Exhibit 4

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

DYLAN BRANDT, by and through his mother, JOANNA BRANDT, et al.,
Plaintiffs,
vs. CASE NO. 4:21-CV-00450-JM
LESLIE RUTLEDGE, in her official capacity as the Arkansas Attorney General, et al.,
Defendants.

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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PLAINTIFFS' INDEX OF EXHIBITS

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STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED BY and between the parties hereto, through their respective attorneys, that the videotaped deposition of PATRICK LAPPERT, M.D., may be taken on behalf of the Plaintiffs on the 6th day of May, 2022, in Little Rock, Arkansas, by Trena K. Bloye, Certified Shorthand Reporter for the State of Oklahoma, by notice pursuant to the Federal Rules of Civil Procedure.

* * * * * *

VIDEO OPERATOR: Good morning. We are with going on the record at 9:04 a.m. on May 6, 2022. Please note that microphones are sensitive and may pick up whispering and private conversations. Please mute your phones at this time. Audio and video recording will continue to take place unless all parties agree to go off the record.

This is media unit 1 of the video recorded deposition of Patrick Lappert taken by counsel for Plaintiff in the matter of Dylan Brandt, et al. versus Leslie Rutledge, et al., filed in the United States District Court, Eastern District of Arkansas, Central Division, Case Number 4:21-CV-00450-JM. The location of the deposition is in the Arkansas Attorney General's Office at 323 Center Street, Suite 200, in Little Rock, Arkansas.

My name is Mike Tscheimer representing Veritext. The court reporter is Trena Bloye, also representing Veritext. I am not related to any party in this action, nor am I financially interested in the outcome. If there are any objections to proceeding, please state them at the time of your appearance.

Counsel and all present, including remotely, will now state their appearances and affiliations for the record beginning with the noticing

attorney.

MR. OSSIP: Jonathan Ossip from Sullivan & Cromwell for the Plaintiffs.

MR. HOLLAND: Alex Holland from Sullivan & Cromwell for the Plaintiffs.

MS. ECHOLS: Beth Echols with Gill Ragon Owen, the Plaintiffs.

MS. LAND: Amanda Land of the Arkansas Attorney General on behalf of the Defendants.

MR. CANTRELL: Michael Cantrell with the Arkansas Attorney General's Office for the Defendants.

MR. STRANGIO: Chase Strangio with the ACLU for the Plaintiffs.

MS. COOPER: Leslie Cooper with the ACLU for Plaintiffs.

MR. RODGERSON: Brandyn Rodgerson with Sullivan & Cromwell for the Plaintiffs.

PATRICK WALTER LAPPERT, M.D., after having been first duly sworn, deposes and says in reply to the questions propounded as follows, to wit:

EXAMINATION

BY MR. OSSIP:

Q Good morning, Dr. Lappert.

A Good morning.

Q Would you please state your full name for the record?

A Patrick Walter Lappert.

Q All right. And I'm just going to go over some ground rules before we get started. Before I do that, Dr. Lappert, have you ever been deposed before?

A This is my second time.

Q Okay. And when was the first deposition?

A I think it was about eight or nine months ago.

Q Okay. And what case was that for?

A Folwell in North Carolina. It's a lawsuit against the state treasurer seeking a change in policy from the State of North Carolina concerning transgender medicine surgery for beneficiaries of their insurance program.

Q And were you appearing as an expert witness in that case?

A Yes, I was.

Q And I'll go over this in a second. So one thing is Trena is writing down everything that we say, so it's really important that we don't overlap in our answers and questions --

A Okay.

Q -- so that way she can get every word down.

A Sure.

Q And other than that, you said Folwell was the

name of the case? I'm sorry.

A Right.

Q Other than that, no other depositions?

A No.

Q All right. So most of my questions today are going to be asking for more detail about your expert opinions in this case. So I'll be asking questions, the court reporter is going to be writing it down. So, as I said, we should avoid speaking over each other. Similarly, all answers should be verbal, so no nods or also uh-huh is really hard to write that down, so yes or no for those.

My job is also to make sure that everything is very clear today. So if I ask a question and you ever find it unclear, please let me know and I'll try to clarify my question.

A Okay.

Q If you don't do that I'll assume that you understood my question, though. Fair enough?

A Sure.

Q All right. I also want to really make sure that you are comfortable. I personally like to take breaks every hour or hour-and-a-half or so. But we can take a break at any point before then if you like. My only rule is if I have asked you a question, I would

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

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

A Just the meetings with the attorney generals, Mike. We had phone conversations basically about what to expect.
Q Okay. And now I'm going to ask you just a couple of questions about that.
A Sure.
Q But just as a -- I'm not asking ever about the content of those conversations.
A Sure.
Q Just about when they occurred and sort of broader nature of those. So how many phone calls did you have with the attorney general's office in preparation for your deposition?
A Let's see. I had one with Mike Cantrell, I think it must have been some months ago. I do not recall when. And then I had one last night with Mike Cantrell and Amanda here.
Q So just to take those one by one, the first one it was just you and Mike Cantrell?
A As I recall, yes.
Q And then last night, you, Mike, and Amanda?
A Correct.
Q Starting with the one that was just with Mike Cantrell, how long was that phone conversation?
A I would estimate it somewhere around -- less

than an hour.
Q Less than an hour?
A I'm estimating here from some time ago.
Q And approximately when was that?
A I would have to look on my calendar. I don't know off the top of my head.
Q Was it more than a month ago?
A Yes, it was, certainly.
Q Was it more than two months ago?
A Yes.
Q Was it more than six months ago?
A It's probably right around there if I had to take a wild guess.
Q Okay. So right around six months?
A Something like that.
Q And the one last night, nobody else on that call other than you, Mike and Amanda?
A Correct.
Q And how long was that phone conversation?
A Half an hour to an hour.
Q And other than those two phone conversations you had no other meetings or communications in preparation for this deposition?
A I had one other phone call with Amanda, actually, which I think was a week ago.

Q And how long was that phone call?
A About a half an hour.
Q Okay. So you mentioned you reviewed the references and citations from Plaintiff's experts, and those were from the three --
A I believe that's correct, yeah. I don't think I went to any other sources for citations.
Q And I will just say for Trena's benefit, if you could let me finish the question.
A I'm sorry.
Q Oh, no. Everyone does it. It's so natural. So, and approximately how many references and citations did you review?
A Just ball parking, maybe a dozen of the ones that were cited by the expert witnesses for the plaintiff.
Q And no other references and citations in preparation for this deposition?
A Very often when you're reading a journal article they make citations in there that take you -- so you go down a rabbit hole sometimes when you are chasing down a particular argument or a particular piece of evidence. So the beginning point was the citations of your experts, and then at times it would lead me into other -- other citations and references to look down.

Q So just the experts' articles and then maybe others that were cited in those?
A Right. That's generally how I go.
Q Any other documents you reviewed in preparation for today?
A The World Professional Association of Transgender Health, Standards of Care, Version 7; the Diagnostic And Statistical Manual, Version 5; the "Endocrine Society Consensus Statement," just review of that, mostly looking for process and -- yeah, that -- that was pretty much the bulk of my sources there.
Q So you mentioned the references and citations from the plaintiff's experts, I think you mentioned the Complaints, their reports, and then WPATH -- and sorry. If I say WPATH, you mean the World Professional Association for Transgender Health, you'll understand what I mean; right?
A Certainly.
Q So you reviewed the WPATH SOC 7, the DSM V, and the Endocrine Society guidelines. Is that fair to say?
A I think that's fair, yes.
Q All right. Anything else?
A Nothing that comes to mind.
Q All right.
A You know, I take that back, sir. Because I'm

looking in the world of how transgender and plastic surgery intersect I did a lot of rereading of textbooks and sort of historic sources in the world of plastic and reconstructive surgery to get a better sense of the ethics of decisionmaking and consent, obtaining consent. I did do some additional reading in terms of the history of surgical -- medical-surgical consent, and then also reviewed the history of transgender surgery. So that's like old textbooks, we're going way back.
Q And were any of those textbooks or sources not cited in your expert report?
A Whenever I -- whenever I, uh, made a claim that I -- I think I cited every -- every particular authors and things like that within the textbook, if it was a textbook, if I recall.
Q Okay. How did you travel to the deposition today?
A I drove.
Q And drove from home?
A Yes, I did.
Q All right. And when did you do that?
A Yesterday. Well, yesterday afternoon.
Q And you spent the night here?
A I did.
Q And is the state paying for your travel and

lodging?
A Yes, they are.
Q Okay. No one else paying for that; correct?
A No.
Q Doctor, what field do you claim to be an expert in?
A Plastic and reconstructive surgery.
Q Any others?
A Well, I have a prior board certification in general surgery with a lot of trauma, critical care training in there. I've also been trained in aerospace medicine. I don't claim expertise in those areas because it's been some years since I was in that field. But the journey from general surgery into plastic surgery is fairly seamless and there is a lot that goes on in the world of reconstructive surgery certainly where I use my general surgery training. But, yeah, that's my area of expertise.
Q All right. So but in terms of what field you're an expert in, only plastic and reconstructive surgery. Is that fair to say?
A I think that's fair.
Q And looking within plastic and reconstructive surgery, you have never performed any gender-affirming surgeries; is that correct?

A It depends on how you couch that question because there's an area of transgender surgery or gender affirmation surgery that's called top surgery that primarily concerns itself with the facial features. And I have done, for example, rhinoplasty on a -- on a person who was very evidently transitioning, so feminizing of his nose. Not a real radical operation. But, yeah, the rest of my surgeries as pertains to transgender persons has been reversal surgeries.

Q Okay. So I want to take that feminizing of the nose for a second. So just to make sure I understand what you mean by that, this was someone that, I think you used the term natal or biological male into somebody who is transitioning to present and live as a woman. Is that fair to say?

A Right. Natal biological male transitioning. Although, at the time he was not very out about it, but there was -- there was evidence in his medical history that that's where he was headed. And I tried to get a better sense of it, but he's very private about it.

Q And you performed the surgery to feminize this individual's nose?

A Right. Had a very masculine hawk-like nose that we toned down a little for him. It was not a real radical operation, but he was certainly satisfied with

the results.

Q Okay. And other than that, no other gender-affirming surgery?

A No gender-affirming surgery. I do, for example, in my office offer sort of adjunct procedures. Like, for example, I have a number of patients who come to me for laser hair removal from their faces. So that's a person who is already socially transitioned, i fact, two people who are socially transitioned who come to me regularly for hair laser hair removal. And --

Q Okay. And --

A I didn't mean to interrupt you.

Q No. Go ahead.

A Also I see a number of patients who I'm helping manage the sequela of their hormone therapy. So acne in their skin caused by androgen medications and things like that.

Q And when was this -- looking to the feminizing rhinoplasty when was that?

A I would guesstimate it somewhere around 2014 perhaps. That would be a guess.

Q 2014.

A This is a guess on my part, sir.

Q And where was that?

A In my office in Madison, Alabama.

Q Was the patient referred to you for this procedure?

A No. Self referral.

Q Okay.

A Then I would add, of course, he didn't present himself as seeking transition. This was a clinical judgment only my part. And his request was so relatively minor it seemed to be within the scope of something simple I could offer him.

Q Okay. So you said he didn't present himself as seeking transition. What do you mean by that?

A Well, he was -- he presented himself as a man, and presented himself as a man seeking a change in the appearance of his nose. But one of the things you do as a plastic surgery, particularly in the case of a man seeking a change in the appearance of their nose, you have to have some sense for what's the motivation for seeking it, because sometimes people can be struggling with severe emotional problems and they see their appearance as the reason for they are emotional problems. And so a lot of what goes into the initial consultation has to kind of address itself to the motivation of the patient.

And he seemed to be well composed, his request was relatively minor, basically just taking the hump off

the top of his nose, and he didn't seem to be heavily emotionally invested in it. So I didn't consider him to be in the category of body dysmorphic disorder, which is one of the things you have to be careful of, especially in men being seeking rhinoplasty. He didn't seem to meet those criteria. So he was a self referral for a cosmetic rhinoplasty.

But the discovery of his transgenderism actually came later because he returned after some months complaining that I hadn't done the right operation, and then it became evident that he had been seeking a much more feminine nose. So what started out as a consultation for just a very visible and simple improvement in a nose turned out to be really a desire for a radical change that he didn't voice at the time of that visit. But it came to light when he returned for his followup that he was really seeking to transition and this was sort of his first step. So I considered that on my part a failure to detect gender identity disorder.

Q And if you had been aware at the time that the purpose of his operation was a gender transition, would you have still provided the procedure?

A Well, it's not so much the purpose as it is the underlying problem that he has. So what would divert me

from deciding to offer him surgery is not the -- his particular intention -- his voiced intention. It's not his voiced index, but it's the emotional aspect that underlies it. That's what would keep me from offering the surgery.

Q But just to go back to my question, though. If you had been aware at the time that his intention, I'll put it that way, was to transition, would you have still performed the procedure?

A Well, again, so the issue is not his intentions. And what it would have caused me to do is to probe more deeply to understand what his motivation was for the transition. Because even the DSM makes a distinction between gender identity disorder and simple gender dysphoria.

And so in his case, because of the anger he evidenced when he came back, it would make me incline more towards a significant diagnosis of gender identity disorder which I put in the category of body dysmorphic disorder, which is really the diagnosis.

So it's not that -- it's not that I would have declined surgery because he was seeking to transition, I would have declined surgery because it would have been pointing me to the more grave diagnosis of body dysmorphic disorder.

Q Okay. So just let me take a few things from that and dig into this. So your understanding is that in the DSM there is a distinction between gender identity disorder and more simple gender dysphoria; is that correct?

A The problem is it's a moving target. So -- so it's a moving target. Since DSM IV it was gender identity disorder, and they made a distinction between that and body dysmorphic disorder. And then DSM III, all of it was body dysmorphic disorder.

So over time the distinction has been made. I don't agree with that parsing the way they do it, but what underlies the whole thing is a form of obsessive compulsive disorder.

Q So, Doctor, you have drawn a distinction between gender identity and gender dysphoria. What's the difference between those two things?

A It's a linguistic decision that the DSM writers made before the publication of DSM V in 2013. And, interestingly, that distinction characterizes the problem with DSM methodology.

So the change between DSM IV and DSM V including this distinction about gender dysphoria. Before that it was gender identity disorder. But the DSM V made that change in 2013. And the justification

they gave for it was sort of a procedural one. But in that same week, or the week before the DSM V came out the National Institutes of Mental Health essentially withdrew from the DSM project. They no longer fund it. The largest funding agency.

It's causing me to stop and think. The largest funding agency for mental health --

Q Doctor, I hate to interrupt you, but so my question, however, was what distinction do you draw between those two things, not what the DSM draws.

What distinction do you draw when you use those two terms earlier?

A Gender dysphoria is a description of the subjective feeling of the patient. Gender identity disorder is perhaps a description of the underlying psychological disturbance and more characteristically body dysmorphic disorder. That's my distinction.

Q Do you know of any professional -- medical professional organizations that draw that distinction?

A Between body dysmorphic disorder and gender identity disorder and gender dysphoria?

Q Between gender identity disorder and gender dysphoria.

A Well, the -- the APA does.

Q And that's in which document?

A DSM V.

Q So in the DSM V there's a distinction between gender identity disorder and gender dysphoria?

A Correct.

Q Okay. And you reviewed the DSM V in preparation for your deposition today?

A A couple of weeks ago, yeah.

Q And going back to the feminizing rhinoplasty that you performed, if it was, I think you said, simple gender dysphoria, then you would have proceeded with the operation if that had been your conclusion?

A In that patient? No, I would not have offered him surgery.

Q And why is that?

A So because the -- you mean if I hadn't known of the evident -- see, in retrospect, in retrospect I see him as seeking something unachievable, and so I would not have offered him surgery because it would have been a liability to him and me both. I don't know if that answers your question or not.

Q Sort of. What was the something unachievable that you concluded he was seeking?

A Well, one of the characteristics of body dysmorphic disorder is a degree of emotional investment in the physical problem. So the underlying -- the

underlying problem is the patient has a profound psychological wound that he does not wish to look at, but living with the psychological wound he seeks an explanation for it. And so he will latch onto something about his physical appearance as an explanation for the underlying sorrow that he has. And that's what underlies body dysmorphic.

And so you can never -- you can never reach the depth of that psychological wound doing an operation. It's very characteristic. And one of the characteristics of body dysmorphic disorder is patients, they keep coming back and keep coming back for more surgeries --

Q Doctor, I'm sorry to interrupt. We only have seven hours today, so I really need you to answer the question that I ask.

A Okay.

Q Which is what is the something unachievable that this patient was seeking in your opinion?

A Happiness.

Q And happiness was unachievable for this person?

A That was my estimation, yeah, in retrospect.

Q Nothing else unachievable that they were seeking?

MS. LAND: Object to the form.

Q (By Mr. Ossip) You can answer.

A Not that I -- not that I could perceive or that I recall right now. But that was at the heart of it. I could never give him the happiness he was seeking, because he was seeking it in the wrong place basically. That's what characterizes the problem.

Q And do you believe this individual had body dysmorphic disorder?

A Right.

Q And also gender identity disorder?

A I only learned that in retrospect.

Q Okay.

A Yeah.

Q But at the time you performed the procedure you didn't believe he had either of those things?

A No. I wouldn't have offered him the surgery because it would have been unethical for me to do so.

Q And do you believe this individual had gender dysphoria?

A In retrospect I do now, yeah.

Q So both gender dysphoria and gender identity disorder?

A Yeah. I don't make a huge distinction between those two things. One describes the subjective feeling the patient has and the other one is more of a clinical

diagnosis of a psychological disturbance.

Q And you would agree with the DSM V's distinction between those two things?

A I don't agree with DSM V on a lot things and that's among them.

Q Okay. But the DSM V does distinguish --

A Yes, it does.

Q And you also mentioned -- you also mentioned two reversal surgeries I believe you called them.

A That's right.

Q And what were -- what were those?

A Removal of breast implants from a 20-something-year-old man who had been in Thailand and got a top and bottom surgery in one visit and then returned to the states, and within a year was suicidal again. He had a sudden sort of awakening and I got a call out of the blue from a pastor in Kansas City. It was a: I understand you're a plastic surgeon who has an understanding of transgender. Can I send this patient to you?

And he was down on his luck guy, had no money, so he came and we removed his breast implants. And, yeah, it was kind of an interesting story there. So, yeah, we got a removal of breast implants and then a subsequent gynecomastectomy for the effects of hormonal

therapy on the patient, yeah.

Q So you did one -- just to clarify, you did one breast implant removal?

A Correct.

Q And no others?

A Correct.

Q And then one gynecomastectomy?

A Correct.

Q Okay. We'll come back to that.

Do you claim to be an expert in the treatment of gender dysphoria?

A No.

Q What about healthcare for transgender people?

A Well, I mean, I've been doing healthcare for people my whole life, so I guess it would depend on what it is you're asking for. If it's, you know, trauma or surgical disease of one kind or another, certainly. And, obviously, those things we talking about earlier that I already offer in my office.

But as far as things specific to gender transitioning, I don't offer those services.

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

A No.

Q And in terms of healthcare for transgender people, nothing outside of plastic and reconstructive

surgery that you have previously discussed here?
A Right. Although, I guess I would characterize it this way that all of the surgeries that are involved in transitioning, whether you're talking about the top surgeries or the genital surgeries involve procedures that I'm fully versed in and have done many times, though I have never applied those specific procedures to, say for example, creating an artificial phallus. I have used the same flap operation for head and neck reconstruction, limb salvage, that sort of things.
So the technology, the techniques, the processes are the same. It's just the application I do not do that surgery in that particular area.
Q So just to pin down on that, though.
A Okay.
Q Those -- but, again, you have never used those techniques to perform any sort of gender-affirming surgery; correct?
A That's correct.
Q Okay. Do you claim to be an expert in mental health?
A No.
Q What about the treatment of minors, by which I mean patients under the age of 18?
A Lots of experience taking care of minors.

