

EXHIBIT A

Declaration of Omar Gonzalez-Pagan in support of
Motion to Exclude Expert Testimony of Dr. Paul W. Hruz
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)

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

MAXWELL KADEL, et al.)	
)	
Plaintiffs)	
)	Cause No.
vs.)	1:19-cv-00272-
)	LCB-LPA
DALE FOLWELL, et al.)	
)	
Defendants)	

VIDEO ZOOM DEPOSITION OF DR. PAUL W. HRUZ

Taken on behalf of the Plaintiffs

September 29, 2021

Sheryl A. Pautler, RPR,

MO-CCR 871, IL-CSR 084-004585

(The proceedings began at 9:31 a.m. Eastern.)

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DALE FOLWELL, et al.)	
)	
Defendants)	

VIDEO ZOOM DEPOSITION OF WITNESS, DR. PAUL W. HRUZ, produced, sworn, and examined on the 29th day of September, 2021, between the hours of nine o'clock in the forenoon and eight o'clock in the afternoon of that day, via Veritext Zoom, before SHERYL A. PAUTLER, RPR, Certified Shorthand Reporter within and for the State of Illinois and Certified Court Reporter within and for the State of Missouri, in a certain cause now pending before the United States District Court for the Middle District of North Carolina, wherein MAXWELL KADEL, et al. are the Plaintiffs, and DALE FOLWELL, et al. are the Defendants.

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1 Q. Okay. What is a wet lab?

2 A. A wet lab is really designating somebody
3 that does hands-on research usually with either
4 in-vitro or in-vivo studies, as opposed to a dry lab
5 which mostly does literature searches or computer
6 programming or things that do not involve
7 experimentation with -- the reason the term comes,
8 from wet reagents like buffers and solutions and
9 bodily fluids.

10 Q. Is your research primarily conducted in a
11 wet lab?

12 A. My -- until recently the vast majority of
13 my research has been conducted in a wet lab. I have
14 participated on a few occasions in clinical trials
15 and have served as an adviser and consultant for
16 colleagues in those types of studies.

17 Q. On how many occasions have you
18 participated in clinical trials?

19 A. I never direct -- well, there was one
20 trial at Washington University where I was more
21 directly involved. But all of -- as far as
22 principal investigator, all of my NIH funded
23 research and service as a principal investigator has
24 been done with my basic science research.

25 Q. Would you agree that clinical trials is

1 not your area of expertise?

2 MR. KNEPPER: Objection, form.

3 A. I would not agree with that statement. I
4 would say that I -- in the course of the last decade
5 that -- as I've been required to investigate the
6 literature surrounding this particular issue of
7 treatment of gender dysphoria, I have developed
8 considerable expertise in clinical trials. And I
9 also have previously served on institutional review
10 boards. I did that while I was a medical student,
11 where I reviewed the ethics of clinical trials
12 and -- and in other ways as well. So I would say
13 that covers my -- is included in my expertise as a
14 physician scientist.

15 Q. (By Mr. Gonzalez-Pagan) Earlier you stated
16 that the testimony you provided in the Bruce
17 deposition was truthful; is that right?

18 A. To the best of my knowledge.

19 Q. In the Bruce deposition, you were asked:
20 So clinical trials is in your area of expertise?

21 And you answered: That is correct.

22 MR. KNEPPER: Objection, form.

23 A. Can you please read that statement again?
24 And it might even be helpful if we went to the area
25 of that deposition so I can see the entire context.

1 But for now maybe you can just reread that just so I
2 understand what that statement said.

3 Q. (By Mr. Gonzalez-Pagan) Well, let's -- my
4 computer is not going to survive today. I
5 apologize. It's on Page 39 of Exhibit 3.

6 A. Is there an easy way to navigate directly
7 to a page without just scrolling down?

8 Q. Unfortunately I don't believe so. It's
9 limitation of the medium. I apologize for that.

10 MR. KNEPPER: I will confirm that. Yeah.
11 I haven't found one either.

12 A. Okay. So which line are you -- I'm on
13 Page 39 right now.

14 Q. (By Mr. Gonzalez-Pagan) All right. So on
15 line -- beginning on Line 23.

16 A. Okay.

17 Q. It says, Question: I see. So clinical
18 trials isn't your area of expertise?

19 Answer: That is correct.

20 Did I read that correctly?

21 A. Well, if you read the preceding lines, it
22 immediately followed a question about my direct
23 participation in clinical trials where I clearly
24 stated that there was only one clinical trial. That
25 was the one I just mentioned to you at Washington

1 University. And similar to what I had in this
2 deposition, my role in that project was relatively
3 minor.

4 So in that sense, that does not mean
5 that I do not have knowledge and experience in the
6 context of clinical trials. It only means I have
7 not directly participated in those clinical trials.
8 Context is important.

9 Q. What is primary research?

10 A. I'm sorry. Primary research?

11 Q. Yeah.

12 A. Oh, so you're -- you're talking about the
13 difference between conducting experimental --
14 directly conducting experiments versus systematic
15 reviews and literature reviews of that nature. Is
16 that the distinction you're trying to get at?

17 Q. Is that what you understand the
18 distinction between primary and secondary research
19 to be?

20 MR. KNEPPER: Objection, form.

21 A. That would be one definition that I would
22 agree with, yes.

23 Q. (By Mr. Gonzalez-Pagan) Okay. Would it be
24 okay if I were to adopt that definition, that
25 primary research refers to conducting experiments --

1 experiments, etc. and not literature review or
2 metanalysis of existing data?

3 A. For the purposes of this deposition, yes,
4 that is fine.

5 Q. With that understanding, have you
6 conducted any primary research relating to gender
7 dysphoria?

8 MR. KNEPPER: Objection, form.

9 A. So if you're asking whether I have
10 directly participated in clinical trials on gender
11 dysphoria, the answer is no.

12 Q. (By Mr. Gonzalez-Pagan) Have you
13 participated in cross-sectional studies related to
14 gender dysphoria?

15 A. Again, I have not -- cross-sectional
16 studies, you're meaning retrospective reviews?

17 Q. It could be longitudinal observational.
18 It could be cohort studies. I guess my question
19 is -- let me back up. Have you conducted any direct
20 research relating to gender dysphoria that is not
21 based on a literature review?

22 MR. KNEPPER: Objection, form.

23 A. It would depend on what your definition of
24 conduct. I have not physically myself done those
25 chart reviews or participated in the clinical

1 setting. My experience to what you had described as
2 primary research is limited to my role as associate
3 or assistant fellowship program director in
4 supervising my fellows, two of whom are doing what
5 we would -- what you would define as primary
6 research.

7 I'm not the primary investigator, but
8 I do have a role in directing my fellows in doing
9 that research to make sure it's of the highest
10 quality and standards that we expect of all of our
11 fellows.

12 Q. (By Mr. Gonzalez-Pagan) When did you
13 resume supervision of the fellowship program?

14 A. The official designation has happened
15 since the time I filed my initial curriculum vitae.
16 However, I have continually throughout my career
17 been involved in the fellowship program.

18 One of the reasons I was reappointed
19 as the assistant program director was that it was
20 recognized that the area of scholarly research
21 needed somebody with my background to be able to
22 help the fellows to be able to select projects,
23 select mentors and conduct research in the most
24 rigorous manner. And that was a shortcoming that
25 had developed since I had formally stepped away from

1 A. Okay.

2 Q. Well, actually, let me -- let me check.
3 We've been going about an hour. Would you like to
4 take a break right now or I can do this line of
5 questioning? And we can --

6 A. I'm actually doing quite well. I'd be
7 fine to keep pressing on.

8 MR. GONZALEZ-PAGAN: Sheryl, is that okay?

9 THE COURT REPORTER: That's fine.

10 Q. (By Mr. Gonzalez-Pagan) Okay. So if we go
11 to the list of publications in your CV. Are you
12 with me?

13 A. I am.

14 Q. In the category of journal articles,
15 No. 48 is titled Deficiencies in Scientific Evidence
16 for Medical Management of Gender Dysphoria. Did I
17 read that correctly?

18 A. Yes. And I do see it here.

19 Q. Is that one of your publications relating
20 to gender dysphoria?

21 A. Yes, it is. And it's probably one of the
22 most highly cited of the papers that I provided.

23 Q. Sure. Is that a publication based on any
24 primary research that you conducted?

25 MR. KNEPPER: Objection, form.

1 A. As which have defined it, no. It's a
2 review of the literature and critical appraisal of
3 the evidence.

4 Q. (By Mr. Gonzalez-Pagan) And that
5 publication is -- that -- sorry. That -- that
6 article was published in the Linacre Quarterly; is
7 that right?

8 A. That is correct.

9 Q. Is the Linacre Quarterly a scientific
10 publication?

11 A. It is an ethics journal. In fact, it's
12 the longest standing continuously published ethics
13 journal in the United States.

14 Q. Who publishes the Linacre Quarterly?

15 A. The NCBC.

16 Q. What does the NCBC stand for?

17 A. The National Catholic Bioethics Center.

18 Q. Turn to 50. Is this one of the other
19 publications you have relating to gender dysphoria?

20 A. It's a letter to the editor.

21 Q. So it's not -- this is not a publication
22 based on any primary research or scientific study
23 you have conducted?

24 MR. KNEPPER: Objection, form.

25 A. As we have defined primary research, it is

1 merely a presentation of -- of concerns about the
2 literature that has already been published.

3 Q. (By Mr. Gonzalez-Pagan) And as I
4 understand this letter to the editor is a commentary
5 on another publication, on another article; is that
6 right?

7 MR. KNEPPER: Objection, form.

8 A. It includes more information than just the
9 article itself. But, yes.

10 Q. (By Mr. Gonzalez-Pagan) And just pure
11 curiosity, I don't know the answer to this, but are
12 letters to the editor peer reviewed?

13 A. This particular one was. I recall when we
14 were submitting this, that we were asked to make
15 changes. And I interpret that as being peer
16 reviewed.

17 Q. Well, I just want to clarify. There's
18 peer review and then there's editorial review; is
19 that right?

20 MR. KNEPPER: Objection, form.

21 A. There are numbers of different types of
22 review; that's correct.

23 Q. (By Mr. Gonzalez-Pagan) Okay. As I
24 understand peer review to mean, it is a process of
25 objecting and circulating an author's work to the

1 scrutiny of others who are experts in the same
2 field; is that right?

3 MR. KNEPPER: Objection.

4 A. That's how it's generally defined yes.

5 Q. Are you saying that the letter to the
6 editor was circulated to experts in the field before
7 it was published?

8 A. I don't know the details of how the letter
9 was handled. I only can say that when we submitted
10 it, we were asked to make revisions. It was
11 reviewed by individuals with understanding of the
12 area that was covered. I don't know any more
13 details. And that's the way generally peer review
14 occurs. One is not usually told who actually
15 reviews the submission.

16 Q. The next publication, it's -- it's No. 2
17 under book chapter. It's titled Medical Approaches
18 to Alleviating Gender Dysphoria. And it's a chapter
19 in the book Transgender Issues in Catholic
20 Healthcare; is that right?

21 A. That is correct.

22 Q. Who publishes the book, Transgender Issues
23 in Catholic Healthcare?

24 A. That was also the NCBC.

25 Q. Is the book a peer-reviewed publication?

1 A. No.

2 Q. Going to the next page, there's a list of
3 invited publications; is that right?

4 A. Yes.

5 Q. No. 6 is your article titled Growing
6 Pains, Problems With Pubertal Supression in Treating
7 Gender Dysphoria.

8 Did I read that correctly?

9 A. Yes, you did read it correctly.

10 Q. Is this a peer-reviewed publication?

11 A. It is not peer reviewed. It was
12 editorially reviewed.

13 Q. The growing pains article was published in
14 the New Atlantis; is that right?

15 A. That is correct.

16 Q. Is the New Atlantis a scientific journal?

17 A. It is not considered a scientific journal
18 in the definition that we normally designate it. It
19 was -- it's a journal that provides more broad
20 readership to be able to distill topics of relevance
21 at an understandable level to the lay public.

22 Q. At the time of the publication of the
23 article, who published the New Atlantis?

24 A. Well, the New Atlantis.

25 Q. Was the new Atlantis a publication of the

1 ethics and public policy center?

2 MR. KNEPPER: Objection, form.

3 A. I believe that may be true. I didn't pay
4 much attention to that.

5 Q. (By Mr. Gonzalez-Pagan) Let's turn to
6 Exhibit No. 3, Page 44 -- sorry -- Page 46.

7 A. I went too far.

8 Q. You know what, it could probably be me.
9 It's a few later. It's Page 49. I do apologize.
10 Page 49.

11 A. I'm still scrolling, so. Okay. I'm
12 there.

13 Q. Okay. Beginning on Line 13, it reads;
14 Question: Okay. And the New Atlantis was founded
15 by the Ethics and Public Policy Center; is that
16 right?

17 Answer: I believe that that is
18 correct.

19 Question: Okay. And that's a center
20 dedicated to applying the Judeo-Christian moral
21 tradition to critical issues of public policy; is
22 that your understanding?

23 Answer: I believe that question came
24 up at the last deposition. And I believe that
25 that's an accurate statement.

