EXHIBIT 74

SUBMITTED UNDER SEAL

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION
Civil Action No. 2:22-cv-184-LCB

BRIANNA BOE, et al.,
Plaintiffs,
UNITED STATES OF AMERICA,
Intervenor Plaintiff,
v.
HON. STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama, et al.,
Defendants.
_____/

2 Biscayne Boulevard
Miami, Florida
April 29, 2024
9:58 a.m. - 3:22 p.m.

DEPOSITION OF KENNETH GOODMAN

* * * * * MARKED CONFIDENTIAL * * * * *

Taken before SUZANNE VITALE, R.P.R., F.P.R. and Notary Public for the State of Florida at Large, pursuant to Notice of Taking Deposition filed in the above cause.

APPEARANCES:

On behalf of Plaintiff:

HUMAN RIGHTS CAMPAIGN
1640 Rhode Island Avenue, Northwest
Washington, DC 20036
BY: CYNTHIA CHENG-WUN WEAVER, ESQ.
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On behalf of Defendants:
ALLIANCE DEFENDING FREEDOM
44180 Riverside Parkway
Lansdowne, Virginia 20176
BY: PHILIP SECHLER, ESQ.
psechler@adflegal.org

ALSO PRESENT:
Jennifer Levi, Esq.
Aime Murphy, Esq.

I N D E X

Thereupon:
KENNETH GOODMAN,
a witness named in the notice heretofore filed, being of lawful age and having been first duly sworn, testified on his oath as follows:
DIRECT EXAMINATION
BY MR. SECHLER:

Q. Could you please state your name?
A. Kenneth Goodman.
Q. Dr. Goodman, my name is Phil Sechler. I represent the Defendants in this case.
You have been retained to testify as an expert in this case; is that right?
A. Yes.
Q. And who retained you?
A. My colleagues from the Human Rights Coalition.
Q. When were you retained?
A. Last year. I don't recall exactly.
Q. 2023?
A. Yes.
Q. Do you recall the season? Was it the winter, fall?
A. I do not.
Q. Okay. You're not a medical doctor?

A. I am not.
Q. You don't practice medicine?
A. I do not.
Q. You've never practiced medicine?
A. Never.
Q. You've never treated patients?
A. No.
Q. You don't have authority to prescribe medications?
A. I do not.
Q. And you don't provide recommendations as to particular forms of treatment?
A. I do not.
Q. You're not a psychiatrist or psychologist?
A. No.
Q. You're not an expert in mental health?
A. No.
Q. Nor an expert in the study of cognitive development?
A. Correct.
Q. Do you have any publications on mental health?
A. I have some that bear on behavioral health construed broadly, especially regarding ethical issues.

Page 6

Q. What publications do you have that bear on mental health construed broadly?
A. Well, developmental psych -- joint publications, a chapter with a colleague in Child Psychiatry, something on end-of-life care and behavioral health.
I'd really like to look at my CV to recall that exactly.
Q. Sure. Let me mark two exhibits, Dr. Goodman.
This will be Number 2.
(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 1.)
(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 2.)
BY MR. SECHLER:
Q. Dr. Goodman, I'm handing you documents marked 1 and 2.
A. Thank you.
Q. When you get a moment, can you identify the documented marked as Exhibit 1, sir?
A. Exhibit 1 is titled "Expert Rebuttal Report of Kenneth W. Goodman," et cetera.
Q. Is that a report that you prepared?
A. Yes, sir.

Page 7

Q. Is your signature on page 14?
A. It is.
Q. Did you have any help preparing that report?
A. No.
Q. How many hours did it take you to prepare the report?
A. Five, six, seven.
Q. Have you formed any opinions in connection with this case other than what is set forth in Exhibit 1?
A. Not to the best of my recollection. This is a case that raises large issues and it might very well be that I have opinions that might bear on it but which are not articulated in that report.
Q. Were you asked to form any opinions that are not articulated in that report?
A. No.
Q. And as you sit here today, do you know whether you've formed any opinions that are not set forth in that report?
A. No, not that are salient.
(Reporter clarification.)
Q. Now if I can ask you to take a look at paragraph 9 of Exhibit 1, which is on page 4.

Page 8

A. Uh-huh.
Q. Is that a list of the documents that you reviewed in connection with preparing your report?
A. I'm not seeing a list.
Oh, sorry, page 9, yes?
Q. No, I'm sorry, page 4, paragraph 9.
A. Oh, sorry.
Q. That's okay.
A. In paragraph 11?
Q. No, I think it's paragraph 9, sir.
A. Oh, sorry. I beg your pardon. Of course. Yes.
Q. And is that a list of documents that you reviewed in connection with preparing your report?
A. Yes.
Q. Did you review any other documents other than what's set forth in paragraph 9 in reviewing your report?
I think I misspoke. Let me just restate that.
Did you review any other documents other than what's set forth in paragraph 9 in preparing your report?
A. Excluding the literature in the field, excluding my reading about this in general.

Page 9

I mean, these are the documents I reviewed for the sake of the report. One might actually read something else during the course of the preparation of the report.
Q. Did you review anything other than what's set forth in paragraph 9 --
A. No.
Q. -- in the course of preparing the report?
A. For the sake of the report, no.
Q. And as you sit here today, have you viewed any other materials, other than what's set forth in paragraph 9, in connection with this case?
A. No.
Q. You didn't review any of the depositions so far that have been taken?
A. I don't recall which once I've been given. These are the ones that I used in the preparation of this report.
Q. Well, paragraph 9 talks about reports of other experts, does it not?
A. These reports, yes.
Q. It doesn't mention any depositions, does it?
A. No, it doesn't.
Q. Did you review any depositions in

Page 10

connection with this case?
A. No.
Q. Could you identify the documents --
A. Mine. Sorry.
Q. But when you say yours --
A. No, I'm trying to be literal and explicit. I wrote a deposition. I might have made a reference to it. I might have had a look at it in preparing my report.
Q. A deposition you gave in a previous case?
A. You know, that's a question that's interesting, whether one -- if one's written something, does one review it? How does one review it?
I might have recalled it. Does that count as a review? I don't think so. I think for our purposes, no.
Q. Can you identify the document marked as Exhibit 2?
A. That is my curriculum vitae.
Q. And is that a current curriculum vitae?
A. It was as of a few months ago. It changed in the last week.
Q. How did it change?
A. I've added some publications and

Page 11

presentations.
Q. Would you be willing to share an updated copy of your CV?
A. Of course.
Q. And counsel can send it to us.
Is the CV marked as Exhibit 2 true and accurate in all respects?
A. To the best of my knowledge, yes, sir.
Q. Now, I think where we were, we were going to identify the publications you have authored broadly dealing with mental health.
A. So, for example, the one numbered 66.
Q. What page?
A. Twenty-seven.
Number 81 on page 28. There are three headings, "Chapters," "Publications," "Other Publications."
I'm trying to find what I believe to have been a chapter. Bear with me a moment, please.
Publication 20 on page 21.
So they're the closest ones that seem to bear on of that broad field.
Q. Is it fair to say, Dr. Goodman, that you're not a scientist?
A. Is it fair to say? I think it's fair to

Page 12

say that -- it might be fair to say that I was -- I spent time in a laboratory in computer science and write about that. But I think on an ongoing basis, it's probably fair to say that I'm not a scientist.
Q. You don't see patients suffering from gender dysphoria?
A. I do not.
Q. You've never made a diagnosis of gender dysphoria?
A. I have not.
Q. You've never been involved in the treatment of gender dysphoria?
A. I've been, on occasion, consulted by my colleagues.
Q. Well, you are consulted by your colleagues who are clinicians with respect to ethical issues from time to time, right?
A. Correct.
Q. But none of those consultations have involved gender dysphoria; isn't that right?
A. No, some of -- well, orthogonally. Most accurate answer is no.
Q. No, they did not involve gender dysphoria?
A. I'd say no. There are a lot of cases -- so -- I think the right answer is no.

Page 13

There are cases involving patients, for example, if I may, involving patients who are born with pseudohermaphroditism and there are questions about how they ought to be treated.
These are patients, for example, with one ovary and one testicle. It's not what we're talking about, but it's not wholly unrelated.
Q. And what was the term that you used for that kind of a patient?
A. Well, there's several terms and they change. Pseudohermaphroditism.
Q. How many patients with pseudohermaphroditism have you treated?
A. That I --
Q. I'm sorry. Have you been involved in consulting with the clinicians who are your colleagues?
A. Yes. One, two.
Q. You have not written anything on the topic of gender dysphoria?
A. No.
Q. You've not publicly spoken on the topic of gender dysphoria?
A. No.
Q. Now, in connection with your report, have

Page 14

you reviewed any studies evaluating the benefits or harms of transition medications administered to minors?

A. My job entails that I remain more or less up to date about many issues in healthcare, and in the course of that -- carrying out that responsibility, I have, over the years.

Q. Okay. Are you familiar with the Cass Review?

A. Yes.

Q. You understand that that review came out at the beginning of this month, April 2024?

A. Yes.

Q. Have you read that?

A. I have.

(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 3.)

BY MR. SECHLER:

Q. Doctor, I'm handing you a document marked Exhibit 3.

Dr. Goodman, I've handed you a document marked as Exhibit 3.

Is this the document entitled the "Cass Review" that you have reviewed?

A. Yes.

Page 15

Q. When did you review it?

A. The week that it came out.

Q. How long did you spend reviewing it?

A. A couple of hours and not in one sitting.

Q. Let me ask you to turn to page 13.

Might as well just take that clip off.

Before I ask you about page 13, you're familiar with the reputation of Hilary Cass?

A. I'm familiar with what's been reported about her since the report came out. I was unfamiliar with her before.

Q. Did she have a reputation -- are you familiar with the reputation she has in the medical community?

A. I believe so, yes.

Q. And what is the reputation Dr. Cass has in the medical community?

A. She's well regarded.

Q. Now let me ask you to take a look at page 13, the second column, the third paragraph, last sentence.

I'll direct you to that sentence, and I'll read it, "The reality is that we have no good evidence on the long-term outcomes of interventions to manage gender-related distress."

Page 16

Do you see that?

A. I do.

Q. You're aware that the Cass Review reported that this month?

A. Yes.

Q. Do you agree with that statement?

A. The statement uses the phrase "good evidence" and it's an absolute statement, and so it's a judgment that I think a reasonable person with an equally good reputation might dispute.

Q. Did you dispute it, sir?

A. I'm not competent to assess the scientific evidence. I am relying, as many others, on the judgment of experts, and I just believe there are -- I think it's well known there are experts who would take issue with the idea -- with the framing "no good evidence" et al. That's an absolute statement and I think there are colleagues who would disagree.

Q. Would you agree, sir, that the Cass Review took into account a robust amount of evidence to reach that conclusion?

A. Yes.

Q. And if we look at page 57, do you see there Figure 7?

A. I do.

Page 17

Q. Do you see that figure depicts the vast amount of information that was taken into account --

A. Uh-huh.

Q. -- in connection with the Cass Review?

A. I do.

Q. Let me ask you to turn, sir, to page 29.

Directing your attention to paragraph 58, which says, "Although a diagnosis of gender dysphoria has been seen as necessary for initiating medical treatment, it is not reliably predictive of whether that young person will have long-standing gender incongruence in the future, or whether medical intervention will be the best option for them."

Did I read that correctly?

A. Yes.

Q. Do you agree with that statement?

A. I don't. Having earlier determined my background as a non-scientist, this is a dispute among scientists -- or a report by a scientist. It's making a conclusion about the ability of that -- evidence to reliably predict something. And so I don't know that I'm competent to actually agree or disagree.

Indeed, there are many treatments for

Page 18

which reliable predictions are elusive.
Q. What kind of treatments are those?
A. Pediatrics. Many of them. Oncology, surgery, different kinds of surgery, neurosurgery.
Once again, you're -- my job is to be broadly aware of issues and concerns across the health professions, and to say that something must be reliably predictive would foreclose on a number of interventions that people believe are appropriate in pediatric care.
Q. Have you formed any opinions on the safety of medical interventions to treat gender dysphoria in minors?
A. No. Not other than -- than -- if it were unsafe, the inference is the people who perform it do so believing that it is safe.
There are people who are scientists and clinicians, and so my opinion is going to be shaped by their clinical judgment about the safety and efficacy of intervention.
So to that extent, I regard it as -- I regard it by -- by virtue of my experience and education and knowledge, which when it comes to the safety and efficacy of medical procedures is dependent on that of others. I believe that the

Page 19

trusted colleagues regard it as safe and, therefore, appropriate.
Q. What did the Cass Review say about the safety of medical interventions to treat gender dysphoria in minors?
A. Cass Review was concerned about the safety of gender-affirming therapy.
Q. And would you regard that as a pretty credible source, to be concerned about the safety of medical interventions for adolescents suffering from gender dysphoria?
A. Credible but not necessarily dispositive.
Q. Would you rule it out in your practice?
A. My job is to not -- is to constantly be aware of evidence in pediatrics and adult care of all kinds of research. And so one doesn't rule anything out easily or quickly.
Q. Would you agree that medical interventions to treat gender dysphoria in minors pose a substantial risk of harmful effects?
A. Well, that -- substantial risk of harmful effects is a medical or clinical judgment and I -- it would be inappropriate for me to have an opinion on that other than those that I've already shared with you by proxy.

Page 20

There's always a risk in any medical intervention. If you are asking whether this has systematically more greater or frequent risk than others, I'm not able to assess that.
Q. Would you agree that loss of sexual response and the ability to experience orgasm is a risk of a harmful effect?
A. If that were a risk, that would be an adverse risk, yes.
Q. And it would be a harmful risk, would it not?
A. I think so.
Q. Would you agree that a cardiovascular risk is a substantial risk of a harmful effect?
A. Once again, I'm not -- whether something is substantial or not in a probabilistic science, which is medicine, is one that I would be incompetent to agree or disagree with. There are substantial risks overwhelmingly in many medical procedures.
Q. What did the Cass Review say regarding the efficacy of medical interventions to treat gender dysphoria in minors?
A. As I recall, and perhaps it would be helpful if you can tell me where that conclusion is

Page 21

made, that it was skeptical.
Q. Did you come to agree with that opinion?
A. The evolution of medical intervention -- medical science -- in fact, science in general, is sometimes a very slow and accretive process.
Whether or not the latest report -- I beg your pardon.
Can I change my mind about that water?
And so in an environment in which the evidence is what it is and the reports of various sorts are being offered on a regular basis, I don't regard in the -- in this context that conclusion as dispositive framed by the fact that -- if you're asking me an empirical question about medical science -- thank you so much.
Q. Let me direct your attention to page 32 of Exhibit 3.
If you look at the second sentence of paragraph 82, it says, "There was sufficient -- insufficient/inconsistent evidence about the effects of puberty suppression on psychological or psychosocial well-being, cognitive development, cardio-metabolic risk, or fertility."
Did I read that correctly?
A. You did.

Page 22

Q. Do you agree with that conclusion?
A. I'm not -- not having reviewed the evidence that she did and, moreover, probably not being competent to do so, I don't know that I agree or disagree.
I have spent a lot of time writing about biomedical evidence and am of the view that, as I say, in any particular intervention, is generally slow, accretive, and probabilistic. At any given point in the history of treatment of any disease, that can be true.
But I'm not competent to -- not having either reviewed or being competent to review the evidence she reviewed, I'm not entirely sure I'm in a position to agree or disagree.
Q. Okay. And, Doctor --
A. I note her concern.
Q. Let me ask you to turn to page 194.
If you look at paragraph 16.14 at the bottom of the first column.
Do you see that?
A. Uh-huh.
Q. And the second sentence, "As a result, the evidence for the indicated uses of puberty blockers and masculinizing/feminizing hormones in adolescents

Page 23

are unproven and benefit/harms are unknown."
Did I read that correctly?
A. You did.
Q. Do you agree with that conclusion?
A. Normally in biomedical research, we don't prove or disprove things. Proof is usually a function of logic. So you demonstrate usually. And so I would -- I'm concerned about the use of the term "proven."
I would -- if I had the chance to ask her, I would say, "By proven, you mean what?"
I note her concern, that she believes that the evidence -- the indicated uses is -- is -- she regards as inadequate.
Q. Have you --
A. Once again, I have not reviewed the evidence that she has.
Q. So have you formed an opinion on the efficacy of medical interventions to treat gender dysphoria in minors?
A. I think that too is beyond my capacity.
Q. You understand there has been a sharp increase in the number of minors presenting with gender dysphoria over the last ten years?
A. I have heard that.

Page 24

Q. Would you agree it is now disproportionately natal females who are presenting with gender dysphoria?
A. That, I don't know. Disproportionately. If that's the case, I'm happy to agree to it.
You're asking me which male/female or female to male, that one is more than the other?
Q. Yes.
A. I believe I've heard that. Once again, this is -- this is not -- I have low confidence in my belief about what I've heard recently about that.
Q. Have you formed any opinions as to the characteristics of the population of patients who are presenting with gender dysphoria?
A. No.
Q. And so I take it you've not formed any opinions about the reasons why there is a sharp increase in the presentation of patients with gender dysphoria over the last ten years?
A. Correct.
Q. Changing gears.
Dr. Goodman, what is a clinical practice guideline?
A. A clinical practice guideline is a document that is produced by various organizations

Page 25

to support physicians and others in practice that would include interventions addressed by the guideline.
Q. Have you been involved in the development of any clinical practice guidelines?
A. No.
Q. Have you drafted any conflict-of-interest policies for the development of any clinical practice guidelines?
A. No.
Q. Have you reviewed conflicts-of-interest issues in connection with the development of clinical practice guidelines, apart from your work in this case?
A. I am familiar with the issue of concerns for conflicts of interest as they arise in guidelines and review of evidence, yes.
Q. I'm not talking about the review of evidence.
I'm talking specifically about clinical practice guidelines, okay?
A. Which are based on available evidence.
Q. Correct. But I'm talking specifically about clinical practice guidelines. So let me repeat the question.

A. Please.
Q. Have you been involved in reviewing any conflicts-of-interest issues in connection with the development of clinical practice guidelines?
A. I have reviewed conflicts-of-interest issues as a matter of my professional interests and duties, not in conjunction with any particular guideline.
Q. Right. I understand you are experienced with conflicts of interest. That's not my question.
My question is whether you have reviewed conflicts-of-interest issues in connection with the development of clinical practice guidelines?
A. So that's ambiguous as to between whether I was asked particularly in the context of the Cochrane Collaboration to -- that aided them in such a thing, or whether or not, when it became an issue, I reviewed the issue. The latter is true. The former is not.
Q. Okay. So putting the Cochrane Collaboration --
A. For instance. Sorry.
Q. Putting the Cochrane Collaboration aside, let me ask again.
Have you been involved in the review of

conflicts-of-interest issues related to the development of clinical practice guidelines, apart from your reference to the Cochrane Collaboration?
A. "Review" overstates it, perhaps, given what I think you are -- what you're asking. But I am familiar with the issue of conflict of interest as it arises in the preparation of clinical practice guidelines.
Did that rise to the level of formal review? No.
Is it part of what I do in my interest in evidence-based practice? Yes.
Q. Have you written on the issue of conflicts of interest in the development of clinical practice guidelines?
A. I don't recall. I wrote a book about this once. I don't recall how much I would have spent on -- on evidence-based practice, I mean, and, hence, the role of practice guidelines.
Q. Do you know whether or not your book mentions conflicts of interest arising from the development of clinical practice guidelines?
A. No, I don't recall. This will happen to you one day, Counselor.
Q. I'm not far behind you, sir.

