Attachment C
(cont'd)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

DIANE J. SCHROER, : VOLUME II
Plaintiff, :
vs. : Civil Action No.
JAMES H. BILLINGTON, : 05-1090(JR)
Defendants. :

TUESDAY, MARCH 13, 2007, 10:00 A.M.

DEPOSITION OF CHESTER W. SCHMIDT, JR., M.D.

Pursuant to notice, the deposition of CHESTER W. SCHMIDT, JR., M.D., Tuesday, March 13, 2007, commencing at 10:00 a.m., at the United States Attorney's Office, 36 South Charles Street, Fourth Floor, Baltimore, Maryland 21201, before Belinda D. Lomax, Notary Public.

Ref No.: 8869-6

APPEARANCES:
On behalf of Plaintiff:
SHARON M. MCGOWAN, ESQUIRE
KEN CHOE, ESQUIRE
American Civil Liberties Union Foundation
125 Broad Street, 18th Floor
New York, New York 10004-2400
(212) 549-2593 phone
(212) 549-2650 fax

On behalf of Defendant:
BEVERLY M. RUSSELL, ESQUIRE
JULIA K. DOUDS, ESQUIRE
U.S. Attorney's Office of the District of Columbia, Civil Division
555 4th Street, North West
Room E-4915
Washington, D.C. 20530
(202) 307-0492 phone
(202) 514-8789 fax

APPEARANCES (continued):
On behalf of the Library of Congress:
JESSIE JAMES, JR., ESQUIRE
CHARLES L. TETREAULT, ESQUIRE
Library of Congress
Office of the General Counsel
James Madison Memorial Building
Washington, D.C. 20540-1050
(202) 707-1595 phone
(202) 707-1594 fax

CONTENTS

EXAMINATION OF CHESTER W. SCHMIDT, JR., M.D.

	PAGE
BY MS. MCGOWAN	236

EXHIBITS	MARKED
41 - Curriculum vitae	326
42 - Article	353

P R O C E E D I N G S

CHESTER W. SCHMIDT, JR., M.D.
having been duly sworn, testified as follows:

EXAMINATION

BY MS. MCGOWAN:

Q Good morning, Dr. Schmidt. I'm here with my colleague, Ken Choe. We're continuing your deposition. As you have been sworn, your testimony today is under oath. We went through a series of instructions last time. Unless you feel that you would like me to go over them again, we can just proceed with our questions.

The only thing that I will just sort of remind you is that if you don't understand a question, please ask me and I will be happy to clarify it or ask it again. If you do answer the question, I will assume that you have understood the question. Is that okay?

A Yes.

Q And is there any reason that you would be unable to give complete and accurate testimony today?

Page 241

case.
For example, schizophrenia is probably a neurodevelopmental disorder and falls into the disease model although there are behavioral, dimensional and life story issues associated with every case. The other cases, you know, that we call the walking wounded, relatively mentally healthy people who are stressed or anxious or depressed, it's more likely their life story is a predominant aspect of understanding their particular case and the disease.
There may be some disease. There may be some behavioral issues. There may be some personality/dimensional issues at play, but the life story is probably the predominant aspect of that model that helps to understand their particular case, or that particular case.
Q And why did you discontinue your work on this monograph?
A Well, I haven't really discontinued it. I just haven't -- I haven't completed it.
Q In your thinking about this monograph, do

Page 242

you agree with this four-point framework that was developed by Dr. McCue and Slavney?
A. It's really not a matter of agreement or disagreement. It's more a matter of finding an appropriate way to apply the model to gender identity disorders. I have had difficulty sorting that out. So that has been part of the delay in my completing that monograph.
Q And have you consulted with either Dr. McCue or Dr. Slavney in the course of your work on this monograph?
A No, not specifically about the monograph. They are both colleagues at Hopkins. I see them from time to time but I have not consulted with them specifically about the monograph.
Q Have you prepared any drafts of any sections or portions of the monograph so far?
A I have. I've got bits and pieces that I have collected. I'm not very happy with it.
Q During our discussion a few weeks ago, we were talking about the various conclusions in your report, and there were just a few I wanted to go

Page 243

over just to make sure that I am clear about your response. Then we will tackle some new material
First, you testified that gender identity is a social construct and not a biological fact; is that right?
A That is correct.
Q You also testified that there is no credible science either proving or disproving any biological explanation for gender identity; is that right?
A That's correct.
Q When I asked you whether you considered this to still be an open question, do you recall agreeing with me?
A I do.
Q So my question is if there is no credible science either proving or disproving any biological explanation for gender identity, then how are you so certain that gender identity is exclusively a social construct and in no way influenced by biology?
MS. RUSSELL: I'm going to object to the

Page 244

question. It misrepresents Dr. Schmidt's testimony. If you understand, you can go ahead and answer.
THE WITNESS: Because it is -- it's an aspect of sex that has been developed in the field as an understanding of one aspect of sex. Other aspects of things like gender role or sexual orientation, they are -- they are, if you will, made up of concepts that speak to the social aspect, I believe, of sex and are, you know, obviously have a relationship to sex but they are not -- they are not biologic in the sense that sex, I believe, is biological.
BY MS. MCGOWAN:
Q And when you say "it is an aspect of sex," what is the "it" you're referring to?
A In this case, it is gender identity disorder. I mean gender identity.
Q Okay. Do you believe that sexual orientation is exclusively a social construct, or do you believe that there is any biological influences with respect to sexual orientation?

