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Transcript of Dr. Quentin Van Meter

Date: March 18, 2019
Case: Grimm -v- Gloucester County School Board

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Pl. Trial Ex. 097

Transcript of Dr. Quentin Van Meter
Conducted on March 18, 2019

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
NEWPORT NEWS DIVISION

GAVIN GRIMM, :CASE NO. 4:15-cv-54
Plaintiff, :
v. :
GLOUCESTER COUNTY SCHOOL :
BOARD, :
Defendant. :

Deposition of Dr. Quentin Van Meter
Atlanta, Georgia
Monday, March 18, 2019
10:03 a.m.

Job No.: 233197
Pages 1 - 219
Reported by: Robyn Bosworth, RPR, CRR, CRC, CCR

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Deposition of Dr. Quentin Van Meter, held at:

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Pursuant to Notice, before ROBYN BOSWORTH, RPR, CRR, CCR, CRC, CCR-B-2138.

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ALSO PRESENT:
MARCY HAMPTON (via videoconference)

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E X H I B I T S

(Attached to Transcript)

P R O C E E D I N G S

DR. QUENTIN VAN METER,

having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. BLOCK:

Q Good morning, Dr. Van Meter. My name is Joshua Block. I'll be taking your deposition today. I represent the plaintiff, Gavin Grimm, in this lawsuit.

Have you ever had your deposition taken before?

A I have.

Q Great. So you're familiar with the procedure here. I'll be asking questions, and you'll be providing answers. There's three ground rules I'd like to go over with you.

The first, as you already know, is that we have the court reporter writing down everything that we say, so it's important that we don't talk over each other, so I'd appreciate it if you could wait for me to finish a question before you start answering, and I will wait for you to finish answering before I ask the next question. Agreed?

A Agreed.

Q Second, because the court reporter is writing things down, and because the video is a little fuzzy, it's important that you don't respond with visual cues like nodding your head or saying "uh-huh." All your answers need to be verbal so they can appear on the transcript. Okay?

A Okay.

Q And third is it's my job to ask questions that you can understand, so if I say anything that is unclear or you would like me to repeat or rephrase the question, please let me know. And if you do answer my question, I'm going to take that to mean that you understood it. Okay?

A Okay.

Q Great. So let's start with the document that's been marked by the court reporter as Exhibit Number 1.

(Exhibit 1 was marked for identification and is attached to the transcript.)

BY MR. BLOCK:

Q If you turn to -- a couple pages into the document there's a photocopy with your letterhead on it. Let me know if you found that page.

A I have it here.

Q Great. Do you recognize this letter?

A I do.

Q What is it?

A This is a statement of my opinion regarding information that I gleaned from reviewing records on the Gavin Grimm case.

Q Great. And if you flip to the end of the letter and look at the next page, there's a document that appears to be your CV; is that right?

A That is correct.

Q Okay. So I'll be asking some questions both about the letter and about your CV here.

So let's go back to the beginning of your letter. If you look at paragraph 9.

A Okay.

Q The second sentence says: I have testified at Georgia state legislative committee

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hearings; is that right?
A That is correct.
Q What was the subject of your testimony?
A This was regarding obesity in children, as I recall.
Q And how many times did you testify at the Georgia state legislative committee hearings?
A I testified once, I believe.
Q And in your testimony did you discuss at all any information related to transgender children?
A I did not.
Q Can you think of any way that the subject matter of your testimony at the Georgia state legislative committee hearings would have relevance to the issues in this case?
A No.
Q Okay. So going to the next sentence, you say: In the past six years, I have testified by deposition in Harlen Schneider versus J. Enrique Lujan, MD, in the Circuit Court of the First Judicial Circuit of Okaloosa County, Florida, Civil Division; is that right?

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A That's correct.
Q And what was that case about?
A It was a medical malpractice case.
Q And what was your testimony about?
A It was in -- it was for the defense -- excuse me, for the plaintiff in regard to the quality of medical care. Specific diagnosis, I do not remember.
Q And was this for an endocrine condition?
A This was for an endocrine condition.
Q And to the best of your memory, was the diagnosis at all related to either gender or sexual differentiation?
A It was not.
Q The rest of that sentence after the semicolon says that you also testified in the case of plaintiff, Kimora Gilmer. What was that case about?
A That case was about the death of a young child who had acute onset of thyroid illness which was not recognized by the medical treating facility or the physician, and the patient died as a result.

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Q What was your testimony?
A My testimony was as an expert witness talking about the standard of care in a primary care setting, and the need to have consulted endocrinology appropriately, and that was not done.
Q Now, when you give expert testimony regarding the standard of care, what sources do you look to to determine what the standard of care is?
A Routinely, they will be referencing textbooks. If there are published standards of care outside of a textbook, if it's already outdated or has been updated I will refer, after researching the literature, to the most recent standards of care.
Q Are guidelines from the Endocrine Society one of the sources you look to in other areas of endocrine medical practice to determine what the standard of care is?
A Yes, but I'd like to clarify, there's a difference between guidelines and standards of care, as I understand it. Guidelines are suggestions; standards of care, in terms of my worldview, are what are published and recognized as the -- as the

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most common and generally accepted ways to treat a patient.
Q So in your opinion the standards of care would be found in this textbooks as opposed to guideline recommendations?
A I am not sure.
Q But the guidelines from the Endocrine Society are at least one source that you would usually look to to determine the applicable standard of care; is that fair?
A Not exactly.
Q Could you explain that further?
A Guidelines from the Endocrine Society are based on opinion of the committee that developed the guidelines. They are not necessarily accepted across the board as standards of care.
Q So where would you find the accepted standards of care in that case?
A Most likely they would be in published textbooks.
Q In published textbooks?
A Yes.

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Q So to find the standards of care for treating gender dysphoria, would someone then look to textbooks on treating gender dysphoria?

A They could. There are standards of care published by the American Psychological Association in their handbook published in 2014. The exact name of that textbook, whether it's the Handbook of Human Sexuality or -- it's a title very similar to that, but it's a published textbook of guidelines.

Q Okay. So published textbooks of guidelines from the American Psychological Association would be a source for determining the standards of care for treating gender dysphoria in your opinion?

A Yes.

Q Is there anything else that would be a source for determining the standards of care?

A You could look to articles across the world's literature to see the broad spectrum of opinion and come up with what would be the best-case scenario for the patient.

Q And in general articles that are peer

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reviewed would be the best source of articles to look at; is that right?

A Yes. The whole concept of peer review ideally is to have a team of, if you will, referees that have a broad background that essentially go through and check all the references to make sure that they are valid, that the opinions stated from the references match the information published in the paper. So that would be -- and by peer review, it's somebody in the field of endocrinology, and perhaps in a field of subspecialty so that there is a very critical assessment of the validity of what's being published.

Q So when you say "look at the broad spectrum of opinion," is there a way to quantify what qualifies as a broad spectrum of opinion?

MR. CORRIGAN: Object to the form of the question.

Go ahead.

A A broad spectrum --

BY MR. BLOCK:

Q Sorry. No, no, I'll clarify. Is there a

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way to quantify what constitutes a broad spectrum of opinion for purposes of identifying the standard of care?

MR. CORRIGAN: Same objection.

Go ahead.

A Can you restate the question?

BY MR. BLOCK:

Q Sure. You referenced looking at articles to find a broad spectrum of opinion in order to derive a standard of care. Is there some sort of number of articles that you would look at for that purpose?

A More than the number of articles, the number clearly is important if you were trying to look at the balanced approach to review the subject at hand, there is sort of a general process when you review information and review literature that you look at every side of the subject, every published paper and the quality of that paper and lay them all out in front of you, if you will, and come up with what is a balanced approach to developing your opinion based on different research, different sides

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of an issue, so that you come up with what is best for the patient.

Q So when you have determined your opinion regarding treatment for gender dysphoria, did you look at all sides of the research in forming your opinion, including materials that supported your view and materials that contradicted your view?

A Yes, I did.

Q What sources did you look to for finding opinions that were different from your own?

A I looked at the bibliography for the Endocrine Society guidelines, I looked at the bibliography for the World Professional Association of Transgender Health, I looked in the Handbook of -- that I referred to published in 2014 by the American Psychological Association, I looked at the DSM-V criteria, I looked at articles published in the Journal of Endocrinology and Metabolism, the Journal of Pediatrics, a number of additional journals that I could reference if you need the specifics.

Q And when did you conduct this research?

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A I've been doing this probably five or six years in depth.
Q What research have you done since the time that you filed your declaration in the Carcano versus McCorey case?
A I've done a fair amount of additional research because there have been articles published since that time.
Q Let's look at your declaration in Carcano versus McCorey, which is marked as Exhibit 2 by the court reporter.
(Exhibit 2 was marked for identification and is attached to the transcript.)
A I have it here.
BY MR. BLOCK:
Q Great. And does this appear to be a copy of the declaration that you wrote for that case?
A It does.
Q Who first contacted you about being an expert in the Carcano case?
A I actually do not remember.
Q Do you remember what organization they

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were from?
A It would be a guess.
MR. CORRIGAN: Don't guess.
A Okay. I do not recall exactly, so I don't want to misstate.
BY MR. BLOCK:
Q Well, can you describe, in the best of your recollection, how you came to be an expert in that case?
A We had published the American College of Pediatricians guidelines for care of transgender patients, and that was used, I think, as a reference point for whoever contacted me to ask me to be -- to provide information for this case.
Q To the best of your knowledge, has the American College of Pediatricians ever been used as a source for determining what the standard of care is in a court proceeding?
A Yes, it has been -- the American College has filed amicus briefs on a number of subjects, and I do not know whether transgender specifically was one of those. I don't know what level of court it

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has ascended to, but I know it has been used as a document in transgender cases.
Q But my question is not amicus briefs, but if a physician or pediatrician was going about determining the standards of care for a condition, is the American College of Pediatricians publication a source that they would look to?
A Yes, they would review it.
Q Are you aware of any instance in which an expert witness testifying in a case has relied upon them?
A They have mentioned them specifically. I can't give you a specific case, but I know they have been referenced.
Q So you say you don't recall who contacted you about being an expert in the Carcano case. Is it your recollection that you were contacted by someone as opposed to you being the person that initiated contact?
A Yes, I was contacted.
Q And if you look at your declaration. Go back to your declaration in this case.

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MR. CORRIGAN: So Exhibit 1, not Exhibit 2?
MR. BLOCK: Correct.
BY MR. BLOCK:
Q So paragraph 10 says: I provided an expert declaration in the case of Carcano v. McCorey and U.S. v. North Carolina on August 12, 2016; is that right?
A That's correct.
Q And the declaration we just looked at as Exhibit 2 is a copy of that declaration, correct?
A It is.
Q So next sentence says: I testified in Springfield, Illinois, as a plaintiff's expert witness in the case of Cooley versus Paul.
What was that case about?
A That was a case of a child, it had nothing to do with transgender, it was a child who was treated with excessive amounts of steroid over a number of years who suffered severe medical consequences as a result.
Q What was the subject of your testimony?

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A Subject of the testimony was the standard of care for treatment of children with steroids for whatever reason and the monitoring of the side effects of those drugs.

Q And for all of these -- all of the malpractice cases we've discussed so far, did you ever reference the American College of Pediatricians as a source for determining your standard of care in your testimony?

A I did not because the issues that were raised were not issues where the College had a position statement.

Q Did you reference the Endocrine Society in any of your testimony in those cases?

A Not so much the Endocrine Society, but endocrine -- published endocrine textbooks for children.

Q The next sentence in your declaration says: I testified in court in Hamilton County, Ohio, on February 2018 in regard to Jessica Siefert, a transgender teen that had been removed from the custody of her biological parents.

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Can you tell me about that case?

A I was to provide information to the judge as an expert witness on the subject of transgender medicine presenting the broad spectrum of opinion on the appropriate treatment.

Q And you testified in court to a judge in that case?

A I testified by Skype to a judge.

Q How did you come to be involved in that case?

A The parents' attorney found me because of the position statement of the American College of Pediatricians.

Q And who was the parents' attorney?

A Let me think for one moment if I can remember the name. I can provide it after the fact. I don't want to guess.

Q What was the context in which this teenager had been removed from the custody of her biologic parents?

A The Hamilton County Child Protective Services removed the child from the family at the

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request of the clinic which was treating this young lady because the parents would not give permission for hormonal treatment for their female child. And so the clinic brought charges, and the Hamilton County DFCS assumed custody of the child and kept her in their custody and were requesting that they be able to grant custody to the grandparents, who indicated they would allow hormone treatment to continue.

And so the parents were requesting returned custody to them from Hamilton County DFCS, and the judge made the decision, after all the proceedings, to give the child custody to the grandparents.

Q And was that the end of the case?

A As far as I know.

Q Do you know if the judge made any findings of fact regarding your testimony?

A I do not. I do know that she made a specific request that the child be evaluated by mental health practitioners who were completely independent of the children's hospital who were part

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of the mechanism for getting the child taken away from her parents. The judge couldn't believe that the evaluation was not done by an independent practitioner because of the way their practitioners testified about the care of that child.

Q But the independent practitioner that the judge asked to do another evaluation ended up agreeing with the clinic; is that right?

A I do not know. The child was 17 years and 10 months of age at the time of the proceedings, and so it's a bit moot. Two months into the proceedings she was age of consent, so she could pretty much do whatever she chose.

Q Do you have a copy of the testimony that you provided in that case?

A I do not.

Q What is -- in your declaration the next sentence says: I testified via Skype in Alberta Province, Canada.

What was that case about?

A That case was a suit by parents in the school district in Alberta who had a child, an

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autistic child, who was recruited into an organization at school without the parents' knowledge.

The child was approached by a teaching assistant for the class with kids with special needs and autism, and that -- without the parents' notice, the teaching assistant told the girl that, first, she was a lesbian, and then secondarily that she was transgender. The parents were not aware of any of this information, and so their concern was the school did not share information that was important for the parents to know about their child in the school setting, and they thought that that was an inappropriate thing for the school district to take the responsibility without the knowledge of the parents. So that was -- that was the crux of the case.

Q So what was your testimony about?

A My testimony was just to give them some background information about what transgenderism as a concept is, the historical background of how it has come to be as a concept in medicine, and to give

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the broad spectrum of published literature background for that case.

Q And did you testify in court too?

A No, this was just by Skype. This was -- actually, this -- I was interviewed -- was not in court. I was interviewed by the plaintiffs' attorneys.

Q Do you know what the --

A I'm sorry.

Q Do you know what the outcome of that case was?

A I want to correct. I was interviewed by the defense attorneys primarily, I'm sorry.

I do not know what the outcome is.

Q If we can turn to your CV. Do you have any education or training related to gender dysphoria or gender identity disorder?

A My training at my fellowship at Johns Hopkins was the first introduction to me of what then was called transsexualism, but which is now referred to in current terminology as transgenderism. So that was in 1978 that I was

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introduced to that concept.

Q Have you had any other training?

A No specific training because there is not a -- there is not a curriculum, if you will, to teach transgender medicine that is available.

Q Did you have any clinical training?

A The clinical training was in the fellowship years, and then subsequently meeting with experts in the field, attending a conference of the joint Pediatric Endocrine Society and European Society of Pediatric Endocrinology in New York, but it was not so much a course, it was just a conversation.

Q And would conversations of that sort generally in your field qualify as clinical training?

A No.

Q Okay. So the only training that you had related to transsexualism, gender identity disorder, gender dysphoria, took place during your fellowship at Johns Hopkins; is that right?

A That's correct.

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Q So during your fellowship, did you actually provide any treatment for people with transsexualism, gender identity disorder or gender dysphoria?

A I did not personally do so, but I was -- the attending physicians and -- were providing the care. It was we were used as consultants to evaluate the clinical status of these patients, but we did not specifically write prescriptions for medication, we did not make recommendations for surgery.

Q You did a pediatric -- a fellowship in endocrine pediatrics; is that right?

A That's correct.

Q So what role, if any, did you have in providing recommendations for the treatment of adults with transsexualism, gender identity disorder or gender dysphoria?

A Well, we were sort of observers, if you will, of the clinical circumstances because these were adult patients, and we were pediatric trainees. Johns Hopkins's adult endocrinology division did not

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take care of these patients.
Dr. John Money was the professor on the faculty, and he worked exclusively with the pediatric department, developed his own protocol, and treated adult patients, and we were taught about that, and we were instructed about what was going on with those patients, their clinical status, and their response to therapy.
Q So you were -- in terms of how you were informed about the treatment of those patients and their responses, could you tell me the context in which you were informed of that?
A That we were informed that with clinical conference -- case conferences.
Q About how many of those?
A I recall four specific patients that we learned about in a fair amount of detail at the time. I remember I still have teaching slides from those patients in my teaching slide library. There were, I believe, as many as 12 patients overall in the program during the time that I was there at Johns Hopkins, and those cases were subsequently

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reviewed and reported in the medical literature.
Q And did you provide any input in the treatment of those patients?
A I did not.
Q Did not?
A I did not.
Q You say in your report that during your time at Johns Hopkins you had above-average exposure to children with disorders of sexual differentiation; is that right?
A That's correct.
Q What do you mean by "above-average exposure"?
A Well, the endocrine fellowship training programs are essentially all university based, and because Johns Hopkins was the place where steroid biochemistry and physiology and the physiology of sexual differentiation was primarily outlined, the effect of steroid hormones on the development of the fetus, patients were referred there because the faculty were world renowned. And so comparing that to another center in another city, we tended to get

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more referrals there because of the reputation, if you will, of the clinical faculty.
Q So how many children were you exposed to regarding disorders of sexual differentiation?
A In the two years of my clinical fellowship I would -- and this is an estimate -- would say somewhere between 50 and 75 patients.
Q And did you treat any of those patients?
A Yes, I did.
Q How many of them did you treat?
A I would say almost all those patients that I told you about are patients that I actually treated or was involved in the treatment. There were -- as a fellow you share the treatment experience with other training fellows. Because of the numbers of patients we all got to see most of these very interesting patients.
Q Now, all of these patients were children with DSDs, not transsexualism, gender identity disorder or gender dysphoria; is that right?
A That's correct.
MR. CORRIGAN: What's a DSD?