So what was your reference to the Cochrane Collaboration, if you wouldn't mind explaining that?
A. Only that if one is -- I mentioned it because when it was alleged that certain Cochrane Collaboration reports had been -- that some of the people that prepared them were conflicted in one way or another, I tried to learn more about that.
Q. Were you retained by the Cochrane group?
A. No.
Q. Were you retained in connection with someone who had an interest?
A. No.
Q. So that was just kind of a matter of curiosity that you reviewed that?
A. Or a matter of -- well, the good thing about my job is I'm obligated to be curious about many things.
Q. Let me ask you -- we'll mark a new document here.
MS. CHENG-WUN WEAVER: Can I remove Exhibit 3?
MR. SECHLER: You can, thank you.
(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 4.)
BY MR. SECHLER:

Q. I'm handing you a document marked as Exhibit 4.
A. Yes.
Q. And this is the supplemental report of Dr. James Cantor; is that right?
A. Correct.
Q. And you reviewed this in connection with your preparation of your report?
A. I did.
Q. How much time did you spend reviewing Dr. Cantor's report?
A. Couple of hours.
Q. Now, if you can turn to page --
A. Ninety minutes, I'd say.
Q. Turn to page 42, Dr. Goodman.
Do you see paragraph 97 there at the bottom of page 42?
A. Yes.
Q. It lists six references, four on page 42 and two on the top of page 43.
Do you see that?
A. I do.
Q. And you didn't review those six references; is that correct?
A. I am familiar with them, especially the

WHO documents, but I didn't rereview them for the purpose of this exchange.

Q. And -- let's mark a couple of those.

(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 5.)

BY MR. SECHLER:

Q. I'm handing you, Dr. Goodman, an exhibit marked as Exhibit 5.

Can you identify the document marked as Exhibit 5, sir?

A. It is titled, "Clinical Practice Guidelines We Can Trust" by the Institute of Medicine, one of the National Academies of Science.

Q. And this is the sixth reference listed by Dr. Cantor in paragraph 97; is that right?

A. It is.

Q. Have you reviewed the document marked as Exhibit 5 previously?

A. I -- when it was produced, I had a look at it. I don't know if that counts as adequate review for our purposes here. I'm familiar with the document.

Q. If you look at page 2, I believe there's copyright of 2011?

A. Yes, 2011.

Q. And have you reviewed this document any time more recently than 2011?

A. No.

Well, perhaps 2012.

Q. You understand this is one of the documents that Dr. Cantor relied upon for purposes of his report?

A. As he reports, yes.

Q. And how could it be that you could respond to Dr. Cantor's opinions without reviewing one of the documents he relied on for his report?

A. With particular regard to what? Sometimes -- however it is that Dr. Cantor processed that report and was able to give his opinion, I'm responding to his opinion with broad familiarity with the report.

If you can be more specific about what I said about Cantor's report that is concerning, I'll be able to explain how that's entirely possible.

Q. Okay. Let me mark another document.

(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 6.)

BY MR. SECHLER:

Q. I'm handing you, Dr. Goodman, a document marked as Exhibit 6.

Before I ask you about Exhibit 6, sir, are you familiar with WPATH?

A. I am.

Q. And what is WPATH?

A. It's the group that produced the practice guidelines we're discussing today.

Q. And are you familiar with SOC-8?

A. I am.

Q. And what is SOC-8?

A. It's the standards of care, version 8, for health and transgender in gender diverse people. It's version 8.

Q. Is that the document that is marked as Exhibit 6?

A. Six, yes, it is.

Q. Now, if you turn to page S247 of Exhibit 6.

A. Yes.

Q. If you look at the first column, you see a sentence that begins, in the middle of first paragraph, "The process for development"?

A. Yes.

Q. Let me read that for the record. "The process for development of the SOC-8 incorporated recommendations on clinical practice guidelines" --

let me start that again. Strike that.

Reading from page S247 of Exhibit 6, "The process for development of the SOC-8 incorporated recommendations on clinical practice guidelines development from the National Academies of Medicine and The World Health Organization that address transparency, conflict-of-interest policy," et cetera, et cetera.

Do you see that?

A. I do.

Q. So do you regard that as a claim by WPATH that these recommendations incorporated conflict-of-interest recommendations from the Institute of Medicine?

A. It says, "Incorporated recommendations on clinical practice development," yes.

Q. And you understand the Institute of Medicine is the National Academies of Medicine?

A. I do.

Q. And what is the reputation of the Institute of Medicine?

A. It's very highly regarded.

Q. Now, you understand that Dr. Cantor in his report opines that, in fact, WPATH violated the recommendations of the Institute of Medicine in

Page 34

developing SOC-8?
A. I recall that he does make that allegation, yes.
Q. How can you respond or dispute that allegation if you have not reviewed the clinical practice guidelines of the Institute of Medicine -- strike that.
How can you respond to Dr. Cantor's opinion in that regard if you did not review the conflict-of-interest recommendations of the Institute of Medicine marked as Exhibit 5?
A. One of the things that you'll have noticed, both in these documents and your questions, is when someone said, "I've relied on," "I've incorporated," "I have referred to," this happens a great deal in lots of exchanges, perhaps most especially in academia and the law, where when there are two large bodies -- when there's a lot of documentation, and I say to you, "I took this into account when I was framing my report or writing that article or developing that brief," that is inherently vague.
If someone doesn't give a point-by-point list of what they did and how they took it into account, that is very difficult to be able to say,

Page 35

"Ah, there's a point-by-point refutation."
I don't believe for anybody to be able to assess these documents it's necessary to try and figure out the points at which either WPATH or Cantor or anybody else had clear mapping rules between it, this document and any conclusion. That would require a great deal of effort and I don't think anyone has done that yet.
Q. So in connection with your work on this case, Dr. Goodman, have you formed an opinion as to whether WPATH violated the guidelines that the Institute of Medicine has issued for the development of clinical practice guidelines?
A. I don't have an opinion about that.
Q. Now --
A. In the Institute of Medicine report, there are quite a few of them. That's sort of the forensic analysis I was suggesting that I don't think anyone has done.
When someone takes into account something or refers to it or embodies it or somehow metabolizes it, that's going to be with greater or lesser degrees of specificity, and that's something that happens all the time, as you know, in the law and in academia, to be able to say, "Here's the

Page 36

precise dispositive report that I used in framing this opinion." Sometimes the mapping rules between them is inexplicit.
Q. I was asking, sir, whether or not you formed an opinion that there was a violation?
A. I have not formed that opinion, no.
Q. Now, you would agree -- one more document. And you can keep the Exhibit 6 nearby, and I'm handing you a document marked as Exhibit 7.
A. Yes.
(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 7.)
BY MR. SECHLER:
Q. Can you identify the document marked as Exhibit 7, sir?
A. This is the World Health Organization's Handbook for Guideline Development.
Q. And would you agree that the two documents marked as Exhibit 6 and Exhibit 7 are two documents that Dr. Cantor relied upon in his assessment of conflicts of interest?
A. Yes.
Q. And would you agree that both of those documents concern conflicts of interest arising in the development of clinical practice guidelines?

Page 37

A. Yes.
Q. Now, you cited other authorities in your report, did you not?
A. Yes.
Q. And do you recall what authorities you cite?
A. I would like very much to be able to refresh my memory.
Q. You might want to keep Exhibit 1 handy since that is your report and you're free to look at it at any time.
So are the authorities you cited with respect to conflicts of interest set forth in Footnote 1 of page 5 of Exhibit 1?
A. Yes.
Q. Do any of those authorities address conflicts of interest in the development of clinical practice guidelines?
A. I don't think they do. I don't recall. There's just conflicts of interest -- conflicts of interest.
Q. Why did you not cite authorities that deal with conflicts of interest in the development of clinical practice guidelines?
A. Because there's no difference among them.

Page 38

In other words, if you have a conflict of interest, you have -- or not, then that's independent of whether or not -- what you might be conflicted in the preparation of. In other words, what frames a conflict of interest or any other kind of conflict is going to be independent of the context in which you're conflicted.

Q. So is it your testimony, sir, that the documents marked as Exhibit 6 and 7 are superfluous of the authorities that you cited in Footnote 1 of your report?

A. Not superfluous at all. They -- this was a conceptual analysis, if you will, of conflicts of interest.

I regarded these reports being -- inasmuch as they govern a great deal of science in the United States of America, to be particularly salient. Whether one is doing research, whether one -- and this is what the ones I cite were focused on. Or whether one is practicing in a clinical context. Whether or not you have a conflict of interest is independent of whether you're developing a practice guideline, doing an empirical study, or practicing in any number of professions.

I was focusing on the ones that govern

Page 39

research in the United States of America.

Q. When you were doing your work for your report, did you look for any authorities dealing with conflicts of interest in the development of clinical practice guidelines?

A. I was familiar with them.

Q. What authorities were you familiar with?

A. For example, the World Health Organization has several.

There's actually quite a few of these and I chose to focus on the conflict-of-interest regulations -- or the conflict-of-interest advice, regulations, requirements that, in fact, govern overwhelming all science in the United States of America, and I thought that that would be most salient for our purposes.

I am familiar with WHO guidelines. In fact, I operate under them.

Q. So apart from the WHO guidelines and the Institute of Medicine guidelines, what other conflicts-of-interest policies can you identify that deal with conflicts in the development of clinical practice guidelines?

A. Offhand, I cannot think of any. There must be several.

Page 40

Q. Now, if you turn, sir, to Exhibit 6 -- sorry, Exhibit 5. Turn to page 78.

Do you see the first paragraph, sir, defines conflict of interest as, "A set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest"?

A. Yes.

Q. And would you agree with that definition of conflict of interest?

A. I would not disagree with it. There are a number of them. This is one that I would agree with.

Q. So a conflict of interest exists when there's a risk of undue influence; is that right?

A. Yes.

Q. If you look at page 79 of Exhibit 5, the second paragraph on the page, the first sentence states, "Biases resulting from conflict of interest may be conscious or unconscious."

Would you agree with that?

A. Yes.

Q. So sometimes it's hard to tell whether a conflict of interest actually causes an undue influence; is that right?

Page 41

A. Correct.

Q. So why is the management and identification of conflicts of interest important in the development of clinical practice guidelines?

A. Because whether it's conscious or unconscious, one wants to be able to identify and prevent bias.

Q. How would bias affect the development of clinical practice guidelines?

A. If, for instance -- well, let me -- the reason I cited the authorities that I did in the context with which I'm most familiar is in environments where, for instance, someone is doing -- is consulting for a particular entity, amalgamated widgets, but one's also in one's daily work doing research on widgets, the -- for example, if my employer were asking me to do -- to do that research or I was otherwise as part of my job conducting such an empirical inquiry, then it would be reasonable for my employer and others to be concerned if it was also the case that I was being paid as a consultant for an entity that manufactures these devices. That's the most common form of conflict that arises in biomedical science.

In other words, if someone is receiving

Page 42

compensation that's directly related to something -- directly related to usually research, by the way, or consulting that's related to the topic of research and in that case, therefore, the concern for me being biased might be that I want to please the person for whom I am consulting or the entity for which I am consulting.

That is by far and away the most common form of conflict of interest in biomedical research.

Q. Sir, I'm sorry, I meant to ask specifically about clinical practice guidelines.

How could the presence of bias affect the development of clinical practice guidelines?

A. Well, if there were bias, then one would want to know how it affected the guidelines.

We've actually seen people who've erred in the wrong direction to avoid the appearance of a conflict of interest, up to and including patients somehow regarding their physicians with conflicts as more reliable because, therefore, they're working for industry and that can infer some extra authority for them.

So one might be -- interesting phenomenon, I would suggest.

So the point, of course, is that if

Page 43

someone is either conflicted or trying to avoid the appearance of conflict, that bias might, I suppose, somehow become reflected in the final work product, whether it's a scientific report or practice guideline or any other such thing.

Q. Do you believe it's important in the development of clinical practice guidelines to identify and manage conflicts of interest?

A. Yes.

Q. For any reason other than what you just said?

A. No.

Q. You see that, continuing on in the paragraph that we were looking at in Exhibit 5, page 79, the sentence says, "Biases may influence choices made throughout the guideline development process, including conceptualization of the question, choice of treatment comparisons, interpretation of the evidence, and, in particular, drafting of recommendations."

Do you see that?

A. I do.

Q. Would you agree that all of those things could be unduly influenced by the presence of bias in the development of clinical practice guidelines?

Page 44

A. In principal, yes.

Q. Would you agree that WPATH's standards of care have been influential in directing the clinical practice of gender dysphoria?

A. I reckon they have. That in some sense is an empirical question. I don't think any of us is capable of answering right now.

But generally speaking, in the -- you weren't asking me about the zeitgeist though --

COURT REPORTER: I'm sorry, about the?

MR. SECHLER: The spirit of the time.

So it is -- I mean, to be really precise, that's an empirical question, and I'm not competent to answer it.

BY MR. SECHLER:

Q. Did you see, when you reviewed the Cass report, that the team that prepared that found WPATH's SOC-8 to lack developmental vigor?

A. I recall that was one of the criticisms, yes.

Q. Do you agree with that?

A. I -- without a clear understanding of developmental vigor and of further review of both documents, I don't really think it would be appropriate for me to comment on that important and

Page 45

rebuttable conclusion.

I mean, it's -- I have noted it. It is significant, given the source, but I'm not competent or able -- maybe I am competent, but I'm certainly unable in the circumstances to be able to say yes or no to that question. It would be irresponsible, I think, to do so.

Q. When you said, "further review of both documents," what are you referring to?

A. The WPATH document and the Cass report.

Q. What is a guideline development group?

A. Generally speaking, a group of experts in the field that the guideline addresses that attempts to produce a guideline for others.

Q. So a group that develops the guidelines?

A. I think that -- that bit of circularity is, by definition, what -- what is a guideline development group, is it's a group that develops guidelines. That's really the best answer and it's circular.

To go on would be -- I tried to help a little by saying it's a group of people who have expertise to develop the guidelines.

Q. Let's talk about financial conflicts of interest.

Page 46

Would a member of the guideline development group have a financial conflict of interest when he or she stands to gain financially from recommendations in the guidelines?

A. When you say, "stands to gain financially," could you elaborate on that a little?

My grandfather used to own shares in RC Cola. Whenever we went out shopping, he insisted we buy RC Cola because he thought it might improve the value of his shares. That made sense at the time. It was preposterous, of course.

To gain financially in a way that would matter in that way is -- would always be a concern.

Let's just say yes with the opportunity because I think your next question is going to be -- well, in principle, non-trivial financial gain would be a source of concern.

Q. How do you define non-trivial?

A. Your question to me was?

Q. I'll ask the court reporter to read it back.

(Last question read back.)

THE WITNESS: So could you clarify "stands to gain financially." That was the point about the RC Cola. I don't know if it helped the

Page 47

stock or not, but if he stood to gain financially because one of his 14 shares went up 30 cents, that's a financial gain and that's really -- obviously not what we're talking about today.

BY MR. SECHLER:

Q. So receive a non-trivial amount of income. How's that? Would that be a financial conflict of interest?

A. If that were to occur as a direct result of a guideline, then it might very well.

Q. Well, let me ask you about a specific example.

A. Also might not.

Q. Are you aware that when the American Heart Association developed guidelines for lowering a risk of heart attack, members of that guideline development group had financial relationships with manufacturers of cholesterol-lowering drugs?

A. That has been the concern for many such other guidelines. I don't recall that in particular but sounds right to me.

Q. So would members of the guideline development group reviewing the risks of a heart attack have a financial conflict of interest by

Page 48

having a financial relationship with manufacturers of cholesterol-lowering drugs?

A. They might.

Q. Can you explain why they might?

A. It is possible -- the reason we have these guidelines is to try and guide best practice.

It is possible that someone might gain financially but might not alter their opinion in the process. That's the reason for the -- the number of reasons we require that, when there are conflicts identified, they be managed.

Whether or not the management in any particular case is adequate to the task is a further question.

So, for instance, the cardiologists might plausibly suggest, "I have given you my honest, best critical assessment and it is a mere coincidence that, in fact, I'm benefiting from this financially."

Now, we may raise our eyebrows on that, but it's not impossible that they are right. It's also entirely possible that if they're deriving a direct benefit from the manufacturer of a product, that, in fact, their conclusions could have been biased.

Page 49

In other words, there's not a direct causal connection between the conflict and the bias. It's just of such great concern that we try and manage it for the sake of the process.

Q. And I'm not asking you about management right now.

I'm asking about whether the conflict exists, okay? Before we talk about management; is that fair?

A. Fair enough.

Q. Would you say that a conflict of interest exists if a member of a guideline development group has a financial relationship with a manufacturer of a product that is being evaluated in --

A. Yes.

Q. -- the guidelines?

Why is that a financial conflict of interest?

A. Because it's a -- because they are being paid by someone who directly benefits -- who might directly benefit; namely, the manufacturer might directly benefit from the practice that follows the guidelines.

Q. And the financial relationship that that member of the guideline group might have could be

Page 50

income received directly from the manufacturer, correct?
A. That's usually what it is. That's what they were concerned about with the cardiologists, if I recall correctly.
Q. It could also be a large equity share in the company, correct?
A. Institutions very often struggle with definition of what "large" counts as. But in principle, sure.
Q. Is there a rule of thumb that you use to distinguish between non-trivial and trivial --
A. I think the National Institutes -- sorry.
Q. -- income for purposes of financial conflicts of interest?
A. I do not use one at all. My institution and that of many other institutions rely on the National Institutes of Health and that number has changed over the years. It ranges from 5,000 to $25,000.
Q. Do you know what it is today?
A. It's $25,000.
Q. So you could be paid $20,000 from the manufacturer of a treatment that is being evaluated by a guideline development group and that payment

Page 51

would not constitute a financial conflict of interest in your opinion?
A. Oh, it might very well do so. You might be paid a dollar and a quarter and that would constitute a financial conflict of interest. We began by discussing how this can be very subtle and sometimes unconscious. So in principle, yes.
Q. Can clinical services that a member of the guideline development group performs constitute a financial conflict of interest?
A. For the sake of credible guidelines, I would hope very much not.
If you don't have the expertise entailed by that, I'd be concerned about your capacity to contribute to the preparation of guidelines.
Q. So let me ask you about the development of guidelines for the evaluation of chiropractic treatment.
Would you think that chiropractors would have a financial conflict of interest to be on such a group?
A. I do not think that the practice of a profession itself constitutes a conflict in the preparation of a guideline. Otherwise, we could have no guidelines.

