IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF SOUTH DAKOTA

TERRI BRUCE,)
Plaintiff,)
vs.) No. 17-5080
STATE OF SOUTH DAKOTA and)
LAURIE GILL, in her official)
capacity as Commissioner of)
of the South Dakota Bureau)
of Human Resources,)
Defendants.)

DEPOSITION OF DR. DANIEL SUTPHIN, M.D., FACS
TAKEN ON BEHALF OF THE PLAINTIFF
JULY 17, 2018

(Starting time of the deposition: 8:50 a.m.)

INDEX

(Original exhibits retained by the court reporter to be copied and attached to the transcript.)

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Deposition of DR. DANIEL SUTPHIN, M.D., FACS, produced, sworn and examined on the 17th Day of July, 2018 between the hours of 9:00 a.m. and 5:00 p.m. at the offices of Alaris Litigation Services, 711 N. 11th Street, in the City of St. Louis, State of Missouri, before Rebecca Brewer, Registered Professional Reporter, Certified Realtime Reporter, Missouri Certified Shorthand Reporter, and Notary Public within and for the State of Missouri.

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IT IS HEREBY STIPULATED AND AGREED by and between counsel for the Plaintiff and counsel for the Defendant that this deposition may be taken in shorthand by Rebecca Brewer, RPR, CRR, CCR, Certified Court Reporter, and Notary Public, and afterwards transcribed into typewriting; and the signature of the witness is not waived.

* * * * *

DR. DANIEL SUTPHIN, M.D., FACS,

Of lawful age, produced, sworn and examined on behalf of the PLAINTIFF, deposes and says:

EXAMINATION

QUESTIONS BY MR. BLOCK:

Q Good morning, Dr. Sutphin.

A Good morning.

Q My name is Josh Block. I'll be taking your deposition today. I represent the plaintiff in the case. Have you ever had your deposition taken before?

A Yes.

Q How many times?

A Once.

Q Okay. So you -- you're a little bit

experienced with how this goes, at least. I just want to repeat some ground rules I'm sure you heard before when you've had your deposition taken before. So the first is, as you know, the court reporter's typing down everything we say. So it's important that when you answer my questions, you respond verbally instead of nodding your head.

A Okay.

Q The second is to make sure to wait until I'm done talking before you start speaking and I'll wait until you're done talking before I start speaking, so there's no cross talk and the reporter can write everything down, okay?

A Understood.

Q Great. The third thing is, you know, it's my job to ask you questions that you understand. And so, if for any reason you're unclear with what I'm asking, can we agree that you will say so and let me know so I'll rephrase the question?

A Yes, sir.

Q Great. And so if you answer the question, I'm going to assume that you understood it. Is that okay?

A Yes.

Q Great. Is there any reason why you can't

give your full and truthful testimony today?

A No, sir.

Q Great. Let's begin. So, start by marking as Exhibit A a document entitled Expert Declaration of Daniel Sutphin.

MR. JOHNSON: Just a suggestion. It's easier with Judge Viken if we just go consecutive, so if we go 9, but it's your deposition.

MR. BLOCK: Well, you know the judge, so you if you want to go with 9, that's okay with me.

MR. JOHNSON: Just throwing it out. We haven't marked it yet. Otherwise, I wouldn't have said anything.

MR. BLOCK: No, I haven't. All right. We can mark it as Exhibit 9.

(Deposition Exhibit 9 marked.)

Q (By Mr. Block) Do you recognize that document?

A Yes, sir.

Q Does it appear to be a copy of the expert declaration you submitted in this case?

A If I may review quickly just to verify. Yes, sir.

Q If you could turn to the -- after, actually, the text of your declaration to the CV.

A Yes, sir.

Q Great. I just want to review some elements of the CV with you. So, for education and medical training, let's start at the bottom and go to the top. So you received your undergraduate degree at Carson-Newman College, is that right?

A Yes, sir.

Q Now, while attending Carson-Newman College, did you study gender dysphoria at all?

A No, sir.

Q Did you study psychology or psychiatry at all?

A Other than the mandatory requisites for a liberal arts degree, no, sir. It was just pretty focused and just kind of arts sciences, so I had a minor in history. That was my relief from arts sciences.

Q For -- so after you finished college, you went to University of Tennessee College of Medicine for your M.D., is that right?

A Yes, sir.

Q Now, while you attended there, did you study gender dysphoria at all?

A No. And to my recollection, it wasn't really something on the radar screen. At that time, even as it relates to my specialty, I had had no exposure to plastic surgery at that time.

Q Did you study psychology or psychiatry?

A No, sir.

Q So following that, you had an internship at University of Tennessee Medical Center, is that right?

A Yes, sir.

Q And during your internship, did you study gender dysphoria at all?

A No, sir.

Q Did you study psychology or psychiatry?

A No, sir.

Q So, following your internship, you had a residency at University of Tennessee Medical Center. During the residency, did you study gender dysphoria at all?

A No, other than of my own accord just in reading, it really -- and even to date, in most programs isn't part of the curriculum, for better or for worse. I think many would argue for worse that it's not, but that's something that I think is probably changing, but at the time that I went

through training, it really was not on the radar screen.

Q So, you said as part of your own reading. Did you do your own reading about gender dysphoria during your residency?

A Not so much about gender dysphoria, but about sex reassignment surgery, as it was referred to at the time.

Q And what reading did you do?

A Just what was available through hard text, which was quite limited.

Q And what prompted you to start that reading?

A It's a fascinating problem from the standpoint of what -- what motivates a person who has otherwise physiologically healthy anatomy. What drives them to want to do that? And, technically speaking, the operation, some of them are amongst the most complex in plastic surgery, so --

Q And so, is this -- when would you estimate you first, you know, began asking that question and doing your reading on it?

A Oh, I honestly don't -- I don't -- I couldn't put a date on it, really. So much has happened in my professional life in the last decade

and just in my personal life, my wife would often accuse me of saying, You're the worst at dates, including your own children's birthdays, so --

Q Would you be able to place it in one of your residencies?

A Probably wasn't in earnest until I was at UCSF in San Francisco.

Q All right. So, for -- well, let's just finish up till we get to there. So, for, you know, you have three different residencies, University of Tennessee, two in Knoxville, one in Chattanooga, is that right?

A Correct. They were different specialties as well. In general surgery, I don't know that one would ever encounter gender dysphoric patients as a focus of one's training, irrespective of your geography in the country. There's just not that -- other than perhaps within neurology, which is an element of exposure that, depending upon the program in general surgery that you attend, you may have some exposure to it. For instance, at UT, we would make a month in urology or gynecologic surgery.

Q So, did you have any exposure?

A No, sir. No, sir.

Q Okay. And, now, just so I'm just clear on

the record, I'll just ask the questions for each of the different residencies, so I just have them clear. So for the first residency in department of surgery, just to confirm, you had no training in gender dysphoria in treating gender dysphoria?

A Correct.

Q And you had no training on psychology or psychiatry?

A Correct. If I may make one quick correction. When you mentioned psychiatry, we did do formal psychiatry rotations in med school.

Q Tell me about those.

A I don't recall the exact amount of time. I just recall thinking, during the rotation, I'm -- as many surgeons are, I like to be able to see tangible results and I derive great satisfaction from being able to offer somebody something that provides them a cure, a resolution of something, it's very tangible, and in observing the psychiatrists that were our mentors, they expressed many occasions that one of their primary frustrations with their field of specialty, and it overlaps in some degrees with the medical disciplines like internal medicine, is that they feel they treat chronic disease and never really

achieve a cure, so to speak. I just didn't find that very appealing.

Q What type of -- can you give some examples of the types of diseases they expressed frustration treating as chronic diseases?

A Schizophrenia, depression/severe depression. Those are two that come to mind.

Q So, I had thought that treatment for depression had been improving. What was your sort of just understanding from interacting with them about the difficulties in treating depression?

A Well, my -- and forgive me. That's a question I really don't understand. My understanding from the people that were training me or my own observations?

Q Either one.

A Okay. It wasn't inherently appealing to me to just provide medicine to someone. I also am a person who enjoys using my hands, whether with art or with surgery. And so that was an element that was kind of obviously devoid from treatment for those patients, but the other reality, to me, simplistic as it may be in the background, is the world is a rotten place. It's a hard place, sometimes, for all of us. And it was hard to sort

through chemical imbalance versus people just trying to cope with the reality of their existence. Two weeks ago I talked to a patient who came in to see me with a mass on his ear and he's a very -- he's just enjoying life, a retired guy with his family, and he was very concerned about the spot on his ear. Looks benign enough to him but, as a professional, the biopsy came back for something called Merkel cell carcinoma and it's very -- it's a relatively unusual tumor. And I said, I think we need to do some imaging studies to see, because he also had lymph node involvement, it felt to me, in his neck. And, unfortunately, on the PET CT scan, his liver is filled with metastasis in the scapula as well on the contralateral, or other side. That is horrible and he is depressed and unfortunately there's nothing we can offer within the medical realm to help him. Now, thank goodness that's not the case for everybody who's feeling bummed out or blue, but that's an example of the reality of -- and that's one of the things that is both a blessing and a curse about the surgical realm. It pairs away quickly sentiment and discussion and moves to the realm of reality, you know.

Q Right.

A It's hard to say that to that man. It's hard to tell him, when he says to you, with his son sitting there, Really, I need you to tell me honestly, Dr. Sutphin. What do you -- do I need to -- I mean, will I be hear at Christmas? And I, you know, with humility after recognizing, No. 1, we don't know all the answers, though we might like to as physicians, No. 2, based on what we do know, I can't say that I think you will be, so I think you need to get -- start getting your things together as quickly as you can.

Q So, going back to psychiatry and psychology. I, you know, I take it that --

A I have no formal training, beyond just my brief mandatory exposure for a couple months in med school.

Q Based on what you were saying, is another difference between psychiatry and, you know, surgery, or other medical conditions, is that there's not some sort of, you know, diagnostic test that you can search for to confirm whether or not someone's depressed?

A I don't -- I'm not familiar enough with psychiatry to know. I know there's a battery of questions for many disorders that are sufficient to

provide diagnosis for those who are professionals in that realm, but it is -- it is true that those who practice in the disciplines of psychiatry deal with what we often would say in medicine is inorganic disease or supratentorial, as opposed to disease that may be readily diagnosed by putting a hand there or visualizing with eyes or, you know, perceivable as the reality, you know, if somebody comes in with a ruptured AAA, aortic aneurysm, that's not -- none of us are going to disagree about that, you know, that's a condition that's grave and readily apparent on a CT scan or discernible by physical examination, in the worst case scenario.

Q And psychiatric conditions are generally not discernible by physical examination or by some objective verification?

A Being someone who's outside the discipline, I can't say that. I think we -- any of us, without even medical training, can observe a person and say, that person doesn't seem well, you know, if, for instance, we came to a meeting like this today and you see a surgeon sitting across from you and he's got his buttons the wrong way and half of his face is shaved and his hair's a mess, you would have valid concern that I'm not a physician,

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but he doesn't seem well. Something's amiss for him. That could be a myriad number of possibilities. He may have just been up all night with American Airlines flying all over the country or he may really -- he may have an alcohol problem. It could be any number of things, but just even unprofessional observation will lead you to assume that something's not exactly typical for a surgeon, at least.

Q So, just going back to our boring list. For the third residency, in the department of plastic surgery and reconstructive surgery at University of Tennessee, during that residency, did you have any training in treating gender dysphoria?

A No, sir.

Q Did you have any training in psychology or psychiatry?

A No, sir.

Q Okay. And so, finally, the fellowship at UCSF, during that fellowship, did you have any training in treating gender dysphoria?

A At that point, I did have some exposure to gender dysphoric patients and that was really the first occasion that professionally I'd encountered with a patient in that condition. Even at that

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stage, just a few relatively short years ago, there was no formal, well-organized program as UC. And as is submitted in my declarations, I think that's an area of need that's been recognized nationwide and Dr. Delgado at Miami, who I don't know personally, suggests that we really need dedicated fellowships, that the current state of training in the United States in plastic surgery, this is something that is lacking. Given the location in San Francisco, by default, I think, really, we were even sensing a need at that point to be able to address those patients other than, okay, well, yeah, we know some procedures, we can execute procedures, but we still don't really understand what's bringing to the table here. And so that's kind of where I found myself taking care of patients, not on a regular basis, but occasionally we would see somebody at San Francisco General would come in -- or I remember on one occasion, at St. Mary's Hospital, taking care of a patient who had undergone a metoidioplasty and was having some complications with that. But it wasn't a formalized component. Of course, at that juncture, I was doing a dedicated fellowship in microsurgery. And so, the curriculum was not structured specific to transgender surgery and I

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think, obviously, even as Dr. Schecter is testimony of, I think he's working on developing a fellowship for people within the discipline of microsurgery to tend specifically to transgender patients. Just wasn't that formal presence at that point.

Q So, do the procedures that are involved in sex reassignment surgery follow within the rubric of microsurgery?

A Some, yes, sir.

Q Which ones?

A Phalloplasty is probably the predominant technique that would be best executed, utilizing my microsurgical technique.

Q Does vaginoplasty?

A Depending on whether intestinal transposition is utilized.

Q So, if no intestinal transposition, then it doesn't fall within microsurgery?

A No, it does not. And even in most cases, for intestinal transposition, there's not a need for microsurgical technique unless, perhaps, there's a vascular complication that requires utilizing -- disrupting the native blood supply to the intestine.

Q And mastectomy doesn't fall within microsurgery, does it?

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A No, sir.

Q During this fellowship, did you have any training in psychiatry or psychology?

A No.

Q You also said this was around the time when you started doing your own reading on SRS, is that right?

A Yes, sir.

Q And so, what sources did you begin to read?

A The only sources that I could find at the time were basically limited to our plastics literature, occasionally urology literature.

Q Did you read only in medical journals or did you read beyond that as well?

A Such as? Forgive me, I don't understand the question.

Q Sorry. Were there other writings, from a philosophical perspective or from a non-medical perspective, on SRS that you read at that time?

A Only perhaps what was in the lay press.

Q So, going to the next section of your CV, on work history, you know, maybe we can make this a little bit -- go a little bit quicker by, you know, asking you if, you know, during any of these

professional work history stints you ever treated someone for gender dysphoria.

A I don't know if I treated them, if that would be the primary diagnosis. I treated gender dysphoric patients, yes, sir.

Q So, give me an example of what treatment you gave for gender dysphoric patients.

A Male to female patients that had complications with their breast implants or infection.

Q Any other context?

A No. I did not treat a patient specifically with gender dysphoria, but a spouse of a patient. A lady came to see me about her consult for her breast implants and, to my recollection, she had a technique which is not commonly accepted within well-credentialed plastic surgery. She had a number of implants stacked in her breast to make them inordinately large, basically. Her spouse was a transgender female.

Q I'm sorry, by transgender female, do you mean someone whose sex assigned at birth was female or someone whose sex assigned at birth was male?

A Male. So I didn't treat that individual specifically and, in fact, the patients or the

patient who was coming to me for counsel, I think ultimately decided to seek care elsewhere. I expressed concern to her that, given the stretching of her breast envelope, what she wanted to accomplish wasn't going to be safely doable. She had been multiply operated previous times, including some surgeries outside the country, so --

Q The complications that you did see and treat for breast implants, were those complications different from the type of complications that a cisgender female would experience having breast implants?

A No more related to the complication of the implant itself; common complications like device failure or infection around the device.

Q So the fact that the implant was -- as part of -- was provided as part of gender transition didn't make it more likely to result in a complication than if it had been provided to a cisgender woman?

A I don't know any reason why, per se, no.

Q Going back for one second to your fellowship at UCSF. When you were there, about how many gender dysphoric patients do you estimate you interacted with?

A Oh, it was probably no more than 25 total.

Q And what sort of treatment did you provide them?

A Again, most occasions it was dealing with complications of the surgery. Many of them were, thankfully, non-operative. The lady I alluded to previously who developed bleeding and incisional dehiscence after a metoidioplasty thankfully didn't require surgery. There were other occasions where we would take care of trans female patients who were male at birth and had developed complications with their implants. To that end, the question that you mentioned earlier, is there any reason for failure in that patient population? Not so much an anatomic reason other than the male pectoralis implants are usually more well developed, depending upon the stage at which the patient underwent transformation. And certainly that patient population, I don't ever recall seeing an individual who had undergone transition, pre-pubertal. So, they had a fully male phenotype in terms of skeletal development and muscular development. And if the implant's in a submuscular position, certainly that could lead to increased implant migration. The behavioral pattern in terms of those people, in terms of S&M and

bondage, I would not say are typical for -- but who can say that sexual proclivities of, I mean, across the country, between male, female, cis, or transgender, that's far beyond my expertise, but that was something that may perhaps lead to increased failure, but that would be a common issue, whether a person's a biological male or female, if you smash the implant repetitively, it's going to rupture, you know, so no matter what your gender or where the thing is located. So pretty elementary, not microsurgical techniques. That may have reflected the knowledge base of the surrounding surgical community, even in an area like San Francisco, which is keen, certainly, to be able to provide this care to people that really reflects the rapid growth, even in the last decade, so --

Q Can you explain more about the rapid growth that's happened in the past decade?

A Well, I can just share with observation in terms of authors like Dr. Schecter, who are working diligently to be able to bring a greater knowledge base to various disciplines, I think he -- I can't speak for him, but he would probably be the first to say, not just plastics, but outside of plastic surgery, disciplines like neurology as well.

Q Just want to be clear on understanding what you're saying. Is it fair to say that, you know, the medical community's familiarity with treating gender dysphoria has increased dramatically over the past decade?

A I have no objective proof of that, but my subjective impression, at least there's a greater awareness of it. The fact that it's not reflected in any of my training, I don't believe, is geographical. I think it's time specific.

Q And do you think that -- so the fact that -- well, strike that. Before I move on from your professional work history, I just want to make sure that I'm not missing any other context in your education or your professional work history in which you've treated gender dysphoric patients.

A No, sir.

Q And during the fellowship, or in your subsequent work history, were you ever involved in performing or assisting to perform the transition surgery as opposed --

A No, sir. I was not. Really, my knowledge has been self-directed, to try to learn more, how can we better care for these people? They're human just as you or I. And so, that's really been my

own, self-directed. And I think that's true. I'm not anything special in that regard. Every surgeon, whether this is transgender surgery or whether this is laparoscopic surgery, a neurosurgeon practicing in 1989 or you're a vascular surgeon practicing in the early '90s before endovascular therapy was available, you're going to continually work to critically analyze what's coming down the pipeline of treatment so you can continue to provide good care for people, whatever their background is, whatever their orientation is, whatever their sexuality is.

Q You continue to evaluate new material?

A Yes, sir. Absolutely. That's our duty and obligation. We wouldn't be practicing good medicine if we didn't.

Q And do you think that in deciding what sort of procedures should be covered by insurance, that an insurance company should be, you know, looking at new material and reevaluating decisions in light of new material?

MR. JOHNSON: Lack of foundation.

Q (By Mr. Block) You can go ahead and answer.

A Well, if I could speak for insurance

companies, I would be in a very different place right now. I have no concept of what insurance companies do, don't do, or why they do what they do. I continue to be amazed. I've had insurance companies deny treatment for patients for many different reasons and, if I understood why, there would be a large plaque on my wall called the Nobel Prize.

Q Has anyone, you know, in your training or your work experience asked you to perform surgery for gender transition?

A No, sir. No, sir.

Q And in your -- going down on your CV, for your research presentations and publications, am I right that none of your research listed on your CV concerns treatment for gender dysphoria?

A Yes, sir.

Q And none of the research on your CV concerns performance of transition-related surgeries?

A Correct.

Q And none of the research on your CV concerns psychological or psychiatric care?

A Correct.

Q And have you conducted any other research,

presentations, or publications not listed on your CV?

A No, sir. I just received a request to be a potential author, actually, for Merkel cell, management of Merkel cell cancer, but I have not embarked on that. But that would not be original research. That would be a literature review and synopsis of that. That's the only other thing that's not on my CV right now.

Q What's the difference between original research and literature review?

A In the context that I use it, I mean, for instance, if you look at my CV, the research done with botulinum toxins. That is the concept that's nidus and whose caring to fruition began just with a clinical question that I had as opposed to a question where I'm gathering data from -- just to offer my colleagues a synopsis of what exists in the medical literature at the present, you know, what's valid today may not be valid tomorrow, depending on what we learn overnight. It's that kind of thing.

Q So, what do you think qualifies you to provide expert testimony on the -- on transition-related surgery and its medical necessity?

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A Just an evaluation, I guess, as a plastic surgeon, many of the principles and techniques that are being utilized, obviously, are inherently derived from plastic surgery, whether they're local regional flaps, whether they're surgical techniques. And I think that based on my training, which is excellent technical training, offers me the ability to discuss, with clinical acumen within my specialty, what these complications actually mean. And what does it mean to have a 40 percent stricture rate versus 10 percent and how does really affect people's lives? Because whether they're male or female or transgender or cisgender, if you can't void properly, that's a life-altering thing. And certainly, as I'm going to, you know, as a plastic surgeon, looking toward the future, I have to, as I alluded to earlier, I have to critically analyze literature based on what -- what the literature says to know whether it's something I need to get on board with, so to speak, or whether it's something that, really, I need to refrain from. And that's just my own personal opinion, obviously.

Q So, do you think that anyone who has completed plastic surgery fellowship would have similar competence to be an expert on these issues?

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A I think anyone who has completed fellowship training with a microsurgical background would be able to discuss, intelligently, some of the risks and potential benefits of some of these techniques, yes, sir.

Q Is there anything that distinguishes you from anyone else who has completed a fellowship in plastic surgery with a microsurgery background -- I apologize if I didn't use the right term -- is there anything that distinguishes you from anyone else who has that credential in providing expert testimony on this specific issue?

A You probably have to talk to my patients to make that determination. But in an academic sense, no, sir. No, sir.

Q So, without, you know, revealing the substance of any conversations, when were you first retained to be an expert in this case?

A I honestly don't remember the date. It was in the calendar year 2018, to my recollection. Earlier in the calendar year, probably before spring.

Q Okay. So, we'll just refer to that as early 2018. Is that --

A May I ask?

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MR. JOHNSON: No, just --

A I don't recall the specific date, quite honestly.

Q (By Mr. Block) Okay. And before you were retained as an expert in this case, had you spoken to anyone about your concerns with SRS?

A No, sir.

Q Do you --

A Patients? That's a question I don't know that I fully understand.

Q Thanks for asking me to clarify. Had you --

A I mean, I've spoken to colleagues and said, Hey, what do you think? I mean, this is a pretty high complication rate, but --

Q So, in what context did you speak to colleagues about SRS?

A Just observation, phone conversations. Given the practice location, I'm practicing in an underserved area, so I would contact colleagues about microsurgical cases and just chat over whatever, you know, you don't see each other or talk to each other professionally very often and you try to catch up, what's going on.

Q So, if no one has asked you to perform

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SRS, you know, what prompted you to, you know, pick up the phone and have these conversations with colleagues?

A It wasn't a conversation where I called with that being the nidus. It was a conversation where, what's happening, what's going on in your world? I've got this patient who's, you know, an 88-year-old person who, I think, really needs a free flap, what would you do? That sort of thing. It wasn't a lengthy or extensive conversation.

Q Do you -- do you have any knowledge of if -- I'll take that away. Have you spoken to any of your colleagues about being an expert in this case?

A No, sir.

Q Have you -- before you were retained as an expert in this case, had you expressed any interest to colleagues about providing expert testimony regarding SRS?

A In 2016, when I was still in New Mexico, I submitted that there was a call for opinion regarding the -- there was an injunction issued in a federal court, I think out of Texas, and there was a call for opinion, public opinion. And there was a gentleman by the name of Imbody, Jonathan Imbody,

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that I got an e-mail. I don't think it was directed specifically to me, per se, just making a request, as, you know, if anybody who has any background in plastic surgery and is willing to make some comments and provide testimony about your impressions.

