County, Florida is the Defendant.
22
23
24
25

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1 center in St. Louis.
2 And that's how that happened. Dr. Hruz
3 e-mailed me -- it's either the same day or the next
4 day, and invited me to lunch.
5 Q. Where did you go -- did you end up going to
6 lunch?
7 A. We did.
8 Q. Where did you go?
9 A. At the Wild Flower in the Central West End.
10 Q. And what -- you said it was in 2013?
11 A. Yes.
12 Q. Do you recall what month?
13 A. October.
14 Q. Okay. Was anybody else at the lunch?
15 A. No.
16 Q. Do you recall approximately how long the
17 lunch was?
18 A. Maybe 45 minutes.
19 Q. Was your conversation recorded?
20 A. No.
21 Q. I guess, to your knowledge, you may not
22 know, right?
23 A. To my knowledge. I did not record it.
24 Q. Okay. What -- what did you -- when you were
25 going to have that lunch with Dr. Hruz, what was the

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1 purpose of it, in your mind?
2 A. Well, the e-mail that he sent me stated that
3 he wanted to meet to -- I think he kind of positioned
4 it as wanting to learn more about this experience, and
5 he shared that he -- he was well aware that Dr. Abby
6 Hollander was working with me, or that I had
7 approached her about starting a pediatric gender
8 center inside the hospital, and that he was having
9 great difficulty being open to that concept based on
10 his morals.
11 He said that he did not -- part of the note
12 I remember said something about he did not agree with
13 the -- the recommended standards of care, or something
14 like that, for our children, that he didn't believe
15 that it was appropriate medically or spirit -- or that
16 it -- or that it wouldn't meet their spiritual needs,
17 or something like that.
18 And so I realized -- I realized -- I felt
19 like it was going to be not a great meeting, but I was
20 still willing to meet with him because I felt that
21 maybe, you know, the parent perspective could be
22 helpful to him.
23 Q. Now, was that document, was that in an
24 e-mail that he conveyed that information to you?
25 A. Yes.

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1 Q. Do you still have that e-mail?
2 A. I do.
3 Q. Okay. Have you shown that e-mail to counsel
4 in the room?
5 A. I did.
6 Q. Do you have it with you now?
7 A. I don't.
8 Q. Okay. To the best of your knowledge, can
9 you tell me everything, aside from what you've already
10 told me, that that e-mail says in it?
11 A. Those -- those were the sticking points for
12 me, because I found it very odd that he would be
13 talking about faith or morals or spiritual needs in
14 the context of this conversation. It was not -- I
15 talk to many medical professionals in my work with
16 TransParent, and it's the first time that somebody was
17 so overtly upfront that it was problematic due to
18 their faith on some -- at least on some level. So I
19 can't remember it. It wasn't -- it was longer --
20 the -- the note was longer than that, but those were
21 the points that have stuck out with me.
22 Q. Okay. Other than that e-mail, do you have
23 any other document that reflects communication you
24 have had with Dr. Hruz?
25 A. There's -- I mean, after he e-mailed me, I

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1 e-mailed him and told him that I, you know, was very
2 excited to meet with him, although I was -- you know,
3 I think I expressed some disappointment because
4 Dr. Spack had shared that he was, you know, I guess
5 against a pediatric gender center at St. Louis
6 Children's Hospital and -- but that, you know, I
7 was -- I would be very happy to have the conversation
8 or something like that. And then he e-mailed me back
9 and said, "Thank you for responding so quickly," and
10 he would have his secretary reach out to me to set a
11 date and time.
12 Q. Okay. So this meeting that you were going
13 to have with him that ended up being a lunch, was any
14 part of that meeting in the context of receiving
15 medical care, opinions or services?
16 A. No.
17 Q. Okay. Were you going to learn anything from
18 Dr. Hruz you would personally use with you or your
19 family members when it comes to treatment for any type
20 of disorders?
21 A. No.
22 Q. Was it just to learn about Dr. Hruz's
23 position on the pediatric gender center at the
24 Washington University?
25 A. Well, he called the meeting, so I -- I --

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1 again, I really wanted to go, because I understood
2 that he had a lot of influence on whether or not the
3 center moved forward. And I had been talking with
4 other doctors and people on their DSD team at
5 St. Louis Children's Hospital about moving this
6 forward, but it really had stalled.
7 And so I -- I just felt like being the head
8 of Endocrine, that he would have a lot of influence
9 over that decision. And so for me, that is why I
10 wanted to go and meet with him, to see if I could say
11 anything that would might make -- that might make him
12 more interested in doing something like that.
13 Q. So would you characterize this as a business
14 meeting?
15 A. Not really. I'm -- not really. I guess --
16 I guess --
17 Q. Were you hoping to come away from that
18 meeting with some type of support from Dr. Hruz for
19 the establishment of the pediatric gender center?
20 A. I guess I just felt like all of the
21 treatment for our kids was going through a person that
22 reported to Dr. Hruz. And so I guess I felt like he
23 may not have enough information to support it or not
24 support it. He wasn't seeing any of our kids.
25 There -- there were only a handful of our kids at the

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1 time.
2 You know, this is four years ago before
3 everything really opened up in St. Louis as far as
4 treatment and care for kids. But I just understood
5 that he -- and especially since he had already said in
6 his e-mail that he didn't support the center, I guess
7 I was hopeful that the parent perspective might be
8 helpful.
9 Q. Okay. Now, did I understand you to say that
10 you were aware that Dr. Hruz was providing treatment
11 to your -- when you say "our kids," are you referring
12 to TransParent --
13 A. Yes.
14 Q. -- members' kids?
15 A. Yes.
16 Q. Okay. So to your knowledge, as of 2013, to
17 your knowledge, was Dr. Hruz treating transgender
18 children?
19 A. He was not, that I -- to my knowledge.
20 Q. Okay. So in terms of that -- that lunch
21 meeting, can you tell me everything you can remember
22 from the meeting?
23 A. Yes.
24 MR. GONZALEZ-PAGAN: Form.
25 Q. (By Mr. Harmon) Well, let me ask it a

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1 different way. Can you tell me, to the best of your
2 recollection, everything Dr. Hruz said to you during
3 the lunch meeting?
4 MR. GONZALEZ-PAGAN: Form. You can answer.
5 THE WITNESS: Oh.
6 Q. (By Mr. Harmon) Yeah, you can answer.
7 A. Yeah. So after, you know, introducing
8 ourselves I started off with trying to tell him a
9 little bit about my family and our experience, but
10 I -- I really didn't get very far. He interrupted me
11 fairly quickly, probably within a minute or so, two
12 minutes tops, and said that he had reviewed my
13 brochure from TransParent and that he knew that my aim
14 was to normalize the transgender experience, but that
15 it would never be a normal experience. It was not a
16 normal experience, and it would never be normal.
17 We went on to talk more about, you know,
18 his -- he -- he actually started talking about Pope
19 John Paul II's writings on gender and -- and how they
20 explain God's plan for gender, and that I should
21 consider reading them. And he said, you know, this
22 idea that -- the idea of doing surgeries on
23 transgender people is -- is wrong, that, you know, we
24 should not be, you know, changing bodies.
25 And I said -- I -- I argued with him on that

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1 point that, you know, there are men that have man
2 boobs, and I said they have theirs surgically removed
3 or altered. And I said wouldn't that be the same
4 thing, and -- and why is that okay, but not removing
5 the breast for a transgender boy, and he said,
6 "Because male breasts aren't used for anything, but
7 female breasts lactate and provide nourishment to
8 babies. So, therefore, it would be -- it would go
9 against, you know, God's plan to remove breasts from
10 women." Something -- something very close that.
11 He said several times during this
12 conversation, as I tried to tell him, you know, how
13 hard it was for my child living a transgender life,
14 you know, but that -- but what a great -- what a great
15 son I've had since I allowed him to transition, how
16 happy he was. And he said that, you know, what a -- I
17 kept saying, "What a normal life -- like if you met my
18 son, you would never know. He's a very normal little
19 boy."
20 And he kept saying, he kept insisting that
21 my child was not normal and would never be normal.
22 And he said that to me at least three or four times
23 during our conversation.
24 He said -- and -- and at the same time he
25 just kept saying, "If only you would read Pope John