Q Do you claim to be an expert in that?
A Well, in certain areas of the care of minors. So I have expertise, for example, in cranial facial reconstruction of congenital deformities. I have experience with reconstruction of congenital deformities of children's hands, congenital deformities of abdominal wall in children, that sort of thing, cleft pallet.
Q You're not a pediatrician, though; correct?
A No.
Q And you don't claim to be an expert in pediatrics?
A I'm not a pediatricianist.
Q And you mentioned -- and going back to the breast implant removal you said was a reversal surgery, when was that?
A Let's see. It would have been before the pandemic. It was 2017 or 2018, somewhere in there. This is a guess on my part.
Q And what about the gynecomastectomy?
A In the same year, about seven -- seven months later.
Q And you said that the breast implant was referred to you; is that correct?
A From a -- from a priest in Kansas City. It wasn't a professional referral from a doctor. It was a

priest trying to help a man in distress.
Q And how did the priest in Kansas City come to refer a patient to you?
A This young man just wandered into this church. He had -- he had been suicidal the day before, he had the pistol in his mouth, and he had this revelatory event. This is his medical history, it's in his chart. And rather than take his own life he had the sense that there is a God, and he walked out into the street and went to a church, walked in and talked to a priest who happened to hear me give a presentation two years previously in Denver on the subject of the care of transgender persons who are in distress, and he called me up and sent this young man to me. And, uh, yeah, it's a miraculous thing really.
Q So the priest in Kansas City heard your presentation in Denver and that's how that priest came to know you?
A That's right, that's right.
Q And what year was presentation in Denver?
A I'm going to say 2015, if I have to guess, 2015, 2016, somewhere in there.
Q And was that at a conference?
A Actually it was sponsored by a seminary out there, St. John Vianney Seminary. And it was a

conference for educators and pastors on the subject of care of persons who experience transgender and gender dysphoria, those sorts of things.
Q And who was the sponsor of that presentation?
A I would have to look. I know it was held at the seminary, the St. John Vianney Seminary. It might have been the archdiocese of Denver. I'm not sure about that.
Q And did your presentation have a name of that or a title that you gave that presentation under?
A I think it was Catholic Anthropology and Transgender Medicine or something like that.
Q And is that a presentation that you have given in other settings?
A Yes. Well, similar settings, similar settings, other diocese. Word gets out and other bishops and priests want to hear the talk.
Q And how many times have you given that presentation?
A I would just be wildly estimating somewhere in the 40, 50 times over the last seven years, yeah. It's a very highly demanded. Everyone wants to understand transgender.
Q And all of those are at diocese?
A I'm trying to think if there are any

exceptions. I think that would be -- diocese in schools, chancery education, priest retreats, that sort of thing, yeah.

Q So all of them in connection with the Catholic church?

A I think so. Well, not -- I wouldn't be absolute about that. Again, I have given the talk so many times. I'm trying to think if there is any other -- if it occurs to me can I come back with that.

Q You can always, if you have any change you can always come back to that.

A Okay. Thank you.

Q Okay. Sorry. Give me one second.

A So I had it backwards.

Q Oh, is that missing --

A No, no. I had it backwards. It was Transgender Christian Anthropology.

MR. OSSIP: Actually, I'm sorry. In the thickness of this some pages got ripped off. I don't know if you can move the sticker or something.

COURT REPORTER: I might be able to.

MR. OSSIP: Sorry about that. First technical mishap of the day.

COURT REPORTER: There we go.

MR. OSSIP: Awesome. All right. Crisis

averted.

(Plaintiffs' Exhibit 1 was marked for identification and made a part of the record.)

Q All right, Doctor. The court reporter is now handing you another document that has been marked Exhibit 1.

A Okay.

Q Can you flip to the second page. It should be inside of that.

A Right. And that's the title, that's the title of the talk.

Q And is that the presentation that you gave?

A Let's see. So this -- I'd have to -- so November -- oh, this is when you copied it or was that when I sent it out? 2018. This might have been from another Denver conference.

Again, what I'll do, I have a basic talk for audiences that we talk -- I just described to you that I will modify based on, like, local questions or demand, the nature of the audience, sometimes I will take slides out and put slides in. But this is kind of a general talk here. Yeah, this is probably the one that I gave at Denver.

Q Okay.

A Or something very close to it I would say.

Q But roughly the same --

A Roughly, yes, sir.

Q And that is the one that you gave in Denver; correct?

A Again, I don't know if this is exactly the one I gave in Denver. It looks like one I might have given in Denver. Like I said, I modify it. I was just trying to see if there was a date stamp on it. But if it was --

Q Well, do you see the day it says -- in that bottom corner it says Monday, November 5, 2018.

A Right. So if that's the date that I -- this is probably a talk that I put into a pdf format that I sent back to the organizer for distribution to the audience. So if that's the date, this may be a different talk given in the Denver.

Q So if you --

A Oh, there it is. That's it's. That's the image right there.

Q Well, yeah, for the benefit of the record, can you flip all the way to the back then. I'm sorry. It's a little unwieldy one.

A Right. Okay.

Q And do you see the Gospel of Life Conference,

2018?

A Correct, yes.

Q Yeah, go ahead.

A So this would have been a subsequent conference in Denver obviously invited back, because I know I gave the presentation at St. John Vianney Seminary before I went and presented at this conference, probably by a year or maybe more, two years, something like that.

Q Okay.

A But, yeah, that's an example how I modify the talk for the particular audience.

Q Okay. All right. And that was -- and who was the host of this conference?

A The Augustan Institute it looks like, FOCUS, which is I guess the Fellowship of Catholic University Students. And then the Gospel of Life, it's the Human Life Apostolate at the Archdiocese of Denver, something like that.

Q And all of these organizations are affiliated with the Catholic Church in some way?

A Yeah, all the names I see here, yeah.

Q Okay. We can put that to the side for now.

A Okay.

Q And so -- okay. So that was -- I'm just trying to remember how we got to that and it was because of the

priest in Kansas City?
A Exactly, exactly. The miracle of Kansas City.
Q Right. So then looking to the gynecomastectomy, how did that patient come to be in your care?
A Same patient.
Q Oh, okay. So there is only one patient, just two procedures?
A Correct.
Q Okay. And one was the implant removal --
A Correct.
Q -- and the other was the gynecomastectomy?
A Correct.
Q Gynecomastectomy. Excuse me.
A Very good.
Q Okay. And no other reversal surgeries?
A Correct.
Q So only one patient in your career has presented for a reversal; correct?
A Correct.
Q Okay. And both those procedures were in the 2017 to 2018 time period?
A Yeah. They were within six or seven months of each other. We took out his implants and just gave him time to resolve to see how much glandular tissue he had

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

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

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

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

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

A No.

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

A Yes, I have.

Q Which lawsuit or lawsuits?

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

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

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

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

Q What do you mean by a private matter?

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

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

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

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

A Yes, as I recall I did.

Q And you were never deposed you said?

A No.

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

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

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

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

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

Q Okay.

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

Q But you submitted an expert report --

A I believe so, yes.

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

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

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

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

Q Sometime around 2018 is when the report was submitted?

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

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

A Right.

Q Do you know what court that was in?

A I do not.

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

A I don't.

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

A As I recall it, yes.

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

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

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

A I do not, no.

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

Q Same as this case. Okay. And you were actually retained; correct?
A Yes.
Q And did you submit an expert report in that case?
A I did.
Q How many reports?
A I'm trying to remember if we had a rebuttal on that one. I think it was just the -- my initial -- there may have been a rebuttal report as well, yeah.
Q Okay. So an initial and possibly a rebuttal?
A Correct.
Q But you're not sure right now?
A Not off the top of my head.
Q And you testified in that case?
A Yes, I was.
Q Did you testify at any hearings in that case?
A I have not.
Q And have you testified at trials in that case?
A I have not.
Q Okay. Do you know if the court has accepted you as an expert in that case?
A I think it's being debated right now.
Q And by "being debated," you mean whether or not your testimony should be admitted as expert testimony?

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

on. I don't know what -- it's a fairly recent thing, because as of the date that the law passed, I think 20 minutes later they called me.
Q So 20 minutes after the law was passed, the state called you?
A Correct.
Q And who from the state contacted you?
A I don't remember.
Q Was it someone from the state attorney general's office?
A As I recall that, yeah. The particular person, I don't remember. But I believe it was the attorney general's office, yeah.
Q So had a lawsuit even been filed yet at that point?
A No. That's what happened. The lawsuit got filed immediately. And they immediately said, Okay, well, let's get our experts in.
Q Well, you said -- okay. Sorry.
You said 20 minutes after the law was passed they contacted you. But is that because within that same 20 minutes the lawsuit was filed?
A Correct.
Q Okay. So all very fast it sounds like.
A Yes. Everybody had it sort of loaded in the

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

fees in the case?
A They asked me what my fees were and I told them and they didn't raise a fuss about it so -- and then they asked me for the report.
Q Got it. But you're still working on the paperwork?
A Yeah. I don't know what's left to be done. Perhaps it's all done.
Q You haven't been deposed in that case, have you?
A No.
Q What about a hearing?
A Nothing.
Q So you have not appeared at a hearing?
A Well, I appeared at legislative hearings.
Q Okay.
A But not at any proceedings relative to the lawsuit that's been filed.
Q Okay. We'll come back to that. But nothing related to the lawsuit; correct?
A Right.
Q Okay.
A Correct.
Q And then you mentioned Florida. Who contacted you about Florida?

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

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

lawsuits. Let's put that all to the side. Outside of litigation have you ever served as an expert regarding the treatment of gender dysphoria?

A No.

Q What about for surgical procedures related to gender dysphoria?

A As directly applied to the treatment of gender dysphoria?

Q Yes.

A No, I have not.

Q So you mentioned that you testified at a legislative hearing in Alabama; correct?

A Several times.

Q Okay. At several different hearings?

A Right. So it's a bicameral legislature and there were parallel bills in the house and the senate and they had the hearings on one side. It was the health and whatever it is department or -- committee rather. These terminologies. And the other one was the judiciary. So I had to testify in front of both over the course of two years, repeat visits for bills that have failed to move and things like that.

Q And when was the first such hearing?

A So the most recent iteration was early 2022. And it's a short legislative session so it occurs in the

early part of the year. So previous to this year, 2022, would have been the same process in 2021, I believe it was.

Q So --

A Testifying twice on the same day, once in 2021 and then 2022 again. I think those are the dates. You're obviously are gleaning that I have difficulty remembering dates.

Q No. We're just going for your best recollection sitting hearing today.

A Certainly.

Q So but again, in 2021, we think, two times on the same day, though; correct?

A Yes.

Q And then the same thing in 2022?

A That's right.

Q Okay. And how did you -- looking back to that first time in 2021, how did you come to testify at those hearings?

A An advocacy group, I think it's the Eagle Forum, in Alabama had contacted me. I don't remember how I came to their attention. But they sent me a draft of the bills that they were trying to get sponsorship or they had sponsorship for. And they asked me what I thought and would I be willing to testify to the

responsible committees that were reviewing the bills and I said I would.

Q And do you recall who from the Eagle Forum contacted you?

A Margaret Clark or Eunie Smith, one of those dear women. They are just precious little people.

Q And so it sounds like you knew them before they contacted you.

A No, no, I had never met them before.

Q But you met them both after that?

A On the day I went down there.

Q And is that the only meeting you have had with them?

A So I made two trips down there. And the first time there was -- it was a more drawn-out process because they wanted me to accompany them touring around the capital building, so it was a drawn-out process. The second time it was very brief, I met them in the hallway, we walked into the hearing room, bye. That was pretty much it.

Q And both of those women are members of the Eagle Forum; correct?

A It's my understanding, yes.

Q Okay. And is it your understanding that the Eagle Forum had prepared the draft of the bill?

A I don't know who wrote it. I know who were the sponsors of it, but I don't know who actually crafted the thing. I know that Eagle Forum has a legal, obviously a very active legal department. They may have crafted it. I don't know who.

Q And who did you understand the sponsors of the bill to be?

A Shay Shellnutt, and he's on the house side. And then on the senate side -- oh, gosh. It will probably wake me up at two in the morning when I remember his name.

Q That's okay.

A I'll call you.

Q Sounds good. But did you -- those sponsors, did you meet with them in preparation for your testimony?

A It was a brief. Glad you're here, need some coffee, see you there kind of meeting, yeah. Nothing substantive, yeah.

Q So just on that day, though.

A Yes, sir.

Q Okay. Have you testified in any other state legislatures about this issue?

A No.

Q So only in Alabama?

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

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

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

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

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

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

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

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

A Not that I'm aware of.
Q Okay. And if I refer to something as the Arkansas law you'll understand that I mean Arkansas's Act 626, which is also known as the SAFE Act. Is that fair?
A That's fair.
Q Okay. And you mentioned you were only contacted after that law was passed; correct?
A That's my recollection of it. I don't remember any contact before it was passed. I remember -- my recollection is that I remember hearing about it in the news before I heard anything about it from...
Q And when you say you heard about it in the news, you heard about the law's passage?
A That's my recollection, that I heard that first before I heard from the attorney general.
Q But you did not advocate for the passage of that law; correct?
A None.
Q And you had no interaction with the legislature?
A No.
Q Did you lobby in any way for this law?
A No.
MS. LAND: Object to form.

Q (By Mr. Ossip) Okay. And no one from the state contacted you about the law before it was passed; correct?
A Not that I remember.
Q Okay. All right. And you never submitted any testimony supporting the law when it was in the legislature?
MS. LAND: Objection, asked and answered. Object to form.
Q (By Mr. Ossip) You can answer.
A Not that I remember.
Q All right. Do you recall when you got that email from Mike?
A It had to have been over a year ago I think, or maybe right around a year ago.
Q Do you recall if that was before or after this lawsuit was filed?
A I do not know that, no.
Q Okay. Did you know Mike Cantrell before he emailed you?
A No.
Q Did you know anyone else in the Arkansas Attorney General's Office?
A No.
Q And when were you actually retained by the

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

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

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

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

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

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

get charged for child abuse if he prescribes anabolic steroids to a young athlete. Technically it isn't abuse to the body of that child. But generally it's not called child abuse. It's called, you know, misprescribing and pill rolling and various other things that doctors do. This is kind of in that category. It's medical malpractice, not child abuse.

Q So you believe it's medical malpractice to provide gender-affirming medical care to minors?

A I do.

MS. LAND: Objection to form.

Q (By Mr. Ossip) All right. We'll come back to that. Let's move on.

Did you work with anyone else in preparing your reports or testimony in this case?

A No.

Q Did you work with the state?

A No.

Q So every word of your report was written by you?

A Yeah, the whole thing was written by me. It went through, I guess, an editing process in terms of spelling and punctuation kind of issues like that and it came back as a -- as a -- in the format of a legal brief, which I then signed and submitted, yeah. But I

composed the whole thing.

Q Okay. So, and the editing process you mean that counsel for the state was editing; correct?

A Right. Yeah, punctuation and spelling and paragraph numbering and things like that.

Q Did anyone other than counsel for the state edit your report?

A No.

Q Did you have any research assistance in preparing your report?

A None.

Q How are you compensated in this case?

A Hourly and travel.

Q And you have listed your hourly rate in your report; correct?

A Yes, I did. I think it's on the first page.

Q Okay. And that is still the rate that you receive?

A Correct.

Q How much have you billed to date in this case?

A Somewhere around $17,000.

Q And, now, best estimate what's the total amount of time you've spent on this case, whether you have billed for it or not?

A I don't know, 50, 70 hours. I'm -- that's --

that's a -- I don't know where that number came from, but -- it might actually be more than that. You know, when --

Q So definitely more than 50 hours?

A I guess. I don't know. I'm so lax about that that, you know, I'll find myself reading about something and I didn't mark my little log and I'm two hours into some paper somewhere. I try to be punctual about timekeeping, but --

Q So do you expect to receive any additional compensation in connection with your reports?

A None.

Q Okay. All right. So now I'm going to do a brief name association exercise so bear with me. But I'm just going to ask if you know who the following people are. So the first one is Dr. Steven Levine.

A Right. I don't know him personally but he's a psychiatrist I believe, pediatrics psychologist or psychiatrist. Is that right?

Q Just going from what you know.

A Oh, okay.

Q And do you know if Dr. Levine is an expert for the state in this case?

A I think he might be, yeah.

Q But you're not sure?

A Not right -- sitting here right now, no.

Q Okay. And you've never met Dr. Levine?

A I don't think I have.

Q What about Dr. Paul Hruz?

A Right, I know Dr. Hruz.

Q And where do you know Dr. Hruz from?

A I first met him at an ADF conference. We were both presenters. He came and gave an hour-long talk on pediatric endocrinology, and I gave a similar talk on plastic surgery and transgender.

Q Okay. And --

A And I've seen -- you know, we're now friends.

Q Before that conference you did not know him?

A No.

Q Okay. And by ADF, do you mean the Alliance Defending Freedom?

A Correct.

Q Sorry. Just trying to make things go a little faster today. Okay.

When did you first become familiar with ADF?

A Wow, that was some years ago. And essentially what it was -- I didn't know who they were, but I got an invitation to come down and give a presentation. And so it was, you know, down in Arizona and the first time I had met or heard of any of it was walking into their

building and meeting an attorney named Jeff -- I'll think of his last name. Jeff something. And going into a large conference room and giving my presentation.

Q And that was at the ADF headquarters building?

A It must be. It was a lovely place and it was in Arizona. I think --

Q Do you know where in Arizona?

A Phoenix? I don't know. It all kind of looks the same down there to me.

Q I think Arizona is beautiful.

A No, it is beautiful. It's all developed about the same time so it's hard to judge Phoenix from Tucson sometimes.

Q Sure. And when was that conference?

A Again, it may be in 2016 or '17, just a wild guess there.

Q Okay. And you said you -- you didn't know ADF before you got that invitation.

A No.

Q Do you know who or -- strike that.

Do you know how ADF came to invite you to this conference?

A I don't know who they talked to. Again, since I give the talk so frequently in various venues around the country, somebody might have heard of it or maybe

seen a recording of it.

Q Okay. That's helpful. So just to get the timeline right, this is after you started giving the presentation we discussed earlier?

A I suspect it was, because that's really kind of when a larger public audience was asking for the talk.

Q Okay.

A Again, the first several times I gave it was in very small groups of priests and religious educators and things like that.

Q And before that conference you had never met Dr. Hruz; correct?

A That was the first time I met him, yes.

Q And what did you discuss at the conference?

A Well, so the conference was organized kind of as a -- as an information gathering visit. There was a variety of speakers. Paul Hruz talked about endocrinology. I talked about plastic surgery.

There was a presentation on pediatrics. There was a presentation on psychology, psychiatry. There was a presentation on -- there might have been a presentation on law, but I'm not positive about that. Yeah.

Oh, there were a couple of people there who were -- that lived the experience of transgender. There

was a young man named Hasci Horvath who works for the University of San Francisco, he manages their medical information processes and the guy is a genius remembering papers and authors and years and findings. But he had the lived experience of transitioning himself, and so he talked about his experience.

Q And you mentioned people with the lived experience and being transgender. Was there anybody else other than Hasci Horvath?

A There was a trans female there from Asia. And I'm trying to remember her name. But I believe she was residing in Thailand, but was an author, ran a -- some web blog or something about it. Again, the lived experience, fully transitioned transgender female.

Q And by that you mean that she identified as a woman?

A Oh, in every respect, yeah, fully. And had been living as a trans female for probably 25 years, had undergone surgery in the late 80s or 90s somewhere in the southwest. Might have been a transgender surgeon in Colorado or Arizona that had done her surgeries. Yeah, definitely.

Q Do you know who Mark Regnarus is?

A I have heard his name and I think I have read some articles by him.

Q Do you know if Mark Regnarus was at that ADF conference in Arizona?

A I don't know. I don't think -- I don't know. It doesn't ring a bell.

Q But he could have been there?

A I don't know.

Q You wouldn't disagree if somebody else said he was there; correct?

A I wouldn't have any basis for disagreeing.

Q What about Dr. Levine?

A I know there was a psychiatry, psychology presentation, but I can't remember who it was. So if you were to tell me that Dr. Levine was at that conference I wouldn't argue with you about it. But we didn't -- I didn't talk with him individually. Maybe that's the reason I don't remember. I don't know.

Q And how many people total were present at that conference?

A A ballpark guess, maybe a dozen.

Q And how many of those gave presentations?

A I think everybody there was there to give a presentation.

Q And I think you had mentioned you were invited by an attorney. Did the attorney give a presentation?

A I think just sort of an introduction. Hi,

welcome aboard, this is the issue we're looking at, this is kind of the conflicts in the greater society that we're seeing, if you need anything, I'm here kind of thing, yeah.

I do not remember him -- he might have given another presentation. Gosh, it was so long ago. He might have given another presentation on the law. He might have been the one who gave that presentation. It might have been another attorney that was there by the name of Gary McCaleb.

Q And if Gary McCaleb was there, do you know if he gave a presentation?

A I think he did. I think he gave a presentation, yeah.

Q Okay.

A I'm almost confident he did, because he brought to light the fact that he was a Navy veteran and I've got 24 years in the Navy. I think we had a conversation over lunch about that.

Q At that meeting were you asked to serve as an expert witness in cases about transgender issues?

A No.

Q You were never asked?

A No one asked me.

Q Okay. Was the group -- was the entire

conference asked?

MS. LAND: Objection to form.

A That -- I mean, that might have been what Gary McCaleb was talking about or maybe the attorney Jeff, I will remember his name, talking about maybe some sense that they had that there might be future legal issues and that you might be called upon to give your expert opinion, but there was no invitation to give a particular -- you know, to a particular case or a particular legal issue. It was probably more like, you know, being a witness in a -- a very complicated public issue is. I think that's what it was about.

