IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	NO. 4:22-CV-00325-RH-MAF
	)	
	)	
JASON WEIDA, et al.,	)	
	)	
Defendants.	)	

VIDEOCONFERENCE DEPOSITION OF
G. KEVIN DONOVAN, M.D., M.A.
LOCATED IN SAND SPRINGS, OKLAHOMA
TAKEN ON BEHALF OF THE PLAINTIFFS
ON MARCH 22, 2023

REPORTED BY: JANA C. HAZELBAKER, CSR

A P P E A R A N C E S

(All parties are appearing via videoconference.)

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C O N T E N T S

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PLAINTIFFS' INDEX OF EXHIBITS

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PLAINTIFFS' INDEX OF EXHIBITS

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S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and among the attorneys for the respective parties hereto that the videoconference deposition of G. KEVIN DONOVAN, M.D., M.A., may be taken on behalf of the Plaintiffs, on MARCH 22, 2023, located in SAND SPRINGS, Oklahoma, by Jana C. Hazelbaker, Certified Shorthand Reporter within and for the State of Oklahoma, pursuant to Notice.

IT IS FURTHER STIPULATED AND AGREED by and among the attorneys for the respective parties hereto that all objections, except as to the form of the question, are reserved until the time of trial, at which time they may be made with the same force and effect as if made at the time of the taking of this deposition.

* * * * * *

G. KEVIN DONOVAN, M.D., M.A.,
having been first duly sworn at 9:03 a.m. CST, deposes and says in reply to the questions propounded as follows, to wit:

DIRECT EXAMINATION

BY MS. DUNN:

Q So, good morning, Dr. Donovan. As I mentioned before, my name is Chelsea Dunn. I'm an attorney for the plaintiffs in the lawsuit Dekker, et al. versus Weida. I will be deposing you today. I work for an organization by the name of Southern Legal Counsel.

If you don't mind just introducing yourself and stating and spelling your name for the record, I would appreciate it.

A Yes. My full name is Gerard Kevin Donovan. G-e-r-a-r-d, K-e-v-i-n, D-o-n-o-v-a-n.

Q Thank you, Dr. Donovan. Just as an initial question, have you ever been deposed before?

A Yes.

Q Okay. I'm going to go over a couple ground rules, just so that we're on the same page for expectations today and that there's no confusion.

The court reporter here is writing down everything you say, so if you can respond to my

questions using verbal answers, for example, yes or no instead of shaking your head or nodding, that would be a lot -- it's a lot easier for her to transcribe our conversation today.

We also -- I think in natural conversation people have a tendency to start answering a question sometimes before it's done, so if you can be careful not to speak over me or to begin answering my question until I finish it, I will try to do the same and not talk over you as well. Is that fair?

A Yes, ma'am.

Q You're welcome, as we mentioned before, to take a break at any time. Please just answer -- if you'll finish answering the question that's on the table before you request a break, that -- you know, that -- we would ask that you finish answering the question before we take a break.

You can also speak to your attorney at any time, but, again, please finish answering my question unless there is an issue of privilege.

You can also -- if you, later in the deposition, realize that you gave an answer earlier that wasn't full and complete, you're welcome to supplement your testimony. Or if you realize that you were mistaken, you can also correct your

testimony, please just let us know.

You can also ask for documents to refresh your memory as to something. So if there's something that would help your memory, please let us know what that is.

Have you taken any medications today that would affect your ability to answer my questions truthfully and fully?

A No.

Q Are you ill or is there anything else going on that would affect your testimony today?

A No.

Q The oath you've taken that the court reporter provided is the same oath that you would take in a court of law. So do you understand that you are testifying today under penalty of perjury?

A Yes.

Q And your oath is to answer, not just truthfully, but also the whole truth. So do you understand that you're expected to give full and complete answers today?

A Yes.

Q Thank you.

Before we begin, I just want to talk a little bit about the topic of our deposition today.

So this case is about healthcare that is commonly used to treat individuals -- I'm sorry, to treat gender dysphoria for transgender people. We refer to that sometimes as "gender-affirming care." Are you comfortable with my use of that term?

A You can use any terminology that you want.

Q And if I refer to gender-affirming care, do you understand that that means, for example, medical treatment such as the administration of cross-sex hormones, gender-confirming surgeries, or puberty-blocking medications?

A I do.

Q Have you been retained as an expert witness by the defense in this case?

A Yes.

Q And you understand that you -- your report was submitted to the Court by the defendants as expert testimony in order to advance their case against the plaintiffs?

A Yes.

Q And what expert testimony were you specifically asked to provide in this case?

A I was asked to testify as a medical ethicist.

Q And what opinions were you asked to

provide?

A Opinions about the propriety of the gender-affirming care.

Q And what are your opinions as to the propriety of gender-affirming care?

A I think it's problematic.

Q And when you say "problematic," what do you mean?

A I mean I think that there are some problems regarding the approach, the diagnosis and treatment approach.

Q Can you explain what problems you believe there are with the diagnosis and treatment approach for gender-affirming care?

A Well, geez, that's a lot, but then we have hours, don't we?

I think that the -- that there are problems in the concept.

I think there are problems in the application of that concept to a diagnosis for individuals.

And I am aware of problems that have been identified by many others, in terms of the treatments themself and the justification for them.

Q When you say problems identified by

"others," who are those others?

A Oh, they're in the literature.

Q Your opinions are fully set forth in your expert declaration that was signed on February 15th, 2023; is that correct?

A I believe so.

Q So I will pull up that document so that we can both confirm.

(Document is displayed).

Can you see the document labeled "Expert Declaration of Kevin Donovan, M.D., M.A."?

A Yes, I can.

Q Is this your expert report?

A Looks like it.

Q Do you need to review it to be sure?

A No, no. Let's just go ahead.

Q Okay. I'll just quickly scroll down to where your signature is.

Can you confirm that you signed this document?

A It looks like it. Thank you.

(Whereupon, Exhibit Number 1 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So I would like to ask that

this be marked as Plaintiffs' Exhibit 1.

Did anyone besides you contribute to writing this report?

A No.

Q Did anyone besides you edit this report?

A I don't recall. I know I submitted it to the defense attorneys and I don't think that they -- they may have edited something on it for clarity. I'm not sure.

Q And when you say you "submitted it to defense attorneys," who did you submit it to?

A Well, I sent it in to -- to Gary Perko or Michael Beato or somebody in that group.

(Whereupon, Exhibit Number 2 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'm going to stop sharing this document and I'm going to show you a document that was provided to us as your bibliography for your report.

(Document is displayed).

Dr. Donovan, do you recognize this document?

A It looks -- I think so, yeah.

Q And is this a document that you prepared?

A Yes.
Q And what -- what is it?
A I'm sorry?
Q What --
A It's a bibliography.
Q And it's a bibliography for -- for what?
A In reference to my previous paper.
Q And so this is a bibliography of the sources you considered and relied upon in the expert declaration that we marked as Plaintiffs' Exhibit 1?
A Yes.
Q And this is -- I'll -- this exhibit will be marked as Plaintiffs' Exhibit 2.

This document was not originally sent along with your report; is that right?
A Correct.
Q So this was provided upon request by plaintiffs' counsel?
A Yes.
Q Are these all of the sources you relied upon in preparing the report and expert declaration that was marked as Plaintiffs' Exhibit 1?
A That would be difficult to say because so many things I rely on are also part of my own expertise. But in terms of articles, I think that's

a reasonable summation.

Q Are there any other sources you can identify that you relied upon for your expert declaration that is not listed in this bibliography?

A No, not at present.

Q When did you first become aware of this case, Dr. Donovan?

A Some months ago.

Q Can you give us an estimate of perhaps the time of year?

A I'm trying to think when I first was contacted. It was -- it was probably -- I'd have to go back and look. It was probably in the fall or something. Or, no, it was probably the end of summer.

Q End of summer.

And do you recall who contacted you?

A I believe I got an email from Gary Perko asking if I would be willing to help them with the case.

Q When were you formally engaged as an expert witness in this matter?

A If I can -- I think I've got this handy.

MR. BEATO: Dr. Donovan, just from your memory.

THE WITNESS: Oh. Sometime in the fall.

Q (By Ms. Dunn) Have you been contacted by Holtzman Vogel previously to be an expert witness in any other matter?

A No.

Q You also prepared a report to support the Florida Medicaid rule prohibiting coverage for gender-affirming medical treatments; is that right?

A Yes.

Q That report was an attachment to a, quote, "generally accepted professional medical standards" report prepared by the agency for healthcare administration?

A I believe so.

Q All right. So a couple of those terms that I just used are terms where we frequently use abbreviations.

So when I refer to GAPMS, G-A-P-M-S, I'm referring to Generally Accepted Professional Medical Standards, which is a -- it's a standard employed by the Agency for Healthcare Administration of Florida.

When I refer to AHCA, that's A-H-C-A, and that stands for Agency for Healthcare Administration, and that is the Florida Medicaid agency who is the defendant -- one of the defendants in this case.

Do you understand that?

A Thank you. Yes.

Q And if you -- if you later in the deposition can't recall what those acronyms mean, please feel free to ask for clarification.

A It's almost certainly going to be needed.

Q Okay. Who contacted you to provide your report in support of the AHCA GAPMS memo?

A Someone from -- I believe it was the health department in Florida.

Q Do you remember the name of that individual?

A No, I'm sorry, I don't.

Q I apologize. I have a sinus infection, so I might cough occasionally.

Do you recall any -- the names of any other individuals at AHCA that you worked with in providing and submitting the report for the GAPMS memo?

A I think there was only, like, one or two names. And, no, I'm sorry, I don't -- I don't have those in my head.

Q You don't recall them. Okay.

Do you know how the agency got your name in order to contact you about that report?

A It must have been suggested to them by

someone else, but I'm not sure.

Q What did you do to prepare for today's deposition?

A I re-read some of the things that I had submitted, as well as some other articles on the topic.

Q And when you say you "re-read things you had submitted," which things that you submitted did you re-read?

A The two that you've just mentioned. Perhaps I should be -- re-familiarize myself with what I said.

Q And so that would include the expert declaration that we marked as Plaintiffs' Exhibit 1?

A Yes, ma'am.

Q And that also includes the report you submitted to the Agency for Healthcare Administration in support of its GAPMS process?

A Yes.

Q You said you reviewed some other articles in preparation for today. Which articles were those?

A Oh, about perhaps a dozen different articles, including the one I just saw in the British Medical Journal yesterday.

Q Can you please clarify what article that

was?

A Well, fortunately, that one I can tell you because it's still sitting here.

It was entitled "BMJ Investigation: Gender Dysphoria in Young People is Rising and so is Professional Disagreement," by Jennifer Block.

Q All right. What other articles have you reviewed?

A Well, certainly articles that I'd already used to -- to compose my various expert witness and expert opinion papers.

Q That --

A And other things -- and, quite frankly, other things I just kind of peruse randomly, so I didn't really make notes of which they were. I probably have -- some of them were online and some of them I actually have as printouts from an old file. And I -- I couldn't tell you specifically.

I also was sent the -- some of the forms or reports from the attorney's office, and of course I reviewed those as well. But some of those --

Q What --

A -- were some of the things we've just been talking about.

Well, the -- the expert witness

declarations from the people on the plaintiffs' side.

Q Which expert declarations from the plaintiffs' side did you read?

A Karasic and Antonnaria.

Q Were there other expert declarations in this case that you reviewed, including any of the defendants' expert declarations?

A I'm sorry, there was a third one from the plaintiffs' side, but it seemed to have so little to do with what I had been talking about. I'd have to go back and see who that was by.

And I actually didn't have a -- an opportunity, because I got them so late, to look at all the defendants' declarations.

Q Did you look at any of the defendants' declarations?

A Not in depth, no.

Q Did you review even briefly any of the defendants' declarations?

A Probably. Probably.

Q Do you recall --

A But because they were -- yeah, not -- I cannot specifically recall because they just were parallel to what I was focusing on and didn't overlap that much.

Q Did you have any meetings with anyone in order to prepare for today's deposition?

A We had about a 10- or 15-minute meeting with the defense attorneys.

Q Which defense attorney?

A I think it was Gary Perko and one other in the room.

Q Did you talk or speak with anyone else about your deposition in preparation?

A My wife.

Q I'm sorry, I was getting some background noise on my laptop I wanted to get rid of.

So you earlier mentioned that you had some things right beside you that you had used to prepare for today. What are those things?

A Oh, the -- I'm trying to make sure I have the right -- my expert report.

The -- the "Ethicist's View of Transgender Treatment for Children" that I had sent in.

And, actually, I was just looking at that BMJ article because it had just come out.

Q Are those the only three things that you have?

A Oh, I mean, no. Look at my study. I've got a lot of things in my files, but not things that

I've been looking at this morning.

Q So when you say you have things right beside you, it's merely your expert report, your report that you submitted during the GAPMS process, and the article from the British Medical Journal that you referenced?

A That's -- yeah, that's a pretty fair summary.

Q Is that --

A I mean, there are other things I could find, but that's it.

Q But when you're -- I'm sorry. I'm speaking about the things that you're referencing that are right beside you that you said you could refer to.

Is there anything other than those three documents that I just listed?

A Not currently, no, but I -- like I said, if you need me to, I can find things. They're all close by.

Q Well, so -- so I think what we're experiencing right now is one of the limitations of a virtual deposition, which it's obviously much more convenient because we're all able to be in our own respective locations.

But, generally, if someone were to come to

a deposition with paperwork, we would be entitled to see what that paperwork is.

And so what I'm trying to understand is what paperwork have you compiled in order to use in this deposition? What is sitting beside you that you intended to reference or that you brought with you or -- or put together for the purposes of this deposition?

A Okay. No, I think you've got it then. That was it.

Q Okay. Thank you.

Have you been deposed -- I'm sorry, you told me you've been deposed before, Dr. Donovan. Can you explain to me the circumstances in which you've been deposed before?

A Well, I've been an expert witness for both sides in malpractice trials.

Q How many times have you been deposed before?

A Maybe as many as half a dozen.

Q Is medical malpractice the only subject on which you've been deposed in the past?

A There was one trial in which we were discharging a faculty member with cause and so I testified in that as well. "We" being the

university.

Q But that would be an employment dispute?

A Yes, I guess so.

Q And which university was that that you were working for?

A That was the University of Oklahoma.

Q The malpractice cases that you were deposed in, what types of care were at issue in those approximately six cases?

A I'm not sure what you mean by "what types of care." Medical care.

Q What type of medical treatment was at issue?

A Oh, my background is in pediatric gastroenterology, so those were all associated with that type of care.

Q Okay. So they were all cases related to pediatric gastroenterology treatments?

A Correct.

Q And have you testified at trial in any matter?

A At one of those, yes.

Q Which --

A One of those malpractice cases.

Q So one of the medical malpractices?

A One of the medical malpractice cases went to trial.
Q Were there any other cases that you have testified at trial?
A Not that I recall.
Q Okay. Have you submitted written expert reports in other cases?
A I actually don't recall doing that.
Q Have you -- is it fair to say that you have never provided an expert report previously about the treatment of gender dysphoria?
A Yes, that's fair.
Q Is it also fair to say that you've never testified previously about the treatment of gender dysphoria?
A That's correct.
Q Did you know any of the defendants' other experts prior to this case?
A Personally, no.
Q Had you ever met any of the defendants' other experts prior to this case?
A No.
Q Did you know any of the plaintiffs' experts prior to this case?
A Not personally. I mean --

Q How did you -- did you know them in some other capacity?
A I have seen people at meetings.
Q Has a court ever disqualified you as an expert witness, to your knowledge?
A No.
Q Has a court ever limited the scope of your testimony, to your knowledge?
A No.
Q Have you ever provided testimony in support of the claims of a transgender person?
A No.
Q All right. I'm going to pull up another document, if it will cooperate.
MR. BEATO: Take your time.
(Document is displayed).
Q (By Ms. Dunn) Do you recognize this document, Dr. Donovan?
A Can I see this? Is that the question?
Q Do you recognize the document?
A Oh, yes.
Q And what is this document?
A This is my curriculum vitae that was prepared for Georgetown University School of Medicine.

Q And this is the curriculum vitae that was provided to us, along with your expert report. Do you recall providing it for that purpose?

A Yes.

Q Is this document a complete and accurate depiction of your professional experiences, your curriculum vitae?

A I believe so.

(Whereupon, Exhibit Number 3 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I would like to mark this as Plaintiffs' Exhibit 3.

So I'm going to begin by asking you some questions about your education. So you received your medical education at the University of Oklahoma in the years of 1970 to 1974?

A Correct.

Q And then you received your -- I'm sorry, you completed a pediatrics residency at the Baylor College of Medicine --

A Yes.

Q -- in -- 1974 through 1977?

A Correct.

Q Your fellowship was in pediatric

gastroenterology at the University of Oklahoma from 1977 to 1979; is that right?

A Yes.

Q And then you did an additional fellowship at the National Institutes of Health in the neonatal and pediatric medicine branch?

A Yes.

Q And that was in 1979 through 1980?

A Yes.

Q And then you additionally got your masters in bioethics at the University of Oklahoma in 1994?

A Correct.

Q Why did you return to graduate school in order to get your degree in bioethics?

A I had been asked to be the chair of the ethics committee at our teaching hospital and I thought that I should develop more expertise. And I had a great interest in the topic.

Q And when you say "at the university" or "medical school," are you speaking of the University of Oklahoma?

A Well, I was at the University of Oklahoma, but I took a sabbatical and went to study at Georgetown with Edmund Pellegrino at that time. That's when I began the masters and then completed it

at the University of Oklahoma.

Q But you said you had been asked to chair the ethics committee at -- at where? At which institution?

A At one of our teaching hospitals, Saint Francis Hospital.

Q Okay. I see a hospital. Okay.

Have you received any other medical education besides what we just discussed?

A Well, all physicians receive continuing medical education, so quite a bit of that, but I haven't acquired any other degrees.

Q All right. And you mentioned the Pellegrino Center for Clinical Bioethics. I'm going to scroll down to your reference to your position there.

What is the Pellegrino Center for Clinical Bioethics?

A It is probably best characterized as a think tank in bioethics. It provides education, provides for both students and trainees in medicine, as well as for faculty. It provides ethics consultation in the hospital and pursues scholarly activities, including writing papers.

Q You were the director of that center from

2012 to 2020?

A Yes.

Q And what is that? What did being director of that center entail for you specifically?

A Well, I basically helped with the -- the planning and the activities of the center, as well as the education -- educational activities and the consultation activities in the hospital.

Q In this role, did you routinely work in a hospital where you would evaluate patients for medical conditions and refer and prescribe them for treatment?

A That isn't a part of bioethics.

At the time I was still seeing patients in my medical specialty and so I did consultations there as well. But bioethicists do not directly treat patients. They do respond to consultations from treating physicians, nurses and families to help them sort through ethical issues.

Q And as the director of the Pellegrino Center, were you actively consulting on those types of cases?

A Yes.

Q Did you engage in your clinical practice in pediatric gastroenterology the entire eight years

that you were the director of the Pellegrino Center?

A No. I stopped around 2018. They were short-handed when I arrived, but they acquired more faculty, and I was fairly busy with my primary job.

Q Can you quantify how frequently you would provide ethical consultations as the director of the Pellegrino Center?

A We did it in rotation. We had a team that did it. And I think we were getting maybe 150 or more consults annually.

Q So the center would receive 150 consults total annually?

A Uh-huh. Yes.

Q And how many -- it was on a rotation. How many different individuals from the Pellegrino Center were rotating through those consultations?

A Approximately, four.

Q So would it be fair to say that there were approximately 35 to 40 consultations for each -- each individual?

A Approximately. The problem with the math is that we had a couple of people who didn't take consults as frequently because of their other jobs and others who did it more frequently. I was in the "more frequently" category. But, overall, that's

close enough.

Q The Georgetown University -- I'm sorry, the Pellegrino Center at Georgetown University was established to "fill a unique need for bioethics that's oriented towards clinical medicine and strongly rooted in the Catholic and Jesuit tradition."

Is that a fair description of its mission or purpose?

A Yes.

Q Can you explain what it means to have a program of bioethics that is strongly rooted in the Catholic and Jesuit tradition?

A Well, Jesuits have a somewhat unique approach to education, as you're probably aware. They do like to focus on what they call "cura personalis", or care of the whole person.

The particular approach that Edmund Pellegrino used in the ethical sphere was called "virtue ethics" as opposed to, say, the more -- other approaches. Some would be casuistry, some would be ideological, and some would be -- well, he was also heavily philosophical, although he, himself, was not a philosopher. Several of our members were and had Ph.Ds in philosophy, as well as other things.

Q How does theology interact with ethical challenges that arise in the care of particular patients for ethicists at the Pellegrino Center?

A I'm sorry, could you repeat that? You kind of flaked out a little bit.

Q Yeah, of course.

What role does theology play for the consultants at the Pellegrino Center in assisting with the ethical challenges that arise in the care of patients?

A I wouldn't say that it plays a direct role because, you know, it is theological principles just like philosophical principles. And just ethical principles are always there in the background, in terms of how we assess and -- and work through various cases.

Q Is Georgetown University Medical Center a Catholic healthcare institution?

A Yes.

Q I want to share another document.

(Document is displayed).

Do you recognize this document, Dr. Donovan?

A Yes.

Q What is this document?

A These are the Ethical and Religious Directives for Catholic Healthcare Services, commonly referred to as the "ERDs."

(Whereupon, Exhibit Number 4 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) ERDs.

I'd like to mark this document as Plaintiffs' Exhibit 4.

Is Georgetown University Medical Center -- I'm sorry. Let me -- I'm going to restart that question.

Are ethical consultations and advisements at the Pellegrino Center for clinical bioethics guided by these ethical and religious directives?

A Yes, they are.

Q And are your views as an ethicist guided by this document?

A Yes.

Q Did you rely on this document during your active work as an ethical consultant at the Pellegrino Center?

A Yes.

Q I'm going to turn to Page 9 of the document and zoom in on Directive Number 5.

This directive reads: "Catholic Healthcare Services must adopt these directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the directives for administration, medical, and nursing staff, and other personnel."

Did you follow this directive during your time as the director of the Pellegrino Center?

A Yes.

Q I'm now turning to Directive Number 9 which states that, "Employees of a Catholic healthcare institution must respect and uphold the religious mission of the institution and adhere to these directives. They should maintain professional standards and promote the institution's commitment to human dignity and the common good."

As director of the Pellegrino Center and an employee of G Medical Center, are you bound to uphold the religious mission of the institution?

A Yes.

Q And as the director of the Pellegrino Center and an employee of the Georgetown University Medical Center, you had to adhere to these directives as well; is that correct?

A Yes.
Q And you have to adhere to these directives without exception; is that correct?
A I don't know what that would mean.
Q Well, so it means that a doctor at a Catholic hospital can't provide a patient with medical care that is not aligned with the mission of the institution; is that right?
A Yes, I can accept that.
Q So you can't even refer a patient for a type of care that is not aligned with these directives?
A That would depend on the circumstances of the issue at hand.
Q So I'm going to stop sharing this document and open one more.
(Document is displayed).
Do you recognize this article, Dr. Donovan? I'm happy to scroll through it if that would help.
MR. BEATO: Oh, Dr. Donovan, I believe you're muted. Happens to me all the time.
THE WITNESS: Yes, I was muted and also not recognizing it, so it's a twofer.
Q (By Ms. Dunn) This is an article that was published in 538. I'm going to scroll down to Page 6

of this article and I will show you -- here you are quoted in this article.

Is that -- is this "Dr. G. Kevin Donovan, a bioethicist at Georgetown University," is that you that this article is referencing?

A It should be, yes.

Q And so you say here that, "Catholic healthcare institutions need to be careful to ensure that they're not perceived as offering or endorsing a prohibited form of care."

Is that -- do you recall making that statement?

A I don't recall. I must have been interviewed over the phone, but I would agree with that statement.

Q And so would referring a patient for a type of care that is not aligned with a Catholic healthcare institution be consid- -- or be potentially perceived as offering or endorsing a prohibited form of care?

A It would be -- depend on why it's not aligned with the -- with the values you're talking about.

Q Well, let's give an example. Would this include a referral for contraceptives?

A For contraceptives, you really -- well, it also depends on how you're using the term "contraceptive" because, you know, birth control in general is not prohibited, but certain forms are.

Q So it would include referring a patient for a prohibited form of contraceptive?

A Yes.

Q In this article you're referred to as a "Catholic ethicist." Is that something you would label yourself as?

A I don't typically, no, although both words are correct.

(Whereupon, Exhibit Number 5 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I don't think I asked yet, but I would like to mark this exhibit as Plaintiffs' Exhibit 5.

I'm now going to return to the -- what has been marked as Plaintiffs' Exhibit 4, the Ethical and Religious -- the ERDs, as you refer to them.

And we're going to look at Directive Number 3, which is on Page -- and, I'm sorry, I'm going to share my screen in just one moment.

(Document is displayed).

We're looking at Directive Number 3 which is on Page 9.

So this lists certain people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination.

Are LGBTQ people included in this list of people whose social conditions make them particularly vulnerable to discrimination?

MR. BEATO: Object to form, but, Dr. Donovan, you can answer that question.

THE WITNESS: Well, I was -- I was reading the paragraph that she mentioned. And the -- the answer would be they're not specifically listed. They're certainly not eliminated. They would be considered people vulnerable to discrimination.

Q (By Ms. Dunn) But they're not listed here in this list of individuals that the Catholic Healthcare Institution should distinguish itself by service to an advocacy for?

A I don't see them in that particular listing, no.

Q All right. Thank you. So we will move away from this document for now.

I want to go back just briefly to a piece of paper I can't find right now. Here we go.

(Document is displayed).

Are you currently the director of the Pellegrino Center?

A No.

Q When did you leave?

A Just before -- well, during the pandemic.

Q Okay. And why did you leave?

A Well, because I had been doing it for nearly ten years and had already found someone to turn it over to.

Q And so you made the choice to leave that institution?

A Yes.

Q Do you remain on faculty at the Pellegrino Center?

A I am still working part time until the end of this semester.

Q And what does that mean, to be working part time?

A That means that I participate in educational activities and meetings by Zoom primarily, but also write papers with my colleagues and such.

Q How many hours -- are you still currently teaching classes at the Pellegrino Center?

