1 UNITED STATES DISTRICT COURT
2 NORTHERN DISTRICT OF FLORIDA
3
4 AUGUST DEKKER, et al.,)
5) Case No.
6 Plaintiffs,)
7) 4:22-cv-00325-RH-MAF
8 vs.)
9)
10 JASON WEIDA, et al.,)
11)
12 Defendants.)
13 March 17, 2023 10:03 am Zoom
14 DEPOSITION OF: Dr. Quentin Van Meter
15 This deposition was taken remotely via Zoom.
16 Signature of this deposition is reserved.
17
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1 Gloucester County School Board case, is that right?
2 A. That's correct.
3 Q. That was in 2019, is that right?
4 A. That's right. It wasn't testimony in court.
5 It was a deposition.
6 Q. In that deposition you testified that you have
7 not done any scientific research related to
8 transsexualism, gender dysphoria or gender identity
9 disorder, is that correct?
10 A. That's correct.
11 Q. You also testified that you have not done any
12 scientific research related to transgender people, is
13 that correct?
14 A. That's correct.
15 Q. And you testified that you have not done any
16 scientific research related to gender identity issues, is
17 that correct?
18 A. Correct.
19 Q. And all of that remains true today, is that
20 right?
21 A. Yes, I have not been involved in a designed
22 research study of transgender treatment or transgender
23 patients.
24 Q. On your CV on I believe it's page 5 of your CV
25 you list a number of publications, is that right?

1 29
1 A. Let me get to page 5. Yes.
2 2 Q. Of these only three are pertaining to gender
3 3 dysphoria or transgender people, is that correct?
4 4 A. Let me review to make sure I am speaking
5 5 correctly. For some reason, the copy I have it does not
6 6 look like it's a complete list. So, if you can read to
7 7 me the ones that -- I'm looking at my most recent
8 8 addition. Let me just go to the top to be sure it is.
9 9 Yes.
10 10 Q. Let me just show you five of your CV as
11 11 contained in Exhibit 1, is that right?
12 12 A. So, the publication Mike Laidlaw and I and
13 13 others that's a letter to the editor. There is my
14 14 article on bringing transparency to the treatment of
15 15 transgender persons, and Mike Laidlaw and our letter to
16 16 the editor on the erythrocytoisis in a cohort of
17 17 transgender men. So, those three. There are three of
18 18 them of all of those that deal with transgender as an
19 19 issue.
20 20 Q. Are there any other beyond those three
21 21 publications, the two letters to the editor and the
22 22 article in Issues?
23 23 A. No, no.
24 24 Q. None of those three are original peer-reviewed
25 25 research, is that correct?

32

1 stated is actually their policy. It's conjecture on my
2 part.
3 Q. Sitting here today you can say that they've
4 been reviewed by an editor, but you do not know if they
5 were true peer-reviewed in the sense that we have
6 discussed it?
7 A. That's correct.
8 Q. Thank you. And in the article for Issues in
9 Law and Medicine, do you know whether that was true peer-
10 reviewed?
11 A. Yes, it was true peer-reviewed.
12 Q. You mentioned earlier that you have a number of
13 patients, transgender patients. How many transgender
14 patients do you have?
15 A. It's now about 20 patients.
16 Q. How many transgender patients have you ever
17 worked with?
18 A. Those are the cases I'm speaking of.
19 Q. So, in your whole experience you've worked with
20 20 transgender individuals as patients?
21 A. That's correct.
22 Q. You didn't provide medical treatment to any of
23 these patients, is that right?
24 A. That's correct.
25 Q. Given that you're a pediatric endocrinologist

1 35
1 permission to be able to communicate with the counselors
2 they are seeing. The parents sign a release form so that
3 I can do so, and I am sort of coordinating an ongoing
4 review just to have someplace for the parents and the
5 patients to come back to, sort of a medical home, as this
6 process is moving forward. In that way I'm sort of a
7 primary care hub for them so that all of the things that
8 need to go on that we recommend are being monitored so
9 that I can make sure that they're not lost to follow-up.
10 Q. What do you mean lost to follow-up?
11 A. Where we don't know what's going on. They
12 don't come back for follow-up. It's difficult to do
13 that. It requires responsibility on the part of the
14 parents to make appointments or to keep appointments that
15 are made. So, we try to keep track of those so that we
16 don't lose the ability to monitor how they are
17 progressing and how they are resolving their mental
18 health issues. So, again it's a primary care type of an
19 issue in the sense that we are a clearinghouse to follow
20 these patients and make sure that they are adequately
21 receiving the counseling that they need.
22 Q. You're not a mental health provider, is that
23 right?
24 A. I am not.
25 Q. And you said you speak to the counselors for

1 36
1 these patients, is that right?
2 A. That's correct.
3 Q. Do you make referrals?
4 A. I do. Well, I will say I give information on
5 how to contact. In terms of insurance some of these
6 individuals have to have a referral from their primary
7 care provider, and I'm not viewed as a primary care
8 provider by insurance. So, some insurance companies will
9 allow a specialist to cross refer to other specialists in
10 the pediatric world, but some require that the
11 pediatrician who is listed in their insurance policy has
12 to make that decision about a referral. So, I will
13 recommend individuals, counselors, in the geographic
14 region where the patient lives that are convenient to
15 their home address; and if necessary, I will talk to
16 their primary care provider and indicate by letter that
17 this is what I recommend; would they be willing to make
18 the referral.
19 Q. So, you said that you serve as a primary care
20 hub for these patients, but they actually have actual
21 primary care providers that are not you, is that right?
22 A. That is correct.
23 Q. Let me just ask this a little bit more plainly.
24 Are you working with these 20 families to ensure that
25 they do not receive or go down the path of obtaining

1 37
1 medical treatment for gender dysphoria?
2 A. I check on what's happening, where they are
3 going, what decisions they've made. The cases that come
4 to me are most often parents who are not willing to
5 consent to any medical intervention just by design. I
6 mean my reputation is known in the transgender community
7 is if you want to have full access to medical care, this
8 is not the endocrinologist you need to go to. So, it's
9 a matter of selection, preselection if you will, of
10 families that come to me where it has to do with parental
11 consent, either one or both of the parents.
12 Q. So, let me just ask a little bit more
13 specifically. You do not treat this patient's gender
14 dysphoria, is that correct?
15 A. No, that's an issue for their mental health
16 providers.
17 Q. So, you have never provided treatment for
18 gender dysphoria?
19 A. No, I have not.
20 Q. You've never provided treatment for gender
21 identity disorder?
22 A. No, I have not. Those are both mental health
23 issues, specifically mental health issues that are
24 addressed by a licensed certified mental health
25 providers, and I am not such a person.

1 45
1 record at 11:12 am.
2 BY MR. GONZALEZ-PAGAN:
3 Q. Dr. Van Meter, we were about to discuss some
4 more of the specifics of your report. This is Exhibit 1.
5 In paragraph eight of your report, the second sentence
6 states to the contrary there is no biologic basis for
7 gender identity, and you cite to the DSM-5, is that
8 right?
9 A. Yes.
10 Q. How does the DSM-5 support your statement?
11 A. What was your question again exactly? I'm
12 sorry.
13 Q. Sure. You state there is no biologic basis for
14 gender identity, and you cited to the DSM-5 as support.
15 How does the DSM-5 support your statement?
16 A. I don't have a DSM-5 open right in front of me,
17 but there is a statement about fluidity and the
18 desistance rates.
19 Q. The DSM-5 doesn't say that there's no biologic
20 basis for gender identity, is that right?
21 A. I would have to go through sentence by
22 sentence. I know DSM-4 specifically said so. DSM-5 I
23 believe has -- I can't speak on that exactly.
24 Q. I'm going to show you what's been marked as
25 Exhibit 6. Can you see my screen?