1 Did I read that correctly?

2 A. You did read it correctly, yes.

3 Q. And you stand by that testimony?

4 A. Yes. I have no reason -- it's not
5 something that I consider all that important. And I
6 don't usually retain that. I've got so many other
7 pieces of information for me to retain. But, yes.

8 Q. Going back to your CV, under invited
9 publications.

10 A. I'm there.

11 Q. Okay. The next publication is an article
12 titled The Use of Cross-Sex Steroids in Treating
13 Gender Dysphoria; is that right?

14 A. That is correct.

15 Q. It was published in the National Catholic
16 Bioethics Quarterly; is that right?

17 A. That is correct.

18 Q. Is this article, The Use of Cross-Sex
19 Steroids, a peer-reviewed publication?

20 A. No, it is not.

21 Q. Is the National Catholic Bioethics
22 Quarterly a peer-reviewed journal?

23 A. No.

24 Q. Is the National Catholic Bioethics
25 Quarterly a scientific journal?

1 A. No. It is an ethics journal.

2 Q. All right. And the next publication, 8,
3 under publications in your CV is Experimental
4 Approaches to Alleviating Gender Dysphoria in
5 Children; is that right?

6 A. Yes.

7 Q. And this is another one of your
8 publications that relates to gender dysphoria?

9 A. Yes.

10 Q. Is this a peer-reviewed article?

11 A. It is published in the same journal as
12 No. 7. And it is not a peer-reviewed journal.

13 Q. Okay. Do you have any other publications
14 besides the ones that we just went through that
15 relate to gender dysphoria?

16 MR. KNEPPER: Objection, form.

17 A. So there are -- I have no publications
18 that have been added since the time I submitted this
19 CV and it reflects my publications to date.

20 Q. (By Mr. Gonzalez-Pagan) Do you have any
21 other publications besides the ones that we've
22 discussed today relating to transgender people?

23 A. Not that I recall.

24 MR. GONZALEZ-PAGAN: All right. I
25 actually do need to break. So if we can go off

1 scientific understanding of this condition. To my
2 understanding, the transition from this definition
3 as gender identity disorder to gender dysphoria was
4 not based upon new scientific information.

5 It was more of a desire to alleviate
6 the discomfort that one has in that label. So how
7 we classify that really rests on the premises that
8 one has about the underlying etiology. And I think
9 that there are -- are more than one valid hypothesis
10 or I should say premises that can be put forward,
11 not necessarily all of equal weight.

12 Q. (By Mr. Gonzalez-Pagan) Okay. But what is
13 your understanding of the condition of gender
14 incongruent?

15 MR. KNEPPER: Objection, form, scope.

16 A. It's a very broad question. Could you
17 narrow it down a little bit?

18 MR. GONZALEZ-PAGAN: John, what's the
19 objection of the scope? I thought Dr. Hruz is
20 here to testify about gender-affirming
21 treatment for the condition of gender dysphoria
22 and gender incongruent.

23 MR. KNEPPER: Hold on, Omar. You're free
24 to ask the questions. I think the question I'm
25 trying to understand is: Are you trying to ask

1 him to testify about -- as a psychiatrist or a
2 psychologist? And it's not clear to me, you
3 know, what the definition of gender
4 incongruence -- are you -- it's not clear to me
5 when you use that term, are you trying to say
6 it's the ICD-11 definition or are you using
7 something else?

8 I'm happy -- happy to let you continue to
9 pursue this. I'm just as interested as you
10 are. But I want to make sure that as you go
11 through this, we don't end up -- we don't end
12 up down a path where you're trying to say, now,
13 ah-ha, he's coming here pretending to be a
14 psychologist which is outside the scope of what
15 he said he's going to testify to.

16 MR. GONZALEZ-PAGAN: Well, I mean, we have
17 a 90-page report that I'm happy to go through.

18 MR. KNEPPER: Please do.

19 Q. (By Mr. Gonzalez-Pagan) Dr. Hruz, in your
20 report, you state a number of opinions about the
21 validity of the diagnosis of gender dysphoria
22 contained within the DSM; is that right?

23 MR. KNEPPER: Objection, form.

24 A. I would be much more comfortable looking
25 at the specific areas that you're referring to.

1 Because I present many things in my report as
2 hypotheses. And without making definitive
3 statements. So it would be most helpful if we can
4 look at specific areas that you're referring to.

5 Q. (By Mr. Gonzalez-Pagan) Okay. So I guess
6 what I'm curious about is, do you have a particular
7 as a physician scientist, do you have a particular
8 belief as to whether gender dysphoria is a disorder?

9 A. I have multiple scientific premises that I
10 have and continue to consider. Again not of equal
11 weight or validity. One of those premises is that
12 this condition arises from a disconnect between
13 neuronal biology and the bodily form -- sex --
14 bodily form of the body.

15 Another scientific premise is that
16 this condition is due to the number of
17 environmental, social, hormonal and neuronal
18 components. So how we understand this condition is
19 markedly influenced by the premise that we come to
20 address the hypotheses that we're going to need to
21 consider to develop clinical trials to establish
22 safety and efficacy of treatment that provides the
23 greatest benefit to the affected patients.

24 Q. Would you agree there are transgender
25 people in this world?

1 A. Again, we have to be very careful about
2 the terminology that we're using, to acknowledge
3 that the condition of sex discordant gender
4 identity, and there are individuals that -- that
5 express an identity that is not in agreement with
6 their biology is a true statement. That's
7 undeniable that these -- there are individuals that
8 have this experience of discordance between their
9 gender identity and their sex.

10 Q. Do you believe that the experience of
11 discordance between their identity and what you term
12 their biology, is a disorder?

13 MR. KNEPPER: Objection, form.

14 A. So, again, it depends on what premise
15 you're operating under. As far as whether this is a
16 normal experience of -- of a human condition or
17 whether it falls outside of -- of the norm for us as
18 sexed beings. And, again, as a physician scientist
19 I'm obligated to be able to consider all
20 possibilities to be able to do the proper science to
21 get at the ultimate question here as to what we can
22 do to alleviate the suffering.

23 Q. (By Mr. Gonzalez-Pagan) Dr. Hruz, I guess
24 I'm a little confused as to what it is that is your
25 opinion here. Can you briefly summarize for me what

1 more cautious approach by the recognition that the
2 studies that have been done up to this point in time
3 do not give us an answer as to whether this is the
4 best or the only course of intervention to alleviate
5 that suffering. Is that -- is that what you're
6 looking for?

7 Q. Thank you. I appreciate that. In your --
8 as part of your opinions, do you provide -- let me
9 back up.

10 Do you express an opinion as to which
11 modality of care should be provided to people
12 diagnosed with gender dysphoria?

13 A. I believe that it's an ongoing scientific
14 question about what the most efficacious approach is
15 to provide the greatest benefit with the least
16 amount of risk. And that is why I'm participating
17 as an expert witness in this case, to bring to light
18 for the benefit of the court that this is something
19 that needs to be very much investigated to be able
20 to get an answer to that question.

21 Q. Do you express an opinion as to which
22 modality of care should be provided to people
23 experiencing gender dysphoria?

24 MR. KNEPPER: Objection, form.

25 A. I would say because it's an unsettled

1 scientific question, that I don't have a firm
2 opinion as to which is the best approach. Yet as
3 time has gone on, more and more information is being
4 generated that calls into question the
5 affirmation-only approach.

6 Q. (By Mr. Gonzalez-Pagan) And I don't
7 want -- what I'm trying to do is get clarity here.
8 So would it be fair to say that you do not provide
9 an opinion as to which modality of care should be
10 provided for people experiencing gender dysphoria?

11 MR. KNEPPER: Objection, form.

12 A. My opinion is that based upon the lack of
13 evidence for the gender -- gender-affirmation
14 approach, that if we are going to provide
15 interventions for this population that it is best
16 done under a carefully controlled clinical
17 experimental setting.

18 Q. (By Mr. Gonzalez-Pagan) You express that
19 there are ongoing questions as to the efficacy of
20 the gender-affirmation approach; is that right?

21 A. That is correct.

22 Q. Again for clarity's sake, are you --
23 you're not expressing an opinion with -- with
24 medical certainty as to whether the
25 gender-affirmation approach is effective or not; is

1 anxiety?

2 A. I would say that the answer is yes.

3 Q. So for people who experience gender
4 dysphoria and do not have any other co-morbidity,
5 what would you do to address their gender dysphoria
6 while the clinical trials are being conducted?

7 MR. KNEPPER: Objection, form.

8 A. That's a broad question. And it depends
9 upon the individual characteristics of the patient,
10 including their age and including all of the other
11 factors that are associated with that gender
12 dysphoria. Was it a child who is prepubertal? Is
13 it a child who is an adolescent? Is it an adult?
14 Is it a child or an adult that, you know, all of the
15 social situations or circumstances that they're
16 involved in?

17 Again, without having a formal
18 diagnosis of depression or anxiety or these other
19 co-morbidities, all of that is going to impact how
20 one approaches that particular patient.

21 Q. (By Mr. Gonzalez-Pagan) I guess here we're
22 talking about this case, you said it's a provision
23 of coverage for treatment for gender dysphoria; is
24 that right?

25 A. That is the nature of this case, correct.

1 had a new chairman that came on board from the one
2 that recruited me to that position. We disagreed in
3 more than one area.

4 There was also my research program
5 had been rapidly expanding and was getting into the
6 area of drug development. I would say that the role
7 of chief of any division is a thankless job. It
8 requires a tremendous amount of time and effort.
9 And so, you know, the decision to -- to step down
10 from that position was actually very advantageous to
11 my further career development. But, you know, it
12 was one of the -- the gender center was one among
13 many disagreements that I had at that time.

14 Q. Does the Washington University Transgender
15 Center offer pediatric and adolescent
16 gender-affirming care?

17 A. Yes. In the definition that we're talking
18 about here meaning the GnRH agonist or puberty
19 blockers, cross-sex hormones.

20 Q. Does the Wash --

21 A. In addition to --

22 Q. Does the Washington University Transgender
23 Center offer hormone therapy as treatment for gender
24 dysphoria in adults?

25 A. Does the pediatric center -- your question

1 is does the pediatric center provide care for
2 adults?

3 Q. Well, my -- the transgender center offers
4 both care to pediatric and adult patients; is that
5 right?

6 A. So in general, the care that's delivered
7 at St. Louis Children's Hospital spans birth to the
8 low -- early 20s. There are individuals that are
9 adults that are cared for by the adult endocrine
10 division. And there's a separate team of doctors
11 that participate in that care.

12 Q. Are you a member of the Endocrine Society?

13 A. Yes.

14 Q. The Endocrine Society publishes clinical
15 practice guidelines regarding the treatment of
16 gender dysphoria; is that right?

17 A. That's correct. Their initial document
18 came out in 2009 with lead author Hembree and then
19 they had a revision that was done in 2017.

20 Q. Showing you what's been marked as
21 Exhibit 5.

22 (Whereupon Exhibit 5 was
23 introduced for identification.)

24 A. Okay. I see it.

25 Q. (By Mr. Gonzalez-Pagan) Do you recognize

1 THE COURT REPORTER: Thank you.

2 MR. GONZALEZ-PAGAN: Borrowing a word from
3 you, John.

4 Q. (By Mr. Gonzalez-Pagan) What is WPATH?

5 A. It's an organization known as the World
6 Association of Professional Transgender Health. It
7 is -- again, this is the organization that came out
8 with their version seven of the guidelines quite a
9 long time ago to provide their perspective on what
10 should be done for people that experience sex
11 discordant gender identity.

12 Q. Does the Washington University Transgender
13 Center follow the WPATH guidelines?

14 A. Again, I will say that I'm not directly
15 involved in the gender center. My understanding
16 based on conversations with the director of that
17 center, he claims that they do.

18 Q. Do you, yourself, provide treatment for
19 gender dysphoria?

20 A. I will state that I'm a pediatric
21 endocrinologist charged with treating hormonal
22 diseases. And because I have not seen the evidence
23 that supports the proper risk/benefit to that
24 intervention, I do not provide that care, as I don't
25 in any other area where I have not determined

1 appropriate benefit versus risk.

2 Q. Have you ever diagnosed a person with
3 gender dysphoria?

4 MR. KNEPPER: Objection, form.

5 A. I'm a pediatric endocrinologist and my
6 charge is to treat hormone related diseases. And
7 therefore, I've not been called upon to make that
8 diagnosis.

9 Q. (By Mr. Gonzalez-Pagan) Would you agree
10 you do not have any clinical experience providing
11 care for people for gender dysphoria?

12 A. I would not agree with that.

13 Q. Do you provide treatment for people?

14 A. I provide -- I provide treatment for
15 hormone-related conditions that includes people with
16 gender dysphoria.

17 Q. But specifically in treating gender
18 dysphoria, do you have any clinical experience with
19 regards to the treatment of that condition?

20 A. Since I'm a pediatric endocrinologist, my
21 experience is limited to the treating of
22 hormone-related diseases.

23 Q. Is that a no?

24 A. I have not treated with hormones for the
25 purpose of alleviating gender dysphoria. I have

1 however treated patients that have experienced side
2 effects related to that hormonal treatment including
3 obesity, diabetes, dyslipidemia. So in that respect
4 I have treated them, but not to address dysphoria.
5 But, rather, the complications that have occurred in
6 association with that treatment.