Page 245

MS. RUSSELL: Objection: Relevance. Go ahead and answer.
THE WITNESS: I think that has -- the same issue applies. There is no credible scientific support either for or against a biologic basis for sexual orientation or necessarily for it being a social construct. So that, to me, the question is just as open as it is for gender identity. But there has to be -- in my mind, there has to be some sort of anchoring point. Otherwise everything gets relative and then you get lost in the relatively.
The one thing that we do know that's biologically based is sex is determined by xx or xy chromosomes, and that, I think, is pretty well nailed down. The other things, the other aspects of sex are these aspects that have been developed as concepts that, as of yet, have no for sure biologic basis.
BY MS. MCGOWAN:
Q And when you say that these were concepts that have been developed, developed by whom?

Page 246

A By people, by scientists, you know, clinicians and scientists in the field.
Q If a person's sex is their chromosomal configuration as xx or xy, then why aren't all children genetically tested at birth to ensure that the proper sex assignment is made?
A I think that's a cultural, social, legal issue.
Q What do you mean?
A Well, I don't know there is any precedent for doing that. It certainly could be done, but there is nothing that I know of that mandates that.
Q Do you think it should be done?
MS. RUSSELL: I'm going to object: Lacks foundation and relevance. You can answer if you understand.
THE WITNESS: Do I think all you children should be tested? Should be from what perspective? I mean what's the "should be?" What's the context in the "should be?"
BY MS. MCGOWAN:
Q In order to ensure that the proper -- let

Page 247

me start again. In order to ensure that children are assigned the sex at birth that is consistent with their chromosomal configuration, do you feel that children should be tested to ensure that their medical records are an accurate reflection of what you said is their true sex?
MS. RUSSELL: Same objections.
THE WITNESS: I think that the only testing that needs to be done is when there is some ambiguity about the sex of the infant as manifested by the phenotypic morphology. That is if the genitals don't look right or there is something that raises suspicion about the chromosomes. Then I think testing is appropriate. But for the -- for all the rest of the 99 percent of humankind, I don't think it's necessary.
BY MS. MCGOWAN:
Q In the event of this ambiguity, should only the chromosomes be taken into account when assigning a gender to a child? Excuse me. Assigning a sex to a child?
MS. RUSSELL: Objection: Relevance, but

Page 248

you can answer if you understand it.
THE WITNESS: Well, that's, as you know -- I assume you have done the reading. There is a real debate at this point. At one point in time, it was thought that if there was ambiguity, that the best option for the infant and child and later to be adult was to -- was to do -- was to use surgery and hormones to make the -- to make the person as outwardly -- what would be the right word? Would make it easy for the person to live and function in usually the female role because that's the way the surgery usually went, and that surgeons and parents at that time, at one point in time, felt very comfortable about doing that.
Now, as the literature has evolved, there is real discussion about whether that decision should be taken away from the child and that the child should be raised, even if you are doing whatever you can surgically with the genitalia, what has to be done for certain kinds of functions, principally elimination, and that even with ambiguity, that the person be allowed to grow up

Page 249

and then make the decision as to how they want to have their genitalia, which is the principal issue, appear and what gender role or gender identity they wish to adopt as adults, and that they make the decision. So I think that people are -- some folks are of a different mind today than they were in the '60s, '70s, and maybe the '80s.

BY MS. MCGOWAN:

Q And recognizing that there are different views out there, what is your view with respect to whether or not chromosomes should be the determining factor in the assignment of a sex to a child?

A Well, that's not a field. That's not something that I do. So I don't -- I'm not going to speak authoritatively about it. I think that's probably, at this point, a decision that has to be made by the parents.

Q Do you agree that a child should be allowed to grow up and develop their own gender identity and be a participant in the decision about whether or not to engage in any surgical procedures

Page 250

when they were born with ambiguous genitalia?

A That's the same question you just asked. You just asked it in a different way. I believe that's -- I don't believe that that's something that I feel -- that I feel -- I don't believe I have enough contact with that clinical field to take a position on that.

Q Is the fact that chromosomes can't be changed the reason, either in whole or in part, why you believe that a person's biological sex is what their chromosomal configuration would indicate?

A Yes.

Q I believe you testified earlier that a person's hypothalamic sex is also something that cannot be changed once there has been a differentiation; is that right?

A When you talk about the hypothalamus, you're talking about those parts of the brain that are affected by testosterone that then create what we call a male brain versus a female brain?