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THE WITNESS: Disorder of sexual differentiation.
MR. CORRIGAN: Sorry.
BY MR. BLOCK:
Q The fellowship ended in 1980; is that right?
A That is correct.
Q Have you had any training in psychiatry?
A No, I have not, other than its implication and recognition of mental health disorders in the general pediatric population and how mental health issues are related to endocrine diseases, but not specifically in the active treatment with medication.
Q Have you had any training in psychology?
A As part of our pediatric residency program, we were exposed to courses and information on pediatric mental health issues with psychiatry faculty, psychology faculty. In my Navy career of 20 years in the hospitals where I was stationed, there were clinical psychologists on the faculty that regularly integrated their work with the

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endocrine population of patients, most notably the diabetic patients.

Q But you did not personally receive any training; is that right?

A I received training; I just did not have a certification as a mental healthcare provider.

Q Would you feel qualified to appear as an expert witness regarding psychology or psychiatry for a condition other than gender dysphoria?

MR. CORRIGAN: Object to form.

Go ahead.

A No.

BY MR. BLOCK:

Q Have you done any scientific research related to transsexualism, gender dysphoria or gender identity disorder?

A I have not.

Q Have you done any scientific research related to transgender people?

A I have not.

Q Have you done any scientific research related to gender identity issues at all?

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A I have not done any research, I have just reviewed the literature.

Q Have you published any articles or books addressing transsexualism, gender identity disorder or gender dysphoria?

A Our letter in regard to the Endocrine Society guidelines was just published in this month's edition of the Journal of Clinical Endocrinology and Metabolism, so that is published in a peer-reviewed journal. I have submitted for publication an article about the potential pathways of treatment for transgenderism; do not know the status of that acceptance.

Q Tell me the -- what you're referencing as something published in the Journal of Endocrine and Metabolism, that was a letter to the editor; is that right?

A That's correct.

Q Is it your understanding that letters to the editor are peer reviewed?

A They are.

Q And are letters to the editor based on independent research?

A Letters to the editor are very specifically required to have a number of references, and they're reviewed before publication.

Q But my question is about research like your independent research. The letter to the editor wasn't based on that, right?

A No, this was not based on a research study.

Q What is the nature of the peer review for letters to the editor?

A The letters to the editor, as I understand, are reviewed by peers for accuracy, appropriateness of references, and content, and then they are recommended for publication or not.

Q And the second publication you referenced regarding -- was it pathways of treatment for gender dysphoria?

A Yes.

Q What was the name of it? What was the name of that article again?

A It's a commentary article bringing transparency to treatment of transgender persons.

Q And where did you submit that article for publication?

A It has just been submitted to a journal that I do not recall the name of, I'm embarrassed to say. It just was finished last week and sent to the person who was to get it to the publication for review. There was evidently a possibility of several journals, and if it is not accepted or reviewed appropriately, it will be sent to another journal.

Q Is the journal that you submitted it to a peer-reviewed journal?

A Yes, it is.

Q Is the journal called The New Atlantis?

A No.

Q Is it a journal that specializes in endocrinology?

A I do not believe it is.

Q Is it the Journal -- what's the subject matter of the publications in general?

A I don't want to misspeak, so I might -- I

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think I have an idea of the name of the journal called Issues in Law and Medicine.

Q Do you know who publishes it?

A I do not.

Q I'm sorry, did you answer? I couldn't hear.

A I do not know.

Q So other than the letter to the editor, do any of your publications listed on your CV address transsexualism, gender dysphoria, gender identity disorder or related issues?

A They do not.

Q Have you given any presentations about gender dysphoria, gender identity disorder or transgender issues?

A I have.

Q How many?

A 11 or 12.

Q And are any of those presentations listed on your CV at all?

A I do not believe they are.

Q Why not?

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A I didn't think about putting them on, and most of them are in the past year, and I specifically did not think about putting them on the CV, not for any reason other than I was focusing on publications more than anything else. There are a list of presentations given on general endocrine subjects in the past. If you need specifics of those, I can provide that, I just didn't put it on the CV.

Q So where -- in what context did you give these presentations about transgender issues?

A I gave a series of lectures in Australia on behalf of the Australian Family Association, I gave a presentation at the International Federation of Therapeutic Choice, I gave a presentation to the Matthew Bulfin Conference -- joint conference at the American College of Pediatricians, I gave -- and I'm giving another one to this -- the same group this year in early April, and I've given a talk on transgender medicine in the Southern Pediatric Endocrine Society meeting on two occasions.

Q Tell me about this -- the Southern Pediatric Endocrine Society meeting. What sort of meeting is that?

A It is -- it's a regional meeting of pediatric endocrinologists which occurs -- has been occurring annually. We had a year off last year. It involves pediatric endocrinologists in Kentucky, Tennessee, Virginia, South Carolina, North Carolina, Georgia, Florida, Alabama, and Mississippi. So they're inviting -- the invitation is to pediatric endocrinologists in those areas to come together and do a -- either a planning session or case presentations.

Q When did you give your presentation?

A The first presentation was in 2016. The most recent presentation was last month in Orlando, Florida.

Q Do you have copies of your presentations?

A I do.

Q Is it easy for you to provide copies without that being burdensome?

A They're PowerPoint presentations. I could present --

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THE WITNESS: I could give them to you.

MR. CORRIGAN: Okay.

MR. BLOCK: We'll follow up with counsel about that.

BY MR. BLOCK:

Q So looking at the other organizations, I want to make sure I have the list, so you have -- you gave presentations to the Australian Family Association. Is that a medical organization?

A It is -- no, it's not.

Q And you gave a presentation at the International Association of Therapeutic Choice; is that correct?

A That's correct.

Q What is the International Association of Therapeutic Choice?

A It's a consortium of mental health providers around the world, so it's primarily based on, again, mental health issues.

Q Is it fair to say that it's an organization that supports the option of patients seeking therapies to change their sexual

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orientation?
MR. CORRIGAN: Object to form.
Go ahead.
A It's an organization that asks for ability to provide counseling that the patients request.
BY MR. BLOCK:
Q To change their sexual orientation?
A That is often an outcome, but it's not the goal.
Q And does the organization also support the ability of patients to seek therapies that change their gender identity?
A Again, it is at the beginning of this subject, so they have no particular guidelines other than those that are recommended by the American Psychological Association, which they use as a reference for standards of care for treatment.
Q What's your understanding of the American Psychological Association's position on therapy to change a person's sexual orientation or gender identity?
A The concept of the idea is that there is

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fluidity in both circumstances, and that's -- that is their statement specifically, that there is fluidity. It doesn't recommend, as I understand, anything that should or should not be done, other than things that are proven to be harmful.
Q Is there anything that this association focuses on besides sexual orientation or gender identity?
A I do not know.
Q So not that you're aware of?
A Not that I'm aware of.
Q The next organization you referenced sounded like you said Matthew Bulfin. Am I hearing that correctly?
A It's Matthew B-U-L-F-I-N.
Q And what's that?
A It's a conference that's given every other year, I believe, and it involves issues of bioethics in medicine.
Q Is that conference religiously affiliated?
A No, it is not.
Q What organization is the conference

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affiliated with?
A It's affiliated with the American College of Pediatricians and the American Association of Pro-Life Obstetrics and Gynecology.
Q So are there any other organizations that you gave conference presentations to other than the ones that we've discussed?
A I gave a presentation on the history of transgender medicine to the Teens for Truth conference in I believe it was Houston, Texas, in February of 2017, I believe. That could be a guess. I don't want to state that on the record.
Q What is Teens for Truth?
A It was a conference for teens to come together and learn about issues of human sexuality.
Q But what specifically were they learning?
A Things -- cases were presented to them by individuals who had experienced certain issues in their lives that they wished to let the teens know that they needed to be open about these issues, discuss them with their parents, discuss them with a therapist, and hopefully resolve their depression

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and anxiety.
Q So is this -- the presenters are people who said that they formerly identified as being gay or transgender, and that they no longer do so?
A There was no case of transgender in that particular conference. There was a focus on the family and adverse childhood events, so to essentially get the kids to open up about things that had happened in their lives and be able to have a vehicle to bring those things up to their parents or healthcare providers.
Q So the "truth" referenced in Teens for Truth is that someone who struggled with same-sex attraction could have treatment that makes them not be gay; is that right?
A No.
MR. CORRIGAN: Object to the form of the question.
Go ahead.
A The answer is no. It was essentially aimed at trying to get kids to open up about the truth of what was going on in their lives that

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brought them to the point of depression or suicide or severe anxiety.
BY MR. BLOCK:
Q But all of these children, their -- their depression or other anxiety was related also to same-sex attraction; is that right?
A Not all.
Q Many?
A Some.
Q So the conference had nothing to do with overcoming same-sex attraction?
A That was a subject that was discussed.
Q What other subjects were discussed?
A As I recall, concept of sexual abuse was a major topic, coming out from under the concept of sexual abuse; stories of patients who had experienced rape and how that affected their life, and being able to come out whole on the other side of those kind of issues; children who had grown up in families where there was enormous amount of psychological and behavioral malfunction of parents in raising the child, a lot of it that had to do

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with sexual activity and sexual abuse and trying to bring this to the forefront as a reason to seek therapy and to be healed. And the healing had to do with resolution of depression and anxiety, specifically.
Q Did it have anything to do with lessening same-sex attraction?
A If that was -- if that was something that happened, it was not -- it was not shunned as an option, but the option was not specifically to focus on that as the only -- only outcome, it was more on trying to get these children to be able to be functional kids in their lives. If part of the resolution was that they changed their sexual attraction to any degree at all, that was what was viewed as an outcome, but the outcome was primarily to avoid depression and suicide.
Q So what's your understanding of what the name of the organization references with respect to truth?
A The organization, I think, chose the title to be able to allow kids to discuss things with

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their parents, and to discuss things that were very difficult that otherwise would be buried.
Q You're a pediatric endocrinologist, correct?
A That's correct.
Q You have a private practice?
A I do.
Q What's the age range of your patients?
A From birth to completion of their first undergraduate college degree.
Q Have you ever been sued for medical malpractice?
A I have.
Q Have you ever treated or evaluated patients with gender dysphoria, gender identity disorder or gender discordance?
A I have.
Q How many?
A Within the past two years, I have about 12 patients, active patients. I had one patient in 1993 when I came to the Atlanta area. And a family moved from Southern California -- it was a military

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family, and they moved often, and they brought their child in to ask me if I would provide estrogen therapy for that child, who had been evaluated by a psychiatrist in the Los Angeles area, and the parents were advised that upon the next move that that child should be allowed to assume the identity of a female.
When the child came to see me, the patient was 13 years old, had a female name and pronouns, and dressed as a female. The school board of the county asked me to help them develop a policy for that child to be able to -- to have physical education at a time of day when the child could go home from school and not have to worry about sharing locker facilities that did not match the biologic sex. Fayette County School Board here in the Atlanta area allowed the child access to a unisex bathroom in the school. So I helped them develop a policy for that child.
At that particular time I canvassed all of my mentors across the country to ask them how to handle the estrogen therapy, because there was no

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appropriate FDA indication to treat such a child, and there had been no standards of care set up for that.

They advised me that they had no experience in this field subsequent to the closure of the clinic at Johns Hopkins -- no, there were no recommendations professionally by any professional societies in the United States, and so they suggested that I use our practice attorneys to draw up an informed consent for the parents to sign indicating that they were choosing to have their child treated with estrogen at their request, even though we did not know about the potential adverse outcomes that might happen over the long run.

I treated that child for six months, and the family then moved out of the geographic region, and I have no idea what happened to that child after that.

So that was my very first case of a transgender patient in my clinic, and there was no reference source of standards of care or clinical experience that I could find across the United States at the time.

Q This was in 1993, you said?

A Yes.

Q So that was the first transgender patient since your fellowship; is that correct?

A That's correct.

Q So when's the next time you treated a transgender patient?

A Approximately two years ago I began receiving referrals for transgender patients to my private practice office.

Q And so this was after you filed your declaration in Carcano versus McCorey?

A I might be off on the date. It might be that as of three years ago I started seeing transgender patients. It's in the past two years that the numbers have increased.

Q Did these patients all come to you after the American College of Pediatricians had published statements disagreeing with providing hormone therapy to transgender youth?

A They did.

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Q And so what sort of treatment do these people that come to you ask for?

A They ask for anything from hormone therapy to -- hormone therapy specifically, because that's in the purview of endocrinology.

Q In what context are these patients referred to you?

A It's usually a self-referral.

Q Are they familiar with your position on the American College of Pediatricians?

A None have stated so.

Q So what treatment do you provide these people?

A I evaluate their history, I evaluate their physical condition, their status in puberty, I review the -- in depth the family and social history, and then I request the ability to be able to talk to their counselors who have evaluated them in the first place. If they have not done so, I refer them to a general counselor in their area to evaluate the undercurrent emotional issues.

Q And then after that, what do you do? Do you provide any treatment to them?

A I do not provide any hormone treatment.

Q So why make them go through this evaluation if you don't provide that treatment?

A Because that treatment is harmful. It's proven to be harmful. The vast majority of scientific literature looks at the side effects short-term and long-term, and mostly long-term, and indicates that there is potential damage.

So I explain to the parents that I am very much caring and compassionate for this child, and I will do everything I can to help them through and be sure that they have the appropriate evaluation of their mental health issues that are brewing beneath the surface. And I would say without question every single patient that has come in has significant emotional health history issues.

Q So you're not actually providing any treatment to the patients yourself; is that right?

A I am not providing hormone therapy. I am providing them information on what hormones do; I explain the physiology of hormones; I explain the

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history of treatment and the options that are -- that they read about; I discover from them, by interview, what they have learned and what sources they have used to learn that information.

Q So but you don't treat them?

MR. CORRIGAN: Object to form.

A That in my -- I'm not giving them hormones, but I am treating them in the sense of evaluation and continued contact to be sure that their needs are being met in terms of emotional evaluation.

BY MR. BLOCK:

Q What continued contact do you have with them?

A I see them every three months.

Q What diagnostic code do you use to bill it to insurance?

A There is -- there is a code for transgenderism.

Q So you use the diagnostic code for treating transgenderism for follow-up appointments with patients after you tell them that you don't

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provide hormone therapy?

A Well, I code out the physical exam, the evaluation and the history on the initial exam, and then I code out subsequent counseling appointments where it's essentially a conference appointment. If it requires an evaluation of their physical condition and their stage of progression in puberty, that is coded as a physical exam.

Q How many counseling appointments do you have with a typical patient?

A Again, these particular patients are seen every three months.

Q But how many times?

A Ongoing as far as possible.

Q I guess I'm confused about what the check-in would be, like, for the second time.

A The check-in is to ask what they understand. It is a very complex issue to deal with. Particularly in the younger children, I find that many things that we have -- I have interviewed them and found information about from them as individuals, both in private interview with them,

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and also with their parents, is that they, many times because of their age, do not understand a lot of what we talked about and a lot of the information we gathered previously.

So it is very important, based on the maturity of the patient and their understanding, to be able to go back and make sure they are on the same page with me in terms of what I know they know, and what I have taught them, and what I have suggested for them, and how their counseling is going.

Q And so you need to have -- so you need to have, like, a third or fourth or a fifth check-in for that purpose?

A I do not want these patients to be lost, okay? That's the problem. If they're lost to care, then I have not done my job to my best ability. So it's like any condition where you are constantly in touch with the patient, such as a patient with obesity. You keep in touch with them, you bring them back, you see what's going on with all of the issues, school performance, et cetera, et cetera.

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It's a complex review of history and any physical changes, and I demonstrate to them the depth to which I am trying to keep them in the fold and make sure that their needs are being met appropriately.

Q By your phrase "keeping them in the fold," do you mean making sure that they're not receiving gender-affirming hormone therapy?

A I wouldn't be providing that, so if they share that with me, I would assume they're not -- that's not something that I can continue or recommend for them, so I would probably part ways at that point in time and say, you know, you have a choice to come here, or you have a choice to go someplace else. I've done to my best ability all I can to help you. My door is open, you can call 24/7 and request to be in touch with me through my practice, and I will be available to help you with anything that I can.

Q Do you have any qualifications as a mental health counselor?

A I do not.

Q And would you describe your meetings with

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these patients as involving mental health counseling?
A Not mental health counseling, but evaluation of where they stand and how they are doing both physically and emotionally because as an endocrinologist we deal with depression and anxiety in patients very frequently with chronic, nonfatal illness.
Q Do you ever refer the patients to mental health counselors?
A I do.
Q Which ones?
A Ones that are covered by their insurance.
Q Is there any -- is there any specific counselors that you generally try to refer people to, assuming that they're covered by insurance?
A I try to hook them up with a personality that I believe would be a good fit in terms of the child's level of comfort. Most often, adolescent males I refer to male counselors, adolescent females to female counselors.
Q And Allan Josephson, is he one of the

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counselors you refer people to?
A I don't recognize that name.
Q Do you make sure that the counselor that you're referring people to share your views about the dangers of gender-affirming therapy?
A Not often. I basically try to find somebody who is a general counselor who understands anxiety and depression and who will delve into the adverse childhood events which lie beneath the surface.
Q Do you have a preference for referring people to counselors who are members of the American College of Pediatricians?
A They're -- no, I do not because there are not very many members of the American College. American College members, full members are pediatricians, Board-certified pediatricians. There are some ancillary associate members in fields of surgery and mental health who have aligned themselves with the College as being interested in helping and aligning themselves with our guidelines, but those are people from across -- they're not in

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my geographic region.
Q Do you have a preference for referring people to counselors who are members of the Christian Medical and Dental Association?
A I do not.
Q Is that a no? Sorry, I didn't hear.
A That's a no.
Q Are you familiar with the Christian Medical and Dental Association?
A I am.
Q Are you a member?
A I am not.
Q In your practice, your private practice, do you treat children with DSDs?
A I do.
Q How many?
A I have, perhaps, four active patients who qualify as having disorder -- no, I have six patients who I follow currently.
Q Over the course of your career, on average how many patients a year would you say you have with DSDs?