A Not this semester.
Q How recently were you still teaching classes there?
A I had been helping out last semester.
Q And did you teach a full course on your own or would your role have been more of a guest lecturer?
A More of a guest lecturer.
Q When you were the director of the Pellegrino Center, did you teach classes?
A Oh, well, we had classes for medical students, classes for residents, and classes in our master's program, so, yes.
Q And would you be the professor of an entire course or, again, would it be more of a guest lecturer role?
A Both.
Q What classes did you primarily teach?
A For students, it was really just bioethics, medical ethics. It was an ongoing course for medical students throughout the year.
Q So it was just a general bioethics/medical ethics course?
A Yes.
Q Did you do hospital rounds as a treating

doctor at the Georgetown Medical Center?

A I did that in pediatric gastroenterology until I stopped, as I mentioned before.

Q And are you currently a clinical ethical consultant at the center?

A No.

Q When did you stop doing ethical consultations?

A When I was no longer in the vicinity.

Q So when you left in 2020, that would be when your ethical consultation --

A Yes.

Q You also have listed on your resume -- and I will quickly open it. I'm sorry, "resume." Your CV. I'm using the lawyer term.

-- that you are a -- if I can pull it up. Sorry.

(Document is displayed).

-- "senior clinical scholar at the Kennedy Institute for Ethics."

How is that different from being the director of the Pellegrino Center?

A The Kennedy Institute of Ethics is a separate think tank at the other end of the campus and they tend to focus more on philosophical issues

rather than patient care issues.

Q Were the ethics practiced at the Kennedy Institute also aligned with the Catholic and Jesuit tradition of Georgetown University?

A For some --

Q Were they --

A -- but not for all of the faculty, no.

Q Okay. Were they impacted at all by the ethical and religious directives issued by the U.S. Conference of Catholic Bishops that we referenced as Plaintiffs' Exhibit 4?

A Those only apply to hospital practice.

Q All right. And then prior to your work at Georgetown, you were the director of the Oklahoma Bioethics Center?

A Yes.

Q What did this role entail?

A It was a very similar position to the Kennedy Institute.

Q It was more philosophical rather than patient care?

A No, excuse me, I'm sorry, to the Pellegrino Center. No, it was not philosophical, it was teaching students, it was working in the hospital, it was writing papers.

Q So you provided ethical consultants (sic) related to patient care?

A Yes, but not as the director of the Bioethics Center. That was a separate issue for the various hospitals in town, each of which had their own --

Q Okay.

A -- arrangements.

Q So your role as the director of the Oklahoma Bioethics Center was mostly teaching and writing?

A Yes.

Q And any clinical ethical consultations you were doing were in your role at various hospitals?

A Correct.

Q You're also -- later in your CV -- and let's see how quickly I can get here.

(Document is displayed).

Here you list that you're part of the "Dean's conference committee on medical ethics."

What was that?

A Oh, well, the -- the Dean was having us put on little conferences for -- educational conferences on ethics.

Q Okay. So that was just in order to plan

and arrange for educational conferences on ethics issues?

A Right.

Q And you have listed your role as chairman. Were you chairman for all 25 of those years?

A Yes, I believe I was.

Q All right. I'm going to stop sharing temporarily.

So I'd like to talk a little bit about your clinical experience as a pediatric gastroenterologist. So we've -- you have said that before your bioethics appointments your practice primarily focused on pediatrics gastroenterology; is that correct?

A Correct.

Q Can you just give kind of a broad overview of what field of practice that is?

A It concerns itself with the digestive disorders in childhood.

Q Your last position in pediatric gastroenterology was when you were the chief of the division of pediatric gastroenterology at the University of Oklahoma?

A Yes.

Q And that ended in 2012?

A Yes. That's other than the work I -- I also contributed at Georgetown.

Q Okay. So you did do -- I recall now. You said that you did some pediatric gastroenterology work while you were at Georgetown until 2018; is that right?

A Yes.

Q Are you currently working as a pediatric gastroenterologist?

A No.

Q Are you currently teaching any pediatric gastroenterology courses?

A No.

Q Have you ever treated patients experiencing gender dysphoria?

A Not to my recollection.

Q In your report on Page 3 -- so we'll look back. Your report was marked as Plaintiffs' Exhibit 1. So we'll look back at that document.

(Document is displayed).

On Page 3 you say that you "have never prescribed medications nor referred for surgery any patients that consider themselves transgender."

Is that an accurate statement?

A Yes.

Q Is that professional decision guided by the ethical and religious directives of the Catholic Healthcare Services?

A No.

Q You wouldn't -- as a routine matter, you would not have been providing such treatment as a pediatric gastroenterologist; is that right?

A That's correct.

Q And as a bioethicist, you do not typically do routine evaluations of patients and refer them for treatment; is that correct?

A That's correct.

Q So in your professional capacity, referring or providing -- I'm sorry, providing gender-affirming care or referring patients for gender-affirming care would not be something you would have had routinely done, even if you hadn't chosen, personally decided not to do it; is that right?

A Correct.

Q Do you currently have an active license to practice medicine in any state?

A In Oklahoma. I've given up the Washington license.

Q So you no longer -- your license to practice medicine in Washington has expired?

A Yes.
Q And when we say "Washington," we're speaking about Washington, D.C., not the state of Washington?
A Correct.
Q Your Oklahoma medical license, what type of medical license is it?
A It's like an emeritus license. I use it for my --
Q And what is that?
A I use it in my volunteer work here. I'm not practicing as a clinician anymore.
Q And what does your volunteer work entail?
A I have worked for the Oklahoma emergency response people and for various charities around town.
Q And are you providing patient care in those capacities?
A No, not directly.
Q So under this license, can you actively practice medicine?
A No, I no longer am an active clinician.
Q Have any -- has any of your previous medical licenses been suspended for any reason?
A No.

Q Have you ever received any formal discipline by the Board of Medicine of any state or jurisdiction?

A No.

Q Have you ever been the subject of a medical malpractice lawsuit?

A Once.

Q Can you describe the circumstances of that lawsuit?

A There was a complication in a -- after a procedure, and the family filed suit and the defense prevailed.

Q Was that one of the six cases that you referenced being deposed in earlier or --

A Yes.

Q -- was that separate?

Have you ever been the defendant in a lawsuit about discrimination in your medical practice?

A No.

Q Okay. I would now like to talk a little bit about the awards and professional associations that you list in your curriculum vitae, so I'm going to share my screen again. Let me first get to the right place.

(Document is displayed).

So here we have -- let's see -- the section of your CV that lists "Honors and Awards." And I'd like to ask about the Knighthood that you have received.

You list it as "Knight Grand Cross Vatican, the Equestrian Order of the Holy" -- I'm not going to say this properly, I'm sorry -- Equestrian Order of the Holy -- what's that -- the word that starts with "S"?

A Sepulchre.

Q -- "Sepulchre of Jerusalem." What is this award -- or "Knighthood," what does that mean?

A Well, this was an organization founded by Godfrey of Bouillon during the crusades, and they now provide funds for the care and education of Palestinians in the Holy Land.

Q What is the significance of this honor to you specifically?

A It's -- yeah, I think it's a good thing to do.

Q Why did you receive the honor? What did you do to receive this honor?

A They never specifically told me.

Q Does it have any significance to your

career in medicine?

A I would assume it must. I didn't have to slay any dragons.

Q I guess I'm wondering, like, why is it important to list on your CV?

In what way is it relevant to your professional experience?

A Well, it's -- it's an honor, much like the other things that are listed.

You know, if I were British and the queen had knighted me, I would probably list that, too, and assume it had to do with something in my career.

Q So you assume that you received the Knighthood because of your professional service?

A That's a fair guess, but I've never -- never been told.

Q Okay. Are there any requirements or expectations of you as a result of receiving this Knighthood?

A Yes. We are supposed to contribute financially for the welfare of the people living in Palestine and the Holy Land.

Q And those financial contributions are the extent of the expectations?

A Yes.

Q I'm now going to scroll down to what you've listed as "Public Service." So here you list your position as the chairman of the board of directors of Birthright, Incorporated, of Tulsa.

What is this organization?

A Oh, it's an organization to lend assistance to pregnant women and their babies.

Q As chairman of the board of that organization, what do you do?

A Well, I don't anymore. This thing needs updating because I -- I stopped when we left the Tulsa area.

But, basically, the organization looks for ways to supply things like diapers and formula and medical care, or direct them towards medical care, things like that. And some educational things about parenting.

Q When did your service to this organization end?

A When I moved to Washington, D.C.

Q Okay. So that would have been in 2012?

A Correct.

Q Birthright, Incorporated, is not any sort of medical association; is that right?

A Not -- I wouldn't characterize it as

"medical," no.

Q The next line you note that you have been the medical ethics consultant to the Catholic Diocese of Tulsa.

Is that still an active service that you're providing?

A No. The problem -- and I'll explain it now -- is that Georgetown required the CV to be split, for whatever reason, rather than chronological. So those things that were being done while I was at the University of Oklahoma or in Tulsa were separated, which also means that they didn't all get updated.

Q So this would have also ended when you moved to Georgetown in 2012?

A Yes.

Q And that also goes for your role as the director of healthcare issues for the Catholic Diocese?

A Everything. Everything that was listed in Tulsa would have stopped when I was no longer in Tulsa.

Q Under what circumstances does the Catholic Diocese need advice regarding healthcare issues?

A Just from time to time for one issue or

another. I might be --

Q Can you -- oh, I'm sorry.

A -- called or -- pardon?

Q Do you recall any specific examples of why you would be called on these issues?

A Issues such as -- you know, currently there's a lot of concern about brain death, but before that, things like salpingectomies and such. Just -- no, I -- it's rather random and it didn't come up very often, in terms of the Diocese itself.

Q What about your role as a medical ethics consultant. What did that entail?

A Oh, well, you mean like for the various hospital systems?

Q No, for the Catholic Diocese of Tulsa, this position here.

A I assume that that was referring to what we've just been talking about.

Q Are these two positions separate?

A Honestly, I don't remember the study section for the community organization.

This terminology was apparently dictated by Georgetown when my secretary re-did the resume, CV, so I'm not quite sure how she abstracted that out of my previous CV, which is a lot easier to read.

Q I see. So to your recollection you served a single role with the Catholic Diocese of Tulsa and not two distinct roles?

A Yes.

Q And the Catholic Diocese of Tulsa is a religious institution?

A Yes.

Q Are you familiar with an organization by the name of the Catholic Medical Association?

A Yes.

Q Are you a member of the Catholic Medical Association?

A No.

Q Have you ever been a member of the Catholic Medical Association?

A I was going to say no, but I think they actually gave me an honorary membership, when I gave them a talk once, for a year. So possibly, yes.

Q Do you recall when that was?

A I don't know. Ten years ago.

Q Give me just one moment of patience.

MR. BEATO: No problem. Take your time. Technology is not my friend, I can say on the record, so take your time.

THE WITNESS: And doctors are noteworthy

for their patience.

MR. BEATO: Very true.

MS. DUNN: I'm looking for a document. It's not where I expected it to be, but I will be -- I will be able to find it quickly.

(Document is displayed).

Q (By Ms. Dunn) So I'm showing you a press release that was issued by a Catholic Medical Association that we obtained online.

Have you ever seen this document before?

A I -- no.

(Whereupon, Exhibit Number 6 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I've marked this exhibit as Plaintiffs' Exhibit 6, and I'm just going to zoom in briefly.

Were you ever appointed to the Human Fetal Tissue Research Advisory Board of the National Institute of Health?

A I was.

Q Do you know why the Catholic Medical Association would have issued a press release stating that one of their members, you, was appointed to this board?

A I don't know. Wishful thinking?
Q Are you familiar with the mission of the Catholic Medical Association?
A In a general way, I suppose.
Q Are you familiar with resolutions that the Catholic Medical Association has endorsed?
A I'm sorry, as I said, I'm not a member and I don't keep up with what they're doing.
Q Are you familiar with the -- and I hope I'm saying this right -- Lozier Institute?
A Yes.
Q Are you affiliated with the Lozier Institute?
A Yes. They have asked me to speak on various occasions.
Q They've listed you on your website as -- on their website as an associate scholar. Is this an accurate description of your affiliation?
A I believe so.
Q Okay. Is your affiliation with the Lozier Institute active?
A I wouldn't say so, no.
Q When would you say that it ended?
A It was never particularly active. I mean, they did list me as -- on their -- on their list of

associate scholars and I did go out and give a talk on research ethics for them in Kansas at one point, but it was never a very active relationship.

Q Did you provide them with a biography to list on their website?

A I would assume so, yeah.

Q Other than the one talk you mentioned, what other -- have you played any other roles with the Lozier Institute?

A I believe they were the ones who suggested that I be on the human fetal advisory committee.

Q And how did you get appointed to that? Was that a position that you sought?

A No.

Q So how did the Lozier Institute -- how was the Lozier Institute involved with that appointment?

A I think that they made a suggestion. I actually don't know. People approach me at times and say, "Will you serve? Would you be willing to help?" And if I'm interested, I'll say, "Yes."

Q And who approached you about that appointment? Was it someone from the Lozier Institute?

A I think it was actually from HHS.

Q So I guess I'm just curious why you mention

that they were involved with that --

A Because I --

Q -- like, eventual appointment.

A I -- I believe they asked if I would be interested if I were approached.

Q Okay. And then you were later approached?

A To the best of my knowledge.

Q Are you familiar with an organization known as the American College of Pediatricians?

A Yes.

Q Are you a member of the American College of Pediatricians?

A No.

Q Have you ever been a member of the American College of Pediatricians?

A No, I don't believe so.

Q Are you at all familiar with the various position statements of the American College of Pediatricians?

A No, not really.

Q Okay. I'd like to move on to your "Research Publications and Presentations."

So, first, with regard to your clinical research, have you ever conducted primary research involving patients?

A When you say "primary research," how are you using the term?

Q I suppose I'm using it like -- so not like a literature review, but an actual research study that involves human subjects.

A Yes.

Q Can you describe what those research studies were?

A We've been involved in research studies that were multi-institutional on things -- on drugs, and we've been involved in some smaller studies, if I recall, you know, at the local level as well.

I'm struggling right now to remember what would be --

Q Well, let's start --

A All of these were within the realm of pediatric gastroenterology.

Q Okay. So, do you recall, were they during your time with the University of Oklahoma?

A Yes.

Q All of them were during your time at the University of Oklahoma?

A In terms of clinical research, yes.

Q And they were all related to -- the research studies were all related to pediatric

gastroenterology?
A Yes, I believe so.
Q Have you ever conducted any sort of research -- primary research on gender-affirming medical treatments?
A No.
Q So you've not conducted primary research on, for example, puberty blockers?
A No.
Q You haven't conducted primary research on cross-sex hormones?
A No.
Q And you haven't conducted primary research on gender-affirming surgeries?
A That's correct.
Q Have you ever been the principal investigator of a publicly-funded research grant?
A I'm sorry that I'm blocking -- I'm trying to remember if I was PI or not.
Q Well, would it --
A Yeah. But I've been involved in research grants, yes.
Q So let's say either a co-investigator or a principal investigator, have you --
A Yes.

Q -- ever been?
A Yes.
Q Do you recall what that research grant was for?
A Not at present. I'm sorry.
Q That's okay. Were you ever an investigator for a publicly-funded research grant for the study of gender-affirming medical care?
A No.
Q And would that -- the research grants that you are -- that you referenced where you may have been an investigator, was that while you were at the University of Oklahoma?
A Yes, it would have been. Well, there was -- there were a couple of small grants that we did in bioethics issues at Georgetown, but they weren't clinical investigations.
Q Have you ever been an investigator on a privately-funded research grant?
A Well, the Scholl Institute gave us some money at Georgetown for the small thing I was talking about. But, once again --
Q But it wasn't that one?
A -- it wasn't -- it wasn't a clinical thing. We were looking at the -- it's been over ten years

ago, but we were -- I could look it up.

Q You say, "we," you mean yourself and other individuals at the Pellegrino Center?

A Correct.

Q And you've never received a privately-funded research grant to study any sort of gender-affirming medical care?

A Correct.

Q And you've never received any grant that involves the treatment of gender dysphoria?

A Correct.

Q Have you ever taught a course on gender dysphoria?

A No.

Q Have you ever addressed gender dysphoria in any of the courses you have taught?

A Yes.

Q Which -- can you describe in what context?

A Well, in the courses that we've had for either medical students or -- actually, for graduate students.

Q And can you explain what -- what the curriculum was that addressed gender dysphoria?

A It would be a single class on that, not a curriculum.

Q But what was being taught? What specifically -- what was the subject that was being discussed?

A Well, we'd be talking about basically gender dysphoria and transgender individuals and gender-affirming care.

Q And what perspectives were being discussed or shared?

A Without recalling specific aspects of it, they would be very compatible with what I've already written in the reports you just referenced.

Q It would be consistent with the -- when you say "reports," we're talking about the expert report you submitted in this matter that's Plaintiffs' Exhibit Number 1?

A And the -- and the other one, which was --

Q The GAPMS memo report?

A Yes, ma'am.

Q And when were you teaching these courses?

A In the past five years.

Q While at the Pellegrino Center?

A Yes.

Q And were these for medical students or graduate students?

A To my knowledge, only for graduate

students.

Q And when you say "graduate students," that would be -- was there a particular graduate school that was receiving the course where this was discussed?

A It was at Georgetown.

Q But -- I'm sorry, like a specialty. Like a specialty of graduate school or was it a cross-discipline course?

A It would have to be a cross-discipline course from the way you describe it, yes.

Q I guess I'm just cur- -- you know, how do I -- so, for example, my husband is a professor. He teaches a type of physics. So he teaches primarily students in the department of physics. They're students of the University of Florida, but they're graduate students in the department of physics.

So my question is, was there a particular department that the students were graduate students in, or was it -- was it a course that was available to multiple disciplines?

A It -- it was a master's program at Georgetown that's all done through their graduate education office, but it would be open to a wide variety of people who are interested.

Q Okay. And how many times would you say that this topic was addressed in that course?
A In the course? Once.
Q So you only -- I'm sorry. How many courses did you teach for that? So it was one day of a course. How many times was that particular topic addressed?
A Probably once or twice.
Q Okay. And what is the name of the course?
A It was -- the problem is I'm -- I'm struggling because I didn't like the name of it, but it was assigned. But it was basically an introductory course in bioethics.
Q Okay. Is that the name that we would -- if we were to look in the graduate school catalog, is that the name it would be?
A No. I could go find it. They had an abbreviation for it, CACE, but that didn't really give me a good name for the course, either.
Q What did "CACE" stand for?
A I was afraid you were going to ask that. I actually -- I -- it was, like, Advanced Clinical Ethics or something like that. I don't recall exactly. I'm sorry.
Q That's all right. Thank you for searching

your memory.

A And finding nothing.

Q All right. So a large part of your CV includes presentations that you've given. And so in order to make this a little more manageable, I'm going to adhere to the different sections that you have in your CV, which include a division of presentations for -- you know, between those done while you were working at Oklahoma and then those done while you were at Georgetown, which begin later in your CV.

Is that a fair way to kind of -- to try to break it down?

A Sure.

Q So here we start on Page 11. And these are lectures and workshops that you've listed that are national pediatrics.

And that goes until this section -- I'm sorry. There's "National Pediatrics" and then "Regional Pediatrics." So these are all "Pediatrics: Lectures and Workshops," and it goes until Page 25 of your CV.

Were any of these presentations related to the treatment of gender dysphoria in pediatric patients?

A No.
Q And these are presentations, so it looks like they may have started in 1982 and they go until 2004.
So is it fair to say that for that whole period of time you didn't present on the topic of gender-affirming medical care?
A That's true.
Q And then the next section, which starts on Page 26, is about your bioethics presentations. And this is a similar time period, appears to be from the early 1980s until -- until maybe 2008 or 2009.
Were there any bioethics presentations about the treatment of gender dysphoria in either pediatric or adult patients?
A No.
Q All right. I'm just going to ask. So, obviously, in some cases the title of the presentation and the forum isn't totally clear to us from what's listed, so I just have a couple questions about specifically some of these presentations.
So here in 2009 you gave a presentation to the Bioethics Dean's Conference at the Schusterman Learning Center. That was called "The Faith Factor: How does religion or spirituality affect medical

care?"

What was this presentation about?

A Dr. Meixel was talking about some of his patients that -- where either religion or spirituality had made some effect in how they were approached and how we supported them.

Q How does religion affect medical care?

I guess, what is the takeaway?

A Well, it -- there was no single takeaway because, of course, different people have different approaches.

If you're a Jehovah's Witness, everybody will know, you know, that you're supposed to be avoiding blood products.

You know, if you are Muslim or if you are Jewish, not only are there dietary requirements, but if you're observant there may be some strict requirements in terms of the approach to medicine, brain death, transplantation, issues like that.

Q On a couple different pages -- so you list presentations to St. Mary's Church in Tulsa.

Was that your church?

A Yes.

Q And so in -- I guess, in what capacity were you giving presentations at your church?

A Because they asked me.
Q And were you presenting your views as a doctor or your views as a Catholic in these presentations?
A I don't know what presentations we're --
Q So here we have --
A -- talking about.
Q -- on one, "Life and Death Issues: The Catholic Perspective."
A Again, I -- actually, that was 1997. I really don't know what was discussed except I assume it had both to do with life and death.
Q There's another presentation on the topic "Catholic Morality."
Do you recall this presentation?
A No. That was 1993. Been a while.
Q You presented at Oral Roberts University in 1991. I know, obviously, it was quite some time ago, but the title of the presentation was, "Is There a Christian Medical Ethic?"
Do you recall what that presentation was?
A No, I don't.
Q All right. So I'm going to ask about just a couple more presentations and then I think we're due for a short break.

So I'm going to move to the presentations that are listed later in your CV. We -- I mean, I believe -- and you can correct me if I'm wrong -- that these would have been presentations that you would have given since you went to Georgetown. I think that's what this title indicates; is that correct?

A Yes, I believe so. Once again, I'll have to apologize. I didn't prepare this CV myself. This was done by a couple of people trying to fit the Georgetown format, but -- that's the way it looks like it's divided.

Q So -- and that's -- you know, I think we got the hang of it, but obviously if there's anything that needs clarification, please let us know.

So were any of these presentations that you gave while at Georgetown University specific to the treatment of gender dysphoria?

A Not that I recall. It really wasn't something people were requesting at that point.

Q You have never given any sort of lecture or presentation on the treatment -- medical treatment of gender dysphoria, aside from that course that we talked about where you would do one session for your students?

A I think that's correct.
Q And have you ever presented on or lectured on providing informed consent for gender-affirming care?
A Providing informed consent, quite a bit. For gender-affirming care, no.
MS. DUNN: All right. I think that's all of my questions about presentations, so I -- if we'll just -- I think we'll take maybe a five-minute break.
(Recess taken from 10:31 a.m. to 10:37 a.m.)
Q (By Ms. Dunn) We're going to return to your CV, Dr. Donovan, and I'm going to Page 60, which lists your publications. And this is described as "Original Papers in Refereed Journals."
Does the word -- does "refereed" mean the name thing as "peer-reviewed"?
A Yes.
Q Okay. I will use the term "peer-reviewed" today, but our understanding is those are interchangeable?
A Yes.
Q So you have 17 papers listed under "Bioethics" as "original papers and refereed journals."

Of these 17 papers, which were original articles that you were the primary author that underwent a peer-review process?

A These are the papers, I think, before Georgetown then. And if I'm the first author, my name will appear first.

Q So on a number of these articles your name doesn't appear at all.

A Then I'm the sole author in that case.

Q I'm sorry?

A Then I would be the sole author.

Q Well, so here I'm looking, for example, Number 3, which is from the AAP Committee on Bioethics titled "Professionalism in Pediatrics."

There are two other authors and the AAP Committee on Bioethics, but your name is not listed at all. What was your contribution to this article?

A Mary Fallat and Glover and I were all on the Committee on Bioethics. And so she was the primary author on this, but we all contributed and discussed it.

Q Contribute to the actual text of the article or just to discussions about the article?

A Both. Depends on the article, but, yes, usually both.

Q For Number 5, again we have an author DS Kiekema and the AAP Committee on Bioethics called "Responding to Parental Refusals of Immunizations of Children."

Is this also an article that you were an author on?

A Yes, these all were while I was on the Committee on Bioethics at American Academy of Pediatrics.

And Doug Diekema, in that case, was the primary author.

Q Is it common that someone who contributed to an article isn't listed as an author?

A When you look at the paper itself, they list all the members.

Q All right. Well, so let's look at one of these then.

(Document is displayed).

All right. So this is a copy of the article listed -- that we just talked about. I believe it's listed as -- one quick second.

This article is listed as Number 3 in the "Bioethics" section of "Original Papers and Refereed Journals," and this is the article called "Professionalism in Pediatrics."

And the listed authors are Mary Fallat, Jacqueline Glover, and then it says the "Committee on Bioethics."

So are you saying that because the Committee on Bioethics is listed that every member of that Committee on Bioethics is an author of this document?

A Yes, we co-author it.

Q How many members would -- are on the Committee for Bioethics -- or Committee of Bioethics?

A If you scroll down you should be able to get all their names. There are about half a dozen typically. It would sometimes vary.

Q So this is what you're referencing?

A Yeah.

Q Okay.

A That's me.

Q All right. So other than the publications that were -- that you are a co-author on because you are a member of the Committee on Bioethics, which -- let me -- I'm going to pull back up your -- oh, that's the wrong -- I'm sorry. I'm pulling your CV back up.

(Document is displayed).

Which of these articles -- and just let me

know if you need me to scroll further. So other than the publications that were -- that you are a co-author on because of your membership in the Committee on Bioethics of the American Academy of Pediatrics, which articles are peer-reviewed journal articles?

A Well, everything listed in this list should be a peer-reviewed journal article.

Q So let's start with this first article, bio -- sorry, "The Disabled and Their Lives of Purpose."

So this article, do you recognize this?

A Uh-huh. Yes.

Q And actually I'm just realizing, for the court reporter's benefit, I probably need to note that the exhibit we just looked at, which was the "Professionalism in Pediatrics" article, is going to be marked as Plaintiffs' Exhibit 7.

(Whereupon, Exhibit Number 7 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) This article -- did you write this article, Dr. Donovan?

A Yes.

(Whereupon, Exhibit Number 8 was marked for

identification purposes and made a part of the record.)

Q (By Ms. Dunn) I will mark this article as Exhibit 8.

So this article was published in 2007; is that correct?

A Yes.

Q And it is four pages long?

A Approximately.

Q Looks like maybe a little over four.

Did this article summarize any sort of original research?

A It was all original. Typically, the articles in bioethics may be empirical research or they may be learned opinion, if you will, or perspectives.