1 46
1 A. Yes, I can.
2 2 Q. This is a article that was published in the
3 3 Journal of Neuroendocrinology, is that right?
4 4 A. It looks that way, yes.
5 5 Q. The Journal of Neuroendocrinology is a peer-
6 6 reviewed journal, is that right?
7 7 A. I'm not familiar with it. So, I can't state
8 8 exactly.
9 9 (Plaintiff's Exhibit No. 6 was
10 10 marked for identification.)
11 11 BY MR. GONZALEZ-PAGAN:
12 12 Q. You said that you have read a number of the
13 13 literature in the context of gender identity and gender
14 14 dysphoria over the last 15 years. This is an article
15 15 that you've encountered?
16 16 A. No.
17 17 Q. The last sentence of the abstract states --
18 18 well, the title of the article is neurobiology of gender
19 19 identity and sexual orientation. Did I read that
20 20 correctly?
21 21 A. Yes, you did.
22 22 Q. And the last sentence of the abstract -- let me
23 23 zoom in a little bit -- states nonetheless despite the
24 24 many challenges to research in this area existing
25 25 empirical evidence makes it clear that there is a

1 47
1 significant biological contribution to the development of
2 an individualâ€™s sexual identity and sexual orientation.
3 Did I read that correctly?
4 A. You did.
5 Q. Then on page 4 there is a heading gender
6 identity. Do you see that?
7 A. Correct.
8 Q. And the last sentence of the first paragraph
9 after that heading states several extensive reviews by
10 Dick Swaab and coworkers elaborate the current evidence
11 for an array of prenatal factors that influence gender
12 identity including genes and hormones. Did I read that
13 correctly?
14 A. You did.
15 Q. So, you would agree that peer-reviewed
16 scientific literature states that there is empirical
17 evidence that there is a biological basis for a person's
18 gender identity, is that right?
19 A. It stated so in the sentence. I have not read
20 this article to go through point by point and look at the
21 references chosen. So, I cannot comment on the validity
22 of this journal article.
23 Q. Sure, but the article says that?
24 A. The article said that.
25 Q. Let's go to paragraph 10 of your report, the

53

1 A. Yes.

2 Q. This was published in the International Journal

3 of Transgender Health, is that right?

4 A. That's correct.

5 (Plaintiff's Exhibit No. 7 was

6 marked for identification.)

7 BY MR. GONZALEZ-PAGAN:

8 Q. I'm going to go to page S178. That is the

9 references to the SOC 8. Do you see that?

10 A. Yes.

11 Q. The citation to -- and can you see my cursor?

12 A. I can.

13 Q. The citation to Aitken, Steensma, Blanchard, et

14 al, do you see this?

15 A. I do.

16 Q. One of the co-authors of that article is

17 Kenneth Zucker, is that right?

18 A. Yes.

19 Q. If we go to the next page, actually a couple of

20 pages down, there's lots of citations here. There we go.

21 Page S191, do you see a citation to Cohen-Kettenis?

22 A. Yes.

23 Q. Cohen, Kaijser, Bradley, and Zucker, is that

24 right? A. I do. Yeah.

25 Q. So, Zucker is a co-author of this article, is

1 54
1 that right?
2 A. Yes.
3 Q. I could go through this 14 more times, but I
4 will represent to you that there are at least 16 articles
5 of which Dr. Zucker was a co-author that were referencing
6 SOC 8?
7 A. Yes.
8 Q. Would you agree with me then that the SOC 8
9 cites to Dr. Zucker's work?
10 A. I'm sorry, do I agree with which?
11 Q. Would you agree with me then that the SOC 8
12 cites to Dr. Zucker's work?
13 A. It cites to articles in which he was co-author,
14 yes, it does, but only 16 times as you said.
15 Q. Do you know if Dr. McHugh has published any
16 original research with regards to the treatment of gender
17 dysphoria?
18 A. He published essentially a chapter. It would
19 be a chapter of a textbook in the New Atlantis article
20 back in 2016. A subsequent article co-authored with Dr.
21 Paul Roos within the year later in the same journal.
22 Q. The New Atlantis Journal is not a peer-reviewed
23 publication though?
24 A. Not in the sense that all the references are
25 sent out for review as you discussed.

1 55
1 Q. In fact, it's a religiously-affiliated journal?
2 A. I'm unaware of any religious affiliation to
3 that journal.
4 Q. But Dr. McHugh has not published any original
5 research, right? Those are all reviews?
6 A. It's a review of the literature, the entirety
7 of the literature at the time, and it is an extensive
8 review, more extensive than any of the other treatises
9 that I have been able to find on gender identity disorder
10 or gender dysphoria.
11 Q. So, going back to my original question, Dr.
12 McHugh has not published any original peer-reviewed
13 research with regards to gender dysphoria?
14 A. He has not.
15 Q. Is that right?
16 A. That is correct.
17 Q. Do you know if Dr. Zucker applied to be an
18 author of SOC 8?
19 A. I don't know if he did or not. He has had a
20 strained relationship with WPATH in recent years.
21 Q. Do you know if Dr. McHugh applied to be an
22 author of SOC 8?
23 A. No, you don't apply to be an author. The
24 authors are members of WPATH who decide on their own to
25 publish their medical guidelines. So, it's invitation

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1 it's Exhibit 8.
2 MR. GONZALEZ-PAGAN: Thank you, Madam Court
3 Reporter.
4 BY MR. GONZALEZ-PAGAN:
5 Q. Yes, just to correct the record, this is
6 Exhibit 8. Exhibit 7 is SOC 8. Maybe I should have
7 ordered that better. So, let's go to page 111 of this
8 document. Do you see here where it lists the members of
9 the standards of care revision committee?
10 A. Yes, I do.
11 Q. One of the members that wrote the standards of
12 care version 7 is Kenneth Zucker, is that right?
13 A. That's correct.
14 Q. And the standards of care version 7 recommended
15 medical treatment for gender dysphoria in the form of
16 puberty blockers, hormone therapy and surgery, is that
17 correct?
18 A. Yes.
19 (Plaintiff's Exhibit No. 8 was
20 marked for identification.)
21 BY MR. GONZALEZ-PAGAN:
22 Q. On paragraph 13 of your report -- this is again
23 Exhibit 1. The first sentence reads the vast amount of
24 publications which exist including the DSM-5 and the
25 handbook of human sexuality published by the American

59
1 that you cite? You reference to a vast amount.
2 A. The remainder of the references that can
3 pertain to that are the articles on patient desistance
4 which are quoted later in the article, in the report that
5 I prepared.
6 Q. That's the next sentence, right?
7 A. One moment. Let me get back to the document
8 again on my screen. I'm sorry. I inadvertently closed
9 my document.
10 Q. That's the nature of the beast now in the
11 virtual world.
12 A. We were on paragraph 13, is that correct?
13 Q. That's correct.
14 A. One moment. Let me get back to that.
15 Q. It's page 6.
16 A. Those 11 published studies that are listed,
17 yes, that's correct.
18 Q. The sentence reads there are over 11 published
19 studies which clearly prove that desistance occurs in
20 children who have been allowed to proceed uninterrupted
21 from natural puberty ranging 50 to 98 percent of the
22 time?
23 A. That's correct.
24 Q. The studies to which you refer to pertain to
25 subjects diagnosed with gender identity disorder under

1 60
1 the DSM-4, is that correct?
2 A. These are actually all related to gender
3 dysphoria so-called as well as gender identity disorder.
4 Those two are essentially the same. The purpose of
5 changing the wording was to be able to have a diagnostic
6 code that pertained to individuals who had an incongruent
7 gender identity compared to their biologic sex. Those
8 patients are all the same. The name just changed because
9 of the wording in DSM-5.
10 Q. I understand that, but all of those are
11 patients that would have been diagnosed under the DSM-4
12 because the studies occurred before the DSM-5 was
13 published, is that right?
14 A. Actually one study by Zucker and Zane is
15 published subsequent to that that changed the DSM-5.
16 Q. That study looked at patients that were
17 diagnosed in the '80s. It was a long follow-up study for
18 patients diagnosed in the '80s, is that correct?
19 A. No, that was a current study that was done by
20 Dr. Zane in the more recent years.
21 Q. It was published in 2021, is that right?
22 A. That's correct.
23 Q. Yes, and the Zane study actually looked at
24 patients going back to the '80s who were now adults in
25 2021?

1 61
1 A. Yes.
2 Q. So, as children, they would have been diagnosed
3 under the DSM-4?
4 A. Yes, because that was the diagnosis code used
5 at the time.
6 Q. All of those studies pertain to preadolescent
7 children, is that right?
8 A. On purpose, yes, to be started as
9 preadolescents and then proceeded forward.
10 Q. This case concerns coverage for medical and
11 surgical treatments for gender dysphoria, is that
12 correct?
13 A. It is the same population of patients.
14 Q. I'm sorry. That wasn't my question. My
15 question is what do you understand this case to be about?
16 A. About the treatment of patients who have an
17 incongruent gender identity.
18 Q. We're talking about medical treatments,
19 correct?
20 A. Medical treatments.
21 Q. You indicated that you are familiar with the
22 standards of care 7 and standards of care 8, is that
23 right?
24 A. Yes.
25 Q. Are you familiar also with the Endocrine

1 62
1 Society guidelines?
2 A. Very familiar.
3 Q. No medical or surgical treatment is suggested
4 or recommended for pre-pubertal youth, is that right?
5 A. That's correct.
6 Q. What is the desistance rate for transgender
7 adolescents?
8 A. The desistance rate is figured on the patients
9 who lost their incongruence of gender identity by the
10 time they reached young adulthood, at the end of, the
11 complete end of adolescence.
12 Q. But those studies were looking at preadolescent
13 children and following them forward, is that right?
14 A. Some of them were preadolescents, and others
15 were in the midst of puberty, and the ones from Europe
16 were actually children who were in puberty, in some cases
17 two years in, and therefore they were followed and found
18 that the desistance was there as well.
19 Q. But my question is what is the desistance rate
20 for adolescents?
21 A. I would specifically in those reference have to
22 pull and look at the individual desistance rates
23 described in each of those articles, and I do not have
24 that information right in front of me, but I could
25 provide that for you later if you wish.