Q (By Mr. Ossip) Was one of the topics at that conference the difficulty in identifying expert witnesses who are willing to testify in these cases?

A I -- not to my recollection, no. There -- I know there was a lot of commiserating about how few people there are willing to speak publically against transgender medicine and surgery. I know that was a case, because one of the people that was there -- yeah, okay.

So one of the people that was there at that conference was a plastic surgeon himself who had lost his job -- he was the chief of plastic surgery.

Q I just want to keep it to answering my

questions.

A Well, but to your question about whether --

Q My question is yes or no. At that conference was it discussed -- was one of the topics of discussion the difficulty in identifying expert witnesses who are willing to testify in this case?

MS. LAND: Objection to form.

Q (By Mr. Ossip) In these cases. Excuse me.

A It was not a matter of formal presentation. Again, it was just a private discussion between people who were there.

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

A I don't remember that question.

Q Okay. Can you turn to page 90 of the transcript in front of you?

A Certainly.

Q Do you see on line 19 where it starts, "I remember." "I remember a fairly long discussion about the poverty of people who are going to testify because of the risk they take in testifying."

Was that your testimony in the Kadel case?

A Right. And that speaks to what I was starting to relate to you in my answer. I think that was a

conversation among the people who attended the conference. I don't think it was as a formal presentation. I think that was a conversation we were having.

Q And can you turn to page 91?

A Certainly.

Q And do you see, Question, and people -- this is on line 6.

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

Answer, "Yes."

Was that your testimony?

A I guess it was.

Q And do you see where you said, "Before that meeting you had never testified as an expert witness?"

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

Was that by "this moment," you mean in Kadel; correct?

A Correct.

Q And again, you never testified in any other cases; correct?

A No.

Q No hearings as an expert witness?

A Other than the legislative hearings we talked about earlier.
Q But no court hearings.
A Correct.
Q Correct?
A Correct.
Q Okay. At that conference did you offer to be an expert witness in cases involving transgender issues?
A I don't remember. Evidently my recollection of that event is not as strong as I --
Q Do you know if anyone else offered to be an expert witness in transgender issues?
A I don't remember.
Q You don't remember whether Paul Hruz did?
A I remember a willingness on his part, but I don't remember him saying that he would or anything like that. Again, I don't remember the question being asked.
Q But he expressed a willingness?
A We all expressed a willingness, yes.
Q Including you?
A Oh, yes, absolutely, absolutely. It wasn't -- I don't remember it being asked of us, but in our conversations we all expressed a willingness to offer our expert opinions on the issue.
Q Did anyone present not express a willingness?

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

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

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

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

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

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

A Yes, I have.
Q How so?
A Let's see. Walter was at one of the times we testified at the Alabama legislature, he was there for one of those.
Q Okay. And that was on one of those two --
A Right.
Q -- double committee days?
A Correct, yes. And there was a little social gathering at somebody's restaurant that had been sort of -- was catering a little visit there.
Q And that was after the testimony?
A Yeah, that was in the evening.
Q And who was at that social gathering?
A Walter and myself and some people from Eagle Forum and some legislators that were there. I don't remember who else.
Q And would those legislators have included the sponsors of the bill?
A That would make sense, you know.
Q Okay. And what about Laura Perry?
A Laura Perry? I don't remember. That may be the -- that may be the woman from Thailand. The mystery woman from Thailand. It's so long ago.
Q Okay. But, well, unlike Walt Heyer though --

well, let me put it another way. Are you aware of any contact with anyone named Laura Perry outside of, perhaps, the ADF conference?

A I don't remember. I don't remember any such contact.

Q Okay. And just going back to Walt Heyer, so you mentioned you might have seen him at ADF.

A No. I definitely saw him at ADF.

Q Oh, definitely saw him at ADF.

A Yeah. I just couldn't remember whether it was the first or second conference.

Q Okay. That helps. And then at one of the two dual committee meetings. Any other interactions with Walt Heyer?

A I may have seen -- well, it wouldn't surprise me to remember that he was at some other presentation on the subject to some other group, possibly even one of the Catholic presentations I have done. He gets a lot of requests because of his sex change regret website and people are always visiting him with invitations. I know we have crossed paths multiple times. I can't remember the circumstances of all them.

Q You mentioned a website. Do you know what that website addresses?

A Walter Heyer's?

Q Correct?

A Sexchangeregret.com I think it is, yes, .com.

Q And have you visited that website?

A Once or twice, mostly just to find contact information to get ahold of Walt.

Q Got it. And so aside from meetings or conferences do you stay in touch with Walt?

A I mean, we're not in regular communications. Just the occasional email, I hear we're going to be in Montgomery, look forward to seeing you there. Let me drive your car. He loves my car.

Q But just social then?

A Right. Well, I mean, as social as -- the topic that brought us together always comes up.

Q Do you discuss research with Walt?

A With Walt it's mostly discussions of the suffering he encountered all the time and we commiserate about that because I encounter suffering in my own practice and he encounters it in his contact with people who are struggling with their identity.

Q How often do you -- well, strike that. Actually, I think we can move on.

MR. OSSIP: Can I get three?

(Plaintiffs' Exhibit 3 was marked for identification and made a part of the record.)

Q (By Mr. Ossip) The court reporter is handing you Exhibit 3. Take a look at that and see if you recognize that document.

A It appears to be my expert report --

Q All right.

A -- in this Arkansas case.

Q All right. And do you stand by this report as written?

A Yeah, the several times I have read it I didn't find any -- any discrepancies. I'm much more careful about that because there was a discrepancy in my report that I didn't catch and so -- I become a lot more guarded when lawyers ask that question.

Q Got it. I'm not trying to play gotcha.

A No. It always calls to my own fallibility so I always go slowly here. Yeah, this looks like it.

Q You mentioned there was a discrepancy with your report. Which report are you referring to?

A Kadel.

Q Oh, your report in the Kadel case?

A Yeah. They jumped on a discrepancy that was there that I didn't catch that I should have caught.

Q Understood. But you believe that discrepancy, if any, was corrected in this case?

A Oh, there was no such discrepancy in this case.

Q Okay.

A It had to do with the way they titled the thing that was not correct.

Q I see. Can you elaborate on that, please?

A Right. So whenever I present my credentials --

Q Um-hum.

A -- I always -- among the things I talk about in addition to my education is my board certification. So board certified in general surgery, board certified in plastic and reconstructive surgery, recertified in plastic and reconstructive surgery, and I always include the dates.

I let my plastic surgery board certification lapse in the year I retired from surgery. And so -- but I'm -- the way they titled the document was board certified in plastic surgery. He jumped all over that, he said, "You're not board certified in plastic surgery, are you?" I said, "Well, no. I have been board certified in plastic surgery twice and I just let it lapse because I'm retired."

Q Got it. And so when you present your certifications you always put an end date on those?

A I always put the end date on it and I always speak of it in the past tense.

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

offering transgender surgery. I remember reading some report. I remember reading the original publications by Sir Harold Gillies in the post-second world war. So it goes -- this is a running thing that I've been doing, along with a lot of other topics in plastic surgery that I kind of keep a tab on.

But in earnest I would say 2014 when I started digging into it much more aggressively.

Q And what prompted that much more aggressive digging?
A I was at a -- I was at a courage Conference at Villa Nova University, and there was a breakout session for ordained clergy, of which I am, I'm an ordained deacon in the Roman Catholic church. And I went to a breakout session.

And during the course of the breakout session a priest there opined that one day the Roman Catholic church will catch up to the science and we will accept human sexuality as existing on a broad spectrum. And I asked him if he had any access to the particular science that would support that position, he did not. And then I opined from my experience what I knew, you know, based on what we discussed earlier.

And at the conclusion of that the organizer of the conference said, you know, this is an important

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

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

A Well, the demand is that the love of others rather than the use of others. And to live an integral life means to understand the role that sexual expression has in that life.

Q Well, let me put a -- so just -- but any same-sex sexual encounter would be the use of another in that context; correct?

A Well, but it's not peculiar to same-sex attracted persons.

Q Well, when is sex not the use of another?

A When it's --

MS. LAND: Objection to form.

A Well, that's going to be a difficult one. That's going to be a difficult one because it's kind of an individual thing --

Q (By Mr. Ossip) I see.

A -- that may be fleeting. I think the point of the -- the point of me defining chastity that way is to recognize that what -- the love we're called to when I said that we're called to love as Jesus loved, it's to love sacrificially, self-sacrificing the love and to help people to develop that capacity.

What chaste love is something we learn in preadolescence and adolescence and it's something we carry with us through our whole life assuming that it

hasn't been wounded somehow.

Q But to just put an even finer point on it, having same-sex sexual encounters would not be chaste; correct?

MS. LAND: Objection, form.

A Well, it would -- yeah, that's right, by definition. Just as having sex outside of marriage would not be chaste. Just as having, you know, marital or sexual relations with a sibling. Right? There is all kinds of forms of abuse, but it's -- and they are not all of equal importance, but they are all not chaste.

Q (By Mr. Ossip) I see. And so is a same-sex sexual encounter is abuse then?

MS. LAND: Objection to form.

A No. You mischaracterize my word. Abuse is a form of non-chastity, but there are other kinds of non-chastity. Your question was about chastity. So, uh --

Q So you said -- I'm just going to read back what you said.

A Okay.

Q You said, Just as having, you now, the marital sexual relations -- well, you said -- I asked the question, "Just putting a finer point on it, having

same-sex sexual encounters would not be chaste; correct?"

And then you answered, "Well, it would, yeah, that's right by definition, just as having sex outside of marriage would not be chaste. Just as having, you know, marital sexual relations with a sibling. Right? These are all kinds of forms of abuse."

A Oh, I'm sorry. So the last example was a form of abuse. But all of the examples were a form of non-chastity.

Q Okay.

A I guess that's the correct way to put it. Thank you.

Q Okay. And when did you become a chaplain for Courage.

A In -- let's see. Sometime in 2014 I believe. I think it was in 2014.

Q Was that before or after that conference?

A Which conference?

Q Oh, sorry. Was that before or after the conference at Villa Nova?

A No. I had become a chaplain before the -- I mean, I'm sorry. Wait a minute. That's tough. So I was ordained in 2013. The Villa Nova conference I think was in the summer of 2014, and I think I had already

become -- no, it might have been the following year. Sorry.

I think when I went to Villa Nova I was already a chaplain. It may have happened after I was at Villa Nova that I became a chaplain. In fact, I can be certain about that.

Q That it happened after the --

A I think so, yeah.

Q Okay. How did you come to be invited to the Villa Nova conference?

A I -- let's see. I met Father Paul Check at a retreat at Casa Maria in Birmingham in 2014. And Father Paul Check invited me up to Villa Nova. At the time Father Paul Check was the executive director of Courage and he was the retreat master, and we met and had a lot of things in common and he was kind of inviting me into the work based on that meeting at that retreat.

Q And that retreat in Birmingham, was that affiliated with Courage also?

A Yeah. That was a regional retreat. The Southeast Retreat that happens every spring around -- well, the week before Easter, yeah.

Q And you attended that in your capacity as a deacon of the --

A I had just been ordained.

Q Okay.
A I had just been ordained. And one of the -- of the women religious there said, Hey, Dr. Lappert, you're a doctor and a deacon now. I have a brother who is a doctor and a deacon. I'd like you to come down and meet him.
Q And that just happened to be at this --
A Correct, correct.
Q Okay. Serendipity. All right. And when did you join the board of directors of Courage?
A Let's see. Probably about five years, maybe four years ago. I think they are three-year terms and I'm just -- it's my second term.
Q And does the board have any other name other than board of directors?
A No, that's it.
Q Okay. And how many directors are on the board.
A Well, so I'm a non-voting member. There are two of us. And then there -- and it's -- the priests that are on the board that are voting members, I think there is four of them. And then there is a -- so somewhere around seven?
Q Okay. And so going back to our discussion of chastity, a same-sex sexual relationship within a same-sex marriage could not be chaste also; correct?

A Right.
Q Okay. And why is that?
A Because of the nature of sexual relations in same sex acts. So -- so in the eyes of the church sacramental marriage is a different thing from the public civic, civil sort of thing. So the civil relationship under law is not determinative of that, you know.
Q So it's because a same-sex marriage would not qualify as a sacramental marriage under the law of the church; correct?
A Yeah, it's not -- it can't, yeah, exactly.
Q And so that's why it's not chaste?
A I believe that's why.
Q Any other reason?
A I think that's the heart of it there, yeah.
Q Okay. So if canon law were changed to permit same-sex marriages in the eyes of the church, those same-sex marriages would then be chaste; correct?
MS. LAND: Objection to the form, relevance.
A Well, my understanding of canon law is that it cannot violate essential church teachings. So your hypothetical is unimaginable because it's not constant with what the church teaches about marital relations.

The sacrificial relationship between a man and woman, that is a life-giving event. So because of the fact that same-sex sexual relations are not life giving -- that's my understanding of it anyway.
Q (By Mr. Ossip) And those teachings couldn't change?
A I don't think so. I'm not a canon lawyer, but that's my understanding of it. So if you're asking me a hypothetical, that would be my hypothetical answer.
Q Well, and let me ask another hypothetical then. If there is essential teachings -- excuse me -- were changed such that a same-sex marriage is permitted within the eyes of the church, would then that relationship be chaste?
A Right. I mean, if there was some way, but what you're proposing is also an impossibility, because that particular teaching is based on immutable things, the nature of the human person as the church understands it.
MR. OSSIP: Can I get four?
(Plaintiffs' Exhibit 4 was marked for identification and made a part of the record.)
Q All right. Court reporter has handed you what's been marked Exhibit 4. Do you recognize this document?

A It looks like my rebuttal to the expert.
Q All right. And do you stand by that as written?
A I do.
Q Okay. Any inaccuracies you would like to correct?
A Not that I have found.
Q And have you changed your opinions since you signed these reports?
A Not substantively, no.
Q What about non-substantively?
A Well, I mean, some of the things have changed, like the determination -- I believe I talk about it in here, the determination by the Swedish medical board has become much more final in terms of suspending, offering transgender medicine and surgery to adolescents, you know, minors. So where I think when I wrote this it wasn't as -- it was -- looks like they are headed in that direction. Now since then it's definitely they have ceased.
Q But your opinion hasn't changed?
A It has not, no.
Q Just the evidence?
A Right.
Q Okay. Do you intend to provide any opinions in

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

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

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

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

Q Okay. Do you still perform surgery?
A I retired a year ago.
Q Okay. And is that the last time you performed surgery?
A Right.
Q One year ago from today?
A More or less, yeah.
Q Okay. And I'm just going to ask you a few procedures and ask if you ever performed them. Okay, Doctor?
A Okay.
Q Have you ever performed a mastectomy?
A Many times.
Q Breast reduction?
A Many times.
Q Gynecomastectomy?
A Many times.
Q Chest masculinization?
A Never.
Q Breast augmentation?
A Many times.
Q Chest feminization?
A Never.
Q And for all the ones that you said you performed many times, do you believe you are qualified

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

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

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

Q And what do you mean by the confusion is settled?
A Well, they don't think about if they are male or female any longer. They have made a determination for themselves that they are -- now, it doesn't mean it's not going to change. It just means that they are not confused about it. There is clarity somehow in their lives that they have hit on something.
Q So, well, let me -- so is it your opinion that all children who experience gender dysphoria are gender confused?
A Hum, that's a challenging question there. Part of the problem in children -- and I have talked to, you know, quite a few children about it. They are sort of typically in a stage of formulating their story, formulating their words and so that can be very -- so typically they are confused, but some of them are more clear, perhaps, than others. It's not a black or white thing.
Generally in adolescence there is some level of confusion whether they are transgender or not. They are confused about themselves, confused about where they are headed in life, and certainly sexual matters confusion is a common thing, less common as adults.
Q And so it's your opinion that there is sort of

a spectrum where confusion tends to be reduced as a person ages; is that correct?
A Generally, yeah. It's not a certainty, but generally there is less confusion as time goes on.
Q So it is not your -- well, let me put it this way. You'd agree it's not the case that anyone who claims to be transgender is actually just confused about their gender?
A No, I wouldn't make a blanket statement that all persons who are a transgender are confused.
Q Okay. Is it possible to have a gender identity that differs from a person's sex assigned at birth?
A All right. I'm going to take issue with that term because that doesn't make sense to me. Sex assigned at birth is something -- are you talking about the biological sex as determined at birth?
Q Let me use your -- let me put it this way. If I use the term biological sex, you'll understand that to be the same way that other people might say sex assigned at birth; correct?
A Sure.
Q Okay. So let's say biological sex then. Is it possible to have a gender identity that differs from biological sex?
A Yes.

Q Okay. Have you -- is it your opinion that being transgender is a delusion.
MS. LAND: Object to form.
A So the historic understanding of transgender is being a subset of obsessive compulsive disorder. And up until -- as we talked about earlier, up until recently it was -- it was out of that category of body dysmorphic disorder. What -- what historically the understanding of that is that what underlies the obsessive -- as with other obsessive compulsive conditions there is a delusional that that keeps intruding into the life of a person that causes them to interpret things incorrectly and seeks explanation.
So -- so for example, the anorexic --
Q Well, let's stay with transgender individuals.
A Sure.
Q So is it your opinion that being transgender is a delusion?
A Well, it goes by degrees. It goes by degrees. So sometimes the content of the delusion is trivial and other times it's suppressive. But there is a -- there is an incorrect thought that underlies the whole thing having to do with how they perceive their body.
Q And what is the incorrect thought?
A That they are, quote/unquote, living in the

wrong body. When people use those terms, that they are living in the wrong body, that's a delusional thought.
Q And that's in all cases?
A As far as I can tell, yeah.
Q So it is your opinion that anyone who identifies as transgender is delusional?
A Well, no, because in -- historically that would have been the case. But the new demographic in transgender is -- is not so much animated by delusion, it's animated by a rehearsed story which they come to believe. Okay. So --
Q Okay. Well -- sorry. Go ahead, Doctor. I didn't mean to interrupt.
A So -- so whereas in the earlier demographic of boy -- prepubertal boy cross-sex identification, if that persisted into adulthood you would typically find that behind that is a misperception of a lived event in childhood, you know, like some trauma, some fear, some personal fear that causes this repetitious explanation in their mind that the reason they are unhappy is because they are the wrong sex presentation.
Just as in the anorexic, the reason I'm unhappy is I'm fat. Or the reason I'm unhappy is because I didn't wash my hands. There is an intrusive thought that causes them to ruminate over something that isn't

the case.
Q And but isn't the case -- let me put that another way. That's because you believe it's impossible to have a gender that differs from your biological sex; correct?
A No, it's not impossible. As we talked about earlier, it happens all the time. What I'm saying is that what informs that is a misunderstanding of themselves and their life.
Q But you would agree that a gender transition is impossible?
A A sex transition is impossible. Gender is a subjective world, and depending on, you know, the person, the success of a subjective perception can vary greatly. I mean, some people are totally -- they transition and they are totally sold. Other people transition and it hasn't answered the mail and they continue to suffer.
Q So can we -- this is Exhibit 5, which is your Declaration.
A That's what I have in front of me.
Q Can you go to paragraph 42?
A Okay.
Q So if you look at the sentence that starts at the very bottom of page 20 where it says, "Claims that

patients can" --
A Right.
Q So you say, "Claims that patients can be a hormonal and surgical treatments obtain a sex chain or gender transition process are misleading and scientifically impossible." Do you agree with that?
A Yes, right, exactly. So when I put the words "gender transition" in quotations, the concept itself is a term of usage. So what is being addressed in these -- in these interventions is sex change. And that's -- that's used by the people interchangeably with gender transition. They are two different things.
Q Okay. Well, let's -- what is the treatment goal for any transgender identified person?
A Happiness.
Q And is it your opinion that in order to achieve that happiness they should stop being transgender?
A No. I'm -- well, so happiness can be a fleeting thing and we certainly see that in the arc of the typical transgender person as they go through transition. It's a kind of a roller coaster for them. And every time they enter into a new process of affirmation there is a tremendous encouragement and so there is a tremendous happiness there.
To offer a child an affirming message and an

explanation for their anxiety is a tremendously uplifting thing for a child, but eventually that will run out and they will move on to the next thing. So happiness is present and then happiness is gone and then happiness comes back at the next step.
So in the case of a child being offered a puberty blockade or something may be a source of tremendous happiness for them. Parents may be relieved and very happy that their child is responding in a positive way, but then you get to the limit of what puberty blockade does for the child and happiness is gone again, and you move on to the next step.
So at every step the goal is happiness, but looking at final trajectory, that is what we're debating here, yeah.
Q So looking -- no. That's a good point. So looking at the final trajectory, though, it's your opinion that happiness will only be achieved in the final trajectory if a person stops identifying as transgender?
MS. LAND: Objection to form.
A No. So for example -- that's not necessarily the case. It's not necessarily the case. So for example, the woman that I met from Thailand, perfectly happy, she hadn't desisted, she hadn't regretted --

maybe she had regretted. She didn't voice it to me, but certainly had issue with doing these things to children. So she had -- I mean, she's a living example of somebody who doesn't regret, who is perfectly happy having a transition. I don't know the circumstances of her childhood, I don't know any of these things. I can just hold her up as an example of a success.
Q (By Mr. Ossip) So looking -- so let's -- if you can go to paragraph 12 of the declaration.
A The --
Q The one that's in front of you.
A Exhibit 5, paragraph 12. Okay.
Q Um, do you see where you say -- this is the third sentence in -- "Patients who experience a gender identity that is discordant with biological sex have an alarmingly high incidence of serious psychosocial morbidity, including depression, anxiety, eating disorders, substance abuse, HIV infection, suicidality and homelessness." Do you see that?
A I do.
Q Do you believe that the best way to prevent these issues is for a transgender person to no longer be transgender?
MS. LAND: Object to the form.
A I would say that the best treatment is to -- is

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to address the underlying despair that the person has and find the source of that despair and do everything in my power to lovingly bring them back into contact with, you know, the fullness of life.