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1 Paul II's writings. If only you would read them, you
2 would understand everything." And I said, "Well, you
3 know, the Bible tells a story about, you know, man
4 was -- woman was created from the rib of man," and I
5 said, "You know, maybe this all started with Adam and
6 Eve because God took a rib from a woman -- or from a
7 man and put it into women, and maybe he crossed that
8 DNA, you know, at the very beginning, and maybe that's
9 why we have transgender people."
10 He said -- he got very irritated with me,
11 and he said, "Not all the stories in the Bible are
12 true."
13 And I said, "Well, then how do you decide
14 which ones you're going to believe and which ones
15 you're not? How do you determine that, like, which
16 ones you follow and which ones you don't follow?"
17 And he -- he reverted right back to -- he
18 goes, "You just need to read Pope John Paul II's
19 writings on gender. It will -- it will explain it all
20 to you."
21 And I said, "Do you realize that kids like
22 mine are at a 41 percent risk of suicide if they don't
23 have acceptance and -- and care from their parents
24 and -- and if they don't get their medical needs met?"
25 And he said, "Some children are born in this

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1 world to suffer and die." And he said, "Do you think
2 I don't ask myself all the time why some people get
3 cancer?" He goes, "I -- I ask myself that all the
4 time."
5 And I said, "Well, people with cancer, at
6 least we try to help them. At least we give them
7 care." And I think the conversation ended shortly
8 after that, and he stood up, and he said, "I -- I have
9 to tell you there will never be a pediatric gender
10 center at St. Louis Children's Hospital. I won't
11 allow it." And I --
12 Q. Did he say why?
13 A. Pardon me?
14 Q. Did he say why he would not allow it?
15 A. Well, based on every -- no, he did not say
16 why. That's how he ended the conversation, but my
17 interpretation would have been based on everything
18 we -- he had just shared with me that he was in
19 disagreement from -- based on his faith.
20 Q. Did he ever say that he would not allow a
21 gender center because of his faith?
22 A. He did not.
23 Q. Okay. That was your interpretation of --
24 A. Yes.
25 Q. -- what the conversation was?

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1 A. I am.
2 Q. How are you aware of what his position is
3 now?
4 A. I saw a -- some papers that he's publishing,
5 and I understand that he is involved in other cases
6 involving students, so Internet searches.
7 Q. Did your conversation with Dr. Hruz anger
8 you?
9 A. My conversation?
10 Q. Yes.
11 A. It -- it perplexed me. I found --
12 Q. Why did it perplex you?
13 A. Again, because it was so religious-based.
14 I -- I was very taken off guard by the religious tone
15 of the conversation, because I -- I figured it would
16 at least be based on science. He would have some
17 science behind his feelings over children like mine,
18 but that is not what I heard in our conversation at
19 all.
20 Q. So your conversation with Dr. Hruz, is it
21 fair to say that it was based on religion and moral
22 viewpoints as opposed to science?
23 A. Yes.
24 MR. GONZALEZ-PAGAN: Form.
25 Q. (By Mr. Harmon) What was the answer?

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

DREW ADAMS, a minor, by and through his next friend and mother, ERICA ADAMS KASPER,

Plaintiff,

v.

THE SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA,

Defendant.

Civil Action No. 3:17-cv-00739-TJCJBT

EXPERT DECLARATION of Paul W Hruz, M.D., Ph.D

1. I have been retained by counsel for Defendants as an expert in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this declaration. My professional background, experience, and publications are detailed in my curriculum vitae, a true and accurate copy which is attached as Exhibit A to this declaration.

2. I received my doctor of philosophy degree from the Medical College of Wisconsin in 1993. I received my medical degree from the Medical College of Wisconsin in 1994. I am an Associate Professor of Pediatrics in the Division of Pediatric Endocrinology and Diabetes at Washington University School of Medicine. I also have a secondary appointment as Associate Professor of Cellular Biology and Physiology in the Division of Biology and Biological Sciences at Washington University School of Medicine. I served as chief of the Division of Pediatric Endocrinology and Diabetes at Washington University from 2012-2017. I served as the

Pl. Trial Ex. 089

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Director of the Pediatric Endocrinology Fellowship Program at Washington University from 2008-2016.

3. I am board certified in Pediatrics and Pediatric Endocrinology. I have been licensed to practice medicine in Missouri since 2000.

4. My professional memberships include the American Academy of Pediatrics, the Pediatric Endocrine Society, the Endocrine Society, and the American Association for Biochemistry and Molecular Biology.

5. I have extensive experience in treating infants and children with disorders of sexual development and am an active member of the multidisciplinary Disorders of Sexual Development (DSD) program at Washington University. The DSD Team at Washington University is part of the DSD-Translational Research Network, a national multi-institutional research network that investigates the genetic causes and the psychologic consequences of DSD.

6. In the nearly 20 years that I have been in clinical practice I have participated in the care of hundreds of children with disorders of sexual development. In the care of these patients, I have acquired expertise in the understanding and management of associated difficulties in gender identification.

7. In my role as the director of the Division of Pediatric Endocrinology at Washington University, I have extensively studied the existing literature related to the incidence, potential etiology and treatment of gender dysphoria as efforts were made to develop a Transgender clinic at Saint Louis Children's Hospital. I have participated in local and national meetings where the endocrine care of children with gender dysphoria has been discussed and debated. I have met individually with several pediatric endocrinologists, including Dr. Norman Spack, who have developed and led transgender programs in the United States. I have also met with parents of

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children with gender dysphoria to understand the unique difficulties experienced by this patient population.

8. Pediatric patients referred to our practice for the evaluation and treatment of gender dysphoria are cared for by an interdisciplinary team of providers that includes a psychologist and pediatric endocrinologist who have been specifically chosen for this role based upon a special interest in this rare patient population. Due to serious concerns regarding the safety, efficacy, and ethics of the current treatment paradigm, I have not directly engaged in hormonal treatment of patients with gender dysphoria.

9. My opinions as detailed in this declaration are based upon my knowledge and direct professional experience in the subject matters discussed. The materials that I have relied upon are the same types of materials that other experts in my field of clinical practice rely upon when forming opinions on the subject. The documents that I have reviewed specifically related to this case are 1.) The first amended complaint for declaratory, injunctive, and other relief for Drew Adams, 2.) The plaintiff's first amended rule 26(a) disclosure and 3.) Drew Adams' medical records. A list of the published literature I have relied on is attached as Exhibit B to this declaration.

10. Over my career, I have provided expert medical record review and testified at deposition in less than a dozen cases. Related to the litigation of issues of sex and gender, I have been designated as an expert witness in *Joaquin Carcaño et al vs. Patrick Mccrory, Jane Doe vs Board of Education of the Highland School District*, and *Ashton Whitaker vs. Kenosha Unified School District.* I have been deposed in the last of these cases. In the past 4 years I have also served as an expert witness in *Dakota Humphrey vs. Stanley Block* and *Liston Ward et al. vs. Janssen Pharmaceuticals*. I have never testified at trial.

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11. I am being compensated at an hourly rate for actual time devoted, at the rate of $350 per hour. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

Case Details

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Basic Terminology

13. Biological sex is a term that specifically refers to a member of a species in relation to the member's capacity to either donate (male) or receive (female) genetic material for the purpose of reproduction. This remains the standard definition that has been accepted and used by scientists, medical personnel, and society in general.