Q How do you spell Imbody?

A I-M-B-O-D-Y.

Q And did he -- was he speaking on behalf of any organization?

A I don't know. I don't know.

Q Are you familiar with the Christian Medical and Dental Association?

A I am. Yes, sir.

Q What's the basis of your familiarity?

A I'm actually a member of CMDA.

Q And CMDA was one of the plaintiffs in that case in Texas, is that right?

A I honestly don't know.

Q How long have you been a member of CMDA?

A Probably since 2000 in a student capacity.

Q And what is CMDA?

A Christian Medical Dental Association.

Q And what does it do?

A Well, it's basically an association of, I would say, like-minded physicians and dentists who

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share a Christian faith. I don't fully know all the capacity of CMDA. I know that they facilitate various missions outreach around the world and serving various areas that are underserved throughout the world. I've never -- never participated in that element, but I know it's a strong element of the organization.

Q So, what's the substance of your participation in the organization?

A Well, I'm a Christian and so, medicine is a very demanding specialty. It's not a position that you can just leave at home. And I think -- I think all of us within medicine, having had friends who come from various different world view perspectives; atheist, Jewish, Mormon, Muslim, all of us have to figure out how are we going to deal with the realities that I was just relating earlier. I'm sitting down with somebody and telling them they're probably not going to be here in a few months. And so I think whatever a person's -- whatever their world view is, I think it's important for them to find that fellowship. That's the basis for my membership.

Q Are there annual or semi-annual meetings that you attend?

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A I've never been to one.

(Deposition Exhibit 10 marked.)

Q So, marking this as Exhibit No. 10. This is a printout of the web page for CMDA. It obviously looks different on paper than it does on the computer screen, but does this appear -- have you visited the website of CMDA at all?

A This looks like it would be legitimate. My dad's in internet security, so he taught me you can make anything look any way you want. He showed me websites that are said to be Bank of America and they're based in Russia, so --

Q But there doesn't appear to be anything wrong with this?

A No, sir. This doesn't appear to be a misrepresentation of anything related to CMDA that I'm aware of.

Q Okay. Great. And under "Our mission and vision" at the bottom of the first page.

A Yes, sir.

Q It says, Our mission. And then it says, Christian Medical and Dental Association motivates, educates, and equips Christian healthcare professionals to glorify God by -- and the first bullet point is serving with professional excellence

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as witnesses of Christ's love and compassion to all peoples. And, second bullet point, Advancing biblical principles of healthcare within the church and to our culture?

A Yes, sir.

Q And do you agree with that mission envision? Is that something that you try to adhere to?

A Yes, sir.

Q And what's your understanding of biblical principles of healthcare?

A Compassion, selflessness, and commitment to excellence.

Q Anything else?

A For me as a Christian that ultimately models Christ, love for us as humans. And I don't see anything discordant with that with care of transgender people. In fact, you know, if you read through the New Testament, I think Paul was probably the original guy to blow up binary definitions in the Book of Galatians; with him there is no male nor female, slave nor free man, there's no Jew or Greek. And so I've never had any -- personally, I can't speak for the whole organization, but for me personally, I've never had any -- if you look at the

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life of Christ, he got himself in a lot of trouble tending to people that were not espoused as and worthy of care. And I can find no better example than that.

(Deposition Exhibit 11 marked.)

Q Another document marked as Exhibit 11. This is a PDF from CMDA's website entitled Transgender Identification. Have you seen this CMDA statement before?

A No, sir, I have not.

Q Okay. So I'll give you a minute to read it and familiarize yourself with it.

A Okay.

Q Okay. So, is there anything in this document that you disagree with?

A No, sir.

Q So, if we go to the very first page, the second paragraph.

A Yes, sir. Biological?

Q No. Starting with "CMDA affirms."

A Okay.

Q CMDA affirms the obligation. Is that the second paragraph? Did I say the first? So the second paragraph on the first page; CMDA affirms the obligation of Christian healthcare professionals to

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care for patients struggling with gender identity, with sensitivity and compassion. CMDA holds that attempts to alter gender surgically or hormonally for psychological indications, however, are medically inappropriate, as they repudiate nature, are unsupported by the witness of scripture, and are inconsistent with Christian thinking on gender in every prior age. Accordingly, CMDA opposes medical assistance for gender transition on the following grounds. Now, so, do you agree that attempts to alter gender surgically or hormonally for psychological indications are medically inappropriate?

A I don't know.

Q Do you agree that they repudiate nature?

A Yes, I do.

Q Do you agree that they're inconsistent with Christian thinking?

A Well, Christian thinking is a very broad -- and as much as I believe that we are created beings and that God does not make mistakes, yes.

Q If you go to the third page, under the heading of CMDA recommendations for Christian healthcare professionals, Item 3, it says -- do you

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have it?

A Yes, sir.

Q It says, CMDA believes that Christian physicians should not engage in hormonal and surgical interventions that alter natural sex phenotypes as this contradicts the basic principles of Christian medical ethics which regards medical treatment as intended to heal and not to harm. Do you agree with that statement?

A I think that Christian medical ethics don't have a monopoly on the intent to heal or not to harm. I think that's true for all of us. I think all of us in this room would agree that our goal is to strive to help anyone. I think -- I'm going to have to speak as my own self, not just as CMDA, though I'm a member of CMDA, that's a body. As Daniel Sutphin, I would agree that it is -- in one sense, sex reassignment surgeries are an advocation of what is natural. That is a biological state the person is born into. And so whether I'm Christian or not, I have to stop and say, why would we -- not just why would the person, but why we, as a culture, abandon -- seems a very debased valuation of the body itself, physical human body, as opposed to a body honoring this is -- this is a special

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structure. And as a surgeon, you know that it is. And I often joke with patients, if you don't believe there's a God, try reconstructing the hand. It's really hard to do. It's a very complex structure that whatever -- whatever one's religious beliefs, you open the hood of a car, something intelligent put that together. You open a human hand -- and I don't practice hand surgery -- it's a pretty amazing design. One millimeter off affects the tendon excursion and flexion. So just from a natural sense, I would have natural questions that is this a valid option. And that's why I say I think we have to first turn to -- we have to look at the medical literature and say, What does it say? What facts are there? Because if the fact is that something helps someone, well, then you have to stop and consider how do I need to adjust my thinking? Is my thinking correct? There's only one God. I'm not him. I don't pretend to know everything. I think in scripture, the principle that I do support that CMDA declares is that male and female, he made them. And I'm a Christian as much as I believe that Jesus Christ is who he said he was, who he claimed to be. And he actually declared that himself while he was on earth. So, some people would just say, well,

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it's a nice fairytale. I respect that. I can't prove that. I can't at all. The New Testament speaks to the truth of what I've seen in my own life and what I've seen in the lives of those around me. I don't -- I don't see any evidence at the present, factual evidence, that tells me that I, as a plastic surgeon, need to engage in this surgery in an effort to save a person's life. And I feel a strong enough sense of obligation to patients, honestly, even for cisgender women, I don't offer cosmetic breast surgery. I really focus my practice on what I would say, I guess, is surgery that I know that what I'm engaging in can produce a tangible -- a tangible result for someone that will not just make them feel better about themselves, that's very gratifying, but restore what disease or nature has taken away, I guess.

Q You spoke about how complicated the human hand is.

A Yes, sir.

Q Do you believe in intelligent design?

A As defined how? I've heard a lot of people define that in different ways. I believe there is a creator and I believe, to me, my faith is an active process where I look, you know, I sit down

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with Josh Block, I talk with him, and Josh is a smart guy and he's got some good ideas and he arrived at those with good reason, somehow. So, what -- how does what I, as Daniel David, think about, how does that compare and where am I amiss? Or where might Josh be, in my opinion? As it relates to intelligent design, I believe in it as much as I think, yes, it's easier for me as an individual to have faith there is a God when I see structures like this and when you operate on the human eye and you know that when you sit as a human and look at me, you can perceive two milliliters of asymmetry in my upper lids, just in casual observation. When you try to restore or correct that, when you try and put it back together again, you realize this is not -- this is pretty neat stuff, so --

Q Do you believe in Darwin's Theory of Natural Selection?

A As defined as what?

Q Well, how -- do you have a definition of it?

A I don't. I don't. I mean, I don't.

Q Okay.

A I've heard a lot of --

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MR. JOHNSON: You've answered it.

Q (By Mr. Block) I mean, do you believe that humans developed through evolution?

A No. I believe we're created beings and that the genome is something that is what our physical manifestations are reflective of, that that's something that allows for -- if that's what you mean by Darwin's Natural Selection, allows manifestations of what we commonly hear as survival of the fittest. You know, if Josh and Daniel live in the desert southwest and they're blue-eyed, fair-skinned white guys, and they don't have any protection, they're going to die pretty quick of melanoma or other related skin cancers over time. They're going to thrive and do better in an overcast Northern European environment.

Q But you don't believe that's how human beings, as a species, developed?

A I don't personally, no, sir.

Q One more question just on this document from CMDA and on the same paragraph that we spoke about last. So Paragraph 3. It says -- just focusing on the first clause of that sentence -- CMDA believes that Christian physicians should not engage in hormonal and surgical interventions that

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alter natural sex phenotypes. And just want to confirm, you agree with that statement, is that right?

A Based on what I've read to date, yes, sir.

Q So, going back to your contact with Jonathan Imbody. Do you know if he was -- sent that e-mail on behalf of CMDA?

A I don't. I'd have to -- I'd have to look at the e-mail.

Q And what did you write in response to the e-mail?

A I have no recollection, honestly, other than I would be happy to provide whatever -- in essence, what I said is I'd be happy to provide any insights that I can, based on my technical expertise in the realm of microsurgery and plastic surgery. If I can help, let me know.

Q And so, after that, do you have any subsequent contact with Jonathan Imbody?

A No, sir.

Q Did you have any contact with anyone from Alliance Defending Freedom?

A No, sir.

Q Do you know what Alliance Defending Freedom is?

A I do.
Q Have you -- have you had any contact with Dr. Paul McHugh?
A No, sir.
Q Have you had any contact with Dr. Paul Hruz?
A Not until having coffee yesterday.
Q When -- what time --
A That was my own request.
Q What time yesterday did you have coffee with him?
A What time? 7, 8:00, 8:30. We met before -- actually, I walked with him over here. I just wanted to see where the building was. He and Jerry were meeting for coffee and I requested, via text, if I could come down and join them.
Q Did you have any contact with him after his deposition?
A No, sir.
Q Have you had any contact with Allan Josephson?
A No, sir.
Q Have you had any contact with Ryan Anderson?
A No, sir.

Q Have you had any contact with Walter Heyer?
A No, sir.
Q So, have you attended any meetings in which the topic of providing, you know, either testimony or scientific studies regarding SRS came up?
A No, sir. I think, actually, I think Dr. Schecter's encouraged it. That will hopefully change, start with getting more information in our meetings within the surgical disciplines, but not to date, I have not.
Q So, between the time you responded to Jonathan Imbody in 2016 and the time that you were retained to be an expert in this case, did you have any communications at all regarding being an expert or providing testimony regarding SRS?
A No, sir. And to be clear, if I might, real quick, Josh, the only thing that I recall about my contact with Imbody is that the decision, if I remember correctly, the injunction came in 2016. I have no recollection specifically of when that contact came, if it was there -- really, I do not remember that specifically. So it may have been -- it was not beyond early 2017, I would think.

MR. BLOCK: So, is now -- I don't need a break, but if you need a break, now is a good time.
MR. JOHNSON: Sure.
(Break Taken.)
Q (By Mr. Block) Just to close the loop on the discussion with Jonathan Imbody. When you replied to him, what research had you done up to that point at the time that you wrote back to him?
A Research regarding?
Q Research regarding SRS and treatment for gender dysphoria.
A Only what I had encountered in practice. Just daily reading, casual observation. The microsurgery techniques that I'm expert in are the same whether a person's transgender or not. Now, the applications, anatomically, are going to be different, but --
Q But you understood the purpose of providing comments or testimony was to oppose providing SRS to patients?
A The purpose in my understanding is to lend candid assessment of what these techniques actually mean. And in terms of -- I mean, you, for instance, Josh, will know things about the legal process that

I might hear -- I might hear the terminology, but I have no concept of what that actually translates to in real life. Someone might hear the term "phalloplasty." Okay. They're probably surgeons and medical personnel who don't really understand how technically that happens and so, that is my purpose and intent; is to be able to speak candidly about that and, also, where possible, to preserve the opportunity for those of us who do not subscribe to transition surgery, to be able to speak freely about it to people. The literature shows clearly, whatever side of the coin we wish to be on, there's a very high complication rate for some of these surgeries. And I don't know that that is clearly and carefully discussed. Though it may be in clinics like Dr. Schecter's, I certainly haven't seen that in the media at large.
Q So, at the time that you wrote to Jonathan Imbody, you had decided, at least for yourself, that providing transition-related surgery was not something that you thought was appropriate?
A In the sense of initiating it. If that makes any -- if that -- is that clear to you? In the sense of providing a transition surgery. For instance, if a patient comes to me, male, female,

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some combination thereof, they're a human being of equal value in God's sight, every bit as me, and they need to be cared for with compassion, with love and with respect. So if they come with a complication, while I don't perform those surgeries, I have a number of women who come to my practice to address the complications of their breast implants. I didn't put them in years ago but they come to me and they have trouble and the same is true of those transgender patients that I've cared for.

Q So, you spoke towards -- in answer to a previous question, you talked about preserving the freedom of people who disagree with providing those surgeries?

A Right.

Q Now, what was your understanding of the legal issue in the Texas case?

A I really don't have any understanding. What I observed is conditions like what's happened, for instance, at Bath Spa University in England, where there is a psychiatrist who wants to bring like a careful analysis of those patients who actually want to go through reversal surgery. And the university, after the initial proposition, not because it's bad science, or because, as

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Dr. Djordjevic, a urologist, said, we actually really need to study these patients not because of those reasons but because the university says, basically, hey, due to the threat of political fallout, we're just not even going to entertain this and, to my mind's eye, that's a disservice no matter what side of this coin we may be; Christian, atheist, indifferent, or otherwise, these people need help and it's really -- it's unprecedented in terms of the nature of the surgery. We're removing an otherwise physiologic organ to satisfy a concept in the patient's mind, and if it does alleviate that, okay, good. That's good to know. What are the complications? What is it going to translate to for them physically? And those people who choose to go through that reversal is it because of those physical complications or because they're dissatisfied? And that would point to observations by some of my psychiatric colleagues, though I'm not a psychiatric professional, I, myself, casually observe. Male, female, cis, trans, whatever it is, as a surgeon, every time we have a patient come before us that's seeking a surgery that's not cancer related, and even if it is, is there an expectation here from the patient that's discordant with

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reality, with biologic reality? If so, how can I address that or even can I? And every surgeon's got to address that freely and I get a sense that that is something that we're -- though we want to give people options, we're moving increasingly toward an environment, at least that I can perceive, that there is no room for objection to say, Hey, is this really the best thing? That's -- and I think for any of us who have ever traveled, thank God we're not in Beijing or Moscow, thus it is decreed, thus shall it be. Maybe it needs to be that way, but I don't see the literature yet to support that.

Q You understand that the issue in this case isn't whether any particular doctor has to perform surgery, is that something you understand?

MR. JOHNSON: I'm going to object to that as vague and indefinite.

Q (By Mr. Block) If you understand that, you can answer.

A I would agree that is vague and indefinite. It seems, based on what I've been able to assess in the case, that the -- the scope is moving continuously, even so recently as to describing medical necessity from the question mark at hand.

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Q Well, so I want to focus, just briefly, on the specific context of is insurance covering a procedure. Now, there are -- do you recognize the difference between the question of whether a doctor should be forced to perform a procedure versus the question of whether a doctor determines that a procedure is medically necessary, should insurance cover it? Do you recognize the difference between those two questions?

A I think, in theory, there is a difference. In reality, I think what the legal community can do with the two is quite amazing and could cross the line.

Q So, in --

A Furthermore, if I may, even in the initial complaint, I sense some of that language that there's -- that Daniel's objection, for instance, or anybody else who may object, is based solely on some Draconian hatred of another human being rather than an honest, candid, what's really going on here? And as a person, when you put a knife on another person's skin, that's a marriage for life. Like it or not. And whether they know or whether they don't, I can sit and talk to a patient, yes, we have to at some point, as surgeons, come to an

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understanding that this person really gets what we're talking about. But, Josh, neither you nor I can fully understand what it is like to live with a urinary fistula. And we're trying to have a meeting and, excuse me, I've got to wear Depends as a 38-year-old man because I wet myself. Even though I may look as a man physically and you may perceive me as a man physically and that may make me feet better about myself, my life is permanently changed. And who's going to fix that and how are we going to fix that? How can we, as a medical community, devise techniques that will provide people the ability to address that? That's the reality of the world as a surgeon. Now, I can go to meetings and I can go to board rooms -- there's an old saying in surgery; never confuse a meeting with reality. But in reality, that's what -- when you deal with the complications of these types of surgeries, I think that's what I sense as being lost, even in the language of the complaint, of, hey, let's have a real candid discussion here. And is your objection because you're just bigoted toward these people or is your objection because you really have candid concerns? Irrespective of your religious belief. Irrespective of who you think Jesus Christ is or

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isn't or whether he ever lived or existed or whether you praise Allah or you praise the flying spaghetti monster if I'm Pastafarian. You ever see that?

Q Um-hmm.

A Immaterial. Certainly what we believe about those things are going to impact how we perceive the human body and its plasticity and what we should do with it.

Q Do you -- do you think that, for, you know, a particular procedure, a medical condition, two different surgeons could, you know, in good faith have different views about whether something --

A Absolutely.

Q Let me --

MR. JOHNSON: Let him finish.

A I'm sorry, my apologies.

Q (By Mr. Block) That two different physicians in good faith have different views on whether something is medically necessary?

A Yes, sir. Absolutely.

Q And in those circumstances, do you think that an insurance company should not cover the procedure if the physician who does think it's medically necessary performs it?

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MR. JOHNSON: Excuse me. Unless you have more circumstances, lack of foundation.

A If I may, if that physician, whether it's me or Schecter or anybody else, can demonstrate a tangible benefit over time, yes, sir. Yes, sir.

Q (By Mr. Block) Even though another physician, looking at the same facts, might say they're not convinced that it's medically necessary?

MR. JOHNSON: Same objection.

A I think in the context that you're stating, it's superseding what I'm trying to communicate and that is if we're talking about altering normal anatomy, there needs to be a clear and well-defined precedent that establishes this actually -- what is our end point? Right now we don't even have one, other than this makes people feel better. If so, for how long? Because once we pull the trigger on it, it's done. It's not a matter of speculation anymore. And there's still -- I don't know that the valid concerns about the psychiatric component of it have been fully addressed, and, furthermore, that's going to be, in reality, a hard thing to do between the different disciplines.

Q I just want to focus, aside from the fact

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that this particular surgery changes characteristics that someone is born with, on the topic of surgeries in general, for other medical conditions.

A Yes, sir.

Q I just want to get your opinion on whether -- when there's disagreement between different informed medical professionals, should that preclude an insurance company from covering care that a particular medical professional believes is medically necessary for their patient?

MR. JOHNSON: I object, complete lack of foundation for that hypothetical.

Q (By Mr. Block) You can answer.

A I'll enter Jerry's objection.

MR. JOHNSON: That's an objection for the record. You answer the best you can.

A Josh, I can only state that unless there is a clear precedent of benefit, whoever it is, me, anybody, I think going back to what I said early on, surgery divides us under very quickly speculation and leaves somebody somewhere going home with that, and the effects, good or bad, good, bad, ugly, indifferent, whatever they may be. So I think it's especially important, whether we're talking about this or any procedure, to really have a

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well-established precedent that demonstrates, yes, this is beneficial to people.

Q So, is there medical disagreement about having, you know, preventative mastectomy to -- if someone has a genetic predisposition to developing breast cancer?

A There's a lot of -- I think from the lawyer's perspective, you're asking a very well-intentioned question. There's a lot of -- there are even tests like Oncotype DX that try to gage that percentage. You're saying in a case where a patient has a high likelihood of developing breast cancer with her certain genetic composition, that it's warranted to counsel her that she may benefit from mastectomy, is that correct?

Q From a preventative mastectomy.

A Yes, sir. Yes, sir. For instance, if we -- if somebody comes to us and we say, We perceive your likelihood of developing breast cancer to be and, again, it's based on perception. We don't have a crystal ball, but based on the best of the literature that we have right now, we perceive that by the time you get to age 55, if your family history is XYZ and you test positive for certain genes like the RCA, we anticipate the likelihood of

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you developing breast cancer to be high enough that you -- it would be reasonable to consider mastectomy.

Q And would knowledgeable, you know, surgeons in good faith, you know, disagree over whether that mastectomy should be performed?

A I don't know of any who would. Maybe my knowledge is not broad enough, but having trained where I have, I've had the privilege of working with some really top people and I don't know of anyone that would argue that fact. I even have a colleague who I trained with whose wife went through that procedure, so --

Q Are there -- are there any other procedures that are performed for prophylactic purposes that there's disagreement within the surgical community about whether the cost of the procedure outweigh the benefits?

A Not that I'm aware of. Prophylactic purposes, no, sir. If there's any that you have in mind that you can think of, I'd certainly be happy to discuss them to the extent my expertise allows, but I can't think of any.

Q Have you ever encountered a situation where there's disagreement over whether the best course of action for treating a condition is surgery or a different type of treatment?

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A Every week in tumor board.

Q Okay. So, in that --

A No, I see that the problem -- the reason disagreement exists is not a -- none of us know with certainty. For instance, we're probably all going to get in a car and go back to the airport today. In most cases, that's going to be fine. When my sister was 18, it wasn't. She died in a car crash. But for most of us, the benefit of getting to the airport on time is worth the very small risk of being killed in a car crash. So, all patients that I see, I counsel in the same regard, whatever their sexuality, whatever -- listen, what we're talking about here, here's what we can say is the anticipated benefit. But, the likelihood of -- you know, if the likelihood of getting hit or killed in a car crash, if we were living in Africa, I might not feel so good about going to the airport in a car. I might actually want to take a cart instead, because the drivers are terrible in some of the places I've worked.

Q Did you use the phrase "a tumor board meeting"? Is that what you said?

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A Yes.

Q A tumor board meeting, is that when several different, you know, physicians, sort of discuss what the best approach is for treating a particular patient's tumor?

A Right.

Q Okay. Now, in those situations, is it possible for two different tumor boards, looking at the same tumor, to disagree over whether or not the risks of surgery are outweighed by the benefits of surgery for that tumor in that patient?

A It is. Generally speaking, the surgeon -- the person who would be responsible for managing the complications and creating them, inadvertently or deliberately, let's say the tumor develops -- it's a tumor in the axilla, and it envelopes the brachial plexus or the brachial nerve, or the artery, the surgeon's going to know better than anybody in the room what that's going to mean in reality when you get there and you have to try to cut around. So, even if the oncologist says, well, that needs to come out, it absolutely needs to come out. The surgeon's going to be able to say, well, you know, I agree, it would be nice to get it out, but the inner position graft we're talking about is a

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ten-centimeter segment, the likelihood of thrombosis for that is -- and we have may have gotten the tumor out and checked the boxes and patted ourselves on the back, but when the patient's arm -- when they have a thrombosis and they end up losing the arm anyways, those are the discussions that I think need to be able to continually happen without --

Q But different surgeons could look at the same tumor and disagree about the --

A They could.

Q -- chances of a positive outcome, is that right?

A They could. But, generally speaking, in conditions such as that, where we're talking about a disease process that's organic, and this is something that I do see happen with these discussions, we move from the organic to the inorganic disease process.

Q I'm just talking about organic diseases.

A An organic disease process, yes, sir.

Q So different surgeons could have different opinions?