So in every example, regardless of, you know, the particular case, if you take the time you'll probably find a wound and you'll find the source of the anxiety and the sorrow. That's where the happiness lies. And that's kind of what's at stake here.

So to just say no longer thinking of themselves as transgender does not solve that problem. What solves that problem is, you know, out of an abundance of charity helping that person to find their way to understand how they were wounded, how they came to be this way and find a way out of the sorrow, not just simply renounce transgender. That's not -- neither the solution nor the explanation. What's at -- what's at stake here is a person who is wounded and grieving. So --

Q (By Mr. Ossip) Okay. And do you believe it's morally wrong for a biological male to socially transition and live as a woman?

A Morally wrong?

Q Yes.

A No.

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Q And same for a biological woman to socially transition and live as a man?

A You know, I don't see that as a moral issue, except in certain circumstances in the eyes of the church, for example, where it creates scandal in the heart of a child. But, no, generally not. If they were using it to mislead somebody into a relationship that the person wasn't aware of, that would be immoral. But to live as the -- in the cross sex self-identity, that's not immoral.

Q And does that go against the teachings of the church.

A What does?

Q Living -- being a biological male, as you have said, and socially transitioning to live as a woman?

A I don't believe it does go against the teachings of the church, no.

Q Okay. And what about if someone went -- well, take a step back. What if someone went beyond social transition and took cross-sex hormones. Still not immoral?

A No, it is in the eyes of the church.

Q So that is immoral?

A Well, any form of mutilation is a -- is a crime against your person, and that is immoral, yeah.

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Q And that includes the use of cross-sex hormones?

A Right.

Q What about the use of puberty blockers?

A Same.

Q And can you explain, how is that a mutilation?

A Well, so it happens by degrees but the effects of puberty blockade radically alter the life course of the child, which will -- is demonstrated to show longstanding issues with osteoporosis, stunted growth, failure of psychosexual development, long-term medical issues, and a near certainty of transitioning to cross-sex hormones.

So whenever you talk about puberty blockade you've got to talk about cross-sex hormones, because the actual clinical experience is that essentially 100 percent of children who are started on a puberty blockade go into cross-sex hormones, which means sterilization of the child, which is a form of mutilation, a destruction of a human capacity, a human function destroyed. Whether or not you do it with a blade it's the same, same story.

Q Is use of the term mutilation to describe the use of puberty blockade --

A That's my own.

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Q And do you know if that's a commonly used term?

A In terms of endocrine management? No, I'm happy to claim that as my own.

Q Okay. And same for -- sorry. Go ahead.

A The reason being, most of the people who speak about this don't speak about it from the perspective -- first of all, when I present these opinions I don't use the teachings of the church to formulate those opinions. This is strictly on the merits of the science and the medical ethics. So, yeah, none of what I have in -- in my report is driven by Catholic church teaching. It's driven entirely by the science, my experience in medicine, surgery, and the citations offered by the plaintiffs' experts.

Q So you don't use the term "mutilation" in anything you filed in this case?

A No, not in terms of the hormonal manipulation, only in terms of the surgery.

Q Okay. Sorry.

A You see where I'm going with that?

Q So you do use -- you do use the phrase mutilation to refer to the surgery; correct?

A Yes, I do.

Q Okay. And is that commonly used within the medical profession to refer to these procedures?

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

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

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

it as much as a diagnosis of a description of a condition. It doesn't -- yeah, I wouldn't put it in the category of diagnostic certainty. Let's put it that way.
Q So you would disagree with the DSM V's inclusion of gender dysphoria?
A Not its inclusion, but its splitting it away. Essentially, they took one of the characteristics of body -- or gender identity disorder, they carved that one -- that one finding away and made it a separate diagnosis in an effort to depathologize what the original diagnosis was. Gender identity disorder I would consider a diagnosis.
Q I see.
A Gender dysphoria is a trait of gender dysphoric people.
Q And can -- what is necessary to move from gender dysphoria into the realm of gender identity disorder?
A Well, gender dysphoria is one of the -- one of the symptoms. Gender dysphoria is a symptom more than a diagnosis. I guess that would be the best way to characterize it. That's my opinion.
Q Okay.
A Not speaking as a psychiatrist here. I'm

speaking as a plastic surgeon with experience of people who have body dysmorphic disorder. I would say gender dysphoria is a symptom of the bigger issue, which is body dysmorphic disorder.

Q And is that because you believe that gender identity disorder is a subcategory of body dysmorphic disorder?

A I do.

Q And do you believe that gender identity disorder is a form of obsessive compulsive disorder?

A I do.

Q And what about gender dysphoria?

A It's a symptom.

Q Okay. A symptom of an underlying condition that is, itself, a form of obsessive compulsive disorder?

A Right. And by degrees. Okay. So obsessive is not an on/off switch. Levels of obsession, levels of compulsion, levels of willingness to seek remedy vary greatly. For some people it's just a recurrent thought that they harbor in their thoughts. Maybe they privately cross dress and that solves the issue for them and they don't even identify as transgender.

But they have this interior wound that's an obsessive thought that keeps presenting itself and they

manage it in private with a behavior. That's the compulsive behavior, maybe as simple as secretive cross dressing. Maybe that's not enough and they want to present themselves publically in that persona to convince themselves that's a source of their problem. And so it's a great spectrum of presentation. But in my mind -- again, I'm not testifying as a psychiatrist. But in my experience as a plastic surgeon, uh -- yeah.

Q And have you received any education or training related to gender dysphoria?

A No. Well, I'm sorry. I did attend a course at the California Society Of Plastic Surgery. It was a weekend, half day thing on the subject of gender dysphoria. I got to hear the luminaries of surgery and medicine and transgender for a whole day there, brought me up to speed.

Q Was that a -- okay. Well, and -- and when was that?

A I want to say 2017, guessing. Guessing somewhere around there. California Society of Plastic Surgery.

Q Other than that no education or training related to gender dysphoria?

A No.

Q Treatment of gender dysphoria?

A Again, I'm not -- well, since it's a symptom I guess every time I talk to somebody who is gender dysphoric and I help them manage their anxiety, I guess I do treat people with -- you know, the man who comes to see me for facial laser hair removal, he and I commiserate just about as often as he comes in and we talk about things and I get to kind of a gauge of his anxiety and how happy he is in his transition process.

Q And, um --

A So technically I suppose that's treatment as a physician.

Q And this individual that sees you for the laser hair removal, do they identify as a man or a woman?

A Oh, very much a woman.

Q And you're using man for what reason?

A Because --

MS. LAND: Object to the form.

A Because we're in a private conversation about something. I would never do that to his face. But I'm using this as an example of a man who is transitioning -- virtually fully transitioned already. When I speak with him it's female because that's the life he's living.

But when I speak to others about him as an example, I have to speak about the reality. Because if

the reality of male didn't exist, the reality of transgender wouldn't exist, so we have to establish that.

Q Okay. And how many -- how many patients transitioning from male to female do you perform laser hair removal on?

A Oh, it's a minority of patients. One to two here and there. I run a very small office now.

Q Well, you mentioned one individual. More than five?

A No. Less than five.

Q Okay. More than one?

A Yes.

Q So somewhere between one and five?

A Yeah, probably two or three.

Q Two or three total?

A Yeah.

Q Okay.

A It's kind of a running total. People come and they go, you know. New patients present.

Q But throughout the entire course of your career, two or three total?

A Oh, in terms of laser hair removal, that's --

Q For an transgender person.

A Yeah. I don't know. Maybe something less than

a dozen I guess. I mean, I've had that laser since 2005.
Q Okay. Have you ever conducted any research related to gender dysphoria?
A No.
Q Treatment of gender dysphoria?
A No.
Q What about research regarding transgender people more generally?
A No. I'm not an academic.
Q So you mentioned that you've -- you talked about a few transgender patients for whom you have provided treatment. Starting with the feminizing rhinoplasty, how old is that patient?
A I'm going to say mid -- late 20s probably. Maybe early 30s at the -- at the oldest.
Q Okay. And for the laser hair removal, none of those were minors; correct?
A No.
Q Okay.
A I do laser hair removal on minors, but not self-identified transgender minors.
Q And why not?
A I just haven't had any.
Q Would you perform it? Would you perform laser

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

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

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

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

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

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

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

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

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

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

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

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physical maturity through the process of cross-sex hormones, but when they arrive at adulthood they are incapable of orgasm, they are incapable of the effects of that on sexual intimacy.

It's also known that higher executive functioning is interfered, the development of higher executive functioning is interfered with. And, again, I would have to, again, cast around for that citation, but I can send it along to you if you like.

Q But nothing other than those consultations with endocrinologists; correct?

A Well, and the public testimony of Marci Bowers.

Q Okay.

A Yeah, who -- as she tells you, has tremendous breadth of experience of transgender persons in transition, surgically transitioning them. In fact, I think she's the one involved with the care of Jazz Jennings.

Q Have you ever diagnosed someone of a gender dysphoria?

A Are you talking about, like, making a formal diagnosis and sending an insurance document? No.

Q I'm just asking if you have ever diagnosed someone with gender dysphoria?

A Yeah, probably. I mean, you know, it doesn't

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enter into the medical record because it's not my area of care.

Q Okay.

A So I don't officially diagnosis people with gender dysphoric.

Q But you have never referred anyone for treatment for gender dysphoria?

A No.

Q What about gender identity disorder?

A Well, no, I take that back. Because I have had parents bring children to me who are experiencing gender dysphoria and I have suggested psychiatrists or psychologists they might speak with, I suppose, or how to find one. So not a formal referral, but a recommendation perhaps.

Q And which psychiatrist or psychologist did you recommend?

A I think I just gave them guidance about how to suss one out.

Q So you mentioned that parents would come to you with their children who they believe are experiencing gender dysphoria; is that correct?

A Both -- maybe all three times recently it's been after mass a mother comes to me and says, Could you come talk to my son, could you talk to my daughter.

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Yeah. So not in my capacity as a physician, but certainly with my knowledge as a physician, but in my pastoral capacity.

Q And did you speak with the parents, the children, or both?

A Both.

Q Okay. Separately or together?

A Both.

Q Both? What did you tell the parents?

A It's mostly a conversation about understanding and mostly helping them manage their guilt that they might have about the suffering of their child, helping to recognize that children suffer from things that oftentimes have no explanation, try reassurance to the parent that, you know, that there is hope for happiness for their child, health and happiness for their child. That's mostly the conversation. Like I said, it's mostly a pastoral thing.

Q And did you recommend any course of action with respect to the treatment of their child?

A Most of the time I talk to parents what I -- the thing I most recommend is to not be judgmental, do not be angry, maintain a loving relationship, give them confidence that they can bring their sorrows to you, because if they can't bring them to you they are going

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to suffer even more. That's mostly what I recommend.

Q But nothing about the treatment of their gender dysphoria or lack thereof?

A Generally those -- in fact, all of the ones that I -- that come to mind right now have not yet risen to the level where they are being recommended for treatment or anything like that. It's just a child struggling and sorrowing, withdrawing from friends and things like that.

Q And this was all in a religious capacity; correct?

A Yeah, as the deacon of the parish.

Q Who do you think should make the decisions regarding a minor's healthcare?

A The parents.

Q What about doctors?

A Well, clearly the doctor has to present the option, so he has to make a decision about what is the best course, what are the options, because that's what consent is all about.

Q What about the government?

A The government should only have to step in if something bad is happening.

Q What about in other aspects of a child's life, who should make those decisions?

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

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

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

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

I don't consider unethical.
Q And why is laser hair removal ethical in the case of use as a gender transition procedure?
A Well, because it's in the category of things that are sort of trivial but helpful. You know, I mean, I do laser hair removal for a variety of reasons.
So, for example, girls with polycystic ovary disease, they will have a condition of hirsutism by varying degrees. Obviously that's not unethical.
But to your question, in the case of a person who is -- who is transitioning, it's a minor thing. Men without beards is a common thing even without lasers. It's not a defining characteristic.
Q So if you're talking about laser hair removal from a biological male who is transitioning to live as a female, the reason why it's ethical is because there are biological males who do not have beards?
A Right.
Q Okay.
A Yeah. It's -- it's not a defining feature of masculinity or femininity for example.
Q Can women with polycystic ovary disease bear children?
A Sometimes. It depends on how well it's managed and the severity of the condition. But, yeah, the

masculizing hormones can have an effect on fertility. And depending on how manageable their particular condition is, it may be a decisive thing. It may be something that, with management, can be overcome.
Q Okay. So we talked about why it's ethical to perform laser hair removal. Is, so -- let me take a step back.
Any other forms of gender transition procedures that you believe are ethical?
A Well, so if a person were to come to me seeking a -- a simple, very simple, like a tip rhinoplasty or something that I could do that would be within the -- you know, the range of normal, which all cosmetic surgeries are, all cosmetic surgeries are within the range of normal and aim themself at solving a subjective perception by the patient that will make them happy. So if somebody just happens to be transitioning and they want to tip rhinoplasty, I don't see any reason not to do that.
Q And what do you mean by a "range of normal"?
A Range of normal, there is a tremendous amount of overlap between the -- sort of the Gaussian curve of any particular trait that's called masculine and any particular trait that's called feminine. And their area of overlap sometimes is very broad and sometimes it's

very narrow. Facial hair is a one of those things. It's a very ethnic thing, it's very a racial thing.
Q Okay. I think I understand. So just help me out for a second. So when you say the range of normal you mean if you are performing a procedure on, let's say, a biological male, right, you think it's ethical so long as it's within that Gaussian curve for a biological male; correct?
A Let me see if I understand how you phrase that. So -- so really the question is to transition to do -- transition procedures on defining characteristics. So, for example, genitalia is a very narrow thing, presence or absence pretty much.
There are the very small tails, which are disorders of sexual differentiation or disorders of sexual development, which is a very freited area of conversation. So in the case of those features, there's virtually no overlap, genitalia.
In the case of breasts for example, breasts there are some overlap, but there are defining pathologies that cause the overlap. Okay? So for example, in the case of breast reduction, size of breasts as a reason for surgery, gynecomastia versus macromastia, there is really no overlap there, although they have the same characteristic, too much breast

tissue.
Q Okay. But just to go back to my question, the reason why it's ethical is because it's within that curve of what is normal for a biological male; correct?
A Yeah. It's a small non-risk procedure that's within the range of normal.
Q And why does the range of normal affect the ethics of the procedure?
A Well, because it -- the person could be presenting for it without you knowing that their motivation is transitioning. You know, so, for example -- well, let me answer your question directly, then.
How does it being in the range of normal affect the ethics of the decision?
Q Well, you have said that it does; correct? I'm just asking why.
A It affects the -- the ethics, I guess, of my own personal decisionmaking in the matter, whether or not I would perform a procedure, you know.
Q Okay.
A I'm not here testifying as an ethicist. I'm not an ethicist, a biomedical ethicist. I'm not expertise (sic.) in that either.
Q Okay. So all of the testimony about whether it

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

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

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

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

can lead to a clinical trial.
But in order to make it to clinical trial it has to be a circumstance where there isn't a high likelihood of harm, because if you are going to randomize people into a clinical trial, both arms have to be demonstrated safe or hold out a promise of efficacy.
And so if you can't demonstrate that then you probably will not get through the institutional review board that will allow you to experiment on a child.
So -- so in cases where the potential harm is small and the potential benefit is great, then certainly it can come to that. But from where I sit I don't see that as a likely circumstance, just because the permanence. The permanent effects of sterilization and irreversible genital surgery and irreversible mastectomy, that's a very grave matter and you can't take it back.
It's a different matter if you're testing the efficacy of asthma medication and you've got some experience with one or the other. Yeah, clinical trial.
Q What about laser hair removal? We talked about that before; right?
A Right.
Q Clinical trial?

A Does that require clinical trial?
Q Well, do you think that doctors should be able to provide minors with laser hair removal as part of gender transition procedures in the context of clinical research?
A I don't know of any circumstance where laser hair removal is necessary in a child other than children who have -- and I've treated them -- children who have hirsutism secondary to endocrinopathy. If they have a pathological endocrinological condition, that doesn't even require a clinical trial. Because laser is known to be efficacious, the condition is demonstrable, it's an objective condition, it's cause can be demonstrated and the result can be anticipated.
Q Let's go back to my question, though. Is there any circumstance in which you think doctors should be able to provide what's -- what we've agreed as being called gender transition procedures to minors in the context of clinical research?
A I cannot think of a circumstance where it would be indicated -- where it would happen. I can't think of a circumstance where anything that is ethically plausible would rise to the level of a clinical trial.
Q What about in any other research context?
A Children enrolled in a research prospective

study?
Q Yes.
A Right. Whether the risk of harm is small, where the risk of harm is small and the likelihood of benefit is significant.
Q So you'd agree that should be permitted?
A Oh, absolutely. It's permitted all the time.
Q So just to go back a second. Do you think that clinical trials should never be done in the case of gender-affirming medical care for minors because the care is always harmful?
MS. LAND: Objection; form.
A Well, let me take them in order. So known harms of puberty blockade, yeah, that would be a disqualifier. Known harms of cross-sex hormones in high dosages, that would be a known harm. Irreversible mastectomy, known harm. Genital surgery -- well, children don't yet get genital surgery under standard of care. They would. All known harms, grave matter. So knowing that I wouldn't subject any of those treatments to clinical trial.
Q (By Mr. Ossip) So, I mean, I think earlier your said the question was whether or not the benefits outweigh the harms; correct?
A Right.

Q So it's not just a question of the harm; right? It's also a question of the benefit?
A Absolutely.
Q And I understood that your testimony -- well, let me take a step back.
Is it your testimony in this case that there is insufficient evidence as to the benefits of gender transition procedures?
A That's precisely what's at stake here.
Q And how would one develop that evidence?
A So if you cannot do a clinical trial -- clinical trials would be level 2 to level 1 evidence. So a clinical trial level 2 would be a non-blinded study, for example. Level 1 would be like multi-center randomized placebo controlled, let's go for it. You can't do that with these techniques, these particular issues.
Q Got it.
A So the best you can get to is a level 3, which would be like a longitudinal population-based study of outcomes, which is precisely what the Dhejne study, it's pronounced the Dhejne study, the 2011 Swedish study, that's precisely what that evidence shows us.
It's a gigantic study population in an LGBT-affirming society where every level, every incident,

every moment of care in that medical system is recorded in the same language, whether that person is going to a hospital, clinic, a transgender clinic, a pediatric clinic, a school nurse, a prison hospital, a psychiatric hospital.

Everybody goes in the same database so you can query that database and say, I have a transgender person here who is suffering from alcoholism. What is their relative risk of alcoholism compared to age-sex matched controls. So that's a level 3 evidence, which may be the highest you can get to. But it shows us very dramatically what the potential benefit is long term. That's a 30-year study.

Q And so would you support doctors being able to provide gender transition procedures to minors in the context of a level 3 study?

A So a level 3 study is -- is a study of -- study of an existing database. So it's not -- it's not necessarily a prospective study. Right? Because what happens is you already have the study population. They are the patients that have been historically cared for, and what you are comparing them to is the age sex-match cohort.

Q Okay. Well, here is where I'm confused, Doctor.

A Okay.

Q So you're saying that we need more evidence, we need to conduct more research; correct?

A That -- that -- without that evidence it's unethical to proceed.

Q All right. How would one generate that research?

A Well, a literature search will show you. So, for example -- here is a good example. It can be a literature review that gets you to better levels of evidence, or it can be a literature review that shows you that the level of evidence you have is even worse.

So the Dhejne study that we talked about, that's level 3 evidence and it points away from offering the services because of long-term result. It definitely demonstrates, by the way, that short-term it's a benefit to the patient. You look at their study and it will show you that fully transitioned patients will experience essentially the same levels of hospitalization, same levels of suicide, same levels of self-harm, alcoholism, violate crime, whatever, as the general population age sex-match controls, benefit, search to eight years.