Page 52

Q. Are you aware whether or not the Institute of Medicine believes that the practice of medicine and income derived from clinical services can constitute a financial conflict of interest?
A. I don't recall. Depends in the context, I suppose. But -- I beg your pardon.
Q. That's okay.
A. I don't recall.
Q. So let me ask you to take a look at page 79 of Exhibit 5. And reading the second sentence of this page, "Financial (commercial or non-commercial) conflicts of interest typically stems from actual or potential direct financial benefit related to topics discussed or products recommended in guidelines. Direct financial commercial activities include clinical services from which a committee member derives a substantial proportion of his or her income."
Did I read that correctly?
A. You did.
Q. Do you agree that clinical services from which a committee member derives a substantial proportion of his or her income can be a financial conflict of interest?
A. So this is a complicated question. This,

Page 53

of course, is oracular when it comes -- you'll notice there's no citation there.
It is an assertion that basically says that it -- it seems plausible on its face, depending on your income, I suppose, one, it might be possible, but I think the Institutes of Medicine would also be mindful of the fact that, if you're going to have clinical guidelines for heart, lungs, kidneys, or anything else, you need to have people who practice in those fields.
Without being able to refresh myself about the context of that, I venture to say that the Institute of Medicine would know better than to say the people who practice in the field that the guidelines are being developed for are, therefore, not apt, appropriate, or competent to do so. And that if you were to have a guideline that had no one who practiced in that field, that that guideline would be -- would be fit for purpose.
Q. I'm sorry, sir, I don't believe I understand whether you answered my question, so I'll ask the court reporter to repeat it.
(Last question read back.)
THE WITNESS: Depending on how much probabilistic weight you can assign to "can

Page 54

be," sure, yes.
BY MR. SECHLER:
Q. And can you explain what you mean by probabilistic weight?
A. "Can be" is a hypothetical, right? I can -- it's probabilistic. One might have no -- might have no effect at all. It might have great effect. Like many other probabilistic phenomenon, especially related to conflicts of interest.
In other words, I -- some individual might -- most I would think -- we rely a great deal, especially in this context, on professionals who are doing what I said earlier; namely, I might very well benefit from something or other, but that is not affecting my judgment.
The allegation that somebody is going to -- I -- not the allegation. The suggestion that someone who's competent to practice cardiology and she derives a substantial part of her income from the practice of cardiology should not be included in the development of cardiology guidelines because they can be influenced would undermine the entire guideline process.
So it "can be," in principal, not impossible, can be.

Page 55

Q. And you understand that the Institute of Medicine recommends that information about income from clinical services be collected in the course of identifying potential conflicts of interest?
A. I don't recall that, but I will trust that they do exactly that.
Q. And why don't you take a look at page 82 and 83 of Exhibit 5. And just referring you to the bullet point --
A. Uh-huh.
Q. -- that starts at the very bottom of 82. "Disclosure should reflect all current and planned commercial (including services from which a clinician derives a substantial proportion of income)."
A. Yes.
Q. And you think it is important to collect information about services from which a clinician derives a substantial proportion of income in managing and identifying conflicts?
A. I think that depends on the granularity. I mean, if someone is a physician in the practice of cardiology, how precise -- do you want to know about percentage of her practice? The dollar value of her practice? This is actually not explicit as regards

Page 56

to that.
In principle, what this is calling for is as much transparency as possible. If someone practices cardiology, then someone who says, "I practice cardiology," has, by virtue of that declaration, arguably met that recommendation, hewed to or adhered to that recommendation. Because cardiologists have different incomes depending on their practice.
Q. Right. My only question to you, Dr. Goodman, is as an expert in medical ethics, would you expect a guideline -- an organization developing clinical practice guidelines to collect information from the members of the guideline development group on the amount of income they receive from clinical services that are being evaluated?
A. No. As I say, I don't -- different people have different clinical practices.
Would you be concerned, for example, if a cardiologist made $100,000 a year as opposed to $300,000 a year, or double those amounts, which is probably more accurate? And the question then is, that becomes a very interesting question about the ways in which compensation might affect behavior and

Page 57

might cause bias.
It might be that the person who makes far more money relies on it less than the person who makes far less money. There is no direct mapping between how much one makes in the practice of one's profession and the likelihood that that alone is going to be significant.
Once it's disclosed, as a matter of ethics, that I practice -- one practices cardiology, one practices gender-affirming care, one practices nephrology, then one is able to infer, directly and easily, that that person derives income from that practice.
I am not sure what else you're suggesting should be sought.
Q. Well, are you saying then that organization developing clinical practice guidelines need not collect the information that we just said Exhibit 5, page 82, 83 says should be disclosed?
A. "Disclosure should reflect all current and planned commercial activities," which is exactly what they've done by saying, "I practice cardiology."
Now, what they should also disclose is "I also am paid by a manufacturer of a drug that makes

Page 58

heart medicine to do research or as a consultant."
The disclosure of the activity is what we're discussing. That's what that calls for. And I'm saying that I think that that has become reasonably close to the standard.
Q. So if there was a guideline development group evaluating the efficacy and safety of cardiac bypass surgery, you would not want to know how much, if anything, the members of that group make by performing cardiac bypass surgery; is that your testimony?
A. If I could know what I would do with that information having acquired it. The suggestion that, with enough granularity, we would be able to predict whether any particular individual would be biased or not would, in fact, be a great accomplishment, which is why I don't know that customarily people ask for the annual income of -- maybe you do know this -- in cardiology or any of the medical specialties.
If someone is a cardiologist, working on a practice guideline, do they disclose how much money they make per year in that practice? I don't know the answer to that.
Q. I am not asking you about annual income.

Page 59

I'm asking about income derived specifically from the treatment being performed, which is cardiac bypass surgery. And you're saying you wouldn't want to know and wouldn't ask the members of the guideline development group to disclose the amount they would make from the treatment that's being evaluated?
A. If you're doing cardiac bypass, that's all you're doing or you're not going to be any good at it.
So the question is, if someone derives a substantial percentage of their income, which would be one's compensation for one doing one's job, substantial could even be 100 percent of it, then whether that amount is X or two times X would not help anybody decide whether or not that person is fit for purpose on the guideline development group.
I'd be concerned about all of them in the way that one might be. But that takes me to RC Cola again. The idea that somebody is already deriving a substantial part of their income from something might, therefore, alter their -- their clinical -- their judgment and guideline development because they think it might improve their clinical income is, I suppose, a risk.

Page 60

But if -- I just don't know if there's a standard that says disclose your annual income if it's derived wholly from this or if it's a percentage of it. If it's only a percentage of it, suppose somebody is an endocrinologist and they only derive a small percentage of their income from gender-affirming care, what would that number say to you?
And the answer is -- your question is framed in such a way as to miss the opportunity to point out that our goal here in trying to identify conflicts of interest is to reduce bias. And we are in a position where the people who are most competent who have expertise in developing guidelines are in some broad way conflicted in the way you're suggesting simply because they derive their income from precisely the thing that gives them expertise in developing the guideline. And so we're at a bit of a tight spot there.
If you're suggesting the particular amount that one makes of money in that practice is a necessary condition for being able to avoid bias, no, I wouldn't agree to that. I don't know -- I don't know what would be appropriate and that's why -- that's why these documents are so thick.

Page 61

Q. Can you identify any authority in the field of medical ethics that supports a view that practitioners who derive income from clinical services being evaluated by a guideline development group do not have a conflict of interest?
A. There were several negatives there. Would you mind reframing that.
(Last question read back.)
THE WITNESS: No.
BY MR. SECHLER:
Q. In fact --
A. But that's offhand.
Might very well be the Institute of Medicine.
Q. And you disagree with the Institute of Medicine and the statement they make on Exhibit 5, page 79, that, "Direct financial commercial activities include clinical services from which a committee member derives a substantial proportion of his or her income"?
A. No, I don't disagree.
What I'm saying is that doesn't produce a practical way of assessing it. It's a broad and very sweeping statement. I don't -- as I said earlier, it is oracular. One might have a debate --

Page 62

not entirely dissimilar to the one that you and I might be regarded as having now -- about whether or not the practice of something itself conflicts one in guiding colleagues about the practice.

And so the idea that everyone who contributes to a practice guideline is, therefore, conflicted I think produces an unhappy consequence for practice guidelines in general.

Q. You're aware that the Institute of Medicine recognizes that the most knowledgeable individuals regarding the subject matter addressed by a clinical practice guideline are frequently conflicted?

A. How could they do otherwise, the Institute of Medicine?

Q. So I'm not asking you, sir, right now about how you manage, in the extent to which you disclose anything. I'm asking simply whether you collect the information.

My question to you, sir, is, would you want to know, in connection with the development of clinical practice guidelines, the amount of income committee members receive from treatments being evaluated by the committee?

A. No, I don't think -- once again, for the

Page 63

reasons I've given you earlier, that granularity is not going to be particularly useful unless you gather lots of other information.

Once it's been disclosed that a substantial part of someone's income, livelihood comes from this, we have enough to be mindful of the fact that that is going to be an issue. Whether it's this amount of money or that amount of money, I don't think advances the practice.

If it were research, then I would want to know exactly how much they're being paid by the company. But surely there's a difference between someone who receives a check from a drug manufacturer which has a number on it and someone whose livelihood comes from seeing patients, for instance, are really quite different activities and, therefore, a completely different profile with regards to a conflict that we would be concerned might introduce bias.

Q. So if you don't collect any information from committee members about clinical services, you won't know how much -- how much they stand to gain from the evaluations that are being done?

A. By "any information," do you mean to include the fact that they have that practice or --

Page 64

because we've already determined that that's something you should know. In fact, it's probably the reason they were on your guideline group in the first place.

"Any information," if what you want to mean by that is a dollar amount that they receive in income from the practice of medicine, I don't think that would be useful in any guideline preparation.

Q. And just to be clear, it's not in the practice of medicine.

My question is, would you want to know the dollar amount of income that a committee member receives from performing or administering the treatment being evaluated?

A. What of that would not be in the practice of medicine?

Q. You can answer my question.

A. So it is in the practice of medicine. If you're practicing medicine and you make a certain salary, I wouldn't mind if someone disclosed their salary.

What I'm suggesting is the suggestion that everybody who is on guideline committee needs to disclose their personal income would not be as compelling a bit of information as to know what else

Page 65

they're receiving that might also be known to increase the risk of bias.

The suggestion that the more money you make, the more likely you are to be biased is a -- which is -- these questions only make sense given that hypothesis, is itself an interesting hypothesis and I don't know whether it's true or not.

I'm curious about a lot of things, Counselor, and I understand the question.

Would I like to know? I'd like to know a whole lot of things that -- about finances in North America and healthcare. For our purposes, I would say that the annual dollar amount that a physician makes in compensation in the practice of gender-affirming care is not going to help the guideline committee prevent, reduce bias.

What would matter is if they're being paid by a separate company, for example, that makes hormonal drugs.

Q. Would you want to know the proportion of their total income that comes from a particular practice being evaluated, whether that's 5 percent or 75 percent?

A. I'm inferring it's 100 percent. So no, I -- once again, given other financial interests

Page 66

that people have in the world, I don't think that that dollar amount particularly matters.

A percentage, I would again defer -- I would ask you to help guide me in answering your question. Is it a standard across medical specialties to collect that information? And I just don't know the answer to that.

Q. You don't know whether it's a standard to collect the information I'm asking you about?

A. I do not know, for example, if cardiologists need to disclose their annual income to participate in a guidelines development group. I actually do not know that.

Q. If you look at page 78 of Exhibit 5. You see the last sentence of the first paragraph. There are a number of clinical practice guideline developers mentioned.

Do you see that?

A. Uh-huh.

Q. You need to say yes or no.

A. Uh-huh. I see it, yes. I beg your pardon. I apologize. I apologize.

Q. So --

A. Yes, I see the last sentence on page 78, first paragraph.

Page 67

Q. And listed there are the American Heart Association, the American Thoracic Society, the American College of Chest Physicians, the American College of Physicians, and the World Health Organization.

Do you see that?

A. I do.

Q. And they're all clinical practice guideline developers, correct?

A. Correct.

Q. And have you reviewed their conflict-of-interest policies for developing clinical practice guidelines?

A. No.

Q. And you don't know whether or not their policies require the disclosure of information on revenue received from clinical services related to the topics in the guidelines?

A. No.

Do they?

Q. Let's take a break.

A. Thank you.

(Recess taken 11:20 to 11:33.)

BY MR. SECHLER:

Q. Dr. Goodman, referring you to your report

Page 68

marked as Exhibit 1, and specifically the paragraph 12, which was on pages 4 and 5, and the last sentence of that paragraph states, "Such conflicts require some form of management by the institution issuing the guidelines."

Do you see that?

A. I do.

Q. Could you explain what kind of management is required to be in place by an organization that is issuing clinical practice guidelines?

A. I'm not sure I have an opinion about what kind of management process is required. There are actually probably several that would be apt.

The intent here was to declare the process is important. The details of it might need to be managed in the context.

Q. So why don't you identify the several that you believe would be apt?

A. If one is receiving consulting income, for example, which is the most common one that we encounter in this jurisdiction, then that would require that, if someone is being paid as a consultant by an entity that manufactures a product that is used in the practice that the guidelines are intended to guide, then that amount would need to be

Page 69

disclosed, as to the duration of it, and that would be the initial part of it.

Then there would need to be some assessment about whether or not it exceeds any particular threshold, which, as we've already learned, can vary over time, depending on the practice, depending on the amount, depending on...

One may make a great deal of money in one's practice but -- but -- but that's the regular part of the practice. It's the extra check that you get from the drug company every so often that we have come to learn to be most concerned about.

Q. So in addition to disclosure, would there be other elements of the policy?

A. A process for determining whether or not there, therefore, needs to be -- so in the example that I'm giving you, one might be told you need to reduce the amount of outside compensation you're receiving.

One might be told -- one can -- one needs to either terminate that -- either reduce it or terminate it or alter your role on the other end.

So, for example, the scientist who's being paid by the pharmaceutical company might be told that she cannot any longer analyze data from the

Page 70

research that she's doing that bears on the company's product or related products. It might even be a competing company's product, by the way.

Q. So a member's role on the committee could be restricted in some respect?

A. Not the role on the committee would be restricted. The actual -- what they do in the world would be restricted.

In other words, if you want to serve, if you want to continue doing this -- once again, in what I think the locus classicus, if you will, is, you have somebody, might not even be a physician, who's receiving money as a consultant and doing scientific research. You might be told in the conduct of your research, we're not -- you will not be allowed to analyze the data.

You might be told any publications that result from it need to disclose that you received this other compensation that was unrelated -- that was conceptually related to the research but not for the research. In other words, you were paid as a consultant to help a study on drug development or molecule design or discovery or something like that. And that might need to be disclosed in publications.

So you either -- you either reduce the

Page 71

amount you're receiving from one source; on the other side, you might have your activities restricted to reduce the risk of bias.

Q. Could a conflict of interest rise to the level of requiring disqualification or exclusion of a member from a guideline development committee?

A. I don't know. In my experience, which is as I've described, no one wants to be disqualified from doing their thing.

They will generally -- therefore, people will either agree to the reduction of outside compensation or -- and/or agree to altering their roles when it comes to the research that they're doing.

If someone were to say, "I refuse to take less money and I refuse to acknowledge that I'm receiving money in publications," then the institution could very well say that we're not going to let you do the research here.

Q. And so these actions that might be taken, including restriction or limiting the amount of income received, those would be all part of a policy of the guideline development -- of an organization developing clinical practice guidelines would issue?

A. They very well could be.

Page 72

Q. Is there any other element of a policy on conflicts of interest that you would expect to see in an organization developing clinical practice guidelines?

A. It really depends. For example, who's making the assessment? Would it be an institutional official? Would it be a separate committee, that sort of thing?

And one might plausibly want to determine that in advance. In other words, what constitutes a conflict is part one. Now as part of the assessment, as part of the management process, one might want to say let's be clear about who is doing that assessment and supervising that management.

Q. Let me ask you this, Dr. Goodman: How many conflict-of-interest policies for guideline development organizations have you seen prior to involvement in this case?

A. I am familiar with the WHO's because I actually -- I operate under it. In other words, I've had -- in my work, complete conflict-of-interest documentation all the time.

In fact, if one gives a talk, a physician who -- not just a physician but, for instance, a physician who's giving a lecture, that's going to be

Page 73

certified for continuing medical education credits needs to go through a very similar process. And I am familiar with some of those. It's not guideline development.

So I think I'd have to limit it to the ones I recall from the archives, if you will, that is, my experience over the years, including that of the World Health Organization. Otherwise, no.

Q. Apart from the World Health Organization, can you recall reviewing the conflict-of-interest policy of any other organization that was developing clinical practice guidelines?

A. I do not recall.

Q. Are there any other elements that you would expect to be included in a conflict-of-interest policy for a group developing clinical practice guidelines other than what you've mentioned?

A. Not offhand. I believe I've shared what I think are the key elements of a conflict-of-interest process, a conflict-of-interest management process.

Q. What would you expect that process to be documented in a policy?

A. In my experience, there's -- if not a formal policy, then some sort of guideline or

statement somewhere that says here's what we're going to do.

Policy, as you know, rises to the level as -- it can be quite official. And, in fact, depending on the context, that might very well be best practice.

In the development of practice guidelines, I'm not sure that I would insist on a policy as long as everyone who is involved knew that this is what is expected of them and the documentation is kept. And it's documented in a certain way. In other words, it's a -- it's a -- might even be a clarification by me -- from me of -- by policy, since there are lots of different policies, there's procedures, there's guidelines and many of them have the same effect.

Institutions have policies of different kinds. Some of them actually have legal consequences. And so I think there could be -- one could be pluralistic in accepting their various structures that would lay out what the process is.

Q. Whether we call it a policy or not, you would expect the process to be documented in writing somewhere and laid out, right?

A. Generally speaking, yes.

Q. So did WPATH have any conflict-of-interest policy laid out in writing in connection with its development of SOC-8?

A. I've seen reference in SOC-8 to -- to -- now I can't remember. WPATH actually has a conflict of interest, attends to conflict of interest in one way or another.

I can't recall now what -- whether it was a formal written policy or not.

Q. Whether it was formal, do you recall seeing anything in writing that laid out the process that WPATH would follow in managing conflicts of interest?

A. I do not recall, no.

Q. Do you know what thresholds they applied in considering income that might be received that could constitute a conflict of interest?

A. That wouldn't be the sort of thing a guideline group would, as we've been discussing -- if it's not outside consulting income, then there would be no concern for such a threshold.

Q. Well, you would expect there to be a threshold for outside consulting income, right?

A. Outside consulting income, yes.

Q. Do you know what threshold WPATH applied

for outside consulting income?

A. No, I don't recall.

Q. Do you know what level of conflict WPATH deemed to be worthy of public disclosure?

A. No, but I appreciate your help in referring me to that document, to the place where they address it.

I do not recall. I just don't recall.

Q. Well, let me ask you to take a look at another document here. This is Exhibit 8 I'm handing you, Dr. Goodman.

A. This is what I recall.

THE REPORTER: I need one second to reopen a file.

(Short pause.)

BY MR. SECHLER:

Q. Dr. Goodman, I've handed you a document marked as Exhibit 8, which is one of the disclosure forms that WPATH produced in this litigation.

(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 8.)

BY MR. SECHLER:

Q. Did you undertake yourself in connection with your work in this case to collect and review the disclosure forms that WPATH produced in

discovery?

A. No, I did not.

Q. Let me ask you to take a look at the top of page 1084, which is the first page of Exhibit 8.

Do you see the second paragraph starts with the sentence, "Interests must be disclosed using the WPATH disclosure form."

Do you see that?

A. I do.

Q. Then there's a second sentence in that paragraph.

Do you see that?

A. I do.

Q. Are you aware of anything in writing, other than those two sentences, that describes the process that WPATH followed in managing conflicts of interest?

A. No.

Q. In your view, sir, is that -- are those two sentences a sufficient conflicts-of-interest policy for an organization developing clinical practice guidelines?

