

# Exhibit 4

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

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4 DYLAN BRANDT, by and through his mother,  
5 JOANNA BRANDT, et al.,  
6 Plaintiffs,

vs.

CASE NO.

4:21-CV-00450-JM

7 LESLIE RUTLEDGE, in her official  
8 capacity as the Arkansas  
9 Attorney General, et al.,  
Defendants.

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VIDEOTAPED/ORAL/VIDEO CONFERENCE  
DEPOSITION OF PATRICK WALTER LAPPERT, M.D.  
TAKEN ON BEHALF OF THE PLAINTIFFS  
LITTLE ROCK, ARKANSAS  
ON MAY 6, 2022

REPORTED BY: TRENA K. BLOYE, CSR

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1 APPEARANCES

2

3

4 For the Plaintiffs:

5 SULLIVAN & CROMWELL, LLP  
 JONATHAN J. OSSIP  
 6 ALEXANDER HOLLAND  
 BRANDYN RODGERSON (Appearing via video conf.)  
 7 125 Broad Street  
 New York, New York 10004-2498  
 8 212-558-4000  
 ossipj@sullcrom.com  
 9

10 GILL RAGON OWEN  
 BETH ECHOLS  
 425 West Capitol Avenue  
 11 Suite 3800  
 Little Rock, Arkansas 72201  
 12 501-376-3800  
 echols@gill-law.com  
 13

14 ACLU OF ARKANSAS  
 GARY SULLIVAN  
 CHASE STRANGIO (Appearing via video conf.)  
 15 LESLIE COOPER (Appearing via video conf.)  
 904 West 2nd Street  
 16 Little Rock, Arkansas 72201  
 17

18 For the Defendants:

19 OFFICE OF THE ARKANSAS ATTORNEY GENERAL  
 AMANDA LAND  
 20 MICHAEL CANTRELL (Appearing via video conf.)  
 323 Center Street  
 21 Suite 200  
 Little Rock, Arkansas 72201  
 22  
 23  
 24  
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1 STIPULATIONS

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4 IT IS HEREBY STIPULATED AND AGREED BY and

5 between the parties hereto, through their respective

6 attorneys, that the videotaped deposition of PATRICK

7 LAPPERT, M.D., may be taken on behalf of the Plaintiffs

8 on the 6th day of May, 2022, in Little Rock, Arkansas,

9 by Trena K. Bloye, Certified Shorthand Reporter for the

10 State of Oklahoma, by notice pursuant to the Federal

11 Rules of Civil Procedure.

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1 VIDEO OPERATOR: Good morning. We are  
 2 with going on the record at 9:04 a.m. on May 6, 2022.  
 3 Please note that microphones are sensitive and may pick  
 4 up whispering and private conversations. Please mute  
 5 your phones at this time. Audio and video recording  
 6 will continue to take place unless all parties agree to  
 7 go off the record.  
 8 This is media unit 1 of the video  
 9 recorded deposition of Patrick Lappert taken by counsel  
 10 for Plaintiff in the matter of Dylan Brandt, et al.  
 11 versus Leslie Rutledge, et al., filed in the United  
 12 States District Court, Eastern District of Arkansas,  
 13 Central Division, Case Number 4:21-CV-00450-JM. The  
 14 location of the deposition is in the Arkansas Attorney  
 15 General's Office at 323 Center Street, Suite 200, in  
 16 Little Rock, Arkansas.  
 17 My name is Mike Tscheimer representing  
 18 Veritext. The court reporter is Trena Bloye, also  
 19 representing Veritext. I am not related to any party in  
 20 this action, nor am I financially interested in the  
 21 outcome. If there are any objections to proceeding,  
 22 please state them at the time of your appearance.  
 23 Counsel and all present, including  
 24 remotely, will now state their appearances and  
 25 affiliations for the record beginning with the noticing

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1 attorney.  
 2 MR. OSSIP: Jonathan Ossip from Sullivan  
 3 & Cromwell for the Plaintiffs.  
 4 MR. HOLLAND: Alex Holland from Sullivan  
 5 & Cromwell for the Plaintiffs.  
 6 MS. ECHOLS: Beth Echols with Gill Ragon  
 7 Owen, the Plaintiffs.  
 8 MS. LAND: Amanda Land of the Arkansas  
 9 Attorney General on behalf of the Defendants.  
 10 MR. CANTRELL: Michael Cantrell with the  
 11 Arkansas Attorney General's Office for the Defendants.  
 12 MR. STRANGIO: Chase Strangio with the  
 13 ACLU for the Plaintiffs.  
 14 MS. COOPER: Leslie Cooper with the ACLU  
 15 for Plaintiffs.  
 16 MR. RODGERSON: Brandyn Rodgeron with  
 17 Sullivan & Cromwell for the Plaintiffs.  
 18 PATRICK WALTER LAPPERT, M.D.,  
 19 after having been first duly sworn, deposes and says in  
 20 reply to the questions propounded as follows, to wit:  
 21 EXAMINATION  
 22 BY MR. OSSIP:  
 23 Q Good morning, Dr. Lappert.  
 24 A Good morning.  
 25 Q Would you please state your full name for the

Page 8

1 record?  
 2 A Patrick Walter Lappert.  
 3 Q All right. And I'm just going to go over some  
 4 ground rules before we get started. Before I do that,  
 5 Dr. Lappert, have you ever been deposed before?  
 6 A This is my second time.  
 7 Q Okay. And when was the first deposition?  
 8 A I think it was about eight or nine months ago.  
 9 Q Okay. And what case was that for?  
 10 A Folwell in North Carolina. It's a lawsuit  
 11 against the state treasurer seeking a change in policy  
 12 from the State of North Carolina concerning transgender  
 13 medicine surgery for beneficiaries of their insurance  
 14 program.  
 15 Q And were you appearing as an expert witness in  
 16 that case?  
 17 A Yes, I was.  
 18 Q And I'll go over this in a second. So one  
 19 thing is Trena is writing down everything that we say,  
 20 so it's really important that we don't overlap in our  
 21 answers and questions --  
 22 A Okay.  
 23 Q -- so that way she can get every word down.  
 24 A Sure.  
 25 Q And other than that, you said Folwell was the

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1 name of the case? I'm sorry.  
 2 A Right.  
 3 Q Other than that, no other depositions?  
 4 A No.  
 5 Q All right. So most of my questions today are  
 6 going to be asking for more detail about your expert  
 7 opinions in this case. So I'll be asking questions, the  
 8 court reporter is going to be writing it down. So, as I  
 9 said, we should avoid speaking over each other.  
 10 Similarly, all answers should be verbal, so no nods or  
 11 also uh-huh is really hard to write that down, so yes or  
 12 no for those.  
 13 My job is also to make sure that everything is  
 14 very clear today. So if I ask a question and you ever  
 15 find it unclear, please let me know and I'll try to  
 16 clarify my question.  
 17 A Okay.  
 18 Q If you don't do that I'll assume that you  
 19 understood my question, though. Fair enough?  
 20 A Sure.  
 21 Q All right. I also want to really make sure  
 22 that you are comfortable. I personally like to take  
 23 breaks every hour or hour-and-a-half or so. But we can  
 24 take a break at any point before then if you like. My  
 25 only rule is if I have asked you a question, I would

Page 10

1 like you to answer it before we take that break.  
 2 A Sure, certainly.  
 3 Q All right. And Amanda is also here  
 4 representing the State. And she may object to a  
 5 question that I ask. This is typically just a legal  
 6 thing that we work out later. So unless she instructs  
 7 you otherwise, you should still answer the question.  
 8 Okay?  
 9 A Certainly.  
 10 Q All right. Any reason, such as medication,  
 11 that you can't give truthful and accurate testimony  
 12 today?  
 13 A No.  
 14 Q All right. So you have been retained by the  
 15 Defendants as an expert witness in this case; is that  
 16 correct?  
 17 A Correct.  
 18 Q And how did you prepare for your deposition  
 19 today?  
 20 A Well, I began by reading the Complaint, I guess  
 21 it's called, and then reading other expert testimony  
 22 relating to that Complaint, and then reviewing the  
 23 references and citations that were used in the  
 24 Plaintiff's expert testimony or expert -- whatever you  
 25 call it. It's testimony I guess. Reviewing those

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1 particular journal articles, sometimes publications of  
 2 various kinds to see where the strength of the  
 3 scientific support was for the plaintiffs and then  
 4 reviewing that, and just keeping up with the current  
 5 literature in the world of transgender medicine and  
 6 surgeries.  
 7 Q You mentioned that you reviewed the other  
 8 expert testimony. Do you recall which specific expert  
 9 testimony you reviewed?  
 10 A So there was -- there was one by Dr. Turban,  
 11 and I think even a rebuttal from Dr. Turban. There was  
 12 one from Dr. Antommaria, and I think also his rebuttal.  
 13 There was one from Dr. Deanna Adkins that I reviewed. I  
 14 think that's -- those were the three.  
 15 Q Okay. Did you review any of the other defense  
 16 expert reports?  
 17 A Let's see if I did or not. Because there is no  
 18 other expert that speaks in terms of the surgical aspect  
 19 of it, so I don't remember reading the defense expert  
 20 testimony, although I might have. It's been a while.  
 21 It's been almost a year now, so.  
 22 Q Okay. But not recently?  
 23 A Not recently.  
 24 Q And did you meet with anyone in preparation for  
 25 your deposition?

Page 12

1 A Just the meetings with the attorney generals,  
 2 Mike. We had phone conversations basically about what  
 3 to expect.  
 4 Q Okay. And now I'm going to ask you just a  
 5 couple of questions about that.  
 6 A Sure.  
 7 Q But just as a -- I'm not asking ever about the  
 8 content of those conversations.  
 9 A Sure.  
 10 Q Just about when they occurred and sort of  
 11 broader nature of those. So how many phone calls did  
 12 you have with the attorney general's office in  
 13 preparation for your deposition?  
 14 A Let's see. I had one with Mike Cantrell, I  
 15 think it must have been some months ago. I do not  
 16 recall when. And then I had one last night with Mike  
 17 Cantrell and Amanda here.  
 18 Q So just to take those one by one, the first one  
 19 it was just you and Mike Cantrell?  
 20 A As I recall, yes.  
 21 Q And then last night, you, Mike, and Amanda?  
 22 A Correct.  
 23 Q Starting with the one that was just with Mike  
 24 Cantrell, how long was that phone conversation?  
 25 A I would estimate it somewhere around -- less

Page 13

1 than an hour.  
 2 Q Less than an hour?  
 3 A I'm estimating here from some time ago.  
 4 Q And approximately when was that?  
 5 A I would have to look on my calendar. I don't  
 6 know off the top of my head.  
 7 Q Was it more than a month ago?  
 8 A Yes, it was, certainly.  
 9 Q Was it more than two months ago?  
 10 A Yes.  
 11 Q Was it more than six months ago?  
 12 A It's probably right around there if I had to  
 13 take a wild guess.  
 14 Q Okay. So right around six months?  
 15 A Something like that.  
 16 Q And the one last night, nobody else on that  
 17 call other than you, Mike and Amanda?  
 18 A Correct.  
 19 Q And how long was that phone conversation?  
 20 A Half an hour to an hour.  
 21 Q And other than those two phone conversations  
 22 you had no other meetings or communications in  
 23 preparation for this deposition?  
 24 A I had one other phone call with Amanda,  
 25 actually, which I think was a week ago.

Page 14

1 Q And how long was that phone call?

2 A About a half an hour.

3 Q Okay. So you mentioned you reviewed the

4 references and citations from Plaintiff's experts, and

5 those were from the three --

6 A I believe that's correct, yeah. I don't think

7 I went to any other sources for citations.

8 Q And I will just say for Trena's benefit, if you

9 could let me finish the question.

10 A I'm sorry.

11 Q Oh, no. Everyone does it. It's so natural.

12 So, and approximately how many references and citations

13 did you review?

14 A Just ball parking, maybe a dozen of the ones

15 that were cited by the expert witnesses for the

16 plaintiff.

17 Q And no other references and citations in

18 preparation for this deposition?

19 A Very often when you're reading a journal

20 article they make citations in there that take you -- so

21 you go down a rabbit hole sometimes when you are chasing

22 down a particular argument or a particular piece of

23 evidence. So the beginning point was the citations of

24 your experts, and then at times it would lead me into

25 other -- other citations and references to look down.

Page 15

1 Q So just the experts' articles and then maybe

2 others that were cited in those?

3 A Right. That's generally how I go.

4 Q Any other documents you reviewed in preparation

5 for today?

6 A The World Professional Association of Transgender

7 Health, Standards of Care, Version 7; the Diagnostic And

8 Statistical Manual, Version 5; the "Endocrine Society

9 Consensus Statement," just review of that, mostly

10 looking for process and -- yeah, that -- that was pretty

11 much the bulk of my sources there.

12 Q So you mentioned the references and citations

13 from the plaintiff's experts, I think you mentioned the

14 Complaints, their reports, and then WPATH -- and sorry.

15 If I say WPATH, you mean the World Professional

16 Association for Transgender Health, you'll understand

17 what I mean; right?

18 A Certainly.

19 Q So you reviewed the WPATH SOC 7, the DSM V, and

20 the Endocrine Society guidelines. Is that fair to say?

21 A I think that's fair, yes.

22 Q All right. Anything else?

23 A Nothing that comes to mind.

24 Q All right.

25 A You know, I take that back, sir. Because I'm

Page 16

1 looking in the world of how transgender and plastic

2 surgery intersect I did a lot of rereading of textbooks

3 and sort of historic sources in the world of plastic and

4 reconstructive surgery to get a better sense of the

5 ethics of decisionmaking and consent, obtaining consent.

6 I did do some additional reading in terms of the history

7 of surgical -- medical-surgical consent, and then also

8 reviewed the history of transgender surgery. So that's

9 like old textbooks, we're going way back.

10 Q And were any of those textbooks or sources not

11 cited in your expert report?

12 A Whenever I -- whenever I, uh, made a claim that

13 I -- I think I cited every -- every particular authors

14 and things like that within the textbook, if it was a

15 textbook, if I recall.

16 Q Okay. How did you travel to the deposition

17 today?

18 A I drove.

19 Q And drove from home?

20 A Yes, I did.

21 Q All right. And when did you do that?

22 A Yesterday. Well, yesterday afternoon.

23 Q And you spent the night here?

24 A I did.

25 Q And is the state paying for your travel and

Page 17

1 lodging?

2 A Yes, they are.

3 Q Okay. No one else paying for that; correct?

4 A No.

5 Q Doctor, what field do you claim to be an expert

6 in?

7 A Plastic and reconstructive surgery.

8 Q Any others?

9 A Well, I have a prior board certification in

10 general surgery with a lot of trauma, critical care

11 training in there. I've also been trained in aerospace

12 medicine. I don't claim expertise in those areas

13 because it's been some years since I was in that field.

14 But the journey from general surgery into plastic

15 surgery is fairly seamless and there is a lot that goes

16 on in the world of reconstructive surgery certainly

17 where I use my general surgery training. But, yeah,

18 that's my area of expertise.

19 Q All right. So but in terms of what field

20 you're an expert in, only plastic and reconstructive

21 surgery. Is that fair to say?

22 A I think that's fair.

23 Q And looking within plastic and reconstructive

24 surgery, you have never performed any gender-affirming

25 surgeries; is that correct?

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1 A It depends on how you couch that question  
2 because there's an area of transgender surgery or gender  
3 affirmation surgery that's called top surgery that  
4 primarily concerns itself with the facial features. And  
5 I have done, for example, rhinoplasty on a -- on a  
6 person who was very evidently transitioning, so  
7 feminizing of his nose. Not a real radical operation.  
8 But, yeah, the rest of my surgeries as pertains to  
9 transgender persons has been reversal surgeries.  
10 Q Okay. So I want to take that feminizing of the  
11 nose for a second. So just to make sure I understand  
12 what you mean by that, this was someone that, I think  
13 you used the term natal or biological male into somebody  
14 who is transitioning to present and live as a woman. Is  
15 that fair to say?  
16 A Right. Natal biological male transitioning.  
17 Although, at the time he was not very out about it, but  
18 there was -- there was evidence in his medical history  
19 that that's where he was headed. And I tried to get a  
20 better sense of it, but he's very private about it.  
21 Q And you performed the surgery to feminize this  
22 individual's nose?  
23 A Right. Had a very masculine hawk-like nose  
24 that we toned down a little for him. It was not a real  
25 radical operation, but he was certainly satisfied with

Page 19

1 the results.  
2 Q Okay. And other than that, no other  
3 gender-affirming surgery?  
4 A No gender-affirming surgery. I do, for  
5 example, in my office offer sort of adjunct procedures.  
6 Like, for example, I have a number of patients who come  
7 to me for laser hair removal from their faces. So  
8 that's a person who is already socially transitioned, i  
9 fact, two people who are socially transitioned who come  
10 to me regularly for hair laser hair removal. And --  
11 Q Okay. And --  
12 A I didn't mean to interrupt you.  
13 Q No. Go ahead.  
14 A Also I see a number of patients who I'm helping  
15 manage the sequela of their hormone therapy. So acne in  
16 their skin caused by androgen medications and things  
17 like that.  
18 Q And when was this -- looking to the feminizing  
19 rhinoplasty when was that?  
20 A I would guesstimate it somewhere around 2014  
21 perhaps. That would be a guess.  
22 Q 2014.  
23 A This is a guess on my part, sir.  
24 Q And where was that?  
25 A In my office in Madison, Alabama.

Page 20

1 Q Was the patient referred to you for this  
2 procedure?  
3 A No. Self referral.  
4 Q Okay.  
5 A Then I would add, of course, he didn't present  
6 himself as seeking transition. This was a clinical  
7 judgment only my part. And his request was so  
8 relatively minor it seemed to be within the scope of  
9 something simple I could offer him.  
10 Q Okay. So you said he didn't present himself as  
11 seeking transition. What do you mean by that?  
12 A Well, he was -- he presented himself as a man,  
13 and presented himself as a man seeking a change in the  
14 appearance of his nose. But one of the things you do as  
15 a plastic surgery, particularly in the case of a man  
16 seeking a change in the appearance of their nose, you  
17 have to have some sense for what's the motivation for  
18 seeking it, because sometimes people can be struggling  
19 with severe emotional problems and they see their  
20 appearance as the reason for they are emotional  
21 problems. And so a lot of what goes into the initial  
22 consultation has to kind of address itself to the  
23 motivation of the patient.  
24 And he seemed to be well composed, his request  
25 was relatively minor, basically just taking the hump off

Page 21

1 the top of his nose, and he didn't seem to be heavily  
2 emotionally invested in it. So I didn't consider him to  
3 be in the category of body dysmorphic disorder, which is  
4 one of the things you have to be careful of, especially  
5 in men being seeking rhinoplasty. He didn't seem to  
6 meet those criteria. So he was a self referral for a  
7 cosmetic rhinoplasty.  
8 But the discovery of his transgenderism  
9 actually came later because he returned after some  
10 months complaining that I hadn't done the right  
11 operation, and then it became evident that he had been  
12 seeking a much more feminine nose. So what started out  
13 as a consultation for just a very visible and simple  
14 improvement in a nose turned out to be really a desire  
15 for a radical change that he didn't voice at the time of  
16 that visit. But it came to light when he returned for  
17 his followup that he was really seeking to transition  
18 and this was sort of his first step. So I considered  
19 that on my part a failure to detect gender identity  
20 disorder.  
21 Q And if you had been aware at the time that the  
22 purpose of his operation was a gender transition, would  
23 you have still provided the procedure?  
24 A Well, it's not so much the purpose as it is the  
25 underlying problem that he has. So what would divert me

Page 22

1 from deciding to offer him surgery is not the -- his  
 2 particular intention -- his voiced intention. It's not  
 3 his voiced index, but it's the emotional aspect that  
 4 underlies it. That's what would keep me from offering  
 5 the surgery.  
 6 Q But just to go back to my question, though. If  
 7 you had been aware at the time that his intention, I'll  
 8 put it that way, was to transition, would you have still  
 9 performed the procedure?  
 10 A Well, again, so the issue is not his  
 11 intentions. And what it would have caused me to do is  
 12 to probe more deeply to understand what his motivation  
 13 was for the transition. Because even the DSM makes a  
 14 distinction between gender identity disorder and simple  
 15 gender dysphoria.  
 16 And so in his case, because of the anger he  
 17 evidenced when he came back, it would make me incline  
 18 more towards a significant diagnosis of gender identity  
 19 disorder which I put in the category of body dysmorphic  
 20 disorder, which is really the diagnosis.  
 21 So it's not that -- it's not that I would have  
 22 declined surgery because he was seeking to transition, I  
 23 would have declined surgery because it would have been  
 24 pointing me to the more grave diagnosis of body  
 25 dysmorphic disorder.

Page 23

1 Q Okay. So just let me take a few things from  
 2 that and dig into this. So your understanding is that  
 3 in the DSM there is a distinction between gender  
 4 identity disorder and more simple gender dysphoria; is  
 5 that correct?  
 6 A The problem is it's a moving target. So -- so  
 7 it's a moving target. Since DSM IV it was gender  
 8 identity disorder, and they made a distinction between  
 9 that and body dysmorphic disorder. And then DSM III,  
 10 all of it was body dysmorphic disorder.  
 11 So over time the distinction has been made. I  
 12 don't agree with that parsing the way they do it, but  
 13 what underlies the whole thing is a form of obsessive  
 14 compulsive disorder.  
 15 Q So, Doctor, you have drawn a distinction  
 16 between gender identity and gender dysphoria. What's  
 17 the difference between those two things?  
 18 A It's a linguistic decision that the DSM writers  
 19 made before the publication of DSM V in 2013. And,  
 20 interestingly, that distinction characterizes the  
 21 problem with DSM methodology.  
 22 So the change between DSM IV and DSM V  
 23 including this distinction about gender dysphoria.  
 24 Before that it was gender identity disorder. But the  
 25 DSM V made that change in 2013. And the justification

Page 24

1 they gave for it was sort of a procedural one. But in  
 2 that same week, or the week before the DSM V came out  
 3 the National Institutes of Mental Health essentially  
 4 withdrew from the DSM project. They no longer fund it.  
 5 The largest funding agency.  
 6 It's causing me to stop and think. The largest  
 7 funding agency for mental health --  
 8 Q Doctor, I hate to interrupt you, but so my  
 9 question, however, was what distinction do you draw  
 10 between those two things, not what the DSM draws.  
 11 What distinction do you draw when you use those  
 12 two terms earlier?  
 13 A Gender dysphoria is a description of the  
 14 subjective feeling of the patient. Gender identity  
 15 disorder is perhaps a description of the underlying  
 16 psychological disturbance and more characteristically  
 17 body dysmorphic disorder. That's my distinction.  
 18 Q Do you know of any professional -- medical  
 19 professional organizations that draw that distinction?  
 20 A Between body dysmorphic disorder and gender  
 21 identity disorder and gender dysphoria?  
 22 Q Between gender identity disorder and gender  
 23 dysphoria.  
 24 A Well, the -- the APA does.  
 25 Q And that's in which document?

Page 25

1 A DSM V.  
 2 Q So in the DSM V there's a distinction between  
 3 gender identity disorder and gender dysphoria?  
 4 A Correct.  
 5 Q Okay. And you reviewed the DSM V in  
 6 preparation for your deposition today?  
 7 A A couple of weeks ago, yeah.  
 8 Q And going back to the feminizing rhinoplasty  
 9 that you performed, if it was, I think you said, simple  
 10 gender dysphoria, then you would have proceeded with the  
 11 operation if that had been your conclusion?  
 12 A In that patient? No, I would not have offered  
 13 him surgery.  
 14 Q And why is that?  
 15 A So because the -- you mean if I hadn't known of  
 16 the evident -- see, in retrospect, in retrospect I see  
 17 him as seeking something unachievable, and so I would  
 18 not have offered him surgery because it would have been  
 19 a liability to him and me both. I don't know if that  
 20 answers your question or not.  
 21 Q Sort of. What was the something unachievable  
 22 that you concluded he was seeking?  
 23 A Well, one of the characteristics of body  
 24 dysmorphic disorder is a degree of emotional investment  
 25 in the physical problem. So the underlying -- the



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1 underlying problem is the patient has a profound  
 2 psychological wound that he does not wish to look at,  
 3 but living with the psychological wound he seeks an  
 4 explanation for it. And so he will latch onto something  
 5 about his physical appearance as an explanation for the  
 6 underlying sorrow that he has. And that's what  
 7 underlies body dysmorphic.  
 8 And so you can never -- you can never reach the  
 9 depth of that psychological wound doing an operation.  
 10 It's very characteristic. And one of the  
 11 characteristics of body dysmorphic disorder is patients,  
 12 they keep coming back and keep coming back for more  
 13 surgeries --  
 14 Q Doctor, I'm sorry to interrupt. We only have  
 15 seven hours today, so I really need you to answer the  
 16 question that I ask.  
 17 A Okay.  
 18 Q Which is what is the something unachievable  
 19 that this patient was seeking in your opinion?  
 20 A Happiness.  
 21 Q And happiness was unachievable for this person?  
 22 A That was my estimation, yeah, in retrospect.  
 23 Q Nothing else unachievable that they were  
 24 seeking?  
 25 MS. LAND: Object to the form.

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1 Q (By Mr. Ossip) You can answer.  
 2 A Not that I -- not that I could perceive or that  
 3 I recall right now. But that was at the heart of it. I  
 4 could never give him the happiness he was seeking,  
 5 because he was seeking it in the wrong place basically.  
 6 That's what characterizes the problem.  
 7 Q And do you believe this individual had body  
 8 dysmorphic disorder?  
 9 A Right.  
 10 Q And also gender identity disorder?  
 11 A I only learned that in retrospect.  
 12 Q Okay.  
 13 A Yeah.  
 14 Q But at the time you performed the procedure you  
 15 didn't believe he had either of those things?  
 16 A No. I wouldn't have offered him the surgery  
 17 because it would have been unethical for me to do so.  
 18 Q And do you believe this individual had gender  
 19 dysphoria?  
 20 A In retrospect I do now, yeah.  
 21 Q So both gender dysphoria and gender identity  
 22 disorder?  
 23 A Yeah. I don't make a huge distinction between  
 24 those two things. One describes the subjective feeling  
 25 the patient has and the other one is more of a clinical

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1 diagnosis of a psychological disturbance.  
 2 Q And you would agree with the DSM V's  
 3 distinction between those two things?  
 4 A I don't agree with DSM V on a lot things and  
 5 that's among them.  
 6 Q Okay. But the DSM V does distinguish --  
 7 A Yes, it does.  
 8 Q And you also mentioned -- you also mentioned  
 9 two reversal surgeries I believe you called them.  
 10 A That's right.  
 11 Q And what were -- what were those?  
 12 A Removal of breast implants from a  
 13 20-something-year-old man who had been in Thailand and  
 14 got a top and bottom surgery in one visit and then  
 15 returned to the states, and within a year was suicidal  
 16 again. He had a sudden sort of awakening and I got a  
 17 call out of the blue from a pastor in Kansas City. It  
 18 was a: I understand you're a plastic surgeon who has an  
 19 understanding of transgender. Can I send this patient  
 20 to you?  
 21 And he was down on his luck guy, had no money,  
 22 so he came and we removed his breast implants. And,  
 23 yeah, it was kind of an interesting story there. So,  
 24 yeah, we got a removal of breast implants and then a  
 25 subsequent gynecomastectomy for the effects of hormonal

Page 29

1 therapy on the patient, yeah.  
 2 Q So you did one -- just to clarify, you did one  
 3 breast implant removal?  
 4 A Correct.  
 5 Q And no others?  
 6 A Correct.  
 7 Q And then one gynecomastectomy?  
 8 A Correct.  
 9 Q Okay. We'll come back to that.  
 10 Do you claim to be an expert in the treatment  
 11 of gender dysphoria?  
 12 A No.  
 13 Q What about healthcare for transgender people?  
 14 A Well, I mean, I've been doing healthcare for  
 15 people my whole life, so I guess it would depend on what  
 16 it is you're asking for. If it's, you know, trauma or  
 17 surgical disease of one kind or another, certainly.  
 18 And, obviously, those things we talking about earlier  
 19 that I already offer in my office.  
 20 But as far as things specific to gender  
 21 transitioning, I don't offer those services.  
 22 Q And you don't claim to be an expert in those?  
 23 A No.  
 24 Q And in terms of healthcare for transgender  
 25 people, nothing outside of plastic and reconstructive

Page 30

1 surgery that you have previously discussed here?

2 A Right. Although, I guess I would characterize

3 it this way that all of the surgeries that are involved

4 in transitioning, whether you're talking about the top

5 surgeries or the genital surgeries involve procedures

6 that I'm fully versed in and have done many times,

7 though I have never applied those specific procedures

8 to, say for example, creating an artificial phallus. I

9 have used the same flap operation for head and neck

10 reconstruction, limb salvage, that sort of things.

11 So the technology, the techniques, the

12 processes are the same. It's just the application I do

13 not do that surgery in that particular area.

14 Q So just to pin down on that, though.

15 A Okay.

16 Q Those -- but, again, you have never used those

17 techniques to perform any sort of gender-affirming

18 surgery; correct?

19 A That's correct.

20 Q Okay. Do you claim to be an expert in mental

21 health?

22 A No.

23 Q What about the treatment of minors, by which I

24 mean patients under the age of 18?

25 A Lots of experience taking care of minors.

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1 Q Do you claim to be an expert in that?

2 A Well, in certain areas of the care of minors.

3 So I have expertise, for example, in cranial facial

4 reconstruction of congenital deformities. I have

5 experience with reconstruction of congenital deformities

6 of children's hands, congenital deformities of abdominal

7 wall in children, that sort of thing, cleft pallet.

8 Q You're not a pediatrician, though; correct?

9 A No.

10 Q And you don't claim to be an expert in

11 pediatrics?

12 A I'm not a pediatricianist.

13 Q And you mentioned -- and going back to the

14 breast implant removal you said was a reversal surgery,

15 when was that?

16 A Let's see. It would have been before the

17 pandemic. It was 2017 or 2018, somewhere in there.

18 This is a guess on my part.

19 Q And what about the gynecomastectomy?

20 A In the same year, about seven -- seven months

21 later.

22 Q And you said that the breast implant was

23 referred to you; is that correct?

24 A From a -- from a priest in Kansas City. It

25 wasn't a professional referral from a doctor. It was a

Page 32

1 priest trying to help a man in distress.

2 Q And how did the priest in Kansas City come to

3 refer a patient to you?

4 A This young man just wandered into this church.

5 He had -- he had been suicidal the day before, he had

6 the pistol in his mouth, and he had this revelatory

7 event. This is his medical history, it's in his chart.

8 And rather than take his own life he had the sense that

9 there is a God, and he walked out into the street and

10 went to a church, walked in and talked to a priest who

11 happened to hear me give a presentation two years

12 previously in Denver on the subject of the care of

13 transgender persons who are in distress, and he called

14 me up and sent this young man to me. And, uh, yeah,

15 it's a miraculous thing really.

16 Q So the priest in Kansas City heard your

17 presentation in Denver and that's how that priest came

18 to know you?

19 A That's right, that's right.

20 Q And what year was presentation in Denver?

21 A I'm going to say 2015, if I have to guess,

22 2015, 2016, somewhere in there.

23 Q And was that at a conference?

24 A Actually it was sponsored by a seminary out

25 there, St. John Vianney Seminary. And it was a

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1 conference for educators and pastors on the subject of

2 care of persons who experience transgender and gender

3 dysphoria, those sorts of things.

4 Q And who was the sponsor of that presentation?

5 A I would have to look. I know it was held at

6 the seminary, the St. John Vianney Seminary. It might

7 have been the archdiocese of Denver. I'm not sure about

8 that.

9 Q And did your presentation have a name of that

10 or a title that you gave that presentation under?

11 A I think it was Catholic Anthropology and

12 Transgender Medicine or something like that.

13 Q And is that a presentation that you have given

14 in other settings?

15 A Yes. Well, similar settings, similar settings,

16 other diocese. Word gets out and other bishops and

17 priests want to hear the talk.

18 Q And how many times have you given that

19 presentation?

20 A I would just be wildly estimating somewhere in

21 the 40, 50 times over the last seven years, yeah. It's

22 a very highly demanded. Everyone wants to understand

23 transgender.

24 Q And all of those are at diocese?

25 A I'm trying to think if there are any

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1 exceptions. I think that would be -- diocese in  
 2 schools, chancery education, priest retreats, that sort  
 3 of thing, yeah.  
 4 Q So all of them in connection with the Catholic  
 5 church?  
 6 A I think so. Well, not -- I wouldn't be  
 7 absolute about that. Again, I have given the talk so  
 8 many times. I'm trying to think if there is any  
 9 other -- if it occurs to me can I come back with that.  
 10 Q You can always, if you have any change you can  
 11 always come back to that.  
 12 A Okay. Thank you.  
 13 Q Okay. Sorry. Give me one second.  
 14 A So I had it backwards.  
 15 Q Oh, is that missing --  
 16 A No, no. I had it backwards. It was  
 17 Transgender Christian Anthropology.  
 18 MR. OSSIP: Actually, I'm sorry. In the  
 19 thickness of this some pages got ripped off. I don't  
 20 know if you can move the sticker or something.  
 21 COURT REPORTER: I might be able to.  
 22 MR. OSSIP: Sorry about that. First  
 23 technical mishap of the day.  
 24 COURT REPORTER: There we go.  
 25 MR. OSSIP: Awesome. All right. Crisis

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1 averted.  
 2 (Plaintiffs' Exhibit 1 was marked for  
 3 identification and made a part of the  
 4 record.)  
 5 Q All right, Doctor. The court reporter is now  
 6 handing you another document that has been marked  
 7 Exhibit 1.  
 8 A Okay.  
 9 Q Can you flip to the second page. It should be  
 10 inside of that.  
 11 A Right. And that's the title, that's the title  
 12 of the talk.  
 13 Q And is that the presentation that you gave?  
 14 A Let's see. So this -- I'd have to -- so  
 15 November -- oh, this is when you copied it or was that  
 16 when I sent it out? 2018. This might have been from  
 17 another Denver conference.  
 18 Again, what I'll do, I have a basic talk for  
 19 audiences that we talk -- I just described to you that I  
 20 will modify based on, like, local questions or demand,  
 21 the nature of the audience, sometimes I will take slides  
 22 out and put slides in. But this is kind of a general  
 23 talk here. Yeah, this is probably the one that I gave  
 24 at Denver.  
 25 Q Okay.

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1 A Or something very close to it I would say.  
 2 Q But roughly the same --  
 3 A Roughly, yes, sir.  
 4 Q And that is the one that you gave in Denver;  
 5 correct?  
 6 A Again, I don't know if this is exactly the one  
 7 I gave in Denver. It looks like one I might have given  
 8 in Denver. Like I said, I modify it. I was just trying  
 9 to see if there was a date stamp on it. But if it  
 10 was --  
 11 Q Well, do you see the day it says -- in that  
 12 bottom corner it says Monday, November 5, 2018.  
 13 A Right. So if that's the date that I -- this is  
 14 probably a talk that I put into a pdf format that I sent  
 15 back to the organizer for distribution to the audience.  
 16 So if that's the date, this may be a different talk  
 17 given in the Denver.  
 18 Q So if you --  
 19 A Oh, there it is. That's it's. That's the  
 20 image right there.  
 21 Q Well, yeah, for the benefit of the record, can  
 22 you flip all the way to the back then. I'm sorry. It's  
 23 a little unwieldy one.  
 24 A Right. Okay.  
 25 Q And do you see the Gospel of Life Conference,

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1 2018?  
 2 A Correct, yes.  
 3 Q Yeah, go ahead.  
 4 A So this would have been a subsequent conference  
 5 in Denver obviously invited back, because I know I gave  
 6 the presentation at St. John Vianney Seminary before I  
 7 went and presented at this conference, probably by a  
 8 year or maybe more, two years, something like that.  
 9 Q Okay.  
 10 A But, yeah, that's an example how I modify the  
 11 talk for the particular audience.  
 12 Q Okay. All right. And that was -- and who was  
 13 the host of this conference?  
 14 A The Augustan Institute it looks like, FOCUS,  
 15 which is I guess the Fellowship of Catholic University  
 16 Students. And then the Gospel of Life, it's the Human  
 17 Life Apostolate at the Archdiocese of Denver, something  
 18 like that.  
 19 Q And all of these organizations are affiliated  
 20 with the Catholic Church in some way?  
 21 A Yeah, all the names I see here, yeah.  
 22 Q Okay. We can put that to the side for now.  
 23 A Okay.  
 24 Q And so -- okay. So that was -- I'm just trying  
 25 to remember how we got to that and it was because of the

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1 priest in Kansas City?  
 2 A Exactly, exactly. The miracle of Kansas City.  
 3 Q Right. So then looking to the  
 4 gynecomastectomy, how did that patient come to be in  
 5 your care?  
 6 A Same patient.  
 7 Q Oh, okay. So there is only one patient, just  
 8 two procedures?  
 9 A Correct.  
 10 Q Okay. And one was the implant removal --  
 11 A Correct.  
 12 Q -- and the other was the gynecomastectomy?  
 13 A Correct.  
 14 Q Gynecomastectomy. Excuse me.  
 15 A Very good.  
 16 Q Okay. And no other reversal surgeries?  
 17 A Correct.  
 18 Q So only one patient in your career has  
 19 presented for a reversal; correct?  
 20 A Correct.  
 21 Q Okay. And both those procedures were in the  
 22 2017 to 2018 time period?  
 23 A Yeah. They were within six or seven months of  
 24 each other. We took out his implants and just gave him  
 25 time to resolve to see how much glandular tissue he had

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1 developed, because I had no way of judging that.  
 2 All of his transitioning had been done outside  
 3 of my view so I didn't know how much was native -- or I  
 4 should say hormonally induced breast tissue and how much  
 5 of it was implant.  
 6 Q And let's see. Were both those procedures  
 7 conducted in your office?  
 8 A Yes, they were.  
 9 Q Okay. So those were both in an outpatient  
 10 setting?  
 11 A Right.  
 12 Q Okay. And going back to the feminizing  
 13 rhinoplasty -- oops, I'm so sorry.  
 14 Did you conduct any follow-up after that second  
 15 visit from that patient?  
 16 A I saw him back probably three or four times  
 17 trying to sort out his anxiety really. Because  
 18 rhinoplasty surgery, you don't actually see the final  
 19 result for about 12 months, so followup with rhinoplasty  
 20 has never been complete until it's been a year. And at  
 21 a year you take your post-operative photos, so I would  
 22 have seen him at intervals in that year.  
 23 Q And so when you say you're trying to work out  
 24 his anxiety, what do you mean by that?  
 25 A Well, he was very characteristic of body

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1 dysmorphic patients because he came back after his  
 2 surgery and in the first three months was thrilled,  
 3 ecstatic about his result and talked about how all his  
 4 friends agreed this was the best thing ever and he was  
 5 thrilled. And then suddenly -- and this is kind of  
 6 characteristic -- somewhere between about three months  
 7 and six or seven months he came back in massive distress  
 8 and despair and saying that I hadn't done the right  
 9 operation.  
 10 And that's -- the moment those words came out  
 11 of his mouth I knew that I had failed to detect what was  
 12 really underlying his -- his desire for surgical  
 13 modification.  
 14 Q So as of the last visit do you know what this  
 15 individual's gender identity was?  
 16 A How he viewed himself?  
 17 Q How this individual --  
 18 A He was still not out. He was still not out.  
 19 Q Well, I want to draw a distinction. Did this  
 20 person identify as a man or a woman or non-binary?  
 21 A Yeah, all right. So this is -- this is my  
 22 clinical assessment of what's going on there. So he  
 23 always presented himself as a man, but in the course of  
 24 his repeated visits to me he was becoming more and more  
 25 feminine in his presentation, yeah. So did he come with

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1 a diagnosis from a licensed social worker saying  
 2 transgender, no; or pediatrician referral, transgender,  
 3 no, none of those things. This is a clinical judgment  
 4 on my part.  
 5 Q But this person, this individual always used  
 6 male pronouns during your conversations with him?  
 7 A Yeah. I mean, it was always a man, yeah.  
 8 Q Okay. And never claimed to be transgender and  
 9 never claimed to be seeking a gender transition?  
 10 A Right.  
 11 Q You just had assessed that this may be his  
 12 intention?  
 13 A Correct. Well, yeah, it was becoming more  
 14 evident as he came to me through that year something  
 15 else was going on in his life.  
 16 Q And when you said you were -- I think you said  
 17 that you were assisting with anxiety. Were you treating  
 18 this patient for anxiety?  
 19 A No. It's more of the doctor-patient  
 20 relationship in trying to get him to sort of kind of  
 21 take a breath and draw back a little bit and let the  
 22 postoperative process one its course before judging the  
 23 result.  
 24 Q Did you diagnosis this patient with anxiety?  
 25 A No, it's not a psychiatric diagnosis. It's a

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1 characteristic of post-surgical patients that they will  
2 often experience anxiety about the result, whether it's  
3 reconstructive -- less so with reconstructive surgery,  
4 but certainly is the case with aesthetics patients, that  
5 at times they will have a period of anxiety that you  
6 have to help them weather.

7 Q And so did you ever refer this patient to  
8 mental health care?

9 A No.

10 Q All right. Changing topics a little bit, have  
11 you ever been approached to work as an expert witness in  
12 any other lawsuit?

13 A Yes, I have.

14 Q Which lawsuit or lawsuits?

15 A So I told you about Folwell in North Carolina.  
16 And I was contacted also by the Attorney General's  
17 Office, the State of Alabama. That's brand new. I  
18 haven't gotten a good look at that yet.