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A With DSDs? The six patients I mentioned are patients that are in the practice that are geographically in the Atlanta metro area or within the state where we're the closest -- we are a conveniently located practice. So the number is fairly stable.
These are really rare kids. Those that require any sort of team approach, we are developing a DSD multi-specialty clinic at Emory University locally where they can get essentially local care for any urologic or gynecologic types of surgeries, and so it's a newly developing entity we have put together in the Atlanta metro area. It is brand new.
Before that the cases were rare enough that if -- I would refer back to Johns Hopkins a number of the patients over the years I practiced in Atlanta who required any surgical intervention.
MR. CORRIGAN: What do you think about a break?
MR. BLOCK: We can -- that's okay, we can do that. Five minutes?

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MR. CORRIGAN: Sure.
THE WITNESS: Good.
MR. BLOCK: Okay, great.
(Recess 11:17-11:28 a.m.)
BY MR. BLOCK:
Q So before the break we were talking about your treatment of transgender patients or patients with gender dysphoria, and I just want to make sure I have an understanding of the facts.
So from the date of your end of your fellowship, the next time you treated someone with gender dysphoria or gender identity disorder was in 1993; is that correct?
A That is correct.
Q And then since 1993, you haven't treated any other transgender children until a couple of years ago; is that correct?
A That is correct.
Q And by "couple of years," that means two or three years?
A Yes.
Q And what is the total number of patients

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with gender dysphoria that you've treated during that time period?
A 12.
Q 12 total.
Are all 12 of them -- 12 of them currently active patients?
A Let me think for a minute. I think one -- one patient has left the geographic area.
Q So you're currently seeing 11?
A I included the -- well, 11 is fine, yes.
Q Okay. And what is the longest that one of these active patients has been seeing you for?
A Three years.
Q And how many appointments would you say you've had with that patient over the course of three years?
A That one has had six -- six visits.
Q And does that patient -- does that patient expect to have more visits in the future?
A The visits tapered off. The patient is primarily managed by the mental health provider.
Q When is the last time you've seen that

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patient?
A About six months ago.
Q And how old is the patient?
A The patient would now be around 15.
Q And has the patient, to the best of your knowledge, received any gender-affirming therapy?
A No.
Q Have any of your patients, to the best of your knowledge, received gender-affirming therapy?
A I do not know of any who have.
Q Have any of the patients that you've seen for transgender issues socially transitioned?
A Some were socially transitioned as they presented. One is still socially transitioned. The others have essentially stopped the social transition.
Q But they had started the social transition before seeing you, and after they saw you they stopped?
A That's correct.
Q And would you say that you encouraged them to stop social transition?

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A Their mental health therapist made that -- helped them guide them toward that advice. I specifically -- again, my role is to explain what the options are and what I know about complications, and I do not -- I do not force the patient to take any particular route other than to stick with the therapist. I'm very, very insistent on the fact that they maintain their contact with the therapist. And if the therapist ends up not being a good fit not -- for any other reason other than they don't get along, I find a new therapist.
I'm in a role, if you will, of sort of a subset of primary care in that -- in the world of transgender in that I am taking the responsibility of making sure that the therapy is continuing, and the patient is not lost to follow-up.
Q And when the patients come to you in the first instance, how many of these 12 had therapists that had already treated them and recommended that they see an endocrinologist?
A It's an estimate of about half of them were already seen by a therapist.

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Q And half weren't?
A And half were not.
Q So the half that were already seen by the therapist, how many of them did you encourage to find a different therapist?
A All of them.
Q All of them?
A Yes.
Q And why did you encourage them to have a different therapist?
A Because it was my sense that the therapist that they were seeing was not dealing at all with the basic issues that I could glean, was not paying attention to the undercurrent depression and anxiety.
Q And you saw yourself as being able to diagnose that more than their therapist that they had before seeing you?
A The patients gave the history of what they were -- what the sessions were about, the parents gave the history of their input and what was told to them by the therapist, and it did not include any

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treatment for depression or anxiety, it did not include any evaluation in depth of what the parents shared with me.
So in those cases I felt that it seemed that they were being superficial and not actually paying attention to the undercurrent mental health issues, and so instead of trying to treat those mental health issues and evaluate them in depth, I referred them to somebody who could do a better job.
Q And that was your opinion for all of the patients that you saw that had already been seeing a therapist; is that right?
A That is correct.
Q So when you encouraged them to see a different therapist, did you -- what was the explanation you gave them for why you were encouraging them to see a different therapist?
A Because I felt that their emotional health history had not been adequately evaluated by feedback given to me by either the patient or the parents or both.
Q So the therapists that they were referred

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to, did you have any prior knowledge of those therapists' opinions with respect to treatment for gender dysphoria?
A In one case I did.
Q And what was your knowledge of those opinions?
A This particular individual essentially said that they had had a good deal of clinical experience, that they would not necessarily have an agenda set ahead, but they wanted my -- they wanted me to know that they might possibly suggest affirmation therapy.
Q And you referred that patient to that therapist?
A I did.
Q What are the age ranges of these patients when they come to you?
A I have had a patient as young as six, and patients as old as 17.
Q So in what context -- half of the patients had not been seeing a therapist, so how do they come to be in your office in that case?

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A The parents either sought out an endocrinologist and found me because I was on their insurance plan, or they were referred by their pediatrician.
Q Did any -- to the best of your knowledge, any of the patients that came to you know in advance of your opinions with regard to gender-affirming therapy?
A I do not know.
Q Do you know if their parents knew?
A I do not know.
Q Did any of them come to you with -- did all of them come to you seeking gender-affirming therapy, or did any of them come to you to talk someone out of seeking gender-affirming therapy?
MR. CORRIGAN: Object to the form of the question.
Go ahead.
A All of them came to me with concern that there were issues of gender incongruence to some degree.
They asked what kinds of services I

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provide, and I tell them that I provide an in-depth evaluation of their physical condition, and a review in depth of their family and social history with siblings and adults in their lives, and that I am fairly up front as I get to the end of my evaluation to say that I do not provide hormone treatment therapy, but that I do recommend before they go anywhere that they seek out a very thorough, in-depth evaluation of their mental health.

BY MR. BLOCK:

Q So to the best of your knowledge, none of the parents of the patients knew in advance that you would not be providing transition-related care?

A I did not know, and I did not ask.

Q So you had said that there was one situation where you knew in advance the therapist's views on gender-affirming care before you made the referral, but for the other 11 therapists that you referred people to, you didn't know their views in advance?

A The one that I referred to was the very first case that I asked among my mental health

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practitioners in the Atlanta area who had referred to me and I had referred to them in my medical history of treating patients in Atlanta, and the one psychiatrist, one child psychiatrist that I had the most referrals from and who I referred to very often suggested that this person was the counselor who had the most clinical experience, and he knew her personally and thought that she unquestionably would review everything with an open mind, and that I should consider talking with her, which I did, and I found out that she -- the insurance that she accepts is very limited, so it ends up not being possible for the parents to get to her very often as a result of that.

In the meantime, I began talking to the other providers and asking them if they would help me with evaluations of kids that came to me with transgender issues in regard specifically to going in and looking at the review of adverse childhood events and family dynamics that would set up depression and anxiety that needed to be evaluated, and that's the depth of what I know about.

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Many of these people say they had no specific training in transgender issues, but I said, that's not what I'm asking you to do. I'm asking you to evaluate the undercurrent pathology, emotional pathology that exists that I sense is going on based on my clinical experience with these patients, clinical literature which says that that's the issue, and that I would like to have them evaluated, and I've not had any pushback with those practitioners.

Q So you've -- with the one exception of this therapist that doesn't take a lot of insurance, the other therapists you've referred people to don't have any experience treating transgender individuals?

A I don't know. They do have experience in treating mental health in general, and this is a mental health issue.

Q Right. But for transgender individuals, they don't have any experience specifically with respect to that; is that correct?

A I do not know.

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Q And when you provide -- when you have a conversation with the therapist that you're referring them to, do you disclose that you do not provide gender-affirming care in your practice?

A I do.

Q So -- and do they -- how do they respond once you disclose that?

A They respond that they're very interested in evaluating the patient, and they will provide that service.

Q Have any therapists declined?

A I had one therapist who said that they were not comfortable with the idea of treating transgender patients; that they would prefer not to.

Q And did you have any prior knowledge whether any of these therapists provided counseling to people struggling with same-sex attraction?

A I do not.

Q Did any of the therapists that you talked to indicate in advance that they agreed with your views with respect to not providing gender-affirming therapy?

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A They respect the fact that I practice as I do, and they would evaluate the patient, and if they were unsuccessful with their endeavors would be open-minded to recommend, if necessary, other places to go to treat.

Q What do you mean by "unsuccessful with their endeavors"?

A This is a long-term process of evaluation, which is why these cases are all ongoing. This is therapy that takes a long time to work with the families and the patients to understand all the dynamics. This is experience that's been published by -- primarily by Kenneth Zucker in his extensive work with these families.

It is not an easy problem to solve. It takes a lot of attention and time. And so if at the end of -- if they're not successful with getting this child to improve their mental health, they're going to try to find somebody else who can do that for them if they're not -- if it's not working for them.

Q So success would be defined as improving

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mental health without having any gender-affirming therapy?

A I think because of the fact they know I do not provide gender-affirming therapy, that they would let me know if the issue was beyond their area of expertise and success, and they would refer to somebody else.

Q So the only therapy that they personally would be able to provide would be to address mental health issues without providing gender-affirming therapy, and if -- but they would not themselves as part of their treatment be providing any gender-affirming therapy, that wasn't an option for what they would personally be providing?

A I don't know what they provide. I just know that I refer to them to evaluate the undercurrent issues, and that's where my focus is. I think that they would rather -- well, I can't speak for what they do.

Q Did you refer these patients just for evaluation?

A Evaluation and treatment.

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Q So to provide ongoing therapy also?

A Yes.

Q And if the -- and the therapists report back to you on the state of their treatment?

A They do.

Q And for the patients, how many of the patients would you view as having improved psychologically?

A It's a process in the work. I would say two patients of those have resolved their issues successfully and moved on, and the rest are works in progress.

Q So of the 12, two you would say have successfully resolved their issues?

A Yes.

Q And how do you determine that; how do you know that they've successfully resolved their issues?

A Feedback from the therapist, and the patient's own description of how they feel, and the fact that their gender incongruence has resolved.

Q I'm sorry, are you still speaking?

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A Yes. No, no, I finished. I said that --

Q Okay.

A -- the way I know is input from the therapist, and also input from the patients themselves in terms of what they describe of no longer being -- feeling that they are born into the wrong body.

Q How old were these two patients?

A One was 15, and one was 17.

Q You referenced Kenneth Zucker; is that right?

A Yes.

Q Who is Kenneth Zucker?

A He is a Ph.D. psychologist from Toronto who established a clinic for evaluation of children with transgender issues. He coined the term "gender identity disorder." I believe he's a member of the World Professional Association of Transgender Health. He is widely published, widely respected for his opinions on evaluation and treatment with mental health -- providing mental healthcare.

Q You would view him as an expert in the

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field; is that right?
A Yes.
Q And you would view his therapy as being in accordance with proper standards of care for treating transgender youth; is that right?
A That is correct.
Q And you said he's a member of WPATH; is that right?
A I believe he is. I don't know of the status of that membership. I know he has been in the past.
Q Are you aware of Dr. Zucker's views on the appropriateness of hormone therapy for transgender youth whose dysphoria persists through adolescence?
A I believe he indicates that as an adult that those patients could be considered for therapy. If their lifelong evaluation and therapy did not bring about desistance of their gender incongruence, that hormone therapy could be appropriate.
Q I want to just make sure we're talking about terms like "adults," when we use that term. My -- so my question is people whose gender

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dysphoria persists through adolescence, not necessarily legal age of majority in a given country, is it your understanding -- what's your understanding of his views in providing hormone therapy for people whose dysphoria persists through adolescence?
MR. CORRIGAN: Object to form of the question.
Go ahead.
A My understanding is that if with consistent therapy there is persistence of gender incongruence, that those specific patients, and there are a very small percentage of them -- it might be warranted for them to be considered for hormone therapy.
BY MR. BLOCK:
Q And do you think someone providing hormone therapy to those patients is engaging in child abuse?
A If they are treating a child, I would say that that is essentially treating the patient and causing harm. Whether I specifically use the term "child abuse," it is known to have inappropriate long-term effects, it is not evaluating -- it's not paying attention to the core issue, it is preventing that child from being able to make it through natural puberty with their natal hormones to allow them to resolve these issues through counseling and personal experience of living in the biologic body unaltered by opposite hormone therapy.
So it is -- I would say it is inappropriate to do that.
Q So my question isn't about people who have not yet come through puberty. My question is about people whose dysphoria persist through puberty. So, for example, someone who is 16 years old and falls within that small category of people we referred to earlier about for whom Dr. Zucker thinks treatment might be appropriate, do you think it is child abuse to provide that group of teenagers with gender-affirming hormone therapy?
A So adolescence goes actually up through age 21, technically. It happens that age of majority sort of falls in the last stages of adolescence in this country. I would think that it's inappropriate for a patient to be treated while they are still going through puberty.
Puberty goes up in boys -- the final stages of an average travel through puberty for a boy is 18 and for a girl is 16 and a half, so the hormonal changes that are happening in the process of puberty that is physiologic continues to that point. The development of the brain, however, continues up through age 25.
So there are things that are supposed to happen as a result of going through puberty. If it is altered, if it is stopped in any way, if it is then changed with cross-sex hormones, you are throwing into the human body hormones that are incompatible with the physical biologic body, and you are creating harm.
So I would say my purview of patients as far as I can make recommendations is up through the age of consent. If they come to me after, as one patient has, I still recommend to them that they consider carefully other options and pay attention

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to other options instead of doing hormone-affirming and surgical therapy. That's my advice to them at that point in time.

Q Dr. Zucker's published research on rates of persistence and desistance of gender dysphoria among children; is that right?

A Yes, he has.

Q And what's your understanding of what his research shows about the age at which persistence is more likely than desistance?

A A persistence occurs at the end of puberty as they have finished going through puberty. Desistance occurs anywhere along the way.

Q So it's your understanding of Dr. Zucker's research that rates of desistance remain high until boys reach the age of 21 or girls reach the age of 16 or 16 and a half?

A No, there is a curve of slower amounts of desistance. The vast majority of patients who are allowed to go through natural puberty desist.

Q Yes, but for people who continue to have gender dysphoria once they start going through

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puberty, are you familiar with the rates of desistance for that group of people?

A That group of people if left alone desist. It's a smaller percentage as they get older and farther along in puberty, but blocking puberty is not an appropriate thing to do because it's not physiologic.

So the desistance rates from his published work show that there are -- as you got older and older the desistance rate lessened, but that in the group of all the patients, including those who entered puberty, that desistance was remarkably high.

Puberty is a six-and-a-half-year event for a boy and about a five-year event for a girl. Five or six years. And so that is a time spectrum during which if you say if you enter puberty, he's talking about people that have been in puberty, who have been counseled, who have not had affirmation medical therapy, that the majority of those kids desist. A small percentage do not, and his recommendation personally, based on his experience, is those would

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be patients who would be candidates potentially for hormone therapy.

Q And do you know either way about whether he thinks the age where desistance rates are no longer high comes around age 15 or so?

A That -- his opinion has changed as far as I know. His first published studies in his paper in 2012 indicated older age. I have not had a direct conversation with him but have had opportunity to know his opinions, and he is waffling a little bit on the upper end of that, saying that there are patients in late adolescence versus young adulthood. It's a matter of semantics more than anything else.

Q So but you disagree with his view that hormone therapy should be considered for transgender youth whose dysphoria persists until late adolescence; is that right?

A Yes, I do. I'm not -- he is not an endocrinologist. I am. I'm aware of the endocrine side effects and the long-term morbidity that's caused by cross-hormone therapy, and I could not recommend it for any adult.

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But I do not practice adult medicine. I'm a pediatrician. I go up through my age range up through age 21 or 22, and in no circumstance would I recommend cross-hormone therapy personally as an endocrinologist. That's my field of expertise.

Q But that's a view that Dr. Zucker does not share?

A I don't know about his background in endocrinology and why he makes that recommendation, but -- and I don't know the exact age. I know it was late adolescence because the desistance rates that he published originally and that also come up from studies in Europe show desistance is very, very high.

Q I just want a yes-or-no question that Dr. Zucker disagrees with you with respect to providing hormone therapy for people whose gender dysphoria persists until late adolescence.

MR. CORRIGAN: Object to form.

Go ahead.

A I think the term here is -- that we're wrestling with is "late adolescence," what he means

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by late adolescence, and what I mean by late adolescence, and I don't personally know now what he means by late adolescence. I knew what he published before, and I don't know what his opinion is today.
BY MR. BLOCK:
Q He thinks hormone therapy could be considered appropriate for some people, and you think hormone therapy is never appropriate for anyone; is that correct?
A Would you restate that question?
Q Yeah. So he thinks that gender-affirming hormone therapy may be medically appropriate for some people, and you think it is never medically appropriate for anyone; is that right?
A That is correct.
Q Do you consider yourself to be an expert in gender dysphoria?
A I am -- I consider myself an expert in the endocrine management of patients with gender dysphoria.
Q When do you think you became an expert?
A With experience of treating patients, with

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experience of background at Johns Hopkins. Essentially -- I consider myself as having more experience than most because of my longevity of clinical experience and training from Johns Hopkins. So it could be argued what is an expert, and I guess you can ask me specifically what you mean.
Q Well, at the time that a patient came to you in 1993 seeking treatment, did you at that time consider yourself to be an expert in treating gender dysphoria?
A I considered myself having as much clinical experience as anybody I knew, and I verified that by talking to people in the field of endocrinology across the United States and found that what I knew they knew, and we forged together forward with a treatment plan.
Q So in 1993, would you have put yourself forward to be an expert witness in a case involving the treatment of transgender individuals?
MR. CORRIGAN: Object to the form of the question.
Go ahead.