Q So how would you describe this particular article? Was it --

A More like the latter.

Q The learned opinion?

A Uh-huh.

Q Okay. And where was this article published?

A It says "The Linacre Quarterly."

Q Do you know anything about that journal?

A Yes. It's the journal published by -- I believe that's CMA.

Q So The Linacre Quarterly is the official publication of the Catholic Medical Association?

A Yes.

Q Do you know if the individuals who serve as peer-reviewers for this journal are required to be members of the Catholic Medical Association?

A You're not even supposed to know who the peer-reviewers are in a refereed journal.

Q Yeah, I understand the concept of blind review, but do individuals who have -- that's a different question.

Do peer-reviewers have to be members of the Catholic Medical Association?

A I don't know.

Q Now, do you recall what the peer-review process for that article entailed?

A I don't remember it being any different than the peer-review process for any other articles. You submit it, they send it out to their peer-reviewers. Peer-reviewers make suggestions or -- or recommend that it be published or not be published.

Q All right. So going back to your CV. So

this first article there was -- it did appear in a peer-reviewed journal and that journal was the -- is the official journal of the Catholic Medical Association.

This article -- Number 2. This article -- was this article published in a peer-reviewed journal?

A Oh, I had forgotten Mary and I did that.

Okay. I believe it was being peer-reviewed, but that publication looks like was in eMedicine and I don't know.

Q What is that publication?

A That's an online journal.

Q So we attempted to find this article using that website and could not.

So this says "From WebMD" and we're -- I'm just trying to figure out what that means. Is this a Web -- is this an article that was published on WebMD?

A Apparently, yes.

Q So -- but WebMD is not a peer-reviewed medical journal.

A It shouldn't be, no, so I don't know why that's there, but --

Q Okay. So, then, are --

A If, unless -- yeah, I don't know. I don't know.

Q So is 2 -- we can say that's not an article in a peer-reviewed medical journal?

A I would have to try and find it myself.

Q Okay.

A Once again, these things may have been jumbled a little because they were all redone upon my arrival at Georgetown.

Q Sure. Number 3, we already talked about, that is a publication that you were a co-author on as a member of the Committee of Bioethics.

A Uh-huh.

Q Number 4 is an article that was published in a state medical journal?

A Uh-huh.

Q Is that -- that was a peer-reviewed medical journal?

A I believe it was.

Q Do you know that for sure?

A I can't recall.

Q Number 5, again, it looks like this was -- oh, no, I'm sorry, this was also in a state medical journal. Do you know if this was a peer-reviewed medical journal?

A It was the same journal and I believe -- I'm not sure they're publishing that journal anymore, but I believe they were reviewing it at a peer review. I believe.

Q Do you know that for sure?

A I couldn't tell you.

Q Number 8 was another -- it's a clinical report from the American Academy of Pediatrics.

Is that -- was that something that you were a co-author on because of your position on the Committee of Bioethics or was it a different type of publication?

A Well, Mary and I were on the committee together. She's a pediatric surgeon. I don't know if that was done separately or through the committee at the time.

Q Okay. Number 8 here, we have an article titled "Ethical Issues with Genetic Testing in Pediatrics."

This was also one that you are a co-author on as a member of the AAP Committee on Bioethics?

A Yeah. It looks like all the rest on that page fit in that same category.

Q Okay. So we -- we -- so 8 through -- well, let's go down. Eight through 14, it looks like, were

all publications that you were a co-author on as a member of the Committee on Bioethics?

A Looks like it.

Q And do you know if these -- that type of publication is peer-reviewed?

A Well, it's peer-reviewed but not in the usual fashion because it goes through the internal workings of the American Academy of Pediatrics.

And I'm not sure the best way -- maybe that's why they listed these as "refereed" rather than "peer-reviewed." Although, I wouldn't have thought there was a difference. But they are reviewed and then sent back or accepted or not accepted. So to that extent there's a similar mechanism.

Q When you say "accepted" or "not accepted," do you mean --

A For publication.

Q -- accepted by the Academy of -- the American Academy of Pediatrics at large?

A Well, no. No. The academy at large doesn't peer-review. I mean, it would be -- or referee. It would be through the mechanisms of the various editorial boards and the hierarchy.

Q Okay. And these types of publications, the

clinical reports and the policy statements, are these -- do you consider these types of publications reliable?

A I'm not sure what you mean by "reliable."

Q Are they the type of materials that physicians would routinely rely on in conducting a clinical practice?

A Yes.

Q All right. The last three articles on this page are Numbered 15 through -- I'm sorry, not on this page, in this section -- are Numbered 15 through 17.

And so 15 was published in a journal by the name of Christian Bioethics and it was titled "Decisions at the End of Life: Catholic Tradition."

Was this a peer-reviewed article?

A Yes.

Q And are you familiar with the mission statement of the Christian Bioethics Journal?

A No.

Q Is it -- are you -- are you aware that that journal offers contributions and publications from Christian perspectives?

A I would have assumed that by its name, yes.

Q 16, the article "Does Shooting Abortionists

Reveal a Lack of Faith?"

This is also a publication in Linacre Quarterly; is that right?

A Yes.

Q And that Linacre Quarterly, again, is the journal -- the official journal of the Catholic Medical Association?

A I believe so, yes.

Q Do you recall if this article would be considered empirical research versus a learned opinion like the article we discussed before?

A No, that would be a learned opinion.

Q And I should have asked that for 15 as well. Would that article have been empirical research or a learned opinion?

A If I recall -- and remember, that was, you know, a long time ago, about -- over 20 years ago, but it would have combined a little bit of both because it would have required some research, but not empirical research. It wasn't -- you can do bioethics articles that actually involve live people sometimes, but this was not in that category.

Q Okay. And then 17, again, was published in that state journal we previously discussed?

A Yes.

Q All right. And then this next section of articles, these are all articles related to your practice as a pediatric gastroenterologist?

A Yes.

Q All right. I'm going to now skip down to the end of your CV where your publications from your time at Georgetown are listed.

So I am flipping to what is Page 78 on your CV. I guess there's no limitation here like in the other section that notes that these are publications in peer-reviewed or a refereed journal.

Do you know which of these articles appeared in peer-reviewed or refereed journals?

A Well, the journal articles should have been in peer-reviewed or refereed journals, but not everything there is a -- a journal article, as you can see. Some of them were chapters in books.

Q And your Number 1 is a chapter in a book; is that right?

A Correct, in the geriatrics book.

Q Okay. Number 2 and 3 are pieces in the Italian Encyclopedia of Bioethics?

A That's right.

Q All right. Number 4, is this a peer-reviewed journal article?

A Yes, it is.
Q You're sure it's a peer-reviewed journal article, not an editorial?
A On which one, Number 4?
Q Ebola, Epidemics, and --
A I think that was -- no, that was in an online journal. I think that was just an article, I believe.
Q Are you seeing this new document?
A Oh, it says "editorial." Okay. So that must have been an editorial.
Q Okay. So this article was an editorial, not a peer-reviewed research article -- or peer-reviewed article?
A Correct.
Q Okay. The next -- oh, I should go back to your -- let you see, too.
(Document is displayed).
The next article here, Number 5, also -- this is also an editorial by the name of "Doctors, Documentation, and the Professional Obligation: Has everything changed?"
A Okay.
Q That's an editorial; is that right?
A Yeah. That surprised me because they

decided to make it an editorial.

The next one was just a local publication at Georgetown, though.

Q And this is like an online student newspaper; is that right?

A Yeah.

Q This article here titled "Beneficence in Utero, a Framework for Restricted Prenatal Whole-Genome Sequencing to Respect and Enhance the Well-Being of Children," that was an article in the American Journal of Bioethics?

A Yes.

Q And this is -- was that article peer-reviewed?

A Yes.

Q Do you -- are you aware of the difference between an open peer commentary and a peer-reviewed article?

A Well, this was AJOB commentary, as I recall, but it's a peer-reviewed journal.

Q Well, it's a peer-reviewed journal but was the article itself peer-reviewed?

A I don't know how AJOB does it, but seeing as how they accepted the article, I would assume that they had some peer review involved.

Q If you'll give me just one second, I'm trying to pull up the article and I'm having trouble. So I'm going to stop sharing and try to figure this out.

MR. BEATO: No problem. Take your time.

Q (By Ms. Dunn) All right. I apologize. I was having trouble opening the type of file.

(Document is displayed).

So this is a screenshot from the journal of your publication. And this here -- it lists this article as an open-peer commentary.

And so are you familiar with whether or not an open-peer commentary is peer-reviewed?

A Well, we were invited to offer a commentary, but I don't know that they're automatically accepted. So the process for accepting or not accepting, I would assume, involves some mechanism of review.

(Whereupon, Exhibit Number 9 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So I'm just going to share another document.

I'm sorry. So if we could mark that last exhibit, which is the article -- I'm sorry.

I realize I didn't mark the "Ebola, Epidemics, and Ethics" article. That should be Article -- or, I'm sorry, Exhibit 9.

(Whereupon, Exhibit Number 10 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) The "Beneficence in Utero," open-peer commentary, will be Exhibit 10.

(Whereupon, Exhibit Number 11 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I'm now showing you an email which I'm going to mark as Exhibit 11.

So I will represent to you that this is an email that we sent to the editors of the American Journal of Bioethics. We asked them if open-peer commentaries are subject of peer review.

And their response was that open-peer commentaries are not peer-reviewed.

So can we agree that the open-peer commentary you provided that was marked as Exhibit 10 was not a peer-reviewed journal article?

A There you go. It says "Reviewed by our editorial team."

(Document is displayed).

Q All right. This article labeled as Number 8, "Physician Assistant Suicide in the Medical Profession," this was another Georgetown specific publication. It looks like perhaps a blog.

A Okay.

Q Is that correct?

A I assume.

Q Do you recall writing this publication?

A The publication, I probably did. The listing of these were all done by my secretary just when everything -- anything would be published.

Q And then Number 9 --

A As I recall, she didn't even list -- differentiate on these between peer-reviewed and not peer-reviewed, did she?

Q She didn't, so that's why we are asking these questions because we were unable to fully determine.

A Oh, okay.

Q And so Number 9, again, would be a blog post. That would not be a peer-reviewed article?

A I can't actually read that, so --

Q I'm sorry. Number 9 says -- is "PAS: Unwise, Uncontrollable, and Unnecessary," and then it lists an HTTP that appears to be a blog.

A Okay.
Q So that would not be a peer-reviewed article?
A I wouldn't think so.
Q And then Number 10 here, is this a book?
A Chapter.
Q A chapter in a book?
A Yes.
Q Do you recall what the name of the book?
Oh, I'm sorry, the book is "Palliative Care in Catholic Healthcare - Two Millennia of Caring for the Whole Person"; is that right?
A Right.
Q And this publication at Number 11 is "PAS" -- and I'm assuming that PAS -- and you correct me if I'm wrong -- is that the acronym for Physician Assistant Suicide?
A Correct.
Q Okay. "PAS: How should Catholic healthcare respond?"
And that article appeared in the Healthcare Ethics USA?
A Correct.
Q Are you aware that that Healthcare Ethics USA is a publication of the Catholic Health

Association?

A Yes.

Q And this article -- it's not a medical journal that's subject to peer review; is that right?

A It's an ethics journal.

Q Is it a peer-reviewed journal?

A I don't think it is. I think it's one like the other one, editorial reviewed.

Q Okay. Number 12 here, this is a book review you wrote?

A Yes.

Q And so that would not be a peer-reviewed article?

A No.

Q And 13, another article in the American Journal of Bioethics titled "How We Should Conceive of Creation: Natural Birth as an Ethical Guidepost for Neonatal Rescue."

Do you recall if that article was peer-reviewed?

A Well, I think that one was. I think that that was a -- I think Doug McAdams actually wanted to do that himself, but that may have been another one where they were responding to an AJOB article.

So the reason I wouldn't know is because I

wasn't the primary author on those. So if it was peer-reviewed and the comments from the reviewers come back, they come to the primary author.

(Whereupon, Exhibit Number 12 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I understand. So I'll just quickly show you the, I guess post -- I don't know, post -- or the journal page that references this article and we'll mark this as Plaintiffs' Exhibit 12.

So this article again is an open-peer commentary.

A Okay.

Q So we can agree that that is not a peer-reviewed article?

A It's been a learning experience for me. Thank you.

Q I'm going back to your CV.

(Document is displayed).

The next article is a publication, it looks like, in the Catholic Health Association.

Do you know what this -- whether this is a peer-reviewed journal?

A I would expect that's only reviewed by the

editors.

Q This article -- or this publication, "Reflections by a Christian Scholar," here at Line 18 -- or Number 18 is an "In Press Proceeding," but is this a lecture that was presented at a conference?

A That was -- it was.

Q Okay. And it will be published as such?

A Yes.

Q 19, there's an article that you co-authored with some other individuals that's called "Affirming Ethical Options for the Terminally Ill."

This was published in the Heritage Foundation publication; is that right?

A Apparently, right.

Q And the Heritage Foundation is not an academic medical journal?

A No.

Q Okay. Would this be a transcript of a lecture as well?

A I believe so.

Q Okay. And did you participate in that lecture, or in what capacity were you --

A I would have given it.

Q Would it have been at a Heritage Foundation event? Is that when that occurred?

A Yes.
Q Okay. The next article at Line -- at Paragraph 20, "The Deadly Advocacy of Doctor-Assisted Suicide."
This is a Washington Times article?
A Uh-huh. That looks requested.
Q Not a peer- --
A Not peer-reviewed.
Q Not peer-reviewed.
21 is an article you wrote with another individual called "Strangers in a Strange Land: How Our Founding Principles and a Bitter Pill Undo the Assimilation of U.S. Catholics."
This article was also in The Linacre Quarterly; is that right?
A Yes.
Q And as we've said, The Linacre Quarterly is the official publication of the Christian -- I'm sorry, the Catholic Medical Association?
A Peer-reviewed.
Q And this is peer-reviewed.
Do you know that this particular article was peer-reviewed?
A Yes.
Q So, to your knowledge, a commentary is

peer-reviewed?

A What are you talking about, Strangers in a Strange Land?

Q Yes.

A Well, they sent it back and forth to us. Did they look -- I don't know how they decide to list things in their journal, but I know that they required us to go through peer review.

Q So I guess I'm wondering, is there -- there is a distinction between "editorial review" and "peer review." Are you certain that this particular publication was peer-reviewed?

A Well, when they send it back -- and as I recall they sent it back with suggestions -- so that would have been peer-reviewed.

Q So --

A If you get messages from peer-reviewers, that means it's peer-reviewed.

Q Well, I do think there's a difference. I think the editors of the journal can give you comments and edits, but a peer-review process is different and requires practicing professionals who are your peers to provide comments and, you know, editorial sugg- -- or maybe not even editorial suggestions, but to provide comments.

So I do think there is a distinction, as noted in that email from American Journal of Bioethics, between editorial review and peer review.

So I'm just trying to determine if you are certain that that article was peer-reviewed or whether it could have just been subject to editorial review.

A To the best of my recollection, it was.

Q It was. Okay.

And would you say that that article, the "Strangers in a Strange Land," would that article be better described as empirical research or a learned opinion?

A More in the learned opinion category.

(Document is displayed).

Q Going back to your CV.

At 22 we have a document titled "Ethical Dilemmas in Pediatric Lipidology. Endotext Pediatrics."

Do you know if that -- is that a book or do you know what -- where that publication appeared?

A No, that -- that is done by the endocrinologist I was doing it with, Don Wilson, so he just told me that that was published.

Q Okay. So --

A And just for my permission and I said "Sure."

Q So is it a chap- -- I'm confused. Is it a chapter in a book or a publication?

A I believe it's a publication.

Q Okay. Number 23 here, this is another -- it's a chapter in, I think, the same book that we saw at the beginning, is that right, "Ethical Decision-Making in the Elderly"?

A No, that's the subsequent edition of --

Q So it's an update to that first entry on this publication list?

A Yeah, but it's already been published, so that hasn't been -- caught up yet. But, yes, that's now published.

Q Okay. 24, is this another -- your "CPR, DNR, and the Patient's Good," is this another book that you've contributed to?

A Yes.

Q And 25 would be similar. This "Ethical Issues in the Provision of Nutrition and Hydration" in Pellegrino's Compendium, that's, similarly, a book?

A Yes. They --

Q And 26 -- I'm sorry.

A They told us it will be published this fall.

Q Okay. And then 26, which is "Chapter 101 ethics in Prenatal/Neonatal Medicine," identified as the "Handbook in Neonatology," is that another book publication -- a book -- a publication related to a book?

A Yes.

Q Okay. And I believe that's the end of the publications that we have listed in your CV.

So you don't have any articles that you've published that underwent peer review where the topic was gender-affirming medical care; is that right?

A Yes. I've said that.

Q Okay. Well, I'm not sure we talked about publications. We talked about presentations and teaching, but I just want to confirm that you also haven't authored any publications that underwent peer review that were related to gender-affirming care.

A Correct.

Q You have been listed as an author on one article related to gender-affirming medical care; is that right?

A Yes.

Q And what article was that?
A That was the Laidlaw article.
Q And this article was an open-peer commentary; is that right?
A Correct.
(Document is displayed).
Q And this is the article we're talking about?
A Yes.
(Whereupon, Exhibit Number 13 was marked for identification purposes and made a part of the record.)
Q (By Ms. Dunn) All right. I will mark this as Plaintiffs' Exhibit 13.
So this article did not undergo peer review; is that right?
A Actually, you were the one who pointed out to me it underwent an editorial review, not a peer review.
Q Okay. Because it's in the American Journal of Bioethics and we looked at that email which clarified that?
A Right.
Q Okay. So this commentary argues that minors alone cannot consent to gender-affirming care

medical treatments; is that correct?

A Yes, that's correct. That minors should not be permitted to consent without the involvement of their parents to the gender-affirming care.

Q And so it's not suggesting that parents and legal guardians cannot provide informed consent?

A It was responding to an article that said, in fact, that if they don't perform -- or don't offer informed consent, they should be able to bypass the parent.

Q But this article itself isn't suggesting that parents can't provide informed consent for their children?

A No.

Q The article mentions -- so in the first paragraph the article states -- and I will -- I can highlight with my cursor. Actually, I can't. It won't let me.

But right here near where my cursor is, it states that, "Watchful waiting with support for gender-dysphoric children and adolescents up to the age of 16 years is the current standard of care worldwide, not gender-affirmative therapy."

What is "watchful waiting"?

A Okay. They were using the -- the term as

a -- as an approach to supporting children without puberty blockers or hormones.

Q And watchful waiting is not a type of care that you provided as a clinician; is that right?

A That's right.

Q And what evidence is relied on to support the contention that watchful waiting is the current standard of care?

A Well, he actually -- Dr. Laidlaw listed the -- the article right there, I believe.

Q So that's based on the de Vries and Cohen-Kettenis article published in 2012?

A Uh-huh. Yes.

Q So if we scroll down to the bibliography, that article is listed here. And I believe -- so it's called the "Clinical Management of Gender Dysphoria in Children and Adolescents. The Dutch Approach."

What supports the contention that the Dutch Approach is the worldwide standard of care?

A I think that he was talking about in places other than America.

Q But in what way does this article establish that the Dutch Approach is a worldwide standard of care?

A I think it's difficult to answer -- for anybody to answer what is the worldwide standard. Perhaps the Dutch Approach was certainly one that had been significant in the world and they were kind of leaders in the approach to children with transgender care.

Q Are there any sources cited that support what the standard of care in the United States would be?

A You mean within this article or elsewhere?

Q Within this article.

A I would have to go back and re-read it to answer that. I'm sorry.

Q And we've established today that your field of specialty is not pediatric endocrinology, correct?

A Correct.

Q Did you write any of the information in this commentary about puberty-blocking medications?

A No. No. My contribution was only on the ethical aspects.

Q Okay. So if we move further on in the article, this sentence here which provides opinions about GnRH analogues that suggest or assert that they cause infertility, what evidence was relied on in making this assertion?

A Once again, I wasn't writing the innercological (phonetic) parts of this.

Q So you're not familiar with any of the evidence that would suggest -- or any evidence that would suggest that GnRH analogues cause infertility?

A I have read this, yes.

Q Is that -- is it not -- I mean, is that fact, that the impact of GnRH analogues on fertility, is that not relevant to the bioethics opinions presented in this article?

A Yes.

Q So wouldn't it be important to be familiar with any such evidence?

A Yes.

Q Okay. So what evidence is being cited to support that contention?

A Once again, I'm going to have -- I haven't read this article in some time, so I would have to go back through it to see what evidence it cites.

Q There's about two paragraphs there. Would you -- would that help you to review to determine if there is evidence being cited to support that assertion?

I can zoom out, I can zoom in, whatever makes it easier.

A Which -- I'm sorry, where are we reading right now?

Q I believe the relevant text is in the section "Puberty-Blocking Agents and Infertility."

A Okay. I'm just reading along with you, I'm sure. "There are no randomized controlled studies for the use of puberty-blocking agents including safety for stopping normal puberty. Endocrine Society has published revised clinical guidelines in 2017, including adolescents. The" -- better scroll up. Let's see what else we've got.

-- "quality of evidence for PBA is noted to be low. In fact, all the evidence in the guidelines with regard to treating children/adolescents is low to very low because of the absence of proper studies. These same guidelines, however, recommend arresting normal puberty at Tanner Stage II. This is highly significant because it's the pubertal stage occurring before menarche in girls and before spermarche in boys. Continued suppression of pituitary gonadal axis by PBA will maintain a state of immaturity of the male and female gonads. As a result, though the child will likely grow in stature, the gonads and entire pelvic genitalia will remain stunted at Tanner 2. The condition of cross-sex hormones will

not change this condition. As a result, the patient will be infertile as an adult. The continued administration of cross-sex hormones may lead to permanent sterilization. Gonadectomy, of course, would also ensure sterility."

Is that what you were talking about?

Q No. I'm talking -- I'm asking. My question is, there's an assertion made here that as a result the patient will be infertile as an adult. And there's no citation provided.

So I'm asking what evidence is being relied on to support that assertion.

A Okay. And that's a very reasonable question, but I -- this is not the only place I have read that. It is not referenced in this short commentary.

Q So there's no evidence being provided to support the assertion that the administration of GRNH analogues leads to infertility as a result?

A The evidence is not, apparently, re-presented in this short commentary. I don't say that there's no evidence. I'm saying that the references don't seem to be listed for all the statements in the commentary.

Q But there's no evidence being cited in this

article to support that assertion?

MR. BEATO: Object to form.

Dr. Donovan, you can answer that question.

THE WITNESS: I think that you're probably right. Reminding you that absence of evidence is not evidence of absence.

Q (By Ms. Dunn) The article also suggests that puberty-blocking agents impair adults' sexual function. And I'll scroll down. There's a section here on this.

What evidence is provided in this article to support this assertion?

A Once again, I think that you're looking for the type of evidence that can be included in much longer articles. These are space-limited, so both the length of the article and the length of the references is not expansive. That doesn't mean that there haven't been multiple reports of either concerns or actual evidence that these things have occurred, they're just not all listed within this article.

Q Can you name a study that would support this assertion?

A I am certain that there are studies that have supported that assertion. I can't name you one

currently. It would take a little research.

Q Can you name any study that would support the assertion that the administration of GRN- -- GnRH analogues causes infertility?

A The same answer.

Q So your assertion is that providing the citation in the text would make this article too long to include. Is that what you're suggesting?

A No. No. It was clearly a matter of choice and it was not chosen to include all the references that could have conceivably been included.

Q Is it common in medical publications to make an assertion and not provide the evidence on which the author relies?

A It is common not to list every possible reference, of course. It is also common to list references. And some of the time you list references, depending on the type of article you're writing, whether it's an original article or a response article, whether it's an extensive article or a brief summary. So there will be variability.

Q Well, but this article, though, is discussing the fact that children should not be able to make decisions around medical transition and it relies specifically on these assertions of the

harmful impacts and yet it fails to cite any evidence to support those assertions. Is that not right?

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: Yeah, I don't -- no, I don't think that's exactly right. Of course, it cites some evidence and you see that there are references listed, but there aren't references listed for everything.

Once again, how long is the article, how many references are listed will depend a lot on what you can put in there, how much that even the editors will allow.

Q (By Ms. Dunn) Well, there's ten articles listed, and not a single one assert -- not a single one of these articles supports the contentions about the harmful impacts that the authors are alleging.

MR. BEATO: I apologize. Is that a question?

Q (By Ms. Dunn) Well, you can strike that.

MR. BEATO: Counsel, would you mind if we take a five-minute break, or would you like to continue asking questions?

MS. DUNN: Let me just finish asking questions about this article and then I think it

would be a good time for a break.

MR. BEATO: Of course. Of course.

Q (By Ms. Dunn) So I'll move on to the section of the article that's more about an adolescent's ability to consent. I assume that that would be relevant to the bioethics contributions you made to this article?

A Yes.

Q And so here we -- in this section, the "Co-morbid Psychiatric Condition" section, on what's marked with the Bates number AHCA EXP 002078, it says that there's an "additional issue related to an adolescent's decision to take puberty-blocking agents without any parental involvement."

And then it cites to "associated psychological conditions."

So is this suggesting that because youth with gender dysphoria may have other psychiatric conditions, that that means that they're not able to assent to this type of treatment?

A Well, it certainly would be a reason for concern if someone had autism or schizophrenia or profound depression, all of which have been associated with transgender adolescence, that it might impair their ability to provide fully informed

consent.

Q Currently there are no -- the standards of care regarding the administration of this type of treatment to minors does require parental consent; isn't that right?

A Yes.

Q And there are protocols used by clinicians to obtain informed consent for patients who do not have capacity to consent for themselves in other circumstances; isn't that right?

A Yes.

Q So there are frequently situations where patients may have a psychiatric condition that can impact their ability to provide informed consent and there are protocols to -- that apply to those situations?

A But those protocols do not allow for the direct consent of the children. That is parental permission being sought.

Q Yeah, but there are situations where adults may not have capacity to consent because of psychiatric conditions and there are protocols in place where physicians are still able to obtain informed consent and provide treatment; isn't that right?

A That's a different situation altogether if we're talking about an adult. But you're also talking about an impaired adult who, therefore, their ability to provide an informed consent with full capacity would be questionable.

Q But what I'm saying is that there are standards and protocols that clinicians engage in in these types of situations; isn't that right?

A That's kind of a general statement that's hard to disagree with. There are situations and approaches to situations.

Q You published this article with Michael Laidlaw and Michelle Cretella; is that right?