Q Yes.

A I don't think they change either.

Page 251

Q So if hypothalamic sex is also something that cannot be changed, then why, in your view, does chromosomal configuration matter more than hypothalamic sex with respect to what an individual's sex is?

A Don't know that you I said that one is more. It's the chromosomes that determine the hypothalamic changes because the chromosomes are the ones that determine whether there is going to be testosterone or not, and it is the testosterone or testosterone like substances that cause the neurodevelopmental changes that cause the male brain. So they are linked together.

Q My understanding was, when we discussed this last time, that I presented you with a hypo where the genes of an individual were xy but all other aspects, biological aspects of their sex, hormones, internal and external genitalia, and hypothalamic sex, were all female.

You described that as being phenotypically female but genotypically male, that in that case you would describe the sex of that individual as

Page 252

male?

A Correct.

Q So my question is to the extent that only the one aspect, being chromosomes, is xy, is designated male, but all other aspects, including an aspect that likewise cannot be changed once developed, being the hypothalamic sex, when all of those are female, why, in your view, does chromosomes trump everything else with respect to what an individual's sex is?

A Because I believe that, again, there has to be an anchoring point from which you start when you say what sex is from a biologic point of view. So, in my opinion, the biologic configuration is that anchoring point.

The fact that there are errors of nature, you know, in very rare cases, that the hypothetical that you gave could be any one of the symptomatic deficiencies that don't allow the testosterone to do what it normally does, to me, does not mitigate the fact that there has to be an anchoring point to be called sex.

Page 253

The fact that we have other social constructs to understand gender identity, gender role, sexual identity, those kinds of things, are fine. They are very helpful constructs, but the biologic anchoring point for me is the chromosomal configuration.

Q And why do you find the immutability of the chromosomes to be the touchstone of sex?

A Because that's what the field has defined it as. I mean, that's what biologists consider sex to be. Again, there has to be some kind of anchoring point or you slip into a kind of relativity that makes things a terrific morass.

Q And are you aware of others in the field of gender identity disorders who would define sex more broadly than just chromosomes?

A Oh, absolutely, sure.

Q When we spoke during the first part of your deposition, you said that the bases for your definition of sex as chromosomal configuration were the following, and I want go through this list to make sure I have the complete list. The

Page 254

dictionary, your knowledge of the field of sexology, your years of usage of the term, the fact that your colleagues use the term sex in a similar way, and the 1972 publication of John Money listed in the references section of your report; is that right?

A Yes.

Q Is there anything else that belongs on that list?

A For the moment, no. I can't think of anything right at the moment.

Q With respect to the dictionary, I just want to clarify. Is there any particular dictionary upon whose definition you are relying for your conclusion that a person's sex is their chromosomal configuration?

A No, I don't think so. I think I looked at a couple of them.

Q Do you recall which ones you looked at?

A I think the Webster and Oxford.

Q Any others?

A No.

Page 255

Q Did you consult any medical dictionaries?

A No, I didn't but that would be a good one to look at, a medical dictionary. That's a good thought.

Q In your view, is there a definitive or a couple of definitive medical dictionaries to which you would look? I'm familiar with law dictionaries but less obviously --

A I think Coomb's, I think, is the principal one, but I'm not sure about that.

Q And with respect to the fact that you mentioned your colleagues use the term sex in a similar way, when I asked you which colleagues used the term sex to mean chromosomal configurations, you mentioned Dr. John Meyer, Dr. Tom Wise, Dr. Paul McCue, all of who are affiliated with John Hopkins; is that right? Do you recall that?

A Yes.

Q When I asked you if you were familiar with anyone else that shares your view that sex is chromosomal configuration, you said that at that time, you couldn't think of anyone specifically.

Page 256

Today do you want to add anyone else to that list?

A Well, I think if you ask any nonpsychiatric physician what is meant by sex, they are going to say that sex is male or female as determined by chromosomes.

Q And why do you think that?

A Well, I'd bet you at least a beer on it because I think it's common sense, I really do. I think it's what we are all taught in medical school by and large, and it's what the biology is.

Q So have you had any specific conversations that you're calling upon when you sort of make the statement that nonpsychiatric physicians would share your definition of the sex?

A No.

Q With respect to Dr. Meyer, has Dr. Meyer published any work specifically addressing the point that a person's sex is their chromosomal configuration?

A Not that I'm aware.

Q Has Dr. Wise?

A I don't think so.