And then the bottom starts to fall out, because they typically have fallen out of the affirmation loop

and the interior wound is still there, and their suicidality returns because it hasn't addressed -- the problem itself hasn't been addressed by the care that they have received.

So that shows us in a level 3 study that long-term what we are interpret -- what the American medical community is interpreting as benefit is really a short-term phenomenon. And this is why it's excusable when experts will cite a paper and say, Well, we've got a followup of three-and-a-half years out of University of Southern California of top surgery.

Well, yeah that's a benefit because the child is still experiencing affirmation messages and the child still has a hope of improvement, but that doesn't mean long term. And remember, we're talking about irreversible things here so we have to talk about the entire arc of their life.

Q So you mentioned that they have fallen out of the affirmation loop.

A Right.

Q Was that in -- was that terminology in the Dhejne study?

A I don't believe it was, no.

Q All right. Where did you get that from?

A My knowledge of the way that transgender care

works. So you know, reading -- for example, if you read in the American literature, it's rare that you find anyone reporting followups beyond -- in the surgical side you're lucky if you find followups beyond the third year.

Q Well, just that idea of them falling out of the affirmation loop, is that supposition on your part?

A Well, it's evidenced by what the reports are of the patient care in the -- in the collected cases, in the single-center studies, multi-center studies, surgical care of transgender persons. The fact that I don't find followups that extend beyond third year tells me they are falling out of that loop.

Q So it's the absence of evidence?

A Evidence you would expect in a body of scientific literature that purports to show long-term benefit.

Q So going back to clinical trials.

A Okay.

Q Should clinical trials regarding the provision of gender transition procedures for minors be banned?

MS. LAND: Object to form, vague.

A Well, um, let's say that -- that suddenly there's level 3 evidence of benefit. Let's say -- I mean, this is all supposition on my part. I don't rule

it out because I'm open to following the science here. I can only -- I can only speak to the level of the science as I know it. Okay? But if there were -- if --

Q (By Mr. Ossip) Sorry. Go ahead, Doctor.

A That's okay. If there were a circumstance where the science was to suddenly present through level 3 evidence of a -- of a tremendous benefit then that would change the risk/benefit equation.

All surgical consent, which any trial like this would have to have, is a risk/benefit equation. In the case of the risk is so high the benefits through a level 3 study would have to demonstrate tremendous benefit.

Q But let me put it another way. Should the government ban those clinical trials?

A I think the government already does. I mean, ethics review boards for clinical trials, I'd have to step back. Because, again, I'm not an academic. Probably Dr. Hruz can answer that question better because he's routinely academic clinical trials.

But I think when you're talking about a lifetime risk of objective harm, infertility, loss of capacity for orgasm, loss for sexual intimacy and inability to breastfeed and all of those things, that's a gigantic body of harms.

And so I think this -- anyone bringing such a

proposal for a prospective study -- I don't think even proponents of transgender see a prospective clinical trial as doable because you couldn't blind the treatment arm.

Q Well, what about a prospective longitudinal study?

A Well, we're living in that right now. We are living in that study right now, because we have a population -- the problem is that our database is not -- so what you're proposing here would actually be a proper database to manage what is already going on. We're living in a longitudinal trial right now.

Q And we're living in a longitudinal -- a prospective longitudinal trial -- I mean, let's put that aside.

We're living in a longitudinal trial because minors are being provided gender-affirming medical care; correct?

A Correct. Correct. And the take-home message there is experimentation. The long-term effects of puberty blockade in gender dysphoric children is not known, that is not known. It's not a known quantity. The reversibility of it is not a fallacy. It is not known.

The long-term effects of cross-sex hormones

long term is not known, other than the known pathologies of hypertension, hypertriglyceridemia, all those other things that are known. But in terms of children being transitioned through puberty block and cross-sex hormone, that's an experiment.

Q And you support additional research then?

A I always have my eyes and ears open for meaningful research. And what I'm looking for in the American literature is when they are actually going to be examining their data long term, and to date that hasn't happened.

Q Earlier we were talking about chest masculinization.

A Okay.

Q Would you agree that that procedure is the same as a mastectomy?

A Yes, it's the same operation.

Q Okay. And it's safe; correct?

A It's a safe operation. The risk in a woman is different than the risk in a man. The risk of postoperative hematoma in a -- in a chest masculinization as it is for gynecomastectomy in a man is higher than it is in a woman getting a breast reduction. So there is minor differences in surgical risk, but all of those risks are small.

Q And it's the same risk, then, as postoperative hematoma as it is for a gynecomastectomy; correct?

A Well, so I would expect a slightly higher risk in the chaste masculinization because part of the technique is -- involves the placement of the incisions, because the incisions are routinely inframammary, a lower crease of the breast. The reach up high on a male chest is more likely to cause accidentally vascular injury. So it wouldn't surprise me to learn that the risk is a little bit higher in a -- I'm sorry -- we're talking about masculinization versus breast reduction.

Q Correct.

A Forgive me. I was on the wrong sheet of music here. Risk is -- actually probably for hematoma in the masculinization is probably less than it is for a breast reduction.

Q So lower risk?

A Lower risk, yeah.

Q Okay.

A It's a small risk either way. It's maybe the 3 to 5 percent range. But it's probably lower risk in the mastectomy because of the dissection plain and the fact that you have to cut through the mass of the breast, which is rich in blood supply, so.

MR. OSSIP: All right. I think we can

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

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

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

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

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

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

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

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

that you see among transgender persons and you were able to demonstrate, you know, that you nearly knock that off the books, that would be a significant benefit. Or psychiatric major depression, substance abuse, if you could demonstrate a major objective benefit then it would be worth having a conversation about that. And again, I would have to defer to the pediatric endocrinologists and the psychiatrists to make that adjudication. But that's the kind of circumstance.

Q So I think this is going back to my confusion.

A Okay.

Q I think you said in order to do this study you would need either level 3, level 4 evidence to show that safety and efficacy of the intervention.

A Yeah. If you're trying to get to a level 2 result, you've got to have everything below that kind of supporting --

Q Okay. So let's talk about the lower levels, then.

A Okay.

Q So you would oppose a prohibition of collecting that research for puberty blockades then; correct?

A Right. Well, so what you're -- when you're talking about level 4 and level 5 evidence you're talking about -- in the case of level 5, for example,

you're talking about anecdotal case reports.

Q Um-hum.

A In the case of a level 4 you're talking about of large case collections, retrospective study of literature, you know, analysis of multiple-collected case reports and things like that.

I'm pretty sure that pediatric endocrinologists right now cannot present you with better than short-term level 4 evidence of a benefit. And that's the problem with the puberty blockers because the consequences are not short-term.

Q So you would support research into long-term, level 4 research into long-term benefits of puberty blockers; correct?

A No. I would probably defer to a -- a longitudinal population based retrospective review because that doesn't put any new children at risk. Right? What you're looking at is what do we have so far? We've been doing this now for a decade. We've been doing puberty blockade and cross-sex hormones for a decade. We should have at least, in some patients, a ten-year followup. But what we're really looking at is even longer term than that. At eight to ten years you're starting to see fall-off.

But in terms of the consequences of hormonal

blockade, we've arrived at that stage when the likes of Marci Bowers, transgender surgeon, is starting to report adverse long-term consequences of puberty blockade. So that's one of the data points you're going to have to weigh against.

Can a child that is entering puberty at age 11 understand what you're talking to them about like when you say, you know, "Like seven years from now you're not going to be capable of an orgasm." Well, they have never even experienced that so they have no way of judging that. "You're going to be infertile." They don't understand what that means.

And so -- but we're getting to the point now where what you really want to do is a historic population-based longitudinal evaluation of the results to date. And I think we're reaching that point in the American literature. Sweden is already there. That's why they are reporting what they're reporting now.

Q And that's just the Dhejne study; correct?

A Well, there is the decision by the Karolinska Institute, they are looking at their own internal review of their processes and their outcomes.

The Karolinska Institute in Stockholm has now -- has now shut down puberty blockade and cross-sex hormones because they are reaching the point where they

are seeing the effects of long-term effects on children. So we're at that point now.

So I wouldn't say let's do research at level 4 and, you know, case collections or case report. I let's look at what we have so far and what is it showing us? And that's a longitudinal population-based retrospective review or examination of the data.

The risks we have right now is the data collection is so slip-shot compared to Sweden and Finland and the UK.

Q So earlier we were talking the about the levels of evidence, you know, through 1 through 5 and you said that -- or you'd agree that level 5 evidence is anecdotal reports and expert opinions; correct?

A Right.

Q Okay.

A Consensus statements I think is in that kind of group too. Sometimes consensus statements rises to the level of level 4.

Q And --

A Um-hum.

Q So I want to direct you to your rebuttal report, which is --

A Okay.

Q -- marked as Exhibit 4.

A Okay.
Q And we're going to go to paragraph 16.
A Level 3, level 4. Paragraph 16? Okay.
Q So going on to the -- it's the last two words of page 8; right?
A "As I."
Q And then going on to the next page you say, "As I will show below all of the articles cited by plaintiffs' experts are of the lowest grade of medical evidence." Correct?
A Correct.
Q Do you mean by that that all of the articles cited by plaintiffs' experts are a level 5 evidence?
A No. Four, five. Four and five.
Q So not the lowest grade.
A No, no. The level 4 for sure, which is low-grade evidence. It's -- it's referred to in much of the literature as being, let's see, low quality. What are the words O'Connell (phonetic) used? Low quality. It's a very low quality or poor to low quality. There's a lot of different words people will use. There is no precision particularly in those words. It's better to speak of level 4, level 5.
Q But it's not the lowest grade.
A No, it's not. Level 4 for sure.

Q Okay. So let's just flip back to paragraph 4. This is paragraph 4C. It's on page 2.
A Okay.
Q Do you see where you say, "The papers chosen by plaintiffs' experts demonstrate systemic problems in the way such articles are peer reviewed."
A Yeah.
Q What do you mean by that?
A Well, let's take for example one of the -- one of the papers cited by the plaintiffs' experts, a paper I think the lead author was Olson-Kennedy. It was out of USC, University of Southern California, their gender clinic. And it was an examination of top surgery in trans males.
And I discuss that -- let's see. Yeah, so I discuss that in paragraph 7 -- beginning at 17 and continuing on, 18. It basically looks at how is the data collected. So articles can be very low quality for a number of reasons.
The first point is -- is how you gather the data, how the patients are selected. The second point is how you interpret the data. And then -- and then the third is conclusions you have drawn.
Q And, Doctor, I'm specifically asking about how the articles were peer-reviewed. Do you know how they

were peer-reviewed?
A Right, yeah. So that particular article appeared in Peds JAMA. And the peer review process in Peds JAMA is probably like it is in most professional journals. They have a board of reviewers who get assigned articles to review and -- prior to acceptance for publication. So JAMA and its various outlets, like JAMA Peds is one of those peer-reviewed journals.
Q So you would agree that the peer -- or it's your understanding that the peer review process in JAMA Pediatrics is the same as in most other medical journals; correct?
A The process is generally the same. The particular players, obviously, vary and the editorial policies probably vary.
Q Okay.
A But the process of peer review is where a peer who is working in the same field and maybe even more than one peer, it might get reviewed by more than one process, will evaluate your process, evaluate your -- your data, the validity, the conclusions drawn.
Does your study have the power to make the judgment because of it's got a big enough study population looking at a variable that, you know, may be broadly varying or narrowly varying. There's a lot of

criteria, but that's the process. And it will get accepted for publication on the basis of that review process.
Q Okay. And JAMA Pediatrics is peer-reviewed; correct?
A As far as I know, yes, it is.
Q Yeah. Do you think that watchful waiting is a scientifically proven treatment model for gender dysphoria?
A It's -- it's -- I would call it a historically proven model. I would have to delve into the details. But when someone like -- gosh, his name just escaped me. Zucker.
Dr. Zucker from Toronto publishes data that shows the desistance rate, meaning children who cease cross-sex self-identification in puberty and young adulthood, that desistance data was arrived at using the watchful waiting model. So you have a comparison group right there that you could compare to your affirmation care model that we're living with right now. It's already in the medical literature. Zucker lost his job because he reported it.
But what does it show us? Watchful waiting isn't a passive process, it isn't a no care process. Watchful waiting is recognizing that the effects of

maturation are going to affect mental and emotional maturation, recognizing that individual treatment by a child psychologist can help a child to understand what kind of fear, anxiety they are trying to manage, can keep them in contact with reality, which is what's called cognitive behavioral therapy. And but the most important element in that is family therapy, family dynamics.

That's what the watchful waiting model is, family therapy, behavioral cognitive therapy, sometimes the use of medications to control the anxiety, not very often, and then recognizing that puberty is going to mature their brains and that's why better than 80 percent of children abandon cross-sex self-identification in adolescents and 92 percent in young adulthood. So that's watchful waiting and it has a track record.

Q And what scientific literature supports the use of watchful waiting for adolescents?

A Zucker, among others. And I would go to him and I would read his citations. Yeah.

Q And what about for adults?

MS. LAND: Objection; form.

A Well, when you reach adulthood watchful waiting is not even on the table. See, watchful waiting

essentially is the diagnostic process in a sense that separate out the children who desisted from the ones who would have persisted.

And so if you have somebody who is in young adulthood who is persistent then -- now, that's a group you might want to study carefully with alternative therapies. Right? Because now you have established the diagnosis.

If I have a desistance rate of 80 percent, but if I start them an affirmation care and I have a persistence rate of 100 percent, something is wrong here. I've misdiagnosed 80 percent of my patients. And so that's the reason why these prospective trials become a risky proposition, because you haven't determined even who has the diagnosis.

Q And by starting them on affirmation care, do you mean to include social transition in that?

A Well, in some measure it does. That's sort of the entry point. But in earnest it begins with puberty blockade.

Q And right now you believe that puberty blockers and cross-sex hormones are too harmful to minors with gender dysphoria to permit clinical trials for those treatments?

A That's my opinion.

Q Do you believe that any patient who reports anxiety is incompetent to give informed consent for surgery?

A No.

Q What about depression?

A I would have to look at that carefully. You know, situational depression is a very different thing from a -- a chronic and severe depression, depressed state.

So I can -- I've often taken care of patients who are depressed over their diagnosis of breast cancer, for example. It's a very depressing thing to find out, but that's a situational depression that I can help the patient through even just as a plastic surgeon who can offer her the hope that she's going to be reconstructed and things like that.

Very different from a patient who is coming to me seeking a remedy for depression by getting aesthetic surgery. That's a completely different -- completely different person.

So to get a consent form in the cancer patient, I don't see any problem with that. To obtain consent for managing depression in a cosmetic aesthetic patient, I've got a real problem with that.

Q Well, let's move way from aesthetic; right?

I'm talking about surgery in general, in all areas of surgery.

A Okay.

Q Do you believe that a patient with depression is incompetent to give informed consent for surgery?

A Given the qualifiers I just gave you, I would not make a blanket statement that's it's an absolute gold standard disqualifier. It's not.

Q Okay.

A It's a situational thing.

Q What about patients experiencing suicidal ideation?

A That's a problem.

Q So never competent to give --

A No.

Q -- informed consent?

A That speaks of a profound psychological disturbance. Anyone who is seriously considering ending their life is dealing with a level of anxiety, and perhaps even a misperception of the world they are living in that I would consider renders them incompetent to give informed consent.

Q In any context?

A I can't think of an exception. I can't think -- you might present me with an exception and I

might say ah-ha, but I can't think of one.
Q And is that a generally accepted view in the medical profession?
A Pretty confident in that.
Q And what about a suicide attempt?
A Well, I would have to look into how remote that is. Is it a recent, is this an ongoing problem?
And also, the other thing you have to consider in that decisionmaking is what are you proposing with the surgery? So if a person is suicidal because they -- you know, they have got a gangrenous leg, well, I could maybe make a case that part of what's animating their suicidality is the fact that they are walking around with this stinking leg and that they would have a very high likelihood of a better disposition if I did the amputation. Right? Very, very important to kind of categorize what you are submitting them for.
If you're -- if you're proposing an elective operation, an elective operation and the person is recently suicidal, I would not off them a consent form. I would offer them a referral for psychiatric evaluation to see if they are -- if they are -- if their suicidality is being adequately managed.
If the reason for surgery is an elective procedure to obviate suicidality, well, if I can manage

the suicidality then I don't have the indication for the surgery, so I wouldn't give them the consent form then because they no longer want it. They wanted the surgery to manage suicidality. If the suicidality is managed, why even offer them the surgery?
Q All right. But so just going back for a second, so you'd agree that -- again, that patients who report anxiety are competent to give informed consent for surgery; correct?
MS. LAND: Object to form.
A Right. Depending on the particulars of their anxiety. But as a general principle anxiety is not sufficient to render somebody incompetent.
Q (By Mr. Ossip) Okay.
A Right.
Q Can informed consent be obtained in cases where the long-term benefits of an intervention have not been demonstrated?
A Yes, I think so. I think so. You know, balancing that against immediate risk of harm. So if you're talking about a low risk of immediate harm, lacking long-term data on benefit, yeah, I guess that would be reasonable, um-hum; certainly in the case of something that's an immediate danger that you're using surgery to obviate, then absolutely.

Q And let's see. Does informed consent require an objective measurement with known error rates that could be used before the procedure to predict who will benefit from it?
A That is sort of an ideal circumstance. But it's generally what we aim for. So, for example, when you're -- when you're talking about cancer surgery, you know, a known danger, if I was going to, you know, accept a patient for it -- say, for example, somebody is referred to me for a thyroidectomy because the endocrinologist has diagnosed a thyroid cancer, well, I'm going to want to see the evidence. If the evidence is just, "Well, I felt a lump, it's going to be cancer," I would go, "Well, that has very high known error rates and I'm not going to accept that as evidence for a thyroidectomy."
If he comes back and says, "Well, I've got an ultrasound and the ultrasound shows an echoic lesion in the right lobe," I will say, "Well, that's interesting, low probability of cancer," I still won't offer surgery because the error rate is too high. You've got a pathology report, I'll go, "Excellent," and I'll look at that slides. Do you see the difference?
Q Well, let's just go back to my question. So you would agree that informed consent does not require

an objective measurement with known error rates that can be used before the procedure to determine who could benefit from it?
A It's not a sine qua non, right.
Q Not a requirement? To avoid Latin.
A Well, okay. I'm just trying to stay with you here. Having tests that -- with known error rates is a very important and indispensable thing when you're talking about a life-changing operation. Like a thyroidectomy is a life-changing operation and I'm going to want to have known error rates. If it's an unknown error rate what you have used to diagnose something where I'm going to do an operation that's life changing, that's unacceptable.
Q So any thyroidectomy that was performed in a time when there was not a known error rate, that was -- then informed consent for that procedure was impossible?
A Well, no. You're in a circumstance there where to the best of your ability. Some even with my own training era, a general surgery (sic.) in the 80s the diagnostic specificity has gotten better.
Take an appendectomy for example. When I was a junior resident in general surgery, if you weren't -- if you weren't taking -- if 20 percent of your appendectomies weren't normal, normal appendix removed,

the chief of surgery would say you're not doing enough appies, because he's afraid of somebody rupturing their appendix and you not attending to it.

So but now the likelihood of a negative appendectomy is some number approaching zero.

Q Well, just again, just to get --

A You do the best you can.

Q I want to avoid the longer tangential examples. Okay, Doctor?

So just again, you're saying the question is to the best of your ability; correct?

A What's the best level of evidence you can get.

Q Okay. And that's sufficient to get informed consent?

A Right. The less uncertainty, the better. An error rate speaks to uncertainty.

Q And have you ever performed a procedure that lacked an objective measurement with known error rates to determine who would benefit from the procedure?

A I'm not a trailblazer in surgery. I generally go with what I have been trained up in in areas that has proven results and things like that. I'm trying to think if I have ever done anything experimental. I'm not that kind of surgeon.

Q Well, you -- we'll come back to that.

Is it always a breach of medical ethics to perform a purely cosmetic procedure on someone under the age of 18?

A The -- you know, in my training for board certification, the American Society of Plastic Surgery, one of the things they would review is things like that, doing, like, for example a breast augmentation on an adolescent high school age female. If I presented a case like that for my board certification I probably would have been dismissed for it.

Q Well, my question is yes or no. Is it always a breach of medical ethics to perform purely cosmetic procedures on someone under 18?

MS. LAND: Object to form.

A So there we would have to get into the definition of cosmetic, because we're getting to the fine details here. So if cosmetic, you know, you could grade asymmetry of the breast in Poland syndrome to be cosmetic, but that would be a fairly heartless approach to a girl suffering from Poland syndrome.

So technically I'm not solving a functional deformity, but it's an objective deformity. She's not within the range of normal for a female. It could be considered cosmetic, but that would not be problematic because it's a reconstructive operation.

But on the other hand, if a girl comes in who has a minor asymmetry in their breast, and that's a common thing, and she wants to have large breast implants put in, I would say no.