65
1 2018 to 2020. It's hard to find that reference, but it
2 was there for a while, and then there are case reports of
3 the individuals who have de-transitioned if you will once
4 they have made that decision, and there are cases
5 increasing in number that are basically coming to the
6 surface indicating that that's what they went through and
7 that they are de-transitioning because of the desistance
8 of their gender and congruity.
9 Q. Understood. My question still remains the
10 same. Are there any peer-reviewed scientific articles
11 that lay out, look specifically at the desistance rate of
12 adolescents with gender dysphoria?
13 A. I am unaware of articles specifically with
14 adolescents, but I will be happy to look into that and
15 provide those for you.
16 Q. Isn't one of those articles the one by
17 Christina Olson that showed a desistance rate of 2.5
18 percent?
19 A. Dr. Olson's research has come under criticism.
20 I don't know the paper. I would be happy to review it
21 for you if it can be provided to me to look at how she
22 determined her denominator and numerator.
23 Q. So, you're not familiar with the Olson study?
24 A. I have certainly heard of it, but I have not
25 critically reviewed the paper.

66

1 Q. What is the desistance rate for adults?

2 A. By the time they're adults I don't think

3 there's any published data. It is thought that if they

4 persist with their gender incongruence into adulthood

5 that they tend to stay there. However, there are

6 articles describing the difficulty of collecting data

7 because the de-transitioners basically do not come forth

8 and report themselves. In reports we find that they are

9 not cared for by the people that transitioned them, and

10 so, there's no data collected anywhere that says one way

11 or the other, but those who are de-transitioning

12 specifically report that they did not return to the

13 places where they were treated because those places did

14 not want to treat them and refused to treat them. The

15 numbers are not available anywhere.

16 Q. So, this is based on what then?

17 A. This is based ...

18 Q. Your statements are based on what?

19 A. They are based on reports from de-

20 transitioners.

21 Q. Has any of this been published scientific

22 literature?

23 A. No.

24 Q. You stated that it's known that for most adults

25 by the time they're adults their gender incongruence

1 72
1 is where those are gleaned from. Those are called
2 convenience samples. They represent nowhere close to the
3 population, and the design of the questionnaire is not
4 adequate enough to look at any causality whatsoever.
5 Q. I understand, Dr. Van Meter. I have 20 more
6 pages of questions. So, I think we need to stick to the
7 questions that's asked if you will. My question is is
8 the safety and efficacy of a treatment in the United
9 States determined by whether a study follows every
10 patient with that condition?
11 A. Yes is the answer.
12 Q. So, in order for a treatment in the United
13 States to be effective, we know the outcomes for every
14 patient as part of the study that has that condition in
15 the United States?
16 A. If they are a part of a study, absolutely yes.
17 Q. I'm not asking if they're part of a study. I'm
18 asking you if the entire population?
19 A. There is no way to do that. There is no way to
20 get that information.
21 Q. So, that is a standard that is not possible to
22 meet for the treatment of gender dysphoria either?
23 A. That is correct.
24 Q. Paragraph 16 of your report, the second clause
25 of that sentence states wait-and-see has been used by

1 73
2 1 others to describe waiting until completion of puberty at
3 2 the age of consent since by that time the vast majority
4 3 of patients have desisted. On what peer-reviewed
5 4 literature do you rely on for that proposition?
6 5 A. The statements of the researchers and the
7 6 statements in documents describing what gender dysphoria
8 7 is and what has been used as the design of treatment.
9 8 Q. So, which studies are you referring to here?
10 9 A. The ones in Europe and Dr. Kenneth Zuckers'
11 10 particular paper itself.
12 11 Q. So, you're referring to Dr. Zucker, right?
13 12 A. Correct.
14 13 Q. By use via the Center for Addiction and Mental
15 14 Health, is that right?
16 15 A. That's correct.
17 16 Q. And you're referring to the European studies.
18 17 Are you referring to the Dutch studies?
19 18 A. Dutch among others, but most of it is from the
20 19 Dutch protocol study.
21 20 Q. Is your statement that no medical treatment is
22 21 provided in those contexts until after the completion of
23 22 puberty?
24 23 A. Those patients were counseled, and if they did
25 24 not meet the criteria for the medical treatment, they
25 counted those patients in some of those studies all the

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1 way, and that's where they said their desistance rates
2 were; and that's what the range was between I think the
3 lowest was 50, and the highest in the Dutch protocol or
4 the Dutch studies was up in the 90 percent range.
5 Q. In the Dutch protocols they would provide
6 puberty blockers beginning at age 12, isn't that right?
7 A. They would if it was appropriate. If they did
8 not, they left those patients out of the medical
9 treatment. It turns out that -- I won't muddy the waters
10 with that, but yes, they did not empirically treat every
11 patient that came in to be studied.
12 Q. But they would provide medical care beginning
13 at age 12?
14 A. As young as age 12 they provided puberty
15 blockers to those who met the criteria of being, you
16 know, completely mentally stable, no undercurrent issues,
17 no coerced parental consent, very specific kinds of
18 criteria that they used.
19 Q. Dr. Kenneth Zucker at the Center for Addiction
20 and Mental Health under that center's protocols they
21 would provide medical treatment to some adolescents, is
22 that right?
23 A. No, they did not.
24 Q. You say that the wait-and-see model has been
25 used by others to describe waiting until completion of

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1 puberty. What about after puberty is completed? What
2 about when somebody is an adult? Should they not have
3 access to medical care?
4 A. I stick specifically to the subject of
5 adolescents below the age of consent. I cannot speak of
6 the appropriateness of medical treatment thereafter. I
7 have an opinion, but I'm not going to -- I don't cite
8 literature on the subject and don't pretend to be an
9 expert in treating adults.
10 Q. So, as we stand here today, your opinions are
11 limited to those under 18?
12 A. Correct.
13 Q. On the next paragraph going on to the next
14 page, so paragraph 17, the last sentence states her
15 theory that social affirmation in pre-pubertal patients
16 does not lead to medical and surgical interventions
17 during puberty is false. Did I read that correctly?
18 A. Yes, you did.
19 Q. For that proposition you cite to the Endocrine
20 Society guidelines for the endocrine treatment of gender
21 dysphoric and gender incongruent persons. I'm happy to
22 go to the references to show you?
23 A. That's correct.
24 Q. How does the Endocrine Society guidelines
25 support your statement that that is false?

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1 A. I do, yeah. yes.
2 Q. And 31 is Van Meter QL, personal patient
3 interview, is that right?
4 A. That's correct.
5 Q. So, your statement there that the pause in US
6 transgender clinic is often for as little as a month is
7 based on a single patient interview?
8 A. Actually there are two patient interviews from
9 a local clinic here, patients that came to me locally.
10 Q. So, it is based on two patients' interviews?
11 A. Yes, two of my 20.
12 Q. So, based on two patient interviews you then
13 are making a generalized statement about all US trans
14 clinics?
15 A. I am making a statement of my own personal
16 experience. I have had antidotal reports from others who
17 have had patients leave both from parents, and I've come
18 to know parents of desisting children who have stated
19 that they were given puberty blockers within a month in
20 the case of Planned Parenthood, the drugs are often
21 given, given antidotally at the first visit. So, there
22 is no screening of mental health that can be adequately
23 done and resolve deep-seated issues, and patients are
24 treated as soon as a month. Historically, again
25 antidotally from reports of individuals who have de-

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1 transitioned, they were offered drugs at three months
2 into their evaluation.
3 Q. And you cite to no literature then for this
4 proposition?
5 A. No, there is no study. Nothing has been
6 published because the data is not able to be found. It
7 is kept within those transgender clinics.
8 Q. Go ahead.
9 A. It's not published data over the vast number of
10 60 plus transgender clinics, and there's no data
11 published at all by Planned Parenthood in terms of the
12 timing of first visit and initiation of any medical
13 treatments. No one is allowing us to see the data from
14 all of the centers.
15 Q. Is that normal that all the data of all of the
16 centers ...
17 A. Yes, that would be ...
18 Q. Released?
19 A. When they are doing an ongoing clinical
20 experiment, that data exists and should -- we should have
21 access to it. It's not published. We should be able to
22 obtain it, but we cannot get that data.
23 Q. But my question wasn't we should. My question
24 is is that normal. Is it normal for academic health
25 clinics particularly, for example, DSD clinics to release

