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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA

CASE NO.: 4:22-cv-00325-RH-MAF

AUGUST DEKKER, et al.,

Plaintiff(s),

-vs-

JASON WEIDA, et al.,

Defendant(s).

_____ /

ZOOM

DATE: Tuesday, March 21, 2023

TIME: 10:02 a.m. - 3:44 p.m.

*****PORTIONS OF TRANSCRIPT MARKED CONFIDENTIAL*****

DEPOSITION OF MICHAEL BIGGS, PH.D.

Taken on behalf of the PLAINTIFFS before
Jennifer L. Bush, RPR, FPR, FPR-C, Notary Public in and
for the State of Florida at Large, pursuant to Notice of
Taking Deposition in the above cause.

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A P P E A R A N C E S
APPEARING ON BEHALF OF THE PLAINTIFF(S):

Jennifer Altman, Esquire
Marcus Leonard, Esquire
Shani Rivaux, Esquire
Ana Gonzalez
Pillsbury Winthrop Shaw Pittman LLP
600 Brickell Avenue, Suite 3100
Miami, FL 33131
786-913-4900
Jennifer.altman@pillsburylaw.com

Omar Gonzalez-Pagan, Esquire
Lambda Legal Defense & Education
Fund, Inc.
120 Wall Street, 19th Floor
New York, NY 10005
212-809-8585
Ogonzalez-pagan@lambdalegal.org

Carl S. Charles, Esquire
1 West Court Square, Suite 105
Decatur, GA 30030
404-897-1880
Ccharles@lambdalegal.org

Simone Chriss, Esquire
Chelsea Dunn, Esquire
Southern Legal Counsel, Inc.
1229 NW 12th Avenue
Gainesville, FL 32601
352-271-8890
Simone.chriss@southernlegal.com

APPEARING ON BEHALF OF THE DEFENDANT(S):

Michael Beato, Esquire
Holtzman Vogel Barantorchinsky &
Josefiak PLLC
119 S Monroe Street, Suite 500
Tallahassee, FL 32301
Mbeato@holtzmanvogel.com

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I N D E X

THE WITNESS:

MICHAEL BIGGS, PH.D.

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BY MR. BEATO		236		

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PLAINTIFFS' EXHIBITS

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Exhibit 2	Report	23

1 WHEREUPON,

2 MICHAEL BIGGS, PH.D.,
3 called as a witness on behalf of the PLAINTIFFS, after
4 having been first duly sworn, was examined and testified
5 as follows:

6 THE WITNESS: I do.

7 DIRECT EXAMINATION

8 BY MS. ALTMAN.

9 Q. All right. Well, good afternoon, sir. I
10 know for us it's morning but for you it is afternoon.
11 Can you hear me okay?

12 A. I can, yes.

13 Q. So I tend to have a loud voice. If for any
14 reason you think I'm yelling at you, I want to warn you
15 in advance I'm not. I do tend to have a loud voice, and
16 I am using the computer audio. So just keep that in
17 mind.

18 Also keep in mind that if you can't hear me
19 or the questions break up, certainly ask me or tell me
20 what the electronic situation is and I'm happy to try and
21 nullify it.

22 So I'm going to take your deposition today.
23 My name is Jennifer Altman. I'm with the law firm of
24 Pillsbury Winthrop Shaw Pittman. Have you had your
25 deposition taken before?

1 A. No, I haven't.

2 Q. So let me give you a few of the ground
3 rules that we're going to hopefully live by today. I'm
4 going to ask you questions and you are going to answer
5 them. I'm not trying to trick you. So that means if you
6 don't understand a question, simply ask me to rephrase
7 it. I'm happy to do so.

8 If you don't hear a question, simply tell
9 me you didn't hear it and I'm happy to repeat it for you.
10 If you answer a question, I'm going to assume that you
11 understood the question, is that fair?

12 A. Yep.

13 Q. So you just hit on without --
14 unintentionally one of the garden-variety rules of depos.
15 You can't shake your head no or shake your head yes. The
16 wonderful court reporter on my screen over to the right
17 can't take down nods or head shaking. You need to answer
18 out loud audibly.

19 That means if it's a yes, it's a yes. If
20 it's a no, it's a no. Uh-huh is not an answer because
21 that could be yes or no. So please always answer the
22 question out loud for the court reporter's benefit.

23 Also for the court reporter 's benefit, who
24 is going to be working really hard today to make sure the
25 transcript is accurate, you may be able to predict the

1 question that I'm going to ask you, or you may feel it
2 incumbent upon you to start answering a question because
3 you want to either clarify something or bring something
4 up.

5 For the court reporter's benefit, you
6 always need to wait until I've completed my question
7 fully, take a pause because Michael may want to object,
8 put an objection on the record, and then answer the
9 question. That way we'll have a clean record for the
10 Court. Does that make sense to you?

11 A. Yes.

12 Q. Okay. You are nodding a lot. But make
13 sure you say yes or no.

14 A. Yes.

15 Q. If you need to take a break, I'm happy to
16 accommodate you. I can't do so when there is a question
17 pending, so keep that in mind in terms of timing any
18 breaks that you think you'll need. Does that make sense?

19 A. Yes.

20 Q. And, sir, have you ever been -- have you
21 ever been charged with or convicted for any crime of
22 malfeasance, fraud, any kind of misstatements?

23 A. No.

24 Q. And are you taking any drugs today that
25 would impact your ability to fully and robustly answer

1 the questions that I'm about to ask you?

2 A. No.

3 Q. All right. So let's get started. So are
4 you a medical doctor?

5 A. No.

6 Q. Have you gone to medical school?

7 A. No.

8 Q. Have you had any medical training
9 whatsoever?

10 A. No.

11 Q. Have you ever treated anyone with gender
12 dysphoria?

13 A. No.

14 Q. Have you ever prescribed treatment for
15 anyone with gender dysphoria?

16 A. No.

17 Q. Do you perform medical research relating to
18 gender dysphoria?

19 A. Yes.

20 Q. What medical research do you perform
21 relating to gender dysphoria, sir?

22 A. One example would be getting data --
23 getting data on the suicide rate of transgender
24 adolescence at the London clinic.

25 MS. ALTMAN: Someone needs to mute their

1 phone, please. Thank you.

2 BY MS. ALTMAN:

3 Q. Getting data on suicide rates, and I didn't
4 hear the rest of it, sir.

5 A. Suicide rates of children attending their
6 pediatric clinic, gender clinic in London, called the
7 Tavistock, and publishing that research.

8 Q. Okay. So you didn't conduct the research,
9 did you, sir?

10 A. Yes, I conducted the research. I submitted
11 freedom of information requests to get the numbers that I
12 used in the article.

13 Q. Uh-huh. What -- what actual research, sir,
14 did you perform in order to determine the basis or
15 reasoning for any suicides that you allegedly studied?

16 A. There was no information on the reason --
17 on the reasons for the suicides. It was the number --
18 (Audio interference.)

19 THE WITNESS: -- I was doing research on.
20 (Reporter asks for clarification.)

21 MS. ALTMAN: Yes, sir -- yes, ma'am. Can
22 you hear him okay?

23 MS. REPORTER: Yes, I can. It was just
24 that the word "the number" blurred out. That's
25 all.

1 MS. ALTMAN: No problem.

2 BY MS. ALTMAN:

3 Q. Sir, so again, you didn't perform any
4 analysis to determine the basis for any suicides that
5 occurred at the Tavistock clinic, did you?

6 A. I performed the analysis to estimate the
7 suicide rate.

8 Q. Right. You -- you got a number from
9 someone using a Freedom of Information Act, right?

10 A. Yes.

11 Q. Okay. Freedom of Information Act request,
12 correct?

13 A. Yes.

14 Q. And you multiplied a number by the number
15 of individuals treated, correct?

16 A. I also had to ascertain the number of
17 individuals treated, which was a required extensive
18 Freedom of Information Act requests.

19 Q. Right. So you issued some Freedom of
20 Information Act request, but that's not my question.
21 What analysis did you perform into the reasons that
22 anyone in your Freedom of Information Act requests
23 committed suicide?

24 A. My research was not on the reasons. It was
25 on the rate of suicides, the number of suicides as

1 proportion of patient -- of patient time spent in the
2 clinic.

3 Q. Okay. And we're going to -- and we're
4 going to get to that research later. But I just want to
5 be clear on the record. As you sit here today, you have
6 no basis on which you can testify as to the reasons why
7 any individuals from the Tavistock clinic committed
8 suicide, correct?

9 A. That's correct. Just a correction. It is
10 Tavistock, T-A-V-I-S-T-O-C-K.

11 Q. Okay. Sorry if I'm pronouncing it wrong.
12 I will do better. But your answer is the same, correct?

13 A. Yes.

14 Q. Okay. Excellent. Have you performed any
15 clinical studies relating to gender dysphoria?

16 A. Could you define "clinical"?

17 Q. What do you understand that word to mean,
18 sir?

19 A. Do you mean that whether I was acting in a
20 clinical capacity?

21 Q. Do you understand the word "clinical" to
22 mean acting in a clinical capacity, sir?

23 A. That could be one interpretation, yes.

24 Q. Okay. And so I want you to then use that
25 interpretation and tell me whether or not you've

1 performed any clinical studies -- studies relating to
2 gender dysphoria?

3 A. No.

4 Q. Do you believe gender dysphoria exists?

5 A. Yes.

6 Q. Do you believe people can be transgender?

7 A. Yes.

8 Q. Do you believe that being transgender is a
9 choice?

10 A. I'm struggling to answer that question.

11 Q. Why?

12 A. Because in some ways, everything is a
13 choice, isn't it?

14 Q. No. Do you have an answer for the
15 question, sir?

16 A. I don't -- I think in some cases it might
17 be a choice and some cases it's not.

18 Q. Okay. Do you believe people can have
19 gender -- gender identity that is not aligned with their
20 gender assigned at birth?

21 A. Yes.

22 Q. Do you believe that a trans -- transgender
23 male is a boy?

24 A. Yes.

25 Q. Do you believe that a transgender female is

1 a girl?

2 A. Yes.

3 Q. Do you believe the medical professionals
4 are in the best position to determine proper health care
5 treatment?

6 A. Sometimes.

7 Q. And by your "sometimes," I assume you mean
8 sometimes not?

9 A. Sometimes not, correct.

10 Q. Okay. What would be the scenarios under
11 which a health -- a medical professional would not be in
12 the best position to determine proper health care
13 treatment?

14 A. If their treatment was based on faulty
15 research.

16 Q. Anything else?

17 A. That would be the main -- of course it
18 could also be if they had a financial incentive to offer
19 certain treatments.

20 Q. Are you being paid for your time today,
21 sir?

22 A. Yes.

23 Q. Do you have a financial incentive to
24 testify consistent with the defendants' position in this
25 case?

1 A. No.

2 Q. So why would your character be any better
3 or worse than a medical professional who is making
4 medical decisions who has a financial interest in the
5 treatment?

6 A. I think the sums -- the amount of money
7 matters. And I didn't say that medical professionals
8 always had -- were influenced by financial incentives,
9 but sometimes they might be.

10 Q. Well, as you sit here today, do you have an
11 example of any individual that you are aware of, relevant
12 to this case, that you think is financially incented
13 (sic) to perform a certain treatment?

14 A. No.

15 Q. Okay. So you are just using that sometimes
16 that's the case, correct?

17 A. Yes.

18 Q. Do you believe that -- that experts
19 sometimes have a financial incentive to testify in a
20 particular way?

21 A. Sometimes, yes.

22 Q. Okay. You would agree with me, would you
23 not, sir, that a medical professional is in the best
24 position -- the best position to determine the
25 appropriate care to be rendered to transgender

1 individuals, right?

2 A. Sometimes.

3 Q. And the -- the sometimes not is the same
4 answer you gave a moment ago?

5 A. Yes. If it's based on -- if a medical
6 judgment is based on faulty research.

7 Q. Would you agree with me, sir -- I'm sorry,
8 were you done or no? I apologize.

9 A. I'm done.

10 Q. Okay. You would agree with me, sir, that
11 it's -- it's medical professionals that -- that should be
12 conducting medical research, correct?

13 A. I think academics of all -- if they have
14 the skills and competence should be conducting important
15 research, including medical research.

16 Q. Sir, you are not suggesting to the Court
17 that a academic is qualified to render medical opinions,
18 are you?

19 A. Opinions on an individual patient, no.

20 Q. Well, what -- what about a class of
21 patients, sir, are you suggesting to this Court that a
22 academic has the capacity to render medical opinions?

23 A. That really depends on whether that -- for
24 example, the academic could come up with good arguments,
25 good data, published in a peer review journal, for

1 example.

2 Q. But that -- they can't perform medical or
3 clinical research, can they, sir?

4 A. Well, they can perform scientific research.

5 Q. Based on other people's research, right,
6 you can report on other people's research. You don't
7 perform the research yourself, correct?

8 A. Not taking measurements, for example, no,
9 that's certainly true.

10 Q. Well, let's use an example here, sir.
11 You've not performed any medical research, have you?

12 A. Well, I gave you an example earlier of my
13 suicide paper, which I believe would come under the
14 category of medical research. I can give you another
15 example on bone density, if you'd like.

16 Q. Okay. Why don't you give me that example.
17 I won't stipulate that I think your example on suicide
18 complies but let's try bone density.

19 A. So bone density was published by the same
20 gender clinic. Information on bone density was released
21 thanks to my complaints to the health research authority
22 in Britain. They released the data and I was able to
23 publish a short letter to the editor in the Journal of
24 Pediatric Endocrinology and Metabolism that analyzed the
25 distribution of bone density after two years on

1 gonadotropin-releasing hormone agonists.

2 Q. Okay. We're going to get to that study
3 later. But with regard to that, again, all you did was
4 make a Freedom of Information Act request to the
5 Tavistock clinic, correct?

6 A. No, I made a complaint -- I made a
7 complaint to the health research authority. The health
8 research authority forced the researchers to release that
9 data.

10 Q. Okay. And it was their data, sir --

11 A. Yes.

12 Q. -- that you relied upon, correct?

13 A. Yes.

14 Q. And so you didn't perform any actual
15 clinical or medical research. You relied on the data
16 that was compiled by someone else, correct?

17 A. I did not perform the bone density scans,
18 that's correct.

19 Q. And -- and you are not qualified to read a
20 bone density scan, are you, sir?

21 MR. BEATO: Object to form.

22 But, Dr. Biggs, you can answer that
23 question.

24 THE WITNESS: What I analyzed was Z-scores
25 which are based on normal distribution. It's very

1 standard statistics.

2 BY MS. ALTMAN:

3 Q. Did you understand my question?

4 A. Yes, and I -- yes.

5 Q. Okay. My question was, you are not
6 qualified to review a bone density scan, correct, sir?

7 A. The bone density is converted into a
8 Z-score which is based on a normal distribution and met
9 the standard statistics of a normal distribution.

10 So the original bone density score, I could
11 not -- that would not be within my ambit. When it is
12 converted into a Z-score, normalized for aging sakes,
13 then I -- that is within the ambit of myself or anybody
14 else who is qualified who understands statistics.

15 Q. So, again, the answer to my question is you
16 are not qualified to read the scan, correct?

17 MR. BEATO: Object to form.

18 But, Dr. Biggs, you can answer that
19 question.

20 THE WITNESS: Correct.

21 BY MS. ALTMAN:

22 Q. Okay. Thank you. Do your -- do your
23 personal beliefs in any way impact your opinions in this
24 case?

25 A. My personal beliefs are based on what

1 I've -- what -- the research that I've done. So, of
2 course, that then in turn contributes to my opinions.

3 Q. Okay. Other than the -- the two instances
4 you mentioned and the research that you've done, which
5 we're going to get to in a little bit, I'm just trying to
6 understand where you -- whether you have any other
7 personal beliefs that impact your testimony here today.

8 A. Yes.

9 Q. Okay. And what are those personal beliefs
10 that impact your testimony here today?

11 A. Those personal beliefs are that gays --
12 being gay and lesbian or being a feminine boy or a
13 masculine girl are entirely normal variations on human
14 experience and do not require medicalization.

15 Q. What about transgender individuals?

16 A. Sorry, what about -- can you -- can you --

17 Q. Yes -- yeah, you said gays and lesbians, if
18 I wrote this down correctly, are normal variations and do
19 not require medicalization, did I hear you correctly?

20 A. Yes.

21 Q. Okay. And so my question is, what about
22 transgender individuals, do they require medical --
23 medicalization?

24 A. They might or they might not.

25 Q. Okay. Tell me the circumstances, sir, in

1 which you are qualified to determine when a transgender
2 individual requires medicalization?

3 A. Well, it's partly, of course, their choice
4 and it's partly whether they can consent as an adult to
5 treatments.

6 Q. Did you understand my question, sir? My
7 question is, tell me how you are qualified to determine
8 when a transgender individual requires medicalization?

9 A. It's my belief that lifelong medical
10 intervention requires an adult to consent to that --
11 that -- that serious significant step.

12 Q. So maybe third time is the charm. Did you
13 understand my question? My question is, please tell me
14 how you are qualified to determine --

15 MR. BEATO: Counsel -- counsel -- counsel,
16 he already answered the question twice.

17 MS. ALTMAN: He actually didn't answer the
18 question at all, Michael.

19 MR. BEATO: He did answer the question.

20 MS. ALTMAN: Michael, he didn't answer the
21 question. You get to object to the form.

22 BY MS. ALTMAN:

23 Q. Sir, my question is, how is it that you are
24 qualified to determine when a transgender individual
25 requires medicalization?

1 MR. BEATO: Object to form.

2 Dr. Biggs, you can answer that question.

3 THE WITNESS: I've already answered it.

4 BY MS. ALTMAN:

5 Q. Really, what was your answer, sir, how you
6 are qualified to determine when a transgender
7 individual's entitled to medicalization?

8 MR. BEATO: Object to form.

9 Dr. Biggs, you can answer that question.

10 THE WITNESS: I believe that the -- the --
11 the lifelong medical intervention that comes with,
12 let's say, cross-sex hormones is something that an
13 adult can consent to make a good choice when they
14 are presented with the cost and the benefits of
15 that treatment.

16 BY MS. ALTMAN:

17 Q. Sir, my question is about your
18 qualification, not your beliefs, your qualifications. My
19 question was and is, what qualifies you to make
20 determinations as to when a transgender individual
21 receives medical care?

22 MR. BEATO: Object to form.

23 Dr. Biggs, you can answer that question.

24 THE WITNESS: I'm making a statement, a
25 general statement about principles of treatment

1 and consent. I'm not choosing whether one
2 particular individual can or cannot get treatment.

3 BY MS. ALTMAN:

4 Q. But that's not my question, sir. My
5 question is not about them. It's about you. What is
6 your qualifications, what are your qualifications to make
7 a statement that a transgender individual sometimes or
8 sometimes not requires medicalization?

9 MR. BEATO: Object to form.

10 Dr. Biggs, you can answer that question.

11 THE WITNESS: I won't.

12 BY MS. ALTMAN:

13 Q. You won't what?

14 A. I -- I -- I have answered to the best of my
15 ability that question.

16 Q. So as you sit here today, you can't tell
17 the Court what qualifications, if any, you have to make
18 determinations as to when a transgender individual
19 requires medicalization, correct?

20 MR. BEATO: Object to form.

21 Dr. Biggs, you can answer that question.

22 THE WITNESS: I'm -- I -- I've said what
23 I've -- what I -- what I want to say on that
24 question.

25 BY MS. ALTMAN:

1 Q. Okay. Sir, you were retained by the
2 experts in this case, correct?

3 A. Yes.

4 Q. What -- and today, as I understand it, you
5 are here to provide testimony relating to your opinions,
6 correct?

7 A. Yes.

8 Q. And we're going to mark as Exhibit 1 to
9 this deposition the deposition notice. And Ana is going
10 to bring that up just so that you can see it. Maybe she
11 is. Maybe she's not?

12 MS. GONZALEZ: I need -- I'm sorry. I need
13 somebody to give me my -- the hostess disabled my
14 screen sharing, so they need to allow me to do it.

15 MS. REPORTER: It's enabled.

16 MS. GONZALEZ: Okay.

17 (Plaintiffs' Exhibit 1 is marked for
18 Identification.)

19 BY MS. ALTMAN:

20 Q. All right. Sir, do you see what we've put
21 up on the screen, which we'll mark as Exhibit 1 for
22 identification?

23 A. Yes.

24 Q. And have you seen a copy of this before?

25 A. Yes.

1 Q. And it's this notice of your deposition
2 that has brought you here today, correct?

3 A. Yes.

4 Q. And we're going to also mark --

5 MS. ALTMAN: Thank you very much, Ana.

6 BY MS. ALTMAN:

7 Q. Sir, did you prepare an expert report in
8 this matter?

9 A. Yes.

10 Q. And we're going to bring that up and we're
11 going to mark that as Exhibit 2 to your deposition.

12 (Plaintiffs' Exhibit 2 is marked for
13 Identification.)

14 THE WITNESS: Yes.

15 BY MS. ALTMAN:

16 Q. And do you recognize this? And Ana will
17 scroll through it for you just so that you can see it.

18 A. Yes.

19 Q. And if you can confirm for the record, sir,
20 that this is indeed the expert report that you prepared
21 on behalf of the defendants in this case. And we'll mark
22 this as Exhibit 2 for identification.

23 A. Yeah, insofar as all I've seen on the
24 screen looks like my deposition.

25 Q. Your report, sir?

1 A. The report, sorry, report, yes.

2 Q. Okay. Sir, did anyone assist you in
3 writing this report?

4 A. No.

5 Q. Did anyone write any portion of the report
6 for you?

7 A. No.

8 Q. Did you share the report with anyone before
9 it was finalized?

10 A. No.

11 Q. Did you review any of the defendants' other
12 experts' reports before you finalized your own?

13 A. No.

14 Q. Have you reviewed any of the deposition
15 testimony of experts in this case?

16 A. No.

17 Q. Okay. And we're going to get back to your
18 report later. But that was your --

19 MS. ALTMAN: If we go to the last page,
20 Ana, with his signature. Up one, up one, there
21 you go.

22 BY MS. ALTMAN:

23 Q. That's your signature, sir, on page 22?

24 A. Yes.

25 Q. Okay. And -- and in it you see above it

1 that you swore under the penalty of perjury that the
2 statements and opinions contained therein are your own,
3 correct?

4 A. Correct, yes.

5 Q. Okay.

6 MS. ALTMAN: Thank you, Ana. We'll be
7 using it later, so we can just put them aside for
8 now.

9 BY MS. ALTMAN:

10 Q. Sir, you wrote your doctorate, your Ph.D.
11 in the rise and decline of a mass movement, American
12 workers and strike wave of 1886; is that right?

13 A. Yes.

14 Q. And you would agree with me that that has
15 nothing to do with gender dysphoria, correct?

16 A. Yes.

17 Q. And you would agree with me it has nothing
18 to do with transgenderism, correct?

19 A. Yes.

20 Q. And you don't treat patients who suffer
21 from gender dysphoria, correct?

22 A. No, I don't.

23 MS. ALTMAN: Somebody needs to mute their
24 phone, please. Thank you. Somebody.

25 BY MS. ALTMAN:

1 Q. You are not an ethicist, are you?

2 A. No.

3 Q. You are not a clinician of any kind,
4 correct?

5 A. Correct.

6 Q. You are not a bioethicist, correct?

7 A. Correct.

8 Q. You are not an endocrinologist, correct?

9 A. Correct.

10 Q. You are not a psychiatrist, correct?

11 A. Correct.

12 Q. You are not a psychologist, correct?

13 A. Correct.

14 Q. You are not a surgeon, correct?

15 A. Correct.

16 Q. You are not engaged in the drafting of
17 health care policy, are you, sir?

18 A. No.

19 Q. You are not a pharmacist; isn't that right?

20 A. I'm not a pharmacist.

21 Q. And you've never worked under a pharmacist;
22 isn't that correct?

23 A. Correct.

24 Q. And we've discussed, at least as I
25 understand from your testimony, you have no medical

1 training, correct?

2 A. Correct.

3 Q. You have no training or experience in
4 endocrinology, correct?

5 A. Correct.

6 Q. No clinical experience in providing gender
7 affirming care, correct?

8 A. Correct.

9 Q. You have no mental health training,
10 correct, sir?

11 A. Correct.

12 Q. You are not a licensed nurse, are you?

13 A. I'm not a licensed nurse.

14 Q. And you are not licensed to practice
15 medicine in any country in the world, right?

16 A. Correct.

17 Q. Now, sir, you would agree with me that you
18 first began considering issues relating to gender
19 dysphoria in 2016 or 2017, do I understand that
20 correctly?

21 A. I believe 2017.

22 Q. So about five years or so, correct?

23 A. Yes, that would be six years, yes, I think.

24 Q. I guess depending on when it was in 2017,
25 but I'll give you -- I'll give you six years, no worries.

1 What independent research have you
2 performed on gender dysphoria as opposed to simply
3 critiquing other people's research and articles?

4 A. So I would say that my independent research
5 was the article on suicide rates at the Tavistock, which
6 we've discussed; the analysis of bone density; and the
7 article -- my most recent article on the Dutch part on
8 the history and -- on the Dutch Protocol.

9 Q. Well, we talked about the suicide rates and
10 the bone density and we're going to talk about them a
11 little more later.

12 But with regard to the Dutch Protocol, what
13 you did was merely analyze what they did; isn't that
14 correct?

15 A. It was an extensive literature of
16 historical account, yes.

17 Q. Right. You reviewed what they did,
18 correct, and gave your spin on it; isn't that right?

19 A. That's not how I would -- would -- would
20 refer to an extent -- a literature review and -- and
21 analysis and historical account.

22 Q. Okay. But it's a literature review of
23 what -- of someone else's work, correct?

24 A. Correct.

25 Q. And it's a historical account of someone

1 else's work, correct?

2 A. Correct.

3 Q. You didn't perform any of the underlying
4 clinical research, did you, sir?

5 A. No.

6 Q. Have you gone back personally and
7 interviewed any of the cohorts that were involved in the
8 Dutch Protocol?

9 A. I have talked to two patients from the
10 Dutch -- from the Dutch clinic subsequent -- subsequent
11 to that article.

12 Q. So after the article, you spoke to them?

13 A. Yes.

14 Q. So when you published the article, you
15 would agree with me, you had not spoken to anyone that
16 participated in the Dutch Protocol, correct?

17 A. Well, there is one -- the -- the article
18 acknowledges some input at the end from one Dutch
19 patient, but the -- most of the article was completed
20 before I met that person.

21 Q. Okay. And so who are the two patients that
22 you say you spoke to?

23 A. I'm not going to name them.

24 Q. Sir, you are under oath, obligated by law
25 to tell the truth and to answer my questions. Who are

1 the two patients? We're happy to mark this part of the
2 transcript as confidential. There is a protective order
3 in place.

4 A. Okay. One is called [REDACTED], [REDACTED]
5 [REDACTED]

6 Q. And the other?

7 A. Is called [REDACTED], [REDACTED], and I don't
8 have his sir name to hand.

9 Q. Okay. Do you have it somewhere in your
10 office?

11 A. I do -- I could get that, yes.

12 Q. Well, did you list your interviews of these
13 individuals in your -- your research or -- or attachments
14 to your report as something that informed your decisions
15 in this case and your opinions in this case?

16 A. The article and the Dutch Protocol has a
17 footnote acknowledging feedback from a Dutch de- -- one
18 Dutch detransitioner. There is a footnote in there, I
19 believe as an exhibit in my report.

20 Q. And which of the two that you just
21 mentioned is the detransitioner?

22 A. [REDACTED].

23 Q. When did you speak to this individual?

24 A. Six months ago.

25 Q. Do you have notes of your conversation with

1 this individual?

2 A. No.

3 Q. Did you take notes of your conversation
4 with this individual?

5 A. No.

6 Q. Did you record the conversation?

7 A. No.

8 Q. Does your conversation with this person
9 influence your testimony or opinions in this case?

10 A. It provides background.

11 Q. Other than background, sir?

12 A. No, not other than background.

13 Q. So, again, with regard to the Dutch
14 Protocol, just so that we're on the same page, you
15 reviewed other people's clinical work and other people's
16 research and reported on it, correct?

17 A. Correct.

18 Q. You didn't perform any of the underlying
19 studies or tests, did you, sir?

20 A. No.

21 Q. Did you interview any of the -- the
22 physicians or medical professionals that were involved in
23 that study?

24 A. No.

25 Q. Did anyone stop you from doing that?

1 A. No.

2 Q. Did anyone stop you from interviewing any
3 of the other individuals that participated in that study?

4 A. No.

5 Q. You were trying to do in-depth and
6 independent research, sir. Any reason why you didn't
7 reach out to the authors of the study or any of the other
8 participants in the study to get a robust analysis of the
9 import of the research and the historical, I guess,
10 recreation of the Dutch Protocol?