Q (By Mr. Ossip) So okay. I think I'm understanding. So the question of whether that would be ethical would be whether or not you are moving someone from outside the range of normal for their biological sex to somewhere inside the range of normal for their biological sex?

A That's a good way to put it, yeah, it is. That's reasonable, um-hum, I think.

Q All right. Do cosmetic surgeries ever sacrifice function?

A If a cosmetic operation puts in jeopardy a human function I would -- I would expect or hope that it only happened accidentally or through some misadventure, either preoperatively, intraoperatively, or postoperatively. To sacrifice function for a cosmetic result is one of those bedrock plastic surgery ethos. We sacrifice function all the time for a reconstructive procedure. But to sacrifice it for a purely cosmetic procedure would be -- it better be accidental.

Q Well, that's a good -- let's dig into that a little bit.

A Okay.

Q So you said it better be accidental. So that gets to the intention of the physician; correct?

A Right, or his knowledge, his competence.

Q Is it ethical to perform a cosmetic surgery that carries a risk of sacrificing function?

A No. All operations have some risk. And so, for example, every time I do a rhinoplasty there is a potential risk that they are going to have a perforation of their septum if there is some accidental misadventure in the course of raising the flaps. And I explain that to the patient and every rhinoplasty surgeon does.

So your risk of septal perforation is somewhere around 3 to 4 percent. That's an acceptable risk because the management of it is certainly within reach of an office procedure most of the time.

So it's not uncommon that there is some measurable risk, but the risk ought to be very low and it ought to typically happen through a misadventure, like I'm raising the flap and I accidentally pierce that flap.

Q And how much risk of a functional loss is acceptable for a cosmetic procedure?

A It better be in the low single digits, you know.

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Q So, like, we talked about Poland syndrome. So let's -- and breast augmentation. Is it -- it's -- is it your testimony that's never ethical for someone under the age of 18 except for patients with a congenital breast deformity to receive a breast augmentation?

MS. LAND: Object to form.

A Well, okay. I can think of an example where it might be acceptable, but there again you're sort of skirting outside the range of normal. So a girl with what's called pectus excavatum where the chest is sunk in because of a developmental process, to conceal that pectus excavatum using autologous fat grafting augmentation rather than an implant would be a very reasonable thing to do for her.

But there again, you're still -- even though the defect would be close to within the range of normal and even if pectus excavatum is not an uncommon thing, I think it would be very reasonable to offer a girl who is in her high school years, who has done most of her skeletal growth already at that point to maybe offer -- she might be 16, 17, at that point I think it would be reasonable.

On the other hand, an otherwise normal, healthy girl who comes in who just wants bigger breasts, I think that's problematic.

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Q (By Mr. Ossip) And do you think that's unethical just looking at that particular case?

A I don't want to judge my colleagues, but I would consider it myself to be unethical if I was to do that.

Q Okay.

A I would judge myself to be unethical in doing that.

Q But is that a generally accepted view in the medical profession?

A I remember hearing it more than once when I was in training.

Q But are surgeons subject to discipline for performing such augmentations?

A They are subject to discipline following discovery. And a lot of these things go undetected I suppose. But, yeah, surgeons are at times disciplined. It's not a very common thing in the world of plastic surgery, but it happens.

Q But just to be clear, you're saying that physicians who conduct or perform a purely cosmetic breast augmentation on a minor are subject to professional discipline?

A Not as a general rule, no, not as a -- I think because it goes undiscovered virtually.

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Q Well, let's take a case where it is discovered; right?

A Okay. Okay.

Q Is such a physician subject to professional discipline?

A Probably at least review of the case and to see if it's a trend. Right? For example, if I was doing breast augmentations on minor females in the local hospital and I had an extrusion of an implant, because she's active and she doesn't pay attention to postoperative orders and forgot to take her antibiotic -- I don't know -- the implant extrudes and has to be removed because of infectious complication, that's going to appear in the morbidity report. And if the morbidity report comes up and goes, "Oh, Dr. Lappert did a breast augmentation that suffered complications in a 16-year-old girl, is this a trend?" And if that medical board at that hospital reviews my operative records and say, "Oh, look, he does these surgeries all the time," then that might get examination.

Q So let's go to your rebuttal report.

A Okay.

Q So that's --

A Is it 5? No. That's --

Q That is 4.

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A Four. Okay. That's right.

Q And I want to go to paragraph 6.

A Paragraph 6. Okay.

Q So let me know when you are there.

A I'm there.

Q So do you see that first sentence, you say, "Cosmetic breast augmentation for anything other than congenital breast deformities, such as Poland syndrome, in minors is not considered ethical professional conduct."

A Again, that's -- that's where my training has taught me. And then I have a reference for you. Reference 3, from the seminars and plastic surgery.

Q Right. And that's that Jordan and Corkrine article?

A Right, right, right.

Q And does that article say it's unethical to perform purely cosmetic breast augmentations?

A No. It raises it as a question. It doesn't declare it so, but it raises it as an ethical question worthy of examination, yeah.

Q Okay. Are breast reductions ever performed for strictly cosmetic reasons?

A Yes.

Q And does this sacrifice function for the sake

of a cosmetic result?
A It hopefully does not.
Q But it risks it?
A Right, yeah, there is always risks. So if you want to hear it, I can expound; if not --
Q That's okay. I just want to keep it moving.
A Sure.
Q But you would agree that a purely cosmetic breast reduction can be ethical?
A Oh, absolutely. I do them all the time. I did them all the time.
Right. The distinction between a cosmetic and a reconstructive breast reduction has to do with did the patient present with orthopedic problems and what is the way the specimen you submit. So those are subjective criteria that span between cosmetic and.
Q Do you consider gender affirming surgeries to be cosmetic or reconstructive?
A They're -- I call them aesthetic rather than cosmetic.
Q What's the distinction between aesthetic and cosmetic?
A So cosmetic just speaks to the fact that you're changing the form. Right? Aesthetics speaks to the fact that you're changing the form affects the

subjective life of the patient, and that's an important distinction to make because it helps you address risk.
So an aesthetic operation for somebody who has, like, a daily problem with explaining why they look tired. Maybe they're a bank teller and everybody is always, "You're not getting enough sleep, hon."
Well, I can solve the tired-looking face with an aesthetic operation. I can make their face look rested and that solves an objective problem that they are suffering every day. That's a very important thing to offer people. And I always make that distinction when talking about risk with patients because they're not doing it for nothing. They are doing it for objective reality, which is their subjective life.
If I put them at great risk to do that, now we've got an important conversation to have. If I can do it with little to no risk then that's a chip shot conversation.
Q And cosmetic surgeries don't involve that --
MS. LAND: Object to form.
Q -- objective benefit?
A No. Cosmetic surgery -- I make the distinction because of the way people understand cosmetics. Cosmesis is just about the change in appearance. Aesthetics is about the result of the change.

And what we're -- the most important conversation we're having, especially when you're talking about trans children, is the subjective effect of surgery.
Q (By Mr. Ossip) So I guess are all cosmetic surgeries aesthetic?
A Right.
Q But not all aesthetic surgeries are cosmetic?
A Okay. An aesthetic operation involves a cosmetic change. The term "aesthetics" just calls to mind the fact of the motivation for the operation and the expected result of the operation. Cosmesis is just the physical change. Aesthetics is the more inclusive category. So aesthetics includes cosmetic procedures, but speaks to the subjective result of those cosmetic procedures. Does that help?
Q Maybe. But again are there any aesthetic procedures that are not cosmetic?
A Aesthetic procedures. I can't think of it because aesthetics is about the perception of the physical reality. Whether you're talking about the aesthetics of this room, the aesthetics of that painting or the aesthetics of somebody's nose.
Q So the answer is no; right?
MS. LAND: Object to form.

A Yeah.
Q (By Mr. Ossip) Okay. And do you know if the -- but either way, you don't consider gender-affirming surgeries to be reconstructive; correct?
A No, it's not, absolutely reconstructive surgery.
Q Do you know in the American Society of Plastic Surgeons considers gender-affirming surgeries to be reconstructive?
A Yeah, they do.
Q They do?
A Yeah.
Q So let's talk for a second about facial feminization surgery.
A Okay.
Q Is there any loss of function there?
A There is a risk of loss of function, but no expected loss of function.
Q And that would put it in the realm of ethical then; correct?
A Right. In terms of just surgical risk and how it applies to ethics. And putting aside the entire question of body dysmorphic disorder. We'll just put that aside. Surgical risk and how surgical risk affects ethical decisionmaking. Surgical risk low, not

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

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

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

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

A law passes that you can't do transition hormonal therapy then that would have a significant impact on his practice I would imagine.

Q And what's your understanding of Dr. Antommaria's practice?

A He's a psychiatrist; right? Pediatric psychiatrist.

Q What does it mean to divide the human person from our own bodies?

A So that's an anthropological concept of what you define as the essence of being a human person. So if you define the human person as a spirit being that occupies a body then that speaks of a division between the subjective life of the person and their embodied self, and that's a difficult issue because it goes against everything I ever learned about the human person as a physician.

I don't know of any human person apart from their body, I don't -- and the consequences of their body existing in the world. The fact that they have a voice, the fact that they do things.

So -- so when a child is given this idea that their essential self is a spirit that is in the wrong body, that's a -- that's a psychological division that's being created in the life of that child. In my

experience it's not natural for a child to speak that way. A child -- it's not natural. In my experience the child is given language like that.

Q And -- well, when you say in your experience, what do you mean by that?

A Taking care of children for 30 years.

Q In what capacity?

A As a pediatric surgeon and cleft craniofacial care and, you know, trauma situations and coming into my clinic with minor birth defects and, you know, I mean, in my -- in my practice of plastic surgery a significant proportion are children, or were children until a year ago.

And I'm in the habit of not only taking the history from the parents, but trying to get a sense that the child has of what they're experiencing, so I always talk directly to the child in the presence of the parents to get a sense for how they're understanding their circumstance. And it is my experience that children don't speak about their bodies as being something separate.

Q So I just -- one thing I want to get back to. You said a big proportion of your practice as a plastic surgeon up until a year ago was children; correct?

A Yeah.

Q What proportion?

A Probably somewhere between 15 and 20 percent.

Q Okay.

A Years before that it was much larger. I directed a congenital deformities clinic at the Portsmouth Naval Hospital and had a very large enrollment of children with birth defects.

Q So you talked about there being -- well, let me ask it another way. So why is it a problem to divide the human person from our own bodies?

MS. LAND: Object to the form.

A Well, in terms of the issue in question it may predispose decisionmaking that would incline the person to treat their bodies as a separate object of domination, if you will, or an object of care. So speaking of your body the way you speak of a shirt. Right? I'm going to have the collars narrowed. I'm going to have my breasts removed, that kind of thing, objectifying their own body when, in fact, their body is part of their subjective life in important ways, which is where this problem comes from. It's a misinterpretation of what they're body is telling them about who they are.

Q And by "this problem," you mean transgender?

A Right. Gender dysphoria, gender identity

issues, gender incongruence. Why does a child feel separated from their body in a way where they view their body as the enemy to their happiness. That's a very important thing.

Q And all of those things come from a misinterpretation?

A Yeah. Clearly, yeah.

Q And is that a medical issue?

A It's a psychological issue.

Q And what is the treatment for that psychological issues?

A Well, so to view your own body as the source of your problems apart from some objective -- is the analog to that would be like the anorexic girl. And anorexia predominates in adolescent females.

For them to view their unhappiness is caused by a misperception of their own body. So the anorexic misperceives a skeletal body as being obese, so that's where the misperception, misapprehension is. Why? Because she would rather not look at the internal wound that is causing her to feel unsafe or unloved, and so she sees something that's not there.

And that's directly applicable to the child that looks at their body and sees something that's not objectively there. They see a body that's an enemy to

their happiness and they see their own genitalia, for example, as not really a part of themselves, so that's a misperception.

Q In both cases it's a delusion?

A Well, by degrees. By degrees it's a delusion. So in the case of the anorexic, delusion has three criteria. One of them is it's a fixed firm belief. And that's, interestingly, one of the diagnostic criteria in DSM by diagnosing gender dysphoria in the child is the fixity of the belief. Persistent, insistent, and consistent is what they say.

Well, persistence in a belief does not make it true, and that's the problem with the delusion. So it's not -- it's not amenable to logical argumentation is the other criteria. So they are insistent on it, it's not amenable to logical argumentation. And the third thing is it's an impossibility. Those are the diagnostic criteria for delusion.

Transgender, gender dysphoria that rises to the level of seeking surgical intervention in the case of the historic demographic. Meaning boys who persisted into young adulthood, right, now you've gotten to the point where it's persistent, right? It's a consistent thing. They have lived it since childhood. It's not amenable to objective argumentation, and it's an

impossibility as surely as an anorexic girl is obese.

What's the impossibility? Well, it's impossible that a boy with a Y chromosome in every somatic cell of their body is, in fact, a girl. There's no basis for making that claim. It's a subjective claim based on a misperception of their body. So it meets all the criteria.

Now, contrast that with the late-onset gender dysphoric female, rapid-onset gender dysphoria, you're going to have a hard time demonstrating delusional thinking there. What you're more than likely encountering is a persistence in a social -- what's the term that's used.

The social contagion model is the term that's been applied to it, where it's a -- it's a shared belief among groups of people. You don't generally find this happening, isolated case. You will find three cases in middle school. You will find a group of women in college age who suddenly are cross-sex identifying or agender or non-gender or something like that.

Yeah, and so if you look into that you'll typically find an event of injury or something has happened. But what -- a delusion doesn't lie behind that.

And that speaks to a very important thing. The

fact that you have two completely different mechanisms at work, one onset prepubertal, one onset in adolescence, young adulthood, one associated with delusional thinking, the other one not associated with delusional thinking. How could you possibly claim that it's the same process? And how could you possibly claim that it has the same cure? It makes so sense.

And the other thing you cannot claim is that it's biological caused, because you're proposing some massive mutation in the human genome that would cause a 5,000 percent increase in this diagnosis in seven years.

Q So you -- so you would --

A Sorry.

Q It's your -- it's your belief that what you're calling early onset and late-onset gender dysphoria have different cures?

A Well, I have a hard time imagining that -- that problems with completely different origins and completely different demographics are likely to have the same cure.

Q And what do you think the cure is for early onset gender dysphoria?

A Well, historically, you get an 80-plus percent cure rate, which under any other circumstance would be considered like trip to Stockholm for the Nobel Prize

cure rate. 80 percent in a -- in a period of years, and over 90 percent, that's -- that's the cure is -- and it may get better with time. Maybe we find another therapy. But right now watchful waiting, family tear, the things we talked about.

Q And by "cure" in that context, you mean desisting from a transgender identity?

A Right. The child achieves happiness without requiring -- the child achieves that happiness that is sought for them without requiring a lifetime of medications or permanently altering surgeries. You've reached a resolution of the anxiety, a resolution of the dysphoria without subjecting the child to surgery and a lifetime of medicine. That's a win.

Q Okay. And what is the cure for late-onset gender dysphoria?

A Well, I don't think it's been studied adequately because the diagnostic category was only proposed by Lisa Littman back in 19 -- I mean, 20 -- is it 2019, 2018, somewhere around in there. I'm not sure. I'll have to check on the dates. So this is a recently recognized group, although other clinicians have reported there is a shifting demographic, especially the people looking at the sudden burgeoning of the diagnosis, they recognize that whereas in the past only

20 percent of new diagnoses were female, now greater than 60 percent were female.

Lisa Littman proposed this is a different phenomenon, rapid-onset gender dysphoria, social contagion model.

Q So you would support research into -- sorry. Strike that.

You would support research assessing potential cures of late-onset gender dysphoria?

A Right. Well, so that research would have to begin with a look into the causes of the problem, causes of the problem looking for common factors, because that would direct your research in terms of remedy.

Q Okay.

A So, I mean, a tumor is a tumor, but a tumor caused by cancer is a very different creature from a tumor caused by a blow to the leg. And so the first thing is what's caused the tumor. What caused the gender dysphoria.

Q All right. Is gender dysphoria that persists for 20 years a delusion?

A Depends on if it's the child onset one versus the adolescent and adult onset one. The likelihood of it being animated by a delusional thought -- it's not a blanket major delusion versus trivial delusion or

trivial misunderstanding. But there is some misperceived event likely in the early onset, or as I don't know in the adult onset. I don't see evidence for a delusion. And it may come to light, but I never read an article that --

Q So even if it persisted for 20 years that would not, in your mind, rise to the level of delusional thought?

A In the case of a female with rapid-onset gender dysphoria, late-onset gender dysphoria?

Q What you're calling late-onset gender dysphoria.

A Okay. That's the category. Ask me the question again, please.

Q If that persists for 20 years --

A Okay.

Q -- would that rise to the level of delusional thinking?

A No. I could see where -- I could see where a subtle habit of life and a comfort in the life chosen would be -- would have resolved the unhappiness in some measure and I wouldn't even categorize it as a dysphoria at that point because they have arrived at some reconciliation of the way they are living their life and they are at peace about their life. Problem solved.

Q But it would -- I guess I'm confused. But --

A You mean if they -- I'm sorry.

Q So but for somebody who had early onset gender dysphoria and that persists for the same length of time, that is delusional thinking.

A It's vastly more likely that there is a delusional thought that animates that that's driving a compulsive behavior. You know, that's a very high likelihood. I'm using historical, you know, what's been reported in the literature, again, going to when I was in residency.

Q And going back to the phrase "dividing the human person from our own bodies," is that a religious issue?

MS. LAND: Object to form.

A No. I consider that to be an anthropology medicine issues. I don't recall ever attending a lecture, reading a paper, reading a textbook in medicine and surgery that ever described the human person as a spirit creature that occupies a body. Never heard it. Never heard it. So I don't have to turn to my religious education. This is fundamental to what it means to be a doctor in the western world.

Q (By Mr. Ossip) But is that limited to the western world?

A Different -- different cultures have a different view of the human person. And I cannot speak to that. I can only speak to the -- to the world view that gave us science and medicine.

Q So this is a cultural view?

MS. LAND: Object to form.

A I think it's a scientifically based world. I think those two become inseparable, because it's the culture that gave rise to the science. The scientific revolution didn't happen just anywhere. It happened in a particular place at a particular time. And that happens to be the western world; in fact, you know, after the 12th century, western European world. That's where the science and the medicine that we're speaking about today came from. So what gave rise to all these wonderful medical advancements and technologies is the child of that culture.

So I wouldn't separate it from that culture, but I also wouldn't ascribe everything to that culture, because there is scientific evidence that now supports what we're doing. Now what we're doing is scientifically based, but it's animated by a culture that's willing to accept the fact that the world presents itself up to us in a predictable way, and if you come back tomorrow and make the measurement on that

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

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

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

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

sexual union has two aspects that up until the 1960s were never separated. The unitive effect. The bonding of two people together in the act of love, and it's procreative consequences.

To utterly separate all those things to where now it's -- it has -- you've destroyed even the unitive aspect, putting aside the fact that you've rendered the person sterile, you have even perverted, if not utterly destroyed the unitive aspect with such things as the effect of puberty blockade on orgasm for example or the effect of loss of sensibility following the construction of artifical vagina and the moving of the glands to the clitoris position.

You degrade the unitive of functioning in doing those things. There is no surgeon that's so good that that's going to be perfectly preserved. Some achieve very near perfection. But the lion share of people having this surgery will report a loss of sensation, in addition to their utter loss of fertility.

So what that speaks to is a willingness to do that puts a value on sexual relations that's out of proportion to its meaning. If you're willing to destroy a human function in pursuit of a sexual life that may or may not be achievable that's -- that suggests to me -- by perversion I don't mean like "you pervert."

Perversion means a distortion or a twisting. Not pervert like a legal definition. It is perverting truth.

Q And is that a medical opinion?

A That's my opinion.

Q And is that -- and part of that opinion is that is interferes with what you view as natural human reproductive capacity; correct?

A Well, that's one of its features. One of its features, yeah.

Q Is there anything wrong with assisted reproductive technology?

A I have ethical problems with it. I have personal contact with it, but I have ethical problems with it.

Q What are those ethical problems?

A The fact that the human person is turned into a commodity. That fact that it's associated with a marketing process that encourages people to believe they have a right to another person. This is rife in the world of transgender surgery because of the consultation that people undergo before their transition surgery. They are encouraged or given the option of reproductive -- what's called fertility preservation. It doesn't actually preserve fertility. It preserves

gametes for future proxy pregnancies or something like that.

So first thing is it turns the child into a commodity. The second thing is it encourages people to believe they have a right to a child.

Q And you believe a person does not have a right to a child?

A No person has a right to another person. That's the language of slavery.

Q And so someone who claims, "I have the right to have a child," is using the language of slavery?

MS. LAND: Object to form and relevance.

A I think there's skirting along that, but because they haven't given thought to what they just said. Again, the way that the fertility doctors market their services is with the idea of entitlement. And a lot of plastic surgeons do precisely the same thing. A lot of people selling all kinds of things sell entitlement to the service or entitlement to the benefit.