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1 discussed, and I have had no luck in that. I would have
2 been happy to publish my article in pediatrics. I sent
3 an article to JAMA to be considered and published, and
4 also a letter to the editor of JAMA, and they were
5 refused publication. So, it's a very stilted kind of
6 acceptance if you will. My colleagues have had the same
7 thing happen to them. So, it's very difficult to get
8 things published. You work critically. You use the
9 avenues you do have, and that's why two of the things
10 that prior to the author of went in as letters to the
11 editor because that's a way you can get through the bias
12 if you will against what you're trying to publish. So,
13 publication of things on the concerns about social,
14 medical and surgical affirmation are very often rejected
15 for publication.
16 Q. Going back to my question though, there's a
17 difference between publishing a piece as a review or an
18 opinion or a case report. Case reports are very specific
19 types of publications, is that right?
20 A. That's correct.
21 Q. So, my question was why didn't you publish case
22 reports about your two patients that you referred to
23 here?
24 A. Because I have a medical practice. I am
25 involved in advocacy for these kids. I have not taken

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1 the time specifically to do that, and I very frankly have
2 been discouraged from sending things in as case reports
3 or editorials or letters to the editor because of a
4 refusal to publish them.
5 Q. Have you attempted to publish a case report?
6 A. I have not sent a letter or a case report in.
7 It's just I am discouraged from putting the effort into
8 doing this when I realize the likely outcome is it will
9 be rejected.
10 Q. (Inaudible.)
11 A. That question broke up. I'm sorry?
12 Q. (Inaudible) publishing these case reports?
13 A. Again, the first half of your sentence I could
14 not hear.
15 Q. Has anybody, any person, actively discouraged
16 you from publishing case reports or articles or letters?
17 A. No, no one discouraged me actively.
18 Q. For these two patients what were the ages of
19 the patients?
20 A. One was 11, and the other was -- these are both
21 females. The other patient was 11 or 12.
22 Q. How do these patients identify now?
23 A. I'm sorry, again, the distortion of your voice
24 unfortunately.
25 Q. How do these patients identify now?

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1 Q. In Sweden within the Karolinska Institute there
2 will be the provision of that care within that specific
3 protocol?
4 A. Only in that specific protocol which has not
5 yet been developed.
6 Q. But it's not stopping the care completely?
7 A. No, it is recommending that it cannot be
8 applied to the general population until the clinical
9 study is complete. To do a clinical study on this would
10 require that you have a control arm, and this is their
11 intention as well.
12 Q. I apologize. I know that we're going to try
13 not to interrupt each other.
14 A. It will be a very small number of patients in a
15 controlled trial, not to be done outside of that trial.
16 Q. In Sweden there are six different hospitals
17 that provide care, and the hospital to which the
18 statement that you cite pertains only to one, is that
19 right?
20 A. I do not know those facts.
21 Q. In Finland they will still continue providing
22 this care in some circumstances, is that right?
23 A. They did not forbid that care.
24 Q. In the United Kingdom they continue to provide
25 this care in some circumstances, is that right?

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1 A. I think the most recent directive -- and I
2 don't have a reference for that -- said no, they will not
3 do that at all, that there will be no such care.
4 Q. I believe the review is still ongoing, isn't
5 that true?
6 A. The review is ongoing?
7 Q. They have moved from the Tavistock centralized
8 system of the GIDS to a regionalized model, is that
9 right?
10 A. That was one of the suggestions in order to be
11 able to get the waiting times cut down because the
12 waiting time for the centralized system was well beyond
13 usefulness, and they wanted to get the access to the
14 counseling, appropriate counseling, to happen in local
15 areas and have those physicians recognizing that that
16 needed to be provided.
17 Q. So, then you would agree then that it is true
18 that not all of these countries that you've cited have
19 stopped providing this care completely?
20 A. That would be a correct statement.
21 Q. Let's turn to paragraph 22. The second and
22 third sentences of the paragraph read as follows: This
23 describes using survey data obtained by advertising
24 through advocacy sites such as the Trevor Project or the
25 US transgender survey to anyone with an interest in the

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1 Q. But it included people who had the transition?
2 A. I cannot speak to that specifically.
3 Q. You refer to people who died as a result of
4 their efforts to transition. On what sources do you rely
5 on for that statement?
6 A. Someone who's dead can't respond to -- it's
7 just logic. A dead person can't respond to a survey.
8 Q. But are you aware of anybody who has died
9 because of the prevention of medical treatment for gender
10 dysphoria?
11 A. Surgical in particular, I know of specific
12 cases who had taken their lives.
13 Q. Taken their lives is different from dying as a
14 result of the care, isn't that right?
15 A. I would say if the patient went through with
16 care and took their lives, that that's a failure of --
17 that's related to the care.
18 Q. I understand that you would say or you would
19 find that that may be ineffective, but my question is
20 they didn't die because of the care?
21 A. I can't speak to that.
22 Q. Later on you state these databases show
23 potential correlation at best but prove no direct
24 causation. Did I read that correctly?
25 A. Yes.

1 1 proposition that any independent review board would have
2 2 halted the study?
3 3 A. By the design of the independent review boards.
4 4 Every single study that I have participated in that is
5 5 with an independent review board. The independent review
6 6 board is specifically to be independent of any
7 7 relationship with the organization or university which it
8 8 is attached to, and there is a safety committee, and
9 9 there are stopping criteria. So, if there is a death of
10 10 a patient, the study is halted and externally reviewed to
11 11 see whether or not the death is related to the procedure
12 12 that is being studied, and that's how IRBs and safety
13 13 committees are done. In ethical research those are the
14 14 protections of patients who are in clinical studies.
15 15 Q. I understand that. It still doesn't answer my
16 16 question is there any particular parameter, publication,
17 17 standards for independent review boards that you cite
18 18 that say that?
19 19 A. That's the design. Every IRB I've ever worked
20 20 with has those criteria established. That's the purpose
21 21 of them.
22 22 Q. So, what your statement then that any
23 23 independent review board would have halted the study is
24 24 really speculation. It may be informative speculation,
25 25 but it is speculation?

1 1 A. I cannot account for all the IRBs. You are
2 2 correct.
3 3 Q. In that paragraph the next sentence you state
4 4 it is flawed because regret and de-transition is known to
5 5 occur much later than two years after interventions
6 6 begin?
7 7 A. That's correct.
8 8 Q. You say that regret and de-transition are known
9 9 to occur much later than two years. When are regret and
10 10 de-transition known to occur?
11 11 A. After ten years of continuous medical and/or
12 12 surgical treatment.
13 13 Q. What literature do you cite for that
14 14 proposition?
15 15 A. That is from the DeHayne article.
16 16 Q. I thought you told me that you didn't recall
17 17 that the DeHayne article spoke about regret or de-
18 18 transition?
19 19 A. In terms of statistical numbers it did not
20 20 categorize those as I recall, but it mentions that regret
21 21 occurs after ten years. It does not give a percentile.
22 22 Q. And you didn't cite the DeHayne article in this
23 23 paragraph, right?
24 24 A. I do not believe I relatively put a reference
25 25 in at that point to the DeHayne article, no, I did not.

1 1 Q. Let's turn to paragraph 28 of your report. The
2 2 second sentence says in my experience patients were
3 3 convinced they had gender dysphoria because of the online
4 4 influence to which they were exposed. To what extent do
5 5 you refer to?
6 6 A. To what extent do I refer to?
7 7 Q. To what experience do you refer to?
8 8 A. The patients that have been my transgender
9 9 patients. Every one of them, the first thing I do in an
10 10 interview is to find out where they got information, what
11 11 were their sources, and that is published in articles I
12 12 did not cite that the websites are where patients learn
13 13 about information. They go to their phones and social
14 14 media and talk to each other. They admit that freely.
15 15 They go to see pictures. These are not things that are
16 16 daily references in their lives. Newspapers and library
17 17 reference books are not where kids go generally for
18 18 information. The most information they get is from
19 19 online sources. So, to say that that is not true is to
20 20 just not deal with reality.
21 21 Q. Of course, they couldn't look at books if they
22 22 get removed from the school libraries, right?
23 23 A. They can't look at books that do the
24 24 instructions of where to go, what hormones can be used.
25 25 I mean the school library may have an article or a book