14. Gender, a term that had traditionally been reserved for grammatical purposes, is currently used to describe the psychologic and cultural characteristics of a person in relation to biological sex. Gender therefore exists in reference to societal perceptions, not biology.

15. Gender identity refers to a person's individual perception of being male or female.

16. Sexual orientation refers to a person's arousal and desire for sexual intimacy with members of the male or female sex.

Human sexuality in relation to fundamental biology and observed variations

17. Sex is genetically encoded at the moment of conception due to the presence of specific DNA sequences (i.e. genes) that direct the production of signals that influence the formation of bipotential gonad to develop into either a testis or ovary. This genetic information is normally present on X and Y chromosomes. Chromosomal sex refers to the normal complement of X and Y chromosomes (i.e. normal human males have one X and one Y chromosome whereas normal human females have two X chromosomes). Genetic signals are mediated through the activation or deactivation of other genes and through programmed signaling of hormones and cellular transcription factors. The default pattern of development in the absence of external signaling is female. The development of the male appearance (phenotype) depends upon active signaling

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processes.

18. For members of the human species, sex is normatively aligned in a binary fashion (i.e., either male or female) in relation to biologic purpose. Medical recognition of an individual as male or female is typically made at birth according to external phenotypic expression of primary sexual traits (i.e., presence of a penis for males and presence of labia and vagina for females).

19. Due to genetic and hormonal variation in the developing fetus, normative development of the external genitalia in any individual differs with respect to size and appearance while maintaining an ability to function with respect to biologic purpose (i.e. reproduction). Internal structures (e.g. gonad, uterus, vas deferens) normatively align with external genitalia.

20. Reliance upon external phenotypic expression of primary sexual traits is a highly accurate means to assign biologic sex. In over 99.9% of cases, this designation will correlate with internal sexual traits and capacity for normal biologic sexual function. Sex is therefore not "assigned at birth" but is rather recognized at birth.

21. Due the complexity of signals that are involved in normal sexual development, it is not surprising that a small number of individuals are born with defects in this process. Defects can occur either through inherited or *de novo* mutations in genes that are involved in sexual determination or through environmental insults during critical states of sexual development. Persons who are born with such abnormalities are considered to have a disorder of sexual development (DSD). Most often, this is first detected as ambiguity in the appearance of the external genitalia.

22. Normal variation in external genital appearance (e.g. phallic size) does not alter the basic biologic nature of sex as a binary trait. "Intersex" conditions represent disorders of normal development, not a third sex.

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23. Medical care of persons with DSDs is primarily directed toward identification of the etiology of the defect and treatment of any associated complications. Similar to other diseases, tools such as the Prader scale are used to stage the severity of the deviation from normal. In children with DSDs, characterization based upon phenotype alone does not reliably predict chromosomal sex nor does it necessarily correlate with potential for biological sexual function. Decisions on initial sex assignment in these rare cases require detailed assessment by a team of expert medical providers.

24. Standard medical practice in the treatment of persons with DSDs has evolved with growing understanding of the physical and psychologic needs and outcomes for affected individuals. Previously, it was felt that a definitive sex assignment was necessary shortly after birth with the belief that this would allow patients with DSDs to best conform to the assigned sex. Current practice is to defer sex assignment until the etiology of the disorder is determined and, if possible, a prediction can be made on likely biologic and psychologic outcomes. When this cannot be done with confidence, a presumptive sex assignment is made. Factors used in making such decisions include chromosomal sex, phenotypic appearance of the external genitalia, and parental desires. The availability of new information can in rare circumstances lead to sex reassignment. Decisions on whether to surgically alter the external genitalia to align with sex are generally deferred until the patient is able to provide consent.[1]

Gender Dysphoria in relation to Biological Sex

25. Although gender usually aligns with biological sex, some individuals experience discordance in these distinct traits. Specifically, biologic females may identify as males and biologic males may identify as females. As gender by definition is distinct from biological sex,

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one's gender identity does not change a person's biological sex.

26. Individuals who experience significant distress due to discordance between gender identity and sex are considered to have "gender dysphoria".[2] Although the prevalence of gender dysphoria has not been established by rigorous scientific analysis, estimates reported in in the DSM-V are between 0.005% to 0.014% for adult males and 0.002% to 0.003% for adult females. Thus, gender dysphoria is a rare condition. It is currently unknown whether these estimates are falsely low due to under-reporting, or if changing societal acceptance of transgenderism and the growing number of medical centers providing medical intervention for gender dysphoria affects the number of persons who identify as transgender. Recent data indicates that the number of people seeking care for gender dysphoria is increasing with some estimates as high as 20-fold.[3,4]

27. There is strong evidence against the theory that gender identity is determined at or before birth and is unchangeable. This comes from identical twin studies where siblings share genetic complements and prenatal environmental exposure but have differing gender identities.[5]

28. Further evidence that gender identity is not fixed comes from established peer reviewed literature demonstrating that the vast majority (80-95%) of children who express gender dysphoria revert to a gender identity concordant with their biological sex by late adolescence.[6,7] It is not known whether individuals with gender dysphoria persistence have differing etiologies or severity of precipitating factors compared to desisting individuals.

30. The etiology of gender dysphoria in individuals with gender dysphoria remains to be identified. Theories include prenatal hormone exposure, genetic variation, and postnatal environmental influences. Based upon the currently available but incomplete dataset, it is likely that gender dysphoria is multifactorial with differing qualitative and quantitative influences in any given individual.

31. The recently coined concept of "neurological sex" as a distinct entity or a basis for classifying individuals as male or female has no scientific justification. Limited emerging data has suggested structural and functional differences between brains from normal and transgender individuals. These data do not establish whether these differences are innate and fixed or acquired and malleable. The remarkable neuronal plasticity of the brain is known and has been studied extensively in gender-independent contexts related to health and disease, learning and behavior.

Gender Ideology

32. The modern attempt to equate gender identity with sex is not based upon sound scientific principles but rather is based upon ideology fueled by advocacy. Although worldviews among scientists and physicians, similar to society at large, differ, science is firmly grounded in physical reality not perception. The inherent link between human sexual biology and teleology is self-evident and fixed.

33. The claims of proponents of transgenderism, which include opinions such as "Gender identity is the primary factor determining a person's sex" and "Gender is the only true determinant of sex" must be viewed in their proper philosophical context. There is no scientific basis for redefining sex on the basis of a person's psychological sense of 'gender'.

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34. The prevailing, constant and accurate designation of sex as a biological trait grounded in the inherent purpose of male and female anatomy and as manifested in the appearance of external genitalia at birth remains the proper scientific and medical standard. Redefinition of the classification and meaning of sex based upon pathologic variation is not established medical fact.

Potential Harm Related to Gender Dysphoria Treatments

35. The fundamental purpose of the practice of medicine is to treat disease and alleviate suffering. An essential tenet of medical practice is to avoid doing harm in the process. Due to the frequent lack of clear and definitive evidence on how to best accomplish this goal, treatment approaches can and do frequently differ among highly knowledgeable, competent, and caring physicians.

36. Persons with gender dysphoria as delineated in the DSM-V experience significant psychological distress related to their condition with elevated risk of depression, suicide, and other morbidities. Thus, attempts to provide effective medical care to affected persons are clearly warranted.

37. Efforts to effectively treat persons with gender dysphoria require respect for the inherent dignity of those affected, sensitivity to their suffering, and maintenance of objectivity in assessing etiologies and long-term outcomes. Desistance (i.e. reversion to gender identity concordant with sex) provides the greatest lifelong benefit and is the outcome in the majority of patients and should be maintained as a desired goal. Any forced societal intervention that could interfere with the likelihood of gender dysphoria resolution is unwarranted and potentially harmful.