11 A. As an academic, we rely on what is
12 published in the literature. Including, of course -- and
13 that includes, let's say, journalist interviews with
14 the -- with the clinicians. That's also part of the
15 literature --

16 Q. Is it your testimony -- just so I
17 understand the scope of what an academic does, is it your
18 testimony under oath that academics don't interview
19 individuals to get background or other information to
20 ensure that what they are publishing is accurate?

21 A. There is a wide variety of academic
22 research. Some is statistical; some is based on
23 hypnography. This particular case was based on the
24 published literature.

25 Q. Okay. But you are not suggesting that --

1 that all academics would not interview, whether it be
2 doctors, physicians, statisticians or others that perform
3 clinical research, are you?

4 A. No.

5 Q. Have you performed any scientific studies?

6 A. Yes, the articles that I've already
7 discussed earlier. I would consider those scientific.

8 Q. You are referring to the -- the bone
9 density, the suicidality, and the Dutch Protocol?

10 A. Well, the bone density and the suicidality,
11 yes.

12 Q. Okay. And you believe those qualify as
13 scientific studies, sir?

14 A. Yes.

15 Q. Okay. And we'll get in more detail with
16 them later.

17 You are not a scientist, are you?

18 A. I would consider myself a social scientist.

19 Q. Well, you are a sociologist, correct?

20 A. Yes.

21 Q. Have you ever conducted any peer-reviewed
22 studies?

23 A. Yes.

24 Q. And what peer-reviewed studies have you
25 conducted?

1 A. The four peer-reviewed studies, which are
2 listed in my expert report, are the study on suicide.

3 Q. Uh-huh.

4 A. The -- the comparison of Dutch and English
5 gonadotropin-releasing hormone agonist. The critique of
6 Turban, all three, were published in Archives of Sexual
7 Behavior. And all three were peer-reviewed. And the
8 fourth would be the article we just discussed on the
9 Dutch Protocol, which is published in the Journal of Sex
10 & Marital Therapy, also peer-reviewed.

11 Q. Okay. Sir, you would agree with me that
12 because an article -- I'm sorry, strike that.

13 Because a journal is peer-reviewed, doesn't
14 mean that your work was peer-reviewed, correct?

15 A. No, this is -- that's -- that's incorrect.
16 All of those four that I listed were peer reviewed.

17 Q. That wasn't my question, sir. My question
18 was, you would agree with me that just because an article
19 or a letter to the editor appears in a peer-reviewed
20 journal, doesn't mean they are peer reviewed, correct?

21 A. Correct.

22 Q. Okay. What is your specific bases for
23 claiming that your study on suicide was peer-reviewed?

24 A. Because I received reviewers' reports from
25 my peers, and I had to revise and resubmit the articles

1 to meet their objections. And on the second round of
2 revisions, it was accepted. That is what peer review
3 means.

4 Q. And we're going to talk about those later.
5 I just want to get your testimony on each of these now.
6 And your article regarding the comparison of Dutch and
7 other GnRH --

8 A. Again, it was sent to three or four peer
9 reviewers. The editor said that I had to meet their
10 objections and their criticisms. And then I submitted
11 the revised version, along with my response to their
12 criticisms, and it was ultimately accepted. That's what
13 peer review means.

14 Q. Well, so we'll talk about what peer review
15 means. Right now I just want to get your answers to my
16 question, thanks.

17 And the -- the third one, was that the bone
18 density?

19 A. The third was the critique of what Turbans
20 were on puberty blockers and suicide.

21 Q. Okay.

22 A. And very helpfully, the editor included the
23 first footnote on this article. This article was peer
24 reviewed by three reviewers and the editor. But it was
25 the same process as I just -- as I explained previously.

1 The same peers, they sent back critiques.
2 I had to meet those objections. And it was ultimately --
3 after revision, it was published.

4 Q. You would agree with me that the study on
5 suicide and the -- the second one, the comparison of the
6 Dutch GnRH don't contain such a footnote, correct?

7 A. They don't contain such a footnote,
8 correct.

9 Q. Right. And your testimony is the only
10 basis on which you could support a position that they
11 were indeed peer-reviewed, correct?

12 A. That's incorrect. I could give you the
13 reviewers' reports.

14 Q. Did you include those with your production
15 in this case?

16 A. No.

17 Q. And the fourth one, sir?

18 A. The fourth one is the Journal of Sex &
19 Marital Therapy, the Dutch Protocol.

20 Q. Same question, sir, what is the basis on
21 which you --

22 A. It was sent --

23 Q. Let me just finish the question.

24 -- have evidence of this publication was
25 peer-reviewed?

1 A. Was sent off to review by two or three, I
2 can't quite recall, but it was two or three of --
3 reviewers. They sent back criticisms and suggestions. I
4 revised the paper in light of their criticisms and
5 suggestions. And it was then accepted for publication.

6 Q. And with regard to at least numbers one,
7 two, and four that we've been talking about, the -- the
8 fact that you deemed them being peer-reviewed because you
9 responded to certain responses and criticisms does not
10 necessarily mean they were indeed peer-reviewed within
11 the medical community; isn't that right, sir?

12 A. I disagree completely with that, with your
13 assertion.

14 Q. So it is your testimony under oath that you
15 believe that -- that your articles number -- the first
16 one, the second one and the fourth one qualify as
17 peer-reviewed studies?

18 A. Yes.

19 Q. Is that your testimony?

20 A. Yes, indeed, yes.

21 Q. And we're going to get back to those
22 articles later. But have you participated in any
23 scientific studies about the efficacy of gender-affirming
24 care?

25 A. No.

1 Q. Have you interviewed any transgender
2 individuals who benefited from gender-affirming care?

3 A. No.

4 Q. Has anyone stopped you from interviewing
5 any transgender individuals who benefited from
6 gender-affirming care?

7 A. No.

8 Q. Has anyone stopped you from participating
9 in any scientific studies about the efficacy of
10 gender-affirming care?

11 A. No.

12 Q. Did you ask to interview the plaintiffs in
13 this case?

14 A. No.

15 Q. Did you interview or speak with anyone from
16 WPATH before issuing your opinions in this case?

17 A. No.

18 Q. Have you ever interviewed or spoken with
19 anyone from WPATH in order to formulate your opinions
20 regarding puberty blockers?

21 A. No.

22 Q. Have you spoken to or interviewed anyone
23 with a contrary point of view before issuing your
24 opinions in this case?

25 A. Well, I've spoken to many people with

1 contrary points of view, yes.

2 Q. Okay. Who have you spoken with?

3 A. Not -- not in the -- you know, in the last,
4 let's say, you know, month or two months or something.

5 Q. Well, what about the last six months, who
6 have you spoken to that holds contrary views to yours
7 about puberty blockers?

8 A. Probably not in the last six months, no.

9 Q. What about the last year?

10 A. Yes, I've spoken to people -- individuals,
11 yes.

12 Q. Okay. Who?

13 A. A doctoral student of mine.

14 Q. Who?

15 A. Rema -- well, a former doctoral student of
16 mine called Rema Maja (Phonetic).

17 Q. Anyone else?

18 A. No.

19 Q. Any reason, sir, you don't, as an academic,
20 seek out people who have contrary views so that you can
21 have a full and robust analysis of particular issues?

22 A. Well, we seek out contrary views when we
23 look at the published literature. I mean, that's what we
24 do. We look at, you know, contrary views as -- as
25 published.

1 Q. Okay. So, for the record, what contrary
2 literature have you looked at in the past year?

3 A. Well, almost everything I -- a lot of the
4 material that I cite would have contrary points of view.

5 Q. Okay. And when you say that you cite, you
6 mean in connection with your report in this case?

7 A. Yes.

8 Q. Okay. Anything else?

9 A. No.

10 Q. Did you participate in the drafting of the
11 GAPMS memo at issue in this case?

12 A. No.

13 Q. Did you participate in the drafting of the
14 rule at issue in this case?

15 A. No.

16 Q. Did you refer to the DSM-5 as part of your
17 work?

18 A. Yes.

19 Q. And describe for the record, sir, how
20 specifically you refer to it and what ways you utilized
21 the DSM-5 in your opinions -- in forming your opinions in
22 this case?

23 A. Well, the DSM-5 provides the -- the
24 accepted definitions of gender dysphoria.

25 Q. Okay. How did you use that definition,

1 sir, in your opinions in this case?

2 A. Well, I think I -- I believe I cited in my
3 article on the Dutch Protocol, which was one of the
4 exhibits.

5 Q. Okay. And how did that inform your
6 opinions in this case?

7 A. It provides a good --

8 Q. The definition of gender dysphoria, how did
9 the DSM-5 definition of gender dysphoria inform your
10 opinions in this case?

11 A. It demonstrates that gender dysphoria is
12 based on the patient's beliefs and desires.

13 Q. Is that all it says, sir?

14 A. Yes.

15 Q. It's just a patient's belief and desire --

16 A. Well, there are certain particular --

17 Q. Let me just -- we agreed I get to finish
18 the question and then you get to answer. So I'm going to
19 try not to interrupt you. You could try not to interrupt
20 me as well.

21 Sir, is it your testimony that gender --
22 someone being gender dysphoria is solely based on their
23 belief and desire?

24 A. Yes.

25 Q. Anything else that informs whether or not

1 somebody is suffering from gender dysphoria other than
2 their belief and desire?

3 A. Clinical -- clinically significant
4 impairment or distress.

5 Q. Anything else?

6 A. No.

7 Q. You would agree that it is outside your
8 area of expertise to interpret the DSM-5, correct,
9 because you are not a clinician; isn't that right?

10 (Simultaneously speaking.)

11 MR. BEATO: Object to form.

12 And, Dr. Biggs, you can answer that
13 question.

14 (Simultaneously speaking.)

15 MS. REPORTER: Wait a minute. Hold on.

16 What was the objection?

17 MR. BEATO: Form.

18 And, Dr. Biggs, you can answer that
19 question.

20 THE WITNESS: Correct, I'm not a clinician.

21 BY MS. ALTMAN:

22 Q. Right. And, therefore, it is outside your
23 expertise to interpret the DSM-5; isn't that right?

24 A. I can interpret what is written in the
25 DSM-5.

1 Q. You are not a clinician, sir, correct?

2 A. Correct.

3 Q. So by "interpret it," you mean you can read
4 the words on the page, is that your definition?

5 A. I can read, interpret, and analyze, yes.

6 Q. Well, sir, you are not a clinician who is
7 qualified to analyze the DSM-5, are you?

8 A. I'm qualified to analyze the DSM-5. I'm
9 not a clinician.

10 Q. And what qualifies you to do that, sir?

11 A. My academic training.

12 Q. Anything else?

13 A. No.

14 Q. Now, sir, you would agree with me that a
15 letter to the editor is not the same thing as an actual
16 peer-reviewed publication, correct?

17 A. I disagree with you.

18 Q. And what's the basis for your disagreement,
19 sir?

20 A. My disagreement is based on the fact that
21 my -- in almost all journals -- in all journals, apart
22 from one that I know of, that is correct, namely a
23 literature by definition is not peer-reviewed.

24 Archives of Sexual Behavior is peculiar in
25 that it calls what -- another journal would be called a

1 research note or a short article, which would be
2 peer-reviewed. For some reason, the Archives of Sexual
3 Behavior calls that a letter to the editor. I do not
4 know the --

5 Q. Okay.

6 A. -- category for a short research note or
7 short article.

8 Q. Apologies. I didn't mean to interrupt you.

9 But above the four studies that you claim
10 were peer-reviewed, only one of them has a footnote
11 indicating that it was peer-reviewed, right?

12 A. Correct. But just to add -- add to that,
13 no article -- peer-reviewed articles never have a
14 footnote saying if they are peer-reviewed. And in -- and
15 in any -- in other journals.

16 So the absence of a -- the absence of a
17 footnote indicating it is peer-reviewed is not evidence
18 that it was not peer-reviewed.

19 Q. Agreed. So let's -- as you sit here today
20 under oath, what actual evidence do you have that they
21 are deemed peer-reviewed letters to the evidence -- and
22 let me finish the question, because it -- you might think
23 I'm done. I understand, and I don't want you to repeat
24 your testimony, that you received comments from people
25 and that you incorporated those comments and then it was

1 published.

2 My question is, what actual evidence do you
3 have that that constitutes peer-reviewed?

4 A. That is the definition of peer-reviewed. I
5 know the difference between something that's not
6 peer-reviewed and not -- and something that is
7 peer-reviewed because other letters to the editors which
8 are published in other journals were not peer-reviewed,
9 and I've never claimed them to be peer-reviewed.

10 Q. Right. And I think your definition, using
11 it loosely, has said if you get comments from people and
12 are required to incorporate them before publishing, that
13 constitutes peer-reviewed.

14 Do I understand your definition correctly?

15 MR. BEATO: Object to the form.

16 Dr. Biggs, you can answer that question.

17 THE WITNESS: Yes; that's right.

18 BY MS. ALTMAN:

19 Q. Okay. Other than that belief, that anyone
20 that provides commentary or suggestions or criticisms to
21 your report and you review them, and then your letter to
22 the editor is published, in your mind, that constitutes
23 peer review, is that fair?

24 A. With -- one addition should be made, and
25 that is that you are not -- you have to meet those

1 objections. And it is not clear whether it will be
2 ultimately published or not. So you get criticisms but
3 you have -- you -- you don't know, when you try to
4 reshape the article based on those criticisms, you've got
5 no guarantee whether the editor might say, well, you
6 haven't done enough to meet those.

7 Q. Understood. I just want to make sure we're
8 speaking the same language. That your definition of peer
9 review is that the Archive of Sexual Behavior provided
10 you with some criticisms, suggestions from a few of your
11 colleagues, you -- you reviewed those, incorporated them,
12 and ultimately, your letters to the editor were
13 published, correct?

14 A. Correct.

15 Q. And I just want to make sure,
16 definitionally, that is your definition of peer-reviewed,
17 correct?

18 A. Correct.

19 Q. And beyond that, just so we don't leave the
20 deposition today with any questions about it, you have no
21 other evidence that your letters to the editor were
22 peer-reviewed, correct?

23 A. Correct.

24 Q. And you would agree with me that journals
25 don't peer review every type of publication, correct?

1 A. Correct.

2 Q. What patient-based independent research did
3 you undertake to write these articles, these letters to
4 the editor?

5 A. There was no patient-based research.

6 Q. Have you engaged in any clinical trials?

7 A. No.

8 Q. Have you ever had any of your letters to
9 the editor or other writings rejected by a medical
10 association publication on gender dysphoria?

11 A. Yes.

12 Q. And can you explain which --

13 A. I -- for example, I had a letter to the
14 editor to Pediatrics that was rejected.

15 Q. What was it about?

16 A. It was a comment on a study of cross-sex
17 hormones.

18 Q. And is that study on cross-sex hormones
19 something that you've included in your materials in this
20 case?

21 A. No.

22 Q. Why not?

23 A. Because I wanted to focus entirely on
24 puberty blockers.

25 MS. ALTMAN: Counsel, we would ask that

1 that be produced.

2 BY MS. ALTMAN:

3 Q. Any other letters to the editor or
4 submissions that you -- on gender dysphoria or
5 transgenderism or cross-sex hormones or puberty blockers
6 that have been rejected by any medical association
7 publication?

8 A. Well, certainly I have an article on
9 surgeries that was rejected by Archives of Sexual
10 Behavior.

11 Q. What kind of surgery?

12 A. Gender -- transgender-related surgeries.

13 Q. Was that article included in your
14 bibliography, sir?

15 A. No. Well, it wasn't an article.

16 Q. What was it?

17 A. Well, it's -- an article that implies it's
18 been published. It's not been published, so it is like
19 it's a rejected paper.

20 Q. Okay. I'm sorry. Was your rejected paper
21 listed in your bibliography?

22 A. No.

23 Q. Okay. Why not?

24 A. Because I wanted to focus on puberty
25 suppression.

1 MS. ALTMAN: Michael, we would ask that
2 that rejected -- what did you refer to it as?
3 Rejected paper --

4 THE WITNESS: Paper.

5 MS. ALTMAN: -- be produced to us.

6 MR. BEATO: So just to clarify, you would
7 like us to produce to you an article that he did
8 not cite in his bibliography and in his expert
9 report?

10 MS. ALTMAN: Correct. Two articles,
11 actually -- or rejected papers.

12 MR. BEATO: I will consult with my
13 colleagues, thank you.

14 MS. ALTMAN: No problem.

15 BY MS. ALTMAN:

16 Q. Any other articles or rejected papers, sir?

17 A. I think -- I -- as I recall now, I believe
18 that is -- that is all.

19 Q. Okay. Well, if you think of any others
20 during the deposition, please let me know, okay?

21 A. Yes.

22 Q. Okay. Thank you. Have you made any
23 commentary submission on gender-affirming medical care?

24 A. Sorry, I didn't understand the question.

25 Q. Yeah, have you -- have you provided or

1 written any commentary submissions on gender-affirming
2 medical care?

3 A. What is commentary submission?

4 Q. Have you done any -- other than letters to
5 the editor and what you refer to as peer-reviewed letters
6 to the editor, and other than what you've already
7 testified, is there anything else that you have written
8 on gender dysphoria that's not otherwise listed in your
9 bibliography?

10 A. No.

11 Q. Do you consider the archive on sexual
12 health to be a peer-reviewed medical journal?

13 A. It's a peer-reviewed journal. I believe
14 it's under -- might be classified under psychology or
15 sexology.

16 Q. Right. So I'm asking, do -- you would
17 agree with me it is not a peer-reviewed medical journal,
18 correct?

19 A. Correct.

20 Q. Have you -- have any of your writings
21 related to gender dysphoria been published in a
22 peer-reviewed medical journal?

23 A. Yes.

24 Q. And which ones are those?

25 A. The -- the -- the journal of pediatric and

1 endocrino- -- pediatric and endo- -- pediatric and --
2 yeah, pediatric and endocrinology -- pediatric medicine
3 and endo- -- endocrinology. There's -- one on bone
4 density was published in that medical journal. That
5 particular letter was not peer-reviewed but it is a
6 peer-reviewed journal.

7 Q. Okay. Anything else?

8 A. No -- no, I should correct that. Another
9 letter to the editor, which was not peer-reviewed, was
10 published in The Journal of Sexual Medicine.

11 Q. Which one was that?

12 A. It is a comment on the -- the Costa study.
13 It is -- it is cited in my report.

14 Q. Okay. Which one -- just say it again, the
15 comment on what, I'm sorry?

16 A. It's a -- it's a comment on a -- an article
17 by Costa, et al.

18 Q. Okay.

19 A. Again, I should emphasize, that was not
20 peer-reviewed but it is a peer-reviewed journal.

21 Q. Anything else?

22 A. No.

23 Q. You had a submission on Turbans and
24 credible assumptions about sex, does that sound familiar?

25 A. Yes.

1 Q. Was that rejected by any publication?

2 A. Yes. I should -- that -- I -- thank you
3 for reminding me of that. That was rejected from a --

4 Q. You are welcome.

5 A. -- pediatric -- I'm not -- I wouldn't want
6 to give you -- mislead you by giving you the journal but
7 it was rejected by one journal, yes.

8 Q. Anything else?

9 A. No, I do not believe so.

10 Q. Now, sir, in your report, you don't -- you
11 also don't mention that you participated in a panel
12 before the Florida Board of Medicine, do you?

13 A. No, I did not. I did not think that was
14 relevant.

15 Q. Right. You didn't include it on your CV
16 either, right?

17 A. Possibly not.

18 Q. Why?

19 A. Because it was a eight-minute presentation
20 and that's not really significant enough to be included
21 on my CV.

22 Q. Well, for what it's worth, I think it was
23 12 minutes because I've listened to it. But I could be
24 wrong.

25 But you would agree with me that it -- it's

1 relevant because it's the very issue for which we're here
2 today; isn't that correct?

3 MR. BEATO: Object to form.

4 THE WITNESS: Correct.

5 MR. BEATO: Dr. Biggs, you can answer that
6 question.

7 THE WITNESS: Correct.

8 BY MS. ALTMAN:

9 Q. Okay. So is there any reason why you chose
10 not to disclose the fact that you were a panelist in the
11 Florida Board of Medicine meeting held in October?

12 A. No. I was told explicitly in preparing my
13 report that I had to say which -- what legal cases I had
14 participated in and it did not -- it did not occur to me
15 that that could be counted as a -- as a legal case.

16 Q. Who asked you to participate in that?

17 A. It was one of the members of the board of
18 medicine.

19 Q. Who?

20 A. Patrick -- Patrick -- I'm afraid I'm
21 blanking on the surname.

22 Q. Okay. Were you paid for your time?

23 A. No.

24 Q. And you would agree with me that your
25 testimony before the board of medicine was essentially

1 the same as the opinions you are rendering in this case,
2 correct?

3 A. Very similarly, yes.

4 Q. Okay. And you also testified and answered
5 questions at a committee -- the Health and Human Services
6 committee, right?

7 A. No, I don't -- oh, yes, sorry, yes, I did.
8 Yes, yes, you're right. Yes.

9 Q. Okay. And you didn't list that in your
10 bibliography or CV either, correct?

11 A. No, correct.

12 Q. Who asked you to participate in that?

13 A. I believe somebody from the Health and
14 Human Services e-mailed me and asked me if I would
15 participate. I'm afraid I can't recall their name.

16 Q. Were you paid for that?

17 A. No.

18 Q. You volunteer a lot of your time, sir, to
19 this issue, correct?

20 A. Well, one was 12 minutes and the other one
21 was, I don't know, same amount of time.

22 Q. You had prepared materials for those
23 meetings?

24 A. Yes, but I believe as an academic, if
25 you've done research in the public interest of your

1 research, then you should be willing to -- that's part of
2 the job description.

3 Q. And you would agree with me that both the
4 board of medicine meeting that I referred to and the
5 committee meeting relating to the Health and Human
6 Services, they're aligned with the defendants in this
7 case in terms of the work that they are trying to do,
8 correct?

9 A. Yes, correct.

10 Q. And you're being paid by the defendants in
11 this case for your time today?

12 A. Yes.

13 Q. And you were paid for your work in
14 connection with preparing your report?

15 A. Yes.

16 Q. How many hours in total have you expended
17 in your analysis and in preparing your report in this
18 case?

19 A. I'm not -- probably about -- I think my --
20 preparing my report was like eight hours, but I
21 couldn't -- I don't have the exact figures to hand. And
22 preparing rebuttals to three -- the rebuttals that I -- I
23 received was another six hours. Preparation for this
24 deposition was maybe another two hours.

25 Q. And when did you prepare for this

1 deposition?

2 A. I prepared for it yesterday.

3 Q. Did you meet with anyone?

4 A. No.

5 Q. Did you speak to anyone from the defendants
6 or their counsel?

7 A. We had a five-minute discussion on just the
8 procedures with Michael I think on -- it was on Friday.

9 Q. And the Michael you are referring to is the
10 Michael Beato that's here on this call?

11 A. Yes, indeed, yes.

12 Q. Other than your five-minute meeting with
13 Mr. Beato and you said you spent two hours yesterday,
14 correct?

15 A. Yes.

16 Q. What did you do to prepare yesterday?

17 A. I reviewed my -- my -- my statement. And I
18 looked at several of the references that were in the
19 rebuttals.

20 Q. Okay. And we're going to get back to that
21 in a second.

22 A minute ago you mentioned there was a
23 Patrick who you couldn't remember his last name. Does
24 the last name Hunter sound familiar?

25 A. That sounds familiar, yes.

1 Q. Okay. And is he the same Patrick Hunter
2 that's also involved with SEGM and Genspect?

3 A. I don't know about Genspect, but SEGM, yes,
4 definitely. Yes, that's him.

5 Q. Okay. And for -- for the Court's benefit,
6 can you describe the work of SEGM, the way -- the way you
7 pronounced it?

8 A. So SEGM, S-E-G-M, the Society for
9 Evidence-Based Gender Medicine, is a group of concerned
10 clinicians, doctors, researchers who are concerned about
11 the basis for medical care of children, in particular,
12 who identify as transgender.

13 Q. Well, they are not just concerned about it
14 they are against it, correct?

15 A. Not against -- no, we're -- we're against
16 what we see as unjustified -- medically unjustified care.
17 We're in favor of care of people with gender dysphoria.

18 Q. Okay. And the "we," you included yourself,
19 correct?

20 A. I'm on the board of advisors, yes.

21 Q. Correct. And we're going to talk about
22 that later but I think you described it as being against
23 medically unjustified care, correct?

24 A. Yes, correct.

25 Q. And I don't want to beat the dead horse but

1 it's not within your purview to determine what is
2 medically justified or not, correct?

3 MR. BEATO: Object to form.

4 Dr. Biggs, you can answer that question.

5 BY MS. ALTMAN:

6 Q. Let -- I'll -- I'll withdraw it and I'll
7 ask it different.

8 Sir, it's -- you've already agreed, you're
9 not a medical doctor, correct?

10 A. Correct.

11 Q. Okay. And it's not within your purview to
12 determine what is medically justified or not, correct?

13 A. I disagree with that because I believe that
14 anyone who can look at the empirically researched
15 literature, published literature and can make their own
16 evaluation based on their reading of the literature.

17 Q. Meaning -- I'll give you that. You can
18 read the literature and draw your own personal
19 conclusion, right?

20 A. Correct.

21 Q. But you are not qualified to make a medical
22 determination as to what is justified; isn't that right?

23 MR. BEATO: Object to form.

24 Dr. Biggs, you can answer the question.

25 THE WITNESS: Correct.

1 BY MS. ALTMAN:

2 Q. Okay. When did you get on the board of
3 SEGM?

4 A. I can't give you the exact date. Two years
5 ago, three years ago.

6 Q. How did you have occasion to decide to join
7 that board?

8 A. I believe I was invited by somebody but I
9 can't quite remember who invited me.

10 Q. You would agree that -- that SEGM is an
11 advocacy group, correct, for their -- for their position,
12 correct?

13 A. Correct. Like WPATH in that regard.

14 Q. Well, I asked you earlier whether or not
15 you met with anyone from WPATH and you said no, correct?

16 A. Correct.

17 Q. And I think you also testified that you've
18 never even tried to reach with any -- reach out or meet
19 with anyone from WPATH, correct?

20 A. Correct.

21 Q. Have you ever been qualified as an expert
22 in the United States?

23 A. No.

24 Q. Have you ever testified as an expert in the
25 United States?

1 A. No.

2 Q. Have you ever been qualified as an expert
3 ever?

4 A. Well, I have testified as an expert witness
5 in -- in one court case in United Kingdom and one court
6 case in Australia.

7 Q. Okay. Let's talk about those for a minute.
8 The one you referenced, the first one is the Keira Bell
9 matter; is that correct?

10 A. Correct.

11 Q. And you refer to it on page 2 of your
12 report as Keira Bell and Mrs. A versus Tavistock NHS
13 Trust, correct?

14 A. Yes.

15 Q. And what was the subject matter of your
16 testimony in that case?

17 A. It was about the puberty blockers in
18 general and the -- the Tavistock's concealing of
19 information about their research on puberty blockers in
20 particular.

21 Q. Now, that case was ultimately reversed,
22 correct?

23 A. Correct.

24 Q. And ultimately, an Appellate Court ruled in
25 favor of Tavistock, correct?

1 A. Correct.

2 Q. And with regard to your testimony, were you
3 actually qualified by that Court as an expert in the
4 efficacy of puberty blockers?

5 A. I don't know. I don't know -- I know that
6 my -- my report was submitted. I know that my report was
7 referred to by -- by the barrister in their proceedings.
8 I know it was part of the bundle that was submitted to
9 the judges.

10 Q. But you don't know whether or not the Court
11 ever qualified you as an expert on the efficacy of
12 puberty blockers, correct, sir?

13 A. Correct.

14 Q. And perhaps I missed it but did you produce
15 that report in this case?

16 A. No.

17 Q. Why not?

18 A. Because I was superseded by -- that was
19 quite a few years older. My -- the expert report that I
20 provided is much more comprehensive and based on much
21 more research and later -- later -- later publications.

22 Q. Is that the only reason you didn't produce
23 it, sir?

24 A. Yes.

25 Q. And what year was that?

1 A. I -- I don't recall. I know that the case
2 was during the -- just after -- must have been 2021, I
3 believe, but I'm not swearing to that.

4 Q. And so what post -- we're in -- I hope I
5 found one thing we can agree on today. We're in the year
6 2023, right?

7 A. Correct.

8 Q. March of 2023, correct? What research have
9 you reviewed post 2021 up through today that has altered,
10 impact, or otherwise changed your opinions than those you
11 offered in the Tavistock case?

12 You mentioned that you looked at additional
13 research. I just want to understand what you looked at
14 between 2021, so all of 2022 and the three months that is
15 2023, what new research have you looked at?

16 A. Well, for example, the -- the study on
17 mice, I believe, is -- postdates my Tavistock testimony.

18 Q. Anything else?

19 A. Dutch. I mean, many -- many, many Dutch --
20 of the Dutch articles have come out since then.

21 Q. Anything else?

22 A. I can't -- I'm not -- I can't go through
23 and -- and give you every list, every article that has
24 come out between 2021 and 2023, but my bibliography is --
25 should include all of those.