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A That was not a topic of medical treatment at that time, that was a standard of care. So as much as anybody could be defined as an expert, I would have had as much clinical experience as most people who were defined as experts at the time.
BY MR. BLOCK:
Q Wouldn't someone who had actually provided hormone therapy to someone be more qualified as an expert in 1993?
MR. CORRIGAN: Object to form.
Go ahead.
A There weren't people at that time that were in the mainstream of medicine that we know of, okay? Children were not treated with hormone therapy that anybody in the field of pediatric endocrinology was aware of at the time that I could find in this country.
BY MR. BLOCK:
Q But you had not -- at that time you hadn't treated adult transgender people with hormone therapy either; is that right?
A No, I was aware and taught extensively

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about hormone intervention of those adult patients.
Q But you hadn't treated them?
A I did not treat them specifically. I was taught about the treatment, and the case studies were reviewed as they were ongoing.
Q So your view is that once you finished your fellowship in 1980, you had sufficient qualification to be an expert in the treatment of gender dysphoria?
A No.
Q So at what point did you develop sufficient qualification to be an expert in the treatment of gender dysphoria?
A Over the past six to 10 years, since the publication of the guidelines of the Endocrine Society in 2009, specifically, I began the evaluation of the world's literature that I could find and discussions among my endocrine peers to gain as much knowledge as I possibly could, and I was aware of the number of increases in gender transition clinics that were growing and developing in the United States. I was a little bit alarmed

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about the fact that those clinics were established without anybody who had had any training of any kind in a formal curriculum, and I was worried about the quality of medicine.

I began looking at the effects of -- I already knew what we were doing in the field of endocrinology trying to prevent the side effects of opposite hormone effects on the human body as the patients developed through adolescence and young adulthood. Those are disease states for which we had standards of care to treat.

So as I began seeing that these guidelines were being implemented, I became concerned and learned more and more and more about what was going on and became then as much of an expert by evaluation of literature; discussion amongst my peers. And then I began treating patients -- these patients as they came to my office as of about three years ago.

So that is how I would say that I understand the treatment of transgender patients, the adverse effects of hormone therapy, and -- both

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short term and long term, and so that's where I would say that I would ask patients to come to see me for the specific reason because of my expertise, evaluation, and concern for those patients.

So the word "expert" is hard to nail down. I would say experienced.

Q Did you say patients came to you for a specific reason; did I hear that right?

MR. CORRIGAN: Object to form.

A They come to me because they have an issue of concern about gender incongruence. They know that I'm a endocrinologist, and that's where they're supposed to go to get evaluated to look at their stage of puberty, to find out what resources are available to them.

BY MR. BLOCK:

Q So I have the time frame right, the first Endocrine Society guidelines on treating trans kids was published in 2009; is that right?

A That's correct.

Q So you said it was about five or six years after that that you conducted the literature review

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that has made you an expert in this area; is that right?

A No, it was at that time when they were published that I became quite concerned about the recommendations being essentially 180 degrees out of the mainstream of hormone evaluation and hormone treatment effects in children, and so I began in depth at that point in time starting to review the literature and discuss among my peers.

Q Beginning around 2009?

A Yes.

Q If we can turn to your declaration in this case, Exhibit 1, to paragraph 34. If we can look at the second sentence: There has been a flurry of non-peer-reviewed articles in journals and newsletters circulated to general pediatricians that promote the ideology of transgenderism without specific support.

What non-peer-reviewed articles are you referring to?

A There are articles in what we call throwaway journals. They're called Pediatric

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Annals, Contemporary Pediatrics, Pediatric News, Endocrinology Today, these are -- Endocrinology Today is aimed at endocrinologists. But these are things that come to physicians' offices free of charge, they're also available online now instead of in the print versions. They are articles written talking about transgender health, talking only affirmation.

When they first started being published back in as early as 19 -- excuse me, 2004, there was mention up front in each of these articles about the high desistance rate in children and adolescents, and then, more recently, that has essentially disappeared.

But these are articles that when you look at the references, many times they are discussions on Good Morning America, they are references to conferences that WPATH provides teaching sessions or local conferences in geographic regions, they're not in peer-reviewed journals.

Q Is it your position that all of the articles that are supportive of gender-affirming

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therapy are published in non-peer-reviewed journals?
A No.
Q So, in fact, many of the articles are published in peer-reviewed journals; is that right?
A No, some are.
Q Are any of these articles cited in your report?
A The ones in peer-reviewed journals? Yes.
Q Yes. Which ones?
A Pediatrics, International Journal of Transgenderism, Journal of the American Academy of Child and Adolescent Psychiatry, PLoS One, Child and Adolescent Psychiatry -- excuse me, that's not a journal, that's a textbook. Those are the ones that I've cited.
Q Which is the one that you said was a textbook?
A It was Zucker's chapter, Child and Adolescent Psychiatry.
Q So is Pediatrics a journal that is viewed as a source of guidance in your field?
A Pediatrics is a peer-reviewed journal,

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yes.
Q Is it viewed as a source of guidance by practitioners in your field for --
A Yes, it is.
Q Yes?
A Yes.
Q Would you consult articles in Pediatrics as part of your review of literature for determining the standard of care?
A Yes, I would.
Q Now, when you previously discussed how you determined standards of care and you talked about conducting a broad survey, how do you decide which of the opinions in that broad survey are going to constitute the standard of care?
A I review the article thoroughly, I look at the design of research if there is research involved. If it's a summary view I look for what's recommended in terms of breadth of opinion. There are articles written that are ostensibly to cover the entire field, all aspects of it, all opinions, and come up with a sort of presentation at the end,

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what we call a balanced presentation for the reader then to make an assessment, and perhaps the writer of that particular review article would do the same.
I look at things like the Endocrine Society guidelines and the references they use, I look -- and, again, when you go to the specific references, that's a step beyond just reading the article, it's actually looking at what studies are referenced to look those up.
It's an arduous task, but on key issues, many times I will request of my local medical librarian copies of those articles so that I can see whether or not what was gleaned from that reference is actually proving the point or not.
In some cases I already know the articles, and if I find that they're at odds with what the author cites them to represent, that brings into question the quality of the article.
So the design of the research, and then the number of references and where they come from allows me to make a personal opinion on -- and then I discuss that amongst my endocrine -- pediatric

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endocrine peers to find out what they feel and how they approach things, and we go from there.
Q When you were conducting your research regarding treating gender dysphoria, was anyone -- were you receiving any payment from any source while conducting that research?
A No.
Q No?
A "No" is the answer, yeah.
Q So tell me if I am mischaracterizing this, but my understanding from your earlier testimony is you had said that standards of care means the most generally accepted way of treating. Is that something that you believe?
MR. CORRIGAN: Object to form.
Go ahead.
A Standards of care are somewhat fluid in that sometimes they are published, sometimes they are not, sometimes they are in development and changed with new developments that come along, so they are essentially a consensus across the board of practitioners. Often they are guided by a

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professional organization, hopefully with a balanced approach so that the guidelines that they develop to become or be considered standards of care represents all aspects of the subject thoroughly reviewed and brought to the table for consideration.
BY MR. BLOCK:
Q And is it your understanding that standards of care are always supported by 30-year long-term research studies?
A They are a combination of longstanding review of literature, clinical research studies in the past, and then new studies that have -- that might be on the forefront of the issue.
Q So are there any standards of care representing the general consensus of practitioners that are not supported by long-term studies?
A Yes, the Endocrine Society guidelines are not supported by any long-term studies of quality.
Q So I'm talking about -- by "Endocrine Society guidelines" are you referring to guidelines regarding treatment of transgender people or in general Endocrine Society guidelines for other

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conditions as well?
A The ones that I pay attention to are those that are published that are germane to children, and it just so happens having spent a lot of time looking specifically at the transgender guidelines I found, with critical review, that there was very little scientific basis for the recommendation.
I have not done the same thing in depth with every single one of the Endocrine Society guidelines because many of them deal with patient populations that are adult and disease states that are in adults that do not pertain specifically to children.
So in things like treatment of type 1 diabetes and those types of things, those guidelines, again, are graded, and they generally are based on good scientific evidence.
Q Sitting here today, you don't -- you don't know whether the quality of research supporting the Endocrine Society guidelines for gender dysphoria is of higher or lower quality than the research of the Endocrine Society guidelines for other conditions?

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A In the guidelines that I have read, these guidelines have very low scientific evidence compared to the others that I reviewed.
Q Which others have you reviewed?
A Treatment of hypercortisolism, treatment of thyroid disease in the perinatal period. Those are some that come to the forefront in recent times. Treatment of disorders of sexual differentiation is another one.
Q Treatment disorders of sexual differentiation guidelines are supported by long-term research?
A Yes, they are.
Q And I asked a question asking about standards of care, and you answered talking about the Endocrine Society guidelines, so I want to get an answer to my question about standards of care.
So my question is: Is it your understanding that the standard of care with respect to a particular issue is always supported by long-term research?
MR. CORRIGAN: Object to form.

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Go ahead.
A It should be.
BY MR. BLOCK:
Q But is it?
A No.
Q Why not?
A I would only be conjecturing as to why not.
Q And yet a particular treatment might represent the consensus of practitioners among a field even if it is not supported by long-term research; is that right?
A It's a consensus of some individuals in the field, not all individuals in the field.
Q But I'm talking about consensus for purposes of standard of care.
A I can't answer that. The standards of care is a term that gets applied to things that are published.
I am not -- my experience with standards of care previously was in dealing with medical malpractice and what the standard of care was in

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terms of the disease state and the applied treatment and whether or not it met that standard or if it was outside the standard of care, and if it was, were there extenuating circumstances as to why it was.

The standards of care from WPATH are published as standards of care by that organization, and they call them standards of care, they don't call them guidelines. It's SOC. And so it's basically use of the language to promote that as a pathway for treatment by that organization.

Q What, in your view, is the accepted standard of care for treating gender dysphoria in adolescence?

A Accepted standards of care that has been proven effective are -- well, my standard of care, which is based on what has been proven to be effective in allowing desistance to occur, is that in-depth counseling be the predominant feature of treatment, and that hormone manipulation is not.

Q I'm not asking about your standard of care, I'm asking for what are the consensus standards of care for treating gender dysphoria in

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adolescence?

MR. CORRIGAN: Object to form.

Go ahead.

A All I know is my conversations with my endocrine peers is that they are alarmed by what has been reported as a standard of care by WPATH. I would say that the majority of endocrinologists I talk to do not understand the guidelines or why they are recommended. They are labeled as standard of care by an organization that calls them a standard of care, and that's what they are, they are recommendations.

BY MR. BLOCK:

Q Is there any written material or sources that you think do represent the consensus standards of care among practitioners for treating gender dysphoria in adolescence?

A No, they are being developed.

Q By whom?

A Endocrinologists and mental healthcare providers.

Q What do you mean by "being developed";

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they're being written down?

A They're being developed, they're being put together. Conversations are happening, groups are getting together who are concerned about WPATH recommendations, about the Endocrine Society recommendations, and they're asking for a dialogue so that everyone can basically come to the table and open up a discussion instead of having it be dictated from one side of the equation.

Q What organization are they having these discussions in?

A It's nothing organized specifically. It's a number of individuals who are concerned across the country who are representatives from their field of interest. We talked about it at length at the Southern Pediatric Endocrine Society at that meeting. Many, many concerned folks. Probably 75 percent of the people expressed significant concern about the WPATH guidelines and wondered what should or could be done to essentially come back to the table and redevelop guidelines that took into account the entire complexity of the issue.

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Q Come back to the table and redevelop guidelines in the Endocrine Society or through a different organization?

A Well, this is the Southern Pediatric Endocrine Society, so that's not -- that's its own loose organization that represents pediatric endocrinologists in the southeastern United States, so cannot speak to the other subgroups.

The Pediatric Endocrine Society has a special interest group in transgender health, and it was our hope that at the annual meeting next month in Baltimore that we could come together and have a discussion with individuals in that special interest group about our concerns.

It turns out that the special interest group for transgender medicine is not meeting at the Pediatric Endocrine national meeting in Baltimore. There will be a session on disorders of sexual differentiation, which I intend to attend.

Q So as far as you're aware, there are no written drafts of any guidelines from a medical organization that you think represents a consensus

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standards of care for treating gender dysphoria in adolescence?

A There are no written guidelines that is a consensus of the broad spectrum of endocrinologists across this country. There are guidelines written by a special interest group, but not by the majority of endocrinologists across the country.

Q Do you provide treatment for precocious puberty in your practice?

A I do.

Q To delay puberty -- you do. Sorry.

And are there long-term studies on the long-term effects of providing treatment for precocious puberty?

A The treatment for precocious puberty is usually short lived. It's on an average about a year and a half to two years. It is rarely longer than that.

Because of that, there are studies now of 18 years of experience, in particular with Depot Lupron, that look at the effectiveness of treatment, the restarting of puberty naturally, the fertility

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of those individuals who have been treated, any general health issues that happened, and in that young child group -- age group who were not of the age of puberty but are starting puberty, there appears to be benefit socially in terms of, particularly in females, of avoiding menstruation in the very early primary grades, also preserving adult height to some extent. And those are the two goals for which we use that interruption of therapy.

But it is not approved or recommended for long-term use, and it is not approved or recommended for the age of adolescence when calcium bone accretion occurs, and when brain development is very dependent upon the presence of those hormones as the body physiologically goes through puberty.

Q Are there long-term studies on the safety of the treatment, though, the negative health effects?

A There are long-term studies in adults because the GnRH agonists, as they are called, that's gonadotropin-releasing hormone agonists, were used extensively and for longer periods of time in

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adults with hormone-dependent tumors, prostate cancer in males, and estrogen-dependent tumors in females, and there are evidently mental health issues that have surfaced in the long term that are now being recognized and evaluated by the companies that developed those therapies. We do not have any long-term experience in children because the therapy is not used for long term.

Q Going back to paragraph 35 of your declaration, you say -- sorry, yeah, 35, about seven or eight sentences in, the sentence begins with "The response to these guidelines." It says: The response to these guidelines was the burgeoning of gender identity clinics in the United States from three to over 45 in a period of seven years.

Do you see where I'm reading from?

A I do.

Q So is your opinion that the Endocrine Society guidelines led to more gender identity clinics?

A Yes.

Q So these hospitals with these clinics all

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followed the Endocrine Society guidelines; is that right?

A These clinics decided that they needed to have gender identity clinics to treat patients who would be coming into their practices. I do not know why each of the individual clinics developed, because I am not a part of those clinics, I don't know what administrative decisions were made. It is just an interesting phenomenon that once the guidelines were published that there was literally this very rapid increase in the number of centers treating children.

Q And these centers treat the children in accordance with the Endocrine Society guidelines; is that right?

A I do not know each individual center, I just know a few of the centers where I've had a chance to have a dialogue with the clinic directors. And in the case of the clinic in Cincinnati, I was told that 100 percent of patients were affirmed. I have tried to find out as best I can just by asking people directly the percentage of patients that are

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affirmed and those that are sent through counseling, and I am not given a clear answer, but I have the sense that the patients go in the door, and they're affirmed.

Q By "affirmed" you mean provided hormone therapy, cross-sex hormone therapy?

A Initially they are affirmed with counseling to the family to allow the patient to live in the role they wish to assume, trying to get the family to adjust to that and accept that, and then to work with the school systems to be sure that the child is called by the pronouns they wish to be called and the name that they wish to be called by, and then when they -- they show the first signs of puberty to have puberty blocked, and then at some point in time after that, now as young as age 13 or 14, to receive cross-sex hormones, to have mastectomies if they are a female wishing to trans to a male identity, and then to wait, at least so far in this country, to age 18 before they have any additional surgical procedures done.

Q And these gender identity clinics are all

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over the country; is that right?

A That is correct.

Q How many patients would you estimate they're treating?

A I only have anecdotal evidence that in the state of New York that there is 700 patients per year. I don't know if it's a single clinic or a multiplicity of clinics in a healthcare system.

I know that in the local system here in Atlanta, that in 2016 they had 45 patients in that calendar year that were maintained as patients. In 2017 that number increased to around 80. The data for 2018 has yet to be published.

Those data I happen to know because it's part of the U.S. News and World Report grading system that if you have a transgender clinic that's active, you get higher point scores on your area of excellence in providing children's healthcare. So that I know at least for our local healthcare system is a strong motivation for them to maintain a transgender clinic is because they get recognition nationally as being a center of excellence at a

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higher level the higher the points that they garner.

Q So -- but you know what the numbers are for the upcoming year?

A I do not.

Q You do not.

At the Southern Pediatric Endocrine meeting that you were at, were there these gender identity clinics at any of the states where the meeting participants came from?

A Yes.

Q About how many?

A I knew specifically of two in Florida, one in Virginia, I knew of the Emory clinic as well, was not -- there's a clinic -- a gender identity clinic in South Carolina. There were no members from that organization or that state at the meeting, as it turned out. I don't specifically know about Kentucky. Mississippi I'm not aware of. Alabama has a gender identity clinic in Birmingham, although the person that is in charge of that clinic, who I know personally, was not in attendance at the meeting.

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Q You personally know the person in charge of the clinic in Alabama, is that what you said?

A Yes. I personally know the two in Florida, I do not personally know the person that runs the clinic in Virginia, I do personally know the person that runs the clinic in South Carolina, don't know who runs it in Mississippi, and that's -- those are people I know personally.

Q So the people that you know personally who run these clinics, do you think they are practitioners of child abuse?

A I think they are misguided in terms of recommending hormone therapy. The term "child abuse" is a flashy term in my worldview to catch attention. I would say that my concern for these individuals is that there are going to be adverse outcomes in their patient population because of what they recommend and what they -- how they are treating, and I don't think that they are necessarily paying attention to the broader literature, which says that that treatment is harmful more than it is beneficial. They are very

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much drawn to the Endocrine Society guidelines because they are convenient, and they themselves have no personal experience.

Q Do you consider them just in their -- as practitioners to be unqualified as -- in general as pediatric endocrinologists?

A Not at all.

Q You consider them to be conscientious practitioners?

A I do.

Q And you think that they are acting in what they believe is the best interest of their patients?