1 1 talking about the concept of transgender and the support
2 2 and the benefits. Those are available in some school
3 3 libraries.
4 4 Q. If they are removed, they have to go online
5 5 then to try to find that information, right?
6 6 A. Most teenagers live online. So, I think they
7 7 use those influences certainly to find out something
8 8 deeper than a book that has cartooned pictures. They
9 9 want to see results, and they want -- so, they are
10 10 definitely influenced by the online presence of
11 11 information.
12 12 Q. To what literature do you cite? You mentioned
13 13 that there were some articles that you did not cite. So,
14 14 what literature is that?
15 15 A. I will be able to provide those to you. I
16 16 can't quote them from memory.
17 17 Q. But you did not include them in your report
18 18 then?
19 19 A. I did not include them in my report.
20 20 Q. These articles to which you referred to, are
21 21 they be peer-reviewed scientific studies?
22 22 A. I cannot specifically cite the article. So I
23 23 can't tell you those which were any kind of -- they're
24 24 published, and I don't know about the peer review.
25 25 Q. You later state in that same paragraph social

1 1 media now presents them with a one-size-fits-all solution
2 2 which offers acceptance and celebrity instantly. What
3 3 peer-reviewed literature do you cite for this
4 4 proposition?
5 5 A. There's no literature cited because it is a
6 6 common theme in all the patients that I see, and when we
7 7 discuss these among other people who are in the field of
8 8 gender medicine, they mention it frequently. So, it's
9 9 sort of a known background without having to look in peer
10 10 review to, -- you know, the color green is green. You
11 11 don't need a peer-reviewed journal to tell you that.
12 12 When you hear over and over again the circumstances of
13 13 the patients, their stories, it is routinely a reason.
14 14 They want to be accepted, and that gives them acceptance.
15 15 Q. Just to clarify here, when you're saying about
16 16 your patients, you mean the 20 patients you have seen in
17 17 the last 30 years, right?
18 18 A. That's correct.
19 19 Q. So, you're making your observations here based
20 20 on your knowledge from 20 people?
21 21 A. And the stories of other people in the field.
22 22 It is not an uncommon thing to discuss the reason
23 23 particularly amongst the mental health providers. They
24 24 share that information from their own clinical
25 25 experience.

1 1 Q. And, you know, you mentioned acceptance, but
2 2 you also say celebrity instant. What do you mean by
3 3 that?
4 4 A. They become to be transgendered is a very shiny
5 5 object to the patient. If they have not been accepted
6 6 but they feel they will be much more accepted and special
7 7 amongst their peers, then that is the celebrity they're
8 8 looking for. They're looking for acceptance for
9 9 something that makes them happy and different than they
10 10 are so they can be someone else. So, that is the
11 11 celebrity effect among the patients. They suddenly have
12 12 friends they never had before. They were invited to
13 13 places they had not been invited to before because the
14 14 concept of being inclusive, being all-inclusive. Instead
15 15 of being an outrider that had very few friends, they
16 16 suddenly find there are bunches of people online that
17 17 state that they are wonderful, that they are happy, that
18 18 they've chosen the right thing, and they didn't have that
19 19 beforehand. So, that's what I mean by celebrity.
20 20 Q. So, Dr. Van Meter, I'm honestly a little bit
21 21 confused by what you mean by this because I guess it's
22 22 your statement saying that some people choose to be
23 23 transgender because it's going to make them popular?
24 24 A. It makes them accepted. Yes, I am saying that.
25 25 Q. Do you know the rates of bullying and

1 1 A. Because it's easy. Nothing is ever easy. No,
2 2 I do not want to suggest such.
3 3 Q. You conclude the paragraph with this statement:
4 4 Before the advent of social media transgender teens tend
5 5 to parental support and counseling which resolved the
6 6 gender identity confusion 60 to 98 percent of the time.
7 7 Did I read that correctly?
8 8 A. You did.
9 9 Q. I imagine that you're referring to the 11
10 10 studies that we were talking about earlier, is that
11 11 right?
12 12 A. Some of the references in there, yes, Kenneth
13 13 Zucker specifically.
14 14 Q. And we established that none of the studies
15 15 were looking specifically at desistance in adolescence,
16 16 correct?
17 17 A. Not specifically in adolescence, no.
18 18 Q. And in particular you cite here to an article
19 19 by Kenneth Zucker titled the developmental
20 20 biopsychosocial model for the treatment of children with
21 21 gender identity disorder, is that right?
22 22 A. That's correct.
23 23 Q. I'm going to show you what's been marked as
24 24 Exhibit 9.
25 25 MR. GONZALEZ-PAGAN: Madam Court Reporter, I

1 1 Q. Have you seen this document before?
2 2 A. I have not.
3 3 Q. I will represent to you that it is a statement
4 4 by the American Psychiatric Association dated May 23,
5 5 2008, on the appointment of Kenneth Zucker as the chair
6 6 of the DSM-5 sexual and gender identity disorders
7 7 workgroup?
8 8 A. Yes.
9 9 Q. The fifth paragraph, do you see my cursor?
10 10 A. I do.
11 11 (Plaintiff's Exhibit No. 10 was
12 12 marked for identification.)
13 13 BY MR. GONZALEZ-PAGAN:
14 14 Q. Let me just zoom that in a little. The fifth
15 15 paragraph states for adolescent patients including those
16 16 who first came to the clinic as young children Dr. Zucker
17 17 follows the standards of care guidelines of the World
18 18 Professional Association for Transgender Health. The
19 19 treatment options include helping patients make a
20 20 satisfactory transition to the opposite sex, including
21 21 the institution of hormonal treatment to facilitate
22 22 transition. In some cases treatment may include helping
23 23 an interested adolescent obtain sex reassignment surgery.
24 24 Did I read that correctly?
25 25 A. You did.

1 1 DSM-4 was proposed and voted in and up to 2013. The
2 2 landscape changed dramatically in terms of incidents and
3 3 subsequent clinical studies. So, this is a clarification
4 4 of those concepts, and I would like to do an AV
5 5 comparison, so one by one I could say that they are
6 6 completely different.
7 7 Q. At the bottom of the table it says it should be
8 8 noted that for adolescents and adults the criteria DSM-4
9 9 TR were written in a relatively vague manner and were not
10 10 in fully polythetic format. Did I read that correctly?
11 11 A. Yes, you did.
12 12 Q. Let's go to the bottom of page 904 going into
13 13 page 905. Do you see my cursor, that last paragraph on
14 14 page 904?
15 15 A. I do.
16 16 Q. It states it was therefore argued that in DSM-5
17 17 the currently proposed A1 criterion be a necessary
18 18 symptom in making the GD diagnosis. We contend that the
19 19 presence of this symptom will, if anything, make the
20 20 diagnosis more restrictive and conservative. Given the
21 21 critiques leveled at the DSM-4 criteria it was deemed
22 22 that reduction of false positives is preferable to false
23 23 negatives. Did I read that correctly?
24 24 A. You did.
25 25 Q. So, you would agree that the changes from the

1 1 DSM-4 to the DSM-5 were just not changing the name?
2 2 A. Having seen those tables, yes, I would agree.
3 3 Q. Let's go to paragraph 33 of your report. The
4 4 second sentence starting on page 14 going into page 15 it
5 5 states the overwhelming increase in the number of
6 6 patients presenting to Tavistock is what caused the NHS
7 7 to take a deeper look at what caused the rise, and
8 8 lessening social stigma was clearly shown not to be the
9 9 cause, and then you cite to number 50 in your references,
10 10 is that right?
11 11 A. I'm sorry. I am trying to scroll down and get
12 12 where you are. We're on what page?
13 13 Q. Of course, yes. I apologize. Page 14 going
14 14 into 15. It's the sentence that starts -- do you see
15 15 that sentence?
16 16 A. I am looking for it and don't see it in the
17 17 paragraph. Is this paragraph 31?
18 18 Q. 33, 33.
19 19 A. 33, I'm sorry. My page numbers are different.
20 20 The overwhelming increase in the number of patients
21 21 presenting to Tavistock, yes.
22 22 Q. You see that the citation is to number 50 in
23 23 your reference?
24 24 A. Yes.
25 25 Q. That's a newspaper article, is that right?