Page 257

Q Has Dr. McCue?
A I don't know he's done anything specifically to the biology, but some of his -- that piece that he did on surgical sex certainly, I think, speaks to his position about the biology of the issue that we're discussing, yeah.
Q What piece are you referring to?
A It is called "Surgical Sex."
Q What, his thesis in the article?
A Well, he thinks that the surgical reassignment surgery is unethical.
Q And as either a separate conclusion or part of that conclusion, does he discuss what we're talking about here, namely what is sex?
A I don't think specifically, but I think if you read the article, you can infer what his position is with regard to the logic, his logic. I don't want to -- my reading of his article is that the logic is that the biology is not altered in gender identity disorders, and that people are normal x or xy males or females, and that it's

Page 258

medically unethical to be providing the surgery that destroys normal tissue, and that it's the only --
Although there are some stereotaxic surgeries that are available for very difficult cases or treatment resistant cases for obsessive compulsive disorders and there have been some stereotaxic brain surgeries for a couple other disorders that have been done, kind of refinements of the old lobotomies, which are, of course, discredited, it is one of the few, if only, psychiatric conditions that are treated by surgery, and that it is totally inappropriate from his point of view.
Q And we discussed last time the fact that you do not share Dr. McCue's view that it is unethical categorically to perform sex reassignment on individuals with gender identity disorders, correct?
MS. RUSSELL: Objection to the form. You can answer.
THE WITNESS: That's correct.

Page 259

BY MS. MCGOWAN:
Q But with respect to the premises that you were discussing earlier with respect to the fact that biology is not altered notwithstanding sex reassignment, and that sex is chromosomes, those are some of Dr. McCue's conclusions that you do agree with, correct?
A Yes. If I'm reading him correctly and inferring correctly, I would agree with those, if in fact I am understanding his position correctly.
Q On your C.V. and in your expert report you state that you teach psychiatry at John Hopkins, correct?
A I do.
Q How long have you taught psychiatry?
A Probably 40 years now.
Q Do you teach specifically about gender identity in all of your courses?
A In all of my courses?
Q Right.
A No. The only place we teach medical students and house staff or residents about gender

Page 260

identity is within the context of the sexual behavior consultation. We do do -- we are responsible -- and from time to time I do it and sometimes I don't do it -- we are responsible also for the year one and two courses, I think, in human sexuality in which there is, I think, one lecture on gender issues. But the bulk of my teaching experience with regard to gender identity disorders is within the clinic that I co-founded 36 years ago.
Q And is it accurate to describe the clinic as more of a specialized program within the psychiatry department?
A Absolutely, yeah. It is devoted to human sexual disorders.
Q When was the last time that you taught about gender identity?
A Two weeks ago.
Q And in the clinic setting, do you teach exclusively about gender identity disorder, or do you also discuss gender identity as a concept more generally?

Page 281

pass in the cross gender role, and demonstrating pretty much to the person, because that's the person that counts, that they done get the job.

Q The person that you're referring to is the therapist?

A No, the patient.

Q Okay.

A Then if they fulfill that process or carried it off and they wanted surgery, then most of the patients don't ask for a referral. They know who they want to go to. My role in those cases was then to write a letter saying that the patient had worked with me, had met these criteria, and that there were no contraindications for the surgery.

I never recommended for or against and don't recommend for or against because, as I think we talked about in the previous part of the deposition, I strongly believe that this is an elective decision that has to be made by the patient, that the therapist and the care giver should take a completely neutral role in the

Page 282

decision making.

Q During that --

A Except when there are contraindications, either medical or psychiatric and/or medical.

Q During that period in the 1970s when you were involved in the treatment of the patients, roughly how many gender identity patients were under your direct care in the course of a year, say, on average?

A Probably no more than two or three a year because this was a specialty and it was only a part and today it's only a portion of what I do. It's not what I do 100 percent. So I never carried more than two or three patients at a time.

Q With respect to these patients, do you recall roughly how many patients for whom you ultimately wrote the letter that you were describing explaining that you were satisfied that there were no comorbidities?

A I probably only had to write maybe a half a dozen letters because, first of all, I never saw more than two or three patients a year, and many of

Page 283

the patients don't make it. They just don't have the wherewithal either emotionally, intellectually or financial, or a combination of those things to have met those criteria. It's not easy.

Q During the time in the '70s when you were treating patients, you mentioned that this was a portion of your overall workload. What percentage of your time were you spending on the treatment of gender identity patients as opposed to other areas of your work?

A Well, I think you want to put it in terms of the clinical, the clinical load that I did. So I think it would represent no more than 10 or 15 percent of my clinical activities. That is for the treatment side. The evaluation side would add another five or ten percent. So somewhere between 15 and 20 percent of clinical work, the other being general outpatient work and inpatient work.

Q Was your outpatient and inpatient work, this other roughly 80 to 85 percent, was that with gender identity patients?

A No. That's with general adult psychiatry

Page 284

Q Actually, I will take this out so you can refer to it if you need to. It's Exhibit 34, which is your report. I will direct you to Paragraph 7, is what I'm referring to.

In Paragraph 7 of your report you say that you have not treated or managed cases of GID since the mid 1980s, but as we discussed in the previous deposition and as you mentioned in your report, you continue to evaluate patients who come to the Sexual Behavior Consultation Unit. Do I have that correct?

A Yes, you do.

Q So during the period from the mid '80s, when you ceased managing cases, how many patients on average would you say you evaluated per year?

