UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA

CASE NO.: 4:22-cv-00325-RH-MAF

AUGUST DEKKER, et al.,

Plaintiff(s),

-vs-

JASON WEIDA, et al.,

Defendant(s).
_____/

ZOOM

DATE: Tuesday, March 21, 2023
TIME: 10:02 a.m. - 3:44 p.m.

*****PORTIONS OF TRANSCRIPT MARKED CONFIDENTIAL*****

DEPOSITION OF MICHAEL BIGGS, PH.D.

Taken on behalf of the PLAINTIFFS before Jennifer L. Bush, RPR, FPR, FPR-C, Notary Public in and for the State of Florida at Large, pursuant to Notice of Taking Deposition in the above cause.

A P P E A R A N C E S

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I N D E X

PLAINTIFFS' EXHIBITS

WHEREUPON,

MICHAEL BIGGS, PH.D.,

called as a witness on behalf of the PLAINTIFFS, after having been first duly sworn, was examined and testified as follows:

THE WITNESS: I do.

DIRECT EXAMINATION

BY MS. ALTMAN.

Q. All right. Well, good afternoon, sir. I know for us it's morning but for you it is afternoon. Can you hear me okay?

A. I can, yes.

Q. So I tend to have a loud voice. If for any reason you think I'm yelling at you, I want to warn you in advance I'm not. I do tend to have a loud voice, and I am using the computer audio. So just keep that in mind.

Also keep in mind that if you can't hear me or the questions break up, certainly ask me or tell me what the electronic situation is and I'm happy to try and nullify it.

So I'm going to take your deposition today. My name is Jennifer Altman. I'm with the law firm of Pillsbury Winthrop Shaw Pittman. Have you had your deposition taken before?

A. No, I haven't.

Q. So let me give you a few of the ground rules that we're going to hopefully live by today. I'm going to ask you questions and you are going to answer them. I'm not trying to trick you. So that means if you don't understand a question, simply ask me to rephrase it. I'm happy to do so.

If you don't hear a question, simply tell me you didn't hear it and I'm happy to repeat it for you. If you answer a question, I'm going to assume that you understood the question, is that fair?

A. Yep.

Q. So you just hit on without -- unintentionally one of the garden-variety rules of depos. You can't shake your head no or shake your head yes. The wonderful court reporter on my screen over to the right can't take down nods or head shaking. You need to answer out loud audibly.

That means if it's a yes, it's a yes. If it's a no, it's a no. Uh-huh is not an answer because that could be yes or no. So please always answer the question out loud for the court reporter's benefit.

Also for the court reporter 's benefit, who is going to be working really hard today to make sure the transcript is accurate, you may be able to predict the

question that I'm going to ask you, or you may feel it incumbent upon you to start answering a question because you want to either clarify something or bring something up.

For the court reporter's benefit, you always need to wait until I've completed my question fully, take a pause because Michael may want to object, put an objection on the record, and then answer the question. That way we'll have a clean record for the Court. Does that make sense to you?

A. Yes.

Q. Okay. You are nodding a lot. But make sure you say yes or no.

A. Yes.

Q. If you need to take a break, I'm happy to accommodate you. I can't do so when there is a question pending, so keep that in mind in terms of timing any breaks that you think you'll need. Does that make sense?

A. Yes.

Q. And, sir, have you ever been -- have you ever been charged with or convicted for any crime of malfeasance, fraud, any kind of misstatements?

A. No.

Q. And are you taking any drugs today that would impact your ability to fully and robustly answer

the questions that I'm about to ask you?

A. No.

Q. All right. So let's get started. So are you a medical doctor?

A. No.

Q. Have you gone to medical school?

A. No.

Q. Have you had any medical training whatsoever?

A. No.

Q. Have you ever treated anyone with gender dysphoria?

A. No.

Q. Have you ever prescribed treatment for anyone with gender dysphoria?

A. No.

Q. Do you perform medical research relating to gender dysphoria?

A. Yes.

Q. What medical research do you perform relating to gender dysphoria, sir?

A. One example would be getting data -- getting data on the suicide rate of transgender adolescence at the London clinic.

MS. ALTMAN: Someone needs to mute their

phone, please. Thank you.

BY MS. ALTMAN:

Q. Getting data on suicide rates, and I didn't hear the rest of it, sir.

A. Suicide rates of children attending their pediatric clinic, gender clinic in London, called the Tavistock, and publishing that research.

Q. Okay. So you didn't conduct the research, did you, sir?

A. Yes, I conducted the research. I submitted freedom of information requests to get the numbers that I used in the article.

Q. Uh-huh. What -- what actual research, sir, did you perform in order to determine the basis or reasoning for any suicides that you allegedly studied?

A. There was no information on the reason -- on the reasons for the suicides. It was the number --

(Audio interference.)

THE WITNESS: -- I was doing research on.

(Reporter asks for clarification.)

MS. ALTMAN: Yes, sir -- yes, ma'am. Can you hear him okay?

MS. REPORTER: Yes, I can. It was just that the word "the number" blurbed out. That's all.

MS. ALTMAN: No problem.

BY MS. ALTMAN:

Q. Sir, so again, you didn't perform any analysis to determine the basis for any suicides that occurred at the Tavistock clinic, did you?

A. I performed the analysis to estimate the suicide rate.

Q. Right. You -- you got a number from someone using a Freedom of Information Act, right?

A. Yes.

Q. Okay. Freedom of Information Act request, correct?

A. Yes.

Q. And you multiplied a number by the number of individuals treated, correct?

A. I also had to ascertain the number of individuals treated, which was a required extensive Freedom of Information Act requests.

Q. Right. So you issued some Freedom of Information Act request, but that's not my question. What analysis did you perform into the reasons that anyone in your Freedom of Information Act requests committed suicide?

A. My research was not on the reasons. It was on the rate of suicides, the number of suicides as

proportion of patient -- of patient time spent in the clinic.

Q. Okay. And we're going to -- and we're going to get to that research later. But I just want to be clear on the record. As you sit here today, you have no basis on which you can testify as to the reasons why any individuals from the Tavistock clinic committed suicide, correct?

A. That's correct. Just a correction. It is Tavistock, T-A-V-I-S-T-O-C-K.

Q. Okay. Sorry if I'm pronouncing it wrong. I will do better. But your answer is the same, correct?

A. Yes.

Q. Okay. Excellent. Have you performed any clinical studies relating to gender dysphoria?

A. Could you define "clinical"?

Q. What do you understand that word to mean, sir?

A. Do you mean that whether I was acting in a clinical capacity?

Q. Do you understand the word "clinical" to mean acting in a clinical capacity, sir?

A. That could be one interpretation, yes.

Q. Okay. And so I want you to then use that interpretation and tell me whether or not you've

performed any clinical studies -- studies relating to gender dysphoria?

A. No.

Q. Do you believe gender dysphoria exists?

A. Yes.

Q. Do you believe people can be transgender?

A. Yes.

Q. Do you believe that being transgender is a choice?

A. I'm struggling to answer that question.

Q. Why?

A. Because in some ways, everything is a choice, isn't it?

Q. No. Do you have an answer for the question, sir?

A. I don't -- I think in some cases it might be a choice and some cases it's not.

Q. Okay. Do you believe people can have gender -- gender identity that is not aligned with their gender assigned at birth?

A. Yes.

Q. Do you believe that a trans -- transgender male is a boy?

A. Yes.

Q. Do you believe that a transgender female is

a girl?

A. Yes.

Q. Do you believe the medical professionals are in the best position to determine proper health care treatment?

A. Sometimes.

Q. And by your "sometimes," I assume you mean sometimes not?

A. Sometimes not, correct.

Q. Okay. What would be the scenarios under which a health -- a medical professional would not be in the best position to determine proper health care treatment?

A. If their treatment was based on faulty research.

Q. Anything else?

A. That would be the main -- of course it could also be if they had a financial incentive to offer certain treatments.

Q. Are you being paid for your time today, sir?

A. Yes.

Q. Do you have a financial incentive to testify consistent with the defendants' position in this case?

A. No.

Q. So why would your character be any better or worse than a medical professional who is making medical decisions who has a financial interest in the treatment?

A. I think the sums -- the amount of money matters. And I didn't say that medical professionals always had -- were influenced by financial incentives, but sometimes they might be.

Q. Well, as you sit here today, do you have an example of any individual that you are aware of, relevant to this case, that you think is financially incented (sic) to perform a certain treatment?

A. No.

Q. Okay. So you are just using that sometimes that's the case, correct?

A. Yes.

Q. Do you believe that -- that experts sometimes have a financial incentive to testify in a particular way?

A. Sometimes, yes.

Q. Okay. You would agree with me, would you not, sir, that a medical professional is in the best position -- the best position to determine the appropriate care to be rendered to transgender

individuals, right?

A. Sometimes.

Q. And the -- the sometimes not is the same answer you gave a moment ago?

A. Yes. If it's based on -- if a medical judgment is based on faulty research.

Q. Would you agree with me, sir -- I'm sorry, were you done or no? I apologize.

A. I'm done.

Q. Okay. You would agree with me, sir, that it's -- it's medical professionals that -- that should be conducting medical research, correct?

A. I think academics of all -- if they have the skills and competence should be conducting important research, including medical research.

Q. Sir, you are not suggesting to the Court that a academic is qualified to render medical opinions, are you?

A. Opinions on an individual patient, no.

Q. Well, what -- what about a class of patients, sir, are you suggesting to this Court that a academic has the capacity to render medical opinions?

A. That really depends on whether that -- for example, the academic could come up with good arguments, good data, published in a peer review journal, for

example.

Q. But that -- they can't perform medical or clinical research, can they, sir?

A. Well, they can perform scientific research.

Q. Based on other people's research, right, you can report on other people's research. You don't perform the research yourself, correct?

A. Not taking measurements, for example, no, that's certainly true.

Q. Well, let's use an example here, sir. You've not performed any medical research, have you?

A. Well, I gave you an example earlier of my suicide paper, which I believe would come under the category of medical research. I can give you another example on bone density, if you'd like.

Q. Okay. Why don't you give me that example. I won't stipulate that I think your example on suicide complies but let's try bone density.

A. So bone density was published by the same gender clinic. Information on bone density was released thanks to my complaints to the health research authority in Britain. They released the data and I was able to publish a short letter to the editor in the Journal of Pediatric Endocrinology and Metabolism that analyzed the distribution of bone density after two years on

gonadotropin-releasing hormone agonists.

Q. Okay. We're going to get to that study later. But with regard to that, again, all you did was make a Freedom of Information Act request to the Tavistock clinic, correct?

A. No, I made a complaint -- I made a complaint to the health research authority. The health research authority forced the researchers to release that data.