38. There is an urgent need for high quality controlled clinical research trials to determine

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ways to develop supportive dignity affirming social environments that maintain affirmation of biological reality. To date, three approaches have been proposed for managing children with gender dysphoria.[8] The first approach, often referred to as "conversion" or "reparative therapy", is directed toward actively supporting and encouraging children to identify with their biological sex. The second "neutral" approach, motivated by understanding of the natural history of transgender identification in children, is to neither encourage nor discourage transgender identification, recognizing that the majority of affected children if left alone will eventually realign their gender with their sex. The third "affirming" approach is to actively encourage children to embrace transgender identity with social transitioning followed by hormonal therapy.

39. The gender affirming approach, which includes use of a child's preferred pronouns, use of sex-segregated bathrooms, other intimate facilities and sleeping accommodations corresponding to a child's gender identity, has limited scientific support for short-term alleviation of dysphoria and no long-term outcomes data demonstrating superiority over the other approaches. Claims that the other approaches have been scientifically disproven are false. Decades of research, most notably the pioneering work of Dr. Kenneth Zucker, have supported the efficacy of a more conservative approach for the majority of patients experiencing gender dysphoria.[8,9]

40. Feelings of anxiety, depression, isolation, frustration, and embarrassment are not unique to children with gender dysphoria, but rather are common to children who differ physically or psychologically from their peers. Difficulties are accentuated as children progress through the normal stages of neurocognitive and social development. In the clinical practice of pediatric endocrinology, this is most commonly seen in children with diabetes. Attempts to deny or conceal the presence of disease rather than openly acknowledge and address specific needs can

have devastating consequences including death. With proper acknowledgment of the similarity and differences between children with gender dysphoria and other developmental challenges, prior experience can guide the development of effective approaches to both alleviate suffering and minimize harm to school aged children experiencing gender dysphoria.

41. The Endocrine Society published in 2009 clinical guidelines for the treatment of patients with persistent gender dysphoria.[10] The recommendations include temporary suppression of pubertal development of children with GnRH agonists (hormone blockers normally used for children experiencing precocious puberty) followed by hormonal treatments to induce the development of secondary sexual traits consistent with one's gender identity. This guideline was developed using the GRADE (Recommendations, Assessment, Development, and Evaluation) system for rating clinical guidelines. As directly stated in the Endocrine Society publication, "the strength of recommendations and the quality of evidence was low or very low." According to the GRADE system, low recommendations indicate "Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate". Very low recommendations mean that "any estimate of effect is very uncertain". An updated set of guidelines was published in September of 2017.[11] The low quality of evidence presented in this document persist.

42. Clinical Practice Guidelines published by the World Professional Association for Transgender Health (WPATH), which is currently in its 7th iteration, similarly, though less explicitly, acknowledge the limitation of existing scientific data supporting their recommendations given and "the value of harm-reduction approaches".

43. Treatment of gender dysphoric children who experience persistence of symptoms with hormones (pubertal suppression and cross-hormone therapy) carries significant risk. It is

generally accepted, even by advocates of transgender hormone therapy, that hormonal treatment results in sterility which in many cases is irreversible.[12] Emerging data also show that treated patients have lower bone density which may lead to increased fracture risk later in life.[13] Other potential adverse effects include disfiguring acne, high blood pressure, weight gain, abnormal glucose tolerance, breast cancer, liver disease, thrombosis, and cardiovascular disease.[14]

44. Since strategies for the treatment of transgendered children as summarized by the Endocrine Society guidelines are relatively new, long-term outcomes are unknown. Evidence presented as support for short term reductions in psychological distress following social transition in a "gender affirming" environment remains inconclusive. When considered apart from advocacy based agendas, multiple potential confounders are evident. The most notable deficiencies of existing research are the absence of proper control subjects and lack of randomization in study design. Although appropriate caution is warranted in extrapolating the outcomes observed from prior studies with current treatments, adults who have undergone social transition with or without surgical modification of external genitalia continue to have rates of depression, anxiety, substance abuse and suicide far above the background population.[15,16]

45. Evidence cited to support societal measures that promote or encourage gender transition, including the plaintiff's demand for use of multi-user sex-segregated restrooms corresponding with the plaintiff's gender identity, as a medically necessary treatment for gender dysphoria is limited. Recent studies reporting reductions in dysphoria following social transition of adolescent patients are small, poorly controlled and of insufficient duration to draw definitive conclusions regarding long-term efficacy. Long-term follow up of patients with gender dysphoria who have undergone social and hormonal transition with or without surgical intervention has

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shown persistent psychological morbidity far above non-transgendered individuals with suicide attempts 7-fold and completed suicides19-fold above the general population.[15,16]

46. Of particular concern is the likelihood that forced societal affirmation including a requirement that the St. John's County School District allow students to use sex-segregated bathrooms corresponding to gender identity rather than access to single unit facilities, will interfere with known rates of gender resolution. Any activity that encourages or perpetuates transgender persistence for those who would otherwise desist can cause significant harm, particularly in light of the current treatment paradigm for persisting individuals. As noted, permanent sterility can be expected with hormonal or surgical disruption of normal gonadal function. This is particularly concerning given that children are likely incapable of making informed consent to castrating treatments.[17]

47. Dignity affirming support for adolescents with gender dysphoria does not necessitate facilitation of a false understanding of human sexuality in schools. Rather, policy requirements that can increase persistence of transgender identification have significant potential for inducing long-term harm to affected children.

48. There remains a significant and unmet need to better understand the biological, psychological, and environmental basis for the manifestation of discordance of gender identity and biological sex in affected individuals.[18] In particular, there is a concerning lack of randomized controlled trials comparing outcomes of youth with gender dysphoria who are provided mandated access to sex-segregated bathroom facilities corresponding with gender identity to youth provided single user facilities. This includes understanding of how forced public encouragement of social gender transition affects the usual progression to resolution of gender dysphoria in affected children. Such studies can be ethically designed and executed with

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provision of other dignity affirming measures to both treatment groups. Without this scientific evidence, it is impossible to assert that the approach using sex-segregated bathrooms is an essential component of treatment.

49. Limitations on this report: My opinions and hypotheses in this matter are subject to the limitations of all documentary and related evidence, the impossibility of absolute prediction, as well as the limitations of social and medical science. I have not met with, nor interviewed, plaintiff Drew Adams. 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. 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 Michael Spellman, for distribution as consistent with the relevant laws.

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: November 2, 2017

Paul W. Hruz, M.D., Ph.D.

Curriculum Vitae

Paul W. Hruz, M.D., Ph.D.

Date: 10/18/2017 08:36 AM

Personal Information

Birthplace:	WI
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Present Positions

Associate Professor of Pediatrics, Endocrinology and Diabetes
Associate Professor of Pediatrics, Cell Biology & Physiology
Researcher, Developmental Biology

Education and Training

1987	BS, Chemistry, Marquette University, Milwaukee, WI
1993	PhD, Biochemistry, Medical College of Wisconsin, Milwaukee, WI
1994	MD, Medicine, Medical College of Wisconsin, Milwaukee, WI
1994 - 1997	Pediatric Residency, University of Washington, Seattle, Washington
1997 - 2000	Pediatric Endocrinology Fellowship, Washington University, Saint Louis, MO

Academic Positions and Employment

1996 - 1997	Locum Tenens Physician, Group Health of Puget Sound Eastside Hospital, Group Health of Puget Sound Eastside Hospital, Seattle , WA
2000 - 2003	Instructor in Pediatrics, Endocrinology and Diabetes, Washington University in St. Louis, St. Louis, MO
2003 - 2011	Assistant Professor of Pediatrics, Endocrinology and Diabetes, Washington University in St. Louis, St. Louis, MO
2004 - 2011	Assistant Professor of Pediatrics, Cell Biology & Physiology, Washington University in St. Louis, St. Louis, MO
2011 - Pres	Associate Professor of Pediatrics, Cell Biology & Physiology, Washington University in St. Louis, St. Louis, MO
2011 - Pres	Associate Professor of Pediatrics, Endocrinology and Diabetes, Washington University in St. Louis, St. Louis, MO
2012 - 2017	Division Chief, Endocrinology and Diabetes, Washington University in St. Louis, St. Louis, MO
2016 - Pres	Researcher, Developmental Biology, Washington University in St. Louis, St. Louis, MO