A That's right. Correct.

Q Are you aware that Michelle Cretella is the executive director of the American College of Pediatrics?

A I have heard that. She was not at the time.

MS. DUNN: All right. I think that this is probably a good time for the break that you asked for, Michael.

MR. BEATO: Excellent.

(Lunch recess taken from 11:35 a.m. to 12:10 p.m.)

Q (By Ms. Dunn) So I wanted to just follow up on one thing we talked about before the break, and that was -- I asked about the affiliation of your co-author, Michelle Cretella.

And you stated that at the time of the article she wasn't affiliated with the American College of Pediatricians; is that right?

A No. You said she was executive director, and I think she just did that recently.

Q Okay. At the time that you all wrote the article together, was she affiliated with the American College of Pediatrics in any way?

A Probably.

Q Okay.

A But, however, I don't belong to the ACP, so I don't know. I mean, I think she was.

Q Do you know anything about that organization?

A Very little. I mean, it's pediatricians who didn't agree with the AAP on certain issues.

Q Sure. So I just -- I'm going to point you to a couple documents, so I'm going to share my screen.

(Document is displayed).

This is a document from the American

College of Pediatricians entitled "Homosexual Parenting: A Scientific Analysis."

Have you ever seen this document?

A No.

Q Okay. So this document is -- it's a policy statement of the American College of Pediatrics which states that, "There's sound evidence that children exposed to the homosexual lifestyle may be at increased risk for emotional, mental, and even physical harm."

You were not aware of the American College of Pediatrics' position on this issue when you --

A I've never seen this before, no.

Q So you were not aware of this policy position when you made the decision to co-author a publication with Michelle Cretella?

A No.

(Whereupon, Exhibit Number 14 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I'm just going to mark that -- that exhibit that we just talked about, the American College of Pediatrics' policy statement on homosexual parenting as Exhibit 14.

And then I'm going to show you another

policy statement from the American College of Pediatricians.

Have you ever seen this policy statement?

A No.

(Whereupon, Exhibit Number 15 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) Okay. So I'm going to mark this as Plaintiffs' Exhibit 15. This is a policy statement from the American College of Pediatrics stating that there's "No evidence that psychotherapy for unwanted homosexual attraction is any more or less harmful than the use of psychotherapy to treat any other unwanted psychological or behavioral adaptation."

You are not familiar with this policy statement?

A Correct.

Q And you were not aware of this policy statement when you made the decision to co-author the publication -- a publication with Michelle Cretella?

A First time I've seen it was today.

Q Would it have changed -- if you had known about this, would it have changed your decision to be an author on that publication?

A It didn't seem like those two really are directly connected to each other.

Q So would it have changed your decision to be an author --

A No.

Q -- on that publication?

A I don't know. I haven't read the article, so it's hard to say whether it would change or not change.

Q Well, I suppose, knowing that -- I mean, I -- just understanding what I -- what I read from this document, that it's a policy position issued by this organization of which your co-author plays a leadership role, that states that there's "No evidence that psychotherapy for unwanted homosexual attraction is any more or less harmful than the use of psychotherapy in other contacts," would knowing that that was a policy position of the American College of Pediatricians have changed your decision to co-author a publication with Michelle Cretella?

A I agreed to co-author based on the topic at hand and not anybody else's CV. So the answer would be I don't see how it would.

Q And same for the exhibit that we marked as Exhibit 14, the policy statement on homosexual

parenting.

If you had been aware of that policy statement, would it have changed your decision to co-author a publication with Michelle Cretella?

A Well, once again, it's speculative. I don't know exactly what it says, but I was -- I was part of the -- the effort on the other paper simply on the basis of that paper alone.

Q We also talked about a number of your publications appearing in The Linacre Quarterly, and that that is the official journal of the Catholic Medical Association; is that right?

A Yes.

Q Are you aware of -- actually, I'm just going to open -- one second. So I'm going to show you a document.

(Document is displayed).

(Whereupon, Exhibit Number 16 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So this is a cover page of Resolutions of the Catholic Medical Association. I will mark this exhibit as Plaintiffs' Exhibit 16.

Have you ever seen this -- these -- this is a printoff of a web page. So have you ever seen this

web page of the Catholic Medical Association?

A I don't think so.

Q So the website states that, "The following are resolutions accepted as positions at the Catholic Medical Association."

And we're going to jump to the resolutions that are listed in the topic of "Family and Sexual Education." Specifically I'm going to look at Resolution 8-12, which is a resolution on transgender treatments.

Resolution 8-12 reads that, "The Catholic Medical Association does not support the use of any hormones, hormone-blocking agents, or surgery in all human persons for the treatment of gender dysphoria."

Were you aware of this resolution of the Catholic Medical Association?

A No. As I've mentioned, I'm not a member of the Catholic Medical Association.

Q And if you --

A I wasn't aware of this.

Q You weren't aware of this?

A No.

Q If you had been aware of this, would it have changed your decision to publish in the Catholic Medical Association's official journal?

A Well, I -- I imagine that I would probably be pleased if anybody agrees with me.

Q So are your beliefs aligned with this resolution?

A I don't know because I haven't seen the full text of it. I just see a title there.

Q So this is the full text of the resolution. The title is "8-12: Resolution on Transgender Treatments." And then it says "Be it resolved."

A Well, then, that does sound reasonable.

Q Okay. And then if we move down to Resolution 8-13, which is the "Resolution on Gender Dysphoria," it reads, "Be it resolved that the Catholic Medical Association and its members reject all policies that condition all persons with gender dysphoria to accept as normal a life of chemical and surgical impersonation of the opposite sex. Further, that the use of puberty-blocking hormones and cross-sex hormones and surgical reassignment surgery be rejected."

Were you aware of this resolution of the Catholic Medical Association?

A No. Like I said, I've never seen this page before and I don't know if any of these were ever adopted.

Q These are on the website of the Catholic Medical Association as adopted resolutions.

A Okay.

Q I'll represent that to you. And so if you had been aware of this resolution, would it have impacted your decision to publish in The Linacre Quarterly, the Catholic Medical Association's official publication?

A No.

Q And are your beliefs around the treatment of gender dysphoria aligned with this Resolution 8-13?

A I would not have used this language, but I don't have severe disagreements with it.

Q Okay. At this point we're going to turn back to what has been marked as Plaintiffs' Exhibit 1. And that is your report, which is not on my screen anymore, so I'm going to have to stop that share again.

(Document is displayed).

This, we already identified, as the expert declaration that was provided, written by you and provided to plaintiffs by the defendants in the lawsuit that brings us here today, Dekker versus Weida.

You stated that you yourself drafted this report fully and completely?

A Yes.

Q And does this report comprise the totality of your opinions around the provision of gender-affirming care medical treatments?

A Well, when you say "totality," that would mean like I have no other thoughts or opinions, so that's probably not the best way to characterize it, but it certainly is my opinion.

Q Okay. So here you state that you "Have not testified as an expert in the past five years at any court hearing, trial or deposition."

So when we talked about the depositions that you participated in earlier in our conversation today, those all predated the last five years?

A That's right.

Q So you -- and we've talked a little bit about your position as the founding director of the Oklahoma Bioethics Center, which you reference here.

Does that organization still currently exist?

A I am not quite sure of its status. I think someone took it over from me and someone else took it over from him, and I don't know what involvement

she's having currently.

I know that there is still some bioethics education going on through the university, but I don't know if it's under the umbrella of the Bioethics Center or not.

Q In Paragraph 8 you mentioned that you "Have chaired the IRB, the Institutional Ethics Research Board, for 17 years at SFH."

What is "SFH"?

A That was one of the teaching hospitals. Saint Francis Hospital.

Q So "SFH" stands for Saint Francis Hospital?

A Correct.

Q And are you currently the chair of IRB and Saint Francis Hospital in Tulsa, Oklahoma?

A No.

Q So the way this is phrased it always seems present tense. When did you stop being the chair of the Institutional Research Ethics Board at SFH?

A Oh, when I left Tulsa.

Q And when was that?

A Or Georgetown.

Q So in 2012?

A Right.

Q Okay.

A So it was in the -- 17 years before that or -- yeah.

Q So scrolling down to Paragraph 10, you state that you "Have studied and consulted on issues surrounding transgender patients, both minors and adults, locally and nationally."

We just -- we discussed your background and your CV extensively and you weren't able to identify presentations, and other than one article, publications surrounding issues on transgender patients; isn't that right?

A No, I've not been writing about it but I've discussed it with people locally and nationally.

Q And in what context have you discussed it with people?

A Well, I'm not quite sure -- what context?

Q Well, in what -- who were you discussing these issues with?

A Oh, various colleagues.

Q Can you name those --

A Other bioethicists.

Q So let's start with nationally. Who nationally were you speaking about on issues surrounding transgender patients?

A I would be speaking to bioethicists, you

know, informally, not -- not for meetings or publication.

Q Can you name any of the bioethicists that you had these conversations with?

A I'm sure I can. I'm not sure if they want to be involved or not, so I'd want to clear it with them first.

Q Were these informal conversations that were occurring at meetings of some sort?

A Oh, boy, there hasn't been a meeting in, like, three years where people had the opportunity for informal conversation. So, no, these would be either locally or over the phone or Zoom or something.

Q So how many Zoom conversations would you say you've had with other national bioethicists on transgender issues in patients?

A I mean, the purpose of the -- well, no, that's not true. I was going to say the purpose wasn't specifically to talk about transgender issues, but you'd be talking about bioethical issues in general. But, no, we've had a couple conversations, either by phone or Zoom, maybe half a dozen times where the primary topic probably was transgender issues.

Q Now, you say "half a dozen." That means six -- like around six?
A Around that, yeah.
Q And --
A I mean, I don't keep track of them, so I'm just guessing at this point.
Q What time period were these conversations occurring?
A These would have been in the recent past because not many, many people were having these discussions over ten years ago.
Q So in the last ten years you would say you've had approximately six conversations by Zoom or by phone with other bioethicists around --
A Well, no. I mean, that's -- that's -- that's a little narrow. I know I've had a lot more conversations than that. You know, you asked me about by Zoom, so that would probably be no more than half a dozen, I suspect. By phone, more than that certainly, and even in person. So, I'm sorry, I didn't keep a tally. People call me, ask me my opinion, or if we're in a discussion and they ask me what do I think about such and such, then I'll tell them.
Q What you're referencing is kind of informal

consultations of your opinion on these things?

A Absolutely.

Q So I think I'll just say, going back to the ground rules we started with, I may be -- and this may be partially my fault -- occasionally maybe asking you a question too quickly and cutting you off. And so I just want to remind both of us to try not to interrupt each other and -- you know, if you try not to interrupt me with my question, I'll try not to interrupt your answer. I'll pause before I jump in with my -- with additional questions.

So this sentence says, "I've studied or been consulted on." So it seems like what we were just talking about was "been consulted on."

So what instances -- I guess, can you provide some context for this statement that you "have studied issues surrounding transgender patients locally and nationally"?

A Oh, yes. Yes, I've been reading up on the available literature and journals and other places, even in the popular press and in blogs and such.

Q So when you say "studied," you just mean reading up on the medical literature?

A Reading up on medical literature is studying, you betcha.

Q Sure. And I guess I'm wondering, like, how are you -- so in what way are you identifying the sources that you're studying?

A How do I --

Q How are they coming to your attention?

A Oh, well, through -- they're published journals, both online and paper.

Q Can you name any studies that have had significance with regard to your position -- or, I'm sorry, let me strike that and start again.

Can you name any specific studies that have been meaningful in your position on issues surrounding transgender patients?

A Not so easily that there would be any study or a couple of studies that would be meaningful. I take little bits from everything I read and form my own opinions.

Q What specific issues have you studied surrounding transgender adult patients?

A Okay. I'm having a little trouble --

Q Hearing me?

A No, I heard you, I just didn't understand you completely I'm afraid. What do you mean, "what issues"?

Q Well, you -- I'm just asking what you mean

by your terminology. So you say that you "have studied issues surrounding transgender patients." Specifically, what issues related to transgender patients have you studied?

A Well, I think that the things that I have read about and been concerned about exactly parallel those that you see in the younger patients, as well, in terms of the concept, the diagnosis and the treatment and the results.

Q So can you estimate how many times you've been consulted on issues specific to transgender patients?

A No. I mean, these are not formal consultations, these are discussions.

Q I'm sorry. So going back to your role providing ethical consultations, either -- I guess at Georgetown would have been primarily the period of time we're talking about. Can you estimate how many of those ethical consults would have related to transgender patients?

A None of the hospital consults related to transgender patients as transgender patients.

Q So you've not given an ethical consult with regard to patient care for a patient that was transgender?

A Not for an individual patient, no.
Q And that extends to both children and adults?
A Correct.
Q Moving on to Paragraph 11 where you say, "For ethical as well as medical reasons, I have never prescribed medications nor referred for surgery any patients that consider themselves transgender."
These medical reasons you reference -- going back to your specialty, you're a pediatric gastroenterologist. We've established that. That's right, right? Is that right?
A Yes.
Q Did any of your pediatric gastroenterology patients identify as transgender, to your knowledge?
A No --
Q To your knowledge --
A -- not to my knowledge.
Q Oh, I'm sorry, I cut you off again. I apologize.
What were you saying?
A I just said "not to my knowledge."
Q To your knowledge, have any of your pediatric gastroenterology patients been diagnosed with gender dysphoria?

A Not to my knowledge.
Q Have you ever prescribed a medication to a patient in your role as a bioethicist?
A That's not the role of a bioethicist.
Q Okay. I just wanted to confirm that.
Do bioethicists treat medical conditions with surgical referrals?
A That's not the role of the bioethicist.
Q Okay. When you -- so turning back to Paragraph 11, when you refer to ethical reasons that you don't prescribe medications, is that because your activities as a bioethicist are informed by your Catholic faith?
A No, it's because I think that it's unethical.
Q Do you think that it's unethical because it's not consistent with the ERDs that we talked about as Plaintiffs' Exhibit 4?
A No, I think it's unethical on the face of it. I don't think you have to be Catholic, Muslim, Jewish, or none of the above to come to the same conclusions.
Q In Paragraph 12 you say that, "None of your opinions are biased by professional income."
The entirety of your career in medicine

didn't involve patients who present to you for a gender dysphoria diagnosis; is that right?

A That's correct.

Q And none of your writings, presentations, or positions dealt with issues affecting trans people; is that right?

A Not entirely right, but mostly right.

Q And when you say "not entirely," are you referencing the one article we looked at before?

A No, I'm saying I'm very careful about absolutes.

Q Understood.

In Paragraph 14 you reference your review of the literature. Have you reviewed all of the literature pertaining to gender dysphoria?

A No one has reviewed all the literature pertaining to practically anything, including gender dysphoria.

Q Is the literature you've reviewed limited to -- or, I suppose, is the bibliography you provided a fair representation of the literature you've reviewed in preparing this expert report?

A It would have to be a representation, sure. Provided, it's -- I consider it fair, but it's not, you know, complete. There are many things that I

would look at that I didn't consider important enough to include in the bibliography, including the things that I look at and think, "Well, that's wrong, but it's good to know that that's how they feel."

Q So are there other sources that you considered in preparing this expert report?

A Sure. Many.

Q And are you able to list those sources?

A No.

Q And why not?

A Too many. There's just too many. And some of them I read in their entirety, and some of them I didn't, and some of them are just off of things like the CDC site, a WPATH site, and some of them aren't. It's just -- it's a whole gemish. Anybody who just reads an article and considers themselves an expert isn't working hard enough.

Q So when you prepare an expert report for submission in a case like this, we are entitled to know what your sources for your expert opinion are.

So, you know, I -- I -- I think we either need to understand that that bibliography is the list of sources you relied on exhaustive, or we're entitled to know what additional sources you considered and relied upon in writing this report.

Are you able to provide that list?

A I could probably -- no, I couldn't, really. I -- there's just -- there's too many things that I look at and read on a relatively frequent, if not constant, basis. And some of them I thought were pertinent and some of them not so pertinent. I thought the pertinent ones would be in the bibliography.

But I would be hesitant, like you saw when we were looking at other articles, to say that you have an exhaustive bibliography for any article. There's always more that could be added, but there are some practical limitations.

Q If a source is not listed in your bibliography, would that mean that you did not consider it pertinent to your report?

A No, I didn't say it wouldn't be pertinent but it may not be something I felt needed to be included.

As a for instance, all the regulations that govern human -- research with human subjects. Well, there's huge tomes that include all that. I don't think that that necessarily needs to be included in the brief bibliography that I submitted. You know, all the various statements from medical associations

about this one way or the other may have been things that I have read, but I don't see that they added much to my bibliography so I didn't include them.

I see something several times a week on this subject and I look at it and I read it and I see if it adds any new information or, you know, can alter my -- my perspective or sometimes reinforce my opinion, but that doesn't necessarily mean that it belongs in the bibliography.

Q To be clear, for your work as an expert you wrote a report, which is being submitted to a court of law.

Do you understand that?

A Yes.

Q This report is comprised of your opinions that are being presented to a judge as evidence in a court case.

Do you understand that?

A Yes.

Q Okay. And when we ask for the sources upon which you relied, we are provided with a bibliography that has been marked as Plaintiffs' Exhibit 2, which I will pull up, and I believe has approximately seven sources on it.

(Document is displayed).

So this was the bibliography we were provided. You've already confirmed that; is that correct?

A Yes.

Q In submitting that report, we -- so the Federal Rules of Civil Procedure require that an expert who provides a written report must disclose the facts or data that are considered by the witness in forming their opinions.

So we are entitled to know all facts and data that you relied upon in forming your opinions. And when we asked for that information, we were given this bibliography.

Are there additional sources that needed to be added to this bibliography that are facts or data that were considered by you in forming your opinions?

A I didn't feel that I needed to add anything else to the bibliography.

Q So this bibliography --

MR. BEATO: Chelsea -- I apologize. You can continue, Chelsea.

Q (By Ms. Dunn) So this bibliography is a complete document of the facts and data considered by you in forming your opinions in your expert report; is that correct?

A Well, I -- those are articles considered by me in forming my report.

Those are not the only things that I thought about, nor the only things that I read, nor the only things that have influenced me over the last decade, or over the last year, or over the last few months. You know, there's a lot of things that I have read. I thought these were pertinent to the report.

Q Dr. Donovan, I appreciate that these are the most pertinent, but you are required under the Federal Rules of Civil Procedure to provide a report that contains the facts and data that you considered in forming your opinions.

A These are facts and data that I considered in forming my opinion. It is not --

Q But is it a complete document of those facts and opinions?

A Of course not. It can't be because there's no way that I can tell you everything that has affected my thinking.

MR. BEATO: So, Dr. Donovan, let me -- let me step in.

For the studies that you reference in your bibliography, those are a sufficient and accurate

representation of the studies that you relied on when issuing your expert report; is that correct?

THE WITNESS: Yes, I believe so.

MR. BEATO: And if there are additional studies that you think of that could've -- well, strike that.

Okay. So you think it's a sufficient and accurate representation of the studies that you relied on for your expert report, correct?

THE WITNESS: I -- yes, with the provisos that I've already said. There are other things that I would consider important, but -- once again, all the CDC documents or -- now, those -- I didn't include those. Did I rely on them? Have they guided my understanding of, for instance, the requirements of appropriate human research? Well, sure.

Q (By Ms. Dunn) So setting aside various sources of background knowledge that you brought to this report, when you were writing this report, are these the specific sources you were referencing in writing your report?

A I don't know how to answer that any better than I have.

MR. BEATO: Then the answer would be "yes."

Q (By Ms. Dunn) Are these the only specific

sources you referenced in writing your report?

A Of course not.

MS. DUNN: I'm sorry, we need a short break, please.

MR. BEATO: Okay.

(Recess taken from 12:44 p.m. to 1:19 p.m.)

Q (By Ms. Dunn) So, Dr. Donovan, when we were talking before about the obligations that are associated with submitting an expert report to a federal court, I was referencing a rule which is the Federal Rule of Civil Procedure 26(a) -- I'm going to make sure I get this right -- (a)2(b). And this governs when someone who's been retained as an expert provides a written report to the Court. I'm going to read from that rule.

So that rule says: "Unless otherwise stipulated or ordered by the Court, this disclosure must be accompanied by a written report prepared and signed by the witness. If the witness is one retained or specially employed to provide expert testimony in the case or one whose duties as the party's employee regularly involve giving expert testimony.

"The report must contain, 1: A complete statement of all opinions the witness will express

and the basis and reasons for them.

"2: The facts or data considered by the witness informing them.

"3: Any exhibits that will be used to summarize or support them.

"4: The witness's qualification.

"5: A list of all other cases which the witness testified as an expert at trial or by deposition.

And, "6: A statement of the compensation to be paid for the study and testimony in this case."

Were you instructed that your report was required to contain all of the opinions that you intend to offer in this case?

A Yes, I believe I was, but I think perhaps, you know, when we're talking about the opinions that I intend to offer, I don't think that was the conversation you and I were having previously.

Q Well, I'm sorry, I'm just starting with the first subsection.

A Oh, okay.

Q So were you instructed that the report has to contain all of the opinions you intend to offer in this case?

A Yes.

Q And does your expert report that we've been referencing as Exhibit 1 contain all of the expert opinions you intend to offer in this case?

A Yes, I believe so.

Q Okay. Were you instructed that your expert report must contain the facts or data considered by you, the witness, in forming those opinions?

A Yes.

Q Okay. And did you provide all of the facts or data that you considered in forming your opinions, either in the report or in the bibliography that accompanies it?

A I would say, yes, in the report or the bibliography.

Q Okay. So turning back to your report. Give me a second.

MR. BEATO: No problem. No problem whatsoever.

Q (By Ms. Dunn) Okay. So back to your declaration. So here you say that you relied on your "years of experience as a physician and medical ethicist and your review of the literature as documented in your report."

So we should be able -- your report will demonstrate any literature that you relied upon in

forming your opinions; is that correct?

MR. BEATO: Dr. Donovan, you're muted.

THE WITNESS: It's hard to answer that way. Sorry.

Yes, I believe so.

Q (By Ms. Dunn) In Paragraph 15 you refer to yourself as an "unbiased observer." And you make comparisons to the fact that it's preferable to have unbiased observers make opinions on the diagnosis of brain death. But those unbiased observers still have to have qualifications in order to render opinions on these issues; is that correct?

A Yes.

Q And what are your qualifications to render opinions on the provision of gender-affirming care?

A Well, they would be, I think, analogous to rendering opinions on the diagnosis of brain death.

My perspective is that of an ethicist. I'm not a neurologist or a neurosurgeon or a transplant surgeon, but when you are talking about -- particularly in today's topic, you know, whether or not what we are doing constitutes appropriate informed consent and whether or not it is -- or should be considered research versus standard of care, yeah, I've had years of experience in

discussing these topics and -- and completely ready and able to render an opinion on it.

Q But you've never -- you haven't had any specialized -- well, you haven't been a -- participated in presentations or publications around the provision of gender-affirming care specifically?

A You mean, if I don't have a large public record on it? It certainly doesn't mean that you haven't been reading up on it, done some research and formed an opinion.

Q But you do have a large body of publications and presentations on issues such as physician assisted suicide or brain death; isn't that correct?

A Relatively large. Yeah, I've got those things. Those have been issues for many years now.

This case, for instance, is certainly less than a year old.

Q You reference, in Paragraph 17, a "diagnosis of transgenderism."

What is a diagnosis of transgenderism?

A Diagnosis of someone who is being transgender or that they believe that they are transgender.

Q Where does that diagnosis exist?

A Where does the diagnosis what? I'm sorry.
Q Exist. Where's that diagnosis provided for? Is that a medical diagnosis?
A You mean, who provides the diagnosis? Is that what you're asking me?
Q Well, no. Is that a medical diagnosis?
A Well, it certainly is supposed to be, yes.
Q Where is the criteria for that -- or where's the diagnostic criteria for transgenderism?
A Well, the diagnostic criteria for transgender patients is found in both DSM and WPATH.
Q And the what?
A W-P-A-T-H criteria.
Q But that diagnosis is gender dysphoria, not transgenderism; isn't that correct?
A Yes. But gender dysphoria only occurs in those who have identified as transgender.
Q But transgenderism is not a diagnosis that's reflected in the DSM-5 or in the WPATH standards of care, correct?
A Okay.
Q Is that correct?
A Yes, I believe so.
Q You refer here to a person presenting themselves as a -- or a person having a gender

identity that's different from the sex assignment at birth as an aberration. Is that fair to say?

A I think that's quite fair to say. You know, if you talk about the norm being what is predominant, then that would have to be statistically described as abnorm.

Q What is your basis for asserting that a person asserting their gender identity is akin to asserting a delusion that they are a chicken?

A Well, I think that if someone came in with something that seemed to define -- defy both the visual evidence and common sense, that you would not necessarily take that at face value.

Q Are you a licensed psychiatrist?

A No, I'm not a licensed psychiatrist, but I do know the difference between a person and a chicken.

Q Have you ever diagnosed any sort of mental health condition?

A I'm sure I have because I've had patients who had to be referred.

Q You've -- you have been the one to provide the diagnosis of a mental health condition?

A Well, when you suspect it, you refer it to someone to care for them, sure.

Q But is that providing a diagnosis for the patient or is that referring someone for a diagnosis?

A It's a presumptive diagnosis.

Q You then state that, "This is the approach now being taken by many psychiatrists and surgeons and endorsed by medical society."

Is the approach you're referring to in this sentence the approach of someone saying that they are a woman and someone else immediately clothing them in a dress?

A No. I'm saying that the -- the problem is that we are accepting the mis-diagnosis. Or not even a mis-diagnosis, but the mistreatment rather.

Q And what is the mistreatment you're referring to here?

A In terms of patients with gender dysphoria, I think it's not conceptually sound to say that you are a man or a person in a man's body but you think you're supposed to be in someone else's body or some other body or yourself or alter that body in order to look like that. Those are approaches that just don't really seem to fit with a common sense approach.

If we had a patient with anorexia nervosa and she had a dysmorphia and she said, "I am too fat," the last thing that I would recommend we do is

to help her body conform to her self-image.

Q So you're comparing gender dysphoria to anorexia nervosa?

A Well, they're both distortions of bodily image, yes.

Q But affirming a patient with anorexia desire to limit their calorie intake could lead to dehydration; is that correct?

A And worse.

Q And it could lead to starvation or even death?

A Yes.

Q Yes. And so your position is that it is mistreatment to affirm someone's gender identity if it's not aligned with their sex assigned at birth?