A As I said, it's probably -- as I said, I probably am involved with something in the range of 12 cases a year.

Q After making or -- in the cases where you are evaluating, are you ever being asked to provide a second opinion or confirm somebody else's diagnosis, or are you usually making the diagnosis

in the first instance?
A I would say in most of the cases, the diagnosis in the first instance although some of the cases, you know, have been through the hands of other people or other institutions and have come to us for another opinion. It's not so much another opinion. I guess you can say another opinion, but they don't like what they got elsewhere or they are very concerned about what they got elsewhere.
We have seen cases that have been incredibly mishandled, and either the patients or frequently parents recognize that they are going down the wrong trail and have to change, you know, get other people involved because things are going terribly poorly. So I guess you could say that's a second opinion, but it's really -- it's more a matter of their dissatisfaction with what happened elsewhere.
Q What percentage of the cases that you see would fall into that category of people coming to you for additional guidance or a second opinion?
A Maybe 2 or 3 a year out of the 12.

Q And is there a trend that you have noticed with respect to what the dissatisfaction is that leads people to Hopkins for a second opinion or additional guidance?
A A trend. I don't think with regard to this aspect, no. I don't think there has been a trend.
Q Are there certain types of dissatisfaction that you hear expressed more frequently than others?
A Generally two groups. One group of these patients tend to be younger people still close in with their family in which there is the -- either the patient and/or the family or both are very confused about the treatment that they are receiving elsewhere and are concerned about the recommendations, you know.
A very recent blatant one was a clinic in New England was pushing this kid through the process of hormones and surgery. He was schizophrenic. He was absolutely off the wall, and the parents realized that something really was

going bad here. So they brought their son down. He was in his 20s, and is it was really unfortunate. There are cases like that, less extreme.
Then the other group are patients that have gotten into the hands of people, often psychiatrists, who don't know anything about gender identity disorder and they are completely at a loss as to what to do. They are getting nowhere with the psychiatrists and the therapists with regard to direction, focus or anything. Then they are just -- either the patient or the psychiatrist make the referral because they have kind of lost the thread of where they are going. So one group is a disaster and the others are not as disasterous as the therapy kind of stalled out.
Q After either making or confirming or reevaluating and providing a diagnosis of patients, I believe you testified that after that evaluation, you then refer patients to a provider either in Baltimore, if they are local, or in their home community; is that right?

A Correct.
Q With respect to these patients, are you ever consulted in a follow-up way?
A Yeah. What we do is we suggest to both the patient and the person to whom we make the referral that, you know, that the patient come back every three, six months and just check in with us if they think that's going to be helpful to them, and we can then act as a resource for these patients going forward, both for them and for their therapist.
Q Are you ever consulted specifically about whether or not a candidate is an appropriate candidate for a sex reassignment surgery?
A Yeah. I'm in the midst of one of those right now. A patient came six years ago, started working with a therapist, came back recently, reevaluated him, and they are in the process of working with him to decide whether he wants to go forward with surgery or not.
Q With respect to the opinion that is sought from you, am I correct that you see your role as

Page 289

one of identifying any potential co-morbidities or other disqualifying factors that might exist as opposed to actually recommending affirmatively that a patient go forward with the surgery; is that right?

A Well, it's a slightly different nuance to it. Yes. If there are contraindications, we will deal with them or work with them. If the patient, in my opinion, has no contraindications and wants a letter from me, then I would say what I have done with the patient.

The patients usually give me a release so that we can release their file to the person they want it to go to. We would send them all the information that we collected about the patient, and my letter would say that there are no contraindications for the surgery.

Q What sort of led to your discontinuing the direct treatment or management of cases of GID in the mid 1980s?

A It was mostly just time. By the mid '80s, I had -- I was directing the department of

Page 290

psychiatry at Bayview, which had grown substantially, and I was also president of the faculty practice plan at Bayview, which was a substantial responsibility because along with the chairman of the medical board and president of the hospital, we were in the process of completely redoing the hospital. So I had a very, very heavy administrative load and responsibilities.

I had to make some cuts somewhere. So I cut down most of my outpatient work. The only inpatient work that I retained was a rotation on my inpatient services at Bayview, inpatient psychiatry, my continuance in the Sexual Behavior Consultation Unit on Friday afternoons, and my taking a rotation in the hospital doing consults for med surg. So I really cut back all my outpatient work that was not related to these functions.

Q Am I correct that the responsibility of heading the department of psychiatry at Bayview was not a gender identity specific responsibility?

A No.

Page 291

Q Similarly with your responsibility as president of the faculty practice plan, that was more a general psychiatry responsibility; is that correct?

A It was the entire faculty, all the departments.

Q With respect to why you shifted your workload, you mentioned that it was mostly a function of time. Were there any other factors?

A No. It was time.

Q Was your discontinuation of the direct treatment or management of GID cases related in any way to the decision of Johns Hopkins to discontinue sex reassignment surgery for patients with GID?