19 And then as far as lawsuits, I think Florida is  
20 in the process of asking for my help.

21 Q Okay. So you said you've been approached,  
22 aside from -- sorry, Doctor.

23 A There's also a case in Cincinnati, which is a  
24 private matter, that is a couple of years old. I  
25 haven't seen or heard from them in quite some time.

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1 Q What do you mean by a private matter?

2 A I think it's a lawsuit -- as I recall it's a  
3 lawsuit. I'd have to review. But it's not a -- it's  
4 not a litigation about a law or anything like that.  
5 It's a -- it's about a bad result I think. Or it might  
6 have actually been a child custody, yeah, injury to the  
7 family due to loss of custody of their child over a  
8 transgender issue. That's what I think it was. Again,  
9 I'm -- I'd have to pull that file up, but that's...

10 Q And you appeared as an expert witness in that  
11 case?

12 A I have not appeared, no. They just asked for  
13 expert -- what do you call it. Expert report, I guess.  
14 But I haven't been deposed, I have not appeared.

15 Q Well, did you submit an expert report in that  
16 case?

17 A Yes, as I recall I did.

18 Q And you were never deposed you said?

19 A No.

20 Q And what issues were you asked to opine on in  
21 that case?

22 A I think they were interested in my  
23 understanding of the progression of how the  
24 transitioning process works, the scientific evidence  
25 that's used in support of affirmation care. They wanted

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1 to understand affirmation care as it applies to  
2 adolescent children, what the expectations would be as  
3 far as the course of care for the child, that sort of  
4 thing.

5 Q So you were appearing in that case as an expert  
6 in affirmation care?

7 A I did not appear in that case. I -- again, I  
8 would have to refresh my memory on how they approached  
9 me. But as I it they were contacting me to explain from  
10 a surgeon's perspective how -- and -- well, essentially,  
11 how children enter into that process of transitioning  
12 and wind up in a surgical consultation, for example, top  
13 surgery.

14 Q Okay.

15 A It was a fairly limited question as I remember  
16 it.

17 Q But you submitted an expert report --

18 A I believe so, yes.

19 Q I'm sorry. Can you -- if you let me finish the  
20 question. And you signed that expert report and  
21 submitted it to the court?

22 A I would have -- I would have to refresh my  
23 memory on the extent of my participation in that case.

24 Q And when was that -- what was the timeline for  
25 your involvement in that case?

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1 A It would have been before the -- perhaps 2018,  
2 somewhere in there.

3 Q Sometime around 2018 is when the report was  
4 submitted?

5 A I think. I think so, somewhere in there.

6 Q And do you know -- well, and you said  
7 Cincinnati; is that correct?

8 A Right.

9 Q Do you know what court that was in?

10 A I do not.

11 Q Do you know if it was in state or federal  
12 court?

13 A I don't.

14 Q And you mentioned it was -- you think it was a  
15 child custody case?

16 A As I recall it, yes.

17 Q Okay. And were you retained by one of the  
18 parties in that case to serve as an expert?

19 A I'm trying to remember the attorney. Right,  
20 yes. So it was the attorney for the family. And I  
21 would have to -- I would have to dig around in my files  
22 to find the details.

23 Q Do you know if the court accepted your report  
24 in that case?

25 A I do not, no.

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1 Q Okay. And so you said you were asked to --  
 2 well, sorry, strike that.  
 3 Was the extent of your opinions in that case  
 4 limited to surgery?  
 5 A So, uh, again, I would have to review the --  
 6 what I sent to the attorney. But it had a lot to do  
 7 with how the diagnosis is made that leads to the  
 8 transition process and how the -- kind of the  
 9 decisionmaking steps that would lead a child along that  
 10 process, possibly culminating in mastectomy.  
 11 Q But you don't claim to be an expert in the  
 12 diagnosis of gender dysphoria; correct?  
 13 A No.  
 14 MS. LAND: Object to form.  
 15 Q (By Mr. Ossip) Okay. Then you also mentioned  
 16 the Folwell case. That was in North Carolina; correct?  
 17 A Correct.  
 18 Q And you were retained by the state treasurer  
 19 during that case?  
 20 A Correct.  
 21 Q And what issues were you asked to opine on  
 22 there?  
 23 A The same.  
 24 Q Okay. The same as the Cincinnati case?  
 25 A The same as this case.

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1 Q Same as this case. Okay. And you were  
 2 actually retained; correct?  
 3 A Yes.  
 4 Q And did you submit an expert report in that  
 5 case?  
 6 A I did.  
 7 Q How many reports?  
 8 A I'm trying to remember if we had a rebuttal on  
 9 that one. I think it was just the -- my initial --  
 10 there may have been a rebuttal report as well, yeah.  
 11 Q Okay. So an initial and possibly a rebuttal?  
 12 A Correct.  
 13 Q But you're not sure right now?  
 14 A Not off the top of my head.  
 15 Q And you testified in that case?  
 16 A Yes, I was.  
 17 Q Did you testify at any hearings in that case?  
 18 A I have not.  
 19 Q And have you testified at trials in that case?  
 20 A I have not.  
 21 Q Okay. Do you know if the court has accepted  
 22 you as an expert in that case?  
 23 A I think it's being debated right now.  
 24 Q And by "being debated," you mean whether or not  
 25 your testimony should be admitted as expert testimony?

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1 A Correct. The last communication I had with the  
 2 attorney was that the plaintiff's attorneys had moved to  
 3 have me removed from the expert list.  
 4 Q Okay. And that -- as far as you're aware that  
 5 motion has not been decided; correct?  
 6 A I have not heard a decision in it.  
 7 Q Okay. And you mentioned Alabama. Well,  
 8 actually, let's go back to -- I'm sorry.  
 9 When did you submit your expert report in that  
 10 case?  
 11 A Again, I'm going to guess it's going to be  
 12 about a year ago. I think it was at the -- I think it's  
 13 in the first part of 2021.  
 14 Q So when were you -- so Alabama. When --  
 15 when -- sorry. Strike that.  
 16 You were retained by the state in Alabama;  
 17 correct?  
 18 A Well, we're in the process of that. I have not  
 19 been officially yet, no, sir.  
 20 Q So you have not even signed an engagement with  
 21 the state; correct?  
 22 A I filled out some forms. But there is some  
 23 processes they keep emailing me about having to do with  
 24 payment and things they haven't ironed out yet. So,  
 25 yeah, it's one of these governmental paper chases going

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1 on. I don't know what -- it's a fairly recent thing,  
 2 because as of the date that the law passed, I think 20  
 3 minutes later they called me.  
 4 Q So 20 minutes after the law was passed, the  
 5 state called you?  
 6 A Correct.  
 7 Q And who from the state contacted you?  
 8 A I don't remember.  
 9 Q Was it someone from the state attorney  
 10 general's office?  
 11 A As I recall that, yeah. The particular person,  
 12 I don't remember. But I believe it was the attorney  
 13 general's office, yeah.  
 14 Q So had a lawsuit even been filed yet at that  
 15 point?  
 16 A No. That's what happened. The lawsuit got  
 17 filed immediately. And they immediately said, Okay,  
 18 well, let's get our experts in.  
 19 Q Well, you said -- okay. Sorry.  
 20 You said 20 minutes after the law was passed  
 21 they contacted you. But is that because within that  
 22 same 20 minutes the lawsuit was filed?  
 23 A Correct.  
 24 Q Okay. So all very fast it sounds like.  
 25 A Yes. Everybody had it sort of loaded in the

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1 fax machines, I guess.  
2 Q Okay.  
3 A Just waiting to push the button.  
4 Q Just lawyers and doctors still use fax  
5 machines; right? Let's see.  
6 Okay. But you have not actually been retained  
7 yet in that case; correct?  
8 A It's not official yet, no.  
9 Q And you have not prepared a report for that  
10 case; correct?  
11 A I -- I did write a report for them, but it was  
12 just sent as a draft. There's nothing that's been -- I  
13 just sort of sent them a draft of information for them  
14 to look over while we're working through the  
15 administrative processes. But it has not been reviewed,  
16 hasn't been edited, hasn't been finalized, nothing.  
17 Q But you prepared this draft and you were not  
18 yet engaged by the state; correct?  
19 A Yeah, I guess that's correct. I'm not sure. I  
20 guess what hasn't been completed yet is the -- I don't  
21 know. I don't understand the paperwork. I guess it  
22 would be more correct to say they have engaged me  
23 because they asked for the document, so they must have  
24 decided I'm worthy of it.  
25 Q But have you come to an agreement as to your

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1 fees in the case?  
2 A They asked me what my fees were and I told them  
3 and they didn't raise a fuss about it so -- and then  
4 they asked me for the report.  
5 Q Got it. But you're still working on the  
6 paperwork?  
7 A Yeah. I don't know what's left to be done.  
8 Perhaps it's all done.  
9 Q You haven't been deposed in that case, have  
10 you?  
11 A No.  
12 Q What about a hearing?  
13 A Nothing.  
14 Q So you have not appeared at a hearing?  
15 A Well, I appeared at legislative hearings.  
16 Q Okay.  
17 A But not at any proceedings relative to the  
18 lawsuit that's been filed.  
19 Q Okay. We'll come back to that. But nothing  
20 related to the lawsuit; correct?  
21 A Right.  
22 Q Okay.  
23 A Correct.  
24 Q And then you mentioned Florida. Who contacted  
25 you about Florida?

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1 A The office of -- I forget what they call  
2 themselves. The office that manages the state Medicaid  
3 program.  
4 Q Okay. I'm from Florida, but would not be able  
5 to tell you what that is. So the office that manages  
6 the state Medicaid, that's who contacted you?  
7 A Right.  
8 Q And when was this?  
9 A A couple of weeks ago.  
10 Q And is this about a lawsuit in Florida?  
11 A No.  
12 Q For what purpose did they contact you?  
13 A In anticipation, I guess, of what was going be  
14 to the fallout when the state of Florida determines that  
15 Medicaid funds should not be used for the transitioning,  
16 surgical or medical, of children. That was the question  
17 they were asking me about.  
18 Q So it's your understanding that this  
19 determination hasn't been made yet?  
20 A Right.  
21 Q And that if it will be made they anticipate a  
22 lawsuit and want to hire you as an expert?  
23 MS. LAND: Objection to form.  
24 A That's my understanding.  
25 Q (By Mr. Ossip) All right. So you haven't --

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1 well, strike that.  
2 Have you signed an engagement with the state in  
3 Florida?  
4 A That's one of those other ones that's in  
5 process. Everything is happening so quickly right now  
6 and they all sort of blur together, you know.  
7 Q Got it. Have you prepared a report in that  
8 case yet?  
9 A I have not. It's not a case to my  
10 understanding. They just asked me a lot of questions.  
11 Q But you have not sent them a draft report or  
12 anything?  
13 A No.  
14 Q Okay. All right. So you mentioned the child  
15 custody case in Cincinnati, the Folwell case in North  
16 Carolina, and then these preliminary cases in Alabama  
17 and Florida. No other appearances as an expert other  
18 than this case; correct?  
19 A Right.  
20 Q Okay. Has a court ever accepted your testimony  
21 as an expert?  
22 A No, not yet. As I say, the first case is the  
23 Folwell case and that's what's being contested right  
24 now.  
25 Q Understood. So, okay. So that was all

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1 lawsuits. Let's put that all to the side. Outside of  
 2 litigation have you ever served as an expert regarding  
 3 the treatment of gender dysphoria?  
 4 A No.  
 5 Q What about for surgical procedures related to  
 6 gender dysphoria?  
 7 A As directly applied to the treatment of gender  
 8 dysphoria?  
 9 Q Yes.  
 10 A No, I have not.  
 11 Q So you mentioned that you testified at a  
 12 legislative hearing in Alabama; correct?  
 13 A Several times.  
 14 Q Okay. At several different hearings?  
 15 A Right. So it's a bicameral legislature and  
 16 there were parallel bills in the house and the senate  
 17 and they had the hearings on one side. It was the  
 18 health and whatever it is department or -- committee  
 19 rather. These terminologies. And the other one was the  
 20 judiciary. So I had to testify in front of both over  
 21 the course of two years, repeat visits for bills that  
 22 have failed to move and things like that.  
 23 Q And when was the first such hearing?  
 24 A So the most recent iteration was early 2022.  
 25 And it's a short legislative session so it occurs in the

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1 early part of the year. So previous to this year, 2022,  
 2 would have been the same process in 2021, I believe it  
 3 was.  
 4 Q So --  
 5 A Testifying twice on the same day, once in 2021  
 6 and then 2022 again. I think those are the dates.  
 7 You're obviously are gleaned that I have difficulty  
 8 remembering dates.  
 9 Q No. We're just going for your best  
 10 recollection sitting hearing today.  
 11 A Certainly.  
 12 Q So but again, in 2021, we think, two times on  
 13 the same day, though; correct?  
 14 A Yes.  
 15 Q And then the same thing in 2022?  
 16 A That's right.  
 17 Q Okay. And how did you -- looking back to that  
 18 first time in 2021, how did you come to testify at those  
 19 hearings?  
 20 A An advocacy group, I think it's the Eagle  
 21 Forum, in Alabama had contacted me. I don't remember  
 22 how I came to their attention. But they sent me a draft  
 23 of the bills that they were trying to get sponsorship or  
 24 they had sponsorship for. And they asked me what I  
 25 thought and would I be willing to testify to the

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1 responsible committees that were reviewing the bills and  
 2 I said I would.  
 3 Q And do you recall who from the Eagle Forum  
 4 contacted you?  
 5 A Margaret Clark or Eunie Smith, one of those  
 6 dear women. They are just precious little people.  
 7 Q And so it sounds like you knew them before they  
 8 contacted you.  
 9 A No, no, I had never met them before.  
 10 Q But you met them both after that?  
 11 A On the day I went down there.  
 12 Q And is that the only meeting you have had with  
 13 them?  
 14 A So I made two trips down there. And the first  
 15 time there was -- it was a more drawn-out process  
 16 because they wanted me to accompany them touring around  
 17 the capital building, so it was a drawn-out process.  
 18 The second time it was very brief, I met them in the  
 19 hallway, we walked into the hearing room, bye. That was  
 20 pretty much it.  
 21 Q And both of those women are members of the  
 22 Eagle Forum; correct?  
 23 A It's my understanding, yes.  
 24 Q Okay. And is it your understanding that the  
 25 Eagle Forum had prepared the draft of the bill?

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1 A I don't know who wrote it. I know who were the  
 2 sponsors of it, but I don't know who actually crafted  
 3 the thing. I know that Eagle Forum has a legal,  
 4 obviously a very active legal department. They may have  
 5 crafted it. I don't know who.  
 6 Q And who did you understand the sponsors of the  
 7 bill to be?  
 8 A Shay Shellnutt, and he's on the house side.  
 9 And then on the senate side -- oh, gosh. It will  
 10 probably wake me up at two in the morning when I  
 11 remember his name.  
 12 Q That's okay.  
 13 A I'll call you.  
 14 Q Sounds good. But did you -- those sponsors,  
 15 did you meet with them in preparation for your  
 16 testimony?  
 17 A It was a brief. Glad you're here, need some  
 18 coffee, see you there kind of meeting, yeah. Nothing  
 19 substantive, yeah.  
 20 Q So just on that day, though.  
 21 A Yes, sir.  
 22 Q Okay. Have you testified in any other state  
 23 legislatures about this issue?  
 24 A No.  
 25 Q So only in Alabama?



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1 A Correct.  
2 Q Did you ever submit any report to any other  
3 legislatures?  
4 A I don't think I did. I think my first contact  
5 with Arkansas -- again, I'm working from poor memory.  
6 My first contact with Arkansas was after the law had  
7 been passed, so I don't think I offered anything to any  
8 legislatures besides Alabama.  
9 Q One second. I'm sorry, Doctor. Let me put  
10 this another way. Did you ever make any recommendations  
11 to any other state legislatures?  
12 A I don't remember if I did or not. I don't --  
13 there may have been somebody from Texas that I had a  
14 phone conversation with, or maybe sent some -- a letter  
15 in brief or something like that to, but I -- I don't  
16 have a clear memory of that. I've had contact with  
17 people from Texas, but I don't think it was ever  
18 anything particularly formal.  
19 Q Any other states other than Texas and Alabama?  
20 A Not to my knowledge. Not to my recollection, I  
21 should say.  
22 (Plaintiffs' Exhibit 2 was marked for  
23 identification and made a part of the  
24 record.)  
25 Q All right. So you have just been handed what's

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1 been marked by the court reporter as Exhibit 2. And if  
2 you open up and you look at that inside cover --  
3 A Right.  
4 Q -- have you seen this document before?  
5 A I have probably seen it in digital form, yeah,  
6 when I -- when I signed it.  
7 Q Okay. And that's your transcripts from the  
8 deposition that we were discussing earlier in the North  
9 Carolina case; correct?  
10 A It sure looks like it.  
11 Q And that's Kadel versus Folwell?  
12 A Have I been mispronouncing it? Is it Kadel or  
13 Kadell (phonetic)? Yeah.  
14 Q All right. Bear with me one second. And could  
15 you turn with me to page 54? And that's using the page  
16 numbers in the top right corners.  
17 A Page 54.  
18 Q Correct. And do you see the line numbers on  
19 the left side of the page?  
20 A I do.  
21 Q And if you go down to line 15 you see,  
22 Question, "You had involvement in those legislative  
23 efforts in Utah, didn't you?"  
24 Answer, "I think I made some recommendations to  
25 them, yes, I did."

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1 Does that refresh your recollection sitting  
2 here?  
3 A It does, but it doesn't bring to mind exactly  
4 what they had asked me about. But, yeah. Okay.  
5 Q Do you know if there was any report submitted  
6 to the legislature in Utah?  
7 A I don't know what -- what they produced. Let's  
8 see. I'm thinking that this was another one of those  
9 telephonic, Do you have a minute, Doc, can I ask you  
10 some questions, that kind of thing. I don't remember  
11 having any other relationship with the State of Utah and  
12 I'm pretty sure I did not submit any report to them,  
13 but, yeah.  
14 Q So if somebody submitted a report that had your  
15 name on it in that legislature, you would have never  
16 seen it; correct?  
17 A Gosh, again I'm struggling here.  
18 MS. LAND: Object to the form.  
19 A I'm struggle here. I don't know what they --  
20 what Utah has done. I haven't had any contact with  
21 anyone from Utah in a long, long time, if any.  
22 Q (By Mr. Ossip) Okay. So you may have had a  
23 phone conversation with them?  
24 A That's my -- that's about the only thing I can  
25 offer you is it must have been a phone conversation,

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1 because I don't have a file that says "Utah" on it.  
2 Q And do you know who you would have had --  
3 A No.  
4 Q Well, sorry. Strike that.  
5 And in Texas who did you have a conversation  
6 with?  
7 A Let's see. I think I spoke with a woman in the  
8 attorney general's office who we had a very long phone  
9 conversation as she was just basically picking my brain  
10 to get an understanding of the issue at hand of gender  
11 transitioning children and was just looking for my  
12 perspective on the details, so it was a long  
13 conversation about that. That conversation must have  
14 been over a year ago.  
15 Q And was that phone conversation limited to  
16 discussions of surgery?  
17 A Diagnosis of -- how the diagnosis is made by  
18 other providers and referral is then made and the  
19 absence of confirmation of diagnosis by the surgeon, the  
20 experimental nature of the interventions, those sorts of  
21 things.  
22 Q And which interventions are you referring to?  
23 A She wanted to know about all of it, so  
24 everything from social transitioning to top surgery in  
25 children.

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1 Q Do you claim to be an expert in social  
2 transitioning?  
3 A No.  
4 Q What about endocrinology?  
5 A Well, I have to -- as a -- with my background  
6 in general surgery and plastic and reconstructive  
7 surgery I have to understand endocrinology. So, for  
8 example, when I was a general surgeon, if I was going to  
9 do a thyroidectomy I would have to understand what the  
10 endocrinopathy was about and the confidence I might have  
11 in the diagnosis. So the diagnostic side of  
12 endocrinology I had to understand. I had to understand  
13 the metabolic side of endocrinology before embarking on  
14 surgery for endocrinopathic diseases, so --  
15 Q But, Doctor, sitting here today you don't claim  
16 to be an expert in endocrinology; correct?  
17 A I wouldn't offer myself as an expert.  
18 MS. LAND: Object to form.  
19 Q (By Mr. Ossip) Okay. And so you spoke with  
20 somebody from the attorney general's office. Was that  
21 about legislation that was pending in Texas?  
22 A No. And I didn't find this out until after a  
23 second conversation was the reason they were seeking an  
24 understanding of transgender medicine and surgery was  
25 because they were trying to determine if, under existing

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1 law, family law, if transgender medicine and surgery  
2 would fall under the category of child abuse. I think  
3 that's what they ultimately did. So the phone  
4 conversation was about understanding the process,  
5 understanding what transitioning is about.  
6 Q And in that conversation -- well, let me take a  
7 step back. I'm sorry.  
8 So you mentioned one conversation, a long phone  
9 call with somebody from the attorney general's office.  
10 Were there any other conversations with Texas?  
11 A No.  
12 Q Just one long phone call with the AG?  
13 A Right.  
14 Q And in the course of that phone call did you  
15 opine that providing gender-affirming medical care is  
16 child abuse?  
17 MS. LAND: Object to form.  
18 A I think the way I present it -- first of all, I  
19 generally don't like to use the term child abuse when  
20 talking in a sort of public forum about things like this  
21 because it's a terrible thing to visit upon the parents  
22 of a child who is suffering with this, so I tend to  
23 avoid the use of that term.  
24 The -- what I -- as I recall the conversation,  
25 they wanted to know the details and the expected

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1 outcomes of transitioning --  
2 Q (By Mr. Ossip) So, Doctor --  
3 A -- and possible complications.  
4 Q So, Doctor, we've really got to stick to my  
5 questions because we only have seven hours and I don't  
6 want to have to run over our time and ask to come back  
7 for a second day. Okay?  
8 So looking at the question yes or no. In the  
9 course of that phone conversation did you opine that you  
10 thought that providing gender-affirming medical care was  
11 child abuse?  
12 A It's my recollection I did not.  
13 Q You did not during that phone call? Okay.  
14 Bear with me one second, Doctor. Okay. So we  
15 mentioned Texas, Utah, Alabama. Any other states you  
16 have discussed this issue with government officials?  
17 A Not that I can recall.  
18 Q Could you turn to page 62 of that -- of the  
19 transcript? And if you go down to line 13.  
20 A Line 13.  
21 Q Correct. It says, "There may have been  
22 something in Arizona." Do you see that?  
23 A I do.  
24 Q Does that refresh your recollection at all?  
25 A Not at all.

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1 Q So you still -- you don't know, sitting here  
2 today, whether you did or did not speak to anyone in  
3 Arizona?  
4 A I do not know that.  
5 Q But you may have?  
6 A Well, apparently back a year ago I thought I  
7 might have. But there seems to be as much uncertainty a  
8 year ago as there is today.  
9 Q But, well, so sitting here today again you  
10 don't know one way or another; correct?  
11 A Correct.  
12 Q All right. How did you come to be retained as  
13 an expert in this case?  
14 A I think it was an email from Mr. Cantrell, if I  
15 had to take a guess, from the attorney general's office.  
16 I think it was an email asking if I would be -- if I  
17 could offer any help.  
18 Q And Mr. Cantrell just emailed you out of the  
19 blue?  
20 A That's my recollection.  
21 Q Okay. Nobody put you in contact with him;  
22 correct?  
23 A I did not reach out to him, no.  
24 Q And nobody that you're aware of connected the  
25 two of you?

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1 A Not that I'm aware of.  
2 Q Okay. And if I refer to something as the  
3 Arkansas law you'll understand that I mean Arkansas's  
4 Act 626, which is also known as the SAFE Act. Is that  
5 fair?  
6 A That's fair.  
7 Q Okay. And you mentioned you were only  
8 contacted after that law was passed; correct?  
9 A That's my recollection of it. I don't remember  
10 any contact before it was passed. I remember -- my  
11 recollection is that I remember hearing about it in the  
12 news before I heard anything about it from...  
13 Q And when you say you heard about it in the  
14 news, you heard about the law's passage?  
15 A That's my recollection, that I heard that first  
16 before I heard from the attorney general.  
17 Q But you did not advocate for the passage of  
18 that law; correct?  
19 A None.  
20 Q And you had no interaction with the  
21 legislature?  
22 A No.  
23 Q Did you lobby in any way for this law?  
24 A No.  
25 MS. LAND: Object to form.

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1 Q (By Mr. Ossip) Okay. And no one from the  
2 state contacted you about the law before it was passed;  
3 correct?  
4 A Not that I remember.  
5 Q Okay. All right. And you never submitted any  
6 testimony supporting the law when it was in the  
7 legislature?  
8 MS. LAND: Objection, asked and answered.  
9 Object to form.  
10 Q (By Mr. Ossip) You can answer.  
11 A Not that I remember.  
12 Q All right. Do you recall when you got that  
13 email from Mike?  
14 A It had to have been over a year ago I think, or  
15 maybe right around a year ago.  
16 Q Do you recall if that was before or after this  
17 lawsuit was filed?  
18 A I do not know that, no.  
19 Q Okay. Did you know Mike Cantrell before he  
20 emailed you?  
21 A No.  
22 Q Did you know anyone else in the Arkansas  
23 Attorney General's Office?  
24 A No.  
25 Q And when were you actually retained by the

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1 state to act as an expert in this case?  
2 A I think it was sometime over a year ago.  
3 Q But after that initial email?  
4 A Right. So the email led to, I guess, an  
5 exchange of emails. And as I remember it then the  
6 formal process began for getting my help.  
7 Q And did you sign an agreement to serve as an  
8 expert in this case?  
9 A I believe I did, yes.  
10 Q And who signed that agreement?  
11 A Besides me?  
12 Q Correct.  
13 A I do not know.  
14 Q Okay. You're not aware of anyone other than  
15 the state having signed that agreement?  
16 A I don't -- I don't remember it. I saw some  
17 official signature there, but I don't remember who that  
18 might have been.  
19 Q What did the lawyers for the state ask you to  
20 do in this matter?  
21 A To review the -- to review the Complaint, to  
22 review mostly the expert witnesses, and to offer an  
23 expert opinion on the evidence, my perspective on the  
24 value of the evidence.  
25 Q Any particular issues they asked you to provide

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1 your expert opinion on?  
2 A The initial request was just for a general  
3 overview. The subsequent one related to the rebuttal  
4 asked me to focus more specifically on the surgical  
5 issues.  
6 Q Okay. So when you say the rebuttal, what do  
7 you mean by that?  
8 A After I submitted my expert report there was a  
9 time, a couple of months that passed, and then they sent  
10 me the rebuttals by the three -- the three rebuttals  
11 that we spoke about earlier.  
12 Q The plaintiffs' experts you mean?  
13 A Correct, yeah.  
14 Q Okay. Did counsel for the state provide you  
15 with any other materials to consider?  
16 A None, no.  
17 Q So just the three plaintiff expert reports?  
18 A Yeah, that's my recollection of it. There was  
19 the Complaint and then their expert reports and then I  
20 got copies of the rebuttal.  
21 Q And when was all this?  
22 A Well, the -- the initial documents would have  
23 been sometime, I guess, shy of a year ago. And then the  
24 rebuttals probably came in six months later, because the  
25 whole cycle of me writing my opinion on my expert

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1 report, and then the -- them reviewing them, the  
 2 rebuttals coming back.  
 3 Q Okay. Were you ever instructed to express a  
 4 particular opinion in this case?  
 5 A No.  
 6 Q How did you reach your opinions in this case?  
 7 A Well, the -- my opinions on transgender, the  
 8 issue of transgender medicine surgeries has been a --  
 9 has been an evolving process since I was a resident in  
 10 training. But more recently in this particular case,  
 11 again, as we talked about, the review of the citations  
 12 that the expert -- the plaintiffs' experts submitted,  
 13 review of their merits, review of the of associated  
 14 citations, review of the WPATH Standards of Care, DSM,  
 15 all of those things together, that's what formed my  
 16 opinions, plus my -- my background in plastic and  
 17 reconstructive surgery, issues related to the ethics of  
 18 consent, the issues related to the ethics of surgical  
 19 decisionmaking.  
 20 Q Did anyone instruct you to review or include  
 21 any particular sources in your opinions?  
 22 A No.  
 23 Q Who determined the scope of the matters covered  
 24 in your report?  
 25 MS. LAND: Objection. Form.

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1 A I did.  
 2 Q (By Mr. Ossip) No one else?  
 3 A No one.  
 4 MR. OSSIP: All right. Let's take a  
 5 break here. I'm told we only have ten minutes left on  
 6 this tape.  
 7 VIDEO OPERATOR: All right. This will  
 8 end video part 1 and we are going off the record at  
 9 10:25 a.m.  
 10 (A break was had.)  
 11 VIDEO OPERATOR: We are back on the  
 12 record at 10:41 a.m. This will begin media part 2.  
 13 Please proceed.  
 14 Q (By Mr. Ossip) All right. Thank you. And  
 15 welcome back, Doctor. So earlier we were talking about  
 16 your phone conversation with the attorney general's  
 17 office in Texas. In that discussion did you recommend  
 18 anything to them?  
 19 A I don't remember making any recommendations. I  
 20 remember it as a sort of information-seeking phone  
 21 conversation from their office, more of a conversation  
 22 what might be possible areas to look.  
 23 Q So it's your testimony that you made no  
 24 recommendations during that phone call?  
 25 MS. LAND: Objection; form.

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1 A That's my recollection of that conversation.  
 2 Again, it's over a year ago.  
 3 Q (By Mr. Ossip) Did you tell -- during that  
 4 phone conversation did you opine that gender-affirming  
 5 medical care is always harmful to minors?  
 6 MS. LAND: Objection to form.  
 7 A I don't remember ever giving that opinion. Ask  
 8 me the question again. I might not have understood it  
 9 correctly.  
 10 Q (By Mr. Ossip) Yeah. During that phone  
 11 conversation did you opine that gender-affirming medical  
 12 care is always harmful to minors?  
 13 A Transgender-affirming medical care. That's my  
 14 opinion, yes, it is.  
 15 Q Do you support Texas's decision to investigate  
 16 parents for child abuse if they provide what you just  
 17 described as transgender-affirming medical care to their  
 18 children?  
 19 A I don't support that at all.  
 20 Q So you don't support that Texas did?  
 21 MS. LAND: Object to the form.  
 22 A I don't support the idea that parents should be  
 23 prosecuted for following the advice of physicians.  
 24 Q (By Mr. Ossip) Well, do you support -- strike  
 25 that. Do you believe that children should be removed

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1 from the custody of their parents if their parents are  
 2 offering -- or are providing their children with  
 3 gender-affirming medical care?  
 4 MS. LAND: Objection; form.  
 5 A I generally do not -- I generally do not -- I  
 6 mean, it has to be some pretty severe issue to remove a  
 7 child from their parents. And most of what's happening  
 8 in this area that we're talking about today does not  
 9 rise to that level at all.  
 10 Q (By Mr. Ossip) Okay. And I know that you said  
 11 before you don't like use using the term child abuse in  
 12 public settings. But do you believe it is child abuse  
 13 to provide gender-affirming medical care to minors?  
 14 A I believe it's abusive to the child and the  
 15 family.  
 16 Q And in that case the abuser would be the  
 17 doctors providing the care?  
 18 A Right.  
 19 Q Did Texas ask you to be an expert?  
 20 A No.  
 21 Q Do you believe that doctors should be charged  
 22 with child abuse for providing gender-affirming medical  
 23 care to minors?  
 24 A I wouldn't necessarily use the term child abuse  
 25 because we have other similar laws that -- doctors don't

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1 get charged for child abuse if he prescribes anabolic  
 2 steroids to a young athlete. Technically it isn't abuse  
 3 to the body of that child. But generally it's not  
 4 called child abuse. It's called, you know,  
 5 misprescribing and pill rolling and various other things  
 6 that doctors do. This is kind of in that category.  
 7 It's medical malpractice, not child abuse.  
 8 Q So you believe it's medical malpractice to  
 9 provide gender-affirming medical care to minors?  
 10 A I do.  
 11 MS. LAND: Objection to form.  
 12 Q (By Mr. Ossip) All right. We'll come back to  
 13 that. Let's move on.  
 14 Did you work with anyone else in preparing your  
 15 reports or testimony in this case?  
 16 A No.  
 17 Q Did you work with the state?  
 18 A No.  
 19 Q So every word of your report was written by  
 20 you?  
 21 A Yeah, the whole thing was written by me. It  
 22 went through, I guess, an editing process in terms of  
 23 spelling and punctuation kind of issues like that and it  
 24 came back as a -- as a -- in the format of a legal  
 25 brief, which I then signed and submitted, yeah. But I

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1 composed the whole thing.  
 2 Q Okay. So, and the editing process you mean  
 3 that counsel for the state was editing; correct?  
 4 A Right. Yeah, punctuation and spelling and  
 5 paragraph numbering and things like that.  
 6 Q Did anyone other than counsel for the state  
 7 edit your report?  
 8 A No.  
 9 Q Did you have any research assistance in  
 10 preparing your report?  
 11 A None.  
 12 Q How are you compensated in this case?  
 13 A Hourly and travel.  
 14 Q And you have listed your hourly rate in your  
 15 report; correct?  
 16 A Yes, I did. I think it's on the first page.  
 17 Q Okay. And that is still the rate that you  
 18 receive?  
 19 A Correct.  
 20 Q How much have you billed to date in this case?  
 21 A Somewhere around \$17,000.  
 22 Q And, now, best estimate what's the total amount  
 23 of time you've spent on this case, whether you have  
 24 billed for it or not?  
 25 A I don't know, 50, 70 hours. I'm -- that's --

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1 that's a -- I don't know where that number came from,  
 2 but -- it might actually be more than that. You know,  
 3 when --  
 4 Q So definitely more than 50 hours?  
 5 A I guess. I don't know. I'm so lax about that  
 6 that, you know, I'll find myself reading about something  
 7 and I didn't mark my little log and I'm two hours into  
 8 some paper somewhere. I try to be punctual about  
 9 timekeeping, but --  
 10 Q So do you expect to receive any additional  
 11 compensation in connection with your reports?  
 12 A None.  
 13 Q Okay. All right. So now I'm going to do a  
 14 brief name association exercise so bear with me. But  
 15 I'm just going to ask if you know who the following  
 16 people are. So the first one is Dr. Steven Levine.  
 17 A Right. I don't know him personally but he's a  
 18 psychiatrist I believe, pediatrics psychologist or  
 19 psychiatrist. Is that right?  
 20 Q Just going from what you know.  
 21 A Oh, okay.  
 22 Q And do you know if Dr. Levine is an expert for  
 23 the state in this case?  
 24 A I think he might be, yeah.  
 25 Q But you're not sure?

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1 A Not right -- sitting here right now, no.  
 2 Q Okay. And you've never met Dr. Levine?  
 3 A I don't think I have.  
 4 Q What about Dr. Paul Hruz?  
 5 A Right, I know Dr. Hruz.  
 6 Q And where do you know Dr. Hruz from?  
 7 A I first met him at an ADF conference. We were  
 8 both presenters. He came and gave an hour-long talk on  
 9 pediatric endocrinology, and I gave a similar talk on  
 10 plastic surgery and transgender.  
 11 Q Okay. And --  
 12 A And I've seen -- you know, we're now friends.  
 13 Q Before that conference you did not know him?  
 14 A No.  
 15 Q Okay. And by ADF, do you mean the Alliance  
 16 Defending Freedom?  
 17 A Correct.  
 18 Q Sorry. Just trying to make things go a little  
 19 faster today. Okay.  
 20 When did you first become familiar with ADF?  
 21 A Wow, that was some years ago. And essentially  
 22 what it was -- I didn't know who they were, but I got an  
 23 invitation to come down and give a presentation. And so  
 24 it was, you know, down in Arizona and the first time I  
 25 had met or heard of any of it was walking into their

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1 building and meeting an attorney named Jeff -- I'll  
2 think of his last name. Jeff something. And going into  
3 a large conference room and giving my presentation.  
4 Q And that was at the ADF headquarters building?  
5 A It must be. It was a lovely place and it was  
6 in Arizona. I think --  
7 Q Do you know where in Arizona?  
8 A Phoenix? I don't know. It all kind of looks  
9 the same down there to me.  
10 Q I think Arizona is beautiful.  
11 A No, it is beautiful. It's all developed about  
12 the same time so it's hard to judge Phoenix from Tucson  
13 sometimes.  
14 Q Sure. And when was that conference?  
15 A Again, it may be in 2016 or '17, just a wild  
16 guess there.  
17 Q Okay. And you said you -- you didn't know ADF  
18 before you got that invitation.  
19 A No.  
20 Q Do you know who or -- strike that.  
21 Do you know how ADF came to invite you to this  
22 conference?  
23 A I don't know who they talked to. Again, since  
24 I give the talk so frequently in various venues around  
25 the country, somebody might have heard of it or maybe

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1 seen a recording of it.  
2 Q Okay. That's helpful. So just to get the  
3 timeline right, this is after you started giving the  
4 presentation we discussed earlier?  
5 A I suspect it was, because that's really kind of  
6 when a larger public audience was asking for the talk.  
7 Q Okay.  
8 A Again, the first several times I gave it was in  
9 very small groups of priests and religious educators and  
10 things like that.  
11 Q And before that conference you had never met  
12 Dr. Hruz; correct?  
13 A That was the first time I met him, yes.  
14 Q And what did you discuss at the conference?  
15 A Well, so the conference was organized kind of  
16 as a -- as an information gathering visit. There was a  
17 variety of speakers. Paul Hruz talked about  
18 endocrinology. I talked about plastic surgery.  
19 There was a presentation on pediatrics. There  
20 was a presentation on psychology, psychiatry. There was  
21 a presentation on -- there might have been a  
22 presentation on law, but I'm not positive about that.  
23 Yeah.  
24 Oh, there were a couple of people there who  
25 were -- that lived the experience of transgender. There

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1 was a young man named Hasci Horvath who works for the  
2 University of San Francisco, he manages their medical  
3 information processes and the guy is a genius  
4 remembering papers and authors and years and findings.  
5 But he had the lived experience of transitioning  
6 himself, and so he talked about his experience.  
7 Q And you mentioned people with the lived  
8 experience and being transgender. Was there anybody  
9 else other than Hasci Horvath?  
10 A There was a trans female there from Asia. And  
11 I'm trying to remember her name. But I believe she was  
12 residing in Thailand, but was an author, ran a -- some  
13 web blog or something about it. Again, the lived  
14 experience, fully transitioned transgender female.  
15 Q And by that you mean that she identified as a  
16 woman?  
17 A Oh, in every respect, yeah, fully. And had  
18 been living as a trans female for probably 25 years, had  
19 undergone surgery in the late 80s or 90s somewhere in  
20 the southwest. Might have been a transgender surgeon in  
21 Colorado or Arizona that had done her surgeries. Yeah,  
22 definitely.  
23 Q Do you know who Mark Regnarus is?  
24 A I have heard his name and I think I have read  
25 some articles by him.