7 Q. Clarify, you said association, yes?

8 A. That's correct.

9 Q. Do you have proof -- do you have proof
10 that it was caused by the treatment for gender
11 dysphoria?

12 A. If I thought I had enough evidence to say
13 cause, I would have said caused. I said
14 association.

15 Q. Thank you. You've given a number --
16 Strike that.

17 Have you given presentations
18 regarding gender dysphoria?

19 A. Yes.

20 Q. Have any of these presentations been at
21 medical conference -- conferences or settings?

22 A. Yes. I've -- well, I've delivered many
23 lectures to major academic centers during medical
24 grand rounds. And I'm happy to detail those for
25 you. It includes University of Tennessee, Texas

1 Tech, Notre Dame, the University of Montevideo. And
2 there are probably others. I can't remember. So --
3 and so as being a grand rounds presentation in major
4 medical centers, yes.

5 Q. Aside from grand rounds, have you provided
6 any presentations regarding gender dysphoria at any
7 medical conferences or sites?

8 A. Well, I would consider grand rounds a
9 conference.

10 Q. Grand rounds is when there's an invited
11 lecturer at a particular hospital and everybody is
12 invited to attend; is that right?

13 A. So you're asking about national meetings,
14 like the Endocrine Society meetings or such?

15 Q. Well, let me just clarify what grand
16 rounds are for the record. So what are grand
17 rounds?

18 A. Grand rounds are usually a recurring
19 series of talks given by experts in various fields
20 to the relevant scientific community about topics of
21 interest to those physicians. And generally, it
22 involves the presentation of high quality scientific
23 evidence for the conditions that those physicians in
24 the audience would encounter.

25 Q. Okay. So you have not conducted any

1 studies for any gender dysphoria, right?

2 A. I believe we answered that question
3 earlier when we went through my CV.

4 Q. Well, I'm just wondering what your
5 presentation of the grand rounds are since you have
6 not conducted any such study?

7 A. It was providing the same types of
8 evidence that I presented in my expert declaration
9 about the scientific studies that have been done or
10 need to be done in this field. Presenting the
11 various hypotheses for etiology and potential
12 treatment. The various side effects that are known
13 or potentially could occur. So it includes all
14 of -- or very similar information regarding the
15 scientific studies that I presented in my expert
16 declaration.

17 Q. And now, to continue aside from grand
18 rounds, have you provided any presentations
19 regarding gender dysphoria in any other medical
20 conferences or settings?

21 A. I would have to -- I'd have to think
22 through my list. It's actually most of the major
23 presentations that I've made are listed within my
24 CV. So I'd have to look back as to what I listed
25 there. But if you're asking about the Endocrine

1 Society or the pediatric Endocrine Society or those
2 types of organizations, I have not presented at
3 those conferences.

4 Q. Are you familiar with the gender and sex
5 conference?

6 A. Yes. And are you referring to the one in
7 Madrid.

8 Q. That was going to be my question. Did you
9 participate in the gender and sex conference in
10 Madrid in 2018?

11 A. I don't recall the exact date. But if it
12 was 2018, yes, I did present there.

13 Q. Did you know that the conference was
14 billed as, quote: A rebellion against the gender
15 ideology and its freedom destroying damaging law,
16 closed quote?

17 A. I -- I don't recall that language being
18 presented to me when I agreed to present at that
19 conference.

20 Q. Did you know that the conference was
21 focused on opposing what it termed "gender
22 ideology"?

23 A. You know, again, I was asked -- and this
24 is true for -- if you're going to go through the
25 list of all of the places that I've spoken at. When

1 I've been invited to present at any of these
2 conferences, my desire is to provide the most
3 accurate and up-to-date scientific information
4 related to the condition of gender dysphoria.

5 I am willing to present to any
6 audience that is willing to hear that information.
7 I don't make judgment about what the motives are of
8 the individuals organizing the conference. But
9 merely serve with my area of expertise and my
10 knowledge to be able to further that discussion in a
11 productive manner. And that applies to that sex and
12 gender conference in Madrid.

13 Q. Who organized the gender and sex
14 conference in Madrid?

15 A. I do not recall the entity. I'm sure
16 you'll tell me. But again that wasn't who invited
17 me was not as important as whether I was going to be
18 given the opportunity to present the information
19 objectively on this particular condition within my
20 area of expertise.

21 MR. GONZALEZ-PAGAN: Oh, shoot. John, I
22 just published an exhibit without a label. Do
23 you have any objection to me calling it
24 Exhibit 6?

25 MR. KNEPPER: Having done that very same

1 thing, Omar, let me take a look at it. But,
2 no, I -- I cannot imagine I will have an
3 objection. Actually it labeled it as Exhibit 6
4 automatically, but there's no stamp.

5 MR. GONZALEZ-PAGAN: There's no stamp,
6 yes.

7 MR. KNEPPER: Sheryl, you'll have to put
8 the stamp on it. But I'm completely okay with
9 calling that Exhibit 6.

10 MR. GONZALEZ-PAGAN: Thank you.

11 (Whereupon Exhibit 6 was
12 introduced for identification.)

13 Q. (By Mr. Gonzalez-Pagan) Dr. Hruz, I'm
14 showing you what's been marked as Exhibit 6.

15 A. I can see it.

16 Q. And I apologize for the formatting. Some
17 pages don't print as well as others. This appears
18 to be a press release following the conclusion of
19 the gender and sex conference which you were talking
20 about; is that right?

21 A. I've never seen this document before.

22 Q. Okay. If you go to the second page.

23 A. Okay. I think I'm there.

24 Q. It talks about the gender and sex -- in
25 the paragraph beginning eight speakers, sort of --

1 A. Okay. I'm there. I've got it now.

2 Q. Okay. It speaks of the gender and sex
3 conference as being organized by HazteOir.org and
4 its international platform, CitizenGo; is that
5 right?

6 A. That's what it says here, yes.

7 Q. And does that -- is that in keeping with
8 your recollection about who organized the gender and
9 sex conference?

10 A. Yes. I seem to recall now that you've
11 jogged my memory. That is correct.

12 Q. Okay. And then on the third page in the
13 middle, there's a paragraph beginning: The rest of
14 the panel experts and lecturers was made up by
15 Professor Glenn Stanton; Dr. Paul Hruz; the
16 sociologist, Gabriella Kuby; and the former
17 transsexual, Walt Heyer.

18 Did I read that correctly?

19 A. I see the paragraph that starts Stanton
20 assured that and, in quotes, the gender theory is
21 unscientific, is that what you're --

22 Q. Just above.

23 A. Oh.

24 Q. I skipped the links in reading those.

25 A. Ah, okay. I see that, yes.

1 Q. Okay. So it is your recollection then
2 that you presented at this conference; is that
3 right?

4 A. Oh, yes. I do recall the conference. I
5 just didn't until you reminded me. I didn't know
6 who organized it.

7 Q. You used the term "gender ideology" in
8 your report; is that right?

9 A. I have used that term in the course of my
10 investigation of this condition, yes.

11 Q. What is gender ideology?

12 A. I would define ideology is including
13 statements that are made on a non -- a
14 non-scientific basis with premises and goals that
15 are outside of science.

16 Q. Do you consider any healthcare
17 professional that subscribes to the gender-affirming
18 treatment model to be a gender ideolog?

19 A. I think you're conflating different terms.
20 You mentioned gender-affirming medical care and
21 ideology; those are two separate --

22 Q. Well, that's my question. My question is,
23 does somebody that provides or advocates for
24 gender-affirming treatment, is that person a person
25 who subscribes to the gender ideology?

1 turn to, to be able to define, you know, the
2 condition and the treatment approach. And I --

3 Q. Isn't that true for many psychiatric
4 conditions?

5 A. Absolutely. I would -- absolutely. It is
6 not unique to the area of gender dysphoria. In
7 fact, in talking, you know, to those that are
8 engaged more in the field of psychiatry, they will
9 acknowledge that the rudimentary nature of the
10 discipline in comparison to the rest of the
11 medical -- medical enterprise, it is a very known
12 and serious shortcoming. And there is a desire
13 certainly to -- to fill in those gaps.

14 And there's actually hope that as
15 time moves forward with the advance in tools that
16 one has, to study neurobiology and address some of
17 these questions. But there will be an opportunity
18 to provide clearer answers that are more evidenced
19 based.

20 Q. Sure. But, I mean, isn't that the nature
21 of science and medicine; we don't know everything,
22 period?

23 A. We know far less of the psychiatric
24 conditions that are listed in -- or many of the
25 psychiatric conditions -- I wouldn't say all -- that

1 Q. But your practice is in the field of
2 endocrinology, not psychiatry; is that right?

3 A. I think we've touched upon this earlier,
4 but I'm happy to expound upon that. Is --

5 Q. Well, it's a yes or no.

6 A. I'm a physician scientist. So I'm very
7 qualified to talk about deficiencies in scientific
8 evidence that are present in this particular area.

9 Q. So you're not a psychiatrist?

10 A. I covered that earlier. That I'm a
11 pediatric endocrinologist. Yes, that's correct.

12 Q. Are you aware that the revision of the DSM
13 involves the establishment of a scientific review
14 committee that evaluated and provided guidance on
15 the strength of evidence of any proposed changes?

16 A. You know, that is how they describe the
17 process. I again have asked for the evidence,
18 scientific evidence for the change between gender
19 identity disorder and gender dysphoria and then even
20 the move to shift toward the ICD code of gender
21 incongruence, that is based upon a scientific
22 evidence, rather than something other than that.

23 Q. You also make reference in your report
24 with statements by Thomas Insel, the then director
25 of the National Institute of Mental Health, that it

1 field forward. So I think that's entirely
2 consistent with my interpretation of the whole
3 question.

4 Q. Were you aware that two weeks after the
5 statement that you reference from Dr. Insel,
6 Dr. Insel issued a joint statement with the American
7 Psychiatric Association stating that, quote: The
8 American Psychiatric Association Diagnostic and
9 Statistical Manual of Mental Disorders, along with
10 the International Classification of Diseases
11 represents the best information currently available
12 for clinical diagnosis of mental disorders.

13 Were you aware of that statement?

14 A. Yes. And that is completely in agreement
15 with my opinion that I put forward here as well.

16 (Whereupon Exhibit 7 was
17 introduced for identification.)

18 Q. (By Mr. Gonzalez-Pagan) Showing you what's
19 been marked as Exhibit 7.

20 A. I have it.

21 Q. Okay. This is a statement issued by
22 Thomas Insel, the then director of the National
23 Institute of Mental Health, and Jeffrey Lieberman,
24 the then president elect of the American Psychiatric
25 Association; is that right?

1 A. Yes. I believe -- well, I don't know for
2 sure, but I agree.

3 Q. Okay. Right below DSM-5 and RDoC, colon,
4 shared interests, it states: The authors of this
5 statement.

6 Do you see that?

7 A. I see the two authors, Thomas Insel and
8 Jeffrey Lieberman, correct.

9 Q. All right. Going to the second paragraph,
10 it reads: Today the American Psychiatric
11 Association Diagnostic and Statistical Manual of
12 Mental Disorders, along with the International
13 Classification of Diseases represents the best
14 information currently available for clinical
15 diagnosis of mental disorders. Patients, families
16 and insurers can be confident that effective
17 treatments are available, and that the DSM is the
18 key resource for delivering the best available care.
19 The National Institute of Mental Health has not
20 changed its position on DSM-5. As the National
21 Institute of Mental Health research domain criteria
22 project website states, the diagnostic categories
23 represent that in the DSM-IV and the International
24 Classification of Diseases 10, the main contemporary
25 consensus standard for how mental disorders are

1 diagnosed and treated.

2 Did I read that correctly?

3 A. You read it correctly. Yet what follows
4 in the next paragraph is more pertinent to the
5 statement that I made in the declaration
6 acknowledging the fact that the DSM is not
7 sufficient for researchers and the statement was
8 related to the basis for research funding. So, you
9 know, taken in context, this document is completely
10 in line with the statement that I made about the
11 limitations of the DSM.

12 Q. But the DS -- the DSM -- this is a case
13 about the treatment of gender dysphoria; is that
14 right?

15 MR. KNEPPER: Objection form.

16 A. So as we've been talking about all
17 morning, okay, the ability to have effective
18 treatments is based upon quality research. And if
19 the DSM is not sufficient for researchers to be able
20 to conduct their scientific study, because of how
21 the DSM generates their diagnostic codes, I think
22 that that understanding is completely relevant to
23 why one needs to be aware of that.

24 Q. (By Mr. Gonzalez-Pagan) All right. Going
25 to what is the fifth paragraph, the second to last

1 sentence. It states: As research findings begin to
2 emerge from the RDoC effort, this finding may be
3 incorporated into future DSM revisions and clinical
4 practice guidelines. But this is a long-term
5 undertaking. It will take years to fulfill the
6 promise that this research effort represents for
7 transforming the diagnosis and treatment of mental
8 disorders.

9 Did I read that correctly?

10 A. You did read it correctly.

11 Q. Is there a reason why you did not include
12 this follow-up statement from Dr. Insel regarding
13 the DSM views and reliability in your report?