A They could, yes, sir.

Q And different surgeons could have different opinions about whether they personally

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feel that it is ethical or appropriate for them to perform the surgery, depending on how they view the risks and benefits?

A In theory, they could. In practice, it's less common, I would say, certainly. There should be a general consensus, usually. It's uncommon. I mean, patients come to me for second opinions. If I see any doubt in a patient, I always encourage them to get a second opinion because you're usually going to find if it's something that's a well-established method of care, you're going to find a general consensus, you know, if Dr. Block's a radiation oncologist, he may want to give you an extra two weeks, but Dr. Sutphin, who's also a radi-oncologist, he's going to agree that you need at least four weeks, maybe plus or minus an extra two, depending upon how you handle it. There's usually a pretty well-established consensus.

Q Okay. We can move on to a different line. So when you agreed to serve as an expert in this case, had you already formed an opinion regarding whether transition-related surgery should be covered by insurance?

A Yes.

Q And what was that opinion?

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MR. JOHNSON: Same objection.

THE WITNESS: Sir?

MR. JOHNSON: I said same objection. Just for the record.

THE WITNESS: Okay.

Q (By Mr. Block) So what opinion had you already formed at the time that you agreed to be an expert in this case?

A The opinion that I have formed both before I agreed to be an expert and the opinion I have right now --

Q I want to just focus --

A -- as we sit here this morning, is that I have seen in the literature no tangible benefit to this patient population that is sustained over time that warrants incurring the risks associated with the surgeries. I believe there is something involved that we can't get to with a knife. And I feel disingenuous, as a surgeon, to come and say to a patient, I'm going to do this for you, it may make you feel better, but I don't know that it's really going to fix the problem.

Q So -- and when did you first form that opinion?

A It's hard to say, Josh. I think it's

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really an evolution of what I observed while I was in San Francisco, in combination with what I see coming out in the literature, even this very month. It's not included in my declarations, because it's not in existence, but Dr. Schecter did a nice job, as a guest editor in Clinics in Plastics putting together a segment on transgender surgery. And I think it's -- some of the articles are very well done. Very well done. And they talk about some of the complication rates, particularly for phalloplasty, which is the tour de force. It's kind of, to transgender surgery, what the DIP flap is to breast surgery, which I've executed myself and that is -- I couldn't offer DIP surgery to patients with a complication rate known of 40 plus percent, no matter what their background.

Q So, that information isn't being suppressed by the scientific community, is it?

A I don't know. I don't think there was anything suppressed in this month's clinics, but there's sometimes, like the old song says, you don't know what you don't know.

Q So the people -- anyone who reads that journal or any -- or Dr. Schecter himself, you know, is aware of those complication rates?

A I can't speak for Dr. Schecter. I would presume, in his position, that yes, sir, he would be better qualified than me to speak about his practice and what he observes and obviously he's observed and executed quite a bit.

Q So -- so I want to just pinpoint -- I understand you have an opinion now and that opinion's change and evolved, but I want to try to just pinpoint, you know, what was in your head at a specific moment in time. And so, going back to the time that you first formed an opinion regarding these surgeries, is it fair to say that you began with a presumption that the surgeries were not medically appropriate until sufficient evidence is shown to you to show that they are medically appropriate?

A I begin every surgery that way, Josh. Yes. Yes.

Q So --

A To me, to operate in any other way is irresponsible. If I were to be doing experimental surgery, I would stay at an academic center and, instead, I've chosen to be in an underserved relative obscurity.

Q I don't want to talk about your personal

opinion. I want to talk about it being medically appropriate, as a general matter.

A Right. I've got a question, though, what that means, because I -- contrary to where we want to kind of force this argument in a binary direction, you support it or you don't. No matter what I do, I have to look critically at does the evidence support it? If it does, then my thinking is perhaps off.

Q So, when did you first begin to actually review the scientific literature on it?

A Probably when I was in San Francisco. I mean, there wasn't really much literature at the time of my general or plastic surgery training other than sporadic articles, NPRS.

Q So by the time that you agreed to be an expert in this case, approximately how many articles do you think you read?

A Oh, goodness, Josh, I don't know. At least a hundred. At least a hundred articles.

Q And in what publications would those articles have been?

A Predominately NPRS, also urologic journals, and then journals of psychiatry and sex therapy.

Q Do you regularly read journals of psychiatry and sex therapy?

A No, sir. This sounds smart aleck, but given the demands of my practice, I have to really focus on my practice.

Q So why did you decide to read those for this condition?

A Because it's relevant. It's relevant. It's increasing relevant. It wasn't even discussed ten years ago. And that's testimony based on the fact that, as Delgado's noted, we actually need to start fellowships because this is widely unrecognized and this is not a prevalent and well-discussed element of surgical training and this population seems to be growing considerably.

Q But no one has come to you asking for transition-related surgery as part of gender transformation, right?

A No, sir. Just those patients who have come seeking care with their complications. So if I'm going to provide them safe care that's standard of care, based on whatever we can surmise that might be at this point, then I need to be able to read what exists. So, I'm --

Q So, based on that, you've read at least a

hundred articles and journals regarding this surgery, right?

MR. JOHNSON: That was up to the time he was retained in this case?

Q (By Mr. Block) Yes, up until the time you were retained in this case.

A Yes, sir.

Q And you also --

A I haven't had a ticker, but I would -- based on my usual reading habits and patterns, yes, sir, I would surmise that --

Q And you also read journals in psychiatry and sex --

A Articles.

Q You also read articles in psychiatry and sex therapy for this condition, even though that's not something you normally read as part of your practice?

A Correct. If I may, there's always overlap. We don't exist in boxes. Our minds are attached to our bodies and what we do with our bodies are attached to our minds. So perhaps more than any other patient, but -- not perhaps more. This is the only patient population with what is happening in the mind is dictating what we're going

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to do with the body, as it relates to altering normal anatomic structures. Nowhere else in medicine does this happen. I mean, if I came to you and said -- and you're a surgeon -- Josh, my hand is troubling me. I find tremendous, tremendous distress in it. And you look at me and say, Daniel, your hand is okay. What's -- no, no, you don't understand. You may not understand what's going on in my mind, but if I'm asking you to take my hand off, you got to start looking at the overlap between the two. Because that's an otherwise functional organ that's healthy. And the patient's asking you to take it off and put something in its place without evidence of organic disease. That's unprecedented.

Q And is it your understanding that psychiatrists view that situation as the equivalent of someone with gender dysphoria?

A Parallels have been drawn. I can't speak for psychiatrists in the psychiatric profession at large, but parallels have been drawn.

Q By psychiatrists?

A I would have to look and see whether the authors -- the authors and their institutions are listed, but it doesn't say their specific -- if

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they're in a division of psychiatry versus psychology, I don't know.

Q So you can't -- so right now, you can't speak to whether the psychiatric and psychological community views those two situations as equivalent?

A I cannot speak as a psychiatrist, no, sir.

Q If the research for -- regarding surgery for gender transition did show long-term tangible benefits, would your -- would that change your opinion on -- regarding the medical necessity of the surgery?

A What benefits, specifically?

Q In alleviating the gender dysphoria.

A Well, that's -- that's a broad topic, Josh. I mean, I've read some studies where part of alleviating gender dysphoria, the patient questionnaires talk about how you feel about how your gender will smell. I'm not being crude. So, to me, it's -- it's not moral for me to offer somebody a procedure where the end point is the patient is happier with the appearance of the external genitals and how they smell.

Q So, I mean, is there any rubric by which you think research could demonstrate long-term benefits from transition-related surgery?

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A I think one of the key things would be to determine whether this is something that actually decreases a person's risk and the actual execution of suicide. That's an important one.

Q So, suicide is one -- one rubric. So if the research showed that over the long term, having transition-related surgery decreased a transgender person's risk of suicide, would that change your opinion about the medical necessity providing the surgery?

A It would certainly impact it. I think one thing -- this is a much more complex issue than we want to give it credit for. There are real biological questions that are outside the domain of the concept of gender. There are real questions, as I allude to in my declarations, what happens to intestinal mucosa when it's subjected to repetitive insemination or trauma associated with a sex toy over a 20-year period? Those are valid questions that just aren't answered as of yet. What happens in terms of intimal hyperplasia in vascular disease? We're really going against the grain of what the person physically, naturally, their chromosomes are XX or XY. And what we're doing is, as a medical community, is reversing the flow and so we don't

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really know how the body's going to tolerate that yet. It's a very broad spectrum from risk of breast cancer all the way down to psychosocial inorganic disease like suicide risk. I mean, that's something that is not just exclusive to the transgender community, as unfortunately the high profile cases of Anthony Bourdain and Kate Spade have demonstrated recently. I mean, I've carried a friend of mine to the grave in a casket after he shot himself in the head. None of us ever saw that coming. So I think it's going to be a hardened point to really analyze. There's so many -- it's a multifactorial thing. And I think it would really be a challenge to analyze that, but it's certainly something that has to be considered if that's the case.

Q So --

A And I would applaud those surgeons and clinicians who can help those patients in that way.

Q So even if it was proven to reduce someone's risk of surgery -- sorry, even if surgery was proven to reduce someone's risk of suicide, you would still have other concerns --

A Yes, sir.

Q -- besides that?

A Yes, sir.

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Q And based on those other concerns, you would still not support the surgery as being medically necessary?
A Based on what I know today, yes, sir.
Q And if I hear you right, you can't think right now of any study that could be structured to provide you the proof that you would need to indicate that the surgery is medically necessary?
MR. JOHNSON: Existing study or future?
THE WITNESS: Future study.
A Josh, it would take a lot of studies, honestly. We'd have to look -- are we talking cis, male, female? The patient populations and risks with each are going to be different. You know, if you and I start taking estrogens, our risk for DVT based on what we know right now is going to be higher. What is that risk over 25 years? And how can we talk to patients about that? What do we do around the time of surgery? When do we stop those estrogens? Because when we stop them, depending on whether you or I have undergone actual anatomic castration, you know, it's -- it's -- it would require multiple studies looking not just at inorganic disease, like suicide risk, as an end point, but also biologic realities.

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Q In discussing the, you know, some questions about the risks of trauma to -- is it colon tissue that you were talking about? Colon mucosa? Could you say what term you were referring to there?
A Sure. Colonic mucosa is something that is not stratified squamous epithelium, like the vagina is. I mean, this is something that we -- it's just a fact.
Q And so, you expressed concerns about like trauma from like intercourse and insemination --
A Correct.
Q -- with that type of tissue?
A I'm sorry?
Q You expressed concerns about trauma from intercourse and insemination with that type of tissue, is that right?
A Correct.
Q Do those same concerns apply to anal sex?
A Yes.
Q So, do you, you know, have any medical opinions, you know, regarding sexual activity between two men?
A Two men, a man and a woman, whoever is the recipient of anal sex, the rectal vault is not

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biologically and histologically capable of accommodating intercourse as is vaginal tissue, so whether male or female, even potential for disease transmission, the lamina and the basal cellular layer of the vagina is going to be very different than intestinal mucosa. Very different. Intestinal mucosa's much more friable. Much more friable. And the anal complex, the musculature complex, the sphincter of the anus is -- it's designed for exit activity rather than receptive activity.
Q So do you think that anal sex contradicts biological reality?
A Biological reality is you can put a penis or anything in an anus. You can put a finger for examination. You can put a sex toy in the anus or you can put a bottle in the anus or any number of things. Biologically, though, that can be traumatic to the anus and the rectum.
Q Do you think it repudiates nature?
A What is nature? I mean --
Q Well, I'm asking you. You agreed with the statement in CMDA that having altering gender surgically or hormonally repudiates nature. And I'm asking the same question -- I'm asking the same question about anal sex.

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A Nature in the sense of what we observe, physically, in its natural state, not iatrogenically altered, that's irrespective of CMDA's definition, that's how I'm defining the anus, whether it is on a male or female body, its primary function is to control evacuation of excreta. And the mucosa, if we look at it under a microscope, is at risk for trauma compared to vaginal mucosa. And that's something that taking care of homosexual men, or females who engaged in anal receptive sex, as a physician, you need to talk to those patients candidly about that, whatever their preference is, this is something you got to be aware of.
Q Would you use the phrase "repudiates nature" to describe it?
A If we define formulates to function to engage in anal sex seems contrary to the function of the anus.
Q Do you -- do you have any objection to counseling, you know, people who engage in anal sex to use condoms?
A No, sir.
Q Do you have any religious objection to counseling people who engage in vaginal intercourse to use birth control?

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A No, sir.
Q So, do you have any -- do you have any medical views, you know, regarding sexual activity that is not happening for procreative reason?
MR. JOHNSON: Object. Vague and indifferent.
A Can you help me understand better what you want me --
Q (By Mr. Block) Sure. So, if the purpose -- do you believe the purpose of sexual organs is to facilitate reproduction?
A I think that's certainly one part of it.
Q What are other parts of it?
A To facilitate connection between two human beings in an intimate relationship unlike any other.
Q And do you think it's possible -- all right. We can let that go. Marking as Exhibit -- are we on 12?
(Deposition Exhibit 12 marked.)
Q This is the standards of care issued by the World Professional Association of Transgender Health. Have you seen these before?
A Yes, sir.
Q When's the first time you saw them?
A Oh, honestly, I don't know, Josh. It's

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been sometime in the last three years.
Q So, have you read them before responding to the e-mail from Jonathan Imbody?
A I can't say with certainty. I believe so, but I can't say with certainty.
Q Can you say with certainty whether you read them before being retained as an expert in this case?
A Yes.
Q And did you read the whole thing, cover to cover?
A Yes, sir.
Q The whole thing?
A Yes, sir.
Q Did you read -- if you can turn to Page 54, where it has XI and the heading of surgery. Before you agreed to be an expert in this case, you read this whole section in particular?
A Yes, sir.
Q And, you know, is it your understanding that surgeons who provide surgery in accordance with the WPATH standards don't counsel their patients on, you know, the potential harms and complication rates of surgeries?
A I don't know what they counsel them on.

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Q Well, doesn't WPATH tell them what they should counsel them on?
A What WPATH says or any other body says and what people actually do are very different.
Q So my question is: A surgeon who follows the WPATH standards of care, you know, is it your understanding that a surgeon following those standards as they are supposed to be followed does not provide patients with information about side effects and risks and harmful consequences?
A I think they would do that no matter what WPATH says or not. I think if we're going to discuss what WPATH's recommending, I could have this wrong, in terms of the actual cadence of the case in question, but if I understand correctly, when Mr. Bruce sought counsel with his surgeon, his surgeon had already submitted for approval for his procedure without the patient undergoing any prior psychological assessment. I think that occurred in a delayed fashion as opposed to in a manner that I've -- I could be looking at the dates wrong in the case, but the reality of what is recommended and what people do are two different things.
Q I want to focus on what the standards recommend. On the top of Page -- well, you know,

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Page 56 to 57 has a discussion of relationship of surgeons of mental health professionals, hormone-prescribing physicians, if applicable, and patients' informed consent. Do you see that?
A Forgive me, Josh, what page is it?
Q 56.
A And the top?
Q Yeah. I'm looking at the bolded heading.
A Yes, sir, I'm sorry, I was looking at the paragraphs. Okay.
Q Okay. And if you look at the last full paragraph of that section, once a surgeon is satisfied the criteria for specific surgeries have been met, as outlined below, surgical treatment should be considered and preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria; the different surgical techniques available, with referrals to colleagues who provide alternative options, the advantages and disadvantages of each technique, the limitations of a procedure to achieve ideal results. Surgeons

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should provide a full range of before and after photographs of their own patients, including both successful and unsuccessful outcomes, the inherent risks and possible complications of the various techniques. Surgeons should inform patients of their own complication rates with each procedure. And then going to the top of the paragraph on the next page; These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure, ensuring the patients have a realistic expectation of the outcomes, it's important in achieving a result that will alleviate their gender dysphoria. So, do you have any -- is there any information not included here that you think a surgeon should be discussing with a patient before performing transition-related surgery?

A Presumably, the irreversible nature of the surgery and the potential loss of ability to bear children, if that's ever something that, I mean, I've seen patients wax and wane on that idea. I don't see those two items in there and they may be implied, but I don't see them explicitly.

Q Are these -- is the description of the informed consent process that's contained here

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consistent with how the informed consent process works for other types of surgeries?

A Barring those two significant items, yes, sir. That are relevant and germane to this type of surgery, depending upon which -- I mean, if we're talking about forehead remodeling, that's different than hysterectomy, obviously, with that understanding, yes, sir.

Q So I want to turn back to your -- your declaration and I want to go through the sources cited there.

A Yes, sir.

Q So, that's the fourth or fifth to last page. And to the best of your ability, I'd like you to go through the list and tell me which of these sources you had read before agreeing to be an expert in this case.

A I will do this to the best of my ability. No. 1, I have read. No. 2, I have read. No. 3, I have read. I don't think No. 4 that I had read. I don't believe I read that prior. No. 5, I have read. No. 6, I believe I read. No. 7, I had not read. No. 8, I had not read. No. 9, I had not read in detail. I had read the abstract but not the study itself. No. 10, I believe I had read. The

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same as 11.

Q You had read 11?

A Yes, sir. And 12. No. 13 and 14, I have not read. No. 15, I'd only read the abstract. No. 16, the same thing.

Q You had only read the abstract?

A Yes, sir, I believe so. No. 17, I had not read. No. 18, I don't know. I don't know whether I read that. No. 19, I had read. No. 20, I had read. No. 21, I had read before. No. 22, I had not read before. No. 23, I had not read before. No. 24, I had not read the entire article. I read the abstract. No. 25, same thing; only the abstract, not the entire article. No. 26, I had read. No. 27, I had read. 28, I had read. 29 and 30, I had not read. And we're speaking in terms of a time reference from when I was actually retained?

Q Yes.

A No. 31, I had read. No. 32, I had read. No. 33, I had read. No. 34, I believe I had read that, actually, when I was in San Francisco. I had read that previously. No. 35, I had not read. And No. 36, I had not read. And No. 37, I had read.

Q So, it's fair to say that the materials on this list that you had not read at the time that you

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agreed to be an expert didn't play any role in your views regarding the medical necessity of transition-related surgery at that time? So finding what was in your head when you had an opinion regarding transition-related surgery, when you agreed to be an expert -- let me try to rephrase that one more time. Okay? Trying to find the foundation of your opinion at the moment in time when you agreed to be an expert. So, just logically, material that you had not yet read --

A Correct.

Q -- could not have formed the basis of your opinion?

A Yes, sir.

Q Could you say the answer again just for the --

A Yes, sir.

Q Okay. All right. So, in the course of performing research in your capacity as an expert for this case, you had already formed an opinion and you then conducted research to find further support for that opinion, is that right?

A I just conduct research to verify whether my concern is valid or not. Some of these things, actually, as testimony to the continuing evolution

of this topic, only emerged after -- and even this month, July's Clinics in Plastic Surgery, guest edited by Dr. Schecter, those things have only emerged after this deposition begun. And some of those things are not contradictory to my concerns. Dr. Bill Kuzon, the director of the transgender program at Michigan, expressed the same concern that I have. And that is, as he said, and is quoted in Plastic Surgery News, this is the only surgery that I operate on someone for which I really have no diagnosis. And he cautions and, rightly so, that we dare not offer this surgery to anyone without a formal perioperative psychiatric or psychological assessment.

Q Which is what the WPATH standards require, isn't that right?

A That's what they state, correct. But even with that requisite, he still, very candidly, notes that this really -- in my practice, which is vast and varied, to be sure, this is the only patient population that I operate on. And some surgeons are going to be comfortable with that and some are not.

MR. JOHNSON: For the record, that's his statement or yours?

THE WITNESS: That's his statement.

Q (By Mr. Block) He said that some surgeons will be comfortable with it and other surgeons won't?

A No, that's my statement. My apologies.

Q And so -- and, yet, this doctor in Michigan does not draw the conclusion that these surgeries are therefore not medically necessary and should not be covered by insurance, isn't that right?

A I don't know what his conclusion is about the medical necessity or the insurance part of it. He obviously has no objection, personally, to executing a surgery for a patient when he doesn't have a diagnosis, based on -- based on his statement.

Q He does or he does not have an objection to providing surgery without a diagnosis?

A He does not appear to have an objection to that based on the fact that he does perform -- and I would say Dr. Schecter may know Dr. Kuzon personally and the quality of his technique, but I can't imagine, at Michigan, that he could chair and lead a department if he were not a skillful surgeon.

Q When you were conducting research in your capacity as an expert, did you affirmatively search

for literature that demonstrated benefit for transgender people who had had surgery?

A Yes, sir.

Q So you affirmatively sought to find the literature that gave the strongest support in favor of surgery?

A Yes, sir. I mean, please understand, whatever perceptions may be, I don't have an agenda, I want to help these people. And if I can find something that supports helping them with surgery, and like I said earlier, in a sustained tangibly demonstrable way, well, then I need to call CMDA and say, Hey, we can help these people. Let's take a look at this. CMDA hasn't retained me, but to the point that I was questioned earlier about their statements which, again, I had not seen this until today, that's our job as surgeons and physicians; is to be fact finders. Let the facts fall where they may. We have to do what's best for our patient and be confident in our mind and that's to your point earlier, Josh, surgeons may arrive at different conclusions based on the same data or experience.

Q So, I just want to talk about the research you did in your capacity as an expert. And I want to know whether, in your capacity as an expert,

you -- like, did you view your role there as doing a comprehensive review of the literature and finding the strongest evidence that supported surgery or -- well, I'll let it at that. Did you view that as what your role is?

A I don't know that my review is comprehensive, but I certainly tried, yes, sir. And the thing that I could find was subjective sensation of improvement. And which, as some of these resources that I cite note, there's really no good scale specific for trans patients. And that's a problem right now in terms of being able to qualify the data, is what is our measurement. Are we using centimeters? Are we using English? What are we even using? None of us even know at this point.

Q But your view of the data indicates that it does report a subjective sensation of improvement, isn't that right?

A Many studies do, yes, sir.

Q Now, what have you --

A I define no difference, though, in the 2016 CMS review that said, really, the quality of data overall is low. And that's why we're leaving this open for interpretation, is because we really can't find any great data that supports this

surgery, which is really unique and unprecedented in other fields.

Q So what's your understanding of how the success of other psychological treatments for psychological conditions is measured?

A Boy, Josh, that's a -- that's a pretty broad question and, not being a psychiatrist, I can't really comment on it. All I can comment is, within my discipline, where what I'm offering somebody that bears considerable risk and, from my world of microsurgery, that procedures we're talking about do, then I really need to see strong data that that would help a person. I can't speak to the psychiatric element of it.

Q Okay. So, you can speak to how measuring outcomes for surgery for gender dysphoria compares to how outcomes are measured for other types of surgeries, but you can't speak to how those measures of outcomes compare to measurements of outcomes for other conditions in the field of psychiatry, is that right?

MR. BLOCK: Can you read that back?

(The requested portion of the record read back.)

MR. BLOCK: I'll just reword it. Thank you for reading it back and demonstrating how bad

it was.

Q (By Mr. Block) So, you know, you have no basis for opining on how the field of psychiatry measures outcomes for treatment of psychiatric conditions, is that right?

A Any more than my medical background. I would not consider myself expert in that.

Q And gender dysphoria is a psychiatric condition, is that right?

A Gender dysphoria is, if it is a psychiatric condition, then it is -- I think that goes back to the definition of which playing field are we on? Because, if it's a psychiatric condition, we're referring to people in the true sense as male or female and even in the medical record, but we've even removed the term "disorder" and listed it as simply "dysphoria." And I think that's a disservice, because the experience that I have with these patients, they do not -- it's not just simply a sense of intense unease. There's true distress.

Q So, just to clarify, you don't know whether gender dysphoria is a psychiatric condition?

A I believe it is. And that's why I have grave reservation about offering surgery for it.