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1 Q Do you know if Mark Regnarus was at that ADF  
2 conference in Arizona?  
3 A I don't know. I don't think -- I don't know.  
4 It doesn't ring a bell.  
5 Q But he could have been there?  
6 A I don't know.  
7 Q You wouldn't disagree if somebody else said he  
8 was there; correct?  
9 A I wouldn't have any basis for disagreeing.  
10 Q What about Dr. Levine?  
11 A I know there was a psychiatry, psychology  
12 presentation, but I can't remember who it was. So if  
13 you were to tell me that Dr. Levine was at that  
14 conference I wouldn't argue with you about it. But we  
15 didn't -- I didn't talk with him individually. Maybe  
16 that's the reason I don't remember. I don't know.  
17 Q And how many people total were present at that  
18 conference?  
19 A A ballpark guess, maybe a dozen.  
20 Q And how many of those gave presentations?  
21 A I think everybody there was there to give a  
22 presentation.  
23 Q And I think you had mentioned you were invited  
24 by an attorney. Did the attorney give a presentation?  
25 A I think just sort of an introduction. Hi,

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1 welcome aboard, this is the issue we're looking at, this  
 2 is kind of the conflicts in the greater society that  
 3 we're seeing, if you need anything, I'm here kind of  
 4 thing, yeah.  
 5 I do not remember him -- he might have given  
 6 another presentation. Gosh, it was so long ago. He  
 7 might have given another presentation on the law. He  
 8 might have been the one who gave that presentation. It  
 9 might have been another attorney that was there by the  
 10 name of Gary McCaleb.  
 11 Q And if Gary McCaleb was there, do you know if  
 12 he gave a presentation?  
 13 A I think he did. I think he gave a  
 14 presentation, yeah.  
 15 Q Okay.  
 16 A I'm almost confident he did, because he brought  
 17 to light the fact that he was a Navy veteran and I've  
 18 got 24 years in the Navy. I think we had a conversation  
 19 over lunch about that.  
 20 Q At that meeting were you asked to serve as an  
 21 expert witness in cases about transgender issues?  
 22 A No.  
 23 Q You were never asked?  
 24 A No one asked me.  
 25 Q Okay. Was the group -- was the entire

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1 conference asked?  
 2 MS. LAND: Objection to form.  
 3 A That -- I mean, that might have been what Gary  
 4 McCaleb was talking about or maybe the attorney Jeff, I  
 5 will remember his name, talking about maybe some sense  
 6 that they had that there might be future legal issues  
 7 and that you might be called upon to give your expert  
 8 opinion, but there was no invitation to give a  
 9 particular -- you know, to a particular case or a  
 10 particular legal issue. It was probably more like, you  
 11 know, being a witness in a -- a very complicated public  
 12 issue is. I think that's what it was about.  
 13 Q (By Mr. Ossip) Was one of the topics at that  
 14 conference the difficulty in identifying expert  
 15 witnesses who are willing to testify in these cases?  
 16 A I -- not to my recollection, no. There -- I  
 17 know there was a lot of commiserating about how few  
 18 people there are willing to speak publically against  
 19 transgender medicine and surgery. I know that was a  
 20 case, because one of the people that was there -- yeah,  
 21 okay.  
 22 So one of the people that was there at that  
 23 conference was a plastic surgeon himself who had lost  
 24 his job -- he was the chief of plastic surgery.  
 25 Q I just want to keep it to answering my

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1 questions.  
 2 A Well, but to your question about whether --  
 3 Q My question is yes or no. At that conference  
 4 was it discussed -- was one of the topics of discussion  
 5 the difficulty in identifying expert witnesses who are  
 6 willing to testify in this case?  
 7 MS. LAND: Objection to form.  
 8 Q (By Mr. Ossip) In these cases. Excuse me.  
 9 A It was not a matter of formal presentation.  
 10 Again, it was just a private discussion between people  
 11 who were there.  
 12 Q And were people at that meeting asked whether  
 13 they would be willing to participate as expert  
 14 witnesses?  
 15 A I don't remember that question.  
 16 Q Okay. Can you turn to page 90 of the  
 17 transcript in front of you?  
 18 A Certainly.  
 19 Q Do you see on line 19 where it starts, "I  
 20 remember." "I remember a fairly long discussion about  
 21 the poverty of people who are going to testify because  
 22 of the risk they take in testifying."  
 23 Was that your testimony in the Kadel case?  
 24 A Right. And that speaks to what I was starting  
 25 to relate to you in my answer. I think that was a

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1 conversation among the people who attended the  
 2 conference. I don't think it was as a formal  
 3 presentation. I think that was a conversation we were  
 4 having.  
 5 Q And can you turn to page 91?  
 6 A Certainly.  
 7 Q And do you see, Question, and people -- this is  
 8 on line 6.  
 9 Question, "And people at that meeting were  
 10 asked whether they would be willing to participate as  
 11 expert witnesses; right?"  
 12 Answer, "Yes."  
 13 Was that your testimony?  
 14 A I guess it was.  
 15 Q And do you see where you said, "Before that  
 16 meeting you had never testified as an expert witness?"  
 17 Answer, "Before this moment I never testified  
 18 as an expert witness."  
 19 Was that by "this moment," you mean in Kadel;  
 20 correct?  
 21 A Correct.  
 22 Q And again, you never testified in any other  
 23 cases; correct?  
 24 A No.  
 25 Q No hearings as an expert witness?

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1 A Other than the legislative hearings we talked  
2 about earlier.  
3 Q But no court hearings.  
4 A Correct.  
5 Q Correct?  
6 A Correct.  
7 Q Okay. At that conference did you offer to be  
8 an expert witness in cases involving transgender issues?  
9 A I don't remember. Evidently my recollection of  
10 that event is not as strong as I --  
11 Q Do you know if anyone else offered to be an  
12 expert witness in transgender issues?  
13 A I don't remember.  
14 Q You don't remember whether Paul Hruz did?  
15 A I remember a willingness on his part, but I  
16 don't remember him saying that he would or anything like  
17 that. Again, I don't remember the question being asked.  
18 Q But he expressed a willingness?  
19 A We all expressed a willingness, yes.  
20 Q Including you?  
21 A Oh, yes, absolutely, absolutely. It wasn't --  
22 I don't remember it being asked of us, but in our  
23 conversations we all expressed a willingness to offer  
24 our expert opinions on the issue.  
25 Q Did anyone present not express a willingness?

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1 A I don't remember.  
2 Q Did the ADF play any roll in your becoming an  
3 expert witness in this case?  
4 A No.  
5 Q Okay. So you mentioned there was a conference  
6 in either 2016 or 2017 and that was in Arizona possibly.  
7 Have you attended any other of ADF conferences?  
8 A So there was two visits to ADF. And the --  
9 they are all sort of muddled together as to who was  
10 there which time. I started to tell you about the other  
11 plastic surgeon. I was trying to remember if I met him  
12 on the first visit down or the second visit down. And,  
13 yeah, so...  
14 Q Well, so there were two visits. Do you recall  
15 when the second visit was?  
16 A I don't. It had to have been at least a year  
17 after that first one I would think.  
18 Q At least one year after?  
19 A I'd guess, yes. It seems some time had elapsed  
20 since we were there before.  
21 Q Outside of those two conferences have you had  
22 any other contact with ADF?  
23 A An occasional email, I think, from Gary McCaleb  
24 sending a link to an article, some scientific  
25 publications, that sort of stuff. Just sort of chatter

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1 in an email string. That's about it.  
2 Q And all additional communications is with  
3 emails with Gary McCaleb?  
4 A Yeah. That's -- it's been onesies, twosies  
5 over the last couple of years. I can't remember the  
6 last time I got anything from him actually.  
7 Q Okay. But, well, outside of those two  
8 conferences have you had any contact with anyone  
9 associated with ADF other than Gary McCaleb?  
10 A That's the only ones I can remember.  
11 Q And did ADF play any role in your becoming an  
12 expert witness in any other case?  
13 A No, I don't think so.  
14 Q What about before your testimony in the  
15 legislature in Alabama?  
16 A No.  
17 Q What about your conversations with any other  
18 state?  
19 A Not to my knowledge, no.  
20 Q Okay. Is the ADF a scientific organization?  
21 MS. LAND: Objection to form.  
22 A My understanding is that they are a legal --  
23 they certainly have a very strong Christian bent,  
24 evangelical kind of thing. But I think they are  
25 primarily a legal organization.

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1 Q (By Mr. Ossip) And so you said they had a  
2 strong evangelical bent. Would you describe them as a  
3 religious organization?  
4 MS. LAND: Objection to form.  
5 A No. I only say that because there is very few  
6 offices that you go into that have a chapel. Right?  
7 Q (By Mr. Ossip) Okay. So when you walked in  
8 there was a chapel?  
9 A Right, exactly.  
10 Q Okay. That would make sense. And do you know  
11 if they describe themselves as a ministry?  
12 A I don't know. I don't know.  
13 Q Would it surprise you?  
14 A I know that one of the founders is a fellow  
15 named Bill Bright, and he has -- he definitely speaks  
16 ministerially, but I don't know if they officially  
17 describe themselves as a ministry.  
18 Q Got it. Okay. Okay. Perfect.  
19 All right. Let's go back to the names. So  
20 next person, do you know who Dr. Roger Hiatt is?  
21 A Hum. I've read the name somewhere. I  
22 couldn't -- I couldn't tell you where.  
23 Q But you've never met Dr. Roger Hiatt; correct?  
24 A I don't believe I have.  
25 Q And you're not familiar with Dr. Hiatt's work?



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1 A If I was to maybe see his work I'd go, "Oh,  
2 yeah, I remember reading this." But I have a very hard  
3 time linking names with particular documents.  
4 Q I see. But right off the top of your head, you  
5 don't know?  
6 A I don't know.  
7 Q And I think actually I want to go back to  
8 professor Mark Regnarus. Have you met professor  
9 Regnarus?  
10 A I mean, if he was at that conference I probably  
11 met him, but I don't remember meeting him.  
12 Q Got it. But -- well, let me put it another  
13 way. So putting aside the conference, never met him  
14 outside the conference?  
15 A Not that I remember.  
16 Q Okay. And are you familiar with professor  
17 Regnarus' work?  
18 A I remember reading some things that he's  
19 written, but I couldn't tell you exactly what. But if  
20 you were to put it in front of me I would probably raise  
21 my eyebrows and go, "I remember reading this."  
22 Q And what about Dr. Hruz, are you familiar with  
23 his work?  
24 A I read a lot of the things he's written, yes, I  
25 do.

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1 Q Okay. And before that ADF conference have  
2 you -- did you -- strike that.  
3 Before the ADF conference had you ever read any  
4 of Dr. Hruz's work?  
5 A No.  
6 Q Okay. Are you familiar with someone named  
7 Christine Cryer?  
8 A It does not come to mind.  
9 Q What about Billy Burleigh?  
10 A Billy Burleigh. Have I seen that name as an  
11 online -- is it one of these influencer people? I'm not  
12 sure. It's one of those remote things. I'm not sure.  
13 Q So may have seen that name on the internet  
14 somewhere?  
15 A Perhaps, yeah. Maybe that's where I remember  
16 it from.  
17 Q But never met Billy Burleigh?  
18 A I don't remember meeting Billy Burleigh.  
19 Q And Billy Burleigh wasn't at that ADF  
20 conference to the best of your knowledge?  
21 A Now you have got me thinking that the person  
22 from Thailand might have had that name. I don't know.  
23 That was too long ago for me.  
24 Q But you're not sure?  
25 A I'm not sure.

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1 Q Could you have been, could have not been?  
2 A I'm not sure.  
3 Q What about Walt Heyer?  
4 A I know Walter Heyer very well.  
5 Q Where do you know Walter Heyer from?  
6 A Where did I first meet Walter? I don't  
7 remember where I first met him. It may have been at one  
8 of those ADF conferences actually. But, yeah, wonderful  
9 person.  
10 Q And what did Walt Heyer present on the ADF  
11 conference?  
12 A His lived experience. And I can't remember if  
13 it was the first one or the second conference that he  
14 was there.  
15 Q So it could have been different presenters  
16 between the two conferences?  
17 A Oh, there were. Well, there was sort of a mix  
18 and match. Like I intimated before, there was a plastic  
19 surgeon and I had never met another plastic surgeon that  
20 spoke publically on the issue. He may have been at the  
21 second meeting. There was Hasci Horvath that presented  
22 at one of them. There was Walt Heyer that presented at  
23 one of them. I don't know which, first or second.  
24 Q Have you interacted with Walt Heyer outside of  
25 the ADF conference?

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1 A Yes, I have.  
2 Q How so?  
3 A Let's see. Walter was at one of the times we  
4 testified at the Alabama legislature, he was there for  
5 one of those.  
6 Q Okay. And that was on one of those two --  
7 A Right.  
8 Q -- double committee days?  
9 A Correct, yes. And there was a little social  
10 gathering at somebody's restaurant that had been sort  
11 of -- was catering a little visit there.  
12 Q And that was after the testimony?  
13 A Yeah, that was in the evening.  
14 Q And who was at that social gathering?  
15 A Walter and myself and some people from Eagle  
16 Forum and some legislators that were there. I don't  
17 remember who else.  
18 Q And would those legislators have included the  
19 sponsors of the bill?  
20 A That would make sense, you know.  
21 Q Okay. And what about Laura Perry?  
22 A Laura Perry? I don't remember. That may be  
23 the -- that may be the woman from Thailand. The mystery  
24 woman from Thailand. It's so long ago.  
25 Q Okay. But, well, unlike Walt Heyer though --

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1 well, let me put it another way. Are you aware of any  
2 contact with anyone named Laura Perry outside of,  
3 perhaps, the ADF conference?  
4 A I don't remember. I don't remember any such  
5 contact.  
6 Q Okay. And just going back to Walt Heyer, so  
7 you mentioned you might have seen him at ADF.  
8 A No. I definitely saw him at ADF.  
9 Q Oh, definitely saw him at ADF.  
10 A Yeah. I just couldn't remember whether it was  
11 the first or second conference.  
12 Q Okay. That helps. And then at one of the two  
13 dual committee meetings. Any other interactions with  
14 Walt Heyer?  
15 A I may have seen -- well, it wouldn't surprise  
16 me to remember that he was at some other presentation on  
17 the subject to some other group, possibly even one of  
18 the Catholic presentations I have done. He gets a lot  
19 of requests because of his sex change regret website and  
20 people are always visiting him with invitations. I know  
21 we have crossed paths multiple times. I can't remember  
22 the circumstances of all them.  
23 Q You mentioned a website. Do you know what that  
24 website addresses?  
25 A Walter Heyer's?

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1 Q Correct?  
2 A Sexchangeregret.com I think it is, yes, .com.  
3 Q And have you visited that website?  
4 A Once or twice, mostly just to find contact  
5 information to get ahold of Walt.  
6 Q Got it. And so aside from meetings or  
7 conferences do you stay in touch with Walt?  
8 A I mean, we're not in regular communications.  
9 Just the occasional email, I hear we're going to be in  
10 Montgomery, look forward to seeing you there. Let me  
11 drive your car. He loves my car.  
12 Q But just social then?  
13 A Right. Well, I mean, as social as -- the topic  
14 that brought us together always comes up.  
15 Q Do you discuss research with Walt?  
16 A With Walt it's mostly discussions of the  
17 suffering he encountered all the time and we commiserate  
18 about that because I encounter suffering in my own  
19 practice and he encounters it in his contact with people  
20 who are struggling with their identity.  
21 Q How often do you -- well, strike that.  
22 Actually, I think we can move on.  
23 MR. OSSIP: Can I get three?  
24 (Plaintiffs' Exhibit 3 was marked for  
25 identification and made a part of the

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1 record.)  
2 Q (By Mr. Ossip) The court reporter is handing  
3 you Exhibit 3. Take a look at that and see if you  
4 recognize that document.  
5 A It appears to be my expert report --  
6 Q All right.  
7 A -- in this Arkansas case.  
8 Q All right. And do you stand by this report as  
9 written?  
10 A Yeah, the several times I have read it I didn't  
11 find any -- any discrepancies. I'm much more careful  
12 about that because there was a discrepancy in my report  
13 that I didn't catch and so -- I become a lot more  
14 guarded when lawyers ask that question.  
15 Q Got it. I'm not trying to play gotcha.  
16 A No. It always calls to my own fallibility so I  
17 always go slowly here. Yeah, this looks like it.  
18 Q You mentioned there was a discrepancy with your  
19 report. Which report are you referring to?  
20 A Kadel.  
21 Q Oh, your report in the Kadel case?  
22 A Yeah. They jumped on a discrepancy that was  
23 there that I didn't catch that I should have caught.  
24 Q Understood. But you believe that discrepancy,  
25 if any, was corrected in this case?

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1 A Oh, there was no such discrepancy in this case.  
2 Q Okay.  
3 A It had to do with the way they titled the thing  
4 that was not correct.  
5 Q I see. Can you elaborate on that, please?  
6 A Right. So whenever I present my credentials --  
7 Q Um-hum.  
8 A -- I always -- among the things I talk about in  
9 addition to my education is my board certification. So  
10 board certified in general surgery, board certified in  
11 plastic and reconstructive surgery, recertified in  
12 plastic and reconstructive surgery, and I always include  
13 the dates.  
14 I let my plastic surgery board certification  
15 lapse in the year I retired from surgery. And so -- but  
16 I'm -- the way they titled the document was board  
17 certified in plastic surgery. He jumped all over that,  
18 he said, "You're not board certified in plastic surgery,  
19 are you?" I said, "Well, no. I have been board  
20 certified in plastic surgery twice and I just let it  
21 lapse because I'm retired."  
22 Q Got it. And so when you present your  
23 certifications you always put an end date on those?  
24 A I always put the end date on it and I always  
25 speak of it in the past tense.

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1 Q Okay. And so in your -- everywhere it appears  
2 in your report you put an end date; correct?  
3 A I certainly strive to do that, yes, I do.  
4 Q Okay. Any -- and so you stand by every word of  
5 this report, then, just to be clear for the record.  
6 A Yes.  
7 Q Okay. That was my one gotcha. All right.  
8 Including the attachments, if any?  
9 A So the attachments would include what?  
10 Q I believe it's just your CV.  
11 A Okay. Yeah, I stand by that.  
12 Q Okay. Anything that you would like to amend or  
13 correct?  
14 A Not that I -- not that I found the several  
15 times I've read it.  
16 Q When did you first become familiar with the  
17 research that you've cited on the treatment for gender  
18 dysphoria?  
19 A Which particular citation?  
20 Q Well, let me put it another way. When did you  
21 first start reviewing research related to the treatment  
22 of gender dysphoria?  
23 A Oh, well, I remember reading some publications  
24 by a surgeon at, I think it was at UVA, which in the 90s  
25 when I was in training was one of the few places

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1 offering transgender surgery. I remember reading some  
2 report. I remember reading the original publications by  
3 Sir Harold Gillies in the post-second world war. So it  
4 goes -- this is a running thing that I've been doing,  
5 along with a lot of other topics in plastic surgery that  
6 I kind of keep a tab on.  
7 But in earnest I would say 2014 when I started  
8 digging into it much more aggressively.  
9 Q And what prompted that much more aggressive  
10 digging?  
11 A I was at a -- I was at a courage Conference at  
12 Villa Nova University, and there was a breakout session  
13 for ordained clergy, of which I am, I'm an ordained  
14 deacon in the Roman Catholic church. And I went to a  
15 breakout session.  
16 And during the course of the breakout session a  
17 priest there opined that one day the Roman Catholic  
18 church will catch up to the science and we will accept  
19 human sexuality as existing on a broad spectrum. And I  
20 asked him if he had any access to the particular science  
21 that would support that position, he did not. And then  
22 I opined from my experience what I knew, you know, based  
23 on what we discussed earlier.  
24 And at the conclusion of that the organizer of  
25 the conference said, you know, this is an important

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1 topic, deacon Lappert, would you mind putting together a  
2 talk on transgender medicine and surgery, so that  
3 started a much more -- a much deeper dive into the  
4 literature.  
5 Q And was that -- well, let me put it another  
6 way. Would you consider that the origin of the  
7 presentation we discussed earlier?  
8 A The first iteration of this presentation was a  
9 presentation to a clergy retreat day about seven months  
10 after that courage conference.  
11 Q And who organized that clergy retreat day?  
12 A The diocese in Birmingham, Alabama.  
13 Q And is that the diocese for which you are a  
14 deacon?  
15 A That's correct.  
16 Q And what is Courage?  
17 A Courage is a Catholic apostolate that serves  
18 persons who experience same sex attraction who are  
19 seeking to live a chaste life.  
20 Q And are you affiliated with Courage in any way?  
21 A I'm a chaplain for Courage and I am on the  
22 board of directors.  
23 Q Okay. And what do you do as a chaplain for  
24 Courage?  
25 A Lately not much because COVID really took the

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1 wind out of the sails. But generally what a chaplain  
2 does is we run meetings. The meetings are generally  
3 arranged like AA meetings, similar kind of a setup, but  
4 it's informed by Catholic prayer life and Catholic  
5 theology. We meet anonymously like AA. I sort of  
6 referee the meeting, I guide it in prayer, we kind of  
7 establish friendship, a community, and bear one  
8 another's burdens in the struggle for chastity.  
9 Q And what do you know by chastity in this  
10 context?  
11 A The chastity is living an authentic life and  
12 loving other people the way Jesus Christ would love  
13 them.  
14 Q And with respect to persons with same sex  
15 attraction, what does that mean?  
16 A It means the same thing as it means for  
17 anybody. In terms of what chastity asks of us, it  
18 doesn't matter if you're same-sex attracted,  
19 heterosexual, it doesn't make any difference. Chastity  
20 is chastity. It expresses itself differently whether  
21 you're married or single or a priest. But chastity is a  
22 form of authentic love. So it asks of me the same thing  
23 it would ask of somebody who is experiencing same-sex  
24 attraction all their life. It is the same demand.  
25 Q And what is that demand?

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1 A Well, the demand is that the love of others  
2 rather than the use of others. And to live an integral  
3 life means to understand the role that sexual expression  
4 has in that life.  
5 Q Well, let me put a -- so just -- but any  
6 same-sex sexual encounter would be the use of another in  
7 that context; correct?  
8 A Well, but it's not peculiar to same-sex  
9 attracted persons.  
10 Q Well, when is sex not the use of another?  
11 A When it's --  
12 MS. LAND: Objection to form.  
13 A Well, that's going to be a difficult one.  
14 That's going to be a difficult one because it's kind of  
15 an individual thing --  
16 Q (By Mr. Ossip) I see.  
17 A -- that may be fleeting. I think the point of  
18 the -- the point of me defining chastity that way is to  
19 recognize that what -- the love we're called to when I  
20 said that we're called to love as Jesus loved, it's to  
21 love sacrificially, self-sacrificing the love and to  
22 help people to develop that capacity.  
23 What chaste love is something we learn in  
24 preadolescence and adolescence and it's something we  
25 carry with us through our whole life assuming that it

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1 hasn't been wounded somehow.  
2 Q But to just put an even finer point on it,  
3 having same-sex sexual encounters would not be chaste;  
4 correct?  
5 MS. LAND: Objection, form.  
6 A Well, it would -- yeah, that's right, by  
7 definition. Just as having sex outside of marriage  
8 would not be chaste. Just as having, you know, marital  
9 or sexual relations with a sibling. Right? There is  
10 all kinds of forms of abuse, but it's -- and they are  
11 not all of equal importance, but they are all not  
12 chaste.  
13 Q (By Mr. Ossip) I see. And so is a same-sex  
14 sexual encounter is abuse then?  
15 MS. LAND: Objection to form.  
16 A No. You mischaracterize my word. Abuse is a  
17 form of non-chastity, but there are other kinds of  
18 non-chastity. Your question was about chastity. So,  
19 uh --  
20 Q So you said -- I'm just going to read back what  
21 you said.  
22 A Okay.  
23 Q You said, Just as having, you now, the marital  
24 sexual relations -- well, you said -- I asked the  
25 question, "Just putting a finer point on it, having

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1 same-sex sexual encounters would not be chaste;  
2 correct?"  
3 And then you answered, "Well, it would, yeah,  
4 that's right by definition, just as having sex outside  
5 of marriage would not be chaste. Just as having, you  
6 know, marital sexual relations with a sibling. Right?  
7 These are all kinds of forms of abuse."  
8 A Oh, I'm sorry. So the last example was a form  
9 of abuse. But all of the examples were a form of  
10 non-chastity.  
11 Q Okay.  
12 A I guess that's the correct way to put it.  
13 Thank you.  
14 Q Okay. And when did you become a chaplain for  
15 Courage.  
16 A In -- let's see. Sometime in 2014 I believe.  
17 I think it was in 2014.  
18 Q Was that before or after that conference?  
19 A Which conference?  
20 Q Oh, sorry. Was that before or after the  
21 conference at Villa Nova?  
22 A No. I had become a chaplain before the -- I  
23 mean, I'm sorry. Wait a minute. That's tough. So I  
24 was ordained in 2013. The Villa Nova conference I think  
25 was in the summer of 2014, and I think I had already

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1 become -- no, it might have been the following year.  
2 Sorry.  
3 I think when I went to Villa Nova I was already  
4 a chaplain. It may have happened after I was at Villa  
5 Nova that I became a chaplain. In fact, I can be  
6 certain about that.  
7 Q That it happened after the --  
8 A I think so, yeah.  
9 Q Okay. How did you come to be invited to the  
10 Villa Nova conference?  
11 A I -- let's see. I met Father Paul Check at a  
12 retreat at Casa Maria in Birmingham in 2014. And Father  
13 Paul Check invited me up to Villa Nova. At the time  
14 Father Paul Check was the executive director of Courage  
15 and he was the retreat master, and we met and had a lot  
16 of things in common and he was kind of inviting me into  
17 the work based on that meeting at that retreat.  
18 Q And that retreat in Birmingham, was that  
19 affiliated with Courage also?  
20 A Yeah. That was a regional retreat. The  
21 Southeast Retreat that happens every spring around --  
22 well, the week before Easter, yeah.  
23 Q And you attended that in your capacity as a  
24 deacon of the --  
25 A I had just been ordained.

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1 Q Okay.

2 A I had just been ordained. And one of the -- of

3 the women religious there said, Hey, Dr. Lappert, you're

4 a doctor and a deacon now. I have a brother who is a

5 doctor and a deacon. I'd like you to come down and meet

6 him.

7 Q And that just happened to be at this --

8 A Correct, correct.

9 Q Okay. Serendipity. All right. And when did

10 you join the board of directors of Courage?

11 A Let's see. Probably about five years, maybe

12 four years ago. I think they are three-year terms and

13 I'm just -- it's my second term.

14 Q And does the board have any other name other

15 than board of directors?

16 A No, that's it.

17 Q Okay. And how many directors are on the board.

18 A Well, so I'm a non-voting member. There are

19 two of us. And then there -- and it's -- the priests

20 that are on the board that are voting members, I think

21 there is four of them. And then there is a -- so

22 somewhere around seven?

23 Q Okay. And so going back to our discussion of

24 chastity, a same-sex sexual relationship within a

25 same-sex marriage could not be chaste also; correct?

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1 A Right.

2 Q Okay. And why is that?

3 A Because of the nature of sexual relations in

4 same sex acts. So -- so in the eyes of the church

5 sacramental marriage is a different thing from the

6 public civic, civil sort of thing. So the civil

7 relationship under law is not determinative of that, you

8 know.

9 Q So it's because a same-sex marriage would not

10 qualify as a sacramental marriage under the law of the

11 church; correct?

12 A Yeah, it's not -- it can't, yeah, exactly.

13 Q And so that's why it's not chaste?

14 A I believe that's why.

15 Q Any other reason?

16 A I think that's the heart of it there, yeah.

17 Q Okay. So if canon law were changed to permit

18 same-sex marriages in the eyes of the church, those

19 same-sex marriages would then be chaste; correct?

20 MS. LAND: Objection to the form,

21 relevance.

22 A Well, my understanding of canon law is that it

23 cannot violate essential church teachings. So your

24 hypothetical is unimaginable because it's not constant

25 with what the church teaches about marital relations.

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1 The sacrificial relationship between a man and woman,

2 that is a life-giving event. So because of the fact

3 that same-sex sexual relations are not life giving --

4 that's my understanding of it anyway.

5 Q (By Mr. Ossip) And those teachings couldn't

6 change?

7 A I don't think so. I'm not a canon lawyer, but

8 that's my understanding of it. So if you're asking me a

9 hypothetical, that would be my hypothetical answer.

10 Q Well, and let me ask another hypothetical then.

11 If there is essential teachings -- excuse me -- were

12 changed such that a same-sex marriage is permitted

13 within the eyes of the church, would then that

14 relationship be chaste?

15 A Right. I mean, if there was some way, but what

16 you're proposing is also an impossibility, because that

17 particular teaching is based on immutable things, the

18 nature of the human person as the church understands it.

19 MR. OSSIP: Can I get four?

20 (Plaintiffs' Exhibit 4 was marked for

21 identification and made a part of the

22 record.)

23 Q All right. Court reporter has handed you

24 what's been marked Exhibit 4. Do you recognize this

25 document?

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1 A It looks like my rebuttal to the expert.

2 Q All right. And do you stand by that as

3 written?

4 A I do.

5 Q Okay. Any inaccuracies you would like to

6 correct?

7 A Not that I have found.

8 Q And have you changed your opinions since you

9 signed these reports?

10 A Not substantively, no.

11 Q What about non-substantively?

12 A Well, I mean, some of the things have changed,

13 like the determination -- I believe I talk about it in

14 here, the determination by the Swedish medical board has

15 become much more final in terms of suspending, offering

16 transgender medicine and surgery to adolescents, you

17 know, minors. So where I think when I wrote this it

18 wasn't as -- it was -- looks like they are headed in

19 that direction. Now since then it's definitely they

20 have ceased.

21 Q But your opinion hasn't changed?

22 A It has not, no.

23 Q Just the evidence?

24 A Right.

25 Q Okay. Do you intend to provide any opinions in

Page 110

1 this case other than what you said in your reports?  
2 A No.  
3 Q All right. You also submitted a declaration  
4 opposing the Plaintiff's motion for a preliminary  
5 injunction in this case; correct?  
6 A I don't know what that means.  
7 Q Okay. Well, let me help you out.  
8 A Okay.  
9 Q Probably should have started with the document.  
10 (Plaintiffs' Exhibit 5 was marked for  
11 identification and made a part of the  
12 record.)  
13 Q All right. So take a look at that, what's been  
14 marked --  
15 A I'm trying to see how that --  
16 Q Exhibit 5.  
17 A Okay. So this is what -- so I have actually  
18 written three different things. Okay. Whew.  
19 Q But you do recognize that document now?  
20 A Yeah. I mean, all the content of it looks like  
21 my words, absolutely. So obviously I had something --  
22 this was the first and then this is the second and this  
23 is the rebuttal. Okay.  
24 Q And you stand by that document as well;  
25 correct?

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1 A Uh, yes.  
2 Q Okay. All right. And you wrote all -- looking  
3 at all three of these documents, you wrote every word  
4 yourself; correct?  
5 A Right, yeah. No, nobody has written anything  
6 for me.  
7 Q You physically typed every word?  
8 A Yeah.  
9 Q All right.  
10 A I get no help.  
11 Q And what do you -- okay. Well, if we look at  
12 that, the Declaration, that's Exhibit 5, which you were  
13 just handed.  
14 A Okay.  
15 Q And if we can go to paragraph 11, which they  
16 are numbered on the left side.  
17 A I see that.  
18 Q And you look, this is the second sentence of  
19 paragraph 11, and you say, "All opinions are offered to  
20 a reasonable degree of medical certainty." Do you see  
21 that?  
22 A I do.  
23 Q And what do you mean by a reasonable degree of  
24 medical certainty?  
25 A Well, the fact that I cannot -- I cannot make

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1 a -- any -- any -- well, some of it, I cannot make a  
2 statement of absolute certainty in some instances there  
3 as to, you know, like probability of complications or  
4 likelihood of favorable or unfavorable outcomes. That's  
5 kind of generally what you're talking about when you  
6 talk about scientific medical evidence, is that it's  
7 contingent upon the quality of your data, contingent  
8 upon the quality of your interpretation of the data,  
9 contingent upon some things that are not necessarily  
10 within my control. So reasonable degree of medical  
11 certainty.  
12 Q Okay. Well, is everything you say in your  
13 reports to a reasonable degree of medical certainty?  
14 MS. LAND: Objection to form.  
15 A I think so, yeah.  
16 Q (By Mr. Ossip) Okay. And in your declaration  
17 also?  
18 A I think so. I try to be reasonable.  
19 Q But, well, so when you define that, you put  
20 that in terms of uncertainty; correct?  
21 A Right. I -- I point to the fact that depending  
22 on the evidence -- the source of the data, depending on  
23 the quality of the scientific data you are getting it  
24 will affect the level of certainty. So we find that is  
25 certainly the case with offering surgery to -- to

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1 parents and children, you have to -- you cannot speak  
2 with -- in 100 percent anything. You have to be able to  
3 present to them what's the likelihoods.  
4 Q So let's look just to the opinions that you've  
5 offered in this case.  
6 A Okay. All right.  
7 Q To what degree of certainty do you offer those  
8 opinions?  
9 A Reasonable.  
10 Q And how certain is that?  
11 A Gosh, I guess certain enough for me to write it  
12 down and have citations and support it with reasoned  
13 arguments and scientific evidence wherever I can find  
14 it.  
15 Q But you didn't have anything in particular in  
16 mind in terms of certainty level?  
17 MS. LAND: Objection to form.  
18 A With respect to the overall -- this overall  
19 document, no. I can only -- I can only speak  
20 specifically in specific cases of particular citations.  
21 Q (By Mr. Ossip) Okay.  
22 A So if you're asking me if I cite a particular  
23 document to support a particular opinion, then I can  
24 offer you some level of certainty. But in the  
25 generality of this document I can only say reasonable.

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1 Q Okay. Do you still perform surgery?  
 2 A I retired a year ago.  
 3 Q Okay. And is that the last time you performed  
 4 surgery?  
 5 A Right.  
 6 Q One year ago from today?  
 7 A More or less, yeah.  
 8 Q Okay. And I'm just going to ask you a few  
 9 procedures and ask if you ever performed them. Okay,  
 10 Doctor?  
 11 A Okay.  
 12 Q Have you ever performed a mastectomy?  
 13 A Many times.  
 14 Q Breast reduction?  
 15 A Many times.  
 16 Q Gynecomastectomy?  
 17 A Many times.  
 18 Q Chest masculinization?  
 19 A Never.  
 20 Q Breast augmentation?  
 21 A Many times.  
 22 Q Chest feminization?  
 23 A Never.  
 24 Q And for all the ones that you said you  
 25 performed many times, do you believe you are qualified

Page 115

1 to perform those procedures?  
 2 A Very much so.  
 3 Q What about for chest masculinization?  
 4 A It's the same operation. It's the -- they only  
 5 differ in terms of the subject. So for example a  
 6 chest --  
 7 Q Sorry. I just want to keep us on track.  
 8 MS. LAND: No. Hold on, objection.  
 9 You're not letting him explain his answer. And you have  
 10 cut him off a couple of times and you're using his  
 11 testimony from a previous case and you're also using  
 12 that to follow up on some of the answers that you're  
 13 cutting off, so I'm going to you object to you cutting  
 14 him off.  
 15 MR. OSSIP: I'm going to object to the  
 16 speaking objection and ask you to answer the question,  
 17 which is are you qualified to perform chest  
 18 masculinization. Yes or no, Doctor.  
 19 THE WITNESS: Yes.  
 20 Q (By Mr. Ossip) Okay. Are you qualified to  
 21 perform chest feminization? Yes or no.  
 22 A Yes.  
 23 Q All right. You would agree that all of the  
 24 procedures we just discussed are very safe; correct?  
 25 A Yeah. In terms of surgical risk, yes. Yes,

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1 absolutely.  
 2 Q Okay. Do you consider yourself an expert in  
 3 medical ethics?  
 4 A I would consider myself very experienced in  
 5 medical ethics.  
 6 Q Do you hold yourself out as an expert in  
 7 medical ethics?  
 8 A I do not.  
 9 Q What about bioethics?  
 10 A I do not.  
 11 MR. OSSIP: Okay. Should we take a break  
 12 here?  
 13 VIDEO OPERATOR: All right. This will  
 14 end media part 2. We're off the record at 11:36 a.m.  
 15 (A break was had.)  
 16 VIDEO OPERATOR: We are back on the  
 17 record at 11:52 a.m. This will begin media part 3.  
 18 Please proceed.  
 19 Q (By Mr. Ossip) All right. Welcome back again,  
 20 Doctor.  
 21 A Thank you.  
 22 Q Doctor, how do you define the term transgender?  
 23 A So transgender is a condition, human condition  
 24 where there is dissonance between biological sex, the  
 25 objective biological sex and the subjective perception

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1 of gender.  
 2 Q And that's what you mean when you say  
 3 "transgender" in your report; correct?  
 4 A Yes.  
 5 Q All right. And your opinions in this case are  
 6 only offered in connection with that definition of the  
 7 term transgender; correct?  
 8 A I think so.  
 9 Q You use the term "gender confused" or "gender  
 10 confusion" interchangeably with the word "transgender";  
 11 is that correct?  
 12 A Well, in the case of children I do, yeah. It's  
 13 a different situation in adults. But the -- it's -- it  
 14 was -- the matter we're talking about here is the  
 15 experience in children, preadolescent and adolescent  
 16 children. So because it's such a changeable thing and  
 17 has evidenced changed over time, then, yeah, I use it  
 18 primarily when I'm talking about children, gender  
 19 confusion.  
 20 Q But you don't use that term in connection with  
 21 adults?  
 22 A Generally, no. Generally in adults there is no  
 23 confusion anymore. The dysphoria may persist,  
 24 obviously, but the confusion is usually fairly settled  
 25 by the time they are adults.

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1 Q And what do you mean by the confusion is  
2 settled?

3 A Well, they don't think about if they are male  
4 or female any longer. They have made a determination  
5 for themselves that they are -- now, it doesn't mean  
6 it's not going to change. It just means that they are  
7 not confused about it. There is clarity somehow in  
8 their lives that they have hit on something.

9 Q So, well, let me -- so is it your opinion that  
10 all children who experience gender dysphoria are gender  
11 confused?

12 A Hum, that's a challenging question there. Part  
13 of the problem in children -- and I have talked to, you  
14 know, quite a few children about it. They are sort of  
15 typically in a stage of formulating their story,  
16 formulating their words and so that can be very -- so  
17 typically they are confused, but some of them are more  
18 clear, perhaps, than others. It's not a black or white  
19 thing.

20 Generally in adolescence there is some level of  
21 confusion whether they are transgender or not. They are  
22 confused about themselves, confused about where they are  
23 headed in life, and certainly sexual matters confusion  
24 is a common thing, less common as adults.

25 Q And so it's your opinion that there is sort of

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1 a spectrum where confusion tends to be reduced as a  
2 person ages; is that correct?

3 A Generally, yeah. It's not a certainty, but  
4 generally there is less confusion as time goes on.

5 Q So it is not your -- well, let me put it this  
6 way. You'd agree it's not the case that anyone who  
7 claims to be transgender is actually just confused about  
8 their gender?

9 A No, I wouldn't make a blanket statement that  
10 all persons who are a transgender are confused.

11 Q Okay. Is it possible to have a gender identity  
12 that differs from a person's sex assigned at birth?

13 A All right. I'm going to take issue with that  
14 term because that doesn't make sense to me. Sex  
15 assigned at birth is something -- are you talking about  
16 the biological sex as determined at birth?

17 Q Let me use your -- let me put it this way. If  
18 I use the term biological sex, you'll understand that to  
19 be the same way that other people might say sex assigned  
20 at birth; correct?

21 A Sure.

22 Q Okay. So let's say biological sex then. Is it  
23 possible to have a gender identity that differs from  
24 biological sex?

25 A Yes.

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1 Q Okay. Have you -- is it your opinion that  
2 being transgender is a delusion.

3 MS. LAND: Object to form.

4 A So the historic understanding of transgender is  
5 being a subset of obsessive compulsive disorder. And up  
6 until -- as we talked about earlier, up until recently  
7 it was -- it was out of that category of body dysmorphic  
8 disorder. What -- what historically the understanding  
9 of that is that what underlies the obsessive -- as with  
10 other obsessive compulsive conditions there is a  
11 delusional that that keeps intruding into the life of a  
12 person that causes them to interpret things incorrectly  
13 and seeks explanation.

14 So -- so for example, the anorexic --

15 Q Well, let's stay with transgender individuals.

16 A Sure.

17 Q So is it your opinion that being transgender is  
18 a delusion?

19 A Well, it goes by degrees. It goes by degrees.  
20 So sometimes the content of the delusion is trivial and  
21 other times it's suppressive. But there is a -- there  
22 is an incorrect thought that underlies the whole thing  
23 having to do with how they perceive their body.

24 Q And what is the incorrect thought?

25 A That they are, quote/unquote, living in the

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1 wrong body. When people use those terms, that they are  
2 living in the wrong body, that's a delusional thought.

3 Q And that's in all cases?

4 A As far as I can tell, yeah.

5 Q So it is your opinion that anyone who  
6 identifies as transgender is delusional?

7 A Well, no, because in -- historically that would  
8 have been the case. But the new demographic in  
9 transgender is -- is not so much animated by delusion,  
10 it's animated by a rehearsed story which they come to  
11 believe. Okay. So --

12 Q Okay. Well -- sorry. Go ahead, Doctor. I  
13 didn't mean to interrupt.

14 A So -- so whereas in the earlier demographic of  
15 boy -- prepubertal boy cross-sex identification, if that  
16 persisted into adulthood you would typically find that  
17 behind that is a misperception of a lived event in  
18 childhood, you know, like some trauma, some fear, some  
19 personal fear that causes this repetitious explanation  
20 in their mind that the reason they are unhappy is  
21 because they are the wrong sex presentation.

22 Just as in the anorexic, the reason I'm unhappy  
23 is I'm fat. Or the reason I'm unhappy is because I  
24 didn't wash my hands. There is an intrusive thought  
25 that causes them to ruminate over something that isn't



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1 the case.

2 Q And but isn't the case -- let me put that

3 another way. That's because you believe it's impossible

4 to have a gender that differs from your biological sex;

5 correct?

6 A No, it's not impossible. As we talked about

7 earlier, it happens all the time. What I'm saying is

8 that what informs that is a misunderstanding of

9 themselves and their life.

10 Q But you would agree that a gender transition is

11 impossible?

12 A A sex transition is impossible. Gender is a

13 subjective world, and depending on, you know, the

14 person, the success of a subjective perception can vary

15 greatly. I mean, some people are totally -- they

16 transition and they are totally sold. Other people

17 transition and it hasn't answered the mail and they

18 continue to suffer.

19 Q So can we -- this is Exhibit 5, which is your

20 Declaration.

21 A That's what I have in front of me.

22 Q Can you go to paragraph 42?

23 A Okay.

24 Q So if you look at the sentence that starts at

25 the very bottom of page 20 where it says, "Claims that

Page 123

1 patients can" --

2 A Right.

3 Q So you say, "Claims that patients can be a

4 hormonal and surgical treatments obtain a sex chain or

5 gender transition process are misleading and

6 scientifically impossible." Do you agree with that?

7 A Yes, right, exactly. So when I put the words

8 "gender transition" in quotations, the concept itself is

9 a term of usage. So what is being addressed in these --

10 in these interventions is sex change. And that's --

11 that's used by the people interchangeably with gender

12 transition. They are two different things.

13 Q Okay. Well, let's -- what is the treatment

14 goal for any transgender identified person?

15 A Happiness.

16 Q And is it your opinion that in order to achieve

17 that happiness they should stop being transgender?

18 A No. I'm -- well, so happiness can be a

19 fleeting thing and we certainly see that in the arc of

20 the typical transgender person as they go through

21 transition. It's a kind of a roller coaster for them.

22 And every time they enter into a new process of

23 affirmation there is a tremendous encouragement and so

24 there is a tremendous happiness there.