1 Q. Right. Well, I don't want to rely on your
2 bibliography. I want to understand what you personally
3 relied on in rendering your opinions in this case that
4 came out post your -- your work in the Tavistock matter.

5 A. Well, I've -- I've explained -- I mean,
6 several articles from the -- from the -- from the
7 Netherlands.

8 Q. Uh-huh.

9 A. There was, for example, another -- it was
10 an article from an Australian clinic that demon- -- that
11 showed -- that had very, very high rates, I think some
12 near 97, 98 percent of -- of children who started
13 releasing hormone agonists continued on to cross-sex
14 hormones. That would be an example.

15 Q. Okay. Well, let's talk about that for --
16 for just a second.

17 Did you interview any of the children that
18 started on GnRH that were referenced in that Australian
19 article?

20 A. No.

21 Q. Did you do any analysis of -- of what --
22 what medical or psychological factors influenced
23 determinations as to whether or not they went on to
24 cross-sex hormones?

25 A. No.

1 Q. Did you do any kind of clinical studies to
2 determine whether or not those individuals were indeed
3 transgender?

4 A. No.

5 Q. Have you done any kind of clinical studies
6 of -- associated with the Australian article that you
7 represented that 97 to 98 percent of children who went on
8 GnRH went on to take cross-sex hormones?

9 A. No.

10 Q. Now, sir, you indicate in your report that
11 you testified, if I understand you correctly, in another
12 matter which you identify as expert witness statement for
13 name suppressed Australian family court, 2022, do you
14 recall that in your report?

15 A. Correct.

16 Q. What is that? Putting the name aside for
17 the minute, what was the nature of your testimony, what
18 were you asked to do?

19 A. It was one of six experts asked by the
20 Australian family court to -- to discuss the case of a
21 child, age 11, who was wanting the -- the mother wanted
22 the child to get puberty blockers, the father did not.
23 And so the conflict came to the Australian family court.

24 Q. What were you asked to do?

25 A. I was asked to provide my -- my evidence on

1 the -- the efficacy and side effects of -- of puberty
2 blockers.

3 Q. And were you qualified as an expert in that
4 case?

5 A. I don't believe that the Australian family
6 court system either qualifies or not qualifies experts.

7 Q. Did you testify in the Australian court?

8 A. Again, the Australian system does not have
9 testimony from the experts. So I had -- we had an expert
10 conference of -- all the experts on both sides had a
11 meeting to decide where we agreed and where we disagreed.
12 But as in the Keira Bell case, experts did not -- do not
13 testify.

14 Q. Okay. So were you deposed -- I guess not,
15 because you said you've never been deposed before.

16 A. Yeah, correct.

17 Q. So the two matters in which you've been
18 engaged -- just want to make sure I understand it
19 correctly -- to your knowledge, you weren't qualified as
20 an expert in either case, correct?

21 A. Correct.

22 Q. And neither case you gave testimony,
23 correct?

24 A. Correct.

25 Q. Neither case you gave a deposition,

1 correct?

2 A. Correct.

3 Q. And in the latter case of the Australian
4 family, you said there was an expert conference of the
5 experts on both sides?

6 A. Correct.

7 Q. And do the experts make a recommendation to
8 the court?

9 A. The -- our aim was to -- to decide where we
10 agreed and where we disagreed.

11 Q. Right. And so my question is, did you --
12 the six of you, if I got the number right, collectively
13 make a recommendation to the court?

14 A. No, because we agreed. But we agreed on
15 where we disagreed, if you like.

16 Q. Okay. Was there any -- any recommendation
17 that you provided to the court in that case?

18 A. Other than my -- my -- my -- the report
19 that I submitted, no.

20 Q. Okay. So you did submit a report in that
21 case?

22 A. Yes, yes.

23 Q. And that was in 2022, correct?

24 A. Correct.

25 Q. And you haven't included that in your

1 materials in this case, correct?

2 A. Correct.

3 Q. In -- in each of those matters, the
4 Tavistock matter and the Australian family matter, were
5 the individuals in those cases suffering from gender
6 dysphoria?

7 A. Yes.

8 Q. In both cases?

9 A. Yes.

10 Q. And if I understood you correctly, the
11 expertise for which you were retained in the Tavistock
12 matter was to provide your opinions on -- on puberty
13 blockers; is that correct?

14 A. Correct.

15 Q. And I think the second basis for your
16 opinions was, according to you, the failure to have
17 provided certain information or disclose certain
18 information, correct?

19 A. Correct.

20 Q. Now, in that case, the appeals court
21 determined that medical professionals are -- are indeed
22 qualified to determine whether or not an individual
23 provides consent, correct?

24 A. Yes.

25 Q. Now, sir, if I recall correctly, on the

1 Health and Human Services committee, there were other
2 individuals who testified or spoke -- were speakers along
3 with you, correct?

4 A. Correct.

5 Q. One of them was Dr. Laidlaw, correct?

6 A. Yes.

7 Q. One of them was Dr. Levine, right?

8 A. Yes.

9 Q. Another was Chloe Cole, a detransitioner;
10 isn't that right?

11 A. Yes.

12 Q. Was anyone present to speak on behalf of --
13 of those that support gender-affirming care?

14 A. I can't recall.

15 Q. As you sit here today, are you aware of
16 anyone that -- that was invited to speak about the
17 provision of gender-affirming care?

18 A. I believe the chair of the committee said
19 that he had invited a surgeon in Florida with a very
20 Irish name, I'm afraid it is not on the tip of my tongue,
21 and that she had -- Galica, is it -- Galica her surname?
22 -- and she had refused to attend.

23 Q. Anything else that you recall about those
24 that believe gender-affirming care is appropriate in
25 terms of their invitation to speak at that committee

1 meeting?

2 A. No, I'm afraid I'm not -- I'm not aware of
3 anything.

4 Q. Fair enough. But you would agree with me
5 that no one did speak on the provision of
6 gender-affirming care in a positive way, correct?

7 A. I believe not.

8 Q. Now, sir, you would agree with me that
9 Dr. Laidlaw, Dr. Levine also are against providing
10 gender-affirming care, in particular to minors, correct?

11 A. Correct.

12 Q. Do you have any opinions on puberty
13 blockers that -- and I know the answer to this but I'm
14 going to ask it anyway -- as it pertains to adults?

15 A. No.

16 Q. Do you have any opinions on the provision
17 of cross-sex hormones as it pertains to adults?

18 A. No.

19 Q. Do you have any opinions with regard to
20 cross-sex or -- or surgical procedures as it pertains to
21 adults?

22 A. No.

23 Q. Now, at that committee meeting --

24 MR. BEATO: I apologize, Ms. Altman. I
25 just note that we've been going for about an hour

1 and 30 minutes. Do you mind if somewhere we work
2 in just a brief five-minute break? I -- I don't
3 mean to interrupt.

4 MS. ALTMAN: Oh, no, it is okay. Happy to
5 do it right now. That's fine. So five minutes.
6 It is 11:24, why don't we regroup at 11:30.

7 (A brief recess was taken from 11:24 a.m.
8 to 11:31 a.m.)

9 BY MS. ALTMAN:

10 Q. Sir, just to -- to put a finer point on it,
11 other than the opinions in your report on puberty
12 blockers, you are not offering any opinions on cross-sex
13 hormones, correct?

14 A. Correct.

15 Q. You are not offering any opinion on the
16 medical care to be received by adults, correct?

17 A. Correct.

18 Q. Sir, do you know who finances SEGM?

19 A. No.

20 Q. You have no knowledge whatsoever as to who
21 finances that organization?

22 A. No, I don't.

23 Q. Do you know how many members it has?

24 A. I don't believe it has members.

25 Q. What do you think it has; if they are not

1 members, what would you call it?

2 A. Well, there is a board of advisors. I
3 don't know how many people are on the board of advisors,
4 maybe 20, 12. I really don't know.

5 Q. Do you meet?

6 A. There is a common library of articles in
7 Zotero, in a software called Zotero.

8 Q. I assume these articles are all anti
9 providing gender-affirming care to individuals; is that
10 correct?

11 MR. BEATO: Objection -- object to form.
12 Dr. Biggs, you can answer that question.

13 THE WITNESS: No, that's incorrect. It is
14 the literature of rela- -- relevant to gender
15 care.

16 BY MS. ALTMAN:

17 Q. Okay. And so you would -- your -- it's
18 your testimony that the literature relevant to gender
19 care is both those that propose it and those that are
20 against it?

21 A. Yes.

22 Q. Okay. And do individuals upload
23 information into that database?

24 A. Yes.

25 Q. And would that be individuals that are on

1 the board of advisors or can anyone update or upload
2 information into that database?

3 A. I don't know. I just use it, so I assume
4 that there are maybe five people who can -- who can
5 upload information. I'm not -- I'm not aware of the
6 details.

7 Q. Do you know who the five people are?

8 A. No.

9 Q. Can you upload information into that
10 database?

11 A. I don't know if I have uploading permission
12 or not. I've never uploaded anything.

13 Q. But you indicated that you do use it; is
14 that correct?

15 A. Yes, if I can come across a reference,
16 then -- and then I can look in the second database to get
17 the article quickly.

18 Q. Sir, your opinions in this case are limited
19 to puberty blockers, correct?

20 A. Yes.

21 Q. And, again, you are not -- you are not
22 providing any opinions relating to gender dysphoria
23 specifically as it pertains to adults, correct?

24 A. Correct.

25 Q. Now, sir, at the committee meeting for the

1 Health and Human Services, you -- you stated that you
2 read published literature regarding gender-affirming care
3 and determined that it was of poor quality, do you recall
4 that testimony?

5 A. Yes.

6 Q. What literature specifically did you review
7 that you believe is of poor quality?

8 A. There -- well, one of the landmark studies
9 would be the de Vries, et al., 2011 and the de Vries, et
10 al., 2014, which was the -- the first cohort of -- well,
11 they started out with 70 children who were -- who got
12 puberty blockers in the Netherlands.

13 Q. And it's -- it is your position that --
14 that those -- that published literature was of poor
15 quality, is that your testimony?

16 A. Yes.

17 Q. Based on what qualifications, sir, do you
18 have to make a determination that those -- the published
19 literature was of poor quality?

20 A. Well, it's The National Institute For
21 Clinical Excellence, called NICE, N-I-C-E, in Britain has
22 reviewed -- has reviewed the literature -- that
23 literature with reference to the GRADE system, G-R-A-D-E,
24 of -- of research, where -- where the research is of high
25 quality and low quality, and has assessed those studies

1 of -- as being of very low quality.

2 Q. So you've not done any studies to determine
3 whether it's of poor quality or low quality. You are,
4 again, citing to someone else's analysis, correct?

5 A. I've also considered the -- the literature
6 myself.

7 Q. When you just answered my question, sir,
8 you referred to NICE's evaluation of whether or not using
9 their grading system it was of low quality; isn't that
10 right?

11 A. Yes.

12 Q. Okay. And that's what you were relying
13 upon when you were before the Health and Human Services
14 committee when you represented that the published
15 literature was of poor quality?

16 A. It's partly -- that's one -- that's one
17 contributor to my judgment. I also base it on the -- my
18 own review of the literature. So another example of poor
19 quality would be very high rates of attrition that are
20 not explained.

21 Q. Well, let's just focus on that for a
22 second. You didn't try and reach out to the individuals
23 that -- that you claim were no longer available or didn't
24 participate in order to determine their results, did you?

25 A. Correct.

1 Q. So you are just saying the -- the mere fact
2 that there was what you refer to as a significant amount
3 of attrition, in your opinion, makes -- makes it of poor
4 quality; is that correct?

5 A. Yes, that's one factor, yes.

6 Q. Okay. But as far as you know, those
7 individuals could all be very happy, well adjusted, not
8 suffering from depression or anxiety or any other
9 disease, correct?

10 A. Correct.

11 Q. You don't know one way or another?

12 A. Correct.

13 Q. So you have no way to dispute the results
14 of those -- the two studies you mentioned, de Vries 2011
15 and 2014, correct?

16 A. Correct -- no, actually, hold on. Can I --
17 can I change my answer there? One -- one -- one example
18 was the -- one of the major findings was the gender
19 dysphoria was eliminated after -- after the -- after the
20 medical procedures. And that is based on the scale,
21 which they changed the scale halfway through the study.

22 Q. Okay. So that doesn't tell you, sir, that
23 gender dysphoria wasn't eliminated. All you could say is
24 that they changed the scale, correct?

25 A. Yes --

1 MR. BEATO: Object to form.

2 Dr. Biggs, you can answer that question.

3 BY MS. ALTMAN:

4 Q. Right?

5 A. There was no evidence either way.

6 Q. Right. So you can't say the evidence is
7 bad or good, correct?

8 A. If researchers change the scale halfway
9 through a study, that is a sign of very poor research.

10 Q. Well, sir, while it may be, in your
11 opinion, a sign of very poor research, what it isn't a
12 sign of is individuals who originally had gender
13 dysphoria who no longer suffer from gender dysphoria,
14 correct?

15 A. Correct.

16 Q. And you can't testify and you have no
17 information from which you could testify or provide
18 opinions about whether or not any of these individuals
19 indeed were -- received relief from -- from their gender
20 dysphoria because of the medical treatments that they
21 received, correct?

22 A. Largely correct. I mean, the -- the child
23 who died as a result of surgery, I don't believe that
24 they were cured of their gender dysphoria.

25 Q. Okay. Well, let's talk about that

1 individual for a minute. You would agree with me, sir,
2 that that individual, if I'm remembering the one that you
3 referred to in your report, died of a surgical procedure,
4 correct?

5 A. Yes, correct.

6 Q. And you would agree with me that the --
7 the -- to your knowledge, you have no basis on which to
8 opine that puberty blockers had any causation whatsoever
9 in that individual's death; is that right?

10 A. I disagree because puberty blockers meant
11 that the -- the individual had to go through a more
12 dangerous form of vaginoplasty.

13 Q. Okay. But, sir, puberty blockers was not
14 the causation of that individual's death, correct?

15 A. It was indirect -- an indirect cause.

16 Q. Sir, you understand my question. The
17 person died of a complication from surgery; isn't that
18 right?

19 A. Correct, but the chance of a surgical
20 complication was increased because of the particular type
21 of procedure they had to undergo because of puberty
22 blockers.

23 Q. Sir, what medical basis do you have to make
24 that statement? Are you a surgeon?

25 A. Because the surgeons who -- who performed

1 that operation stated that that was the reason why they
2 had to undergo that more complicated surgery.

3 Q. Are you a surgeon?

4 A. No.

5 Q. Did you review the surgical notes from that
6 case?

7 A. I reviewed the article.

8 Q. I didn't ask if you reviewed the article.
9 I understand the confusion. My question is, did you
10 review the surgical notes of that patient from that case?

11 A. No.

12 Q. Did you do any analysis whatsoever of the
13 medical treatment, meaning looking at the actual medical
14 records, of the individual that died in that case?

15 A. No.

16 Q. Did you speak to the doctors directly to
17 determine what happened in that particular case to that
18 particular patient?

19 A. No, they -- they -- there was no need to
20 speak to them because they published an article which
21 described what happened.

22 Q. So the answer to my question is no, you
23 didn't, right?

24 A. Correct.

25 Q. Okay. Have you ever spoken to a surgeon

1 who provides surgery, gender-affirming surgery, to
2 determine how that procedure is performed today?

3 A. No.

4 Q. Have you spoken to any surgeon that
5 performs bottom surgery today to determine what impact,
6 if any, puberty blockers has on their ability to provide
7 such surgery?

8 A. No.

9 Q. Sir, are -- are you suggesting or
10 representing to the Court that you've read all of the
11 published literature on the provision of gender-affirming
12 care?

13 A. No, not all of it, no.

14 Q. Other than what you've testified with
15 regards to the two de Vries studies, is there any other
16 literature that you reviewed that you believe is of poor
17 quality?

18 A. I guess there is other research. For
19 example, there is a study by Tordoff, which again had a
20 very high rate of attrition which was unexplained,
21 Tordoff 2022, I believe.

22 Q. Okay. And, sir, the fact that there is a
23 high rate of attrition doesn't mean that the underlying
24 merits of the study were incorrect; isn't that right?

25 A. Well, the higher the rates of attrition,

1 the worse the -- the study because the less inferences
2 can be drawn from it.

3 Q. Well, I'm talking about the actual care,
4 sir. Just because there is a high rate of attrition
5 doesn't mean that the results of the care that are
6 reported in that study are not correct, are not reliable;
7 isn't that right?

8 A. Well, we don't know the results for the --
9 the patients who were -- who -- who were not measured,
10 who did not come back to the clinic, correct.

11 Q. You don't know one way or the other, right?

12 A. Correct.

13 Q. And you can't surmise that -- that their
14 results were bad, can you?

15 A. Correct.

16 Q. And -- or the other way around, right, you
17 just don't know?

18 A. Correct.

19 Q. And you didn't do anything yourself to
20 reach out to any of the individuals that were part of the
21 Tordoff study that -- that had left the study or weren't
22 reporting back to determine what their -- their results
23 were, did you?

24 A. Correct.

25 Q. And I assume you would agree with me that

1 medical professionals are in a better position to
2 ascertain and weigh the reliability of studies and
3 research in the area of gender dysphoria, correct, sir?

4 A. Correct.

5 Q. And you are not suggesting to this Court
6 that as between yourself and a medical director, that you
7 are in a better position to evaluate research than they
8 would be, right?

9 A. I think one's ability to evaluate should be
10 based on, you know, one's publications, for example.

11 Q. Okay. And in the committee meeting, the
12 Health and Human Services committee meeting, you said you
13 have published original research of your own, do you
14 recall making that statement?

15 A. Yes.

16 Q. Is that the research that we discussed
17 earlier with regard to suicidality and bone density?

18 A. Yes.

19 Q. Is there anything else?

20 A. No.

21 Q. That you were referring to?

22 A. No.

23 Q. What statistical methodology did you employ
24 in your -- your analysis of suicidality?

25 A. Calculating a -- calculating a rate. So

1 you have a denominator and numerator. The denominator is
2 the number of deaths and the -- sorry, the numerator is
3 the number of deaths and the denominator is the number of
4 years -- individual years at risk.

5 Q. So simple math, right?

6 A. Yes.

7 Q. But -- but what you also testified and --
8 and extrapolated that somehow this suicide rate, as
9 compared to healthy teenagers, was greater than 1
10 percent, correct?

11 A. I don't recognize what you are saying in
12 the question.

13 Q. Okay. You don't recall saying that in your
14 report and at the -- at the Health and Human Services
15 meeting?

16 A. I believe what I said was that the suicide
17 rate of the -- of clinic referred adolescence to the
18 Tavistock was, by my best estimate, about five or six
19 times higher than comparable in the overall population.

20 Q. Well, let's just make sure we're talking
21 about the same thing so that there is no confusion. So
22 I'm looking at page 5 and 6 of your report. And, again,
23 you were referring to the teenager that died of
24 fasciitis, correct?

25 A. Can I -- I'm just consulting my -- can I --

1 Q. Well, I'm going to read you the relevant
2 portion but feel free to pick up your report or we can
3 pull it up on the screen. But I'm at the bottom of page
4 5 --

5 MR. BEATO: Would it be best to pull it up
6 on the screen, just so everyone is reading the
7 same thing?

8 MS. ALTMAN: Yes. I'm going to wake Ana
9 up.

10 Ana, if you can go to page 5 of the report,
11 Exhibit 2, that would be --

12 MS. GONZALEZ: I'm here. Let me just share
13 the screen again and I'll take you to it.

14 MS. ALTMAN: Bottom of page 5.

15 MS. GONZALEZ: Okay. I'm there.

16 BY MS. ALTMAN:

17 Q. Okay, sir, do you see at the bottom of
18 page 5?

19 A. Yes.

20 Q. And if we can go on to page 6. There you
21 go, top of page 6. Did I not read that correctly? "In a
22 cohort of healthy teenagers, a death rate exceeding 1
23 percent is alarming."

24 A. Yes.

25 Q. Do you see that now?

1 A. Yes, yes.

2 Q. Okay. And so you referred in your -- in
3 your statistical methodology, you compared the death rate
4 to a cohort of healthy teenagers; isn't that right?

5 A. I'm sorry, when I was -- when I was
6 replying earlier, I thought you were talking about
7 my suicide -- the study of suicide at Tavistock.

8 Q. Oh, okay. So now that we're -- again,
9 that's why we pulled it up, to make sure we're on the
10 same page. Do you see your opinion in this case?

11 A. Yes, yes.

12 Q. Okay. And here you say, "In a cohort of
13 healthy teenagers, a death rate exceeding 1 percent is
14 alarming."

15 A. Yes.

16 Q. I read that right?

17 A. Correct.

18 Q. Okay. And so you would agree with me that
19 individuals suffering from gender dysphoria are not
20 necessarily healthy teenagers, are they?

21 A. They are physically -- often physically
22 healthy.

23 Q. Do you know, sir? Did you do any analysis
24 to determine whether or not the death rate, using the
25 example that you gave, which we'll go into why I don't

1 agree with it, but did you do any analysis to determine
2 what the death rate of those suffering from gender
3 dysphoria is?

4 A. We do -- the Amsterdam gender clinic does
5 have a very good -- does actually keep extremely good
6 records of the number of patients it sees and their death
7 rate. And that's -- the death rate is certainly much
8 lower than 1 percent, normally, of its -- of its clinical
9 referred patients.

10 Q. Well, what is it?

11 A. I don't have the figures at hand.

12 Q. Okay. So as you sit here today, you don't
13 know what the death rate is of those that suffer with
14 gender dysphoria, correct?

15 A. Correct.

16 Q. And, sir, with regard to this 1 percent
17 that you calculated as some reliable measure of the death
18 rate, you are basing it on one patient who died from a
19 failed surgical proceeding; isn't that right?

20 A. Correct.

21 Q. They didn't die from puberty blockers, from
22 the administration of puberty blockers, did they?

23 A. The administration of puberty blockers
24 increased the risk of dying in surgery because of the
25 effect of -- on -- of the vagio- -- the --

1 Q. I -- and I heard when you said that before,
2 sir. But you would agree with me that giving puberty
3 blockers did not cause this individual to die. They had
4 a failed result from a surgical procedure; isn't that
5 right?

6 A. Correct.

7 Q. And giving cross-sex hormones was not the
8 cause of death of this individual, correct?

9 A. Correct.

10 Q. And so you would agree with me, sir, that
11 your statement in your report is grossly misleading to
12 suggest to this Court that there is a 1 percent death
13 rate in this particular study because an individual died
14 from a surgical complication; isn't that right?

15 MR. BEATO: Object to form.

16 But, Dr. Biggs, you can answer that.

17 THE WITNESS: I disagree with that
18 characterization. 70 -- there were 70 patients in
19 the study and one died. So that's a death rate
20 exceeding -- in that study, a death rate exceeding
21 1 percent.

22 BY MS. ALTMAN:

23 Q. And that's -- that's the sole basis for
24 your opinion that the -- that it's an exceedingly high
25 death rate?

1 A. In that study, yes.

2 Q. Yeah. And in that study, sir, that study
3 wasn't designed to analyze the efficacy or return rate of
4 surgical procedures, was it?

5 A. It was designed to look at the Dutch
6 Protocol, which was three -- which had three components;
7 puberty blockers, cross-sex hormones, and then surgeries
8 up to 18.

9 Q. Okay. And so it's your -- it's your
10 position, based upon your statistical analysis of
11 dividing the numerator and the denominator, that -- that
12 the death rate is greater than 1 percent, correct?

13 A. In that study, yes. I'm not claiming that
14 that is extrapolating that -- other situations or
15 other -- other groups of patients.

16 Q. Okay. But that -- your report doesn't say
17 that, does it?

18 A. It is implied by the -- the wording of
19 the -- of that sentence.

20 Q. No, sir. What -- what your sentence says,
21 "In a cohort of healthy teenagers, a death rate exceeding
22 1 percent is alarming." Isn't that what your sentence
23 says in your report?

24 A. Yes, but it is clearly based on a
25 discussion of those 70 -- of those 70 patients.

1 Q. But those 70 patients were not healthy
2 teenagers. They were those that suffered from gender
3 dysphoria; isn't that correct?

4 A. Yes, but they're physically health -- they
5 were physically healthy.

6 Q. How do you know that, sir, what did you
7 look at in order to make this statement you just made?

8 A. There was no -- they would not have been
9 given gonadotropin-releasing hormone agonist if they --
10 if they were not physically healthy.

11 Q. Have you done any research or analysis to
12 determine whether or not this statement you just made on
13 the record under oath is accurate?

14 A. That is based on my reading of the 2011 and
15 2014 articles by de Vries, et al.

16 Q. Okay. So other than reading those two
17 articles, my question is, have you done any study or
18 analysis to determine whether or not any of the
19 individuals in that 70-person study suffered from
20 comorbidity?

21 A. No.

22 Q. Have you done any analysis whatsoever in
23 either of those studies to determine whether or not any
24 of those individuals had -- had other health issues or
25 concerns?

1 A. No.

2 Q. Sir, if there are 70 people in a study
3 about puberty blockers and one dies in a car accident,
4 does that mean the death rate as a result of the puberty
5 blockers is greater than 1 percent?

6 A. No.

7 Q. And just to -- to make sure I -- I put a
8 pin -- a fine pin in this, in your report, what your
9 statement is, is unrelated really to the 70-person study
10 because you make a blanket general statement that "in a
11 cohort of healthy teenagers, a death rate exceeding 1
12 percent is alarming," did I read that statement -- that
13 sentence correctly?

14 A. Yes, you read that sentence correctly, yes.

15 Q. Now, sir, with regard to puberty blockers,
16 what specific studies or analysis have you personally
17 performed or participated in performing?

18 A. May we have the full screen again, if we're
19 finished with that expert -- or do you want to keep it?

20 Q. You mean you would like to take away the
21 expert report?

22 A. No, just -- I mean, it just -- just it
23 might be easier just so I can see.

24 Q. Sure, sure, sure. I just want to make sure
25 I understood your request.

1 A. So --

2 Q. And, actually, before you answer that
3 question, I have a different question for you.

4 Do you have anything other than our names
5 and our pictures up on your screen in front of you?

6 A. No.

7 Q. Are you reading from any e-mails?

8 A. No.

9 Q. Are you reading from any texts?

10 A. No.

11 Q. Are you receiving, reviewing, or reading
12 any e-mails, texts, or other information about your
13 testimony in this case today?

14 A. Absolutely not.

15 Q. Okay. Excellent. So do you have any
16 materials in front of you?

17 A. Yes, I have the printed-out deposition --
18 or sorry, the report, report, expert report.

19 Q. No worries. Anything else?

20 A. No.

21 Q. Anything else up on your screen?

22 A. No.

23 Q. Okay. So now I go back to my question.
24 With regard to puberty blockers, what specific studies or
25 analysis have you personally performed or participated in

1 performing?

2 A. I have not personally performed any studies
3 on -- on puberty blockers.

4 Q. Have you participated in performing any
5 studies on puberty blockers?

6 A. No.

7 Q. Now, sir, I did listen to your testimony
8 before the Health and Human Services committee, and one
9 of the things you said during that committee meeting is
10 that puberty-blocking drugs perform, and I quote,
11 "chemical castration," do you recall that testimony?

12 A. Yes.

13 Q. And is that an opinion that you are
14 rendering in this case, that puberty blockers perform
15 chemical castration?

16 A. Well, if they block the -- the production
17 of sex hormones.

18 Q. Well, you didn't say that, sir, you said
19 chemical castration.

20 A. Correct.

21 Q. You would agree with me those are two
22 different things. One sounds pretty ominous, right?

23 MR. BEATO: Object to form.

24 But, Dr. Biggs, you can answer that.

25 THE WITNESS: Yes, castration is -- does

1 sound ominous, yes.

2 BY MS. ALTMAN:

3 Q. Correct. But you chose to use those words
4 in the Health and Human Services committee meeting,
5 right, "chemical castration"?

6 A. Yes.

7 Q. Because you wanted to send a particular
8 message, right?

9 A. Correct.

10 Q. You could have said they blocked the
11 production of sex hormones, right?

12 A. Correct.

13 Q. And you could have also said that once you
14 stop taking puberty blockers, the production of sex
15 hormones reignites, correct?

16 A. Yes.

17 Q. But you didn't do that, did you, sir?

18 A. No.

19 Q. Why?

20 A. Because in 93 or 95 or 98 percent of cases,
21 the child will continue on to cross-sex hormones.
22 It's -- it's very unusual for a child to stop taking
23 hormone agonists.

24 Q. But, sir, the puberty blockers does not, in
25 fact, create or -- or result in chemical castration;

1 isn't that correct?

2 A. Correct.

3 Q. But that's not what you said to the Health
4 and Human Services committee, right? I assure you, I've
5 listened to your testimony.

6 A. Correct.

7 Q. You said that puberty blockers performed
8 chemical castration. That's not correct, is it, sir?

9 A. Well, that is the terminology that is used
10 when the drugs are used for, let's say, people -- a man
11 with severe sexual disorders.