Q But when it comes to treating psychiatric conditions --

A Correct.

Q -- you don't have any knowledge of whether the efficacy of those treatments are measured on the basis of a subjective sense of improvement, do you?

A I don't follow the psychiatric literature otherwise. And I don't know of any other realm within psychiatry where psychiatric disorders have any overlap in their treatment with surgical conditions.

Q So, understanding that, unlike many other psychological psychiatric treatments, this treatment is provided through surgery, I want to just focus on how the field of psychiatry measures outcomes and improvements. And you have no basis for offering an opinion on whether the measurements being used for gender dysphoria differ than the measurements being used to judge improvement for other psychiatric conditions?

A I'd have to see what conditions we're talking about to determine whether I consider that a valid measurement or not.

Q All right. So, sitting here today, you have no basis to offer an opinion on that?

A I won't speculate on speculation. I would have to see objective evidence or fact or preexisting, well-defined psychiatric disorder and how that's measured and what we're talking about before I could be able to comment specifically.

Q Okay. So, the -- so, the testimony that you have provided, you know, is not testimony that opines on whether the proof being offered for the efficacy of treating gender dysphoria with surgery is any better or worse than the proof being offered for how other psychiatric conditions are treated?

A Can you say that one more time?

Q Yeah. So, you expressed concern that there's -- there's no tangible result that you can see with your own hands to measure whether gender dysphoria is treated through surgery, is that right?

A I expressed concern that there is no well-documented well adhered to by WPATH or any other organization, to my knowledge, standard by which we, as a medical community, are measuring these patients.

Q Okay.

A That's my --

Q I want to focus on, you know, one component of the opinion, which is that the

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improvement is being measured by subjective descriptions of improvement from the patients, is that right?

A I think, Josh, if we're going to measure subjective descriptions, we have to be able to tie them to benefit, real benefit, to a patient. I mean, you can come in and see me with a raging abscess in your axilla, your armpit, that hurts badly. And I can give you a steroid shot and you can subjectively walk out and feel better, but I haven't fixed the problem. And so, you can report on a patient outcome questionnaire and you can get online and go on and say, Dr. Sutphin is the bee's knees. I went in, I feel better, I'm better, but I don't -- I repeat, again, I don't know of any well ascribed to standard by which we are measuring these patients over a time, subjectively or otherwise.

Q How do you think -- when someone is treated for depression, how do you think improvement is measured by the psychiatric community?

A I would defer to the psychiatrists to -- I don't know what the standard of care is for subjective measurement in that regard. I don't know that.

Q For all you know, it could be exactly the

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same as the standard for gender dysphoria?

A I don't believe that to be the case, based on the subjective measures that I answered in the literature that I've read, but it could be.

Q So when you talk about comparing risks for rewards and benefits, since you're not a psychiatrist, how can you quantify the value of having improvements to the patient's mental health and subjective sense of well-being, after undergoing SRS? Who can you value that when comparing the benefits with the risks?

A By observation. I have to form, as is every surgeon, an opinion. And we're talking one thing and saying another. We're saying that these patients are not impaired but yet they are. So this is a person who comes with a condition that is distressing to the point that they want, in many cases, an otherwise normal healthy part of their body removed, amputated, or they need castration, seek castration, I guess we have to define, first is that well? Is that a well state? Because before I could begin to qualify whether I think the risks of complications are justified, we have to first come to an agreement is that well or not.

Q As someone who is not a psychiatrist, do

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you have a basis for making that determination?

A I can make my own determinations independently, but even the APA, there was disagreement about that in 2012 when they shifted their position from disorder to dysphoria. It's a valid question. Because if somebody has a true disorder, that's a different thing than dysphoria. Dysphoria is a normal part of the human experience, as we discussed earlier. I mean, that's part of our life's experience. If we can still follow the common English definitions of disorder and dysphoria as Merriam Webster defines them.

Q You said depression is also part of the normal human condition in life experiences, isn't that right?

A Correct.

Q And, yet, the psychiatric community has treatments for depression, isn't that right?

A I believe, yes, sir.

Q And --

A How efficacious those are are open to speculation.

Q How efficacious the treatments for depression are are open to speculation?

A Yes, sir. And, again, the psychiatrists

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would be better qualified to comment on that.

Q Is alleviating mental distress a valid goal of treatment, in your view?

A Absolutely.

Q So, if the evidence showed that surgery for gender dysphoria was successful in alleviating a patient's mental distress, why isn't that a sufficient benefit to justify the surgery?

A Well, like we were talking earlier, what is the cost? I'm not talking financially, either. I'm speaking physiologically, what is the cost to the patient?

Q Right. Well, is the cost -- do you think the benefit of alleviating mental distress can ever be a sufficient benefit to outweigh the cost in providing a surgery for any condition?

A Potentially, yes.

Q Like what?

A I can't think of any other off the top of my head. I don't know of any other condition where we would operate to alleviate distress.

Q So sitting here, it seems that you're very knowledgeable about, you know, how the physical costs and benefits of a surgery operate, but you don't have a significant knowledge base on how to

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measure the psychiatric benefits of the surgery, is that a fair statement?

A Which surgery we speaking of?

Q About SRS. You don't have a knowledge base that allows you to -- to --

A That's part of my concern. And it may be that my knowledge base is deficient, but based on what I can gather, and the evidence right now of some of my colleagues at tertiary centers like Dr. Hazen are that we don't have any good measures of this right now. We've got to do a better job of forming measurements for subjective success. We don't even have any measures on how to counsel patients. Let's say a female patient comes to me and says, Well, I've done due diligence. I've honored the WPATH guidelines. I've been through the process. I've been on hormone therapy. I've lived in a separate role for a year. I've done these things and now I'd like metoidioplasty or phalloplasty. Dr. Hazen points out, Well, you know what? We don't even really have good data about how to cancel those. And that is just one very specific segment of this patient population. Very specific.

Q Is it possible that the amount of data we have is, nevertheless, the same as the amount of

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data we have for treating other psychiatric conditions?

A I don't know about other psychiatric conditions, Josh. I've had to focus within the realm of my -- those things touch. When I see patients who come to me for various issues, I can't exclude that inorganic element of their existence nor do I seek to in this case.

Q So a psychiatrist with experience treating gender dysphoria would be better qualified than you to weigh the mental health benefits of SRS? Would that be a fair statement?

A Their opinion would be important, so long -- unless the psychiatrist wants to pick up the knife and incur the responsibility for the complications. It's a team approach.

Q Yeah, I'm discussing --

A But I'm not operating in a vacuum. That's, in essence, what I think is a danger and, yes, as we brought these to the table, as these state, we still have an obligation to speak about complications, but we don't operate in vacuums. We have to be able to form an opinion about whether we're doing, irrespective of what anybody else -- I mean, a referring physician may send me a patient,

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as happened not that long ago, who they believe was an absolutely great candidate for an immediate breast reconstruction. The patient was -- had some factors in their profile that, to my mind's eye, made them not a good candidate and the patient was not happy about it. She said, Can I get this somewhere else? You may well and I'd be happy to provide you a second opinion and referral, if you'd like. The patient returned after having a mastectomy and unfortunately experienced some problems. And said, You know, thank you for being straight up with me.

Q Do you know if insurance covered the mastectomy that she had?

A Yes, she had breast cancer.

Q Going back to my previous question, the question isn't whether surgery should be performed. I'm focusing on assessing the mental health benefit side of the scale. And my question is whether a psychiatrist with experience treating gender dysphoria would be better equipped than you to weigh the mental health benefits of the procedure.

A May I ask a question? And this is sincere. Are we speaking about me in a personal sense or me as a surgeon? Is this individual

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specific?

Q Individual specific.

A Depends on the psychiatrist. I would have to form my opinion about who that individual is and what their qualifications and what the testimony of their practice is.

Q So if a clinician has worked with hundreds of patients who were suicidal before having surgery and then, after having surgery, reported no longer being suicidal and having their severe distress be resolved, is that relevant information to consider in determining whether or not the surgeries are valid medical treatments?

A Yes, sir.

Q And have you had any firsthand, you know, interactions with patients who were in the midst of being gender dysphoric?

A Yes, I have.

Q What interactions?

A Perioperative assessment for candidacy for mastectomy, actually.

Q I thought that you hadn't played any role in treating patients, you know --

A I didn't perform her surgery.

Q Okay. So what did you do?

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A I just assessed the patient. She was in the clinic and presented to talk about the complications of mastectomy. I was serving as a fellow staffing a clinic for residents. So I come in with the resident and I talk to her, just as I would any other woman, about what the risks of mastectomy are. I can't say what guidelines she had been through or followed at that point. It was a county hospital facility serving an indigent population, so I couldn't tell you that any more than the case in question, that she had gone through a thorough vetting such as this, but I was off the service. I don't know whether she ever had her surgery. It was a consultation and I felt like we had a good exchange. But yes, sir.

Q How many other consultations have you provided over the course of your career with gender dysphoria?

A No more than 25. I don't know a specific number, Josh, but it's no more than 25.

Q Would you think that a clinician trained in psychiatry would be better equipped than you to measure whether someone's psychiatric distress was resolved or alleviated through surgery?

A Perhaps. It's possible. It's possible.

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May I ask it on the basis of specialty or numbers of experiences?

Q Well, both. Or either. How about on the basis of specialty?

A Possibly.

Q And how about on the basis of numbers?

A Possibly as well.

Q And someone who had the training and the numbers has an even greater possibility of being better equipped to measure?

A I think there's value to both.

(Break Taken.)

Q Let's go to your -- we're back on the record. Let's go to your declaration or your report again. So if you can turn to Paragraph 22.

A Yes, sir.

Q You say, Point of regret in vacillation regarding the surgical outcome of sex reassignment surgery, as expressed by patients who have undergone such surgery, has also even been described in media outlets, such as Newsweek, the BBC, and LGBTQnation.com and then for citations, you cite, in your references, to 13, 14, and 35.

A Yes, sir.

Q If we look to Reference 13 and 14, I want to get them marked as exhibits.

(Deposition Exhibits 13 and 14 marked.)

Q So having marked as 13 the Newsweek website and marked as 14 the BBC website, could you take a quick look and confirm that those are stories you were citing to?

A Yes, sir. Okay. So that's the BBC, yes, sir, I think that's the article that I read. Yes, sir. These are the articles.

Q So, how did you come across these articles?

A Just Googling.

Q Just Googling?

A Yes, sir. And to your point earlier, Josh, I mean, really trying to look at this, the internet is not a source of Christian thought by default in any way, form, or fashion. And so, to candidly assess this, I need to look at everything and that's, quite honestly, I mean, like I cite here, these news sources are not in any way, form, or fashion Christian affiliated. And so to really look at this from a candid perspective of those who may have gone through this, what actually happens, this is something that's pretty quiet and it's -- yes, those are the sites.

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Q What Google terms did you use?

A I honestly don't recall.

Q For the BBC article, you know, it's dated August 1st, 2007. Isn't that right?

A I'd have to check. Yes, sir.

Q And if you look at this Newsweek article, if you turn to the second page.

A Yes, sir.

Q It's repeating quotes that were given to a British publication called The Telegraph, isn't that right?

A The quotes by Dr. Djordjevic?

Q Yeah.

A It appears to be what they cite, yes, sir.

Q And then it sites to a BBC documentary on the next page?

A Okay.

Q So -- and both articles discuss that documentary and a person named Charles Kane, is that right?

A He appears in both, that's correct.

Q So it doesn't seem to me to be a representative sample of what, you know, you would find on Google in America in 2018, Googling about the condition, so I'm wondering if there's any

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other, you know, qualifier or search term that led you to, you know, these articles in particular.

A The only term I can think of is regret; is there any regret? That's a valid question. If we're changing a person's body irreversibly, any candid mind is going to say, well, how many people actually regret this?

Q Did you read the published peer-reviewed literature on rates of regret?

A Yes, sir.

Q Why didn't you cite to that in your report?

A The rate of regret, actually, is relatively low. And that goes all the way back to Dr. Meyer's study, which Dr. Schecter, I noticed, said is outdated. That study, back in 1979, actually commented on that. They really didn't find that much regret amongst their patients. My purpose was not to -- my purpose was to find out is there regret, not necessarily that it's a small proportion. I just want to read the experience of those who may have had regret, because they should have a voice. Now, they may be a very small proportion, very small proportion, but one of the severe limitations of this population is the

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followup. I don't want to state things that you already know. But followup is an issue. And when you have occasions like that, such as Bath Spa University, where we won't even allow a study to be conducted to look at those patients who express regret and go through with reversal of the surgery, it's difficult to reference well-defined literature because it's not even being given an opportunity to be formed in academia.

Q But there is literature, aside from this incident in the UK, there is published literature on regret, right?

A There's literature that looks, to my knowledge, at regret as an incidence and it is generally low.

Q Wouldn't that be something to acknowledge if the report was designed to have a evenhanded assessment of the medical necessity of the care?

A Not in the sense of looking at complications of it.

Q Well, your report has a paragraph talking about regret.

A Correct.

Q And it would seem to me that a more reliable source to cite regarding rates of regret

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would be the published peer-reviewed medical literature instead of like articles found on Google.

A Oh, I agree. The problem, again, is the lack of literature on this patient population. I can tell you in this month's Plastics it appears to me that one section entitled penile prosthesis has been lifted from a transgender web page that was first put up in 2013. And that's in a medical -- that's supposed to be the so-called gold standard of literature by which we're basing -- now, it may be good information. I don't think that it comes from the internet, ergo, it's patently wrong or invalid is a legitimate statement, but --

Q But wouldn't it be relevant in your report to have acknowledged the rates of regret are reported to be low?

A I don't know that it would be. This -- what happens -- it's immaterial if the rate of regret is low. For those who do have regret, what do we then do? And do they exist? If we're talking about a minority population and we're looking critically at the whole gamut of the population, I think it's a valid question.

Q But, your report is designed to talk about, you know, the medical necessity of providing

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this care in general and to the extent that regret is talked about at all, it seems to me to be a relevant fact when formulating, you know, policies about whether procedure should or should not be covered to acknowledge the rate of regret is low. Do you disagree with that?

A If there's long-term followup data and there's not, in many cases.

Q So you don't think that those studies should even be, you know, cited to or in your report?

A I would be happy to cite any study that anyone wants to produce that cites that. Part of the job of a surgeon, Josh, is to look critically at the whole spectrum. And if we're going to talk about why we shouldn't do a surgery, well, what are the valid concerns? I don't, in any way, state or imply that that's a large patient population. I just say that these are -- this does happen. This does occur. How often, I don't know. And one -- I think one of the articles actually states that very clearly. It comes of something as a surprise to learn the medical profession does not yet know the answer to this question.

MR. JOHNSON: For the record, reading from

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Exhibit 13 --
A My apologies. I'm actually reading, I think -- yes, if these are both considered Exhibit 13, this is the BBC article, Exhibit 14, my apologies.
Q (By Mr. Block) Is the fact that some people regret the procedure a reason to deny the procedure to everyone when the majority of people don't regret it?
A No, no, Josh. The thing, though, is that person's a real human being. Now, what do we do for them? And to be a competent surgeon, we, as surgeons, have to deal with this frequently. Other colleagues that might delve into areas of treatment that they really don't know how to manage the complications for. So any -- any competent and ethical, I would argue, surgeon is going to look at, okay, what happens if and when things don't go like we'd hoped, either physically or psychiatrically? What happens when these people -- we don't even have the answer of questions of how do we determine whether this is a valid -- if the patient wants to go detransition, what do we then do? How do we assess them? There's no literature in the psychiatry world that I'm aware of that states

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here's how we take these people through this protocol.
Q Isn't that exactly what, you know, the article by Dr. Jvorvicich is describing, is about?
A Where are you reading?
Q Sorry. On --
A No, he's just observing the fact that, hey, I'm seeing people who are coming back and they can't get this anywhere else. And just FYI, this is happening. Let's talk about this kind of thing.
Q And he suggests, you know, areas for study for indicating what is -- what's more likely to lead to regret, doesn't he?
A Yes, he makes -- he basically raises the flag and says, hey, we need to look at this. And this points, again, to my concern and my objection is that to call this -- to speak about this like it's well studied and to liken it to something like an appendectomy is not really a valid -- there's still many, many areas of this realm of care that not just in surgery, but other elements of care that just don't seem to be thought out to this point or defined to this point. Not that they shouldn't be. I would argue they should be. But at this juncture and this statement I am saying this is not a panacea

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for everyone. It may work for many people but regret does exist.
Q And do you think that the WPATH standards of care say it's a panacea for everyone?
A Immaterial what they say. I respect the WPATH, but I still have to function independently.
Q But you're rebutting this idea that it's a panacea for everyone. And I'm asking whether the proposal to provide coverage in accordance with the WPATH standards of care means that it's a panacea for everyone.
A I don't see anything in this document that says it's a panacea nor do I see anything in this document that says here's what we do when we find a patient, here's what options we give our patients if they express regret. I may have missed that, Josh, but they don't exist.
Q This seems like an issue that you're concerned about that isn't particularly germane to the question of whether or not providing care to patients who are diagnosed with gender dysphoria and meet the WPATH standards of care should be provided that surgery. It seems you're answering a separate question about what should happen to a separate group of patients who, you know, regret surgery.

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A Well, there's no way for us to have a crystal ball to know, Josh. And when part of my job, as a surgeon, when somebody comes to me about any surgery, is to know to the best of my ability every potential scenario and what happens in the unlikely event that you develop a DVT, thank God that's a low complication with XYZ surgery, what happens, Dr. Sutphin, if that occurs? What happens if I get a seroma? And what if I just have a breast reduction surgery and I regret it?
Q Is that a reason, though, the fact that a small percentage of people regret a surgery, is that a reason to deny providing the surgery to everyone else?
A I don't think that I posit it as such.
Q So does that mean no?
A No, no, it's just something that needs to be acknowledged, I think. And I, in no way intention, form or fashion, I don't believe I indicate that in that statement. I just raise the issue that this does exist because I haven't seen it in the complaint.
Q Do you have any reason to quarrel with the regret statistics that were cited in Dr. Schecter's rebuttal report?

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A Do you all have a copy of that with you before I say yes or no? May I just review, please?

Q Yeah, sure. Well, let's mark it Exhibit 15; the rebuttal report of Dr. Schecter.

(Deposition Exhibit 15 marked.)

Q I believe his -- on Page 7 at the bottom, he doesn't have the numbers, but in the last sentence of that paragraph he says, All available research indicates that reports of regret are extremely low when gender confirming surgery is provided in accordance with the WPATH standards. Do you have any reason to dispute that?

A I haven't read -- it appears he cites the Amsterdam cohort of gender dysphoria. And that's a report, not plural reports, so I would have to read the report, but I would --

Q You haven't read anything to indicate that regrets for people provided surgery in accordance with the WPATH standards are not extremely low?

A No, sir. No, sir.

Q And, you know, at the time that you wrote your report, did you have any understanding of whether or not the patients discussed in the Dr. Djordjevic article had been prescribed surgery in accordance with the WPATH standards?

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A Josh, looking -- I don't know Dr. Djordjevic, his -- but I know, based on his presence and the scope of his practice, I would presume that he is a competent and technically safe surgeon and to the same principles that we've been talking about, he's not just going to operate on anyone. Now, the WPATH standards are a body constantly in evolution, so as the study Dr. Schecter alludes to, the vast majority of that study was conducted, a significant component, based on the dates, 1975 through -- 1972, excuse me, through 2015, I haven't been able to read and see what is their followup rate. Did they get a catchment of 50 percent of patients? Did even half the people follow up? That's another problem in reviewing this patient population; whether that followup was due to suicide. Conversely, they could have been so thrilled with their result they never came back again. It's hard to know.

Q I'm just talking about the Dr. Djordjevic study, is it your understanding he was the one that performed the original surgeries for these patients?

A No, sir.

Q So the fact that he's a competent surgeon in performing surgery doesn't mean the patients

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discussing the study who regretted their surgeries necessarily had their surgeries performed by a competent surgeon in accordance with the WPATH standards?

A Correct. Absolutely. I would have to look at that paper again, Josh, to remember specifically whether all of those patients had been -- I think they came from geographically diverse areas in Europe. I don't remember if there was an American in that study or not. But you're absolutely right. It's impossible to say whether those surgeons were operating in accordance with the standards now ascribed by WPATH or whether those were even competent surgeons. It's difficult to say given the nature of their surgeries. Most surgeons will not, I don't believe, undertake a so-called bottom surgery without having had some technical training and knowhow. But that's speculation.

Q So, this article by Dr. Djordjevic has nothing to say, one way or another, about rates of regret among people who have had surgery in accordance with the WPATH standards, is that right?

A No, no. I don't think that was the intent of his article. And certainly not -- not the intent of my -- you know, like I tell patients that I see,

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if the complication rate of flat necrosis is one percent and I operate 100 people, it doesn't matter to those -- that patient what happened with the other 99. They've had a complication. And it matters profoundly to them. And I need to know, as a surgeon, how do I safely take them through that process? Both the clinical and psychiatric element of disappointment, discouragement, depression, how do I help that patient through? And am I qualified to do so by myself or do I need additional help to do so?

Q And those concerns apply to all sorts of surgery, is that right?

A Yes, sir.

Q Those concerns aren't unique to surgery for gender dysphoria?

A No, sir.

MR. JOHNSON: Going to another area or can we take a break for lunch?

MR. BLOCK: Just want to ask a few questions about the things cited in the --

MR. JOHNSON: Sure.

Q (By Mr. Block) So, in Paragraph 25 of your report, you reference a Dr. Charles Ihlenfeld, is that right?

A Yes, sir.
Q Okay. How did you become aware of Dr. Charles Ihlenfeld?
A I don't know. I presume through Googling and researching. Dr. Benjamin's life was very fascinating to me, Harry Benjamin, and I think that's honestly how I first -- I thought, I wonder whatever happened to that guy? You know,because when you start off a practice and you're kind of paired up with somebody, it's interesting that he started, if I remember it, Ihlenfeld began either in endocrinology or internal medicine, and I can't remember which, and then decided to go into psychiatry. And that kind of resonated with me. What would make you abandon your primary specialty in a quest to figure something out that you're willing to go through the struggle of a whole new training process? Why would you do that? I think that's, you know, the best of my recollection how I first came across Dr. Ihlenfeld.
Q Did you read any articles by Walt Heyer?
A I've read articles by Heyer, yes.
Q Is there any chance that is how you came across Dr. Ihlenfeld?
A There's a chance but my -- before ever --

to my recollection, I actually came across Mr. Heyer subsequent to reading about Benjamin.
Q How did you come across Dr. Heyer? I mean, how did you come across Walt Heyer?
A He came up in the regrets Google search, which, obviously, he expresses considerable regret.
Q So you read his posts on the public discourse website, is that right?
A I don't know. I've read some of his posts, but in an effort to -- given his -- given his experience, and if I understand correctly, he's a Christian, given his experience, I felt it better just to try and look, is there anybody outside -- obviously Heyer feels very strongly. Is there anybody who is not in any way, form, or fashion expressing some of the sentiments that Heyer does, as it relates to his concept of his personal faith, is there anybody else who expresses any concern?
Q Is the fact that he, Dr. Ihlenfeld, married a same sex partner, is that information that you learned through Walt Heyer's writings?
A No, it is not.
Q How did you learn that information?
A It was actually a self-described blog, I believe, or it was a alumni type affair that I don't

remember what institution he graduated from, but there was an announcement that he had married whoever the gentleman, Mr. Packard, in 2008.
Q So you found that just independently Googling Dr. Ihlenfeld, right?
A Yes, sir. And to my recollection, Josh, it's a self-entered caption that, you know,if we go on a Yale or UT site, we can say, Josh Block XYZ, Daniel Sutphin XYZ. I think it was of his own accord based on the presentation of it.
Q But do you generally look at the alumni listings of doctors' publications or doctors who publish?
A Sure. Absolutely. I want to know where they came from, what are their credentials, where do they train? That's extremely important to me. I mean, there's value to me. It's, you know, it's a privilege to speak with a guy who trained at Yale Law School, you know, that's an accomplishment. So, that's -- you know, I take that very seriously.
Q At the last sentence of the paragraph, you say, Despite his caution regarding the limitations of sex reassignment surgery, it's understood that Dr. Ihlenfeld does not harbor, quote, sex stereotypes, discomfort with gender non-conformity,

and moral disapproval of people who are transgender, close quote. And are you saying the reason why he doesn't is because he is married to a same sex partner?
A That's why I said "presumably" and "based on his practice" and the fact that he began his practice with Dr. Benjamin and cared for these patients far more than I have in terms of sheer numbers. That's why I cite that.
Q But you agree that the fact that someone is gay doesn't necessarily mean that they might not possess discomfort or moral disapproval with transgender people, right?
A Sex stereotypes, discomfort with gender non-conformity. Dr. Ihlenfeld, at the time he married Bill Packard, was engaging in a gender non-conforming relationship. So he's, in one sense, very courageous, and based on the testimony of his professional life, has no moral disapproval. These are all the reasons that people like me are disqualified, by virtue of my Christian faith, is that, well, Daniel can't care about these people and the only reason he won't take care of them is because he's a backwards bigoted so-and-so, rather than, actually, he's really looking critically at

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the data and trying to determine what's really going on to help these people. It would be very easy to say, sure, let's move forward with the surgery rather than -- rather than taking the time to sit down and work through and do we even have a safe environment to sit down and work through; how did you arrive at this point?