1 1 cancer is going to die because there is no other option.
2 2 When there is another option, putting together an arm
3 3 that includes sterility and sexual dysfunction would not
4 4 be considered ethical, and therefore when I say no IRB,
5 5 no functioning IRB that is ethically respected would do
6 6 such a study.
7 7 Q. So, even though you call for the need for
8 8 random control trials in this context, you think that no
9 9 respectable IRB should approve it?
10 10 A. Would be likely to approve it. You know, IRB
11 11 makes that decision. I know from my experience in IRBs
12 12 and the courses that we are assigned to take in order to
13 13 do clinical research, general clinical criteria for
14 14 research, GPCs, it states that, you know, you've got to
15 15 have an IRB to be sure that ethical and safe studies are
16 16 designed and monitored. I don't know what they're going
17 17 to do in Sweden where they say that the only way patients
18 18 can get treatment is within a protocol. I don't know
19 19 what their standards are, but it would be difficult to
20 20 use an arm in a study that unquestionably takes
21 21 functioning organs, fully functioning body organs, and
22 22 removes them and causes sterility by that means and
23 23 others. These are not diseased organs to begin with.
24 24 This is not a physical condition. I'm sorry.
25 25 Q. It is a real condition. Gender dysphoria is a

1 1 real condition?
2 2 A. It is a real condition.
3 3 Q. The study that you cite with regards to
4 4 effective treatment is the one by Kenneth Zucker
5 5 published in 2012 having to do with children?
6 6 A. Children and adolescents actually so stated.
7 7 Q. But that study, that's the same study that said
8 8 that the treatment paradigm for adolescents was
9 9 different?
10 10 A. I'm sorry, I didn't understand your question.
11 11 Q. That study said that the treatment paradigm for
12 12 adolescents was different than for children?
13 13 A. Yes.
14 14 Q. In paragraph 38 of your report you conclude the
15 15 paragraph by stating in reference to the studies cited by
16 16 Dr. Olson-Kennedy no reputable editor would accept such
17 17 studies for publication in peer-reviewed journals. Did I
18 18 read that correctly?
19 19 A. No, heretofore no reputable editor.
20 20 Q. But these are peer-reviewed studies that were
21 21 published in scientific journals?
22 22 A. Yes, they were.
23 23 Q. So, is it your opinion then that the editors of
24 24 the Journal of the American Medical Association are just
25 25 not reputable?

1 1 A. They are approving things that heretofore would
2 2 not have necessarily been reported.
3 3 Q. Is that true also for the editors in the
4 4 Journal of Pediatrics?
5 5 A. Yes.
6 6 Q. Is that true then for the editors in the
7 7 International Journal of Pediatric Endocrinology?
8 8 A. Yes.
9 9 Q. Is that true then for the editors in the
10 10 Journal of Adolescent Health?
11 11 A. Yes.
12 12 Q. What about the Journal of Sexual Medicine, the
13 13 same?
14 14 A. Again, I would say that I don't know. I have
15 15 seen one article from that journal, and the one article
16 16 is well referenced front to back. It is not a mainstream
17 17 journal per se.
18 18 Q. But your opinion is that heretofore there's
19 19 just no reputable editors in any of the journals?
20 20 A. No.
21 21 Q. And these studies actually went through two
22 22 peer reviews, is that right?
23 23 A. This study being which?
24 24 Q. Well, the studies referenced by Dr. Kennedy,
25 25 Turbine, et al, 2020, Tourduf, et al., 2022, Aquila, et

1 1 al., 2020, Standard Mason, et al. 2020, Devry, et al.,
2 2 2011, Devry, et al., 2014, all of these were studies that
3 3 went through peer review, is that right?
4 4 A. The fact that they're published in those
5 5 journals would suggest they did.
6 6 Q. Let me ask you something. In your report you
7 7 make distinction, and I think you did earlier when
8 8 speaking about the standards of care published by
9 9 Dolopathy which you call them they're not true standards
10 10 of care but guidelines, you made that distinction between
11 11 standards of care and clinical guidelines, is that right?
12 12 A. Yes, I did.
13 13 Q. We talked earlier that you were deposed in 2019
14 14 in the Grimm case, is that right?
15 15 A. Yes.
16 16 Q. In that deposition you testified that one would
17 17 most likely find accepted standards of care in published
18 18 textbooks, is that right?
19 19 A. That's where they are referenced and archived
20 20 if you will, yes.
21 21 Q. I'm going to show you what's been marked as
22 22 Exhibit 13. Can you see the screen?
23 23 A. I do.
24 24 Q. This is the cover page of Lewis's Child and
25 25 Adolescent Psychiatry, a comprehensive textbook, 5th

1 1 edition, published in 2018. Is this the type of textbook
2 2 to which you refer?
3 3 A. That's a textbook that has been published, and
4 4 I referred to. I don't know if I've done it this
5 5 particular deposition, excuse me, but there's the prior
6 6 edition and this edition. I am familiar with the
7 7 contents, not specifics, but I have read both of them.
8 8 (Plaintiff's Exhibit No. 13 was
9 9 marked for identification.)
10 10 BY MR. GONZALEZ-PAGAN:
11 11 Q. Okay, let's go to the next page. Obviously,
12 12 this is an excerpt, not the entire textbook. Textbooks
13 13 are pretty big. The next page which starts on page 632
14 14 there's a chapter titled chapter 5.14 gender dysphoria
15 15 and gender incongruence. Do you see that?
16 16 A. I do.
17 17 Q. One of the co-authors of this chapter in this
18 18 medical textbook is Kenneth Zucker, is that right?
19 19 A. That is correct.
20 20 Q. Let's go to page 640 of the document. Do you
21 21 see the heading for treatment of adolescents?
22 22 A. Yes.
23 23 Q. Let me zoom a little bit more just to make it
24 24 bigger. Under that heading the first sentence reads
25 25 once children have reached puberty when gender identity

1 1 persists in the vast majority of cases and medical
2 2 intervention is often considered. Did I read that
3 3 correctly?
4 4 A. You did.
5 5 Q. Let's go to the next page. There's a heading
6 6 that reads summary. Do you see that?
7 7 A. I do.
8 8 Q. The last sentence it states for those children
9 9 who continue to have strong cross-sex identification in
10 10 adolescence pubertal blockade and cross-sex hormone
11 11 therapy to align patients' bodies with their identities
12 12 have been shown to improve mental health outcomes. Did I
13 13 read that correctly?
14 14 A. You did.
15 15 MR. GONZALEZ-PAGAN: I think this may be a
16 16 natural stopping point. Let's just take a five-
17 17 minute break. Can we go off the record?
18 18 COURT REPORTER: All right, we are off the
19 19 record at 2:23 pm.
20 20 (Off the record for a short break.)
21 21 (Back on the record.)
22 22 COURT REPORTER: All right, we are back on the
23 23 record at 2:30.
24 24 BY MR. GONZALEZ-PAGAN:
25 25 Q. Dr. Van Meter, have you spoken to anybody on

1 1 Exhibit 14. Do you see my screen?
2 2 A. Yes.
3 3 Q. This is a document titled psychotherapy for
4 4 unwanted homosexual attraction among youth, American
5 5 College of Pediatricians, January, 2016. Do you
6 6 recognize this document?
7 7 A. I do.
8 8 (Plaintiff's Exhibit No. 14 was
9 9 marked for identification.)
10 10 BY MR. GONZALEZ-PAGAN:
11 11 Q. This is one of the position statements of the
12 12 American College of Pediatricians, is that right?
13 13 A. It is an article. It's not a particular
14 14 position statement. It basically is a review of the
15 15 literature and a presentation on the subject of mental
16 16 health services provided to patients with unwanted
17 17 homosexual attraction.
18 18 Q. Page 10, do you see that there?
19 19 A. Yes.
20 20 Q. The second to last paragraph, let me ask you
21 21 this. Do you stand by the statements contained within
22 22 this document published by the American College of
23 23 Pediatricians?
24 24 A. My personal position is that therapy for
25 25 individuals who have unwanted same-sex attraction should

1 1 psychotherapy because even though it hasn't been shown to
2 2 be fully effective 100 percent of the time, it shouldn't
3 3 be banned?
4 4 A. It should not be banned.
5 5 Q. The first sentence of the second to last
6 6 paragraph, do you see my cursor?
7 7 A. Yeah.
8 8 Q. It reads no therapy, whether medical,
9 9 psychological or surgical is 100 percent effective. All
10 10 treatments have some degree of failure. In addition, all
11 11 therapies carry a degree of risk for unwanted side
12 12 effects. Did I read that correctly?
13 13 A. You did.
14 14 Q. And you agree with that statement?
15 15 A. Yes.
16 16 Q. I'm going to show you what's been marked as
17 17 Exhibit 15. Do you see my screen?
18 18 A. I can.
19 19 Q. Is that another publication of the American
20 20 College of Pediatricians, is that right?
21 21 A. Correct.
22 22 (Plaintiff's Exhibit No. 15 was
23 23 marked for identification.)
24 24 BY MR. GONZALEZ-PAGAN:
25 25 Q. It is titled homosexual parenting, a scientific