A I am saying that we don't have enough information to be certain of the correct approach and, therefore, to embark upon that approach without seeking that information is wrong.

Q And what particular types of medical treatment are you referencing?

Are you speaking of the administration of cross-sex hormones?

A Yes.

Q Are you speaking of gender-affirming

surgeries?

A Yes.

Q And are you speaking of the administration of puberty-blocking medications?

A Yes.

Q And so it is your opinion that affirming someone's gender identity, if it is not aligned with their sex assigned at birth, is mis- -- is medical mistreatment?

A I think it is fraught with problems because I think that it is probably applying a treatment that does not match the needs of the patient.

Q Earlier you said that you have given presumptive diagnoses for mental health conditions.

When you're licensed as a medical doctor -- or I guess you're a pediatric endo- -- I'm sorry.

Does your license allow you to diagnose mental health conditions?

A My license? Yes.

Q Okay. So you say that -- so going back to this approach. When you say "this is the approach," I just want to make sure that we're both talking about the same -- you know, what you are referring to as "this approach."

And you're talking about the approach of

providing medical care that affirms someone's gender identity when it doesn't match their sex assigned at birth. Is that accurate?

A Yes.

Q Okay. And you say that "many psychiatrists are taking this approach."

What is the basis to say that?

A Well, I -- I don't think that that's in contention that many psychiatrists are providing or endorsing gender-affirming care. I didn't specifically give you data on that, but I think that that's pretty widely known.

Q You then go on to say that, "Perhaps, as a result the number of individuals who identify as transgender has exploded over the past decade"; is that correct?

A It has certainly increased, it has.

Q And you said a number of 20 to -- to a factor of 20 to 40; is that right?

A That's right, that's what I've read.

Q Where did you get that information?

A Actually, the CDC had that information in their database.

Q So you didn't -- you cited to -- in your bibliography, which I'll quickly turn to -- I stopped

sharing. I could have just stayed where I was.

(Document is displayed).

So you cite to -- here on this first line there's a "CDC Youth Risk Behavior Survey" and then there's a link to the Williams Institute.

Is this the data you're using to make that 20- to 40-factor assertion?

A I believe that's where it came from.

Q And so the Williams report that's linked here -- I'll just quickly pull up that source, just so we can look at it together.

(Document is displayed).

So this is the Williams Institute report that is found at the end of that link.

Do you recognize this report?

A Not in that form, but I'm sure that must be it.

(Whereupon, Exhibit Number 17 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) Okay. I'm going to mark this as Exhibit 17.

So this study -- I'll zoom in a little bit -- or this report cites to data from the CDC, a couple of different surveys, it looks like, the

Behavior Risk Factor Surveillance System, the Youth Risk Behavior Survey, and then some other survey data.

Is this the document where you got -- when you reference the CDC, is this the document where you got that information?

A I believe so, or links from it.

Q Okay. And do you know where in this report it cites a 20- to 40-factor increase?

A I'm sorry, I'd have to read the whole thing again to find that.

Q So here on this first -- on this first page it says, "Youth ages 13 to 17 comprise a larger share of the transgender-identified population than were previously estimated, currently comprising about 18 percent of the transgender-identified population in the U.S. up from 10 percent previously."

Is that relevant to how you determined there was a 20- to 40-factor increase?

A No, the 20 to 40 is actually what I read in the CDC survey, but I don't see it -- as a matter of fact, I can hardly see what you've got there at all, but that's okay.

Q Oh, I'm sorry.

A Small print.

Q I'm happy to share your screen.

So I'll just -- I guess what I'll represent to you is that we could not -- looking at your bibliography, we could not find the 2017 data that you were citing to. So are you saying that you received that information -- that information came directly from the CDC and not from this report?

This report is what was linked and we thought that that indicated that that's where it came from.

A Well, I -- I believe that that information may be there.

That's the executive summary, isn't it? Not the entire report?

Q Correct.

A Yeah.

Q All right. I will stop sharing this document and go back to your bibliography.

(Document is displayed).

So going back to your report, in Paragraph 19 you state that, "80 percent of young males who present early" -- and I assume that you mean by this present with a gender identity that's different than their sex assigned at birth. Is that what you're referencing?

A Yes.
Q Okay. So young males presenting early, that "80 percent of those young males would historically revert in their self-perception by the time they had completed puberty."
Where did -- what is your evidence of that statement?
A Oh, that -- that's been widely published and repeatedly published.
Q Can you name the study that that information comes from?
A I'm sure I could. It's more than one source, but, yeah.
Q Can you name those studies?
A Not right now, no.
Q Why didn't you cite to this -- the studies that you relied upon in formulating that assertion in this report?
A Once again, I had relied upon a large number of things. Not everything that was listed in the bibliography, as I mentioned before.
Q But you are aware that it was your obligation to provide the data and resources you relied upon in forming your opinions when you submitted this report?

A Well, I understood that I would present my opinion and/or the data in the bibliography. And my opinion has been formed by a much broader reading sources than -- than are involved even in this case. So --

Q I understand --

A -- my opinion, you know, was not strictly just a matter of -- of opinion on the -- on this particular case. And, in fact, you know, I have read these and somewhere have articles that do demonstrate that. So I thought that that was important.

I hadn't really seen anybody contesting that as a fact. Sometimes what people are doing is showing that it may be transition for females, but that -- that is a fact that had been clearly established in the past and I didn't think that that would be very controversial.

Q This fact was of significance to your opinion; is that right?

I mean, you cited it in your report so it has had some significance to your opinion.

A Okay.

Q Is that right?

A Yeah.

Q And you are under an obligation to provide

the data and evidence that you are relying upon to come to your opinions. We've discussed that already.

Do you understand that?

A I -- yes, we've discussed that.

Q And you haven't -- you are unable right now to provide the source of evidence on which you relied in making this statement.

A Well, you did say that you wouldn't accept anything more at this point. I could, if you want, go back through my files and find that.

Q You -- well, so perhaps I should ask it this way. You did not disclose the data or evidence you were relying upon in making this assertion when you submitted your report?

MR. BEATO: Counsel, I think we can agree that for this proposition there's not a citation to it and it's not involved in the bibliography. I think we've established that.

MS. DUNN: Well, I think the witness needs to say that, though, if you don't mind, Michael.

Q (By Ms. Dunn) So you did not disclose the data or evidence you relied upon in making this particular assertion when you submitted your report; is that correct?

A I did not. I did not list things in the

bibliography that supported every statement that I made.

Q Okay. You also say that, "We are now seeing a much larger number of females."

What is your source for this assertion?

A No one denies that. That data is available as well. And I believe you'll find it in the bibliography. I could go through the articles and bring that out for you, but, you know, I'd have to open up the articles and find them.

Q So if we turn to your bibliography, can you tell me in looking at it which of these articles would support that assertion?

A Not at this time.

Q And you did not specifically provide a citation for that source of -- I'm sorry, for the evidence or data upon which you make this assertion in your report?

A I didn't footnote the report itself.

Q You then say that, "The two leading explanations for this unexplained phenomenon are greater social acceptance or social contagion."

What sources do you rely upon in making that assertion?

A Actually, this was suggestions that have

been made that I do have listed in there.

But I'm -- like I said, the way I write, I read and then I write. But I wasn't asked to footnote these so I didn't. I could find them in the -- in the articles that you have, I'm sure, but it's going to take me some time to pull those out again.

Q So these are -- could be described as perhaps hypotheses? Is that what you're suggesting?

A Yes. Explanations could be hypotheses.

Q But as the literature stands, there's no scientific evidence that links social contagion as a cause of gender dysphoria?

A There has been, as you know, a description by Littman and all about the -- about gender dysphoria in young females being almost like a social contagion. And she had documented that. I didn't list that one in there, it's just -- I thought that was a worthwhile and interesting observation.

But, once again, it's an unexplained phenomenon with potential explanations. It's not data.

Q So just to be clear, are we referencing the Littman report that -- you did list this in your bibliography. Is that what you're referencing right

now, the rapid --
A Yes.
Q -- onset gender dysphoria?
A Yes.
Q And are you aware that there was a correction issued with regard to this article?
A I'm aware that she got a lot of flack about that in a subsequent article as well, yeah. It's -- it was not embraced by the community.
Q And so you're aware that there was a correction issued by the publication that featured her article?
A I had heard about that.
Q Have you read it?
A Nope.
(Document is displayed).
Q So what I'm showing you on the screen is the correction to the Littman article that you listed in your bibliography.
You have not seen this document before?
A I don't recall seeing this.
Q You said you don't recall seeing it?
A Nope.
(Whereupon, Exhibit Number 18 was marked for identification purposes and made a part of the

record.)

Q (By Ms. Dunn) And we will mark this as Plaintiffs' Exhibit 18.

And if you'll look at -- so here it says, "Emphasis that this is a study of parental observations which serves to develop hypotheses."

So this specifically says that, "Rapid-onset gender dysphoria is not a formal mental health diagnosis at this time. The report did not collect data from adolescents and young adults or clinicians and, therefore, does not validate the phenomenon."

Are you aware that this correction was issued with regard to this hypothesis?

A Well, this doesn't actually correct anything that I had just said, though, that you were reading to me because, in fact, I wasn't making a -- an argument so much about rapid-onset gender dysphoria, but also pointing out that we are seeing more females currently than in the past when male predominance was the usual or the norm.

And then I pointed out that there may be some potential explanations for that. That's all I did.

And this still says it's a "study of

parental observations and serve to develop hypotheses."

Q So this article --

A (Inaudible) hypotheses.

Q You would agree this article is hypothesis-generating rather than hypothesis testing or validating?

A That's all I was using it for.

Q Okay. Turning back to your report.

(Document is displayed).

You say that -- in Paragraph 20 you say that, "There's no biochemical, hormonal, radiological, or genetic basis for confirming a diagnosis of gender dysphoria"; is that correct?

A That's correct.

Q What is your evidence to make this assertion?

A Because there is no evidence. There is -- there is no biochemical, hormonal, radiological, or genetic. Nobody has held out that there is. I didn't really think that needed further explication. None of the people treating it say that they have a hormonal or a biochemical or a radiological or a genetic basis that they can point to.

Q So you're not aware of any studies that

demonstrate that genes or hormones might influence gender identity?

A I didn't say that. "Might"? Might is a different thing from diagnosing.

(Whereupon, Exhibit Number 19 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So I'm going to share an article titled "Neurobiology of Gender Identity and Sexual Orientation." This was published in the Journal of Neuroendocrinology in 2018.

We'll mark this as Plaintiffs' Exhibit 19.

Are you familiar with this study, Dr. Donovan?

A I am aware of it. I haven't read this article.

Q And so you were not aware that this article, on Page 4, states that, quote, "Several extensive reviews by Dick Swaab and coworkers elaborate the current evidence for an array of prenatal factors that influence gender identity, including genes and hormones."

A "And evidence of a genetic contribution to transsexuality is very limited." Yeah. I mean, this -- this basically is not diagnostic.

Q So my question is whether you were aware of this study when you made your assertion in your report.

A This study has nothing to do with what I said. It confirms what I said in that there is no genetic basis that allows us to diagnose it.

Are you saying that this is a genetic basis for the diagnosis of gender dysphoria?

Q I'm saying that there is evidence in the literature -- that this article notes that there is evidence in the literature that there are prenatal factors that could influence gender identity, including genes and hormones.

A There is -- there are suggestions. None of these are proven in humans. These are all hypotheses that I think are worth noting, but none of these are used to diagnose a child or an adult with gender dysphoria or as transgender.

Q But my point is that you had not read this study when you made your assertion in your report because you -- you told me when I opened this study that you had not read it; is that correct?

MR. BEATO: Object to form.

Dr. Donovan, you can answer the question.

THE WITNESS: I was aware of the study. I

had not read it. I didn't think it was particularly worth a great deal of time when they were unable to use their findings to form a diagnosis on individual patients, which was really what I was pointing to.

Q (By Ms. Dunn) Give me just one quick second. Not a break.

So, I guess, going back to the report -- and I'll just close this other exhibit to hopefully get there.

(Document is displayed).

When you say -- or when you take issue with the fact that self-report -- that there's no way to confirm a diagnosis other than self-report, are you suggesting that medical conditions that rely on self-support -- I'm sorry, that rely on self-report of symptoms are invalid? I mean, there are other conditions that rely on self-report.

A No, I didn't say that. And the term I used, by the way, was self-perception rather than just self-report --

Q And what's --

A -- because symptoms can be reported.

No, I said "self-perception." And all I would say with that is if that's all we have to go on, we should proceed cautiously.

Q Is there a difference between self-perception and self-report?

A Well, first you have to perceive in order to report.

Q You wouldn't agree that just because a diagnosis is based on self-report that it should go untreated?

A I'm sorry, please restate that so I'm clear.

Q So the mere fact that a diagnosis is based on self-report doesn't mean that the condition should go untreated?

A No, it shouldn't go untreated if there is a condition that a patient is reporting. It should be confirmed and the treatment should be conformed appropriately.

Q And that sort of confirmation is done by a clinician, according to diagnostic criteria; is that right?

A To the extent that you say it, yes.

Q So even in the case of patients with gender dysphoria, a clinician is confirming that diagnosis.

A Insofar as it can be confirmed, yes.

Q But you're not suggesting that there must be a biochemical, hormonal, radiological, or genetic

test to confirm every diagnosis?

A I don't think there's anyone who is trying to make that diagnosis who would not welcome some sort of confirmatory evidence. And that's what I'm saying. And we don't have that.

Q In Paragraph 22 you talk about a "treatment approach that is to provide puberty blockers for young prepubertal patients followed by cross-sex hormones followed by various levels of surgical reconstruction."

Are you aware that puberty blockers block puberty?

A Well, of course.

Q So in what context would a puberty blocker be given to a patient who is prepubertal?

A You can only block puberty if it hasn't occurred. So puberty blockers are for those who have not gone through puberty completely. They're not given after Tanner Stage 2.

Q But a patient receiving puberty blockers would be at Tanner Stage 2, so they would be beginning to move through the process of going through puberty?

A That's what they're supposed to block with those medications.

Q And just to confirm this, your clinical practice was not in endocrinology; is that correct?

A I was a pediatrician. All my patients were supposed to go through puberty eventually.

Q Understood. But your clinical practice was not in endocrinology --

A No.

Q -- is that correct?

A No.

Q And what evidence do you have to support your contention that any youth who receives puberty blockers goes on to cross-sex hormones?

A It's by far the norm.

Q What evidence do you have to support that assertion?

A It has been reported repeatedly, including by the people who are using the puberty blockers and cross-sex hormones. It's not in contention.

Q But what evidence are you relying on to make this statement?

A It's -- that's the multiplicity of sources.

Q Is there one source in your bibliography that you can point us to?

A I'm sure I can find that as well, yes.

Q If I were to show you your bibliography

right now --

A If I were to read the articles again. I don't even highlight them, typically, but I could find it for you.

Q But if I were to show you your bibliography today, you would not be able to identify to me which source contains the support for this assertion?

A I suspect it's in more than one.

Q But if I provided you with your bibliography today, you would not be able to point me to the -- any one of the specific sources that contain the information to support this assertion?

A Given enough time, I would.

MR. BEATO: Object to the form.

You can repeat that, Dr. Donovan.

THE WITNESS: Say what?

MR. BEATO: Could you repeat your answer? I made an objection, but could you repeat your answer?

THE WITNESS: I don't even remember the last answer. I'm sorry.

Q (By Ms. Dunn) Can you point me to which of these sources you rely on in making this assertion?

A I'm sure I could, given enough time.

Q Can you do it right now?

A Nope.
Q And then what evidence do you have to support the contention that any person who receives hormones goes on to have a surgery of some sort?
A I didn't say that.
Q Well, you summarized the treatment approach as being -- as moving from one of these types of treatment to the next.
A That's true.
Q And do you have any evidence to support the contention that a person who receives hormones then goes on to surgery?
A That is the sequence. That's not contentious. That's what WPATH -- I didn't say everyone did, I just said that's the sequence.
Q So you say that treatment -- here you say, "Treatment is determined by the patient."
What does that mean?
A I mean you can't have surgery unless the patient wills it.
Q But you also can't have surgery unless a clinician supports it; isn't that correct?
A Well, that's true, but that really isn't in contention here.
Q Well, this is -- you've framed in your

report that this is self-determined. And I -- I just want to be clear, you're not -- your opinion, you're not stating that this is something that happens without clinician approval, correct?

A I didn't say it would happen without clinician approval. Patients should not self-castrate.

Q In Paragraph 23 you say that, "The studies that support this approach have come under increased scrutiny, with international scientific and clinical bodies expressing concerns about the safety, efficacy, and scientific basis for the current interventions."

What international scientific bodies are you referring to?

A Those in Finland, Sweden, England, Australia, and New Zealand.

Q And what sources are you relying on in making that statement?

A Well, the -- and these are published sources as well.

Q Are they in your bibliography?

A They are in a bibliography. I think that they're in the one that we have for this as well.

Q I'm sorry, I don't understand that.

Are they in the bibliography that was provided with your expert report -- or after your expert report?

A Yes. Certainly the Abbruzzese one mentions that. I'm trying to think which others may have done that.

The Levine report may have, as well, and I think I could find it in the Clayton report, too, but I'd have to look.

Q Do you have any sources directly from these international scientific bodies, or you're relying on these -- these articles that you've referenced in your bibliography?

A No, they've published them.

Q I'm sorry, who's published them?

A No, no, the various medical associations in those countries have published their concerns. This isn't just from the articles itself.

Q And did you rely on those sources when you made this statement in your report?

A I also read those, yes.

Q And did you cite them in your bibliography to your report?

A Once again, I didn't cite everything that I read.

Q So you said that you think that this was mentioned in the Abbruzzese article?

A I believe it was, yes.

Q So I'm just -- I'm going to pull up this article for you -- for us. And this is the Abbruzzese article that's listed in your bibliography. Abbruzzese, Levine and Mason are the authors?

A Yes.

(Document is displayed).

Q I can -- is this --

A Oh, no, this isn't the one. They had -- it was an evaluation of the original Dutch studies involved, so it wouldn't be in there.

Q So this is the Abbruzzese article that is cited in your bibliography, so when you reference "Abbruzzese" in identifying a source where you would have received this information about the international bodies, you're not speaking of this article called "The Myth of Reliable Research in Pediatric Gender Medicine"?

A That's correct.

Q You're thinking of an article that's not listed in your bibliography?

A I can't say that.

(Whereupon, Exhibit Number 20 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) Well, there's no other Abbruzzese article -- sorry.

Before I move on to there, I'd like to mark this as Plaintiffs' Exhibit 20.

So going back to your bibliography, there's no other Abbruzzese article that's listed here.

A Then we must assume that it was not the Abbruzzese article.

Q Okay. So you can't identify which of the source -- you said it might be in either the Levine or Clayton articles?

A I --

MR. BEATO: Object to form.

Dr. Donovan, you can answer that.

THE WITNESS: I believe so. Once again, this was not a controversial statement, so I didn't make a point of highlighting the reference for it.

Q (By Ms. Dunn) So did you just -- you decided not to reference anything that you found to be non-controversial?

A I didn't say that.

Q Just going back to the Abbruzzese study

that you did cite, in what way did you rely on this study in your report, do you recall? Or this -- I'm sorry, this article.

A Well, they were critiquing the original Dutch studies that talked about the diagnosis and -- and, therefore, the treatment protocols for gender dysphoria, only it wasn't called "gender dysphoria" at the time. It was also called the "gender-identity disorder," I think, at that time.

And it turns out the literature itself was so poorly done that it shouldn't have served for the -- for the development of the widespread treatment protocol for this condition.

Q Are you aware that one of the authors of this article is affiliated with the Society for Evidence-Based Gender Medicine?

A Well, it says that there.

Q Yeah. Are you familiar with the Society for Evidence-Based Gender Medicine?

A Not particularly, no. I've heard of it.

Q What do you know about it?

A That they have real problems with -- with the diagnosis and treatment of gender identity disorder.

Q Are you a member?

A No.
Q Have you done any work for Society for Evidence-Based Gender Medicine?
A No.
Q Do you know how they're funded?
A No.
Q In Paragraph 23 -- I'm sorry, I'll re-share your report so that we can be specific.
(Document is displayed).
In Paragraph 23 you say that, "Three European countries have begun to form more conservative and cautious treatment guidelines."
What countries are these?
A Well, Great Britain, you know, the Tavistock Clinic was closed and they re-did their approach.
And Finland has said that they are concerned about their own approach.
And so is Sweden.
I believe France has already done that, as well, too, but I haven't read up on that.
Q Did any of these countries ban this sort of medical treatment?
A To my knowledge, nobody has yet banned that approach.

Q And when you say that they --
A But have they expressed concerns? Yes. And re-evaluated, yes.
Q What evidence do you have that these countries have formed more conservative and cautious treatment guidelines?
A Well, the Brits themselves said that they -- they closed Tavistock in order to actually slow down their enthusiasm for gender affirmation and to spread it around to other clinics and hospitals in Great Britain who would take a more cautious approach.
Q What is your source for that?
A There's a report in the British literature.
Q Is that report cited in your bibliography?
A It's not.
Q And in England, the care is still being provided, just by local clinics instead of centralized clinic; is that right?
A Yes, that's my understanding.
Q In Paragraph 24 you assert that, "Initial psychological evaluations of the patient have often become minimal or almost non-existent."
What is your evidence for this assertion?
A The next line does point out what has been

reported. I thought that was also in the bibliography.

Planned Parenthood clinics have been reported by those going to them that they will give a prescription after a single visit, sometimes within the same day.

Q You're saying that that comes from patient reports?

A Uh-huh.

Q So the only source that we are given related to Planned Parenthoods from your -- I'm sorry, when we were provided with your sources, was a printoff of the Planned Parenthood of Texas.

Is that what you're referencing?

A I'm sorry, I'm not sure what you're referring to.

Q Okay. I'll pull it up.

(Document is displayed).

So this was provided to us when we asked for sources upon which you relied. And this was actually provided in response to your GAPMS report.

But is this what you were referencing when you say that hormones are provided after a single visit?

A Actually, scroll down. I think that may be

one of the places where they -- yeah. Well, I guess, "If you are eligible, Planned Parenthood staff may be able to start hormone therapy as early as the first visit."

Yeah, I'd say that was it.

Q Yeah, is this the only --

A At least one of them.

Q Is this the only evidence that you have of that?

A No.

Q What other evidence do you have of that assertion?

A There have been patients who have also described this, and that's been published in the lay literature.

Q And what literature is that published in?

A Online. I'd have to find it.

Q These aren't --

A But the fact that Planned Parenthood -- the fact that Planned Parenthood also says the same thing made me think that it was probably accurate.

Q Are these your patients that we're talking about?

A Of course not.

Q They're just anecdotes or reports that --

A Patients that have gone to Planned Parenthood and received hormonal treatment on the first day.

Q And these are things that you've read online?

A Yep.

Q Have you confirmed this information in any way?

A I think Planned Parenthood just confirmed it right in front of us.

Q Well, this actually says, "If you are eligible, Planned Parenthood may be able to start hormone therapy as early as the first visit."

Do you know what it means to be eligible?

A The patient said that they went in and said that they wanted it and they got it. That sounds like they were eligible.

Q But does it say that there are no psychological exams being provided? This report does not say that, correct?

A It would be difficult to follow the guidelines in a single day, seeing as how it's supposed to be over a prolonged period of time to confirm the diagnosis.

Q But you have not confirmed that Planned

Parenthood is doing -- the patient may have gotten a psychological exam elsewhere and then gone to Planned Parenthood.

How -- have you confirmed that that's not what's happening?

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: You mean, have I visited the Planned Parenthood office and asked to see the psychological report that didn't exist? No.

Q (By Ms. Dunn) And so you're basing this assertion on reports that you've seen online and this statement from this website?

A And there are other reports for other locations. It's not just Planned Parenthood who have done this. But, yes, I think if a patient goes to Planned Parenthood, says they didn't bring a psychological report, that they were given their hormones on the first day. One of them said over the phone even. That seems like it's plausible. And nobody has come out to deny it.

Q But you haven't confirmed that this is actually the way the care is being provided?

A What sort of confirmation are you looking for?

Q Well, I guess I'm looking for evidence that's something more than just ambiguous printout of a website and, you know --

A And a patient statement?

Q -- things you've read online.

A I'm sorry. And the patient's statement doesn't count?

Q Well, unless you can point -- I think it -- without you identifying where online you've seen them, I think it's hard to assign credibility to that sort of statement.

And you're not able to identify to us where you read these patient reports?

MR. BEATO: Object to form.

Dr. Donovan, you can answer the question.

THE WITNESS: They could be found.

Q (By Ms. Dunn) Did you identify where you read these patient reports in your expert report?

A No.

Q And did you disclose that in your bibliography?

A Actually, I think that was touched on by one or two papers in the bibliography, as well. But, once again, you know, it wasn't the --

Q Can you tell us --

A -- sole topic of the paper, so I'd have to go through each one.

Q Can you identify right now to me which of these articles support that statement that there aren't psychological examinations being provided of patients with gender dysphoria?

A Not today.

Q Are you aware to do so would be inconsistent with the standard of care prescribed by WPATH?

A Absolutely.

Q You agree that that would be inconsistent with the standard of care?

A Yes.

Q And you agree that that would be inconsistent with the standard of care required by the Endocrine Society clinical guidelines?

A Yes.

Q Do you know of any instances of this happening in the state of Florida?

A No.

Q Do you know of any instances where someone was prescribed any sort of gender-affirming medical treatment without a psychological evaluation and that was covered by the Florida Agency for Medicaid?

A I don't know who's prescribing these in Florida.

Q But you're not aware of any instances where someone received a gender-affirming medical treatment without a psychological evaluation and that care was covered by Florida's Medicaid program?

A No.

MR. BEATO: Counsel, I think we've been going for about an hour. Would you mind if we take a break?

MS. DUNN: Absolutely. Let's take a break.

(Recess taken from 2:19 pm. to 2:27 p.m.)

(Whereupon, Exhibit Number 21 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So before the break we were looking at a PDF of a website of the Texas Planned Parenthood. I did not mark that as an exhibit and so I'd like to have that marked as Plaintiffs' Exhibit 21.

All right. So we'll go back to your report, Dr. Donovan. And in Paragraph 25, you reference that, quote, "With further study it has come to light that complications such as arrested maturation, physiological changes, fertility

challenges, hematological changes, and osteoporosis can all result from treatment with puberty blockers and may be irreversible."