A. Now that I'm able to refresh my memory and see this, I think this is a document that is adequate to the task.

Page 78

Q. So it's adequate --
A. In other words --
Q. Go ahead.
A. Including subsequent statements there.
Is your question -- please repeat your question.
Q. I'll ask the court reporter to repeat it.
(Last question read back.)
THE WITNESS: Well, those two sentences are two sentences. The next paragraph goes on to managing them. So those two sentences alone, no. In the larger context, yes.
BY MR. SECHLER:
Q. Well, do you have any indication in the document before you as to the threshold that WPATH would apply to financial conflicts of interest?
A. No.
Q. Do you have any indication in the document --
A. I beg your pardon. Pardon me. One second.
This refers to the $5,000 at the bottom of the first page. Is that what you're referring to?
Q. I'm asking you, sir, whether or not you're aware of the amount of financial conflict of

Page 79

interest that would require some action on the part of WPATH to manage a financial conflict of interest?
A. I beg your pardon.
If I understand your question, this sets -- this basically suggested that anything over $5,000 would need to be managed.
Q. And are you saying then, sir, you understand this document to say that anything over $5,000 would be too much and there would have to be some action taken with respect to the member, perhaps limiting that income or restricting their participation?
A. Under the management of conflicts of interest, it seems to be implied that more than $5,000, that there -- that the board reviews and accesses --
COURT REPORTER: I'm sorry?
THE WITNESS: The WPATH board reviews and assesses disclosure forms. So I think -- and, therefore, if it were more than $5,000, the board in assessing them would determine whether or not that was beyond the threshold.
BY MR. SECHLER:
Q. They would determine whether or not it was beyond the threshold, right?

Page 80

A. Yes.
Q. You don't know as you sit here looking at this policy what exact level of financial interest would require them to take action, for instance, restricting somebody's activities?
A. I think the implication is it would be $5,000.
In other words, if someone is making more than $5,000 from an outside source, management of conflicts may include prohibiting relationship in SOC-8, open discussions, et cetera.
So it seems to be describing the process that you're asking for, does it not?
Q. Well -- so you're saying that the 5,000-dollar limit on the page just refers to what needs to be disclosed by the person filling out this form, right?
A. Right.
Q. And you're saying that anything that is disclosed by the person filling out this form rises to the level that it needs to be acted upon by the organization?
A. As is standard.
Q. Would you expect conflicts of interest to be publicly disclosed by an organization that is

Page 81

developing clinical practice guidelines?
A. Would I expect?
Q. Let me repeat it.
Should financial conflicts of interest be disclosed by an organization developing clinical practice guidelines?
A. There are circumstances -- see, public disclosure, of course, is itself a vague concept.
Would it be disclosed on request? Would it be disclosed on a website? Would it be disclosed on an advertisement somewhere? Different entities that do this -- and some of them are compelled by, once again, my institution -- or any institution that receives money from the federal government needs now to make a public disclosure of that. I think that when possible that's a good practice.
Perhaps there's balance to be struck on some occasions between what someone might regard as privacy and confidentiality on one hand and the need for public disclosure on the other.
So should they? I think that that -- I would like to -- for example, if I were consulted by this organization, I'd want -- it would be good process on my part to actually review all of these and have a discussion about how common it is.

Page 82

So, therefore, I might advise one way or another depending on whether or not someone -- if someone is making a lot of money from the manufacture of endocrine drugs, that obviously is the greatest concern that one might have. One of the concerns that one might have here.

Generally speaking, transparency is good. Balancing against other values and considerations is sometimes useful in the process.

Q. And why is transparency good?

A. Oh, that's a big question, Counselor.

Transparency is good when it comes to the practice -- when it comes to these issues so the -- so that others appropriately locate it can help make -- so the people, for example, to whom the guidelines apply will be able to make an assessment about them.

Q. And you're aware that the Institute of Medicine endorses your view of transparency, are you not?

A. I am -- I can't imagine they would disagree.

Q. If you look at Exhibit 5 before you, sir, and turn to page 77.

If you look at the second full paragraph,

Page 83

which I'll read, "Transparency also requires statements regarding the development team members' clinical experience and potential conflicts of interest as well as the guideline's funding source."

Do you see that?

A. Uh-huh.

Q. You need to say yes or no.

A. I'm actually -- I was actually not so much saying yes or no as just wanting to read it.

Yes, that's what it says.

Q. This requires a disclosure of all conflicts of interest, right?

A. It actually doesn't say "all" here. It does require the disclosure of interest for all members of the development group, but it actually is not explicit about -- it basically says clinical experience, potential conflicts of interest as well as the guideline's funding sources.

There's the implication, therefore, all? One might say, well, what a reasonable person might expect in the circumstances. So if it were, for example, de minimis or trivial, I don't know if the scope of that would apply to that.

Q. Well, it says, "potential conflicts of interest," does it not?

Page 84

A. It does.

Q. And there's no exception, is there?

A. None given.

Q. Is there any implied?

A. The nature of a potential conflict of interest suggests that it might be de minimis. Generally speaking. I'm just -- I'm parsing you as literally as I can. It doesn't explicitly say "all."

So once we're now trying to get the force of this, the implication of this, now we're trying to figure out whether the intent, which otherwise here is very clear, why did they not say "all" if they meant all.

Q. What does the World Health Organization's policy say with respect to the disclosure of conflicts of interest and whether it includes "all"?

A. I would need to refer to that.

Q. You don't remember offhand?

A. Not offhand at all.

Q. What do -- and I take it you don't know what other conflict-of-interest policies say with respect to whether all conflicts of interest need to be disclosed publicly?

A. The question to me is --

Page 85

Q. Let me repeat that. That was not a good question.

And I take it you do not know what other policies regarding conflicts of interest in the development of clinical practice guidelines say regarding disclosure and whether it includes all conflicts?

A. No, not offhand, no.

Suppose, for instance -- I mean not to -- not to -- if one wanted to offer a reductive argument. Supposed one were given a dollar, one dollar. If I'm poor enough, that's a conflict of interest.

I guess what I'm trying to say is one can imagine someone wanting to -- it would be -- it would not be offensive to the process if, for instance, there were trivial potential conflict that were not disclosed. That raises the further debate about who determines whether it's trivial or not.

But one might be forgiven for saying, look, I -- to help you, my -- many other universities used to have representatives at pharmaceutical companies on medical campus but paying for lunch, giving gifts, that sort of thing. Some people chose not to accept a cup of coffee.

Page 86

If they did accept a cup of coffee from the pharmaceutical company, would that be "all" in disclosing conflict of interest? And the answer is yes, if it was "all," that would have to include the cup of coffee.

We live in an environment that is shaped, as you well know, by extraordinary marketing efforts by some of these industries. And that's their business. I mean, that's what they do. They're trying to facilitate the practice of their drug.

But in the environment, there were some people who would regard something as a cup of coffee as quite literally something that they would disdain for fear of some appearance of a conflict. And so, therefore, all matters in the context, I would think, and one could have a debate about that, especially when it come to the pharmaceutical industry -- that's obviously not what anyone here is contemplating here. I'm sharing it with you because we're trying to be precise about "all," and I can imagine a circumstance where agreeing to all would end up being absurd or inapt.

Mind you, I never had a cup of coffee from a pharmaceutical company.

Q. I thought you mentioned there was a

Page 87

threshold applied to determine those financial conflicts of interests that needed to be managed.

A. Correct.

Q. And would you expect financial conflicts of interest that needed to be managed above the threshold to be publicly disclosed?

A. Would I expect them or would I recommend them or ought they to be? And the -- which of those was it?

Q. All three. Thank you.

A. Happy to help.

Q. Expect, recommend, and ought.

A. That's good. I hate to go all lawyerly on you, but it does depend.

Public disclosure and the mechanism for disclosure needs to be balanced against a number of other values. One, whose -- for example, there might be contractual reasons why -- it needs to be disclosed for internal purposes, but public disclosure would be forbidden.

I'm imagining agreements between industry and individuals where certain things need to be -- obviously need to disclose as compelled or required in the circumstance, but that doesn't entail necessarily full public disclosure.

Page 88

Generally speaking -- and that's where we were earlier with transparency. Generally speaking, transparency is good. The granularity of transparency, the circumstances under which it needs to be compelled, the thresholds for doing so would shape the answers to all of those. Especially the ones that I'm most interested in; namely, whether one ought to do such a thing.

So I think, generally speaking, it depends. Which is not as -- ethics and the law are not dissimilar in that regard. One should really have a whole lot more information before making a recommendation that broad.

As I say, I haven't reviewed any of the WPATH disclosure documents. I don't know -- I don't know what any of them make. I don't even know if it rises to an issue.

Q. Can you identify any literature in the field of medical ethics that allows an organization developing clinical practice guidelines to pick and choose which conflicts of interest it chooses to disclose publically?

A. Framed that way, no.

Q. Do you know what standard WPATH used to determine what conflicts of interest to publicly

Page 89

disclose?

A. Is it not given? Pardon me a moment.

No, I don't know.

Q. Continuing on through Exhibit 8, you see the last block -- first of all, would you agree that WPATH did not ask members of the guideline development committee to disclose the amount of income they received through clinical services that were being evaluated in the guidelines?

A. Yes, apparently not.

Q. And do you see the last block on the third page of Exhibit 8 has an interest that the member filling this form out wrote down?

And I'll read it, "I work clinically with trans and gender diverse patients, thus my everyday work is influenced by the SOC."

Do you see that?

A. Yes.

Q. And do you know whether or not WPATH obtained additional information from this member to get details?

A. Oh, I do not know.

Q. And in your view, it's fine for WPATH not to ask for details of the work of and the amount of income that this member receives?

Page 90

A. Yes.
What would they do with the information other than use to certify they're competent to serve on the committee, on the group?
Q. Do you know how many members serve or served on WPATH's SOC-8 revision committee?
A. It's quite a few. I don't recall the number. It's quite a few. I mean, I'm recalling the list of authors on the front page. I don't recall the number.
Q. Do you know what percentage of the members of the SOC-8 revision committee derive income from clinical services provided for gender dysphoria?
A. I do not know.
Q. Are you familiar with Marci Bowers?
A. The name rings a bell.
Q. Marci Bowers was on the SOC-8 revision committee?
A. Okay.
(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 9.)
BY MR. SECHLER:
Q. Mr. Goodman, I'm handing you a document marked as Exhibit 9, which is a listing of the SOC-8 contributors or members of the revision committee of

Page 91

SOC-8.
Do you see that?
A. I do.
Q. Have you undertaken to review whether or not anyone on this list is -- had a conflict of interest in connection with the revision of SOC, the development of SOC-8?
A. No, I recall tabbing through this some time ago. I don't recall doing so with that granularity.
Q. Let me ask you to turn -- these pages are not numbered. But if you go five pages from the back, you'll see a surgery chapter for adolescents and adults.
A. Yes.
Q. You see the sixth person listed in that is Marci Bowers?
A. Yes.
Q. Do you have any idea how many vaginoplasties Marci Bowers has performed in her career?
A. It says more than 2,100.
Q. Do you have any idea how many vaginoplasties Marci Bowers performs in a week?
A. No.

Page 92

Q. Do you have any idea how much a vaginoplasty costs?
A. No.
Q. Am I correct, sir, that vaginoplasty is essentially the construction of a vagina from tissue from a penis?
A. I would ask -- you're asking me a medical question. My understanding is you can use different kinds of tissue.
Q. To do what?
A. To do a vaginoplasty.
Q. Which is what?
A. The creation of a vagina.
Q. Do you think that there's any financial conflict of interest for somebody who performs thousands of vaginoplasties to be on the committee that evaluates surgery for adolescents and developing clinical practice guidelines on that topic?
A. By virtue of the practice?
Q. My question stands.
A. I can imagine someone saying this is precisely the kind of person who should be writing these guidelines.
Q. I'm asking what you say as the ethics

Page 93

expert, Dr. Goodman.
A. The idea -- if she already has a thriving practice, it's not clear how much more it will thrive. I mean, if she's doing that many of them and guidelines support her practice, which is obviously the concern that's being articulated here, how many more can she do even with supportive guidelines?
This ends up being a calumny against the people who do this professionally.
The physicians and surgeons I know who do this, like most physicians who do most things, do it because they do it. That is to say, it is their calling.
To suggest that any physician practices medicine in order to acquire vast personal wealth at the expense of sick people I think is a calumny against the profession that is -- not that you're making it, of course. But I don't think it's a problem at all. I think that these are the people who are most able to advise about such a thing.
And to suggest that she would alter her clinical judgment or her contribution to the guidelines because it's what she does for a living is -- is -- I am not concerned in the way you have

Page 94

asked, in other words.
Q. And can you identify any reference in the field of medical ethics that supports your view that a clinician with that level of work in a field and with the practice being evaluated does not have a financial conflict of interest?
A. Nor that, nor its opposite. I don't know if that issue has been addressed in the ethics literature one way or another.
Q. Didn't we just look, sir, at the Institute of Medicine policy on conflicts of interest?
A. I'm sorry. I thought -- we've already determined that one's practice needs to be disclosed as part of the process that one, in fact, through their practice, might have a conflict of interest according to the Institute of Medicine.
And what, therefore, the -- does the ethics literature suggest, therefore, that someone who has that conflict ought not to be doing the procedure? No.
Q. Sir, I'm not asking about how a conflict like this might be managed, whether it requires disclosure, restriction, exclusion. We're not there yet.
I'm just asking whether you, if you were

Page 95

recommending the collection of information on potential conflicts, would ask members of a guideline development committee to at least reveal how much income they gained from procedures being evaluated by the committee.
And I take it your testimony is that none, that "I don't care how much money you make as a result of clinical services that are being evaluated because we're glad to have you on the committee. Thanks for being a part. We don't think you're going to be biased."
That's your advice to a clinical practice guideline committee, right?
MS. CHENG-WUN WEAVER: Objection to form.
THE WITNESS: Counselor, I wouldn't frame it like that at all.
What I want to say, the larger question is this: Is that disclosure of her annual income useful in determining whether or not she is going to be biased or not?
My opinion is that knowing someone's personal income does not help with that determination. If that is one's practice, if that is what one does, and one is already doing it, even if it's really lucrative, then it's

Page 96

hard for me to understand how it is that that would be included as part of a management process.
So, therefore, am I curious? I'm curious about what everyone makes. Do I believe that that disclosure is necessary for the credibility of the process? No, I do not.
BY MR. SECHLER:
Q. Sir, you keep changing my question to whether or not you want to know somebody's annual income.
My question is whether, for Marci Bowers, who performed thousands of vaginoplasties, you would want to know any information surrounding the financial remuneration that she receives from that particular surgery as she is helping draft a chapter on surgery for adolescents in adults with gender dysphoria?
A. And my answer can -- remains no because the kind of conflicts that we are most concerned about, the ones that are most common, the ones that are most erosive are those that do not arise from the actual practice of -- in a specialty that's related to the guideline.
If she were getting money from a drug

Page 97

company for surgical equipment, for example, then that would -- I might have a different opinion.
Q. Right. I understand that's your testimony, sir. And that's why I was pointing you to page 79 of Exhibit 5, which states that "Direct financial commercial activities include clinical services from which a committee member derives a substantial portion of his or her income."
And would you agree, sir, that that does not support your position?
A. I would think that, if the Institute of Medicine were so keen to make that clear, it would explicitly say, "Ask for a number."
What it's saying is -- it's a very large grained, if you will, criterion here. Do you derive a substantial percentage of your income from this? They don't say what's your annual income in the process.
They're asking at very large granularity, "Is this how you make a living?" And wisely, I would think, they don't ask for a particular number because people make lots of different amounts of money and different amounts of money are more or less salient to different people depending on a bunch of factors that are beyond our remit here.

Page 98

If knowing one's annual income was so important, I would think the Institute of Medicine would explicitly ask for it, as opposed to generally saying it.

Q. So how is the Institute of Medicine going to find out if any member of a guideline development group receives a substantial proportion of his or her income from something being evaluated without asking about it?

A. Well, asked and answered, right? Do you derive a substantial percentage of your income? Yes.

In which case, that's all the Institute of Medicine seems to be asking for.

Q. And did WPATH ask that question?

A. Oh, sorry, I don't know that question. Well, did they ask it? I mean, it seems to be answered in all of these bios here in the affirmative.

Q. I'm talking about the conflict-of-interest disclosure form.

A. The conflict-of-interest disclosure form does not -- let me just refresh my memory.

No. Other than -- no.

Q. And you would agree that to that extent,

Page 99

the conflict-of-interest disclosure form that WPATH put together conflicts with the Institute of Medicine's recommendations?

A. No. I wouldn't agree to that at all.

What I would say is if -- in fact, what I'd be curious to know is whether or not someone putting together a group of cardiologists for cardiology guidelines asked the people to -- would solicit membership and say -- and reach out to them and say, as part of our conflict of interest -- "you were chosen to be on the committee because of your practice. Now, for the conflict-of-interest part of our policy, would you disclose whether that's part of your practice or not?"

In other words, I don't think that in the circumstances the composition of a guideline's group, unless, for instance, there were some other kind of consideration, which I can't think of right now, it would be in violation of that when it's obvious on its face that that was the reason they were included in the first place.

Q. You agree that the WPATH did not collect information from the members of the guideline development committee on whether or not they derived a substantial proportion of their income from

Page 100

clinical services being evaluated, right?

A. Counsel, let me --

Q. This is not a conversation, sir. This is a question and answer. So if you don't want to answer that question, that's fine.

A. No, it's not that I don't want to answer it.

What you're suggesting though, what your question amounts to is, were -- suppose we were constituting a conflict of interest -- sorry, a practice guideline group, we are seeking out people who have expertise in the practice that we're proposing to guide.

So if one's already reached out to someone because of their practice, I'm not entirely sure that the question is particularly apt. In other words, of course you're here because you derive a substantial percentage of your income; otherwise, we wouldn't have asked you to be on the guideline group in the first place.

So, therefore, to suggest any organization has failed to make explicit a question is -- is not a matter of process. It's a matter of -- it's a kind of redundancy.

Should they have done it in anticipation

Page 101

of this? Oh, I have no idea. But once again, if someone is recruited because of their clinical practice, asking them what their clinical practice is doesn't make sense in the context.

Q. Can you identify any reference or piece in the field of medical ethics that regards clinical services, especially those services from which a committee member derives a substantial proportion of his or her income as not a financial conflict of interest?

A. I don't know how often George Bernard Shaw is quoted in such circumstances. He famously said, "I'll forever despair for civilization as long as surgeons are paid for cutting off arms."

This in some sense -- in other words, you have a conflict of interest -- if you get paid for cutting off arms and you cut off arms, then you've got a conflict of interest.

The only way that ends is to impugn the integrity of every physician, and I don't think that -- that that advances any cause here.

Are there physicians who do things for the sake of acquiring greater income? Oh, I don't know. I reckon there are some.

But to suggest that your practice itself

Page 102

conflicts -- that a busy practice or a growing practice for whatever reason is generated by a desire for more income is a thorough going critique of the medical profession, which I am not prepared to agree to.

So, therefore, no, I don't think -- I don't think that WPATH erred in not asking the people they solicited whether or not the substantial percentage of their income is derived from the process the guidelines are intended to support or guide.

Q. Can service as a paid expert witness in litigation be a conflict of interest for a member of a guideline development group?

A. Oh, I don't know. I'd have to think about that.

It depends on the context, I think. Expert witness for whom? I mean, in what context?

Q. Let's say they're providing opinions that relate to the topics being evaluated.

A. Maybe. I need to know more about --

Q. Have you ever -- have you ever considered this issue before I asked it, whether or not services as an expert witness constitutes conflict of interest?

Page 103

A. All the time.

Q. With respect to clinical practice guidelines?

A. Never.

Q. So if you look at the page we were just looking at, page 79, you see that in that same paragraph, "Serving as a paid expert witness," is one of the things that can constitute a financial conflict of interest?