Exhibit A

Appointments and Committees

NIH Study Sections

2005	NIH- NIDDK Special Emphasis Panel ZDK1 GRB-6
2009	NIH- ACE Competitive Revisions ZRG1 AARR-H (95) S
2009	NIH- AIDS and AIDS Related Research IRG
2011	NIH- Pediatric Endocrinologist K12 ZDK1 GRB-C
2014	NIH- Special Empahsis Panel ZRG1 BBBPY 58
2014	NIH- AIDS and AIDS Related Research IRG
2015	NIH- Cardiovascular and Respiratory Sciences Special Emphasis Panel ZDK1 GRB-J (02)
2015	NIH- NIDDK Special Emphasis Panel ZRG1 CVRS-Q (80)
2016	NIH Special Emphasis Panel ZRG1 AAR-M
2016	American Diabetes Association Research Grant Review Committee

Local Appointments

2017 - Pres	Board of the Catholic Medical Association, St. Louis Guild

University Affiliations

2008 - 2016	Director, Pediatric Endocrinology & Diabetes Fellowship Program
2010 - Pres	Pediatric Computing Facility Advisory Committee
2012 - 2017	Director, Division of Pediatric Endocrinology & Diabetes
2012 - Pres	Disorders of Sexual Development Multidisciplinary Care Program
2013 - Pres	Molecular Cell Biology Graduate Student Admissions Committee
2014 - Pres	Research Consultant, ICTS Research Forum - Child Health
2014 - Pres	Director, Pediatric Diabetes Research Consortium

Hospital Affiliations

2000 - Pres	Attending Physician, St. Louis Children's Hospital

Thesis Committees (*Chair)		Advisor
2008 - 2011	Kelly Diggs-Andrews	Simon Fisher
2008 - 2010	Irwin Puentes	Simon Fisher
2008 - 2010	Tony Frovola	Kelle Moley
2009 - 2010	Lauren Flessner	Kelle Moley
2010 - 2012	Katie Boehle	Kelle Moley
2010 - 2013	Candace Reno	Simon Fisher
2011 - 2016	Thomas Kraft	Paul Hruz
2013 - 2015	Chi Lun Pui	Audrey Odom
2013 - 2016	Leah Imlay	Audey Odom
2014 - Pres	Anne Robinson	Katie Henzler-Wildman
2015 - Pres	Allyson Mayer	Brian DeBosch

Scholarship Oversight Committees

2013 - 2016	Brittany Knipsein (Advisor: David Rudnick)
2016 - Pres	Pamela Smith (Advisor: Michael Whyte)

Licensure and Certifications

1997 - Pres	Board Certified in General Pediatrics
2000 - Pres	MO Stae License #2000155004
2001 - Pres	Board Certified in Pediatric Endocrinology & Metabolism

Honors and Awards

1987	National Insitute of Chemists Research and Recognition Award
1987	Phi Beta Kappa
1987	Phi Lambda Upsilon (Honorary Chemical Society)
1988	American Heart Association Predoctoral Fellowship Award
1994	Alpha Omega Alpha
1994	Armond J. Quick Award for Excellence in Biochemistry
1994	NIDDK/Diabetes Branch Most Outstanding Resident
1998	Pfizer Postdoctoral Fellowship Award
2002	Scholar, Child Health Research Center of Excellence in Developmental Biology at Washington University
2013	Julio V Santiago, M.D. Scholar in Pediatrics

Editorial Responsibilities

Editorial Ad Hoc Reviews

	AIDS
	AIDS Research and Human Retroviruses
	American Journal of Pathology
	American Journal of Physiology
	British Journal of Pharmacology
	Circulation Research
	Clinical Pharmacology & Therapeutics
	Comparative Biochemistry and Physiology
	Diabetes
	Experimental Biology and Medicine
	Future Virology
	Journal of Antimicrobial Chemotherapy
	Journal of Clinical Endocrinology & Metabolism
	Journal of Molecular and Cellular Cardiology
	Obesity Research
2000 - Pres	Journal of Biological Chemistry
2013 - Pres	PlosOne
2016 - Pres	Scientific Reports

Editorial Boards

2014 - Pres Endocrinology and Metabolism Clinics of North America

Professional Societies and Organizations

1992 - 2004	American Medical Association
1994 - 2005	American Academy of Pediatrics
1995 - 2014	American Association for the Advancement of Science
1998 - Pres	American Diabetes Association
1998 - Pres	Endocrine Society
1999 - Pres	Pediatric Endocrine Society
2004 - Pres	American Society for Biochemistry and Molecular Biology
2004 - Pres	Society for Pediatric Research
2004 - 2007	American Chemical Society
2005 - Pres	Full Fellow of the American Academy of Pediatrics
2013 - Pres	International Society for Pediatric and Adolescent Diabetes

Major Invited Professorships and Lectures

2002	St. Louis Children's Hospital, Pediatric Grand Rounds, St. Louis, MO
2004	National Disease Research Interchange, Human Islet Cell Research Conference, Philadelphia, PA
2004	NIDA-NIH Sponsored National Meeting on Hormones, Drug Abuse and Infections, Bethesda, MD
2005	The Collaborative Institute of Virology, Complications Committee Meeting, Boston, MA
2005	University of Indiana, Endocrine Grand Rounds, Indianapolis, IN
2006	Metabolic Syndrome Advisory Board Meeting, Bristol-Meyers Squibb, Pennington, NJ
2007	American Heart Association and American Academy of HIV Medicine State of the Science Conference: Initiative to Decrease Cardiovascular Risk and Increase Quality of Care for Patients Living with HIV/AIDS, Chicago, IL
2007	Medical College of Wisconsin, MSTP Annual Visiting Alumnus Lecture, Milwaukee, WI
2007	St Louis Children's Hospital, Pediatric Grand Rounds, St Louis, MO
2007	University of Arizona, Minority Access to Research Careers Seminar, Tucson AZ
2008	Boston University, Division of Endocrinology, Diabetes and Nutrition, Boston, MA
2009	St Louis Children's Hospital, Pediatric Grand Rounds, St Louis, MO
2010	American Diabetes Association Scientific Sessions, Symposium Lecture Orlando, FL
2010	University of Missouri Kansas City, School of Biological Sciences, Kansas City, MO
2011	Life Cycle Management Advisory Board Meeting, Bristol-Myers Squibb, Chicago, IL.
2013	St Louis Children's Hospital, Pediatric Grand Rounds, St Louis MO
2013	St Louis Children's Hosptial CPU Lecture, St Louis MO
2014	Pediatric Academic Societies Meeting, Vancouver, Canada.
2014	American Diabetes Association 74th Scientific Sessions, San Francisco, CA.
2017	University of Michigan, Division of Pediatric Endocrinology Ann Arbor, MI.
2017	Napa Institute National Conference Napa, CA.
2017	Catholic Medical Association National Conference Denver, CO.

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Consulting Relationships and Board Memberships

1996 - 2012 Consultant, Bristol Myers Squibb
1997 - 2012 Consultant, Gilead Sciences

Research Support

Non-Governmental Support

(Hruz)
Gilead Pharma
Novel HIV Protease Inhibitors and GLUT4

MHI-2017-593 (DeBosch) 2/1/2017- 1/31/2020
CDI
Prevention And Treatment Of Hepatic Steatosis Through Selective Targeting Of GLUT8

Completed Support

II (Hruz) 2/1/2012- 1/31/2015
CDI
Solution-State NMR Structure and Dynamics of Facilitative Glucose Transport Proteins

R01 (Hruz) 9/20/2009- 5/31/2014
NIH
Direct Effects of Antiretroviral Therapy on Cardiac Energy Homeostasis
The goal of this project is to characterize the influence of antiretroviral therapies on myocardial energy homeostasis and to elucidate how these changes in substrate delivery adversely affect cardiac function in the stressed heart.