Q. Okay. And it was their data, sir --

A. Yes.

Q. -- that you relied upon, correct?

A. Yes.

Q. And so you didn't perform any actual clinical or medical research. You relied on the data that was compiled by someone else, correct?

A. I did not perform the bone density scans, that's correct.

Q. And -- and you are not qualified to read a bone density scan, are you, sir?

MR. BEATO: Object to form.

But, Dr. Biggs, you can answer that question.

THE WITNESS: What I analyzed was Z-scores which are based on normal distribution. It's very

standard statistics.

BY MS. ALTMAN:

Q. Did you understand my question?

A. Yes, and I -- yes.

Q. Okay. My question was, you are not qualified to review a bone density scan, correct, sir?

A. The bone density is converted into a Z-score which is based on a normal distribution and met the standard statistics of a normal distribution.

So the original bone density score, I could not -- that would not be within my ambit. When it is converted into a Z-score, normalized for aging sakes, then I -- that is within the ambit of myself or anybody else who is qualified who understands statistics.

Q. So, again, the answer to my question is you are not qualified to read the scan, correct?

MR. BEATO: Object to form.

But, Dr. Biggs, you can answer that question.

THE WITNESS: Correct.

BY MS. ALTMAN:

Q. Okay. Thank you. Do your -- do your personal beliefs in any way impact your opinions in this case?

A. My personal beliefs are based on what

I've -- what -- the research that I've done. So, of course, that then in turn contributes to my opinions.

Q. Okay. Other than the -- the two instances you mentioned and the research that you've done, which we're going to get to in a little bit, I'm just trying to understand where you -- whether you have any other personal beliefs that impact your testimony here today.

A. Yes.

Q. Okay. And what are those personal beliefs that impact your testimony here today?

A. Those personal beliefs are that gays -- being gay and lesbian or being a feminine boy or a masculine girl are entirely normal variations on human experience and do not require medicalization.

Q. What about transgender individuals?

A. Sorry, what about -- can you -- can you --

Q. Yes -- yeah, you said gays and lesbians, if I wrote this down correctly, are normal variations and do not require medicalization, did I hear you correctly?

A. Yes.

Q. Okay. And so my question is, what about transgender individuals, do they require medical -- medicalization?

A. They might or they might not.

Q. Okay. Tell me the circumstances, sir, in

which you are qualified to determine when a transgender individual requires medicalization?

A. Well, it's partly, of course, their choice and it's partly whether they can consent as an adult to treatments.

Q. Did you understand my question, sir? My question is, tell me how you are qualified to determine when a transgender individual requires medicalization?

A. It's my belief that lifelong medical intervention requires an adult to consent to that -- that -- that serious significant step.

Q. So maybe third time is the charm. Did you understand my question? My question is, please tell me how you are qualified to determine --

MR. BEATO: Counsel -- counsel -- counsel, he already answered the question twice.

MS. ALTMAN: He actually didn't answer the question at all, Michael.

MR. BEATO: He did answer the question.

MS. ALTMAN: Michael, he didn't answer the question. You get to object to the form.

BY MS. ALTMAN:

Q. Sir, my question is, how is it that you are qualified to determine when a transgender individual requires medicalization?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: I've already answered it.

BY MS. ALTMAN:

Q. Really, what was your answer, sir, how you are qualified to determine when a transgender individual's entitled to medicalization?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: I believe that the -- the -- the lifelong medical intervention that comes with, let's say, cross-sex hormones is something that an adult can consent to make a good choice when they are presented with the cost and the benefits of that treatment.

BY MS. ALTMAN:

Q. Sir, my question is about your qualification, not your beliefs, your qualifications. My question was and is, what qualifies you to make determinations as to when a transgender individual receives medical care?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: I'm making a statement, a general statement about principles of treatment

and consent. I'm not choosing whether one particular individual can or cannot get treatment.

BY MS. ALTMAN:

Q. But that's not my question, sir. My question is not about them. It's about you. What is your qualifications, what are your qualifications to make a statement that a transgender individual sometimes or sometimes not requires medicalization?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: I won't.

BY MS. ALTMAN:

Q. You won't what?

A. I -- I -- I have answered to the best of my ability that question.

Q. So as you sit here today, you can't tell the Court what qualifications, if any, you have to make determinations as to when a transgender individual requires medicalization, correct?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: I'm -- I -- I've said what I've -- what I -- what I want to say on that question.

BY MS. ALTMAN:

Q. Okay. Sir, you were retained by the experts in this case, correct?

A. Yes.

Q. What -- and today, as I understand it, you are here to provide testimony relating to your opinions, correct?

A. Yes.

Q. And we're going to mark as Exhibit 1 to this deposition the deposition notice. And Ana is going to bring that up just so that you can see it. Maybe she is. Maybe she's not?

MS. GONZALEZ: I need -- I'm sorry. I need somebody to give me my -- the hostess disabled my screen sharing, so they need to allow me to do it.

MS. REPORTER: It's enabled.

MS. GONZALEZ: Okay.

(Plaintiffs' Exhibit 1 is marked for Identification.)

BY MS. ALTMAN:

Q. All right. Sir, do you see what we've put up on the screen, which we'll mark as Exhibit 1 for identification?

A. Yes.

Q. And have you seen a copy of this before?

A. Yes.

Q. And it's this notice of your deposition that has brought you here today, correct?
A. Yes.
Q. And we're going to also mark --
MS. ALTMAN: Thank you very much, Ana.
BY MS. ALTMAN:
Q. Sir, did you prepare an expert report in this matter?
A. Yes.
Q. And we're going to bring that up and we're going to mark that as Exhibit 2 to your deposition.
(Plaintiffs' Exhibit 2 is marked for Identification.)
THE WITNESS: Yes.
BY MS. ALTMAN:
Q. And do you recognize this? And Ana will scroll through it for you just so that you can see it.
A. Yes.
Q. And if you can confirm for the record, sir, that this is indeed the expert report that you prepared on behalf of the defendants in this case. And we'll mark this as Exhibit 2 for identification.
A. Yeah, insofar as all I've seen on the screen looks like my deposition.
Q. Your report, sir?

A. The report, sorry, report, yes.
Q. Okay. Sir, did anyone assist you in writing this report?
A. No.
Q. Did anyone write any portion of the report for you?
A. No.
Q. Did you share the report with anyone before it was finalized?
A. No.
Q. Did you review any of the defendants' other experts' reports before you finalized your own?
A. No.
Q. Have you reviewed any of the deposition testimony of experts in this case?
A. No.
Q. Okay. And we're going to get back to your report later. But that was your --
MS. ALTMAN: If we go to the last page, Ana, with his signature. Up one, up one, there you go.
BY MS. ALTMAN:
Q. That's your signature, sir, on page 22?
A. Yes.
Q. Okay. And -- and in it you see above it

that you swore under the penalty of perjury that the statements and opinions contained therein are your own, correct?

A. Correct, yes.

Q. Okay.

MS. ALTMAN: Thank you, Ana. We'll be using it later, so we can just put them aside for now.

BY MS. ALTMAN:

Q. Sir, you wrote your doctorate, your Ph.D. in the rise and decline of a mass movement, American workers and strike wave of 1886; is that right?

A. Yes.

Q. And you would agree with me that that has nothing to do with gender dysphoria, correct?

A. Yes.

Q. And you would agree with me it has nothing to do with transgenderism, correct?

A. Yes.

Q. And you don't treat patients who suffer from gender dysphoria, correct?

A. No, I don't.

MS. ALTMAN: Somebody needs to mute their phone, please. Thank you. Somebody.

BY MS. ALTMAN:

Q. You are not an ethicist, are you?
A. No.
Q. You are not a clinician of any kind, correct?
A. Correct.
Q. You are not a bioethicist, correct?
A. Correct.
Q. You are not an endocrinologist, correct?
A. Correct.
Q. You are not a psychiatrist, correct?
A. Correct.
Q. You are not a psychologist, correct?
A. Correct.
Q. You are not a surgeon, correct?
A. Correct.
Q. You are not engaged in the drafting of health care policy, are you, sir?
A. No.
Q. You are not a pharmacist; isn't that right?
A. I'm not a pharmacist.
Q. And you've never worked under a pharmacist; isn't that correct?
A. Correct.
Q. And we've discussed, at least as I understand from your testimony, you have no medical

training, correct?

A. Correct.

Q. You have no training or experience in endocrinology, correct?

A. Correct.

Q. No clinical experience in providing gender affirming care, correct?

A. Correct.

Q. You have no mental health training, correct, sir?

A. Correct.

Q. You are not a licensed nurse, are you?

A. I'm not a licensed nurse.

Q. And you are not licensed to practice medicine in any country in the world, right?

A. Correct.

Q. Now, sir, you would agree with me that you first began considering issues relating to gender dysphoria in 2016 or 2017, do I understand that correctly?

A. I believe 2017.

Q. So about five years or so, correct?

A. Yes, that would be six years, yes, I think.

Q. I guess depending on when it was in 2017, but I'll give you -- I'll give you six years, no worries.

What independent research have you performed on gender dysphoria as opposed to simply critiquing other people's research and articles?

A. So I would say that my independent research was the article on suicide rates at the Tavistock, which we've discussed; the analysis of bone density; and the article -- my most recent article on the Dutch part on the history and -- on the Dutch Protocol.

Q. Well, we talked about the suicide rates and the bone density and we're going to talk about them a little more later.

But with regard to the Dutch Protocol, what you did was merely analyze what they did; isn't that correct?

A. It was an extensive literature of historical account, yes.

Q. Right. You reviewed what they did, correct, and gave your spin on it; isn't that right?

A. That's not how I would -- would -- would refer to an extent -- a literature review and -- and analysis and historical account.

Q. Okay. But it's a literature review of what -- of someone else's work, correct?

A. Correct.

Q. And it's a historical account of someone

else's work, correct?

A. Correct.

Q. You didn't perform any of the underlying clinical research, did you, sir?

A. No.

Q. Have you gone back personally and interviewed any of the cohorts that were involved in the Dutch Protocol?

A. I have talked to two patients from the Dutch -- from the Dutch clinic subsequent -- subsequent to that article.

Q. So after the article, you spoke to them?

A. Yes.

Q. So when you published the article, you would agree with me, you had not spoken to anyone that participated in the Dutch Protocol, correct?

A. Well, there is one -- the -- the article acknowledges some input at the end from one Dutch patient, but the -- most of the article was completed before I met that person.

Q. Okay. And so who are the two patients that you say you spoke to?

A. I'm not going to name them.

Q. Sir, you are under oath, obligated by law to tell the truth and to answer my questions. Who are

the two patients? We're happy to mark this part of the transcript as confidential. There is a protective order in place.