25 To offer a child an affirming message and an

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1 explanation for their anxiety is a tremendously

2 uplifting thing for a child, but eventually that will

3 run out and they will move on to the next thing. So

4 happiness is present and then happiness is gone and then

5 happiness comes back at the next step.

6 So in the case of a child being offered a

7 puberty blockade or something may be a source of

8 tremendous happiness for them. Parents may be relieved

9 and very happy that their child is responding in a

10 positive way, but then you get to the limit of what

11 puberty blockade does for the child and happiness is

12 gone again, and you move on to the next step.

13 So at every step the goal is happiness, but

14 looking at final trajectory, that is what we're debating

15 here, yeah.

16 Q So looking -- no. That's a good point. So

17 looking at the final trajectory, though, it's your

18 opinion that happiness will only be achieved in the

19 final trajectory if a person stops identifying as

20 transgender?

21 MS. LAND: Objection to form.

22 A No. So for example -- that's not necessarily

23 the case. It's not necessarily the case. So for

24 example, the woman that I met from Thailand, perfectly

25 happy, she hadn't desisted, she hadn't regretted --

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1 maybe she had regretted. She didn't voice it to me, but

2 certainly had issue with doing these things to children.

3 So she had -- I mean, she's a living example of somebody

4 who doesn't regret, who is perfectly happy having a

5 transition. I don't know the circumstances of her

6 childhood, I don't know any of these things. I can just

7 hold her up as an example of a success.

8 Q (By Mr. Ossip) So looking -- so let's -- if you

9 can go to paragraph 12 of the declaration.

10 A The --

11 Q The one that's in front of you.

12 A Exhibit 5, paragraph 12. Okay.

13 Q Um, do you see where you say -- this is the

14 third sentence in -- "Patients who experience a gender

15 identity that is discordant with biological sex have an

16 alarmingly high incidence of serious psychosocial

17 morbidity, including depression, anxiety, eating

18 disorders, substance abuse, HIV infection, suicidality

19 and homelessness." Do you see that?

20 A I do.

21 Q Do you believe that the best way to prevent

22 these issues is for a transgender person to no longer be

23 transgender?

24 MS. LAND: Object to the form.

25 A I would say that the best treatment is to -- is

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1 to address the underlying despair that the person has  
 2 and find the source of that despair and do everything in  
 3 my power to lovingly bring them back into contact with,  
 4 you know, the fullness of life.  
 5 So in every example, regardless of, you know,  
 6 the particular case, if you take the time you'll  
 7 probably find a wound and you'll find the source of the  
 8 anxiety and the sorrow. That's where the happiness  
 9 lies. And that's kind of what's at stake here.  
 10 So to just say no longer thinking of themselves  
 11 as transgender does not solve that problem. What solves  
 12 that problem is, you know, out of an abundance of  
 13 charity helping that person to find their way to  
 14 understand how they were wounded, how they came to be  
 15 this way and find a way out of the sorrow, not just  
 16 simply renounce transgender. That's not -- neither the  
 17 solution nor the explanation. What's at -- what's at  
 18 stake here is a person who is wounded and grieving.  
 19 So --  
 20 Q (By Mr. Ossip) Okay. And do you believe it's  
 21 morally wrong for a biological male to socially  
 22 transition and live as a woman?  
 23 A Morally wrong?  
 24 Q Yes.  
 25 A No.

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1 Q And same for a biological woman to socially  
 2 transition and live as a man?  
 3 A You know, I don't see that as a moral issue,  
 4 except in certain circumstances in the eyes of the  
 5 church, for example, where it creates scandal in the  
 6 heart of a child. But, no, generally not. If they were  
 7 using it to mislead somebody into a relationship that  
 8 the person wasn't aware of, that would be immoral. But  
 9 to live as the -- in the cross sex self-identity, that's  
 10 not immoral.  
 11 Q And does that go against the teachings of the  
 12 church.  
 13 A What does?  
 14 Q Living -- being a biological male, as you have  
 15 said, and socially transitioning to live as a woman?  
 16 A I don't believe it does go against the  
 17 teachings of the church, no.  
 18 Q Okay. And what about if someone went -- well,  
 19 take a step back. What if someone went beyond social  
 20 transition and took cross-sex hormones. Still not  
 21 immoral?  
 22 A No, it is in the eyes of the church.  
 23 Q So that is immoral?  
 24 A Well, any form of mutilation is a -- is a crime  
 25 against your person, and that is immoral, yeah.

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1 Q And that includes the use of cross-sex  
 2 hormones?  
 3 A Right.  
 4 Q What about the use of puberty blockers?  
 5 A Same.  
 6 Q And can you explain, how is that a mutilation?  
 7 A Well, so it happens by degrees but the effects  
 8 of puberty blockade radically alter the life course of  
 9 the child, which will -- is demonstrated to show  
 10 longstanding issues with osteoporosis, stunted growth,  
 11 failure of psychosexual development, long-term medical  
 12 issues, and a near certainty of transitioning to  
 13 cross-sex hormones.  
 14 So whenever you talk about puberty blockade  
 15 you've got to talk about cross-sex hormones, because the  
 16 actual clinical experience is that essentially 100  
 17 percent of children who are started on a puberty  
 18 blockade go into cross-sex hormones, which means  
 19 sterilization of the child, which is a form of  
 20 mutilation, a destruction of a human capacity, a human  
 21 function destroyed. Whether or not you do it with a  
 22 blade it's the same, same story.  
 23 Q Is use of the term mutilation to describe the  
 24 use of puberty blockade --  
 25 A That's my own.

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1 Q And do you know if that's a commonly used term?  
 2 A In terms of endocrine management? No, I'm  
 3 happy to claim that as my own.  
 4 Q Okay. And same for -- sorry. Go ahead.  
 5 A The reason being, most of the people who speak  
 6 about this don't speak about it from the perspective --  
 7 first of all, when I present these opinions I don't use  
 8 the teachings of the church to formulate those opinions.  
 9 This is strictly on the merits of the science and the  
 10 medical ethics. So, yeah, none of what I have in -- in  
 11 my report is driven by Catholic church teaching. It's  
 12 driven entirely by the science, my experience in  
 13 medicine, surgery, and the citations offered by the  
 14 plaintiffs' experts.  
 15 Q So you don't use the term "mutilation" in  
 16 anything you filed in this case?  
 17 A No, not in terms of the hormonal manipulation,  
 18 only in terms of the surgery.  
 19 Q Okay. Sorry.  
 20 A You see where I'm going with that?  
 21 Q So you do use -- you do use the phrase  
 22 mutilation to refer to the surgery; correct?  
 23 A Yes, I do.  
 24 Q Okay. And is that commonly used within the  
 25 medical profession to refer to these procedures?

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1 A I doubt it.  
2 Q Okay.  
3 A I doubt it, for the reason we talked about  
4 earlier, the poverty of surgeons willing to speak out  
5 against this.  
6 Q And that's because -- okay. Well, strike that.  
7 A I know why.  
8 Q Do you think that any doctor that provides  
9 gender-affirming medical care is acting unethically?  
10 A I wouldn't make that --  
11 MS. LAND: Objection, asked and answered  
12 and form.  
13 Q (By Mr. Ossip) You can answer.  
14 A I wouldn't make that blanket statement, no.  
15 No, because I have been responsible for the training of  
16 surgical residents, medical residents, pediatrician  
17 residents and things like that, and they are very  
18 heavily influenced by their learning environment and if  
19 they experience is that this is normal, it's such a  
20 bewildering new world to them that they may step out  
21 into practice before they realize they are doing  
22 something. They might ask questions in the terms of  
23 ethics.  
24 So what we would call culpability is a pretty  
25 variable thing. But to see a senior surgeon, who should

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1 know better, yeah, I'm going to have a problem with  
2 that.  
3 Q And when should a senior surgeon know better?  
4 A Yeah, pretty early on. Pretty early on.  
5 Q Well, can you explain that a little bit more?  
6 What -- what would a surgeon encounter that would lead  
7 that surgeon to know better?  
8 A Well, in the case of surgeons offering  
9 transgender surgery, what I would hope is that a  
10 familiarization with the world literature on that  
11 subject would show them that gender-affirmation surgery  
12 does not solve the suicide problem, does not solve the  
13 hospitalization problem, does not solve the substance  
14 abuse problem, does not solve the psychiatric problems.  
15 And armed with that information he might stop and ask  
16 himself, Am I doing something that's for the good of the  
17 patient or not, or am I just here living a good life,  
18 doing lots of surgeries?  
19 Yeah. So familiarization with the world  
20 literature would talk him out of it. Even in his own  
21 experience, recognizing his own patients coming back, am  
22 I doing them good? A junior surgeon might not see that  
23 because he didn't have enough experience.  
24 Q So any senior surgeon who performs  
25 gender-affirming surgeries would be acting unethically

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1 in your view?  
2 A I consider it unethical. But, again,  
3 culpability is the question here. What did you know and  
4 when did you know it. Yeah, and it's a -- it's a new  
5 territory in the American world. It's old territory in  
6 Europe. But in the American experience of transgender  
7 and surgery this is a new territory because they haven't  
8 been doing it long enough.  
9 Q Okay. And what about referrals for  
10 gender-affirming medical care? Is a doctor that refers  
11 a patient for gender-affirming medical care also acting  
12 unethically?  
13 A Again, if they knew the likelihood of a good  
14 outcome versus the likelihood of an injury to the  
15 patient, then, yeah, they should know it's unethical.  
16 Q Dr. Lappert, what is gender dysphoria?  
17 A Gender dysphoria is unhappiness experienced by  
18 a person who feels that their gender is discordant with  
19 their biological sex. So it's a description of a  
20 subjective unhappiness over an underlying condition of  
21 discordance between their gender, their subjectively  
22 perceived gender, and their objectively determined sex.  
23 Q And do you believe that gender dysphoria is a  
24 legitimate diagnosis?  
25 A I think -- it's not -- I don't -- I don't view

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1 it as much as a diagnosis of a description of a  
2 condition. It doesn't -- yeah, I wouldn't put it in the  
3 category of diagnostic certainty. Let's put it that  
4 way.  
5 Q So you would disagree with the DSM V's  
6 inclusion of gender dysphoria?  
7 A Not its inclusion, but its splitting it away.  
8 Essentially, they took one of the characteristics of  
9 body -- or gender identity disorder, they carved that  
10 one -- that one finding away and made it a separate  
11 diagnosis in an effort to depathologize what the  
12 original diagnosis was. Gender identity disorder I  
13 would consider a diagnosis.  
14 Q I see.  
15 A Gender dysphoria is a trait of gender dysphoric  
16 people.  
17 Q And can -- what is necessary to move from  
18 gender dysphoria into the realm of gender identity  
19 disorder?  
20 A Well, gender dysphoria is one of the -- one of  
21 the symptoms. Gender dysphoria is a symptom more than a  
22 diagnosis. I guess that would be the best way to  
23 characterize it. That's my opinion.  
24 Q Okay.  
25 A Not speaking as a psychiatrist here. I'm

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1 speaking as a plastic surgeon with experience of people  
2 who have body dysmorphic disorder. I would say gender  
3 dysphoria is a symptom of the bigger issue, which is  
4 body dysmorphic disorder.  
5 Q And is that because you believe that gender  
6 identity disorder is a subcategory of body dysmorphic  
7 disorder?  
8 A I do.  
9 Q And do you believe that gender identity  
10 disorder is a form of obsessive compulsive disorder?  
11 A I do.  
12 Q And what about gender dysphoria?  
13 A It's a symptom.  
14 Q Okay. A symptom of an underlying condition  
15 that is, itself, a form of obsessive compulsive  
16 disorder?  
17 A Right. And by degrees. Okay. So obsessive is  
18 not an on/off switch. Levels of obsession, levels of  
19 compulsion, levels of willingness to seek remedy vary  
20 greatly. For some people it's just a recurrent thought  
21 that they harbor in their thoughts. Maybe they  
22 privately cross dress and that solves the issue for them  
23 and they don't even identify as transgender.  
24 But they have this interior wound that's an  
25 obsessive thought that keeps presenting itself and they

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1 manage it in private with a behavior. That's the  
2 compulsive behavior, maybe as simple as secretive cross  
3 dressing. Maybe that's not enough and they want to  
4 present themselves publically in that persona to  
5 convince themselves that's a source of their problem.  
6 And so it's a great spectrum of presentation. But in my  
7 mind -- again, I'm not testifying as a psychiatrist.  
8 But in my experience as a plastic surgeon, uh -- yeah.  
9 Q And have you received any education or training  
10 related to gender dysphoria?  
11 A No. Well, I'm sorry. I did attend a course at  
12 the California Society Of Plastic Surgery. It was a  
13 weekend, half day thing on the subject of gender  
14 dysphoria. I got to hear the luminaries of surgery and  
15 medicine and transgender for a whole day there, brought  
16 me up to speed.  
17 Q Was that a -- okay. Well, and -- and when was  
18 that?  
19 A I want to say 2017, guessing. Guessing  
20 somewhere around there. California Society of Plastic  
21 Surgery.  
22 Q Other than that no education or training  
23 related to gender dysphoria?  
24 A No.  
25 Q Treatment of gender dysphoria?

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1 A Again, I'm not -- well, since it's a symptom I  
2 guess every time I talk to somebody who is gender  
3 dysphoric and I help them manage their anxiety, I guess  
4 I do treat people with -- you know, the man who comes to  
5 see me for facial laser hair removal, he and I  
6 commiserate just about as often as he comes in and we  
7 talk about things and I get to kind of a gauge of his  
8 anxiety and how happy he is in his transition process.  
9 Q And, um --  
10 A So technically I suppose that's treatment as a  
11 physician.  
12 Q And this individual that sees you for the laser  
13 hair removal, do they identify as a man or a woman?  
14 A Oh, very much a woman.  
15 Q And you're using man for what reason?  
16 A Because --  
17 MS. LAND: Object to the form.  
18 A Because we're in a private conversation about  
19 something. I would never do that to his face. But I'm  
20 using this as an example of a man who is  
21 transitioning -- virtually fully transitioned already.  
22 When I speak with him it's female because that's the  
23 life he's living.  
24 But when I speak to others about him as an  
25 example, I have to speak about the reality. Because if

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1 the reality of male didn't exist, the reality of  
2 transgender wouldn't exist, so we have to establish  
3 that.  
4 Q Okay. And how many -- how many patients  
5 transitioning from male to female do you perform laser  
6 hair removal on?  
7 A Oh, it's a minority of patients. One to two  
8 here and there. I run a very small office now.  
9 Q Well, you mentioned one individual. More than  
10 five?  
11 A No. Less than five.  
12 Q Okay. More than one?  
13 A Yes.  
14 Q So somewhere between one and five?  
15 A Yeah, probably two or three.  
16 Q Two or three total?  
17 A Yeah.  
18 Q Okay.  
19 A It's kind of a running total. People come and  
20 they go, you know. New patients present.  
21 Q But throughout the entire course of your  
22 career, two or three total?  
23 A Oh, in terms of laser hair removal, that's --  
24 Q For a transgender person.  
25 A Yeah. I don't know. Maybe something less than

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1 a dozen I guess. I mean, I've had that laser since  
 2 2005.  
 3 Q Okay. Have you ever conducted any research  
 4 related to gender dysphoria?  
 5 A No.  
 6 Q Treatment of gender dysphoria?  
 7 A No.  
 8 Q What about research regarding transgender  
 9 people more generally?  
 10 A No. I'm not an academic.  
 11 Q So you mentioned that you've -- you talked  
 12 about a few transgender patients for whom you have  
 13 provided treatment. Starting with the feminizing  
 14 rhinoplasty, how old is that patient?  
 15 A I'm going to say mid -- late 20s probably.  
 16 Maybe early 30s at the -- at the oldest.  
 17 Q Okay. And for the laser hair removal, none of  
 18 those were minors; correct?  
 19 A No.  
 20 Q Okay.  
 21 A I do laser hair removal on minors, but not  
 22 self-identified transgender minors.  
 23 Q And why not?  
 24 A I just haven't had any.  
 25 Q Would you perform it? Would you perform laser

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1 hair removal on a self-identified transgender minor if  
 2 they presented to you?  
 3 A It would be a very unlikely event. Because the  
 4 use of puberty blockade, generally you are only having  
 5 to do laser hair removal on people who have gone through  
 6 puberty who are seeking to present as females.  
 7 Q Was it your understanding that all transgender  
 8 minors use puberty blockers?  
 9 A No, they don't.  
 10 Q And so let's say one presented to you who was  
 11 not using puberty blockers. Would you perform laser  
 12 hair removal on that minor?  
 13 A So for a boy who is under 18 who maybe was  
 14 started on cross-sex hormones, the odds are they are not  
 15 going to have facial hair. That's just really unlikely  
 16 and I haven't seen any.  
 17 Would I do laser hair removal on a boy? I  
 18 would consider it if it would afford me an opportunity  
 19 to develop a doctor-patient relationship with them and  
 20 see if I could help them in some other way.  
 21 Q And what do you mean by "some other way"?  
 22 A Again, if the person looks distressed, I have  
 23 the inclination to help people who are distressed. So  
 24 if a child is distressed over something -- and you  
 25 know --

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1 Q And how would -- I'm sorry, Doctor. I didn't  
 2 mean to interrupt.  
 3 A Oh, that's probably it.  
 4 Q And I -- well, how would you help?  
 5 A I guess just having a conversation, an adult  
 6 conversation with somebody who is struggling in life.  
 7 Like I said, it's like the pastoral side of me as the  
 8 deacon. I don't have recourse to theological language  
 9 in that circumstance because I'm there as a doctor. But  
 10 it's my inclination to just want to help people out.  
 11 Q To provide them advice?  
 12 A Or maybe a discussion so they can have their  
 13 own insight into their own life.  
 14 Q Have you read the SAFE Act?  
 15 A That's the Arkansas -- I have. It's been --  
 16 it's been some months since I last read it.  
 17 Q Okay. Yeah, let's go to that.  
 18 (Plaintiffs' Exhibit 6 was marked for  
 19 identification and made a part of the  
 20 record.)  
 21 Q So the court reporter is handing you what's  
 22 been marked as Exhibit 6. Do you recognize that  
 23 document?  
 24 A Yes, I do.  
 25 Q And is that the SAFE Act?

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1 A Appears to be.  
 2 Q All right. Bear with me one second. So if you  
 3 look at the bottom. I don't think it's on the first  
 4 page, but you can see some page numbers?  
 5 A Okay.  
 6 Q And we want to go to page 6.  
 7 A Okay.  
 8 Q And then there is line numbers on the left  
 9 side. There's a lot of numbers on this. But if you see  
 10 the line No. 10, and then if you look to the right of  
 11 that you see 6(A) in parentheses. Do you see that?  
 12 A I see.  
 13 Q And then it says "Gender transition  
 14 procedures." Do you see that?  
 15 A I see that.  
 16 Q And that defines gender transition procedures  
 17 under the SAFE Act; correct?  
 18 A Appears, yes.  
 19 Q And do you understand this to refer to medical  
 20 interventions to align a person's body with a gender  
 21 that does not match their natal sex?  
 22 A If you can give me a moment to reread it  
 23 because it's been some months since I read it.  
 24 Q Take your time.  
 25 (The witness reviewed the document.)

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1 Q Okay. And so do you understand this to refer  
2 to medical interventions to align a person's body with a  
3 gender that does not match their natal sex?  
4 A Yes, that appears to be.  
5 Q All right. And it's the same, when you use the  
6 phrase gender-affirming medical care, that's the same  
7 thing; correct?  
8 MS. LAND: Object to form.  
9 A This is -- the larger included term would be  
10 services. But so surgical versus medical? Is that your  
11 question.  
12 Q (By Mr. Ossip) Well, earlier we spoke about  
13 gender-affirming medical care --  
14 A Okay.  
15 Q -- to mean surgical or otherwise.  
16 A Okay. Fine.  
17 Q And you'd agree that's the same thing what's  
18 called gender transition procedures under the SAFE Act?  
19 A I would agree.  
20 Q Have you ever provided gender transition  
21 procedures to patients?  
22 A Well, as we talked about earlier in the adults  
23 getting laser hair removal that would be under the  
24 category of gender transition procedure, quote/unquote,  
25 top, an adult, yeah.

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1 Q Yeah. And -- okay. Any others?  
2 A Other than the reversion that we talked about,  
3 the desistant, the regretter?  
4 Q Well, that would not be a --  
5 A Oh, that's right. That wouldn't fit this  
6 category. Okay, yeah. So no others.  
7 Q Okay. Do you believe that the provision of  
8 gender transition procedures is tyrannical?  
9 MS. LAND: Object to the form.  
10 A I have never heard the term "tyrannical"  
11 applied to the provision of services.  
12 Q (By Mr. Ossip) Well, let me ask it another way.  
13 Do you believe it's a form of tyranny over our own  
14 bodies?  
15 MS. LAND: Object to the form.  
16 A Oh, oh. You're asking a theological question.  
17 Q (By Mr. Ossip) I'm just asking if you believe  
18 that.  
19 A Right. So that's actually -- you must have got  
20 that from one of my presentations in one of my public  
21 conferences. So that's actually sort of a paraphrase of  
22 Pope Francis when he talks about the ecology of the  
23 body.  
24 And he likens the abuse of the environment,  
25 environmental abuse and ecological problems, he likens

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1 transgender medicine and surgery to that, only the  
2 ecology is the ecology of the body. And he likens that  
3 tyranny to the tyranny of, you know, the industrial  
4 destruction of the environment. I think that's probably  
5 where that came from. I might have paraphrased Pope  
6 Francis in that. I don't think I ever coined that term  
7 myself.  
8 I generally don't speak of this as tyranny. I  
9 speak of it more as medical malpractice.  
10 Q Have you spoken of it as tyranny before,  
11 though?  
12 A It might have been at a Catholic conference  
13 quoting Pope Francis.  
14 Q And how many times do you think you have  
15 referred to it as tyranny?  
16 A It must be very few because, like I said, I  
17 don't do that.  
18 Q And I think before -- and how many times have  
19 you referred to gender transition procedures provided to  
20 minors as child abuse?  
21 A I can't tell you how many times.  
22 Q But you have done some.  
23 A Never addressed to the parents that way. So I  
24 would never do it at a conference where parents are  
25 present. So, for example, I gave a presentation in -- I

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1 don't know where that was. It was a Courage conference  
2 but it was a breakout session for parents and I would  
3 never speak of it as abuse there, because, again, the  
4 parents are as much victims as the child.  
5 Q Do you think that gender transition procedures  
6 are evil?  
7 MS. LAND: Object to form.  
8 A Okay. So evil meaning something bad visited  
9 upon a person physically like, yeah, like, being  
10 stricken with a disease or something like that or some  
11 harm comes to a person, yeah. When persons are harmed,  
12 that's generally evil. If they are harmed by accident  
13 or incident then that's not evil. But if they are  
14 harmed intentionally, that's evil.  
15 Sometimes the intention behind it is  
16 ill-informed and so that goes to the culpability of the  
17 agent that harmed them. But generally speaking the harm  
18 itself could be called an evil because it harms the  
19 person, yeah.  
20 Q And gender transition procedures harm the  
21 person is your opinion?  
22 A Yes, it is.  
23 Q Okay. And is it your opinion that the  
24 provision of gender transition procedures increase the  
25 risk of suicide?

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1 A I don't know that for a fact. What I do know  
2 is that it doesn't solve the problem of suicide.  
3 Q And what's your source for that belief?  
4 A The best source for that is the 2011 article by  
5 Dhejne out of Sweden that is a longitudinal 30-year  
6 study of transgender persons and outcomes and has a  
7 cohort that is a valid and valuable cohort of patients  
8 so that you can compare and see the merits of the  
9 particular intervention. And it shows us that fully  
10 transitioned persons in adulthood, when you get beyond  
11 about seventh or the eight year, have a 17-fold higher  
12 likelihood of suicide than age-sex matched controls,  
13 whether the sex matching is trans sex or biological sex,  
14 the result is the same.  
15 And that persons transitioning to male,  
16 presenting as male have a 40-fold higher likelihood of  
17 successful suicide compared with age-sex matched  
18 controls. And it's a very difficult study to refute.  
19 Even if sometimes the authors will come back and restate  
20 their conclusions, the data -- they can't take the data  
21 back. The data clearly shows that.  
22 Q And this is just for the court reporter. This  
23 article written by Cecilia Dhejne, and that's  
24 D-h-e-j-n-e. Correct?  
25 A Is that the right pronunciation?

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1 Q Yes.  
2 A We all debate it. Denah (phonetic)?  
3 Q I believe so.  
4 A Okay. Okay. Thank you.  
5 Q But don't quote me on that either. And that is  
6 the study, though; correct?  
7 A The 2011 study, exactly. I think it was in  
8 PLoS.  
9 Q Okay. And PLoS 1; correct?  
10 A Correct.  
11 Q Okay. And any other sources that you rely on  
12 for the belief that the provision of gender transition  
13 procedures does not affect the risk of suicide?  
14 A That's the most compelling one. The other  
15 studies that are -- that are coming forward now are out  
16 of Finland that directly address the issue of  
17 suicidality and anxiety in children as well as -- so  
18 Finland has taken the same step back. The Public Health  
19 Service in Great Britain at the Tavistock Portman  
20 Institute, they have essentially determined, as the  
21 Swedes, that the provision of puberty blockade and  
22 cross-sex hormones to -- and certainly mastectomy  
23 surgery to minors has to be offered on a case-by-case  
24 basis and tightly controlled by a major review board.  
25 So the fact that they are not seeing -- they

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1 were -- they were early adopters in those countries.  
2 They are well ahead of us. So if they are seeing the  
3 long-term results, that's the other reason.  
4 Q So okay. Let's take that -- let's take a step  
5 back there. You mentioned studies in Finland; correct?  
6 A Right.  
7 Q Which studies are those?  
8 A Gosh. I have to look that up here. You have  
9 to give me a minute here. Let's see. It would probably  
10 be in this one.  
11 Q Well, let me put it another way, Doctor. Would  
12 those studies be cited in your report?  
13 A Right. I cite them in the Declaration that's  
14 Exhibit 5 under paragraph 13 that makes reference to the  
15 NICE study in England that affected the policy at the  
16 Tavistock Portman Institute, the study in Sweden. There  
17 is a similar study that I have to hunt around with to  
18 give you the reference. I can send it along to you if  
19 you like. The Cochrane Review, British Royal College of  
20 Psychiatrists. That's all listed there. And let's see  
21 if I annotated that for you.  
22 Q That's okay. I think the thing I want to  
23 figure out is nothing other than what's cited in your  
24 report, though; correct?  
25 A No, I don't have any other outside sources that

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1 come to mind, yeah.  
2 Q Okay. And do you believe that gender  
3 transition procedures affect brain development?  
4 A Puberty blockade is known to affect brain  
5 development.  
6 Q And what -- do you have a source for that  
7 belief?  
8 A Well, my consultation with endocrinology  
9 people, people who are reading the writings of, for  
10 example Paul Hruz, who is very knowledgeable of the  
11 endocrinology on brain development, just general human  
12 development.  
13 So what is known about that is -- and in fact,  
14 one of the most recent sources, this is excellent, is  
15 Dr. Marci Bowers in California who is one of the most  
16 accomplished transgender surgeons, who she will tell you  
17 in public that, I have done 2000 births and I've done  
18 2000 gender transitions, surgical transitions. And  
19 she's publically stated in a conference that you can  
20 find online that children that have received puberty  
21 blockade by the time she is taking care of them as  
22 adults, almost universally none of them are capable of  
23 orgasm. That developmental step in their psychosexual  
24 development never happened because of a poverty of  
25 testosterone in early adolescence, and so they get to

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1 physical maturity through the process of cross-sex  
2 hormones, but when they arrive at adulthood they are  
3 incapable of orgasm, they are incapable of the effects  
4 of that on sexual intimacy.  
5 It's also known that higher executive  
6 functioning is interfered, the development of higher  
7 executive functioning is interfered with. And, again, I  
8 would have to, again, cast around for that citation, but  
9 I can send it along to you if you like.  
10 Q But nothing other than those consultations with  
11 endocrinologists; correct?  
12 A Well, and the public testimony of Marci Bowers.  
13 Q Okay.  
14 A Yeah, who -- as she tells you, has tremendous  
15 breadth of experience of transgender persons in  
16 transition, surgically transitioning them. In fact, I  
17 think she's the one involved with the care of Jazz  
18 Jennings.  
19 Q Have you ever diagnosed someone of a gender  
20 dysphoria?  
21 A Are you talking about, like, making a formal  
22 diagnosis and sending an insurance document? No.  
23 Q I'm just asking if you have ever diagnosed  
24 someone with gender dysphoria?  
25 A Yeah, probably. I mean, you know, it doesn't

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1 enter into the medical record because it's not my area  
2 of care.  
3 Q Okay.  
4 A So I don't officially diagnosis people with  
5 gender dysphoric.  
6 Q But you have never referred anyone for  
7 treatment for gender dysphoria?  
8 A No.  
9 Q What about gender identity disorder?  
10 A Well, no, I take that back. Because I have had  
11 parents bring children to me who are experiencing gender  
12 dysphoria and I have suggested psychiatrists or  
13 psychologists they might speak with, I suppose, or how  
14 to find one. So not a formal referral, but a  
15 recommendation perhaps.  
16 Q And which psychiatrist or psychologist did you  
17 recommend?  
18 A I think I just gave them guidance about how to  
19 suss one out.  
20 Q So you mentioned that parents would come to you  
21 with their children who they believe are experiencing  
22 gender dysphoria; is that correct?  
23 A Both -- maybe all three times recently it's  
24 been after mass a mother comes to me and says, Could you  
25 come talk to my son, could you talk to my daughter.

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1 Yeah. So not in my capacity as a physician, but  
2 certainly with my knowledge as a physician, but in my  
3 pastoral capacity.  
4 Q And did you speak with the parents, the  
5 children, or both?  
6 A Both.  
7 Q Okay. Separately or together?  
8 A Both.  
9 Q Both? What did you tell the parents?  
10 A It's mostly a conversation about understanding  
11 and mostly helping them manage their guilt that they  
12 might have about the suffering of their child, helping  
13 to recognize that children suffer from things that  
14 oftentimes have no explanation, try reassurance to the  
15 parent that, you know, that there is hope for happiness  
16 for their child, health and happiness for their child.  
17 That's mostly the conversation. Like I said, it's  
18 mostly a pastoral thing.  
19 Q And did you recommend any course of action with  
20 respect to the treatment of their child?  
21 A Most of the time I talk to parents what I --  
22 the thing I most recommend is to not be judgmental, do  
23 not be angry, maintain a loving relationship, give them  
24 confidence that they can bring their sorrows to you,  
25 because if they can't bring them to you they are going

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1 to suffer even more. That's mostly what I recommend.  
2 Q But nothing about the treatment of their gender  
3 dysphoria or lack thereof?  
4 A Generally those -- in fact, all of the ones  
5 that I -- that come to mind right now have not yet risen  
6 to the level where they are being recommended for  
7 treatment or anything like that. It's just a child  
8 struggling and sorrowing, withdrawing from friends and  
9 things like that.  
10 Q And this was all in a religious capacity;  
11 correct?  
12 A Yeah, as the deacon of the parish.  
13 Q Who do you think should make the decisions  
14 regarding a minor's healthcare?  
15 A The parents.  
16 Q What about doctors?  
17 A Well, clearly the doctor has to present the  
18 option, so he has to make a decision about what is the  
19 best course, what are the options, because that's what  
20 consent is all about.  
21 Q What about the government?  
22 A The government should only have to step in if  
23 something bad is happening.  
24 Q What about in other aspects of a child's life,  
25 who should make those decisions?



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1 MS. LAND: Objection to the form.  
 2 A I don't understand your question.  
 3 Q (By Mr. Ossip) Well, you said that with regard  
 4 to decisions about a child's medical care, the parent  
 5 should make those decisions; correct?  
 6 A Yes.  
 7 Q What about decisions about other aspects of a  
 8 child's life?  
 9 A Could you give me an example? Maybe that would  
 10 help me.  
 11 Q Are you familiar with a bill that's entitled  
 12 Parental Rights In Education that was passed in Florida  
 13 earlier this year?  
 14 A Yeah.  
 15 Q Okay. Some people have called this the Don't  
 16 Say Gay bill; correct?  
 17 A Some people call it that, yeah.  
 18 Q Yeah. Did you lobby in support of that  
 19 legislation?  
 20 MS. LAND: Objection; form.  
 21 A I think I sent a letter or I did a public --  
 22 somebody interviewed me. I can't remember. Maybe it  
 23 was a video. Oh, no, that was an interview that was  
 24 video recorded about the legislation. Yeah, that's what  
 25 it was. So it was -- let me see if I can remember

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1 who -- who it was.  
 2 Some, some media people video recorded me on --  
 3 on the subject. Yeah, I think that's what it was. I  
 4 didn't lobby in terms of the legislation as I remember  
 5 it.  
 6 Q (By Mr. Ossip) But you spoke in favor of the  
 7 bill; correct?  
 8 A Right.  
 9 Q And that's because, at least in part, you  
 10 believe parents know what's best for their children;  
 11 correct?  
 12 A As a general rule, yeah.  
 13 Q Right.  
 14 A That's the default position I should say.  
 15 Q Do you believe that the parents of the minor  
 16 plaintiffs in this case know what's best for their  
 17 children?  
 18 MS. LAND: Objection; form.  
 19 A So that's a different question. That's a  
 20 different question. The one question is to who has  
 21 primary responsibility for the decisionmaking, which is  
 22 the parents. And then the second question addresses  
 23 itself to what do the parents know to be in the best  
 24 interest of their child.  
 25 If a child is being -- if the parents are being

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1 misinformed about the best course of care and it's known  
 2 by outside agencies then those outside agencies need to  
 3 step in. So, yeah.  
 4 So for example, if a -- if a family brings  
 5 their child to the pediatric endocrinologist and they  
 6 have determined that the best course for their child is  
 7 to have some hormonal support so they can be stronger  
 8 and be more competitive in sports because they have a  
 9 lot of emotional attachment to success in sports, if the  
 10 doctor said, Yeah, that's the best course of events and  
 11 the doctor didn't attempt to talk the parents out of it,  
 12 then the parents would not culpable for that. The  
 13 doctor would be culpable.  
 14 Because to give steroids to a high school  
 15 athlete is evil and there are laws against that. And so  
 16 the government at that point steps in and maybe has  
 17 questions about the licensing of that endocrinologist if  
 18 they were actually misleading parents and selling them  
 19 anabolic steroids. The difference here is just which  
 20 particular hormone you are using and when you're talking  
 21 about transgender, but it's the same problem.  
 22 Parents have primacy, but parents can be  
 23 misinformed by either misinformed doctors or doctors who  
 24 are intentionally misleading. The default is that the  
 25 doctor is misinformed as well.

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1 Q (By Mr. Ossip) And whenever that happens you  
 2 think that the state should take that decision away from  
 3 the parents and give it to the government; correct?  
 4 MS. LAND: Objection; form.  
 5 A Yeah. So that -- I wouldn't say whenever, but  
 6 there are circumstances where the gravity is so  
 7 significant that the state has a duty of protection.  
 8 You know, the -- the Jehovah's Witness child who is  
 9 bleeding out who gets a transfusion, the state knows  
 10 it's a life and death thing, sometimes the state steps  
 11 in. If there is a known harm that is grave and the  
 12 parents are being misinformed then the state does have a  
 13 duty to protect.  
 14 Q (By Mr. Ossip) Well, in what circumstances  
 15 should the state prohibit a form of medical care?  
 16 A When the state understand there to be a known  
 17 harm that outweighs any potential good. And it would  
 18 have to be severely outweighs potential good, yeah.  
 19 Q And in any such case, the state should ban that  
 20 care?  
 21 A I can't think of any exception.  
 22 Q You think that providing gender transition  
 23 procedures is unethical in all cases; correct?  
 24 A Um, well, I mean, we've talked about laser hair  
 25 removal that would be a gender transition procedure that

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1 I don't consider unethical.

2 Q And why is laser hair removal ethical in the

3 case of use as a gender transition procedure?

4 A Well, because it's in the category of things

5 that are sort of trivial but helpful. You know, I mean,

6 I do laser hair removal for a variety of reasons.

7 So, for example, girls with polycystic ovary

8 disease, they will have a condition of hirsutism by

9 varying degrees. Obviously that's not unethical.

10 But to your question, in the case of a person

11 who is -- who is transitioning, it's a minor thing. Men

12 without beards is a common thing even without lasers.

13 It's not a defining characteristic.

14 Q So if you're talking about laser hair removal

15 from a biological male who is transitioning to live as a

16 female, the reason why it's ethical is because there are

17 biological males who do not have beards?

18 A Right.

19 Q Okay.

20 A Yeah. It's -- it's not a defining feature of

21 masculinity or femininity for example.

22 Q Can women with polycystic ovary disease bear

23 children?

24 A Sometimes. It depends on how well it's managed

25 and the severity of the condition. But, yeah, the

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1 masculinizing hormones can have an effect on fertility.

2 And depending on how manageable their particular

3 condition is, it may be a decisive thing. It may be

4 something that, with management, can be overcome.

5 Q Okay. So we talked about why it's ethical to

6 perform laser hair removal. Is, so -- let me take a

7 step back.

8 Any other forms of gender transition procedures

9 that you believe are ethical?

10 A Well, so if a person were to come to me seeking

11 a -- a simple, very simple, like a tip rhinoplasty or

12 something that I could do that would be within the --

13 you know, the range of normal, which all cosmetic

14 surgeries are, all cosmetic surgeries are within the

15 range of normal and aim themselves at solving a subjective

16 perception by the patient that will make them happy. So

17 if somebody just happens to be transitioning and they

18 want to tip rhinoplasty, I don't see any reason not to

19 do that.

20 Q And what do you mean by a "range of normal"?

21 A Range of normal, there is a tremendous amount

22 of overlap between the -- sort of the Gaussian curve of

23 any particular trait that's called masculine and any

24 particular trait that's called feminine. And their area

25 of overlap sometimes is very broad and sometimes it's

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1 very narrow. Facial hair is a one of those things.

2 It's a very ethnic thing, it's very a racial thing.

3 Q Okay. I think I understand. So just help me

4 out for a second. So when you say the range of normal

5 you mean if you are performing a procedure on, let's

6 say, a biological male, right, you think it's ethical so

7 long as it's within that Gaussian curve for a biological

8 male; correct?

9 A Let me see if I understand how you phrase that.

10 So -- so really the question is to transition to do --

11 transition procedures on defining characteristics. So,

12 for example, genitalia is a very narrow thing, presence

13 or absence pretty much.

14 There are the very small tails, which are

15 disorders of sexual differentiation or disorders of

16 sexual development, which is a very freited area of

17 conversation. So in the case of those features, there's

18 virtually no overlap, genitalia.

19 In the case of breasts for example, breasts

20 there are some overlap, but there are defining

21 pathologies that cause the overlap. Okay? So for

22 example, in the case of breast reduction, size of

23 breasts as a reason for surgery, gynecomastia versus

24 macromastia, there is really no overlap there, although

25 they have the same characteristic, too much breast

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1 tissue.

2 Q Okay. But just to go back to my question, the

3 reason why it's ethical is because it's within that

4 curve of what is normal for a biological male; correct?

5 A Yeah. It's a small non-risk procedure that's

6 within the range of normal.

7 Q And why does the range of normal affect the

8 ethics of the procedure?

9 A Well, because it -- the person could be

10 presenting for it without you knowing that their

11 motivation is transitioning. You know, so, for

12 example -- well, let me answer your question directly,

13 then.

14 How does it being in the range of normal affect

15 the ethics of the decision?

16 Q Well, you have said that it does; correct? I'm

17 just asking why.

18 A It affects the -- the ethics, I guess, of my

19 own personal decisionmaking in the matter, whether or

20 not I would perform a procedure, you know.

21 Q Okay.

22 A I'm not here testifying as an ethicist. I'm

23 not an ethicist, a biomedical ethicist. I'm not

24 expertise (sic.) in that either.

25 Q Okay. So all of the testimony about whether it

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1 is or is not ethical, that's not your expert opinion  
2 then; correct?  
3 MS. LAND: Object to the form.  
4 A No. The particular case of me doing laser hair  
5 removal on a transgender female is what I'm addressing  
6 there.  
7 Q (By Mr. Ossip) Okay.  
8 A It's a -- yeah.  
9 Q Are you part of any organization that opposes  
10 the transgender procedures?  
11 A Organization? I'm not a member of really any  
12 organizations, other than being, you know, a member  
13 of -- well, none -- certainly my membership in church  
14 has nothing to do with opposing -- so I would say no.  
15 Q So it's your -- so Courage does not oppose the  
16 provision of gender transition procedures?  
17 A Courage doesn't take a position on it.  
18 Q Okay. What about the church as a whole?  
19 A The church has been alarmingly mute on the  
20 subject. There have been -- there are documents in the  
21 church. For example, the catechism of the Catholic  
22 church speaks specifically about genital mutilation, so  
23 the church speaks very loudly in that regard. The  
24 separation of the unitive from the procreative aspects  
25 of human sexuality, the church speaks very loudly about

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1 that. But it's not a public declaration. You would  
2 have to go looking for it.  
3 Q Okay.  
4 A Yeah.  
5 Q And you're not a member of ADF; correct?  
6 A No, I'm not.  
7 Q Okay. Do you agree with Finland's approach to  
8 gender transition procedures for minors?  
9 A Let's see. I often conflate Sweden with  
10 Finland, the Scandinavian countries. My recollection is  
11 they have moved it into the category of subject to  
12 intensive review before offering, and that I would  
13 certainly agree with.  
14 Q And so you agree that minors can still obtain  
15 gender transition procedures under that model; correct?  
16 A Well, so I would want to be present in the room  
17 when they are going through that review. And I can't  
18 think of a circumstance where that would be the best  
19 choice for any child. But I would defer to the  
20 experience of the Fins and their large medical care  
21 system and their database and how they interpret it.  
22 But any move in that direction I would  
23 certainly welcome. But if there -- if there's gonna be  
24 a let's potentially review this case, I would love to be  
25 in the room and hear on what basis they would be

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1 offering puberty blockade, cross-sex hormones,  
2 transition surgery.  
3 Q But you would defer to the Fins on that;  
4 correct?  
5 A At this point that's all I could offer, yeah.  
6 Q Okay. And what about Sweden, do you agree with  
7 their approach?  
8 A I agree with the direction in which they are  
9 taking it, that's right. And they are definitely, they  
10 have put the brakes on the medical-surgical  
11 transitioning of minors subject to institutional review  
12 and rare events.  
13 Q And what about the UK? What's your  
14 understanding of their approach?  
15 A So the UK, that was driven by a decision of the  
16 Crown Court in the case of Kyra Bell who sought damages  
17 for her hormonal and surgical transitioning and won her  
18 case. And as a result of that case the public health  
19 service put the brakes on the Tavistock Portman  
20 Institute's affecting the transgender services to  
21 minors.  
22 They walked it back and then sort of walked it  
23 forward again, and that's sort of a moving target right  
24 now. But it seems to be the direction they are going,  
25 and let's put the brakes on this until further review.