Q To your knowledge, has Dr. Ihlenfeld worked with this population since the early 1980s?

A That I don't know.

Q And is it possible that someone whose experience is based on the state of the art as of the early 1980s might have a view that differs from someone whose experience is based on the state of the art as of today?

A Sure. Absolutely. I think, though, what Dr. Ihlenfeld observed is just what I recorded. It's very true. And it resonates with me professionally. Whatever we're doing for these people surgically, we can build a penis on you and we can cut the penis off and make a neo-vagina that, for all intents and purposes, would fool anyone externally, but the core of it, there's something there that is difficult to define. It really is. And I don't know that we're doing a good service to

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people by just saying we now created a structure, move through the structure, and there.

Q So what do you think should be provided to people who are experiencing distress from gender dysphoria?

A I don't know. I think it begins with a psychiatric assessment.

Q And so the answer to the question is something that is in the realm of psychiatry, is that right?

A It begins "in the realm of."

Q And so, when you say you don't know, why don't you know?

A I don't know that anyone does who's candid.

Q Is there any form of treatment for people with gender dysphoria that you think is medically justified?

A I think that psychiatric consideration and counseling is a starting point. And based on the available data that we have, surgically speaking, I conclude the same thing that I stated earlier. Aside from my own personal faith, I don't see that the risk associated with the surgery justifies the benefit. I don't think we've qualified the benefit

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well yet and I don't think that we've been able to describe how sustained is that benefit, whether it's an inorganic benefit or whether it's any other form of benefit.

Q Do you think that someone who's transgender could, with the benefit of therapy, stop being transgender or have their gender identity aligned with the sex assigned to them at birth?

A Possibly.

Q On what basis do you believe that's a possibility?

A Based on the description of -- I mean, somebody even like Walter Heyer, obviously his -- we could discredit him based on his faith. But he is an individual who has made a number of transitions. I don't know of anybody in the public sphere who's been through more than he has. I could be wrong in that.

Q Do you think that insurance should cover therapy designed to help a transgender person align their gender identity with the sex assigned to them at birth?

MR. JOHNSON: Object to lack of foundation.

Q (By Mr. Block) You can answer.

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A I decline.

Q Well, no, no --

MR. JOHNSON: I object. I'm lodging an objection for the court to rule on, but unless I say you don't answer, you have to answer.

THE WITNESS: All right.

Q (By Mr. Block) So, do you think that insurance should cover psychological therapy designed to help a transgender person align their gender identity with the sex assigned to them at birth?

A If I may, I want to be very clear, I think the declaration that sex assignment, as it's being used in these guidelines, is a total farce.

Q All right. So let's take out the issue of the terminology of sex assigned at birth. Do you think insurance should cover therapy designed to help a transgender person have their gender identity match up with their biological sex?

MR. JOHNSON: Same objection.

A I don't see any reason why there's not a valid reason for that.

Q (By Mr. Block) So you think there's adequate level of proof at this time for that to be covered as a medically necessary service?

MR. JOHNSON: Same objection. Lack of foundation.

A No, sir. I'd just say that I don't see any reason why there's not.

Q (By Mr. Block) Are you aware of --

A Unlike the surgery, I can see that there's a high complication rate, ergo, I say, until we have better data, I don't see a valid reason for us to supporting this surgically. I don't know of any complications, from sitting down and talking with somebody, about how did you arrive at this, I mean, and the patients that I've had the privilege of doing so with, who have been candid about such, just to listen to them, not because I have any agenda, I just want to know, How do you arrive at this point in your life? Tell me about your life. I'm genuinely interested.

Q (By Mr. Block) I just want to get, for the record, a clear answer to the question. You don't see any reason why insurance should not cover it, is that right?

MR. JOHNSON: Same objection.

Q (By Mr. Block) You don't see any reason why insurance should not cover psychological therapy designed to help a transgender person align their

gender identity with their biological sex?

MR. JOHNSON: Same objection.

A I don't. I think that's -- I don't know of any risk associated with that.

Q (By Mr. Block) Are you -- have you read any of the literature on -- on the psychological harms from conversion therapy?

A No, sir. I'd certainly be -- whatever literature would like to be put forth, I'd be happy to read through it and suggest whether I think it's valid or not.

Q And are you aware if there's any literature demonstrating the efficacy of treatment designed to help the transgender person align their gender identity with their biological sex?

A I am not. That's exactly why I said I don't see any reason why there's not a reason for it. I'm not aware of any reason there's not.

Q Do you think that insurance should cover psychological therapy designed to help a transgender person live consistently with their gender identity without any medical interventions?

MR. JOHNSON: Same objection.

A One more time.

Q (By Mr. Block) So, do you think there's

any reason why insurance should not cover gender-affirming psychological therapy that helps someone socially transition?

A I don't know. I don't have enough experience with that element of non-operative -- the non-operative patient population to know. I don't know. I don't see, necessarily, any reason why there's not. The only thing that I don't know is what is the risk for that patient population if they remain in that role that is not aligned with their biological sex. I don't know that. In terms of domestic violence, et cetera, the other variables that have been variously talked about, I don't know. I don't know that anyone does right now well.

Q Well, is your -- is your level of confidence on gender-affirming psychological therapy equal to your level of confidence in providing psychological therapy to align someone's gender identity with their biological sex?

A One more time.

Q We have two types of psychological therapy and we're talking about do you think that either of them should be considered, you know, medically necessary treatment covered by insurance. And Jerry objects to --

MR. JOHNSON: Can I just have a standing objection any time you ask what he feels should be covered by insurance? Lack of foundation objection.

MR. BLOCK: Okay. Perfect.

Q (By Mr. Block) So -- and so, and my question is: Do you -- are your feelings or is your medical view about the necessity of those two types of therapies the same or do you think that one of those therapies has a firmer foundation of being medically necessary than the other?

A I don't have any evidence to support one over the other.

Q Okay. So, just one more question. In Paragraph 33 of your declaration, you cite to a 1997 study by Meyer, is that right?

A Yes, sir.

Q And in Dr. Schecter's report, you read some criticisms that he had about that study, is that right?

A Yes, sir. I think perhaps the intent of my allegiance to this study was -- can you tell me what page Dr. Schecter --

Q Yeah, sure.

A I don't know that I did a good job of

clarifying what my purpose was in leading to that.

Q So that is Paragraph 25, Page 8 of Dr. Schecter's rebuttal.

A Forgive me, Page -- Section 28?

Q Page 8, Paragraph 25.

A Okay.

Q Well, I'll just read the first -- Dr. Schecter says, Sutphin's citation to a 1979 study by John Meyer shows his apparent unfamiliarity with research in this area. The report is extremely outdated by current standards and was even criticized at the time of publication because of serious methodological flaws. In 1980, Fleming, Steinman, and Bachmann published a paper challenging the report's findings citing methodological problems as well as conceptual flaws in research, design, score reporting, interpretation of data, and conclusions. One striking example of the flaws includes the author's assignment of a negative value of minus one to a person who cohabited with a person of, quote, the non-gendered appropriate sex, unquote. Were you aware of these criticisms of the Meyer study at the time that you wrote your report?

A No, sir. I was not. And to me, they're not really -- my purpose in alluding to this was

not -- the outcome was that, like we discussed earlier, there was a very low rate of regret. But what they did not see was that something that really helped these individuals move forward in any socioeconomic sense as measured at that time. Now, I understand what Dr. Schecter's saying, but I think if we take ourselves out of the current context, Josh, if you and I are homosexual males in 2018, we may both be highly educated professionals operating in an environment that endorses and supports this. But circa late '70s, when this study is going on, early '70s, that's not going to be conducive to forward mobility, so it would be, in my estimation, a valid -- it's not a statement of judgment. It's a statement of what you guys have worked to accomplish in the ACLU in the last 25 years. So I don't know that we can assign values or a judgment statement to that. But no, sir, I have -- that was not the purpose. That was just casual observation. I wasn't relying on that study to make a case that because John Meyer said in 1979 -- and that's why, ergo, we should do this. It's just -- when we look at data we have to -- just because it's old doesn't necessarily mean it's invalid. And just because it's new doesn't necessarily mean it's valid. They

may both be or they may not be. It's just an interesting observation that they both came to this -- and if the context, if we look at the context of the study that I allude to, it was where I'm talking about time. In Dhejne's study, where, really, that's the most comprehensive study, kudos to her and to her team for that assessment. I mean, I don't know where else in the world, other than Sweden, where we have such registries and we can access that data.

Q So, in her study, isn't it true that the outcomes were very different for people who had had surgery over 15 years ago and people who had had surgery within the last 15 years?

A There's question about that. And it's hard to say whether it was societal, exogenous from the patient, or whether it's actually, you know, the technical elements of surgery.

Q So before we get to the causes, I just want to establish like the underlying data. Isn't it right that for people who had had surgery in the past 15 years, the mortality rates were actually the same as the mortality rates of the population at large?

A I'd have to look at that part of the study

again, Josh. I think those patients, one of the things that's interesting about Dhejne's study is that it does provide a perspective over time and certainly, as we get closer to that cutoff window, it's a valid question. Well, maybe -- maybe that's a reflexion of the quality of care, societal change, and/or the fact that we're not capturing those people who more recently had the surgery with the same window of time as those who went for it in the earlier part. Those are all valid considerations, I think.

Q Those are all potential hypotheses that could explain the difference?

A Yes, sir.

Q And if I understand you right, do you believe that, to the extent that negative outcomes with regard to suicidally or other socioeconomic concerns persist after surgery that one potential cause of that could be societal factors of non-acceptance?

A Could be. It could be. And I think any of us acknowledge that, but I also think -- you know, the significance of Dhejne's study is the -- to me, the volume and the time and the candor of the department that's doing it. There's -- I can't

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believe there's any agenda at Karolinska. They're not known for such. But the thing that's interested is Dhejne's conclusion at the end of this study is that very similar to Ihlenfeld's observation years ago and that is, whatever this does, there's still something more than we can get to with a knife. So that's my interest. If I'm going to subject somebody to risk associated with these surgeries, what else is there that we're missing or that we don't have a handle on?

Q I mean, do you -- the fact that a particular medical treatment isn't a panacea for everything that could be bothering the patient is not something unique to gender dysphoria, is it?

A No, but some of the concerns that we have for these people, like the amplified suicide rate, also, those are unique to gender dysphoria.

Q So, if --

A And they could be multifactorial, as we've discussed. It could all just be a reflection of the society's approach to these people, but based on my interaction with the patients that I have interacted with, it's not just societal issue. I've even discussed with patients who have lived outside of our country, and their desired role in gender after

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undergoing penile amputation and vaginoplasty and breast augmentation, and living in a married state, how did it work? Tell me about it. Did you find relief?

Q Who are these people?

A There's one patient that comes to mind. And I don't know in terms of HIPAA what I'm allowed to say or not say.

Q Are you allowed to say in what context, like which of your jobs or locations you came into contact with that person?

A Correct. Yes, sir. In New Mexico.

Q Okay. If -- you agree with me that the Swedish study did not measure the rate of suicide of transgender people who had surgery as compared with the rate of suicide of transgender people who did not have surgery.

A Forgive me, one more time.

Q So --

A I'm starting to lose my --

Q Does the Swedish study -- you agree with me the Swedish study doesn't measure the impact of having surgery on suicide rates?

A Correct. Its purpose is not to study the efficacy of surgery.

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Q It's entirely possible, under the Swedish study, that a transgender person who has, you know, a likelihood of suicide at, you know, five times the norm of the regular population, would actually have had a likelihood of ten times the regular population --

MR. JOHNSON: Finish your question.

Q (By Mr. Block) Would likely have had -- could have had a suicide rate at ten times the regular population without surgery?

MR. JOHNSON: I object. Speculation.

A I would say that that is -- that is speculation. It's an observation.

Q (By Mr. Block) So if the data showed that having surgery dramatically -- I'll take out "dramatically." Start over. If the data showed that having surgery decreased a transgender's person's risk of suicidality, without curing it, would that mean that the treatment shouldn't be provided?

A The treatment being any number of the 43 surgeries --

Q SRS.

A Okay. Let me understand the question. If SRS surgery helps diminish the suicide rate over

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time, I think it would be something that would require, morally, a consideration.

Q So even though it doesn't fully resolve whatever is bothering a patient, the fact that it reduces the risk of suicide is still a valid consideration?

A Yes, sir.

Q Okay. I think we can eat.

(Break Taken.)

Q Welcome back. Some of these questions we've, you know, covered before, but I want to take another pass at a few of them, hopefully and just condensing the questions and responses. So, what would research need to show to convince you that SRS is medically necessary treatment?

A A sustained benefit and reproducible benefit and suicide reduction without the level of risk that's evident in the literature today. I also don't know, again, due to the fact that hormone therapy is requisite before people can get to surgery now, at least if these recommendations are followed, I would need to see prolonged evidence that there's no significant harm that comes to people from use of exogenous hormone therapy.

Q So, if a patient is coming to you who is

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already on hormone therapy and, you know, the question is whether or not surgery is justifiable, you would still want to consider the risk from the hormone therapy in deciding whether or not the surgery is medically justifiable?

A I think the two can't offer exclusive of the other. You know, I have to look at the patient as they are, irrespective of my own sentiments, the person is now on hormone therapy and so I have to, just even as a pragmatic question of care, if they're going to have surgery, we need to actually stop these hormones because of your risk of DVT in the perioperative period is markedly increased. I mean, that's even a recommendation in this month's clinics. It has no literature, that I'm aware of, that support the recommendation but that's the sentiment of the authoring surgeon. And that's Clinics in Plastic Surgery, for the record, that can be reviewed by any of us at the table. Again, that was not even published at the time when I submitted my original declarations, but --

Q So, you said -- in answer to my question, you said you would need to see sustained and reproducible benefit in reducing suicide without the current level of risk. Does that mean that even if

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the literature did show a sustained and reproducible benefit in suicide, you would still not be convinced that SRS is medically necessary treatment because of the current level of risk that exists?

A I think the balance of those two is the art of medicine, SRS surgery or otherwise. That's what we have to, as physicians, really counsel patients and I just don't see that equation at present being reasonable.

Q And under the category of level of risk, I want to make sure I'm capturing everything that falls within that category, so that includes complications from the surgery itself, right?

A Yes, sir.

Q It includes potential, you know, long-term consequences of the surgery itself in terms of mental health? Why don't you tell me a list. Let's do it that way.

A Well, which surgery we speaking about?

Q Let's talk about -- let's talk about mastectomy for a trans man.

A Without any form of further surgery?

Q Yes.

A Okay. Mastectomy for a trans man, you would like to know the risks of the surgery,

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hematoma formation, seroma formation, nipple necrosis, systemic risk of surgery, including DVT, pulmonary embolism, complication related to anesthesia, partial or total mastectomy, flap necrosis, an unfavorable aesthetic outcome, and need for additional surgery.

Q So those are all risks that apply to mastectomy for either purpose of gender dysphoria or for any other reason why a cisgender woman would want a mastectomy, correct?

A Correct.

Q It's not unique to mastectomies performed for transgender men?

A Those are risks inherent with that procedure, yes.

Q We'd also previously talked about unknowns from the simple fact that you are performing the procedure on someone of a different chromosomal or physical makeup when you're performing breast implants for a trans woman as opposed to breast implants for a cisgender woman. Are those risks also present when it comes to mastectomies for a trans man versus mastectomies for a cisgender woman?

A I'm not sure that I'm following.

Q Are there any other risks? Does the fact

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that this is being performed for the purpose of gender transition create any other long-term unknowns about the safety of it?

A Yes, to my estimation. Because the population is so fluid and not particularly well defined and anybody who's expert in this field will tell you, not every trans man has the same -- that's candidly known, has the same desire or need for XYZ surgeries, not every same trans woman. There's tremendous fluidity between the two. And that's one of the more challenging elements to me about care for this; is how do we decide who's actually going to do well with this surgery and, again, at the end of the day is the issue of we're cutting off perfectly healthy sexual organs. Those organs -- we, as a society, assign those organs certain inherent value due to their function, but as I mentioned earlier, for those with body identity and integrity disorder, there's really nothing different about my hand than my testicles at the end of the day, not anatomically not functionally, but in a sense from a surgeon talking about taking off one functional part of the body that is not diseased, I just can't justify that in my mind, Josh, as a valid and sound option.

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Q So, regardless of what the science shows in terms of benefit and regardless of what the science showed in terms of tangible risks, you don't see any way that it can justify performing surgery to remove healthy tissue?

A Well, the problem is, it's speculative. The science doesn't show it. It doesn't.

Q Yeah, but, you know, so as an expert, you can engage in speculation, and I'm just want to know if there's any test or if there's any studies that can satisfy your request for proof or not.

A That would be -- those would be litmus tests for the same thing we discussed.

Q Even after that, even after all those litmus tests were met, you would still have significant concerns about the fact that it's being -- that an operation is being done to remove healthy tissue?

A Personally, I would, but that would not preclude, in the case at hand, the approval of insurance companies saying, okay, let's march forward with this, unhindered. Because we see there's good, good evidence to support that. And it would certainly make me question, well, maybe I need to change my practice. I would still have a level

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of discomfort and that's just an honest level of discomfort. I mean, that's just -- gosh. And any of us who are candid and you've got to reach a point and obviously some of us as surgeons are completely satisfied in our mind and to our understanding about what they are about surgically is in the best interest of the patient. I have no disparaging remark for that individual. Within the scope of their practice, they've achieved that station where they feel confident in that. I just don't see that personally myself. So I'd have to clarify if I'm in the role of Daniel David Sutphin, personally, or if we're talking about, as we were earlier alluding to, insurance companies.

Q No, that was useful to clarify. Is it your position that, based on the current state of the science, no doctor would be justified in performing SRS to treat gender dysphoria?

A I can't see that. I would have to talk to the doctor and find out what their grounds -- I don't see anything in the literature that supports the risk of the surgery to my estimation.

Q So --

A Incurring the risks that the patient will go home and live with. Those such as Dr. Schecter,

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who practiced the surgery daily, perhaps weekly, may have a differing opinion, but I do not find that personally, no, sir.

Q Do you think that doctors who perform SRS right now are violating the standard of care that applies in their field?

A I think there is no well-defined standard of care. I think that's why we're having a discussion. If there was an excellent standard of care, I don't think that would be, really, a valid discussion. I think it's something that we need to work on. Because at the end of the day, ultimately Dr. Schecter and Dr. Sutphin, I would presume to say this for him, both have a sincere and genuine interest in the person across from them as their patient. They might have a different opinion about how to go about it, but I don't think there's any standard of care to say.

Q And it's not uncommon for doctors to have different opinions about how to best treat a patient, right?

A Not uncommon.

Q And even when doctors disagree about the best interest for a patient, it's still proper for insurance companies to cover procedures that a

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doctor determines to be in that patient's best interest, right?

MR. JOHNSON: I still have my standing objection.

A I think it's something that should be considered and I think that's a statement of the CMS paper; is we don't see anything, really, that strongly supports a uniform declaration for this. But we will trust the Schecters and we will trust the Sutphins of the world to candidly take care of these people and make recommendations.

Q So, why isn't that policy appropriate for the state of South Dakota to have in its decisions about what procedures to cover?

A I can't speak for the state of South Dakota, but I can say that, to my estimation, if you're talking about the very thing I mentioned in my declarations, if you're talking about an unprecedented surgery, it should require an unprecedented level of support. A surgery that's taking off physiologically healthy tissue, surgical castration and amputation for dysphoria, is unlike anything else in medicine.

Q So you think it should have an unprecedented level of support to justify it?

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A Yes, I think it requires a -- if we're going to do something that is unlike anything else in medical care, surgical care, specifically, I think it does require that, yes, sir.

Q Is that a personal view; that it should require an unprecedented level of support? Or is there, you know, a medical principle that a more unusual type of surgery should require an unprecedented level of support?

A I think that's a medical principle. I mean, if we're -- I'm not an astronaut, obviously, but if we're going to send somebody to the moon, we better do a lot of work, perhaps more so than when we're just sending an inanimate object into orbit. If we're doing something that is truly unique, it's not assigning a value to it, it's just assigning a fact that a candid mission, we're not sure we can do it, absolutely, but what does it actually mean in terms of benefit and risk? That's what, objectively, no matter my assumptions of nature, religion or otherwise, objectively, that's what it boils down to.

Q So, when considering any surgery, you always have to weigh the benefits versus the risks, right?

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A Yes, sir.

Q And here, for surgery for gender dysphoria, the asserted benefits are mainly psychological, isn't that right?

A That's part of the problem. I haven't defined what the benefits are. As I alluded to earlier, I've seen everything in papers from "I'm satisfied with the way my genitals smell" to "I'm satisfied with the way that they look."

Q You've referenced the genital smell thing a couple times. What paper is it that talks about that?

A It's in NPRS. I'll work to locate it and send it to you.

Q So, if the goal of the -- if the asserted benefit is that it relieves significant psychological distress, that benefit is in the domain of psychiatric care, isn't that right?

A It may begin there. But when the person enters the OR, they're in the operative domain.

Q And I'm focusing on the benefits that someone is supposed to get from the surgery. Those aren't tangible benefits you can see -- those aren't the sort of tangible changes that you typically look at when you perform surgery, right?

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A These are very tangible changes.

Q But benefits is what I'm talking about. The psychiatric benefits are not the sort of tangible benefits that you usually see when you perform surgery?

A I would request that we specify specifically what benefits the state and/or Daniel Sutphin should expect to see with these surgeries. That's what concerns me. We're missing that. There's not well defined. That's something that's even acknowledged by authors on these papers that, really, we don't have any good metrics to assess whether we're doing it -- we're firing lots of shots, but where's our target? What is our target?

Q So it seems the metrics aren't the metrics you typically look at when you assess the benefits of surgery? Can you agree to that?

A Which surgery?

Q When you -- any surgery. The benefits that are asserted for gender dysphoria are not the types of benefits that, as a surgeon, you usually are looking for and assessing for as the benefit providing the surgery, right?