14 A. You know, I could have put the entire
15 document that you have here into the report. The
16 point being made, I think, is one that I fully agree
17 with. I think that as we be able to -- are able to
18 incorporate science into the DSM, it is going to
19 increase in its validity and its usefulness. But in
20 its current state there is acknowledged in this
21 statement itself by the fact that this research is
22 needed. It acknowledges the deficiencies that
23 currently exist. So there's a whole host of other
24 things that I could have included in my declaration.
25 The point that was intended, I think, was

1 sufficiently made and supported even by this
2 document that you put forward as a new exhibit.

3 Q. Sure. But in clinical qualification to
4 your statement is that that doesn't exist yet, and
5 that the DSM is the best current available tool that
6 we have according to this statement?

7 MR. KNEPPER: Objection, form.

8 A. The point I made is that there are
9 deficiencies in how it was -- or limitations how the
10 DSM has been put together. And that is relevant to
11 the understanding of how we put forward hypotheses
12 for efficacious treatments. And so I would say
13 that, you know, that's -- the state of knowledge in
14 this area is -- is what is of concern and how we are
15 using the DSM beyond its capabilities without
16 knowledge of molecular or physiologic mechanisms for
17 most of the psychiatric diseases is a major
18 limitation which is acknowledged by the authors of
19 this document. That is what I believe is important
20 for the court to recognize and to understand as we
21 move forward in this conversation.

22 Q. (By Mr. Gonzalez-Pagan) In your report you
23 speak of three modalities of treatment for gender
24 dysphoria; is that right?

25 A. I would say three different categories

1 based upon different underlying scientific premises.
2 I think the reality of interventions are much
3 broader than that and not as easily demarcated into
4 three categories. But indeed, I do present those in
5 my declaration.

6 Q. And these modalities, are they reparative
7 therapy, watchful waiting and the affirming
8 approach?

9 A. That is how I presented it, correct. And,
10 again, if it would be helpful, if we're going to
11 talk about it, if we can direct ourselves to that
12 part of my declaration.

13 Q. We'll get there. Are you familiar with
14 Ken Zucker's work?

15 A. Yes, I am.

16 Q. In fact, you repeatedly cite Dr. Zucker
17 throughout your report; is that right?

18 A. Yes, I do, among other people, yes.

19 Q. What do you understand to be the model of
20 care that Dr. Zucker employed?

21 A. Broadly speaking prior to his clinic being
22 shut down was to approach care in a way to
23 understand the underlying basis for the sex
24 discordant gender identity in that era was referred
25 to as gender identity disorder.

1 And to -- one of the approaches that
2 he used was to help facilitate an individual to
3 realign their gender identity with their sex. And
4 if that was not possible, would then advocate for
5 moving forward with affirmative approaches.

6 Q. So under Dr. Zucker's model, affirming
7 care would be provided if there was persistence of
8 cross-gender identification into adolescence and
9 adulthood?

10 A. Based upon the information that Dr. Zucker
11 had at the time that he was engaged in that care,
12 that was how he proceeded, yes. He was not privy to
13 the information that has come forward in the last
14 several years about outcomes with that affirmative
15 approach.

16 Q. What is the watchful waiting model?

17 A. Again, all of these approaches are based
18 upon different scientific premises and it is based
19 upon the experience that the majority of prepubertal
20 children that experience sex discordant gender
21 identity, if merely left alone, will have
22 spontaneous realignment of their gender identity
23 with their sex.

24 And it is again, whether it's
25 intended or not, perceived as to be a desirable

1 outcome. And that those individuals that have that
2 experience will not be exposed to gender-affirming
3 medical interventions with all the associated risks
4 and questionable benefits that we -- that I
5 mentioned already. And I certainly can share more
6 information if you would like.

7 Q. Let me introduce you to what's been marked
8 as Exhibit 8.

9 (Whereupon Exhibit 8 was
10 introduced for identification.)

11 Q. (By Mr. Gonzalez-Pagan) Do you have access
12 to the exhibit?

13 A. Yeah. I'm seeing it now, correct.

14 Q. This is a publication on -- it's an
15 article on adolescent health medicine and
16 therapeutics; is that right?

17 A. I'm seeing that here. Is this a
18 peer-reviewed journal -- a peer-reviewed article,
19 just so I know?

20 Q. I'll answer that question for you then.
21 The answer is yes, but it's the next exhibit.

22 A. Okay. I'm sorry. Did you have a question
23 for me?

24 Q. Not yet.

25 A. Okay.

1 Q. I will represent to you that this is a
2 peer-reviewed journal, but -- and I'll come back
3 to -- to another exhibit to discuss that with you.
4 But turning --

5 A. The reason I ask that was because it's a
6 review article. And even in peer-reviewed journals,
7 not all reviewed articles are reviewed with the same
8 rigor. So that's -- but thank you.

9 Q. Let's exit out of that exhibit. And if my
10 computer will cooperate.

11 (Whereupon Exhibit 9 was
12 introduced for identification.)

13 Q. (By Mr. Gonzalez-Pagan) All right. I'm
14 introducing what's been marked as Exhibit 9.

15 A. I have the document, just so you know.

16 Q. Great. Do you see where it describes the
17 journal as an international peer-reviewed, open
18 access journal focusing on health, pathology and
19 treatment issues specific to the adolescent age
20 group?

21 A. That's true. Just below the ISSN number.

22 Q. Correct.

23 A. Yes, I see that.

24 Q. Okay. So you would agree that it is a
25 peer-reviewed journal?

1 A. Yes. They're claiming it is. I would
2 have no reason to doubt that.

3 Q. Okay. So going back to Exhibit 8. If you
4 can turn to Page 61 of the document.

5 A. Okay. Are you referring to the
6 highlighted area?

7 Q. Well, we're going to go to the bottom of
8 the right-hand -- right-hand column.

9 A. Okay.

10 Q. Under the watchful waiting model.

11 MR. KNEPPER: And, Omar, let's identify on
12 the record the highlighting is not in the
13 underlying document, but it's been added.

14 MR. GONZALEZ-PAGAN: For the record, the
15 highlighting in the exhibit has been added by
16 me. Otherwise the document is unaltered.

17 Q. (By Mr. Gonzalez-Pagan) The highlighted
18 portion states -- reads: In contrast to live in
19 your own skin approach, a young child's
20 demonstration of gender nonconformity, be it gender
21 identity, expressions or both, is not to be
22 manipulated in any way, but observed over time. If
23 a child's cross-gender identification and
24 affirmations are persistent over time, interventions
25 are made available for a child to consolidate a

1 transgender identity, once it is assessed, through
2 therapeutic intervention and psychometric assessment
3 as in the best interest of the child. These
4 interventions include social transition (the shift
5 from one gender to another, including possible name
6 change, gender marker change and gender pronoun
7 changes), puberty blockers and, later, hormone and
8 possible gender-affirming surgeries.

9 Did I read that correctly?

10 A. Yes.

11 Q. So under the watchful waiting model,
12 gender-affirming care is provided for adolescents
13 and adults if they persist in the cross-gender
14 identification; is that right?

15 MR. KNEPPER: Objection to form.

16 A. That's correct according to this use of
17 the model, yes.

18 Q. (By Mr. Gonzalez-Pagan) Well, the watchful
19 waiting model was developed by -- it's the Dutch
20 model. It was developed in the Amsterdam Center of
21 Expertise on Gender Dysphoria; is that right?

22 A. That's my understanding.

23 Q. Under the gender-affirmative model,
24 medical and -- no medical and surgical interventions
25 are initiated until after the onset of puberty; is

1 that right?

2 A. If you're talking about there's no reason
3 to block puberty that hasn't started yet or to
4 intervene with cross-sex hormones until that age;
5 that is correct.

6 Q. Did you disclose to the -- in your report
7 that under Dr. Zucker's model, under the watchful
8 waiting model, and under the gender-affirmative
9 model, gender-affirming medical treatment is
10 indicated if cross-gender identification persists
11 into adolescence and adulthood?

12 A. I would challenge you on the assertion
13 that it's indicated. I would say that the model
14 itself bases itself on the next step of
15 intervention. Whether there's a prudent approach is
16 really what is of concern with the literature that
17 we have available. So the models itself indeed --
18 and they actually differ in not only in the timing
19 of when one engages.

20 The affirmative model actually begins
21 earlier with social affirmation, not just medical
22 intervention. And there's different scientific
23 premises that are underlying -- underlie these two
24 different approaches.

25 Q. But under each of the models of the three

1 models that we've discussed, medical and surgical
2 care is provided as a mode of treatment?

3 MR. KNEPPER: Objection, form.

4 A. Under the model. So let me be clear.
5 Okay. So the reason for the watch and wait approach
6 is to know that in prepubertal children that present
7 with gender dysphoria, that the vast majority of
8 them will have that spontaneous realignment, other
9 gender identity with their sex, by varying estimates
10 ranging from 50 to 98 percent. I think 88 --
11 85 percent is a good average based upon the
12 published literature.

13 That means that this would apply to
14 15 -- at most 15 percent, maybe even less, that
15 would have persistence. It also makes the
16 assumption -- and this is certainly one that one
17 considers with the current social environment as to
18 whether the influence of the social affirmation
19 component, you know, is -- is provided.

20 So the underlying premises are
21 different in the two models. One has a premise that
22 there are a number of factors that led to the gender
23 dysphoria. And the vast majority of individuals,
24 that they may differ from one patient to another.
25 There is no biological test that one can do to

1 determine which of these individuals are going to
2 have persistence or have that spontaneous
3 realignment. And the safest course of action is to
4 do nothing until things are sorted out.

5 The gender-affirmative model makes a
6 scientific premise that when one experiences sex
7 discordant gender identity, it reflects something
8 that is innate and immutable. And, therefore, a
9 prudent approach would be to immediately engage in
10 social affirmation followed by these hormonal
11 interventions. I hope that I've stated that clearly
12 enough for you and for the court.

13 Q. (By Mr. Gonzalez-Pagan) Sure. But
14 ultimately as to the question for transgender people
15 who persist in their cross-gender identification by
16 definition into adolescence and adulthood, medical
17 care and surgical care if indicated under any of the
18 three models, that being Zucker's model, the
19 watchful waiting model or the gender-affirming
20 model?

21 A. I don't know that I would distinguish what
22 we were talking about earlier with the Zucker model
23 being -- I think you're doing that more as the
24 reparative therapy.

25 And this is based upon again the

1 issue at hand of the emerging scientific evidence
2 that leads one to question whether this provides a
3 long-term solution to the problem of dysphoria.
4 And, again, I will state again that there are many
5 concerns about the presumption in proceeding with
6 affirmative care that can be challenged by the
7 outcomes that one is observing about how well these
8 individuals are doing after receiving the
9 gender-affirmative care.

10 So this is -- these are statements in
11 this particular paper by Dr. Ehrensaft that is based
12 upon the presumption that those are -- who receive
13 the affirmative approach are going to be completely
14 cured of their difficulties that they experience.
15 And my point is that when you say indicated, it
16 fails to recognize the -- the challenges that are
17 emerging for that outcome.

18 Q. Sure. But my last question wasn't whether
19 it was indicated. My last question is whether under
20 each of the three models -- and let me clarify
21 something. You discuss a reparative therapy model
22 in your report; is that right?

23 A. Yes. Can we again go to that part just so
24 you can direct me just so we can be looking exactly
25 at what I wrote.

1 Q. Sure. It's Page 49 going into Page 50.

2 A. Thank you very much. Okay. Very good.

3 Q. My point is --

4 A. I do remember what I wrote. I just want
5 to make sure we're talking about the same thing.

6 Q. My point is that -- that I'm trying to
7 distinguish actually there are four models, if you
8 will. The Ken Zucker model is distinguished from
9 reparative therapy in that -- in a significant way.

10 And let's go to Page 61 of Exhibit 8,
11 the highlighted portion above the watchful waiting
12 model. It states: If by the arrival of puberty a
13 child is still exhibiting cross-gender
14 identification and expressing a cross-gender
15 identity, that child should be supported in
16 transitioning to the affirmed gender including
17 receiving puberty blockers and hormones once it is
18 assessed from clinical interviews and psychometric
19 testing that the affirmed gender identity is
20 authentic.

21 Did I read that correctly?

22 A. Yes.

23 Q. Okay. So my question was whether you
24 disclose in your report that under the watchful
25 waiting model and/or Ken Zucker's approach,

1 gender-affirming medical care is provided after the
2 onset of puberty?

3 A. I'm trying to -- let's go back again to my
4 report and the context of the discussion that I'm
5 putting forward. You said that was -- we were on
6 page -- page or bullet point No. 59, I think you
7 said.

8 Q. Page 49, going into 50.

9 A. 49. Okay. That's where I -- that's where
10 I lost you. I was on 59. Sorry. So I would also
11 add that the presentation of three broad
12 categories -- and you've mentioned a variation of
13 one of those categories saying there are four
14 approaches. I would -- I would posit it that
15 there's a number of other hypotheses that have been
16 put forward about treatment approaches that --

17 Q. Did you disclose any of those other
18 approaches in your report beyond the three that you
19 listed in this paragraph?

20 A. Let me explain what I mean by that. Okay?
21 As I repeatedly said in my declaration that there
22 are multiple hypoth -- alternative hypotheses that
23 can be put forward about the most prudent approach
24 to care. These broad categories provide the
25 foundation for understanding the design and

1 implementation of these various applications of
2 these broad categories.