A. Okay. One is called [redacted], [redacted]

[redacted]

Q. And the other?

A. Is called [redacted], [redacted], and I don't have his sir name to hand.

Q. Okay. Do you have it somewhere in your office?

A. I do -- I could get that, yes.

Q. Well, did you list your interviews of these individuals in your -- your research or -- or attachments to your report as something that informed your decisions in this case and your opinions in this case?

A. The article and the Dutch Protocol has a footnote acknowledging feedback from a Dutch de- -- one Dutch detransitioner. There is a footnote in there, I believe as an exhibit in my report.

Q. And which of the two that you just mentioned is the detransitioner?

A. [redacted].

Q. When did you speak to this individual?

A. Six months ago.

Q. Do you have notes of your conversation with

this individual?

A. No.

Q. Did you take notes of your conversation with this individual?

A. No.

Q. Did you record the conversation?

A. No.

Q. Does your conversation with this person influence your testimony or opinions in this case?

A. It provides background.

Q. Other than background, sir?

A. No, not other than background.

Q. So, again, with regard to the Dutch Protocol, just so that we're on the same page, you reviewed other people's clinical work and other people's research and reported on it, correct?

A. Correct.

Q. You didn't perform any of the underlying studies or tests, did you, sir?

A. No.

Q. Did you interview any of the -- the physicians or medical professionals that were involved in that study?

A. No.

Q. Did anyone stop you from doing that?

A. No.

Q. Did anyone stop you from interviewing any of the other individuals that participated in that study?

A. No.

Q. You were trying to do in-depth and independent research, sir. Any reason why you didn't reach out to the authors of the study or any of the other participants in the study to get a robust analysis of the import of the research and the historical, I guess, recreation of the Dutch Protocol?

A. As an academic, we rely on what is published in the literature. Including, of course -- and that includes, let's say, journalist interviews with the -- with the clinicians. That's also part of the literature --

Q. Is it your testimony -- just so I understand the scope of what an academic does, is it your testimony under oath that academics don't interview individuals to get background or other information to ensure that what they are publishing is accurate?

A. There is a wide variety of academic research. Some is statistical; some is based on hypnography. This particular case was based on the published literature.

Q. Okay. But you are not suggesting that --

that all academics would not interview, whether it be doctors, physicians, statisticians or others that perform clinical research, are you?

A. No.

Q. Have you performed any scientific studies?

A. Yes, the articles that I've already discussed earlier. I would consider those scientific.

Q. You are referring to the -- the bone density, the suicidality, and the Dutch Protocol?

A. Well, the bone density and the suicidality, yes.

Q. Okay. And you believe those qualify as scientific studies, sir?

A. Yes.

Q. Okay. And we'll get in more detail with them later.

You are not a scientist, are you?

A. I would consider myself a social scientist.

Q. Well, you are a sociologist, correct?

A. Yes.

Q. Have you ever conducted any peer-reviewed studies?

A. Yes.

Q. And what peer-reviewed studies have you conducted?

A. The four peer-reviewed studies, which are listed in my expert report, are the study on suicide.

Q. Uh-huh.

A. The -- the comparison of Dutch and English gonadotropin-releasing hormone agonist. The critique of Turban, all three, were published in Archives of Sexual Behavior. And all three were peer-reviewed. And the fourth would be the article we just discussed on the Dutch Protocol, which is published in the Journal of Sex & Marital Therapy, also peer-reviewed.

Q. Okay. Sir, you would agree with me that because an article -- I'm sorry, strike that.

Because a journal is peer-reviewed, doesn't mean that your work was peer-reviewed, correct?

A. No, this is -- that's -- that's incorrect. All of those four that I listed were peer reviewed.

Q. That wasn't my question, sir. My question was, you would agree with me that just because an article or a letter to the editor appears in a peer-reviewed journal, doesn't mean they are peer reviewed, correct?

A. Correct.

Q. Okay. What is your specific bases for claiming that your study on suicide was peer-reviewed?

A. Because I received reviewers' reports from my peers, and I had to revise and resubmit the articles

to meet their objections. And on the second round of revisions, it was accepted. That is what peer review means.

Q. And we're going to talk about those later. I just want to get your testimony on each of these now. And your article regarding the comparison of Dutch and other GnRH --

A. Again, it was sent to three or four peer reviewers. The editor said that I had to meet their objections and their criticisms. And then I submitted the revised version, along with my response to their criticisms, and it was ultimately accepted. That's what peer review means.

Q. Well, so we'll talk about what peer review means. Right now I just want to get your answers to my question, thanks.

And the -- the third one, was that the bone density?

A. The third was the critique of what Turbans were on puberty blockers and suicide.

Q. Okay.

A. And very helpfully, the editor included the first footnote on this article. This article was peer reviewed by three reviewers and the editor. But it was the same process as I just -- as I explained previously.

The same peers, they sent back critiques. I had to meet those objections. And it was ultimately -- after revision, it was published.

Q. You would agree with me that the study on suicide and the -- the second one, the comparison of the Dutch GnRH don't contain such a footnote, correct?

A. They don't contain such a footnote, correct.

Q. Right. And your testimony is the only basis on which you could support a position that they were indeed peer-reviewed, correct?

A. That's incorrect. I could give you the reviewers' reports.

Q. Did you include those with your production in this case?

A. No.

Q. And the fourth one, sir?

A. The fourth one is the Journal of Sex & Marital Therapy, the Dutch Protocol.

Q. Same question, sir, what is the basis on which you --

A. It was sent --

Q. Let me just finish the question.

-- have evidence of this publication was peer-reviewed?

A. Was sent off to review by two or three, I can't quite recall, but it was two or three of -- reviewers. They sent back criticisms and suggestions. I revised the paper in light of their criticisms and suggestions. And it was then accepted for publication.

Q. And with regard to at least numbers one, two, and four that we've been talking about, the -- the fact that you deemed them being peer-reviewed because you responded to certain responses and criticisms does not necessarily mean they were indeed peer-reviewed within the medical community; isn't that right, sir?

A. I disagree completely with that, with your assertion.

Q. So it is your testimony under oath that you believe that -- that your articles number -- the first one, the second one and the fourth one qualify as peer-reviewed studies?

A. Yes.

Q. Is that your testimony?

A. Yes, indeed, yes.

Q. And we're going to get back to those articles later. But have you participated in any scientific studies about the efficacy of gender-affirming care?

A. No.

Q. Have you interviewed any transgender individuals who benefited from gender-affirming care?
A. No.
Q. Has anyone stopped you from interviewing any transgender individuals who benefited from gender-affirming care?
A. No.
Q. Has anyone stopped you from participating in any scientific studies about the efficacy of gender-affirming care?
A. No.
Q. Did you ask to interview the plaintiffs in this case?
A. No.
Q. Did you interview or speak with anyone from WPATH before issuing your opinions in this case?
A. No.
Q. Have you ever interviewed or spoken with anyone from WPATH in order to formulate your opinions regarding puberty blockers?
A. No.
Q. Have you spoken to or interviewed anyone with a contrary point of view before issuing your opinions in this case?
A. Well, I've spoken to many people with

contrary points of view, yes.

Q. Okay. Who have you spoken with?

A. Not -- not in the -- you know, in the last, let's say, you know, month or two months or something.

Q. Well, what about the last six months, who have you spoken to that holds contrary views to yours about puberty blockers?

A. Probably not in the last six months, no.

Q. What about the last year?

A. Yes, I've spoken to people -- individuals, yes.

Q. Okay. Who?

A. A doctoral student of mine.

Q. Who?

A. Rema -- well, a former doctoral student of mine called Rema Maja (Phonetic).

Q. Anyone else?

A. No.

Q. Any reason, sir, you don't, as an academic, seek out people who have contrary views so that you can have a full and robust analysis of particular issues?

A. Well, we seek out contrary views when we look at the published literature. I mean, that's what we do. We look at, you know, contrary views as -- as published.

Q. Okay. So, for the record, what contrary literature have you looked at in the past year?

A. Well, almost everything I -- a lot of the material that I cite would have contrary points of view.

Q. Okay. And when you say that you cite, you mean in connection with your report in this case?

A. Yes.

Q. Okay. Anything else?

A. No.

Q. Did you participate in the drafting of the GAPMS memo at issue in this case?

A. No.

Q. Did you participate in the drafting of the rule at issue in this case?

A. No.

Q. Did you refer to the DSM-5 as part of your work?

A. Yes.

Q. And describe for the record, sir, how specifically you refer to it and what ways you utilized the DSM-5 in your opinions -- in forming your opinions in this case?

A. Well, the DSM-5 provides the -- the accepted definitions of gender dysphoria.

Q. Okay. How did you use that definition,

sir, in your opinions in this case?

A. Well, I think I -- I believe I cited in my article on the Dutch Protocol, which was one of the exhibits.

Q. Okay. And how did that inform your opinions in this case?

A. It provides a good --

Q. The definition of gender dysphoria, how did the DSM-5 definition of gender dysphoria inform your opinions in this case?

A. It demonstrates that gender dysphoria is based on the patient's beliefs and desires.

Q. Is that all it says, sir?

A. Yes.

Q. It's just a patient's belief and desire --

A. Well, there are certain particular --

Q. Let me just -- we agreed I get to finish the question and then you get to answer. So I'm going to try not to interrupt you. You could try not to interrupt me as well.

Sir, is it your testimony that gender -- someone being gender dysphoria is solely based on their belief and desire?

A. Yes.

Q. Anything else that informs whether or not

somebody is suffering from gender dysphoria other than their belief and desire?

A. Clinical -- clinically significant impairment or distress.

Q. Anything else?

A. No.

Q. You would agree that it is outside your area of expertise to interpret the DSM-5, correct, because you are not a clinician; isn't that right?

(Simultaneously speaking.)

MR. BEATO: Object to form.

And, Dr. Biggs, you can answer that question.

(Simultaneously speaking.)

MS. REPORTER: Wait a minute. Hold on. What was the objection?

MR. BEATO: Form.

And, Dr. Biggs, you can answer that question.

THE WITNESS: Correct, I'm not a clinician.

BY MS. ALTMAN:

Q. Right. And, therefore, it is outside your expertise to interpret the DSM-5; isn't that right?

A. I can interpret what is written in the DSM-5.

Q. You are not a clinician, sir, correct?
A. Correct.
Q. So by "interpret it," you mean you can read the words on the page, is that your definition?
A. I can read, interpret, and analyze, yes.
Q. Well, sir, you are not a clinician who is qualified to analyze the DSM-5, are you?
A. I'm qualified to analyze the DSM-5. I'm not a clinician.
Q. And what qualifies you to do that, sir?
A. My academic training.
Q. Anything else?
A. No.
Q. Now, sir, you would agree with me that a letter to the editor is not the same thing as an actual peer-reviewed publication, correct?
A. I disagree with you.
Q. And what's the basis for your disagreement, sir?
A. My disagreement is based on the fact that my -- in almost all journals -- in all journals, apart from one that I know of, that is correct, namely a literature by definition is not peer-reviewed.
Archives of Sexual Behavior is peculiar in that it calls what -- another journal would be called a

research note or a short article, which would be peer-reviewed. For some reason, the Archives of Sexual Behavior calls that a letter to the editor. I do not know the --

Q. Okay.

A. -- category for a short research note or short article.

Q. Apologies. I didn't mean to interrupt you.

But above the four studies that you claim were peer-reviewed, only one of them has a footnote indicating that it was peer-reviewed, right?