A I think that they are practicing in what they do believe is the best interest, but I also believe they are not informed. And when they have a chance -- when I have a chance to talk with many of them, they -- they are kind of taken aback by the fact that there is so much evidence that shows what the Endocrine Society guidelines recommend is contrary to the long-term health of the patient.

They had not considered that. It was not presented to them. They trusted the Endocrine

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Society to be the voice of reason and assumed that all this information had already been reviewed and came out with a predominantly positive outcome, and they are, a lot of them, quite astonished.

Q Is it your opinion that the Endocrine Society guidelines do not discuss adverse health effects?

A They discuss them in three of the recommendations in the first iteration, and four in the second iteration, the 2017. They are the only scientifically valid graded recommendations that carry literature with them, and all of them say that there is concern that there are no long-term studies of the long-term effects, that they are aware of, of the hormone -- cross-hormone therapy and puberty blocking, and that there must be studies designed to assess that before they can -- they would assess as being safe and sound. Despite those statements, they recommend that the treatment be done.

Q If we look at paragraph 45 of your declaration --

MR. CORRIGAN: It ends at 41.

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A Mine ends at 41.

BY MR. BLOCK:

Q That's what I meant, 41. Apologies. The second sentence in paragraph 41 says: Allowing a biologic female to use the male-designated bathroom facility is one of several, quote, gender affirming, unquote, care options, but it is creating harm to at least two parties. The harm to the gender incongruent person is that it promotes a pathway to inevitable long-term medical and psychological morbidity.

And that's what you think, right; that's your view?

A That is my opinion.

Q All right. So what if the student has already completed puberty, has had surgery, and is taking hormones, is that harm still present?

A The harm has been done.

Q So what additional harm is inflicted by allowing that student to at that point use restrooms consistent with their gender identity?

A Well, you are adding to the long-term

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psychological morbidity of that patient, which is proven to happen in the long-term studies of adults who have lived 20 to 30 years in a transgendered identity situation. Their mental health issues are still quite high.

So if you -- your -- anything you do that keeps the patient away from the therapy that they need -- and all of these patients -- and Dr. Zucker recommends exactly the same, despite whether or not they are given hormone therapy, they are never emotionally well, and they need long-term mental health.

So if you add something that is -- we're talking about -- in the case of the school system, we're talking about kids that would not have had surgery yet. So we're talking about kids that might have had cross-hormone therapy and been socially transitioned. At that point in time you are adding affirmation that that is a beneficial -- proven beneficial event to allow them to have a presence in the bathroom of the opposite of their biologic sex.

And there are no studies that say that

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that is true; there are no studies that say that that is not true. There are no studies in existence.

Q So you think -- in terms of adults you think that affirming an adult transgender person's gender identity is harmful to their health?

A I do.

Q Are there any long-term studies on the mental health outcomes of people who identify as being formerly transgender?

A No, they are beginning to develop at this point in time. They have not been available on those who have desisted subsequent to medical and surgical because these patients are just now beginning to come out to the forefront. A, it is the age with which they approach this, they have been transgendered long enough to recognize and to have the strength to return back to their biologic sexual identity and are now beginning to speak out, write, publish, gather like-minded people together so that they can publish their clinical experience.

But this is a brand-new group. This is

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where -- this is the end point of people who did -- had these things only as adults, not as children, back as far as 30 years ago.

Q So but -- so there are published studies saying that even after receiving treatment, the population of transgender people may have, as a whole, poorer health outcomes than the population of non-transgender people, right? Those are the studies you were referring to previously; is that right?

A That's correct.

Q But there are no studies on assessing what their mental health outcomes would have been without the gender-affirming care, right?

A No.

Q So what you're saying -- "no" means there are no long-term studies, correct?

A There are no long-term reputable studies. There are long-term things that are published, but they are laced with -- as essentially a Cochrane review of those -- all those studies shows that the study design is extremely poor, that it is -- it's a

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preselected population, does not represent 100 percent.

The only study that's published that has 100 percent of participants evaluated at the end is the Swedish study, which is condemned outright because it says what it says. There is incredible amount of increase in mental health morbidity as a result of medical and surgical transitioning. It's the only study that had 100 percent of participants.

Q Sorry. That's your understanding of what the Swedish study says, that as a result of receiving care affirming their identity, the mental outcomes are worse as a result of receiving that treatment?

A It compares it to no one, unfortunately. That's the one downside to that is it did not have a control group of those who did not receive medical and surgical care. It was a review of 100 percent of the patients.

So it's called into question without a control group to say that you're comparing itself to itself, but the statistics are there that there's a

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19-fold increase in completed suicides compared to the general Swedish population.

Q So but there are -- so for the type of treatment that you are recommending of just having counseling for underlying health issues, there is no scientifically valid study saying that those health outcomes are better than what the health outcomes would be if the same patient received gender-affirming care?

A That's absolutely correct. We have one study which is all affirmation which is Zucker's, and we have the one study all surgical and medical from Sweden, okay. We know Zucker reported all of his patients, not just some of his patients. Sweden reported all of their patients, not just some. What has not been done is a longitudinal study of side-by-side groups randomized to an arm of counseling only versus affirmation with counseling, medical treatment, and surgery.

No such study exists or has been designed. There needs to be that study, and until that study is completed and the results are evaluated 20 to 30

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years post treatment, post beginning of treatment, we will not be able to say without question that one is better than the other in terms of long-term outcome.

What we do -- what we do know is that there are so many adverse side effects of the medical and surgical side that creates medical morbidity that would not otherwise exist that the logical assumption is we are creating a disease state by intervening that way, we are creating mentally healthy individuals by doing the affirmation pathway, and what we need to do is have an unbiased study that looks side-by-side, and no study exists.

Q If that study were conducted and the evidence in that study showed that the mental health outcomes for people receiving affirming -- gender-affirming care were better, would you then provide gender-affirming hormones in your medical practice?

A I would -- there are two issues here: There's the mental health which is very important,

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and there's the medical health in terms of side effects. So I would have to have -- be shown that the medical side effects and the mental health effects were predominantly beneficial and the downside and adverse effects on both sides were minimal before I would recommend that.

Q So but if the evidence did show that, then you would personally provide gender-affirming hormone therapy?

A I probably wouldn't because I wouldn't be practicing medicine at that time, I probably would not be alive, so it's a theoretical question.

Q Yeah, but so asking a theoretical question, let's say the study came out tomorrow, would you in that situation personally provide gender-affirming hormone therapy, or are there other reasons why you may still not provide it?

MR. CORRIGAN: Object to form of the question.

Go ahead.

A Yeah, if the medical and mental health issues were better in the affirmed pathway, I

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would -- I would likely change my mind.

BY MR. BLOCK:

Q Let's look at the paragraph 41 again. Near to the bottom it says: The second party harmed is the student without gender incongruence who must suffer emotionally while being told they must tolerate the presence of an opposite sex individual in a sexually segregated space and embrace the regulation which gives the gender incongruent person special privileges as if it were based on civil rights founded on immutable biology.

Did I read that right?

A Yes.

MR. CORRIGAN: Let me -- can I interrupt for a second?

MR. BLOCK: Yeah.

MR. CORRIGAN: He's not going to offer that opinion. I can tell you that in this case he's not going to offer that opinion. I know it's in his thing, and you can ask him about it, but he's not going to offer that opinion at trial.

MR. BLOCK: Okay.

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BY MR. BLOCK:

Q I'd still like to ask you a few questions. So the harm that you're talking about there is not harm limited to the possibility of exposure to nudity; is that right?

A It is primarily harm due to exposure to nudity, and that is just a general survey of asking any adolescent males and females in a social discussion, how would you feel if a naked person of the opposite sex entered your locker room naked and while you were naked? Would that bring you a zone of comfort, would you grade it as neither one way or the other or fantastically wonderful, can't wait until it happens, or I wouldn't want that to happen? And it's pretty much universal, I wouldn't want that to happen.

That's just a nonscientific study. There is no -- I am not aware -- I would just assume that the standards that we have set up legally in sexually segregated spaces is there for a reason for privacy. And whoever has done any sociologic studies of that -- we could go back. I am not aware

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of those studies. At this point in time it has been essentially what I would refer to as common sense.

Q So but talking about a restroom in particular, not someone walking in naked into a locker room, talking specifically about a restroom, is it your opinion that there is harm to a non-transgender person in having to tolerate the presence of a transgender person in the restroom even if there is no exposure to nudity?

A I have -- I'm not aware of any study that says that. Outside of a courtroom if you ask my opinion, exposure to -- if you're in a restroom standing in front of a urinal and you have your pants down around your ankles, and you've inserted a device through which you can direct urine from your vagina into the urinal, I think that would probably cause some people to take notice, but there's no study. I'm not aware of any study.

Q How about if someone uses a stall?

A What happens in a stall if it's got floor-to-ceiling --

MR. CORRIGAN: Object to form.

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Go ahead.

A If it's in privacy, I can't tell you.

BY MR. BLOCK:

Q So in that situation there would be no harm to the non-transgender student?

MR. CORRIGAN: Object to form.

A I cannot say that.

BY MR. BLOCK:

Q So you don't know whether it would be harmful?

A I do not know whether it would be harmful.

Q You say special privileges, as if they were based on a civil right founded on immutable biology. Do you think that civil rights should be based only on immutable biology?

MR. CORRIGAN: Object to form, legal conclusion.

Go ahead.

A So I think in terms of things like religious faith, that is something that is not immutable biology, and I think that intolerance of religious faith becomes an issue of the right of

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expression and -- personal right of expression.

I don't feel that something that is furthering a detrimental mental health issue is a civil right, especially when it is advertised as if it is immutable biology and it's based on that that we can treat that person as if that were a biologic race or a biologic sex, which it is not.

BY MR. BLOCK:

Q Do you have a medical basis for an opinion on what traits should be protected by civil rights laws and which ones shouldn't?

MR. CORRIGAN: Object to the form. That's why he's not giving the opinion.

Go ahead.

A Yeah, I mean, my personal opinion here in this deposition is I would think that race and gender -- and biologic sex are immutable and should be considered to allow people to have specific rights or not be denied rights.

BY MR. BLOCK:

Q So if the person using the boys' restroom is a transgender teenage girl who has been having

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affirming hormone therapy since before -- had puberty blockers and affirming therapy and has fully developed breasts, do you think that it is harmful to the non-transgender boy to tolerate the presence of her in the restroom?

MR. CORRIGAN: Object to form.

Go ahead.

A I cannot say that that person would be harmed. It depends on the individual.

BY MR. BLOCK:

Q So what about the -- what about the transgender girl who has been receiving affirming hormone therapy, is changing in the school locker room, do you think that's harmful to the non-transgender boys in the locker room with her?

MR. CORRIGAN: Object to form. We're not here to talk about locker rooms. He'll answer the question.

Go ahead.

A I would personally assume that there would be a level of discomfort of having opposite sex nudity in the same locker room.

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BY MR. BLOCK:
Q But their chromosomal sex is the same, so if the opposite sex nudity is solely as a result of hormone therapy, then is your answer the same?
MR. CORRIGAN: Same objection.
Go ahead.
A Yes, it would be.
BY MR. BLOCK:
Q So what -- so it would be -- it would be better -- just to clarify that question and answer, so it would be uncomfortable for a non-transgender boy to be in a locker room with a transgender girl, meaning someone who is assigned male at birth but has fully developed breasts as a result of hormone therapy?
A That would be --
MR. CORRIGAN: Object to form.
Go ahead.
A That would be uncomfortable in my opinion.
BY MR. BLOCK:
Q And do you have an opinion on whether it would be harmful?

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A I cannot opine on that. I think there would be uncomfortableness. I don't -- it depends on the individual.
I would imagine in the scheme of things for a biologic male who has very large breasts that have been induced by hormone therapy, that that would cause people to notice, comment, to not be comfortable, to try to figure out what's going on, and that they might think that they would -- they definitely would be uncomfortable. I don't know if it causes mental harm. I'm not a mental health practitioner.
Q Do you have a medical opinion on whether that transgender girl with breasts who was assigned male sex at birth should be using the boys' locker room or a separate facility by herself?
MR. CORRIGAN: Object to form.
Go ahead.
A I think that for the sake of all parties that there needs to be a private space for that person to disrobe where they are comfortable in a private space and other people are comfortable in

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their private space. So a gender-neutral changing space, if you will.
BY MR. BLOCK:
Q But the person who has to use that space would be the transgender girl, not the non-transgender boys; is that right?
A It would be available for anybody.
Q And it would be better if she used that separate facility?
MR. CORRIGAN: Object to form.
Go ahead.
A It would be better if she used that facility because of privacy of other individuals. There are also biologic males who feel very self-conscious about their physical appearance who would like to have a gender-neutral space where they are completely private where they don't have to disrobe in front of anybody of either sex because of how they feel about themselves. Adolescent boys who have a small amount of breast development are very, very sensitive about that and often very embarrassed, and if they were -- if the school would

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provide a neutral space for that person to disrobe, shower, and redress, there would be benefit to both parties.
BY MR. BLOCK:
Q How about the presence of a non-transgender boy who is gay in the male locker room --
MR. CORRIGAN: Object to form.
BY MR. BLOCK:
Q -- would that create harm to other boys who have to tolerate his presence?
MR. CORRIGAN: We're far afield from the designation.
Go ahead.
A No, I don't see that would. If that gay boy were uncomfortable, I would like to have that gay boy have a place to go where he is comfortable. So if there were a private space for him to disrobe, shower, and dress, that should be made available.
BY MR. BLOCK:
Q But if he prefers to shower and disrobe in the same locker room that everyone else showers and

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disrobe, you don't have any opinion that he shouldn't be allowed to do that?
MR. CORRIGAN: Object to form.
A There should be no reason why he should not be able to. He should be able to use that male locker facility.
MR. BLOCK: This is an okay place for me to take a break if it's okay with you. I can also keep going if that's what you prefer.
MR. CORRIGAN: I'm always up for a break. Any ideas on how long we'll be doing this?
MR. BLOCK: A couple hours.
MR. CORRIGAN: Okay. We'll take a break.
MR. BLOCK: Sorry, what?
MR. CORRIGAN: We'll take a break.
MR. BLOCK: Okay. So how about see you at 10 minutes?
MR. CORRIGAN: Sure. Are you going to have lunch, or what are you going to do about that?
MR. BLOCK: We'll have a longer break for lunch then, so come back at 1:30.
MR. CORRIGAN: That's fine. That should

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be fine.
(Recess 1:02-1:39 p.m.)
BY MR. BLOCK:
Q Good afternoon, Dr. Van Meter.
You're a fellow with the American College of Pediatricians; is that right?
A Yes.
Q And you've been a fellow since 2007, correct?
A That is correct.
Q Did you have any role at the American College of Pediatricians before 2007?
A No.
Q How did you first come into contact with the American College of Pediatricians?
A The inaugural president was a personal friend of mine. He encouraged me to join the organization because it had very specific benefits for children's health that were somewhat different and more appropriate than the other major pediatric professional organization, the American Academy of Pediatrics.

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Q Did he identify any particular recommendations or positions that were more appropriate than the recommendations of the American Academy of Pediatrics?
A Well, the American Academy of Pediatrics, I was a member during my residency and joined in 1976, was very active in local chapters, I was a chapter chairman for the Uniformed Services West, was the legislative committee director for the Georgia chapter. I am still a member of the Georgia chapter of the AAP because an awful lot of what they do has a lot of benefit for children and also looks after the ability for pediatricians to be able to practice quality medicine.
Q So what made him think that you had a need for looking at an organization with different policy recommendations?
A The American College guidelines on a number of subjects are essentially based on what is purely the published science, and it's devoid of political flavor. It basically says we're going to be taking care of the needs of children, not the

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wants of the adults. The American Academy had been leaning toward paying more attention to the wants of the adults in a number of areas.
I put together in 1994-1995, I believe, what I sort of thought of as a children's Bill of Rights for healthcare for the state of Georgia, and we passed it through the House and the Senate chambers in the Georgia legislature but not in the same year because of the way the legislature ran, and we were unable to get both houses to approve of it and get it to the Governor's desk for signature. We brought that document from Georgia to the national AAP, where it was essentially devoured by politics and thrown away.
And that was the beginning of my sense that the American Academy of Pediatrics and its very small executive group of district chairmen was not speaking for pediatricians, and certainly not speaking in some very important areas about the welfare of kids.
So Joe Zanga knew that. Joe Zanga was actually the president of the American Academy of

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Pediatrics at the time that that resolution came to the floor and was shouted down, and he just was flabbergasted.

And I think that he knew how I felt about that, so he asked me if I wanted to consider joining another professional organization that was going to be free from the political needs of the adults in the room and essentially took care of the biologically and scientifically proven needs of children, and that's basically the motto of the American College of Pediatricians is "Best for Children," and that's -- everything we do is through that filter.

Q So after 2007, were there any specific policies of the American Academy of Pediatrics that you disagreed with?

A There were issues of demeaning the value of heterosexual parents adopting children versus same-sex parents adopting children. They came out with a policy statement which was really, really unfortunately very poorly written and very badly documented in the technical support documents which

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favored -- at least favored, if not suggested, that same-sex parenting was probably more beneficial than heterosexual biologic parenting, and certainly more than heterosexual families adopting children. That was -- that was a statement that was very hard to justify because it wasn't based on science.

So that was one issue, but that actually happened before I even joined the College. I was still -- I had a bad feeling about the American Academy based on their rejection of our children's Bill of Rights, which had broad political spectrum support from both sides of the political aisle, which was trashed.

And I thought knowing how the -- how those things happen, how policies are made and how little of the membership has input -- at no time as a general member was I asked to give any input or review policy statements that were being adopted by the American Academy of Pediatrics.

They specifically condemned circumcision, and then they turned around and then reapproved circumcision, then they approved genital mutilation

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of females, and then they quickly withdrew that, and they were just following the political winds. That's not good for any professional organization to do flip-flops and make policy statements that are embarrassing and clearly not based on science.