Research Program (Hruz) 6/1/2009- 5/31/2012
MOD
Regulation of GLUT4 Intrinsic Activity
The major goals of this project are to investigate the ability of the GLUT4 tethering protein TUG and an UBL-domain containing N-terminal fragment of this protein to alter the intrinsic activity of the insulin responsive facilitative glucose transporter, to determine whether protein ubiquitination influences this association, and to characterize the role of the GLUT4 binding site on the modulation of glucose transport.

R01 (Hruz) 4/1/2007- 1/31/2012
NIH
Mechanisms for Altered Glucose Homeostasis During HAART
The goal of this project is to identify the cellular targets of HIV protease inhibitors that lead to peripheral insulin resistance, impaired beta-cell function, and alterations in hepatic glucose production and to elucidate the molecular mechanisms of these effects.

R01 Student Supp (Hruz) 6/10/2009- 8/31/2011
NIH
Mechanisms for Altered Glucose Homeostasis During HAART
The goal of this project is to identify the cellular targets of HIV protease inhibitors that lead to peripheral insulin resistance, impaired beta-cell function, and alterations in hepatic glucose production and to elucidate the molecular mechanisms of these effects.

(Hruz) 3/9/2010- 6/8/2011
Bristol-Myers Squibb
Protective Effect of Saxagliptin on a Progressive Deterioration of Cardiovascular Function

II (Hruz) 2/1/2008- 1/31/2011
CDI
Insulin Resistance and Myocardial Glucose Metabolism in Pediatric Heart Failure

Past Trainees

2014 - 2014 David Hannibal, Clinical Research Trainee
2005 - 2005 Dominic Doran, DSc, Postdoctoral Fellow
Study area: HIV Protease Inhibitor Effects on Exercize Tolerance
2002 - 2010 Joseph Koster, PhD, Postdoctoral Fellow
Study area: Researcher
2010 - 2014 Lauren Flessner, PhD, Postdoctoral Fellow
Present position: Instructor, Syracuse University
2008 - 2011 Arpita Vyas, MD, Clinical Fellow
Study area: Research
Present position: Assistant Professor, Michigan State University, Lansing MI
2008 - 2009 Candace Reno, Graduate Student
Study area: Research
Present position: Research Associate, University of Utah
2005 - 2005 Helena Johnson, Graduate Student
2007 - 2008 Kai-Chien Yang, Graduate Student
Study area: Research
Present position: Postdoctoral Research Associate, University of Chicago
2007 - 2007 Paul Buske, Graduate Student
Study area: Research
2006 - 2006 Ramon Jin, Graduate Student
Study area: Research
2009 - 2009 Stephanie Scherer, Graduate Student
Study area: Research
2006 - 2006 Taekyung Kim, Graduate Student
Study area: Research
2008 - 2008 Temilope Aiyejorun, Graduate Student
Study area: Research
2011 - 2016 Thomas Kraft, Graduate Student
Study area: Glucose transporter structure/function
Present position: Postdoctoral Fellow, Roche, Penzberg, Germany
2005 - 2005 Jeremy Etzkorn, Medical Student
Study area: Researcher
2003 - 2004 Johann Hertel, Medical Student
Study area: Research
Present position: Assistant Professor, University of North Carolina, Chapel Hill, NC
2003 - 2003 John Paul Shen, Medical Student
Study area: Research
2007 - 2007 Randy Colvin, Medical Student
Study area: Researcher
2011 - 2011 Amanda Koenig- High School Student, Other
Study area: Research
2009 - 2009 Anne-Sophie Stolle- Undergraduate Student, Other
Study area: Research
2004 - 2005 Carl Cassel- High School Student, Other
Study area: Research
2004 - 2004 Christopher Hawkins- Undergraduate Student, Other
Study area: Researcher
2010 - 2010 Constance Haufe- Undergraduate Student, Other
Study area: Researcher
2010 - 2011 Corinna Wilde- Undergraduate Student, Other
Study area: Researcher
2008 - 2012 Dennis Woo- Undergraduate Student, Other
Study area: Researcher
Present position: MSTP Student, USC, Los Angeles CA
2007 - 2007 Jan Freiss- Undergraduate Student, Other
Study area: Researcher
2004 - 2004 Kaiming Wu- High School Student, Other
Study area: Research
2011 - 2012 Lisa Becker- Undergraduate Student, Other
2009 - 2009 Matthew Hruz- High School Student, Other
Study area: Research
Present position: Computer Programmer, Consumer Affairs, Tulsa OK
2011 - 2011 Melissa Al-Jaoude- High School Students, Other
2002 - 2002 Nishant Raj- Undergraduate Student, Other
Study area: Researcher
2010 - 2010 Samuel Lite- High School Student, Other
Study area: Research

Clinical Responsibilities

	General Pediatrician, General Pediatric Ward Attending: 2-4 weeks per year, St. Louis Children's Hospital
Pres	Pediatric Endocrinologist, Endocrinology Night Telephone Consult Service: Average of 2-6 weeks/per yr, St. Louis Children's Hospital
Pres	Pediatric Endocrinologist, Inpatient Endocrinology Consult Service: 4-6 weeks per year, St. Louis Children's Hospital
Pres	Pediatric Endocrinologist, Outpatient Endocrinology Clinic: Approximately 50 patient visits per month, St. Louis Children's Hospital

Teaching Responsibilities

	Facilitator, Cell Biology Graduate Student Journal Club, 4 hour/year
	Facilitator, Discussion: Pituitary, Growth & Gonadal Cases, 2 hours/year
2000 - Pres	Lecturer, Medical Student Growth Lecture (Women and Children's Health Rotation): Variable
2000 - Pres	Lecturer, Metabolism Clinical Rounds/Research Seminar: Presentations twice yearly
2000 - Pres	Lecturer, Pediatric Endocrinology Journal Club: Presentations yearly
2009 - Pres	Lecturer, Markey Course-Diabetes Module
2009 - Pres	Facilitator, Medical Student Endocrinology and Metabolism Course, Small group
2009 - Pres	Facilitator, Biology 5011- Ethics and Research Science, 6 hours/year
2016 - Pres	Facilitator, Medical Student Endocrinology and Metabolism Course, Small group
2016 - Pres	Lecturer, Cell Signaling Course, Diabetes module, 3 hours/year