A. Correct. But just to add -- add to that, no article -- peer-reviewed articles never have a footnote saying if they are peer-reviewed. And in -- and in any -- in other journals.

So the absence of a -- the absence of a footnote indicating it is peer-reviewed is not evidence that it was not peer-reviewed.

Q. Agreed. So let's -- as you sit here today under oath, what actual evidence do you have that they are deemed peer-reviewed letters to the evidence -- and let me finish the question, because it -- you might think I'm done. I understand, and I don't want you to repeat your testimony, that you received comments from people and that you incorporated those comments and then it was

published.

My question is, what actual evidence do you have that that constitutes peer-reviewed?

A. That is the definition of peer-reviewed. I know the difference between something that's not peer-reviewed and not -- and something that is peer-reviewed because other letters to the editors which are published in other journals were not peer-reviewed, and I've never claimed them to be peer-reviewed.

Q. Right. And I think your definition, using it loosely, has said if you get comments from people and are required to incorporate them before publishing, that constitutes peer-reviewed.

Do I understand your definition correctly?

MR. BEATO: Object to the form.

Dr. Biggs, you can answer that question.

THE WITNESS: Yes; that's right.

BY MS. ALTMAN:

Q. Okay. Other than that belief, that anyone that provides commentary or suggestions or criticisms to your report and you review them, and then your letter to the editor is published, in your mind, that constitutes peer review, is that fair?

A. With -- one addition should be made, and that is that you are not -- you have to meet those

objections. And it is not clear whether it will be ultimately published or not. So you get criticisms but you have -- you -- you don't know, when you try to reshape the article based on those criticisms, you've got no guarantee whether the editor might say, well, you haven't done enough to meet those.

Q. Understood. I just want to make sure we're speaking the same language. That your definition of peer review is that the Archive of Sexual Behavior provided you with some criticisms, suggestions from a few of your colleagues, you -- you reviewed those, incorporated them, and ultimately, your letters to the editor were published, correct?

A. Correct.

Q. And I just want to make sure, definitionally, that is your definition of peer-reviewed, correct?

A. Correct.

Q. And beyond that, just so we don't leave the deposition today with any questions about it, you have no other evidence that your letters to the editor were peer-reviewed, correct?

A. Correct.

Q. And you would agree with me that journals don't peer review every type of publication, correct?

A. Correct.
Q. What patient-based independent research did you undertake to write these articles, these letters to the editor?
A. There was no patient-based research.
Q. Have you engaged in any clinical trials?
A. No.
Q. Have you ever had any of your letters to the editor or other writings rejected by a medical association publication on gender dysphoria?
A. Yes.
Q. And can you explain which --
A. I -- for example, I had a letter to the editor to Pediatrics that was rejected.
Q. What was it about?
A. It was a comment on a study of cross-sex hormones.
Q. And is that study on cross-sex hormones something that you've included in your materials in this case?
A. No.
Q. Why not?
A. Because I wanted to focus entirely on puberty blockers.
MS. ALTMAN: Counsel, we would ask that

that be produced.
BY MS. ALTMAN:
Q. Any other letters to the editor or submissions that you -- on gender dysphoria or transgenderism or cross-sex hormones or puberty blockers that have been rejected by any medical association publication?
A. Well, certainly I have an article on surgeries that was rejected by Archives of Sexual Behavior.
Q. What kind of surgery?
A. Gender -- transgender-related surgeries.
Q. Was that article included in your bibliography, sir?
A. No. Well, it wasn't an article.
Q. What was it?
A. Well, it's -- an article that implies it's been published. It's not been published, so it is like it's a rejected paper.
Q. Okay. I'm sorry. Was your rejected paper listed in your bibliography?
A. No.
Q. Okay. Why not?
A. Because I wanted to focus on puberty suppression.

MS. ALTMAN: Michael, we would ask that that rejected -- what did you refer to it as? Rejected paper --

THE WITNESS: Paper.

MS. ALTMAN: -- be produced to us.

MR. BEATO: So just to clarify, you would like us to produce to you an article that he did not cite in his bibliography and in his expert report?

MS. ALTMAN: Correct. Two articles, actually -- or rejected papers.

MR. BEATO: I will consult with my colleagues, thank you.

MS. ALTMAN: No problem.

BY MS. ALTMAN:

Q. Any other articles or rejected papers, sir?

A. I think -- I -- as I recall now, I believe that is -- that is all.

Q. Okay. Well, if you think of any others during the deposition, please let me know, okay?

A. Yes.

Q. Okay. Thank you. Have you made any commentary submission on gender-affirming medical care?

A. Sorry, I didn't understand the question.

Q. Yeah, have you -- have you provided or

written any commentary submissions on gender-affirming medical care?

A. What is commentary submission?

Q. Have you done any -- other than letters to the editor and what you refer to as peer-reviewed letters to the editor, and other than what you've already testified, is there anything else that you have written on gender dysphoria that's not otherwise listed in your bibliography?

A. No.

Q. Do you consider the archive on sexual health to be a peer-reviewed medical journal?

A. It's a peer-reviewed journal. I believe it's under -- might be classified under psychology or sexology.

Q. Right. So I'm asking, do -- you would agree with me it is not a peer-reviewed medical journal, correct?

A. Correct.

Q. Have you -- have any of your writings related to gender dysphoria been published in a peer-reviewed medical journal?

A. Yes.

Q. And which ones are those?

A. The -- the -- the journal of pediatric and

endocrino- -- pediatric and endo- -- pediatric and -- yeah, pediatric and endocrinology -- pediatric medicine and endo- -- endocrinology. There's -- one on bone density was published in that medical journal. That particular letter was not peer-reviewed but it is a peer-reviewed journal.

Q. Okay. Anything else?

A. No -- no, I should correct that. Another letter to the editor, which was not peer-reviewed, was published in The Journal of Sexual Medicine.

Q. Which one was that?

A. It is a comment on the -- the Costa study. It is -- it is cited in my report.

Q. Okay. Which one -- just say it again, the comment on what, I'm sorry?

A. It's a -- it's a comment on a -- an article by Costa, et al.

Q. Okay.

A. Again, I should emphasize, that was not peer-reviewed but it is a peer-reviewed journal.

Q. Anything else?

A. No.

Q. You had a submission on Turbans and credible assumptions about sex, does that sound familiar?

A. Yes.

Q. Was that rejected by any publication?
A. Yes. I should -- that -- I -- thank you for reminding me of that. That was rejected from a --
Q. You are welcome.
A. -- pediatric -- I'm not -- I wouldn't want to give you -- mislead you by giving you the journal but it was rejected by one journal, yes.
Q. Anything else?
A. No, I do not believe so.
Q. Now, sir, in your report, you don't -- you also don't mention that you participated in a panel before the Florida Board of Medicine, do you?
A. No, I did not. I did not think that was relevant.
Q. Right. You didn't include it on your CV either, right?
A. Possibly not.
Q. Why?
A. Because it was a eight-minute presentation and that's not really significant enough to be included on my CV.
Q. Well, for what it's worth, I think it was 12 minutes because I've listened to it. But I could be wrong.
But you would agree with me that it -- it's

relevant because it's the very issue for which we're here today; isn't that correct?

MR. BEATO: Object to form.

THE WITNESS: Correct.

MR. BEATO: Dr. Biggs, you can answer that question.

THE WITNESS: Correct.

BY MS. ALTMAN:

Q. Okay. So is there any reason why you chose not to disclose the fact that you were a panelist in the Florida Board of Medicine meeting held in October?

A. No. I was told explicitly in preparing my report that I had to say which -- what legal cases I had participated in and it did not -- it did not occur to me that that could be counted as a -- as a legal case.

Q. Who asked you to participate in that?

A. It was one of the members of the board of medicine.

Q. Who?

A. Patrick -- Patrick -- I'm afraid I'm blanking on the surname.

Q. Okay. Were you paid for your time?

A. No.

Q. And you would agree with me that your testimony before the board of medicine was essentially

the same as the opinions you are rendering in this case, correct?

A. Very similarly, yes.

Q. Okay. And you also testified and answered questions at a committee -- the Health and Human Services committee, right?

A. No, I don't -- oh, yes, sorry, yes, I did. Yes, yes, you're right. Yes.

Q. Okay. And you didn't list that in your bibliography or CV either, correct?

A. No, correct.

Q. Who asked you to participate in that?

A. I believe somebody from the Health and Human Services e-mailed me and asked me if I would participate. I'm afraid I can't recall their name.

Q. Were you paid for that?

A. No.

Q. You volunteer a lot of your time, sir, to this issue, correct?

A. Well, one was 12 minutes and the other one was, I don't know, same amount of time.

Q. You had prepared materials for those meetings?

A. Yes, but I believe as an academic, if you've done research in the public interest of your

research, then you should be willing to -- that's part of the job description.

Q. And you would agree with me that both the board of medicine meeting that I referred to and the committee meeting relating to the Health and Human Services, they're aligned with the defendants in this case in terms of the work that they are trying to do, correct?

A. Yes, correct.

Q. And you're being paid by the defendants in this case for your time today?

A. Yes.

Q. And you were paid for your work in connection with preparing your report?

A. Yes.

Q. How many hours in total have you expended in your analysis and in preparing your report in this case?

A. I'm not -- probably about -- I think my -- preparing my report was like eight hours, but I couldn't -- I don't have the exact figures to hand. And preparing rebuttals to three -- the rebuttals that I -- I received was another six hours. Preparation for this deposition was maybe another two hours.

Q. And when did you prepare for this

deposition?

A. I prepared for it yesterday.

Q. Did you meet with anyone?

A. No.

Q. Did you speak to anyone from the defendants or their counsel?

A. We had a five-minute discussion on just the procedures with Michael I think on -- it was on Friday.

Q. And the Michael you are referring to is the Michael Beato that's here on this call?

A. Yes, indeed, yes.

Q. Other than your five-minute meeting with Mr. Beato and you said you spent two hours yesterday, correct?

A. Yes.

Q. What did you do to prepare yesterday?

A. I reviewed my -- my -- my statement. And I looked at several of the references that were in the rebuttals.

Q. Okay. And we're going to get back to that in a second.

A minute ago you mentioned there was a Patrick who you couldn't remember his last name. Does the last name Hunter sound familiar?