So that's why I finally relinquished my membership in the American Academy. I held on as long as I could to the national organization. The Georgia chapter has its own unique ability to help kids in Georgia deal with Medicaid issues and access to care, things that are near and dear to all of our hearts here as practitioners in the state of Georgia. They're very effective, and they are highly respected in our legislature, so I've maintained my membership with them.

Q So you've been on the board of directors since 2008, right?

A Yes.

Q When did you become vice president?

A Two and a half years ago.

Q And when did you become president?

A It was earlier than anticipated because we

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restructured and developed the position of executive director, and the current president was elevated to that position as a paid employee, and so as vice president, I assumed the presidency on the 1st of July of 2018.

Q When was the American College of Pediatricians formed?

A I believe it was 2002.

Q Why did it form?

A Dr. Zanga was very upset about the issue before the recommendation in regard to the condemning or belittling the benefits of heterosexual parenting, which sociologic research had shown was solid and beneficial to children. The Academy refused to recognize that, and so that was the turning point for, I guess, a nucleus of people who decided that they wanted an organization that actually, again, forgot the needs and political wants of adults and looked after what is best for children.

Q By belittling heterosexual parenting, you mean that the American Academy of Pediatrics said

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that parenting by same-sex couples is not harmful to children?

A No, that's not -- they said that, but they also essentially inferred that it was possibly better than for heterosexual parenting. That's just stepping across the line without any scientific evidence at all.

What it did is it forced individuals to critically go back through, and there was one particular individual who went through every single reference on the technical support paper for that and found it completely full of holes, misrepresenting science.

And, again, it was an agenda that seemed to be pushed through by a very small nucleus of individuals, perhaps 35 people at that time were speaking for 60,000 members who were in the American Academy of Pediatrics at the time as members. And I was one at that time, and I never -- I never saw anything published, it wasn't placed in any place for review or discussion, it just happened, and so that's -- that was the turning point.

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Q Did Dr. Zanga believe that same-sex couples should be allowed to legally adopt?

A Yes.

Q He did believe it should be legal?

A Yes.

Q Isn't it true that the American College of Pediatricians filed a legal brief supporting Florida's law prohibiting same-sex couples from adopting?

A The problem is that there is subsequent research that has been out that's -- that shows that there are detrimental effects of that, and that if there is a detrimental effect it should be explained and not accepted as a -- an unharmful beneficial thing when there is actual harm that happens.

So if there is a circumstance where there is no other place for a child to go and circumstances are that -- are as such that a same-sex couple can adopt a child, but do not advertise it as equal to or better than a heterosexual couple.

Q Did the American College of Pediatricians

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take a position defending a Florida law that prohibited same-sex couples from adopting under any circumstance?

MR. CORRIGAN: Let me interject here. Why are we talking about this? How does this have anything whatsoever to do with our case?

MR. BLOCK: He's the president of this organization.

MR. CORRIGAN: But what does that have to do with anything? I don't see how -- we're here talking about transgender individuals, and we're talking about restroom use, and that's what our case is about, and this talking about whether or not the organization that he's the president of filed a brief in a case dealing with whether same-sex couples can adopt children has nothing to do with that.

I think -- I think we're wasting time, I don't think there's anything related to the case, it has nothing to do with anything in his report, there's just no basis for it, Josh. And if you have some basis for it, then please tell me.

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MR. BLOCK: He's saying that this organization has standards of care for treating people with gender dysphoria that are better than the American Academy of Pediatrics, they use this as a reputable organization, more reputable than the American Academy of Pediatrics. This is completely fair game.

MR. CORRIGAN: But those things have nothing to do with each other.

MR. BLOCK: David, if you want to -- this is totally fair game. I'm going to be asking these questions. You can object to their relevance.

MR. CORRIGAN: I think this deposition is going off track to talk about things unrelated to this case for a purpose having nothing to do with this case, and I don't want that to happen, I don't think it should happen. I don't think -- this would not be legitimate cross-examination at trial. There's zero chance a judge would say, let's talk about the position of the American College on whether or not same-sex couples can adopt. I just can't imagine that's admissible testimony or ever

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could be in this case.
MR. BLOCK: It goes to bias, and we're allowed to develop a record on that.
MR. CORRIGAN: But what is the bias that it goes to?
MR. BLOCK: Well, why don't you wait until we finish asking questions about their positions, and I think it will be shown.
MR. CORRIGAN: If you want to get to questions that have anything to do with our case and bias, that's fine. I don't think this bias has anything to do with bias in our case.
So -- so let's make sure we're clear because I'm -- at some point I'm going to instruct him not to answer, and we're going to have to take it to the judge, so you may want to be really careful about how long you spend on things having nothing to do with our case because I'm not going to sit here and just have this deposition be about thing that are unrelated to our case. I've been very patient, and now you're crossing over.
BY MR. BLOCK:

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Q So is it true that Joseph Zanga characterized -- is it true that Zanga described the organization as one with the Judeo-Christian traditional values?
A That might be his opinion. There is nothing in its charter that is based on any tenet of religious faith. No particular faith is required for membership. That is not a question that is asked afore of members as they apply. The membership criteria is Board-certification in pediatrics. It does not require that you be a person of faith of any strife or person without any particular religious faith, any political strife, without any sexual orientation, without -- there is no -- that's not part of what makes up the organization.
Q Let's go to Exhibit 4.
(Off-the-record discussion.)
(Exhibit 4 was marked for identification and is attached to the transcript.)
BY MR. BLOCK:
Q Do you have that document in front of you?

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A I do.
Q Do you recognize what this document is?
A It is, I believe, from the website, College website.
Q It's on the part of the website that says About Us; is that right?
A That's correct.
Q Would you turn to -- go down to Core Values of the College. You see that. Yes?
A Yes.
Q Number 2 says: Recognizes that good medical science cannot exist in a moral vacuum.
What does -- what do you mean by that?
A It means that ethics play an incredible role in the practice of medicine and the application of science to medicine.
Q So when it says that science cannot exist in a moral vacuum, is the Academy -- the College's position on care for transgender people based on a moral principle?
A It's based on a scientific principle. It's based on an ethical principle to do no harm,

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yes.
Q So what -- just if you can explain the relationship between science and the moral principles. How -- are there ever situations where the two come into conflict?
A Well, I think that there is an issue here in terms of transgenderism of not paying attention or avoiding the reality of solid science to promote a social agenda, and that is -- there is harm as a result of that, and that's not -- that's objectionable in terms of a moral precept.
Q But what is the moral background that science is located in when you say "can't exist in a moral vacuum"?
A If you do not pay attention to concepts of ethics you will likely do harm to your patients, and that's to be avoided.
Q If you turn the page -- so the bottom of this page says history. If you turn the page it appears under history where it says -- if you look to the third line down, third sentence, it says: The College bases its policies and positions upon

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scientific truths within a framework of ethical absolutes.

What ethical absolutes does this refer to?

A This refers to sort of the Hippocratic oath, if you will, again keeping to the basic principles we all swear to when we accept our medical degree of doing no harm to patients, not ending life, the Hippocratic principles, but overall, above all do no harm.

Q Let's look at -- so this'll be -- this is Exhibit 5.

(Exhibit 5 was marked for identification and is attached to the transcript.)

BY MR. BLOCK:

Q Do you recognize this document?

A I do.

Q Sorry, do you have the document in front of you?

A I do.

Q Okay. Do you recognize this document?

A I do.

Q Okay. The title of the document is Gender

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Ideology Harms Children, correct?

A That is correct.

Q And if you turn the page, there are -- there's three authors it's attributed to, and one of them is you; is that correct?

A That's correct.

Q So at the very beginning of the document it says: The American College of Pediatricians urges healthcare professionals, educators, and legislators to reject all policies that condition children to accept as normal a life of chemical and surgical impersonation of the opposite sex.

Did I read that right?

A Yes, you did.

Q So according to this document, schools shouldn't be sending a message that gender transition is normal, right?

A That is correct.

Q And schools should be discouraging students from transitioning genders, correct?

A To their -- to their detriment to affirm.

Q So the schools should discourage it?

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A It should not -- yeah, they should discourage it.

Q Do you think that a school is acting in the best interest of a child by calling the child by pronouns that are different than the sex assigned to them at first?

A We don't feel that that is appropriate or beneficial to the child.

Q So you think it's harmful to the child?

A Yes.

Q And by agreeing to use the child's -- changing a child's new name as consistent with their gender identity, you think that's harmful to the child also, right?

A Yes.

Q And go to -- are you aware -- are you aware about what Gloucester County School Board's policies are with respect to what pronouns it uses to refer to transgender children?

A I was aware in this particular case that they allowed this patient to assume a new name and new pronouns.

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Q And you believe that allowing them to do so was harmful to him, correct?

A I do.

MR. CORRIGAN: Just to be clear, he's not being offered for those opinions. His only opinions where he's being offered for are strictly with respect to restroom use, which is the issue in the case.

BY MR. BLOCK:

Q So is there any basis to conclude that using the restroom as opposed to being referred to by particular pronouns is uniquely harmful or -- to a transgender student?

A It is part of the process of affirming something which at the time is just a gender confusion, a state of mind, not a biologic reality, and anything that promotes that is not of benefit to the child. And --

Q Turn the page to paragraph 8. It says: Conditioning children into believing a lifetime of chemical and surgical impersonation of the opposite sex is normal and helpful is child abuse.

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Did I read that right?
A You did.
Q So when I referenced the term "child abuse" before you said it was a flashy term. Am I accurately characterizing your testimony?
A Yes.
Q So why do you use that term here in this paragraph?
A Primarily for emphasis.
Q The next sentence says: Endorsing gender discordance as normal via public education and legal policies will confuse children and parents, leading more children to present to, quote, gender clinics, unquote, where they will be given puberty-blocking drugs. This, in turn, virtually ensures they will, quote, choose a lifetime of carcinogenic and otherwise toxic cross-sex hormones, and likely consider unnecessary surgical mutilation of their healthy body parts as young adults.
Did I read that right?
A You did.
Q So is one of the harms in allowing a

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transgender student to change pronouns and names and restroom usage consistent with their identity that it will confuse non-transgender students as well?
A It is confusing to non-transgender students because they do not understand, especially at young ages, what is -- is happening to their classmates, or they are in a state of mind with Erikson's basic premise of being very concrete thinkers, and they think a five-year-old child is essentially, from what I've read, not being an expert in the field of mental health, but what the experts say, a five-year-old believes that if a man leaves a room and comes back in dressed as a woman and wearing women's makeup, to appear to be a woman, that that man has changed into a woman. That's the level of psychological assessment at that age.
By age seven there is an ability for a child to recognize that perhaps that is just a costume and not a real person of the opposite sex.
So if you were, at the elementary school age, promoting aggressively that gender is whatever you want it to be, you are basically bringing in an

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ideology that is programming the child to be confused and upset. And there are certainly clinical cases where that's happened, and the parents have brought legal action against school systems.
Q Let's look at the last -- the very end of the statement. So this is after the clarification at the bottom of the paragraph, the bottom line is the final sentence says: For this reason, the College maintains it is abusive to promote this ideology, first and foremost for the well-being of the gender dysphoric children themselves, and secondly, for all of their non-gender-discordant peers, many of whom will subsequently question their own gender identity, and face violations of their rights to bodily privacy and safety.
Did I read that right?
A You did.
Q What do you mean by it will cause many of their non-gender-discordant peers to question their own gender identity?
A Well, there is a phenomenon with the

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advent of social media where the incidence of gender identity issues has exponentially -- has geometrically increased, and the ratio has flipped from two-to-one male to female to two-to-one female to male. It's a social contagion phenomenon amongst kids who are coming together as groups and deciding that they are transgender and would like to have their surgeries done together and travel to the identity of the opposite sex.
These kids are coming out of the woodwork literally in larger and larger numbers as a social contagion phenomenon. Society itself, it's not that it's just more acceptable. It exceeds that kind of mathematical computation. So it is -- it is a contagion that's happened, and it's certainly promoted by Internet.
Q So if the school affirms the gender identity of the transgender student, that transgender student could spark a social contagion that causes other students to say they're transgender too?
A Absolutely. It has happened, and it's

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documented.
Q So by not allowing the transgender student to use the same restrooms as cisgendered students with their gender identity, the school is stopping the spread of a social contagion; is that right?
MR. CORRIGAN: Object to the form of the question. The witness is not being called in this case to discuss these very issues; he's not speaking on behalf of the school board.
Go ahead.
A I have no proof to say that not allowing use in a bathroom would make that difference. Again, there is no study I'm aware of that says using the gender-identified non-biologic sex bathroom has any benefit or any detriment to the long-term outcome of a patient. Those studies have not been done.
BY MR. BLOCK:
Q So my question is that you believe that if a transgender student is affirmed and allowed to use the bathroom consistent with their identity, then that is more likely to cause other students to think

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they might be transgender too?
MR. CORRIGAN: Object to form of the question.
Go ahead.
A It is theoretically quite possible.
BY MR. BLOCK:
Q So going to Exhibit -- going to jump ahead here to Exhibit -- I think this is 8.
(Exhibit 8 was marked for identification and is attached to the transcript.)
BY MR. BLOCK:
Q Do you have that document in front of you?
A Almost.
Q Do you have it in front of you now?
A I do.
Q The title of this article is, Dr. Quentin Van Meter: How Faulty Research by a 1950's Sexual Revolutionist Guided the Modern Transgender Movement; is that right?
A Yes.
Q And do you recall giving an interview to Breitbart for purposes of this article?

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A I did.
Q Did you read this article when it came out?
A Yeah, I saw it after it came out.
Q Was there anything in the article that you thought was inaccurate or mischaracterized your views?
A I had some questions about sort of interpretive sentences when I read it. I would have to read it back through completely to go back through and pick those out again, but in general the flavor and the purpose of the article was to -- was to essentially discuss John Money and his influence on the sexual health, mental health side of issues in this country.
Q Sorry, if you give me one second. If you turn to page 4 of 6.
A I have it.
Q So the second paragraph there, it says: According to Van Meter, since the transgender movement has developed every patient that come to him claiming to be in the wrong body, quote, have

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come from a totally dysfunctional family, unquote.
And just to continue this next paragraph says, quote, there's nothing normal about the environment where these children are brought up, unquote, he said. Quote, there are emotional traumas left and right. It's so obvious that what we're doing is painting over the trauma, unquote.
Do those quotes accurately reflect what you told the reporter for this article?
A Yes.
Q So do you think that if someone is transgender or thinks they're transgender it's the fault of the family?
MR. CORRIGAN: Object to form.
A If the child is transgender, they have chosen this as an answer to relieve them of dealing with a stress that is in their environment. Sometimes it's the family, sometimes it's the extended family or the social environment of the child.
BY MR. BLOCK:
Q But if someone is transgender, that often

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indicates that they come from a totally dysfunctional family; is that right?

A The word "totally" might be a pejorative type of word that was used in the interview. There is always trauma, always emotional trauma, and always a level of dysfunction in the family. Divorce, separation, sexual abuse, death, all those things affect the child.

Q You think that is true for all transgender people?

A All the transgender patients I have cared for.

Q So all 12 --

A Yes.

Q -- of them?

A Yes.

Q How about the one in 1993?

A There was a lot of trauma. This was a military family that moved every six to nine months. I did not broach the subject of sexual abuse by any member of the family, siblings or adults, but the child was severely traumatized by the rapidity and

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frequency of moves from community to community.

Q Last paragraph of this article, which is page 5, it says, quote, this is the recruitment of a cult, unquote, Van Meter said. Quote, it's so scary, and I'm so overwhelmingly worried about the welfare of the population of people 30 years out, unquote.

Is that quote accurate -- an accurate reflection of what you told the reporter?

A Yes.

Q So can you explain what you mean by "this is the recruitment of a cult"?

A This is an ideology which is promoted by some to essentially use this as a valid medicalized diagnosis to gather children and to treat them, and their purpose is to see what happens when the treatment is over and make a decision then, just like John Money did some 40 years earlier with an idea that was not based on any known science that -- to be beneficial, and then to come out with an experimentation at the other end.

The cult aspect of it is what's happening

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on the Internet and the recruitment of patients by websites and blogs, and all that's happening as if they're pulling in the kids unwittingly, most often against their parents' wishes and without their parents' knowledge, and then they are sucked into the ideology, which is very much like a cult.

Q You think the American Academy of Pediatrics is recruiting children into a cult?

A The American Academy of Pediatrics produced a statement written by one individual promoting this concept, and specifically and most dangerously saying that under no circumstance is there any need for psychological evaluation.

That is one individual, the author of that paper, and 35 -- as many as 35, perhaps a little less, of administrative people rubber stamping this as a promotional position of the American Academy of Pediatrics.

It is abysmal, it is embarrassing, it is dangerous, and the fact that they say they represent and are supported by all now 67,000 members is entirely and completely untrue.

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Q Do you think the author of that paper is recruiting children into a cult?

A I don't know the author. I cannot speak to that. I just know that he wrote a paper and a position that's based on really essentially fraudulent -- fraudulent information. He misquotes papers. He ends up saying the papers say one thing to support his point, and when you pull the reference, you find out that it does not support the paper.

The article was very carefully critiqued by an independent psychologist in the field of psychology and lesbian gay psychology, and he himself is a pro -- a proponent, an advocate for gay people, and he tore this apart as absolutely abysmal trash.

Q So you believe that schools can help kids by discouraging students from being transgender; is that right?

MR. CORRIGAN: Object to form of the question.

Go ahead.

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A I believe schools can help kids by making sure that the family is fully aware and that they are aware that there is counseling going on and there's an intervention that the family is involved in, and I think that's as far as schools can go. That's as much as I can say on that subject.
BY MR. BLOCK:
Q But they shouldn't be sending a message that being transgender is an equally acceptable lifestyle to have?
MR. CORRIGAN: Object to form, not designated for this purpose.
Go ahead.
A Yes, I think that's inappropriate for them to be promoting something which, as Kenneth Zucker said, is not a delusional disorder but is a delusion.
BY MR. BLOCK:
Q So would one way to send that message be to stigmatize transgender students, would that be a way of sending that message?
A No.