You don't cite any evidence to support this statement in your report, correct?

A Within the report or in the bibliography are we saying now?

Q Well, so first of all there's no citation here to support this statement; is that correct?

A No, I -- like I said, I didn't use footnotes on this.

Q And which of the sources in your bibliography provide the evidence to support that assertion?

A I think you'll find it in the Levine and I think probably in Robbins as well. Probably in Clayton as well, too, because she was talking about the dangers.

Q I'm going to pull up the Clayton article that you reference.

A Okay.

(Document is displayed).

Q Do you recognize this document?

A Looks like -- yes.

Q And this is the Clayton article that's

included in your bibliography?

A Yes, looks like it.

(Whereupon, Exhibit Number 22 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'd like to mark this as Plaintiffs' Exhibit 22.

This article is a letter to the editor; is that correct?

A This looks like, yeah, the one -- the story about Rose. I don't know that they talked as much about the -- in this particular one about the adverse effects. I'd have to look on the next page.

(Document is displayed).

Okay. It's really hard for me to read this because the print is so small.

Oh, that's bigger. That's good. Thanks.

Okay. This, I think, concentrates more on the surgical problems than the hormonal problems. Is that right? Slide slowly.

Yeah, I think this is one on the -- bring it up a little bit more, if you would, Ms. Dunn.

Q Up this way?

A The other way, I think. Yeah.

Oh, I guess she did talk about hormonal

treatments there, but that wasn't really as pointed.

Let's go down to the next page. I think that this one was really better for the -- go ahead down.

Further down. Thanks.

Can you scroll down a little bit? I'm having trouble.

Well, she does mention irreversible and long-term adverse effects with the treatments on fertility and sexual function and bone, brain, cardiovascular functioning.

So, yeah, she -- this wasn't the highlight of it but she certainly does go into it as well.

Q Just to be clear, though she may reference those things, this is a letter to the editor, correct?

A Yes.

Q And letters to the editor are not peer-reviewed?

A No.

Q And Ms. Clayton is actually, it appears, a student at the University of Melbourne when she wrote this?

A If you say so.

Q Well, her email address indicates that

she's a student. Do you know otherwise?

A No.

Q And she --

A (Inaudible).

Q I'm sorry?

A No. I see that now.

Q And she is a -- at the School of Historical and Philosophical Studies at the University of Melbourne; is that right?

A That's what it says there.

Q She's not a medical doctor?

A No.

Q You also referenced the Robbins article that you cite in your bibliography.

A Yeah. Let's look there. I thought that was pretty good, too.

Q Is that -- can you read that or should I zoom in more. I'm trying to -- oh, wait, I haven't shared my screen. I apologize.

(Document is displayed).

Can you read this or should I zoom in more? I'm trying to balance getting --

A That's okay. I can see some of that.

Q Is this the Robbins article that you were referencing in your bibliography?

A I believe so. Looks like it, yes. July '19, yes. Okay.

(Whereupon, Exhibit Number 23 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'd like to mark this as Plaintiffs' Exhibit 23.

This is not an article in a peer review research publication, correct?

A Neither was the Planned Parenthood thing. I mean, no, I'm just looking for reports. Right.

Go ahead.

Q So you said that this supported your contention of the harmful effects of puberty blockers that you cite in your report; is that correct?

A I'm sorry. Say that again.

Q When I asked -- and I'll go back to your report. When I asked what supported your assertion that complications can result from puberty blockers, you said that you believed the Robbins article may provide that information; is that right?

A I said that or the Levine. Like I said, I'd have to look, so --

Q But I just want to clarify --

A -- I'm going to look with you.

Q I'm sorry?
A Yeah. Yeah. I said I'm perfectly willing to look through these with you.
Q Sure. But my question is, this is not an article in a peer-reviewed journal?
MR. BEATO: Object to form.
Dr. Donovan, you can answer.
THE WITNESS: I don't know that this is peer-reviewed.
Q (By Ms. Dunn) If we go back to your bibliography, it looks like this is published on a website called thepublicdiscourse.com.
A I doubt that's peer-reviewed, then.
Q And, in fact, it appears -- and correct me if I'm wrong, but it appears that this article merely summarizes another article; is that correct?
A It refers to the Levine article a lot, yeah.
Q Okay.
A This was not so much to establish the side effects, which had already been reported, but actually to talk about what I thought was interesting which was why informed consent then was difficult, given what we know and mostly what we don't know.
Q So, I'm sorry, I don't believe I'd asked a

question, so if you can just limit yourself to responding to the questions I ask, I would appreciate it.

A I thought I was responding, why we were using something -- why we were using this article.

Q That's not what I -- I just asked whether that article was summarizing another article.

A Okay.

Q So, then, you also stated that it's possible that you were relying on the Levine article, which you cited in your bibliography. And I will pull that up.

(Document is displayed).

Is this the article you were referencing?

A Uh-huh.

Q Or you referenced.

A Yes.

(Whereupon, Exhibit Number 24 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I'll ask that this be marked as Plaintiffs' Exhibit 24.

So do you know where in this article that the complications associated with puberty blockers are discussed?

A Let's scroll through it.
Q Please tell me if I'm going too fast.
A We may have to go back, but keep going.
Let's go down further, more so toward the -- keep going.
Keep going. Let's go down to see if we can't find a section on the harms as well.
Keep going.
Q Should I keep going or --
A Sure. Sure. Whoa, slow down.
Go back a little. Thank you.
Okay. Let's go down a little further. Okay. Now, you do see -- I'm sorry, I assumed you saw some of those. No, that was --
Q I'm sorry?
A Nevermind. It's hard to do it this way.
Just keep scrolling down, let's see if we get to the prepubertal part again because he's kind of switching back and forth.
Oh, those are the social risks for children being considered for puberty block A, not the physiological risks.
I think we've passed it, but keep going down, why don't you.
Scroll it. Keep going.

No, keep going because you're on the social.

No, you're still in the social area. Keep going. I think it's probably above us.

Okay. Keep going.

Keep going down.

Keep going down, please.

Oh, go up. Way up where we were talking about the --

Q Is this --

A Let's go above the --

Q -- what you're referencing?

A Huh?

Q Is this what you're referencing or --

A Possibly. Let me -- I think that there was even more than that, so I think he covered it.

Okay. Sorry. Let's go back down. Too quick. Too quick. I can't read that fast.

Q Sorry, did you not want me to go the whole way down?

A Well, no, I wanted to see -- I think it --

Okay. Scroll up a little bit.

Scroll up a little bit.

And up a little bit.

Up a little bit.

Okay. Up a little bit.

Okay. Go on.

And I think this is a really good article, but I think it is also focusing more on the informed consent thing than the -- than the puberty-blocking hormone issues.

Q So you're not able to identify a place in this article that --

A Let's go up a little bit more. Sorry. Let's go --

Okay. Not seeing it there.

Q Okay. So you're not able to identify where in this article is any evidence to support the assertions you made about complications associated with puberty blockers?

A Not in this article.

Q Okay. And we looked at the other two articles that you said from your bibliography might contain that information and you weren't able to identify where in those articles?

A That's two.

Q I'm going to go back to your report.

(Document is displayed).

So in addition to listing these complications, you say that they may be irreversible.

Do you -- can you cite to any evidence for that assertion?

A It's a maybe. The problem, of course, is that what we need is evidence-based answers with this. And it's not just that, you know, we're citing the wrong articles today, but for many of these the evidence is pretty thin or non-existent at this point.

Q But I'm just asking whether you have evidence cited to support your assertion that these complications may be irreversible?

A They may be.

Q But you have not provided any --

A That doesn't make them --

Q I'm sorry. My question is whether you have provided any citation in your report that supports the assertion that these complications may be irreversible?

A No, not on this bibliography.

Q Okay. So no citations in the report and no sources you can point to on the bibliography; is that correct?

A The citations -- none of the citations were in the report. That's (inaudible) footnotes.

Q So then in Paragraph 26 you say, "In any

medical condition where the cause is unknown, the treatment's uncertain, and the adverse effects of intervention are not fully elucidated, a proposed course of therapy would have to be seen as experimental."

So you say "cause unknown."

Do causes of medical conditions have to be known in order to treat them?

A That's not what it says, but it's certainly helpful. If you know what the cause is, then your treatments can be modeled to the cause more certainly.

Q Sure. But does every medical condition have to have an identified cause in order to be treated?

A Nope. Advantageous but not necessary.

Q Aren't there many medical diagnoses for which a cause is unknown but there is a clearly established treatment protocol?

A Yes. I think those are preferable.

Q But there are medical diagnoses for which a cause is unknown but there is still a clearly established treatment protocol?

A And I said that that would be preferable, yes.

Q What does it mean that treatments are uncertain?

A It means that we don't really have a good idea of whether or not these are the proper treatments or the proper diagnosis with a proper risk-to-benefit ratio and good outcomes over the long term.

Q Is that a scientific phrase that you're using?

A Which one?

Q That treatment's uncertain.

A It's not unscientific.

Q You say that, "As a result of this, that the cause is unknown, the treatments are uncertain, and the adverse effects are not fully elucidated, that the treatment must be seen as experimental."

Is your definition of whether treatment is experimental guided by the same standards that Florida's Agency for Healthcare Administration uses to determine if a treatment is experimental?

A I would imagine they are very close.

Q Did you consider evidence-based clinical practice guidelines in determining -- or in coming to your opinion that a treatment is experimental?

A If clinical practice guidelines are truly

evidence based, then they should be considered. I don't think we have those.

Q Do you consider -- do you know what standards the Agency for Healthcare Administration is required by regulation to use in determining that a type of treatment is experimental?

A I don't know their regulations.

Q So your opinion that this treatment is experimental does not reflect --

A Is my --

Q So your opinion that it's experimental, it doesn't reflect the agency's standards?

A They were asking my opinion, so I gave them my opinion.

Q But not based on their standards, based on your own standards?

A Yes.

Q But you don't offer an opinion about whether gender-affirming medical care is consistent with the standards AHCA uses to determine that treatment is experimental?

A Well, I would see their standards and be able to answer that more accurately. I would strongly assume that they use the same sort of care and precision in deciding these things.

Q But in formulating the opinions that are contained in this report, you did not -- you had not referenced the standards used by AHCA to determine whether medical care is experimental?

A I was using more generalized standards. Widely accepted.

Q Does your opinion that the treatments for -- of gender -- I'm sorry -- gender-affirming medical treatments are experimental apply to all medical treatments for gender dysphoria?

A Could you rephrase that?

Q Yes. So just more clear -- a point -- like -- excuse me -- to provide more clarification.

This paragraph follows some discussion of puberty blockers.

Is your opinion regarding a, quote, "proposed course of therapy as experimental" referencing specifically puberty blockers or is it referencing the other sorts of gender-affirming care we have been discussing today?

A I think it should apply to the entire sequence of interventions that we've been discussing.

Q So including -- so puberty blockers, cross-sex hormones, and gender-affirming surgeries?

A Correct.

Q Your report doesn't list any complications attendant to cross-sex hormones; is that right?

A It doesn't list them. There were other people actually, as I understood it, listing all the things that you've been asking about, including that. I didn't feel it was necessary to -- to reiterate all that, seeing how what we were really talking about was the ethical implications of informed consent and the --

Q Well --

A -- and the standards for research versus clinical care.

Q So today we're just talking about your report. And so my question is just whether you listed any complications attendant to cross -- the administration of cross-sex hormones.

And you did not -- your report does not list such complications; is that right?

A That's correct, I believe.

Q You also don't offer an opinion about complications related to gender-confirming surgeries; is that correct?

A About their complications, I didn't get into that. That's not to say there aren't complications, I just didn't feel the need to iterate

them.

Q Your report doesn't list those complications?

A No need.

Q But it does say that those treatments are experimental; is that right?

A Yes.

Q And you're aware that these types of treatment have all been provided in the clinical context for years and even decades. Are you aware of that?

A Of course.

Q So gender-confirming surgeries were first performed in the 1930s; is that right?

A The first one I knew about was Christine Jorgensen in Sweden.

Q Which was in the 1930s; is that correct?

A No. I think she was more in the '50s or '60s.

Q Cross-sex hormones became available in the 1930s as well; isn't that right?

A Well, no. The hormones have been available, but -- for this use? Is that what you're talking about?

Q Yeah. I'm sorry. Cross-sex hormones were

first used for this type of treatment in the 1930s?

A These things have been used for a long time. Only recently have they become popular and widely applied.

Q Do you think the use of puberty-delaying medications to treat gender dysphoria in adolescents was first referenced in medical literature around 25 years ago? Isn't that right?

A Sounds right.

Q In the next paragraph, Paragraph 27, you're responding to Dr. Karasic's report and you suggest that, "Healthcare providers treating patients for gender dysphoria should include protocols for de-transitioning."

Do you have any evidence to support the contention that that is not happening?

A I didn't say it wasn't happening. He was concerned about his patient's -- or some patient's de-transitioning.

And I said, in that case, you know, protocols to manage that are appropriate.

Q But he was referencing the fact that patients were being forced to de-transition by the fact that their medical care would no longer be covered by Florida's Medicaid system, correct?

A And I -- I'm assuming that he himself was assuming that's their only source for the ongoing treatment, which I wouldn't know, but he did say that.

Q Well, Medicaid is health insurance coverage for individuals who cannot afford to pay for their own healthcare, is it not?

A That's true.

Q So it's safe to assume that many individuals who have lost coverage for this type of care are unable to access it elsewhere, correct?

A There's a fair presumption.

Q You reference a, quote, "idea" of a quote, "conveyor belt of treatment."

Do you know of any Medicaid patients in Florida that were on a conveyor belt of treatment who were unable to stop receiving gender-affirming treatment if they wanted?

A I don't think Dr. Karasic or myself were referring to any individual patients, so, no.

Q But you would agree that having to stop receiving gender-affirming medical treatment because you can't afford the treatment is different than voluntarily deciding to stop the treatments, right?

A Different in what way?

Q Well, it's different for a patient to no longer be able to afford a treatment versus choosing to stop a treatment; is that correct?

A Well, there would be differences, but the differences might be financial. The differences probably wouldn't be the effect on the withdrawal from the medications. I think those would probably be about the same.

So would there be some differences? Probably.

Would there be similarities? Undoubtedly.

Q No, I'm sorry, I'm not referencing the impacts of discontinuing that treatment, I'm saying that as a factual matter, it is different for someone to no longer be able to afford a type of medical care than that they choose to stop that medical care. Those are the two different circumstances that should not be treated identically.

A Well, those would be the financial impacts that I think you were referring to.

Q So when we were talking about the conveyor belt of treatment, I just want to confirm because I think your answer was a little bit ambiguous.

You do not know of any patients in Florida who have not been able to stop receiving

gender-affirming treatment if they so chose?

A My exchange with Dr. Karasic was not about any specific Florida patients, that's correct.

Q You're not aware of that actually happening?

A No.

Q You say that, "To begin treatment of such patients without knowing how to successfully discontinue such treatment, and to not warn patients of this issue in advance, again reflects unfavorably on the issue of informed consent for the treatment of patients identifying as transgender."

What basis do you have to believe that patients and clinicians don't know how to continue -- discontinue that treatment?

A Dr. Karasic was talking about those who would suddenly have to de-transition.

I was talking about the need to be able to plan for that.

Q But are you --

A If you don't plan for that, then what I was saying about it being a medical failure on the practitioner's part would come into play.

It is not just a loss of funding, which I'm sure has occurred in other circumstances for

patients, but other circumstances as well that might cause them to be forced into de-transition or a decision about that.

Q But do you have any knowledge or evidence upon which to suggest that clinicians and patients aren't able to thoughtfully discontinue that treatment?

A I'm advocating that they thoughtfully discontinue the treatment.

Q And I'm saying, do you have any evidence to believe that's not happening?

A I was responding to Dr. Karasic's concern. I wasn't concerned that that wasn't going to happen.

Q In your conclusion on Paragraph 28 -- I'm sorry, Paragraph 29 of your conclusion, you compare gender-affirming care to a lobotomy.

Are you aware that nearly all lobotomies were performed without informed consent from patients and guardians?

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: I wouldn't know how to know that all lobotomies were performed without informed consent. I believe that, in fact, the single case that I did cite was with informed consent.

Q (By Ms. Dunn) You cited a case?
A Yes, President Kennedy's sister.
Q Were you aware that lobotomy was not supported by major medical associations?
A Yeah. It was considered innovative surgery at the time for psychiatric problems. It didn't last long enough to seek widespread support from medical association.
Q So you cited a single case with regard to the informed consent. Do you have evidence to demonstrate whether or not the care was being provided without informed consent in any other case?
A No, no. You're the one who was asking about informed consent for these. I was just pointing out that they did exist and they were a mistake.
Q Of course, but you have likened it to gender-affirming care, so I'm just trying to determine whether these -- to your knowledge, these procedures were being done without informed consent.
A You are correct that they could not be done with informed consent, seeing as how people had no clear idea of what the long-term consequences would be but proceeded anyway.
And to that extent it's very similar to

what we're seeing with the treatment for gender dysphoria currently.

Q Well, but lobotomies were also not supported by major medical associations at the time.

A I don't think the issue in the lobotomy was whether or not there was a major medical association that supported it or not, I think it was actually the procedure itself, and the consequences known or unknown, and the ability to give informed consent for that procedure. That's where you actually find the strongest parallels.

Q So just to be clear, the case that you've cited, the sister of President John F. Kennedy, she did not consent to that treatment; is that correct?

A I --

Q She did not provide informed consent for that treatment?

A I don't know.

Q When you cited it as --

A I don't see how she could.

Q -- a case where --

A I don't see how she could.

Q Okay. But in gender-affirming care situations, there are protocols for informed consent?

A A protocol for informed consent is not the

same as obtaining informed consent. Only if it's followed, and it has to be followed by providing all the elements of informed consent.

Those elements include the capacity to understand what's going on; the absence of coercion in the decision-making process, either positive or negative; the comprehension so that you can understand all the risks, benefits and alternatives that are presented to you.

But when those things are not even available, then the possibility of informed consent is reduced or absent.

Q What evidence do you have that that isn't happening, that that information is not being provided in this context?

A Because the information is not available, according to even the people who are providing it.

For instance, Robert Garofalo, who is the chief of adolescent medicine at Lurie Children's Hospital in Chicago, told a podcast interviewer last year that the evidence base remained a challenge. It's a discipline where the evidence base is now being assembled and it's truly lagging behind clinical practice. He said it's -- he thinks it's being done safely.

But now I think we're really beginning to do the type of research where we're looking at short, medium, and long-term outcomes of the care that we are providing in a way that I think hopefully will be reassuring to institutions and families and patients, or will also shed a light on the things that we could be doing better.

Q Did you cite that podcast in your report?

A No, I'm just telling you.

Q Did you rely on --

A In response to your question. You said, you know, why would I think that.

Q Well, saying that there's room for there to be more research and to improve the evidence base for the treatments is different from saying that people are not being fully informed of the risk of which we are aware.

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: We first have to be aware of the risks and the benefits. Neither of those are clearly elucidated in the present day.

Q (By Ms. Dunn) Well, these treatments have been provided for decades at this point, and so there's some --

A Provision --
Q -- information --
A I'm sorry.
Q There is information about the risks. And the standards of care and clinical guidelines that are applicable to this care require that that information be disclosed to the patients and their -- and in the case of minors, to the patients and their guardians; isn't that correct?
A No, not entirely.
Should they be required? Yes.
Is it? But the problem is, of course, even when things are done for decades, if they are not well documented, done in an orderly fashion where the risk, benefits, alternatives, and outcomes can be clearly delineated, then, in fact, you can't give informed consent because you don't have the information to give.
Q What evidence do you have to suggest that the informed consent process that's being engaged in is not sufficient?
A The fact that they can't tell what's going to happen to children and adolescents and young adults ten years from now or 15 years from now or 20 years from now because the data is so sloppy the

information isn't there.

Q What evidence do you have to support that statement?

A There is evidence to support that statement. There is evidence from many sources.

Q What evidence -- can you please cite to the evidence that you rely upon in making that statement?

A I -- I can, but, you know, I -- I turned in a lot of different reports with citations and giving you that answer right today will be difficult, but certainly not impossible if you're willing to receive it.

Q Well, I'm asking if you, right now, can cite to me the data and information upon which you are presenting this opinion?

MR. BEATO: Object to form. I also think that Dr. Donovan's answers speak for themselves.

But, Dr. Donovan, if you want to provide another answer --

THE WITNESS: I don't have any other answer. I think I've answered it.

Q (By Ms. Dunn) Okay. I think at this point I will stop sharing your expert declaration and we will move on to look at the report you provided in support of Florida's GAPMS process. So let me just

pull that up.

(Document is displayed).

Do you recognize this document, Dr. Donovan?

A Yes.

Q And what is it?

A The title reads: "Florida's Medicaid Project: Treatment for Transgender Children Medical Experimentation Without Informed Consent: An Ethicist's View of Transgender Treatment for Children."

Q And this is the report you provided to the Agency of Healthcare Administration in Florida in the course of their process to determine whether or not gender-affirming care was experimental?

A Yes.

(Whereupon, Exhibit Number 25 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) And I'm going to mark this as Plaintiffs' Exhibit 25.

How did you become involved in preparing this report?

A I was contacted and asked if I would be willing to help.

Q And do you recall the names of any of the individuals who you spoke with from the agency in your work with them?

A I'm sorry, I don't.

Q Did anyone assist you in preparing this report?

A No.

Q Did you draft the report solely on your own?

A Yes.

Q Did you consult with anyone in preparing the report?

A No, not really.

Q Did you consult with anyone not at the agency, any other bioethicist or any other medical professionals?

A No.

Q Okay. So going into the substance of the report itself. I'm on Page 1 of the report, which is also, in this version of the document, marked as Appendix 237. Just give me one quick second.

In the second paragraph here, the second sentence says that, "Currently less than half of state Medicaid programs provide gender-affirming care."

Do you see that reference?

A Yes.

Q And that cites to a Williams Institute report from 2019?

A Yes.

Q When you say "less than half provide," are you referring just to those states that have affirmatively included coverage for gender-affirming care?

A I'm not quite sure what the question means.

Q So when you say that "less than half of states cover," does that mean that less than half the states have policies that exclusively provide for coverage?

A All that I know is what I read, that less than half the state Medicaid programs provide gender-affirming care.

Q So I'm going to pull up the Williams report that you've referenced.

Do you recognize this report? Is this what you were relying on? I can scroll down to the executive summary if it helps.

Is this the report that you relied on?

A It's not on the screen.

Q Oh, I'm sorry. Thank you. This is me

getting a little tired.

(Document is displayed).

Is this the Williams report that you referenced?

A I don't know. It doesn't look like the way I saw it, but it probably is. Sure.

(Whereupon, Exhibit Number 26 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'll mark this as Plaintiffs' Exhibit 26.

So this report actually splits the states into three different categories.

One is those states that have affirmative coverage for gender-affirming care. And in that category are 18 states and D.C.

Then after listing all those states, it notes that 20 states have no express statute or policy addressing coverage. And so in these states coverage for gender-affirming medical treatments may be covered, but there's not an affirmative coverage policy.

And then the last category is the 12 states that have express bans on coverage.

Is this the information that you reviewed

in making the statement in your report that "less than half the states cover gender-affirming care"?

A Yes.

Q And would you agree that even fewer than half the states, so closer to 25 percent of states, only 12 states explicitly exclude gender-affirming care. Is that accurate?

A That's what it says, 12 have expressed bans, 18 have expressed coverage.

Q And the other 20 states may cover gender-affirming care; is that correct?

A It's -- the law is silent, it says, so --

Q But you don't have any information that one of those states do or do not cover gender-affirming medical treatments?

A I'm sorry, you faded out there. Try again.

Q I'm sorry. You don't have any information as to whether or not those 20 states in fact do cover gender-affirming medical treatment?

A It just says that they -- okay. They're silent. I will remain silent myself.

Q I'm just saying you don't have any information to confirm that they do not cover it?

A Okay. Nothing --

Q It's possible that they do.

A Nothing beyond the report itself.

Q You reference the Belmont report providing ethical requirements for medical research and informed consent; is that correct?

A Correct.

MR. BEATO: Chelsea, the GAPMS report is not on the screen.

MS. DUNN: Yeah. Thank you. I'll pull it up.

(Document is displayed).

Q (By Ms. Dunn) So now we're on Page 2 of your report, which is labeled as Appendix 238. And here you reference the Belmont report regarding informed consent for research; is that right?

A Yes.

Q The Belmont report governs biomedical and behavioral research involving human subjects; is that right?

A Yes.

Q Those guidelines apply to research being done when human beings are the subjects of that research; is that correct?

A Yes.

Q The Belmont report does not apply in providing clinical care in clinical settings; is that

right?

A Well, the way you state it, you have to understand that, first off, the Belmont report was an expert opinion. It was not a law or a regulation itself. It did talk about clinical research. So it will involve human beings in clinical setting.

Q Sure. But providing gender-affirming medical treatment in the clinical setting is different than biomedical and behavioral research involving human subjects, right?

A I am sad to report that, yes, that's true.

Q So these ethical principles don't apply to the type of clinical care that the plaintiffs in this case were receiving?

A Absolutely wrong.

Q Well, I mean, are you offering an opinion about the clinical care that our plaintiffs have received?

A No. You just said that the principles as enumerated in the Belmont report don't apply to clinical care. But, of course, they do. They talk about, you know, the principles of autonomy, beneficence, justice, non-maleficence, and fully informed consent, and all of those apply to clinical care whenever it should be delivered.

Q Your opinion, your report, states that, "There are deficiencies in each of these categories in the current approach to treating minors with gender dysphoria."

How do you know that?

A I think it's kind of spelled out in the report itself.

Q Well, what is your evidence, though, for saying that there are deficiencies in the clinical care that's being provided?

A By the nature of the care and the inability to give informed consent because of the things that are not known, that are not included in an adequate evidence base.

Q Aren't there always unknown risks to medical treatments?

A Yes, but we should minimize those to the extent possible. That's the point of doing research on innovative therapies in order to get evidence-based data.

Q But the way that you're framing it, someone could never provide informed consent because a doctor could never explain every single possible unknown risk.

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: Actually, now you're sounding -- no offense -- a little like a lawyer because, in fact, that's often what is brought up. Of course, physicians can't tell you every unknown risk. How can anyone tell you what's unknown?

What they can do is strive mightily to determine what the risks, outcomes, and benefits are through carefully constructed trials that are then widely reported through the -- to the world so that they can then be applied.