A. That sounds familiar, yes.

Q. Okay. And is he the same Patrick Hunter that's also involved with SEGM and Genspect?

A. I don't know about Genspect, but SEGM, yes, definitely. Yes, that's him.

Q. Okay. And for -- for the Court's benefit, can you describe the work of SEGM, the way -- the way you pronounced it?

A. So SEGM, S-E-G-M, the Society for Evidence-Based Gender Medicine, is a group of concerned clinicians, doctors, researchers who are concerned about the basis for medical care of children, in particular, who identify as transgender.

Q. Well, they are not just concerned about it they are against it, correct?

A. Not against -- no, we're -- we're against what we see as unjustified -- medically unjustified care. We're in favor of care of people with gender dysphoria.

Q. Okay. And the "we," you included yourself, correct?

A. I'm on the board of advisors, yes.

Q. Correct. And we're going to talk about that later but I think you described it as being against medically unjustified care, correct?

A. Yes, correct.

Q. And I don't want to beat the dead horse but

it's not within your purview to determine what is medically justified or not, correct?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

BY MS. ALTMAN:

Q. Let -- I'll -- I'll withdraw it and I'll ask it different.

Sir, it's -- you've already agreed, you're not a medical doctor, correct?

A. Correct.

Q. Okay. And it's not within your purview to determine what is medically justified or not, correct?

A. I disagree with that because I believe that anyone who can look at the empirically researched literature, published literature and can make their own evaluation based on their reading of the literature.

Q. Meaning -- I'll give you that. You can read the literature and draw your own personal conclusion, right?

A. Correct.

Q. But you are not qualified to make a medical determination as to what is justified; isn't that right?

MR. BEATO: Object to form.

Dr. Biggs, you can answer the question.

THE WITNESS: Correct.

BY MS. ALTMAN:

Q. Okay. When did you get on the board of SEGM?

A. I can't give you the exact date. Two years ago, three years ago.

Q. How did you have occasion to decide to join that board?

A. I believe I was invited by somebody but I can't quite remember who invited me.

Q. You would agree that -- that SEGM is an advocacy group, correct, for their -- for their position, correct?

A. Correct. Like WPATH in that regard.

Q. Well, I asked you earlier whether or not you met with anyone from WPATH and you said no, correct?

A. Correct.

Q. And I think you also testified that you've never even tried to reach with any -- reach out or meet with anyone from WPATH, correct?

A. Correct.

Q. Have you ever been qualified as an expert in the United States?

A. No.

Q. Have you ever testified as an expert in the United States?

A. No.
Q. Have you ever been qualified as an expert ever?
A. Well, I have testified as an expert witness in -- in one court case in United Kingdom and one court case in Australia.
Q. Okay. Let's talk about those for a minute. The one you referenced, the first one is the Keira Bell matter; is that correct?
A. Correct.
Q. And you refer to it on page 2 of your report as Keira Bell and Mrs. A versus Tavistock NHS Trust, correct?
A. Yes.
Q. And what was the subject matter of your testimony in that case?
A. It was about the puberty blockers in general and the -- the Tavistock's concealing of information about their research on puberty blockers in particular.
Q. Now, that case was ultimately reversed, correct?
A. Correct.
Q. And ultimately, an Appellate Court ruled in favor of Tavistock, correct?

A. Correct.
Q. And with regard to your testimony, were you actually qualified by that Court as an expert in the efficacy of puberty blockers?
A. I don't know. I don't know -- I know that my -- my report was submitted. I know that my report was referred to by -- by the barrister in their proceedings. I know it was part of the bundle that was submitted to the judges.
Q. But you don't know whether or not the Court ever qualified you as an expert on the efficacy of puberty blockers, correct, sir?
A. Correct.
Q. And perhaps I missed it but did you produce that report in this case?
A. No.
Q. Why not?
A. Because I was superseded by -- that was quite a few years older. My -- the expert report that I provided is much more comprehensive and based on much more research and later -- later -- later publications.
Q. Is that the only reason you didn't produce it, sir?
A. Yes.
Q. And what year was that?

A. I -- I don't recall. I know that the case was during the -- just after -- must have been 2021, I believe, but I'm not swearing to that.

Q. And so what post -- we're in -- I hope I found one thing we can agree on today. We're in the year 2023, right?

A. Correct.

Q. March of 2023, correct? What research have you reviewed post 2021 up through today that has altered, impact, or otherwise changed your opinions than those you offered in the Tavistock case?

You mentioned that you looked at additional research. I just want to understand what you looked at between 2021, so all of 2022 and the three months that is 2023, what new research have you looked at?

A. Well, for example, the -- the study on mice, I believe, is -- postdates my Tavistock testimony.

Q. Anything else?

A. Dutch. I mean, many -- many, many Dutch -- of the Dutch articles have come out since then.

Q. Anything else?

A. I can't -- I'm not -- I can't go through and -- and give you every list, every article that has come out between 2021 and 2023, but my bibliography is -- should include all of those.

Q. Right. Well, I don't want to rely on your bibliography. I want to understand what you personally relied on in rendering your opinions in this case that came out post your -- your work in the Tavistock matter.

A. Well, I've -- I've explained -- I mean, several articles from the -- from the -- from the Netherlands.

Q. Uh-huh.

A. There was, for example, another -- it was an article from an Australian clinic that demon- -- that showed -- that had very, very high rates, I think some near 97, 98 percent of -- of children who started releasing hormone agonists continued on to cross-sex hormones. That would be an example.

Q. Okay. Well, let's talk about that for -- for just a second.

Did you interview any of the children that started on GnRH that were referenced in that Australian article?

A. No.

Q. Did you do any analysis of -- of what -- what medical or psychological factors influenced determinations as to whether or not they went on to cross-sex hormones?

A. No.

Q. Did you do any kind of clinical studies to determine whether or not those individuals were indeed transgender?

A. No.

Q. Have you done any kind of clinical studies of -- associated with the Australian article that you represented that 97 to 98 percent of children who went on GnRH went on to take cross-sex hormones?

A. No.

Q. Now, sir, you indicate in your report that you testified, if I understand you correctly, in another matter which you identify as expert witness statement for name suppressed Australian family court, 2022, do you recall that in your report?

A. Correct.

Q. What is that? Putting the name aside for the minute, what was the nature of your testimony, what were you asked to do?

A. It was one of six experts asked by the Australian family court to -- to discuss the case of a child, age 11, who was wanting the -- the mother wanted the child to get puberty blockers, the father did not. And so the conflict came to the Australian family court.

Q. What were you asked to do?

A. I was asked to provide my -- my evidence on

the -- the efficacy and side effects of -- of puberty blockers.

Q. And were you qualified as an expert in that case?

A. I don't believe that the Australian family court system either qualifies or not qualifies experts.

Q. Did you testify in the Australian court?

A. Again, the Australian system does not have testimony from the experts. So I had -- we had an expert conference of -- all the experts on both sides had a meeting to decide where we agreed and where we disagreed. But as in the Keira Bell case, experts did not -- do not testify.

Q. Okay. So were you deposed -- I guess not, because you said you've never been deposed before.

A. Yeah, correct.

Q. So the two matters in which you've been engaged -- just want to make sure I understand it correctly -- to your knowledge, you weren't qualified as an expert in either case, correct?

A. Correct.

Q. And neither case you gave testimony, correct?

A. Correct.

Q. Neither case you gave a deposition,

correct?

A. Correct.

Q. And in the latter case of the Australian family, you said there was an expert conference of the experts on both sides?

A. Correct.

Q. And do the experts make a recommendation to the court?

A. The -- our aim was to -- to decide where we agreed and where we disagreed.

Q. Right. And so my question is, did you -- the six of you, if I got the number right, collectively make a recommendation to the court?

A. No, because we agreed. But we agreed on where we disagreed, if you like.

Q. Okay. Was there any -- any recommendation that you provided to the court in that case?

A. Other than my -- my -- my -- the report that I submitted, no.

Q. Okay. So you did submit a report in that case?

A. Yes, yes.

Q. And that was in 2022, correct?

A. Correct.

Q. And you haven't included that in your

materials in this case, correct?

A. Correct.

Q. In -- in each of those matters, the Tavistock matter and the Australian family matter, were the individuals in those cases suffering from gender dysphoria?

A. Yes.

Q. In both cases?

A. Yes.

Q. And if I understood you correctly, the expertise for which you were retained in the Tavistock matter was to provide your opinions on -- on puberty blockers; is that correct?

A. Correct.

Q. And I think the second basis for your opinions was, according to you, the failure to have provided certain information or disclose certain information, correct?

A. Correct.

Q. Now, in that case, the appeals court determined that medical professionals are -- are indeed qualified to determine whether or not an individual provides consent, correct?

A. Yes.

Q. Now, sir, if I recall correctly, on the

Health and Human Services committee, there were other individuals who testified or spoke -- were speakers along with you, correct?

A. Correct.

Q. One of them was Dr. Laidlaw, correct?

A. Yes.

Q. One of them was Dr. Levine, right?

A. Yes.

Q. Another was Chloe Cole, a detransitioner; isn't that right?

A. Yes.

Q. Was anyone present to speak on behalf of -- of those that support gender-affirming care?

A. I can't recall.

Q. As you sit here today, are you aware of anyone that -- that was invited to speak about the provision of gender-affirming care?

A. I believe the chair of the committee said that he had invited a surgeon in Florida with a very Irish name, I'm afraid it is not on the tip of my tongue, and that she had -- Galica, is it -- Galica her surname? -- and she had refused to attend.

Q. Anything else that you recall about those that believe gender-affirming care is appropriate in terms of their invitation to speak at that committee

meeting?

A. No, I'm afraid I'm not -- I'm not aware of anything.

Q. Fair enough. But you would agree with me that no one did speak on the provision of gender-affirming care in a positive way, correct?

A. I believe not.

Q. Now, sir, you would agree with me that Dr. Laidlaw, Dr. Levine also are against providing gender-affirming care, in particular to minors, correct?

A. Correct.

Q. Do you have any opinions on puberty blockers that -- and I know the answer to this but I'm going to ask it anyway -- as it pertains to adults?

A. No.

Q. Do you have any opinions on the provision of cross-sex hormones as it pertains to adults?

A. No.

Q. Do you have any opinions with regard to cross-sex or -- or surgical procedures as it pertains to adults?

A. No.

Q. Now, at that committee meeting --

MR. BEATO: I apologize, Ms. Altman. I just note that we've been going for about an hour

and 30 minutes. Do you mind if somewhere we work in just a brief five-minute break? I -- I don't mean to interrupt.

MS. ALTMAN: Oh, no, it is okay. Happy to do it right now. That's fine. So five minutes. It is 11:24, why don't we regroup at 11:30.

(A brief recess was taken from 11:24 a.m. to 11:31 a.m.)