A. I see that, yes. There are quite a few things listed here.

Q. Do you know whether WPATH collected information from members of the SOC-8 revision committee on whether or not they were serving as expert witnesses?

A. I do not know.

Q. And would you agree that, to that extent, that decision not to -- strike that.

Would you agree that WPATH should have asked members of the SOC-8 revision committee whether they were serving as expert witnesses in related litigation?

A. The Institute of Medicine, as we determined, is a reputable organization. There is a list here of potential conflicts of interest, which

Page 104

all on their face seem quite reasonable.

The citation here which I'm trying to look at is an article from a journal that missed a lot of these.

Whether or not any organization, let alone WPATH, asks all of these questions, I do not know.

I would like to know what the standard is. Sometimes for the credibility of a process, you might omit one or add others that are not listed here.

So that -- a particular institution does not hew precisely to this list on page 79 from this reference on page 106. I don't think whether they did it precisely or did more or did less would be useful in determining the credibility of the process.

Since you flagged serving as a paid expert witness, for what and in what context? For example, one might want to know. Is it salient, in other words?

So one could edit this right now and say this actually has not been framed very well. If I were to edit it, I would want to say serving as an expert in a case in some salient way.

So it might or might not have been

Page 105

salient.

Q. What standard is it that you'd want to know more about?

In your answer, you mentioned that there's a standard you'd want to know more about.

A. If there was a standard, I'd want to know more about it.

I wasn't referring to any one in particular.

This is a reputable, professional medical organization's statement including how a -- let's be clear here, "Direct financial commercial activities include clinical services from which a committee member derives a substantial proportion of his or her income; consulting; board membership for which" -- and this goes on actually through a rather long list and it includes serving as a paid expert witness, and I can't think of any reason to dispute that as an inclusion.

But I don't think a failure to hew to it in that way would be adequate to impugn the integrity of any guideline, in part because I do not know what, generally speaking, medical practice guideline groups query their members about in advance.

Page 106

So to say that anyone has left out one of these might or might not be interested in reporting it.

Q. Now, if you turn back to Exhibit 1, Dr. Goodman, which is your report.

Let me ask you, sir, to turn to page 9 and the last sentence of paragraph 21.

A. Yes.

Q. Do you see you write, "The idea of an intellectual conflict is not established in the literature"?

A. Yes.

Q. And where did you get that idea, sir?

A. My familiarity with the literatures is I guess the best source of that.

Q. Did you do any research before making this statement that the idea of an intellectual conflict is not established in the literature?

A. I made my statement based on my belief that the concept of intellectual conflict is not established in the literature. Other things are.

Q. Were you suggesting that Dr. Cantor was straying from what is established in the medical literature in his report?

A. I was suggesting that the term of art that

Page 107

is used in the discussion of conflicts of interest is usually described as a conflict of conscience.

I think that's, perhaps, what Dr. Cantor meant.

Q. And not intellectual conflict?

A. I'm not sure what an intellectual conflict is.

I could -- we could speculate. When we teach graduate students, for example, we teach them to be -- to do rigorous science and don't be -- and not to be beguiled by their own hypotheses which they're keen to support because that gets you a publication. In other words, think critically.

Intellectual conflict, maybe that's what he had in mind. In fact, I've often thought I'd like to ask him. Were you thinking of Karl Popper's criterion of falsifiability? I suspect not.

Q. So turn back to Exhibit 5, Dr. Goodman.

A. Yes.

Q. And back to page 78.

A. Yes.

Q. And the last sentence of the first paragraph which refers to the clinical practice guideline developers that we were talking about earlier.

Page 108

Do you remember that?

A. Yes, we've seen that before.

Q. And you see it says they, "all have conflict-of-interest policies encompassing financial and intellectual conflicts"?

A. Yes, I see that.

Q. And you weren't aware that the Institute of Medicine had discussed intellectual conflicts when you wrote your report, were you?

A. No, I just said it wasn't established in the literature.

Q. So the policy by the Institute of Medicine about clinical practice guidelines and conflicts of interest is not part of the literature?

A. Oh, it is part of the literature. Would you say it is thereby established because Institute of Medicine says so?

Q. You see the citation next to the sentence I just read you?

A. Yes.

Q. Do you know who Gordon Guyatt is?

A. I do.

Q. You agree he's a well-established scientist?

A. I do.

Page 109

Q. You agree he's a scientist who's made great contributions in the world of evidence-based practice?

A. Significant, important.

"Great" is vague.

Q. Have you looked at his article, as cited here, to determine whether or not he uses the phrase "intellectual conflicts"?

A. Not in many years. Were he to have, it wouldn't change my opinion.

Q. How many articles do you need to read that say "intellectual conflict" before you would think that it's established in the literature?

A. Fourteen.

Q. Fourteen?

A. No, I beg your pardon.

The question of when a concept becomes established in the literature, I understand is important for this process. But it is inherently a vague one and I really don't know how to answer that question.

What I can say with confidence is that the concern that people have is over conflicts generally of conscience. And that's what I inferred, especially in the context of Dr. Cantor's report,

Page 110

him to be concerned about. That's all.
Q. When you did your report, were you aware that Dr. Guyatt uses the term "intellectual conflict of interest"?
A. I did not recall that.
Q. Let me ask you to take a look at Exhibit 10.
(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 10.)
THE WITNESS: I'm looking at Exhibit 10.
BY MR. SECHLER:
Q. This is an article called "The Vexing Problem of Guidelines and Conflict of Interests: A Potential Solution."
Do you see that?
A. Yes.
Q. This seems pretty on point to the topic we've been discussing today, isn't it?
A. Apparently so.
Q. You have not read this?
A. It's been some time. It rings a bell.
Q. Do you know whether or not you read this?
A. I cannot recall.
Q. So if you look at the first sentence of

Page 111

the summary at the top of page 2, do you see it says, "Issues of financial and intellectual conflict of interest in clinical practice guidelines have raised increasing concern"?
A. I see that.
Q. Is it still your testimony, sir, that the idea of intellectual conflict is not established in the literature?
A. Yes.
Q. Now, in your report, you use the term "conflict of commitment," correct?
A. Correct.
Q. And if you look at paragraph 21 of your report on page 8, you discuss that?
A. I mention it.
Q. And what is a conflict of commitment, in your opinion?
A. Generally speaking, it is where someone's duty as, for instance, to an employer, might be affected by other duties acquired that use or take up time that would detract from the primary duty.
That is to say, if you work for a law firm, you can't spend a lot of time practicing for another law firm. That would be a conflict of commitment because your employer, and yours and mine

Page 112

and all of ours, expect us to be working full time for them.
This comes a lot in the scientific world where people do consulting. However, in a conflict of commitment in that context would arise if, in fact, some scientists were spending so much time doing consulting that his or her day job might be less well attended to than expected. Usually for a time, just a time.
Although, I reckon it could apply to other kinds of commitments as well.
(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 11.)
BY MR. SECHLER:
Q. I am going to ask you to take a look at Exhibit 11.
Can you identify this document, sir?
A. This appears to be a PowerPoint presentation -- oh, you put the pictures -- a PowerPoint presentation that I gave in 2007, at a conflict-of-interest symposium.
Q. If you turn to page 8, I believe, you have a slide discussing conflicts of commitment; is that right?

Page 113

A. Yes.
Q. And one of the things you mention is "publication and authorship."
Do you see that?
A. Uh-huh.
Q. You need to say yes or no.
A. I beg your pardon. Yes, I see that, "publication and authorship."
Q. How can publication and authorship be a conflict of commitment?
A. One might -- several ways, actually.
One which is, once again, my employer might be expecting me to be spending my time doing other things. I might be publishing articles that are -- or offering articles that are not part of what I was hired to publish. I might -- I might in that publication or authorship need to do research that would similarly detract from my duties to my employer. Or I might have, for example, a concern about a particular -- for example -- it might be, for example, social and policy advocacy, which is probably best described as conflict of conscience.
These are not mutually exclusive concepts. Interests, commitment, conscience.
Q. So what is social and policy -- strike

Page 114

that.
How does social and policy advocacy constitute a conflict of conscience?
A. If, for example -- there's a famous example in the literature having to do with whether or not the termination of pregnancy increases the risk of breast cancer. Epidemiologists have studied this over the years.
And then in a single couple of months, many years ago, two articles came out, one showing a correlation, not a -- a correlation. Another not showing a correlation. And it turns out that both the studies raised concern because of the publicly known views of the principal investigators about the right to be able to obtain an abortion. In other words, there might have been concern that finding a causal relationship, as was suggested by one of the articles, was more in support of a particular -- a value that the investigator held.
Q. In Exhibit 11, you called that conflict of commitment, but it also can be a conflict of conscience?
A. It can be, yes.
Q. Should an organization developing -- strike that.

Page 115

How should an organization developing clinical practice guidelines identify potential conflicts of conscience?
A. I don't know. I'm not sure any institution should do that.
This was a talk not about -- this was a talk from -- oh, dear, how many years ago was that? Not a bad talk although -- these may be copyrighted images, and I hope they're not.
I could imagine a lot of people at a university saying any attempt to identify what the values of your faculty are before you hire them or allow them to give presentations or do research would be out of bounds for a number of different reasons.
Which values bear on this sort of thing and how would one articulate them, and many of us are still trying to form these in different sorts of ways.
The point that was made for the students who were here was, if you are an advocate, an ardent advocate for something, that's something to bear in mind when you're making public utterances about it.
In fact, there's a larger issue about whether scientists of any sort should be advocates

Page 116

at all. It's a wonderful debate and it has reached no conclusion.
If you care strongly about what the answer should be, should you be doing science in that domain? And that's why -- and that's a legitimate and interesting unresolved question. Whether or not that's best described as a conscience or commitment is further open to dispute. I don't think much hangs on the termalogic description.
Q. In fact, if you go to the next page after the picture of the dogs.
A. You see one is a fox.
Q. One of them is a fox.
A. After that?
Q. Yes. Page 10, I guess. There is a slide titled "Non-Financial Conflicts."
Do you see that?
A. Uh-huh.
Q. And here, you quote the following statement: "Non-financial conflicts of interest are more subtle yet more pervasive and cannot be eliminated. They require continuous attention if they are to be managed successfully."
Do you see that?
A. I do.

Page 117

Q. So how would you advise an organization to pay attention to and manage non-financial conflicts?
A. You flatter me, Counselor. This is one slide from a 15-year-old talk that I do not remember.
It's a good quote and it's making a broader point to students about research integrity. It's in the context of research integrity, particularly what you study, how you study it, and that sort of thing.
If someone -- first of all, we need to be a lot clearer than certainly this slide is about what it means for there to be a non-financial conflict, what kinds there are, what is their scope, and how do we assess them when, in fact, we still have debates about what a threshold should be for a clearly measurable financial conflict of interest.
This going to the mental state of investigators in research projects about whether or not they care about their results. We've had students who say, "I really, really, really need a publication or I'm not going to get my visa renewed." What kind of conflict is that?
Is it a conflict of interest? Is it a conflict of commitment? Is it a conflict of

Page 118

conscience? So it would nice if these terms were precise. They are not.

This is, generally speaking, the idea that all things being equal, it would be -- it would be -- it would be good to be clear about whether or not -- one -- well, I say whoever this guy Goodman is, let's ask him to be far more specific about what it means to be a non-financial conflict of interest, which is actually not his phrase. He's quoting it.

I've given you examples of what non-financial conflicts might be. Interest is used in that case as a metaphor.

So the point here is there's an aspirational point to graduate students about the responsible conduct of research. I'm sure it doesn't qualify me to extrapolate from it to be able to advise a guideline board about how it ought to attend to this sort of thing.

Q. Are you qualified to advise a guideline board how they should attend to non-financial conflicts of interest?

A. I don't know. I reckon so. But I'm not sure anyone is and why it would be different for one more than another.

It's a great question though.

Page 119

Q. So how would you advise a guideline development organization to pay continuous attention and manage non-financial conflicts?

A. Well, one, if they were to decide that that was worthwhile, I'd say we're going to need to do some conceptual analysis here and identify what constitutes a non-financial conflict.

At that point, I'd be talking about conflicts of conscience and conflicts of commitment. There may be others.

As for example, anybody who has an interest -- as I say, unless Dr. Cantor and others are referring to a very interesting and difficult problem in epistemology and the philosophy of science; namely, to what degree can we stop scientists from wanting a particular result, not because it will advance a social cause but because it will confirm their hypotheses. At that fundamental granularity one might be said to have a conflict that is not financial.

This is nuanced and complex, and the literature I say goes back to epistemology and the philosophy of science. I teach my grad students about this to challenge them about different kinds of ways in which bias can be introduced into their

Page 120

research.

Now, whether a guideline group which is itself not doing research can profitably be advised about avoiding, managing such conflicts is itself an interesting question. And if I were to be asked to do so, I'd expect to do a lot of preparatory work beforehand precisely to capture those nuances. Whether they're applicable in the current instance is a separate question.

Q. So after this conceptual exercise, where you discuss what constitutes a non-financial conflict, what more would you advise them to do in terms of paying continuous attention to managing?

A. My students?

Q. No, a guideline development group.

A. This was not intended for guideline development groups. This was intended for graduate students.

Q. Would you agree that a guideline development group should pay continuous attention to non-financial conflicts of interest?

A. I am not entirely sure whether or not conflicts of -- such conflicts would be salient for a guideline development group.

I'd be more concerned about financial

Page 121

conflicts of interest. In other words, what would such a conflict be for somebody on a guideline development group? And I'm not sure what that is yet.

I can tell you what it is for a scientist, but I'm not sure I can tell you what it is for somebody who is evaluating scientific work with the goal of producing a practice guideline.

I think the arc of all of this is both very, very broad and quite nuanced. The intention of this talk, as best I remember it, was to talk to scientists who do biomedical research and are, therefore, confronted always with pressure to confirm their hypotheses. It's a well-known problem in the sciences. That was the intent of this topic.

Q. Have you ever been a member of WPATH?

A. No.

Q. Have you ever been associated with WPATH?

A. No.

Q. Have you ever done any work for WPATH?

A. No.

Q. Do you have any friends or family members who have been associated with WPATH?

A. Not to the best of my knowledge.

Q. Have you ever spoken to anyone from WPATH?

Page 122

A. No.
Q. Do you know what WPATH did to manage non-financial conflicts of interest?
A. No.
MS. CHENG-WUN WEAVER: Can we stop at 1:00?
MR. SECHLER: Sure.
THE WITNESS: What time is it now?
MR. SECHLER: Ten of.
BY MR. SECHLER:
Q. Do you know how many members on the WPATH SOC-8 revision committee would consider themselves to be trans activists?
A. No, I do not know.
Q. Would you think that self-declaration of yourself as a trans activist could constitute a non-financial conflict of interest in when it comes to developing the SOC-8 guidelines?
A. No more than a cardiologist who is an activist for clean arteries would be conflicted if they were asked to be on a cardiology guideline committee.
Q. I have one video. I might have two, actually, just to make things interesting.
A. I like videos.

Page 123

Q. I'm going to mark as the next exhibit Exhibit 12.
(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 12.)
BY MR. SECHLER:
Q. This is the source and we will upload the video or the link.
I'm going to show you a video clip.
MS. CHENG-WUN WEAVER: Is this 12?
MR. SECHLER: Yeah, it's 12.
BY MR. SECHLER:
Q. So I'm going to play the video marked as Exhibit 12, or I should say described in the document marked as Exhibit 12, and I think the court reporter will take down the audio and I'll ask you questions about it.
A. Good.
I just realized that there are people on Zoom here and I don't know who they are.
MS. CHENG-WUN WEAVER: There's counsel for the U.S. Department of Justice. They represent the Defendant -- sorry, the Plaintiff intervenors, and there's an attorney for Alabama from the U.S. DOJ.

Page 124

THE WITNESS: Thank you.
(Whereupon a video was played and taken down to the best of the court reporter's ability:)
"I was also questioning the impact of technology on gender. Medical interventions allow some of us to change our primary and secondary sex characteristics. We have phalloplasty that creates a penis and a scrotum and testicles. We have vaginoplasty that creates a vagina and a vulva. We have chest masculinization and breast augmentation. All of which create bodies that are readable to outsiders, but it's clear that cisgender bodies are still a reference point.
"But will technology give us options that are artistic and creative?
"Artificial limbs even now can transmit rudimentary sensory data back to the wearer. And it seems to me that a fully functional artificial sensate penis is maybe not that far off.
"But do we have to stick to penis and vagina norms? Can we have genitalia that look like flowers or -- or abstract sculpture? Can we have multiple? Can they be interchangeable?

Page 125

And what about other areas of the body?
"Now, communication is another form of technology that shapes our identities through access to the Internet and media. And we may soon have technologies that allow us to engage even more immersively.
"Accept us? You should revere us. We're confronting boundaries and deconstructing assumptions made by history and society, and we are evolving gender into something wonderous. We hope the world will learn from our wisdom, but our very presence demonstrates the immeasurable potential for human existence.
"I know that many would fear the gender-queer planet we represent. But we are here. We are trans and non-binary and gender queer. And to all those opposed out there, I say, it's about time you got used to it.
Thank you very much."
(Video concluded.)
BY MR. SECHLER:
Q. So, Dr. Goodman, do you see anything in that video that would suggest that that member of the SOC-8 revision committee might not have a non-financial conflict of interest?

Page 126

By the way, I should -- let me just stop for a second. So we watched a video. That was Laura Jacobs, who is a member of the WPATH, SOC-8 revision committee.

My question, just to repeat it for the record, do you see anything in that video that would suggest to you that Laura Jacobs might have a non-financial conflict of interest?

A. Well, what I found striking about the video, of course, is how much of it was not devoted to gender-affirming therapy but to other speculative futuristic, even what's been sometimes called trans-humanistic considerations.

I think what was clear in a very small part of the video was that she supports the availability of gender-affirming care.

Beyond that, it may suggest many things, but I'm not sure that it suggests a conflict of the sort that we've been discussing. In other words -- so, no.

There are a lot of things in that video which one might discuss profitably and enjoy discussing. Talking about the future of medicine and humanity is always interesting. There are people who are doing similar -- not dissimilar,

Page 127

anyway, work in neuroscience, which is all really rather quite speculative.

Strip away the speculative part of that video and you have somebody who has declared their support of gender-affirming therapy, which one could have inferred -- which is inferrable from the very fact that they're serving on WPATH.

In other words, I don't think anyone would seriously suggest that a guideline group, be it for gender-affirming therapy or cardiology or any other such thing, must include people who oppose cardiologic interventions or oppose gender-affirming therapy.

There are many controversial things in the practice of medicine. My job -- my colleagues are thinking and worrying about all of them. But I am reminded of -- so the answer is no, not from that. That was -- it was interesting. I hadn't heard it before. I think it would be interesting to discuss and analyze further. But the core part of it was a simple -- was I support gender-affirming care.

I don't think WPATH is addressing or anybody who is doing this now is seriously contemplating the creation of genitals that look like flowers necessarily.

Page 128

Q. So if you were advising WPATH as the ethics expert and you saw that, during the development of the guidelines, you would not suggest that WPATH get more information from Laura Jacobs to determine whether there was a non-financial conflict of interest?

A. I think we've already determined that the fact that one performs a procedure -- I don't know what -- is she a physician? What does she do?

Q. Laura Jacobs is listed in Exhibit 13. I'm sorry, Exhibit 9.

A. Is it under surgery again?

Q. Let me -- yeah, Exhibit 9.

These pages are not numbered, but if you go to the middle.