But it's a very different thing when you're thinking of yourself as entitled to another human person. We get comfortable with the idea of entitlement and we forget to think about the fact that we're talking about another human person. So people inadvertently

will slip into the language of slavery not knowing what they have said.

Q And so -- well, let me -- just to clarify, you do not agree that people have the right to bear children, then?

MS. LAND: Object to form.

A Okay. So they have a right not to be interfered with in doing that. So, for example, if you were like a public hygiene person in some expanded government and you came to my house and said, You are forbidden to have intimacy with your wife because there's too many people living in Little Rock, that would be an unjustice. So in that sense I have a right to that. I have a right not only to conjugal life, but to the consequences of conjugal life. That's quite a different thing from saying I have the right to do extraordinary things in order to acquire another person.

The child in the first example is a natural consequence of my right, conjugal life. Right? Natural consequence of what I am entitled to.

But I could not make the claim, you know, if my wife is childless or if we were childless to walk into a government agency and say, "I have a right to a child. Make it happen."

Q (By Mr. Ossip) So let's take another -- sorry.

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

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

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

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

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

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

record.)
Q The court reporter is handing you what I believe has been marked Exhibit 8.
A Right.
Q And from the cover, do you recognize this document?
A Sure do.
Q And have you read this document before?
A I have.
Q All right. And this is, I'll represent, an excerpt from the Courage handbook -- or the Handbook For Courage and Encourage Chaplains.
A All right.
Q If you open it up you will see there is page 81.
A I see that.
Q And do you see, it's on the second column on the right side, there's a quote that starts: Everyone, man and woman, should acknowledge and accept his, in brackets, or her, close brackets, sexual identity. Do you see that?
A I do.
Q What does that mean?
A Well, in reading that and I remember reading this, that -- that I -- that's a somewhat poorly

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

Q Okay. And then do you see where it says, Each person's moral obligation is to respond to his or her sexual identity by accepting and cooperating with the plan of God."

A I do.

Q And that means living with a gender identity that is congruent with one's biological sex.

MS. LAND: Objection; form.

A I think that's what the writers intended, yeah. That's not -- those are not my words, but I think that -- I tend to agree with you that that's probably what the writers of the catechism intended, yeah.

Q Okay. And do you agree with that?

A Let me reread it now because I will be chided for disagreeing with church teaching. (Reading)

Okay. So what that -- my understanding of that sentence is that the Catholic church views each individual person as a special creation of God that has a sexual identity and that that sexual identity is part of the order that God has designed for that person and that, you know, a person's moral duty is to be congruent with God's design for your life. So to act against God is a moral problem. And I think that's what that's saying is there is a moral obligation because it speaks to the nature of your creation, that your nature is

evidence of God's plan.

That's one of the breakthroughs in the 12th, 13th century that western civilization said that the world teaches you what God's plan is, so study -- it's the world of science -- and you will understand God. That's what -- I think that's what that sentence is saying.

Q And the moral duty in that context is to identify with and live as the gender that corresponds with one's biological sex?

A Okay. First and foremost, your moral duty is to your conscience. So the way the church teaches is your conscience is the first arbiter of your decisionmaking, but your conscience needs to be an informed conscience. So if your conscience is telling you to do something that is not in agreement with what the church is teaching, then it is your moral obligation to inform your conscience.

So you need to prayerfully examine what the church is proposing in its anthropology here and ask yourself, What am I doing wrong? And some people are never able to make that hurdle because they cannot be convinced that the -- what the church is proposing and so they live contrary to that. And sometimes their ignorance is culpable, sometimes their ignorance is

excusable.

Q But in any case, part of that moral duty, assuming your conscience is informed, is to identify and live as the gender that corresponds with your biological sex?

MS. LAND: Object to form and relevance.

Q (By Mr. Ossip) You can answer.

A To kind of sum up what this is embodied in here, what the church teaches, is that to inform your conscience with the truth gives you an obligation to the truth. It's a moral obligation to the truth.

Because in the eyes of the church and in the eyes of the faith, the truth isn't just a book full of propositions, like the DSM III. The truth is a person. And so -- and so to willfully ignore the truth is to turn your back on the person of Jesus Christ.

So that's why -- I didn't expect to have a theological conversation with people on the subject, but that's the heart of the teaching right there. You have an obligation, a moral obligation to your conscience, you have an obligation to inform your conscience with the truth, and then, having learned the truth, you have an obligation to live that truth.

Q Okay.

A Because recognizing the truth without action is

an empty -- empty thing.

Q And the truth here is biological sex?

A The nature, your nature. So that's, again, where the -- what the church teaches is that nature -- your human nature is a singularity. It's essential to the teachings of the church and it's essential, historically, to the teachings of medicine. It's that it's a singularity. Body and soul together comprise a single human nature. Human nature is not the soul lover here and the body over there. And the separation of those two, in fact, is diagnosable. It's called death.

Q So one's biological sex and, therefore, sexual identity is part of the order that God has designed for a person; correct?

MS. LAND: Objection; form, relevance, asked and answered.

A All right. So that -- that speaks to a very important point here and I'm glad you raised it. That is there are events in a person's life that will alter that ideal that you just laid out there, that under ideal circumstances perfect congruence, body and soul, sexual manifestation of sexual biology, and the gender identity of the person, the ideal circumstance.

But there are accidents of life in both arenas. You can have problems on the developmental side and you

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can have problems on the psychological developmental side that -- that lead to problems that may be insurmountable, either biologically medically or psychologically culturally. Yeah.

Q (By Mr. Ossip) But it is a problem?

A Gender incongruence is a problem.

MS. LAND: Objection.

A That's why we have a whole medical community that's devoted to resolving that problem.

Q (By Mr. Ossip) And what is gender incongruence?

A Where your perception of your sex differs from your biological sex.

Q So earlier we talked about your consultation with families with children who were experiencing gender discordance; correct?

A Right. In my pastoral role as a deacon, yeah.

Q And was that -- so that was all in your role as a deacon; right?

A Right. The couple of kids I've seen have been, again, families approaching me after mass concerned about their suffering child, can you talk to them kind of thing.

Q And was any of that part of your work with Courage?

A No. That's just my work in my parish.

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Q Okay. Doctor, you won't engage in the -- well, what gender transition procedures will you provide, Doctor?

A So are you asking -- I'm just trying to think if there is a difference in your question from the one you asked me earlier where we talked about laser hair removal.

Q So I think you said you would provide that as part of a gender transition; correct?

A Yeah, sure.

Q Any others that you would provide?

A I can't think of any. I would not do breast surgery, I would not do genital surgery.

Q And why would you not do breast surgery?

A Because I consider them morally and ethically culpable.

Q How so?

A My examination of the operations, my examination of the medical evidence, my examination of the -- my understanding of the nature of the suffering and its causes would essentially exclude me from ever offering such procedures. I have to confess to some guilt every time my transfemale comes in for facial hair removal. I have pangs of guilt that I'm offering and billing for the service, but I still go in there every

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time and talk to her and we're friends. But, yeah, I mean, I still struggle with that one, I have to confess.

Q Yeah. And -- well, I guess let's explore that. Why do you struggle with that?

A Because I never -- again, my obligations to the truth -- I'm trying to cultivate and maintain a friendship in doing it. I'm not trying to transition the person. I'm trying to keep them as a friend. And, yeah -- so, yeah, that's -- I think that's about the whole of it, yeah.

I struggle with it because you don't want to affirm somebody in a delusional thought that's contrary to the truth. And as we talked about earlier, I have a moral obligation to the truth because he's a person.

Q And this applies to patients of any age; correct?

A Right.

Q And earlier we talked about what you have called the poverty of evidence supporting these procedures; correct?

A Yeah.

Q So let's say one day reliable and valid scientific research supports gender transition procedures, would you provide the care then?

A That would be like a Copernicus moment in my

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world. I would have to step back and totally reexamination what I have learned as a physician and surgeon. I would have to -- I would have to examine the validity of the scientific claim. I would solicit the opinions of trusted professionals and let them examine the scientific evidence and together commiserate over that.

But if it's compelling evidence then I would have to reexamine my world view. I would happily do that. Not happily. I would willingly do it, but not happily.

Q Willingly reexamine your world view?

A Yeah, exactly, about how I view the human person even because it's contrary to so much of what I learned from medicine and surgery that -- and my life experience. I would have to reexamine a lot of things.

Q But what about -- so you talked about reexamining your world view. But what about providing those procedures?

A Well, so I would have to have confidence in the evidence before I would provide those procedures.

Q But let's say you did have confidence in the evidence, would you provide the procedures?

A Yeah. My practice of medicine and surgery, I like to think, has been historically scientifically

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

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

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

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

A That the human person is somehow divided and that the body has no meaning apart -- that the essential meaning of a human person is a spiritual one.

Which, if you're asking me as a Catholic deacon to expound on theology, that's a heresy, yeah. And to cause children to suffer through this ordeal when it can be avoided, if you're asking me is this a spiritual warfare, you know, I sometimes speculate publically about whether it is or not.

Q What do you mean by "spiritual warfare"?

A Things unseen at work in the world.

Q You mean the forces of the devil?

MS. LAND: Objection to the form.

A Well, that's a fairly medieval way to speak about things like that. I wouldn't have used those words.

Q (By Mr. Ossip) What words would you have used?

A That there is -- there is a spiritual, almost like a contagion that causes people to suffer and that the more people harm each other the more that is abroad in the world, yeah.

Q And so is the transgender delusion also contrary to western thought?

A Because it's a -- it's a division of the human person, their single nature into two separate and

unseparable (sic.) things by separating them, then, yes, it is contrary to the western tradition.

Q And that -- that is also your medical opinion as well, correct, Doctor?

A Because the medical opinion derives from the western tradition. All the things we've been talking about here are the product of western medicine, our understanding of the sexes, you know, the biological basis of sex is a -- is a western contribution, all of it.

Q Doctor, did you do an interview for a radio show and podcast called "Tactics Radio"?

A That's that squirrely young man in Montgomery I think. I think I might have, yeah.

Q Sounds right to me.

A He was a bit of a squirrel. I'm sorry. I shouldn't have said that publically.

Q Let's see. So we're just going to play you another recording again. This is just to confirm that this was you on the video.

MR. HOLLAND: This one has video.

MR. OSSIP: You can see him again.

MR. HOLLAND: Yeah, and the squirrely man.

(The video played.)

Q (By Mr. Ossip) And that was you on that recording?

A Yes, it was.

Q And do you stand by all that?

A I do.

MR. OSSIP: And I'll represent that this has been marked as recording B for the purposes of this deposition.

(Plaintiffs' Exhibit B was marked for identification and made a part of the record.)

MR. OSSIP: Do you want to take a break here?

THE WITNESS: I'm ready to go whenever you are. So if you need a break, take it by all means.

MR. OSSIP: All right. Let's take a five-minute break.

VIDEO OPERATOR: This will end media part 5. We are off the record at 4:24 p.m.

(A break was had.)

VIDEO OPERATOR: We are back on the record at 4:41 p.m. This will begin media part 6. Please proceed.

Q (By Mr. Ossip) Okay. Thank you. All right. Dr. Lappert, we're going to play you one more

recording right now. The question is just whether this is you speaking in the recording.

(The video was played and was later marked Plaintiffs' Exhibit D.)

Q (By Mr. Ossip) And, Dr. Lappert, what was you speaking; correct?

A Absolutely.

Q And you stand by everything you said in that?

A I certainly do, yes.

Q And that's a recording that's been marked D for the purposes of this deposition.

MS. LAND: I think you may have skipped one.

MR. OSSIP: Yeah. That's okay.

MS. LAND: Okay.

Q (By Mr. Ossip) Doctor, would you analogize transgender surgery to a medical procedure that creates a monster?

A No. Well, that's a -- that's a term I suppose -- it wouldn't surprise me if I had at one point in some flight of ideas there. But monster in the sense of a fabrication, an attempt at fabricating a human person that's not natural, I suppose.

Q So it wouldn't surprise you if you said that?

A I would not, no. Yeah, using that shelly use

of the word monster. I'm not saying that transgender persons are monsters. I'm not saying that people who suffer with transgender or gender identity or gender dysphoria are monsters. I'm saying that the process is monstrous.

Q And by the process, you mean --

A The -- the willful destruction of the natural structure of the person and the creation of counterfeits.

Q And that's gender transition procedures?

A Surgeries, yeah.

Q What about hormone replacement therapy?

A Not in the same category.

Q We're going to play another recording now. This one has been marked as E for the purposes of this deposition.

(The video played and was later marked as Plaintiff's Exhibit E.)

Q (By Mr. Ossip) Doctor, that was you speaking; correct?

A Yes. I was using my pedagogical Jewish exaggeration.

Q And, Doctor, you're not currently Jewish; correct?

A I'm more Jewish now than I ever was.

Q How so?

A Because I'm a Catholic, which is a completed Jew.

Q What do you mean by that?

A That all the promises that were made to the people of God in the Old Testament were fulfilled in the life of Jesus Christ.

Q Doctor, do you think that discussing gender identity issues sexualizes children?

A Yes.

Q Do you think it grooms them for sexual abuse by older people?

A Yes.

Q Do you recall being asked about that in your deposition for the Kadel case?

A I don't remember, no.

Q All right. So I'd like to direct you to page 462 of the transcript from Kadel.

A Oh, Kadel? I'm sorry. 462?

Q Yeah. And that's Exhibit 2 for the record.

A Okay.

Q And do you see starting on line 8, you say --

A Yes.

Q It says, Question, "And you think that discussing gender identity issues with children means

grooming them for potential later sexual abuse; right?"

Answer, "No."

A Let me see where the questions were coming from first. Give me just a moment.

Q Um-hum.

A Okay.

Q And so --

A One moment, please. I'm sorry. Right. So the questions that were being asked by Mr. Nepper looks like they were seeking a distinction between grooming that leads to further treatment versus grooming that leads to sexualization, and so I agreed with that distinction.

And then -- and then he asked the question directly, "And you think that discussing gender identity issues with children means grooming them for potential later sexual abuse; right?"

And my no answer was directed to I think the question at hand, which was the use of the word grooming in connection with leading to further treatment.

Let's see -- no, no. We're talking about here -- for future -- preparing them for these interventions. Right? It lays the groundwork whereby sexualizing their thoughts in a way that's not consummate with their best interest. Right.

Q Doctor, let's take a step back. So you were

specifically talking about -- let's see. I think you were specifically talking about your presentation to the Denver conference; correct?

A I think that's what that was about because I'm talking about a slide or something here. I didn't get a chance to review the whole thing. Let's see. Slide.

Yeah, so that's the slide he's talking -- the questions about the slides, slide 23. So I would agree that most likely from that Denver conference, which we saw was recorded. And so I think the question he was asking is grooming for preparation for future -- for future treatment events, you know, grooming -- like for example, social transitioning. It's my opinion social transitioning, a child, grooms them for puberty blockade because it encourages them to believe that -- that the manifestations of puberty is a disagreeable event.

Q Well, Doctor --

A Yeah.

Q -- so, but again the question was -- let me put it this way.

A Okay.

Q So looking at just that question alone, you would disagree with the answer being no; correct?

A As it's in Nepper?

Q Just where it stays -- well, let me ask it

another way. But you do think that discussing gender identity issues with children means grooming them for potential later sexual abuse; correct?

MS. LAND: Objection; form.

A Okay. So on 461, question 12?

Q (By Mr. Ossip) This is 462 starting on line 8.

A I'm sorry. (Reading.)

We're talking here about grooming them for future --

Q But you would agree that the answer to that question is yes; correct?

A Gosh, I'm lost now. So yes would mean that I think all grooming is oriented toward sexual abuse.

Q No. Well, all right. We can move on, Doctor. I think you have given your answer.

You discussed -- during that deposition in Kadel you also discussed that Life Site article; correct?

A I don't remember, but...

COURT REPORTER: What article?

MR. OSSIP: Life Site.

THE WITNESS: Yeah, that was Exhibit 7. I don't remember discussing it in that deposition.

VIDEO OPERATOR: Doctor, let me get you to raise your mic up.

THE WITNESS: I'm sorry.

VIDEO OPERATOR: Thanks.

THE WITNESS: Um-hum.

Q (By Mr. Ossip) Well, if you go to that article, so that's --

A Okay.

Q -- Exhibit 7 and you go to the second page.

A Okay.

Q Do you see in the middle of that page where it says, "Regarding children, Lappert said, sexualizing them at a young age with these ideas is grooming them for later abuse."

By that did you mean sexual abuse?

A No. We're talking about the abuse of medicine and surgery there.

Q And you did not mean sexual abuse when you gave that quote; correct?

A I don't think it was about sexual abuse, because that's sort of a distant effect I suppose. But, no, I think we're talking here about the abuse of transgender medicine and surgery which results in injury to the child. So, yeah.

Q All right. And you're -- earlier we talked about your interview for this article. And this interview was recorded; correct?

A The Life Site? I don't remember it, but I'm suspecting that it was recorded at some conference where I gave a presentation. Some reporter asked if they could ask me some questions. I don't remember where it was recorded, though.

Q If you look up a little bit do you see where it says, "Appearing on a recent broadcast of Relevant Radios, Trending With Timmerie"?

A Right, I do.

Q And is that the source for the quotes for this article?

A It sounds like it. I don't know if it was just the reporter listening to that broadcast and then writing this article or if she actually talked to me or interviewed me.

Q Okay. So I'm going to play you a part of that, that podcast now.

A Okay.

Q And this has been marked as recording F for the purposes of this deposition.

(The video played and was later marked Plaintiffs' Exhibit F.)

Q (By Mr. Ossip) And, Doctor, that was you on the recording; correct?

A Yes, it was.

Q And you'd agree that there you were talking about sexual abuse; correct?

A Yeah. So on the one hand we're talking about the medical and surgical abuse, the grooming process that leads to that. Both of them are originating from sexualizing children. But in this case we're talking about a different kind of abuse, in this case sexual abuse.

Any time a child's mind is turned toward sexual things and encouraged to think of themselves as a sexual creature it makes them relatively easy prey.

Q So changing topics a little bit, Doctor, have you ever had a malpractice lawsuit filed against you?

A One that was dismissed before it ever went anywhere.

Q So you never were deposed for that?

A No, no.

Q All right. And what was the topic of that lawsuit?

A The -- the woman had a breast -- I did a breast cancer reconstruction on her. This is in Scotts Bluff, Nebraska. And she had I think it was an anesthetic complication. And I was named in that suit just because I was the surgeon. And ultimately she dropped the suit because there was no evidence that she was mistreated.

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

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

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

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

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remedy to their difficulties.
Q And do you frequently have pastoral visits with your surgical patients?
A I can't tell you how many times I've talked people out of cosmetic surgery. Talk women out of breast augmentations all the time. Talk men out of facial surgery all the time, yeah.
Q And what's the nature -- well, how do you talk them out of it?
A Well, it kind of depends on the strength and the understanding that the person brings to the visit. Very often I recognize that I don't have enough of a friendly relationship with the person to where they would take such advice. So I'm not free to offer advice under those circumstances, but sometimes it's as simple as saying that I don't have the skills they are looking for.
Q And is that true?
A Largely. I suppose the fact that I haven't done a whole training program on penile inversion vaginoplasty, I've never been trained in that. So I would -- I would honestly say no, I'm not capable of that surgery. Or somebody who is seeking some radical change to their face, I don't do radical face surgeries other than reconstructions. So I would be perfectly

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truthful in saying "I don't have the skills to do what you're asking."
Q Okay. So why do you call those pastoral visits?
A Because I'm seeking to establish an emotional bond with the patient and try to understand what their sorrow is, what the origin of their sorrow is, what's going on in their life.
Can I give you an example? Woman comes to me seeking a breast augmentation, very common presentation. The examination would support doing a breast augmentation. But in getting into the reason for her visit, suddenly she's talking to me about how her husband is ignoring her, her husband doesn't have any interest in her. "If I have a breast augmentation it will save my marriage."
For me to affirm her in the idea that a breast augmentation is going to save her marriage would be an injustice, so I talk her out of it.
Q Do you ever incorporate religious content into this?
A I don't have to.
Q Do you ever?
A Sometimes I do with people I know from my parish who have problems like this and are happy to

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speak to me using the language of religion. But I generally don't run my practice using the language of religion, nor do I give opinions, medical opinions based on my religion. It's a separate thing.
Q So earlier we talked about Courage. I just want to go back to that one more time.
A Sure.
Q Does Courage provide any services -- well, strike that.
What is Courage's approach to individuals with gender discordance?
MS. LAND: Objection; asked and answered.
A So --
MS. LAND: And form.
A The only thing that would speak to that would be what you -- what you read earlier out of the Courage handbook is the recognition that there's an underlying reality. But Courage doesn't offer any interventions, nor any referrals, nor anything else, persons with transgender or gender identity issues or gender dysphoria.
Q (By Mr. Ossip) Does Courage have members experiencing gender identity issues?
A Let's see. I'm trying to think through everybody I know in Courage. It's such a huge group.