BY MS. ALTMAN:

Q. Sir, just to -- to put a finer point on it, other than the opinions in your report on puberty blockers, you are not offering any opinions on cross-sex hormones, correct?

A. Correct.

Q. You are not offering any opinion on the medical care to be received by adults, correct?

A. Correct.

Q. Sir, do you know who finances SEGM?

A. No.

Q. You have no knowledge whatsoever as to who finances that organization?

A. No, I don't.

Q. Do you know how many members it has?

A. I don't believe it has members.

Q. What do you think it has; if they are not

members, what would you call it?

A. Well, there is a board of advisors. I don't know how many people are on the board of advisors, maybe 20, 12. I really don't know.

Q. Do you meet?

A. There is a common library of articles in Zotero, in a software called Zotero.

Q. I assume these articles are all anti providing gender-affirming care to individuals; is that correct?

MR. BEATO: Objection -- object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: No, that's incorrect. It is the literature of rela- -- relevant to gender care.

BY MS. ALTMAN:

Q. Okay. And so you would -- your -- it's your testimony that the literature relevant to gender care is both those that propose it and those that are against it?

A. Yes.

Q. Okay. And do individuals upload information into that database?

A. Yes.

Q. And would that be individuals that are on

the board of advisors or can anyone update or upload information into that database?

A. I don't know. I just use it, so I assume that there are maybe five people who can -- who can upload information. I'm not -- I'm not aware of the details.

Q. Do you know who the five people are?

A. No.

Q. Can you upload information into that database?

A. I don't know if I have uploading permission or not. I've never uploaded anything.

Q. But you indicated that you do use it; is that correct?

A. Yes, if I can come across a reference, then -- and then I can look in the second database to get the article quickly.

Q. Sir, your opinions in this case are limited to puberty blockers, correct?

A. Yes.

Q. And, again, you are not -- you are not providing any opinions relating to gender dysphoria specifically as it pertains to adults, correct?

A. Correct.

Q. Now, sir, at the committee meeting for the

Health and Human Services, you -- you stated that you read published literature regarding gender-affirming care and determined that it was of poor quality, do you recall that testimony?

A. Yes.

Q. What literature specifically did you review that you believe is of poor quality?

A. There -- well, one of the landmark studies would be the de Vries, et al., 2011 and the de Vries, et al., 2014, which was the -- the first cohort of -- well, they started out with 70 children who were -- who got puberty blockers in the Netherlands.

Q. And it's -- it is your position that -- that those -- that published literature was of poor quality, is that your testimony?

A. Yes.

Q. Based on what qualifications, sir, do you have to make a determination that those -- the published literature was of poor quality?

A. Well, it's The National Institute For Clinical Excellence, called NICE, N-I-C-E, in Britain has reviewed -- has reviewed the literature -- that literature with reference to the GRADE system, G-R-A-D-E, of -- of research, where -- where the research is of high quality and low quality, and has assessed those studies

of -- as being of very low quality.

Q. So you've not done any studies to determine whether it's of poor quality or low quality. You are, again, citing to someone else's analysis, correct?

A. I've also considered the -- the literature myself.

Q. When you just answered my question, sir, you referred to NICE's evaluation of whether or not using their grading system it was of low quality; isn't that right?

A. Yes.

Q. Okay. And that's what you were relying upon when you were before the Health and Human Services committee when you represented that the published literature was of poor quality?

A. It's partly -- that's one -- that's one contributor to my judgment. I also base it on the -- my own review of the literature. So another example of poor quality would be very high rates of attrition that are not explained.

Q. Well, let's just focus on that for a second. You didn't try and reach out to the individuals that -- that you claim were no longer available or didn't participate in order to determine their results, did you?

A. Correct.

Q. So you are just saying the -- the mere fact that there was what you refer to as a significant amount of attrition, in your opinion, makes -- makes it of poor quality; is that correct?

A. Yes, that's one factor, yes.

Q. Okay. But as far as you know, those individuals could all be very happy, well adjusted, not suffering from depression or anxiety or any other disease, correct?

A. Correct.

Q. You don't know one way or another?

A. Correct.

Q. So you have no way to dispute the results of those -- the two studies you mentioned, de Vries 2011 and 2014, correct?

A. Correct -- no, actually, hold on. Can I -- can I change my answer there? One -- one -- one example was the -- one of the major findings was the gender dysphoria was eliminated after -- after the -- after the medical procedures. And that is based on the scale, which they changed the scale halfway through the study.

Q. Okay. So that doesn't tell you, sir, that gender dysphoria wasn't eliminated. All you could say is that they changed the scale, correct?

A. Yes --

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

BY MS. ALTMAN:

Q. Right?

A. There was no evidence either way.

Q. Right. So you can't say the evidence is bad or good, correct?

A. If researchers change the scale halfway through a study, that is a sign of very poor research.

Q. Well, sir, while it may be, in your opinion, a sign of very poor research, what it isn't a sign of is individuals who originally had gender dysphoria who no longer suffer from gender dysphoria, correct?

A. Correct.

Q. And you can't testify and you have no information from which you could testify or provide opinions about whether or not any of these individuals indeed were -- received relief from -- from their gender dysphoria because of the medical treatments that they received, correct?

A. Largely correct. I mean, the -- the child who died as a result of surgery, I don't believe that they were cured of their gender dysphoria.

Q. Okay. Well, let's talk about that

individual for a minute. You would agree with me, sir, that that individual, if I'm remembering the one that you referred to in your report, died of a surgical procedure, correct?

A. Yes, correct.

Q. And you would agree with me that the -- the -- to your knowledge, you have no basis on which to opine that puberty blockers had any causation whatsoever in that individual's death; is that right?

A. I disagree because puberty blockers meant that the -- the individual had to go through a more dangerous form of vaginoplasty.

Q. Okay. But, sir, puberty blockers was not the causation of that individual's death, correct?

A. It was indirect -- an indirect cause.

Q. Sir, you understand my question. The person died of a complication from surgery; isn't that right?

A. Correct, but the chance of a surgical complication was increased because of the particular type of procedure they had to undergo because of puberty blockers.

Q. Sir, what medical basis do you have to make that statement? Are you a surgeon?

A. Because the surgeons who -- who performed

that operation stated that that was the reason why they had to undergo that more complicated surgery.

Q. Are you a surgeon?

A. No.

Q. Did you review the surgical notes from that case?

A. I reviewed the article.

Q. I didn't ask if you reviewed the article. I understand the confusion. My question is, did you review the surgical notes of that patient from that case?

A. No.

Q. Did you do any analysis whatsoever of the medical treatment, meaning looking at the actual medical records, of the individual that died in that case?

A. No.

Q. Did you speak to the doctors directly to determine what happened in that particular case to that particular patient?

A. No, they -- they -- there was no need to speak to them because they published an article which described what happened.

Q. So the answer to my question is no, you didn't, right?

A. Correct.

Q. Okay. Have you ever spoken to a surgeon

who provides surgery, gender-affirming surgery, to determine how that procedure is performed today?

A. No.

Q. Have you spoken to any surgeon that performs bottom surgery today to determine what impact, if any, puberty blockers has on their ability to provide such surgery?

A. No.

Q. Sir, are -- are you suggesting or representing to the Court that you've read all of the published literature on the provision of gender-affirming care?

A. No, not all of it, no.

Q. Other than what you've testified with regards to the two de Vries studies, is there any other literature that you reviewed that you believe is of poor quality?

A. I guess there is other research. For example, there is a study by Tordoff, which again had a very high rate of attrition which was unexplained, Tordoff 2022, I believe.

Q. Okay. And, sir, the fact that there is a high rate of attrition doesn't mean that the underlying merits of the study were incorrect; isn't that right?

A. Well, the higher the rates of attrition,

the worse the -- the study because the less inferences can be drawn from it.

Q. Well, I'm talking about the actual care, sir. Just because there is a high rate of attrition doesn't mean that the results of the care that are reported in that study are not correct, are not reliable; isn't that right?

A. Well, we don't know the results for the -- the patients who were -- who -- who were not measured, who did not come back to the clinic, correct.

Q. You don't know one way or the other, right?

A. Correct.

Q. And you can't surmise that -- that their results were bad, can you?

A. Correct.

Q. And -- or the other way around, right, you just don't know?

A. Correct.

Q. And you didn't do anything yourself to reach out to any of the individuals that were part of the Tordoff study that -- that had left the study or weren't reporting back to determine what their -- their results were, did you?

A. Correct.

Q. And I assume you would agree with me that

medical professionals are in a better position to ascertain and weigh the reliability of studies and research in the area of gender dysphoria, correct, sir?

A. Correct.

Q. And you are not suggesting to this Court that as between yourself and a medical director, that you are in a better position to evaluate research than they would be, right?

A. I think one's ability to evaluate should be based on, you know, one's publications, for example.

Q. Okay. And in the committee meeting, the Health and Human Services committee meeting, you said you have published original research of your own, do you recall making that statement?

A. Yes.

Q. Is that the research that we discussed earlier with regard to suicidality and bone density?

A. Yes.

Q. Is there anything else?

A. No.

Q. That you were referring to?

A. No.

Q. What statistical methodology did you employ in your -- your analysis of suicidality?

A. Calculating a -- calculating a rate. So

you have a denominator and numerator. The denominator is the number of deaths and the -- sorry, the numerator is the number of deaths and the denominator is the number of years -- individual years at risk.

Q. So simple math, right?

A. Yes.

Q. But -- but what you also testified and -- and extrapolated that somehow this suicide rate, as compared to healthy teenagers, was greater than 1 percent, correct?

A. I don't recognize what you are saying in the question.

Q. Okay. You don't recall saying that in your report and at the -- at the Health and Human Services meeting?

A. I believe what I said was that the suicide rate of the -- of clinic referred adolescence to the Tavistock was, by my best estimate, about five or six times higher than comparable in the overall population.

Q. Well, let's just make sure we're talking about the same thing so that there is no confusion. So I'm looking at page 5 and 6 of your report. And, again, you were referring to the teenager that died of fasciitis, correct?

A. Can I -- I'm just consulting my -- can I --

Q. Well, I'm going to read you the relevant portion but feel free to pick up your report or we can pull it up on the screen. But I'm at the bottom of page 5 --

MR. BEATO: Would it be best to pull it up on the screen, just so everyone is reading the same thing?

MS. ALTMAN: Yes. I'm going to wake Ana up.

Ana, if you can go to page 5 of the report, Exhibit 2, that would be --

MS. GONZALEZ: I'm here. Let me just share the screen again and I'll take you to it.

MS. ALTMAN: Bottom of page 5.

MS. GONZALEZ: Okay. I'm there.