MR. BEATO: Here's a question, Counsel. Would you mind if we take a five-minute break or do you have related questions that you would like to ask Mr. Donovan?

MS. DUNN: No. I was about to pull up the Belmont report, so we can take a break now. It's a fine time.

(Recess taken from 3:21 p.m. to 3:26 p.m.)

Q (By Ms. Dunn) So, Dr. Donovan, before we broke we were talking about informed consent. Is it your position that nobody can ever provide informed consent to gender-affirming care?

A Well, I told you before I'm not fond of absolutes, but I think that there are deficiencies in

the body of knowledge about what is termed "gender-affirming care" that prevent fully informed consent from being available.

Q Which suggests that there's no way that gender-affirming care can be provided with fully informed consent. Is that your opinion?

A I will accept your suggestion.

Q Well, I guess, are there circumstances -- any circumstances where a patient can provide fully informed consent to gender-affirming care?

A I think that's what we answered the first time. I think that we have some serious knowledge gaps. We have embarked on a program of what's termed "gender-affirming care" for a diagnosis of gender identity disorder, now gender dysphoria, that actually started without us knowing all the risks, benefits, alternatives, and long-term outcomes. And I don't think we've made great progress in that regard, even though it's been going on, as you pointed out, for years.

Q But the end result of that is that because of these unknowns that you cite, you don't believe that any -- that a patient can provide fully informed consent to any of the gender-affirming medical treatments we're discussing today?

A Informed consent can't be obtained without information. That's the informed part. And I think we have an information gap.

Q So it's your opinion that a patient can't provide fully informed consent to any of the gender-affirming medical treatments we've been discussing today?

MR. BEATO: Object to form.

But, Dr. Donovan, you can answer that.

THE WITNESS: You're saying to any of them, and they can certainly, you know, consent to certain aspects of them because certain aspects they'll be able to say, you know, "If I do a mastectomy, what are the risks, benefits, alternatives?"

How that relates to, you know, gender dysphoria is still problematic, but the surgery itself, it's been done a lot.

Q (By Ms. Dunn) Well, so --

A In other circumstances, I mean.

Q I guess, if a patient can provide informed consent, what is -- I'm -- are you saying the patient can provide informed consent about these treatments or that they cannot?

A Well, you were the one who said that -- kind of made it an absolute, they couldn't do it to

any aspect of them.

And I was pointing out that there are aspects of them in which they can be informed.

If I were to offer -- if I were a surgeon and offered a patient a mastectomy, I could tell them the risks, benefits, the alternatives to a mastectomy and the expected outcomes. But I couldn't tell them how that would affect their diagnosis of gender dysphoria with certainty.

Q So you're saying the treatments themselves might be able to have gender-affirming care, but the treatments for the purposes of the treatment of gender dysphoria cannot be made with fully informed consent?

A Yeah, that one was a little jumbled. Can you try again --

Q Right.

A -- please?

Q So you're saying that the procedures themselves may be -- people may be able to provide fully informed consent to the procedures themselves, but they can't provide fully informed consent to the use of those procedures to treat gender dysphoria?

A That would be partially true. And that's going to be more true for, for instance, surgical

procedures which have been done and would be done again in very much the same mode.

You know, using puberty-blocking agents or cross-sex hormones for these indications would be much more difficult, even though we know how those -- how those apply in other diagnoses and other indications. So there you have a problem.

Q I'm just going to go back to your report.

(Document is displayed).

You make a reference in the third paragraph that, "The rules for their involvement" -- which is referencing the involvement of children in research studies -- or vulnerable subjects in research studies, are set out in the, quote, "Code of Federal Regulations 46 CFR 401 through 409."

So when we looked up this reference we found a section of the U.S. Code that appears to be on shipping.

A No, I don't think that was mistyped. I can go right behind me and find that. I mean, the CFR has the rules about informed consent in children on the shelf behind me. I'm pretty sure those are the right numbers. 46: 401-409.

Do you want me to go look?

Q Well, no, I'll pull up --

MR. BEATO: Dr. Donovan, it's --

Q (By Ms. Dunn) I'm going to pull it up in one moment.

(Document is displayed).

So if you see here in the Code of Federal Regulations, we have Title 46, Part 401 to 40 -- here it's just 404, but it appears to be about shipping regulations. I can zoom in, I think.

A No, no, no, no, no. You're not in the ICH Guidelines.

Q What's different about the citation?

A Well, it's the Code of Federal Regulations and ICH Guidelines, Title 21, Good Clinical Practice.

Q Title 21?

A Uh-huh.

Q Okay. So you listed Title 46.

A No, no. The -- I think it was Part 46, wasn't it? Yeah, Part 46, "The Protection of Human Subjects."

Q Well --

A Under Title 45, Part 46.

Q I'm sorry, I'm a little confused. So if we could just take it -- so you've listed --

A IR -- this is fairly standard and widely available. These are the IRB Clinical Investigator

Reference Guides put out by -- you know, by the -- well, the NIH and the ICH Guidelines by the FDA because this is FDA regulated.

And you're looking for IRB Clinical Investigator Reference Guide, which should be under, I guess, Title 45. Part 46 is "Protection of Human Subjects."

Q All right. So maybe this is a citation discrepancy. I'm not sure. What I'm trying to just identify is how we would identi- -- how we would find what you're citing to.

So 46 CFR, in legal citation, means Title 46 of the Code of Federal Regulations.

What title of the Code of Federal Regulations are you intending to reference?

A It's Title 45, Part 46.

Q Okay. And is it Sections 401 through 409? Is that correct?

A Let me double check and make sure. Yep.

Q Okay. Thank you for that clarification.

A Sure.

Q All right. I'm scrolling down in your report to Page 3, which is marked as Appendix 239.

And here we talk about -- you talk about the various interventions, which I'm assuming you use

that word to reference the medical treatments or procedures we've been talking about today.

And so first you reference "surgeries." You say that, "The semantic shift from sex change operations to gender-affirming surgeries is important."

What do you mean by this?

A I'm looking for the context.

Q The first paragraph under "Surgery," the very last sentence.

A Oh, okay. I'm sorry, what's the question there?

Q What do you mean when you say "the semantics shift is important"?

A It's basically what I was trying to point out with the rest of the paper, that, you know, we -- we have switched from calling -- from differentiating gender from sex, to begin with, and then we've started calling it affirming surgery. We don't call it just a mastectomy or a penectomy anymore.

So, you know, when you say that I am going to do an affirming surgery for you, that's a very positive connotation when a patient first hears it as well.

If you said I'm going to do a mastectomy or

penectomy, I think that that probably wouldn't sound as appealing.

Q Do you have reason to believe that clinicians are not using the name for the procedure with their patients?

A I didn't say that. I just said that they are referring to it now as a "gender-affirming surgery," as you know.

Q Well, gender-affirming surgery is the category, but I'm just -- do you have any evidence to believe that the term -- the word penectomy or mastectomy is not being used in individual consultations when someone is seeking that type of surgery?

A I have good evidence that they're using gender-affirming surgeries, but I think that that's really kind of the point I was trying to make.

Q What evidence are you citing?

A Well, they are using "gender-affirming surgery." You used "gender-affirming surgeries." We all hear that.

Q Well, we use -- of course we use that term to describe multiple surgeries that are for the purposes of treating gender dysphoria.

What I'm asking is whether you have any

evidence to support the notion that a clinician isn't using the actual name of the procedure with the patient, i.e., a penectomy or a mastectomy.

A No.

Q Okay. The shift in terminology -- the goal of that shift in terminology was for there to be less stigma associated with the condition.

Is that problematic?

A Well, what we have done, then, is to take a gender identity disorder and say that that is no longer a disorder. It's only a disorder if you're unhappy with it.

The fact that you are a physical male who believes he is or should be a female is normal or should be treated as normal, according to the shift in the terminology and the shift in the approach. I think a lot of people are having some difficulty with that shift.

Q What do you mean "a lot of people are having difficulty with that shift"?

A I think that people are finding it difficult to just believe the concept, that this man is actually a female gender or this woman is actually a male gender. I think that part of the evidence for that, because you like evidence, is that we're

involved in a lawsuit over that right now.

Q But who are the people that are having trouble with that change in semantics or that shift?

A Well, I think it's a wide number of people, if you just look at things that are being discussed, but I'm sure the people you're suing would fall in that category as well.

Q Do you think this shift is problematic for the individuals experiencing gender dysphoria?

A I do.

Q Why?

A Because I think that -- I think that we are taking a psychological problem and applying a medical/surgical solution to it, which doesn't probably -- no, forget "probably" -- doesn't really directly address the underlying problem.

Q What is the underlying problem?

A I think the underlying problem is that we have men who assert that they are in a -- that they are females in a male body and the reverse.

Q Do you have any evidence to cite to to support the assertion that the medical treatments we're discussing today are not effective in addressing the diagnosis?

A I don't think we have evidence one way or

the other, but I think that the -- it is highly unlikely if, in fact, the basic underlying problem is psychiatric or psychological.

Q But are you -- do you have any evidence to cite, with regard to your assertion that surgeries and medical treatments are not effective in treating the condition of gender dysphoria?

A Well, I really think that's what we've been discussing all day is the absence of this evidence, that it is effective.

Q But you have not provided any citation to support the fact that it is not effective.

A Nor have I seen sufficient proof that it is. So I think that, in this case, when you don't have evidence that what you're doing is good, it's difficult to have evidence that what you're doing is not good because we don't have the long-term outcomes being clearly delineated.

I mean, we -- you've pointed out that we've been doing this for over a decade on a larger scale, but for a couple of decades and more on a smaller scale and yet we really don't have -- I can't tell you the number of people who have claimed benefit after 20 years or what that's done to their suicide rate. We do know that in adults the suicide rate has

gone up, not down after ten years. But these are important questions that need to be answered and we really should be answering those.

Q So my question is not -- my question was specific to whether or not you have provided evidence or citation in your report to support the contention that gender-affirming medical treatments are not effective to treat gender dysphoria.

A And my response --

Q Have you cited an evidence or citation?

I mean, just look at your report, Dr. Donovan. I'm just asking, is there a citation or evidence to support that contention?

A And what I'm trying to explain is that in the absence of evidence, you know, that isn't evidence of absence.

What we're dealing with right now is an entire situation that is evidence-deficient.

Q But I'm not asking about the situation. I'm asking a yes or no question as to whether or not there is a citation or evidence -- a source of evidence cited in your report.

MR. BEATO: Object to the form.

THE WITNESS: And I not only answered that, but I also gave you a reason why there is no answer

for that.

Q (By Ms. Dunn) I don't believe I've heard -- it's a yes or no question and I don't believe I've heard a yes or a no.

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: There is no sufficient evidence as to the outcomes.

Q (By Ms. Dunn) So is that a no, that you have not provided a citation to a source of evidence to support the contention that gender-affirming surgeries and medical treatments are not effective to treat gender dysphoria?

MR. BEATO: Counsel, I think the report speaks for itself and I think Dr. Donovan's answer speaks for itself.

MS. DUNN: Michael, if you have an objection, you're welcome to state it, but I'm asking a yes or no question and I'm not being given a yes or no answer.

THE WITNESS: You're not being given a yes or no answer by me because a yes or no answer would be inappropriate. I could give you a yes or no answer, but it would not actually help clarify the truth, it would obfuscate it.

Q (By Ms. Dunn) I'm merely asking whether you provided a source of evidence to support your contention that gender-affirming medical treatments are not effective to treat gender dysphoria.

If you -- that is a yes or no question.

A It is a yes or no question, but a yes or no answer is inappropriate when there is no such evidence. It's like asking for evidence of aliens.

You know, have I proven that there is no evidence? Proving the negative is much harder than affirming the positive, as you know.

Q But I haven't asked you to prove, I've merely asked if you cited evidence in your report.

MR. BEATO: Object to form.

THE WITNESS: Evidence to do what?

Q (By Ms. Dunn) To support the contention that gender-affirming medical treatments are not effective to treat gender dysphoria.

A And how is "support" and "prove" different because I'm confused now.

Q A supporting citation just demonstrates that you relied on some sort of evidence. And I'm merely asking if you have cited any such evidence in your report.

A There is no such evidence to cite.

Q And, similarly, you haven't cited any such evidence in your bibliography?

A And there is no such evidence to prove that it is effective long term.

Q Back to your report. I just want to make sure I'm in the right place.

So you state that, "The lack of sexual maturity in younger patients, especially previously delayed by puberty-blocking agents, makes the sparse tissue more difficult to work with and outcomes less favorable with problems such as wound rupture are more likely."

What is your evidence to support this assertion?

A This is information that I have received from surgeons. This is not personal experience.

Q How did you receive this evidence from surgeons?

A This was in reading their reports.

Q And are those reports cited here?

A No.

Q Are they cited in your bibliography?

A Everything that's cited here is cited within the body of the thing. This doesn't have a separate bibliography, to my recollection. No, it

doesn't.

Q Okay. I'm sorry, but it wouldn't be a source that would be cited in the bibliography you provided with your expert report?

A This was stated by surgeons who do this surgery, so I don't think it's controversial enough to need a separate citation.

Q Well, this is evidence that you're relying on. I'm just asking if you have cited a source for that evidence.

A And, no, I didn't, because I didn't think this was anything controversial, seeing as how the surgeons themselves have mentioned this.

Q You then say that, "These are challenges that are not routinely described to minors at the beginning of their treatment progression."

What is your evidence to support that contention?

A Simply because it -- I don't think it's even widely known by people.

Q Do you have a source of evidence that you can cite to for that assertion?

A Are we talking about the same assertion or something --

Q No, the assertion that these challenges are

not routinely described. I'm just asking how --

A I certainly haven't been able to find them as part of the routine description anywhere in surgery for adolescents, but if I'm wrong, I'd be happy to be corrected.

Q Other than this one -- this issue identified with individuals who begin their treatment with puberty blockers, you don't describe any other ethical issues or complications related to gender-affirming surgeries in this part of the report; is that right?

A Everything I described is -- is there.

Q What do you mean by that?

A Well, what did you mean by that? This is --

Q Well, I'm asking if there are other ethical issues that you've identified with gender-affirming surgeries.

A I think the fact that they're being done is the ethical issue, actually. We're talking in this report on -- not on adults, but on children.

Q So now we'll move on to this section that's called "Hormonal Treatment." It's on the same page, Page 3 of your report marked as Appendix 239.

Here you again cite to "80 percent of

minors who identify as transgender will reverse this identity by the time they reach their mid 20s."

Do you cite any evidence in this report to support this assertion?

A Actually, I think we found that in the other reference, but I don't have a specific citation on that paragraph, no.

Q Are you saying that this source was included in your bibliography?

A Yeah. I thought we found that 80 percent when we were looking through there.

Q To my recollection, you were not able to identify that source from your bibliography.

A Okay.

Q Is that inconsistent with your recollection?

A It's been a long day, Counselor. I'm not sure.

Q But there's no citation here to support that assertion?

A That's right.

Q You say that, "Sex hormones have an important and lasting effect on brain development and adolescent psychology."

That's right here right before the end of

this paragraph.

There's no citation or source of evidence for this assertion in your report; is that correct?

A That's correct, I don't have citations for every statement.

Q Do you know of any studies that show the administration of cross-sex hormones to be harmful to brain development?

A What I said was they have an important and lasting effect. And I think that, yes, those studies do exist.

I think that most people recognize that if they have ever been an adolescent, or had one in the family, it's -- didn't seem like it was that controversial a concept to require a separate citation. But, yes, there is evidence for that, you're right.

Q There's evidence for what?

A For the fact that there are important effects and lasting effects on brain development and adolescent psychology.

Q But you did not cite any research or studies to support this assertion?

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: What you see is what you get. Everything that I cited is right there. And if it's not there, then it wasn't cited in this paper.

Q (By Ms. Dunn) And in your report you don't describe other ethical issues related to the administration of cross-sex hormones?

A I didn't cite any. That doesn't mean there aren't any.

Q Specific to this report, there are no other ethical issues related to the administration of cross-sex hormones addressed.

A Okay. Not specifically.

Q And I'm just -- I see you flipping through papers. Are you just looking at the same report that I have on the screen?

A Yes, it's easier to read.

Q That's absolutely fine, I just wanted to confirm that's what you're looking at.

And if you're looking at a different section than me at some point, if you're referencing it, if you'll just please direct me to that section.

A Sure.

Q So the next section addresses "Puberty Blockers." You state that, "Children and parents are only told that this is a benign intervention whose

effects are easily reversible and that potential effect on the development of bone density may be mentioned."

What evidence do you have that this is the exhaustive information provided to children and their parents?

A Actually the people who provide them have written this in their own papers. It is not cited --

Q Well, who --

A It is not cited there, but those people who have written papers about transitioning have frequently said on their websites, you know, what I'm saying there.

Q Can you direct us to those sources?

A It can be done.

Q Can you do that right now today?

A No.

Q You go on to discuss a case of a child in Sweden. Where did you get this information?

A I'm trying to read where you are.

Q I'm sorry, it's just the next sentence, I think.

A Oh. I'm sorry, that was reported. I didn't cite the -- the location of the report, but it was reported publicly in the literature.

Q There's no cite, though, in your report?
A Once again, Counselor, if you don't see it right there, you're right, it's not a specific citation.
Q You go on to note that, "Sweden changed its guidelines for gender-affirming care to reflect that GnRH analogues should only be used in exceptional cases."
Do you know what the criteria in those Swedish guidelines is?
A No.
Q So I'm going to pull up the Swedish Guidelines for the Treatment of Gender Dysphoria.
(Document is displayed).
Do you recognize -- have you ever seen this document, Dr. Donovan?
A Is that the one from February of last year?
Q Let's see if there's a date on it. I don't see a date on it.
Do you recognize the document itself, though?
A No, I don't. I said I hadn't seen that. And maybe this preexisted the changes, do you think?
Q Let's just -- if you want to take a -- oh, I'm sorry. Here if you look at this paragraph this

references "2022," so this must be a recent document.

A Okay. Let me read then.

Q Sure.

A "A systemic review published in 2022 by the Swedish Agency for Health Technology Assessment and Assessment of Social Services shows the state of knowledge largely remains unchanged compared to 2015. High quality trials such as RCTs are still lacking."

Q I'm sorry, I don't need you to read --

A "The evidence on treatment" --

Q Sir?

A -- "efficacy and safety is still" --

Q Dr. Donovan?

A I think what I'm looking for is in here.

Q Okay.

A -- "is still insufficient and inconclusive."

Q Yeah, I'm not asking you to read from the document. I'm sorry. I was just asking -- I wasn't able to confirm a date, but I think based on this sentence we can both agree that it was published sometime after -- sometime in 2022 or 2023.

A Okay.

Q So do you know the criteria that's used to determine if a case is so-called "exceptional" for

the purposes of the provision of GnRH analogues?

Are you familiar with the criteria?

A Well, it's saying here, to minimize the risk it should offer more closely to those used in the Dutch protocol.

Q And so that requires "early onset of gender incongruence, persistence of gender incongruence until puberty, and a marked psychological strain in response to pubertal development is among the recommended criteria."

Is that accurate?

A That's what that says, yes.

Q Is this significantly different than, for example, the Endocrine Society guidelines?

A I will defer to your knowledge.

Q So you are not -- you are not aware whether the new Swedish guidelines are significantly different from the clinical guidelines for endocrine treatment that are used here in the U.S.?

A I haven't even had a chance to read this in its entirety, so I can't answer that. I'm sorry.

Q Well, but -- so I guess the reason I'm asking is just because you reference that this case should only be provided in exceptional cases, to suggest that it's more restrictive than the criteria

for this care here in America.

Do you know for a fact that that is correct?

A All I know is what the National Board of Health and Welfare from Sweden said that, "The risks of puberty-suppressing treatment with GnRH analogues and gender-affirming hormonal treatment currently outweigh the possible benefits. The treatment should be offered only in exceptional cases."

Q But these --

A That was a quote --

Q These guides -- I'm sorry.

A That was a quote from the Swedish source and I don't know that that quote --

Q Again, I'm not asking you to read the document. I'm asking about the --

A But you are -- you are giving me this as the source of it, but I'm not certain that you're actually giving me the proper source.

Q You don't think that this publication from the National Board of Health and Welfare is an accurate reflection --

A The one that contains that quote, I don't think that it -- it -- necessarily. I'd have to read the whole thing to know that that's where the quote

came from.

Q What quote? I'm sorry. What are you talking about?

A The quote that says that "The risks currently outweigh the possible benefits and treatment should be offered in exceptional cases."

Q You're saying that you --

A Puberty blockers. From the Swedes.

Q Are you saying that this isn't the source that you got your quotation from?

A I'm not recognizing what you're showing me here. I'm sorry.

Q So that -- understanding that, what I'm asking is that you --

A It says, "Until a research study is in place, the NBHW deems that the treatment" --

Q Dr. Donovan, I'm sorry, I'm not asking you to read from this document.

A -- "may be given in exceptional cases."

Q If you can wait until I've posed a --

MS. DUNN: I think we might need to take a break.

MR. BEATO: That's fine. We can take a five-minute break.

(Recess taken from 4:02 p.m. to 4:08 p.m.)

(Whereupon, Exhibit Number 27 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) So, again, I have to clear up my sloppiness around labeling exhibits. So the Swedish guidelines we just looked at will be marked as Plaintiffs' Exhibit 27.

So I'm just going to go back to your report again, Dr. Donovan, and move on to the section that you reference, quote, "The Fundamental Flaw," which is on Appendix 240.

(Document is displayed).

So in this section you say, in the second sentence of this paragraph, that "After close scrutiny, it can only be seen as off-label experimental."

And by that you're referencing -- the "it" you're referencing is gender-affirming care, as we -- we discussed already, the hormonal treatments, the gender-confirming surgeries and the puberty-blocking medications; is that right?

A Yes.

Q And so this seems to associate off-label medications with experimentation. Is that the suggestion you're making?

A No, not exactly.
Q So what do you mean by "off-label experimentation"?
A Well, that's two different phrases. One is "off label," the other is "experimentation."
Experimentation is when you are -- sometimes it's also referred to as innovative practice, but when you're doing things that are trials in which the outcomes have not been sufficiently determined or documented.
The --
Q Just to be clear --
A -- "off label" part is referring to the FDA approval, which is useful if it's for a specific indication, but is not necessary for --
Q So -- I'm sorry. I didn't mean to cut you off.
So just to be clear, those terms are interchangeable --
A No.
Q -- off label and experimental?
A No. No, they're not interchangeable.
Q So a medication -- just because a medication is used off label doesn't mean that that medication is necessarily experimental?

A I have used medications off label for indications that were clearly documented but never had sought FDA approval.

Q In this paragraph you talk a little bit more about what we discussed earlier with, "The change in terminology in the DSM-5 led to a shift from seeking to correct the underlying cause of the dysphoria to instead focusing on transitioning to one's affirmed gender."

Is that a fair -- is that what you're writing about here in this report?

A That is a quote, yes.

Q Okay. And what do you rely on in this discussion around the impact of the change in semantics?

A I was quoting. I was quoting the people who put out the DSM-5 and the American Psychiatric Association. You know, those are quotes.

Q Do you have any other -- was there any other source you relied on in your discussion of this change of semantics?

A I mean, this was the APA's rationale. I thought that they would be reliable in terms of what they were intending.

Q And perhaps to be more specific, in your

bibliography -- which I'll flip over to very quickly --

(Document is displayed).

-- you cite a source that's named "Gender dysphoria in the DSM-5: The change in terminology." That's "HLI.org/resources/DSM-5-gender-dysphoria/."

A Well, no, I wasn't using --

Q Is --

A I'm sorry, I didn't mean to interrupt. I thought that was -- that was not what I used in this report.

Q So you did not -- in talking about that change in semantics, you didn't rely on that Human Life International article?

A True.

Q Do you know how it was used in your expert report?

A I don't know. We could go back through it, I suppose.

Q Well, we can table that momentarily.

Do you believe that this shift in semantics in changing the diagnosis to gender dysphoria, do you believe that change was harmful?

A Well, I think it shifted the focus away from the patients presenting with what they describe

as "being in the wrong body" as saying that that is somehow normal and not a disorder.

Q Do you believe that the best course of treatment for a person experiencing gender dysphoria is to help that person understand they're not trapped in the wrong body?

A I think that that probably would be the best approach and I think that it should have been compared to what is being done.

Q You say that -- and I think it's going to be in the next paragraph, so let me just find where I'm referencing so I can point you directly.

In this second paragraph on this page, we're currently on Page 5 of your report marked as Appendix 241, you say -- the third sentence in this second paragraph you say, "Self-diagnosing psychiatric conditions is always fraught with the possibility of error."

You aren't a psychiatrist by -- in your practice; is that right?

A That's correct.

Q You're also not a licensed mental health professional; is that correct?

A Correct.

Q How often during your time as a clinician

did you provide mental health diagnoses when you were a pediatric gastroenterologist?

A I'm sorry, I lost you there.

Q Oh, I'm sorry.

A Can you repeat that?

Q Yes, of course. I think the Internet is getting a little buggy.

So you testified that there were occasions where you would give presumptive mental health diagnoses to patients in your --

A Yes.

Q -- pediatric gastroenterology practice; is that right? I'm sorry, did you --

A Yes.

Q Yeah. The answer to that was yes?

A I said "Yes."

Q I'm sorry, I think I lost you then, so I apologize.

Can you estimate how many patients --

A Okay. I think you're right. We're having some problems.

Q Yeah. I apologize for that. I don't know if it's our Internet, but let's try to do the best we can.

Can you estimate how many patients during

your time as a clinician you provided a mental health diagnosis for?

A No.

Q You can't even give an estimate of that?

A No. I mean, no. I was in practice for 30, 40 years. I couldn't begin to guess accurately.

Q Was it common for you to be providing mental health diagnoses for your pediatric patients?

A Oh, no, I wouldn't be providing them, I would be suspecting them and referring them.

Q So, I guess, was that a common instance that happened frequently?

A No, because the psychiatric diseases in children aren't that common compared to the other types of diseases.

Q And so, again, you weren't actually providing these diagnoses, you suspected diagnoses and were making referrals to mental health clinicians?

A Correct.

Q So what basis do you have to support a statement that self-diagnosing psychiatric conditions is always fraught with the probability of error?

A I said "possibility of error." And I -- I don't see that as terribly controversial. I don't

see anyone in psychiatry disagreeing with that.

I would find any patient whose self-diagnosis always fraught with the possibility of error. And not just in psychiatry, in medicine in general.

Q How do we -- what conditions are self-diagnosing?