A. Yes.

Q. Did you find Laura Jacobs on the chapter of Assessment and Therapeutic Approaches of Non-Binary?

A. Yes.

Q. Okay.

A. She's been candid with her description. What more would one advise a group to want to know about her? This is an advocate, as self-described, an advocate, activist.

Page 129

So if that -- if activism on behalf of a medical procedure constitutes such a conflict, then yes. If it's not, then no.

One -- that certain areas of medicine are settled, like cardiology, would make it unusual for someone to fault a cardiologist for saying, "I'm an advocate for better heart health. I'm an advocate for drug-eluding stents for people with vascular problems. I'm an advocate for heart surgery for people who have heart conditions."

And, in fact, we sometimes urge our colleagues in the practice of medicine to be advocates for access to healthcare in their specialty. I don't think that simpliciter constitutes a conflict.

Q. Do you agree that a guideline development group should be composed of individuals with diverse perspectives, training, and experiences?

A. Well, diverse perspective, training is rather quite vague.

As regards what, for example?

Q. Do you think -- have you ever heard that before, what I just said?

A. It's a kind of a say to get key phrase. In other words, diverse perspectives are generally

Page 130

thought to be, in many processes, to be -- to be good, namely.

We see this in courts all the time. It's good to hear different perspectives to try and find out what the best approach is.

So disagreement, for example, can be good. If one achieves disagreement through a diverse or variant perspective, that's good. But now we need to be very clear about what it means to have a variant perspective. It's a credible one.

Q. Do you know whether there were any practitioners on the SOC-8 revision committee who have expressed skepticism or concerns about performing medical treatment on minors presenting with gender dysphoria?

A. I do not know.

Q. Do you know whether or not there were any detransitioners represented on the committee?

A. No, I do not know. No, I do not know.

But if it helps, especially in academic context, a potentially useful analogy is in the form of institutional animal care and use committees.

I'm giving you something. A detransitioner is someone who I assume opposes gender-affirming care; is that right?

Page 131

MR. SECHLER: Can you repeat the question?

BY MR. SECHLER:

Q. I think we're off the question, Dr. Goodman.

A. Well, let me reframe my response.

What's a detransitioner, to make sure I understand your question? Whether a detransitioner is on WPATH, I don't know. But it would help me answer your question by knowing what you regard a detransitioner to be.

Q. Do you know what "detransitioner" means?

A. I have -- I believe I know.

Q. What is your belief?

A. I'd rather you tell me what you intend by using the term in your question.

Q. What do you believe the term to mean?

A. I think we have an impasse. You're asking me a question using a term, and I'm asking you to clarify your intent in using the term.

Q. And you said you have an understanding of what it means, and I am asking you what it means.

A. And I'm waiting for you to tell me your intent.

Q. Okay. We'll move on. I asked the questions, sir. Not you.

Page 132

This is Exhibit 13.

A. The point, of course, is if one is unalterably opposed to cardiology and believes that cardiology is wrong, then one should not be on a guideline committee that's producing cardiologic guidelines. That's not a diverse perspective. That's a saboteur. And that was the point I was trying to make earlier. That's not a diverse perspective.

If you don't believe in a particular approach or a medical procedure, and there are many in the world -- in fact, many things that happen in medicine are controversial. In fact, that's why we have offends who do what I do because a lot of stuff is really quite controversial and we're worried about all of it.

But the idea that you're opposed to animal research does not make you a good, diverse member of an animal care use committee. If you're opposed to human experimentation in children, you should not be on an institutional review board that reviews human subjects research involving children.

If you have an objection to cosmetic surgery or the kind of gender-affirming therapy that happens in Miami all the time on adolescents, by

Page 133

which I mean breast augmentation, if you object to that, then you shouldn't be on a committee that's guiding that.

That was the force of your question. And that's the answer.

Merely to suggest that diverse perspectives are being excluded by not having people who oppose to the very thing being addressed is not a credible stance for any guideline committee.

Q. So people opposed to gender-affirming care provided to adolescents should not be on SOC-8?

A. What would they have to contribute to the medical guidelines?

Q. Is that your answer?

A. They would have nothing to contribute to the medical guidelines; therefore, there's no reason to include them.

Q. Okay.

MR. SECHLER: I can withdraw exhibit -- that last exhibit. We can take a break for lunch.

(Lunch recess from 1:03 p.m. - 1:35 p.m.)

BY MR. SECHLER:

Q. Welcome back from lunch, Dr. Goodman.

A. Thank you.

Page 134

Q. Let me ask you to turn back to your report, Exhibit 1. I'll direct your attention to paragraphs 26 and 27.

You used the term "valid consent" to describe the consent that healthcare practitioners should receive from patients before providing medical treatment?

A. Yes.

Q. And what are the elements of valid consent?

A. The first gives the more common term its broad usage; namely, adequate information. So if someone is going to be a patient or participant in research, then that person needs to receive such information as a reasonable person would want to know to decide whether to move forward or not. That's the adequate information component.

Second component is voluntariness. Actually, these are no particular order for our purposes. The second one is voluntariness; namely, that the decision whether or not to move forward is freely given, not induced or coerced in any way.

The third competent is, generally speaking, mental capacity; namely, the ability to -- generally the ability to understand and appreciate

Page 135

all that information in the first place.

Q. And referring you to the adequate information competent you mentioned.

A. Uh-huh.

Q. Adequate information about what?

A. About procedure or the experiment that's about to be conducted. What are the risks? What are the benefits? What are the alternatives?

Q. I believe in Footnote 7 in your report you cite six references in support of this general discussion.

Do you see that?

A. I do.

Q. Are these authoritative treatises in the field of medical ethics?

A. I believe them to be.

Q. Are minors considered a vulnerable population in the field of medical ethics?

A. They are.

Q. And what does vulnerable mean in your field?

A. So someone is vulnerable if -- there's a large group -- in fact, there's a great debate over what constitutes vulnerability.

Minors are generally considered

Page 136

vulnerable. Prisoners are considered vulnerable. Sometimes people with low language ability or education are considered vulnerable.

Vulnerability is shaped by concern that someone might -- that it might impede voluntariness.

Q. What does it mean to be vulnerable?

A. To be susceptible to -- to anything that would impede voluntariness.

Q. Why are children considered -- strike that.

Why are minors considered vulnerable?

A. Minors makes it clear that we have, in our society and many others, for a number of reasons, had to stipulate age of majority.

And so minors is generally speaking -- well, someone who's not 18 years old yet, we know plenty of people who -- minors who have great insight before that age and there's plenty of adults who lack that insight.

But the concern, of course, is, one, for their ability to understand and appreciate the information; therefore, impeding their ability to knowingly agree to move forward. That's the main consideration is that -- one of them. Ordering is not -- ordering the different criteria is not going

Page 137

to be helpful.

Generally speaking, a minor and others are going to be regarded as vulnerable in part because they will not be able wholly to understand and appreciate the information as part of the adequate information and criterion.

Q. And what about the other two criteria, does a minor's age have an effect on whether they have the mental capacity to understand the information or whether or not their involuntariness?

A. So the first -- so, yes, being intellectually immature, which, once again, we stipulate as being up through the age of 17, for a number of important legal purposes, entails that -- the inference that that person might not be able to understand the information and, therefore, unable to meet that criteria.

The other concern is they might be more susceptible to inducement or coercion.

(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 13.)

MR. SECHLER: I need a new 13.

BY MR. SECHLER:

Q. This is a report from the American Academy

Page 138

of Pediatrics entitled "Informed Consent and Decision-Making in Pediatric Practice."

Do you see that?

A. I do.

Q. Are you familiar with this piece?

A. I'm aware of it. I have not reviewed it in some time.

Q. Is this considered an authoritative piece in connection with informed consent in pediatrics?

A. I don't know how it's considered. Generally, the American Academy of Pediatrics is a reputable organization and its technical reports are accordingly given appropriate weight.

Q. If you look at page E7, I'd like to direct your attention to some language.

A. Yes.

Q. If you look at the third column on the page and the first paragraph in that column.

A. Uh-huh.

Q. There's language in the middle that starts, "The prefrontal cortex."

Do you see that?

A. I do.

Q. Let me read that, "The prefrontal cortex where many executive functions are coordinated,

Page 139

including the balancing of risks and rewards, is among the last areas of the brain to mature, with these functions continuing to develop and mature into young adulthood."

Did I read that correctly?

A. You did.

Q. And is that your understanding of the development of executive functions in youth?

A. As a non-expert and non-neurologist, that's what they call neuroplasticity and I think it's almost common knowledge. Neuroplasticity.

Q. And how does that relate to the issue of consent by minors that we've been discussing?

A. It's among the reasons why, to obtain medical treatment, we generally require that parents or guardians consent to their children's care.

Q. What would be the harm if you did not require parents or guardians to consent to their children's care?

A. The evolution of thinking about the valid consent process conditions treatment and participation research on -- on a process, the valid consent process, where if someone, by virtue of their lack of age of majority or, for instance, a cognitive -- you don't need to be a minor to lack

Page 140

full capacity, for that reason, to support and protect the process and ensure that the rights -- it may be based on rights at the end of the day, but the rights of the person who's about to be -- to participate in research or to become a patient are respected, we find someone appropriately related to them to consent on their behalf. And so I don't know what the harm is. It might be a wrong.

I mean, if you treated a child for anything without consent, there may be no harm at all. In fact, emergency departments do it all the time. If the kid shows up with a really bad wound and the mom and dad are not there, it would be irresponsible not to treat that patient.

In other cases, we do it because it's a matter of good process and to ensure somebody is participating on behalf of the incapacitated person to ensure the credibility of the consent process.

So I think there may be no harm at all. As regards to human rights, there may be a wrong if you didn't get a surrogate or guardian or proxy consent.

Q. Yeah, I guess that takes us back to the reason why the profession insists upon valid consent at all. Like, what are the purposes for requiring

Page 141

valid consent in order to do a medical procedure on anyone?

A. Well, there are many reasons for that.

I mean, the ethical reason is it honors the right of people to control their bodies and consent to a refused medical treatment.

The origin I wish I could say was the result of a brilliant article by somebody who does what I do for a living. The origin of most of our laws regarding this are actually based on case law.

Canterbury v. Spence. Canterbury v. Spence, where a surgeon did a procedure. While he was operating, he saw something else that he can do, did it, had a bad outcome, and then was sued because he didn't obtain consent for that extra bit.

So the idea is, before you do something to someone, you ought to be able to explain it as completely and reasonably as possible what you're going to do and why. And, therefore, understanding and appreciating that is important.

If one is not able to understand and appreciate it, we still try to protect the rights of people to consent or refuse treatment by identifying a surrogate, a proxy, or other decision-maker.

Q. Now, in your review of the Cass Review,

Page 142

did you note that that review found or stated that brain maturation may be temporarily or permanently disrupted by the use of puberty blockers?
A. I noted that concern.
Q. It was also noted in the review that that could have an impact on the young person's ability to make complex risk-relating decisions?
A. Which we knew before that. In other words -- so, yes, I noted that, yes.
Q. How did you know that before that?
A. Sorry. How did I know which before which?
Q. I'm responding to your answer, "Which we knew before that."
A. Well, we knew that there are many different things that happen to children which might impede their cognition -- medical risk is completely remote from this one -- before or after the age of majority.
There are some that are thought -- for all we know, for some of the science, they might improve the minor. The evidence here is really in evolution. Which is why Cass, in noting it, was not dissuaded from her recommendation that this care still be available.
Q. Well, you know what the Cass Review

Page 143

recommended with respect to puberty blockers, don't you?
A. Did Cass not support the use of puberty blockers, hormones in that context?
Q. What is your understanding after reading the Cass Review --
A. I read it when it came out, and I'd like to be refreshed. We have it here. If you can provide it to me, I'd be grateful.
Q. Sure.
A. I still have my copy.
MS. CHENG-WUN WEAVER: I have it.
THE WITNESS: No, no, I still have it.
BY MR. SECHLER:
Q. Go to page 32. Referring you to the paragraph 84 at the bottom of the second column.
Do you see that?
A. I see it.
Q. Do you see that the second half of that paragraph states, "Because of the potential risks to neurocognitive development, psychosexual development, and longer term bone health, they, puberty blockers, should only be offered under a research protocol."
Do you see that?

Page 144

A. I do.
Q. Was that your understanding, that the Cass Review had a recommendation that puberty blockers be offered only under a research protocol?
A. I did not recall it. I see it now.
In other words, they're not out of bounds. The point that one -- and this is a very common kind of thing that people say, is we would like stronger evidence for all of this sort of thing.
But if they were wholly inappropriate, then they would not even be available under research protocol.
The larger point is let's not miss the opportunity to gather more evidence.
Q. Right.
A. As opposed to let's not do any of it.
Q. Let me ask you to turn back to your report.
A. Yes.
Q. If you go to page 13, your paragraph 32.
A. Yes.
Q. You note that Defendants' experts made certain points, including, "minors lack the intellectual maturity to comprehend that the decision to obtain gender-affirming care might

Page 145

affect future reproductive health."
I'll stop there.
A. Yes.
Q. You don't disagree with that point, do you?
A. Well, you don't mean that they've suggested -- you mean the point that minors lack the intellectual maturity?
Q. Yes. Much better question.
A. I think minors lack the intellectual maturity to consent to any medical intervention. So it's tautologically true.
Q. The next point that was made is, "Adolescents tend to have increased rates of risk-taking behavior."
Do you see that?
A. I see that.
Q. And do you agree with that point?
A. I don't agree or disagree. It's common lore, but I'm not sure that I've seen evidence that shows that -- I actually know of non-adolescents who engage in really risky behavior.
So it's one of those bits of -- it's a cultural understanding about adolescents which some adolescents would take issue with.

Page 146

Q. Have you seen literature suggesting that adolescents tend to over value short-term rewards rather than long-term rewards?
A. No, I have not seen the literature.
Q. Are you familiar with the literature?
A. It's been alluded to. Yes, I am familiar with it.
Q. And do you see the last point there that you referenced, "Some adolescents' sense of urgency stems from hypersensitivity to reward."
Do you see that?
A. Yes.
Q. Do you agree with that?
A. I have no basis to agree or disagree. I don't know the literature on this. I'm trying in the interest of good faith to be explicit about what the experts suggest so that I can respond adequately to them.
If I -- I might be able to agree or disagree with these if I had greater familiarity with the literature.
The idea that adolescents have been taking -- have increased risk-taking behavior is thought to be common knowledge. I have no idea whether it's actually true or not. It may very well

Page 147

be. I do not know.
Q. Do you have any reason to disagree with the proposition that minors are incapable of comprehending long-term implications of medical treatments for gender dysphoria?
A. I think that varies by the age of the minor. We've seen 17, 16, 15-year-olds for whom we do organ transplants.
We've actually had cases where we've had donors, sibling donors -- risk of being an organ donor for a sibling entails extraordinary risk and yet many institutions have done it. Mindful of the fact, all -- all of the concerns we have about minors' capacity to consent, we -- so your -- as framed, that's much too sweeping.
I think some do, some don't, and that may be actually assessable, if we can assess it, which I'm not sure we can, on a case-by-case basis.
Q. What about a minor who's prescribed puberty blockers at Tanner stage two? Are you familiar with Tanner stage 2?
A. I'm familiar with the Tanner stages.
Q. And do you think that someone that age, a minor that age would appreciate the implications of the inability to experience orgasm?

Page 148

A. Unlikely. However, that's all true for everything. In other words, the ability of a minor to understand and appreciate with an adult's comprehension things like future reproductive potential or orgasms or future disability or any number of consequences of any medical procedure are precisely why we ask guardians and parents to consent on their behalf, hoping that those guardians in good faith will understand more about orgasms than their children.
Q. Would you agree that such treatments should not be provided to minors without consent from their parents regarding this?
A. I can't think of a circumstance where you would not want someone to legally authorize -- before we called them legally authorized representatives to do such a thing. But that's also true for any medical intervention, absent an emergency.
Q. Now, does valid consent require the clinician to have certain information about the risks and likely benefits of the proposed treatment?
A. Certain information?
Q. Have a certain amount of information?
A. Certain amount.

Page 149

Q. A level, a minimum?
A. Well, to be sure, one, the challenge of the consent process is to be able to communicate in a meaningful way to your patient, whether it's an adult or a patient, about salient facts that bear on the intervention. And so I -- no more or less so than anywhere else I would think in medicine, right?
Q. Well, are there some procedures or circumstances where they -- the field doesn't know enough to be able to even get informed consent?
A. There are many interventions where we -- consider pediatric oncology where, by the way, there you're in some sense asking a minor to contemplate the risk of their own death. I think that that's also something that children are not particularly very good at. And yet, we regularly allow their parents on their behalf to consent to participating in research trials where the study agent might expedite their death.
And the debate is what's adequate information. And that is -- that is really quite challenging. I mentioned pediatric oncology because we lack a great deal of information and that is never taken to be a good reason to not provide treatment to the patient.

Page 150

You provide the information as best you have it in the context.

Do you wish you had more? In many cases, yes, and that's true for many interventions in pediatrics.

Q. Can you think of any intervention where there's just not enough known to even ask anyone, parent, adult, anyone, for valid consent because you just don't know enough about the benefits and the risks?

A. I think that our regulatory structure allows physicians in good faith to make decisions, we call it off-label use, where it says that I have a duty to treat this patient. I'm not entirely confident of all the tools in my armamentarium now. Nevertheless, it would be irresponsible to do nothing and, therefore -- but you would not treat someone over someone's objection, I don't think, if that's -- I'm not sure if that was the force of your question.

Q. Well, you were positing a clinician who may have a belief that something could work.

What about a situation where there really wasn't a basis to believe that, given the current state of the knowledge?

Page 151

Do you think that clinician could still proceed under a theory of valid consent from the patient?

A. It wouldn't be a theory. It would basically be to say, as long as one were clear, that the evidence base is -- is not what we wished it were and, in fact, there's a term of art in medical practice for that, is you treat something empirically.

That's a fancy way of saying the doctor has no idea whether it will work or not. And on the other hand, inaction is regarded to be inappropriate for any number of reasons.

So yes, I can imagine circumstances where one might strongly recommend that something -- for example, the legally authorized representative, that even in the absence of gold standard evidence is, nevertheless, prudent or -- to consider a particular treatment.

It depends, once again, entirely on the procedure and what the alternatives are.

Q. So you can't think of any procedures where there's not enough information to get valid consent?

A. I'd like some examples of candidates for that. In other words, what is it that a physician

Page 152

might contemplate with no information or evidence whatsoever?

Q. Okay.

A. I don't know what those are.

Q. So what about lobotomies; are you familiar with lobotomies?

A. I am familiar with -- I have a layperson's familiarity with lobotomies. But also, by the way, electroconvulsive therapy, where many people have completely -- there I've acquired the belief from experts that, while people don't like it, it actually will save a lot of lives.

And so evidence for whom, with what understanding, with what broad agreement, our entire discussion is shaped by the fact that scientists don't agree about this and, therefore, individual clinicians have created responsibility in recommending procedures.

Whether or not lobotomies are appropriate or not, I have no opinion on that.

Q. You have no opinion as to whether or not the University of Miami hospital would perform a lobotomy on somebody who came in and asked for it?

A. I'm sure if someone said, "I would like a lobotomy, please," they would probably demure.

Page 153

But I thought your question was, is it possible that there is some neurosurgeon or psychiatrist who might say the only hope for saving this patient is a lobotomy.

At that point, I think someone might say, all right, that would be -- not be morally unacceptable. It would be edgy, but patients don't get treated for anything simply because they asked for it.