A I think, Josh, and I'm not trying to be

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difficult, there's such a broad spectrum. Let's say we're talking about facial contouring surgery versus that that a child would undergo for micrognathia, the child with micrognathia has a obvious, noticeable defect that we all look at the child and say, My goodness. A gender dysphoric patient is aiming for something that is in their mind; a vision of what they want to be. I'm not making a statement whether that's good, bad, none of that. They have a vision. And so what are we going to measure as their level of satisfaction with that? I don't know. And that's not even with the mastectomy surgery and this -- I, as a surgeon, may see that you're healing well, but the patient may see something much different and obviously they're already arriving the day of the surgery, I may say, You are well formed and apparently healthy, but you see something that is hideous, so much so -- and I do mean the patient may say that; "this is hideous to me," "I hate this." And may even use expletives to describe it. I need this off. That represents, to me, just as a casual observer, this is a serious level of discord. Doesn't answer the question of whether I may be able to help them or not. Even if I perform a penectomy, for instance, how do I know

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that what I'm about to do -- this is changing their body permanently. For instance, in the last two months, I performed a penectomy for a patient who had severe lymphedema. His penis was over 40 centimeters long, hung past the level of his knees. I don't remember the specimen weight, but it was in pounds. Something like 8 to 12 pounds. I can't recall the exact weight. But with that surgery in mind, he had reached the point where the tip of the penis had grown so large and heavy it was necrosing. And giving all the other factors involved in his case, he was at risk of developing a severe infection of the penis that would spread to his body. He already had that occur once and had loss the scrotum. Going into that surgery, I know the result of the surgery and he's not going to be a good candidate for reconstruction of the penis, but I know, on my end, as a surgeon, what I hope to be able to accomplish. And talking to the patient, I can talk to him and say -- and document that he understands that the ability to maintain or achieve an erection and/or penetrative intercourse after this surgery is non-existent without reconstructive measures. And, furthermore, given some of the systemic problems that the patient has, including

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obesity, diabetes, unmanaged, poorly managed, he's going to be at very high risk for any future efforts of reconstruction. If I see a transgender patient, I'm just hanging my hat on the fact that whichever psychologist or psychologist who saw the patient previously has made a determination that, okay, but ultimately -- and I have to make my own determination. I think this patient understands this. I do. I think they get it.

Q So the benefit is in the patient's mind when it's performed for gender dysphoria, is that right?

A As best I can tell, yes, sir.

Q And the field of medicine that is devoted to determining whether someone's state of mind has actually improved is psychiatry, right?

A Psychiatry is devoted to mental disorders, yes, sir.

Q So, is it fair to say that a psychiatrist is better equipped to assess whether a mental benefit has actually been achieved than you are?

A I would say the same thing as I did earlier; that it depends on the psychiatrist, but even if they were better trained, this creates a unique situation in all of medicine where a surgeon

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is basically operating at the behest of a psychiatrist, based on patient desire, which is obviously discordant with the reality of their body. That's uncharted water. It's been done, absolutely. But I just -- doing something and actually being able to affect a change that justifies the risks that come with certain procedures, I think, are two different things.

Q So, from the perspective of a surgeon, such as yourself, determining whether your surgery has resulted in a psychological benefit is uncharted waters, from the perspective of a surgeon like yourself?

A No, sir. But determining so, when the patient comes to me with obvious pathology and disorder, and irrespective of our terminology, dysphoria or disorder, I would argue that disorder is a better term. I think the people who experience this would tell us, I live with this every day. This dominates my life. This is horrible. Help me. That's not just dysphoria, in my estimation. That's a true disorder. But dysphoria is something that, to my estimation, and it's not an exclusive -- I know, in his statements, Dr. Schecter commented about the fact that I allude to patients who undergo

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breast augmentation. Now, I can't note all the motivation for every woman who undergoes that procedure in the United States, but they're punitively so dissatisfied with the state of their body that is otherwise healthy that they're willing to pay a surgeon and undergo a procedure with associated risks to have a change with that. No one objects to that. But no one expects for an insurance company to cover that surgery in relief of those patients' state. Now, Dr. Schecter wisely notes, and I understand, the fact that the patient who comes to us with gender -- what is now called dysphoria -- is a different patient than a patient that comes to us for breast augmentation. The gender dysphoria patient, in my opinion, has a true disorder. And at least those in my experience, those who I had the privilege of caring for, have more than just dysphoria. It's a true life-altering disorder that dominates their thought process and their existence.

Q As a surgeon, you don't have -- you don't have frequent experience in determining whether a patient's mental disorder has been successfully cured?

A I don't. And I'm not satisfied, frankly,

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based on the criterion that I've seen that the psychiatry community does either. But if they had, we wouldn't be having any discussion. It's a debate that's been unfolding for years.

Q But in the context of any treatment for any mental disorder, as a surgeon, you do not have experience in assessing whether any mental disorder has been successfully cured?

A I don't practice in that realm. My realm is, and responsibility, is to verify that what I do and to the extent that I'm called upon to do so, that we as a surgical community do so in a safe and reproducible manner with an outcome that is more than just subjective.

Q And so -- and you think that it's not enough for -- to justify performing surgery as treatment for gender dysphoria, it's not enough for the psychiatric community to show that it improves mental health based on the same level of proof that applies to other mental disorders? You think an exceptionally higher standard of proof should be used when the treatment is surgical?

MR. JOHNSON: Lack of foundation.

A I don't remember. I understand what you're saying, but, for instance, if we're talking

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about affecting permanent change on the body for no other reason other than a psychiatric disorder, it's a different circumstance than if somebody presents to us with Stage 4 breast cancer. There's organic demonstrable disease that, without relief of that exophytic cancer on the person's breast, we're not going to be able to save their life, but we can, at least, enable them to experience a death with some dignity and resolution of that physical pain.

Q You're not used to treating inorganic disease as a surgeon?

A I wouldn't say that. Every person that comes to me comes with some set of circumstances that they may not wish to openly discuss. And sometimes they do. And they extend beyond the realm of organic disease process. A young woman who comes to me at 35 who's been the butt of every joke from seventh grade on because of the shape of her nose to the point she really thought about suicide by the time she was a senior in high school, there's other stuff there.

Q Are you providing medical treatment for that condition?

A No, sir. What I do ties into that treatment. And that person's coping structure, it

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seems to me, is a different structure than those who have encountered gender dysphoria, as we're calling it today. And, again, I will respect the terminology that's requested that we use, but I disagree with it. And I don't think it does a good service to these people. There may be those who are more dysphoric, but there's truly a disordered patient population that I don't think we're helping by saying it's just dysphoric and it's not -- I don't think it's a good thing for them.

Q Is it your understanding that the medical community doesn't distinguish between people with severe gender dysphoria and people with less severe gender dysphoria?

A The medical community is very large and nondescript. All I can say is what I see in these guidelines and the American Psychiatric Association in terms of terminology. And that's all I can observe.

Q I mean, isn't -- don't WPATH and the other -- let's talk about WPATH. Doesn't it say that -- whether surgery is medically necessary to alleviate a person's dysphoria depends on the individual needs of the patient?

A I would have to look specifically at that

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part. I know what the general sentiment is. I would also say, as a surgeon, and I may have just missed this, I don't know which surgeons actually constitute the -- other than Dr. Schecter, I think Djordjevic has also said on WPATH as well -- which of those surgeons constitute the rendering body of opinion for this.

Q Let's talk about the body of opinion. You're aware that the American Medical Association has issued a statement saying that surgical care for gender dysphoria is medically necessary, right?

A Yes, sir. I'm not a member of the AMA deliberately. Not for that reason, but I alluded to the fact that the AMA is so far departed from many American physicians that it's not thought to represent, even a number of years ago, no more than 15 percent of us.

Q So, putting aside your views about those statements, I just want to get on the record your knowledge that the statements exist. So, you're also aware that the American Psychiatric Association has issued a statement saying that gender dysphoria -- I mean, transition-related surgery is a medically necessary treatment for gender dysphoria, right?

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A Can you read the statement specifically? I don't know that I've seen that.

Q All right. I mean, without using the exact word of the statement, are you aware that they -- have you read their statement in the past regarding transition-related care for gender dysphoria?

A The statement that I recall -- and I haven't read that statement recently, Josh, but the statement that I recall is that it's considered a valid option in their estimation. But I don't recall, I could be wrong, this medically necessary term is getting utilized a lot. Medically necessary for what? If I say a breast reduction, for instance, is medically necessary, a woman who comes me with a J cup-sized breast has certain manifestations of her macromastia that we expect to alleviate with the surgery and many of those are sentiments of relief of physical pain and improvement in certain symptoms physically observable, like notching in the shoulders from bra straps, maceration of the skin on the under surface of the breasts.

MR. JOHNSON: Can we take a quick break, Josh?

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MR. BLOCK: Yeah, could we just --

MS. COOPER: No, can he finish the answer?

MR. JOHNSON: I'm sorry, I thought he was done.

A That really was -- I mean, just those symptoms are observable. Forgive me. I lost my train of thought.

MR. BLOCK: It's okay. Okay. You can take a break.

MR. JOHNSON: If you want, she can read your answer back. I thought you were done.

(The requested portion of the record read back.)

A And those are -- those are observable.

(Break Taken.)

Q (By Mr. Block) And I really don't want to belabor these questions on my end. Just want to establish the American Psychiatric Association, the American Psychological Association, and the American Medical Association have all issued statements recognizing treatment, surgical treatment, as an accepted protocol for treating gender dysphoria?

A If I understand, I think it's an accepted option for me to -- the AMA, as I've stated, is an organization that has its own course very well. I don't subscribe, necessarily, to what the AMA says

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politically, socially, or in this case medically.

Q So you disagree with the AMA's position on this issue?

A In this instance, yes, sir.

Q And you disagree with the American Psychological Association's position, right?

A If I may finish real quick. The American Psychological Association is very well and fine, but as a surgeon, my decision to operate is not based off of the recommendations alone. The American Psychiatric Association, I appreciate that. But as they themselves acknowledge our quality of data is very low. This is our -- our consensus. We really don't have anything to support this. Now, all of us in life have to make a choice about who we going to listen to? How much credence do we put -- you know, if Josh is my lawyer and he tells me, Daniel, I need you to consider these things, I respect Josh's training, his background, and I, irrespective of our opinions, he's an expert in this. I need to hear what he's saying. The American Psychiatric Association, based on their most recent statement, unless there's been a new one that I'm unaware of, issued their declaration with a caveat that we really -- this is low quality data evidence. And,

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again, going back to the issue as the guy, who, at the end of the day, or gal, who's responsible for putting a knife on someone's skin, we've got to take that responsibility seriously.

Q So -- so, just for the record, so, you disagree with the position of the American Psychiatric Association and the American Psychological Association and the American Medical Association on this issue?

A Based on the data available right now.

Q Is it possible for there to be a medical consensus that proves to be wrong?

A Yes.

Q So, it's possible for there to be a medical consensus on an issue and still have certain physicians and researchers disagree with that consensus, is that right?

A Well, if I may understand your question correctly, Josh, what you're saying is: Is it possible to be wrong? Is it possible to have disagreement? Both are possible.

Q So, if -- I want to turn to the complaint.

(Deposition Exhibit 16 marked.)

Q This is a copy of the original compliant as filed. And you reviewed this complaint as part

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of the process of writing your declaration, right?
A Yes, sir.
Q So, I want to focus on the first paragraph says, The State of South Dakota provides healthcare coverage to state employees through the South Dakota State Employee Healthcare Plan. Under the plan, all state employees are, quote, entitled to medically necessary services and supplies, if provided by or under the direction of a physician, unquote. The plan defines medically necessary as, quote, healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine, unquote. Did I read that right?
A Yes, sir. Based on the copy I'm looking at.
Q Okay. So, is it your understanding that it's possible to provide treatment for symptoms of a disease without curing the underlying condition?
A Yes, sir.
Q And is that a legitimate form of medicine to treat symptoms, even if it doesn't cure the underlying condition?
A Yes, sir.

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Q And I want to focus on the phrase, "meet accepted standard of medicine." What's your -- just from -- not from the perspective of a lawyer, but just from a perspective as a physician, what's your understanding of what it means to meet accepted standards of medicine?
A I think it depends on your specialty, Josh, at least in the United States. The organizations which participate in the governance of standards and observation of them, such as the American College of Surgeons, the American Society of Plastic Surgeons, and the American Board of Surgeons and the American Board of Plastic Surgery are, in the surgical realm, those bodies that help us define as surgeons what are the accepted standards. And, to my knowledge, as of the time that I submitted my declarations, there was no such consensus statement from any of those bodies. And that's why, in my declaration, I stated it's unknown whether the plaintiffs or, I believe, Dr. Brown at that time, had considered those valid sources of consideration. They were not mentioned or alluded to.
Q If there were a statement from the American Society of Plastic Surgeons regarding

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whether insurance should cover surgical care for gender dysphoria, would that be evidence of a medical consensus on the issue?
MR. JOHNSON: Object. Lack of foundation.
A Possibly. It depends upon how the organization goes about arriving on consensus. And, unfortunately, in the case of many bodies, it may just be, you know, we are the board, we have thus decided, and thus shall it be. You know, us four here today have made a decision without any opportunity for consideration or critical assessment and here's how it's going to be.
Q And is that your understanding of how the American Medical Association and the American Psychiatric Association or the American Psychological Association operate?
A I don't know how they operate.
Q Is that your understanding of how the American Society of Plastic Surgeons operated?
A The American Society of Plastics Surgeons, I imagine, would call for opinion from members and review -- form a consortium, a body, to review the literature at hand. And make a determination. That's speculation. I don't know. I do not sit on the board, so I don't know the proceedings that

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would effect a formal statement.
Q If the American -- so, focusing on this phrase, "meet accepted standards of practice" --
A Forgive me, Josh, of medicine?
Q Sorry. Thank you. Meet accepted standards of medicine. So focusing on the phrase, "meet accepted standards of medicine," it's possible for the accepted standards of medicine at any given time to be wrong, isn't that right?
A Yes, sir.
Q And further research can reveal that the accepted standards of medicine should be changed, is that right?
A Yes, sir.
Q And, in fact, there's often additional research that must be done on how to treat a condition, even when accepted standards of medicine are currently in place?
A Yes, sir. There's -- sometimes. I don't know about often but, yes, sir, sometimes.
Q Is it possible that treatment for gender dysphoria has -- let me rephrase that. Would it be fair to say that you disagree with the conclusion of the AMA, the American Psychiatric Association and the American Psychological Association, that

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surgical treatment for gender dysphoria meets accepted standards of medicine?

A It would be fair to say, as I previously stated, I appreciate the American Psychological Association, but I do not base my care upon their recommendations. I value the American Psychiatric Association, but as of to date, their recommendations are made on low quality evidence and I would not ask anyone else to make a decision based on low -- of this magnitude, based on low quality evidence, any more than I would ask myself to do so. In terms of the American Medical Association, I do not have any comment about what their recommendations are or not. I'm not a member and I can't comment on them further, beyond what I've already stated.

Q Do you believe that it's impossible for an accepted standard of medicine to exist if there are physicians who disagree with that standard?

A One more time; if it's impossible for a standard to exist?

Q I want to separate out two issues. One, is there currently -- is treatment for gender dysphoria currently accepted by -- sorry. Is surgical treatment for gender dysphoria currently

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accepted by the medical profession from the question of whether or not it should be accepted by the medical profession and --

A Well, like I said, the medical profession is a pretty large body, Josh.

MR. JOHNSON: Let him ask his question.

Q (By Mr. Block) So, in determining accepted standards of medicine, you think that refers to sort of a poll of general membership? Is that what you think determines accepted standards of medicine for the context of providing a certain treatment?

A I don't know that I understand the question as it's couched. It seems very broad to me.

Q Well, you know, let's go back to the CMDA statement, if we could.

A If I may be clear, up to this date I have never seen the CMDA statement and have never based my guidelines or my decisions medically on this statement.

Q Of course. Of course.

MR. JOHNSON: What's the number on that, Josh?

MR. BLOCK: I think --

THE WITNESS: I've got 11, Josh.

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Q (By Mr. Block) You have 11? That's even better.

A Is that what we're all on?

Q Yeah. So, if you go to the first page under heading of C; social.

A C, social.

Q And then Bullet Point 2. So this is on the first page. It says, In our current social context, there is a prevailing view that removing traditional definitions and boundaries is a requirement for self-actualization, thus, Christian healthcare professionals find themselves in the position of being at variance with evolving use of gender identity in which patients seek validation by the medical community of transsexual desires and choices that may be socially approved, but which are contrary to a Christian world view. And so, do you agree that your -- the prevailing view today is that transgender patients seeking to transition should be validated by the medical community?

A Well, Josh, I think there's a popular sentiment. It's well founded that none of us want to hurt anybody. We don't want to keep anybody from getting what they need. But popular sentiment is not, at this point, supported by, based on what I

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have read, objective evidence. In terms of the variance of Christian world view versus the remainder of society, that's been the case for the last 2000 years, going back to the statement I first alluded to that Paul said in the Letter to the Galatians; In Christ, there's no difference between male or female, Jew or Greek, slave nor free man. That was the most radical statement the world at the time had heard and it wasn't a very popular thing to ascribe to, based on any of those cultural members; Jews, slaves, free men. And it certainly wasn't popular based on the sentiment and value of women at the time in the culture to say, Mr. Man, this lady that you've been treating like trash and chattel for the last ten years of your marriage is actually of equal worth in the sight of God as you. Those were radical ideas that were grossly at variance. So that's a statement that, as we review, I -- that doesn't seem anything new, based on the last 2,000 years of history, based on what my knowledge is. But, again, in terms of the surgical societies, I don't find any contradistinction in the opinion that I've formed right now with the bodies at large which govern this process; that is, survey the process of the practice of medicine in the United States of

America, including the American College of Surgeons, the American Board of General Surgery, and Plastic Surgery and the ASPS.

Q Are you -- none of those organizations have issued a statement saying that surgical treatment for gender dysphoria is not medically necessary, have they?

A No, sir. Not that I'm aware of.

Q And --

A But neither, to my knowledge, have they issued a statement saying that those who would not engage in the practice or have reservation about the same are practicing unsafe or unsound medicine.

Q Agree with that? And isn't it true that -- just want to find it -- that the American Society of -- that the American Society of Plastic Surgeons hosts seminars and classes on providing surgery to treat gender dysphoria?

A Dr. Schecter, I think he's been active in orchestrating some of those things, perhaps since -- I do not know this date specifically, but perhaps since 2015.

Q And isn't it true that he also provides classes to the American College of Surgeons on providing surgery to treat gender dysphoria?

A I believe he does. I've never attended one and I applaud him for, as any honest clinician would want to do, if he feels that he's found a technique that is advantageous and helpful to the patient population, that he's striving to promulgate that.

Q And in order to be board certified, isn't the topic of surgery to treat gender dysphoria one of the topics that you can be questioned on at board certification?

A You could be questioned on any topic.

Q Including providing surgery to treat gender dysphoria?

A Correct.

Q The American Society of Plastic Surgery, their website is plasticsurgery.org, isn't that right?

A I believe so, Josh. I'd have to pull up their web address. I don't pay that close attention in my log.

Q Going to your declaration, you cite Footnote 33, when you're citing the statistics about plastic surgery, you cite to a document on plasticsurgery.org.

A Is that the breast augmentation numbers?

Q Yeah, Plastic Surgery Statistics Full Report, 2016. So you view that website to be a reliable source of information?

A I do.

Q And are you aware that the website categorizes the surgical procedures as either cosmetic or reconstructive?

A Yes, sir.

Q And what's the difference between cosmetic surgery and reconstructive surgery, in your understanding?

A Cosmetic surgery is something that is performed to improve an already existing structure to a greater degree of satisfaction in the patient's estimation. Reconstructive surgery is something done to reconstruct what disease or trauma has taken away from the patient.

Q And is your understanding that reconstructive surgery is regarded as medically necessary?

A In many cases it's considered medically necessary.

Q And are you aware that the website for the American Society of Plastic Surgeons lists gender confirmation surgeries as an example of

reconstructive procedures?

A I haven't seen that. I didn't see that it was classified as reconstructive. I would be interested to note who made the decision to classify it as such because it doesn't -- to my estimation, the definition I just provided you, it's like a mastectomy, and it's very inconsistent with the things that we've talked about previously. One of the key movements in those who advocate for this is to change language. What is blue is now orange and what is orange is now blue. And the plain language in understanding reconstructive surgery, it's a restorative procedure. We might say it's restorative in a sense that we're operating from the patient's frame of reference, in their mind, they say this is what I always should have been, but, in fact, what we're dong is we are -- it's extirpative procedures. We're taking away what's already biologically present.

Q So you would disagree with any decision to describe surgery for gender dysphoria as reconstructive surgery?

A If I may finish, it depends on the surgery. For instance, a mastectomy, a phalloplasty would be considered reconstructive, though you're

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really building something that's not really -- you're not reconstructing it. You're building it from a nascent, de novo state, which is, again, is unprecedented in medicine. Let's say in a male patient who loses his penis to an explosive device, you're rebuilding what was there to begin with. In a phalloplasty for a trans male, you're creating something that never existed to begin with and I think Dr. Schecter would agree if you don't recognize that fact, you're headed for serious complications. Of course, you recognize that fact as a surgeon. There's different inherent risks and complications that come with that statement. Statement of fact. Not of value. Just of fact.

Q But you would label it -- I just want to focus on whether the label "reconstructive surgery" would apply to it. And it's your opinion the label of reconstructive surgery should or should not apply to phalloplasty?

A I almost think we should call it neo-constructive surgery. It really -- and you'd have to ask others who practice it like Dr. Schecter, on a regular basis, whether they think the level of expertise really rises to that. I believe it does. It's -- even, for instance, if I

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do a deep flap for breast reconstruction, that's reconstructive. I'm restoring the tissue to the place that once upon was, trying to connect a neo-urethra of a phallus, a neo-phallus to a native urethra, and contend with the complication rates at the pars fixa, which is the place where the native female urethra terminates, is really -- I mean, it's a tour de force.

Q If someone has a congenital abnormality, like a growth that's then removed, does that mean that it can be categorized as reconstructive surgery because it's taking something off?

A Well, I wouldn't categorize it for that. For instance, cleft lip, they may be born with that deformity, but you're reconstructing the upper lip. Our daughter, Kali, was born with a hemangioma that progressed and sized to the point that by the time I was a fellow at UC, actually, she required surgery. She developed a mass that was probably a tangelo size mass on her breast bud. And there was some concern whether that would actually interfere with her future breast development. The surgery that she had was extirpative in nature. I would not describe it as reconstructive, but --

Q Okay. For gynecomastia in men, in

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cisgender men, what is your understanding of the medical purpose of performing gynecomastia surgery?

A It can be done for different reasons. Occasionally the patients that I've cared for and that you read about in the literature do complain of pain and discomfort, asymmetry and, social embarrassment. But, more commonly, insurance-related indications are progressive growth without arrest and failure to subside objectively on examination.

Q Is there any medical harm that would result from not performing surgery? Let me rephrase that. Is surgery indicated to, you know, prevent some other medical harm from happening to the patient?

A I would say, in most cases, no. Unless there's a mass involved. And usually that could be ascertained in terms of the diagnosis with less invasive means, like corneal biopsy or something, if there's a real concern for oncologic process, but in most cases, if the chief indication is soreness and discomfort, that's one of the presupposed goals of the procedure; is to alleviate that.

Q To alleviate the physical soreness and discomfort?

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A Yes, sir.

Q Is one of the goals to alleviate the social discomfort?

A Can be. In cases there are -- there may be a case where insurance does not approve the same and the patient or the patient's guardian determines that they would wish to pay for that out of pocket.

Q How do you measure whether someone's physical discomfort has been improved from gynecomastia surgery?

A A patient's sentiment, what they express, and what I can appreciate on examination in terms of palpation.

Q And how do you measure whether a patient's social discomfort has improved as a result of gynecomastia surgery?

A Primarily the patient.

Q Gynecomastia surgery has medical risks, doesn't it?

A By medical, I presume you mean surgical risks, yes, sir.

Q Is someone generally under general anesthesia for that surgery?

A It varies. It varies.