12 Q. But we're not talking about that, sir, and
13 you weren't talking about that before the Health and
14 Human Services committee, were you, about a pedophile,
15 right?

16 A. That's the same drugs, it's the same drugs
17 being used in the same dose.

18 Q. Sir, do -- are puberty blocker -- puberty
19 blockers used for gender dysphoria in perpetuity?

20 A. Not normally, no.

21 Q. Okay. So we're not talking about the same
22 thing, are we, sir?

23 A. They are also not used in perpetuity
24 necessarily for -- for men with severe sexual deviation.

25 Q. Sir, why did you not tell the Health and

1 Human Services committee that puberty blockers merely
2 block the production of sex hormones until you stop using
3 them?

4 A. Because I wanted to draw the parallel with
5 their use in -- in prisons and mental institutions.

6 Q. Is that where you believe people with
7 gender -- gender dysphoria belong, in prisons and mental
8 institutions?

9 MR. BEATO: Object to form.

10 Dr. Biggs, you can answer that.

11 THE WITNESS: No.

12 BY MS. ALTMAN:

13 Q. Then why would you draw that parallel?

14 A. I draw that parallel because the same drugs
15 are being used in -- to -- to chemically castrate sex
16 offenders as a -- used for gender dysphoric youth.

17 Q. And they are also used for precocious
18 puberty, right?

19 A. Yes.

20 Q. And they are also used for endometriosis,
21 correct?

22 A. Correct.

23 Q. Well, why didn't you draw one of those
24 parallels?

25 A. Because for endometriosis, for example,

1 they would be used for a much shorter period of time than
2 they are used for -- for gender dysphoric youths --
3 youth.

4 Q. What about for puberty -- for precocious
5 puberty, sir, they can be used for years in precocious
6 puberty?

7 A. Precocious puberty means -- use of -- the
8 use for precocious puberty means blocking an abnormally
9 early puberty in order to allow natural puberty to
10 commence at the -- at the sort of more appropriate time,
11 which is very different from stopping natural puberty
12 altogether.

13 Q. Sir, the reason you chose to use the words
14 "chemical castration" was because you wanted the
15 committee in that particular case to see puberty blockers
16 utilized in some way as -- as a lethal medication rather
17 than its actual use in treatment of gender dysphoria;
18 isn't that right?

19 A. No, I disagree that -- that the -- that
20 puberty blockers are ever a lethal -- a lethal
21 medication. I mean, that's -- that's not how I would
22 cast -- how I would characterize puberty blockers, as
23 lethal.

24 Q. Really? Well, then I'm sorry. Then I
25 guess we can go back to your greater percent -- greater

1 than 1 percent death rate a few minutes ago when you
2 attributed this one death to puberty blockers.

3 So which one is it, is it lethal or is it
4 not lethal?

5 A. Lethal suggests that it has a very, very
6 high rate of -- of -- of death or, indeed, inevitably
7 causes death. That is not my -- that has never -- not
8 and never been my -- my -- my position.

9 Q. It hasn't. Even when you said in your
10 report "in a cohort of healthy teenagers, a death rate
11 exceeding 1 percent is alarming"?

12 A. Alarming, yes.

13 Q. Alarming, okay. So -- so back to your --
14 your testimony. What do you mean by the terminology that
15 you use, chemical castration? What did you mean by that
16 when you said that to the committee?

17 A. I wanted to draw the parallel between the
18 use of the same -- the same drug in the same dose to
19 children who are suffering from gender dysphoria to the
20 use of men with severe sexual deviation.

21 Q. Do you think people who suffer from gender
22 dysphoria have -- are sexual deviants?

23 A. Absolutely not.

24 Q. Do you believe people who are transgender
25 are sexual deviants?

1 A. Absolutely not.

2 Q. But yet you chose to make that parallel
3 before the Health and Human Services committee, right?

4 A. Correct. The parallel is saying that maybe
5 we should take -- think twice before providing the same
6 sort of drugs that -- with those effects to young
7 children as we do to men with sexual deviation.

8 Q. Uh-huh. And the people that should think
9 twice, though, are those people that are qualified to
10 render medical opinions, right?

11 A. I think everybody should think twice about
12 it.

13 Q. Uh-huh. Other than what you've testified
14 on the record and what's contained in your report, what
15 is the specific bases for your testimony that providing
16 puberty blockers is equivalent to chemical castration?

17 A. It's my review -- review -- reading of the
18 two articles -- or three articles reviewing the use of
19 gonadotropin-releasing hormone agonist for sex offenders
20 or for men with -- with severe deviation. One of the
21 articles is Dutch, one of them is American, and one is
22 English.

23 Q. Anything else?

24 A. No.

25 Q. As a sociologist, sir, what qualifications

1 do you have to make such a statement?

2 A. I read the -- I read those articles and I
3 looked at the -- the drugs that were being used and the
4 dose that they were being used, and I compared those to
5 the -- to the literature on gender dysphoria.

6 Q. And any other basis, sir, on which you
7 believe you are qualified to make such a statement?

8 A. No.

9 Q. What studies have you performed on this
10 issue other than reading other people's research on the
11 subject?

12 A. None.

13 Q. Now, sir, you would agree with me that GnRH
14 merely suppresses certain hormones while the person is
15 taking the medication; and that once they stop the
16 medication, they typically begin producing the hormones
17 that were suppressed, correct?

18 A. Correct.

19 Q. And you are not rendering an opinion in
20 this case to the contrary, are you?

21 A. No.

22 Q. And you are not offering an opinion on the
23 medical efficacy of puberty blockers for those with
24 gender dysphoria, are you?

25 A. I'm not sure I understand the question.

1 Q. I'm happy to rephrase it. Are you offering
2 any opinions in this case on the medical efficacy of
3 gender-affirming care?

4 A. I'm offering opinions on -- on puberty
5 blockers, yes.

6 Q. Okay. And, specifically, other than what
7 you've testified on the record, do you have any other
8 opinions about puberty blockers other than what you've
9 already testified on the record?

10 A. No.

11 Q. And you are not qualified, sir, to render
12 any opinion on whether or not there are any medical side
13 effects to puberty blockers, are you?

14 A. No.

15 Q. And as you sit here today, you have no
16 medical training or experience that would qualify you to
17 render any such opinions; isn't that right?

18 A. Correct.

19 Q. Now, you would agree with me, and I believe
20 you've already acknowledged, that puberty suppressors are
21 prescribed to children with precocious puberty, right?

22 A. Yes.

23 Q. Precocious puberty occurs in children,
24 correct?

25 A. Yes.

1 Q. Sometimes as young as 5, I believe,
2 according to your own testimony, correct?

3 A. Yes.

4 Q. And for how many years might those children
5 take puberty blockers?

6 A. I believe up until the age of around 9.

7 Q. So it could be as much as four or five
8 years, correct?

9 A. Correct.

10 Q. And you would agree that that's a standard
11 protocol for precocious puberty if in a five-year-old,
12 might be to give them puberty blockers, correct?

13 A. Yes -- yes.

14 Q. And you agree that when a child stops
15 taking the puberty blockers, he or she should begin
16 normal puberty as usual, correct?

17 A. Yes.

18 Q. I would assume, sir, since you are not a
19 doctor or a pharmacist, you've never prescribed
20 puberty -- puberty suppressors for children experiencing
21 precocious puberty, have you?

22 A. Correct.

23 Q. And you are unqualified to do so, correct?

24 A. Correct.

25 Q. Have you performed any research in the area

1 of providing puberty suppressors to children with
2 precocious puberty?

3 A. No.

4 Q. You seem to be very interested in the
5 provision of puberty suppressors to children. Why have
6 you not engaged in any research of providing children
7 with precocious puberty -- puberty suppressors?

8 A. Well, that's not -- just not a topic that
9 I've investigated, except insofar as it pertains to
10 gender dysphoria.

11 Q. Well, it's the same thing, right, it's
12 providing puberty blockers to children, right? Different
13 diagnoses but both to children, correct?

14 A. At a different -- at a different age as
15 well.

16 Q. One, generally teenagers, one younger,
17 correct?

18 A. Precocious puberty, let's say, a child may
19 start puberty at 5 and they would be stopped until 8 or
20 9, and then they would allow their normal puberty to
21 continue to -- to emerge.

22 Whereas for gender dysphoria, you are
23 stopping and you will not -- typically, in 93 and 95 and
24 98 percent of cases, you will -- the child will never
25 experience puberty.

1 Q. Well, sir, you would agree with me that --
2 that it would be up to the minor, their parents, and
3 their medical professionals whether or not they would go
4 on to take cross-sex hormones; isn't that right?

5 A. Correct.

6 Q. It's not up to you to decide that, is it?

7 A. Certainly not up to me, correct.

8 Q. Okay. And you would agree with me that --
9 that the child, the parent, and the medical professional
10 is in the best position to make those determinations,
11 correct?

12 A. Well, it would have to be based on the
13 evidence, right.

14 Q. But -- but not you, right?

15 A. Not me personally but on the -- on the
16 evidence.

17 Q. Right. And it's not your testimony, as --
18 as you are providing to the Court, that the medical
19 professionals that are treating these individuals aren't
20 as facile with the medical literature as you are?

21 MR. BEATO: Object to form.

22 BY MS. ALTMAN:

23 Q. That's all right. It was a bad question,
24 I'm going to withdraw it.

25 Sir, it is not your testimony or your

1 opinion in this case that medical professionals -- well,
2 strike that.

3 It is not your testimony, sir, that you are
4 the only individual that's reviewing medical literature
5 with regard to the treatment of gender dysphoria and
6 puberty blockers, is it?

7 A. No; that's correct.

8 Q. You would agree with me that other
9 individuals, even myself, could read the same literature
10 that you are reading and draw conclusions from it,
11 correct?

12 A. Correct.

13 Q. And -- and, in fact, they might draw
14 different conclusions than you, correct?

15 A. Yes.

16 Q. Have you ever provided an opinion that
17 giving GnRH to children for precocious puberty will
18 impact their -- impact their brain development?

19 A. No.

20 Q. Have you ever provided an opinion that
21 giving GnRH to children for precocious puberty will
22 impact their bone density?

23 A. No.

24 Q. Have you ever provided an opinion that
25 giving GnRH to children for precocious puberty is a -- is

1 equivalent to the chemical castration?

2 A. No.

3 Q. But these are all opinions that -- that
4 you've rendered in this case when that same drug is given
5 for gender dysphoria, correct?

6 A. Correct.

7 Q. You believe providing puberty blockers for
8 precocious puberty will impact a child's mental health?

9 A. I have no opinion on that.

10 Q. Have you -- have you performed any
11 independent research whatsoever with regard to providing
12 puberty blockers to children with precocious puberty?

13 A. No.

14 Q. Do you believe that providing puberty
15 blockers to children for precocious puberty will impact a
16 young child's sexual function?

17 A. I have no opinions on that.

18 Q. But you do have an opinion on it when it
19 comes to providing that same drug for those with gender
20 dysphoria, right?

21 A. Yes.

22 Q. And those opinions are encapsulated in your
23 report in this case, correct?

24 A. Correct.

25 Q. Are you qualified to determine when a child

1 has precocious puberty?

2 A. No.

3 Q. Would you agree with me or do you agree
4 with me that you are not qualified to opine on the
5 physiological differences in administering GnRH to a
6 five-year-old with precocious puberty versus a
7 13-year-old who is evidencing gender dysphoria, correct,
8 sir?

9 A. Correct.

10 Q. Who diagnoses precocious puberty?

11 A. An endocrinologist.

12 Q. Who diagnoses gender dysphoria?

13 A. It would usually be a psychologist.

14 Q. You would agree with me that in neither
15 case it is a sociologist, right?

16 A. Correct.

17 Q. Who determines the course of treatment for
18 a child with precocious puberty?

19 A. An endocrine -- endocrinologist.

20 Q. Who determines the course of treatment for
21 a child with gender dysphoria?

22 A. It would be a psychologist, perhaps with a
23 endocrinologist as well.

24 Q. You would agree with me it is not a
25 sociologist, correct?

1 A. Correct.

2 Q. In your testimony, you told the Health and
3 Human Services committee that taking GnRH decreases bone
4 density, right?

5 A. Yes.

6 Q. But, sir, you are not qualified to render
7 an opinion on the medical impact of using puberty
8 blockers with regards to bone density; as you've already
9 testified, all you've done is read other people's
10 research, correct?

11 A. No. I've conducted my own statistical
12 analysis of the bone density that was produced by data
13 from the -- from the Tavistock.

14 Q. And that's what we talked about earlier,
15 right, those were other people's scans and analysis, and
16 then you just relied on that, correct, you didn't do the
17 scans yourself?

18 A. I did not do the scans myself.

19 Q. Right. So you are relying upon, you know,
20 the -- the quality of somebody else's work, correct?

21 A. Correct.

22 Q. Good or bad?

23 A. Correct.

24 Q. What education, skill, or training do you
25 have that would enable you to provide opinions on the

1 medical consequences of using puberty blockers?

2 A. Well, I have a Ph.D. in -- from Harvard
3 for -- which gives me an ability to look at quantitative
4 research and to analysis literature.

5 Q. And your Ph.D., sir, was not in anything
6 related to the treatment of gender dysphoria, correct?

7 A. Correct.

8 Q. And it wasn't anything related to the use
9 of puberty blockers, was it?

10 A. Correct.

11 Q. And, sir, you would agree with me that if
12 there were any side effects from taking puberty blockers,
13 they would be the same whether someone takes it for
14 precocious puberty or gender dysphoria, correct?

15 A. Well, that would depend on what age they
16 took it and for how long.

17 Q. Okay. But you would agree with me,
18 depending upon what age they are and how long they took
19 it, the side effects could be the same, correct?

20 A. Yes.

21 Q. Have you ever advocated that puberty
22 blockers not be given to children for precocious puberty?

23 A. No.

24 Q. And you are not suggesting to this Court
25 that it has an impact on bone density only when it is

1 given for gender dysphoria, are you?

2 A. No.

3 Q. Could have an impact in precocious puberty,
4 right?

5 A. It could, yes. That's not my --

6 Q. And -- and it would be up to medical
7 professionals -- not yourself as a sociologist -- if
8 giving puberty blockers, to monitor the patient to whom
9 they are given, correct?

10 A. Correct.

11 Q. And they would do testing, correct?

12 A. Correct.

13 Q. And if they saw issues, vis-à-vis decreases
14 in bone density, they could take medical intervention as
15 a result of that, correct?

16 A. Yes.

17 Q. And that's true whether they were given for
18 precocious puberty or gender dysphoria, correct?

19 A. Yes. But the -- the crucial difference is
20 the age at which you are doing -- doing the intervention.

21 Q. Because you believe that at -- at a -- at
22 an older age, the level of hormones increase -- the
23 increase in hormones has a greater impact on bone
24 density, is that your position?

25 A. Bone density is laid down in adolescence,

1 yes. So that's the -- that's the most important time in
2 which you are laying down the -- the bone density for
3 which you are using -- you are -- for life -- you know,
4 you are then using it for the rest -- for the rest of
5 your life.

6 Q. And you would agree with me, sir, that
7 those that are prescribing puberty blockers for those
8 with gender dysphoria during adolescence have the ability
9 to monitor those patients, correct?

10 A. They do have the ability to monitor the
11 patients, yes.

12 Q. And they have the ability to utilize
13 medical intervention if they see decreases or impact on
14 bone density, correct?

15 A. I don't know that there is any medical
16 intervention for decreases in bone density. The only --
17 they are recommending taking vitamin D and more
18 weightbearing exercise. I suppose vitamin D is medical
19 intervention.

20 Q. Well, you just named two of them right
21 there, right?

22 A. Yes.

23 Q. Okay. And there might be others. You
24 don't know because you are not a medical doctor, correct?

25 A. Correct.

1 Q. Now, in your testimony before the
2 committee, you referenced -- and I believe this is also
3 in your report -- one individual who had -- at 15 had
4 osteoporosis, do you recall that?

5 A. Yes.

6 Q. Did you review that individual's medical
7 records to determine the origin or diagnosis of that
8 person's osteoporosis?

9 A. No.

10 Q. You would agree with me that -- that many
11 teenagers who are not -- do not suffer from gender
12 dysphoria and don't take puberty blockers can have
13 osteoporosis, correct?

14 A. Yes.

15 Q. And yet you chose to suggest to the Health
16 and Human Services committee that this one individual,
17 because they had osteoporosis, it was in some way related
18 to puberty blockers, even though you had absolutely no
19 basis to make that statement; isn't that correct?

20 MR. BEATO: Object to form.

21 Dr. Biggs, you can answer that question.

22 THE WITNESS: Are we -- are you referring
23 to the English child that I mentioned or the
24 Swedish child?

25 BY MS. ALTMAN:

1 Q. The 15-year-old child. I don't have -- I
2 can pull up your audio from the Health and Human
3 Services. I honestly don't remember if she was Swedish
4 or English. But regardless, you didn't do any
5 investigation whatsoever to determine whether or not
6 there was a pre-existing condition or reason for the
7 osteoporosis; isn't that right?

8 A. The Swedish clinicians were so concerned
9 about this case that it changed their policy on giving
10 puberty blockers. So the Swedish had made that
11 determination.

12 Q. Did you understand my question?

13 A. Yes.

14 Q. Did you understand my question?

15 A. Yes.

16 Q. Do you need me to ask it again?

17 A. Sure.

18 Q. Okay. My question is, you didn't do any
19 independent research or analysis to determine whether or
20 not the 15-year-old that you referenced in your testimony
21 before the Health and Human Services committee had any
22 pre-existing condition or other reason that she suffered
23 from osteoporosis; isn't that right?

24 A. I did not, no. I was repeating what the
25 Swedish clinicians had found.

1 Q. Right. You were repeating somebody else's
2 research, correct?

3 A. Yes.

4 Q. Okay. And you didn't do any independent
5 study or analysis to determine whether or not that
6 particular individual that you represented to the Health
7 and Human Services committee in a way as to suggest that
8 the osteoporosis was derived from giving the puberty
9 blockers. You did not do any independent analysis to
10 determine whether that's correct; isn't that right?

11 A. Yes.

12 MR. BEATO: Object to form.

13 But, Dr. Biggs, you can answer the
14 question.

15 BY MS. ALTMAN:

16 Q. I think he said I was right, correct?

17 A. Yes.

18 Q. As you sit here today, you don't have any
19 basis to testify under oath that the individual you noted
20 to the committee was diagnosed with osteoporosis because
21 of receiving puberty blockers; isn't that true?

22 A. I was reporting what the Swedish -- the
23 Swedish doctors had found.

24 Q. Right. And so what I said was true,
25 correct, you have no basis under which to testify to this

1 Court or to have testified before the committee under
2 oath that the individual you noted was diagnosed with
3 osteoporosis as a result of receiving puberty blockers,
4 correct?

5 A. No, I disagree with that characterization.
6 I did have a basis for my statement. The statement --
7 the basis was based on the -- the conclusions drawn from
8 the -- by the Swedish clinicians.

9 Q. And you don't know, as you sit here today,
10 whether or not anyone, whether it is in the Swedish
11 clinicians or the English ones, whether or not they did
12 any independent analysis to determine whether or not the
13 15-year-old's osteoporosis was caused from factors other
14 than or in addition to puberty blockers; isn't that
15 correct?

16 A. Yes.

17 Q. And, sir, even though -- well, strike that.

18 You would agree with me that there is no
19 consensus on any long-term impact on bone density with
20 regards to the use of GnRH alone or with cross-sex
21 hormones; isn't that correct?

22 A. No, there is a consensus.

23 Q. Of the long-term impact? What is the
24 consensus, sir, in your opinion?

25 A. Well, the consensus is that puberty

1 blockers will reduce bone density or bone density will
2 not accrue as fast as it should, so it will reduce
3 relative to the age and sex. And then in some cases it
4 will increase again with cross-sex hormones. But it will
5 not increase -- it will remain below the level relative
6 to age and sex than it was at the commencement.

7 Q. Okay. And other than what you just said,
8 do you have any other opinions on that subject?

9 A. No.

10 Q. And so if I understood you correctly, you
11 agree with me that providing cross-sex hormones, at that
12 point an individual's bone density would accrete, perhaps
13 not at the same level, but would continue to accrete
14 while they are taking cross-sex hormones, correct?

15 A. Yes, but they do not reach the level at
16 which they -- they remain below where they were in terms
17 of relevant to age and sex.

18 Q. Okay. And you don't know -- as you sit
19 here today, you have no ability to opine or provide an
20 opinion on whether or not that will have any long-term
21 detrimental impact on any individual's life, correct?

22 A. Well, we know that the lower your Z-score,
23 typically below 2.5, the more likely you are to have
24 osteoporosis in later life.

25 Q. And as you sit here today, sir, you can't

1 testify or provide an opinion on how many individuals who
2 took puberty blockers and then cross-sex hormones will
3 suffer with osteoporosis later in life, correct?

4 A. Correct.

5 Q. You have no basis to provide an opinion in
6 this court on that subject, correct?

7 A. Well, this is -- if we know that people
8 that -- that have a Z-score minus 2.5 are very high --
9 are very likely to have a very high risk of osteoporosis
10 than -- in -- later in life, then we know that if we have
11 a group of people with a large number below minus 2.5,
12 then the risk of them developing osteoporosis later in
13 life is elevated.

14 Q. Okay. And my question is, as you sit here
15 today, do you know how many people with a Z of less than
16 minus 2.5, who took puberty blockers and cross-sex
17 hormones, suffer from osteoporosis?

18 A. No, there is no published study on that.

19 Q. Okay. Have you taken any steps to conduct
20 a published -- conduct and then publish a study on that?

21 A. No.

22 Q. But it sounds like it is something
23 important to you, correct?

24 A. Yes, yes.

25 Q. And you are espousing that concern in the

1 Health and Human Services committee and in your report in
2 this case, correct?

3 A. Yes.

4 Q. Well, sir, what have you done to study it?

5 A. I don't have access to the patients to
6 study it. But I believe that that's an -- that is an
7 urgent thing for, for example, the Tavistock gender
8 clinic to have -- to study.

9 Q. Okay. And what have you done to try and
10 create interest in studying this issue?

11 A. Publishing a letter to the editor in the
12 journal of pediatric and endocrinology and metabolism
13 showing that the -- that the initial results of puberty
14 suppression after two years are very -- unusually high
15 number of children have low bone density.

16 Q. And anything else that you've done other
17 than publish your letter to the editor?

18 A. That's the main thing I've done, yes.

19 Q. And you haven't independently studied this,
20 correct?

21 A. Correct.

22 Q. Sir, you would agree with me that it is a
23 medical doctor, not a sociologist, who determines whether
24 or not GnRH should be used with a patient, correct?

25 A. For an individual patient, yes.

1 Q. Sir, what is the basis of your statement
2 that you made at the Health and Human Services committee,
3 what is the scientific basis for the statement that the
4 purpose of treating someone with puberty suppressors who
5 has been diagnosed with gender dysphoria is, and I quote,
6 "to begin taking cross-sex hormones for the rest of their
7 lives."

8 What is the scientific basis for that
9 statement that you made to the committee?

10 A. Because that is the explicit stages of
11 the -- in the Dutch protocol. First stage is puberty
12 suppression, second stage is cross-sex hormones, and the
13 third stage is surgery.

14 Q. Well, sir, that's not the statement you
15 made. And I just want to make sure we unpack it. You
16 told the committee that the purpose of someone taking
17 puberty suppressors for gender dysphoria is to begin
18 taking cross-sex hormones for the rest of their lives.
19 What is your scientific basis for that statement?

20 A. This is the rationale that was advocated by
21 the Dutch clinicians, like Peggy Cohen-Kettenis and
22 Gooren and Henrietta Delemarre-van de Waal -- quite a
23 mouthful -- of why puberty blockers were -- why they
24 advocated for puberty blockers.

25 Q. But I didn't ask what their scientific

1 basis is. I asked what yours was. What is your
2 scientific basis for making that statement to the Health
3 and Human Services committee?

4 A. Reading the explicit statements by the
5 advocates for puberty blockers.

6 Q. The Dutch Protocol?

7 A. Yes.

8 Q. And that was how long ago?

9 A. Well, the -- that was in -- well, that --
10 published many things from the 1990s to -- down to today.

11 Q. Okay. And -- but your specific rationale
12 for that statement was the Dutch Protocol, correct?

13 A. Yes.

14 Q. Okay. And that's one study, correct?

15 A. The Dutch Protocol is a generic term to
16 describe the use of puberty -- early puberty suppression
17 followed by cross-sex hormones.

18 Q. Right. And you --

19 A. When it was adopted in America, it was
20 known as the Dutch Protocol. When it was adopted in
21 Britain, it was known as the Dutch Protocol. That's the
22 generic name for it.

23 Q. I got that. And so my question, though,
24 sir, is a little more nuance. And that is, you made a
25 statement that the purpose of taking puberty suppressors

1 in those -- in those diagnosed with gender dysphoria, is
2 to begin taking cross-sex hormones for the rest of their
3 lives. That's what you said.

4 And, sir, you would not be in a position to
5 determine for any specific patient on any specific day in
6 any -- with any specific doctor what the purpose that
7 they were prescribed puberty suppressors was; isn't that
8 right?

9 MR. BEATO: Object to form.

10 But, Dr. Briggs, you can answer that.

11 BY MS. ALTMAN:

12 Q. Do you understand the question?

13 A. Yes, but the -- the rationale of this is to
14 enable the individual to pass better to prevent the
15 development of secondary sex characteristics. So --

16 Q. Sir, you don't know what anyone's
17 individual purpose is in taking puberty suppressors;
18 isn't that right? That's between an individual, their
19 family, if they are a minor, and their physician; isn't
20 that correct? You can't jump into the mind of any
21 particular person and determine what their purpose for
22 taking puberty blockers is; isn't that right?

23 MR. BEATO: Object to form.

24 Dr. Biggs, you can answer that question.

25 THE WITNESS: I certainly can't jump into

1 the mind of any particular person, correct.

2 BY MS. ALTMAN:

3 Q. And so you make these broad sweeping
4 statements that the purpose of taking puberty blockers is
5 to take -- is so that they can take cross-sex hormones
6 for the rest of their life. But that's up to the
7 individual, isn't that correct, and their physician and
8 their family; isn't that right?

9 MR. BEATO: Object to form.

10 But, Dr. Biggs, you can answer that
11 question.

12 THE WITNESS: Yeah, I mean, we know that
13 not -- from 93, 95, 97, 98 percent of children who
14 go on puberty blockers will continue to cross-sex
15 hormones.

16 BY MS. ALTMAN:

17 Q. Did you understand my question?

18 A. Yes, and I answered it.

19 Q. No. You told me the percentages of people
20 that you believe will go on to cross-sex hormones. You
21 didn't answer my question, which was, the decision of
22 whether or not to take puberty blockers and the decision
23 whether or not to take cross-sex hormones is not one for
24 you to make. It is between a patient, their physician,
25 and their parents; isn't that correct?

1 A. Correct.

2 Q. And you would agree with me that the
3 purpose of taking puberty blockers at a time when a
4 person is experiencing distress due to gender dysphoria
5 is actually to alleviate the distress for the child;
6 isn't that correct?

7 A. That's possibly the short-term aim, yes.

8 Q. Sir, have you reviewed any studies that
9 attributed a greater than 1 percent death rate in healthy
10 teenagers for those taking puberty blockers?

11 A. No.

12 Q. What is the death rate of children
13 diagnosed with gender dysphoria who are prohibited from
14 receiving gender-affirming care?

15 A. I don't believe we know that -- those
16 figures.

17 Q. Sorry about that.

18 What research have you performed on the
19 impact of children with gender dysphoria who are
20 prevented from reading -- from receiving gender-affirming
21 care?

22 A. I've not conducted such research.

23 Q. Since you professed to be interested in the
24 subject matter, why have you not undertaken any
25 independent research into what medical interventions can

1 assist those with -- those suffering from gender
2 dysphoria?

3 A. Can you repeat the question, sorry.

4 Q. Sure. You seem to be interested in -- if I
5 understand what your report is in this case and your
6 testimony before the Health and Human Services committee,
7 and the two cases in which you indicate in your report
8 that you participated in, you seem to be interested in
9 puberty suppressors and those with gender dysphoria.

10 Did I get that right?

11 A. Yes.

12 Q. Okay. And so, since you seem to be
13 interested in the subject matter, why have you not
14 undertaken any independent research into what medical
15 interventions can assist those suffering from gender
16 dysphoria?

17 A. I'm concerned about puberty blockers and
18 that's the thing that I've been focused on.

19 Q. But we talked about -- talked about it
20 earlier. You are very concerned about puberty blockers
21 but only as it pertains to gender dysphoria, not as it
22 pertains to precocious puberty, correct?

23 A. Yes.

24 Q. What is the death rate of children
25 diagnosed with gender dysphoria?

1 A. I don't think we have figures -- any
2 figures -- any sort of figures that would be, you know,
3 generalizable across different situations.