A No.

Q And do you know why John Hopkins discontinued providing sex reassignment surgery as part of its services for GID patients?

A There was a very good article in one of the Baltimore magazines within the last couple months. I think it's called "Identity." It sets out the history.

Page 292

I think it's a pretty accurate description of the beginning of the program, the individuals who were involved, the processes of the program, and what led to the discontinuance of the program. It's consistent with my understanding of the history. Of course, I had no direct involvement in those decisions.

The article suggests that the -- that the program ended because of the number of people that were actually getting the operation were relatively few, that there was growing discontent principally among the surgeons with regard to the how ethical this all was. Dr. McCue came on board as chairman of psychiatry and had, even from the outset of his chairmanship, had very definite views with regard to this surgery.

Then John Meyer wrote an article about the follow-up. He was able to find a handful, I think only 14 patients, that had been operated on at Hopkins. He did a follow-up study on them, and the follow-up study says generally that their level of satisfaction with the surgery was pretty good, but

Page 329

some scientific basis for making a change. That's what my work group was responsible for, those two categories, the dysfunctions and the paraphilias.

Q Was there any overlap in membership between the sexual disorders work group and the gender identity disorders work group?

A No, no, there wasn't.

Q And how is one selected to be a participant in a DSM work group?

A The chairman of our work group was a person named Allen Francis. He worked with a number of other people. They just made it their decision by asking around and by getting a consensus as to who they thought had some capability in a particular area and who would, you know, who could function as a good chairman.

Q Do you have any sense of why you were asked to participate in one group as opposed to another, the sexual disorder work group as opposed to the gender identity disorder work group?

A The gender identities had been located in child developmental disorders, in a separate part

Page 330

of the DSM, for quite a while although it had been moved by DSM-III, I believe. It had been moved into the section it now is in. But historically --

And these are the vagaries, and point directly to some of the criticisms about DSM. You know, I'm not sure why that decision was made but it was made, you know. I was asked to do what I did and I had no control over the decision as to not including the gender identity disorders, which would have made sense to me because they are all grouped together in one section of the DSM, but they weren't and I had no control over that decision.

Q So in 1988, when you were asked to, I believe, serve as the chair; is that right, of the DSM sexual disorders work group?

A Yes.

Q At that time, was your work focused more on questions of sexual dysfunction and paraphilias then gender identity disorder?

A No, no.

Q And today, what percentage of your work is

Page 331

sexual disorders and what percentage of your work is gender identity disorders?

A Well, I think I already answered that question when you asked me as to the percentage split. In terms of the intake, it's about a quarter of the total evaluation load for the year. So that would be a fair representation of the amount of time spent, that I spend within the SBCU apportioning my time to those three general categories.

Q And of your overall workload, how much of your time is spent at the SBCU as a percentage of your overall responsibilities?

A Well, it's a five-hour block on Friday afternoons. So it's a little more than half a day a week if, you know, you base it on a 40-hour week, which, of course, we're not, but if you took a 40-hour week, it's one-eighth. I never was real good at math.

Q Have you ever served on a DSM work group that was charged with addressing gender identity disorder as part of its subject area?

Page 332

A No.

Q I want to look at your publications on your C.V., if we could, which I believe starts on what's marked Page 7 of your C.V., the bibliography that's listed. Looking at these publications, I'm hoping you can identify for me which publications relate to gender identity disorder or transsexuality?

A Let's start with Number 20. Number 20 has some relationship at least as far as the issue of transvestism or cross dressing. I haven't done much writing about it. Thirty-four has some elements of cross dressing. Fifty-one.

Now, since I gave you this, in the trial before the judge on the Koselik case, I realized I had admitted another article that, again, it more has to do with transvestism and it was really, really interesting. It was in collaboration with George Brown. You may know who George Brown is. I'm sure you do.

George and Tom and I did a paper and it did not make it -- this C.V. is -- I'm a full

professor and I really don't care about my C.V. anymore. I made my bones and I don't have to prove myself to anybody anymore. So over the years I have had secretaries, different secretaries, and each secretary, this is an amalgam of the work of these secretaries, and there are mistakes on here.

They tried to absolutely pick me apart in that trial but they didn't get anywhere. But one of the interesting things that came up is that, and I since corrected it. So I can get you another copy. I believe it's corrected.

Q Okay.

A But there would only be one more article that relates to the issue of cross dressing. And because Brown is on that article, you can make of that what you will, that it's there or not there.

Q Then with respect to the other publications here, they appear to be chapters and books. Anything else on your C.V. that you would consider to be related to --

A Well, in those chapters, in the "Principals of Ambulatory Medicine." That's a

medical textbook.

Q That's Number 11 under the "Chapters" section?

A Yeah. It gets repeated over and over again because the book keeps being republished, you know, the next edition, the next edition. But in that chapter there is a certain section on gender identity disorders but it's pretty general.

Q Anything else?