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No. It's almost entirely -- well, okay.
So Encourage does. Family members of persons experiencing gender dysphoria, the Encourage side does. But generally speaking people who are in the world of transitioning have no interest whatsoever in what Courage has to offer.
Q Okay.
A And we don't go seeking them or drag them off to some conversion. It's strictly supporting the family members who are struggling with it.
Q So earlier we talked about the presentation that you give on I believe it is transgenderism and Christian anthropology; is that correct?
A Correct.
Q And you mentioned you gave that about 40 to 50 times?
A I'm just ball -- I'm just guessing, you know.
Q Yeah.
A Virtually exclusively to church groups.
Q And in that presentation you talk about the medical issues related to gender transition treatments; correct?
A That's right.
Q Including those for minors?
A Yeah. So the discussion we have about minors,

I -- you know, that sort of varies from one talk to another. The surgeries for minors is usually a discussion of top surgery, which is pretty much limited to a very small group of people. The majority of transgender stuff done with children is medical.

Q But your -- but that presentation goes beyond surgery; correct?

A Right. We discuss everything. Social transition, medical transition, and surgical transition in adults primarily. I discuss the range of surgeries that are offered to adults who are having affirmation care, affirmation surgery. So I get into the details of that because I find that the public has a great misunderstanding about what plastic surgeons are capable of, so I want the audience to understand what's actually happening and being presented as an actual sex change, which turns out to be typically a counterfeit front with complications.

Q You also discuss religious content in presentation; correct?

A To religious groups I do. Yes, I do.

Q So it's a mix of both; correct?

MS. LAND: Object to form.

A My presentations are a mix of both?

Q (By Mr. Ossip) Yeah.

A Yeah. I would say the lion share of my presentations are to church groups, the only ones that have shown interest.

Q Okay.

A I haven't been invited by the American Society of Plastic Surgery to give a presentation on the moral problems of transgender surgery.

Q Were any other --

A Probably not going to happen, though. I have not.

Q And no other medical organization; correct?

A I'm trying to remember. Christian Medical and Dental Association. No, I haven't presented to them either, no.

Q Okay. Have you ever tried to help someone with gender dysphoria become comfortable with their biological sex?

A In terms of a therapeutic relationship with them.

Q In any way?

A Well, so for the example we have of the children, the one or two children that I have talked to in the parish library, it's been more -- and none of it has resolved by the way -- it's been more a conversation about seeking the origin of their anxiety.

So, for example, in the one child that first comes to mind, she's undergoing a lot of anxiety over the fact that her father is sort of out of the picture because he devotes all of his time to taking care of her special needs sister. And it's possible that she's misinterpreting family dynamics there and thinking that her father is ignoring her because of her appearance. I don't know.

But that's an example of what I do. I don't try to change anybody's sexual identity. I try to understand what is the cause of their dysphoria.

Q And so it's only been one or two children that you have spoken to about this?

A Again, that's sort of a running total, but right now there is one or two, yeah.

Q How many total children with gender dysphoria have you spoken to in your lifetime?

A In my capacity as a doctor or in my capacity as a deacon?

Q In both.

A Well, as a doctor, maybe one or two. I don't know.

Q And that's in both capacities?

A No. In the deacon arena children, you know, the late-onset gender dysphoria thing, there's been

three or four girls in the last two years alone, yeah.

Q Any other people you have spoken to in your capacity as a deacon?

A I don't think so.

Q And how many times did you meet with each of these people in your capacity as a deacon?

A Well, let's see. One of them I have met with three times. One of them I only got to meet one time. One of them maybe twice, three times maybe.

Q Okay. All right. So just changing topics a little bit again, have you ever been subject to any kind of professional discipline?

A No.

Q Nothing about a state medical board?

A Never.

Q No professional society?

A Never.

Q What about military discipline?

A Never.

Q No administrative actions?

A Never.

Q Summary proceedings?

A Never.

Q Okay. So you mentioned a couple instances of testimony. Have you ever been in court for any other

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

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

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

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

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

A It may have been something Walter Heyer may have written. It's been a while since that visit. That was over a year-and-a-half ago.
Q And was that all to the parents?
A Right.
Q You never provided any articles to the children?
A No.
Q Didn't refer them to any websites?
A No.
Q Looking to the children, did you -- during your conversations did you ever discuss Catholic teaching about gender transition?
A No.
Q What about with the parents?
A So the discussion with the parents may have been more difficult because they are a Spanish speaking family. The child speaks perfect English. The parents struggle with it and I would have a very hard time making any such conversation in Spanish.
Q Well, my question was with the parents did you discuss Catholic teaching about gender transition?
A I don't think so.
Q And you mentioned they were Spanish speaking. That applies to all three of the children we are

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

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

they can trust.
Q And what opinion is it that you hope they will value?
A That I value them as a person and that I don't reject them as a person and that they may one day ask themselves, Why do I believe what I believe?
Q And what is it that you believe?
A I believe that the human person is a singular nature. I believe that we are binary in our construction, that that binary is ordered towards a unity that is a life giving unity and that informs my life as a physician and as a deacon.
Q And the reason why you're hoping that they ask themselves why you believe what you believe is because you hope that they will adopt that belief too; correct?
MS. LAND: Object to form, relevance.
A Well, I mean, I would -- I would love it if they did because I think that's where human happiness lies. But I also want them to trust me as a friend because what's very common and very likely in the -- in the life arc of persons who have this difficulty is you have a nearly 50/50 chance of experiencing some very dark time in their life when the transition is over and no one is interested any longer and they are alone and sorrowing, I don't want them to feel alone. I don't

want them to feel as if there is nothing further to be done, I don't want them to kill themselves.
Q (By Mr. Ossip) So you mentioned going back to the parents of children that you had conversations with in your capacity as a deacon. You mentioned helping them find, was it a psychiatrist for their child?
A Psychological counselor. Usually children who are having these experiences are better served by family counseling. And so one of the things that's probably most necessary in a child having that experience -- and, I mean, the girl we were speaking about earlier, it's written all over her dynamic is there is a real conflict between her and her father and the way the mother mediates in that whole issue and how it alienates her daughter.
So for example her, I suggested some family counseling I think I found them a family counselor in Huntsville. But yeah, that's how it sits right now.
Q And how did you find that family counselor?
A I did a Google search looking for family counselors that would be convenient, who spoke Spanish. Because they need to be Spanish speakers to take care of that family.
Q Any other qualifications in that search?
A I generally will look for counselors that

don't -- well, what was my search criteria there? In the family counseling side that's pretty much it. That's pretty much it. If they are a legitimate and qualified family counselor who can speak, and their kid is Spanish, that was enough for me.
Q And what makes them legitimate or qualified?
A Well, they have got the credentials of counseling, licensed social worker, counselor, family counselor. I don't fully understand the credentialing process on the counseling side of things. But I would hope that people who advertise themselves as family counselors are qualified to do this.
Q So you're just looking for whether they advertise themselves as a family counselor?
A Yeah. I don't remember exactly what I saw on that particular website, but my guess is there must have been some credential thing that they present. Most providers put their credentials on it.
Q Okay. And you mentioned three families. Did you assist all three of them in finding a family counselor?
A Well, so one of them was beyond family counseling because in this circumstance it was a young man who was at the very early stages of beginning a social transition and had not had any contact yet with

any medical providers, but was absolutely resolute that this was the right thing to do. And that was kind of a heartbreaking visit.
He was even -- you know, that was -- so there was nothing I could offer, because there is nothing you can offer to somebody who is not interested in what you're offering. And he's beyond family counseling because he is already ignoring his parents and not in -- under their purview, no longer living at home. Basically, I think he was in his first semester of college.
Q So this was not a minor then?
A Seventeen years old. Seventeen, maybe going on 18, but 17.
Q And was in college?
A Just going off to college or might have been down there for a semester. It was one of those. A kid I recognized from around the parish.
Q And this 17-year-old began a social transition?
A Yeah, he was, he was. In his manner and his clothing and I think he had -- wore makeup, he wore a sort of a blousy-looking shirt. You can still call it a shirt, but it looked kind of blousy. I think he was wearing fingernails, wearing some facial makeup and definitely crafting his mannerisms to present himself as

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

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

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

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

Q And why did you caution?
A Because I'm concerned about what's going to happen to his body if he takes high-dose sex steroids.
Q Because you didn't want him to take them?
MS. LAND: Object to form.
A Right, for medical reasons. Not, per se, for the transgender transition, but the fact -- basically cautioning him -- giving him the side of the conversation that he probably wasn't hearing, which is the consequences of high-dose sex steroids. I think he hadn't heard that. He seemed to be surprised in hearing it, but I don't think it had any effect.
Q So you mention going back or taking a step back, you mentioned a variety of discussions with children and families from your parish about gender dysphoria; correct?
A Right.
Q How many of those were at the church and how many were in your physician's office?
A The only one was in my physician's office was the one we just discussed.
Q All the rest were in the library?
A I'm pretty sure, yeah.
Q Okay.
A And all of those were basically deacon Lappert

talking to parishioner child.
Q But the one in your office was Dr. Lappert.
A As I recall she specifically had approached me as Dr. Lappert.
Q And was that --
A I think that's the reason I asked to meet them at the office, because --
Q Was that consultation within the scope of your experience as a plastic surgeon?
A No. I was there just because of my knowledge of the subject and the parents just wanted me to talk. It was not a plastic surgical consultation. It wasn't a transitioning consultation. It was a visit with the hope of that child hearing some of the -- some of the difficulties he's going to encounter if he embarks on transitioning. So I --
Q Well, I mean, you said it was a medical visit; correct?
A That's what we talked about. That's all I had the chance to talk about.
Q And what type of medical visit was it?
A Just general visit to a doctor who knows about transgender medicine.
Q And you -- sorry. Go ahead, Doctor.
A No. Go ahead.

Q And you consider yourself a doctor who knows about transgender medicine?
A I spend a lot of time studying and reading on it, yes, I have.
Q And that was since 2014; correct?
A Right.
Q And you feel qualified to provide care to patients seeking transgender medicine?
A No. But I -- I consider myself adequately qualified sort of at the primary care level to discuss medical risks with a family and a patient in the same way that I would discuss, you know, the risk of malignancy in a woman who has a family history of breast cancer. I'm not an oncologist, but I know enough about it that if I have concerns I can refer them to somebody I might trust.
So it's sort of at the primary care level, and that's kind of what that visit was. It was, sadly, not a very effective visit.
Q So that was a primary care visit; correct?
A Right, yeah, simple visit.
Q How many primary care visits do you typically do in a year?
A I do quite a few of them actually, because I run a skin care consultation service and I provide skin

care services. And people will present with odd little things they don't know what to make of them. And, yeah, I've got quite an extensive experience in dermatology and I can read the difference between a malignancy and mole and a harbinger of some visceral disease.
So I'm an easy visit to somebody they know. And if I say, you need to see an endocrinologist, you need to see a dermatologist, you need to see somebody else I will make the referral for them.
Q And how many of those primary care visits involve patients presenting who are seeking gender transition?
A Some number approaching zero probably. I mean, these are just the patients we've talked about here. I don't have a practice in offering advice to transgender -- or gender dysphoric patients. I don't advertise it as a service. I don't present myself as an expert in that regard. I do express myself as a physician who has knowledge of the subject who can offer some guidance on it, but that's about the extent of it.
Q And you felt qualified to, in a medical capacity, have that visit with that patient; is that correct?
A Absolutely.
Q Do you consider that child a patient?

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

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

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

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

"Transgenderism, a Surgeon's Perspective"?
A So that's not a podcast. That's a Light House Media CD. So, yes.
Q But it's a talk; correct?
A Correct.
Q Okay. I'm just gonna -- we're gonna play a minute of this. This has been marked as C, recording C for the purposes of this deposition.
(Audio recording was played and later marked as Plaintiffs' Exhibit C.)
MR. OSSIP: And that's your voice in this recording; correct, Doctor?
A Yes, it is.
Q And that's that Light House talk; is that correct?
A I believe that's correct, yeah.
Q All right. Doctor, do you have -- well, you have religious beliefs concerning gender transition. Is that fair to say?
A Yes, I do.
Q And what are those beliefs?
A That the human person is a single nature, that the mutilation of genitalia or otherwise bodily mutilation is a -- is a, from the religious perspective, is a sin against your bodily integrity. That pretty

much would cover transgender.
Q And when does something rise to the level of mutilation?
A Well, so the intentional destruction of a structure like the breasts I would put in the category of mutilation. The intentional destruction of the native genitalia I would put in the category of mutilation. But the church considers mutilation including things like the division of the vas deferens in a vasectomy, are the tying of the fallopian tubes the church considers to be a mutilation.
Q What about facial feminization surgery?
A I don't believe anybody would consider that a mutilation.
Q Why not?
A Because you're not destroying function. You're just changing aesthetic contours. It's not a functional surgery. But the others are problematic because they destroy a function.
Q And do you think that -- that such a mutilation is a sin?
MS. LAND: Object to form and relevance.
A All right. So, again, I always make the distinction, I don't present the sin side of things when I'm talking about medical issues. But when religious

issues come in, I do. When I offer an expert opinion like the one I've offered here I don't bring my religion into it. But in terms as a Catholic do I think that mutilation is a sin, yes.
MR. OSSIP: Sorry, just give me one second, Doctor. I apologize.
Sorry. Can we go off the record for one second?
VIDEO OPERATOR: Off the record at 6:06 p.m.
(A pause was had.)
VIDEO OPERATOR: We're back on the record at 6:07 p.m. Please proceed.
Q (By Mr. Ossip) Doctor, is it your view that performing gender transition procedures is against Catholic truth about the nature of a person?
MS. LAND: Object to form and relevance.
A Do I believe that gender transition procedures, surgeries are against -- I'm sorry.
Q (By Mr. Ossip) Yeah. Is it your view that performing gender transition procedures is against Catholic truth about the nature of a person?
A Yes.
Q Okay. In what way?
A Because it ignores the reality of the single

nature of the human person.
Q And again, that reality of the single nature of a human person, that's not limited to Catholic teaching; correct?
A No. That's natural law. So the thing to understand about Catholic teaching when you're talking about these issues is that the foundation of all of it is natural law and that the -- the Catholic truth is basically just a -- the story of its perfection in eternity basically.
So you have to -- you have to understand and accept the nature of the human person if you're going to propose that that nature is going to be perfected by the grace of God. That's why it's an important issue in the Catholic church.
Q And what you're describing is natural law is also a predicate to the practice of medicine in our view?
A Very important predicate, exactly. Because if you get the natural truths, everything from body temperature to heart rate wrong, you're not going to treat them correctly.
Q And how does one determine natural law?
A Well, it's evident. One studies nature. So you study the nature of the human person and it includes

things like taking their pulse and taking their temperature and doing all those things that medicine has been involved in for the last thousand years and you come to an understanding of it, just as -- and that understanding changes with time.

Particularly in the area of reproduction, it's changed a lot in the last 100 years. But, yeah, you -- it's the study of the nature of the human person. That's what science is about, the study of nature, philosophy of nature, the philosophical sciences.

Q Well, is natural law a predicate to science or is science a predicate to natural law?

MS. LAND: Object to form.

A I'm not sure I understand what you mean by predicate.

Q (By Mr. Ossip) Well, do you use science to determine natural law or does natural law determine the course of science?

A You use the scientific method to study natural law, but the scientific method itself is based on the idea of natural law, because that revolution that happened in the 12th and 13th century was the recognition of the fact that what you measure today will be the same tomorrow and that you can come to understand things because of their repeatability, their constancy.

Which in the -- in the Catholic world view is speaking to the unchanging nature of God. Right? No shadow of turning in him.

So -- so that was the foundation of science. So science is based on the study of the natural world. And the recognition of the scientific method begins with recognizing that the natural world is regular, orderly, logical, repeatable, all of those things. So it's a both/and I think is the more correct way to look at that philosophically.

Q And that there is unchangeable truths?

A There are unchanging truths, yeah.

Q And that includes biological sex?

A Yes.

Q And that includes gender?

A No. Gender seems to be a very fluid thing because the subjective life of a person is a very fluid thing. Gender is in the category of the person's subjectivity. And the real Christian story is the subjectivity of the human person is where all the trouble comes from. Right, yeah.

So, yeah, the unchanging things, obviously in the absence of disease or harm or things like that, then changing things are the observable, the measurable, those sorts of things. And diagnoses that lead to

surgery and medical care rely on that, obviously, very heavily.

And so the natural law, for example, spills over into the truth, the -- actually, the scientific objective truths of the human body and how the body responds to influences of medications and hormones and trauma and all those other things.

Q And -- okay. I think -- I'm just going to check my notes. Give me one second, Doctor.

A Sure.

Q Let me ask one more actually.

Doctor, are you familiar with something called the GRADE approach?

A The what approach?

Q The -- well, are you familiar with Grading of Recommendations, Assessment, Development and Evaluation?

A Oh, I see. That's a -- I've never heard those terms. I used SOAP approach when I was learning diagnostic and evaluation or the HPI approach. But I -- is that GRADE approach, is that a psychiatric process?

Q I'm just asking, are you familiar with the GRADE approach?

A I've never heard it.

MR. OSSIP: Okay. All right. I think that's all I have. Thank you, Doctor, for your time and

for hanging out with us today.

THE WITNESS: Sure.

MR. OSSIP: And with that I'll pass the witness.

EXAMINATION

BY MS. LAND:

Q Dr. Lappert, did any of the questions asked by Mr. Ossip change your opinions that you have previously given in this case?

A No.

Q A lot has been asked of you of your religious views today. Are any of the opinions that you gave as an expert in this case based upon any of the religious views you have testified to today?

A No.

MR. OSSIP: Objection to form.

A No. My expert opinion and my testimony today is informed by my knowledge of the science and my experience as a physician-surgeon.

Q (By Ms. Land) Were any of the recordings played for you today, specifically recordings, A, B, D, E, F and C, in which you heard yourself speaking given in your capacity as a medical doctor?

A They were given in my capacity as deacon and surgeon together, yes, so.

Q Were you giving any of those recordings -- or excuse me.

Were you speaking in any of those recordings in your capacity of giving consultation to any patients?

A No.

MR. OSSIP: Objection to form.

MS. LAND: No further questions.

MR. OSSIP: Can you give us one minute, please?

VIDEO OPERATOR: You want to go off the record?

MR. OSSIP: Yeah.

VIDEO OPERATOR: Okay. We're off the record at 6:16 p.m.

(A pause was had.)

VIDEO OPERATOR: We're back on the record at 6:16 p.m. Please proceed.

MR. OSSIP: All right, Doctor. I just want to once again, thank you for your time with us and I have no more questions for you.

THE WITNESS: Thank you.

VIDEO OPERATOR: Okay. This concludes today's testimony given by Dr. Patrick Lappert. The total number of media used was six, which will be retained by Veritext. And we are going off the record

at 6:16 p.m.

(A discussion was had off the record.)

MS. LAND: Okay. I would just like us to go on the record on behalf of Dr. Lappert and say that we would like to review and sign.

(Deposition concluded.)

C E R T I F I C A T E

I, Trena K. Bloye, Certified Shorthand Reporter within and for the state of Oklahoma, certify that PATRICK WALTER LAPPERT, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, in the case aforesaid; that the witness chooses to read and sign the deposition; that the above and foregoing videotaped deposition was taken by me in shorthand and thereafter transcribed; that the same was taken on May 6, 2022, at 9:04 a.m., at the Arkansas Attorney General's Office, 323 Center Street, Suite 200, Little Rock, Arkansas, that I am not an attorney for, nor a relative of any of said parties or otherwise interested in the event of said action.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal this 18th day of May, 2022.

Trena K. Bloye, CSR
State of Oklahoma CSR No. 1522

AMANDA LAND, ESQ.
aland@arkansasag.gov

May 20, 2022

RE: BRANDT, et al. vs. RUTLEDGE, et al.
5/6/2022, Patrick W. Lappert (#5163564)

The above-referenced transcript is available for review.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason, on the attached Errata Sheet.

The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at erratas-cs@veritext.com.

Return completed errata within 30 days from receipt of testimony.

If the witness fails to do so within the time allotted, the transcript may be used as if signed.

Yours,
Veritext Legal Solutions

BRANDT, et al. vs. RUTLEDGE, et al.
5/6/2022 - Patrick W. Lappert (#5163564)

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Patrick W. Lappert Date

BRANDT, et al. vs. RUTLEDGE, et al.
5/6/2022 - Patrick W. Lappert (#5163564)

ACKNOWLEDGEMENT OF DEPONENT

I, Patrick W. Lappert, do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

_____ _____
Patrick W. Lappert Date
*If notary is required

SUBSCRIBED AND SWORN TO BEFORE ME THIS
_____ DAY OF _____, 20___.

_____
NOTARY PUBLIC

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.

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