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1 What that review has yielded, I haven't checked  
2 in on in the last couple of months. But my  
3 understanding is there is significant change at  
4 Tavistock Portman.  
5 Q And do you agree with their approach?  
6 A Of review of results? Absolutely I do. And I  
7 look forward to the day when American medical systems do  
8 the same thing.  
9 Q Well, do you agree the UK's approach to the  
10 treatment of transgender -- or of minors with gender  
11 dysphoria?  
12 A Well, as I say, I don't know what they're  
13 present, most recent decision is. But their historic  
14 treatment of transgender minors I disagree with  
15 wholeheartedly.  
16 Q Okay. Do you think that doctors should be able  
17 to provide minors with gender transition procedures in  
18 the context of clinical research?  
19 A Well, the clinical research has to be driven by  
20 the levels of evidence and the risks to the patient. So  
21 levels of evidence that -- that -- that drive clinical  
22 research can be fairly low-level evidence, like level 4  
23 or level 5 evidence were you've got anecdotal reports or  
24 case collections, retrospective reviews, literature  
25 reviews that suggest a possible course of treatment that

<p style="text-align: right;">Page 166</p> <p>1 can lead to a clinical trial.</p> <p>2 But in order to make it to clinical trial it</p> <p>3 has to be a circumstance where there isn't a high</p> <p>4 likelihood of harm, because if you are going to</p> <p>5 randomize people into a clinical trial, both arms have</p> <p>6 to be demonstrated safe or hold out a promise of</p> <p>7 efficacy.</p> <p>8 And so if you can't demonstrate that then you</p> <p>9 probably will not get through the institutional review</p> <p>10 board that will allow you to experiment on a child.</p> <p>11 So -- so in cases where the potential harm is</p> <p>12 small and the potential benefit is great, then certainly</p> <p>13 it can come to that. But from where I sit I don't see</p> <p>14 that as a likely circumstance, just because the</p> <p>15 permanence. The permanent effects of sterilization and</p> <p>16 irreversible genital surgery and irreversible</p> <p>17 mastectomy, that's a very grave matter and you can't</p> <p>18 take it back.</p> <p>19 It's a different matter if you're testing the</p> <p>20 efficacy of asthma medication and you've got some</p> <p>21 experience with one or the other. Yeah, clinical trial.</p> <p>22 Q What about laser hair removal? We talked about</p> <p>23 that before; right?</p> <p>24 A Right.</p> <p>25 Q Clinical trial?</p>	<p style="text-align: right;">Page 168</p> <p>1 study?</p> <p>2 Q Yes.</p> <p>3 A Right. Whether the risk of harm is small,</p> <p>4 where the risk of harm is small and the likelihood of</p> <p>5 benefit is significant.</p> <p>6 Q So you'd agree that should be permitted?</p> <p>7 A Oh, absolutely. It's permitted all the time.</p> <p>8 Q So just to go back a second. Do you think that</p> <p>9 clinical trials should never be done in the case of</p> <p>10 gender-affirming medical care for minors because the</p> <p>11 care is always harmful?</p> <p>12 MS. LAND: Objection; form.</p> <p>13 A Well, let me take them in order. So known</p> <p>14 harms of puberty blockade, yeah, that would be a</p> <p>15 disqualifier. Known harms of cross-sex hormones in high</p> <p>16 dosages, that would be a known harm. Irreversible</p> <p>17 mastectomy, known harm. Genital surgery -- well,</p> <p>18 children don't yet get genital surgery under standard of</p> <p>19 care. They would. All known harms, grave matter. So</p> <p>20 knowing that I wouldn't subject any of those treatments</p> <p>21 to clinical trial.</p> <p>22 Q (By Mr. Ossip) So, I mean, I think earlier your</p> <p>23 said the question was whether or not the benefits</p> <p>24 outweigh the harms; correct?</p> <p>25 A Right.</p>
<p style="text-align: right;">Page 167</p> <p>1 A Does that require clinical trial?</p> <p>2 Q Well, do you think that doctors should be able</p> <p>3 to provide minors with laser hair removal as part of</p> <p>4 gender transition procedures in the context of clinical</p> <p>5 research?</p> <p>6 A I don't know of any circumstance where laser</p> <p>7 hair removal is necessary in a child other than children</p> <p>8 who have -- and I've treated them -- children who have</p> <p>9 hirsutism secondary to endocrinopathy. If they have a</p> <p>10 pathological endocrinological condition, that doesn't</p> <p>11 even require a clinical trial. Because laser is known</p> <p>12 to be efficacious, the condition is demonstrable, it's</p> <p>13 an objective condition, it's cause can be demonstrated</p> <p>14 and the result can be anticipated.</p> <p>15 Q Let's go back to my question, though. Is there</p> <p>16 any circumstance in which you think doctors should be</p> <p>17 able to provide what's -- what we've agreed as being</p> <p>18 called gender transition procedures to minors in the</p> <p>19 context of clinical research?</p> <p>20 A I cannot think of a circumstance where it would</p> <p>21 be indicated -- where it would happen. I can't think of</p> <p>22 a circumstance where anything that is ethically</p> <p>23 plausible would rise to the level of a clinical trial.</p> <p>24 Q What about in any other research context?</p> <p>25 A Children enrolled in a research prospective</p>	<p style="text-align: right;">Page 169</p> <p>1 Q So it's not just a question of the harm; right?</p> <p>2 It's also a question of the benefit?</p> <p>3 A Absolutely.</p> <p>4 Q And I understood that your testimony -- well,</p> <p>5 let me take a step back.</p> <p>6 Is it your testimony in this case that there is</p> <p>7 insufficient evidence as to the benefits of gender</p> <p>8 transition procedures?</p> <p>9 A That's precisely what's at stake here.</p> <p>10 Q And how would one develop that evidence?</p> <p>11 A So if you cannot do a clinical trial --</p> <p>12 clinical trials would be level 2 to level 1 evidence.</p> <p>13 So a clinical trial level 2 would be a non-blinded</p> <p>14 study, for example. Level 1 would be like multi-center</p> <p>15 randomized placebo controlled, let's go for it. You</p> <p>16 can't do that with these techniques, these particular</p> <p>17 issues.</p> <p>18 Q Got it.</p> <p>19 A So the best you can get to is a level 3, which</p> <p>20 would be like a longitudinal population-based study of</p> <p>21 outcomes, which is precisely what the Dhejne study, it's</p> <p>22 pronounced the Dhejne study, the 2011 Swedish study,</p> <p>23 that's precisely what that evidence shows us.</p> <p>24 It's a gigantic study population in an LGBT-</p> <p>25 affirming society where every level, every incident,</p>

<p style="text-align: right;">Page 170</p> <p>1 every moment of care in that medical system is recorded  2 in the same language, whether that person is going to a  3 hospital, clinic, a transgender clinic, a pediatric  4 clinic, a school nurse, a prison hospital, a psychiatric  5 hospital.  6 Everybody goes in the same database so you can  7 query that database and say, I have a transgender person  8 here who is suffering from alcoholism. What is their  9 relative risk of alcoholism compared to age-sex matched  10 controls. So that's a level 3 evidence, which may be  11 the highest you can get to. But it shows us very  12 dramatically what the potential benefit is long term.  13 That's a 30-year study.  14 Q And so would you support doctors being able to  15 provide gender transition procedures to minors in the  16 context of a level 3 study?  17 A So a level 3 study is -- is a study of -- study  18 of an existing database. So it's not -- it's not  19 necessarily a prospective study. Right? Because what  20 happens is you already have the study population. They  21 are the patients that have been historically cared for,  22 and what you are comparing them to is the age sex-match  23 cohort.  24 Q Okay. Well, here is where I'm confused,  25 Doctor.</p>	<p style="text-align: right;">Page 172</p> <p>1 and the interior wound is still there, and their  2 suicidality returns because it hasn't addressed -- the  3 problem itself hasn't been addressed by the care that  4 they have received.  5 So that shows us in a level 3 study that  6 long-term what we are interpret -- what the American  7 medical community is interpreting as benefit is really a  8 short-term phenomenon. And this is why it's excusable  9 when experts will cite a paper and say, Well, we've got  10 a followup of three-and-a-half years out of University  11 of Southern California of top surgery.  12 Well, yeah that's a benefit because the child  13 is still experiencing affirmation messages and the child  14 still has a hope of improvement, but that doesn't mean  15 long term. And remember, we're talking about  16 irreversible things here so we have to talk about the  17 entire arc of their life.  18 Q So you mentioned that they have fallen out of  19 the affirmation loop.  20 A Right.  21 Q Was that in -- was that terminology in the  22 Dhejne study?  23 A I don't believe it was, no.  24 Q All right. Where did you get that from?  25 A My knowledge of the way that transgender care</p>
<p style="text-align: right;">Page 171</p> <p>1 A Okay.  2 Q So you're saying that we need more evidence, we  3 need to conduct more research; correct?  4 A That -- that -- without that evidence it's  5 unethical to proceed.  6 Q All right. How would one generate that  7 research?  8 A Well, a literature search will show you. So,  9 for example -- here is a good example. It can be a  10 literature review that gets you to better levels of  11 evidence, or it can be a literature review that shows  12 you that the level of evidence you have is even worse.  13 So the Dhejne study that we talked about,  14 that's level 3 evidence and it points away from offering  15 the services because of long-term result. It definitely  16 demonstrates, by the way, that short-term it's a benefit  17 to the patient. You look at their study and it will  18 show you that fully transitioned patients will  19 experience essentially the same levels of  20 hospitalization, same levels of suicide, same levels of  21 self-harm, alcoholism, violate crime, whatever, as the  22 general population age sex-match controls, benefit,  23 search to eight years.  24 And then the bottom starts to fall out, because  25 they typically have fallen out of the affirmation loop</p>	<p style="text-align: right;">Page 173</p> <p>1 works. So you know, reading -- for example, if you read  2 in the American literature, it's rare that you find  3 anyone reporting followups beyond -- in the surgical  4 side you're lucky if you find followups beyond the third  5 year.  6 Q Well, just that idea of them falling out of the  7 affirmation loop, is that supposition on your part?  8 A Well, it's evidenced by what the reports are of  9 the patient care in the -- in the collected cases, in  10 the single-center studies, multi-center studies,  11 surgical care of transgender persons. The fact that I  12 don't find followups that extend beyond third year tells  13 me they are falling out of that loop.  14 Q So it's the absence of evidence?  15 A Evidence you would expect in a body of  16 scientific literature that purports to show long-term  17 benefit.  18 Q So going back to clinical trials.  19 A Okay.  20 Q Should clinical trials regarding the provision  21 of gender transition procedures for minors be banned?  22 MS. LAND: Object to form, vague.  23 A Well, um, let's say that -- that suddenly  24 there's level 3 evidence of benefit. Let's say -- I  25 mean, this is all supposition on my part. I don't rule</p>

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1 it out because I'm open to following the science here.  
 2 I can only -- I can only speak to the level of the  
 3 science as I know it. Okay? But if there were -- if --  
 4 Q (By Mr. Ossip) Sorry. Go ahead, Doctor.  
 5 A That's okay. If there were a circumstance  
 6 where the science was to suddenly present through level  
 7 3 evidence of a -- of a tremendous benefit then that  
 8 would change the risk/benefit equation.  
 9 All surgical consent, which any trial like this  
 10 would have to have, is a risk/benefit equation. In the  
 11 case of the risk is so high the benefits through a level  
 12 3 study would have to demonstrate tremendous benefit.  
 13 Q But let me put it another way. Should the  
 14 government ban those clinical trials?  
 15 A I think the government already does. I mean,  
 16 ethics review boards for clinical trials, I'd have to  
 17 step back. Because, again, I'm not an academic.  
 18 Probably Dr. Hruz can answer that question better  
 19 because he's routinely academic clinical trials.  
 20 But I think when you're talking about a  
 21 lifetime risk of objective harm, infertility, loss of  
 22 capacity for orgasm, loss for sexual intimacy and  
 23 inability to breastfeed and all of those things, that's  
 24 a gigantic body of harms.  
 25 And so I think this -- anyone bringing such a

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1 proposal for a prospective study -- I don't think even  
 2 proponents of transgender see a prospective clinical  
 3 trial as doable because you couldn't blind the treatment  
 4 arm.  
 5 Q Well, what about a prospective longitudinal  
 6 study?  
 7 A Well, we're living in that right now. We are  
 8 living in that study right now, because we have a  
 9 population -- the problem is that our database is not --  
 10 so what you're proposing here would actually be a proper  
 11 database to manage what is already going on. We're  
 12 living in a longitudinal trial right now.  
 13 Q And we're living in a longitudinal -- a  
 14 prospective longitudinal trial -- I mean, let's put that  
 15 aside.  
 16 We're living in a longitudinal trial because  
 17 minors are being provided gender-affirming medical care;  
 18 correct?  
 19 A Correct. Correct. And the take-home message  
 20 there is experimentation. The long-term effects of  
 21 puberty blockade in gender dysphoric children is not  
 22 known, that is not known. It's not a known quantity.  
 23 The reversibility of it is not a fallacy. It is not  
 24 known.  
 25 The long-term effects of cross-sex hormones

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1 long term is not known, other than the known pathologies  
 2 of hypertension, hypertriglyceridemia, all those other  
 3 things that are known. But in terms of children being  
 4 transitioned through puberty block and cross-sex  
 5 hormone, that's an experiment.  
 6 Q And you support additional research then?  
 7 A I always have my eyes and ears open for  
 8 meaningful research. And what I'm looking for in the  
 9 American literature is when they are actually going to  
 10 be examining their data long term, and to date that  
 11 hasn't happened.  
 12 Q Earlier we were talking about chest  
 13 masculinization.  
 14 A Okay.  
 15 Q Would you agree that that procedure is the same  
 16 as a mastectomy?  
 17 A Yes, it's the same operation.  
 18 Q Okay. And it's safe; correct?  
 19 A It's a safe operation. The risk in a woman is  
 20 different than the risk in a man. The risk of  
 21 postoperative hematoma in a -- in a chest  
 22 masculinization as it is for gynecomastectomy in a man  
 23 is higher than it is in a woman getting a breast  
 24 reduction. So there is minor differences in surgical  
 25 risk, but all of those risks are small.

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1 Q And it's the same risk, then, as postoperative  
 2 hematoma as it is for a gynecomastectomy; correct?  
 3 A Well, so I would expect a slightly higher risk  
 4 in the chaste masculinization because part of the  
 5 technique is -- involves the placement of the incisions,  
 6 because the incisions are routinely inframammary, a  
 7 lower crease of the breast. The reach up high on a male  
 8 chest is more likely to cause accidentally vascular  
 9 injury. So it wouldn't surprise me to learn that the  
 10 risk is a little bit higher in a -- I'm sorry -- we're  
 11 talking about masculinization versus breast reduction.  
 12 Q Correct.  
 13 A Forgive me. I was on the wrong sheet of music  
 14 here. Risk is -- actually probably for hematoma in the  
 15 masculinization is probably less than it is for a breast  
 16 reduction.  
 17 Q So lower risk?  
 18 A Lower risk, yeah.  
 19 Q Okay.  
 20 A It's a small risk either way. It's maybe the 3  
 21 to 5 percent range. But it's probably lower risk in the  
 22 mastectomy because of the dissection plain and the fact  
 23 that you have to cut through the mass of the breast,  
 24 which is rich in blood supply, so.  
 25 MR. OSSIP: All right. I think we can

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1 stop for lunch now maybe.  
 2 VIDEO OPERATOR: All right. This will  
 3 end media part 3. We are off the record at 1:08 p.m.  
 4 (A break was had.)  
 5 VIDEO OPERATOR: We are back on the  
 6 record at 2:16 p.m. This will begin media part 4.  
 7 Please proceed.  
 8 Q (By Mr. Ossip) All right. Welcome back,  
 9 Doctor.  
 10 A Thank you.  
 11 Q Doctor, do you believe that minors should be  
 12 prohibited from participating in randomized clinical  
 13 trials concerning treatment for gender dysphoria?  
 14 A No.  
 15 Q And do you believe that minors should be  
 16 prohibited from participating in long-term treatment  
 17 outcome studies with adolescents with gender dysphoria?  
 18 A No. We have to do that.  
 19 Q And anything that prevents those would be  
 20 counterproductive; correct?  
 21 A Well, as -- as we talked about before, what  
 22 could prevent it is the risk/benefit analysis before you  
 23 embark on a clinical trial. What might prevent a  
 24 clinical trial is that the risk to the child is so great  
 25 that it's not ethical to subject them to it. But as a

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1 general principle I would say we have to find a way to  
 2 find out, to come up with answers to that.  
 3 We talked about one of them being an  
 4 examination of the longitudinal study data. But if  
 5 there is a way to formulate a prospective clinical trial  
 6 that wouldn't put the children at risk, that would make  
 7 theoretical sense to me because it's higher-level  
 8 evidence.  
 9 Q I guess I'm still struggling with this. So  
 10 you're saying that we need prospective longitudinal  
 11 studies assessing these treatments because they are  
 12 higher-level evidence; correct?  
 13 A I'm saying that the higher level of evidence,  
 14 the better it is for all of us. But some of those  
 15 techniques of research are inaccessible right now  
 16 because of risk of harm to the child. So we may only be  
 17 able, right now, to settle with level 3 evidence.  
 18 Q And level 3 evidence still requires a group of  
 19 a patient population receiving the intervention;  
 20 correct?  
 21 A Right, yeah. That's the whole idea is that you  
 22 have a cohort and you have the study group. And that  
 23 study group is happening right now, like we talked about  
 24 earlier, that we're living in a prospective trial.  
 25 The problem with the prospective trial that we

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1 are living in is the data gathering is very slip-shot.  
 2 Q Yeah.  
 3 A Whereas in Sweden it's not because of the  
 4 centralized database.  
 5 Q Right.  
 6 A So the thing I fear is that the quality of  
 7 level 3 evidence is going to be poor because of the poor  
 8 data gathering.  
 9 Q But you agree that a prohibition of the  
 10 intervention would make a level 3 trial -- or a level 3  
 11 study impossible; correct?  
 12 A Any -- any study that's prohibited for ethical  
 13 reasons puts it out of reach. So, for example, if I  
 14 proposed a clinical trial to subject people to, uh,  
 15 frigid temperatures, that could potentially kill them in  
 16 order to find out, you know, what the limits of human  
 17 hypothermia are, that would be an unethical thing and  
 18 that data wouldn't be accessible to me. That data is  
 19 accessible to me because they did that research on my  
 20 family members who are incarcerated in Auschwitz.  
 21 Q Yeah.  
 22 A So that's unethical data gathering.  
 23 Q And so you talked about unethical data  
 24 gathering. And the same answer -- your answer would be  
 25 the same if it was legally prohibited; correct?

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1 A Right. So it's a question of is the specialty  
 2 policing itself or does it need intervention. If a  
 3 specialty is policing itself, the state doesn't need to  
 4 intervene. If the ethics boards that are governing  
 5 research are preventing the research then the state  
 6 doesn't have to intervene. Sometimes the state does  
 7 have to intervene. You know, there was longitudinal  
 8 stuff going on with lobotomy. Eventually, no  
 9 lobotomies, please.  
 10 Q And is that because the state prohibited  
 11 lobotomies?  
 12 A I think at some point in certain jurisdictions  
 13 the state did enter in. But, ultimately, the people  
 14 doing it, because enough data had flowed in that's the  
 15 results, the long-term results were becoming evident  
 16 that the specialty policed itself, the neurosurgeons  
 17 policed themselves out of it.  
 18 Q And that was because the procedures were being  
 19 conducted and the data was collected; correct?  
 20 A Right, yeah. The evidence -- you've got to  
 21 have the evidence there, yeah.  
 22 Q Okay. So earlier we talked about the SAFE Act;  
 23 correct?  
 24 A Okay.  
 25 Q Would you support an exception to the SAFE

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1 Act where -- and we agree that the SAFE Act prohibits  
 2 gender transition procedures; correct?  
 3 A Yes.  
 4 Q Would you agree to an exception for gender  
 5 transition procedures for minors in clinical trials?  
 6 MS. LAND: Object to form.  
 7 A I'm trying to think of a circumstances where  
 8 that might happen. I mean, it's definitely a worthy  
 9 thought because, as you pointed out it's good to know in  
 10 a safe way. I suppose if -- if a particular question is  
 11 being asked that could be answered through a clinical  
 12 trial that didn't put the child at risk I guess that  
 13 would be a reasonable thing.  
 14 So, for example, the effect of social  
 15 transitioning, the data on that is very poor. You know,  
 16 social transitioning of children through the affirmation  
 17 model, the data of outcomes is very poor in that regard  
 18 and so that would be a low risk to the child, and I  
 19 don't know -- I would have to defer to the  
 20 psychiatrists, the child psychiatrists to make an  
 21 estimation of that risk. But I could imagine there  
 22 might be a circumstance where you could test social  
 23 transitioning versus not social transitioning.  
 24 Q (By Mr. Ossip) Well, you would agree that all  
 25 medical interventions involve risk to the patient;

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1 correct?  
 2 A Some level of risk, yeah.  
 3 Q And so --  
 4 A In some cases trivial.  
 5 Q And so you said that a clinical trial would be  
 6 permitted if it didn't put the child at risk. Under  
 7 what circumstances could a clinical trial not put a  
 8 child at risk?  
 9 A I suppose I could be more accurate and say: If  
 10 the risk was so small compared to the potential  
 11 benefits, as we talked about before, the risk/benefit  
 12 equation of clinical trials. So if -- if you can come  
 13 up with a study model that puts the child -- every time  
 14 you introduce a child to a new medication you run the  
 15 risks of, say, adverse reaction, or any time you subject  
 16 the child to, you know, any modality of care whether  
 17 you're talking about managing fever. Tylenol has risks.  
 18 The risks are so small that they are acceptable within  
 19 the confines of a monitored clinical trial.  
 20 Q Just early today we were discussing levels of  
 21 evidence, and you have used the terms level 1, level 2,  
 22 level 3, level 4, level 5; correct?  
 23 A Um-hum.  
 24 Q And are those the levels of evidence that the  
 25 American Society of Plastic Surgery uses to

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1 categorize --  
 2 A That's the one that I use, yeah, that's right.  
 3 Q Okay. And do you recall testifying about those  
 4 levels of evidence in your deposition for the Kadel  
 5 case?  
 6 A I believe that question came up, yeah.  
 7 Q And when you use those levels here, you mean  
 8 those the same way you used them there; correct?  
 9 A I try to stick to that -- that model, uh-huh,  
 10 yeah.  
 11 Q Perfect. I just figured that was easier than  
 12 going through all --  
 13 A Sure, yeah. And so -- yeah.  
 14 Q Perfect.  
 15 A I think the question that came up in the Kadel  
 16 case is what is meant by low-quality evidence.  
 17 Q And you'd agree that when clinical trials are  
 18 unavailable, doctors have to rely on less definitive  
 19 information in making treatment recommendations;  
 20 correct?  
 21 A Right.  
 22 MS. LAND: Object to form.  
 23 Q (By Mr. Ossip) So we talked about -- you said  
 24 if the question about whether or not research should be  
 25 permitted on a particular intervention, talking about a

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1 minor, is whether the risk was small compared to the  
 2 benefit; right?  
 3 A Right. I mean, that's one of the factors that  
 4 Anderson took, what's the likelihood?  
 5 Q Okay. I want to just move away -- I know we  
 6 talked about clinical trials. But let's -- let's  
 7 include any level 1, 2, or 3 evidence. Okay? Are you  
 8 with me?  
 9 A I am.  
 10 Q Okay. So looking at those types of research  
 11 are -- is the use of puberty blockers for the -- as a  
 12 gender transition procedure as defined in the SAFE Act,  
 13 would that research be permissible?  
 14 A In terms of what we have been discussing about  
 15 that -- that risk/benefit thing?  
 16 Q Yes.  
 17 A I would put puberty blockade in the high risk  
 18 category, a very high risk category. And in order to  
 19 justify the use of those in a clinical trial I would  
 20 have to have level 4, at least, evidence -- certainly  
 21 level 3 would be preferable -- of a long-term benefit to  
 22 the child. Right?  
 23 So if I have -- if I have a level 3 study that  
 24 shows me long-term benefits, significant, like for  
 25 example if you took the alarmingly high suicide rate



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1 that you see among transgender persons and you were able  
 2 to demonstrate, you know, that you nearly knock that off  
 3 the books, that would be a significant benefit. Or  
 4 psychiatric major depression, substance abuse, if you  
 5 could demonstrate a major objective benefit then it  
 6 would be worth having a conversation about that. And  
 7 again, I would have to defer to the pediatric  
 8 endocrinologists and the psychiatrists to make that  
 9 adjudication. But that's the kind of circumstance.  
 10 Q So I think this is going back to my confusion.  
 11 A Okay.  
 12 Q I think you said in order to do this study you  
 13 would need either level 3, level 4 evidence to show that  
 14 safety and efficacy of the intervention.  
 15 A Yeah. If you're trying to get to a level 2  
 16 result, you've got to have everything below that kind of  
 17 supporting --  
 18 Q Okay. So let's talk about the lower levels,  
 19 then.  
 20 A Okay.  
 21 Q So you would oppose a prohibition of collecting  
 22 that research for puberty blockades then; correct?  
 23 A Right. Well, so what you're -- when you're  
 24 talking about level 4 and level 5 evidence you're  
 25 talking about -- in the case of level 5, for example,

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1 you're talking about anecdotal case reports.  
 2 Q Um-hum.  
 3 A In the case of a level 4 you're talking about  
 4 of large case collections, retrospective study of  
 5 literature, you know, analysis of multiple-collected  
 6 case reports and things like that.  
 7 I'm pretty sure that pediatric endocrinologists  
 8 right now cannot present you with better than short-term  
 9 level 4 evidence of a benefit. And that's the problem  
 10 with the puberty blockers because the consequences are  
 11 not short-term.  
 12 Q So you would support research into long-term,  
 13 level 4 research into long-term benefits of puberty  
 14 blockers; correct?  
 15 A No. I would probably defer to a -- a  
 16 longitudinal population based retrospective review  
 17 because that doesn't put any new children at risk.  
 18 Right? What you're looking at is what do we have so  
 19 far? We've been doing this now for a decade. We've  
 20 been doing puberty blockade and cross-sex hormones for a  
 21 decade. We should have at least, in some patients, a  
 22 ten-year followup. But what we're really looking at is  
 23 even longer term than that. At eight to ten years  
 24 you're starting to see fall-off.  
 25 But in terms of the consequences of hormonal

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1 blockade, we've arrived at that stage when the likes of  
 2 Marci Bowers, transgender surgeon, is starting to report  
 3 adverse long-term consequences of puberty blockade. So  
 4 that's one of the data points you're going to have to  
 5 weigh against.  
 6 Can a child that is entering puberty at age 11  
 7 understand what you're talking to them about like when  
 8 you say, you know, "Like seven years from now you're not  
 9 going to be capable of an orgasm." Well, they have  
 10 never even experienced that so they have no way of  
 11 judging that. "You're going to be infertile." They  
 12 don't understand what that means.  
 13 And so -- but we're getting to the point now  
 14 where what you really want to do is a historic  
 15 population-based longitudinal evaluation of the results  
 16 to date. And I think we're reaching that point in the  
 17 American literature. Sweden is already there. That's  
 18 why they are reporting what they're reporting now.  
 19 Q And that's just the Dhejne study; correct?  
 20 A Well, there is the decision by the Karolinska  
 21 Institute, they are looking at their own internal review  
 22 of their processes and their outcomes.  
 23 The Karolinska Institute in Stockholm has  
 24 now -- has now shut down puberty blockade and cross-sex  
 25 hormones because they are reaching the point where they

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1 are seeing the effects of long-term effects on children.  
 2 So we're at that point now.  
 3 So I wouldn't say let's do research at level 4  
 4 and, you know, case collections or case report. I let's  
 5 look at what we have so far and what is it showing us?  
 6 And that's a longitudinal population-based retrospective  
 7 review or examination of the data.  
 8 The risks we have right now is the data  
 9 collection is so slip-shot compared to Sweden and  
 10 Finland and the UK.  
 11 Q So earlier we were talking the about the levels  
 12 of evidence, you know, through 1 through 5 and you said  
 13 that -- or you'd agree that level 5 evidence is  
 14 anecdotal reports and expert opinions; correct?  
 15 A Right.  
 16 Q Okay.  
 17 A Consensus statements I think is in that kind of  
 18 group too. Sometimes consensus statements rises to the  
 19 level of level 4.  
 20 Q And --  
 21 A Um-hum.  
 22 Q So I want to direct you to your rebuttal  
 23 report, which is --  
 24 A Okay.  
 25 Q -- marked as Exhibit 4.

<p style="text-align: right;">Page 190</p> <p>1 A Okay.</p> <p>2 Q And we're going to go to paragraph 16.</p> <p>3 A Level 3, level 4. Paragraph 16? Okay.</p> <p>4 Q So going on to the -- it's the last two words</p> <p>5 of page 8; right?</p> <p>6 A "As I."</p> <p>7 Q And then going on to the next page you say, "As</p> <p>8 I will show below all of the articles cited by</p> <p>9 plaintiffs' experts are of the lowest grade of medical</p> <p>10 evidence." Correct?</p> <p>11 A Correct.</p> <p>12 Q Do you mean by that that all of the articles</p> <p>13 cited by plaintiffs' experts are a level 5 evidence?</p> <p>14 A No. Four, five. Four and five.</p> <p>15 Q So not the lowest grade.</p> <p>16 A No, no. The level 4 for sure, which is</p> <p>17 low-grade evidence. It's -- it's referred to in much of</p> <p>18 the literature as being, let's see, low quality. What</p> <p>19 are the words O'Connell (phonetic) used? Low quality.</p> <p>20 It's a very low quality or poor to low quality. There's</p> <p>21 a lot of different words people will use. There is no</p> <p>22 precision particularly in those words. It's better to</p> <p>23 speak of level 4, level 5.</p> <p>24 Q But it's not the lowest grade.</p> <p>25 A No, it's not. Level 4 for sure.</p>	<p style="text-align: right;">Page 192</p> <p>1 were peer-reviewed?</p> <p>2 A Right, yeah. So that particular article</p> <p>3 appeared in Peds JAMA. And the peer review process in</p> <p>4 Peds JAMA is probably like it is in most professional</p> <p>5 journals. They have a board of reviewers who get</p> <p>6 assigned articles to review and -- prior to acceptance</p> <p>7 for publication. So JAMA and its various outlets, like</p> <p>8 JAMA Peds is one of those peer-reviewed journals.</p> <p>9 Q So you would agree that the peer -- or it's</p> <p>10 your understanding that the peer review process in JAMA</p> <p>11 Pediatrics is the same as in most other medical</p> <p>12 journals; correct?</p> <p>13 A The process is generally the same. The</p> <p>14 particular players, obviously, vary and the editorial</p> <p>15 policies probably vary.</p> <p>16 Q Okay.</p> <p>17 A But the process of peer review is where a peer</p> <p>18 who is working in the same field and maybe even more</p> <p>19 than one peer, it might get reviewed by more than one</p> <p>20 process, will evaluate your process, evaluate your --</p> <p>21 your data, the validity, the conclusions drawn.</p> <p>22 Does your study have the power to make the</p> <p>23 judgment because of it's got a big enough study</p> <p>24 population looking at a variable that, you know, may be</p> <p>25 broadly varying or narrowly varying. There's a lot of</p>
<p style="text-align: right;">Page 191</p> <p>1 Q Okay. So let's just flip back to paragraph 4.</p> <p>2 This is paragraph 4C. It's on page 2.</p> <p>3 A Okay.</p> <p>4 Q Do you see where you say, "The papers chosen by</p> <p>5 plaintiffs' experts demonstrate systemic problems in the</p> <p>6 way such articles are peer reviewed."</p> <p>7 A Yeah.</p> <p>8 Q What do you mean by that?</p> <p>9 A Well, let's take for example one of the -- one</p> <p>10 of the papers cited by the plaintiffs' experts, a paper</p> <p>11 I think the lead author was Olson-Kennedy. It was out</p> <p>12 of USC, University of Southern California, their gender</p> <p>13 clinic. And it was an examination of top surgery in</p> <p>14 trans males.</p> <p>15 And I discuss that -- let's see. Yeah, so I</p> <p>16 discuss that in paragraph 7 -- beginning at 17 and</p> <p>17 continuing on, 18. It basically looks at how is the</p> <p>18 data collected. So articles can be very low quality for</p> <p>19 a number of reasons.</p> <p>20 The first point is -- is how you gather the</p> <p>21 data, how the patients are selected. The second point</p> <p>22 is how you interpret the data. And then -- and then the</p> <p>23 third is conclusions you have drawn.</p> <p>24 Q And, Doctor, I'm specifically asking about how</p> <p>25 the articles were peer-reviewed. Do you know how they</p>	<p style="text-align: right;">Page 193</p> <p>1 criteria, but that's the process. And it will get</p> <p>2 accepted for publication on the basis of that review</p> <p>3 process.</p> <p>4 Q Okay. And JAMA Pediatrics is peer-reviewed;</p> <p>5 correct?</p> <p>6 A As far as I know, yes, it is.</p> <p>7 Q Yeah. Do you think that watchful waiting is a</p> <p>8 scientifically proven treatment model for gender</p> <p>9 dysphoria?</p> <p>10 A It's -- it's -- I would call it a historically</p> <p>11 proven model. I would have to delve into the details.</p> <p>12 But when someone like -- gosh, his name just escaped me.</p> <p>13 Zucker.</p> <p>14 Dr. Zucker from Toronto publishes data that</p> <p>15 shows the desistance rate, meaning children who cease</p> <p>16 cross-sex self-identification in puberty and young</p> <p>17 adulthood, that desistance data was arrived at using the</p> <p>18 watchful waiting model. So you have a comparison group</p> <p>19 right there that you could compare to your affirmation</p> <p>20 care model that we're living with right now. It's</p> <p>21 already in the medical literature. Zucker lost his job</p> <p>22 because he reported it.</p> <p>23 But what does it show us? Watchful waiting</p> <p>24 isn't a passive process, it isn't a no care process.</p> <p>25 Watchful waiting is recognizing that the effects of</p>

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1 maturation are going to affect mental and emotional  
2 maturation, recognizing that individual treatment by a  
3 child psychologist can help a child to understand what  
4 kind of fear, anxiety they are trying to manage, can  
5 keep them in contact with reality, which is what's  
6 called cognitive behavioral therapy. And but the most  
7 important element in that is family therapy, family  
8 dynamics.  
9 That's what the watchful waiting model is,  
10 family therapy, behavioral cognitive therapy, sometimes  
11 the use of medications to control the anxiety, not very  
12 often, and then recognizing that puberty is going to  
13 mature their brains and that's why better than 80  
14 percent of children abandon cross-sex  
15 self-identification in adolescents and 92 percent in  
16 young adulthood. So that's watchful waiting and it has  
17 a track record.  
18 Q And what scientific literature supports the use  
19 of watchful waiting for adolescents?  
20 A Zucker, among others. And I would go to him  
21 and I would read his citations. Yeah.  
22 Q And what about for adults?  
23 MS. LAND: Objection; form.  
24 A Well, when you reach adulthood watchful waiting  
25 is not even on the table. See, watchful waiting

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1 essentially is the diagnostic process in a sense that  
2 separate out the children who desisted from the ones who  
3 would have persisted.  
4 And so if you have somebody who is in young  
5 adulthood who is persistent then -- now, that's a group  
6 you might want to study carefully with alternative  
7 therapies. Right? Because now you have established the  
8 diagnosis.  
9 If I have a desistance rate of 80 percent, but  
10 if I start them an affirmation care and I have a  
11 persistence rate of 100 percent, something is wrong  
12 here. I've misdiagnosed 80 percent of my patients. And  
13 so that's the reason why these prospective trials become  
14 a risky proposition, because you haven't determined even  
15 who has the diagnosis.  
16 Q And by starting them on affirmation care, do  
17 you mean to include social transition in that?  
18 A Well, in some measure it does. That's sort of  
19 the entry point. But in earnest it begins with puberty  
20 blockade.  
21 Q And right now you believe that puberty blockers  
22 and cross-sex hormones are too harmful to minors with  
23 gender dysphoria to permit clinical trials for those  
24 treatments?  
25 A That's my opinion.

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1 Q Do you believe that any patient who reports  
2 anxiety is incompetent to give informed consent for  
3 surgery?  
4 A No.  
5 Q What about depression?  
6 A I would have to look at that carefully. You  
7 know, situational depression is a very different thing  
8 from a -- a chronic and severe depression, depressed  
9 state.  
10 So I can -- I've often taken care of patients  
11 who are depressed over their diagnosis of breast cancer,  
12 for example. It's a very depressing thing to find out,  
13 but that's a situational depression that I can help the  
14 patient through even just as a plastic surgeon who can  
15 offer her the hope that she's going to be reconstructed  
16 and things like that.  
17 Very different from a patient who is coming to  
18 me seeking a remedy for depression by getting aesthetic  
19 surgery. That's a completely different -- completely  
20 different person.  
21 So to get a consent form in the cancer patient,  
22 I don't see any problem with that. To obtain consent  
23 for managing depression in a cosmetic aesthetic patient,  
24 I've got a real problem with that.  
25 Q Well, let's move way from aesthetic; right?

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1 I'm talking about surgery in general, in all areas of  
2 surgery.  
3 A Okay.  
4 Q Do you believe that a patient with depression  
5 is incompetent to give informed consent for surgery?  
6 A Given the qualifiers I just gave you, I would  
7 not make a blanket statement that's it's an absolute  
8 gold standard disqualifier. It's not.  
9 Q Okay.  
10 A It's a situational thing.  
11 Q What about patients experiencing suicidal  
12 ideation?  
13 A That's a problem.  
14 Q So never competent to give --  
15 A No.  
16 Q -- informed consent?  
17 A That speaks of a profound psychological  
18 disturbance. Anyone who is seriously considering ending  
19 their life is dealing with a level of anxiety, and  
20 perhaps even a misperception of the world they are  
21 living in that I would consider renders them incompetent  
22 to give informed consent.  
23 Q In any context?  
24 A I can't think of an exception. I can't  
25 think -- you might present me with an exception and I

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1 might say ah-ha, but I can't think of one.

2 Q And is that a generally accepted view in the  
3 medical profession?

4 A Pretty confident in that.

5 Q And what about a suicide attempt?

6 A Well, I would have to look into how remote that  
7 is. Is it a recent, is this an ongoing problem?

8 And also, the other thing you have to consider  
9 in that decisionmaking is what are you proposing with  
10 the surgery? So if a person is suicidal because they --  
11 you know, they have got a gangrenous leg, well, I could  
12 maybe make a case that part of what's animating their  
13 suicidality is the fact that they are walking around  
14 with this stinking leg and that they would have a very  
15 high likelihood of a better disposition if I did the  
16 amputation. Right? Very, very important to kind of  
17 categorize what you are submitting them for.

18 If you're -- if you're proposing an elective  
19 operation, an elective operation and the person is  
20 recently suicidal, I would not off them a consent form.  
21 I would offer them a referral for psychiatric evaluation  
22 to see if they are -- if they are -- if their  
23 suicidality is being adequately managed.

24 If the reason for surgery is an elective  
25 procedure to obviate suicidality, well, if I can manage

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1 the suicidality then I don't have the indication for the  
2 surgery, so I wouldn't give them the consent form then  
3 because they no longer want it. They wanted the surgery  
4 to manage suicidality. If the suicidality is managed,  
5 why even offer them the surgery?

6 Q All right. But so just going back for a  
7 second, so you'd agree that -- again, that patients who  
8 report anxiety are competent to give informed consent  
9 for surgery; correct?

10 MS. LAND: Object to form.

11 A Right. Depending on the particulars of their  
12 anxiety. But as a general principle anxiety is not  
13 sufficient to render somebody incompetent.

14 Q (By Mr. Ossip) Okay.

15 A Right.

16 Q Can informed consent be obtained in cases where  
17 the long-term benefits of an intervention have not been  
18 demonstrated?