Publications

1. Hruz PW, Narasimhan C, Miziorko HM. 3-Hydroxy-3-methylglutaryl coenzyme A lyase: affinity labeling of the Pseudomonas mevalonii enzyme and assignment of cysteine-237 to the active site. *Biochemistry*. 1992;31(29):6842-7. PMID:1637819
2. Hruz PW, Miziorko HM. Avian 3-hydroxy-3-methylglutaryl-CoA lyase: sensitivity of enzyme activity to thiol/disulfide exchange and identification of proximal reactive cysteines. *Protein Sci*. 1992;1(9):1144-53. doi:10.1002/pro.5560010908 PMCID:PMC2142181 PMID:1304393
3. Mitchell GA, Robert MF, Hruz PW, Wang S, Fontaine G, Behnke CE, Mende-Mueller LM, Schappert K, Lee C, Gibson KM, Miziorko HM. 3-Hydroxy-3-methylglutaryl coenzyme A lyase (HL). Cloning of human and chicken liver HL cDNAs and characterization of a mutation causing human HL deficiency. *J Biol Chem*. 1993;268(6):4376-81. PMID:8440722
4. Hruz PW, Anderson VE, Miziorko HM. 3-Hydroxy-3-methylglutaryldithio-CoA: utility of an alternative substrate in elucidation of a role for HMG-CoA lyase's cation activator. *Biochim Biophys Acta*. 1993;1162(1-2):149-54. PMID:8095409
5. Roberts JR, Narasimhan C, Hruz PW, Mitchell GA, Miziorko HM. 3-Hydroxy-3-methylglutaryl-CoA lyase: expression and isolation of the recombinant human enzyme and investigation of a mechanism for regulation of enzyme activity. *J Biol Chem*. 1994;269(27):17841-6. PMID:8027038
6. Hruz PW, Mueckler MM. Cysteine-scanning mutagenesis of transmembrane segment 7 of the GLUT1 glucose transporter. *J Biol Chem*. 1999;274(51):36176-80. PMID:10593902
7. Murata H, Hruz PW, Mueckler M. The mechanism of insulin resistance caused by HIV protease inhibitor therapy. *J Biol Chem*. 2000;275(27):20251-4. doi:10.1074/jbc.C000228200 PMID:10806189
8. Hruz PW, Mueckler MM. Cysteine-scanning mutagenesis of transmembrane segment 11 of the GLUT1 facilitative glucose transporter. *Biochemistry*. 2000;39(31):9367-72. PMID:10924131
9. Hruz PW, Mueckler MM. Structural analysis of the GLUT1 facilitative glucose transporter (review). *Mol Membr Biol*. 2001;18(3):183-93. PMID:11681785
10. Hruz PW, Murata H, Mueckler M. Adverse metabolic consequences of HIV protease inhibitor therapy: the search for a central mechanism. *Am J Physiol Endocrinol Metab*. 2001;280(4):E549-53. PMID:11254460
11. Murata H, Hruz PW, Mueckler M. Investigating the cellular targets of HIV protease inhibitors: implications for metabolic disorders and improvements in drug therapy. *Curr Drug Targets Infect Disord*. 2002;2(1):1-8. PMID:12462148
12. Hruz PW, Murata H, Qiu H, Mueckler M. Indinavir induces acute and reversible peripheral insulin resistance in rats. *Diabetes*. 2002;51(4):937-42. PMID:11916910
13. Murata H, Hruz PW, Mueckler M. Indinavir inhibits the glucose transporter isoform Glut4 at physiologic concentrations. *AIDS*. 2002;16(6):859-63. PMID:11919487
14. Koster JC, Remedi MS, Qiu H, Nichols CG, Hruz PW. HIV protease inhibitors acutely impair glucose-stimulated insulin release. *Diabetes*. 2003;52(7):1695-700. PMCID:PMC1403824 PMID:12829635
15. Liao Y, Shikapwashya ON, Shteyer E, Dieckgraefe BK, Hruz PW, Rudnick DA. Delayed hepatocellular mitotic progression and impaired liver regeneration in early growth response-1-deficient mice. *J Biol Chem*. 2004;279(41):43107-16. doi:10.1074/jbc.M407969200 PMID:15265859
16. Shteyer E, Liao Y, Muglia LJ, Hruz PW, Rudnick DA. Disruption of hepatic adipogenesis is associated with impaired liver regeneration in mice. *Hepatology*. 2004;40(6):1322-32. doi:10.1002/hep.20462 PMID:15565660
17. Hertel J, Struthers H, Horj CB, Hruz PW. A structural basis for the acute effects of HIV protease inhibitors on GLUT4 intrinsic activity. *J Biol Chem*. 2004;279(53):55147-52. doi:10.1074/jbc.M410826200 PMCID:PMC1403823 PMID:15496402
18. Yan Q, Hruz PW. Direct comparison of the acute in vivo effects of HIV protease inhibitors on peripheral glucose disposal. *J Acquir Immune Defic Syndr*. 2005;40(4):398-403. PMCID:PMC1360159 PMID:16280693
19. Hruz PW. Molecular Mechanisms for Altered Glucose Homeostasis in HIV Infection. *Am J Infect Dis*. 2006;2(3):187-192. PMCID:PMC1716153 PMID:17186064