A Well, the way it applies in this particular case is when there's no confirmatory evidence in -- like we've talked about before, in lab, in X-rays, and in other tests --

Q But that's --

A -- that could confirm it. That would be -- that means, basically, the patient comes in with their own diagnosis. And I -- you know, I assume, if somebody overruled that diagnosis, you know, that that would fall in the same category as well. But that wouldn't be my job.

Q Are all psychiatric conditions based on self-reported symptoms?

A No.

Q They can't be -- they can be -- there are psychiatric conditions that are confirmed by lab tests?

A No. But they're not all self-diagnosed. I

don't think most schizophrenics come in and say, "I'm schizophrenic."

Q Well, I guess, what evidence do you have that individuals who are diagnosed with gender dysphoria are self-diagnosing?

A You understand what we've been talking about. This is how they present. They come in and say, "I am a woman. This is a male body." They are the ones who determine that.

Q They're reporting symptoms. But it's a clinician who makes --

A That's not a symptom, ma'am.

Q What -- I -- what evidence do you have that patients experiencing gender dysphoria are self-diagnosing?

A The patients are the ones who claim that they are in the wrong body.

Other people are not walking up to them and saying, "You know, you look just like a man but I think you're a woman." That doesn't happen.

Q But the clinician provides the diagnosis.

A Only after the patient has presented themselves as a woman in a man's body. Okay? You could say they're confirming it, but that doesn't necessarily equate to providing it because it's

already been provided when they enter the room.

Q Have you cited any evidence in your report that individuals experiencing gender dysphoria are self-diagnosing their psychiatric condition?

A I -- this is -- I mean, it's in the definition of "gender dysphoria."

Q I'm sorry, I -- can you provide a citation for that?

A No.

Q The third paragraph on this page you say that, "The claim of urgency, coupled with an impulse towards nonjudgmental empathy, for the disturbed patients has led to a frantic insistence on a single approach."

What is the single -- I'm sorry.

Is the single approach that you're referring to "providing gender-affirming care"?

A Yes.

Q And you call this approach "cult-like"?

A It seems like that to some people and I see why it does.

Q Well, and your source for this statement is two articles that are cited here; is that correct?

A Uh-huh. Yes.

Q One of these articles was from The Daily

Signal; is that right?

A Yes.

Q And were you aware that The Daily Signal is the Heritage Foundation's news organization?

A No.

Q And one was from The Daily Mail Online; is that correct?

A Yes.

Q The Daily Mail Online is a British tabloid?

A Yes. These were reports from parents directly, so they would not appear in the academic literature.

Q But these are your sources for your suggestion that this single approach is cult-like?

A Made the parents feel like, yes, because that's what they said.

Q You say that, "Love-bombing wrongly encourages children to be transgender."

What is your citation for this proposition?

A I'm trying to remember if that was with the same -- the next citation or something else. No, that's a separate citation. I have it in my files, but I don't have it cited here.

Q So there's no citation provided for that statement here?

A That it's the result of overenthusiastic acceptance? I think overenthusiastic acceptance is a reality, but you could also see it as an opinion, you know, is the glass half full or half empty?

I would say that the -- the rush to be affirming is overenthusiastic acceptance.

So perhaps I'm the authority there, because this is an opinion after all.

Q Are you -- do you have personal experience with this so-called love-bombing or overenthusiastic acceptance?

A No, no. These are the opinions that I've formed from reading the experience of others.

Q And are these -- the experiences of others, are they primarily in news articles or what sources are you reading these --

A I think it's very hard to live in today's world without realizing there is a strong urge in schools, in medical circles, and in the general environment to be affirming and only be affirming to someone who presents with a -- with a feeling that they are in the wrong body. I don't think that that's really very controversial or difficult to perceive.

Q Is it your opinion that this is

problematic?

A Absolutely.

Q You say -- I think going down to -- I'm sorry, I'm trying to find a reference here.

So you also discuss an issue that arose in Virginia where a sexual assault was -- well, as you put it, was committed by a, quote, "Self-described trans female."

Do you see that section?

A Yes.

Q And you quote -- or, I'm sorry, you cite to an article here that was published in the Washington Examiner?

A Uh-huh.

Q I'm going to show you that article.

(Document is displayed).

Is this the article that you were citing to?

A Probably.

(Whereupon, Exhibit Number 28 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'm going to -- I will mark this as Plaintiffs' Exhibit 28.

A Can you enlarge it?

Q Of course. Can you tell me where you got the information that this person who committed this sexual assault was a, quote, "Self-described trans female"?

A There was more than one article about this. This is only one that I cited.

Q And here it just says there was "a male perpetrator who was wearing a skirt."

This article, which is the one you cited in your report, doesn't identify this individual as a trans person -- transgender person?

A Oh, no, there have been several reports. I cited one, but this, you know, was clearly reported in the news.

And, yes, the reason he was in the girls bathroom was because he had felt proclaimed to be transgender. I think that that self-diagnosis might be questionable. I don't think that people who truly feel they're transgender are at risk for sexual assaults opposite their biologic sex.

Q I'm just -- at this point I'm just asking about your citation here. So you have described the person who committed this assault as a "self-described trans female," and then you cited this article.

And I just want to confirm that this article does not refer to this person as a self-described trans female.

A Well, this is -- this is a reference to the article, but it looks like -- that does say he was wearing a skirt.

There are a couple of links there. Do they also mention that he had described himself as transgender? Because he had. And we can find it. Do you want to look?

Q Well --

A Can you click those links about "sexual assault" or "May 21 sexual assault"?

Q Dr. Donovan, I'm not asking you to read from the report, respectfully.

I am asking -- you cited this article in your assertion that this individual was a trans female. So I'm just asking -- in looking at this document, it does not state that the individual who committed this assault was a self-described trans female; is that correct?

A And I was saying I think it may be contained in those links about the same incidents.

Q Well, then -- but you did not provide a citation to those particular articles when you wrote

your report?

A I just provided this citation.

Q And I'm going to pull up one more article on this issue.

(Document is displayed).

So this is a CNN article that's about this same sexual assault in Virginia.

Have you ever seen this article, Dr. Donovan?

A I don't recall seeing it.

(Whereupon, Exhibit Number 29 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'm going to mark this as Plaintiffs' Exhibit 29.

So CNN looked into this issue and they report here on this page that they "could not find evidence substantiating that the student identified as transgender or gender-fluid."

Were you aware that that report had not been substantiated by other news sources?

A I don't know how they failed to find it. I don't -- I don't know what this refers to. I don't know if they interviewed him or somebody else. I mean, this tells me nothing.

Q I'm just asking if you were aware that competing news sources were not able to substantiate the claim that this person was a trans female?

A I -- I actually would -- it's easier to say yes or no on this one rather than go into the details, but I'll accept that.

Q So you were not aware that other sources were unable to substantiate that claim?

A An unsubstantiated claim doesn't mean a false claim. That's all I'm trying to indicate here.

But, yes, I -- I don't know anybody who's interviewed the guy directly. The thing was -- it was very difficult to get information on the details. He was in a girl's bathroom wearing a skirt. You know, whether or not he had been diagnosed by himself or someone else as transgender is completely unknown to me. I would doubt the diagnosis that he gave.

Q But you cited to one article, and I'm just asking if you were aware of this other information from another news source.

A And I said "no."

Q You're not aware?

A Not this news source.

Q Thank you.

On Page 6 of your report, which I'll pull

up in just one moment.

(Document is displayed).

You cite to an article by Abigail Schrier. Are you familiar with this article?

A Yes.

Q Do you know where this article was published?

A Oh, there, "Top Trans Doctors Blow the Whistle on Sloppy Care."

Q And where was this article published?

A Says "Emmaus Road Ministries, 5 October 2021."

Q And is that a peer-reviewed source?

A You're not going to find very many discussions about these things in peer-reviewed sources. They basically, you know, have one orientation.

No, this, I don't think, would be a peer-reviewed source either.

Q Moving on to Page 7. We'll go to the second paragraph. So this is Page 7, Appendix 243. The second paragraph.

I'm sorry, I'm having trouble. I think I have a different version of the report pulled up than one of my colleagues, so I'm trying to identify

where --

A Okay. Well, whatever you have is what I'm looking at as well.

Q Okay. Simone was looking at the actual pages in the PDF and not the numbered pages and that's why we had some confusion, so that's my fault. Okay. I'm wondering why I was so confused and now I understand. All right. I apologize in wasting your time in trying to figure that out.

So we're going back up to Page 5, which is Appendix 241. And you say, "The rate of suicide among post-operative transgender adults in a study from Sweden found an incidence 20 times greater than that of the general population."

What study are you citing here?

A I don't see it. I don't even see the -- what you're reading to me.

Q Oh, I'm sorry. It's --

A Which paragraph?

Q -- the second paragraph. I'm looking at the second to last sentence in that paragraph.

A Oh, okay. Yeah. Yes, I do remember reading that. I didn't cite the article there.

Q Can you provide us with a name of that study here today?

A Not off the top of my head, no.
Q Slightly before this, the third to last sentence of that paragraph you say, "Studies have shown that adult transgender persons continue to have evidence of depression and suicidality following treatment."
What studies are you referencing there?
A Actually, I don't know. That may even be the -- among others, may be the same study, but I don't have the reference down there.
Q So there's no citation provided in your report --
A Right.
Q Regarding either of these two studies?
A That's true.
Q Are you aware of any studies that found there were positive mental health outcomes among transgender adolescents and young adults after receiving gender-affirming care?
A Well, there have been positive results reported.
Q And did you consider those studies when you were preparing your opinions in this report?
A Of course.
Q Do you reference any of those studies in

this report?

A If you're going to ask me for citation saying that there's -- on supportive ones, no, I didn't put that in there either.

One of the problems is that so many of these studies have been criticized because of the form in which they were done, how the questions were asked, and how they were reported, who was asked and who wasn't asked, you know, and who refused to ask.

So, yes, I know that they had been reported. I don't know that they are any more convincing evidence.

Q What evidence do you have with regard to those criticisms?

What evidence do you have of those criticisms? What are you referring to?

A Oh, you mean are there criticisms of some of the transgender reports or satisfaction surveys or something?

Q I'm asking what criticisms. I'm asking --

A Yeah. I don't even --

Q -- if you --

A -- have that stated here, so, no, I don't have a citation for that. I didn't even use that citation, seeing as how if it was sloppy work I

didn't think I'd want to cite that.

Q So I'm going to move down again to Page 6. This is marked as Appendix 242. So you reference two phenomena that may be associated with -- you say "this," and I -- I think we're maybe referring to this idea of overenthusiastic affirmation or love-bombing. Is that correct that that's what you're referring to?

A A strong affirmation for the diagnosis and treatment.

Q So you say here that, "It may not only be easier to identify as transgender in today's environment, it may be more difficult to turn one's back on that diagnosis."

What evidence do you have to support this statement?

A I said it "may." That's my opinion, that it may be more difficult to turn one's back if you're being strongly affirmed in any direction.

Q Have you cited any data to support that assertion?

A Well, I think maybe the subsequent lines about re-transitioning and de-transitioning and switching back and forth may be supportive of that.

Q But you're suggesting that because a recent

study found that fewer youth re-transitioned, that that is because it's more difficult to turn one's back on a diagnosis of gender dysphoria?

A Yes.

Q Why -- how can -- I guess, what evidence do you have that the lower rate of re-transition is caused by the fact that it's harder to turn one's back on the diagnosis?

A I'm sorry, I misunderstood your previous question, I'm afraid.

No, I think that enthusiasm and support for the diagnosis may be making it harder for people to then change their minds about their condition.

Q But then when I asked what evidence you had to support that, you cited to the evidence that follows in that paragraph, which is evidence that -- it's a study where the rate of re-transition, where someone changed their gender identity back, is -- is significantly lower than it was in earlier studies.

Does that data support your contention that it's harder to turn one's back on a diagnosis?

A I think that if you are being strongly affirmed, yes, you will be less likely to say, "I change my mind."

Q But what evidence do you have of that, that

that's what's happening?

A It's really kind of what we had just discussed, I think, that, you know, in fact, if you see stronger affirmation you may see fewer people saying that they no longer feel that way compared to historic data.

Q But merely citing a study which says that rates of re-transition have decreased does not necessarily mean that it's because of the cause -- the -- the hypothetis- -- I mean, you hypothesize that there are two phenomena that may be, you know, related to this, but those statistics about lower rates of re-transition don't necessarily prove that that was caused by these phenomena that you identify; isn't that correct?

A It says it may be an explanation.

Q But you have no evidence to demonstrate causation?

A That's why you say things like "it may be an explanation."

Q So here at the top of Page 7, Appendix 243, you say that, "All of this leads to the conclusion that we must ask if this represents a shift towards being trapped in the wrong diagnosis rather than a child being trapped in the wrong body."

What diagnosis would be right in this situation?

A The wrong diagnosis, I think, is when we are saying that your gender identity is both correct and the cause of all your problems.

Q So what diagnosis would be the right diagnosis in that situation?

A Perhaps what used to be thought of as gender identity disorder would be closer to accuracy.

Q And going further down on this page, in the second paragraph about midway through, you say that, "We may be making a fundamental mistake in approaching transgender phenomena, not as a disease or disorder but as a dysphoria that is a cause for affirmation."

So you believe that being transgender should be treated as a disease or disorder?

A It was a disorder until most recently. And I think that the transition to a dysphoria does not serve the interest of the patient.

Q So you believe that the medical community should return to a time when being a transgender person was a mental health condition that was treated only with psychotherapy?

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: I think that it would be a very appropriate thing to do to test that theory. It hasn't been.

Q (By Ms. Dunn) So is it your opinion that the most appropriate treatment for gender dysphoria is psychotherapy with a goal of re-aligning a person's gender identity with their sex assigned at birth?

A That's not what I said, no. I said that both of those approaches are essentially untested hypotheses.

The purely psychiatric or psychological approach has fallen into great disfavor and the affirming approach is the predominant one with, in many cases, a nod towards some psychological discussions. But, in reality, that's not been used as a exclusive approach, nor has it been tested against gender-affirming therapy as it has now been practiced.

Q What is -- what evidence do you rely on to say that gender-affirming care is an untested hypothesis?

A Well, I think that we've kind of covered the fact that the long-term studies have been rather

deficient in testing the results of the therapy.

Q Is there a specific source in your report that supports that the impacts of gender-affirming treatment are unknown?

A Well, I didn't actually say they were totally unknown. I said that what is known is insufficient.

Q And what studies are you relying on to make that assertion?

A Well --

MR. BEATO: Object to the form.

Dr. Donovan, you can answer the question.

THE WITNESS: Okay. I think that what you -- what you have to understand is what I'm saying is that there are -- there's an absence of studies. You can't rely on studies that don't exist.

And in terms of good, scientifically designed and carried out programs with sufficient numbers of patients to actually test a theory, you don't find those.

Q (By Ms. Dunn) But can you cite to any one study that supports this assertion?

A You're asking about a study that supports that there aren't studies?

Q No, a study that supports the fact that

there are unknown risks that are of such a concern that this care should not be provided.

A I'm sorry, that doesn't completely compute. Try that again, if you would be so kind.

Q Well, you're making the assertion that we don't know enough about the impacts of this care in order for it to be provided.

A Yes. And that would be by definition of unknown risk. So you really can't have a study of the unknown risks --

Q So there's no --

A -- because they haven't been able to determine the risks.

Q But what evidence of these unknown risks are you relying on in formulating your opinions about whether the care should be provided?

A Ms. Dunn, there have been suggestions that there could be risks that they've shown up in individuals, but we don't know in how many individuals or how long or how -- whatever. But that is, by definition, an unknown risk.

And by definition, you can't know the unknown risks until you have done the studies that could reveal them.

Q So are you relying on anecdotal, you know,

examples of these risks?

I'm just trying to understand where the information of these unknown risks that keep being referenced -- I just want to -- I'm trying to figure out where that information is coming from, where we can look to to help understand that.

A You are actually giving a good definition for the need to do careful, large, controlled studies because that's how you find unknown risks. Nobody will find an unknown risk without that. At least not be able to document it in large numbers.

Has it been documented in individuals? Of course. This is why people are calling for the studies.

Q But there are always unknown risks in providing medical care. I'm just trying to determine what information you're relying on in saying that this type of care is associated with such a risk that it should not have been provided.

MR. BEATO: Object to form.

Dr. Donovan, you can answer.

THE WITNESS: Actually, I did say that if you were going to provide this care, it should be done in a controlled, experimental venue where you were also comparing it to something else that might

be effective without the risks of surgery or hormones or whatnot. That was actually my contention all along.

Q (By Ms. Dunn) Have you reviewed any studies that demonstrate that gender-affirming care is both -- is safe?

A Safe for what?

Q That it's a safe method of medical treatment.

A Well, I think this is what we've been talking about.

First off, there's no medical treatment that's completely safe. You know, that's just a truism.

But if you're talking about, you know, do we have the studies that demonstrate sufficient safety to overcome concerns about, you know, potential harms, that's exactly what I'm asking for.

Q Have you read any studies that demonstrate that gender-affirming medical treatments are safe and effective?

A Nothing that should be considered definitive or reliable, no. That's why I think the studies need to be done.

Q But there are no studies showing the safety

or efficacy of gender-affirming care that you find credible to rely on?

A I don't think that they have been done carefully in a large enough series of patients for a long enough period of time and conducted in an appropriate manner to be able to answer that question.

Q And what are these studies that you're referring to that are unreliable?

A I haven't found any that should fit the reliability category that we're discussing here, in terms of sufficient numbers, sufficient duration, sufficient design.

You know, and it depends on which kind of question you're trying to ask. So, I mean, are you talking about their psychological benefits or their physical harms or -- you know, basically we just don't have enough to -- to rely on at this stage.

Q So I guess what I'm asking, though, is can you name a single study that you have read that you determined was not reliable?

These studies we're talking about that are not sufficiently reliable, can you name a single one?

A I have read studies and I can't name any that are reliable, so I certainly couldn't name the

ones that aren't.

Q Okay. I'm going to show you a document, Dr. Donovan.

(Document is displayed).

Do you recognize this document?

A I actually don't recognize it, but it's got my name on it, so I believe it.

Q So you don't recall sending this email?

A When was that done? May 12th? No, I sure don't.

(Whereupon, Exhibit Number 30 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) I'm going to mark this as Plaintiffs' Exhibit 30.

Do you recall that Devona Pickle and Jason Weida and Andrew Sheeran were the individuals at the Agency for Healthcare Administration that you worked with?

A That sounds right.

Q Do you recall the draft of the report that you were preparing that was attached to this email?

A No, definitely not.

Q I'm going to pull up a draft of your report so we can see if it might be that one.

(Document is displayed).

Do you recall seeing this draft of your report?

A No.

(Whereupon, Exhibit Number 31 was marked for identification purposes and made a part of the record.)

Q (By Ms. Dunn) Okay. So if we could mark this as Plaintiffs' Exhibit 31.

I'm just going to scroll down to --

A Pardon me. Just to clarify, this is not something I submitted finally; is that right?

Q I believe this was a draft. This wasn't what was publicly released with the GAPMS memo, but this is a draft of that same report, as far as I can tell, that has some, you know, redline edits in it. They're actually green or blue on this copy, but --

A Okay. I can't see any edits at all, but I'll trust you.

Q So I'll just show you. So right here do you see these redlines? Or they're not red, they appear to be green.

But you don't recognize this?

A Not really, no.

Q Well, I'm just going to ask you about a

specific statement in this particular report.

So one difference between this report and the report that we were just reviewing that was the final report, that was publicly released with the GAPMS -- during the GAPMS process is the sentence that's bolded here.

It says, "It should be noted that none of my observations and criticisms are based on any so-called religious objections."

Why did you feel the need to include that statement in this draft of the report?

A Probably hoping to skip the first two hours of this deposition.

Q Is there a reason -- was anyone concerned that your opinions would be viewed as based on religious objections?

A Well, we did seem to spend an inordinate amount of time talking about various religious connections this morning. And I just wasn't -- they were irrelevant to what I was writing, so I thought I would put that in. But it didn't even show up in the last one. Maybe they didn't want to tempt anyone beyond their ability to resist.

Q Do you know why it was removed?

A I don't.

Q Do you know if anyone internal to AHCA, so anyone at the agency, expressed concern that your opinions might be considered to be religious?

A Oh, no, that didn't come from anybody else. That was all me.

Q So today we've reviewed the sources you relied upon in formulating your opinions in the case; is that correct?

A Correct.

Q We've discussed that kind of ad nauseam.

And I'm going to pull up your bibliography just one last time.

(Document is displayed).

Which of these articles are peer-reviewed articles, journal articles that you relied on for your -- your expert report?

A I will have to tell you that I did not rely on exclusively peer-reviewed articles because peer-reviewed articles are extremely difficult to come by in -- on this topic unless you're in favor of gender-affirming care. There is such a strong urge towards supporting it that anything negative is very difficult to get published.

Q Can you identify whether any of these articles were -- are peer-reviewed journal articles?

A I think -- looks like the Clayton one and the Levine one are. And the Abbruzzese one looks like it is. And the DSM is not peer-reviewed, it's just what it is.

Q Well, I'm sorry, so if we can just go a little bit more slowly --

A I'm going from the bottom to the top. Sorry.

Q That's okay. So Clayton we looked at, and I'm happy to pull it up again, but that was a letter to the editor.

A Oh, was it? Well, okay, that wouldn't have been peer-reviewed. That would have been published literature but not peer-reviewed.

So, basically, I think we have been through them all. I don't have anything to change on that then.

Q And you didn't cite to the DSM-5, in fact, you cited to a Human Life International --

A Oh, okay.

Q -- article -- online article on gender dysphoria in the DSM-5. Is that not correct?

A That looks right.

MS. DUNN: I am done with my questions on direct. So at this point I'll turn it over to see if

your attorney has any questions for you. Or not your attorney, I'm sorry, the defense attorney -- defendants' attorney.

MR. BEATO: Sure. And thank you for your testimony, Dr. Donovan. I know it's been a long day, but I just have four questions to ask you.

THE WITNESS: Okay.

CROSS-EXAMINATION

BY MR. BEATO:

Q So we established that you submitted a report attached to the GAPMS report, correct?

A Correct.

Q Did AHCA, the defendant in this case, did AHCA ask you to opine on treatments for gender dysphoria as an experienced ethicist?

A Only as an ethicist.

Q Okay. We reviewed your report attached to the GAPMS report. Do you today stand by the conclusions that you made in your report?

A I do.

Q Dr. Donovan, do you think that treatment for gender dysphoria is a controversial subject matter?

A Yes.

Q And my question is, why wade into this

controversial subject matter?

A Why did I or why do others?

Q Why do you. Why do you specifically.

A Simply because my entire life has been in serving the needs of children and being concerned about the ethical aspects of those treatments, and I thought that there were people reluctant to speak up about this, so I felt somewhat obligated when asked.

MR. BEATO: No further questions.

MS. DUNN: May I just have one brief second? I won't be long, I promise, and then I think we'll be all done.

MR. BEATO: Absolutely.

(Recess taken from 5:02 p.m. to 5:04 p.m.)

MS. DUNN: Thank you for your time today, Dr. Donovan. Plaintiffs are done with their questioning as well.

THE WITNESS: Thank you, Ms. Dunn. I'm happy to hear that you are done.

MR. BEATO: Okay. He will read.

Dr. Donovan, in reading you get to look over the transcript, and if there's any changes you want to make there's a sheet for them.

THE WITNESS: Fine.

MS. DUNN: Plaintiffs will order the

deposition transcript and we'd like it expedited, please.

MR. BEATO: We would like the transcript, too. Not expedited.

(Deposition adjourned at 5:05 p.m. CST)

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J U R A T P A G E

I, G. KEVIN DONOVAN, M.D., M.A., do hereby state under oath that I have read the above and foregoing videotaped deposition in its entirety and that the same is a full, true and correct transcript of my testimony so given at said time and place, except for the corrections noted.

_____

G. KEVIN DONOVAN, M.D., M.A.

Subscribed and sworn to before me, the undersigned Notary Public in and for the State of Oklahoma, by said witness _____, on this the _____ day of _____, 2023.

_____

Notary Public

My Commission Expires: _____

JH

C E R T I F I C A T E

STATE OF OKLAHOMA)
) SS:
COUNTY OF OKLAHOMA)

I, Jana C. Hazelbaker, Certified Shorthand Reporter within and for the State of Oklahoma, do hereby certify that G. KEVIN DONOVAN, M.D., M.A., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, in the case aforesaid; that the above and foregoing videoconference deposition was by me taken in shorthand and thereafter transcribed; that the same was taken on MARCH 22, 2023, located in SAND SPRINGS, Oklahoma; that I am not an attorney for nor relative of any of said parties or otherwise interested in the event of said action.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal this 27th day of March, 2023.

<%8249,Signature%>
Jana C. Hazelbaker, CSR
State of Oklahoma CSR No. 1506

G. Kevin Donovan, M.D. c/o Michael Beato, Esq.
mbeato@holtzmanvogel.com

March 28th, 2023

RE: Dekker, August, Et Al. v. Weida, Jason, Et Al.
3/22/2023, G. Kevin Donovan, M.D., M.A. (#5815158)

The above-referenced transcript is available for review.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason, on the attached Errata Sheet.

The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at transcripts-fl@veritext.com

Return completed errata within 30 days from receipt of testimony.

If the witness fails to do so within the time allotted, the transcript may be used as if signed.

Yours,
Veritext Legal Solutions

Dekker, August, Et Al. v. Weida, Jason, Et Al.

G. Kevin Donovan, M.D., M.A. (#5815158)

E R R A T A S H E E T

PAGE 32 LINE 22 CHANGE teleological

REASON NOT ideological

PAGE 56 LINE 1 CHANGE patients

REASON NOT patience

PAGE 104 LINE 2 CHANGE endocrinological

REASON

PAGE LINE CHANGE

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REASON

G Kevin Donovan 4/07/23

G. Kevin Donovan, M.D., M.A. Date

Dekker, August, Et Al. v. Weida, Jason, Et Al.

G. Kevin Donovan, M.D., M.A. (#5815158)

ACKNOWLEDGEMENT OF DEPONENT

I, G. Kevin Donovan, M.D., M.A., do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

G Kevin Donovan _____ 4/7/2023

G. Kevin Donovan, M.D., M.A. Date

*If notary is required

SUBSCRIBED AND SWORN TO BEFORE ME THIS

_____ DAY OF _____, 20___.

_____

NOTARY PUBLIC

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

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