Q. So why would your employer demure if someone were to ask for a lobotomy?

A. Because the standard for treating patients is based on clinical indications for the treatment. And patients -- the difference in ethics is between requests and refusals.

At the end of the day, a clinician needs to use her judgment to decide whether or not a particular intervention is right for this patient.

Q. Was the information base that was known in the 1940s in this country sufficient to obtain valid consent to perform lobotomies on patients?

A. That's a great question. I have no idea what the answer is to that.

Q. Do you think there's any information base that would be insufficient to perform risky

Page 154

procedures on patients?
A. I still don't know. It might very well -- you asked me a historic question about what was widely known in the 1940s.
What I'm trying to say is I -- I'm looking for examples of something today that might fall under that heading, and the answer is I can't think of anything. But there may very well be something. If I knew more medicine.
Q. Why don't you take a look at Exhibit 3, the Cass Review.
THE WITNESS: You took it away from me again.
MS. CHENG-WUN WEAVER: I'll leave it with you.
BY MR. SECHLER:
Q. Before I ask you about that, though, Doctor --
A. Please.
Q. You can't think of any example that we face today where we may not know enough about the benefits and risks of a treatment to go forward with it and to obtain valid consent?
A. If I understand your question correctly, we do it all the time in pediatrics. We don't have

Page 155

as much evidence as we would like, and nevertheless, we have the evidence we do and that guides decisions about whether to treat the patient or not. You see this especially in complex, rare diseases.
Q. I'm not asking about situations where you go forward.
I'm asking about situations where you don't because you don't know enough. And you can't think of an example where you don't go forward because you don't know enough?
A. Individual clinicians might very well decide based on that that it would be inappropriate.
A surgeon, for example, might say, "I don't understand enough about the risks and I don't want to be responsible for making things worse." And so I'm thinking neurosurgery for the most part or sometimes cardiovascular surgery where you can kill your patient if you do the wrong thing, right?
But other surgeons would say, "I disagree with your assessment of that."
At the end of the day, we place great trust and store in the individual -- in this case, surgeon's ability to be discerning and make judgments that are medically appropriate for the patient.

Page 156

And so I -- but if an individual surgeon were to say, "I don't want to do that," then for that individual surgeon, that would have to be adequate.
Q. Okay. So let me ask you to look at another document before we get to the Cass Review. Exhibit 14.
(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 14.)
BY MR. SECHLER:
Q. So, Dr. Goodman, I've handed you a document marked as Exhibit 14, which is a news report entitled "Face Transplants: Medicine's New Ethical Dilemma."
Do you see that?
A. I do.
Q. And you understand what a full face transplant is?
A. I believe I do.
Q. And what is that?
A. It would be a transplantation of a full face.
Q. And do you recall being interviewed in connection with the procedure of a full face

Page 157

transplant?
A. Not until now.
Q. Well, take your time, if you want to look at that, but on page 2 --
A. That's a good quote, by the way.
Yes, on page 2.
Q. Yeah, on page 2.
A. I'm there.
Q. Actually, beginning at the very bottom of page 1. I'm sorry.
The article quotes you as saying, "The procedure contemplated in Cleveland raises very interesting questions about personal identity and how people think of themselves. That raises questions about the psychological and psychiatric risks and we don't know what those are. We don't know how to communicate to people what it would be like to have a completely new face."
Do you see that?
A. I do.
Q. Did you make that statement on or around December 2005 in connection with this article?
A. I can only infer the answer to that is yes since the article is dated December 7, 2005.
Q. And is a full face transplant a procedure

Page 158

where there's not enough known about the psychiatric and psychological risks to obtain valid consent to a patient?

A. Absolutely not. I would not infer from this that at all.

This is risky. This is rare. This was a case of first impression, by the way, the first in the world, and this is -- and this quote is signaling a number of cautionary messages, in part because no one has ever done it before.

It was on a commentary on the appropriateness of it, that is to say that it's really hard to get this right. Which is -- for face transplants, probably more the case -- well...

I'm sorry. So yes, I said that, and I think it's -- I think I agree with it still.

Q. So if one of your clinicians came to you asking for advice about whether or not they could have valid consent to perform a full face transplant on a patient who was electing it because they didn't like their face, would you give them advice to say, "As long as you tell them honestly that we don't know the risks, go ahead"?

A. No. What I would say -- first of all, the people who get face transplants, such as they are,

Page 159

and I don't know how often this has happened in the last 20 years, seek it not because they want a new face. They seek it because they've been badly disfigured and -- which, by the way, also entails significant psychological and psychiatric risks.

It's when a surgeon or physician becomes involved that the valid consent process needs to take that into account.

If someone were to call me today and say, "Well, we've had 20 years of face transplants," this was a case of first impression in the world and I think the stakes and the knowledge are significantly different.

Q. Well, you changed my hypothetical. My hypothetical wasn't about someone who was disfigured but someone who wanted to have a new face.

Would you say to your clinician, "As long as you tell them that we don't have information about the psychiatric outcome, that you can go ahead and give valid consent"?

A. It depends on the face. By which I mean to say -- years ago, I would be talking to a cosmetic surgeon and I would be expressing an opinion about rhinoplasty, nose jobs, in a minor. And I'd say, "I have grave concerns about

Page 160

rhinoplasty in a minor." And they say, "Look at this nose and what this kid is going through with this nose."

There are certain kinds of procedures which we -- you might be more cautious about it.

If someone came in and looked as good as you, I would say there's no basis for a face transplant.

On the other hand, one might plausibly be able to imagine a circumstance for whatever reason, not disfigurement by accident but something -- I'm thinking in the context of a much restricted kind of procedure, and I change my mind about it when I saw the patient's nose, which was extraordinary, and I said, "Okay, I'm going to change my view about that."

So, in other words, they're not analogous, what happened in face transplants 20 years ago. Even if I were to say today, "Face transplants are a bad idea, don't do them because people want them," I don't -- which I'm not saying, to be clear.

I'm not sure how that advances our discussion.

Q. Well, your rhinoplasty example, if the nose on the minor patient had not been the nose that

Page 161

you saw but something that in your opinion was kind of a common variety nose that wasn't liked, would you then say to your clinician it, "You shouldn't go forward"?

A. I would say, "You have to have a reason to go forward and I don't see the reason here. If you give me a reason, then we can discuss it."

Q. Why do they need a reason to go forward if there's parental consent?

A. Because medical interventions need to be assessed by competent physicians. And there's a lot of things the patients might ask for that are inappropriate. We have an opioid crisis because of that.

The mere requesting of something from a physician does not absolve the physician from using their clinical judgment to decide whether it's right for the patient. So merely if someone asks for something across the arc of -- I mean, if someone says, "I think I have cancer, please give me cancer drugs," you wouldn't do that, even if turns out they're right because it might not -- or they say, "I want this drug and not that one," or "I want" -- in other words, there's a -- the relationship is shaped by valid consent as an ongoing process

Page 162

between clinician and patient, requires a clear understanding about roles and a learned professional like a physician ought to have a -- understand why it is that something has been requested and then make an assessment about whether or not it's appropriate for that patient.

One might very well say, "A first full face transplant is worth giving it a go," as a case of first impression, as it were.

But I don't think they're analogous.

Q. Is parental authority to make medical decisions for minor children constrained compared with the autonomy that adults themselves enjoy?

A. In some respects.

Q. Explain.

A. Jehovah's Witnesses, for example, refuse blood transfusions.

An adult Jehovah Witness will die for want of a blood transfusion. They will honor the adult's valid refusal of blood for whatever the reason is. We don't challenge them on their faith.

A child, however, who is a child of Jehovah's Witnesses, even if the parents are requesting that there not be a transfusion will in most jurisdictions lead to a request for judicial

Page 163

intervention to transfuse the child.

So that's an example of, I think, what you're asking for.

Q. Can you think of any examples where a parent is requesting treatment of a child and, again, you're going to end up in judicial intervention because the hospital won't do it?

A. Well, similar cases. Usually they're shaped by faith, traditions. If someone refuses -- there's certain faiths that do not accept modern medicine and we've had -- there are cases that you're familiar with where children -- where institutions have been compelled over parental objections to provide cancer care, for example, for a child.

Q. Right, so I was just asking about the reverse.

Can you think of an example where a parent has requested on behalf of a child a medical intervention that the hospital did not think was appropriate?

A. Those requests on behalf of the child are medical intervention.

Oh, the hospital is not appropriate. Oh, I don't know. Let me think a second.

Page 164

I think certain behavioral drugs. I'm not sure. I'm not sure offhand. I can imagine there would be some that would be legitimate.

Q. Legitimate refusals to?

A. To accede to a parental request but it would have to be something like that.

Q. What about bariatric surgery, does your employer perform bariatric surgery on obese minors?

A. I do not know.

Q. So how would you define the standard that you just gave an example of? What is the standard that a clinician should apply when determining whether or not to accept parental consent on behalf of a minor?

A. The standard for evaluating the validity of the consent?

Q. Very well spoken, yes.

A. Whether it -- have you, the parent, been given adequate information? Are you, the parent, making on your child's behalf a voluntary decision? And do you, the parent, understand and appreciate what I've just told you?

Q. Well, why wouldn't all those three things be true in the case of a parent who's a Jehovah's Witness who refuses a blood transfusion?

Page 165

A. Because they're not parallel cases at all. Because at the end of day, that child is going to die. And in our society, we've agreed we do not allow parental refusal of ordinary treatments to peril the life and limb of children.

Q. But which of the three things you just mentioned are --

A. They don't apply in that case. That's why we get a court order.

Q. Yeah, but my question is what's the standard that you would apply -- when you evaluate requests from your clinicians, what standard do you apply when determining whether or not the hospital can correctly refuse to accede to a parental request?

A. Only the standard of valid consent and patient best interest.

There's no separate standard for that than there is for anything else.

Q. What do you mean by patient best interest?

A. Well, if, for example, a parent were to request that -- a lobectomy; I want my child to have a lobectomy. Why? I don't know. I heard they're kind of cool or electroconvulsive therapy.

We might not do that and we would do

Page 166

that -- or the surgeon would make that judgment -- once again, the standard at the end of day is in the head of the physician.

It sometimes happens -- and people disagree -- reasonable people disagree as you've discovered throughout this process. Reasonable people disagree.

So suppose a woman has a family history of breast cancer, tests positive for the BRCA1 or 2 genes and someone says, well, one of the best ways to prevent you from developing breast cancer is to do mastectomies.

One might counsel -- one might agree to that depending on the particular facts of the case, the nature of the family history, what we know now about breast cancer genes, and say, you know something, let's do watchful waiting. Or one might plausibility say with the same information, the same patient, you know something, we can see our way clear to doing a mastectomy.

In other words, the standard is not going to give you the same answer in every case. What you want in every case is that the learned professional who's doing this is mindful of these requirements and is using their clinical judgment guided by the

Page 167

best interest of the patient, which is why some surgeons will not take some cases outside of the current domain at all and others will do them.

We have surgeons now do fetal surgery. Others wouldn't consider it, to try to conduct fetal abnormalities.

Q. Would it be appropriate for a parent to refuse to consent to treatment recommended by a gender care doctor and that the child wants to receive?

A. I need to know more about that. It sounds like it would be a very interesting ethics consult.

Q. So you think there are situations where a doctor could recommend medical treatment for gender dysphoria, the child is on board, the parent isn't and it could be a case for judicial intervention?

A. It might be. Once again, I need to know a lot more facts about that.

Once again, generally speaking -- might get a second opinion, too by, the way. I mean, there are number of ways that a case like this would be approached.

The summary -- your proceed is interesting. But a proper answer and a thoughtful answer would require more facts.

Page 168

Normally we recommend taking the advice of -- listen to your doctor, take your doctor's advice. If you don't like your doctor's advice, talk to other doctors.

It's trickier in the case of parents and children. But the question you're asking would be inappropriately answered without a lot more facts.

Q. So what's the role of parental consent if, in your opinion, you could look at a situation and a clinician's determination of best interest and a minor's assent would be sufficient to compel a procedure or go forward with a procedure?

A. Once again, I don't think we'd necessarily be talking about compelling a procedure as much as we might be saying depending on your view of things.

And I'm trying to think of an example that's in a completely different area.

Get a second or third opinion. That's a good idea in cancer care. Sometimes a cancer doctor will say I recommend this. The kid -- once again, I don't how common any of this is. But since your hypothetical is interesting, the child may say, I'm okay with it and the parents say we've got misgivings and we don't want to consent to it yet.

In that case, one would be well advised to

Page 169

learn more about the procedure, talk to other clinicians, talk to more experts and so forth.

Judicial intervention is a dramatic step. It usually is when someone is in imminent risk of dying. But it captures your example of something that we do independently of what a parent wants. It is comparatively rare.

Q. Now, in terms of procedures that the healthcare provider should not accede to the parental request, isn't sterilization of a child or a minor one of them?

A. If I'm not mistaken, that might be addressed in Florida statute.

It's worth mentioning. When you say sterilization, there are a number of procedures that are on analogy.

So, yes, sterilization is sometimes that sort of thing where we're very reluctant to do such a thing, absent other circumstances that make it permissible.

Q. And why is that treated differently?

A. Well, it depends on who is being sterilized by the way. Male, female, is it reversible or not, that sort of thing.

Q. A hysterectomy on a minor female who wants

Page 170

to manage menstruation?
A. You may recall a very interesting case of -- experts who you and your colleagues and your client would agree with and -- a case involving an adolescent female with a severe -- with severe autism spectrum disorder. It was in the news.
And what the family was hoping physicians would do. I don't remember the exact details but the idea is -- Ashley is getting older and Ashley is developing and as she's menstruating, one, this is causing her, the patient, in her mental condition extreme alarm. She's much distressed by the phenomenon of menstruation and she's also getting really large and it's hard for us to carry her because she's not otherwise mobile.
Therefore, if we can impede her development, it would be in her best interest.
At the time, it was a controversial case because it might have involved sterilization for that purpose. That was -- that was against a background.
However, where someone, because of a number of cultural and historical considerations, the sterilization of people with incapacity is quite legally, politically and ethically fraught because

Page 171

we used to sterilize people who had mental disability and we all, I think, would agree that that is out of bounds.
No one is suggesting that anyone here has a mental disability and there are other procedures in reproductive medicine and oncology which imperil the future ability to reproduce which, in fact, we do all the time, especially in oncology.
Q. Was Ashley somebody that you were involved in treating?
A. No, of course not. I don't treat anybody.
Q. I'm sorry. Was Ashley someone your clinicians were involved in treating that you consulted them?
A. You remembered her name.
No. Oh, Ashley, you're talking about the case I just mentioned?
Q. Yes.
A. Oh, no, she was not. I don't remember where she was.
Q. It was just something written up in the literature?
A. It was in the literature. It was a great discussion and also in other media. It was a great moral challenge to figure out what the right thing

Page 172

to do for this child was.
Q. Did you ever express an opinion on it?
A. I don't recall that I did. I was trying to guide colleagues who were -- some of them were emphatic, including surgeons, that it should be done; others not so much.
Q. How did it turn out?
A. I believe -- I don't remember. I believe the committee -- the ethics service they turned to, the ethics committee that they relied on said it would be permissible but I have to have my memory refreshed about it. I just don't know the long-term outcome of it at all.
Q. So apart from an autistic child, would it be permissible for a healthcare provider to perform a hysterectomy on a minor daughter for non-life-threatening reasons?
A. As part of medical treatment for gender dysphoria, yes, with parental consent.
Q. And where does the role of potential regret come in your analysis?
A. It is among the considerations that one would do well to be mindful of.
Q. Do you have any information, Dr. Goodman, on the rate at which minors who have surgery for

Page 173

gender dysphoria come to regret that?
A. I wish I had time to share -- and quite recently, I mean, in the last week or so but a couple of articles in the surgical journals which showed that regret by patients for knee surgery, knee replacement surgery and breast augmentation is at higher rates than gender-affirming care.
Q. Can you identify those articles?
A. Not -- I could with a little bit of time and a computer. In fact, somebody can do a PubMed search right now.
Q. So apart from those articles that you mentioned that you saw in the last couple of weeks, any other information that you have on the rate of regret of minors who undergo surgery for gender dysphoria?
A. I would have to -- I'm familiar that there's literature on this and there's controversy surrounding it. Other than that, that specifically no.
Q. Are you familiar with lawsuits that have been filed against healthcare providers for performing medical treatments for gender dysphoria?
A. I confess, I don't know if -- I'm assuming you're implying there have been some.

Page 174

I don't remember any of them.
MS. CHENG-WUN WEAVER: Can we take a bathroom break?
MR. SECHLER: We can take a break any time.
(Recess taken from 2:27 p.m. to 2:36 p.m.)
BY MR. SECHLER:
Q. Dr. Goodman, why does mental illness limit a patient's ability to provide voluntary consent to medical treatment?
A. It might not.
Generally speaking, however, the concern would be that, depending on the mental illness or deficit, that one might not be able to understand and appreciate the information.
Q. And have you dealt with that as the ethics advisor to clinicians in your hospital?
A. Incapacity often arises in hospitals usually in the context of end-of-life care when surrogates and proxies are appointed.
Q. Have you had situations where you've had capacity questions arise with respect to minors who were suffering behavior maladies?
A. I don't recall. No more than simply because they're minors. Capacity questions arise on

Page 175

their face in all cases with minors, because they're minors.
Q. Well, is there any role for minor assent in connection with medical treatment for gender dysphoria?
A. I believe there is.
Q. Would you think that minor ascent is a necessary condition to proceed with treatment?
A. I cannot think of an example where, if a minor did not assent, one would proceed anyway.
Q. So would you have a question about minor assent in the case of a minor who was autistic, for instance?
A. That's too complicated.
Q. Why is that too complicated?
A. I don't know -- what I mean is if someone is already incapacitated in that way, then by definition, they're not going to be able to assent either, depending on the nature and the severity of the mental condition.
Q. Do you think in those circumstances clinicians should still proceed with transition medications and potentially surgery for gender dysphoria?
A. In the case of any minor or a minor with a

Page 176

severe behavioral abnormality?
Q. Let's talk about autism.
A. I don't know how someone with autism would come to regard themselves as needing -- as having gender dysphoria. It's a hypothetical. It may not be possible.
Q. You're not familiar with any correlation between diagnoses of gender dysphoria and autism?
A. No.
Q. Let me ask you to take a look at the Cass Review which is right there. If you can turn to page 93. If you can go to paragraph 5.41.
A. Okay.
Q. And it states, "Some research studies have suggested that transgender and gender-diverse individuals are three to six times more likely to be autistic than cisgender individuals, after controlling for age and educational attainment."
Do you see that?
A. I do.
Q. Did I read that correctly?
A. Apparently so.
Q. So in the situation of a minor who has assented but who is autistic, would you have any concerns about that minor being referred for

Page 177

transition medications or surgery for gender dysphoria?
A. Forgive me for the skepticism. Some studies have suggested that is -- how should I put this? -- really rather quite vague.
It's not saying -- first of all, I'm not sure what it means to say that a study suggests something. Some, of course, could be two in a hundred. And absent knowing more -- I don't know the reference "Warrier, et al. 2020." I don't know what to say about it. If that's the case, it's the case. But I don't know what kind of evidence makes that the case.
So I don't -- I'm not sure how to respond.
No inference from that would support a position in any particular case, I guess, that would -- that I could comment on.
Q. So I take your point. You are not familiar with any correlation between autism and gender dysphoria?
A. I'm not.
Q. But that wasn't my question. And I'll ask the court reporter to read it back.
(Last question read back.)
THE WITNESS: I have a great many

Page 178

concerns. My job is to be concerned.
If I were in my capacity to be asked to consult in a case, I'd want to know a whole lot more before I would be able to say I'm concerned or I'm not concerned. I really don't -- I don't know enough about this to be able to say anything useful one way or another.
I had -- one of the things we've learned, and you know this too, is that many mental conditions, including autism, are on spectrums and, absent knowing where one is on the spectrum, it would be probably bad form to opine in general about all cases of somebody with a particular diagnosis.
BY MR. SECHLER:
Q. If there was a correlation between behavioral maladies and minors presenting with gender dysphoria, would you recommend any extra steps for clinicians involved in providing medical treatments to those minors?
A. Not necessarily. Based on the strength of the correlation.
Correlation, as you know, is not causation and it might -- there may be other factors that are at play. My general, and I think this is sort of

Page 179

Hornbook Ethics is you should always devote great attention to the consent process and make sure that it's not being impeded in any way.
If in the circumstances one were to believe that that would be impediment to the consent process, which it might or might not be, then one would need to address it.
But we've learned from our colleagues in behavioral health that many people who have really rather quite severe behavioral maladies are no less able to consent or refuse treatment.
(Reporter clarification)
A. The people with severe behavioral maladies are no more or less able to consent. So a process that requires the surrogate component and the law that requires it.
Q. But you would have parental consent in the hypothetical I gave you so why would you be concerned about a problem in the consent process because of a minor who has autism?
A. The job of a parent consenting for any treatment is really difficult. This is a complication that a good parent would say, this is a challenge for me.
If everyone believes that an intervention

Page 180

based on the evidence is in the best interest of the patient, then one needs to weigh the severity of the incapacity that you're describing, which is on top of minor hood in deciding whether to go forward or not -- in deciding whether -- what the appropriate role of assent is.
And that can't be determined unless you know how severe the malady is. It's impossible to determine absent that.
Q. So what is the Nuremberg Code?
A. What does the code -- what is it, what does it do?
Q. Are you familiar with it?
A. I am.
Q. Does it have a role in your practice as a bioethicist?
A. Not anymore. It's a historic document that's been overtaken by others that are far more -- the Nuremberg Code, for example, would prohibit what's now common public health research, for example.
The Nuremberg Code requires the informed consent of everybody in a research environment and yet we've made and discovered reasons for a number of exceptions to that since 1945 or '6.