A I think that's probably pretty much it. There may be, you know, maybe 41. Peter Fagan and I did a chapter on psychosexual disorders in clinical psychology for medical students. There is probably something about gender identity in that. In the book, the book that we edited out of the group, there was certainly several chapters on gender identity disorders that we all contributed to.

Q Is that Number 31 you are referring to on your C.V. the report of the work group?

A Yeah, that. No, no, no. That didn't have anything to do with GID.

Q Okay.

A It's all on Page 23. The first book, "Clinical Management of Sexual Disorders," there was material in there about gender identity disorders.

Q Okay.

A So it's scattered around a little bit.

Q Anything else?

A I think that's it.

Q Without going through obviously the entire list on your C.V., on what other topics have you focused your research on in addition to the work that you have done on gender identity disorders?

A You can see earlier on there was a lot about suicide. Most of my initial publications had something to do with suicide and other aspects of sexual disorders, sexual dysfunctions, and some about the paraphilias.

I contributed to a series of articles, you know, 31, 32, 35, 36, 37, on personality disorder issues associated with substance abuse and HIV use, collaborated with the folks in the burn unit on a

number of articles on psychiatric aspects of trauma and PTSD. So, you know, I'd say those are the major areas and there are other isolated things that are aren't on the list here.

Q And with respect to the articles that you identified as being related to gender identity disorders, which I think I have as Number 20, Number 28, Number 34, Number 51, and the articles that you mentioned with George Brown, Dr. Brown?

A Oh, it is in here.

Q Is it?

A Yeah, 38. It did get in here, 38, Page 15.

Q Okay.

MR. CHOE: May I ask to clarify the record? Is this your most current C.V.?

THE WITNESS: I think so. If it's in here, then it's current.

BY MS. MCGOWAN:

Q How would you describe your involvement in the research in these articles?

A I'm not sure what you mean by involvement.

Page 337

Q Not being a scientist, I'm not sure technically what the right terms are, but I understand that there is usually some significance to being the first author or the second author as far as your role in actually conducting the research as opposed to being someone involved more in developing the analysis.

So with respect to these articles, I'm interested in finding out what your involvement was with respect to both the research and conclusions in the articles.

A Well, I have had various roles depending upon the particular piece that we were doing.

Q So for none of these articles you were first author?

A That's correct, yeah.

Q So, with any of these articles, were you actually involved in the assessment of the subjects of the studies?

A Yes.

Q Is that the case for all of these?

A No. The ones that I wasn't, the sample

Page 338

that George Brown had put together came from Texas. So Tom and I had nothing to do with that. The rest of us on the article helped with the analysis and with writing the paper itself, constructing the paper, thinking through the conclusions, the results and the conclusions sections, making contributions there.

The actual sample came from a sample that Dr. Brown had collected out in Texas. All of the others were from our own clinic.

Q Okay. With respect to your research and writing as opposed to your clinical practice, would you say that you currently had a focus of your research and writing?

A I'm not -- not right now. Except for this monograph I'm working on, I'm not doing a lot of writing. I just changed jobs. So I'm settling into a new position that is like another whole career. So I'm in the midst of a learning curve that I don't have much to contribute to the literature until I spend another year or two. Then what I will be doing is writing more population

Page 339

base and not health care and managed care.

Q You said you just underwent a job change. Just so that I'm clear, a change from what position to what position?

A I stepped down. That's the term that's used. I stepped out the chairmanship at Bayview and now I'm chief medical officer for Johns Hopkins Health Care and chairman of the medical board at John Hopkins Bayview Medicine. It's about two-thirds/one-third.

Q Are you currently formulating either research or article ideas in the area of population based health care, if I have that phrased right?

A Yes.

Q Are you currently formulating research or articles other than the monograph in the field of gender identity or gender identity disorder?

A No. I'd like to get that off my chest.

Q Would you agree that its important to keep up with the research and scholarship in one field?

A True.

Q How many hours a week do you spend

Page 340

reviewing literature in your areas of specialty?

A Well, it's something everyday. Of course, I have done an enormous amount of reading pursuant to these three cases.

Q How many articles per week would you say that you read?

A That have to do with any aspect of my medical work?

Q Yes, as the first part of the question.

A Right. If I had to average it out over the week, I would probably look at two or three articles a day. That does not include the "Wall Street Journal," which is turning out to be one of the better medical journals.

Q And do you read any journals or other publications on a regular basis?

A Well, pursuant to this, yeah. I get the "Archives of Sexual Disorders," and, of course, I read that cover to cover. I'm interested in the field and it's a good journal.

Q Anything else?

A Well, "The American Journal of

Psychiatrists," "The Archives of Psychiatry," "JAMA," "New England Journal of Medicine," and occasionally "The Lancet."

Q Anything else?

A What will happen is that we -- I helped introduce the research arm into Johns Hopkins Health Care, and the folks who are now functioning in that role feed me articles about population based medicine and managed care medicine and then other articles that I had to do some reading on, pain management, and the substance -- the prescription substance abuse issues associated with pain management. That's been on my plate recently.