1 1 analysis, and it was published in May, 2019, is that
2 2 right?
3 3 A. That's correct.
4 4 Q. Do you stand by this document?
5 5 A. I agree with the majority of what's said in the
6 6 article.
7 7 Q. Do you agree that studies appear to indicate
8 8 ...
9 9 A. I see the sentence.
10 10 Q. Do you agree that research has demonstrated
11 11 considerable risks to children exposed to the homosexual
12 12 lifestyle?
13 13 A. Yes, I agree with that as an issue. The extent
14 14 to which can vary significantly, but the environment in
15 15 which the children live having the same-sex parenting
16 16 specifically is what the study showed that there is a
17 17 risk to the children, not the risk to being exposed to a
18 18 homosexual lifestyle and the individual and their
19 19 environment, but specifically to the parenting and
20 20 chronic residence in a household with same-sex parents.
21 21 Q. Thank you. I'm going to be asking you some
22 22 questions now. We're going to completely (inaudible) the
23 23 report now and talk a little bit about your role in the
24 24 GAPMS process and your drafting of Attachment E which
25 25 you've referenced a couple of times in today's

1 1 ADF members as long ago perhaps as six or seven years
2 2 ago. I have helped in providing input for patients and
3 3 have been asked by them to be an expert witness in cases
4 4 of child custody.
5 5 MR. GONZALEZ-PAGAN: Let's take if it's all
6 6 right, and I do believe that with the next set of
7 7 questions we should be over. So, I truly hope that
8 8 we can be out of here probably by 4:30-ish. Let's
9 9 take a five-minute break and go off the record.
10 10 DR. VAN METER: That's fine with me.
11 11 COURT REPORTER: We are off the record at 3:44
12 12 pm.
13 13 (Off the record for a short break.)
14 14 (Back on the record.)
15 15 COURT REPORTER: We are back on the record at
16 16 3:51 pm.
17 17 BY MR. GONZALEZ-PAGAN:
18 18 Q. Mr. Van Meter, I'm going to show you what's
19 19 been marked as Exhibit 28. Well before I do that, we
20 20 left off with you letting me know your communications
21 21 with the Alliance Defending Freedom, is that right?
22 22 A. Yes.
23 23 Q. You said that they go back maybe five, six
24 24 years or so?
25 25 A. Yes.

1 1 Q. In 2017 the Alliance Defending Freedom hosted a
2 2 meeting in Arizona regarding transgender issues. Were
3 3 you present at this meeting?
4 4 A. I was present at one of their meetings. I
5 5 think there was a meeting the year before, that the 2017
6 6 would have been the second or the first. I did go to a
7 7 meeting. That was the subject, but I believe it was the
8 8 second such meeting that they had had.
9 9 Q. Andre Van Mol was present at that meeting as
10 10 well, correct?
11 11 A. He was.
12 12 Q. Paul Hruz was present at that meeting as well,
13 13 correct?
14 14 A. He was.
15 15 Q. So was Patrick Lappert?
16 16 A. Yes, he was. That's when he reminded me I knew
17 17 him from the Navy days.
18 18 Q. Patrick Lappert actually has testified that one
19 19 of the topics discussed at that meeting was the need for
20 20 expert witnesses to support ADF's litigation efforts.
21 21 Was that a topic that was discussed?
22 22 A. I'm sure it was. I can't state exactly, but I
23 23 would have come away with the feeling that they wanted to
24 24 get to know who we were and get to know about us.
25 25 Q. You have not provided expert testimony. We

1 1 went through your expert testimony before. You did not
2 2 provide any expert testimony regarding transgender issues
3 3 until 2017, is that right?
4 4 A. Let me think back. I think that's correct.
5 5 Q. I'm going to show you now what's been marked as
6 6 Exhibit 28. Do you see this email?
7 7 A. I do.
8 8 Q. It is subject line Medicaid coverage for gender
9 9 affirming care, privileged and confidential. Then it has
10 10 a Bates stamp of Grossman0054, is that right?
11 11 A. That's correct.
12 12 Q. The first email is dated July 9, 2022. This is
13 13 after the hearing, is that right?
14 14 A. Yes, it would have been after the hearing.
15 15 Q. The last couple of sentences from this email
16 16 from Miriam Grossman -- well actually before I get to
17 17 that, you're a recipient of this email, is that right?
18 18 A. I'm sorry. I was what?
19 19 Q. You're one of the recipients of this email, is
20 20 that correct?
21 21 A. Yes.
22 22 (Plaintiff's Exhibit No. 28 was
23 23 marked for identification.)
24 24 BY MR. GONZALEZ-PAGAN:
25 25 Q. In the last few sentences Miriam Grossman

1 1 Van Meter. It also includes Michelle Cretella. It also
2 2 includes Gary McCaleb. McCaleb is an attorney at ADF, is
3 3 that right?
4 4 A. Yes, he is.
5 5 Q. It also includes Michael Laidlaw. It also
6 6 includes Paul Hruz. It also includes Paul McHugh. It
7 7 also includes Patrick Lappert and Roger Brooks from the
8 8 Alliance Defending Freedom, and Matt Sharp from the
9 9 Alliance Defending Freedom. Is that right?
10 10 A. Yes, it does among others.
11 11 (Plaintiff's Exhibit No. 29 was
12 12 marked for identification.)
13 13 BY MR. GONZALEZ-PAGAN:
14 14 Q. You received this email?
15 15 A. I'm sorry. Did you ask a question?
16 16 Q. You received this email?
17 17 A. Yes, I did.
18 18 Q. And the subject has to do with the Idaho Vital
19 19 Statistics Integrity Act, is that right?
20 20 A. It does.
21 21 Q. And essentially this is an email that was sent
22 22 after the act was signed into law by the governor, right?
23 23 A. I'm reading that there, yes.
24 24 Q. So, there's an email chain with you, Dr. Hruz,
25 25 Dr. McHugh, Dr. Lappert, Dr. Lehmann, Dr. Cretella, all

1 1 of them involved, right, in this advocacy effort, and
2 2 once they signed the law, you replied on March 30 God is
3 3 with us, is that right?
4 4 A. That's correct.
5 5 Q. What did you mean by that?
6 6 A. That our faith, in our religious lives we have
7 7 guidance and moral circumstances that are part of a
8 8 faith-based individual and that I felt that things went
9 9 our way. So, it's a way of stating that based on our
10 10 faith beliefs that that was the right thing that
11 11 happened, and, you know, we were looked after, and our
12 12 prayers were answered if you will.
13 13 Q. Is it fair to say that part of your advocacy is
14 14 motivated in part by your religious beliefs?
15 15 A. My whole life is motivated by my religious
16 16 faith. My medical practice, my interaction with human
17 17 beings, it is impossible to separate a concept of a moral
18 18 compass and a greater power for me to essentially thrive
19 19 in the image of what I believe is correct on the basis of
20 20 ethics and morality.
21 21 Q. Thank you. I'm going to show you the next
22 22 exhibit. That is Exhibit 30. This is another email
23 23 chain, and it's seven pages, the whole chain, but you are
24 24 among the recipients of part of the chain. This is dated
25 25 March 19, 2020. It has to do with the Idaho Vital

1 Statistics Integrity Act as well, and again among the
2 recipients are yourself, Gary McCaleb, Matt Sharp.
3 Here's your email here. Paul McHugh, Patrick Lappert,
4 Michael Laidlaw, Paul Hruz and all of you. So, this is
5 advocacy at the state legislative level about bills
6 affecting the ability to change the sex designation on
7 birth certificates as well as a bill called VCAP. What
8 is VCAP?
9 A. It's protecting children, the VCAP acronym.
10 For the moment I'm having trouble remembering it, but
11 essentially it's advocating for protecting children from
12 the harm of social, medical and surgical interventions to
13 affirm an incongruent gender.
14 (Plaintiff's Exhibit No. 30 was
15 marked for identification.)
16 BY MR. GONZALEZ-PAGAN:
17 Q. And so, deeper efforts that have been
18 introduced in various states, is that right?
19 A. That's correct.
20 Q. And you have been involved with the advocacy
21 surrounding the bills in various states?
22 A. Yes.
23 Q. Does that include with that list that you
24 testified in Alabama at least? Is that right?
25 A. That's correct.