4 Q. In your testimony before the Health and
5 Human Services committee, you acknowledge that "puberty
6 suppressors for gender dysphoria have been provided for
7 more than a quarter of a century," that's a quote; isn't
8 that correct?

9 A. Yes.

10 Q. As you sit here today, are you aware of a
11 single death caused by an individual who was diagnosed
12 with gender dysphoria and was also taking puberty
13 suppressors?

14 A. Well, the individual we discussed earlier
15 who died of the necrotizing fasciitis, that I would -- I
16 think that was an indirect consequence of puberty
17 blockers.

18 Q. Anyone else?

19 A. No.

20 Q. And what about, as you sit here today, are
21 you aware of a single death caused by anyone who
22 initially took puberty blockers and then cross-sex
23 hormones and that their death was a consequence of taking
24 cross-sex hormones and puberty blockers?

25 A. No.

1 Q. Now, you told the committee that one of the
2 more serious concerns of taking puberty suppression
3 medication along with cross-sex hormones is the impact on
4 sexual function, correct?

5 A. Yes.

6 Q. Sir, again, you are not qualified to render
7 an opinion on whether or not puberty suppressors impact
8 sexual function; isn't that correct?

9 A. Well, I can render an opinion by quoting
10 Dr. Marci Bowers, for example.

11 Q. So you can -- it is your opinion that you
12 can give an opinion based on someone else's opinion?

13 A. Well, that's Marci Bowers' experience, yes.
14 Not just --

15 Q. Well, it is not your experience, is it,
16 sir?

17 A. No.

18 Q. And you don't have any basis under which
19 you can provide any testimony to this Court that taking
20 puberty blockers impacts sexual function; isn't that
21 correct?

22 A. That would -- basis for that would be my
23 reading of the literature, again.

24 Q. Okay. Have you conducted any studies or
25 research with regard to sexual function other than

1 reading Marci Bowers?

2 A. No.

3 Q. Conducted any peer-reviewed studies?

4 A. No.

5 Q. And I think you also mentioned in your
6 testimony before the Health and Human Services committee
7 that there is an unknown impact on emotional, cognitive
8 development, do you recall saying that?

9 A. Yes.

10 Q. And you say that in your report as well,
11 correct?

12 A. Yes.

13 Q. And so this unknown emotional, cognitive
14 development, if it's unknown, it means you don't know
15 whether there is such an impact; isn't that right?

16 A. Correct.

17 Q. So you are just kind of throwing it out
18 there for open discussion?

19 A. Well --

20 (Simultaneously speaking.)

21 BY MS. ALTMAN:

22 Q. -- whether or not that might be the case?

23 A. The Dutch clinicians have continued to
24 emphasize that they have known -- no idea of what the
25 cognitive and emotional effects will be. And they can --

1 they state that many times over -- in many articles.

2 Q. They do. And so you've repeated that, and
3 I appreciate that. But as we sit here today, sir, "they
4 have no idea" means there could be none, right?

5 A. Correct.

6 Q. But, nonetheless, you include that in your
7 report and you talked about it at the Health and Human
8 Services committee, right?

9 A. Yes, but I think randomized clinical trials
10 on animals provide good evidence. And this is the best
11 evidence because it is based on randomized clinical --
12 randomized trials, that there are broad -- broad impacts
13 of puberty suppression on emotional, cognitive
14 development in nonhuman animals.

15 Q. Is that the mice study that you referred to
16 in your report?

17 A. Mice, sheep, and also there is a primate
18 study as well. I don't remember exactly which -- what
19 type of primate --

20 Q. Did you rely on that primate study in
21 forming your opinions in this case?

22 A. Not the prime -- the primate study I know
23 about from one of the rebuttals.

24 Q. Right. Again, you didn't rely on that in
25 rendering your opinions in this case, correct?

1 A. Correct.

2 Q. You have not personally performed any
3 studies on any impact on the emotional, cognitive
4 development, correct?

5 A. Correct.

6 Q. And there is no studies, that you are aware
7 of, that there is any impact on cognitive IQ, either,
8 right?

9 A. There are some studies on cognition.

10 Q. What studies are you referring to?

11 A. There was one by the Dutch clinicians about
12 the tower of London exercise and the tower -- and they
13 showed that puberty blocked -- children with puberty
14 blockers did perform less well on executive functioning
15 than the controlled group. But it was a very small
16 sample.

17 Q. How small?

18 A. I don't remember off the top of my head.
19 It wasn't significant. But it was a...

20 Q. It was not significant -- statistically
21 significant, correct?

22 A. It was statistically significant.

23 Q. It was significant, okay. And you say you
24 don't recall the name of the study?

25 A. The first author was Stufforsus (Phonetic),

1 I think some Dutch name like that.

2 Q. Is it cited in your report?

3 A. I can't remember whether I cited that
4 particular article.

5 Q. Did you rely on it for your opinions in
6 this case?

7 A. Yes, because I've cited it in the -- I
8 believe I've cited it in my article with the Dutch
9 Protocol. I've certainly known about that study for a
10 while.

11 Q. Okay. Now, as you sit here today, sir, you
12 are not qualified and cannot render an opinion to this
13 Court that GnRH has any negative impact on cognitive
14 development; isn't that right?

15 It's just a question, it's an open
16 question, right?

17 A. I believe that the animal studies strongly
18 are suggestive that blocking normal puberty for quite a
19 few years will have cognitive and emotional effects.

20 Effects on --

21 Q. You believe that based on reading other
22 people's work, right?

23 A. Yes.

24 Q. Not any independent research of your own,
25 correct?

1 A. Correct.

2 Q. Sir, have you reviewed the Tower of London
3 study?

4 A. I've read it, yes.

5 Q. Have you read Dr. Edmiston's rebuttal
6 report in this case?

7 A. Yes.

8 Q. And you would agree with me that he says
9 that the Tower of London study shows no effect on -- of
10 GnRH on executive function, do you agree with that?

11 A. No, I disagree.

12 Q. No, did you see that in his report, is my
13 question?

14 A. I did see it, yes.

15 Q. Okay. So you two have a difference of
16 opinion, right?

17 A. Yes.

18 Q. Okay. And you would agree with me,
19 reasonable people can disagree, correct?

20 A. No. I went back to look at the abstract
21 and the abstract says very clearly that there was a
22 difference.

23 Q. You would agree with me, Dr. Edmiston is a
24 medical doctor?

25 A. Yes.

1 Q. And you are not, right?

2 A. Correct.

3 Q. And you would agree with me that the impact
4 on emotional, cognitive development would be the same
5 whether it is prescribed for precocious puberty or gender
6 dysphoria; isn't that right?

7 A. Well, it's -- it's prescribed at completely
8 different ages for those two conditions.

9 Q. Do you understand my question?

10 A. I don't believe the two are directly
11 comparable because precocious -- GnRH for precocious
12 puberty is prescribed much -- at much younger ages than
13 GnRH for --

14 Q. Fair enough. What impact does GnRH have on
15 the emotional, cognitive development with those
16 precocious puberty?

17 A. I don't think we have -- well, I think
18 there are a few studies that -- again, very small, that
19 suggest that may be deleterious effects on IQ for
20 precocious puberty.

21 Q. Okay. But doctors haven't stopped
22 prescribing GnRH for those with precocious puberty
23 because of those studies you just mentioned, have they?

24 A. I believe there is more caution now, but
25 I'm not an expert, so I wouldn't like to really state my

1 claim on that.

2 Q. You don't know one way or another, right?

3 A. Correct.

4 Q. And you haven't analyzed it, correct?

5 A. Correct.

6 Q. And as you just said, you are not an
7 expert, right?

8 A. Not -- I have not reviewed extensively the
9 literature on precocious puberty, no.

10 Q. Right. Or on the impact of GnRH on
11 individuals who were diagnosed with gender -- with
12 precocious puberty who are taking it, correct?

13 A. For precocious puberty, correct, yes.

14 Q. I think I said that, precocious puberty,
15 correct, okay.

16 Now, you mentioned a recent randomized test
17 on mice that were -- GnRH was provided to mice and it
18 showed high level of stress and anxiety, correct?

19 A. Yes.

20 Q. You didn't perform that study, did you,
21 sir?

22 A. No.

23 Q. Have you ever asked an individual diagnosed
24 with gender dysphoria what psychological impact taking
25 puberty blockers has had on him or her?

1 A. Yes.

2 Q. And is that the one individual you
3 mentioned earlier from the Dutch Protocol, I forget their
4 name?

5 A. Yes.

6 Q. Anyone else?

7 A. Yes.

8 Q. Who? I think it was -- [REDACTED] was the
9 one you mentioned earlier?

10 A. Yes. Keira Bell.

11 Q. Okay. Anybody else?

12 A. No.

13 Q. So two people, right?

14 A. Yes.

15 Q. Has anyone stopped you from speaking to
16 individuals with gender dysphoria who are taking puberty
17 suppressors, which you profess to be interested in, from
18 finding out the specific impact that it's had on them?

19 A. No.

20 Q. Now, if I understood your testimony before
21 the Health and Human Services committee, you said that
22 "puberty blockers should only be offered in a proper
23 randomized controlled trial," do you recall saying that?

24 A. Yes.

25 Q. Do you believe that's true for those with

1 precocious puberty also?

2 A. Yes. In fact, there have been some
3 randomized control trials used for precocious puberty.

4 Q. And what were the results of those?

5 A. The results were that it has very -- the
6 only rationale for treatment for precocious puberty is
7 the effect on height. And unless you start very young,
8 that the -- the actual gains in height from block --
9 stopping -- from stopping precocious puberty are minimal.

10 Q. Okay. Anything else?

11 A. No. Not --

12 Q. Now, sir, could you explain to me how can
13 you conduct a -- to use your words, a proper randomized
14 control trial if the medical care has been prohibited?

15 A. You can't.

16 Q. But you think that's what's necessary in
17 order to utilize puberty blockers for those with gender
18 dysphoria, is a proper randomized control trial, right,
19 that's what you told the Health and Human Services
20 committee?

21 A. Yes. I believe that puberty blockers
22 should be offered only as part of a randomized control
23 trial, yes.

24 Q. Uh-huh. And in order to do a proper
25 randomized control trial, you need to be able to provide

1 such care, correct?

2 A. Yes.

3 Q. Sir, you also spoke at the Florida Board of
4 Medicine meeting relating to the development of rules
5 regarding gender-affirming care on October 28, 2022,
6 correct?

7 A. Yes.

8 Q. And I don't know if you saw the agenda for
9 that meeting, but you are identified as an MD?

10 A. That was not my -- that was a mistake,
11 yeah.

12 Q. Right. I just -- did you correct them on
13 that? Did you --

14 A. This is the first time I've heard -- the
15 first time I've heard of it.

16 Q. Okay. And you were listed on that agenda,
17 if you are aware, as a subject matter expert, do -- are
18 you aware of that?

19 A. I did not -- I don't believe I saw the
20 agenda.

21 Q. Okay. But do you consider yourself a
22 subject matter expert?

23 A. Yes, based on my publications, yes.

24 Q. And the subject matter which you are an
25 expert is reading other people's research and then

1 reporting on it, is that the subject matter in which you
2 are an expert?

3 MR. BEATO: Object to form.

4 But, Dr. Biggs, you can answer that
5 question.

6 THE WITNESS: I wouldn't agree with that
7 characterization. I believe that I've done
8 original research on, for example, suicide and on
9 bone density. And I believe that my, you know,
10 publications stand on their own.

11 BY MS. ALTMAN:

12 Q. Sir, who invited you to attend the Florida
13 Board of Medicine meeting?

14 A. I believe it was Patrick. I thought we
15 covered that. Did we not cover that?

16 Q. Well, you said that he invited you to the
17 Health and Human Services committee. Did he also invite
18 you to the Florida Board of Medicine meeting?

19 A. I don't -- I don't believe that I said
20 that. I believe that I said that he invited me to the
21 board of medicine. But I -- for the Health and Human
22 Services, I just got an e-mail from whoever was
23 organizing that, I believe. Maybe --

24 Q. Okay. So just to make sure I'm on the same
25 page with you, Patrick Hunter invited you to the Florida

1 Board of Medicine meeting, and you got an e-mail for the
2 Health and Human Services committee meeting, but you
3 don't recall who it is from?

4 A. Correct.

5 Q. Were you paid for your time at the Florida
6 Board of Medicine?

7 A. I believe I've already said no.

8 Q. What expertise do you have with regard to
9 the medical treatment of gender dysphoria?

10 A. The expertise is the articles that I've
11 published.

12 Q. Well, that's -- that's with regard to
13 puberty blockers?

14 A. Yes. And suicide.

15 Q. My question was broader. What expertise do
16 you have with regard to the medical treatment of gender
17 dysphoria?

18 A. Well, my expertise is concentrated in those
19 areas.

20 Q. And at the meeting, do you recall you
21 provided a statement in research on gender dysphoria,
22 according to the meeting minutes, do you agree with that?

23 A. Yes.

24 Q. And your statement at the Florida Board of
25 Medicine meeting essentially, if not verbatim, mirrored

1 the testimony that you gave at the Health and Human
2 Services committee; isn't that correct?

3 A. Yes.

4 Q. And it's essentially mirrored your report
5 in this case, correct?

6 A. Similar, yes.

7 Q. And I didn't do a side-by-side comparison,
8 but based upon my review of both of your testimony at the
9 committee and your testimony, which I heard the audio of
10 at the Florida Board of Medicine, it appeared as though
11 you were reading from the identical script in both
12 instances; is that correct?

13 A. Yes. That's probably roughly correct, yes.

14 Q. Prior to your statement at the Florida
15 Board of Medicine meeting, had you performed any
16 independent research with regard to gender dysphoria that
17 you were asked to speak about at the meeting?

18 A. No.

19 Q. And, again, I'm not asking you to repeat
20 anything we've talked about on the record. But you
21 didn't perform any independent research on gender
22 dysphoria for your statements that you made at the
23 Florida Board of Medicine meeting, did you?

24 A. Correct.

25 Q. And all of your research is merely

1 reviewing the research of others and then opining on it,
2 isn't that correct, other than we'll get back to your
3 suicidality report and your bone density, correct?

4 A. Correct.

5 Q. And your letter to the editor, okay.

6 Is there any instance in which you believe
7 in individual suffering with gender dysphoria should
8 receive GnRH? Do you have an opinion on that?

9 A. Well, do you mean under 18 or in general?

10 Q. I'm asking if you have an opinion on that.

11 A. For those under 18, I believe that they
12 should -- or under 16, they should have -- they could
13 access GnRH as part of a proper randomized clinical
14 trial.

15 Q. So under 16, part of a proper randomized
16 trial, correct?

17 A. Clinical trial, yes.

18 Q. Right, okay. Older than 16, do you have an
19 opinion on that?

20 A. Well, possibly -- over 18, GnRH is
21 sometimes used as a -- it's called a testosterone blocker
22 but it -- to go with estrogen. And, as I said, I don't
23 have any opinions on, you know, what adults can consider.

24 Q. So we kind of got lost in the question
25 there. And I apologize, I'm sure it is my fault. You

1 said less than 16, proper randomized control trial,
2 right? Clinica trial, correct?

3 A. Yes.

4 Q. Yes, you've got to answer out loud. Sorry
5 about that.

6 A. Yes.

7 Q. And then my question was 16 -- between 16
8 and one, not over 18, what about the people -- the sloth
9 of people between 16 and 18, what do they get? If under
10 16 has to be part of a randomized controlled clinical
11 trial, what about the people between 16 and 18?

12 A. I believe that in some circumstances they
13 may be able to access if they have -- if they are told,
14 you know, about the cost as well as the benefits of that
15 treatment.

16 Q. Okay. So you would agree with me then that
17 someone between the age of 16 and 18, so long as their
18 medical provider consults with them, along with their
19 parents, and discusses the risks versus the rewards of
20 that treatment, that they should be entitled to receive
21 that treatment, correct?

22 A. Yes.

23 Q. All right.

24 MS. ALTMAN: Now is probably a good time
25 for a lunch break. I know for you it is probably

1 a dinner break. We can try -- let's see, it is
2 four hours. It's 1 o'clock here so it's 5 o'clock
3 there, am I right?

4 THE WITNESS: Yes.

5 MS. ALTMAN: Okay.

6 Michael, how long would you like to take?

7 MR. BEATO: Oh, gosh, I defer to Dr. Biggs,
8 what do you think an appropriate time would be?

9 THE WITNESS: Half an hour.

10 MS. ALTMAN: Fine with me. So it's
11 1 o'clock here, 5 o'clock there. So 5:30, 1:30
12 for the rest of us.

13 (A lunch recess is taken at 12:58 p.m. to
14 1:33 p.m.)

15 BY MS. ALTMAN:

16 Q. Sir, did you have a nice short break?

17 A. Yes, yes, good to have a break.

18 MS. ALTMAN: Okay. Michael, and I know you
19 had asked -- I should have probably said this
20 before we got back on the record, but you had
21 asked how long I think I'll go. I think on the
22 outside, like the longest would probably be two
23 hours.

24 MR. BEATO: Oh, okay. Okay.

25 MS. ALTMAN: Fingers crossed. Trying to be

1 as efficient as possible. All right. Well, let's
2 see.

3 BY MS. ALTMAN:

4 Q. Sir, before -- during the break, did you
5 speak with anyone?

6 A. My girlfriend to ask her for a coffee.

7 Q. Other than that, did you speak with anyone
8 about your testimony or about this case?

9 A. No.

10 Q. Okay, good. And did she bring you the
11 coffee?

12 A. She did indeed, yes, yes.

13 Q. Okay, excellent. Excellent. So you are
14 ready to go. Good.

15 So I think you mentioned, if I understood
16 you correctly, that there were randomized controlled
17 trials relating to central precocious puberty, and in
18 particular with regard to the impact on height, do you
19 recall that?

20 A. Yes.

21 Q. What study specifically have you reviewed
22 on that subject?

23 A. I don't have that information to hand.

24 Q. Do you know when those studies were
25 published?

1 A. In the last ten years, I believe.

2 Q. Would they postdate 2019?

3 A. I couldn't say but possibly not.

4 Q. Are you familiar with a study Treatment of
5 Central Precocious Puberty?

6 A. What's the author?

7 Q. I will tell you one second. Erica
8 E-U-G-S-T-E-R?

9 A. That author is not familiar.

10 Q. And that study, sir, was published in
11 2019 -- one second. I just lost my e-mail. And in that
12 study, the author, who -- it was a survey of the
13 literature up in to 2019.

14 And I'll quote what she says, "The main
15 goal of treatment in children with CPP is the
16 preservation of height potential. Although this sounds
17 straightforward, any consideration of height outcomes
18 must acknowledge several limitations."

19 "One is no randomized control studies
20 examining the effect of treatment versus no treatment on
21 height in CPP has ever been conducted, to this author's
22 knowledge."

23 Does that impact your testimony, sir, where
24 you testified that there were indeed random controlled
25 trials?

1 A. No, because --

2 MR. BEATO: Object to form.

3 Dr. Biggs, you can answer that.

4 THE WITNESS: I did cite them in the
5 Dutch -- I did cite at least one randomized
6 control trial on height in my Dutch Protocol
7 article.

8 BY MS. ALTMAN:

9 Q. Okay. We'll get to that. So you would
10 take issue with this author's statement?

11 A. Or perhaps it was an article since 2019.

12 Q. And as you sit here today, you don't know?

13 A. No.

14 Q. Okay. Sir, you appeared on the podcast,
15 Gender: A Wider Lens, do you recall that?

16 A. Yes.

17 Q. And the title of the program in which you
18 appeared was called Medicalization of Children With
19 Gender Identity: Impact of Puberty Blockers, and that
20 was in February of 2023, correct?

21 A. Yes.

22 Q. And that podcast, Gender: A Wider Lens, is
23 supported by Genspect, correct?

24 A. Yes.

25 Q. And Genspect is an organization that holds

1 itself out as an alternative to WPATH; isn't that right?

2 A. That sounds correct, yes.

3 Q. And Genspect believes that gender identity
4 ideology has caused damage and harm; isn't that right?

5 A. Probably, yes. I could -- yes.

6 Q. Do you believe that?

7 A. I believe in many cases, yes.

8 Q. And those cases are, as we've discussed
9 today, nothing different, correct?

10 A. Sorry, could you repeat the question.

11 Q. Yeah, my -- my point was -- and my question
12 was unartful, I apologize. The bases on which you
13 believe gender identity ideology has caused damages and
14 harm are those that you have elucidated in your report?

15 A. Yes.

16 Q. Okay. Nothing other than that is what I'm
17 trying to understand, correct?

18 A. Well, I believe -- there are some other
19 issues, for example, putting rapists in women's prisons
20 that may be under the umbrella of gender identity --
21 gender ideology, but I think that's -- yeah, I didn't
22 know if that's what you were...

23 Q. Well, what do you understand gender
24 identity ideology to be referring to?

25 A. Well, it's not a phrase that I myself use,

1 but I believe it would be suggesting that, for example,
2 that people have a certain -- a gendered soul, which is
3 more important than their biological physical body. And
4 that that gendered soul sort of takes precedence over
5 their -- the reality of their -- of the sex body.

6 Q. Sir, are you suggesting that it is lesser
7 than?

8 A. Well, it's certainly unobservable, like a
9 soul. I'm not saying that -- yeah...

10 It is like a soul, right, it is not
11 observable.

12 Q. Well, not observable to you but it's
13 observable to the person that's experiencing it, isn't
14 that correct, sir?

15 A. Yes, yes.

16 Q. So the fact that you don't see it doesn't
17 mean it doesn't exist, right?

18 A. Yes, exactly. Just as I don't see a
19 Christian soul and I don't know if the Christian soul
20 exists but it is very real to the Christian.

21 Q. Sir, during the podcast, you refer to F.G.,
22 the letters of F.G., and you said was previously
23 identified as B., who was part of an original study and
24 who was followed up on in her 30s.

25 Do you recall giving that statement during

1 your podcast -- during the podcast?

2 A. Yes.

3 Q. And if I understood you correctly, you
4 indicated she did not have a good outcome. That she was
5 ashamed of her genitals and could not hold a
6 relationship, referencing a 2014 follow-up study, do you
7 recall that?

8 A. Yes.

9 Q. And I believe you also referenced that in
10 your report, correct?

11 A. Yes.

12 Q. But that -- that was one person out of an
13 entire group, correct?

14 A. That was the first individual, that was the
15 first individual who had ever been given puberty blockers
16 as a treatment for gender dysphoria, yes.

17 Q. Right. But did you do anything to follow
18 up on any of the others to determine what their outcomes
19 were?

20 A. Well, that person was the only person who
21 was the subject of the case study, which made puberty
22 blockers -- made puberty -- introduced puberty blockers
23 to the -- to their medical community.

24 Q. Right. But I'm asking what steps you took,
25 since you are interested in the subject matter of puberty

1 blockers, to understand what the case studies would be of
2 the other individuals, what specific actions have you
3 taken to undertake that analysis?

4 A. Well, there is only -- that's the one
5 individual who was the subject of a case study. The
6 others are -- come in groups, like the cohort of 17,
7 which was discussed earlier, referred to in de Vries, et
8 al., 2011 and 2014.

9 Q. You would agree with me, would you not,
10 that one example can't be extrapolated to an entire
11 group, correct, that wouldn't be statistically sound?

12 A. Yes.

13 Q. Now, during the podcast and before the
14 Florida Human Health and Services Committee, you said
15 that GnRH for the treatment of gender dysphoria would
16 only be appropriate after proper clinical trials and
17 randomized control group. Remember, we talked about that
18 a little bit earlier, correct?

19 A. (Nodding head yes.)

20 Q. Yes? You have to answer out loud.

21 A. Yes.

22 Q. Sorry.

23 Has any organization that you are a part of
24 attempted to perform such randomized -- proper clinical
25 trials with randomized control groups?

1 A. No, but I know that the Cass inquiry
2 were -- is looking into that.

3 Q. Okay. And why haven't you urged any of the
4 groups that you are a part of to conduct clinical trials
5 with randomized control groups?

6 A. Well, the -- SEGM is probably the most
7 relevant example, we don't have the resources to. But,
8 of course, we advocate. Or many of us would advocate.

9 Q. Well -- and, again, maybe I missed it, but
10 did you -- when you were testifying or speaking at the
11 Florida Board of Medicine, did you encourage them not to
12 ban gender-affirming care so that they could conduct
13 clinical trials with randomized control groups? Because
14 I listened to your statement, I didn't hear that. Did
15 you do it off the record and maybe I missed it?

16 A. I think the implication of saying that
17 puberty blockers should be offered only as part of a
18 clinical trial is a recommendation that those doctors and
19 institutions that are currently offering puberty blockers
20 should do so as part of a clinical -- randomized clinical
21 trial.

22 Q. But you understood, sir, at the time that
23 you were testifying before the board of medicine that
24 Florida had already imposed a ban on gender-affirming
25 care; isn't that correct?

1 MR. BEATO: Object to form.

2 Dr. Biggs, you can answer that question.

3 THE WITNESS: The rule that was being
4 discussed, as I understood it, was to mean that --
5 that would remove the license of somebody who was
6 doing -- providing these kinds of treatments
7 outside of the kind of research that would be
8 constituted as a randomized clinical trial.

9 BY MS. ALTMAN:

10 Q. Have you -- did you -- have you read the
11 rule at issue in this case?

12 A. Issue in this case now, Dekker versus --

13 Q. The case for which you are providing expert
14 opinion, have you read that -- the rule that's at issue?

15 A. I have read the reports on the rule but I
16 don't think I've read the rule itself.

17 Q. Okay. And so you don't know one way or
18 another what the impact of the rule is, correct?

19 A. I don't know the details, no.

20 Q. Okay. Well, would it surprise you that --
21 that the rule prohibits those who receive Medicaid from
22 receiving any kind of gender-affirming care whatsoever,
23 whether they are a child or an adult, does that surprise
24 you?

25 A. No. No, that's my understanding.

1 Q. Right. And so when you were before the
2 Florida medicine, you understood that the rule in place
3 was prohibiting the payment for care for those who are on
4 Medicaid for gender-affirming care of any kind, whether
5 they are a child or an adult, correct?

6 A. I was not aware of that Florida rule when I
7 presented to the board of medicine because I was
8 addressing the proposition before the Florida Board of
9 Medicine.

10 Q. Okay. And do you understand that -- well,
11 strike that.

12 What do you understand the board of
13 medicine rule now is with regard to providing such care?

14 A. It enables -- it means that doctors can
15 lose their license if they provide this care outside of a
16 research setting.

17 Q. And are you aware of any clinical trials
18 and randomized control groups that the state of Florida,
19 the Agency for Health Care Administration has undertaken?

20 A. No, but I would not -- I presume it
21 wouldn't be up to the Agency. It would be up to
22 university clinicians to undertake these trials.

23 Q. And is it your understanding that they
24 could undertake these trials without any risk whatsoever
25 to their license, is that your understanding?

1 A. Yes.

2 Q. Are you aware that there is research
3 indicating that there are benefits to treating
4 individuals with gender dysphoria with puberty blockers?

5 A. Yes.

6 Q. So as you sit here today, you understand
7 that there are both risks and benefits to taking GnRH,
8 correct, for gender dysphoria?

9 A. Yes.

10 Q. And you would agree with me that it is
11 incumbent upon a medical professional, dealing with each
12 individual patient, to explain to that patient the risks
13 and rewards of taking puberty blockers, correct?

14 A. I believe that that sort of discussion must
15 be based on a rigorous review of the costs and the
16 benefits, yes.

17 Q. Okay. And -- but you would agree with me,
18 that's not for you to opine on, correct?

19 A. Well, I believe it is up to me not to opine
20 on but to publish articles or to uncover the results of
21 experiments, like at the Tavistock, which was suppressed
22 by the clinicians. And I believe that it is the duty --
23 incumbent upon somebody like me to publish the results of
24 those -- of those investigations to inform the way that
25 patients and their parents and clinicians undertake

1 there.

2 Q. And you did that, right, you -- you put out
3 your Freedom of Information Act request and you published
4 on the subject, correct?

5 A. Yes.

6 Q. And -- and the import of your publication
7 is that a medical professional, a parent, and a child can
8 read that research and draw their own conclusions as to
9 how they want to proceed, correct?

10 A. Yes.

11 Q. Now, sir, during the podcast, the Gender:
12 A Wider Lens podcast, you acknowledge that suicide rates
13 are five to six times higher for transgender teenagers
14 than non-transgender teenagers, do you recall making that
15 statement?

16 A. Yes, that's based on -- I should say that's
17 based the -- on my research that was done on the
18 Tavistock, yes.

19 Q. Okay. And I just want to juxtapose that
20 with, you don't say that in your report, do you, sir, to
21 the Court?

22 A. I believe I do -- I believe I do. I can --

23 Q. You think your report -- you say somewhere
24 that suicide rates for transgender teenagers is five to
25 six times higher than non-transgender teenagers?

1 A. If I don't in my report, it was with one of
2 the exhibits that was with the report.

3 Q. And, sir, in your report, what you do say
4 is that individuals who -- who report suicide attempts or
5 suicidal ideation don't really want to kill themselves.
6 They are just crying out for help, isn't that what you
7 say?