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MR. CORRIGAN: Object to form, object to foundation.
Go ahead.
A No.
BY MR. BLOCK:
Q So what are the ways they can send that message that transgender students have a delusion?
A They could deal with the student themselves and make sure the student is in the care of a mental health provider.
Q I want to turn to -- actually, you said before you're familiar with the Christian Medical and Dental Association; is that right?
A Yes.
Q How are you familiar with them?
A I took -- A, I know they exist. I'm not a member. I took a course from them on preparation for speaking to the media. It's a generic course that teaches you how to be interviewed, how to respond most effectively to questions so that the -- your interview can be used more appropriately, to not do run-on sentences, to not mumble, to face the

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camera, and they basically train you on how to do that appropriately and give you a critique of what you've done in front of a camera or in front of a microphone so that you can improve some of your bad habits.
Q Have you read their position statement on transgender identification?
A I have not.
Q I'd like to turn to Exhibit 6.
(Exhibit 6 was marked for identification and is attached to the transcript.)
BY MR. BLOCK:
Q Do you have that document in front of you?
A I do.
Q Do you have that document in front of you?
A I do.
Q Do you recognize the document?
A I do.
Q It's called, On the Promotion of Homosexuality in Schools; is that right?
A That's correct.
Q If you look in the right-hand column on

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the fourth checkmark down it says: The homosexual lifestyle carries grave health risks; is that right?
A Yes.
MR. CORRIGAN: Let me interject here. This is something having to do with homosexuality in schools. To my knowledge our case has nothing to do with homosexuality in schools, okay? This is about transgender bathroom -- transgender restroom use. I don't see how this is in any way related, relevant, has any significance whatsoever, so I object to any questions regarding this.
MR. BLOCK: It goes to the credibility of his opinion and whether or not it represents medical mainstream.
MR. CORRIGAN: His opinion is that there's no science to support the notion that using a restroom of any description has any effect on a transgender youth. I don't see how that opinion is in any way influenced by whether or not this American College has a paper on a promotion of homosexuality in schools. Just completely unrelated, not admissible, never going to be part of

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our case.
Go ahead.
MR. BLOCK: You're proffering him as an expert on what the mainstream medical view is, and this goes to his views being outside the mainstream and being based on ideology and not based on science.
MR. CORRIGAN: I am not offering him as an expert on what the mainstream view of anything is. I'm just telling you that his opinion is, based on his review of the literature and et cetera, that there is no scientific basis, medical basis, psychological or other basis for anyone saying that using a particular restroom has any effect on that person one way or the other.
That's what our case is about, and that's what he's going to testify to. He's not going to talk about any of this, and this has nothing to do with our case.
MR. BLOCK: But we can explore bias, and we can explore the ability to draw valid conclusions from reviews of evidence.

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MR. CORRIGAN: If they have anything to do with the case that would be true, but when they have nothing to do with the case, they're just -- it's totally irrelevant, totally tangential, totally collateral, and has nothing to do with the case. So I just don't see the benefit of talking about these types of things.
MR. BLOCK: Bias is always relevant and not collateral.
MR. CORRIGAN: What's relevant?
MR. BLOCK: Bias.
MR. CORRIGAN: What's the bias? Our case is about transgender, it's not about homosexual. You're confusing two concepts.
MR. BLOCK: That he has opinions about homosexuality and gender identity that are based not on science but based on ideology or moral bias.
MR. CORRIGAN: But homosexual is not part of our case, and you're asking questions about homosexual. I just don't see how it has anything to do with -- it's like saying the arm and the pancreas are two parts of the body.

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MR. BLOCK: You can't put forth an expert and not allow me to build a record exploring bias.
MR. CORRIGAN: But again, the bias has to be somehow related to the case. You can't just talk about what kind of bias he may have that has nothing to do with the case.
MR. BLOCK: If you want to take it to the judge and explain why I shouldn't be able to ask him about a document from this organization that is On the Promotion of Homosexuality in Schools, you're welcome to put that issue before the judge.
MR. CORRIGAN: Okay, I will.
MR. BLOCK: Excellent. So you're instructing him not to answer any questions on, On the Promotion of Homosexuality in the Schools?
MR. CORRIGAN: I'm instructing you to ask a question that has something to do with our case. If it's related to this document, I'm not going to object to it, but if it has nothing to do with our case I'm going to continue to object to you asking questions about topics unrelated to the issues in our case.

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MR. BLOCK: You can object all you want. I'm -- but my question -- I'm going to continue asking questions.
MR. CORRIGAN: Ask your next question.
BY MR. BLOCK:
Q So let's look at the second sentence of the bolded at the top, which is a sentence that is very similar to a view that you express in this case. It says, quote, these organizations recommend promoting homosexuality as a normal, immutable trait that should be validated during childhood as early as kindergarten.
So you disagree -- just as you disagree with being transgender as being promoted as a normal, immutable trait, you also disagree with schools promoting homosexuality as a normal, immutable trait; is that right?
MR. CORRIGAN: Object to form.
Go ahead.
A That is correct because there is no biologic basis for same-sex attraction. That has been stated by both sides of political aisle. It is

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a fact there is no biology. It is a combination of things, but it is not biologically based. And that's -- that's in published science, that's truth, that's not a bias. It's been evaluated and scoured and looked for by advocates for the gay community, and they specifically state there is no such basis. So, again, that is science, it's not a bias.

The College is about what is science, not what is about hopeful things that you would wish would be true, but you have to look at everything that's actually biologically sound and proven, and that's what that sentence is based on.

BY MR. BLOCK:

Q And so homosexuality is also not normal, right?

MR. CORRIGAN: Object to form.

A The statement is that promoting it as an immutable biologically based norm is not -- is not based on valid science.

BY MR. BLOCK:

Q If we go to the second checkmark on the right-hand column, just as affirming a transgender

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student's identity can be harmful, this checkmark says: Declaring and validating a student's same-sex attraction during the adolescent years is premature and may be harmful.

Is that right?

MR. CORRIGAN: Object to form.

Go ahead.

A This is based on the handbook of the APA, which says that there is an incredible amount of fluidity in and out of same-sex attraction, and that validation is premature.

BY MR. BLOCK:

Q And can be harmful?

A If it's -- if it's premature and ends up causing ill health, it's harmful.

Q And the next checkmark says that -- you testified that many -- that all transgender people have a dysfunctional -- dysfunction in their background. This checkmark says: Many youths with homosexual attractions have experienced a troubled upbringing, including sexual abuse, and are in need of therapy.

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Is that right?

MR. CORRIGAN: Object to form of the question, object to mischaracterization of prior testimony.

Go ahead.

A The answer to that is yes, it's proven based on published science.

BY MR. BLOCK:

Q So you agree -- and you agree with that. You agree with what that checkmark says, right?

MR. CORRIGAN: Object to form.

Go ahead.

A Yes, I do.

BY MR. BLOCK:

Q And so when it says that youths with homosexual attraction, quote, are in need of therapy, what sort of therapy are they in need of?

A They're in need of therapy to evaluate and treat their depression and anxiety.

Q And that their homosexuality is sort of tapering over underlying depression and anxiety resulting from trauma?

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A No, it coexists and cannot be and should not be validated as being purely due to societal rejection or pressure.

That is such an important right of the gay community to be able to be recognized that their own suffering and anxiety and depression should be treated as for exactly what it is and not to be dismissed as unimportant or not even present.

It is a huge disservice to the mental health of the gay community that that -- that is glossed over as if those things don't exist when they do.

The conservative estimates that I read are that 40 percent of people with a gay lifestyle suffer significant depression and anxiety, and they're not getting the therapy they need.

So the advocates for the gay community strongly are coming out to say they need this therapy, they should be encouraged to go for that therapy. It is not to change anything, it is to make them be functional adults so that you lessen the long-term suicide risk, which is the end of

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severe depression in many cases.
Q And how did you acquire this knowledge?
A Reading standardized publications and articles written today and available for anyone to read.
Q And when you treat patients, do you provide any counseling or discouragement from being gay?
A No.
Q Do you ever talk to them about health risks associated with the homosexual lifestyle?
A I generally try to talk to them first about risks of sexual activity in general, then specifically if there are things that put them at specific risk based on their -- about the things that they do in terms of sexual activity, I point out those things, I talk about STDs, and I talk about depression and anxiety.
Q So before we leave this document, is there anything about this document Exhibit 6, that you disagree with?
MR. CORRIGAN: Object to the form.

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A The purpose of this document was in response to the promotion at the letter of the superintendent of the schools that was done through the Obama Administration which the College felt was a harmful avoidance of the serious and significant issues associated with promotion of this as if it were -- it had no downsides to it in any aspect.
So a statement needed to be brought out that brought up conversations that talked about STDs, that talked about depression and anxiety and the adverse outcomes that can happen. It's not that they always do, but it's a risk. It talks about the risks that these kids face, and if you promote something that has risks, you need to be up in the forefront and mention those risks without glossing over them as if they did not exist.
So that's -- that was the point of the paper is to present the risks. The known, scientifically proven risks.
BY MR. BLOCK:
Q Do you have any religious beliefs related to being lesbian, gay, bisexual or transgender?

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A I do not.
Q Does the -- do you have any religious beliefs about acting on same-sex attraction?
MR. CORRIGAN: I'm going to object to anything about his religious beliefs or his personal beliefs. I don't see how it has relevance or potential relevance.
Go ahead.
A I do not impose my religious faith on anyone. It is my personal journey. I use my religious faith to balance with science to keep me with a compass of doing things that are, again, not in a moral vacuum, that have -- again, focus on, above all, doing no harm, behaving well, not hurting the patient in any possible way that is intentional or based on any bias, not based on any harmful -- harmful ideas I may have about behavior. So it's -- that's where my faith comes into my professional life.
BY MR. BLOCK:
Q The American College of Pediatrician files amicus briefs; is that right?

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A They do.
Q And those amicus briefs express the views of the College, right?
A They do.
Q I'm sorry, I didn't hear the answer.
A I do.
Q So do you play any role in approving the content of amicus briefs?
A I know of some of them, particularly on the transgender issue. Some of the other briefs I'm not an author of, but they were filed. I'm not aware of the absolute design and content, I just know that they exist.
Q But is it fair to attribute statements made in amicus briefs filed on behalf of the American College of Pediatricians to the views of the American College of Pediatricians?
MR. CORRIGAN: Object to form of the question.
Go ahead.
A Yes.
BY MR. BLOCK:

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Q So is it the belief of the American College of Pediatricians that, quote, it's not beyond the scope of a court to acknowledge the moral foundation of God's laws when considering the institution of marriage, unquote?

MR. CORRIGAN: Object to form.

A That is a philosophical, beneficial concept that is -- it's looked at from its scientific validity to have a benefit to the patient or the family that marriage has a historical construct that is based on society and most often verified and sanctified by a religious faith germane to the population, and that is to the benefit of the child to have -- to come from an intact family, and that anything that can be done to promote intact biologic families is probably the most ideal of circumstances. And if something is less than ideal, so be it, but if you're trying to promote what is ideal, you label that as ideal.

BY MR. BLOCK:

Q Does the moral foundation of God's law have any relevance to the treatment of transgender

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people?

A No, I'm basing it on -- purely on science. I don't -- I think the way it would be looking at a theologic concept is it is appropriate to harm children, and if that is -- if your faith structure or your theology suggests that there is harm to be done to a patient and you are doing harm, perhaps that's not within the precepts of what your faith might guide you to do, so that's how it comes into play.

Like it does -- it's an ethical structure to be sure that we are paying attention and validating what we do on science and not falling into a trap of validating something on popularity or social pressure.

Q Is it true that the American College of Pediatricians told the Alabama Supreme Court it should ignore the opinion of the Supreme Court in Obergefell?

THE REPORTER: Supreme Court in...

MR. CORRIGAN: Obergefell. Obergefell.

MR. BLOCK: O-B-E-R-G-E-F-E-L-L.

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A Yes, they did.

BY MR. BLOCK:

Q Do you agree with that?

A The point was, again, the concept of what is best for children is an intact biologic family. That does not have any potential for increased adverse outcomes for the child. And so, again, it's the foundation of the family in that regard and that opinion that the College chose to say what is best for children in an ideal circumstance, the ideal was that the Obergefell decision should not be -- should be ignored at the Alabama court level.

Q And you think that if a court says that the school board in this case should let transgender students use restrooms in line with their gender identity that the school board should ignore that court decision?

MR. CORRIGAN: Object to form, object to foundation.

A I would not make that statement.

MR. CORRIGAN: Witness not being called for that purpose.

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Go ahead.

A I would not make -- I would not tell the school to go against a court decision.

BY MR. BLOCK:

Q So if there's a conflict between what the law requires and what your medical views are, you would think that the school board would need to do what the law requires, right?

MR. CORRIGAN: Object to form.

Go ahead.

A The school board should do what the law requires, and if they are at odds with that law, they should file suit and take it through legal proceedings.

BY MR. BLOCK:

Q Going back to Exhibit 5 just one more time, that's the On the Promotion of Homosexuality in Schools. I just need to know is there anything in this statement that you disagree with? I just want to have that on the record.

MR. CORRIGAN: Object to form, object to foundation.

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Go ahead.
A I'm going to carefully go through each point.
BY MR. BLOCK:
Q Yes, sir, take a minute.
A Okay, I concur with all points.
Q Thank you.
I want to take a couple minutes to revisit what we were talking about before about these 12 patients that you've been treating over the past two to three years related to gender dysphoria.
Is there -- was there any precipitating event that you're aware of that caused people to start coming to you two to three years ago for treatment in connection with gender dysphoria?
A Nothing that I perceived as a specific event. I thought it reflected just a general increase in the number of transgender clinics and the online presence of transgender-promoting websites and blogs that would be responsible, but that is my perception without any basis on scientific research.

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Q Do you identify yourself within your medical network as an endocrinologist who provides treatment for gender dysphoria?
A Yes.
Q And when did you start identifying yourself that way?
A When I began accepting patients and getting feedback from practitioners, when I began discussing things amongst my endocrine peers, that's when I began to make sure that people knew that I was very willing and able to have these patients come to my office for evaluation.
Q And did you start describing yourself as someone who provides treatment for gender dysphoria before or after the first of these 12 patients came to see you?
A I was -- I was quiet and didn't say much because I was gathering information, so it was until actually perhaps a year before the first patient came in at a time when I had put together enough of my own review of the literature to feel very strongly that there was a need for this service, and it happened to coincide with the time that the Emory University medical campus opened their transgender clinic.

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Q So before -- in the time period before you started identifying yourself as a practitioner who provides treatment for gender dysphoria, the only transgender patient who had come to see you was this one in 1993; is that right?
A That is correct.
Q Now, when you describe yourself as a practitioner who provides treatment for gender dysphoria, do you include in that description your -- what your views are with respect to providing gender-affirming hormone therapy?
A The people that I talk to professionally who know me as endocrinology colleagues know how I feel because I've spoken in front of them, so I am assuming everyone knows how I feel.
Q Is there, like, insurance networks or your medical groups that you're associated with, is there like a lookup feature where patients can find a doctor in an area that provides treatment for gender dysphoria, and certain people's names pop up if they identify as that sort of certain practitioner?
A I am not aware I am on such a list.
Q Is it on your website?
A No, it is not.
Q So of the 12 patients that come to you, about how many were referred to you by -- referred to you specifically?
A About half of them are referred, and the other half spontaneously found me.
Q The half who spontaneously found you, to the best of your knowledge, were they aware of your views with respect to gender-affirming therapy?
A I was aware at least two of those. One of the parents sought me specifically because they had seen one of my talks on YouTube.
Q For the ones that were referred -- for the patients who were referred specifically to you, who made those referrals?
A Pediatricians.
Q Pediatricians that you knew?
A Yes.

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Q In what capacity did you know them?
A From prior referrals from endocrine patients over the span of the last 28 years. Up to 28 years.
Q Did those pediatricians -- do you know whether those pediatricians shared your views with respect to gender-affirming therapy?
A I do not.
Q Do you know whether they knew those views at the time they referred the patients specifically to you?
A I do not.
Q You said that two of the patients you think have had success in resolving their dysphoria, and 10 are work in progress; is that right?
A That's correct. One of them moved out of the area, and I don't know what has happened in follow-up with that patient.
Q Are there -- are there any patients who saw you for an initial consultation but then decided to seek treatment with someone else instead of continuing to follow up with you?

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A I am unaware of any.
Q And so the 10 that are in -- that are a work in progress -- or are there nine that are a work in progress? I just want to get the number right.
A That's correct, it's nine.
Q Nine. The nine that are a work in progress, have they reported any lessening of their symptoms of gender dysphoria?
A They are working through issues and seem to be in better mental health, but some of them are still struggling with issues. Some of them are young, so some of them are coming back and just we are revisiting the same overall view, and they're works in progress.
Q So did I get it right that some have shown improvement with respect to depression and anxiety, but at the same time not showing improvement in resolving their feelings of gender discordance?
A I'm trying to specifically categorize those which are not living affirming the gender-incongruent lifestyle, and I think the

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majority of them are back to being -- living in their biologic body as that gender at least outwardly for the school and for purposes of other people outside the family. But the family is working within the family to work these kids through that process and to do healing amongst themselves.
Q For the follow-up visits after the initial visit with these patients, do you conduct a medical exam on the follow-up visit?
A I conduct a medical exam if I sense that something is going wrong. For instance, several of these children are obese and are increasing their body weight significantly because every patient that comes in is weighed and measured, and I want to address that issue because it's a co-morbidity in some ways, but it's also innate for them to become obese. So I'm aware of, in kids like that, that I want to pay attention to those issues.
If the parents describe something that they think is puberty that's happening, I'll do a physical exam. So it is very much case by case.
Q But there's some patients that for the

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follow-up visits you don't conduct a medical examination, correct?
A If it's -- particularly since the visits are designed to try to be three months apart and nothing physically is changing, I would sort of mandatorily do a full physical exam at least once a year.
Q So what happens at a visit like that where there's no medical examination, it's a check-up after three months?
A First it's an interview with everybody in the room, and then it is permission to have the child and either parent. If the parents are not -- are not functional together, I will interview the parents individually, I will then sort of reinterview them together to discuss the things that I have permission to talk about between the two of them that might be constructive of things that I might learn about that situation, and then I ask permission to interview the child individually without the parents in the room.
Q And what do you bill that as to insurance?