Q Of the reading that you do in the course of a week, what percentage would you say involves literature specifically in the area of gender identity and gender identity disorders?

A The last year since I have been first struggling with this monograph, to start with, and then with these three cases, you know, just reading constantly. Everyday I'm doing something. Not only do I have to write for this case, but I'm

writing for the other three cases.

So, you know, almost, you know, a half hour to an hour to three hours a day are consumed by some aspect of one or three of these cases. So I'm up to here with it right now (indicating).

Q As a percentage of your overall reading load?

A I'd say it's at least 30 percent, maybe more.

MR. CHOE: Can I clarify for the record? When the deponent said "up to here with it," he gestured to mid face level.

THE WITNESS: Mid face level, right.

BY MS. MCGOWAN:

Q You're free to amend your gesture if you feel that it's necessary to do so. So prior to getting involved in these three cases and commencing your work on the monograph, what percentage of your overall reading would you say was specifically focused on literature regarding gender identity?

A Probably five percent.

Q And your involvement in these three cases and in the monograph, just so I'm clear, you said that was roughly 18 months ago?

A No, no. The cases go back -- the first case started, I think it was about two years old now. The monograph I had started actually sort of laying out the architecture of it maybe three, maybe almost four years ago, I'm embarrassed to say.

Q Do you participate in any continuing medical education programs specifically regarding gender identity or general identity disorders?

A The only one I do is I do myself for the department of psychiatry on topics in medicine and I do a lecture workshop on GID annually.

Q How long is the lecture? Is it a day-long seminar or one-hour lecture?

A No. It's an afternoon presentation plus workshop probably about three hours, anywhere from 20 to 30 participants.

Q And are you always the presenter of the material?

A Yeah.

Q How long have you done that?

A Five years.

Q So in addition to that program that you put together for Johns Hopkins, are there any other continuing medical education programs that you participate in regarding gender identity and gender identity disorders?

A No.

Q We talked a little bit about the Harry Benjamin Gender Dysphoria Association during the first part of your deposition. We'll call it the Harry Benjamin Association to keep it from being too much of a mouthful. Am I right that you are familiar with the Harry Benjamin Association?

A Yes.

Q What is it?

A It's an organization that is devoted to the study and the care of gender identity disorders.

Q Are you familiar with this organization's work regarding gender identity disorders?

A Sure.
Q How would you describe its work?
A Well, one of the main -- one of its main products are the standards that have been around for a long time. The standards are a description of a model series of treatment and management principals and specifics that lay out, if you will, a course or courses of management and treatment of patients with GID, their evaluation and management of them from the beginning through the end into transition and, you know, conceivably beyond.
I think that's probably what they, you know, what they are best known for. But as a group, they sponsor. I think they encourage research. They encourage the development of clinical programs and in general act as a group of people who wish to take the field forward.
Q Have you ever attended any conferences or workshops sponsored by the Harry Benjamin Association?
A No, I haven't.
Q What is your estimate of the percentage of

people involved in the evaluation and treatment or management of patients with GID who are part of the Harry Benjamin Association?
A You mean across the country?
Q Yes.
A Who are actually dues paying members?
Q Yes.
A I don't know those numbers for sure. I'm going to guess at least a third to 50 percent.
Q Are there any other professional organizations for people who are involved in the evaluation, treatment or management of patients with GID other than the Harry Benjamin Association, that you know of?
A Well, I don't know if they still exist. We went to a couple conferences years ago with the International Association for Gender Identity Disorders. I don't know if they are still in existence.
Then I think under the umbrella of sexual issues in general, there are a couple national societies that I belonged to from time to time and

attended their conferences. Again, on the basis of time, I'm not currently involved.
Q Recognizing that you may not be currently involved, do you recall which societies you have been involved in over the years?
A No. I mean there are two. I was a member for two and I can't remember the exact names right now.
Q And you mentioned --
A Maybe they are on here (indicating). I don't know if they are on here or not.
Q You mentioned attending conferences affiliated with some of these societies. Do you recall roughly how many such conferences you attended over the years?
A Well, there was one of the organizations that I went every year for maybe five or six years, but that's been at least ten years ago.
Q And it was an annual conference?
A Yeah, yeah.
Q Have you ever been a member of the Harry Benjamin Association?

A No.
Q Are there any specific reasons why you have decided not to join the Harry Benjamin Association?
A Not really.
Q Are you familiar with an organization known as the International Academy of Sex Research?
A No.
Q Are you familiar with "The Journal of the International Academy of Sex Research?"
A Well, through all this reading, yeah, I am.
Q Do you subscribe to this journal?
A No.
Q Are you familiar with any of the scholarship published by this journal?
A No. I think it's a pretty low impact journal.
Q So have you ever read an article published by the journal, to your knowledge?
A Yeah, I think, because some of the articles that I have had to wade through in the