Q And there are risks of complications from

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the surgery, is that right?
A Correct.
Q But the surgery isn't life saving, is it?
A Not that we're aware of, no, sir.
Q So, do you believe that the benefits of the surgery are -- outweigh the risks to make it medically justified?
A That depend on the case and the severity of the deformity and the patient's symptoms that you're describing.
Q So, could you explain what would make it medically justified?
A If the patient complains of physical pain, and I can appreciate, on examination, a mass in the retroareolar position of the man's chest wall that I don't believe is going to be amenable to observation alone, then if he complains the pain associated with it is sufficient to warrant acceptance of the risks associated with the procedure, then I would consider it reasonable.
Q Isn't -- doesn't the surgery remove organically healthy tissue?
A It's abnormal tissue.
Q But it's organically healthy?
A No, sir. There's no -- if -- I think

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we're thinking the same thing, Josh, but we're coming from different vocabularies. There's no oncologic disease process. There's no infection. But it is abnormal hypertrophied tissue. In some cases, the actual etiology of which cannot be excluded or confirmed as benign until it's under a microscope.
Q Well, but the surgery is performed --
A It's not normal for males to have breasts, biological males.
Q Yeah, no, I'm getting to that. I'm getting to that. But the surgery, you know, can be medically necessary, even when it's known that the tissue is benign, right?
A Yes, sir. It can be appropriate. Even when the tissue is thought to be benign, yes.
Q But it is -- it is not -- but the tissue does not conform to the type of tissue that males usually have in their chest, is that right?
A I don't know that the tissue "conform" is the right word, but it is not typical physiologic phenotype and it does lead to question, though, in the vast majority of cases, it is only benign disease, the only way to exclude that with certainty is to examine the specimen under the microscope, but

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yes, sir, in the vast majority of cases, it's benign tissue. And by no means would I tell a patient, oh, if you came to me and said, Josh, I think you're going to be all right, you know, we can't say that with absolute certainty until it's under microscope, but I think it's going to be okay. But if it's causing you discomfort, it's causing you pain, are you willing to accept the risks of the surgery? Then that -- yes, sir, that would be how I would approach gynecomastia, depending upon the patient's age.
Q And one of the purposes of the surgery is to bring the person's body into align with the typical male phenotype?
A One of the purposes of the surgery would be to alleviate pain and the other purpose would be to verify no physiologic abnormality, and a third benefit, I would think, would be that it would bring the patient's body into alignment with what already exists in his body. Not to create something or disrupt the state of the body otherwise.
Q But that's an entirely appropriate medical consideration; to bring a person's physical body into alignment with his typical male phenotype?
A Yes, sir, what already exists, yes.

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Q Okay. If there's no -- can surgery for gynecomastia be medically necessary, even when there is no physical pain?
A This is one case, at least in my experience, Josh, that there is a lot of variability from insurance companies and policies. Some policies have exclusions that others don't have. Even with pain, some policies require progressive growth that does not subside over time. It can vary.
Q And how about your own personal belief? Do you provide surgery for gynecomastia even if there's not physical pain?
A If I have any objective concern that there may be occult disease, then yes, sir. And even if I don't operate the patient initially, I see them back in followup to verify that my findings at the time I see them initially are consistent over time and/or resolving. And if that behaves in a manner atypical, then irrespective of just the symptoms of physical pain, I would make a recommendation that they undergo at least tissue biopsy and/or imaging studies like ultrasound.
Q If there's no indication, if there's no -- nothing to indicate that the tissue is not benign

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and the patient is not suffering physical discomfort, just has abnormal growth and extreme social discomfort from it, would you provide the surgery in those circumstances?

MR. JOHNSON: You said is not benign?

A Nothing to indicate the tissue is not benign.

Q (By Mr. Block) So there's no concern about performing a biopsy, the only concerns are that this is abnormal growth that does not subside and the person is suffering social distress from it, would you perform the surgery in those circumstances?

A If I may, I'm going to repeat what my brain is picking up. I have a patient who doesn't appear to have any pain. I have very low concern that there's any pathologic mass suspicious for oncologic process, however, the growth is persisted and the only concern at this point is stigma, is that correct?

Q Well, social distress and anxiety.

A Yes, that would be a reasonable thing. His insurance may not cover it, but I would offer that.

Q Because of the stigma?

A Yes. Yes. To the point in terms of a

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patient like Mr. Bruce, what stigma has the patient had by having breasts alone? I don't know. Those begin to become more complex issues. Furthermore, I've never examined Mr. Bruce and I can't comment on the breast size and considerations associated with that, but most gynecomastia patients as, again, as also noted this month and I think very well noted in the article dealing with the same in Clinics about male to female and female to female chest surgery, there are important differences that need to be recognized between the two surgeries and they're not the same surgeries at all.

Q Understood. So, is it fair to say, in your view, a major distinction between performing surgery for gynecomastia to alleviate distress from social stigma and performing surgery to treat gender dysphoria is that when you're performing gynecomastia on a man, you're removing abnormal tissue, but when you're performing transition-related surgery, you are removing tissue that is normal for that person?

A It's physiologic. We would presume, unless there's a disease state that we know of to be present, the fact that those two are technically different procedures is reflected in CPT

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terminology.

Q I just want to confirm that, you know, a distinguishing thing between those two surgeries that's important to you is that for gynecomastia for a man, the tissue is physiologically abnormal, and for mastectomy for a transgender man, the tissue is physiologically normal?

A Yes, sir.

Q And you're more concerned about tissue that is physiologically normal than you would be about removing tissue that is physiologically abnormal?

A Correct. That represents an abnormal developmental state, which gynecomastia does.

Q Do you think that having gender dysphoria is a normal state?

A That's an interesting question, Josh. I think those that I have observed with what I would describe as a real disorder, no, I don't think it's a normal state, but as opposed to one that can be appreciated physically on examination, that I have a high degree of confidence that I can address with a scalpel, it's something that I would be altering the patient's native biological state to achieve something that I don't know that I can address. And

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my colleagues, again, if they have been able to produce evidence that they're highly confident, very good, but I just not -- I have not seen that data reproduced over time.

Q You've spoken a lot about phalloplasty in particular. Are you aware that some insurance companies cover vaginoplasty and chest surgery but do not cover phalloplasty? Are you aware that some insurance companies make that distinction?

A I never cease to be amazed at the distinctions insurance companies make, yes, sir.

Q Phalloplasty is a much more complicated surgery to perform than those other surgeries I mentioned, right?

A I would agree. And if I may submit, my judgment is not how complex it is. If it's something that's going to help the patient and bears a sufficiently minimal level of risk to achieve a result, that's where we get into the, you know, economics of medicine. It may be something that it should not be, in my estimation, excluded based on the complexity alone.

Q And phalloplasty is a much more expensive a surgery than chest surgery or vaginoplasty, right?

A Yes, sir.

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Q And phalloplasty has a higher rate of complications than chest surgery or vaginoplasty, is that right?
A Yes, sir.
Q Was that a yes?
A Yes. Yes, sir.
Q So --
A To my understanding, considerably more so.
Q So, if an insurance policy didn't cover phalloplasty but did cover chest surgery and vaginoplasty, would that address at least some of the concerns that you raised in your declaration with surgery to treat gender dysphoria?
A Actually, to the contrary. I think it would be somewhat illogical. If these surgeries help people, why are we making our decision -- we may have to make our decisions based solely on economics, but given the fluidity of the patient population and the dynamic state of the same and the fact that we don't have any good parameters to say Patient A, in 90 percent of patients, it's like if you look at that old Meyer study. I think maybe 40 percent of them went on to complete surgery that didn't have surgery initially. What surgeries did they complete? I don't know. I don't know how

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we're going make those decisions and it would be hard, in my estimation, to say, well, you're approved for this but not for that. Based on what? Complexity. That's not a valid reason for telling a patient if we know we can help them.
Q In assessing the risks and the benefits, isn't the risk of complications for a particular surgery a relevant factor?
A It is a relevant factor.
Q So if the risks of complications for phalloplasty are higher than the risks of complications for vaginoplasty and chest surgery, that would be one factor that counts against covering phalloplasty when compared to chest and vaginoplasty, right?
A Can you condense that one more time?
Q Sorry. So, there are three factors I think I've talked about that are different with phalloplasty. One is cost. One is risk of complications. And the third is complexity. And you said that you don't think complexity would be a reason not to cover phalloplasty if you're covering the other surgeries?
A Nor, necessarily, would the complication profile, if it is deemed acceptable for the outcome.

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Right now we don't even have any outcomes data, so if we're going to talk about a urethral stricture rate of 40 percent, what are we shooting for in this whole process? And what are we offering people to expect in terms of benefit on the other end of the spectrum?
Q Is there more data on vaginoplasty than there is on phalloplasty?
A My general sense is that yes, because the number of phalloplasties, in terms of sheer numbers, is greater for vaginoplasty.
Q And are you aware that many trans men choose not to have any surgical procedure other than chest surgery?
A Yes, sir. The thing that I think is a problem is if we're really seeking to help these people and they get to that point in their process, oh, sorry, we can't do that now, and because that, for some individuals -- and it's not necessarily logical, there is no sequence, at least that I'm aware of, that says, you know, you do this, you get that. There's a high degree of variability. And I think if we're going to offer that, why would we cut that person, especially if it's so tied to their well-being, from a psychiatric standpoint, why would

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we cut them off at the chest surgery alone?
Q So if you think that if any form of transition-related surgery is offered then the insurance company would need to cover all forms of transition-related surgery?
A Yes. Because the logic is we're seeking to offer them help to the full extent possible. If you come to me as your surgeon, you're expecting for me to do the best thing for you, no matter what's convenient or cost effective for me. I may be able to parse your surgery into five different surgeries, but if I do a significant number of them together, then it gives you, in some cases, a better benefit in terms of operative exposure, et cetera. So that's what kind of the patient is trusting the physician to offer him or her and our moral obligation to the patient, I think.
Q Yeah, I want to go back to what it means to meet accepted standards of medicine. In your opinion, how is one to determine whether a particular treatment meets accepted standards of medicine?
A Josh, I think we begin with general recommendations that are submitted as widely accepted and reasonably safe. And then we, as

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individuals, have to put those principles into practice and determine whether we can execute them independently or, for instance, whether if someone comes to me seeking a phalloplasty, for instance, I don't have the technical resources available in terms of micro assistant help, I need to refer the patient to Dr. Schecter.

Q When you referred to general standards, were you referring -- when you were referring to general recommendations, were you referring to recommendations from organizations like the AMA and the American Psychiatric Association?

A Again, the relevant recommendations, in my professional world, would come predominantly from those surgical societies.

Q But in determining what the field of psychiatry views as accepted standards of medicine, the recommendations of the American Psychiatric Association and the American Psychological Association would be the relevant recommendations they would be looking to, is that right?

A I view -- I don't know what they -- who "they" are in this case that we're alluding to, but in my case -- and in the case I would submit of plastic surgeons, it would be unprecedented that we

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should operate at the behest of -- solely at the behest of another clinician. That converts the surgeon, in essence, into an automaton who is responding in kind to the order for surgery.

Q So, if -- even if the American Plastic Surgery Association and the American College of Surgeons issued statements saying our general recommendation is that surgery to treat gender dysphoria is medically necessary, you would still disagree with that conclusion, right?

A I'd have to see what the statement's made on. What is the basis for it?

Q The basis being the current science that exists right now.

A If the recommendation was made on the current science, the current literature that we have at our disposal, I question the recommendation.

Q You would think that recommendation is wrong, right?

A I would not ascribe to it.

Q And --

A Based on the state of the current literature, please verify that.

Q Right. And it's possible for there to be a recommendation that's accepted by these medical

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organizations that you think is wrong?

A Well, yes, sir. I mean, I would hope you all, as lawyers, feel the same way about the bar. I mean, George Washington, I believe, if we read the history right, was probably bled to death by his physicians. That was the standard of the day; bloodletting to get the evil humours out, so to speak, by the best physicians, presumably, of the day.

Q But at that time --

A Medical knowledge is ever changing. That we can be sure.

Q So, but at that time, George Washington bloodletting met accepted standards of care as they existed at that time, right?

A Putatively, yes, sir.

Q Yeah, if you're -- if the American Plastic Surgery Association or the American College of Surgeons said that surgical care for gender dysphoria is medically necessary based on the current science, would you recognize those statements as evidence that the procedure meets prevailing accepted standards of medicine, even if you disagree with that conclusion?

A The standard would then be in place

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whether I think it is a valid standard or not, the standard would then be in place, yes, sir.

MR. BLOCK: Okay. Thanks. I need just a minute. It's okay to do a break or I can just look through my papers for 30 seconds?

MR. JOHNSON: We'll take a break.

(Break Taken.)

Q (By Mr. Block) So, back on the record. You had mentioned, in response to your previous question, the CMS coverage decision that said there's no nationwide rule, we'll leave it to doctors to determine if it's medically necessary for the individual patient. And my question is: Is that a decision you support? Do you favor a rule that doesn't have a national determination but leaves it to individual doctors?

MR. JOHNSON: For the record, is that the 2016 decision?

MR. BLOCK: Yes.

A Well, Josh, maybe I'm just simplistic in my way of thinking, but it doesn't really matter what I favor or don't. In terms of just the objective evidence, it seems there's not a concordance to give us direction, one way or the other. So, in that regard, I think those that

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reviewed what they had to work with at the time were not unreasonable.

Q (By Mr. Block) So, was it reasonable for them to say that it is an option? Was it reasonable for CMS to say that surgery for gender dysphoria is an option for individual doctors to pursue based on their determination of medical necessity?

A I don't think it's -- I don't think it's unreasonable.

Q Now, you're aware that Medicare, before 2014, had a rule that prohibited surgery, regardless of the individual views of a treating doctor, right?

MR. JOHNSON: Excuse me, I think you're misstating the studies. There's an '89, 2014, 2016. Maybe I'm misunderstanding your question.

Q (By Mr. Block) Yeah, before 2014, so you're aware that in the past, until the 2014 decision, Medicare had a blanket rule saying it wouldn't cover surgery to treat gender dysphoria under any circumstances, right?

A Yes.

Q And the rule adopted in 2016 is different from a blanket ban on coverage, right?

A Correct.

Q And do you have a preference between CMS's

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current rule and a rule that simply prohibits coverage across the board?

A I think it's in situations from a physician perspective, I think in situations it's more ideal to have a latitude to work with. I think from third party payer perspectives, it's more ideal to have blanket statements one way or the other because it becomes very challenging to sort that group.

Q Is the fact that CMS has -- is the fact that CMS provides -- let me rephrase it again. Do you think that CMS would provide coverage for a condition if it did not meet accepted standards of medicine?

MR. JOHNSON: I'm going to object. Lack of foundation. Speculation.

A I think CMS, in all candor, is an organization that can be very difficult to understand what basis, logical or illogical, exists for their support of one procedure over another, if at all.

Q (By Mr. Block) So, do you think that CMS's decision to provide coverage on an individualized basis is at least evidenced in favor of the conclusion that the procedure meets accepted

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standards?

A Well, I think -- I can't speak for the thought process of those who reviewed the literature, but I think what they're trying to do with candor is really recognize the fact that we don't have the answers that we need quite yet, but we're willing to consider. And that's what all of us, I think, really, must strive to do; is let's consider, let's be candid, let's really look at this and see what can we do to help these people.

Q And would you describe that as the accepted standard right now?

A What's that, Josh?

Q The attitude of there's still more information we need, we don't have all the answers, but we're willing to consider providing the surgery on an individualized basis, would you say that's the prevailing accepted standard right now?

A Within what circle?

Q Within just accepted standards of medicine.

A I mean, I think the American Psychiatric Association has made their declarations, to my opinion, based on subjective sentiment themselves without good objective data, as they candidly note.

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I think in terms of CMS, that's why I'm asking, what body are we talking about? I mean, all of us, I think, I would hope, within medicine, really, are taking that approach of let's look at this, let's see, but I don't think that the statement that -- to raise objections, to raise questions, is illogical and unfounded and, you know, I have it, because I just read it this weekend. I just took it with me. I just got clinics before I came. I mean, we can sit here, all of us, and look at just two of the papers that, you know, came out of clinics in terms of complication rates and say, Yikes. Okay. Well, what -- you know, even if this is fantastic and does alleviate dysphoria, part of our job as surgeons is to think to the next step. What are we going to do now? You know, that's kind of our job and we probably all do that in different ways. But, my statement is --

Q What I'm getting at is just trying to make sure that we're talking about the same thing when we talk about what it means for something to meet accepted standards of medicine. And I hear you to be interpreting that phrase as has it been proven definitively to be effective in a way that outweighs the risks?

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A If I may, if I said proven, what I -- my thought was that I said has it been demonstrated, reproducibly demonstrated. It's difficult to prove anything in medicine and I recognize that. I fully recognize that point.

Q So, my question is whether the phrase "accepted standards of medicine" could, instead, refer to the fact that the research is still out, but given what we know, we're going to say it's an acceptable option for doctors to pursue in their own professional judgment? Is that another plausible definition of accepted standards of medicine?

A Repeat that one more time.

Q Yeah.

A Please.

Q So, the definition I'm suggesting is that something could meet accepted -- the meeting accepted standards of medicine could mean that even though more research needs to be done, it is an acceptable option for doctors to pursue in their own judgment?

A It's -- it's not outside the pale of popular sentiment to pursue, correct.

Q Okay.

A There's a difference in that, and as the

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American Psychiatric Association has candidly demonstrated, one must interpret medical -- there's a difference in medical sentiment and popular opinion, even professional opinion, and standards of care. And it is not obviously necessary for us to have, according to some societies, well-substantiated quality evidence to make a recommendation. Now, different specialties and different individuals than specialties are going to have different comfort levels with those recommendations. But, as surgeons, the effects of what we do are tangible and lasting and often irreversible, so it bears that we consider those things, in my opinion, even greater degree of scrutiny than perhaps other disciplines may.

Q Do you think that the medical community has been too lenient on -- in accepting surgery for gender dysphoria as an appropriate treatment option?

A I don't get that impression. I don't get that impression, no, sir.

Q And why is that?

A My impression is that there are a number of surgeons who have been willing to assist patients in this regard, have found in their own experience that they can execute the surgery, albeit with a

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high degree of complications, but to achieve the benefit for those people that they see in their patient population, they believe it reasonable and thus feel it indicated and appropriate to discuss within the body at large.

Q And those physician's treatment decisions are not outside the bounds of accepted medical opinion?

A Medical opinion is ever changing, Josh. I would say that those decisions are not inherently ill-intended. I think, you know, I have confidence that a physician like Dr. Schecter is working for the good of his patient. As you alluded to earlier in the corrective surgery of Dr. Djordjevic, who can say what was going on? You can get online and read any blog and hear that common complaint from patients that I feel like I just got hustled. And that nobody really took time to talk with me about this and what the implications were. Those are -- whether those are true or not, I can't say. But my impression, as it relates to plastic surgery, is that there are a select number of physicians, including Dr. Schecter, who have found that they can reproduce some things. Now, I don't know Dr. Schecter would be better qualified, certainly

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than I am, to talk about the results of his practice, his complication rates over time, and what he sees as a tangible benefit for these people. But -- and I don't think any candid surgeon would ever discourage a colleague who is striving to do something in the patient's best interest from doing so.

Q But, so it's possible for you to disagree with the decision and still have that decision be within the bounds of accepted standards of medicine, right?

A That's possible, yes, sir, for any of us, any physician in practice.

Q So, do you think the work of Dr. Schecter is within the bounds of accepted standards of medicine as it currently exists?

A Which works specifically?

Q Providing surgery to treat gender dysphoria.

A I think it's in as much as he has satisfied himself that his complication rate -- and I say this because I don't know this. Every surgeon has to look at his own practice and say, okay, for what I'm providing these people and what they're emerging from this with, I'm satisfied that the good

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outweighs the adverse effects. I don't know that. I would presume, based on what I know of Dr. Schecter, that he's operating under that principle.

Q So does that mean that he's meeting accepted standards of medicine?

A There's no standards to meet. As we discussed, the ASP -- we don't have any standards. We being the surgical bodies do not have standards as of to date. That may all change, but -- but we don't have any right now, so I don't -- it's impossible for me to say whether he's meeting standards when there really aren't any to speak of in this regard.

Q So, if -- so, this brings up a good question. If a surgical body has not issued an authoritative statement on a particular procedure, the fact that someone -- it's still possible -- let me start again. In the situation where the medical body has not issued an authoritative statement on a procedure, how do you determine whether or not a physician that chooses to perform that procedure is meeting accepted standards of medicine?

A Well, I can't really think of any occasions where -- within my practice there's

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anybody that is practicing something that is -- that doesn't have some relevant recommendation associated with it.

Q You think gender dysphoria doesn't have a recommendation associated with it, is that right?

A Not from a surgical society. There's one from -- obviously from WPATH.

Q But, is every other surgery that -- that you -- that a trained plastic surgeon performs governed by a particular statement from the American Society of Plastic Surgeons?

A I don't know. I don't know. I don't -- based on the -- my practice, there's nothing that is novel or outside the scope of what is commonly assessed within the purvey of any completion of any ACGME approved process or that would enable a surgeon to complete board certification without knowledge and expertise within those domains of medicine, plastic surgical medicine, I should say.

Q But --

A I haven't referenced the ASPS reference in that regard. It's more of a society web page, and I mentioned in my declaration only in as much that it's a relevant body within the world of plastic surgery for what I think you're discussing, Josh,

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and what you're getting at, probably the more germane body would be the American Board of Plastic Surgery.

Q Okay. To your knowledge, does the American Board of Plastic Surgery include surgery for gender dysphoria as a topic on which people can be tested on for certification?

A I would surmise that it presently may be.

Q And to the best of your knowledge and experience, does the American Board of Plastic Surgery test people on procedures that don't meet accepted standards of medicine?

A In as much as that, yes, they would select to screen out candidates who are practicing cases or in a manner that doesn't meet the standards, yes, those cases may be presented. Their presentation does not, de facto, make them such a case but they can presented. That's speculative.

Q But if -- does the fact that -- taking the -- does the fact that the American Board of Plastic Surgery tests people on their knowledge and ability to perform surgery for treating gender dysphoria indicate that that surgery is accepted or that that surgery meets accepted standards of medicine?

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A Well, this is a case where I would not be qualified to answer because I've not been through the board certification process in a few years. I'm active on CME and actually cede my CME requirements considerably, but I have not seen any -- any CME requisites that require for ongoing certification, knowledge, or competency in that regard.

Q Okay. So, changing topics, so we've been discussing your medical opinion on performing SRS, but you mentioned you also have -- have an opinion based on your faith regarding SRS, is that right?

A Well, I have an opinion on everything based on my faith, yes, sir, it informs my every decision.

Q So, aside from -- aside from your medical view, what is your faith view about providing SRS?

A Josh, my faith view is that the human body is a reflection of a creator. It is not something to be truffled with lightly. Or as if it is something simply a composite clay to be molded to the scope, extent, and nature of myself or anyone else. That is not to say that we can't improve upon disease states and that is not to say that if a disease state is present that, by alteration of the body, that we cannot offer alleviation of pain or

distress, that there's not a valid reason for doing so.

Q Just to be clear, performing SRS to treat gender dysphoria does not fall into that category under your faith view?

A Which category?

Q You know, you said that the human body, you know, should not be altered, you know, just based on people's desires. That does not mean, however, that, you know, we can't perform surgery to, you know, address disease? I just want to confirm that that "does not mean" caveat, you know, doesn't include gender dysphoria as an acceptable -- SRS to treat gender dysphoria as an acceptable treatment that's compatible with your faith view?

A If I may say, I don't think it's wise. I'm not saying we can't. What the rest of the world does and even within our societies, we're going to have disagreement on things. It's very different to say I don't believe this is wise and to say we can't. That's a different matter entirely from saying I don't think this is wise because I don't see what I've already discussed over time a substantiative objective reproducible benefit.