BY MS. ALTMAN:

Q. Okay, sir, do you see at the bottom of page 5?

A. Yes.

Q. And if we can go on to page 6. There you go, top of page 6. Did I not read that correctly? "In a cohort of healthy teenagers, a death rate exceeding 1 percent is alarming."

A. Yes.

Q. Do you see that now?

A. Yes, yes.

Q. Okay. And so you referred in your -- in your statistical methodology, you compared the death rate to a cohort of healthy teenagers; isn't that right?

A. I'm sorry, when I was -- when I was replying earlier, I thought you were talking about my suicide -- the study of suicide at Tavistock.

Q. Oh, okay. So now that we're -- again, that's why we pulled it up, to make sure we're on the same page. Do you see your opinion in this case?

A. Yes, yes.

Q. Okay. And here you say, "In a cohort of healthy teenagers, a death rate exceeding 1 percent is alarming."

A. Yes.

Q. I read that right?

A. Correct.

Q. Okay. And so you would agree with me that individuals suffering from gender dysphoria are not necessarily healthy teenagers, are they?

A. They are physically -- often physically healthy.

Q. Do you know, sir? Did you do any analysis to determine whether or not the death rate, using the example that you gave, which we'll go into why I don't

agree with it, but did you do any analysis to determine what the death rate of those suffering from gender dysphoria is?

A. We do -- the Amsterdam gender clinic does have a very good -- does actually keep extremely good records of the number of patients it sees and their death rate. And that's -- the death rate is certainly much lower than 1 percent, normally, of its -- of its clinical referred patients.

Q. Well, what is it?

A. I don't have the figures at hand.

Q. Okay. So as you sit here today, you don't know what the death rate is of those that suffer with gender dysphoria, correct?

A. Correct.

Q. And, sir, with regard to this 1 percent that you calculated as some reliable measure of the death rate, you are basing it on one patient who died from a failed surgical proceeding; isn't that right?

A. Correct.

Q. They didn't die from puberty blockers, from the administration of puberty blockers, did they?

A. The administration of puberty blockers increased the risk of dying in surgery because of the effect of -- on -- of the vagio- -- the --

Q. I -- and I heard when you said that before, sir. But you would agree with me that giving puberty blockers did not cause this individual to die. They had a failed result from a surgical procedure; isn't that right?

A. Correct.

Q. And giving cross-sex hormones was not the cause of death of this individual, correct?

A. Correct.

Q. And so you would agree with me, sir, that your statement in your report is grossly misleading to suggest to this Court that there is a 1 percent death rate in this particular study because an individual died from a surgical complication; isn't that right?

MR. BEATO: Object to form.

But, Dr. Biggs, you can answer that.

THE WITNESS: I disagree with that characterization. 70 -- there were 70 patients in the study and one died. So that's a death rate exceeding -- in that study, a death rate exceeding 1 percent.

BY MS. ALTMAN:

Q. And that's -- that's the sole basis for your opinion that the -- that it's an exceedingly high death rate?

A. In that study, yes.
Q. Yeah. And in that study, sir, that study wasn't designed to analyze the efficacy or return rate of surgical procedures, was it?
A. It was designed to look at the Dutch Protocol, which was three -- which had three components; puberty blockers, cross-sex hormones, and then surgeries up to 18.
Q. Okay. And so it's your -- it's your position, based upon your statistical analysis of dividing the numerator and the denominator, that -- that the death rate is greater than 1 percent, correct?
A. In that study, yes. I'm not claiming that that is extrapolating that -- other situations or other -- other groups of patients.
Q. Okay. But that -- your report doesn't say that, does it?
A. It is implied by the -- the wording of the -- of that sentence.
Q. No, sir. What -- what your sentence says, "In a cohort of healthy teenagers, a death rate exceeding 1 percent is alarming." Isn't that what your sentence says in your report?
A. Yes, but it is clearly based on a discussion of those 70 -- of those 70 patients.

Q. But those 70 patients were not healthy teenagers. They were those that suffered from gender dysphoria; isn't that correct?

A. Yes, but they're physically health -- they were physically healthy.

Q. How do you know that, sir, what did you look at in order to make this statement you just made?

A. There was no -- they would not have been given gonadotropin-releasing hormone agonist if they -- if they were not physically healthy.

Q. Have you done any research or analysis to determine whether or not this statement you just made on the record under oath is accurate?

A. That is based on my reading of the 2011 and 2014 articles by de Vries, et al.

Q. Okay. So other than reading those two articles, my question is, have you done any study or analysis to determine whether or not any of the individuals in that 70-person study suffered from comorbidity?

A. No.

Q. Have you done any analysis whatsoever in either of those studies to determine whether or not any of those individuals had -- had other health issues or concerns?

A. No.

Q. Sir, if there are 70 people in a study about puberty blockers and one dies in a car accident, does that mean the death rate as a result of the puberty blockers is greater than 1 percent?

A. No.

Q. And just to -- to make sure I -- I put a pin -- a fine pin in this, in your report, what your statement is, is unrelated really to the 70-person study because you make a blanket general statement that "in a cohort of healthy teenagers, a death rate exceeding 1 percent is alarming," did I read that statement -- that sentence correctly?

A. Yes, you read that sentence correctly, yes.

Q. Now, sir, with regard to puberty blockers, what specific studies or analysis have you personally performed or participated in performing?

A. May we have the full screen again, if we're finished with that expert -- or do you want to keep it?

Q. You mean you would like to take away the expert report?

A. No, just -- I mean, it just -- just it might be easier just so I can see.

Q. Sure, sure, sure. I just want to make sure I understood your request.

A. So --
Q. And, actually, before you answer that question, I have a different question for you.
Do you have anything other than our names and our pictures up on your screen in front of you?
A. No.
Q. Are you reading from any e-mails?
A. No.
Q. Are you reading from any texts?
A. No.
Q. Are you receiving, reviewing, or reading any e-mails, texts, or other information about your testimony in this case today?
A. Absolutely not.
Q. Okay. Excellent. So do you have any materials in front of you?
A. Yes, I have the printed-out deposition -- or sorry, the report, report, expert report.
Q. No worries. Anything else?
A. No.
Q. Anything else up on your screen?
A. No.
Q. Okay. So now I go back to my question. With regard to puberty blockers, what specific studies or analysis have you personally performed or participated in

performing?

A. I have not personally performed any studies on -- on puberty blockers.

Q. Have you participated in performing any studies on puberty blockers?

A. No.

Q. Now, sir, I did listen to your testimony before the Health and Human Services committee, and one of the things you said during that committee meeting is that puberty-blocking drugs perform, and I quote, "chemical castration," do you recall that testimony?

A. Yes.

Q. And is that an opinion that you are rendering in this case, that puberty blockers perform chemical castration?

A. Well, if they block the -- the production of sex hormones.

Q. Well, you didn't say that, sir, you said chemical castration.

A. Correct.

Q. You would agree with me those are two different things. One sounds pretty ominous, right?

MR. BEATO: Object to form.

But, Dr. Biggs, you can answer that.

THE WITNESS: Yes, castration is -- does

sound ominous, yes.
BY MS. ALTMAN:
Q. Correct. But you chose to use those words in the Health and Human Services committee meeting, right, "chemical castration"?
A. Yes.
Q. Because you wanted to send a particular message, right?
A. Correct.
Q. You could have said they blocked the production of sex hormones, right?
A. Correct.
Q. And you could have also said that once you stop taking puberty blockers, the production of sex hormones reignites, correct?
A. Yes.
Q. But you didn't do that, did you, sir?
A. No.
Q. Why?
A. Because in 93 or 95 or 98 percent of cases, the child will continue on to cross-sex hormones. It's -- it's very unusual for a child to stop taking hormone agonists.
Q. But, sir, the puberty blockers does not, in fact, create or -- or result in chemical castration;

isn't that correct?

A. Correct.

Q. But that's not what you said to the Health and Human Services committee, right? I assure you, I've listened to your testimony.

A. Correct.

Q. You said that puberty blockers performed chemical castration. That's not correct, is it, sir?

A. Well, that is the terminology that is used when the drugs are used for, let's say, people -- a man with severe sexual disorders.

Q. But we're not talking about that, sir, and you weren't talking about that before the Health and Human Services committee, were you, about a pedophile, right?

A. That's the same drugs, it's the same drugs being used in the same dose.

Q. Sir, do -- are puberty blocker -- puberty blockers used for gender dysphoria in perpetuity?

A. Not normally, no.

Q. Okay. So we're not talking about the same thing, are we, sir?

A. They are also not used in perpetuity necessarily for -- for men with severe sexual deviation.

Q. Sir, why did you not tell the Health and

Human Services committee that puberty blockers merely block the production of sex hormones until you stop using them?

A. Because I wanted to draw the parallel with their use in -- in prisons and mental institutions.

Q. Is that where you believe people with gender -- gender dysphoria belong, in prisons and mental institutions?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that.

THE WITNESS: No.

BY MS. ALTMAN:

Q. Then why would you draw that parallel?

A. I draw that parallel because the same drugs are being used in -- to -- to chemically castrate sex offenders as a -- used for gender dysphoric youth.

Q. And they are also used for precocious puberty, right?

A. Yes.

Q. And they are also used for endometriosis, correct?

A. Correct.

Q. Well, why didn't you draw one of those parallels?

A. Because for endometriosis, for example,

they would be used for a much shorter period of time than they are used for -- for gender dysphoric youths -- youth.

Q. What about for puberty -- for precocious puberty, sir, they can be used for years in precocious puberty?

A. Precocious puberty means -- use of -- the use for precocious puberty means blocking an abnormally early puberty in order to allow natural puberty to commence at the -- at the sort of more appropriate time, which is very different from stopping natural puberty altogether.

Q. Sir, the reason you chose to use the words "chemical castration" was because you wanted the committee in that particular case to see puberty blockers utilized in some way as -- as a lethal medication rather than its actual use in treatment of gender dysphoria; isn't that right?

A. No, I disagree that -- that the -- that puberty blockers are ever a lethal -- a lethal medication. I mean, that's -- that's not how I would cast -- how I would characterize puberty blockers, as lethal.

Q. Really? Well, then I'm sorry. Then I guess we can go back to your greater percent -- greater

than 1 percent death rate a few minutes ago when you attributed this one death to puberty blockers.

So which one is it, is it lethal or is it not lethal?

A. Lethal suggests that it has a very, very high rate of -- of -- of death or, indeed, inevitably causes death. That is not my -- that has never -- not and never been my -- my -- my position.

Q. It hasn't. Even when you said in your report "in a cohort of healthy teenagers, a death rate exceeding 1 percent is alarming"?

A. Alarming, yes.

Q. Alarming, okay. So -- so back to your -- your testimony. What do you mean by the terminology that you use, chemical castration? What did you mean by that when you said that to the committee?