19 A Yes, I think so. I think so. You know,  
20 balancing that against immediate risk of harm. So if  
21 you're talking about a low risk of immediate harm,  
22 lacking long-term data on benefit, yeah, I guess that  
23 would be reasonable, um-hum; certainly in the case of  
24 something that's an immediate danger that you're using  
25 surgery to obviate, then absolutely.

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1 Q And let's see. Does informed consent require  
2 an objective measurement with known error rates that  
3 could be used before the procedure to predict who will  
4 benefit from it?

5 A That is sort of an ideal circumstance. But  
6 it's generally what we aim for. So, for example, when  
7 you're -- when you're talking about cancer surgery, you  
8 know, a known danger, if I was going to, you know,  
9 accept a patient for it -- say, for example, somebody is  
10 referred to me for a thyroidectomy because the  
11 endocrinologist has diagnosed a thyroid cancer, well,  
12 I'm going to want to see the evidence. If the evidence  
13 is just, "Well, I felt a lump, it's going to be cancer,"  
14 I would go, "Well, that has very high known error rates  
15 and I'm not going to accept that as evidence for a  
16 thyroidectomy."

17 If he comes back and says, "Well, I've got an  
18 ultrasound and the ultrasound shows an echoic lesion in  
19 the right lobe," I will say, "Well, that's interesting,  
20 low probability of cancer," I still won't offer surgery  
21 because the error rate is too high. You've got a  
22 pathology report, I'll go, "Excellent," and I'll look at  
23 that slides. Do you see the difference?

24 Q Well, let's just go back to my question. So  
25 you would agree that informed consent does not require

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1 an objective measurement with known error rates that can  
2 be used before the procedure to determine who could  
3 benefit from it?

4 A It's not a sine qua non, right.

5 Q Not a requirement? To avoid Latin.

6 A Well, okay. I'm just trying to stay with you  
7 here. Having tests that -- with known error rates is a  
8 very important and indispensable thing when you're  
9 talking about a life-changing operation. Like a  
10 thyroidectomy is a life-changing operation and I'm going  
11 to want to have known error rates. If it's an unknown  
12 error rate what you have used to diagnose something  
13 where I'm going to do an operation that's life changing,  
14 that's unacceptable.

15 Q So any thyroidectomy that was performed in a  
16 time when there was not a known error rate, that was --  
17 then informed consent for that procedure was impossible?

18 A Well, no. You're in a circumstance there where  
19 to the best of your ability. Some even with my own  
20 training era, a general surgery (sic.) in the 80s the  
21 diagnostic specificity has gotten better.

22 Take an appendectomy for example. When I was a  
23 junior resident in general surgery, if you weren't -- if  
24 you weren't taking -- if 20 percent of your  
25 appendectomies weren't normal, normal appendix removed,

<p style="text-align: right;">Page 202</p> <p>1 the chief of surgery would say you're not doing enough  2 appies, because he's afraid of somebody rupturing their  3 appendix and you not attending to it.  4 So but now the likelihood of a negative  5 appendectomy is some number approaching zero.  6 Q Well, just again, just to get --  7 A You do the best you can.  8 Q I want to avoid the longer tangential examples.  9 Okay, Doctor?  10 So just again, you're saying the question is to  11 the best of your ability; correct?  12 A What's the best level of evidence you can get.  13 Q Okay. And that's sufficient to get informed  14 consent?  15 A Right. The less uncertainty, the better. An  16 error rate speaks to uncertainty.  17 Q And have you ever performed a procedure that  18 lacked an objective measurement with known error rates  19 to determine who would benefit from the procedure?  20 A I'm not a trailblazer in surgery. I generally  21 go with what I have been trained up in in areas that has  22 proven results and things like that. I'm trying to  23 think if I have ever done anything experimental. I'm  24 not that kind of surgeon.  25 Q Well, you -- we'll come back to that.</p>	<p style="text-align: right;">Page 204</p> <p>1 But on the other hand, if a girl comes in who  2 has a minor asymmetry in their breast, and that's a  3 common thing, and she wants to have large breast  4 implants put in, I would say no.  5 Q (By Mr. Ossip) So okay. I think I'm  6 understanding. So the question of whether that would be  7 ethical would be whether or not you are moving someone  8 from outside the range of normal for their biological  9 sex to somewhere inside the range of normal for their  10 biological sex?  11 A That's a good way to put it, yeah, it is.  12 That's reasonable, um-hum, I think.  13 Q All right. Do cosmetic surgeries ever  14 sacrifice function?  15 A If a cosmetic operation puts in jeopardy a  16 human function I would -- I would expect or hope that it  17 only happened accidentally or through some misadventure,  18 either preoperatively, intraoperatively, or  19 postoperatively. To sacrifice function for a cosmetic  20 result is one of those bedrock plastic surgery ethos.  21 We sacrifice function all the time for a reconstructive  22 procedure. But to sacrifice it for a purely cosmetic  23 procedure would be -- it better be accidental.  24 Q Well, that's a good -- let's dig into that a  25 little bit.</p>
<p style="text-align: right;">Page 203</p> <p>1 Is it always a breach of medical ethics to  2 perform a purely cosmetic procedure on someone under the  3 age of 18?  4 A The -- you know, in my training for board  5 certification, the American Society of Plastic Surgery,  6 one of the things they would review is things like that,  7 doing, like, for example a breast augmentation on an  8 adolescent high school age female. If I presented a  9 case like that for my board certification I probably  10 would have been dismissed for it.  11 Q Well, my question is yes or no. Is it always a  12 breach of medical ethics to perform purely cosmetic  13 procedures on someone under 18?  14 MS. LAND: Object to form.  15 A So there we would have to get into the  16 definition of cosmetic, because we're getting to the  17 fine details here. So if cosmetic, you know, you could  18 grade asymmetry of the breast in Poland syndrome to be  19 cosmetic, but that would be a fairly heartless approach  20 to a girl suffering from Poland syndrome.  21 So technically I'm not solving a functional  22 deformity, but it's an objective deformity. She's not  23 within the range of normal for a female. It could be  24 considered cosmetic, but that would not be problematic  25 because it's a reconstructive operation.</p>	<p style="text-align: right;">Page 205</p> <p>1 A Okay.  2 Q So you said it better be accidental. So that  3 gets to the intention of the physician; correct?  4 A Right, or his knowledge, his competence.  5 Q Is it ethical to perform a cosmetic surgery  6 that carries a risk of sacrificing function?  7 A No. All operations have some risk. And so,  8 for example, every time I do a rhinoplasty there is a  9 potential risk that they are going to have a perforation  10 of their septum if there is some accidental misadventure  11 in the course of raising the flaps. And I explain that  12 to the patient and every rhinoplasty surgeon does.  13 So your risk of septal perforation is somewhere  14 around 3 to 4 percent. That's an acceptable risk  15 because the management of it is certainly within reach  16 of an office procedure most of the time.  17 So it's not uncommon that there is some  18 measurable risk, but the risk ought to be very low and  19 it ought to typically happen through a misadventure,  20 like I'm raising the flap and I accidentally pierce that  21 flap.  22 Q And how much risk of a functional loss is  23 acceptable for a cosmetic procedure?  24 A It better be in the low single digits, you  25 know.</p>

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1 Q So, like, we talked about Poland syndrome. So  
 2 let's -- and breast augmentation. Is it -- it's -- is  
 3 it your testimony that's never ethical for someone under  
 4 the age of 18 except for patients with a congenital  
 5 breast deformity to receive a breast augmentation?  
 6 MS. LAND: Object to form.  
 7 A Well, okay. I can think of an example where it  
 8 might be acceptable, but there again you're sort of  
 9 skirting outside the range of normal. So a girl with  
 10 what's called pectus excavatum where the chest is sunk  
 11 in because of a developmental process, to conceal that  
 12 pectus excavatum using autologous fat grafting  
 13 augmentation rather than an implant would be a very  
 14 reasonable thing to do for her.  
 15 But there again, you're still -- even though  
 16 the defect would be close to within the range of normal  
 17 and even if pectus excavatum is not an uncommon thing, I  
 18 think it would be very reasonable to offer a girl who is  
 19 in her high school years, who has done most of her  
 20 skeletal growth already at that point to maybe offer --  
 21 she might be 16, 17, at that point I think it would be  
 22 reasonable.  
 23 On the other hand, an otherwise normal, healthy  
 24 girl who comes in who just wants bigger breasts, I think  
 25 that's problematic.

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1 Q (By Mr. Ossip) And do you think that's  
 2 unethical just looking at that particular case?  
 3 A I don't want to judge my colleagues, but I  
 4 would consider it myself to be unethical if I was to do  
 5 that.  
 6 Q Okay.  
 7 A I would judge myself to be unethical in doing  
 8 that.  
 9 Q But is that a generally accepted view in the  
 10 medical profession?  
 11 A I remember hearing it more than once when I was  
 12 in training.  
 13 Q But are surgeons subject to discipline for  
 14 performing such augmentations?  
 15 A They are subject to discipline following  
 16 discovery. And a lot of these things go undetected I  
 17 suppose. But, yeah, surgeons are at times disciplined.  
 18 It's not a very common thing in the world of plastic  
 19 surgery, but it happens.  
 20 Q But just to be clear, you're saying that  
 21 physicians who conduct or perform a purely cosmetic  
 22 breast augmentation on a minor are subject to  
 23 professional discipline?  
 24 A Not as a general rule, no, not as a -- I think  
 25 because it goes undiscovered virtually.

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1 Q Well, let's take a case where it is discovered;  
 2 right?  
 3 A Okay. Okay.  
 4 Q Is such a physician subject to professional  
 5 discipline?  
 6 A Probably at least review of the case and to see  
 7 if it's a trend. Right? For example, if I was doing  
 8 breast augmentations on minor females in the local  
 9 hospital and I had an extrusion of an implant, because  
 10 she's active and she doesn't pay attention to  
 11 postoperative orders and forgot to take her  
 12 antibiotic -- I don't know -- the implant extrudes and  
 13 has to be removed because of infectious complication,  
 14 that's going to appear in the morbidity report. And if  
 15 the morbidity report comes up and goes, "Oh, Dr. Lappert  
 16 did a breast augmentation that suffered complications in  
 17 a 16-year-old girl, is this a trend?" And if that  
 18 medical board at that hospital reviews my operative  
 19 records and say, "Oh, look, he does these surgeries all  
 20 the time," then that might get examination.  
 21 Q So let's go to your rebuttal report.  
 22 A Okay.  
 23 Q So that's --  
 24 A Is it 5? No. That's --  
 25 Q That is 4.

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1 A Four. Okay. That's right.  
 2 Q And I want to go to paragraph 6.  
 3 A Paragraph 6. Okay.  
 4 Q So let me know when you are there.  
 5 A I'm there.  
 6 Q So do you see that first sentence, you say,  
 7 "Cosmetic breast augmentation for anything other than  
 8 congenital breast deformities, such as Poland syndrome,  
 9 in minors is not considered ethical professional  
 10 conduct."  
 11 A Again, that's -- that's where my training has  
 12 taught me. And then I have a reference for you.  
 13 Reference 3, from the seminars and plastic surgery.  
 14 Q Right. And that's that Jordan and Corkrine  
 15 article?  
 16 A Right, right, right.  
 17 Q And does that article say it's unethical to  
 18 perform purely cosmetic breast augmentations?  
 19 A No. It raises it as a question. It doesn't  
 20 declare it so, but it raises it as an ethical question  
 21 worthy of examination, yeah.  
 22 Q Okay. Are breast reductions ever performed for  
 23 strictly cosmetic reasons?  
 24 A Yes.  
 25 Q And does this sacrifice function for the sake

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1 of a cosmetic result?

2 A It hopefully does not.

3 Q But it risks it?

4 A Right, yeah, there is always risks. So if you

5 want to hear it, I can expound; if not --

6 Q That's okay. I just want to keep it moving.

7 A Sure.

8 Q But you would agree that a purely cosmetic

9 breast reduction can be ethical?

10 A Oh, absolutely. I do them all the time. I did

11 them all the time.

12 Right. The distinction between a cosmetic and

13 a reconstructive breast reduction has to do with did the

14 patient present with orthopedic problems and what is the

15 way the specimen you submit. So those are subjective

16 criteria that span between cosmetic and.

17 Q Do you consider gender affirming surgeries to

18 be cosmetic or reconstructive?

19 A They're -- I call them aesthetic rather than

20 cosmetic.

21 Q What's the distinction between aesthetic and

22 cosmetic?

23 A So cosmetic just speaks to the fact that you're

24 changing the form. Right? Aesthetics speaks to the

25 fact that you're changing the form affects the

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1 subjective life of the patient, and that's an important

2 distinction to make because it helps you address risk.

3 So an aesthetic operation for somebody who has,

4 like, a daily problem with explaining why they look

5 tired. Maybe they're a bank teller and everybody is

6 always, "You're not getting enough sleep, hon."

7 Well, I can solve the tired-looking face with

8 an aesthetic operation. I can make their face look

9 rested and that solves an objective problem that they

10 are suffering every day. That's a very important thing

11 to offer people. And I always make that distinction

12 when talking about risk with patients because they're

13 not doing it for nothing. They are doing it for

14 objective reality, which is their subjective life.

15 If I put them at great risk to do that, now

16 we've got an important conversation to have. If I can

17 do it with little to no risk then that's a chip shot

18 conversation.

19 Q And cosmetic surgeries don't involve that --

20 MS. LAND: Object to form.

21 Q -- objective benefit?

22 A No. Cosmetic surgery -- I make the distinction

23 because of the way people understand cosmetics.

24 Cosmesis is just about the change in appearance.

25 Aesthetics is about the result of the change.

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1 And what we're -- the most important

2 conversation we're having, especially when you're

3 talking about trans children, is the subjective effect

4 of surgery.

5 Q (By Mr. Ossip) So I guess are all cosmetic

6 surgeries aesthetic?

7 A Right.

8 Q But not all aesthetic surgeries are cosmetic?

9 A Okay. An aesthetic operation involves a

10 cosmetic change. The term "aesthetics" just calls to

11 mind the fact of the motivation for the operation and

12 the expected result of the operation. Cosmesis is just

13 the physical change. Aesthetics is the more inclusive

14 category. So aesthetics includes cosmetic procedures,

15 but speaks to the subjective result of those cosmetic

16 procedures. Does that help?

17 Q Maybe. But again are there any aesthetic

18 procedures that are not cosmetic?

19 A Aesthetic procedures. I can't think of it

20 because aesthetics is about the perception of the

21 physical reality. Whether you're talking about the

22 aesthetics of this room, the aesthetics of that painting

23 or the aesthetics of somebody's nose.

24 Q So the answer is no; right?

25 MS. LAND: Object to form.

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1 A Yeah.

2 Q (By Mr. Ossip) Okay. And do you know if the --

3 but either way, you don't consider gender-affirming

4 surgeries to be reconstructive; correct?

5 A No, it's not, absolutely reconstructive

6 surgery.

7 Q Do you know in the American Society of Plastic

8 Surgeons considers gender-affirming surgeries to be

9 reconstructive?

10 A Yeah, they do.

11 Q They do?

12 A Yeah.

13 Q So let's talk for a second about facial

14 feminization surgery.

15 A Okay.

16 Q Is there any loss of function there?

17 A There is a risk of loss of function, but no

18 expected loss of function.

19 Q And that would put it in the realm of ethical

20 then; correct?

21 A Right. In terms of just surgical risk and how

22 it applies to ethics. And putting aside the entire

23 question of body dysmorphic disorder. We'll just put

24 that aside. Surgical risk and how surgical risk affects

25 ethical decisionmaking. Surgical risk low, not

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1 ethically contraindicated.  
2 Q Okay. Sorry. Bear with me one second, Doctor.  
3 A Okay.  
4 MR. OSSIP: Maybe now is a good time to  
5 take a break.  
6 VIDEO OPERATOR: Okay. This will end  
7 media part 4 and we're off the record at 3:00 p.m.  
8 (A break was had.)  
9 VIDEO OPERATOR: We are back on the  
10 record at 3:20 p.m. This will begin media part 5.  
11 Please proceed.  
12 Q (By Mr. Ossip) All right. Welcome back again  
13 Doctor.  
14 A Thank you.  
15 Q So, Doctor, earlier we were talking about a  
16 study by someone named Zucker; is that correct?  
17 A Well, a series of papers on the subject, yeah.  
18 Q Okay. And is it your understanding that Zucker  
19 found that patients who had gender dysphoria after the  
20 onset of puberty were likely to desist?  
21 A No. What -- I -- let me see if I can remember  
22 the details. He's the one who fairly consistently  
23 reported the numbers of desistance in the 80 percent  
24 range, actually it was some spread between 60 and 80  
25 percent, but roughly 80 percent.

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1 And he was talking about desistance in --  
2 during adolescence, not at the onset of adolescence, but  
3 during adolescence. And as I recall the interpretation  
4 of that was that the effects of sex hormones on brain  
5 maturation and -- and perhaps more importantly the  
6 physical changes of puberty, confirmed in the mind of  
7 the child that their biological sex is -- has a reality  
8 that's comfortable for them now.  
9 Q So the answer is, just to go back to the first  
10 word, no; correct?  
11 A You were asking me if it desists at the onset  
12 of adolescence, and I'm saying it happens sometime  
13 during adolescence or, indeed, on adulthood.  
14 Q My question was: Do you think that Zucker  
15 found patients who had gender dysphoria after the onset  
16 of puberty were likely to desist? Yes or no?  
17 MS. LAND: Object to form.  
18 A Oh, no, Zucker didn't address that.  
19 Q (By Mr. Ossip) Okay.  
20 A Zucker didn't address onset after puberty.  
21 That's a whole different diagnosis.  
22 Q And did Zucker address onset prior to puberty  
23 that continued after puberty?  
24 A Right. So those would be the persisters and  
25 that's what he found, that somewhere around 20 percent

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1 would persist into late adolescence and young adulthood.  
2 Q Okay. Do the plaintiffs' experts all have  
3 significant financial and professional conflicts of  
4 interest in this case?  
5 MS. LAND: Object to form.  
6 A I'm not privy to their financial interests.  
7 Q (By Mr. Ossip) Okay. So if you have previously  
8 signed a statement under oath that said that, that would  
9 be false; correct?  
10 A Okay. So the -- when you have someone who, say  
11 an expert who 90-plus percent of their patient load is  
12 transgender persons, I think it would be safe to say  
13 that there is a financial element. Is it an overriding  
14 interest? I -- that might be subject to interpretation.  
15 But it seems that most of the plaintiffs' experts devote  
16 much of their professional life to persons with this  
17 condition and, therefore, their income is derived from  
18 the care of persons with that diagnosis.  
19 Q Just to be clear, we have talked about a couple  
20 of experts; correct?  
21 A Right.  
22 Q So let's talk about Dr. Adkins.  
23 A Okay.  
24 Q Does Dr. Adkins have a significant financial  
25 and professional conflict of interest in this case?

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1 A She as a financial interest, I would imagine,  
2 in terms of continuing to offer the services she offers.  
3 Q But not necessarily a conflict of interest?  
4 A No. Not necessarily, no. But there is a  
5 suggestion of an issue there if --  
6 Q What about Dr. Antommara?  
7 A I don't know what percentage of his patients  
8 are transgender. But as I recall it's a significant  
9 portion of his patients.  
10 Q Where did you come to learn that?  
11 A I don't know if I read his -- I don't know.  
12 That was so long ago that I read that stuff.  
13 Q But you would have no way of knowing whether or  
14 not Dr. Antommara has a significant conflict of  
15 interest; correct?  
16 A I don't know the degree of his conflict of  
17 interest.  
18 MS. LAND: Object to form.  
19 Q (By Mr. Ossip) Do you know whether he has a  
20 conflict of interest at all?  
21 A I would suspect that there was -- there may be  
22 a conflict of interest if decisions about doing these  
23 surgeries, if it -- if it becomes something that is not  
24 legal for him to do, let's say. Let's take a case  
25 example.



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1 A law passes that you can't do transition  
 2 hormonal therapy then that would have a significant  
 3 impact on his practice I would imagine.  
 4 Q And what's your understanding of  
 5 Dr. Antommaria's practice?  
 6 A He's a psychiatrist; right? Pediatric  
 7 psychiatrist.  
 8 Q What does it mean to divide the human person  
 9 from our own bodies?  
 10 A So that's an anthropological concept of what  
 11 you define as the essence of being a human person. So  
 12 if you define the human person as a spirit being that  
 13 occupies a body then that speaks of a division between  
 14 the subjective life of the person and their embodied  
 15 self, and that's a difficult issue because it goes  
 16 against everything I ever learned about the human person  
 17 as a physician.  
 18 I don't know of any human person apart from  
 19 their body, I don't -- and the consequences of their  
 20 body existing in the world. The fact that they have a  
 21 voice, the fact that they do things.  
 22 So -- so when a child is given this idea that  
 23 their essential self is a spirit that is in the wrong  
 24 body, that's a -- that's a psychological division that's  
 25 being created in the life of that child. In my

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1 experience it's not natural for a child to speak that  
 2 way. A child -- it's not natural. In my experience the  
 3 child is given language like that.  
 4 Q And -- well, when you say in your experience,  
 5 what do you mean by that?  
 6 A Taking care of children for 30 years.  
 7 Q In what capacity?  
 8 A As a pediatric surgeon and cleft craniofacial  
 9 care and, you know, trauma situations and coming into my  
 10 clinic with minor birth defects and, you know, I mean,  
 11 in my -- in my practice of plastic surgery a significant  
 12 proportion are children, or were children until a year  
 13 ago.  
 14 And I'm in the habit of not only taking the  
 15 history from the parents, but trying to get a sense that  
 16 the child has of what they're experiencing, so I always  
 17 talk directly to the child in the presence of the  
 18 parents to get a sense for how they're understanding  
 19 their circumstance. And it is my experience that  
 20 children don't speak about their bodies as being  
 21 something separate.  
 22 Q So I just -- one thing I want to get back to.  
 23 You said a big proportion of your practice as a plastic  
 24 surgeon up until a year ago was children; correct?  
 25 A Yeah.

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1 Q What proportion?  
 2 A Probably somewhere between 15 and 20 percent.  
 3 Q Okay.  
 4 A Years before that it was much larger. I  
 5 directed a congenital deformities clinic at the  
 6 Portsmouth Naval Hospital and had a very large  
 7 enrollment of children with birth defects.  
 8 Q So you talked about there being -- well, let me  
 9 ask it another way. So why is it a problem to divide  
 10 the human person from our own bodies?  
 11 MS. LAND: Object to the form.  
 12 A Well, in terms of the issue in question it may  
 13 predispose decisionmaking that would incline the person  
 14 to treat their bodies as a separate object of  
 15 domination, if you will, or an object of care. So  
 16 speaking of your body the way you speak of a shirt.  
 17 Right? I'm going to have the collars narrowed. I'm  
 18 going to have my breasts removed, that kind of thing,  
 19 objectifying their own body when, in fact, their body is  
 20 part of their subjective life in important ways, which  
 21 is where this problem comes from. It's a  
 22 misinterpretation of what they're body is telling them  
 23 about who they are.  
 24 Q And by "this problem," you mean transgender?  
 25 A Right. Gender dysphoria, gender identity

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1 issues, gender incongruence. Why does a child feel  
 2 separated from their body in a way where they view their  
 3 body as the enemy to their happiness. That's a very  
 4 important thing.  
 5 Q And all of those things come from a  
 6 misinterpretation?  
 7 A Yeah. Clearly, yeah.  
 8 Q And is that a medical issue?  
 9 A It's a psychological issue.  
 10 Q And what is the treatment for that  
 11 psychological issues?  
 12 A Well, so to view your own body as the source of  
 13 your problems apart from some objective -- is the analog  
 14 to that would be like the anorexic girl. And anorexia  
 15 predominates in adolescent females.  
 16 For them to view their unhappiness is caused by  
 17 a misperception of their own body. So the anorexic  
 18 misperceives a skeletal body as being obese, so that's  
 19 where the misperception, misapprehension is. Why?  
 20 Because she would rather not look at the internal wound  
 21 that is causing her to feel unsafe or unloved, and so  
 22 she sees something that's not there.  
 23 And that's directly applicable to the child  
 24 that looks at their body and sees something that's not  
 25 objectively there. They see a body that's an enemy to

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1 their happiness and they see their own genitalia, for  
 2 example, as not really a part of themselves, so that's a  
 3 misperception.  
 4 Q In both cases it's a delusion?  
 5 A Well, by degrees. By degrees it's a delusion.  
 6 So in the case of the anorexic, delusion has three  
 7 criteria. One of them is it's a fixed firm belief. And  
 8 that's, interestingly, one of the diagnostic criteria in  
 9 DSM by diagnosing gender dysphoria in the child is the  
 10 fixity of the belief. Persistent, insistent, and  
 11 consistent is what they say.  
 12 Well, persistence in a belief does not make it  
 13 true, and that's the problem with the delusion. So it's  
 14 not -- it's not amenable to logical argumentation is the  
 15 other criteria. So they are insistent on it, it's not  
 16 amenable to logical argumentation. And the third thing  
 17 is it's an impossibility. Those are the diagnostic  
 18 criteria for delusion.  
 19 Transgender, gender dysphoria that rises to the  
 20 level of seeking surgical intervention in the case of  
 21 the historic demographic. Meaning boys who persisted  
 22 into young adulthood, right, now you've gotten to the  
 23 point where it's persistent, right? It's a consistent  
 24 thing. They have lived it since childhood. It's not  
 25 amenable to objective argumentation, and it's an

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1 impossibility as surely as an anorexic girl is obese.  
 2 What's the impossibility? Well, it's  
 3 impossible that a boy with a Y chromosome in every  
 4 somatic cell of their body is, in fact, a girl. There's  
 5 no basis for making that claim. It's a subjective claim  
 6 based on a misperception of their body. So it meets all  
 7 the criteria.  
 8 Now, contrast that with the late-onset gender  
 9 dysphoric female, rapid-onset gender dysphoria, you're  
 10 going to have a hard time demonstrating delusional  
 11 thinking there. What you're more than likely  
 12 encountering is a persistence in a social -- what's the  
 13 term that's used.  
 14 The social contagion model is the term that's  
 15 been applied to it, where it's a -- it's a shared belief  
 16 among groups of people. You don't generally find this  
 17 happening, isolated case. You will find three cases in  
 18 middle school. You will find a group of women in  
 19 college age who suddenly are cross-sex identifying or  
 20 agender or non-gender or something like that.  
 21 Yeah, and so if you look into that you'll  
 22 typically find an event of injury or something has  
 23 happened. But what -- a delusion doesn't lie behind  
 24 that.  
 25 And that speaks to a very important thing. The

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1 fact that you have two completely different mechanisms  
 2 at work, one onset prepubertal, one onset in  
 3 adolescence, young adulthood, one associated with  
 4 delusional thinking, the other one not associated with  
 5 delusional thinking. How could you possibly claim that  
 6 it's the same process? And how could you possibly claim  
 7 that it has the same cure? It makes so sense.  
 8 And the other thing you cannot claim is that  
 9 it's biological caused, because you're proposing some  
 10 massive mutation in the human genome that would cause a  
 11 5,000 percent increase in this diagnosis in seven years.  
 12 Q So you -- so you would --  
 13 A Sorry.  
 14 Q It's your -- it's your belief that what you're  
 15 calling early onset and late-onset gender dysphoria have  
 16 different cures?  
 17 A Well, I have a hard time imagining that -- that  
 18 problems with completely different origins and  
 19 completely different demographics are likely to have the  
 20 same cure.  
 21 Q And what do you think the cure is for early  
 22 onset gender dysphoria?  
 23 A Well, historically, you get an 80-plus percent  
 24 cure rate, which under any other circumstance would be  
 25 considered like trip to Stockholm for the Nobel Prize

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1 cure rate. 80 percent in a -- in a period of years, and  
 2 over 90 percent, that's -- that's the cure is -- and it  
 3 may get better with time. Maybe we find another  
 4 therapy. But right now watchful waiting, family tear,  
 5 the things we talked about.  
 6 Q And by "cure" in that context, you mean  
 7 desisting from a transgender identity?  
 8 A Right. The child achieves happiness without  
 9 requiring -- the child achieves that happiness that is  
 10 sought for them without requiring a lifetime of  
 11 medications or permanently altering surgeries. You've  
 12 reached a resolution of the anxiety, a resolution of the  
 13 dysphoria without subjecting the child to surgery and a  
 14 lifetime of medicine. That's a win.  
 15 Q Okay. And what is the cure for late-onset  
 16 gender dysphoria?  
 17 A Well, I don't think it's been studied  
 18 adequately because the diagnostic category was only  
 19 proposed by Lisa Littman back in 19 -- I mean, 20 -- is  
 20 it 2019, 2018, somewhere around in there. I'm not sure.  
 21 I'll have to check on the dates. So this is a recently  
 22 recognized group, although other clinicians have  
 23 reported there is a shifting demographic, especially the  
 24 people looking at the sudden burgeoning of the  
 25 diagnosis, they recognize that whereas in the past only

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1 20 percent of new diagnoses were female, now greater  
2 than 60 percent were female.  
3 Lisa Littman proposed this is a different  
4 phenomenon, rapid-onset gender dysphoria, social  
5 contagion model.  
6 Q So you would support research into -- sorry.  
7 Strike that.  
8 You would support research assessing potential  
9 cures of late-onset gender dysphoria?  
10 A Right. Well, so that research would have to  
11 begin with a look into the causes of the problem, causes  
12 of the problem looking for common factors, because that  
13 would direct your research in terms of remedy.  
14 Q Okay.  
15 A So, I mean, a tumor is a tumor, but a tumor  
16 caused by cancer is a very different creature from a  
17 tumor caused by a blow to the leg. And so the first  
18 thing is what's caused the tumor. What caused the  
19 gender dysphoria.  
20 Q All right. Is gender dysphoria that persists  
21 for 20 years a delusion?  
22 A Depends on if it's the child onset one versus  
23 the adolescent and adult onset one. The likelihood of  
24 it being animated by a delusional thought -- it's not a  
25 blanket major delusion versus trivial delusion or

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1 trivial misunderstanding. But there is some  
2 misperceived event likely in the early onset, or as I  
3 don't know in the adult onset. I don't see evidence for  
4 a delusion. And it may come to light, but I never read  
5 an article that --  
6 Q So even if it persisted for 20 years that would  
7 not, in your mind, rise to the level of delusional  
8 thought?  
9 A In the case of a female with rapid-onset gender  
10 dysphoria, late-onset gender dysphoria?  
11 Q What you're calling late-onset gender  
12 dysphoria.  
13 A Okay. That's the category. Ask me the  
14 question again, please.  
15 Q If that persists for 20 years --  
16 A Okay.  
17 Q -- would that rise to the level of delusional  
18 thinking?  
19 A No. I could see where -- I could see where a  
20 subtle habit of life and a comfort in the life chosen  
21 would be -- would have resolved the unhappiness in some  
22 measure and I wouldn't even categorize it as a dysphoria  
23 at that point because they have arrived at some  
24 reconciliation of the way they are living their life and  
25 they are at peace about their life. Problem solved.

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1 Q But it would -- I guess I'm confused. But --  
2 A You mean if they -- I'm sorry.  
3 Q So but for somebody who had early onset gender  
4 dysphoria and that persists for the same length of time,  
5 that is delusional thinking.  
6 A It's vastly more likely that there is a  
7 delusional thought that animates that that's driving a  
8 compulsive behavior. You know, that's a very high  
9 likelihood. I'm using historical, you know, what's been  
10 reported in the literature, again, going to when I was  
11 in residency.  
12 Q And going back to the phrase "dividing the  
13 human person from our own bodies," is that a religious  
14 issue?  
15 MS. LAND: Object to form.  
16 A No. I consider that to be an anthropology  
17 medicine issues. I don't recall ever attending a  
18 lecture, reading a paper, reading a textbook in medicine  
19 and surgery that ever described the human person as a  
20 spirit creature that occupies a body. Never heard it.  
21 Never heard it. So I don't have to turn to my religious  
22 education. This is fundamental to what it means to be a  
23 doctor in the western world.  
24 Q (By Mr. Ossip) But is that limited to the  
25 western world?

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1 A Different -- different cultures have a  
2 different view of the human person. And I cannot speak  
3 to that. I can only speak to the -- to the world view  
4 that gave us science and medicine.  
5 Q So this is a cultural view?  
6 MS. LAND: Object to form.  
7 A I think it's a scientifically based world. I  
8 think those two become inseparable, because it's the  
9 culture that gave rise to the science. The scientific  
10 revolution didn't happen just anywhere. It happened in  
11 a particular place at a particular time. And that  
12 happens to be the western world; in fact, you know,  
13 after the 12th century, western European world. That's  
14 where the science and the medicine that we're speaking  
15 about today came from. So what gave rise to all these  
16 wonderful medical advancements and technologies is the  
17 child of that culture.  
18 So I wouldn't separate it from that culture,  
19 but I also wouldn't ascribe everything to that culture,  
20 because there is scientific evidence that now supports  
21 what we're doing. Now what we're doing is  
22 scientifically based, but it's animated by a culture  
23 that's willing to accept the fact that the world  
24 presents itself up to us in a predictable way, and if  
25 you come back tomorrow and make the measurement on that

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1 child you're going to get the same number. That's a  
 2 decidedly western view of the world.  
 3 Q And that's an exclusively western view of the  
 4 world?  
 5 A Not anymore.  
 6 Q And that's because -- well, strike that.  
 7 Is it -- well, should a person have control  
 8 over their own body and its appearance?  
 9 A Yeah. That's --  
 10 Q Yes?  
 11 A Yes.  
 12 Q Is it a mistake for people to view their own  
 13 bodies as something that they can do things to in order  
 14 to provoke happiness in themselves?  
 15 A No. It's a reality.  
 16 (Plaintiffs' Exhibit 7 was marked for  
 17 identification and made a part of the  
 18 record.)  
 19 Q All right. So the court reporter has just  
 20 handed you something that's been marked Exhibit 7. Have  
 21 you seen this document before?  
 22 A Yeah. I'm trying to remember where it was  
 23 published. Oh, Life Site. Okay. Now I remember.  
 24 Q And this article quotes you extensively;  
 25 correct?

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1 A It does, yeah.  
 2 Q All right.  
 3 A I think it's the result of a phone interview.  
 4 Q So there are -- unfortunately there are not  
 5 page numbers on this, but if you -- there is some  
 6 headings, if you see in bold.  
 7 A Okay. Sure.  
 8 Q And I want you to flip to it's the  
 9 second-to-last page. And there's a heading, it says  
 10 "Regarding Objective Truth." It's in the second-to-last  
 11 page.  
 12 A Oh, I'm sorry. I was on -- okay. "Rejecting  
 13 Objective Truth." Yes, okay.  
 14 Q And so do you see that where you say, "One of  
 15 the mistakes that people are making in temporary life is  
 16 viewing themselves as some sort of spirit creature and  
 17 their body is something they own or something they  
 18 possess. They view their own body as something they can  
 19 do things to in order to provoke happiness in  
 20 themselves." Do you see that?  
 21 A I do.  
 22 Q And that second sentence, you don't believe  
 23 that that's a mistake?  
 24 A It's not a categorical one. So that operates  
 25 by degree. So for example, coloring your hair is a

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1 relatively trivial thing to do that provokes happiness.  
 2 Right? Amputating your genitals, of course, would be in  
 3 a whole other category. But they're animated by the  
 4 same kind of idea.  
 5 In the one case it isn't a separation from  
 6 themselves. It's just a coloring of their hair. But to  
 7 view their bodies as being a source of sorrow or  
 8 something to be worked over, like body modification,  
 9 making your face look like a reptile, that would be --  
 10 and there are plastic surgeons that will do that for you  
 11 and don't get censured for it. But it's -- it exists on  
 12 a spectrum.  
 13 And if the society generally views the human  
 14 body as a pallet on which you can exercise dominion then  
 15 it's an easier sell that you can modify a child's body  
 16 to make them happy if they are anxious. That's the  
 17 point I'm making.  
 18 Q And you're not denying that you gave this quote  
 19 for this article; correct?  
 20 A The quote, "They view their own bodies as  
 21 something they can do" -- sometimes I misquote it, but  
 22 let me read that.  
 23 (The witness reviewed the document.)  
 24 A Yeah. No. I stand by that.  
 25 Q Okay. And do you know whether your interview

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1 for this article is recorded?  
 2 A Gosh, I don't remember how it was done. Gosh,  
 3 that was like three years ago almost.  
 4 Q It wouldn't surprise you if it were, though;  
 5 correct?  
 6 A No, it wouldn't surprise me.  
 7 Q Okay.  
 8 A Sometimes people catch me after presentations  
 9 and say, "Would you mind," you know, and it may have  
 10 been something like that. And I know that Life Site,  
 11 for example, is a Catholic media effort and it's very  
 12 likely that somebody from Life Site might have come to  
 13 one of my talks at a Catholic church and asked to  
 14 interview me, asked me a bunch of questions.  
 15 Q Do gender transition procedures pervert our  
 16 sense of human sexuality?  
 17 MS. LAND: Object to the form.  
 18 A Yeah, they -- they pervert and distort. I  
 19 would stand by that, yes they do.  
 20 Q In what way?  
 21 A Well, okay. So the viewing of human sexual  
 22 relations as a recreational process in which you can use  
 23 a person to achieve a satisfaction I think perverts the  
 24 sexual faculty. Because human sexual faculty, again,  
 25 the division in the person comes up again. The human

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1 sexual union has two aspects that up until the 1960s  
 2 were never separated. The unitive effect. The bonding  
 3 of two people together in the act of love, and it's  
 4 procreative consequences.  
 5 To utterly separate all those things to where  
 6 now it's -- it has -- you've destroyed even the unitive  
 7 aspect, putting aside the fact that you've rendered the  
 8 person sterile, you have even perverted, if not utterly  
 9 destroyed the unitive aspect with such things as the  
 10 effect of puberty blockade on orgasm for example or the  
 11 effect of loss of sensibility following the construction  
 12 of artificial vagina and the moving of the glands to the  
 13 clitoris position.  
 14 You degrade the unitive of functioning in doing  
 15 those things. There is no surgeon that's so good that  
 16 that's going to be perfectly preserved. Some achieve  
 17 very near perfection. But the lion share of people  
 18 having this surgery will report a loss of sensation, in  
 19 addition to their utter loss of fertility.  
 20 So what that speaks to is a willingness to do  
 21 that puts a value on sexual relations that's out of  
 22 proportion to its meaning. If you're willing to destroy  
 23 a human function in pursuit of a sexual life that may or  
 24 may not be achievable that's -- that suggests to me --  
 25 by perversion I don't mean like "you pervert."

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1 Perversion means a distortion or a twisting. Not  
 2 pervert like a legal definition. It is perverting  
 3 truth.  
 4 Q And is that a medical opinion?  
 5 A That's my opinion.  
 6 Q And is that -- and part of that opinion is that  
 7 is interferes with what you view as natural human  
 8 reproductive capacity; correct?  
 9 A Well, that's one of its features. One of its  
 10 features, yeah.  
 11 Q Is there anything wrong with assisted  
 12 reproductive technology?  
 13 A I have ethical problems with it. I have  
 14 personal contact with it, but I have ethical problems  
 15 with it.  
 16 Q What are those ethical problems?  
 17 A The fact that the human person is turned into a  
 18 commodity. That fact that it's associated with a  
 19 marketing process that encourages people to believe they  
 20 have a right to another person. This is rife in the  
 21 world of transgender surgery because of the consultation  
 22 that people undergo before their transition surgery.  
 23 They are encouraged or given the option of  
 24 reproductive -- what's called fertility preservation.  
 25 It doesn't actually preserve fertility. It preserves

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1 gametes for future proxy pregnancies or something like  
 2 that.  
 3 So first thing is it turns the child into a  
 4 commodity. The second thing is it encourages people to  
 5 believe they have a right to a child.  
 6 Q And you believe a person does not have a right  
 7 to a child?  
 8 A No person has a right to another person.  
 9 That's the language of slavery.  
 10 Q And so someone who claims, "I have the right to  
 11 have a child," is using the language of slavery?  
 12 MS. LAND: Object to form and relevance.  
 13 A I think there's skirting along that, but  
 14 because they haven't given thought to what they just  
 15 said. Again, the way that the fertility doctors market  
 16 their services is with the idea of entitlement. And a  
 17 lot of plastic surgeons do precisely the same thing. A  
 18 lot of people selling all kinds of things sell  
 19 entitlement to the service or entitlement to the  
 20 benefit.  
 21 But it's a very different thing when you're  
 22 thinking of yourself as entitled to another human  
 23 person. We get comfortable with the idea of entitlement  
 24 and we forget to think about the fact that we're talking  
 25 about another human person. So people inadvertently

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1 will slip into the language of slavery not knowing what  
 2 they have said.  
 3 Q And so -- well, let me -- just to clarify, you  
 4 do not agree that people have the right to bear  
 5 children, then?  
 6 MS. LAND: Object to form.  
 7 A Okay. So they have a right not to be  
 8 interfered with in doing that. So, for example, if you  
 9 were like a public hygiene person in some expanded  
 10 government and you came to my house and said, You are  
 11 forbidden to have intimacy with your wife because  
 12 there's too many people living in Little Rock, that  
 13 would be an injustice. So in that sense I have a right  
 14 to that. I have a right not only to conjugal life, but  
 15 to the consequences of conjugal life. That's quite a  
 16 different thing from saying I have the right to do  
 17 extraordinary things in order to acquire another person.  
 18 The child in the first example is a natural  
 19 consequence of my right, conjugal life. Right? Natural  
 20 consequence of what I am entitled to.  
 21 But I could not make the claim, you know, if my  
 22 wife is childless or if we were childless to walk into a  
 23 government agency and say, "I have a right to a child.  
 24 Make it happen."  
 25 Q (By Mr. Ossip) So let's take another -- sorry.