3 The point of dividing it up into
4 three categories is to really -- and I think that
5 that is still valid -- that the starting underlying
6 scientific hypotheses or the scientific premise, I
7 should say, varies in these three different
8 approaches. How that scientific premise is
9 translated into hypotheses that lead to care
10 approaches is -- is at issue here. And that I think
11 is the important point that I wanted to illustrate
12 for the court. And make it very clear that what is
13 put forward by the plaintiff experts, and they said
14 this repeatedly, is that the affirmation-only
15 approach is the only accepted intervention in the
16 care of gender dysphoria youth. And in this paper
17 here and in my declaration, you know, challenge that
18 as far as the most prudent approach. And that's the
19 point of why it was included in a benefit for the
20 court.

21 The affirmation approach is not the
22 sole approach. And there are alternative approaches
23 that haven't been adequately investigated and that
24 need to be investigated. And this is an area of
25 unsettled controversial treatment that is going on

1 currently.

2 Q. Sure. But ultimately there's a
3 distinction that they are different, right? Under
4 all three of these models, gender medical care and
5 surgical care is provided after the onset of
6 puberty?

7 MR. KNEPPER: Objection, form.

8 A. I would say that is an important
9 distinction because if the underlying --

10 Q. (By Mr. Gonzalez-Pagan) The modalities of
11 treatment, are they different?

12 A. If the outcome of the affirmation approach
13 is proven to be not effective it would change the
14 way that one applies that model to the effected
15 patients.

16 Q. But on the altering model, you're
17 providing medical care after the onset of puberty.
18 So the real difference has to do with prepubertal
19 children and how they're treated; is that right?

20 A. Well, let's talk a little bit about the
21 emerging demographic of what we are experiencing
22 right now. Many of the people --

23 Q. But that's not my question, though.
24 Like --

25 A. Okay. I don't think it applies

1 exclusively to the prepub -- medical care -- I would
2 say the hormonal interventions apply only to people
3 that have progressed at least to stage two puberty.
4 Social affirmation applies across the board and
5 would be relevant whether one presented during
6 adolescence or in childhood.

7 Q. But social affirmation is not a medical or
8 surgical treatment.

9 A. Many would argue that. And I would say in
10 a technical sense, that is true. However, there are
11 many concerns that are evidenced in the literature,
12 that that influences the trajectory of the children
13 as to whether they go on to medical care. So many
14 can and have argued that it is the first step that
15 is leading them on to the subsequent hormonal
16 interventions. So I think it is relevant.

17 Q. In Paragraph 50 in discussing -- in
18 describing the watchful waiting approach, you note
19 that this approach may include the use of
20 scientifically validated treatment, e.g., CBT, for
21 the patient's anxiety, depression, social skill
22 deficits or other issues.

23 But you do not note that
24 gender-affirming medical care and surgical care are
25 provided under this approach. I'm just wondering

1 why you did not provide that context in your report?

2 A. Because that's under the premise that the
3 affirmative approach actually provides benefit, and
4 throughout my declaration I have raised multiple
5 concerns with existing published data that lead to a
6 presumptive or tentative conclusion that at best we
7 should have more caution to that approach.

8 Q. So at best your description of the
9 watchful waiting approach in this paragraph is
10 incomplete?

11 MR. KNEPPER: Objection.

12 A. Let's read through and we can even read it
13 into the record if you'd like, the way that I
14 present that. Because that's where I think it's
15 important to look at this in context.

16 Q. (By Mr. Gonzalez-Pagan) Actually let's
17 just -- let's just go to Paragraph 53 of your
18 declaration. It states: Another controversy --

19 A. Hold on. I'm not there yet.

20 Q. Okay. I'll wait for you.

21 A. It's a long paragraph.

22 Q. Well, I'm right at the beginning of
23 Paragraph 53.

24 A. It starts with "assistance"?

25 Q. Paragraph 53.

1 A. Paragraph 53 talking about another
2 controversy, the watchful waiting treatment; is that
3 what you're talking about?

4 Q. Sure.

5 A. Okay.

6 Q. I'll just read the heading: Another
7 Controversy, the watchful waiting treatment modality
8 involves no medical treatment and is currently the
9 best specifically -- sorry -- is currently the best
10 scientifically supported intervention for young
11 children reporting gender dysphoria.

12 But the watchful waiting model does
13 involve medical treatment; isn't that right?

14 A. Perhaps to clarify that statement when I
15 say young children when we're referring to
16 prepubertal children, that is true, and it is
17 actually included in the Endocrine Society
18 guidelines. As far as the concerns about
19 intervening and the caution that should be expressed
20 precisely because of the high rates of desistence.

21 So that statement, again, when we're
22 talking about social affirmation and your contention
23 as I'm hearing it as you're stating it is social
24 affirmation is not technically a medical
25 intervention. And I think we've already discussed

1 that. That it is relevant as far as the first step
2 in influencing the trajectory of these individuals.

3 Q. This case --

4 A. And there's also --

5 Q. So this case involves gender-affirming
6 care, right?

7 MR. KNEPPER: Object to form.

8 MR. GONZALEZ-PAGAN: I apologize, Sheryl.

9 A. So -- so -- okay. Let's -- let's also
10 move on. So if -- if you then look at the first
11 stage of medical intervention which involves the
12 administration of an GnRH agonist or also known as a
13 puberty blocker, significant concerns that that
14 normal trajectory where you see the majority 50 to
15 98, I would say 85 percent have the desistence.
16 That demographic or that statistic changes
17 drastically in those individuals that have received
18 that first step of pubertal blockade and that
19 actually most of the studies that have been
20 published thus far says the vast majority of -- it's
21 not 100 percent. It's very close to that -- will go
22 on cross-sex hormones. So again that is not -- that
23 is more the affirmative model.

24 The watch and wait model would posit
25 that as a child begins into their puberty, that

1 acknowledging that the bodily changes that occur may
2 heighten the level of dysphoria that they
3 experience. But as they go through that
4 developmental process, that experience of puberty is
5 actually critically important in the overall
6 integration of one's identity with their sex. And
7 that would be consistent with the watch and wait
8 model. So that again, as being presented in this
9 one review article by Dr. Ehrensaft -- much more I
10 could say about that -- I think there's much more to
11 be said about the way that these models are being
12 presented.

13 Q. The study that you -- the study to which
14 you refer regarding persistent cross-gender
15 identification following the provision of GnRH
16 analogue, is that the de Vries study?

17 A. That's the one that shows a hundred
18 percent persistence or a hundred percent moving that
19 across sex hormones. There's been subsequent ones
20 where it's not been a hundred percent, but it's been
21 the 90 percent range.

22 Q. You say that those studies pertain to the
23 application of the gender-affirmation model, but the
24 de Vries study is actually speaking to the watchful
25 waiting model. It is the Dutch model.

1 A. We need to say a lot more about that if we
2 want to flesh that out for you. I don't know that
3 you've adequately characterized the Dutch model.
4 And I will add that the Dutch model was presented a
5 decade ago with a different patient population that
6 is currently presenting at the gender clinics across
7 the world. And even --

8 Q. But that's a different point than -- than
9 the one that we're talking about, right? You
10 indicated that the affirmation model -- studies show
11 that the affirmation model leads into persistence,
12 but you're relying on a study based on the Dutch
13 model.

14 A. Well, I would qualify that statement. I
15 didn't say that it leads to that model, because the
16 way the study was conducted, you know, causal effect
17 cannot be inferred. Okay? So I would moderate
18 that. But I would say it's certainly of concern
19 that that number is drastically different than the
20 prior studies that have shown that rate of
21 spontaneously -- spontaneous realignment with gender
22 identity with sex.

23 Q. But those are different populations,
24 right? I mean, we're talking about prepubertal and
25 pubertal youth versus prepubertal youth?

1 A. Not necessary -- so, again, you know, it
2 would be much more helpful to talk about specific
3 studies. In the de Vries study, the whole basis of
4 giving pubertal blockers applied only to pubertal
5 patients.

6 Q. That's by definition any person who's
7 receiving puberty blockers.

8 A. No necessarily.

9 Q. It has to happen at the onset of puberty.

10 A. Well, yes, onset of puberty, that would be
11 the only indication for giving it in the area of
12 pediatrics.

13 MR. GONZALEZ-PAGAN: All right. How about
14 we break now for lunch?

15 MR. KNEPPER: Dr. Hruz?

16 MR. GONZALEZ-PAGAN: Well, I'm -- I'm
17 hungry, so.

18 MR. KNEPPER: I know. This works with
19 your diet?

20 THE WITNESS: Yeah. I think as we go
21 through this, I'm going to be happy just
22 plowing through. So it's going to have to come
23 from your end if you want to take a break.

24 MR. GONZALEZ-PAGAN: Well, it's coming
25 from my end. Because I -- I'm running on a

1 have to demonstrate a concept of what we call
2 non-inferiority. So if that's the natural outcome,
3 so if there's a realignment with gender identity
4 with sex and that obviates the need for them to go
5 on to receive hormonal treatment of any sort at all,
6 that would be a desired outcome.

7 The challenge is that in those
8 individuals, there is no reliable diagnostic test to
9 predict which of those children are in the category
10 of 85 percent, like we go to this realignment versus
11 the subset that's going to persist in that sex
12 discordant gender identity.

13 So that's the challenge. So I would
14 say I wouldn't be so firm to make an absolute
15 determination of the best course of action, but I
16 wouldn't say that any alternate approach would have
17 to prove that non-inferiority outcome.

18 Q. (By Mr. Gonzalez-Pagan) Okay. And the
19 desistence study speaks to prepubertal youth who
20 were diagnosed with gender identity disorder under
21 the DSM-III or the DSM-IV; is that right?

22 A. So this is -- I'm very much aware of that
23 critique, and the way that people have attempted to
24 dismiss that desistence literature based upon that
25 difference of gender identity disorder versus gender

1 dysphoria. It's very interesting that if you look
2 in detail for example at that same paper the number
3 of people based upon the criteria --

4 Q. I'm sorry, Doctor. I apologize for
5 interrupting. But I guess -- I'm happy to go into a
6 conversation about this. But I guess I have a
7 predicate question, which is I want to establish
8 whether it's true or not that the desistence studies
9 are based on prepubertal children diagnosed with
10 gender identity disorder as opposed to gender
11 dysphoria under the DSM-5?

12 A. Well, older studies would certainly
13 necessitate that they use the diagnostic criteria
14 that was available at the time the study was
15 conducted. And some of them -- and most of those
16 studies were the era prior to the revision of the
17 DSM-5 giving the gender dysphoria diagnosis.

18 Q. Are you aware of any studies looking into
19 the desistence in prepubertal youth using the DSM-5
20 criteria?

21 A. You know, that is an outstanding question
22 and I'm very happy to share with you the problems
23 with that question. In the fact that because of
24 what has happened in the approach to the care of
25 these individuals, the opportunity because of the

1 widespread adoption of the affirmation only approach
2 and the early adoption of social affirmation makes
3 it very challenging to be able to even put forward
4 as a hypothesis a study that would be able to
5 operate under the current diagnosis of gender
6 dysphoria.

7 And I think that's very problematic
8 as we seek to understand the natural history of this
9 disease, and we seek to find ways to alleviate the
10 suffering that will be sustained long-term in these
11 individuals. I think it's the fact that the
12 discussion is not allowed to occur and the studies
13 have not been proposed and conducted. And even if
14 they were, there would be challenges in the current
15 environment of really encouraging that social
16 affirmation approach.

17 So the answer to the question is that
18 there are many problems that currently exist as to
19 why those studies have not been reported and would
20 be very difficult to perform at this point in time,
21 yet would be essential to providing the best care
22 for these individuals.

23 Q. Okay. But you do not know of any studies
24 documenting an 85 percent desistance rate for kids
25 diagnosed -- prepubertal kids diagnosed with gender

1 dysphoria mode in the DSM-5?

2 A. I'm not aware the question has actually
3 been investigated by a scientific trial. Not that
4 there's data that says it doesn't exist, but that it
5 has not been investigated. The only data that's
6 available right now are people that have received
7 that social affirmation which clearly shows that
8 that demographic has changed. And, you know, if you
9 ask this as a hypothesis --

10 Q. I appreciate that, Dr. Hruz. We'll get to
11 the demographic changes later on. But I want to
12 stay focused. So going back, the studies have to
13 do -- the studies in desistance that you reference
14 have to do with prepubertal children; is that right?

15 A. The ones that were done previously that
16 I'm referring to dealt with prepubertal children.
17 Now, there's another component of this, that of --
18 you divided this between prepubertal and adults.
19 And it's very necessary if we're going to adequately
20 address this question to consider what happens
21 during the period of puberty.

22 Q. Okay. Are there studies that document
23 desistance during the period of puberty?

24 A. There are case reports. There are not --
25 and there's a growing -- this gets at the --

1 Q. In your report you state that case reports
2 are not valid scientific evidence.

3 A. They are useful for hypothesis generation.
4 They're not useful for making definitive causal
5 conclusions. That is correct.

6 Q. So are there any studies showing high
7 desistence among adolescence diagnoses with gender
8 identity disorder?

9 A. There are not. And the reason for that,
10 again, is because in many of the studies where one
11 looks at this, there's a very, very high dropout
12 rate in many of the subjects where one can't
13 conclude at all what the outcomes were. Based upon
14 the available evidence, more by case reports of
15 growing number of people experiencing this
16 desistence, that did occur when it's experienced
17 post pubertally would lead one to raise hypotheses
18 to be investigated in a rigorous scientific manner
19 to address that question.