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A That's as a counseling visit as a parent conference. It usually is about a 30-minute visit. Sometimes it's longer if things are sort of opening up and there are re-questions and re-education, or in the case of a split family if it's the first time I've been able to actually interview or take -- get information from a parent who had previously been absent it takes longer, so it's all based on time. But it's done as a parent conference visit.

Q Do you have a license to provide counseling?

A I have a license to provide evaluation of children's health.

Q After the initial evaluation when you're providing continued visits, is it -- would counseling be a fair description of what occurs in those visits?

A No, it's basically information gathering.

Q And what do you do with the information that you gather?

A I record it in the record. If there is education to be done in terms of questions and

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answers about the medical side, those are explained, reexplained.

Often because of the nature of the visits there's a lot of emotional tension, and there's not necessarily a lot of constructive listening, so I go back over again and be sure that everyone understands the medical aspects of what's going on and what they might have read on the Internet, what they might have new concerns about, and I address those things, but I do not do counseling for depression and anxiety.

Q You said you spoke about transgender-related issues to the International Association of Therapeutic Choice; is that right?

A That's correct.

Q How did you come to become familiar with the International Association of Therapeutic Choice?

A I was approached by their director and asked if I would be willing to come and talk on the history of transgender health in the United States.

MR. BLOCK: If you'll just give me a minute. We can go off the record for a second.

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(Recess 2:59-3:02 p.m.)

BY MR. BLOCK:

Q So when you said before that you at some point made it be known that you were interested in seeing patients that were seeking care for gender dysphoria, how did you communicate that to others?

A By word of mouth at regional meetings mostly.

Q Regional meetings of endocrinologists?

A Yes.

Q Do any patients get referred to you through the American College of Pediatricians?

A I -- I actually don't believe I've had a patient come specifically referred from the College. We do have a referral base for pediatricians who are members so that if a family calls and said, is there a pediatrician in my area who's a member of the College, we can tell them who is in their geographic region and hook the two of them up. So that is -- I'm not aware of actually having a family come to me referred by the College.

Q Are you aware of having a family come to

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you being referred by a pediatrician who's a member of the College?

A Yes, because there are members in Georgia, and I would -- I would guess that, yes, that has happened, but I can't -- I don't have a documentation of an individual's name.

Q So during the first visit when someone comes to you for treatment for gender dysphoria, do you conduct an examination to determine how far along in puberty the patient is?

A Absolutely, yes.

Q And so what's the purpose of doing that if you're going to not provide hormone therapy regardless of what stage of puberty the individual is in?

A Well, staging of puberty is in the DNA of being an endocrinologist so that at any visit that we do, whether they have a diagnosis of type 1 diabetes or hypothyroidism or vitamin D deficiency, rickets, staging them in puberty is exceedingly important because it's part of what affects their growth.

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Human growth, statural, and weight gain are related and timed with puberty and are affected by puberty, and so it is essentially, as I said, in our DNA as endocrinologists to be sure we have staged puberty no matter the age of the patient.

We do not assume that just because the concept of a pubertal-related symptom is not brought up that we should not verify that the patient is indeed not pubertal or is pubertal and is in what stage of puberty and how they are growing and how they have grown before if we can gather the data and watch them grow as they move forward.

Q So you do this initial evaluation, you have a discussion where you warn the patients about harms associated with gender-affirming therapy, you encourage them to see a counselor, and then what's the explanation you give for why they should come back for a check-up in three months?

MR. CORRIGAN: Object to form.

Go ahead.

A My story to them is that I am there to care for them, and that I will dedicate my time and

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effort to absolutely everything that is beneficial to them, and that I know this is a confusing, painful experience for them, and that it is my job to monitor how they are doing and how we are moving in the direction that is to their greatest benefit, and so that's why they come back.

And I say it's easy to get lost in the woodwork, and if I don't -- it's the same thing I do with my diabetic patients who don't come back for follow-up, we contact them and make sure that they do come back because we know there is a necessity for them to be followed to be sure all is going as beneficially as it possibly can be, so that's the same principle.

BY MR. BLOCK:

Q But why followed by you instead of by the psychologist or psychiatrist that you're referring them to?

A The psychiatry part is one part of the equation. The questions about what to do in terms of endocrinologic intervention are always hovering around the edge, and the psychologist is very

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definitely interested in anchoring them back to me to discuss anything that -- any questions the parents may have. Particularly with the advent of Internet access, the parents read over and over again about new ideas, new concepts. They need somebody to anchor to that talks about hormones and the effects of hormones, and that's why they come back.

Q So even after the first visit, a parent might come back to you with repeated questions about hormones possibly being a good course of treatment, and you have to explain to the parent repeatedly why they're not; is that right?

A In part, but it's also because most of these families are split families, and one parent will see doubt in the mind of the parent who is the one who's been bringing them in, and the parent needs to come back and be reassured, or the other parent wants to come and hear what I have to say, and we have not talked before.

So this is such a -- this is not something where you have a sit down, one discussion, send them

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to the counselor and you're done. This is a multifaceted approach for a very complex psychological issue that involves a lot of pain and agony, and the patient -- here is the poor patient in the middle trying to figure out what to do, what the answer is.

And if they know that somebody is dedicated to them from the medical side as well as from the counseling side, it is our hope that that gives them some place to hang on to and a sense that somebody really does care, even if they don't necessarily agree with the patient, that they want them to be -- to understand how dedicated we are to their welfare and how compassionate we really are.

It's very difficult to talk to a very sullen 14- or 15-year-old who sees you for the first time and convince them that you're on their team, and so it takes time.

Q But from the very first meeting, though, you make clear to the parents that under no circumstances will you be recommending gender-affirming hormones, right?

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A That's correct.
Q And are there any other conditions that you treat in which you have the series of follow-up conferences without providing medical treatment as part of it?
A It's not often, but diabetes would be one of them. There is so much overlay of issues with compliance and whatnot that don't have to do with physical wellness at the moment that require visits to come back and predominantly talk about behavioral responses and things that are germane to our clinical experience in the field of diabetes, so those kids, we'll bring them back.
Normally they're every three months, but it is not uncommon in the adolescent years for us to see them back a month after they've been seen before to give them a pep talk, try to give them the responsibility for managing their diabetes, set them up for success with telephone contact and office website secure communications so that we can try to invest this child back in their diabetes care.
There are often points in time where the

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mental health issues are so overwhelming that we literally jettison to primarily back to an aggressive mental health intervention scheme and let the diabetes kind of go for a while because it's impossible for those kids to get their blood sugars in control or even care about managing their diabetes when they're overwhelmed with depression, so that's another circumstance where often the visit will be predominantly information gathering, team building, putting together things like that.
Q And you said before that one of the reasons why you decided you wanted to start making it known that you would provide -- that you would see patients seeking care for gender dysphoria was because you thought there was a need for it; is that right?
A That is correct.
Q To the best of your knowledge, is there any other pediatric endocrinologist that you're aware of that provides the same course of office visits that you do to patients who have come to you seeking care for gender dysphoria?

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A It's very limited because the guidelines have been so pervasive, and what happens is that -- and this was an admission by a number of the pediatricians in our regional meeting last month in Orlando is they say, I don't take care of these patients, I send them to the centers. So that's -- they kind of punt. And they are -- they were relieved.
My presentation of a case study of one particular patient just all of a sudden brought into their minds, and they shared this with me, thank goodness. Thank goodness. How do we do this? How do we do this? What have you got written? Can you come talk to us in Birmingham? Can you give us a presentation for pediatricians where we can -- we can get the people in the community to understand that there are other avenues than the transgender clinics as they now exist?
Q But in terms -- but as far as you're aware, are there any other endocrinologists that you are aware of who provide the same course of treatment for gender dysphoria that you provide?

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A Yes. Yes.
Q Who?
A There's a pediatric endocrinologist, Paul Hruz, in St. Louis, I believe Robert Hoffman in Indianapolis. There's just a few of us because we're just -- we're just starting to put together communications that are effective among our endocrine communities.
We can't -- you know, I can't get invited to national endocrine meetings because they won't have me. I've tried the American Association of Clinical Endocrinologists on two occasions over the past three years to do a balance -- what I call a balanced-dialogue type of a presentation, and I specifically have been told no, that that's not going to happen, and it could not happen, so...
And at those very same meetings they had transgender clinic directors do a presentation, which is basically telling everybody, this is what you do, this is how you do it, this is the only way that's effective, send your patients to us, and that's -- that's what happened.

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So it's hard to get -- it's hard to get colleagues unless you literally spend the time of contacting them individually and saying, let us tell you our experience.

I share my -- the paper that I've submitted for publication with other endocrinologists to let them know. When I presented in Orlando, the positive feedback from the community was about three out of four people coming to me afterwards saying, please tell us more, please tell us more, so that's it.

It's a slow -- this movement is just beginning to get an anchor because of the validity in science that we've been able to prove.

Q What's your understanding about why these organizations refuse to let you provide a presentation on the course of treatment you provide?

A I have -- sheer conjecture. I have not been able to talk to the meeting directors directly. I have communicated one way with them most recently both by e-mail and telephone message, and that individual for the meeting of the American

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Association of Clinical Endocrinologists in Los Angeles, I believe it's next week, that person chose not to communicate back with me.

Q In your declaration if you go to paragraph 29 of it, going back to Exhibit 1. Are you at that page now?

A I am.

Q Great. The paragraph 29 says: Up until recent -- up until the recent revision of DSM-IV criteria, the American Psychological Association held that gender identity disorder (GID) was the mental disorder described as a discordance between the natal sex and gender identity of the patient.

Is that right?

A That's true except there is a misstatement. It's the American Psychiatric Association, and I apologize for that inaccuracy. They both have the same initials, APA, but it is the American Psychiatric Association that generates the DSM criteria.

Q And do you have any opinion on whether it was appropriate for the APA to no longer describe

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gender dysphoria as a mental disorder?

A I'm not a mental health practitioner. I really find it difficult to sometimes use the correct words without offending people who are licensed and trained in mental health issues.

I learned actually from Dr. Zucker that the word "disorder" is very specifically chosen and cherished in the mental health community for very specific purposes. Prior to that conversation with him I would -- was thinking that anybody who had transgender or gender incongruence had the disorder, and that, I learned, is not the case. It is sort of living a delusion, but not living with a delusional disorder. So I find that the removal of the "gender identity disorder" is a disservice to the patients.

So did Dr. Zucker, from indirect conversation as I learned in between my statement to the Carcano case and this that when the APA group, again, it doesn't represent all psychiatrists, but it's the group that develops the criteria, and they are -- they're parsed into interest groups, they pushed very strongly to eliminate any pathologic

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reference to gender identity issues.

And Dr. Zucker argued -- and, again, this is not from a conversation with him, but through second parties who talked to him about this personally, he argued that if you remove it, the suffering is going to be legendary as it is, and it's going to be ignored and will not be allowed to be treated by third -- and covered as a service by third parties who cover healthcare costs, insurance mainly, and that medications then wouldn't be covered.

And it was a disservice to the patients to eliminate the disorder, but if they were going to pressure to do that, would they please replace it with "gender dysphoria" so that there was a medical condition that would allow that patient to seek and be treated and have that as covered services by government entities and private insurance.

Q So did I hear you right that one of Dr. Zucker's reasons was to ensure that medicines would be covered?

A That treatment of any kind would be

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covered.
Q But including hormone therapy, correct?
A I assume that, yes, but, again, I didn't write that policy, and I didn't talk to him directly to know.
Q Have you ever talked to Dr. Zucker directly?
A No, I have not.
Q So do you have any views on the APA's decision to remove homosexuality as a mental disorder?
MR. CORRIGAN: Now we're getting far afield again --
A I do not.
MR. CORRIGAN: -- with the conversation about homosexuality. We're not here to talk about homosexuality. Has nothing to do with our case.
Go ahead.
A I do not have any issues with the removal. My issue is that the mental health issues are being overlooked, and that's a disservice to people who are gay and lesbian, and that we should do

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everything we can to help these individuals and advocate for them to recognize things that need treatment instead of pretending that they are not there, and therefore worsening the quality of their life overall.
BY MR. BLOCK:
Q Going back briefly to the formation of American College of Pediatricians, is it accurate to say that the catalyzing event for forming the American College of Pediatricians was the AAP's position on children raised by same-sex parents?
A As I understand it historically, it was.
Q One more minute. I may come back and finish.
(Brief recess.)
BY MR. BLOCK:
Q One more line of questions. In terms of the issues in this case with Mr. Grimm, do you think that by preventing Mr. Grimm from being allowed to use the boys' restroom, that that was actually something that was to his medical and mental benefit to prevent him from using the restroom?

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A In the sense that it was an affirmation, I personally believe that affirmation is harmful, so -- that I would say that was a harmful concept to let him use the bathroom of the sex he wished he were.
Q So when the board decided to stop letting him use the bathroom, you think that -- the bathroom consistent with his gender identity, you think that was to his benefit?
A Yes.
Q Is that right?
A Yes.
Q Okay. And is that because you think by not affirming him, by not letting him use the restroom, the school was making it any less likely that he would continue to be transgender?
MR. CORRIGAN: Object to form of the question.
A Can you restate the question again?
BY MR. BLOCK:
Q Sure. Is it your opinion that by not allowing Mr. Grimm to use the boys' restroom, that

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the school was making it less likely that he would continue to identify as being transgender?
A That would be a -- an opinion of mine personally based on the fact that anything that pushes affirmation ends up pushing the patient farther along on a spectrum which will inevitably involve cross-sex hormones and eventually surgical mutilation.
Q But -- so in Mr. Grimm's case, since he has already had cross-sex hormones and already had surgical chest surgery, and -- is it still your view that preventing him from using the boys' restroom would make it less likely that he would continue to identify as being transgender?
MR. CORRIGAN: Object to form of the question, beyond the scope.
Go ahead.
A So the concept is that, as Dr. Zucker has pointed out in his opinions as well, is that anything that you do that affirms the patient, because there is no -- there's no avenue that is successful up to that point in time in bringing the

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patient to desistance, that you're essentially pushing for ongoing mental health issues that need to be continually addressed.

And I would say that anything that does harm to that child -- the continuation of cross-sex hormones, the acute effects are masculinization of the body, the long-term effects for Mr. Grimm are going to be increased risk for medical conditions that he would not otherwise have as a result of that continued treatment.

So anything that pushes him to continue the hormone therapy, feeling that it is the only avenue or the only beneficial avenue, is to his harm. And therefore I would say if the school chose to not affirm him with a bathroom, that gives him a concept that perhaps there is not benefit in that, there's no proven benefit, no proven harm as an isolated event, but if it's part of the big picture of affirmation, that the Gloucester County School System should have no part of it.

BY MR. BLOCK:

Q But focused specifically on someone who is

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17 or 18 -- which Dr. Zucker does not think that hormones should be precluded for someone who is 17 and 18, correct?

MR. CORRIGAN: Object to form.

Go ahead.

A Dr. Zucker is not an endocrinologist. I'm an endocrinologist. I know about the harmful effects of hormones, and I disagree with that, that opinion of his, if that's what he agrees at this point in time.

Dr. Zucker's opinion on the persistence of the -- of gender dysphoria has to do with children who have started from young childhood and progressed up through adolescence and, despite constant and significant intervention, do not desist. He was not in general talking about kids who in their mid teens make a decision that they are now transgender and are essentially wishing to be the opposite sex. So it's comparing apples to oranges here.

BY MR. BLOCK:

Q So assuming that we're dealing with someone who has consistently from an early age

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identified with the opposite sex and has -- and other therapies have proven not to be successful, they are a junior or senior in high school, does Dr. Zucker's views provide any support for continuing to exclude that individual from using the boys' restroom, that transgender boy?

MR. CORRIGAN: Object to the form of the question.

Go ahead.

A I would say at any point during -- I disagree with Dr. Zucker. If that's -- if that is truly his opinion that the only route left is affirmation, and nothing else should be done to deal with that patient, then you let them go, I would personally disagree based on the long-term effects of affirmation and long-term hormones because without persistence of the incongruity as a concept, that patient is going to have to require the hormone therapy that's eventually going to be causing them a significant medical morbidity.

BY MR. BLOCK:

Q What if a patient has -- is 18 and has had

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genital surgery so that they no longer have -- it's a transgender woman and no longer has their male gonads and needs hormones, in that case would you still oppose gender-affirming hormone therapy for that individual?

A I recommend that that patient go back on the physiologic levels of their natal sex hormones at that age to maintain their body's health without harm.

Q And that would also be your view if the patient were 40 instead of 18, right?

A Yes. Yes.

Q And you think that when it comes to the issues of providing hormones, you are in a better position to make judgments about the benefits and risks than Dr. Zucker is because you are a trained endocrinologist, and he's not; is that right?

A That is correct.

Q And so would the converse be true, that a trained psychologist is in a better position to make decisions about what psychological care a transgender individual needs than an endocrinologist

is?

A Yes.

MR. BLOCK: Okay. That's all the questions I have.

MR. CORRIGAN: He'll read.

(Off the record at 3:31 p.m.)

ACKNOWLEDGEMENT OF DEPONENT

I, DR. QUENTIN VAN METER, do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct and complete transcription of the testimony given by me, and any corrections appear on the attached errata sheet signed by me.

_____ _____

(DATE) (SIGNATURE)

CERTIFICATE

I, Robyn Bosworth, RPR, CRR, CRC, CCR-B-2138, do hereby certify that the witness was first duly sworn by me pursuant to stipulation of counsel and that I was authorized to and did report said proceedings.

I further certify that the foregoing transcript is a true and correct record of the proceedings; that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision; that review was not waived; and that I am neither attorney nor counsel for, nor related to or employed by, any of the parties to the action in which this deposition was taken; and that I have no interest, financial or otherwise, in this case.

IN WITNESS WHEREOF, I have hereunto set my hand this 22nd day of March, 2019.

Robyn Bosworth

ROBYN BOSWORTH, RPR, CRR, CRC, CCR-B-2138