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1 Give me one second, Doctor.  
2 So let's take an example of a child who has  
3 testicular cancer --  
4 A Okay.  
5 Q -- and needs to have his testicles removed.  
6 Would it be inappropriate for a doctor to offer  
7 fertility preservation to that child?  
8 A No. I think it's reasonable thing. That might  
9 put him in the category of artificial insemination of  
10 his future wife in the case of a boy with testicular  
11 cancer.  
12 And I have to put on a different hat here. Now  
13 I'm speaking to you as a physician. If you walked up to  
14 me at a Catholic church and said, What do you think  
15 about this, I would say, You should start talking to  
16 that boy now about his life as an adoptive father,  
17 because in the Catholic teaching it's a different thing.  
18 So I'm speaking here as a medical witness and so it  
19 doesn't enter into the conversation.  
20 Q But your previous answer was also as a medical  
21 witness?  
22 A Well, that's a different category because  
23 you're talking about in vitro fertilization and the  
24 child being treated as a commodity that's for sale.  
25 Different thing.

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1 Q Oh, I see. So in vitro fertilization, you're  
2 drawing a distinction between in vitro fertilization and  
3 artificial insemination; correct?  
4 A Yeah. And, again, speaking now in terms of the  
5 medical ethics now, yeah, it's a very different thing.  
6 It's a very different thing to have massive industrial  
7 process of producing human life, much of it being put in  
8 frozen storage and no one knowing what to do with those  
9 children, that's a very different ethical question than  
10 a trial of artificial insemination from a husband's own  
11 sperm.  
12 Q And the same would be true for preserved ovo?  
13 A Well, that's a different problem because if  
14 you -- if you're doing ovo preservation -- well, okay.  
15 A particular example.  
16 So a woman you preserve ovo who is going to  
17 get, say, cancer therapy, and it's going to render her  
18 ovaries non-functional, if she still has a functioning  
19 womb and is receiving hormonal support you could  
20 conceivably do in vitro for her or, you know,  
21 implantation.  
22 But you would still be relying on this -- so  
23 there are particular circumstances. Are you putting  
24 children into cold storage or is the woman willing to  
25 accept multiple embryos. In the case of embryo -- ovo

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1 preservation, it's not as morally fraught because you  
2 have just ova sitting there. But in the case of in  
3 vitro fertilization you have nose of humanity sitting in  
4 that freezer.  
5 Q So going back to the testicular cancer example.  
6 So, you know, we're talking about fertility  
7 preservation. If the doctor in that case says,  
8 "Although you're having this surgery, you have the right  
9 to have a child and so we can preserve your sperm for  
10 that," is that the language of slavery?  
11 MS. LAND: Object to form and relevance.  
12 A Well, so I would wonder why the doctor needed  
13 to say you have the right to a child. Because, really,  
14 the discussion is if you want to have a hope of having a  
15 child then we ought to preserve sperm.  
16 Q (By Mr. Ossip) But using that phrase, "you have  
17 a right to have a child" in this context --  
18 A I would avoid using that language because,  
19 again, it encourages people to think of other human  
20 beings as their right. There is no such right. It's  
21 better to speak of preserving your hope of having  
22 children than to speak of your right to have a child.  
23 Q And what about same-sex couples? Do you think  
24 that same-sex couples should be allowed to adopt?  
25 MS. LAND: Object to form and relevance.

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1 A I don't want offer an opinion on that. That's  
2 a -- I'm not here as an expert on adoption law.  
3 But one of the issues with adoption -- and I  
4 have five adopted children and so I have been through  
5 adoption processes a lot. And one of the things we have  
6 to be careful about is viewing the child only in terms  
7 of what they are doing for us as adoptive parents and,  
8 rather, viewing it as a responsibility to the child and  
9 what's best for the child.  
10 So adoption is in the service of the child, not  
11 in the service of the couple. The couple benefits from  
12 it, but the adoption isn't in service of the couple.  
13 The adoption is in service for the child and what is  
14 best for the child.  
15 Well, my opinion is that children generally do  
16 better with a mother and a father. I'm not here to  
17 outlaw adoption. In fact, I traveled in China with a  
18 same-sex couple and we both adopted children from China.  
19 I wasn't wagging my finger at them, but I was wondering  
20 the whole time if the child would suffer for having two  
21 mothers and not a father there, knowing what my father  
22 meant to me. And knowing also what fathers mean to a  
23 lot of people who come to me who are having  
24 difficulties. So that would be what I would say about  
25 that. Do I suggest that adoption should by same-sex

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1 couples should be outlawed? No such thing.  
 2 Q So earlier we talked about Courage.  
 3 A Okay.  
 4 Q So what is Courage's approach to individual  
 5 with gender incongruence?  
 6 MS. LAND: Object to form, asked and  
 7 answered.  
 8 A Well, Courage's approach to person's with  
 9 gender incongruence is to punt them off to me, because  
 10 the COURAGE apostolate doesn't aim itself at that  
 11 population. It just happens that there are not many  
 12 resources in the Catholic church to help families or  
 13 persons struggling with gender dysphoria, gender  
 14 identity issues.  
 15 And so they oftentimes will call Courage and  
 16 then, basically, the Courage office puts them in touch  
 17 with me. And mostly it's just long conversations trying  
 18 to reassure parents because -- yeah. Generally the  
 19 children themselves are not interested in anything  
 20 different, so we don't go looking for them and -- and  
 21 drag them off into some conversion therapy or something  
 22 like that.  
 23 Q I guess let me ask you another question. Do  
 24 you know whether Courage opposes gender transition  
 25 procedures?

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1 MS. LAND: Objection; form.  
 2 A I don't think they have an official statement  
 3 on that. It wouldn't surprise me if they did. But I  
 4 don't think -- see, the Courage Apostolate is aimed at  
 5 persons who experience same-sex attraction. And the  
 6 Encourage Apostolate to the families and loved ones of  
 7 persons who experience same-sex attraction.  
 8 Q (By Mr. Ossip) And is Encourage related to  
 9 Courage?  
 10 A Right, it's an outgrowth. Encourage is an  
 11 outgrowth of Courage.  
 12 Q And what's your connection with Encourage?  
 13 A I don't have -- I don't have Encourage group in  
 14 Alabama. They are two separately running things. They  
 15 sort of run in parallel and typically don't involve the  
 16 same people?  
 17 Q So some people are Encourage chaplains but not  
 18 Courage chaplains?  
 19 A Yeah. It's probably more common that they are  
 20 both, given the poverty of clerics in the church right  
 21 now. But I haven't established an Encourage chapter in  
 22 Alabama, only a Courage one. And as I confessed  
 23 earlier, the pandemic hammered it severely.  
 24 (Plaintiff's Exhibit 8 was marked for  
 25 identification and made a part of the

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1 record.)  
 2 Q The court reporter is handing you what I  
 3 believe has been marked Exhibit 8.  
 4 A Right.  
 5 Q And from the cover, do you recognize this  
 6 document?  
 7 A Sure do.  
 8 Q And have you read this document before?  
 9 A I have.  
 10 Q All right. And this is, I'll represent, an  
 11 excerpt from the Courage handbook -- or the Handbook For  
 12 Courage and Encourage Chaplains.  
 13 A All right.  
 14 Q If you open it up you will see there is page  
 15 81.  
 16 A I see that.  
 17 Q And do you see, it's on the second column on  
 18 the right side, there's a quote that starts: Everyone,  
 19 man and woman, should acknowledge and accept his, in  
 20 brackets, or her, close brackets, sexual identity. Do  
 21 you see that?  
 22 A I do.  
 23 Q What does that mean?  
 24 A Well, in reading that and I remember reading  
 25 this, that -- that I -- that's a somewhat poorly

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1 constructed sentence. If they had sent it to me for  
 2 review I might have worded it differently. So I think  
 3 what they are getting at is acceptance of gender, what  
 4 we are calling in this conversation gender identity is  
 5 what they are -- what they are speaking to here. So  
 6 what it -- what it addresses is the desire that everyone  
 7 should be gender congruent, if you will, with their  
 8 biological sex.  
 9 Q All right. And is that -- do you see where --  
 10 it's missing a close quote, but do you see where that  
 11 starts with an open quote before "Everyone"?  
 12 A Okay. Yeah, okay. Everyone, man and woman,  
 13 should acknowledge and accept his or her sexual  
 14 identity.  
 15 Q And after that there is a footnote 91.  
 16 A Right.  
 17 Q And that's citing to catechism No. 2333;  
 18 correct?  
 19 A Number 369 is that I've got. Oh, 2333. You're  
 20 right.  
 21 Q Okay.  
 22 A Okay.  
 23 Q And that was the sentence you were referring to  
 24 earlier; correct?  
 25 A Right.

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1 Q Okay. And then do you see where it says, Each  
 2 person's moral obligation is to respond to his or her  
 3 sexual identity by accepting and cooperating with the  
 4 plan of God."  
 5 A I do.  
 6 Q And that means living with a gender identity  
 7 that is congruent with one's biological sex.  
 8 MS. LAND: Objection; form.  
 9 A I think that's what the writers intended, yeah.  
 10 That's not -- those are not my words, but I think  
 11 that -- I tend to agree with you that that's probably  
 12 what the writers of the catechism intended, yeah.  
 13 Q Okay. And do you agree with that?  
 14 A Let me reread it now because I will be chided  
 15 for disagreeing with church teaching. (Reading)  
 16 Okay. So what that -- my understanding of that  
 17 sentence is that the Catholic church views each  
 18 individual person as a special creation of God that has  
 19 a sexual identity and that that sexual identity is part  
 20 of the order that God has designed for that person and  
 21 that, you know, a person's moral duty is to be congruent  
 22 with God's design for your life. So to act against God  
 23 is a moral problem. And I think that's what that's  
 24 saying is there is a moral obligation because it speaks  
 25 to the nature of your creation, that your nature is

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1 evidence of God's plan.  
 2 That's one of the breakthroughs in the 12th,  
 3 13th century that western civilization said that the  
 4 world teaches you what God's plan is, so study -- it's  
 5 the world of science -- and you will understand God.  
 6 That's what -- I think that's what that sentence is  
 7 saying.  
 8 Q And the moral duty in that context is to  
 9 identify with and live as the gender that corresponds  
 10 with one's biological sex?  
 11 A Okay. First and foremost, your moral duty is  
 12 to your conscience. So the way the church teaches is  
 13 your conscience is the first arbiter of your  
 14 decisionmaking, but your conscience needs to be an  
 15 informed conscience. So if your conscience is telling  
 16 you to do something that is not in agreement with what  
 17 the church is teaching, then it is your moral obligation  
 18 to inform your conscience.  
 19 So you need to prayerfully examine what the  
 20 church is proposing in its anthropology here and ask  
 21 yourself, What am I doing wrong? And some people are  
 22 never able to make that hurdle because they cannot be  
 23 convinced that the -- what the church is proposing and  
 24 so they live contrary to that. And sometimes their  
 25 ignorance is culpable, sometimes their ignorance is

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1 excusable.  
 2 Q But in any case, part of that moral duty,  
 3 assuming your conscience is informed, is to identify and  
 4 live as the gender that corresponds with your biological  
 5 sex?  
 6 MS. LAND: Object to form and relevance.  
 7 Q (By Mr. Ossip) You can answer.  
 8 A To kind of sum up what this is embodied in  
 9 here, what the church teaches, is that to inform your  
 10 conscience with the truth gives you an obligation to the  
 11 truth. It's a moral obligation to the truth.  
 12 Because in the eyes of the church and in the  
 13 eyes of the faith, the truth isn't just a book full of  
 14 propositions, like the DSM III. The truth is a person.  
 15 And so -- and so to willfully ignore the truth is to  
 16 turn your back on the person of Jesus Christ.  
 17 So that's why -- I didn't expect to have a  
 18 theological conversation with people on the subject, but  
 19 that's the heart of the teaching right there. You have  
 20 an obligation, a moral obligation to your conscience,  
 21 you have an obligation to inform your conscience with  
 22 the truth, and then, having learned the truth, you have  
 23 an obligation to live that truth.  
 24 Q Okay.  
 25 A Because recognizing the truth without action is

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1 an empty -- empty thing.  
 2 Q And the truth here is biological sex?  
 3 A The nature, your nature. So that's, again,  
 4 where the -- what the church teaches is that nature --  
 5 your human nature is a singularity. It's essential to  
 6 the teachings of the church and it's essential,  
 7 historically, to the teachings of medicine. It's that  
 8 it's a singularity. Body and soul together comprise a  
 9 single human nature. Human nature is not the soul lover  
 10 here and the body over there. And the separation of  
 11 those two, in fact, is diagnosable. It's called death.  
 12 Q So one's biological sex and, therefore, sexual  
 13 identity is part of the order that God has designed for  
 14 a person; correct?  
 15 MS. LAND: Objection; form, relevance,  
 16 asked and answered.  
 17 A All right. So that -- that speaks to a very  
 18 important point here and I'm glad you raised it. That  
 19 is there are events in a person's life that will alter  
 20 that ideal that you just laid out there, that under  
 21 ideal circumstances perfect congruence, body and soul,  
 22 sexual manifestation of sexual biology, and the gender  
 23 identity of the person, the ideal circumstance.  
 24 But there are accidents of life in both arenas.  
 25 You can have problems on the developmental side and you



<p style="text-align: right;">Page 250</p> <p>1 can have problems on the psychological developmental  2 side that -- that lead to problems that may be  3 insurmountable, either biologically medically or  4 psychologically culturally. Yeah.  5 Q (By Mr. Ossip) But it is a problem?  6 A Gender incongruence is a problem.  7 MS. LAND: Objection.  8 A That's why we have a whole medical community  9 that's devoted to resolving that problem.  10 Q (By Mr. Ossip) And what is gender incongruence?  11 A Where your perception of your sex differs from  12 your biological sex.  13 Q So earlier we talked about your consultation  14 with families with children who were experiencing gender  15 discordance; correct?  16 A Right. In my pastoral role as a deacon, yeah.  17 Q And was that -- so that was all in your role as  18 a deacon; right?  19 A Right. The couple of kids I've seen have been,  20 again, families approaching me after mass concerned  21 about their suffering child, can you talk to them kind  22 of thing.  23 Q And was any of that part of your work with  24 Courage?  25 A No. That's just my work in my parish.</p>	<p style="text-align: right;">Page 252</p> <p>1 time and talk to her and we're friends. But, yeah, I  2 mean, I still struggle with that one, I have to confess.  3 Q Yeah. And -- well, I guess let's explore that.  4 Why do you struggle with that?  5 A Because I never -- again, my obligations to the  6 truth -- I'm trying to cultivate and maintain a  7 friendship in doing it. I'm not trying to transition  8 the person. I'm trying to keep them as a friend. And,  9 yeah -- so, yeah, that's -- I think that's about the  10 whole of it, yeah.  11 I struggle with it because you don't want to  12 affirm somebody in a delusional thought that's contrary  13 to the truth. And as we talked about earlier, I have a  14 moral obligation to the truth because he's a person.  15 Q And this applies to patients of any age;  16 correct?  17 A Right.  18 Q And earlier we talked about what you have  19 called the poverty of evidence supporting these  20 procedures; correct?  21 A Yeah.  22 Q So let's say one day reliable and valid  23 scientific research supports gender transition  24 procedures, would you provide the care then?  25 A That would be like a Copernicus moment in my</p>
<p style="text-align: right;">Page 251</p> <p>1 Q Okay. Doctor, you won't engage in the -- well,  2 what gender transition procedures will you provide,  3 Doctor?  4 A So are you asking -- I'm just trying to think  5 if there is a difference in your question from the one  6 you asked me earlier where we talked about laser hair  7 removal.  8 Q So I think you said you would provide that as  9 part of a gender transition; correct?  10 A Yeah, sure.  11 Q Any others that you would provide?  12 A I can't think of any. I would not do breast  13 surgery, I would not do genital surgery.  14 Q And why would you not do breast surgery?  15 A Because I consider them morally and ethically  16 culpable.  17 Q How so?  18 A My examination of the operations, my  19 examination of the medical evidence, my examination of  20 the -- my understanding of the nature of the suffering  21 and its causes would essentially exclude me from ever  22 offering such procedures. I have to confess to some  23 guilt every time my transfemale comes in for facial hair  24 removal. I have pangs of guilt that I'm offering and  25 billing for the service, but I still go in there every</p>	<p style="text-align: right;">Page 253</p> <p>1 world. I would have to step back and totally  2 reexamination what I have learned as a physician and  3 surgeon. I would have to -- I would have to examine the  4 validity of the scientific claim. I would solicit the  5 opinions of trusted professionals and let them examine  6 the scientific evidence and together commiserate over  7 that.  8 But if it's compelling evidence then I would  9 have to reexamine my world view. I would happily do  10 that. Not happily. I would willingly do it, but not  11 happily.  12 Q Willingly reexamine your world view?  13 A Yeah, exactly, about how I view the human  14 person even because it's contrary to so much of what I  15 learned from medicine and surgery that -- and my life  16 experience. I would have to reexamine a lot of things.  17 Q But what about -- so you talked about  18 reexamining your world view. But what about providing  19 those procedures?  20 A Well, so I would have to have confidence in the  21 evidence before I would provide those procedures.  22 Q But let's say you did have confidence in the  23 evidence, would you provide the procedures?  24 A Yeah. My practice of medicine and surgery, I  25 like to think, has been historically scientifically</p>

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1 driven. So if there is strong science that's in favor  
2 of doing something that's for the good of a person, I'm  
3 an early adopter on things like that.  
4 Q Bear with me one second, Doctor. I apologize.  
5 A Sure.  
6 Q Earlier we spoke about -- well, strike that.  
7 Are you familiar with the Gospel of Life  
8 Conference?  
9 A I think that's the name they had for the one in  
10 Denver. Is that the Denver conference, this -- isn't  
11 that what that was?  
12 Q I'm asking you, Doctor.  
13 A There it is right there. I just refreshed my  
14 memory with Exhibit 1 there.  
15 Q That was in the Denver, then?  
16 A That's the Denver conference. Not the one at  
17 the seminary. This was at a separate location that  
18 happened some time later.  
19 Q Do you know if that conference was recorded?  
20 A Hum. There may have been some Franciscans  
21 there recording it. I'm not positive about that.  
22 Q Do you know if that recording was released as a  
23 podcast?  
24 A I don't know that. Oh, wait a minute. The  
25 Denver conference podcast. There was a -- it might have

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1 been -- it might have been released as a YouTube video,  
2 actually. In fact, I think it was because that's the  
3 conference where they didn't make a provision for me to  
4 have a monitor and I had to keep looking around at the  
5 screen to look at my slides and it was very annoying.  
6 So I think yes, it was put out there on YouTube  
7 or one of those media platforms.  
8 Q And have you ever described identifying as  
9 transgender as being evil?  
10 MS. LAND: Object to the form, asked and  
11 answered.  
12 A I doubt that I've ever said that. I -- I -- I  
13 wouldn't be surprised to hear that I characterize people  
14 who encourage children to think that way as doing evil  
15 to the child.  
16 Q Okay.  
17 A Yeah. I'm not saying anyone is fundamentally  
18 evil. I'm saying they've done an evil thing, as sure as  
19 somebody who hits a child with a car. They have done an  
20 evil to them whether they have done it culpably or not.  
21 MR. OSSIP: So we're -- and actually, do  
22 you want to -- is it marked?  
23 MR. HOLLAND: Um-hum.  
24 Q (By Ms. Land) Okay. So we're going to play you  
25 some audio, Dr. Lappert.

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1 A Um-hum.  
2 Q And I'm going to represent this was taken from  
3 a website that purports to present a recording of the  
4 Gospel of Life 2018 Conference. Okay?  
5 A Okay.  
6 (A discussion was had off the record.)  
7 MR. OSSIP: We did not bring our  
8 speakers. And this will be pretty quick.  
9 THE WITNESS: This is the audio part?  
10 MR. OSSIP: Yeah. There is nothing to  
11 see.  
12 THE WITNESS: Okay.  
13 (The audio recording was played, which  
14 was later marked as Plaintiffs' Exhibit  
15 A.)  
16 Q (By Mr. Ossip) So, Doctor, that was you  
17 speaking; correct?  
18 A Yes, it was.  
19 Q Okay.  
20 A I was addressing a church group. I think it is  
21 a parish in Denver suburbs and I was addressing  
22 religious educators and -- yeah, religious sisters and  
23 various --  
24 MR. OSSIP: And can we go off the record  
25 for 10 seconds? I'm sorry.

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1 VIDEO OPERATOR: We are off the record at  
2 4:18 p.m.  
3 (A discussion was had off the record.)  
4 VIDEO OPERATOR: We are back on the  
5 record at 4:18 p.m. Please proceed.  
6 Q (By Mr. Ossip) All right. And I'll just  
7 represent that this recording has been marked as  
8 recording A for the purposes of this deposition. And  
9 so -- oh, no.  
10 Is being transgender a diabolical attack on the  
11 image of God and the world?  
12 MS. LAND: Objection to form and  
13 relevance.  
14 A No. The -- the encouragement of children to  
15 think that way about themselves, I suspect it is. But  
16 I'm here as a medical expert, not as a theologian.  
17 Q (By Mr. Ossip) Well, do you believe that the  
18 transgender delusion is an attack on your understanding  
19 of who Jesus Christ is and what it means to be  
20 incarnate?  
21 A I do.  
22 MS. LAND: Objection to form and  
23 relevance.  
24 Q (By Mr. Ossip) You do? And what the  
25 transgender delusion in this context?

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1 A That the human person is somehow divided and  
2 that the body has no meaning apart -- that the essential  
3 meaning of a human person is a spiritual one.  
4 Which, if you're asking me as a Catholic deacon  
5 to expound on theology, that's a heresy, yeah. And to  
6 cause children to suffer through this ordeal when it can  
7 be avoided, if you're asking me is this a spiritual  
8 warfare, you know, I sometimes speculate publically  
9 about whether it is or not.  
10 Q What do you mean by "spiritual warfare"?  
11 A Things unseen at work in the world.  
12 Q You mean the forces of the devil?  
13 MS. LAND: Objection to the form.  
14 A Well, that's a fairly medieval way to speak  
15 about things like that. I wouldn't have used those  
16 words.  
17 Q (By Mr. Ossip) What words would you have used?  
18 A That there is -- there is a spiritual, almost  
19 like a contagion that causes people to suffer and that  
20 the more people harm each other the more that is abroad  
21 in the world, yeah.  
22 Q And so is the transgender delusion also  
23 contrary to western thought?  
24 A Because it's a -- it's a division of the human  
25 person, their single nature into two separate and

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1 unseparable (sic.) things by separating them, then,  
2 yes, it is contrary to the western tradition.  
3 Q And that -- that is also your medical opinion  
4 as well, correct, Doctor?  
5 A Because the medical opinion derives from the  
6 western tradition. All the things we've been talking  
7 about here are the product of western medicine, our  
8 understanding of the sexes, you know, the biological  
9 basis of sex is a -- is a western contribution, all of  
10 it.  
11 Q Doctor, did you do an interview for a radio  
12 show and podcast called "Tactics Radio"?  
13 A That's that squirrely young man in Montgomery I  
14 think. I think I might have, yeah.  
15 Q Sounds right to me.  
16 A He was a bit of a squirrel. I'm sorry. I  
17 shouldn't have said that publically.  
18 Q Let's see. So we're just going to play you  
19 another recording again. This is just to confirm that  
20 this was you on the video.  
21 MR. HOLLAND: This one has video.  
22 MR. OSSIP: You can see him again.  
23 MR. HOLLAND: Yeah, and the squirrely  
24 man.  
25 (The video played.)

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1 Q (By Mr. Ossip) And that was you on that  
2 recording?  
3 A Yes, it was.  
4 Q And do you stand by all that?  
5 A I do.  
6 MR. OSSIP: And I'll represent that this  
7 has been marked as recording B for the purposes of this  
8 deposition.  
9 (Plaintiffs' Exhibit B was marked for  
10 identification and made a part of the  
11 record.)  
12 MR. OSSIP: Do you want to take a break  
13 here?  
14 THE WITNESS: I'm ready to go whenever  
15 you are. So if you need a break, take it by all means.  
16 MR. OSSIP: All right. Let's take a  
17 five-minute break.  
18 VIDEO OPERATOR: This will end media part  
19 5. We are off the record at 4:24 p.m.  
20 (A break was had.)  
21 VIDEO OPERATOR: We are back on the  
22 record at 4:41 p.m. This will begin media part 6.  
23 Please proceed.  
24 Q (By Mr. Ossip) Okay. Thank you. All right.  
25 Dr. Lappert, we're going to play you one more

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1 recording right now. The question is just whether this  
2 is you speaking in the recording.  
3 (The video was played and was later  
4 marked Plaintiffs' Exhibit D.)  
5 Q (By Mr. Ossip) And, Dr. Lappert, what was you  
6 speaking; correct?  
7 A Absolutely.  
8 Q And you stand by everything you said in that?  
9 A I certainly do, yes.  
10 Q And that's a recording that's been marked D for  
11 the purposes of this deposition.  
12 MS. LAND: I think you may have skipped  
13 one.  
14 MR. OSSIP: Yeah. That's okay.  
15 MS. LAND: Okay.  
16 Q (By Mr. Ossip) Doctor, would you analogize  
17 transgender surgery to a medical procedure that creates  
18 a monster?  
19 A No. Well, that's a -- that's a term I  
20 suppose -- it wouldn't surprise me if I had at one point  
21 in some flight of ideas there. But monster in the sense  
22 of a fabrication, an attempt at fabricating a human  
23 person that's not natural, I suppose.  
24 Q So it wouldn't surprise you if you said that?  
25 A I would not, no. Yeah, using that shelly use

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1 of the word monster. I'm not saying that transgender  
 2 persons are monsters. I'm not saying that people who  
 3 suffer with transgender or gender identity or gender  
 4 dysphoria are monsters. I'm saying that the process is  
 5 monstrous.  
 6 Q And by the process, you mean --  
 7 A The -- the willful destruction of the natural  
 8 structure of the person and the creation of  
 9 counterfeits.  
 10 Q And that's gender transition procedures?  
 11 A Surgeries, yeah.  
 12 Q What about hormone replacement therapy?  
 13 A Not in the same category.  
 14 Q We're going to play another recording now.  
 15 This one has been marked as E for the purposes of this  
 16 deposition.  
 17 (The video played and was later marked  
 18 as Plaintiff's Exhibit E.)  
 19 Q (By Mr. Ossip) Doctor, that was you speaking;  
 20 correct?  
 21 A Yes. I was using my pedagogical Jewish  
 22 exaggeration.  
 23 Q And, Doctor, you're not currently Jewish;  
 24 correct?  
 25 A I'm more Jewish now than I ever was.

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1 Q How so?  
 2 A Because I'm a Catholic, which is a completed  
 3 Jew.  
 4 Q What do you mean by that?  
 5 A That all the promises that were made to the  
 6 people of God in the Old Testament were fulfilled in the  
 7 life of Jesus Christ.  
 8 Q Doctor, do you think that discussing gender  
 9 identity issues sexualizes children?  
 10 A Yes.  
 11 Q Do you think it grooms them for sexual abuse by  
 12 older people?  
 13 A Yes.  
 14 Q Do you recall being asked about that in your  
 15 deposition for the Kadel case?  
 16 A I don't remember, no.  
 17 Q All right. So I'd like to direct you to page  
 18 462 of the transcript from Kadel.  
 19 A Oh, Kadel? I'm sorry. 462?  
 20 Q Yeah. And that's Exhibit 2 for the record.  
 21 A Okay.  
 22 Q And do you see starting on line 8, you say --  
 23 A Yes.  
 24 Q It says, Question, "And you think that  
 25 discussing gender identity issues with children means

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1 grooming them for potential later sexual abuse; right?"  
 2 Answer, "No."  
 3 A Let me see where the questions were coming from  
 4 first. Give me just a moment.  
 5 Q Um-hum.  
 6 A Okay.  
 7 Q And so --  
 8 A One moment, please. I'm sorry. Right. So the  
 9 questions that were being asked by Mr. Nepper looks like  
 10 they were seeking a distinction between grooming that  
 11 leads to further treatment versus grooming that leads to  
 12 sexualization, and so I agreed with that distinction.  
 13 And then -- and then he asked the question  
 14 directly, "And you think that discussing gender identity  
 15 issues with children means grooming them for potential  
 16 later sexual abuse; right?"  
 17 And my no answer was directed to I think the  
 18 question at hand, which was the use of the word grooming  
 19 in connection with leading to further treatment.  
 20 Let's see -- no, no. We're talking about  
 21 here -- for future -- preparing them for these  
 22 interventions. Right? It lays the groundwork whereby  
 23 sexualizing their thoughts in a way that's not  
 24 consummate with their best interest. Right.  
 25 Q Doctor, let's take a step back. So you were

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1 specifically talking about -- let's see. I think you  
 2 were specifically talking about your presentation to the  
 3 Denver conference; correct?  
 4 A I think that's what that was about because I'm  
 5 talking about a slide or something here. I didn't get a  
 6 chance to review the whole thing. Let's see. Slide.  
 7 Yeah, so that's the slide he's talking -- the  
 8 questions about the slides, slide 23. So I would agree  
 9 that most likely from that Denver conference, which we  
 10 saw was recorded. And so I think the question he was  
 11 asking is grooming for preparation for future -- for  
 12 future treatment events, you know, grooming -- like for  
 13 example, social transitioning. It's my opinion social  
 14 transitioning, a child, grooms them for puberty blockade  
 15 because it encourages them to believe that -- that the  
 16 manifestations of puberty is a disagreeable event.  
 17 Q Well, Doctor --  
 18 A Yeah.  
 19 Q -- so, but again the question was -- let me put  
 20 it this way.  
 21 A Okay.  
 22 Q So looking at just that question alone, you  
 23 would disagree with the answer being no; correct?  
 24 A As it's in Nepper?  
 25 Q Just where it stays -- well, let me ask it

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1 another way. But you do think that discussing gender  
2 identity issues with children means grooming them for  
3 potential later sexual abuse; correct?  
4 MS. LAND: Objection; form.  
5 A Okay. So on 461, question 12?  
6 Q (By Mr. Ossip) This is 462 starting on line 8.  
7 A I'm sorry. (Reading.)  
8 We're talking here about grooming them for  
9 future --  
10 Q But you would agree that the answer to that  
11 question is yes; correct?  
12 A Gosh, I'm lost now. So yes would mean that I  
13 think all grooming is oriented toward sexual abuse.  
14 Q No. Well, all right. We can move on, Doctor.  
15 I think you have given your answer.  
16 You discussed -- during that deposition in  
17 Kadel you also discussed that Life Site article;  
18 correct?  
19 A I don't remember, but...  
20 COURT REPORTER: What article?  
21 MR. OSSIP: Life Site.  
22 THE WITNESS: Yeah, that was Exhibit 7.  
23 I don't remember discussing it in that deposition.  
24 VIDEO OPERATOR: Doctor, let me get you  
25 to raise your mic up.

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1 THE WITNESS: I'm sorry.  
2 VIDEO OPERATOR: Thanks.  
3 THE WITNESS: Um-hum.  
4 Q (By Mr. Ossip) Well, if you go to that  
5 article, so that's --  
6 A Okay.  
7 Q -- Exhibit 7 and you go to the second page.  
8 A Okay.  
9 Q Do you see in the middle of that page where it  
10 says, "Regarding children, Lappert said, sexualizing  
11 them at a young age with these ideas is grooming them  
12 for later abuse."  
13 By that did you mean sexual abuse?  
14 A No. We're talking about the abuse of medicine  
15 and surgery there.  
16 Q And you did not mean sexual abuse when you gave  
17 that quote; correct?  
18 A I don't think it was about sexual abuse,  
19 because that's sort of a distant effect I suppose. But,  
20 no, I think we're talking here about the abuse of  
21 transgender medicine and surgery which results in injury  
22 to the child. So, yeah.  
23 Q All right. And you're -- earlier we talked  
24 about your interview for this article. And this  
25 interview was recorded; correct?

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1 A The Life Site? I don't remember it, but I'm  
2 suspecting that it was recorded at some conference where  
3 I gave a presentation. Some reporter asked if they  
4 could ask me some questions. I don't remember where it  
5 was recorded, though.  
6 Q If you look up a little bit do you see where it  
7 says, "Appearing on a recent broadcast of Relevant  
8 Radios, Trending With Timmerie"?.  
9 A Right, I do.  
10 Q And is that the source for the quotes for this  
11 article?  
12 A It sounds like it. I don't know if it was just  
13 the reporter listening to that broadcast and then  
14 writing this article or if she actually talked to me or  
15 interviewed me.  
16 Q Okay. So I'm going to play you a part of that,  
17 that podcast now.  
18 A Okay.  
19 Q And this has been marked as recording F for the  
20 purposes of this deposition.  
21 (The video played and was later marked  
22 Plaintiffs' Exhibit F.)  
23 Q (By Mr. Ossip) And, Doctor, that was you on  
24 the recording; correct?  
25 A Yes, it was.

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1 Q And you'd agree that there you were talking  
2 about sexual abuse; correct?  
3 A Yeah. So on the one hand we're talking about  
4 the medical and surgical abuse, the grooming process  
5 that leads to that. Both of them are originating from  
6 sexualizing children. But in this case we're talking  
7 about a different kind of abuse, in this case sexual  
8 abuse.  
9 Any time a child's mind is turned toward sexual  
10 things and encouraged to think of themselves as a sexual  
11 creature it makes them relatively easy prey.  
12 Q So changing topics a little bit, Doctor, have  
13 you ever had a malpractice lawsuit filed against you?  
14 A One that was dismissed before it ever went  
15 anywhere.  
16 Q So you never were deposed for that?  
17 A No, no.  
18 Q All right. And what was the topic of that  
19 lawsuit?  
20 A The -- the woman had a breast -- I did a breast  
21 cancer reconstruction on her. This is in Scotts Bluff,  
22 Nebraska. And she had I think it was an anesthetic  
23 complication. And I was named in that suit just because  
24 I was the surgeon. And ultimately she dropped the suit  
25 because there was no evidence that she was mistreated.

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1 Q All right. And you're not an anesthesiologist;  
2 correct?  
3 A No. I'm a plastic surgeon. Cute.  
4 Q And that's the -- and that's the only lawsuit;  
5 right, Doctor?  
6 A Yeah, no. That's the only one I've ever.  
7 Q Okay. And that was dismissed against you;  
8 correct?  
9 A Correct.  
10 Q Okay. So earlier you said that, "Gender  
11 transition procedures pervert and distort our sense of  
12 human sexuality." And you said that "this is because it  
13 separates out the reproductive aspect of sex." Correct?  
14 A That's one of the things. It's not because, a  
15 sole cause, but it's one of the aspects of the -- yeah.  
16 Q Yeah. And is that a medical opinion?  
17 A Well, it's more of a medical moral opinion  
18 that's informed by my understanding of the human person,  
19 yeah. Could I find a journal article to support me in  
20 that? I'm sure I couldn't.  
21 Q But it's a medical moral opinion; correct?  
22 A Yes, it is, yeah.  
23 Q And also earlier you said that church teachings  
24 say that sexualized entity is part of the order that God  
25 has designed for a person and that to act against God's

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1 plan as a moral problem; correct?  
2 MS. LAND: Object to form.  
3 A That's the church teaching on it, yeah.  
4 Q (By Mr. Ossip) And do you agree with that?  
5 A Yeah.  
6 Q You also said that you would not do -- or,  
7 well, I believe you said that based on the evidence as  
8 it stands now you would not do breast regental (sic.)  
9 surgery for gender transition because you do not think  
10 it would be ethical for patients of any age; correct?  
11 A Right.  
12 Q And would you support a law prohibiting such  
13 treatments even for adults?  
14 A No.  
15 Q Why not?  
16 A Because when you are talking about adults, you  
17 are in the arena of people who can make those decisions  
18 who have a long-term view of their own lives. And,  
19 yeah, they have higher executive functioning, they can  
20 give consent. You can counsel them about infertility  
21 and it may not matter a wit to them.  
22 They might not have any sexual life at all but  
23 are merely seeking to live a social life as a fully  
24 transitioned person and sex doesn't even enter into the  
25 question.

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1 In fact, the majority of older transgender  
2 persons don't have a sex life, per se. They have a  
3 life. And so, yeah, so it's a very different thing in  
4 adults.  
5 Q But you would still consider it an intentional  
6 mutilation?  
7 A Yeah, I would.  
8 Q But one that should not be illegal?  
9 A Right.  
10 Q Okay.  
11 A Sort of like other body modification surgery.  
12 It's a --  
13 Q And you don't think that other body  
14 modification surgery should be illegal?  
15 A No. But in children it should, because  
16 permanently life altering, inability to obtain informed  
17 consent.  
18 Q But you have said that you personally wouldn't  
19 do gender transition procedures on adults; correct?  
20 A I will not, no.  
21 Q And why is that?  
22 A Because I -- I wouldn't be doing them any good.  
23 My best understanding of the evidence tells me that it  
24 would be mutilation to no effect. So I do mutilating  
25 surgeries for people, I did up until a year ago. For

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1 example, an amputation of a finger because it interferes  
2 with the function of the hand. That's a willing  
3 mutilation, but I have improved the function of their  
4 hand. They're willing to accept the defect because the  
5 function is so radically improved. So that's an  
6 intentional mutilation that's fully morally acceptable.  
7 But to take a fully functioning structure and  
8 destroy it for the sake of an aesthetic result in my  
9 opinion is not an acceptable approach to plastic  
10 surgery.  
11 Q And is that -- well -- and so it's your belief  
12 that the surgeries are never appropriate, then?  
13 A I cannot think, off the top of my head, of a  
14 transgender genital operation that is ever appropriate,  
15 no.  
16 Q What about top surgery?  
17 A Yeah. You would have to come up with an  
18 exceptional scenario for me to justify doing a  
19 mastectomy for no reason.  
20 Q What about facial feminization surgery?  
21 A So now we're sort of creeping into that less  
22 risk to the patient, less lifelong what we call donor  
23 defect. I might consider it, but there again, I would  
24 probably be having a lot of pastoral visits with them  
25 trying to understand why they are seeking this as a

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1 remedy to their difficulties.

2 Q And do you frequently have pastoral visits with

3 your surgical patients?

4 A I can't tell you how many times I've talked

5 people out of cosmetic surgery. Talk women out of

6 breast augmentations all the time. Talk men out of

7 facial surgery all the time, yeah.

8 Q And what's the nature -- well, how do you talk

9 them out of it?

10 A Well, it kind of depends on the strength and

11 the understanding that the person brings to the visit.

12 Very often I recognize that I don't have enough of a

13 friendly relationship with the person to where they

14 would take such advice. So I'm not free to offer advice

15 under those circumstances, but sometimes it's as simple

16 as saying that I don't have the skills they are looking

17 for.

18 Q And is that true?

19 A Largely. I suppose the fact that I haven't

20 done a whole training program on penile inversion

21 vaginoplasty, I've never been trained in that. So I

22 would -- I would honestly say no, I'm not capable of

23 that surgery. Or somebody who is seeking some radical

24 change to their face, I don't do radical face surgeries

25 other than reconstructions. So I would be perfectly

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1 truthful in saying "I don't have the skills to do what

2 you're asking."

3 Q Okay. So why do you call those pastoral

4 visits?

5 A Because I'm seeking to establish an emotional

6 bond with the patient and try to understand what their

7 sorrow is, what the origin of their sorrow is, what's

8 going on in their life.

9 Can I give you an example? Woman comes to me

10 seeking a breast augmentation, very common presentation.

11 The examination would support doing a breast

12 augmentation. But in getting into the reason for her

13 visit, suddenly she's talking to me about how her

14 husband is ignoring her, her husband doesn't have any

15 interest in her. "If I have a breast augmentation it

16 will save my marriage."

17 For me to affirm her in the idea that a breast

18 augmentation is going to save her marriage would be an

19 injustice, so I talk her out of it.

20 Q Do you ever incorporate religious content into

21 this?

22 A I don't have to.

23 Q Do you ever?

24 A Sometimes I do with people I know from my

25 parish who have problems like this and are happy to

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1 speak to me using the language of religion. But I

2 generally don't run my practice using the language of

3 religion, nor do I give opinions, medical opinions based

4 on my religion. It's a separate thing.

5 Q So earlier we talked about Courage. I just

6 want to go back to that one more time.

7 A Sure.

8 Q Does Courage provide any services -- well,

9 strike that.

10 What is Courage's approach to individuals with

11 gender discordance?

12 MS. LAND: Objection; asked and answered.

13 A So --

14 MS. LAND: And form.

15 A The only thing that would speak to that would

16 be what you -- what you read earlier out of the Courage

17 handbook is the recognition that there's an underlying

18 reality. But Courage doesn't offer any interventions,

19 nor any referrals, nor anything else, persons with

20 transgender or gender identity issues or gender

21 dysphoria.

22 Q (By Mr. Ossip) Does Courage have members

23 experiencing gender identity issues?

24 A Let's see. I'm trying to think through

25 everybody I know in Courage. It's such a huge group.

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1 No. It's almost entirely -- well, okay.

2 So Encourage does. Family members of persons

3 experiencing gender dysphoria, the Encourage side does.

4 But generally speaking people who are in the world of

5 transitioning have no interest whatsoever in what

6 Courage has to offer.

7 Q Okay.

8 A And we don't go seeking them or drag them off

9 to some conversion. It's strictly supporting the family

10 members who are struggling with it.