20 Q. You believe that all medical treatment
21 needs to be subjected to randomized clinical trial?

22 A. It depends on -- so every medical decision
23 that is made is based upon consideration of the
24 overall risk and the overall benefit. And I think
25 that the greater the risk, the greater the scrutiny

1 are certainly --

2 Q. But that's just a hypothesis; is that
3 right?

4 A. You know, all along here, I've been
5 tell -- I've been stating, and I hope very clearly,
6 that much of my opinion is based upon hypotheses and
7 alternative hypotheses, because there is no
8 definitive answer to this question. But the
9 prevailing current hypothesis that's not presented
10 as a hypothesis, it's presented as an established
11 fact, is that gender-affirming interventions are the
12 solution to gender dysphoria. And that is what I
13 challenge. And that is what, I think, is very
14 important for this court to understand, is that the
15 scientific evidence does not support that as being a
16 cure for all of the difficulties that these
17 individuals are experiencing.

18 Q. Going back to the desistence studies.
19 What is the error rate for the desistence studies
20 that you rely on?

21 A. So the error rate is -- there's a number
22 of factors. I'm glad that you brought this up as
23 far as, you know, how we think about the reliability
24 of studies. So this is a problem throughout the
25 literature. And I've addressed this in my

1 Q. (By Mr. Gonzalez-Pagan) Are you aware
2 that the American Psychiatric Association opposes
3 reparative therapy efforts regarding gender
4 identity?

5 A. Now we're into a new line of questioning
6 about medical societies. But I'm aware of -- of the
7 general recommendations for affirmation only. That
8 is entirely consistent with what has been put
9 forward by WPATH, American Psychological
10 Association. There's a little bit more caveat in
11 the Endocrine Society guidelines. I think they're a
12 little bit more cautious in the prepubertal
13 children, at least in the 2009 document cautioned
14 against social affirmation in recognition of the
15 same desistence literature that I'm referring to.
16 Again, not just my opinion. This is the
17 professional societies in the 2009 guidelines
18 acknowledged those studies of being relevant to that
19 consideration of treatment.

20 Q. Sorry. I just don't want us to go down a
21 different path. I'm not talking about the general
22 position statement about gender-affirming care. I
23 am talking about the physician statements regarding
24 conversion therapy. Are you aware that the American
25 Psychiatric Association opposes conversion therapy

1 eff -- conversion therapy efforts?

2 A. The reason I answered in the way I did to
3 your previous question was not to evade the
4 question. It was merely to -- you began with a
5 professional association. And so it's necessary to
6 acknowledge what the basis of those statements are.
7 The APA recommends the affirmative approach to care.

8 Q. Okay. But that's not my question. That
9 is a different position statement. And I'm glad --
10 yeah, the APA does do that. But does the American
11 Psychiatric Association also have a position
12 statement regarding conversion therapy?

13 A. Okay. Thank you. Because you used the
14 word "conversion therapy" for the first time. I
15 think it's very important for us to acknowledge when
16 we're talking about reparative therapy and what
17 people talk about as far as conversion therapy.
18 That's actually a pejorative term that actually is
19 trying to equate these efforts to realign gender
20 identify with sex to a completely different
21 condition related to same sex attraction with
22 methods that virtually everyone would recognize as
23 being unethical.

24 And so I think it's an injustice
25 to -- and the statements are often made in the

1 literature published talking about conversion
2 therapy.

3 Q. All right. One second. Let's just go --
4 let's just go to Page 49 of your report,
5 Paragraph 52.

6 A. Sorry. Paragraph 52?

7 Q. Yeah. So very last sentence going into
8 the next page of your report states: The first
9 approach often referred to as conversion or
10 reparative -- reparative therapy --

11 A. Correct.

12 Q. -- is directed to or actively supporting
13 and encouraging children to identify with their
14 biological sex.

15 Did I read that correctly?

16 A. I could add often incorrectly referred to
17 as conversion therapy. I think that's probably
18 something I could have added to my declaration to
19 indicate that. I think it's incorrect and an
20 injustice to use that term to describe the approach
21 to -- to addressing gender dysphoria.

22 Q. Are you aware that the American -- you
23 know what, let's -- I apologize. I forgot the stamp
24 again. It is marked Exhibit 10. Do you see that?

25 (Whereupon Exhibit 10 was

1 introduced for identification.)

2 A. Correct. I see this.

3 Q. (By Mr. Gonzalez-Pagan) Okay. Under the
4 position heading at the bottom of the page, in
5 Paragraph 2, it states: APA recommends that ethical
6 practitioners respect the identity for those with
7 gender diverse expression.

8 Did I read that correctly?

9 A. I'm in the wrong paragraph. You said the
10 second paragraph?

11 Q. Under -- under the heading position at the
12 bottom of the page?

13 MR. KNEPPER: Omar, I think you made -- I
14 think you swapped gender and diverse. But it's
15 just -- in other words, I think you read gender
16 diverse expression and it's diverse gender
17 expression.

18 Q. (By Mr. Gonzalez-Pagan) Sure. Let me
19 just read that again. Are you there?

20 A. I'm here. Okay. I'm sorry. I was
21 reading the introductory paragraph. Sorry.

22 Q. Okay. It states, Paragraph 2, quote: APA
23 recommends that ethical practitioners respect the
24 identity for those with diverse gender expressions.

25 Did I read that correctly?

1 A. Yes.

2 Q. Then just below that on Paragraph 3 on the
3 next page, it states, quote: APA encourages
4 psycho -- psychotherapies which affirm individual's
5 sexual orientations and gender identities.

6 Did I read that correctly?

7 A. Yes.

8 (Whereupon Exhibit 11 was
9 introduced for identification.)

10 Q. (By Mr. Knepper) Showing you what's been
11 marked as Exhibit 11.

12 A. I see it.

13 Q. Okay. This is a resolution by the
14 American Psychological Association on gender
15 identity change efforts. Is that right?

16 A. That's the title of this document,
17 correct.

18 Q. It's dated February 2021; is that correct?

19 A. That's correct.

20 Q. Go to the second page, third to last
21 paragraph on the right-hand side column. And it's
22 use of GICE as an acronym for gender identity change
23 effort; is that right?

24 A. I see that, yes.

25 Q. It reads: Whereas, GICE has not been

1 shown to alleviate or resolve gender dysphoria
2 (Bradley and Zucker, 1997; Cohen-Kettenis & Kuiper,
3 1984; Gelder and Marks, 1969; Greenson, 1964; Pauly,
4 1965; and SAMHSA, 2015).

5 Did I read that right?

6 A. You did.

7 Q. If you go to Page 3, the last two
8 paragraphs, on the right-hand side column, it
9 states: Be it therefore resolved, that consistent
10 with the APA definition of evidenced-based practice
11 (APA 2005), the APA affirms that scientific evidence
12 and clinical experience indicates that GICE put
13 individuals at significant risk of harm.

14 Be it further resolved that the APA
15 opposes GICE because such efforts put individuals at
16 significant risk of harm and encourages individuals,
17 families, health professionals, organizations to
18 avoid GICE.

19 Did I read that correctly?

20 A. You did.

21 Q. Okay. So the American Psychiatric
22 Association and the American Psychological
23 Association both oppose reparative therapy as a form
24 of treatment; is that right?

25 A. Gender identity change efforts as stated

1 in the document, which again is different than what
2 people generally equate with conversion therapy, in
3 quotes.

4 Q. And the American Psychiatric Association
5 and the American Psychological Association consider
6 gender identity change efforts to be unethical and
7 harmful; is that right?

8 A. That's what's stated in these documents.

9 Q. All right. I will apologize in advance,
10 that exhibit is large and will make navigating it a
11 little difficult. Hopefully it will take a little
12 bit longer to upload.

13 (Whereupon Exhibit 12 was
14 introduced for identification.)

15 Q. (By Mr. Gonzalez-Pagan) Showing you
16 what's been marked as Exhibit 12. It's a document
17 entitled Understanding the Well Being of LGBTQI Plus
18 Population. Is that right?

19 A. That's the title in the document that I'm
20 looking at, yes.

21 Q. It appears to have been published in 2010;
22 is that right?

23 A. It says 2020.

24 Q. Sorry. 2020.

25 A. Okay.

1 correctly. And that many of the studies that are
2 referenced here have major methodologic weaknesses
3 and the strength of the statement based upon that
4 evidence in light of the emerging evidence that is
5 coming forward, for example, in the other studies
6 that we've discussed already today --

7 Q. Well, let's --

8 A. -- this conclusion can be scrutinized.

9 Q. Let's move to the next page. The
10 highlighted statement reads: The available evidence
11 suggests that sexual orientation and gender identity
12 conversion efforts were ineffective and dangerously
13 detrimental to the health of SGD population,
14 especially for minors who are unable to give
15 informed consent.

16 Did I read that correctly?

17 A. I'll say again, you read it correctly.
18 And the meaning of that statement and context of the
19 whole paper is something that we can discuss later.

20 Q. Would you agree that it is the position of
21 the National Academies of Sciences, Engineering and
22 Medicine that conversion therapy is harmful?

23 MR. KNEPPER: Objection, form.

24 A. I don't know whether the small panel of
25 people that were included in generating this

1 consensus statement represents the entire views of
2 the entire membership of that society. I know from
3 my own experience that for the other societies that
4 I'm involved with these types of consensus
5 statements are not brought to the entire membership
6 of the organization. I can only conclude that the
7 members that were present on this panel made those
8 conclusions. I would not go as far as to say that
9 it was supported by every member or even majority or
10 even substantial number of the rest of that group.

11 Q. (By Mr. Gonzalez-Pagan) If you go to the
12 fourth page of the PDF.

13 A. Back up to the top now? Okay.

14 Q. On the last sentence, the second clause,
15 it states: It represents the position of the
16 National Academies on the statement of facts; is
17 that right?

18 A. That is what is stated here, and that is
19 also stated by other organizations that have put
20 forward similar statements. The same concern
21 applies, that just because they put it forward, it
22 does not mean that -- that the entire membership has
23 been able to weigh into this question or those that
24 wish to do so.

25 Q. Was the review that you referenced in

1 A. You know, again I don't have the answer.
2 I don't know.

3 Q. Okay. Are you aware that in the United
4 Kingdom, medical and surgical care is provided for
5 transgender adolescents post puberty and for
6 transgender adults?

7 MR. KNEPPER: Objection to form.

8 A. I guess I didn't understand the question
9 there.

10 Q. (By Mr. Gonzalez-Pagan) Sure.

11 (Simultaneous speakers.)

12 Q. (By Mr. Gonzalez-Pagan) You talk about --
13 you talk about the reviews in the United Kingdom, in
14 Finland and in Sweden. So I'm curious, are you
15 aware -- are you aware whether in the national
16 health system in the United Kingdom, they provide
17 coverage and treatment for gender dysphoria in post
18 prepubertal adolescents and adults?

19 A. So I think it's reflected in the recent
20 Tavistock versus Bell decision. It is recognized
21 that this is an area of controversy and that is an
22 unsettled question about --

23 Q. Well, the Tavistock decision has to do
24 with minors. I'm talking about adults and cross-sex
25 hormones and surgery. Are you aware whether in the

1 United Kingdom they provide coverage and treatment
2 of cross-sex hormones and surgery as a modality of
3 treatment for gender dysphoria?

4 A. Yes, I do.

5 Q. Okay. Same question with regards to
6 Sweden?

7 A. Sweden -- again, I'm a pediatric
8 endocrinologist. And I think that the caution that
9 is put forward in relegating this care to the
10 setting of -- of an experimental setting is where
11 it's been pulled back with concerns based upon
12 the --

13 Q. The restrictions to which you speak all
14 relate to the provision of puberty blockers; is that
15 right?

16 A. No. I think it's more extensive than
17 that. But it -- it acknowledges that based upon the
18 literature that there's not very strong evidence and
19 then instructs that this care be delivered with the
20 safeguards exactly as I'm saying, you know, it
21 should be done here in the United States.
22 Recognizing that this is --

23 Q. That's in the context of minors, though;
24 is that right?

25 MR. KNEPPER: Objection, form.

1 A. Again, that's what I've addressed in my
2 declaration. And that is my --

3 Q. (By Mr. Gonzalez-Pagan) But with regards
4 to transgender adults in Sweden, does the
5 nationalized healthcare system in Sweden provide
6 coverage and treatment for gender dysphoria in the
7 form of hormones and surgical care?

8 A. You know, I would say this is outside the
9 scope if we're getting into a discussion about
10 insurance coverage. My expertise is in looking at
11 the scientific data about the affirmation and
12 other --

13 Q. Well, you rely on the national reviews of
14 Sweden, Finland, and the United Kingdom. So --

15 A. Correct.

16 Q. -- I'm wondering if you rely on the
17 national reviews, I think it's pertinent and
18 relevant whether you disclose in your report that
19 these countries provide for the treatment and
20 coverage of this care?

21 MR. KNEPPER: Objection, form, scope.

22 A. As a pediatric endocrinologist and
23 physician scientist, my service to this court is not
24 to opine upon -- I know it's a big part about this
25 case about insurance coverage. My role in this

1 gender-affirming treatment for adults?