1 1 the Eagle Forum, do you know her to be affiliated with
2 2 the Eagle Forum?
3 3 A. Yes, I believe I actually have her card in a
4 4 pile in my little card catalog if you will.
5 5 Q. Margaret Clark says that Fred Deutsch -- this
6 6 is the representative in South Dakota. She says of him
7 7 your courage to confront this growing abomination. What
8 8 do you understand the growing abomination to be?
9 9 A. I would be putting words in her mouth to know.
10 10 Clearly it's about the rise in transgender affirmation
11 11 efforts.
12 12 Q. Do you consider gender affirmation efforts to
13 13 be a growing abomination?
14 14 A. I am concerned that they are harmful. I don't
15 15 know that I would choose the word abomination. I would
16 16 say it is medical abuse. That is as strong as I would
17 17 put it because of what it does to the human body and how
18 18 it medicalizes a mental health issue and causes morbidity
19 19 for the lifetime of the patient that in many cases cannot
20 20 be undone with medical cross-sex hormones.
21 21 Q. Let's turn to the next exhibit, Exhibit 31.
22 22 This is another email. It's a chain. It's two pages.
23 23 It's a single email actually. It is dated October 30,
24 24 2019, and it is sent by Vernadette Broyles who is the
25 25 president and general counsel of the Child and Parental

1 1 Rights Campaign in Georgia. Do you recognize that?
2 2 A. I do. I recognize who she is, yes.
3 3 Q. And you are among the recipients of this email,
4 4 is that correct?
5 5 A. That's correct.
6 6 (Plaintiff's Exhibit No. 31 was
7 7 marked for identification.)
8 8 BY MR. GONZALEZ-PAGAN:
9 9 Q. It references the Georgia bill, is that right?
10 10 A. Yes, it does.
11 11 Q. And it says kudos to Quentin who makes a
12 12 powerful statement in support of this bill right out of
13 13 the starting gate, is that right?
14 14 A. That's what it says.
15 15 Q. This is about your advocacy efforts to ban
16 16 gender affirming medical care in Georgia, is that
17 17 correct?
18 18 A. Yes.
19 19 Q. Let's go to the next exhibit. This is an email
20 20 chain, three pages, and the top email is from you, and it
21 21 is dated February 4, 2020. Do you see that?
22 22 A. I do.
23 23 Q. You sent this email?
24 24 A. I did.
25 25 (Plaintiff's Exhibit No. 32 was

1 1 marked for identification.)
2 2 BY MR. GONZALEZ-PAGAN:
3 3 Q. Your email says I agree that adopting use of
4 4 cis-gender only validates transgender as a healthy
5 5 variance which it is clearly not. Did I read that
6 6 correctly?
7 7 A. You did.
8 8 Q. In your GAPMS report Attachment E you wrote
9 9 gender discordance is not considered a normal
10 10 developmental variation. Is that right?
11 11 A. There was a buzz in the middle of your
12 12 sentence. I want to make sure I hear all of it.
13 13 Q. In your Attachment E to the GAPMS report that
14 14 you authored you wrote gender discordance is not
15 15 considered a normal developmental variation. Do you
16 16 recall those words?
17 17 A. Yes.
18 18 Q. To what peer-reviewed or scientific literature
19 19 do you cite in support of your statement that being
20 20 transgender is not a healthy variant?
21 21 A. Because it is preceded by mental health
22 22 morbidity conservatively 70 percent, but in my clinical
23 23 experience 100 percent of the patients that come in. So,
24 24 it is based on a psychological concept. It is a
25 25 sociological concept. It causes morbidity. It causes

1 1 you is is being transgender in itself an illness?
2 2 A. I would say it is in the words -- and I trust
3 3 Kenneth Zucker because he is the expert in mental health.
4 4 I can't comment on the mental health issues, but when I
5 5 consult with Kenneth Zucker, he says clearly in his
6 6 personal opinion that to believe you are born in the
7 7 wrong body is a delusion. So, a delusion is a disorder.
8 8 Regardless of what DSM-5 states, you know, he is an
9 9 expert who has been following this and has been respected
10 10 for numbers of decades. If you looked at his first
11 11 bibliography, it was stated how many articles and book
12 12 chapters that he has written on the subject, and he
13 13 personally believes that the dysphoria is a sort of a
14 14 state of mind that needs to be fixed, and it needs to be
15 15 fixed by appropriate interventions that help the mental
16 16 health, and in doing so the majority of those kids
17 17 including adolescents when you talk to them in person
18 18 will benefit greatly from mental health evaluation and
19 19 treatment, and if they get to late adolescence, it's more
20 20 difficult if they have not sought, resolved their
21 21 dysphoria for them to resolve it just with counseling,
22 22 that if it persists into adulthood he sees no reason not
23 23 to use the medical and surgical interventions, but he
24 24 says the most important thing is the counseling.
25 25 Q. Is it your opinion that being transgender is

1 1 not normal?
2 2 A. Yes, I believe that is true.
3 3 Q. Is it your opinion that being transgender is
4 4 not natural?
5 5 A. It's not biologically explained. There is no
6 6 biologic basis for it, and so, if it's something that is
7 7 a state of mind in the individual and it causes them to
8 8 suffer, that's not a normal state.
9 9 Q. Is it your opinion that being transgender is
10 10 wrong?
11 11 A. No, I don't judge the patients who are
12 12 suffering from gender dysphoria. I think it is best to
13 13 get as healthy as you possibly can and to do everything
14 14 you know works to help that patient. So, I have
15 15 compassion for these kids. I know they are all
16 16 suffering, the ones that come see me. So, I treat them
17 17 as clients. They are essentially the center of my
18 18 efforts. I speak to them respectively. I do everything
19 19 I can not to be in any way offensive to the patients
20 20 because my job and my goal is to get them to get out of
21 21 the emotional distress that they are in, and that is my
22 22 focus. So, I don't say it's wrong. That would be sort
23 23 of a pejorative term and judgmental, and I don't have --
24 24 the patients themselves I have compassion for. It is the
25 25 people that are pushing the ideology where I speak

1 against.

2 Q. Let me ask you this, and I know that you have

3 limited your expert opinions to people under 18, right?

4 That's correct, right?

5 A. That's correct.

6 Q. You oppose affirmation of a person's gender

7 identity who's under 18 under any circumstances, is that

8 right?

9 A. Yes, because I don't think they can actually be

10 consented. That's the purpose is that the adolescent has

11 very limited capacity for judgment for long-term

12 consequences of short-term goals. So, knowing that I

13 want the patient to proceed to an age where they're more

14 likely to actually understand exactly what they're

15 getting into. So, that's no five-year-old, seven-year-

16 old, 13-year-old, 15-year-old, 19-year-old maybe, but 18

17 or younger, someone all the way up to age 30, but I'm

18 sticking from under age 18, they cannot wrap their head

19 around the consequences of what they are essentially

20 assenting to. So, I don't want them -- I get them to age

21 18, and I just pray that they get better. Whatever they

22 are suffering for, that their subsequent therapist will

23 be open-minded, take care of the mental morbidity as the

24 core of what needs to be done.

25 Q. Let me stick with this, and then I will follow

1 pronouns for somebody say a 15-year-old you focus a lot
2 on the impact on the family, the impact on their
3 community, the impact in their peer group. What about
4 that person? What about the impact on them?
5 A. I'm sorry, you say the impact on the doctors?
6 It sounded like that's what you said.
7 Q. No, on the adolescent who has the preferred or
8 chosen pronouns that is be inconsistent with that
9 person's assigned sex?
10 A. It makes them uncomfortable unless you explain
11 it as I have done on the advice of one of the clinical
12 counselors who gave me feedback that excuse me if I
13 forget and accidentally use incorrect pronouns. I will
14 try altogether not to say anything that uses a pronoun if
15 I can because I have a particular sense that it's not
16 healthy, but you're my client, and you know, you tell me
17 what it is that you will accept. You know, the child
18 wants something. If they don't get it, they're unhappy.
19 That's not a justification for actions by parents or
20 their environment. Wanting something and not getting it
21 makes them very unhappy.
22 Q. Well you said wanting something now, and
23 earlier in this conversation you mentioned the word
24 choice, and I want to go back to that for a second. Do
25 you believe that people who are transgender make a choice

1 1 to be transgender?
2 2 A. Absolutely.
3 3 MR. GONZALEZ-PAGAN: Let's take a two-minute
4 4 break. I just want to check that I'm done, and if
5 5 not, we're done.
6 6 MR. PRATT: Sounds good.
7 7 COURT REPORTER: We are off the record at 4:40
8 8 pm.
9 9 (Off the record for a short break.)
10 10 (Back on the record.)
11 11 COURT REPORTER: We're back on the record at
12 12 4:42 pm.
13 13 MR. GONZALEZ-PAGAN: Mr. Van Meter, thank you
14 14 for your time today. I appreciate your availability
15 15 and you answering my questions. I'm done with my
16 16 questions for today. I appreciate you being
17 17 available throughout the day.
18 18 DR. VAN METER: Thank you.
19 19 MR. PRATT: Good afternoon, Dr. Van Meter.
20 20 Thank you again for being here this afternoon. We
21 21 appreciate it.
22 22 DR. VAN METER: Thank you very much.
23 23 DIRECT EXAMINATION
24 24 BY MR. PRATT:
25 25 Q. I have just some very, very brief questions for