Page 181

Q. Does voluntary consent require freedom from controlling influences?
A. Well, controlling influences that would undermine the validity of the consent. I mean, people are under all sorts of controlling inferences and that may particularly true in children.
So the question is not controlling influences in general but controlling influences that undermine the consent process.
Q. What would be a controlling influence that undermines the consent process?
A. I don't know. I'm not sure. I'd have to think about that for a while.
Q. Are you aware that children who present with gender dysphoria are typically -- strike that.
Are aware of studies that show that there's a correlation between gender dysphoria diagnoses and clustering of friend groups?
A. Clustering of?
Q. Friend groups.
A. No, I'm not familiar with that.
Q. Are you aware of any papers that suggest that social media and peer pressure may play a role in the presentation of minors for gender dysphoria?
A. Since there's a good chance social media

Page 182

is destroying civilization, I would not be surprised if that were true.
I'm not aware of that.
Q. Are you aware of how WPATH has handled the issue of valid consent in SOC-8?
A. I'd have to be directed to the -- once again, I haven't read this recently.
(Thereupon, the referred-to document was marked for Identification as Defendants' Exhibit 15.)
BY MR. SECHLER:
Q. I'm handing you a document marked as 15.
A. Thank you.
Q. You're welcome.
I'm handing you a document entitled "WPATH Executive Committee Minutes." It is part of the WPATH document production in this case.
And my first question is whether you've seen this document before?
A. I do not recall.
MR. SECHLER: And I should put a note on the record here, I assume we will be treating the transcript and attachments as confidential because this is material covered by protective order and I certainly don't want to be

Page 183

responsible for violating it.
MS. CHENG-WUN WEAVER: Yes, that's right.
MS. LEVI: I just ask it be marked confidential so there's no question.
MR. SECHLER: Yes.
BY MR. SECHLER:
Q. Let me ask you to take a look at part IV which is entitled "SOC-8 update."
Do you see that?
A. I do.
Q. Do you see there's a note about the ethics chapter?
A. I do.
Q. And do you see it says, "This chapter will not be in the SOC-8, after review and review by bioethicists, there were too many things to edit/change. We have discussed with and will work on a standalone white paper."
Do you see that?
A. I do.
Q. Are you aware of why WPATH dropped its ethics chapter?
A. I do not know.
Q. No information on that decision?
A. Not that I recall, no.

Page 184

Q. You weren't one the bioethicists who WPATH consulted?
A. I was not.
Q. Do you know any bioethicists who were consulted by WPATH?
A. I do not know who they consulted. It's possible they consulted with someone I know. But since I don't know, I can't connect those two.
Q. Now, if we go back to Exhibit 6 which is SOC-8 and it's -- it might be right there.
I'd ask you to turn down to page S48. I'm just directing you to the bottom of the page there, the paragraph that carries over on to S49.
Do you see where it states, "From a human rights perspective, considering gender diversity as a normal and expected variation within the broader diversity of the human experience, it is an adolescent's right to participate in their own decision-making process about their health and lives, including access to gender health services."
Do you see that?
A. I do.
Q. Are you aware of any reference in the WPATH SOC-8 standards regarding parental or guardian consent?

Page 185

A. I can't recall. I do not recall.
Q. And do you know the citation here to Amnesty, do you know what that cites to?
A. I do not. I'm not familiar with that document.
Q. Would you expect that to be some kind of study?
A. I don't know what I expect it to be. It might be an analysis of human rights and a study as such. I have no idea.
Q. Would it surprise you to know it's a press release?
A. It wouldn't surprise me. Organizations issue all kinds of documents and in the circumstances -- press release really sounds -- is a kind of calumny. Most organizations that issue them tend to think carefully about them beforehand.
Q. Do you regard press releases as strong evidence to support a statement?
A. Depends on how it was written.
Q. Have you looked at this press release?
A. I have not.
I don't know what the press release version of an ad hominem is. But generally speaking, the argument stands or falls upon the

Page 186

quality of the argument, not the media in which it's published.
Q. Dr. Goodman, do you agree that social pressure and fear of censure is affecting what is published concerning transition medications for minors and the willingness of doctors to voice concerns?
A. I'm not aware of that.
Q. Have any doctors or other scientists expressed to you their concern about being adversely affected for expressing concerns about medical treatment for gender dysphoria?
A. Not in my experience.
Q. Did you see the reference in the Cass report about that issue?
A. I'm not sure I remember it. I understand the issue.
Q. Let's take a look.
If you can turn to page 13.
A. Okay.
Q. If you look at the top of the second column, it states, "There are few other areas of healthcare where professionals are so afraid to openly discuss their views, where people are vilified on social media and where namecalling echos

Page 187

the worst bullying behavior. This must stop."
Did I read that correctly?
A. Yes.
Q. And you have no experience or knowledge of that?
A. I don't practice medicine so I have no direct knowledge of it. I know my colleagues are -- who -- I know of colleagues who are -- who have these concerns.
Q. Concerns about expressing their views regarding treatment of gender dysphoria?
A. The very fact of their practice has elicited vilification.
Q. The practice in gender -- in treating patients with gender dysphoria?
A. Right.
Q. You don't know of anyone who said they are concerned about -- strike that.
How many times, sir, have you served as an expert in litigation?
A. Recently or ever?
Q. Let's start with ever.
A. Ever. Well, my understanding is usually it's not forever. I mean, I've given in the last couple of years, it's been two or three, maybe four

Page 188

times. In my life, maybe 20 -- 15, 20.
Q. Okay. Have any of your opinions ever been excluded or limited by a court for any reason?
A. No.
Q. Has any court found you not competent or not qualified to testify on any subject?
A. No.
Q. How many of those about 20 times ended up with you testifying in court?
A. Three, four, perhaps.
Q. So if you can look at Exhibit 1 again and take a look at paragraph 11 on page 4.
A. Yes.
Q. I believe you list four cases there, right?
A. Yes.
Q. Are there other cases besides those where you've testified in court?
A. Yes.
Q. And what other cases did you testify in court in?
A. I appreciate if I could have my list of previous cases. One of them was a case in Missouri involving a dispute over control, if not ownership, of biological material for research.

Page 189

I have the style at home. I can provide that, if necessary. And that may be the third or fourth one in addition to these. Two of which involved testimony in court. The one in Tennessee did.
I can't recall others.
Q. And the Doe case did, right, the Florida case? You testified in the preliminary injunction hearing?
A. Yeah, I'm picturing a courtroom.
Q. That was in a courtroom, wasn't it?
A. I don't think -- I don't think so, no. I haven't been to court since I was in Nashville. So it would have been Adams and et cetera v. et cetera.
Q. What was that case about, the Adams case?
A. Mandatory waiting periods to obtain an abortion.
Q. Were you testifying on behalf of -- strike that.
Who were you testifying on behalf of?
A. I've forgotten who the et als are.
I was testifying on behalf of those who were opposed to mandatory waiting periods.
Q. And I assume you gave a deposition in that case as well?

Page 190

A. I did.
Q. What about the Gainesville Woman Care case, what did that involve?
A. That involved an expert affidavit, and if memory serves, it was -- the trial was scheduled but a judge actually issued a summary judgment if I'm not mistaken.
Q. It appears you at least testified by deposition in that matter?
A. I think so, yes. Yes.
Q. Do you know what the case was about?
A. That one was -- that was Florida's mandatory waiting period for termination of pregnancy.
Q. How did you come to be involved in those two cases regarding mandatory waiting periods?
A. I do not recall.
As someone who teaches what I teach where valid consent is near the core of it, both in our educational and a frankly our legal system, someone -- I don't know how I came to know them or they came to know me.
Q. Do you do work for the Human Rights Campaign?
A. No.

Page 191

Q. How did you get involved in this case, the case that brings us here today?
A. I was approached by -- this is an Alabama case. The other one was a Florida case.
I don't remember the initial contact. Someone called and said is this something that you have expertise in. I don't keep -- I'd have to -- I mean how did I become involved? Someone called me and asked me.
Q. Do you know who that person was affiliated with?
A. Human Rights Coalition I believe or the ACLU or something.
Q. Have you ever --
A. I don't remember.
Q. Have you done other work for the Human Rights Coalition besides this case?
A. No.
Q. Was the person who contacted you about the Alabama case already involved in Doe versus Ladapo?
A. Yes.
Q. Was it somebody you were working with in connection with your testimony and declaration and expert report and deposition there?
A. Yes.

Page 192

Q. And you don't remember who that is?
A. Absolutely not.
Q. How many lawyers did you work with in the Doe versus Ladapo case?
A. Several.
Was it you? I get a lot of calls and I also get calls that I'm not interested and, frankly, they all run together.
This is salient. This is what you-all do. This is not mostly what I do.
Q. Okay.
A. And I -- I'm looking at this and thinking, what happened in Gainesville which goes back to what year, 2000. I just don't remember.
Q. You were working with The Human Rights Campaign in connection with your retention as an expert in Doe versus Ladapo, correct?
A. Yes.
Q. And at some point, one of the lawyers involved in that case asked you if you could be involved in the Alabama case?
A. Either that or referred me to somebody who was involved in the other case.
Q. And you don't know how long ago that was?
A. No, sometime before I actually was

Page 193

deposed. You have the deposition there I reckon.
Q. Do you have a personal or professional relationship with anyone involved in this case?
A. No, unless the case itself constitutes a professional relationship.
Q. Apart from your professional retention?
A. No.
Q. What did you do to prepare for your deposition today?
A. I tried to get a good night's sleep.
Q. Always a good idea.
A. Failed.
But no, as a matter of fact, after producing -- from what period? From the very beginning?
Q. Sure. Well, I don't want to get into the conversations you've had with counsel.
A. No, I understand.
Q. You said you prepared your report after several hours of work?
A. I was provided. I read a number of documents. I read other things. And as they arose, I tried to -- they seeming salient. I scanned the article that I mentioned to you earlier, the articles that came out last week about knee surgery.

Page 194

Was that preparation for this case? When there's such a case and there's a report or a document or an article, one reads it. Does that equal preparation for the case?

Q. Well, you tell me. I mean, if it does, then you're required to disclose it to us.

A. Well, as I say, I've already disclosed to you that when I read about -- when I heard about this, I tabbed through this report.

When I saw the article last -- literally in the last week, I looked at it online. I haven't printed it yet. I haven't had a chance -- I haven't read it carefully.

Q. And just for the record, when you said "this," you were talking about the Cass report?

A. I'm referring to the Cass report, yes.

Q. Were there any other materials, since the time you prepared your report up until today, besides those articles you mentioned regarding and your Cass Review that you can recall reviewing?

A. No. Sorry, I misunderstood.

Once again, and perhaps the most recent articles I'm still using them to prepare for today's experience. I did not use them to prepare. Sometimes I didn't even use this to prepare. It was

Page 195

due diligence to know what it was about.

Q. This again referring to the Cass Review?

A. The Cass Review, yes.

Q. There's no video.

A. She's watching.

Q. She can't add words, though.

So back to the question, what did you do to prepare for your deposition today? Did you meet with anybody?

A. Not beside counsel on the phone, no.

Q. Well, that's part of my question.

How long did you talk to counsel on the phone without revealing the substance of your conversation?

A. On and off over a couple of hours.

Q. When was that?

A. Over the past six months since we originally -- since they contacted me.

There was an initial contact, I assume. Unlike lawyers, I don't actually log what I do by day and hour. Perhaps I should start.

But when you don't bill for stuff, you lose interest in that sort of thing. You understand.

So several hours at most.

Page 196

Q. Did you meet with counsel in person before this deposition?

A. About this deposition?

Q. Uh-huh, yes.

A. We've spoken on the phone.

Q. But you didn't meet in person to prepare?

A. No. Excuse me. No, I don't think so.

Mind you, in the -- the Tennessee case, does that count as preparation if it's on the same issue, you know, that sort of thing?

Q. You mean the Florida case?

A. The Florida case, yes, sorry. I beg your pardon.

Tennessee, Florida, you know, they all run together after a point.

Q. Have you spoken to anyone besides counsel about your involvement in this case?

A. No.

Q. Colleagues, bosses, students?

A. No.

Q. Have you ever served on an institutional review board?

A. I have.

Q. How many times?

A. I served on -- well, service lasts for a

Page 197

certain duration. I've been on two separate institutional reviews. One of them is from my institution, University of Miami. The other was for a while I served on the institutional review board for Baptist Health of South Florida, a large hospital group in South Florida.

Q. And how long did you serve on the University of Miami's IRB?

A. Eight, ten years. That's approximate.

Q. How long did you serve on the Baptist Health IRB?

A. Half that or less.

Q. And when did your affiliation with the University of Miami IRB conclude?

A. Some years ago. I'm at the University of Miami now for more than 30 years and I would say -- I don't recall. I'd really have to look at my CV and it might not even list the date I was on the IRB. It counts as a form of service which is -- it probably is there.

Q. Let's take a look. Exhibit 2, I believe.

A. Did you take that one from me too? Let's see. If they put table of contents.

Because it is service, if you will, and not strictly academic, that might or might not be

under any number of headings.
See, here's where having it online would be helpful.
Q. It looks like service starts on page 77. That might help.
A. Sometimes -- I'm refreshing my memory, also the Veterans Administration Medical Center, 1992 to 2001.
Q. The IRB there?
A. The IRB there.
And down a little, 1994 to 2000.
Q. What page?
A. I'm on page 78, bottom, fifth from the bottom.
Does that answer your question?
Q. Did you find a year for University of Miami?
A. Yes, 1994 to 2000.
Q. Oh, okay.
A. And that is an alternate from 2000 to 2003. Sometimes you -- there are numbers in alternates.
Q. Did any of the research that you considered in any IRB involve medical treatments for gender dysphoria?

A. No.
Q. Did any of the proposed protocols that you considered involve research on pediatric subjects?
A. Yes.
Q. How many?
A. I can't remember. That would have been -- I can't remember. I mean over that period?
Any number I give you will be speculation. I'd rather not. No fewer than ten for both Baptist and University of Miami. VA doesn't have pediatric patients.
Without -- this is almost a quarter of century ago.
Q. And these are pediatric subjects, right, research subjects?
A. Yeah.
Q. Were there studies that you or your IRB rejected because of the involvement of pediatric subjects?
A. Not that I recall. There were many cases modified.
IRBs are like -- well, they're modified. A study -- not that I remember. It's highly unusual to have a study get that far and be rejected.
MR. SECHLER: Okay, so why don't we just

take one quick break and I'll look through my notes and see if we're done.
MS. CHENG-WUN WEAVER: We're going to read and sign the deposition.
(Recess taken from 3:19 p.m. to 3:21 p.m.)
MR. SECHLER: I don't have any other questions, Dr. Goodman. But thank you very much for your time and attention.
THE WITNESS: Thank you.
MS. CHENG-WUN WEAVER: I'm going to ask one quick question if that's okay.

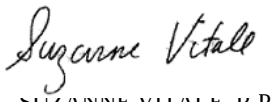
CROSS EXAMINATION

BY MS. CHENG-WUN WEAVER:
Q. Dr. Goodman, did you hear or read anything today that would lead you to change your expert report in this case?
A. I did not.
MS. CHENG-WUN WEAVER: Thank you. That's all I have.
(Concluded at 3:22 p.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF BROWARD)

I, the undersigned authority, certify that KENNETH GOODMAN personally appeared before me and was duly sworn.
WITNESS my hand and official seal this 30th day of April, 2024.



SUZANNE VITALE, R.P.R., F.P.R.
Notary Public, State of Florida
My Commission No. DD179981
Expires: 5/24/2024

CERTIFICATE

STATE OF FLORIDA)
COUNTY OF DADE)

I, SUZANNE VITALE, R.P.R., F.P.R., do hereby certify that I was authorized to and did stenographically report the foregoing deposition of KENNETH GOODMAN; that a review of the transcript was requested; and that the transcript is a true record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

I il, 2024.

Suzanne Vitale

SUZANNE VITALE, R.P.R., F.P.R.
My Commission No. DD179981
Expires: 5/24/2024

Cynthia Cheng-Wun Weaver
cynthia.weaver@hrc.org
May 1, 2024
RE: Boe, Brianna, Et Al. v. Marshall, Steven T., Et Al.
4/29/2024, CONF Kenneth Goodman (#6653486)

The above-referenced transcript is available for review.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason, on the attached Errata Sheet.

The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at cs-southeast@veritext.com.

Return completed errata within 30 days from receipt of testimony.

If the witness fails to do so within the time allotted, the transcript may be used as if signed.

Yours,
Veritext Legal Solutions

Boe, Brianna, Et Al. v. Marshall, Steven T., Et Al.
CONF Kenneth Goodman (#6653486)

ERRATA SHEET

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CONF Kenneth Goodman Date

Boe, Brianna, Et Al. v. Marshall, Steven T., Et Al.
CONF Kenneth Goodman (#6653486)

ACKNOWLEDGEMENT OF DEPONENT

I, CONF Kenneth Goodman, do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

_____ _____
CONF Kenneth Goodman Date
*If notary is required

SUBSCRIBED AND SWORN TO BEFORE ME THIS
_____ DAY OF _____, 20___.

_____
NOTARY PUBLIC