2 A. Again, I would have to say for me to
3 comment specifically about that, we would need to
4 have the document in front of me to be able to look
5 through all of the papers. It was a very extensive
6 study. And there are a number of papers there.

7 And so I would have to look through
8 the papers to specifically look at the inclusion
9 criteria, whether it was exclusively in kids or
10 included adults and, again, how he defined, you
11 know, adulthood, whether it's post prepubertal, post
12 18, early 20s. You know, many people have different
13 definitions of that. And so --

14 Q. All right. Same line of questioning with
15 regards to Finland. Did you disclose that Finland
16 provides through its national -- nationalized health
17 care system gender-affirming treatment for gender
18 dysphoria for adults?

19 MR. KNEPPER: Objection, form, scope.

20 A. I'm going to state again that for me to
21 opine on that, I would need to look at, in those
22 studies, what the inclusion -- inclusion criteria
23 and whether it extended into adulthood.

24 Q. (By Mr. Gonzalez-Pagan) My -- my -- my
25 question is not pertinent to the report. It's not a

1 question of whether they reviewed it. It's a
2 question whether that care is provided in Finland.

3 MR. KNEPPER: Objection, form.

4 A. I will say again that this is a question
5 related to insurance coverage. And I'm a pediatric
6 endocrinologist, physician scientist opining on
7 issues of science, not on medical coverage.

8 Q. (By Mr. Gonzalez-Pagan) One moment,
9 please. Let's take a -- well, actually no. We'll
10 come back. In your report you disclose the Bell v.
11 Tavistock position; is that right?

12 A. That's correct.

13 Q. That was a decision from December 2020 in
14 the United Kingdom?

15 A. Correct. And it was before the appeals
16 court decision came out recently.

17 Q. And you submitted an expert report in
18 Tavistock; is that right?

19 A. In that Bell versus Tavistock case, I did.

20 Q. Are you aware that the Bell v. Tavistock
21 case dealt solely with the ability of a minor to
22 provide informed consent on their own?

23 MR. KNEPPER: Objection to form.

24 A. So the decision was based on that. But
25 that was not what I was opined [sic] to comment on.

1 there's no indication here that this was a
2 peer-reviewed document. It wasn't published in a
3 journal in the typical way that we do it. So it's a
4 Council for Choices -- recommendations of the
5 Council for Choices in Healthcare in Finland. So
6 this is -- the council itself came to this
7 conclusion to answer your question.

8 Q. Let's go back to Exhibit 12.

9 A. I'm there.

10 Q. All right. We're going to go to
11 Page 12-10. It is Page 311 of the PDF.

12 A. I wish there was a way you could just type
13 in the number and get to it.

14 Q. Don't we all.

15 A. Okay. This is with the section that's
16 titled Guidelines and Policies Related to
17 Gender-Affirmation?

18 Q. That's right.

19 A. Very good.

20 Q. The highlighted statement states:
21 Clinicians who provide gender-affirming psychosocial
22 and medical services in the United States are
23 informed by expert evidence-based guidelines. In
24 2012, the World Professional Association for
25 Transgender Health, WPATH, published Version 7 of

1 the Standards of Care for the Health of Transgender,
2 Transsexual, and Gender-Nonconforming People, which
3 have been continuously maintained since 1979, and
4 revisions for Version 8 are currently underway
5 (Coleman, et al., 2012). Two newer guidelines have
6 also published -- have also been published by the
7 Endocrine Society (Hembree, et al., 2017), and the
8 Center of Excellence for Transgender Health (UCSF
9 Transgender Care, 2016). Each set of guidelines is
10 informed by the best available data and is intended
11 to be flexible and holistic in application to
12 individual people. All of the guidelines recommend
13 psychosocial support in tandem with physical
14 interventions and suggest timing interventions to
15 optimize an individual's ability to give informed
16 consent. Mental and physical health problems need
17 not be resolved before a person can begin a process
18 of medical gender-affirmation, but they should be
19 managed sufficiently such that they do not interfere
20 with treatment.

21 Did I read that correctly?

22 A. You indeed read that correctly.

23 Q. Okay. This is a consensus study report by
24 the National Academies of Sciences, Engineering and
25 Medicine of the United States; is that right?

1 record. This is Media Unit No. 5. The time is
2 4:05 Eastern time.

3 Q. (By Mr. Gonzalez-Pagan) Dr. Hruz, one of
4 the critiques in your report is that puberty
5 blockers have not been approved by the FDA as a
6 treatment for gender dysphoria; is that right?

7 A. That is correct. Although it's important
8 to understand why that is a relevant piece of
9 information.

10 Q. Well, let's go to page 50 of your report.

11 A. I'm there.

12 Q. Okay. On the -- there's a number of
13 statements that you bold and italicize, but on the
14 third -- the sentence involving the third bold and
15 italics.

16 A. Okay.

17 Q. It's like in the middle of the page. It
18 states: The off-label prescription of this drug is
19 legal but unethical outside the setting of a
20 carefully controlled and supervised clinical trial.

21 Did I read that correctly?

22 A. You did.

23 Q. And why is that?

24 A. So, again, this relates to the statements
25 that are made that these drugs are known to be safe

1 in this patient population. And we really don't
2 have the scientific evidence to make that statement.
3 Because it's unknown what the -- some of the effects
4 are known, but many of the effects are unknown, to
5 be able to expose people to this intervention, not
6 only to expose them to that, but to make the
7 statement that it is known to be safe with that
8 absence of evidence, it really finds itself outside
9 of what I'd consider ethical.

10 Q. Just for clarify, what do you understand
11 "off-label" use to mean?

12 A. Oh, it's actually very common in the area
13 of pediatrics. It's to prescribe a medication for
14 something that it has not been FDA approved. So it
15 could be for another -- a drug that's approved for
16 one purpose and using it for another purpose. Most
17 often that's how it's used.

18 Q. Have you personally ever prescribed any
19 drugs on an off-label basis?

20 A. Very frequently do.

21 Q. Do you do so even in the absence of
22 randomized clinical control trials?

23 A. Usually when I prescribe them off-label,
24 there are randomized controlled trials in different
25 populations that I turn to. I look at the relative

1 risk and -- but I don't make the statement that we
2 know with definity [sic] about the safety of a
3 medication in a way that we don't have that
4 information.

5 Q. And you said usually. So there are times
6 when you prescribe off-label drugs even in the
7 absence of clinical controlled randomized trials?

8 MR. KNEPPER: Objection, form.

9 A. Usually when I'm prescribing it, what we
10 would consider off-label most often, it is for a
11 condition that is not markedly different for the use
12 that it is being given only that it had been
13 approved most often for adults rather than children.

14 Q. (By Mr. Gonzalez-Pagan) And clinical
15 control trials are actually relatively rare in the
16 pediatric population?

17 A. No. I would say that -- I mean, that's
18 the standard that's accepted especially for
19 medication use. The reason why they're not done in
20 pediatrics is that usually there's a substantial
21 cost associated with that. People are looking at
22 market share and, you know, how much it's going to
23 cost to be able to study that drug in that patient
24 population. Yet it's already been studied in a
25 randomized control trial in a similar population

1 without the same caveats that we consider when we
2 look at this question of pubertal blockade.

3 Q. What is the FDA?

4 A. The Food and Drug Administration.

5 Q. Does the FDA regulate prescription drugs?

6 A. Yes.

7 Q. What is the FDA's decision with regards to
8 a prescription of off-label use of drugs?

9 MR. KNEPPER: Objection, form, scope.

10 A. You know, I don't know that they have a
11 statement that there is an ethical responsibility
12 that all physicians who are prescribing off-label.
13 It also applies both to the prescribing physician
14 and it also applies to the pharmaceutical company
15 that's making the medication.

16 If it's off-label, they cannot market
17 it to a group of people that it wasn't approved for.
18 Physicians that prescribe off-label medications
19 accept the responsibility, you know, for the risks
20 and benefits. And they're obligated to inform their
21 patients of the evidence that they have, where it
22 comes from, and the basis for recommending that
23 medication.

24 That's true for all medications, but
25 certainly when you're using it off-label, you know,

1 it involves consideration of the indication, how
2 applicable the randomized control studies that have
3 been done to approve the drug are applicable to the
4 population that you're going to use it for.

5 (Whereupon Exhibit 14 was
6 introduced for identification.)

7 Q. (By Mr. Gonzalez-Pagan) Showing you what's
8 been marked as Exhibit 14. Do you have that in
9 front of you?

10 A. I do.

11 Q. This appears to be a notice by the Food
12 and Drug Administration in the Federal Register
13 dated November 18, 1994, pertaining to a citizen
14 petition regarding the Food and Drug
15 Administration's policy on promotion of unapproved
16 uses of approved drugs and devices, request for
17 comments.

18 A. I see that.

19 Q. Did I -- did I describe the document
20 correctly?

21 A. I've not read the entire document. But
22 that section that you read was read correctly.

23 Q. Okay. Going on to the second page. It's
24 a highlighted portion. I will represent any
25 highlights in the document were done by me. And

1 there are no other alterations to the document.

2 The highlighted portion reads: Over
3 a decade ago, the FDA Drug Bulletin informed the
4 medical community that once a drug product has been
5 approved for marketing, a physician may prescribe it
6 for uses or in treatment regimens of patient
7 populations that are not included in approved
8 labeling.

9 The publication further stated
10 unapproved, or more precisely unlabeled uses may be
11 appropriate and rational in certain circumstances
12 and may, in fact, reflect approaches to the drug
13 therapy that have been extensively reported in
14 medical literature. Valid new uses of drugs already
15 on the market are often first discovered through
16 serendipitous observations and therapeutic
17 innovations, subsequently confirmed by well-planned
18 and executed clinical investigations.

19 Did I read that correctly?

20 A. You did, indeed.

21 Q. Your report doesn't acknowledge that the
22 long-standing position of the FDA has -- with
23 regards to off-label use of drugs?

24 MR. KNEPPER: Objection, form.

25 A. I would say that this paragraph that you

1 read does not directly apply for the reason for my
2 consideration of this use of GnRH agonist in
3 pubertal adolescence for gender dysphoria is the
4 same. And it's important to note in this paragraph,
5 it says the word "may." It doesn't guarantee that
6 it is. And it reflects the nature of the
7 application that one is providing.

8 (Whereupon Exhibit 15 was
9 introduced for identification.)

10 Q. (By Mr. Gonzalez-Pagan) Introducing what
11 has been marked as Exhibit 15. Noted below, the
12 creator of the document is a printout of a web page
13 from the Food and Drug Administration's website. It
14 is titled Understanding and Approved Use of Approved
15 Drugs Off-Label.

16 Did I read the title of this web page
17 correctly?

18 A. Yes, you did.

19 Q. Okay. Moving on to the second page,
20 there's a highlighted portion. I will stipulate for
21 the record that any highlights in this document were
22 inserted by me and that there are no other
23 alterations to the document.

24 The highlighted portion of the
25 document states: From the FDA perspective, once the

1 FDA approves a drug, healthcare providers generally
2 may prescribe the drug for an unapproved use when
3 they judge that it is medically appropriate for
4 their patient?

5 Did I read that correctly?

6 A. You indeed read it correctly.

7 Q. Before opining as to whether the use of
8 off-label puberty blockers should be considered
9 unethical, did you review the positions of the FDA
10 with regards to off-label use?

11 A. Again, I'm very, very familiar with that.
12 Maybe perhaps not these specific documents, but I --
13 this is entirely consistent with my understanding of
14 the off-label use of drugs.

15 (Whereupon Exhibit 16 was
16 introduced for identification.)

17 Q. (By Mr. Gonzalez-Pagan) Showing you what's
18 been marked as Exhibit 16. I'll represent this is a
19 guidance for institutional review board for clinical
20 investigators published by the Food and Drug
21 Administration dated January 1998. It is titled
22 Off-Label, an Investigational Use of Marketed Drugs,
23 Biologics and Medical Devices.

24 Did I represent the document
25 correctly?

1 A. You correctly read the title of this
2 document.

3 Q. There is a highlighted portion in the
4 first page of the exhibit. I'll represent that all
5 the highlights were added by me to that exhibit.
6 And there are no other alterations to the document.

7 The highlighted statement reads: If
8 physicians use a product for an indication not in
9 the approved labeling, they have the responsibility
10 to be well-informed about the product, to base its
11 use on firm scientific rationale and on sound
12 medical evidence, and to maintain records of the
13 product's use and effects. Use of the marketed
14 product in this manner when the intent is the
15 practice of medicine does not require the submission
16 of an Investigational New Drug Application,
17 Investigational Device Exception or review by an
18 Institutional Review Board.

19 Did I read that correctly?

20 A. You read that section correctly.

21 Q. Do you acknowledge this guidance of the
22 FDA in your report?

23 A. You mean the statement that I made about
24 the ethics of prescribing the medication and the
25 need does not require that, but it does not mean

1 that it's not the approach that should be done. So
2 that one -- for example, it's not malpractice and
3 one's not going to lose their license by prescribing
4 a medication off-label in this manner.

5 However, when we look at the use of
6 this -- the GnRH agonist with a reference that I
7 made to the FDA off-label use involves product use
8 that is not the same as what it is used in the
9 treatment of prepubertal children and the risks
10 require -- and because of the risks of the
11 intervention and the lack of knowledge, it's very
12 different than many of the other times that I myself
13 have used off-labeled use of medications.