8 A. I don't believe that's a fair
9 characterization of what I say. What I say is that it
10 would be -- you cannot just simply take suicidal
11 ideation, extrapolate to that suicide intelligence.

12 Q. Sir, it is not within your wheelhouse to
13 diagnose somebody who has suicidal ideation, is it?

14 A. No.

15 Q. And it is not within your wheelhouse to
16 determine whether or not someone who -- who reports a
17 suicide attempt really means it or not, correct?

18 A. Not in the individual case, no.

19 Q. Well, not in any individual case, correct,
20 sir?

21 A. Not in the individual case, no.

22 Q. Not in any individual case, correct, sir?

23 MR. BEATO: Object to form.

24 Dr. Biggs, you can answer that question.

25 THE WITNESS: Yes.

1 BY MS. ALTMAN:

2 Q. And you -- you didn't mean to imply in your
3 expert report that you, as a sociologist, have any
4 complications to opine on the mental state of an
5 individual and whether they really want to kill
6 themselves or not; isn't that right?

7 A. Correct.

8 Q. And you would agree you have no such
9 qualifications, correct?

10 A. Correct.

11 Q. What was the -- what is the point in your
12 report of -- of that -- that, for lack of a better word,
13 opinion -- of that opinion that most who suffer from
14 gender dysphoria who -- who report a suicide attempt
15 don't really want to kill themselves, what is the basis
16 for you to provide that opinion?

17 A. The point is to combat a particular
18 argument that is often used to advocate for
19 medicalization, saying that -- rather cliché, is it is
20 better to have a live son than a dead daughter or vice
21 versa.

22 And so by exaggerating, the possibility of
23 suicide, it means that individuals or patients and their
24 families more -- have an exaggerated degree of the risk
25 of suicide if they don't take the medication that

1 influences their views on whether they should or
2 shouldn't take the medication.

3 Q. Well, regardless of whether or not you
4 think it is exaggerated, you've acknowledged that
5 transgender individuals have a five or six times greater
6 risk of suicide; isn't that right?

7 A. Yes, there is a difference between absolute
8 rates and relative rates. Absolute rate, fortunately, is
9 very low. The relative rate is, as you say -- at least
10 what I've calculated from the Tavistock, five or six
11 times higher.

12 Q. Okay. And in that regard, sir, I hope you
13 would agree with me that -- that even one suicide is bad,
14 right?

15 A. Yes, absolutely.

16 Q. And you are not suggesting to the Court
17 that we don't pay attention to whether a child is
18 transgender or not to any inclination that they might
19 commit suicide. You are not suggesting we just disregard
20 it because we think they don't really mean it, are you?

21 A. No, absolutely correct.

22 Q. So I guess I'm just trying to understand
23 what the import of including that opinion in your report
24 is, what does it add to your conclusions in this case?

25 A. It adds, as I said, an important caveat to

1 an argument that is often made to push for the
2 medicalization of children, which is they would kill
3 themselves unless they get these drugs. What I was
4 pointing out, based on my research, is that the absolute
5 rate of suicide is thankfully low, at least from what
6 I've -- from the Tavistock clinic.

7 Q. From one study in one jurisdiction, right?

8 A. It's the largest pediatric clinic in the
9 world, but yes, one -- one clinic.

10 Q. You understood my question?

11 A. Yes.

12 Q. Yeah, okay. It's one clinic, correct?

13 A. Yes.

14 Q. Based on data from one fixed period of
15 time?

16 A. Yes, a span over ten years, right.

17 Q. Right. And when was that published?

18 A. Sorry?

19 Q. When was the results finalized?

20 A. When was my article published?

21 Q. Uh-huh.

22 A. I believe it's 2021, I think.

23 Q. Okay. And, sir -- well, strike that.

24 Do you believe that medical doctors who are
25 providing gender-affirming care, that they are attempting

1 to convert cisgender individuals to be transgender?

2 A. No. But I don't know quite what a
3 cisgender individual is.

4 Q. You don't know what, I'm sorry?

5 A. I don't know what you mean by a cisgender
6 individual. That's why it took a while to answer that
7 question.

8 Q. A non-transgender individual, a non -- not
9 homosexual, not lesbian, a heterosexual person, do you
10 believe that doctors who render gender-affirming care are
11 trying to convert cisgender individuals to be
12 transgender?

13 A. No.

14 Q. Do you think that they are trying to
15 convert those who are gay or lesbian to be transgender?

16 A. I don't believe they are intending to do
17 that, no.

18 Q. Okay. Now, sir, on your website you
19 include a blog post that you author, and I'm going to
20 read the title of it. "The astonishing admission in the
21 health research authority report the purpose of puberty
22 blockers is to commit children to permanent physical
23 transition."

24 Do you recall that blog post?

25 A. Yes, yes.

1 Q. And we talked about this a little earlier
2 in connection with another similar statement that you've
3 made. But in this case, you made it on a blog post on
4 your website.

5 And in your blog post, you state that the
6 researchers made what you referred to as "an astonishing
7 admission," and you go on to state that "the admission is
8 the purpose -- that the purpose of puberty blockers is to
9 commit children to permanent physical transition."

10 That's what you say, do you recall that
11 statement?

12 A. Yes.

13 Q. And we talked about it in another context
14 earlier, but I want to then read to you this statement
15 from which you drew that conclusion on your blog post.
16 So I'm going to read that to you.

17 The actual statement that you quote in your
18 blog post says, "It would have reduced confusion if the
19 purpose of the treatment had been described as being
20 offered specifically to children demonstrating a strong
21 and persistent gender identity dysphoria at an early
22 stage in puberty, such that suppression of puberty would
23 allow subsequent cross-sex hormone treatment without the
24 need to surgically reverse or otherwise mask the unwanted
25 physical effects of puberty in the birth gender."

1 Do you recall that quote?

2 A. Yes.

3 Q. Now, that quote, sir, does not say that the
4 purpose of puberty blockers is to ensure transition to
5 cross-sex hormones, correct?

6 A. Well, the purpose is to enable or allow.

7 Q. No, sir, what it says is, for those
8 individuals that persist and are transgender, allowing
9 them to not have fully developed, which would require
10 more complex surgery, is a benefit to those individuals;
11 isn't that what it says?

12 MR. BEATO: Object to form.

13 Dr. Biggs, you can answer that.

14 THE WITNESS: Yes, they -- the -- what I
15 was pointing to is that that statement is a clear
16 statement that the purpose of puberty blockers is
17 the first stage in a course of treatment that will
18 continue on to cross-sex hormones.

19 BY MS. ALTMAN:

20 Q. Sir, that is not what it says. What it
21 says is, for those individuals that choose to go on to
22 cross-sex hormones, puberty blockers will ensure that
23 they have less surgical intervention than those that
24 don't have their puberty blockers; isn't that what the
25 import of the paragraph is?

1 A. Yes. And we know that in that particular
2 study, I believe you are referring to the 44 children in
3 the Tavistock trial, 40 -- out of the 44, 43 went on
4 cross-sex hormones.

5 Q. But that isn't the point, sir, is it? Of
6 the 43, that was their choice because they were -- by
7 choice I mean they were transgender, not that that is a
8 choice. But those individuals that were transgender
9 chose to go on to cross-sex hormones, which would be
10 expected if you are transgender, correct, sir?

11 A. Well, they were diagnosed with gender
12 dysphoria. I don't believe that in the protocol there
13 was any mention of them being transgender. I think the
14 diagnosis was gender dysphoria or gender identity
15 disorder, whichever was the one prevailing.

16 Q. Do you know whether or not the 43
17 individuals you referred to are indeed transgender, sir?

18 A. I would assume so but I wouldn't know. But
19 I --

20 Q. You've not undertaken any analysis to
21 understand that, have you?

22 A. Well, this was a treatment this was
23 intended to treat gender dysphoria.

24 Q. Correct. And for those individuals that --
25 that were indeed transgender, they would go on to

1 cross-sex hormones.

2 But there was nothing in that paragraph
3 that I read to you that said the purpose of puberty
4 blockers is to make their way for a lifelong, you know,
5 experience on cross-sex hormones; isn't that correct,
6 sir?

7 A. I don't agree with that interpretation.

8 Q. Well, sir, I'm not interpreting it. You're
9 actually the one that interpreted it. I'm reading
10 these -- the written word, as it is written.

11 You have extrapolated from that a purpose
12 of giving gender -- puberty blockers that is nowhere in
13 the paragraph that you reference?

14 A. I believe that's an unfair characterization
15 of the way that even clinicians would describe the
16 benefits of puberty blockers.

17 Q. Well, it may be a benefit of puberty
18 blockers but that's not what you said, sir. You said the
19 purpose of puberty blockers, not that a side benefit of
20 puberty blockers is, that for those that go on to
21 cross-sex hormones, the surgical intervention may be
22 lessened. That's not what you said.

23 What you said on your blog post, and you've
24 said it at other times, is that the purpose of puberty
25 blockers is essentially only to transition someone to

1 cross-sex hormones, correct?

2 MR. BEATO: Object to form.

3 Dr. Biggs, you can answer that question.

4 THE WITNESS: Yes. And that's why I use
5 the -- that's why the first articles refer to
6 juvenile transsexuals. Precisely the logic was
7 you give puberty blockers, you stop the
8 development of secondary sex characteristics, and
9 then the patient will go on to cross-sex hormones
10 and surgeries.

11 BY MS. ALTMAN:

12 Q. No, the patient may go on, correct, sir,
13 may go on. You don't know?

14 MR. BEATO: Object to form.

15 BY MS. ALTMAN:

16 Q. It is individual specific, correct?

17 A. Individual specific but 93, 95, 97, 98
18 percent will go on --

19 Q. Which is it, 93, 95 or 97?

20 A. It depends on which studies you look at. I
21 cite I think four of them from different clinics,
22 Australian, Britain, the Netherlands, and Belgium in my
23 witness statement -- report, I believe.

24 Q. And, indeed, that section goes on to say --
25 of the paragraph that you quote, it specifically says,

1 "For children demonstrating a strong and persistent
2 gender identity dysphoria at an early age in puberty,
3 such that the suppression of puberty would allow
4 subsequent cross-sex hormone treatment without the need
5 to surgically reverse or otherwise mask unwanted physical
6 effects of puberty."

7 The language is very clear. It's for those
8 children demonstrating a strong and persistent gender
9 identity dysphoria, isn't that what it says?

10 A. Yes.

11 Q. Now, you say in your report, sir, that
12 there is no objective physical diagnosis for gender
13 dysphoria, do you recall making that statement?

14 A. Yes.

15 Q. Are you suggesting to the Court that you
16 don't believe gender dysphoria exists?

17 A. No.

18 Q. And you'd agree with me that there are many
19 medical conditions for which there is no objective
20 physical diagnosis; isn't that right?

21 A. Yes.

22 Q. And that doesn't mean the condition doesn't
23 exist, does it?

24 A. No.

25 Q. Since you are opining on what treatment

1 transgender adolescents should not receive, do you have
2 an opinion on what treatment they should receive, are you
3 offering such an opinion in this case?

4 A. I don't -- I mean, I did not offer an
5 opinion in my expert report, no.

6 Q. Okay. Are you aware of any research that
7 demonstrates the negative impact on adolescents when they
8 are not prescribed treatment for gender dysphoria?

9 A. Yes.

10 Q. Are you offering an opinion on that in this
11 case? Have you been asked to offer an opinion in this
12 case on that?

13 A. Specifically on puberty blockers, yes.

14 Q. That's not what I said. Let me read my
15 question again.

16 Are you aware of any research that
17 demonstrates negative -- the negative impact on
18 adolescents when they are not prescribed treatment for
19 gender dysphoria? My question was not limited to puberty
20 blockers.

21 A. I'm aware of studies that attempt to
22 demonstrate that, yes.

23 Q. Have you been asked to offer an opinion in
24 this case on that?

25 A. No, I don't believe -- no.

1 Q. You are not providing an opinion in this
2 case on the GAPMS report, are you?

3 A. No.

4 Q. You are not providing an opinion on the
5 rule in this case, correct?

6 A. No. Correct.

7 Q. You are not -- you are not providing an
8 opinion about the process that AHCA followed when
9 arriving at its rule, are you?

10 A. Correct.

11 Q. You are not providing an opinion on the
12 diagnosis of those specific plaintiffs in this case,
13 correct?

14 A. Correct.

15 Q. You don't have an opinion about the proper
16 medical treatment for the plaintiffs in this case,
17 correct?

18 A. Correct.

19 Q. You haven't reviewed their medical records,
20 correct?

21 A. Correct.

22 Q. And you don't review medical records as
23 part of your job as a sociologist generally, correct,
24 sir?

25 A. Yes.

1 Q. Yes; that's correct, right?

2 A. Correct. Yes, correct.

3 Q. You've never met with any of the plaintiffs
4 in this case?

5 A. No.

6 Q. You've never asked to meet with any of the
7 plaintiffs in this case, correct?

8 A. Correct.

9 Q. You've never met or asked to meet any of
10 the medical providers of any of the plaintiffs in this
11 case, correct?

12 A. Correct.

13 Q. And you are not offering an opinion on the
14 qualification of any of the medical providers that treat
15 any of the plaintiffs in this case, correct?

16 A. Correct.

17 Q. As a sociologist, generally speaking, do
18 you -- do you utilize the standards of care for
19 gender-affirming care? Is that part of what you would
20 do, generally speaking, as a sociologist?

21 A. No.

22 Q. And the same question about the American
23 Medical Association's position on the standard of care,
24 is that something you would generally utilize as a
25 sociologist in your work?

1 A. No.

2 Q. And the same is true, sir, with regard to
3 the WPATH standard of care and the Endocrine Society
4 guidelines. Those are not things that you would
5 typically utilize in your work as a sociologist, correct?

6 A. Correct.

7 Q. And you had no role in drafting the WPATH
8 standards of care, correct?

9 A. Correct.

10 Q. You've never provided a diagnosis of gender
11 dysphoria, correct?

12 A. Correct.

13 Q. You've never provided a diagnoses for any
14 medical condition, correct, sir?

15 A. Correct.

16 Q. You've never provided a treatment plan for
17 any medical condition whatsoever, correct?

18 A. Correct.

19 Q. And you are not qualified to provide a
20 medical diagnosis for any medical condition, correct?

21 A. Correct.

22 Q. You've never prescribed drugs of any kind
23 to anyone who is experiencing gender dysphoria, correct?

24 A. Correct.

25 Q. What did you do to prepare your report?

1 A. I read the literature and -- I mean, the
2 report was the culmination of quite a few years of
3 research in this area that was -- resulted in the -- my
4 publications. And so I prepared a report I believe is
5 the evidence for or against the use of puberty blockers
6 for gender dysphoria.

7 Q. Does the report contain all the opinions
8 you intended to provide in this matter?

9 A. Yes.

10 Q. You indicated a moment ago that you read
11 the literature and that the report is a culmination of
12 reviewing all the literature.

13 Is there any literature that you reviewed
14 that you have not identified in your report as having
15 been a basis for the opinions you are offering?

16 A. I don't believe so, no.

17 Q. Does the report contain all the work you
18 needed to render your opinions in this case?

19 A. Yes.

20 Q. Were you provided or did you otherwise have
21 all of the things that you needed to render your opinions
22 in this case?

23 A. Yes.

24 Q. If not, what else would you have needed?

25 A. I said I had everything I needed.

1 Q. I know and I'm asking you to think if there
2 is anything else that you would have needed, could have
3 considered in order to render full, complete, and robust
4 opinions in this case?

5 A. I don't believe so, no.

6 Q. So you don't believe, by example, having
7 conducted any research yourself or -- or spoken to any
8 transgender individuals or people from WPATH or people
9 who have the guidelines published from the endocrine
10 society, none of those things would have helped you
11 inform your opinions in this case?

12 A. No, I don't believe so, no.

13 Q. Is there any work left undone to finalize
14 your opinions in this case?

15 A. No.

16 Q. Any work that you wanted to do that you
17 haven't done?

18 A. No, not for this case, no.

19 Q. Have you been engaged in any other case as
20 a testifying expert?

21 A. No. Well, apart from the two I mentioned,
22 the one in Australia and the one in the UK.

23 Q. Without telling me what case, regardless,
24 without disclosing, have you been engaged as a consulting
25 expert in any other cases on gender dysphoria or puberty

1 blockers?

2 A. No.

3 Q. Other than what's identified, is there
4 anything else that you reviewed in connection with
5 rendering your opinions?

6 A. No.

7 Q. Was there any information that you got from
8 defense counsel, either related to the individual
9 plaintiffs or their caregivers, or any information that
10 you got from defense counsel that you did not otherwise
11 have for review?

12 A. No. The only thing I had was -- the only
13 thing they sent me is some -- about three or -- maybe
14 five rebuttals which mentioned my evidence.

15 Q. Did you review those?

16 A. Yes, I looked at those.

17 Q. Okay. Thank you. When did you write your
18 report?

19 A. January, Feb -- February, I think.

20 Q. Of 2023?

21 A. Yes.

22 Q. And you testified already you did not show
23 a draft of your report to anyone, correct?

24 A. Correct.

25 Q. What did you learn about the lawsuit for

1 which you have been retained as an expert?

2 A. I'm not sure. It must have been -- yeah,
3 I -- to be honest, I can't recall now. Possibly
4 November, but...

5 Q. Well, you testified or spoke at the board
6 of medicine meeting in October of 2022. Does that orient
7 you as to when you may have been contacted about
8 providing expert testimony in this case?

9 A. Perhaps in January, yeah -- yeah, I'm
10 really not clear about the date.

11 Q. Do you have -- regardless of whether you
12 are clear about the date, do you have any kind of
13 approximation for how long ago was it, a year ago, six
14 months ago, eight months ago?

15 A. It was a few -- I think it was either sort
16 of -- either the end of last year or the beginning of
17 this year.

18 Q. Okay. So if I understand you correctly,
19 you believe you were contacted to provide testimony in
20 this case sometime in the late fall of 2022 or early
21 2023; is that correct?

22 A. Yes.

23 Q. Yeah, you can't nod. Yeah, okay.

24 A. Yes, that's right.

25 Q. Thank you. Okay.

1 And who contacted you about being an expert
2 in this case?

3 A. It was one of the lawyers at Holtzman
4 Vogel.

5 Q. Do you know how they got your name?

6 A. I -- no, I don't know but I would assume it
7 was from my appearances in Florida to the Florida Board
8 of Medicine.

9 Q. Do you recall who from the law firm
10 contacted you?

11 A. It might be Gary Perko.

12 Q. Did they ask you your opinions before
13 having you testify in this case?

14 MR. BEATO: So, Mr. Biggs, I'm going to
15 instruct you not to answer any other questions
16 regard -- excuse me, regarding our communications.
17 That's privileged information.

18 I'm instructing him not to answer that
19 question.

20 MS. ALTMAN: Hold on, Michael. My question
21 only called for a yes or no. It wasn't the
22 substance of the conversation.

23 MR. BEATO: Still, I think that verges into
24 the substance of the conversation. I'm
25 instructing him not to answer any more questions

1 relating to that.

2 MS. ALTMAN: Okay. We can talk about it
3 later.

4 MR. BEATO: Sure.

5 BY MS. ALTMAN:

6 Q. You already testified you were not involved
7 with the rulemaking of the GAPMS process, correct?

8 A. Correct.

9 Q. But what you say in your report is, "After
10 reading the scientific literature, I became increasingly
11 concerned about the lack of robust evidence."

12 A. Yes.

13 Q. Do you recall putting that in your report
14 at paragraph 5?

15 A. Yes.

16 Q. Okay. And what specific literature did you
17 review that caused you to be concerned?

18 A. Well, the -- my initial concern was reading
19 the case study of the individual B. or F.G. And the
20 second was reading the sort of gold standard Dutch study
21 of de Vries, et al., at 2011 and 2014, which I was very
22 surprised to see how little evidence there was to justify
23 puberty blockers. That was many years ago. But that was
24 what initially interested me.

25 Q. Anything else that caused you to have great

1 concern?

2 A. Yes. The fact that I discovered that the
3 Tavistock clinic in London had done an experiment or
4 study -- wasn't a proper experiment -- it was a study of
5 early puberty suppression that was designed to replicate
6 the Dutch study, and that they had never published any of
7 the results.

8 Q. Anything else?

9 A. No, those are the main things that led me
10 into this.

11 Q. Okay. And we've already talked about you
12 are aware of literature studies, findings that have a
13 different conclusion than the ones you rely on, correct?

14 A. Yes.

15 Q. In paragraph 6 you state, and I quote, "I
16 have conducted original research on the use of GnRH
17 puberty suppressors," do you recall making that statement
18 in your report?

19 A. Yes.

20 Q. And what original research did you conduct?

21 A. Well, I was the first to publish the
22 results of the -- that English study into -- designed to
23 replicate the Dutch -- the Dutch study.

24 Q. But you didn't conduct the original
25 research, sir, you just wrote about what someone else

1 did, correct?

2 A. It was only due to my efforts that that
3 research saw the light of day. And I was the first
4 person to publish on it.

5 Q. And congratulations. I'm not trying to
6 undermine or demean what you've done, I just want to make
7 sure the record is clear. Because the statement you made
8 in your report is you conducted original research. And
9 you, in fact, did not conduct original research, sir.
10 Someone else conducted original research and you wrote
11 about it, correct?

12 MR. BEATO: Object to form.

13 Dr. Biggs, you can answer that question.

14 THE WITNESS: I believe that what I've done
15 constitutes original research.

16 BY MS. ALTMAN:

17 Q. And the sole original research that you
18 believe you've conducted is publishing the English study
19 that was trying to mimic the Dutch study, correct?

20 A. That's one -- that was one. Another one
21 would be the analysis of bone density.

22 Q. Which, again, you were reporting on someone
23 else's work, correct?

24 A. I was doing original analysis based on data
25 that I myself had elicited -- elicited from the

1 Tavistock.

2 Q. No, sir. Someone else created the data and
3 then you provided your analysis of that data, correct?

4 (Simultaneously speaking.)

5 MR. BEATO: Object to form.

6 Dr. Biggs, you can answer the question.

7 BY MS. ALTMAN:

8 Q. Go ahead, sir.

9 MR. BEATO: What's the answer to the
10 question, Mr. Biggs, just for the record?

11 THE WITNESS: Yes, I conducted the
12 statistical analysis, correct.

13 BY MS. ALTMAN:

14 Q. Right, of someone else's data, correct?

15 A. Yes.

16 Q. Have you engaged in any kind of clinical
17 study with patients that involved GnRH treatments?

18 A. Sorry, what do you mean by "critical
19 study" -- oh, you are saying clinical study?

20 Q. Yes, sir.

21 A. No.

22 Q. Have you been involved directly in any
23 longitudinal studies?

24 A. No.

25 Q. Any observational studies?

1 A. No.

2 Q. Is there any study whatsoever where you
3 have been the primary investigator of data that you
4 collected?

5 A. No.

6 Q. Have you published an original article that
7 underwent a peer-review process analyzing data from a
8 clinical study that you performed with patients treated
9 by GnRH analogs?

10 A. No.

11 Q. So we've kind of gone over this, and I
12 don't want to retread it. I just want to point out in
13 paragraph 7 of your report, you make the same similar
14 statement about "puberty suppression is designed to stop
15 normal puberty in order to prepare the child for taking
16 hormones of the opposite sex."

17 Do you recall making that statement in your
18 report?

19 A. Yes.

20 Q. And we've kind of gone back and forth,
21 debated what that means and whether or not that's an
22 accurate statement. I'm assuming your testimony isn't
23 going to be any different about what you wrote in
24 paragraph 7 than what it is going to be about what you
25 said on your blog post and what you said to the Health

1 and Human Services division, right -- committee, rather?

2 A. Yes.

3 Q. Okay. I just don't want to go over things
4 that we don't need to.

5 In -- in -- in paragraph 9, you say, "GnRH
6 is never tested in any randomized clinical trial," do you
7 recall saying that?

8 A. Yes.

9 MR. BEATO: Would it be helpful -- I
10 apologize for interjecting -- would it be helpful
11 to, when we're quoting Dr. Biggs' report, to put
12 it on the screen just so everyone sees what's
13 being said?

14 MS. ALTMAN: We can, if you want. He said
15 he had it there, so I wasn't going to --

16 THE WITNESS: As long as I can refer to it,
17 then that's fine.

18 MS. ALTMAN: Sure, if you want.

19 But, Michael, if you want it to put on the
20 screen, we're happy to do that too.

21 MR. BEATO: I would prefer that. It just
22 makes things easier so we're all looking at one
23 screen --

24 MS. ALTMAN: You are making me wake Ana up.

25 Ana, are you out there? Thank you.

1 MR. BEATO: Thank you, Ana.

2 MS. ALTMAN: Paragraph 9. There you go.

3 BY MS. ALTMAN:

4 Q. Do you see this statement, sir,
5 paragraph 9, "Puberty suppression as a treatment for
6 gender dysphoria was never tested in any randomized
7 clinical trial, nor were there any preliminary
8 experiments on nonhuman animals"?

9 A. Yes.

10 Q. What specifically did you rely upon in
11 making that -- those two statements?

12 A. The fact that there has -- that there has
13 never been published any -- any randomized clinical
14 trials using puberty suppression as a treatment for
15 gender dysphoria. And the fact that the Dutch
16 endocrinologist, Henrietta Delemarre-van de Waal,
17 actually worked in the laboratory with rats, but she did
18 not do any permanent experiments with rats even though
19 she had the laboratory there.

20 Q. Anything else that you rely upon in making
21 those two statements?

22 A. No.

23 Q. And in paragraph 10, which is on the next
24 page, you make this statement, "The reported improvement
25 in gender dysphoria is flawed because the researchers

1 switched the questionnaire used to construct the
2 measure."

3 Did I read that right?

4 A. Paragraph 10 or paragraph 11?

5 Q. Let's see. I thought it was in ten.

6 A. No, it is not in ten.

7 Q. All right. Hold on. Let me put that one
8 to the side and I'll go back to that in a minute, how
9 about that?

10 But regardless -- and I'm going to go back
11 to the report in a second -- switching the questionnaires
12 doesn't explain how -- that the conclusion would be wrong
13 or improper, does it, sir?

14 A. Yes, it does, because if you ask -- if you
15 start off with a male, a boy who says he's -- one of the
16 questions will be, "Are you distressed about having
17 erections?" And he'll say, "Yes, I am because I'm gender
18 dysphoric," that makes sense, right, so he's gender
19 dysphoria.

20 And then after surgery you say, "Do you
21 hate menstruation?" Now, of course, whether -- if you
22 ask me whether I hate menstruation, I would say no. But
23 it's not because I've been cured of gender dysphoria,
24 it's just because I don't menstruate. So the question
25 is -- obviously can be answered in the negative.

1 That's the kind -- those are the -- that's
2 the reason why the scales -- switching the scales makes a
3 huge difference.

4 Q. Well, but you don't know, sir, do you,
5 whether or not -- switching the scales, whether or not
6 the individual recipient even answered that question, do
7 you? You didn't look at the actual survey results, did
8 you?

9 A. But that is one of the questions that are
10 used in making their gender dysphoria scale.

11 Q. But that wasn't my question. My question
12 is, you didn't go back and look at the underlying
13 questionnaires to determine whether or not individuals
14 properly and correctly responded to questions that would
15 be associated with their specific gender, did you?

16 A. Well, the Dutch clinicians asked males a
17 series of questions, including "are you uncomfortable or
18 does" -- "are you very bothered by menstruation?"

19 Q. Right. My question to you is, you don't
20 know whether or not any particular individual answered
21 that question or how they answered that question,
22 correct?

23 A. I know they would have answered that
24 question because that was required to -- for the scale.
25 I don't know how any particular individual answered that

1 question, no.

2 Q. Right. And what I'm just trying to get at
3 is you didn't go back and look at the underlying results,
4 you relied upon somebody else's reporting of these
5 results, correct?

6 A. Yes, I relied upon the published articles
7 by de Vries, et al., yes.

8 Q. And you didn't conduct any of your own,
9 correct?

10 A. Correct.

11 Q. Meaning that if you thought it would be
12 more appropriate to ask the questions in a different way,
13 you've not taken upon yourself to engage in a study that
14 asks the questions in a way that you believe would have
15 been more appropriate, correct?

16 A. Correct.

17 Q. And I think it is in paragraph 13 but let's
18 just go down there. Hopefully I have it right.

19 In paragraph 13 do you say, "The suspicion
20 must be that at least some of these children could have
21 grown up to be typical gays and lesbians without
22 requiring lifetime medical treatment, and without loss of
23 fertility and sexual function"?

24 Do you recall making that statement?

25 A. Yes.

1 Q. Okay. And you base your opinion on your
2 suspicion; isn't that right, sir?

3 A. Yes, that's what the sentence reads, yes.

4 Q. Right. It's your suspicion. You have no
5 evidence whatsoever to make that statement; isn't that
6 correct?

7 A. The evidence is in the preceding sentence,
8 the first 70 adolescents, the vast majority were
9 homosexual, and only one was heterosexual. The others
10 were bisexual.