Q But even if a substantiative reproducible

objective benefit did exist, you would still, just as a personal matter, have a faith-based objection to performing SRS?

A I would have great trepidation, yes, sir. I would have great trepidation about that.

Q So, would performing SRS conflict with your religious beliefs?

A At the present time, performing a nascent sex reassignment surgery, yes.

Q Would performing SIS conflict with your religious beliefs if data existed proving substantive objective, positive, easily reproducible effects, would performing the surgery, nevertheless, conflict with your religious beliefs?

A It would. And that's not to deny its efficacy.

Q Understood.

A Let's say, for instance, with euthanasia, that's a tough problem, I've watched people suffer with that. My religious belief is -- and I've -- I do think about this more than I care to -- is such that I believe that decision is beyond the scope of my wisdom and judgment and I have yet to meet another human being who, despite their intellectual prowess and academic credentials, has been able to

achieve that state whereby they are qualified to meet that. Even though there's no doubt, though, if you give that person an injection of so much Propofol, they will not suffer, that is incontrovertible, they will be gone. But it doesn't give me a level of comfort that what we did as physicians was the best thing for them, if that makes any sense.

Q It makes complete sense. And you think that someone's -- is it fair to say that you agree that someone's faith-based views on a procedure should be distinct from their medical views on whether it meets accepted standards of care?

A I think the honest person is going to look candidly, as I mentioned earlier, I believe, the only thing that I'm really certain of, I believe there is a God and I am not him. So my views may or may not matter, ultimately. What I seek to do is align my views with my understanding of faith and God and also of the practice of medicine in accord with standard of care, based on the best of our field, no matter what their religious belief is.

Q You look to medical sources and peer-reviewed medical journals when -- when determining whether something meets medical

standards of care?

A I do. And I don't know why there's an inherent contradiction between a person's faith and the execution of their faith and the practice of medicine at a level that's extraordinary or standard of care.

Q Would you view the National Catholic Bioethics Quarterly as a publication that you would look to to determine whether a particular procedure meets accepted medical standards of care?

A I would not. I might not be in disagreement. I don't know that publication. But if my personal religious beliefs are under review, there are a number -- I don't find a number of tenants of the Catholic component of Christianity with what I read in the New Testament. So I don't know that I would even look to that for even religious matters. But, again, there might be some common threads that I might share -- I've never read -- I'm not familiar with that publication.

Q In determining, you know, an answer to a medical question, you would generally rely on peer-reviewed publications, is that right?

A Yes, sir.

Q And peer-reviewed publications in medical

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journals, is that right?
A In combination with the reality of what I see.
Q And is there a distinction, in your mind, between a publication that is peer-reviewed and a publication on medical issues that is not peer-reviewed?
A Well, the principle of peer review is an excellent one. And I think if the integrity of the process is maintained, peer-reviewed literature is ideally stronger that non-reviewed literature, yes, sir.
Q Does your personal faith view inform your medical decision making?
A I believe that it does. I believe that based on -- I mean, as my practice is testament to, I think if you're homosexual, heterosexual, bisexual, transsexual patients, and I see no conflict with what the life of Jesus Christ is in the care of these people. I don't -- I guess there should be a conflict based on the question, but I don't perceive a conflict. I don't. I would hope it would inform my practice.
Q And does your faith view inform what surgical treatments you consider to be medically

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appropriate?
A What do you mean by medically appropriate, Josh? For instance, an 18-year-old girl may show up to my clinic seeking breast augmentation. And she may have with her a 55-year-old male who says that he's paying for the surgery. She's a cis female, not interested in gender transition. My viewpoint, based on my faith, is that I have no business executing that surgery. Can it be safely executed? Oh, yes, to the tune of 300,000 of them a year, but many people say, Well, you're being paternalistic, who are you? It's her body. It is her body. But once I put an incision on it, I start a process that's irreversible. There's ample number of surgeons who may perform that surgery for her and Lord knows, based on what insurance reimburses us for some procedures, it would be very attractive to do that as opposed to the type of work that I do. But to answer your question, my faith informs, yes, sir, my practice, my life, my marriage, how I conduct myself in this deposition, you know, how I conduct myself with the janitor at midnight when I'm walking down the hall in the hospital. I mean, if it didn't, I wouldn't think it a faith worth having. I'd throw it in the trash can.

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Q I want to turn to the rebuttal report of Dr. Schecter, which I think we already marked as an exhibit. And have you reviewed that rebuttal report before today?
A I have reviewed it. In all candor, I reviewed it on the tarmac at O'Hare on my iPhone, so -- and through a series of untoward events in the time since it's been forwarded to me, I have not been able to print it off, so I'm looking at it in print for the first time.
Q Is there anything about his rebuttal report that you disagreed with?
MR. JOHNSON: Object to that. Vague and indefinite.
A The report, as I understand this, is a review of Dr. Schecter's credentials, which are certainly impressive, other than his rebuttal of my comments about the Meyer paper and my drawing a conclusion.
MR. JOHNSON: Go through the report.
A I would state even Point 23, Page 6, that even with proper observation of WPATH guidelines, that's quite a presumption to say that those will, de facto, obviate any potential for patients to go through surgery that may have not been good

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candidates to do so. There's tremendous variability in the quality and credentialing process, as I understand it, of psychology, to say nothing of psychiatry. I think in Point 22 --
Q 22?
A Yes, sir. Dr. Schecter and I obviously see very differently. He has reached a point in his practice where he feels that he has no objection to remove physiologically healthy tissue in pursuit of a goal that he obviously has achieved a level of confidence that he can obviate with his surgery. I haven't seen that based on my experience and observations.
Q So do you, in your experience, are you willing to perform surgery on physiologically healthy tissue in order to prevent disease?
A With reasonable likelihood of development of disease. I think in Point 19, I think my -- my intention in reviewing breast augmentation is different in the sense the point I'm making in that is: Are we talking about a disorder or are we talking about dysphoria? Because there's lots of women who are dysphoric about the state of their body and no one expects that to be covered under insurance. If we're talking about a true mental

disorder that we can alleviate by surgery, general consensus, that's unprecedented and may well be the case. But if it is so, and that's my observation, just Daniel Sutphin, in taking care of these people, if there is mental discord and distress there, there is more than just simple dysphoria. And to couch it in terms that we may think are less discriminatory or emotionally harmful to the patient, I don't do the patient a service if I don't call what's happening what it is and I can do that in a respectful manner and in a manner sensitive and that's my obligation as a surgeon to do so, but I don't help them if I ignore the process. And by not calling it as such, I think it creates a lot of confusion in terms of diagnosis.

Q So your view is that some transgender people have a level of dysphoria that is low enough that it's comparable to the displeasure that a cisgender person might have with their physical body?

A Not only me, but it's even observed in this month's Clinics; that, really, that's actually going to be an issue in the future with insurances because there are people who are really not even dysphoric but are seeking these surgeries and now

what do we do?

Q But you agree that there are at least some transgender people who have dysphoria that is much more severe so that it qualifies, in your view, as rising to the level of a mental disorder, is that right?

A It appears to me to be much more severe than dysphoria.

Q And you agree that that set of people are not comparable to a cisgender person who wants surgery because they're uncomfortable with their body?

A I don't see the degree of distress in that patient population, no, sir.

Q Just want to make sure that the -- I think I understand what you're saying, but you're saying you don't see -- when you said that you don't see that degree of distress in the patient population, you were referring to cisgender women, right?

A Correct. And so, that's part of the illustration in Point 19. That, to me, further underscores, from a state perspective, if what we're talking about is dysphoria, I don't know how we would expect the state to pay for -- or a third party to pay or cover a procedure if what we're

talking about is a real disorder. That's, perhaps, a valid point, if the other criteria that we discussed about, at least to my opinion, are satisfied. Obviously, based on Point 20, Dr. Schecter does not believe the definition of reconstructive and cosmetic surgery. He does not ascribe to that definition of surgery that I do, that I stated earlier. I made no statement in Point 24, whatsoever, regarding the frequency of regret. My only point is to illustrate it does occur. And I did not raise it as such as a statement, gender reassignment surgery should not be performed because there is a large percentage of regret, it's just for consideration, a candid point for consideration. We discussed the Point No. 25. And I do understand Dr. Schecter's -- and how he would perceive that. That's not my point in illustrating that. It's just a casual observation in the sense that I stated earlier. And Point 26, the research, which is research as well as my own clinical expertise, I would say that based on the volume of his practice he does have considerable expertise, show that surgical procedures for gender dysphoria are safe and effective. I would argue that there are so many procedures. Are we talking were trans men, trans

women, what -- that's a very broad statement. I don't know of any other procedure that I would offer reproducibly knowing that the complication rate of something is 40 percent and call that safe.

Q Well --

A I would say it's a procedure fraught with complications and, in fact, one of -- one of our colleagues notes that. Even going so far as to describe a procedure like phalloplasty is a hydra with multiple tentacles of potential pitfalls, so --

Q Let's confine the statement in this paragraph to vaginoplasty and chest surgery.

MR. JOHNSON: Excuse me, paragraph what?

MR. BLOCK: 26.

MR. JOHNSON: 26?

MR. BLOCK: Yes.

A I think it would be better to say "can be executed safely and effectively." They are not, by default, safe and effective. If they were, we wouldn't be talking about fellowships for them.

Q (By Mr. Block) But they can be executed safely and effectively?

A In the hands of people like Dr. Schecter, yes, sir, I would presume, again, I haven't seen his own personal literature, but I would presume that,

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given his practice, that he finds the same to be true. I don't know what he's referencing when he describes the medical community. I'm not sure what he's talking about with these analogous procedures. Presumably any such procedure like mastectomy for a cis woman, to the point that I made earlier, I'm not sure that just because we can execute it safely doesn't mean we necessarily should.

Q Do you agree that the surgical techniques used for these surgeries are adapted from surgical techniques that are performed on cisgender patients?

A Some, not all. For instance, vaginoplasty with penile inversion is truly novel. Very creative, I might add. And just like a plastic surgeon to come up with. I disagree with Dr. Schecter's statement in Point 28, no matter what the ascribed gender of the patient; assigned, perceived, otherwise, there's still the reality of biology and if ignore that we do that to the peril of the patient and to the peril of the medical record. I don't understand Dr. Schecter's use of a subcutaneous mastectomy unless he's performing it for a female patient. That code is, by default, performed for a female patient. The code that was submitted for this case was that for gynecomastia

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and, Josh, those are two very different things. Very, very different. And that's something that, no matter what side of this coin a person is on, we all recognize that there's certain principles you have to acknowledge the IMF. You have to acknowledge the blood supply to the nipple. You have to be aware of the fact that the female nipple is going to be wide and effaced in most cases at this point in a women's life, so I don't -- I think candor is vital, whatever we do and decide, I think we've got to be candid about are we doing a mastectomy, which is the code Dr. Schecter would assign, versus the code that was utilized in this case, which was --

Q So the code Dr. Schecter would assign is consistent with your view of what the proper code would be?

A Yes, sir. Yes, sir. And my apologies if I wasn't clear on that. The code that I understand was used in the case was not this code.

Q Understood.

A And it was not -- it was presented as gynecomastia, not as the reality of a natal female breast. Irrespective of where you come down on the argument, the pathologist needs to know that when he or she gets the specimen, because a woman who's

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obese at 53 of age, you're going to be much more concerned about an occult breast cancer in that than if you're getting a little bit of gynecomastia. Much, much different scenario.

Q In your practice, have you ever submitted authorization requests for a procedure and used the wrong code by accident?

A I would imagine I have, but I never ascribed a letter that ascribes a condition and, based on my interpretation of the language used in the letter seeking approval. There's a big difference in gynecomastia refractory to weight loss and natal female breasts. I don't perceive Dr. Schecter would make that comment in any of his cases. In Section 29, looking specifically at complication rates from chest surgeries. Two recent studies reveal a complication rate among transgender men between 11 and 12 percent in comparison to the complication rate of 43 percent for cisgender women undergoing breast reduction in a 2005 surgery -- or study, excuse me. To the point that I just made, the female breast is different, is a different construct altogether, the biological female breast. And Dr. Schecter, in his discussion here, doesn't go on to reveal what -- we can say major complications,

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moderate complications. I, at this point, have not read this study to know, and No. 5, analysis of breast reduction complications, but it is -- a breast reduction is not the same surgery at all to that of a mastectomy, subcutaneous mastectomy. If I'm understanding the patient population, are we talking about transgender men meaning natal females who are transitioning to men?

Q Yeah, if you look at Footnote 4, female to male transgender chest reconstruction, so these are natal females having chest surgery.

A To answer this more intelligently, I would have to see what is the age. For instance, even in cis women, we notice a -- once a woman gets past the age of 45, her risk of wound healing complications, infection, tends to go up considerably. We think that's likely tied to hormonal-related changes in the breast parenchyma. At that station of life more women may begin to experience menopause. And we, in light fashion, speculate that some of that change is due to change in vascularity of the breast, again, I'd have to look more in depth at that. Those are my comments.

MR. BLOCK: Thank you. Just give me a moment. So we can go off the record.

(Break Taken.)

Q (By Mr. Block) Back on the record. I don't have any other questions. Is there anything that you felt you were unable to say in the course of this deposition that you want to say?

A I've never met Dr. Schecter, don't know him. His name's come up, given his prevalence in some of these discussions, I think it's important to distinguish to the point that I made earlier, even though we can execute a surgery today, part of our obligation of surgeons is to really follow up over time. And that holds for any procedure, whether it's the DIEP flap and abdominal site morbidity. When you see patients who have had the surgery come back in ten years later with abdominal bulge, pain, and even hernia defects, that's not going to show up in the initial literature and that's why, again, I -- I don't see anything in the literature right now that talks about a sustainable long-term benefit to this surgery that will justify a real standard of care transition. I don't -- personally, I don't think that's possible until we can demonstrate, though Dr. Schecter and his comments notes it's safe and effective, what exactly is safe and effective? For the first three months? Effective for making

the person feel subjectively better? Again, that's why I really find studies like Dhejne's useful because that's something that we can all look at and isn't under the subjective purvey of one surgeon or a team of surgeons or a group of patients who are so distraught by this condition they're willing to accept significant complications to alleviate. My position remains as such as what I've stated.

Q And is 15 years usually a good followup period?

A I think it's a great start. I think it's a great start.

Q And one more question. Is -- are there procedures that -- that view as medically appropriate to treat symptoms in the short-term even if they aren't ultimately a care for the condition?

A None that I can think of with the magnitude of what we're talking about here today.

Q Anything on a smaller magnitude?

A No, sir. I mean, not from a surgical perspective, no, sir.

Q So if there's like a growth that is likely to come back, you know, after a period of time, is -- but would the practice be not to perform surgery to remove the growth if you weren't sure it

wouldn't grow back?

A If I knew the likelihood of growth is it's going to grow back, I'm not doing a service to the patient to operate on them in the first place unless they're tripping over it, so to speak. Now, I can go ahead and do the surgery and go for it, but if I know that it's going to be back, if so, when, what is the implication? What are the risks of surgery of doing that procedure? And it's -- that's the one really good thing about this scenario that we're talking about in terms of sex reassignment, gender confirmation surgery, is the -- it's not just in the realm of the theoretical papers like Djordjevic and in this month's Clinics. When you look at that, you don't have to be a professional, you can be a laymen and say, wow, this is the real deal. How do we really know that this is really what's going on and if we're putting these people through these surgeries, boy, what do we have to show for it for them, like 10, 15, 30 years down the road?

Q What treatment should someone with severe gender dysphoria have, in your opinion?

A I don't know, Josh. If I did, I'd certainly be one of the first people out there trying to provide it for them. Like I said earlier,

there would be a nice prize on my wall. I don't know. And I'm fully not satisfied that any of us really do.

Q And so, in your opinion, there's no medical treatment that could be, you know, responsibly offered to them that's consistent with accepted standards of care?

A I think if somebody's willing to ignore the fact that we don't have long-terms outcomes data, I haven't seen a patient in that level of distress yet that I feel comfortable offering. I'm not an endocrinologist but, you know, if you were my brother and this is something you're looking for, obviously, and I actually work with an individual whose natal sex sister, female, has now undergone transition to a male, if you were contemplating this, I would have grave concerns about, gosh, it might make you feel better, but what is -- what is 20, 30 years of estrogen going to do for your body? What's it going to do? And we've not even discussed things like bone structure. Those -- those are valid questions. And I don't think we have sound answers and I think the question of responsibility lies with if we're willing to disregard that or set that aside, that we just don't have those outcome,

and we don't know -- perhaps we can use the word responsible. If we're just ignoring those and pretending like that data exists, it doesn't, and I don't think that's responsible for us to say as a medical community at large. I don't. I don't think that's, you know, when you -- when you become a physician, you need something more than speculation and sentiment. You need -- whether those -- those data exist or they don't, you're trusting a physician to tell you that.

Q Well, I mean, you agree that low quality data exists, right?

A Subjective data. It seems to me, based on what I've read thus far, it's impression. And impression is not without value. But impression, in my mind, is not grounds enough to substantiate incurring the risk to people in executing in real life the procedures that are occurring.

Q And you agree that someone's clinical experience in working with patients and seeing improvement over the long term is also a form of data?

A Yes, sir.

MR. BLOCK: I don't have anything else.

MR. JOHNSON: I've got a few.

EXAMINATION

BY MR. JOHNSON:

Q Listening to your testimony, appears you looked at Dr. Schecter's education and training and experience?

A I have looked at his education and training.

Q And you believe he's a fine and skilled surgeon?

A I believe he has sound credentials.

Q Okay. And I think you've testified, based upon his credentials, he should be able to do a skilled and good vaginoplasty or phalloplasty?

A I can only comment that he has sound credentials. I have not seen any of his patients. I've not been able to subjectively measure the results of his --

Q Well, assume he can do it skillfully and if he reports that the patient tells him that the dysphoria has been helped -- strike that. You have no indication he's not a skilled physician?

A Correct.

Q Okay. And that he could do many forms of SRS surgery?

A Based on what he has put forth, correct.

Q Sure. In your report, you referred to the 2016 CMS study or decision?

A Yes, sir.

Q Okay. That's one that talked about the Swedish study, correct?

A Yes, sir.

Q Okay. Did -- from your reading of the CMS 2016 decision, did CMS look at the literature to try to determine the long-term outcomes of patients that have SRS surgery?

A No, sir. I don't know that they could find any good data on that.

Q But they looked at whatever literature it was they looked at?

A Correct. What was existed at the time. I don't think that they weren't looking. I just know they couldn't find it.

Q Did they say they looked at the Swedish studies?

A Yes.

Q And they looked at other studies, correct?

A I would say, in my impression, Dhejne's study was probably the best quality.

Q Did they say they didn't find high quality evidence of studies that allow them to reach a

conclusion on the long-term outcomes of the surgery?

A My understanding of the CMS paper was that there was not.

Q Strong evidence?

A Strong evidence.

Q Did they suggest more robust studies in the future?

A Yes, sir. Which, I think, incidentally, is the same position that I would posit, put forward.

Q Did you do a search beyond CMS to try and find other studies?

A Yes, sir.

Q And I think your testimony's been that you agree with CMS, there's just not sufficient, strong studies on long-term outcomes?

A Not in my opinion.

MR. JOHNSON: Thank you.

EXAMINATION

BY MR. BLOCK:

Q In your opinion, are there sufficient studies to demonstrate harm from transition-related surgery?

A Yes, sir. What kind of harm are we talking about? I mean, any complication is harm.

We can talk about whether we think it's justifiable or not, but yes, sir.

Q In your opinion, is there a basis to include that having transition-related surgery can increase someone's risk of suicidality?

A I don't know of any data. Dhejne's study, for instance, doesn't -- doesn't address that. It only observes the fact that there is a markedly -- there's a marked increase in suicide for those individuals that have undergone sexual reassignment, but it doesn't comment on whether that incident may have been higher without sex reassignment surgery. It underscores the very concern that I have and that is there's something that we're missing that even though these people may initially feel better, we're not getting to the heart of the matter. And I'm not sure, to answer your earlier question, Josh, I'm just not sure that any of us know. That's not to say we shouldn't do anything. But surgery requires, I mean, that much more caution because the impacts are so profound and tangible for people's lives.

Q Is it fair to say that CMS concluded that there wasn't sufficient data to justify prohibiting coverage for transition-related surgery?

A Well, I guess, depending on how we couch

the term, there was not data to support it. And in one sense they left all of us in a conundrum because it leaves us in this matters of verbiage. There's no data at this point for them to issue a statement saying, hey, we find that this is well supported, move forward.

Q But they had the option of concluding that surgery should never be covered, right?

A They had the option and they -- again, to my estimation, on one hand, they said we don't find the data, but yet, why they didn't issue a statement saying we just -- we're not going to offer it, because we don't -- obviously, they are not basing their decision solely on data either.

Q Well, so it's not fair to say that they didn't see enough data demonstrating significant risk of harm to justify having a blanket prohibition on coverage?

A They didn't issue it. Yes, sir.

Q So, the data was not conclusive enough for them to determine either way?

MR. JOHNSON: Well, excuse me, I'm going to object; asking this witness to testify to the state of mind of thought processes of people that wrote that decision.

A That point is understood. I would also submit that that's no way for us to do surgery. Let's do it because we don't see enough -- we might be able to do it because we're not seeing enough. Let's see if we can -- I don't -- I don't see that as a really valid option for surgery. If we're going to subject another human being to the risk of something, we need to emerge with that, with a high degree of confidence that we can execute it with a reasonably low level of complication, and I can't know what those reviewers -- why they made the decision as they did.

MR. BLOCK: Okay. That's it on my end.

MR. JOHNSON: No more from me. No mas. He'll read and sign.

(Ending time of the deposition: 4:41 p.m.)

STATE OF MISSOURI)
)SS
CITY OF ST. LOUIS)

I, Rebecca Brewer, Registered Professional Reporter, Certified Real-time Reporter, and Notary Public in and for the State of Missouri do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of the said witness was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken, and further that I am not relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

_____ RPR, MO-CCR, Notary Public within and for the State of Missouri

My Commission expires April 7, 2021

Mr. Jerry Johnson
Jerry Johnson Law Office
909 St. Joseph Street, Suite 800
Rapid City, South Dakota, 57701
Jdjbjck@aol.com

In Re: BRUCE vs. STATE OF SOUTH DAKOTA.

Dear Mr. Johnson:
Please find enclosed your copy of the deposition of DR. DANIEL SUTPHIN, M.D., FACS taken on JULY 17, 2018 in the above referenced case. Also, enclosed is the original signature page and errata sheets.

Please have the witness read your copy of the transcript, indicate any changes and/or corrections desired on the errata sheets, and sign the signature page before a notary public.

Please return the errata sheets and notarized signature page to Alaris Litigation Services, 711 N. Eleventh Street, St. Louis, Missouri, 63101 for filing prior to trial date.

Thank you for your attention to this matter.
Sincerely,

Rebecca Brewer, RPR, CCR (MO), CRR

cc: Ms. Leslie Cooper/Mr. Joshua Block

State of)
County of)
I, DR. DANIEL SUTPHIN, M.D., FACS, do hereby certify:
That I have read the foregoing deposition;
That I have made such changes in form and/or substance to the within deposition as might be necessary to render the same true and correct;
That having made such changes thereon, I hereby subscribe my name to the deposition.
I declare under penalty of perjury that the foregoing is true and correct.

_____
DR. DANIEL SUTPHIN, M.D., FACS
Executed this_____day of_____ 2018, at_____.

Notary public:
My Commission Expires:

Signature page to: DR. DANIEL SUTPHIN, M.D., FACS
BRUCE VS. STATE OF SOUTH DAKOTA

WITNESS ERRATA SHEET
Witness Name: DR. DANIEL SUTPHIN, M.D., FACS
Case Name: BRUCE VS. STATE OF SOUTH DAKOTA

Date Taken: JULY 17, 2018

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