14 So the statement itself is accurate.
15 It is consistent with my understanding of the FDA
16 guidelines for that. And I think my statement in my
17 declaration fully reflects the reason why it is of
18 ethical concern in this case.

19 (Whereupon Exhibit 17 was
20 introduced for identification.)

21 Q. (By Mr. Gonzalez-Pagan) Showing you what's
22 been marked as Exhibit 17. Are you familiar with
23 the American Academy of Pediatrics?

24 A. I was a member of the American Academy of
25 Pediatrics for over 20 years.

1 Q. This is a policy statement by that
2 organization titled Off-Label Use of Drugs in
3 Children; is that right?

4 A. That is the title of the statement, yes.

5 Q. I'll represent that there are highlights
6 within this document. Those highlights have been
7 added by me. And there are no other alterations in
8 the document.

9 On the abstract in the highlighted
10 portion, it states: However, off-label drug use
11 remains an important public health issue for
12 infants, children and adolescents, because an
13 overwhelming number of drugs still have no
14 information in the labeling for use in pediatrics.
15 The purpose of off-label use is to benefit the
16 individual patient. Practitioners use their
17 professional judgment to determine these uses. As
18 such, the term "off-label" does not imply an
19 improper, illegal, contraindicated or
20 investigational use. Therapeutic decision-making
21 must always rely on best available evidence, the
22 importance of the benefit for the individual
23 patient.

24 Did I read that correctly?

25 A. You read it correctly. And I would

1 comment that the very last sentence is at the heart
2 of my concern about how it's -- GnRH agonists are
3 being used in the setting of gender dysphoria.

4 Q. So is your critique that the use of GnRH
5 analogues [sic] for the treatment of gender
6 dysphoria is unethical because it's not the best
7 available evidence in your opinion?

8 A. There are many layers to the question. I
9 would say that many of the people that are
10 prescribing these drugs are not even aware of the
11 emerging evidence that is coming forward about lack
12 of efficacy and the risks of these medications.
13 They're relying on their decision based upon
14 statements made by many of the organizations that
15 you mentioned earlier that -- that are not
16 considering the relative risk-benefit analysis. And
17 so a provider, unless they've had the opportunity
18 like myself and others who have been familiar with
19 the literature, are going to be misled with the
20 assumption that this is the available evidence,
21 supports its use.

22 Q. Well --

23 A. Many of the people that are prescribing
24 these medications have not read those papers, not
25 considered those papers, not considered the poor

1 Q. (By Mr. Gonzalez-Pagan) Dr. Hruz, how did
2 you first come to be an expert in transgender
3 litigation?

4 A. Well, I think it was a recognition of my
5 knowledge of the -- of the subject area and -- that
6 I had in a number of different settings including
7 the grand rounds talks that I said previously and
8 some of the things that I've been discussing for the
9 last -- since almost ten years now.

10 Q. Do you know what the Alliance Defending
11 Freedom is?

12 A. Yes.

13 Q. Have you met with staff from the Alliance
14 Defending Freedom in order to discuss how to serve
15 as an expert in cases involving transgender issues?

16 A. My involvement was mostly to tap into my
17 knowledge and expertise in this area, to inform that
18 organization of some of the relevant issues. I've
19 never been coached on how to be an expert witness,
20 nor have I necessarily been encouraged in any way.
21 These requests have generally come from the
22 litigating lawyers, how they received my name or to
23 what extent and in what ways they became familiar
24 with my knowledge and expertise in this area is not
25 known to me.

1 Just like the other groups that I've
2 spoken to, I've been more than willing to be -- to
3 share the knowledge that I've accumulated over this
4 last decade in this area.

5 Q. Did you attend a meeting at the Alliance
6 Defending Freedom offices in Arizona in 2017?

7 A. I don't recall the exact date, but I did
8 travel to Arizona to meet with other individuals
9 that also had unique areas of expertise in the area,
10 yes.

11 Q. Just to clarify, was that one or two
12 meetings?

13 A. I think I've had two separate meetings.
14 The first was much shorter. And the second one was
15 much more of presentations with actual data.

16 Q. What was discussed in that first meeting?

17 A. Again, it was many years ago. But my
18 recollection was just to understand what was going
19 on. It was -- it was the same types of questions
20 about the care that is being proposed and offered.
21 But it was much less defined, I think, at that point
22 in time. It was more of an informal type of
23 meeting.

24 Q. Who was in attendance at that first
25 meeting?

1 A. I suspected you were going to ask me.
2 And, you know, honestly I don't remember the exact
3 composition of the people that were there. If you
4 happen to know, I can acknowledge or deny whether
5 they were there or not. But I've met literally
6 hundreds of people over the last ten years in
7 various settings. I do know that at that first
8 meeting, Allan Josephson was there. And I believe
9 that Mark Ramirez was there as well.

10 Q. Was Jeff Shafer there?

11 A. Yes. He actually at that time was working
12 for ADF.

13 Q. Was Gary McCaleb there?

14 A. Yes. And he was one of the first contacts
15 I had from that group.

16 Q. When they invited you to this meeting,
17 what was the invitation, what did they tell you it
18 was going to be about?

19 A. They had desired to convene a group of
20 people that had knowledge in this area and to be
21 able to discuss that, is my recollection at that
22 point in time.

23 Q. Was Ryan Anderson there?

24 A. He was at one of the meetings, the two
25 meetings, I'm not sure which -- which one.

1 Q. About how many people were in that first
2 meeting?

3 A. Probably about eight to ten if you include
4 Jeff Shafer and Gary McCaleb. You know, no more
5 than a dozen, probably less than that.

6 Q. And the second meeting, you indicated that
7 it involved some presentations; is that right?

8 A. That's correct.

9 Q. Was it also in Arizona?

10 A. Yes.

11 Q. Who was present at the second meeting?

12 A. Similar to the first meeting. And, again,
13 I may get mixed up, the first and second meetings.
14 There were different people that were present. I
15 know that Walt Heyer was at one of the meetings.
16 Oxy Horvath was at one of the meetings as well.
17 You'd have to give me the other names if there was
18 any. I'm drawing a blank. It was a while ago.

19 Q. Was Mark Regnerus at the second meeting?

20 THE COURT REPORTER: I'm sorry. What was
21 that name?

22 A. He was only at --

23 MR. GONZALEZ-PAGAN: Mark Regnerus,
24 R-E-G-N-E-R-U-S.

25 A. I believe he was at one of the meetings.

1 I'm not sure which one.

2 Q. (By Mr. Gonzalez-Pagan) Was Patrick
3 Lappert at one of these meetings?

4 A. He would have been likely at the second
5 meeting.

6 Q. Was Paul McHugh at any of those meetings?

7 A. No.

8 Q. Was Michelle Cortella at any of these
9 meetings?

10 A. I've encountered Michelle at a number of
11 different settings. I'm trying to think back. I
12 honestly -- I just can't remember. She may have
13 been at one of them.

14 Q. Was Quinton Van Meter at any of these
15 meetings?

16 A. I have met with him. I'm just trying to
17 think of what the circumstances and when he was
18 there. Again, you know, I've met so many people
19 over many different years in many different venues.
20 It's challenging for me to remember who was in what
21 meeting.

22 Q. Did the ADF lawyers discuss the need to
23 develop expert witnesses for litigation?

24 A. Again since it was several years ago, I'm
25 trying to remember the exact content. I think the

1 main focus was -- was understanding what was going
2 on to be able to understand from multiple different
3 perspectives. One of the most helpful outcomes for
4 myself was the opportunity to talk to the
5 transitioners. These are adults that have had the
6 experience of going through the affirmation approach
7 only to discover eight to ten years after that, that
8 it did not solve their problems.

9 It was similar to my efforts to
10 connect with parents and -- that were experiencing
11 this with their children as part of my understanding
12 of the unique circumstances facing these
13 individuals. That's what I walked away with more
14 than anything else. Whether there was discussions
15 about, you know, whether there were -- were
16 litigation going on is -- I just don't recall.

17 Q. Were you aware that the Alliance Defending
18 Freedom is a religious organization?

19 A. I think that's -- if you travel to their
20 headquarters, that's hard to miss.

21 Q. Let's go back to your report, Exhibit 1.
22 On the third page, Paragraph 7.

23 A. We're on my expert report. Okay.

24 Q. Page 3, Paragraph 7.

25 A. Thank you. I'm going to go to my clean

1 copy that I have printed out. Okay.

2 Q. Okay. It is mentioned that you also
3 spoken with parents of children experiencing gender
4 dysphoria and earlier you mentioned that you had
5 spoken with Eli Coleman; is that right?

6 A. That is correct.

7 Q. And Eli Coleman is one the authors of the
8 WPATH standards of the care; is that correct?

9 A. He's one of the lead authors, correct.

10 Q. In Paragraph 7 you state that you have met
11 individually and consulted with several pediatric
12 endocrinologists including Dr. Norman Spack, who had
13 developed and led transgender programs in the United
14 States; is that right?

15 A. That is correct.

16 Q. Who's Norman Spack?

17 A. Norman Spack was from Harvard. He was
18 actually probably the first person to introduce the
19 Dutch model of care to the United States. In the
20 latter years of his career, he became a very
21 outspoken advocate for that approach. In fact,
22 Dr. Spack was invited to Washington University very
23 early on when the question was being proposed to
24 start the gender center at Washington University.

25 Q. And you discussed the treatment of gender

1 dysphoria and transgender people with Dr. Spack?

2 A. That's correct.

3 (Whereupon Exhibit 19 was
4 introduced for identification.)

5 Q. (By Mr. Gonzalez-Pagan) Showing you what's
6 been marked as Exhibit 19.

7 A. So this is the declaration for Norm Spack
8 for the Drew Adams case, correct?

9 Q. That's correct, yes. Have you seen this
10 document before?

11 A. I've heard of it. I believe I saw that
12 during the -- my involvement in the Adams case.

13 Q. He mentions that on or about October 19,
14 2014 -- sorry. On Paragraph 8 of the declaration on
15 Page 2, he mentions that on or about October 9,
16 2014, he gave a presentation at St. Louis Children's
17 Hospital regarding the foundation of GeMS, the
18 workings of a gender management program at a
19 pediatric hospital, and in medical treatment and
20 care of gender and nonconforming and transgender
21 children and adolescents; is that right?

22 A. Other than the word "gender" is
23 misspelled, yes.

24 Q. It goes on to say on Paragraph 9 on the
25 next page that following the presentation, he met

1 privately with medical staff including
2 endocrinologists at St. Louis Children's Hospital to
3 answer their questions and share his knowledge and
4 experience.

5 He then goes on to say that he also
6 in that context met privately with you at St. Louis
7 Children's Hospital when you approached him after
8 the presentation.

9 Do you recall that?

10 A. I recall the meeting both with the
11 faculty -- I don't specifically remember the private
12 meeting afterwards. I do remember we had kind of a
13 round table. We actually sat around a circle with
14 other colleagues of mine and addressed questions.
15 But I -- it certainly would be in agreement with
16 where I was at that point in time in an
17 understanding for the proposal for care involving
18 affirmation.

19 Q. He goes on say that during his meeting
20 with you, you directly expressed that you had,
21 quote, a significant problem with the entire issue,
22 closed quote, and, quote, whole idea of transgender,
23 closed quote. He then states that you followed up
24 these comments by stating, quote, for me it is a
25 matter of my faith, closed quote.

1 Do you recall making these statements
2 to Dr. Spack?

3 A. I do not.

4 Q. Do you deny making these statements to
5 Dr. Spack?

6 A. I do not recall making those statements.
7 And it really seems to be -- I'm not sure of the
8 context of the conversation, where that came from.
9 This was a time shortly after our institution was
10 considering the adoption of the affirmative care
11 model for starting their gender center. And very
12 clearly at that point in time, I was very early in
13 investigating the literature and I remember talking
14 with my colleagues at that very same time about the
15 questions that I had about the science, about some
16 of the statements that were being made.

17 One of the questions that came up
18 related to some of the assertions about more in the
19 area of anthropology as far as a human being and
20 whether it was possible for one to change one's sex.
21 I recall that at that point in time, you know, the
22 people were just starting to make the comments like
23 in one of the other cases where Dr. Atkins would
24 make the statements gender is sex. And I certainly
25 challenged those assertions at that time.

1 So this is a period of discovery for
2 me. And for me to make a definitive statement like
3 that is not really even logical from where I was at
4 that point in time.

5 Q. Are you familiar with the St. John Paul,
6 II, Bioethics Center?

7 A. Yes.

8 Q. Is St. John Paul, II, Bioethics Center a
9 religiously affiliated institution?

10 A. I believe it is, yes.

11 Q. Did you speak at the St. John Paul, II,
12 Bioethics Center in November of 2017?

13 A. I'm not sure of the exact date. But I did
14 deliver a talk to that group.

15 Q. During that talk, did you not state about
16 being transgender that, quote, in fact, probably
17 goes back to some of the early heresies in the
18 church, closed quote?

19 MR. KNEPPER: Objection, form, scope.

20 A. You know, I'd have to see the context of
21 when that statement was made and how it was being
22 portrayed to that audience, whether it was in
23 response to a question with context that is not
24 included in your question.

25 Again, as you mentioned, this was a