11 Q. Well, but that doesn't necessarily
12 eliminate the fact that they could be transgender,
13 correct?

14 A. Correct.

15 Q. Right. And so I go back to my point, which
16 is throughout your report, you were -- you used words
17 like -- and we'll get to it -- "suspicion," "belief,"
18 words that are not scientific. They are your musings
19 about what may or may not be.

20 That particular quote is the last sentence
21 on paragraph 13 where you say, "The suspicion must be at
22 least some of these individuals could have grown up to be
23 typical gays and lesbians." But that's your musings
24 about it, that's not science, correct, sir?

25 MR. BEATO: Object to form.

1 Dr. Biggs, you can answer that question.

2 THE WITNESS: I think that's synonymous
3 with a credible hypothesis or, you know, potential
4 hypothesis. The word "suspicion" is just saying
5 that, yeah, I'm -- I cannot prove it. There is no
6 proof, but I believe it is a plausible conjecture
7 or plausible hypothesis.

8 BY MS. ALTMAN:

9 Q. So it is conjecture and hypothesis, not
10 opinion, right, sir?

11 A. Yes, I -- yes.

12 Q. Are you aware of any study that's ever
13 demonstrated that gender affirmation in childhood leads
14 to a child being transgender who otherwise may not have
15 been?

16 A. Well, that would be unobservable because we
17 wouldn't know what the outcome was.

18 Q. So you would agree with me that you have no
19 evidence to support that, correct?

20 You are not aware of any study that
21 supports that, correct?

22 A. Correct.

23 Q. That gender affirmation in childhood leads
24 to a child being transgender who otherwise may not have
25 been, correct?

1 A. Correct.

2 Q. And you are not opining, sir, that puberty
3 blockers somehow make someone transgender and prevents
4 them from being a typical gay or lesbian, are you?

5 A. Yes, I am.

6 Q. You are? That's your testimony, sir, under
7 oath, that if you take puberty blockers, by definition,
8 you won't become a typical gay or lesbian?

9 A. Well, in some cases I believe that children
10 who are taking puberty blockers and turned into what was
11 originally called juvenile transsexuals could have grown
12 up to be feminine boys, gay men, or butch lesbians.
13 That's -- that's my belief, yes.

14 Q. And your -- that's your -- that's what I
15 think you called conjecture, right, your speculation
16 because you have no evidence to support that, correct?

17 A. There is evidence to support that. There
18 is not proof. There is not demonstration. But I would
19 also say -- point out that the Dutch clinicians in an
20 article by Anacker, et al. 2023 acknowledged that
21 possibly gonadotropin-releasing hormone agonists can
22 become a self-fulfilling prophecy. That's not the exact
23 words but that's what they acknowledge as one -- as a
24 credible possibility.

25 Q. A credible possibility?

1 A. Yes.

2 Q. But that's not science, sir, it's just a
3 hypothetical, correct?

4 A. No. This was a statement in -- by the
5 Dutch clinicians in a published and a peer-reviewed
6 journal. I don't remember off the top of my head what
7 journal it was. So they were entertaining this as a
8 possibility.

9 Q. As a possibility, correct?

10 A. Yes.

11 Q. Not a scientific truism, correct, sir?

12 A. How science deals with possibilities.

13 Q. Okay.

14 A. And probabilities.

15 Q. Sir, in paragraph 13 of your report, you
16 also make the following statement: "All this evidence
17 predates the promotion of transgenderism in health care
18 and schools and on social media."

19 Do you see where you wrote that?

20 A. Yes.

21 Q. Okay. And you go on to refer to "the
22 manifesto for the Dutch Protocol fails to mention
23 homosexuality and does not cite any of the studies of
24 feminine boys."

25 Did I read that right?

1 A. Yes.

2 Q. Now, it -- starting with the first
3 sentence, "All this evidence predates the promotion of
4 transgenderism in health care and schools and on social
5 media." What evidence do you have that transgenderism is
6 being promoted in health care, schools, and on social
7 media, what specific evidence do you rely upon for that
8 statement?

9 A. Well, social media was not around then, so
10 clearly there was no promotion on social media. Schools,
11 there is widespread evidence, for example, the use of the
12 book about Jazz Jennings. And on media, you could use
13 Jazz Jennings as perhaps the best example of that.

14 In terms of health care, more and more of
15 the possibility of being transgender in, for example --
16 and the growth of the gender clinics -- of the gender
17 clinics like the gender clinic in Tavistock.

18 Q. Well, how is that promoting transgenderism?

19 A. Well, it's -- it's suggesting to children
20 that this is a possible and perhaps even a desirable way
21 of being.

22 Q. Isn't it just, sir, accepting those who are
23 transgender for who they are?

24 Nobody is converting people to be
25 transgender, are they?

1 MR. BEATO: Object to the form.

2 Dr. Biggs, you can answer that question.

3 THE WITNESS: I would -- I'm quite happy
4 with the phrase that I use there. I do believe
5 that there is more and more publicity to being
6 given -- to being a transgender identity as a
7 potential way of being and a -- and perhaps even a
8 desirable way of being.

9 BY MS. ALTMAN:

10 Q. Well, do you think it is an undesirable way
11 of being?

12 A. I believe that there are -- what is
13 undesirable is becoming a lifelong medical patient.

14 Q. And what is the basis, the medical basis
15 for your statement, the scientific basis for the
16 statement you just made?

17 A. Well, I don't think -- I don't -- who wants
18 to be a lifelong medical patient? I don't think -- yeah,
19 I don't think that's a desirable -- a desirable outcome,
20 if it can be avoided.

21 Q. So that's just more of your suspicions and
22 musings and conjecture. I'm asking whether or not you
23 have actual -- any scientific support for the statements
24 that are in your report?

25 MR. BEATO: Object to the form.

1 Dr. Biggs, you can answer that question.

2 THE WITNESS: That statement, I don't
3 believe, is in my report. It is just simply what
4 you've asked me -- asked me about now.

5 BY MS. ALTMAN:

6 Q. Well, no, I read to you the statement
7 that's in your report, that there is -- apparently, there
8 is -- people are promoting transgenderism in health care,
9 schools, and on social media. And I asked you for the
10 evidence that you have to support that statement?

11 A. Yes, I've said that I think -- believe
12 there is abundant evidence in -- for example, if you look
13 at searches on Google trans. If you look at the --

14 Q. What specific searches -- sir, what
15 specific searches, what specific evidence did you rely
16 upon when you made that statement in your report. I'm
17 asking you the specific evidence that you relied upon?

18 A. If you search for various combinations and
19 permutations of the word "transsexual child,"
20 "transgender child," "trans child," "trans kid," "trans
21 children" and so on, you can see a massive peak in that,
22 particularly after 2005 but more particularly after 2010.

23 Q. Okay. So, sir, it is not my responsibility
24 to conduct these searches. I'm asking you what specific
25 scientific basis do you have before you made that

1 statement in this report, what -- did you do those
2 searches, if so, are they -- are the results listed in
3 your bibliography?

4 MR. BEATO: Object to form.

5 Dr. Biggs, you can answer those questions.

6 THE WITNESS: I did do those searches. The
7 results are not listed in my -- in the
8 bibliography because I thought it was --

9 BY MS. ALTMAN:

10 Q. Why not?

11 A. It was so obvious that the increase in the
12 prominence of transgenderism in health care and schools
13 and social media would be obvious.

14 Q. Sir, did you look at all of the possible
15 reasons why being transgender is more at the forefront
16 today, like perhaps US states that are banning
17 transgender health care -- just as an example, throwing
18 it out there -- and then putting that in the media. Did
19 you look at that, maybe that's the reason why people are
20 more frequent to be discussing the issue?

21 A. Well, bans on health care have only been
22 around for a couple of years. I'm talking about a
23 long -- long-term trend from -- I think I did 1990 to
24 2020. So it's -- yeah, that's the basis of it.

25 Q. So other than your Google searches, is

1 there anything else that you relied upon in making that
2 statement in your report?

3 A. Just to clarify, it wasn't a Google search.
4 It was a search of Google's corpus and the entire body of
5 printed material in -- in the English language.

6 Q. Right. The one -- the things that you did
7 not list in your report as resources, correct?

8 A. Yes.

9 Q. Sir, do you believe it's -- that it is easy
10 to be transgender, it is appealing to be transgender?

11 A. I believe in some cases it can be
12 appealing, yes.

13 Q. What about in others?

14 A. In other cases, it is not.

15 Q. You are not making a -- you are not
16 providing a general opinion that people are jumping on
17 the transgender bandwagon because it is so easy and it is
18 being promoted, are you?

19 A. No. I believe that sometimes it makes
20 sense of an individual's predicament of suffering or
21 distress about their body, about their gender roles.

22 Q. And it might make sense just because they
23 are transgender, right?

24 A. Yes, it might.

25 Q. Right. And you don't know in any

1 particular case whether that's true, right?

2 A. Not in any individual case, no.

3 Q. Now, sir, in paragraph 14 of your report,
4 you spend a lot of time talking about that -- the overlap
5 between gender dysphoria and autistic spectrum
6 conditions, do you recall writing about that in your
7 report?

8 A. Yes.

9 Q. Sir, you would agree with me that being
10 transgender and being on the spectrum are not mutually
11 exclusive, correct?

12 A. Correct.

13 Q. Sir, on the studies pertaining to feminine
14 boys, you agree that all of those studies pertain to
15 preadolescence, mostly prepubertal children under the age
16 of 12, correct?

17 A. Yes.

18 Q. And you would also agree that being gender
19 nonconforming is not the same thing as being transgender,
20 correct?

21 A. It's not necessarily the same, no.

22 Q. And you would also agree by definition
23 those studies don't indicate a desistance rate for people
24 who are actually transgender abandoning a transgender
25 identity, correct?

1 A. Well, the study by Green on Sissy Boys that
2 I cite was -- they specifically identified children,
3 boys, who they thought were going to be transsexual,
4 they -- they refer to pre-transsexual. So they are
5 trying to find the most feminine, most dysphoric
6 children, dysphoric male children.

7 Q. Well, that doesn't mean that they were
8 though, correct, sir?

9 A. Well, the -- they were identifying the most
10 feminine boys they could find who were -- who they
11 thought would be certain to develop into transsexuals or
12 very highly likely to develop into transsexuals.

13 Q. Right. But, again, that's subjective,
14 correct, sir? It is somebody else's, you know, views on
15 whether or not they may or may not be, correct?

16 A. Yes.

17 Q. Now, sir, again, back to your opinions or
18 musings about gender dysphoria and autistic spectrum
19 conditions. As I just asked you, being autistic and
20 having gender dysphoria are not mutually exclusive,
21 correct?

22 A. Correct.

23 Q. And you make this statement, "Children on
24 the autistic spectrum are more likely to face
25 difficulties fitting in with their same sex peers, which

1 makes a transgender identity obviously appealing as both
2 an explanation and a solution." And that's at -- the
3 bottom of page 9 and goes on to page 10.

4 Do you recall making that statement?

5 A. Yes.

6 Q. Is it -- have you done any studies, sir, as
7 to whether or not autistic children or children on the
8 spectrum have difficulty fitting in with both their same
9 sex peers and opposite sex of peers -- peers?

10 A. That was reporting the article that was in
11 the previous sentence. So I'm having -- do we have the
12 right page there?

13 Q. Yeah. Well, that's --

14 A. In the previous -- the last -- yeah, I was
15 reporting on something that was quoted on a literature
16 reviewed by van der Miesen, Hurley and de Vries, 2016,
17 that quotes -- I'm paraphrasing the evidence that this
18 literature review was producing.

19 Which said, essentially, particularly de
20 Vries is one of the clinicians who emphasized this, that
21 children on the autistic spectrum are more likely to face
22 difficulties fitting in with their same sex peers. And
23 the original study was, I think, de Vries -- de Vries, et
24 al., 2010, the original article that I don't cite that --
25 because I'm citing the literature review.

1 Q. Right. So a couple things. Number one, it
2 is not quoted, correct, there is no quotes around that.
3 It's a statement by you, correct?

4 A. It's a -- but it's a paraphrase of the
5 evidence that I provided.

6 Q. Well, it is not attributed to anyone,
7 correct, sir? At the end of the sentence, there's not a
8 footnote, there is not a quote or reference to anybody
9 else's study, right?

10 MR. BEATO: Object to the form.

11 Dr. Biggs, you can answer that question.

12 THE WITNESS: Yes.

13 BY MS. ALTMAN:

14 Q. And, sir, my question is, you make this
15 statement, you make this statement, not anybody else,
16 "Children on the autistic spectrum are more likely to
17 face difficulties fitting in with their same sex peers."

18 And my question to you is, have you done
19 any analysis whatsoever into whether or not children on
20 the autistic spectrum have difficulty fitting in with
21 anyone, whether it is their same sex peers or their
22 opposite sex peers?

23 A. No, I haven't conducted an original
24 research on that -- on that question, no.

25 Q. Okay. And so, sir, you don't know whether

1 or not the fact that -- whether it is same sex or
2 opposite sex peers, that children on the autistic
3 spectrum are, air quotes, becoming transgender because
4 they don't -- they don't feel that they fit in with their
5 peers. You don't have any evidence to support that,
6 correct, sir?

7 A. Well, apart from my reading of the Dutch
8 clinicians like de Vries, correct.

9 Q. Right. But I'm asking you, though, what
10 research or studies you've done to support the statement
11 in this report? Other than --

12 A. I haven't done my own original research on
13 that, no.

14 Q. And perhaps I'm misreading what you are
15 saying. But, I mean, the implication of what you are
16 saying is that autistic spectrum individuals are
17 pretending to be transgender to fit in.

18 Is that what you are trying to convince
19 this Court?

20 MR. BEATO: Object to the form.

21 Dr. Biggs, you can answer that question.

22 THE WITNESS: No, that's not -- that's not
23 how I would characterize it at all. I don't
24 believe they're pretending. I believe they're
25 making sense, as we all do, of their experiences.

1 And that this label helps them make sense of their
2 experiences, and also to provide a potential
3 solution for them.

4 BY MS. ALTMAN:

5 Q. Well, is being transgender a label?

6 A. Yes, among other things, yes.

7 Q. And so label for what, sir?

8 A. Well, it is a label for a particular
9 identity, just like Christian or British or sociologist,
10 these are the ways in which we interact with the social
11 world.

12 Q. Now, you go on to say in the end of that
13 paragraph, "From a sample of over 700 referrals to the
14 G-I-D-S, GIDS, in 2012" -- so ten years ago -- "and
15 2015" -- so less than ten years ago -- "14 to 15 percent
16 were diagnosed with autism" -- you say ASC -- but autism
17 spectrum conditions -- "and this was more than ten times
18 greater than the rate for students in England," which you
19 then cite to.

20 Do you recall that statement in your
21 report?

22 A. Yes.

23 Q. And you go on to say, "The proportion among
24 those subjected to GnRH could be even higher." What's
25 the scientific basis or the evidence for that statement?

1 A. Can I -- I think this may be on page 10.
2 Can we scroll forward --

3 Q. It is on page 10, yes.

4 A. The evidence for that is in the -- the next
5 sentence, because in the first study that was done by the
6 Tavistock kids, of the first 30 patients, almost half of
7 them had autistic spectrum traits.

8 Q. Well, again, we discussed a few minutes
9 ago, they are not mutually exclusive, right, somebody
10 could be both -- have autistic spectrum disorder and also
11 be transgender, correct?

12 A. Yes, yes.

13 Q. In -- in paragraph 20 of your report, you
14 say, "Because of the risk of suicide" -- "because the
15 risk of suicide increases greatly from prepubescence to
16 late adolescence, altering normal cognitive and emotional
17 development with GnRH could reduce the risk of suicide by
18 preventing the child from maturing."

19 Did I read that right?

20 A. Yes.

21 MR. BEATO: Let me just pause here.

22 Ana, could you please scroll down --

23 MS. GONZALEZ: Okay. Sorry.

24 (Simultaneously speaking.)

25 MR. BEATO: Page 13, please. Thank you.

1 Sorry for the interruption, just wanted
2 to...

3 MS. ALTMAN: No, no worries.

4 BY MS. ALTMAN:

5 Q. "Because of the risk of suicide," do you
6 see that, sir, second sentence in paragraph 20?

7 A. Yes.

8 Q. What's the basis, the evidential basis for
9 that statement, sir?

10 A. Well, that's an inference from the way that
11 suicide is much higher, for example, in a 18-year-old
12 than it is in a 10-year-old. We're talking about sort of
13 the general population. So if we're able to sort of --
14 if you, like, freeze a 12-year-old at a sort of mental
15 state of being 12, then one of the logical consequences
16 of that will be less likely to -- to commit suicide than
17 they would be otherwise.

18 Q. So the answer to my question is that you
19 don't have any evidential basis for that statement in
20 your report, correct?

21 A. Correct.

22 Q. It is just an inference that you've drawn?

23 A. Yes. Yes. And, in fact, the next says,
24 "As yet, there is no evidence; however," so exactly,
25 that's the case.

1 Q. But you were engaged to provide opinions in
2 this case, not -- not inferences or musings or
3 suspicions. You were engaged to provide opinions based
4 on scientific evidence, correct, sir?

5 MR. BEATO: Object to form.

6 Dr. Biggs, you can answer the question.

7 THE WITNESS: I mean, the way science works
8 is by entertaining different possibilities and
9 different probabilities.

10 In that case, I think quite fairly, I said
11 that it could be the case. It is not implausible
12 on a theoretical basis that puberty blockers do
13 reduce suicidality. However, there was no robust
14 empirical evidence that that is the case.

15 So I think that gives the full panel of
16 potential impacts of puberty blockers.

17 BY MS. ALTMAN:

18 Q. Sir, you would agree with me that your
19 opinions are contrary to the WPATH standards of care?

20 A. Yes.

21 Q. And they are contrary to the American
22 Medical Association?

23 A. Yes.

24 Q. And they are contrary to the American
25 Academy of Pediatrics?

1 A. Yes.

2 Q. And they are contrary to the Endocrine
3 Society guidelines?

4 A. Yes.

5 Q. And are you aware that your opinion is
6 contrary to the standards of care for gender-affirming
7 care in the United States generally?

8 A. Established clinical practice as its
9 developed, yes.

10 Q. And you don't know, in this particular
11 case, whether the treatments that the plaintiffs were
12 receiving have been helpful or not, correct?

13 A. Correct.

14 Q. And I hope you would agree that the
15 efficacy of puberty suppressors is best left to the
16 experts in the field, meaning, endocrinologists,
17 psychiatrists, and psychologists, correct?

18 MR. BEATO: Object to form.

19 Dr. Biggs, you can answer that question.

20 THE WITNESS: I believe that there should
21 be a robust empirical debate in the literature,
22 signed literature that robustly scrutinizes the
23 evidence for the efficacy and safety of puberty
24 blocks.

25 BY MS. ALTMAN:

1 Q. And I get that. And the robust empirical
2 discussion should occur between medical practitioner,
3 endocrinologist, psychiatrist, psychologist, correct?

4 A. No. It should occur between everybody who
5 has something to say about this, including -- and can
6 publish their work in a peer-reviewed journal.

7 Q. Including yourself; is that right?

8 A. Correct.

9 Q. And I think I asked you this earlier, but
10 just in case, you don't have any clinical experience with
11 puberty blockers, do you?

12 MR. BEATO: Objection to form, asked and
13 answered.

14 Dr. Biggs, you can respond.

15 THE WITNESS: Correct.

16 BY MS. ALTMAN:

17 Q. Yeah, I wasn't trying to ask you the same
18 question again, so I apologize if I did.

19 Now, sir, you've been quoted as making this
20 statement, and I just want to understand it. This is a
21 direct quote. It was in sex and gender. "I do not,
22 however, believe that gender identity supersedes sex any
23 more than I believe that Jesus was the son of God."

24 "Therefore, I oppose any attempt by the
25 university to establish an official doctrine on gender,

1 just as I would oppose the imposition of a single
2 religion or one particular position on Israel,
3 Palestine."

4 Did I read -- do you remember making that
5 statement?

6 A. Yes.

7 Q. Okay. And what does that mean, "I do not,
8 however, believe that gender identity supersedes sex"?

9 A. I do not believe that gender identity or
10 someone's subjectively perceived understanding of
11 themselves should be -- weigh more in society than --
12 than their physical sex.

13 Q. Well, would you agree that it should at
14 least be weighed the same?

15 A. No -- well, depends on the case -- depends
16 on cases -- depends on the case. If you are talking
17 about, for example, should a rapist be put in a women's
18 prison -- a male who has used his penis to rape a woman
19 should be put in a women's prison because his gender
20 identity is that of a woman. I would say, in that case,
21 for example, no. His physical biological sex should take
22 precedence.

23 Q. Sir, have you ever been a prison warden?

24 MR. BEATO: Object to form.

25 Dr. Biggs, you can answer the question.

1 THE WITNESS: No, I haven't.

2 BY MS. ALTMAN:

3 Q. And have you done any research into
4 whatever standards and guidelines are utilized by prisons
5 in determining where prisoners are placed?

6 A. Yes.

7 Q. You have? And is any of that published
8 literature referenced in your bibliography?

9 A. Of this -- of my expert report, no, because
10 it wasn't relevant to the -- what I was being asked to
11 do.

12 Q. And where would that published literature
13 be that you've written on this subject?

14 A. The article is in the -- is in the general
15 controversial ideas.

16 Q. Okay.

17 A. It is specifically about England, England
18 and Wales.

19 Q. Okay. And when was that published?

20 A. I believe 2022.

21 Q. Okay. Sir, you wrote a chapter in a book
22 titled, "Inventing transgender children and young
23 people." Do you recall that?

24 A. Yes.

25 Q. Do you think that you can invent

1 transgender people or children?

2 A. Well, I believe that these labels or social
3 categories are -- vary across cultures and over -- vary
4 over time, like being lesbian or being African American
5 versus, you know, other -- other sorts of identities.
6 So, yes, I believe, in a manner of speaking, that
7 identities are invented, like sociologist or lesbian or
8 so on.

9 Q. You think being a lesbian is invented?

10 A. I believe that the -- the identifying as a
11 lesbian as such is -- is a social construct, and that
12 those have genealogies which we can explore, yes.

13 Q. And you think being transgender is
14 invented?

15 A. In a way that is very common parlance in
16 the social sciences, we talk about the way that
17 constructs change over time and they vary across
18 cultures.

19 Q. Well, what does that mean, sir? I mean,
20 you've testified earlier you agree that transgender
21 people exist, so what does it mean, that they are being
22 invented?

23 A. Well, I believe Christians exist but I --
24 there is also societies in which there was no such thing
25 as a Christianity, right, there's no such thing as a

1 Christian.

2 So there was nobody in 1900 identified as
3 transgender because that -- that label had -- that
4 category had not been created yet.

5 Q. Uh-huh. So your -- if I understand you
6 correctly, you are just suggesting that the name for it
7 has changed?

8 A. And the way it is theorized, the way -- the
9 conceptualization of it, yes.

10 Q. Well, how are we conceptualizing it, how
11 are you conceptualizing it?

12 A. Well, I'm conceptualizing it as a -- kind
13 of a -- as a social identity, which -- which involves, in
14 many cases, a medical physical intervention.

15 Q. Well, as a social identity, is that
16 different from an actual identity?

17 A. Identities are generally social.

18 Q. So all identities are social?

19 A. Yes.

20 MR. BEATO: Counsel, I know we're
21 approaching upon the one hour and 30-minute point.
22 Would it be best --

23 MS. ALTMAN: Happy to take a break,
24 Michael.

25 MR. BEATO: Perfect.

1 MS. ALTMAN: As long as you want.

2 MR. BEATO: So how about we meet -- I don't
3 know --

4 MS. ALTMAN: As long as you want. 3:10?

5 MR. BEATO: I'm sorry?

6 MS. ALTMAN: 3:10 on -- I have 2:57. So
7 3:10. You want to do 13 minutes, you want to do
8 15 minutes, what do you want to do?

9 MR. BEATO: How about 3:05, if that works
10 with you, Dr. Biggs.

11 MS. ALTMAN: 3:05.

12 THE WITNESS: 3:05, yep, that's good.

13 MR. BEATO: I didn't mean to interrupt your
14 train of thought. Just want to get a quick little
15 break.

16 MS. ALTMAN: No problem.

17 MR. BEATO: Thank you very much.

18 (A brief recess was taken from 2:57 p.m. to
19 3:04 p.m.)

20 BY MS. ALTMAN:

21 Q. So, sir, in paragraph 22 you say, "There
22 are anecdotal reports of children experiencing increased
23 suicidal feelings after GnRHa," did I read that
24 correctly?

25 Do you need for us to pull it up on the

1 screen or do you recall making that statement?

2 A. I recall that.

3 Q. Okay.

4 MR. BEATO: And for my benefit, can we --
5 Ana, could you put that on the screen again for my
6 benefit?

7 MS. GONZALEZ: I'm sorry, what paragraph
8 was that? I was copying her e-mail.

9 MS. ALTMAN: P 2, 22.

10 MS. GONZALEZ: Page 22?

11 MS. ALTMAN: Yes, ma'am.

12 MR. BEATO: Paragraph 22.

13 MS. GONZALEZ: Oh, paragraph 22.

14 MS. ALTMAN: I'm sorry, yes, paragraph 22.

15 MR. BEATO: Thank you, Ana.

16 MS. GONZALEZ: You are welcome.

17 BY MS. ALTMAN:

18 Q. All right. Dr. Biggs, first of all,
19 anecdotal reports of children experience increased
20 suicidal feelings of -- feelings after GnRH_a is not
21 scientific evidence, can we agree on that?

22 A. Reports of adverse events are part of the
23 medical -- part of the important documentation and
24 medical -- medical research.

25 Q. Well, sir, you are not -- the only thing

1 you cite to that is this Brik 2020, correct, of one --

2 (Simultaneously speaking.)

3 BY MS. ALTMAN:

4 Q. Let me just finish.

5 Of one teenager who stopped treatment
6 because of the increase in mood problems and suicidal
7 thoughts and confusion attributed to GnRH treatment,
8 correct?

9 A. There is a -- in the next -- I think --
10 believe the subsequent sentence, there is another case.

11 Q. Right. So there is two instances. And --
12 and in the first instance, the child was obviously
13 monitored, which is what you would do when you put
14 someone on any medication, correct?

15 You would -- as a medical practitioner, you
16 would evaluate how that person is -- is doing clinically
17 on the medication, correct?

18 MR. BEATO: Object to the form.

19 (Simultaneously speaking.)

20 MR. BEATO: Dr. Biggs, can you please
21 repeat your answer?

22 THE WITNESS: Yes. So medical
23 practitioners certainly should be monitoring
24 children who are on puberty blockers, definitely.

25 BY MS. ALTMAN:

1 Q. Okay. But that's -- so that's a reason to
2 monitor care, not to ban it; isn't that right, sir?

3 A. Yes.

4 Q. Now, sir, in paragraph 24 on page 16, and
5 going on to page 17, as well, in paragraphs 26 and 27, so
6 paragraphs 24, 26, 27, you consistently use your -- your
7 interpretation rather than science.

8 For example, in paragraph 24 you refer to
9 "One obvious explanation is that clinicians were
10 following the WPATH health recommendations against
11 commencing medical intervention when an adolescent is
12 experiencing an acute mental health crisis."

13 And so you are providing your explanation
14 but that doesn't make it the actual explanation, does it,
15 sir?

16 MR. BEATO: Object to form.

17 Dr. Biggs, you can answer that question.

18 THE WITNESS: Correct. Though, that was
19 not my explanation. It would be the -- of any
20 scientist worth -- any scientist worth his or her
21 salt would suggest that that is a potential
22 explanation.

23 BY MS. ALTMAN:

24 Q. It's one explanation, not necessarily the
25 explanation, correct?

1 A. Absolutely correct.

2 Q. Right. And in paragraph 26, the first
3 sentence, "The Dutch pioneers warned at the outset that
4 patients 'could' end up with a decreased bone density,
5 which is associated with a high risk of osteoporosis."

6 So, again, it could happen, that doesn't
7 mean it will happen, correct?

8 A. Yes.

9 Q. And then further down in the paragraph you
10 say, "In addition, children given GnRHa already have
11 unusually low bone density, perhaps due to the high
12 prevalence of eating disorders."

13 So now, if I read your statement, which is
14 not referencing any evidence whatsoever, now you are
15 musing about whether or not people have low -- already
16 have low bone density because they have a high prevalence
17 of eating disorders, right, sir?

18 MR. BEATO: Object to form.

19 Dr. Biggs, you can answer that question.

20 THE WITNESS: My apologies for not
21 providing a citation. I thought that this would
22 have been sort of common knowledge.

23 One citation I could have used is
24 Olson-Kennedy, who states in her NIH --
25 Olson-Kennedy is not the first author but one of

1 the coauthors of this article which is on bone
2 density on 95 children who were given GnRH, and
3 they're in an NIH-funded study.