20. Turmelle YP, Shikapwashya O, Tu S, Hruz PW, Yan Q, Rudnick DA. Rosiglitazone inhibits mouse liver regeneration. *FASEB J.* 2006;20(14):2609-11. doi:10.1096/fj.06-6511fje PMID:17077279
21. Hruz PW, Yan Q. Tipranavir without ritonavir does not acutely induce peripheral insulin resistance in a rodent model. *J Acquir Immune Defic Syndr.* 2006;43(5):624-5. doi:10.1097/01.qai.0000245883.66509.b4 PMID:17133213
22. Hruz PW, Yan Q, Struthers H, Jay PY. HIV protease inhibitors that block GLUT4 precipitate acute, decompensated heart failure in a mouse model of dilated cardiomyopathy. *FASEB J.* 2008;22(7):2161-7. doi:10.1096/fj.07-102269 PMID:18256305
23. Hruz PW. HIV protease inhibitors and insulin resistance: lessons from in-vitro, rodent and healthy human volunteer models. *Curr Opin HIV AIDS.* 2008;3(6):660-5. doi:10.1097/COH.0b013e3283139134 PMCID:PMC2680222 PMID:19373039
24. Flint OP, Noor MA, Hruz PW, Hylemon PB, Yarasheski K, Kotler DP, Parker RA, Bellamine A. The role of protease inhibitors in the pathogenesis of HIV-associated lipodystrophy: cellular mechanisms and clinical implications. *Toxicol Pathol.* 2009;37(1):65-77. doi:10.1177/0192623308327119 PMCID:PMC3170409 PMID:19171928
25. Tu P, Bhasin S, Hruz PW, Herbst KL, Castellani LW, Hua N, Hamilton JA, Guo W. Genetic disruption of myostatin reduces the development of proatherogenic dyslipidemia and atherogenic lesions in Ldlr null mice. *Diabetes.* 2009;58(8):1739-48. doi:10.2337/db09-0349 PMCID:PMC2712781 PMID:19509018
26. Guo W, Wong S, Pudney J, Jasuja R, Hua N, Jiang L, Miller A, Hruz PW, Hamilton JA, Bhasin S. Acipimox, an inhibitor of lipolysis, attenuates atherogenesis in LDLR-null mice treated with HIV protease inhibitor ritonavir. *Arterioscler Thromb Vasc Biol.* 2009;29(12):2028-32. doi:10.1161/ATVBAHA.109.191304 PMCID:PMC2783673 PMID:19762785
27. Vyas AK, Koster JC, Tzekov A, Hruz PW. Effects of the HIV protease inhibitor ritonavir on GLUT4 knock-out mice. *J Biol Chem.* 2010;285(47):36395-400. doi:10.1074/jbc.M110.176321 PMCID:PMC2978568 PMID:20864532
28. Gazit V, Weymann A, Hartman E, Finck BN, Hruz PW, Tzekov A, Rudnick DA. Liver regeneration is impaired in lipodystrophic fatty liver dystrophy mice. *Hepatology.* 2010;52(6):2109-17. doi:10.1002/hep.23920 PMCID:PMC2991544 PMID:20967828
29. Hresko RC, Hruz PW. HIV protease inhibitors act as competitive inhibitors of the cytoplasmic glucose binding site of GLUTs with differing affinities for GLUT1 and GLUT4. *PLoS One.* 2011;6(9):e25237. doi:10.1371/journal.pone.0025237 PMCID:PMC3179492 PMID:21966466
30. Vyas AK, Yang KC, Woo D, Tzekov A, Kovacs A, Jay PY, Hruz PW. Exenatide improves glucose homeostasis and prolongs survival in a murine model of dilated cardiomyopathy. *PLoS One.* 2011;6(2):e17178. doi:10.1371/journal.pone.0017178 PMCID:PMC3040766 PMID:21359201
31. Hruz PW, Yan Q, Tsai L, Koster J, Xu L, Cihlar T, Callebaut C. GS-8374, a novel HIV protease inhibitor, does not alter glucose homeostasis in cultured adipocytes or in a healthy-rodent model system. *Antimicrob Agents Chemother.* 2011;55(4):1377-82. doi:10.1128/AAC.01184-10 PMCID:PMC3067185 PMID:21245443
32. Hruz PW. Molecular mechanisms for insulin resistance in treated HIV-infection. *Best Pract Res Clin Endocrinol Metab.* 2011;25(3):459-68. doi:10.1016/j.beem.2010.10.017 PMCID:PMC3115529 PMID:21663839
33. Remedi MS, Agapova SE, Vyas AK, Hruz PW, Nichols CG. Acute sulfonylurea therapy at disease onset can cause permanent remission of KATP-induced diabetes. *Diabetes.* 2011;60(10):2515-22. doi:10.2337/db11-0538 PMCID:PMC3178299 PMID:21813803
34. Aerni-Flessner L, Abi-Jaoude M, Koenig A, Payne M, Hruz PW. GLUT4, GLUT1, and GLUT8 are the dominant GLUT transcripts expressed in the murine left ventricle. *Cardiovasc Diabetol.* 2012;11:63. doi:10.1186/1475-2840-11-63 PMCID:PMC3416696 PMID:22681646
35. Vyas AK, Aerni-Flessner LB, Payne MA, Kovacs A, Jay PY, Hruz PW. Saxagliptin Improves Glucose Tolerance but not Survival in a Murine Model of Dilated Cardiomyopathy. *Cardiovasc Endocrinol.* 2012;1(4):74-82. doi:10.1097/XCE.0b013e32835bfb24 PMCID:PMC3686315 PMID:23795310
36. Hresko RC, Kraft TE, Tzekov A, Wildman SA, Hruz PW. Isoform-selective inhibition of facilitative glucose transporters: elucidation of the molecular mechanism of HIV protease inhibitor binding. *J Biol Chem.* 2014;289(23):16100-16113. doi:10.1074/jbc.M113.528430 PMCID:PMC4047383 PMID:24706759
37. Hruz PW. HIV and endocrine disorders. *Endocrinol Metab Clin North Am.* 2014;43(3):xvii-xviii. PMID:25169571
38. Mishra RK, Wei C, Hresko RC, Bajpai R, Heitmeier M, Matulis SM, Nooka AK, Rosen ST, Hruz PW, Schiltz GE, Shanmugam M. In Silico Modeling-based Identification of Glucose Transporter 4 (GLUT4)-selective Inhibitors for Cancer Therapy. *J Biol Chem.* 2015;290(23):14441-53. doi:10.1074/jbc.M114.628826 PMID:25847249
39. Kraft TE, Hresko RC, Hruz PW. Expression, purification, and functional characterization of the insulin-responsive facilitative glucose transporter GLUT4. *Protein Sci.* 2015. doi:10.1002/pro.2812 PMID:26402434
40. Kraft TE, Armstrong C, Heitmeier MR, Odom AR, Hruz PW. The Glucose Transporter PfHT1 Is an Antimalarial Target of the HIV Protease Inhibitor Lopinavir. *Antimicrob Agents Chemother.* 2015;59(10):6203-9. doi:10.1128/AAC.00899-15 PMCID:PMC4576095 PMID:26248369
41. Hruz PW. Commentary. *Clin Chem.* 2015;61(12):1444. PMID:26614228
42. DeBosch BJ, Heitmeier MR, Mayer AL, Higgins CB, Crowley JR, Kraft TE, Chi M, Newberry EP, Chen Z, Finck BN, Davidson NO, Yarasheski KE, Hruz PW, Moley KH. Trehalose inhibits solute carrier 2A (SLC2A) proteins to induce autophagy and prevent hepatic steatosis. *Sci Signal.* 2016;9(416):ra21. doi:10.1126/scisignal.aac5472 PMID:26905426
43. Hresko RC, Kraft TE, Quigley A, Carpenter EP, Hruz PW. Mammalian Glucose Transporter Activity is Dependent upon Anionic and Conical Phospholipids. *J Biol Chem.* 2016. doi:10.1074/jbc.M116.730168 PMID:27302065
44. Kraft TE, Heitmeier MR, Putanko M, Edwards RL, Ilagan MX, Payne MA, Autry JM, Thomas DD, Odom AR, Hruz PW. A Novel Fluorescence Resonance Energy Transfer-Based Screen in High-Throughput Format To Identify Inhibitors of Malarial and Human Glucose Transporters. *Antimicrob Agents Chemother.* 2016;60(12):7407-7414. PMCID:PMC5119023 PMID:27736766
45. Mayer AL, Higgins CB, Heitmeier MR, Kraft TE, Qian X, Crowley JR, Hyrc KL, Beatty WL, Yarasheski KE, Hruz PW, DeBosch BJ. SLC2A8 (GLUT8) is a mammalian trehalose transporter required for trehalose-induced autophagy. *Sci Rep.* 2016;6:38586. PMCID:PMC5138640 PMID:27922102
46. Edwards, R, Brothers RC, Wang X, Maron MI, Tsang PS, Kraft TE, Hruz PW, Williamson KC, Dowd CS, Odom John AR. MEPicides: potent antimalarial prodrugs targeting isoprenoid biosynthesis *Sci Rep.* 2017;In press.

47. Shanmugam M, Heilmeier MR, Hruz PW and Schiltz G. Development of selective GLUT4 antagonists for treating multiple myeloma *Eur J Med Chem*. 2017;In press.
48. Zhang Y, Higgins CB, Mayer AL, Mysorekar I, Evans T, Razani B, Graham M, Hruz PW, and DeBosch, BJ. Transcription Factor EB (TFEB)-dependent Induction of Thermogenesis by the Hepatocyte GLUT Inhibitor, Trehalose *EMBO Reports*. 2017;Submitted.

Invited Publications

1. Hruz PW, Mueckler MM. Structural analysis of the GLUT1 facilitative glucose transporter (review). *Mol Membr Biol*. 2001;18(3):183-93. PMID: 11681785
2. Hruz PW, Murata H, Mueckler M. Adverse metabolic consequences of HIV protease inhibitor therapy: the search for a central mechanism. *Am J Physiol Endocrinol Metab*. 2001;280(4):E549-53. PMID: 11254460
3. Murata H, Hruz PW, Mueckler M. Investigating the cellular targets of HIV protease inhibitors: implications for metabolic disorders and improvements in drug therapy. *Curr Drug Targets Infect Disord*. 2002;2(1):1-8. PMID: 12462148
4. Hruz PW. Molecular Mechanisms for Altered Glucose Homeostasis in HIV Infection. *Am J Infect Dis*. 2006;2(3):187-192. PMCID: PMC1716153 PMID: 17186064
5. Grunfeld C, Kotler DP, Arnett DK, Falutz JM, Haffner SM, Hruz P, Masur H, Meigs JB, Mulligan K, Reiss P, Samaras K, Working Group 1. Contribution of metabolic and anthropometric abnormalities to cardiovascular disease risk factors. *Circulation*. 2008;118(2):e20-8. PMCID: PMC3170411 PMID: 18566314
6. Hruz PW. HIV protease inhibitors and insulin resistance: lessons from in-vitro, rodent and healthy human volunteer models. *Curr Opin HIV AIDS*. 2008;3(6):660-5. PMCID: PMC2680222 PMID: 19373039
7. Flint OP, Noor MA, Hruz PW, Hylemon PB, Yarasheski K, Kotler DP, Parker RA, Bellamine A. The role of protease inhibitors in the pathogenesis of HIV-associated lipodystrophy: cellular mechanisms and clinical implications. *Toxicol Pathol*. 2009;37(1):65-77. PMCID: PMC3170409 PMID: 19171928
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