11 Q So earlier we talked about the presentation

12 that you give on I believe it is transgenderism and

13 Christian anthropology; is that correct?

14 A Correct.

15 Q And you mentioned you gave that about 40 to 50

16 times?

17 A I'm just ball -- I'm just guessing, you know.

18 Q Yeah.

19 A Virtually exclusively to church groups.

20 Q And in that presentation you talk about the

21 medical issues related to gender transition treatments;

22 correct?

23 A That's right.

24 Q Including those for minors?

25 A Yeah. So the discussion we have about minors,

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1 I -- you know, that sort of varies from one talk to  
 2 another. The surgeries for minors is usually a  
 3 discussion of top surgery, which is pretty much limited  
 4 to a very small group of people. The majority of  
 5 transgender stuff done with children is medical.  
 6 Q But your -- but that presentation goes beyond  
 7 surgery; correct?  
 8 A Right. We discuss everything. Social  
 9 transition, medical transition, and surgical transition  
 10 in adults primarily. I discuss the range of surgeries  
 11 that are offered to adults who are having affirmation  
 12 care, affirmation surgery. So I get into the details of  
 13 that because I find that the public has a great  
 14 misunderstanding about what plastic surgeons are capable  
 15 of, so I want the audience to understand what's actually  
 16 happening and being presented as an actual sex change,  
 17 which turns out to be typically a counterfeit front with  
 18 complications.  
 19 Q You also discuss religious content in  
 20 presentation; correct?  
 21 A To religious groups I do. Yes, I do.  
 22 Q So it's a mix of both; correct?  
 23 MS. LAND: Object to form.  
 24 A My presentations are a mix of both?  
 25 Q (By Mr. Ossip) Yeah.

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1 A Yeah. I would say the lion share of my  
 2 presentations are to church groups, the only ones that  
 3 have shown interest.  
 4 Q Okay.  
 5 A I haven't been invited by the American Society  
 6 of Plastic Surgery to give a presentation on the moral  
 7 problems of transgender surgery.  
 8 Q Were any other --  
 9 A Probably not going to happen, though. I have  
 10 not.  
 11 Q And no other medical organization; correct?  
 12 A I'm trying to remember. Christian Medical and  
 13 Dental Association. No, I haven't presented to them  
 14 either, no.  
 15 Q Okay. Have you ever tried to help someone with  
 16 gender dysphoria become comfortable with their  
 17 biological sex?  
 18 A In terms of a therapeutic relationship with  
 19 them.  
 20 Q In any way?  
 21 A Well, so for the example we have of the  
 22 children, the one or two children that I have talked to  
 23 in the parish library, it's been more -- and none of it  
 24 has resolved by the way -- it's been more a conversation  
 25 about seeking the origin of their anxiety.

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1 So, for example, in the one child that first  
 2 comes to mind, she's undergoing a lot of anxiety over  
 3 the fact that her father is sort of out of the picture  
 4 because he devotes all of his time to taking care of her  
 5 special needs sister. And it's possible that she's  
 6 misinterpreting family dynamics there and thinking that  
 7 her father is ignoring her because of her appearance. I  
 8 don't know.  
 9 But that's an example of what I do. I don't  
 10 try to change anybody's sexual identity. I try to  
 11 understand what is the cause of their dysphoria.  
 12 Q And so it's only been one or two children that  
 13 you have spoken to about this?  
 14 A Again, that's sort of a running total, but  
 15 right now there is one or two, yeah.  
 16 Q How many total children with gender dysphoria  
 17 have you spoken to in your lifetime?  
 18 A In my capacity as a doctor or in my capacity as  
 19 a deacon?  
 20 Q In both.  
 21 A Well, as a doctor, maybe one or two. I don't  
 22 know.  
 23 Q And that's in both capacities?  
 24 A No. In the deacon arena children, you know,  
 25 the late-onset gender dysphoria thing, there's been

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1 three or four girls in the last two years alone, yeah.  
 2 Q Any other people you have spoken to in your  
 3 capacity as a deacon?  
 4 A I don't think so.  
 5 Q And how many times did you meet with each of  
 6 these people in your capacity as a deacon?  
 7 A Well, let's see. One of them I have met with  
 8 three times. One of them I only got to meet one time.  
 9 One of them maybe twice, three times maybe.  
 10 Q Okay. All right. So just changing topics a  
 11 little bit again, have you ever been subject to any kind  
 12 of professional discipline?  
 13 A No.  
 14 Q Nothing about a state medical board?  
 15 A Never.  
 16 Q No professional society?  
 17 A Never.  
 18 Q What about military discipline?  
 19 A Never.  
 20 Q No administrative actions?  
 21 A Never.  
 22 Q Summary proceedings?  
 23 A Never.  
 24 Q Okay. So you mentioned a couple instances of  
 25 testimony. Have you ever been in court for any other



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1 reason?  
2 A Gosh, I remember trying to fight a traffic  
3 ticket in suburban Maryland one time.  
4 Q Let's put aside traffic tickets. Any other  
5 reason you have ever been in court?  
6 A No, no.  
7 Q And earlier we talked about a child custody  
8 case.  
9 A Right.  
10 Q And you said you were testifying for the  
11 family; is that correct?  
12 A Again, I would have to pull the -- my notes out  
13 and review them. But as I remember the situation it was  
14 a -- it is a family with a young girl in her mid teens  
15 who suddenly began identifying as a boy who was brought  
16 to the attention of the transgender clinic at the -- I  
17 believe it's the Cincinnati Children's Hospital. I  
18 would have to review my notes.  
19 But in the course of receiving care at the  
20 Cincinnati Gender Clinic the parents resisted hormonal  
21 transitioning. And the clinic assisted the child, as I  
22 understand it the clinic assisted the child in seeking  
23 custody -- being transferred to the child's grandmother,  
24 I think it was, so that the grandmother could be the  
25 decisionmaker because the grandmother was all on board,

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1 and so the parents lost custody of the child.  
2 And as I -- again, I would have to review the  
3 notes. But as I recall the -- they were asking my  
4 opinion about the likelihood that that transitioning was  
5 going to resolve her problems. I think we had a  
6 discussion or presentation. Again, I would have to  
7 review the notes, but, again, that was the question they  
8 were asking.  
9 Q And did you ever testify in that case?  
10 A No.  
11 Q And how old was the child in that case?  
12 A I think when I was first contacted the child  
13 was in her mid to late teens. And I think the  
14 resolution of that was the child aged out of the whole  
15 process. And I don't know if she was an emancipated  
16 minor or and I think the litigation there is harms  
17 caused by to the family by the gender clinic.  
18 Q So the family sued the gender clinic?  
19 A I think that's what the situation is, yeah.  
20 Q All right. So we're going to play you another  
21 portion of what's been marked as recording D for the  
22 purposes of this deposition.  
23 (The video played and was later marked  
24 as Plaintiffs' Exhibit D.)  
25 Q (By Mr. Ossip) And so that was you on a

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1 recording?  
2 A Yes, it was.  
3 Q And you said on there that you had to give  
4 testimony in that case; correct?  
5 A Well, I guess I misspoke. It was, I guess, an  
6 expert opinion.  
7 Q So you submitted an expert report in that case?  
8 A I think that's what happened in that case was  
9 an expert opinion submitted to the lawyers.  
10 Q Okay.  
11 A And I seem to have conflated it with another  
12 case in the news. It may have been in Texas where a  
13 father lost custody of his son who is in that age range  
14 of eight years old or nine years old.  
15 Q Did you 2012 in that Texas case?  
16 A No, no.  
17 MR. OSSIP: Okay. All right. I think  
18 let's take another break.  
19 VIDEO OPERATOR: Okay. We're off the  
20 record at 5:17 p.m.  
21 (A break was had.)  
22 VIDEO OPERATOR: We are back on the  
23 record at 5:30 p.m. Please proceed.  
24 MR. OSSIP: Thanks, Mike. And thank you,  
25 Doctor.

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1 Q (By Mr. Ossip) So, Doctor, you mentioned  
2 meeting with some of the children in your parish with  
3 gender dysphoria up to three times; is that correct?  
4 A I think that's the most times I've met with any  
5 one of them.  
6 Q And some of them you met with fewer times?  
7 A Yeah. I can think of one right off the top of  
8 my head.  
9 Q That you met with one time?  
10 A Right.  
11 Q And did you provide psychotherapy to these  
12 children?  
13 A No.  
14 Q Did you provide any other form of counselling?  
15 A No, other than pastoral kind of discussion of  
16 what it means to suffer and how to bear suffering and  
17 what the possible meaning their suffering might have in  
18 their life. That's pretty much what that's about.  
19 Q Did you share any of your understanding of the  
20 medical science of gender transition procedures?  
21 A With the children, no.  
22 Q What about with the parents?  
23 A I might have answered pointed questions about  
24 is -- you know, is hormone therapy going to be good for  
25 my child kind of questions, but nothing beyond that.

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1 Those visits were pretty much pastoral in nature, yeah.  
 2 Q And how did you answer that question?  
 3 A That I would -- as I recall telling the mother  
 4 that they should put off making any such decision.  
 5 Q And by that you mean not using --  
 6 A Not rushing to any decisions about hormone  
 7 therapy.  
 8 Q And by that you mean not providing hormone  
 9 therapy; correct?  
 10 A Right. Like if anybody is offering hormone  
 11 therapy, delay.  
 12 Q Delay until when?  
 13 A Until you know more. Because my opinion at  
 14 that point is if they know more they will be less likely  
 15 to do it. I think I recommended them to read some  
 16 articles, to -- let's see. There is some resources  
 17 online.  
 18 I think I might have referred one of them to  
 19 Erin Brewer's website because she's -- she's a person  
 20 who lived that transgender experience as a child. I  
 21 might have referred them to Walter Heyer's website for  
 22 the parents to look at so they can understand kind of  
 23 the arc of what happens to children when they are  
 24 experiencing this kind of gender anxiety.  
 25 Q What articles did you refer them to?

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1 A It may have been something Walter Heyer may  
 2 have written. It's been a while since that visit. That  
 3 was over a year-and-a-half ago.  
 4 Q And was that all to the parents?  
 5 A Right.  
 6 Q You never provided any articles to the  
 7 children?  
 8 A No.  
 9 Q Didn't refer them to any websites?  
 10 A No.  
 11 Q Looking to the children, did you -- during your  
 12 conversations did you ever discuss Catholic teaching  
 13 about gender transition?  
 14 A No.  
 15 Q What about with the parents?  
 16 A So the discussion with the parents may have  
 17 been more difficult because they are a Spanish speaking  
 18 family. The child speaks perfect English. The parents  
 19 struggle with it and I would have a very hard time  
 20 making any such conversation in Spanish.  
 21 Q Well, my question was with the parents did you  
 22 discuss Catholic teaching about gender transition?  
 23 A I don't think so.  
 24 Q And you mentioned they were Spanish speaking.  
 25 That applies to all three of the children we are

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1 discussing, the parents of all three of the children.  
 2 A Well, certainly the one -- let's see. The girl  
 3 that I have seen about three times, yeah, her father  
 4 speaks no English. Mother struggles with English. But  
 5 she speaks perfect English. So my conversations with  
 6 the parents would be mostly my broken Spanish to  
 7 recommend sources of information like Walter Heyer and  
 8 such like that.  
 9 Q Looking to the children, did you engage in  
 10 prayer with them to help address their gender dysphoria?  
 11 A Well, did I try to pray them out of their  
 12 dysphoria? No. Any time I meet with a child in the  
 13 library or anywhere else, at the school or at the  
 14 church, every such meeting always begins and ends with  
 15 prayer. But as far as me praying over them to relieve  
 16 that, that's not how I work.  
 17 Q What about with the parents?  
 18 A Similar thing, begin and end with prayer.  
 19 Q So earlier we talked about your presentations  
 20 to church groups.  
 21 A Um-hum.  
 22 Q And those include a mixture of medical  
 23 information and religious content; right?  
 24 A Right. The goal in those presentations almost  
 25 always is for them to be conversant in the language and

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1 understand the medical issues so that they can speak  
 2 intelligently to their friends, their peers, other  
 3 people, and not be disturbed or surprised or angered or  
 4 revulsed when they meet a person who is struggling with  
 5 gender identity.  
 6 One of the problems in the Christian world, and  
 7 like this guy on the radio, one of the problems in that  
 8 world is a tendency for them to speak in words of  
 9 revulsion and confusion and misunderstanding.  
 10 So when I talk to groups like that the very  
 11 first thing I explain to them is that they have to be so  
 12 conversant in things that nothing will repel them and  
 13 they will never respond with anger or disgust, because  
 14 if you do, you cannot make a friend. If you cannot make  
 15 a friend, you cannot help anybody. So that's the  
 16 beginning of very talk, so.  
 17 Q And you mentioned earlier that part of the  
 18 reason why you continue to provide laser hair removal to  
 19 your patient is so you can continue your friendship; is  
 20 that correct?  
 21 A Right.  
 22 Q And why do you want to continue that  
 23 friendship?  
 24 A I think because I have a hope that -- that they  
 25 will value my opinion and see something in my life that

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1 they can trust.

2 Q And what opinion is it that you hope they will  
3 value?

4 A That I value them as a person and that I don't  
5 reject them as a person and that they may one day ask  
6 themselves, Why do I believe what I believe?

7 Q And what is it that you believe?

8 A I believe that the human person is a singular  
9 nature. I believe that we are binary in our  
10 construction, that that binary is ordered towards a  
11 unity that is a life giving unity and that informs my  
12 life as a physician and as a deacon.

13 Q And the reason why you're hoping that they ask  
14 themselves why you believe what you believe is because  
15 you hope that they will adopt that belief too; correct?

16 MS. LAND: Object to form, relevance.

17 A Well, I mean, I would -- I would love it if  
18 they did because I think that's where human happiness  
19 lies. But I also want them to trust me as a friend  
20 because what's very common and very likely in the -- in  
21 the life arc of persons who have this difficulty is you  
22 have a nearly 50/50 chance of experiencing some very  
23 dark time in their life when the transition is over and  
24 no one is interested any longer and they are alone and  
25 sorrowing, I don't want them to feel alone. I don't

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1 want them to feel as if there is nothing further to be  
2 done, I don't want them to kill themselves.

3 Q (By Mr. Ossip) So you mentioned going back to  
4 the parents of children that you had conversations with  
5 in your capacity as a deacon. You mentioned helping  
6 them find, was it a psychiatrist for their child?

7 A Psychological counselor. Usually children who  
8 are having these experiences are better served by family  
9 counseling. And so one of the things that's probably  
10 most necessary in a child having that experience -- and,  
11 I mean, the girl we were speaking about earlier, it's  
12 written all over her dynamic is there is a real conflict  
13 between her and her father and the way the mother  
14 mediates in that whole issue and how it alienates her  
15 daughter.

16 So for example her, I suggested some family  
17 counseling I think I found them a family counselor in  
18 Huntsville. But yeah, that's how it sits right now.

19 Q And how did you find that family counselor?

20 A I did a Google search looking for family  
21 counselors that would be convenient, who spoke Spanish.  
22 Because they need to be Spanish speakers to take care of  
23 that family.

24 Q Any other qualifications in that search?

25 A I generally will look for counselors that

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1 don't -- well, what was my search criteria there? In  
2 the family counseling side that's pretty much it.

3 That's pretty much it. If they are a legitimate and  
4 qualified family counselor who can speak, and their kid  
5 is Spanish, that was enough for me.

6 Q And what makes them legitimate or qualified?

7 A Well, they have got the credentials of  
8 counseling, licensed social worker, counselor, family  
9 counselor. I don't fully understand the credentialing  
10 process on the counseling side of things. But I would  
11 hope that people who advertise themselves as family  
12 counselors are qualified to do this.

13 Q So you're just looking for whether they  
14 advertise themselves as a family counselor?

15 A Yeah. I don't remember exactly what I saw on  
16 that particular website, but my guess is there must have  
17 been some credential thing that they present. Most  
18 providers put their credentials on it.

19 Q Okay. And you mentioned three families. Did  
20 you assist all three of them in finding a family  
21 counselor?

22 A Well, so one of them was beyond family  
23 counseling because in this circumstance it was a young  
24 man who was at the very early stages of beginning a  
25 social transition and had not had any contact yet with

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1 any medical providers, but was absolutely resolute that  
2 this was the right thing to do. And that was kind of a  
3 heartbreaking visit.

4 He was even -- you know, that was -- so there  
5 was nothing I could offer, because there is nothing you  
6 can offer to somebody who is not interested in what  
7 you're offering. And he's beyond family counseling  
8 because he is already ignoring his parents and not in --  
9 under their purview, no longer living at home.

10 Basically, I think he was in his first semester of  
11 college.

12 Q So this was not a minor then?

13 A Seventeen years old. Seventeen, maybe going on  
14 18, but 17.

15 Q And was in college?

16 A Just going off to college or might have been  
17 down there for a semester. It was one of those. A kid  
18 I recognized from around the parish.

19 Q And this 17-year-old began a social transition?

20 A Yeah, he was, he was. In his manner and his  
21 clothing and I think he had -- wore makeup, he wore a  
22 sort of a blousy-looking shirt. You can still call it a  
23 shirt, but it looked kind of blousy. I think he was  
24 wearing fingernails, wearing some facial makeup and  
25 definitely crafting his mannerisms to present himself as

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1 a more feminine side.  
2 Q Do you classify this as late-onset gender  
3 dysphoria?  
4 A In his case it would have been because I had  
5 never saw any sign of it. He was --yeah, it had to be  
6 late teens, obviously. This was -- the parents never  
7 said anything until he came back, I think, from his  
8 first semester in college as I recall. This was a while  
9 back.  
10 Q And you said he wouldn't listen to his parents;  
11 correct?  
12 A You could tell in the dynamic there that he was  
13 sort of wanting for his parents to be on his side. But,  
14 obviously, the reason they brought him to me was for him  
15 to hear the other side in terms of, you know, what's the  
16 outlook for you if you -- if you do hormonal transition,  
17 what's the outlook for you if you do gender transition.  
18 Q And why was it heartbreaking?  
19 A Because there is nothing I could offer. Here  
20 is a room full of people suffering and nothing I can  
21 offer.  
22 Q Why was it obvious that that was the reason  
23 they brought him to you?  
24 A Told me. They said, Doctor, I understand you  
25 know something about trans. My son is -- all of a

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1 sudden he's -- he's saying he's a woman. So I never  
2 turn away anybody who is in distress and so I said, Just  
3 plan to come by my office together and maybe we can  
4 talk, so they did. They showed up and we spent about an  
5 hour talking about things, but it went nowhere.  
6 Q Did he want to be there?  
7 A I think he wanted to be reconciled with his  
8 parents. I don't think he wanted to be there. I think  
9 his parents insisted that he come. And he, out of love  
10 for his parents, came. But I don't think he was there  
11 to listen to anything. He was just there out of love  
12 for his parents.  
13 Q And you didn't refer him to any sort of care;  
14 correct?  
15 A No.  
16 Q Going back to the family counselor, did they --  
17 do you know whether that family counselor supports  
18 gender-affirming care?  
19 A I do not know.  
20 Q Do you know whether they oppose  
21 gender-affirming care?  
22 A No.  
23 Q You never looked into it?  
24 A It was not a criteria for me. It seemed to me  
25 that in her case the disorder in the family dynamics

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1 spoke for themselves quite apart from anything else  
2 going on in her life.  
3 Q And so -- I'm sorry to jump around a little  
4 bit.  
5 A No. That's okay.  
6 Q For the 17-year-old, what did you tell them  
7 about hormone therapy?  
8 A Well, what I usually -- since he would not have  
9 been a candidate for puberty blockade, he would have  
10 been right into cross-sex hormones I talked about the  
11 side effects and consequences of high dose estrogen in a  
12 man. We talked about hypertriglyceridemia,  
13 hypertension, metabolic syndrome, weight gain. We  
14 talked about life-long dependency on it. We talked  
15 about all of those issues and that it had some  
16 likelihood of leading on to surgery if he was still  
17 unhappy after receiving cross-sex hormones.  
18 Q And did you include any discussion of Catholic  
19 teaching in that discussion?  
20 A I don't think we did, because I didn't -- the  
21 vibe -- as I recall the vibe I was getting from that  
22 young man was he was not there to listen to church  
23 teachings. I think he was just there out of obedience  
24 to his parents and he was in a doctor's office. This  
25 was outside the parish. So he was sitting in an

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1 examination chair and we were having a conversation.  
2 Q So, okay. Interesting. So but this was  
3 somebody that you knew through the church that brought  
4 their child to your physician's office for this  
5 discussion?  
6 A Yeah. She approached me not as deacon Lappert,  
7 but Dr. Lappert, you know.  
8 Q Was your goal to get him to -- strike that.  
9 Was your goal to deter him from medical  
10 transition?  
11 A I didn't have any expectation of that. I  
12 didn't have any expectation that the advice I was going  
13 to offer him was going to change the course of his life.  
14 Q Well, putting aside your expectation, what was  
15 your objective?  
16 A I think in that first visit it's to try to  
17 understand what's happened in his life that he all of a  
18 sudden and out of the blue would have such a change of  
19 heart about his life.  
20 Q But you went through all the side effects of  
21 hormone therapy.  
22 A Right, because towards the end of it he was  
23 pretty much talking about the fact that he is  
24 transitioning and so I just cautioned him, cautionary  
25 words about high-dose sex steroids.

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1 Q And why did you caution?

2 A Because I'm concerned about what's going to

3 happen to his body if he takes high-dose sex steroids.

4 Q Because you didn't want him to take them?

5 MS. LAND: Object to form.

6 A Right, for medical reasons. Not, per se, for

7 the transgender transition, but the fact -- basically

8 cautioning him -- giving him the side of the

9 conversation that he probably wasn't hearing, which is

10 the consequences of high-dose sex steroids. I think he

11 hadn't heard that. He seemed to be surprised in hearing

12 it, but I don't think it had any effect.

13 Q So you mention going back or taking a step

14 back, you mentioned a variety of discussions with

15 children and families from your parish about gender

16 dysphoria; correct?

17 A Right.

18 Q How many of those were at the church and how

19 many were in your physician's office?

20 A The only one was in my physician's office was

21 the one we just discussed.

22 Q All the rest were in the library?

23 A I'm pretty sure, yeah.

24 Q Okay.

25 A And all of those were basically deacon Lappert

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1 talking to parishioner child.

2 Q But the one in your office was Dr. Lappert.

3 A As I recall she specifically had approached me

4 as Dr. Lappert.

5 Q And was that --

6 A I think that's the reason I asked to meet them

7 at the office, because --

8 Q Was that consultation within the scope of your

9 experience as a plastic surgeon?

10 A No. I was there just because of my knowledge

11 of the subject and the parents just wanted me to talk.

12 It was not a plastic surgical consultation. It wasn't a

13 transitioning consultation. It was a visit with the

14 hope of that child hearing some of the -- some of the

15 difficulties he's going to encounter if he embarks on

16 transitioning. So I --

17 Q Well, I mean, you said it was a medical visit;

18 correct?

19 A That's what we talked about. That's all I had

20 the chance to talk about.

21 Q And what type of medical visit was it?

22 A Just general visit to a doctor who knows about

23 transgender medicine.

24 Q And you -- sorry. Go ahead, Doctor.

25 A No. Go ahead.

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1 Q And you consider yourself a doctor who knows

2 about transgender medicine?

3 A I spend a lot of time studying and reading on

4 it, yes, I have.

5 Q And that was since 2014; correct?

6 A Right.

7 Q And you feel qualified to provide care to

8 patients seeking transgender medicine?

9 A No. But I -- I consider myself adequately

10 qualified sort of at the primary care level to discuss

11 medical risks with a family and a patient in the same

12 way that I would discuss, you know, the risk of

13 malignancy in a woman who has a family history of breast

14 cancer. I'm not an oncologist, but I know enough about

15 it that if I have concerns I can refer them to somebody

16 I might trust.

17 So it's sort of at the primary care level, and

18 that's kind of what that visit was. It was, sadly, not

19 a very effective visit.

20 Q So that was a primary care visit; correct?

21 A Right, yeah, simple visit.

22 Q How many primary care visits do you typically

23 do in a year?

24 A I do quite a few of them actually, because I

25 run a skin care consultation service and I provide skin

Page 301

1 care services. And people will present with odd little

2 things they don't know what to make of them. And, yeah,

3 I've got quite an extensive experience in dermatology

4 and I can read the difference between a malignancy and

5 mole and a harbinger of some visceral disease.

6 So I'm an easy visit to somebody they know.

7 And if I say, you need to see an endocrinologist, you

8 need to see a dermatologist, you need to see somebody

9 else I will make the referral for them.

10 Q And how many of those primary care visits

11 involve patients presenting who are seeking gender

12 transition?

13 A Some number approaching zero probably. I mean,

14 these are just the patients we've talked about here. I

15 don't have a practice in offering advice to

16 transgender -- or gender dysphoric patients. I don't

17 advertise it as a service. I don't present myself as an

18 expert in that regard. I do express myself as a

19 physician who has knowledge of the subject who can offer

20 some guidance on it, but that's about the extent of it.

21 Q And you felt qualified to, in a medical

22 capacity, have that visit with that patient; is that

23 correct?

24 A Absolutely.

25 Q Do you consider that child a patient?

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1 A Not anymore, no.  
2 Q But you did at that time?  
3 A Anybody who comes to me I consider a patient.  
4 Whether or not that relationship develops, I always  
5 assume it's the beginning of a doctor-patient  
6 relationship.  
7 Q Does that include the people who came to you at  
8 the church?  
9 A Well, if they approach me as a deacon, no, I  
10 don't present myself as their doctor. I present myself  
11 as their deacon.  
12 Q But you, nevertheless, discuss, for example,  
13 the medical consequences of hormone therapy?  
14 MS. LAND: Object to form.  
15 A The conversations I have had in the parish  
16 library have not been with children who were anywhere  
17 close to being offered hormonal therapy.  
18 Q (By Mr. Ossip) But you've discussed it with  
19 their parents?  
20 A No. Again, the Spanish speaking parents, I'm  
21 not conversant, fluent enough in Spanish to even have  
22 that discussion.  
23 Q So you mentioned three families; correct?  
24 A Three families, yeah.  
25 Q So one we already discussed and that was you

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1 recommending they see a family counselor; correct?  
2 A Right.  
3 Q And the second one was the 17-year-old in your  
4 office, you didn't provide any recommendation at all.  
5 A Well, I suppose you could -- it wasn't  
6 recommendation so much as caution.  
7 Q But you didn't refer to any other provider?  
8 A No.  
9 Q And what about the third family, did you refer  
10 them to any other provider?  
11 A I'm trying to remember. I know there is  
12 another child that I've seen a couple of years back. I  
13 would be hard-pressed to offer detailed information  
14 about that child.  
15 I just remember having a conversation. I  
16 remember her being in eighth grade. And I remember her  
17 basically being sort of the doorstep of things because  
18 all of a sudden out of the blue she didn't want to wear  
19 girls clothes, cut her hair short, wanted to change her  
20 name. And I -- it was maybe one or two conversations in  
21 the parish library. Again, trying to plumb what  
22 happened in her life that would cause her to start  
23 thinking this way.  
24 Q And did you have a conversation with the  
25 child's parents?

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1 A I believe the parents were in the room for that  
2 one.  
3 Q Okay. Did you refer this child to any other --  
4 A No, I didn't.  
5 Q -- provider?  
6 A I didn't refer her.  
7 Q All right. And talking about the 17-year-old  
8 who was in your office, did you bill for that office  
9 visit?  
10 A No, no.  
11 Q Why not?  
12 A Because of its informality and the fact that  
13 I don't -- I do lots of gratis visits for parishioners.  
14 It's just what I do.  
15 Q Okay. But that was the only gratis visit for a  
16 person that involved gender transition?  
17 A Right.  
18 MR. OSSIP: Where are we at on time,  
19 Mike?  
20 VIDEO OPERATOR: Let's see. Thirty-eight  
21 minutes.  
22 MR. OSSIP: Okay.  
23 Q (By Mr. Ossip) Doctor, would you describe your  
24 view on gender transition procedures as mainstream  
25 within the medical profession?

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1 A I would consider them common. That's hard to  
2 judge mainstream because of the silence that's out  
3 there. Mostly what you hear is that things like  
4 consensus statement of the Endocrine Society would have  
5 you believe that all endocrinologists believe it. Or  
6 consensus statement from the Pediatric Society that all  
7 pediatricians agree with this. And my experience is  
8 they don't all agree with it, but I just don't know how  
9 many of them agree with it.  
10 Q But you have no idea one way or another?  
11 A I have no idea.  
12 Q And you have no idea how many doctors in the  
13 medical profession agree with you?  
14 A I have no idea.  
15 MR. OSSIP: All right. I think let's  
16 just take one more break now.  
17 THE WITNESS: Sure.  
18 VIDEO OPERATOR: Okay. We're off the  
19 record at 5:54 p.m.  
20 (A break was had.)  
21 VIDEO OPERATOR: We are back on the  
22 record at 6:02 p.m. Please proceed.  
23 Q (By Mr. Ossip) All right. Give me one second,  
24 Doctor.  
25 Doctor, have you ever recorded a podcast called

Page 306

1 "Transgenderism, a Surgeon's Perspective"?

2 A So that's not a podcast. That's a Light House

3 Media CD. So, yes.

4 Q But it's a talk; correct?

5 A Correct.

6 Q Okay. I'm just gonna -- we're gonna play a

7 minute of this. This has been marked as C, recording C

8 for the purposes of this deposition.

9 (Audio recording was played and later

10 marked as Plaintiffs' Exhibit C.)

11 MR. OSSIP: And that's your voice in this

12 recording; correct, Doctor?

13 A Yes, it is.

14 Q And that's that Light House talk; is that

15 correct?

16 A I believe that's correct, yeah.

17 Q All right. Doctor, do you have -- well, you

18 have religious beliefs concerning gender transition. Is

19 that fair to say?

20 A Yes, I do.

21 Q And what are those beliefs?

22 A That the human person is a single nature, that

23 the mutilation of genitalia or otherwise bodily

24 mutilation is a -- is a, from the religious perspective,

25 is a sin against your bodily integrity. That pretty

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1 much would cover transgender.

2 Q And when does something rise to the level of

3 mutilation?

4 A Well, so the intentional destruction of a

5 structure like the breasts I would put in the category

6 of mutilation. The intentional destruction of the

7 native genitalia I would put in the category of

8 mutilation. But the church considers mutilation

9 including things like the division of the vas deferens

10 in a vasectomy, are the tying of the fallopian tubes the

11 church considers to be a mutilation.

12 Q What about facial feminization surgery?

13 A I don't believe anybody would consider that a

14 mutilation.

15 Q Why not?

16 A Because you're not destroying function. You're

17 just changing aesthetic contours. It's not a functional

18 surgery. But the others are problematic because they

19 destroy a function.

20 Q And do you think that -- that such a mutilation

21 is a sin?

22 MS. LAND: Object to form and relevance.

23 A All right. So, again, I always make the

24 distinction, I don't present the sin side of things when

25 I'm talking about medical issues. But when religious

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1 issues come in, I do. When I offer an expert opinion

2 like the one I've offered here I don't bring my religion

3 into it. But in terms as a Catholic do I think that

4 mutilation is a sin, yes.

5 MR. OSSIP: Sorry, just give me one

6 second, Doctor. I apologize.

7 Sorry. Can we go off the record for one

8 second?

9 VIDEO OPERATOR: Off the record at 6:06

10 p.m.

11 (A pause was had.)

12 VIDEO OPERATOR: We're back on the record

13 at 6:07 p.m. Please proceed.

14 Q (By Mr. Ossip) Doctor, is it your view that

15 performing gender transition procedures is against

16 Catholic truth about the nature of a person?

17 MS. LAND: Object to form and relevance.

18 A Do I believe that gender transition procedures,

19 surgeries are against -- I'm sorry.

20 Q (By Mr. Ossip) Yeah. Is it your view that

21 performing gender transition procedures is against

22 Catholic truth about the nature of a person?

23 A Yes.

24 Q Okay. In what way?

25 A Because it ignores the reality of the single

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1 nature of the human person.

2 Q And again, that reality of the single nature of

3 a human person, that's not limited to Catholic teaching;

4 correct?

5 A No. That's natural law. So the thing to

6 understand about Catholic teaching when you're talking

7 about these issues is that the foundation of all of it

8 is natural law and that the -- the Catholic truth is

9 basically just a -- the story of its perfection in

10 eternity basically.

11 So you have to -- you have to understand and

12 accept the nature of the human person if you're going to

13 propose that that nature is going to be perfected by the

14 grace of God. That's why it's an important issue in the

15 Catholic church.

16 Q And what you're describing is natural law is

17 also a predicate to the practice of medicine in our

18 view?

19 A Very important predicate, exactly. Because if

20 you get the natural truths, everything from body

21 temperature to heart rate wrong, you're not going to

22 treat them correctly.

23 Q And how does one determine natural law?

24 A Well, it's evident. One studies nature. So

25 you study the nature of the human person and it includes

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1 things like taking their pulse and taking their  
2 temperature and doing all those things that medicine has  
3 been involved in for the last thousand years and you  
4 come to an understanding of it, just as -- and that  
5 understanding changes with time.  
6 Particularly in the area of reproduction, it's  
7 changed a lot in the last 100 years. But, yeah, you --  
8 it's the study of the nature of the human person.  
9 That's what science is about, the study of nature,  
10 philosophy of nature, the philosophical sciences.  
11 Q Well, is natural law a predicate to science or  
12 is science a predicate to natural law?  
13 MS. LAND: Object to form.  
14 A I'm not sure I understand what you mean by  
15 predicate.  
16 Q (By Mr. Ossip) Well, do you use science to  
17 determine natural law or does natural law determine the  
18 course of science?  
19 A You use the scientific method to study natural  
20 law, but the scientific method itself is based on the  
21 idea of natural law, because that revolution that  
22 happened in the 12th and 13th century was the  
23 recognition of the fact that what you measure today will  
24 be the same tomorrow and that you can come to understand  
25 things because of their repeatability, their constancy.

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1 Which in the -- in the Catholic world view is speaking  
2 to the unchanging nature of God. Right? No shadow of  
3 turning in him.  
4 So -- so that was the foundation of science.  
5 So science is based on the study of the natural world.  
6 And the recognition of the scientific method begins with  
7 recognizing that the natural world is regular, orderly,  
8 logical, repeatable, all of those things. So it's a  
9 both/and I think is the more correct way to look at that  
10 philosophically.  
11 Q And that there is unchangeable truths?  
12 A There are unchanging truths, yeah.  
13 Q And that includes biological sex?  
14 A Yes.  
15 Q And that includes gender?  
16 A No. Gender seems to be a very fluid thing  
17 because the subjective life of a person is a very fluid  
18 thing. Gender is in the category of the person's  
19 subjectivity. And the real Christian story is the  
20 subjectivity of the human person is where all the  
21 trouble comes from. Right, yeah.  
22 So, yeah, the unchanging things, obviously in  
23 the absence of disease or harm or things like that, then  
24 changing things are the observable, the measurable,  
25 those sorts of things. And diagnoses that lead to

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1 surgery and medical care rely on that, obviously, very  
2 heavily.  
3 And so the natural law, for example, spills  
4 over into the truth, the -- actually, the scientific  
5 objective truths of the human body and how the body  
6 responds to influences of medications and hormones and  
7 trauma and all those other things.  
8 Q And -- okay. I think -- I'm just going to  
9 check my notes. Give me one second, Doctor.  
10 A Sure.  
11 Q Let me ask one more actually.  
12 Doctor, are you familiar with something called  
13 the GRADE approach?  
14 A The what approach?  
15 Q The -- well, are you familiar with Grading of  
16 Recommendations, Assessment, Development and Evaluation?  
17 A Oh, I see. That's a -- I've never heard those  
18 terms. I used SOAP approach when I was learning  
19 diagnostic and evaluation or the HPI approach. But I --  
20 is that GRADE approach, is that a psychiatric process?  
21 Q I'm just asking, are you familiar with the  
22 GRADE approach?  
23 A I've never heard it.  
24 MR. OSSIP: Okay. All right. I think  
25 that's all I have. Thank you, Doctor, for your time and

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1 for hanging out with us today.  
2 THE WITNESS: Sure.  
3 MR. OSSIP: And with that I'll pass the  
4 witness.  
5 EXAMINATION  
6 BY MS. LAND:  
7 Q Dr. Lappert, did any of the questions asked by  
8 Mr. Ossip change your opinions that you have previously  
9 given in this case?  
10 A No.  
11 Q A lot has been asked of you of your religious  
12 views today. Are any of the opinions that you gave as  
13 an expert in this case based upon any of the religious  
14 views you have testified to today?  
15 A No.  
16 MR. OSSIP: Objection to form.  
17 A No. My expert opinion and my testimony today  
18 is informed by my knowledge of the science and my  
19 experience as a physician-surgeon.  
20 Q (By Ms. Land) Were any of the recordings played  
21 for you today, specifically recordings, A, B, D, E, F  
22 and C, in which you heard yourself speaking given in  
23 your capacity as a medical doctor?  
24 A They were given in my capacity as deacon and  
25 surgeon together, yes, so.




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1 Q Were you giving any of those recordings -- or  
 2 excuse me.  
 3 Were you speaking in any of those recordings in  
 4 your capacity of giving consultation to any patients?  
 5 A No.  
 6 MR. OSSIP: Objection to form.  
 7 MS. LAND: No further questions.  
 8 MR. OSSIP: Can you give us one minute,  
 9 please?  
 10 VIDEO OPERATOR: You want to go off the  
 11 record?  
 12 MR. OSSIP: Yeah.  
 13 VIDEO OPERATOR: Okay. We're off the  
 14 record at 6:16 p.m.  
 15 (A pause was had.)  
 16 VIDEO OPERATOR: We're back on the record  
 17 at 6:16 p.m. Please proceed.  
 18 MR. OSSIP: All right, Doctor. I just  
 19 want to once again, thank you for your time with us and  
 20 I have no more questions for you.  
 21 THE WITNESS: Thank you.  
 22 VIDEO OPERATOR: Okay. This concludes  
 23 today's testimony given by Dr. Patrick Lappert. The  
 24 total number of media used was six, which will be  
 25 retained by Veritext. And we are going off the record

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1 at 6:16 p.m.  
 2 (A discussion was had off the record.)  
 3 MS. LAND: Okay. I would just like us to  
 4 go on the record on behalf of Dr. Lappert and say that  
 5 we would like to review and sign.  
 6 (Deposition concluded.)  
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1 C E R T I F I C A T E  
 2  
 3  
 4 I, Trena K. Bloye, Certified Shorthand Reporter  
 5 within and for the state of Oklahoma, certify that  
 6 PATRICK WALTER LAPPERT, M.D., was by me first duly sworn  
 7 to testify the truth, the whole truth, and nothing but  
 8 the truth, in the case aforesaid; that the witness  
 9 chooses to read and sign the deposition; that the above  
 10 and foregoing videotaped deposition was taken by me in  
 11 shorthand and thereafter transcribed; that the same was  
 12 taken on May 6, 2022, at 9:04 a.m., at the Arkansas  
 13 Attorney General's Office, 323 Center Street, Suite 200,  
 14 Little Rock, Arkansas, that I am not an attorney for,  
 15 nor a relative of any of said parties or otherwise  
 16 interested in the event of said action.  
 17 IN WITNESS WHEREOF, I have hereunto set my hand  
 18 and official seal this 18th day of May, 2022.  
 19  
 20  
 21  
 22  
 23  
  
 24  
 25 Trena K. Bloye, CSR  
 State of Oklahoma CSR No. 1522

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1 AMANDA LAND, ESQ.  
 2 aland@arkansasag.gov  
 3 May 20, 2022  
 4 RE: BRANDT, et al. vs. RUTLEDGE, et al.  
 5 5/6/2022, Patrick W. Lappert (#5163564)  
 6 The above-referenced transcript is available for  
 7 review.  
 8 Within the applicable timeframe, the witness should  
 9 read the testimony to verify its accuracy. If there are  
 10 any changes, the witness should note those with the  
 11 reason, on the attached Errata Sheet.  
 12 The witness should sign the Acknowledgment of  
 13 Deponent and Errata and return to the deposing attorney.  
 14 Copies should be sent to all counsel, and to Veritext at  
 15 erratas-cs@veritext.com.  
 16  
 17 Return completed errata within 30 days from  
 18 receipt of testimony.  
 19 If the witness fails to do so within the time  
 20 allotted, the transcript may be used as if signed.  
 21  
 22 Yours,  
 23 Veritext Legal Solutions  
 24  
 25

1 BRANDT, et al. vs. RUTLEDGE, et al.  
 2 5/6/2022 - Patrick W. Lappert (#5163564)  
 3 E R R A T A S H E E T  
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 6 REASON \_\_\_\_\_  
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 24 Patrick W. Lappert Date  
 25

1 BRANDT, et al. vs. RUTLEDGE, et al.  
 2 5/6/2022 - Patrick W. Lappert (#5163564)  
 3 ACKNOWLEDGEMENT OF DEPONENT  
 4 I, Patrick W. Lappert, do hereby declare that I  
 5 have read the foregoing transcript, I have made any  
 6 corrections, additions, or changes I deemed necessary as  
 7 noted above to be appended hereto, and that the same is  
 8 a true, correct and complete transcript of the testimony  
 9 given by me.  
 10 \_\_\_\_\_  
 11 \_\_\_\_\_  
 12 Patrick W. Lappert Date  
 13 \*If notary is required  
 14 SUBSCRIBED AND SWORN TO BEFORE ME THIS  
 15 \_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_.  
 16 \_\_\_\_\_  
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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.

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