4 And suggested that they -- the data were
5 from this 95, that they have unusually low bone
6 density due to -- probably due to eating
7 disorders.

8 BY MS. ALTMAN:

9 Q. "Probably" was the word you just used?

10 A. I couldn't -- I cannot quoting what they
11 are saying, but one of the recommendations was that
12 clinicians must always ask about eating disorders because
13 they suggested that calorific deficiency was what was
14 causing this usually low bone density.

15 Q. And that would be part of a clinician's
16 job, right, before they put an individual on any
17 medication, they should do a thorough clinical
18 examination of the patient, correct?

19 A. They certainly should do a thorough
20 clinical examination, yes, you are correct.

21 Q. Right. And that, again, is a reason to do
22 a thorough clinical analysis but not to ban care,
23 correct?

24 MR. BEATO: Object to form.

25 You can answer that, Dr. Biggs.

1 THE WITNESS: Well, this is one of the
2 reasons why, in this particular population of
3 children with -- starting out with on average -- a
4 lower bone density than average, the risks of
5 decreasing that density is going to be more
6 pronounced.

7 So it's -- it's a statistical fact that's
8 important -- is very important in evaluating the
9 costs and the benefits of the treatment.

10 BY MS. ALTMAN:

11 Q. Which is why the clinicians and medical
12 professionals should monitor the care, correct?

13 A. Certainly, they -- clinicians should
14 monitor the care, yes.

15 Q. Right. That's not a reason to ban care,
16 correct, sir?

17 A. It's not -- by itself, it does not say that
18 the care should be banned, correct.

19 Q. And at the bottom of page 17, paragraph 7,
20 again, you use the word "Anecdotally, a British female
21 patient who started GnRH at age 12 then experienced four
22 broken bones at the age of 16," correct?

23 A. Correct.

24 Q. Did I read that right? Right?

25 A. Yes.

1 Q. And, sir, as you sit here today, you don't
2 know why this one individual at the age of 16 had four
3 broken bones, do you?

4 A. No.

5 Q. And, again, on page 19, paragraph 29, you
6 said, second or third sentence, referring to the Dutch --
7 "Dutch clinicians initially promoted puberty suppression
8 as providing space for therapeutic exploration of gender
9 identity without the pressure of physical changes
10 accompanying puberty."

11 Did I read that right?

12 A. Yes.

13 Q. And that makes sense, does it not, sir?

14 A. It was one -- it was a plausible outcome,
15 yes, yes.

16 Q. And the bottom of paragraph 30, again, you
17 use the word "suspicion." "The suspicion is that puberty
18 suppression reinforced gender dysphoria." Do you recall
19 making that statement in your report?

20 A. Yes.

21 Q. Whose suspicion are you referring to there,
22 sir?

23 A. Can I see -- let me --

24 Q. Page 20, the first -- there you go.

25 A. I'm just looking at what comes -- precedes

1 that.

2 Q. Sure.

3 MR. BEATO: Ana, could you go to page 19,
4 please.

5 THE WITNESS: That's okay. No, I've seen
6 it on my paper copy.

7 That is I think any reasonable observer --
8 or any scientific observer would suspect that is
9 one -- one potential possibility, yes.

10 BY MS. ALTMAN:

11 Q. Not to the exclusion of other
12 possibilities, correct, sir?

13 A. Absolutely.

14 Q. So this is just, again, one possible
15 scenario, a hypothetical, but it could be something else
16 completely, correct?

17 A. Yes.

18 Q. And, sir, we talked about social constructs
19 earlier, and you would agree with me that being male or
20 female is also a social construct, correct?

21 A. No, I disagree on that.

22 Q. You do. How so?

23 A. I believe what male and female are
24 biological -- are biological concepts, not sociological
25 concepts.

1 Q. And what's your basis for that statement?

2 A. Reading of the literature around sex.

3 Q. What literature specifically are you
4 referring to?

5 A. Evolutionary literature on the evolution of
6 sex.

7 Q. Is that a specific periodical that you are
8 referring to, the evolution of sex?

9 A. No, I'm referring to a sort of literature,
10 a large scientific --

11 (Phone interruption.)

12 (Reporter asks for clarification.)

13 THE WITNESS: Literature about why sex
14 evolved.

15 BY MS. ALTMAN:

16 Q. And what specific literature are you
17 referring to?

18 A. Well, I'm not -- I'm not going to cite
19 particular articles, but the reason. This is a --
20 there's a huge literature on why sex evolved. And sex
21 has been around for many millions of years. And it so
22 long predates humans and long predates culture, human
23 culture.

24 Q. Based on your -- that's your reading of
25 this sex evolution history, that's your conclusion from

1 it; is that correct?

2 A. Correct.

3 Q. Now, sir, you've been linked to some
4 transphobic tweets, you -- are you aware of that?

5 MR. BEATO: Object to form.

6 Dr. Biggs, you can answer that question.

7 THE WITNESS: Yes.

8 BY MS. ALTMAN:

9 Q. And it's correct, sir, have you been
10 tweeting under the pseudonym Henry Wimbush?

11 A. I used -- that was a student of my Twitter
12 account, yes -- or my -- yes.

13 Q. And I know you talked a lot today about how
14 you want a free and open discourse and people should be
15 able to, you know, give their opinions on various
16 matters. And in keeping to that, why did you hide behind
17 a pseudonym, why didn't you use your name?

18 MR. BEATO: Object to form.

19 Dr. Biggs, you can answer that question.

20 THE WITNESS: Because I believe that
21 evidence shouldn't be based on who -- on the
22 status or the credentials of the person saying it.
23 It should be based on the logic and empirical
24 evidence of the statement -- incorporating the
25 statement.

1 BY MS. ALTMAN:

2 Q. Well, why would you think it would be any
3 less impactful or important if you used your own name
4 versus Henry Wimbush?

5 A. As I said, I don't believe that views
6 should be judged by the -- the identity of the person or
7 the credentials of the person making those statements but
8 on the content of the statement themselves.

9 Q. So you believe -- it's most appropriate to
10 hide behind a keyboard, is that what I'm hearing you say?

11 MR. BEATO: Object to form.

12 Dr. Biggs, you can answer that question.

13 THE WITNESS: I think there is a long
14 history of pseudonymity. I mean, the
15 federalist -- I believe The Federalist Papers, the
16 authors of The Federalist Papers chose to hide
17 behind a keyboard, as you might say.

18 BY MS. ALTMAN:

19 Q. Well, is there any particular reason why
20 you didn't use your real name, sir?

21 A. I think I've already explained why I
22 have -- why I made that decision.

23 Q. Now, you were exposed in an article in The
24 Oxford Student, right?

25 MR. BEATO: Object to form.

1 Dr. Biggs, you can answer that question.

2 THE WITNESS: Correct.

3 BY MS. ALTMAN:

4 Q. And I just want to ask you about some of
5 your tweets. One of them is, and I'm quoting,

6 "Transphobia is a word created by fascists and used by
7 cowards to manipulates morons."

8 Do you recall sending out that tweet?

9 A. Yes.

10 Q. What does that mean?

11 A. So it is a very famous quote by Peter
12 Hitchens, an atheist. And he used the -- originally, of
13 course, the quote was about Islamophobia. And as an
14 atheist, he was objecting to the way his atheism -- or
15 his criticism, let's say, of Islam would be denounced as
16 being Islamophobic.

17 And I was -- I think the tweet indicates
18 that a similar -- there can be a similar silencing of
19 discourse around using the word "transphobia."

20 Q. Well, so you changed the quote. It is not
21 a direct quote, correct, sir?

22 A. No. Exactly. But it's obviously -- to the
23 learned audience, it's obvious what the reference is.

24 I'm ripping off. It's ripping off somebody else's very
25 famous quote.

1 Q. Right. No, and I apologize. Perhaps I'm
2 not the learned audience that you were trying to reach,
3 but I still have some questions about it because I don't
4 understand.

5 What is it you were trying to communicate
6 to the reader, sir, by saying -- are you concerned that
7 people perceive -- would perceive you or anyone else as
8 transphobic?

9 MR. BEATO: Object to form.

10 Dr. Biggs, you can answer that question.

11 THE WITNESS: I believe that important
12 public policy debates around sex and gender are
13 sometimes stifled by accusations of transphobia,
14 yes.

15 BY MS. ALTMAN:

16 Q. Well, has anyone accused you of being
17 transphobic?

18 A. Yes.

19 Q. Who has accused you of that?

20 A. Well, I believe that The Oxford Student
21 article you mentioned does. I can't quote chapter and
22 verse but I believe that's the -- at least the -- the
23 implication.

24 Q. Well, sir, that -- the tweet that you --
25 that they wrote about occurred before the article, right?

1 A. Yes.

2 Q. Right. So they were only interpreting what
3 you were -- you or Mr. Wimbush was putting out into the
4 universe, correct?

5 A. Yes.

6 Q. So they had no reason -- they were not
7 predetermined to be against your tweets. You put that
8 information out into the universe, correct?

9 A. Yes.

10 Q. And so why is "transphobia" a word created
11 by fascists?

12 A. Well, it is a play on words suggesting that
13 there is an authoritarian streak in some forms of the
14 transgender movement, and that includes the
15 short-circuiting of important debates, such as the one I
16 mentioned earlier about sort of, for example, should a
17 rapist be put in a women's prison by short-circuiting of
18 that proper democratic debate through accusations of
19 transphobia.

20 Q. Well, you would agree with me, sir, I
21 assume, that for every opinion that the person that holds
22 the opinion -- strike that.

23 You would agree with me, a actual debate or
24 discussion isn't one-sided. And so the fact that one
25 person believes a person who is a transgender female

1 should not be put in a women's prison, there is someone
2 else that might feel differently, correct?

3 MR. BEATO: Object to form.

4 You can answer, Dr. Biggs.

5 THE WITNESS: Yes.

6 BY MS. ALTMAN:

7 Q. Right. And both can coexist, meaning the
8 person that has the opposite opinion is entitled to that
9 opinion, correct?

10 A. They should be entitled.

11 Q. Right. You are not trying to stifle the
12 debate that you claim you want, are you?

13 A. No, of course not.

14 Q. Okay. Now, I believe you've also made a
15 tweet that claims "transitioning makes you LESS
16 attractive," do you recall that?

17 A. I don't recall that. But if you've read
18 it, I -- that may be the case.

19 Q. And the less is in all caps. Do you
20 believe that transitioning makes somebody less
21 attractive?

22 A. I believe transitioning is likely to reduce
23 your potential pool of sexual partners or romantic
24 partners, yes.

25 Q. Well, that's not what this says. This

1 doesn't say transitioning reduces your pool of potential
2 sexual partners, does it?

3 MR. BEATO: Object to form.

4 You can answer, Dr. Biggs.

5 THE WITNESS: I really do not recall the
6 particular reply or the Twitter thread that --
7 that that was -- that tweet was embedded in. But
8 I believe that my -- to my -- best of my
9 interpretation now, that is the import of that --
10 of that statement.

11 BY MS. ALTMAN:

12 Q. Okay. So is it your testimony here today
13 you weren't trying to imply that transitioning makes
14 someone physically less attractive, all caps?

15 A. It reduces their chance that that
16 individual will find -- reduces the potential pool of
17 romantic and sexual partners to that individual.

18 Q. Why?

19 A. Because, for example, if I'm a heterosexual
20 man and I transition into a woman, if I have breast
21 augmentation and I take estrogen, and I want to find
22 lesbians, female homosexuals to have sex with, that's
23 going to be a relatively small proportion of the lesbian
24 population who will be interested in me as a potential
25 wife or girlfriend.

1 Q. Why would you assume that that would be the
2 only pool of people that might be your opportunity for a
3 sexual partner?

4 A. I believe that that would be one obvious --
5 not the only pool but a significant pool that one
6 would -- might be hoping that one could, you know, swim
7 in, as it were.

8 Q. Well, based on what is your analysis of
9 what pool a transgender female wants to swim in?

10 A. I couldn't cite particular chapter and
11 verse of literature, but I believe there are surveys of
12 who trans people -- their ideal partner would be or what
13 kind of person they are looking for. And a very large
14 number of males who transition, particularly later in
15 life, are looking for lesbian -- lesbian partners.

16 Q. What particular important social commentary
17 were you trying to make with this tweet, I mean, why were
18 you concerned --

19 MR. BEATO: Object to form.

20 BY MS. ALTMAN:

21 Q. Why are you concerned with what sexual
22 partners a person has who has transitioned?

23 MR. BEATO: Object to form.

24 You can answer, Dr. Biggs.

25 THE WITNESS: I'm afraid I genuinely can't

1 remember the context of that tweet.

2 BY MS. ALTMAN:

3 Q. Okay. Well, do you recall a tweet
4 generally about many cis-gay youth have inappropriately
5 transitioned to become straight?

6 A. I can't remember the particular one but I
7 understand what -- what you are getting at.

8 Q. Well, no, what -- what are you getting at?

9 A. The suspicion that I think is in my report,
10 that children who could grow up without being medicalized
11 to become either feminine boys, gay boys, or masculine
12 lesbians have been -- adopted a transgender identity
13 which puts them on the path to -- for lifelong
14 medicalization. An example would be the very first
15 patient who took gender -- GnRH, B. or F.G.

16 Q. Sir, do you believe gender-affirming care
17 is akin to eugenics?

18 MR. BEATO: Object to form.

19 You can answer, Dr. Biggs.

20 THE WITNESS: I believe that it is -- yeah,
21 within a robust debate in public policy, that --
22 that's not an unfair characterization.

23 BY MS. ALTMAN:

24 Q. Well, I don't know -- I didn't ask about
25 robust public policy. I asked you if you believe that

1 gender-affirming care is akin to eugenics?

2 MR. BEATO: Object to form.

3 You can answer, Dr. Biggs.

4 THE WITNESS: Certainly it is creating,
5 particularly when -- it is creating a class of
6 individuals who are not -- who are going to have
7 either no chance or very little chance of
8 giving -- of having children. So it is
9 essentially like sterilizing some individuals.

10 BY MS. ALTMAN:

11 Q. Well, when you say "no chance" or "very
12 little chance" of having children, are you specifically
13 referring to whether or not they can physically carry a
14 child as opposed to having children through other means,
15 surrogate, adoption, fill in the blank?

16 A. Yes, exactly, yes.

17 Q. And so if I understand you correctly, you
18 think that because someone may not be able to -- to have
19 a child, if they were to go through transition, that that
20 is in some way akin to eugenics, is that your testimony?

21 MR. BEATO: Object to form.

22 THE WITNESS: Yes. Could we -- could we
23 remove the deposition so I can just see -- see you
24 a bit better? It just helps me to pick up the
25 questions.

1 MS. ALTMAN: Sure.

2 MR. BEATO: The expert report.

3 THE WITNESS: Sorry, the expert witness
4 statement, yes.

5 MS. ALTMAN: Ana -- she's got it. There
6 you go. Okay. And I'm almost done, if that
7 helps, so...

8 THE WITNESS: Yes.

9 BY MS. ALTMAN:

10 Q. So in what way -- I'm just trying to
11 understand, in what way this is like eugenics, sir?

12 MR. BEATO: Object to form.

13 You can answer, Dr. Biggs.

14 THE WITNESS: So eugenics was a program of
15 sterilizing certain people who are seen as
16 inferior in order to promote the health of the
17 race. And the analogy that was being drawn here
18 is that contemporary medical practices are also
19 sterilizing some children, or putting them on a
20 path to sterilization, in which case they wouldn't
21 be -- ironically, treating them is almost like an
22 inferior type of individual who shouldn't be
23 allowed to reproduce.

24 And that was banned, that's why it was
25 being objected to.

1 BY MS. ALTMAN:

2 Q. Well, you would agree with me, sir, that
3 people who are transgender are choosing their own path,
4 whereas eugenics is someone else charting a course for
5 them, correct?

6 MR. BEATO: Object to form.

7 BY MS. ALTMAN:

8 Q. Someone else made a decision that they are
9 in some way inferior and making a decision for that
10 person or group of people versus being transgender, which
11 is, we all agree, I think you -- yourself agree, is
12 something that's innate to the person, correct?

13 MR. BEATO: Object to form.

14 You can answer, Dr. Biggs.

15 THE WITNESS: I never believe -- and I do
16 not believe I stated that transgen- -- being a
17 transgender was innate. I don't believe I've ever
18 said that.

19 BY MS. ALTMAN:

20 Q. Well, you believe people can be
21 transgender, correct?

22 A. Correct.

23 Q. You've testified to that earlier, correct?

24 A. Correct.

25 Q. Okay. And so are you now suggesting it's

1 not innate, that somebody is superimposing it on someone?

2 MR. BEATO: Object to form.

3 You can answer, Dr. Biggs.

4 THE WITNESS: Well, I believe someone can
5 be a Christian. I don't believe that Christianity
6 is innate in the individual.

7 BY MS. ALTMAN:

8 Q. Well, sir, are you -- are you correlating
9 Christianity with being transgender, I just want to make
10 sure I'm following?

11 MR. BEATO: Object to form.

12 THE WITNESS: I'm just giving you analogy
13 on how to explain -- how I can -- obviously,
14 transgender people exist without necessarily
15 claiming that being transgender is an innate
16 property of the individual.

17 BY MS. ALTMAN:

18 Q. Right. And I'm just trying to understand.
19 Is it your testimony under oath that you believe that's a
20 correct analogy?

21 MR. BEATO: Object to the form.

22 BY MS. ALTMAN:

23 Q. That neither of the two things are innate?

24 MR. BEATO: Object to form.

25 THE WITNESS: Yes, it's a helpful analogy.

1 I mean, like any other analogy, it has limitation.

2 BY MS. ALTMAN:

3 Q. Well, I thought we went through this
4 earlier. And, again, I don't want to retread. But, sir,
5 I thought we agreed that -- and I'm going to give you the
6 benefit of your testimony -- you thought that in some
7 instances transgender could be a choice, but that in many
8 other instances, it is not a choice, correct, do you
9 recall that testimony?

10 A. Yes.

11 Q. Okay. And you -- that's your testimony,
12 right?

13 A. Yes.

14 Q. And so at least in your world, there is at
15 least some subset of people that are transgender and it
16 is not a choice, correct?

17 A. Well, it may not be their choice, it may be
18 the choice, for example, of their parents, for example.

19 Q. But it may be their choice and it may not
20 be their choice, it may be innate, correct?

21 MR. BEATO: Object to form.

22 You can answer, Dr. Biggs.

23 THE WITNESS: I mean, a child who is
24 brought up in a pious Christian home and Christian
25 school and sent to Bible every -- Bible study and

1 church and very -- given a very religious
2 upbringing, I would say that child did not really
3 have a choice to be a Christian. But I don't
4 believe that Christianity is somehow sort of
5 physically innate in them in the way that blue
6 eyes would be, for example.

7 BY MS. ALTMAN:

8 Q. Well, sir, we want to -- you keep focusing
9 on children. Let's try and unpack it a little by not
10 talking about children for a minute.

11 You would agree with me that there are
12 adults that -- that live their life as one gender and
13 ultimately come to terms with the fact that they have a
14 gender identity different from their gender at birth,
15 correct?

16 A. Yes, yes.

17 Q. So let's not talk about parents and
18 Christians and whatever else you want to talk about. I'm
19 talking about adults now.

20 Would you agree with me, sir, that there
21 are transgender individuals, that it is not a choice, it
22 is innate to them?

23 A. I think maybe we have a different
24 understanding of innate.

25 Q. Okay. Well, what's your understanding of

1 innate, sir?

2 A. Innate is something that would -- would
3 be -- would arise regardless of the cultural context.

4 Q. What does that mean, sir? Are you trying
5 to say that every transgender person arises because of
6 the cultural context, is that your testimony?

7 MR. BEATO: Object to the form.

8 BY MS. ALTMAN:

9 Q. Whatever that means?

10 MR. BEATO: Object to form.

11 THE WITNESS: I'm suggesting that there are
12 different societies. Different cultures have
13 different ways of understanding gender. And,
14 obviously, our society, our culture at this moment
15 has an understanding which is encapsulated in the
16 label "transgender." But that is not universal or
17 across -- across different societies, different
18 cultures.

19 BY MS. ALTMAN:

20 Q. Meaning what? That it is your testimony
21 under oath that there are people in other societies and
22 other cultures that -- that have no individuals that are
23 transgender, is that what you want this Court to believe?

24 MR. BEATO: Object to form.

25 THE WITNESS: They might understand

1 their -- their experience in quite different ways.
2 For example, they would not be seeking cross-sex
3 hormones, for example.

4 BY MS. ALTMAN:

5 Q. Who is the they in your sentence?

6 A. No individuals and -- before 1900 were
7 seeking cross-sex hormones.

8 Q. Sir, you are here to provide your opinions
9 today. I'm happy to talk to you at length if you'd like
10 during your deposition about the 1900s. But I'm just
11 trying to understand your testimony here today about
12 what -- what it is today.

13 Is it your opinion under oath that being
14 transgender is a choice?

15 MR. BEATO: Object to form.

16 You can answer, Dr. Biggs.

17 THE WITNESS: In some cases, yes.

18 BY MS. ALTMAN:

19 Q. And in some cases?

20 A. In some cases no.

21 Q. Okay. Thank you very much. And I think I
22 asked you this earlier, but just in case, other than
23 talking to -- to Michael for five minutes, did you
24 discuss your deposition testimony with anyone else?

25 A. No.

1 Q. And I think you also answered you've not
2 read any of the other depositions in this case, correct?

3 A. Correct. Expert witness -- yeah, expert
4 reports.

5 Q. Yes, sir.

6 A. Correct.

7 Q. Do you --

8 A. Except the rebuttals, except the five
9 rebuttals to -- five rebuttals to expert reports.

10 Q. Right. And my question, I'm sorry, was
11 about deposition transcripts. Have you read any
12 deposition transcripts?

13 A. No.

14 Q. No. Did hormone treatments exist before
15 the 1900s?

16 A. No.

17 Q. Did we even understand hormones before the
18 1900s?

19 A. No.

20 Q. So using your analogy before in referencing
21 that before the 1900s, you know, transgender was not a
22 thing, that really isn't a good analogy because it didn't
23 exist, correct, the use of cross-sex hormones?

24 MR. BEATO: Object to the form.

25 You can answer, Dr. Biggs.

1 THE WITNESS: Yes, I think medical --
2 certain medical technologies make certain --
3 certain identities more -- more likely or more --
4 more attractive.

5 MS. ALTMAN: Let me just look at the report
6 real quick, sir, and make sure I don't have any
7 other questions. I'm either just about done or
8 done. So just give me one second.

9 BY MS. ALTMAN:

10 Q. Sir, on the bottom of page 13 of your
11 report, I don't think we need to bring the report up, I
12 just have a quick question.

13 You cite to -- it says, "In the Belgian
14 clinic which experienced the exceptionally high suicide
15 rate," then there is a period and a lowercase,
16 "subsequent correspondence reveals that suicide was" --
17 and I'm quoting -- "suicide was related to many more
18 psychological problems than G.D., and occurred mostly a
19 few years after the start of hormonal treatment."

20 And you cite to an e-mail from Gaia Van
21 Cauwenberg, C-A-U-W-E-N-B-E-R-G, to Avi, A-V-I, Ring,
22 R-I-N-G, an e-mail dated May 27, 2022.

23 Is that your evidence that you are relying
24 upon for that statement, is an e-mail from this one
25 individual to another, or did you have other evidence for

1 that proposition?

2 A. That's the evidence. And that -- the --
3 Van Cauwenberg is one of the authors of that articles --
4 of the article that talks about the high suicide rate in
5 the Belgian clinic.

6 Q. Okay.

7 MS. ALTMAN: I don't have any more
8 questions, sir.

9 Michael.

10 MR. BEATO: And thank you again, Dr. Biggs,
11 for your -- for your testimony. I just have two
12 questions for you.

13 CROSS-EXAMINATION

14 BY MR. BEATO:

15 Q. The first question is, do you think that
16 the subject matter of gender-affirming care is
17 controversial?

18 A. Yes.

19 Q. Then why did you decide to weigh in and
20 opine into this controversial subject matter?

21 A. Because I believed that the empirical
22 evidence did not justify the kind of certainty that was
23 being presented in the practice of gender clinics, like
24 the Tavistock in London, and in the sort of media
25 discussion of the care for transgender children and

1 adolescents.

2 MR. BEATO: No further questions.

3 MS. ALTMAN: You want to tell him his right
4 to read or waive or do you want me to do it?

5 MR. BEATO: You can do it.

6 MS. ALTMAN: So you have the right to read
7 your transcript. Can't make substantive changes
8 but you can read it. Maybe you said yes, the
9 court reporter wrote no or something else. So you
10 have the right to read or waive your transcript.

11 THE WITNESS: How long would I have to
12 do -- to read and -- and approve that transcript?

13 MS. ALTMAN: 30 seconds -- no, I think it's
14 30 days.

15 THE WITNESS: I will take -- I would
16 rather -- I probably would like to read it, then.

17 MS. ALTMAN: Okay.

18 And then I just have one real quick
19 redirect question.

20 REDIRECT EXAMINATION

21 BY MS. ALTMAN:

22 Q. Have you weighed in on whether surgeries
23 should be provided to intersex infants?

24 A. No, I haven't, but I have a strong view
25 that they shouldn't be unless absolutely medically

1 necessary.

2 MS. ALTMAN: So, Ms. Bush, he is going to
3 read it, I think. Did I get that right?

4 THE WITNESS: Yes. Yes, please.

5 MS. ALTMAN: Okay. I believe we are
6 ordering on an expedited basis. So we will take a
7 copy -- the original, I guess. And we want it on
8 an expedited basis.

9 MS. REPORTER: And when is that, when do
10 you want it by? As soon as I can get it to you?

11 MS. ALTMAN: Right, but faster than that.

12 MS. REPORTER: Do you have a specific time
13 frame in mind?

14 MS. ALTMAN: Well, I mean, we're -- I mean,
15 as soon as possible. As soon as you can humanly
16 get it here.

17 MS. REPORTER: That's fine.

18 And then, Michael, do you want a copy?

19 MR. BEATO: Yes, please.

20 (The proceeding is adjourned at 3:44 p.m.)

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CERTIFICATE OF NOTARY PUBLIC

STATE OF FLORIDA

COUNTY OF _____

I, MICHAEL BIGGS, PH.D., certify that I have read the foregoing transcript of my deposition and that the statements contained therein, together with any additions or corrections made on the attached Errata Sheet are true and correct.

Dated this _____ day of _____, 20__.

MICHAEL BIGGS, PH.D.

The foregoing certificate was subscribed to before me this _____ day of _____, 20__, by the witness who has produced a _____ as identification and who did not take an additional oath.

NOTARY PUBLIC

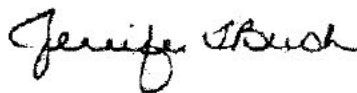
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CERTIFICATE OF OATH OF WITNESS

STATE OF FLORIDA)
COUNTY OF ST. LUCIE)

I, the undersigned Notary Public, in and for the State of Florida, hereby certify that MICHAEL BIGGS, PH.D. personally appeared before me and was duly sworn.

WITNESS MY HAND and official seal in the City of Fort Pierce, County of St. Lucie, State of Florida this March 24, 2023.



Jennifer L. Bush, RPR, FPR
Notary Public
State of Florida at Large.
My Commission: #HH 002112
My commission expires: 9/24/24

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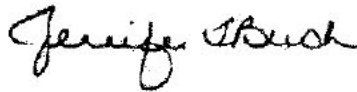
CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF ST. LUCIE)

I, Jennifer L. Bush, Registered Registered
Registered Professional Reporter, do hereby certify that
I was authorized to and did stenographically report the
deposition of MICHAEL BIGGS, PH.D.; and that a review of
the transcript was requested; and that pages 1 through
243, inclusive, are a true record of my stenographic
notes.

I further certify that I am not a relative,
employee, attorney or counsel of any of the parties, nor
am I a relative or employee of any of the parties,
attorneys or counsel connected with the action, nor am I
financially interested in the action.

Dated this March 24, 2023.



Jennifer Bush, RPR, FPR

The foregoing certification of the
transcript does not apply to any reproduction of the same
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direction of the certifying reporter.

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March 24, 2023

MICHAEL BIGGS, PH.D.
C/O Michael Beato, Esquire
Holtzman Vogel Barantorchinsky & Josefiak PLLC
119 S Monroe Street, Suite 500
Tallahassee, FL 32301

RE: DEKKER VS. WEIDA, ET AL.
Deposition of MICHAEL BIGGS, PH.D.

Dear Dr. Biggs:

This letter is to advise you that the transcript of the deposition listed above is completed and is awaiting reading and signing. Depending on the length of the transcript, you should allow yourself sufficient time.

If the reading and signing has not been completed prior to the time of trial, we shall conclude that you have waived the reading and signing of the deposition transcript.

Your prompt attention to this matter is appreciated.

Sincerely,

Jennifer L. Bush, RPR, FPR
CC: All counsel on appearance page

[& - 30s]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate.

The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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

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