A. I wanted to draw the parallel between the use of the same -- the same drug in the same dose to children who are suffering from gender dysphoria to the use of men with severe sexual deviation.

Q. Do you think people who suffer from gender dysphoria have -- are sexual deviants?

A. Absolutely not.

Q. Do you believe people who are transgender are sexual deviants?

A. Absolutely not.
Q. But yet you chose to make that parallel before the Health and Human Services committee, right?
A. Correct. The parallel is saying that maybe we should take -- think twice before providing the same sort of drugs that -- with those effects to young children as we do to men with sexual deviation.
Q. Uh-huh. And the people that should think twice, though, are those people that are qualified to render medical opinions, right?
A. I think everybody should think twice about it.
Q. Uh-huh. Other than what you've testified on the record and what's contained in your report, what is the specific bases for your testimony that providing puberty blockers is equivalent to chemical castration?
A. It's my review -- review -- reading of the two articles -- or three articles reviewing the use of gonadotropin-releasing hormone agonist for sex offenders or for men with -- with severe deviation. One of the articles is Dutch, one of them is American, and one is English.
Q. Anything else?
A. No.
Q. As a sociologist, sir, what qualifications

do you have to make such a statement?

A. I read the -- I read those articles and I looked at the -- the drugs that were being used and the dose that they were being used, and I compared those to the -- to the literature on gender dysphoria.

Q. And any other basis, sir, on which you believe you are qualified to make such a statement?

A. No.

Q. What studies have you performed on this issue other than reading other people's research on the subject?

A. None.

Q. Now, sir, you would agree with me that GnRH merely suppresses certain hormones while the person is taking the medication; and that once they stop the medication, they typically begin producing the hormones that were suppressed, correct?

A. Correct.

Q. And you are not rendering an opinion in this case to the contrary, are you?

A. No.

Q. And you are not offering an opinion on the medical efficacy of puberty blockers for those with gender dysphoria, are you?

A. I'm not sure I understand the question.

Q. I'm happy to rephrase it. Are you offering any opinions in this case on the medical efficacy of gender-affirming care?

A. I'm offering opinions on -- on puberty blockers, yes.

Q. Okay. And, specifically, other than what you've testified on the record, do you have any other opinions about puberty blockers other than what you've already testified on the record?

A. No.

Q. And you are not qualified, sir, to render any opinion on whether or not there are any medical side effects to puberty blockers, are you?

A. No.

Q. And as you sit here today, you have no medical training or experience that would qualify you to render any such opinions; isn't that right?

A. Correct.

Q. Now, you would agree with me, and I believe you've already acknowledged, that puberty suppressors are prescribed to children with precocious puberty, right?

A. Yes.

Q. Precocious puberty occurs in children, correct?

A. Yes.

Q. Sometimes as young as 5, I believe, according to your own testimony, correct?
A. Yes.
Q. And for how many years might those children take puberty blockers?
A. I believe up until the age of around 9.
Q. So it could be as much as four or five years, correct?
A. Correct.
Q. And you would agree that that's a standard protocol for precocious puberty if in a five-year-old, might be to give them puberty blockers, correct?
A. Yes -- yes.
Q. And you agree that when a child stops taking the puberty blockers, he or she should begin normal puberty as usual, correct?
A. Yes.
Q. I would assume, sir, since you are not a doctor or a pharmacist, you've never prescribed puberty -- puberty suppressors for children experiencing precocious puberty, have you?
A. Correct.
Q. And you are unqualified to do so, correct?
A. Correct.
Q. Have you performed any research in the area

of providing puberty suppressors to children with precocious puberty?

A. No.

Q. You seem to be very interested in the provision of puberty suppressors to children. Why have you not engaged in any research of providing children with precocious puberty -- puberty suppressors?

A. Well, that's not -- just not a topic that I've investigated, except insofar as it pertains to gender dysphoria.

Q. Well, it's the same thing, right, it's providing puberty blockers to children, right? Different diagnoses but both to children, correct?

A. At a different -- at a different age as well.

Q. One, generally teenagers, one younger, correct?

A. Precocious puberty, let's say, a child may start puberty at 5 and they would be stopped until 8 or 9, and then they would allow their normal puberty to continue to -- to emerge.

Whereas for gender dysphoria, you are stopping and you will not -- typically, in 93 and 95 and 98 percent of cases, you will -- the child will never experience puberty.

Q. Well, sir, you would agree with me that -- that it would be up to the minor, their parents, and their medical professionals whether or not they would go on to take cross-sex hormones; isn't that right?

A. Correct.

Q. It's not up to you to decide that, is it?

A. Certainly not up to me, correct.

Q. Okay. And you would agree with me that -- that the child, the parent, and the medical professional is in the best position to make those determinations, correct?

A. Well, it would have to be based on the evidence, right.

Q. But -- but not you, right?

A. Not me personally but on the -- on the evidence.

Q. Right. And it's not your testimony, as -- as you are providing to the Court, that the medical professionals that are treating these individuals aren't as facile with the medical literature as you are?

MR. BEATO: Object to form.

BY MS. ALTMAN:

Q. That's all right. It was a bad question, I'm going to withdraw it.

Sir, it is not your testimony or your

opinion in this case that medical professionals -- well, strike that.

It is not your testimony, sir, that you are the only individual that's reviewing medical literature with regard to the treatment of gender dysphoria and puberty blockers, is it?

A. No; that's correct.

Q. You would agree with me that other individuals, even myself, could read the same literature that you are reading and draw conclusions from it, correct?

A. Correct.

Q. And -- and, in fact, they might draw different conclusions than you, correct?

A. Yes.

Q. Have you ever provided an opinion that giving GnRH to children for precocious puberty will impact their -- impact their brain development?

A. No.

Q. Have you ever provided an opinion that giving GnRH to children for precocious puberty will impact their bone density?

A. No.

Q. Have you ever provided an opinion that giving GnRH to children for precocious puberty is a -- is

equivalent to the chemical castration?

A. No.

Q. But these are all opinions that -- that you've rendered in this case when that same drug is given for gender dysphoria, correct?

A. Correct.

Q. You believe providing puberty blockers for precocious puberty will impact a child's mental health?

A. I have no opinion on that.

Q. Have you -- have you performed any independent research whatsoever with regard to providing puberty blockers to children with precocious puberty?

A. No.

Q. Do you believe that providing puberty blockers to children for precocious puberty will impact a young child's sexual function?

A. I have no opinions on that.

Q. But you do have an opinion on it when it comes to providing that same drug for those with gender dysphoria, right?

A. Yes.

Q. And those opinions are encapsulated in your report in this case, correct?

A. Correct.

Q. Are you qualified to determine when a child

has precocious puberty?

A. No.

Q. Would you agree with me or do you agree with me that you are not qualified to opine on the physiological differences in administering GnRH to a five-year-old with precocious puberty versus a 13-year-old who is evidencing gender dysphoria, correct, sir?

A. Correct.

Q. Who diagnoses precocious puberty?

A. An endocrinologist.

Q. Who diagnoses gender dysphoria?

A. It would usually be a psychologist.

Q. You would agree with me that in neither case it is a sociologist, right?

A. Correct.

Q. Who determines the course of treatment for a child with precocious puberty?

A. An endocrine -- endocrinologist.

Q. Who determines the course of treatment for a child with gender dysphoria?

A. It would be a psychologist, perhaps with a endocrinologist as well.

Q. You would agree with me it is not a sociologist, correct?

A. Correct.

Q. In your testimony, you told the Health and Human Services committee that taking GnRH decreases bone density, right?

A. Yes.

Q. But, sir, you are not qualified to render an opinion on the medical impact of using puberty blockers with regards to bone density; as you've already testified, all you've done is read other people's research, correct?

A. No. I've conducted my own statistical analysis of the bone density that was produced by data from the -- from the Tavistock.

Q. And that's what we talked about earlier, right, those were other people's scans and analysis, and then you just relied on that, correct, you didn't do the scans yourself?

A. I did not do the scans myself.

Q. Right. So you are relying upon, you know, the -- the quality of somebody else's work, correct?

A. Correct.

Q. Good or bad?

A. Correct.

Q. What education, skill, or training do you have that would enable you to provide opinions on the

medical consequences of using puberty blockers?

A. Well, I have a Ph.D. in -- from Harvard for -- which gives me an ability to look at quantitative research and to analysis literature.

Q. And your Ph.D., sir, was not in anything related to the treatment of gender dysphoria, correct?

A. Correct.

Q. And it wasn't anything related to the use of puberty blockers, was it?

A. Correct.

Q. And, sir, you would agree with me that if there were any side effects from taking puberty blockers, they would be the same whether someone takes it for precocious puberty or gender dysphoria, correct?

A. Well, that would depend on what age they took it and for how long.

Q. Okay. But you would agree with me, depending upon what age they are and how long they took it, the side effects could be the same, correct?

A. Yes.

Q. Have you ever advocated that puberty blockers not be given to children for precocious puberty?

A. No.

Q. And you are not suggesting to this Court that it has an impact on bone density only when it is

given for gender dysphoria, are you?

A. No.

Q. Could have an impact in precocious puberty, right?

A. It could, yes. That's not my --

Q. And -- and it would be up to medical professionals -- not yourself as a sociologist -- if giving puberty blockers, to monitor the patient to whom they are given, correct?

A. Correct.

Q. And they would do testing, correct?

A. Correct.

Q. And if they saw issues, vis-à-vis decreases in bone density, they could take medical intervention as a result of that, correct?

A. Yes.

Q. And that's true whether they were given for precocious puberty or gender dysphoria, correct?

A. Yes. But the -- the crucial difference is the age at which you are doing -- doing the intervention.

Q. Because you believe that at -- at a -- at an older age, the level of hormones increase -- the increase in hormones has a greater impact on bone density, is that your position?

A. Bone density is laid down in adolescence,

yes. So that's the -- that's the most important time in which you are laying down the -- the bone density for which you are using -- you are -- for life -- you know, you are then using it for the rest -- for the rest of your life.

Q. And you would agree with me, sir, that those that are prescribing puberty blockers for those with gender dysphoria during adolescence have the ability to monitor those patients, correct?

A. They do have the ability to monitor the patients, yes.

Q. And they have the ability to utilize medical intervention if they see decreases or impact on bone density, correct?

A. I don't know that there is any medical intervention for decreases in bone density. The only -- they are recommending taking vitamin D and more weightbearing exercise. I suppose vitamin D is medical intervention.

Q. Well, you just named two of them right there, right?

A. Yes.

Q. Okay. And there might be others. You don't know because you are not a medical doctor, correct?

A. Correct.

Q. Now, in your testimony before the committee, you referenced -- and I believe this is also in your report -- one individual who had -- at 15 had osteoporosis, do you recall that?

A. Yes.

Q. Did you review that individual's medical records to determine the origin or diagnosis of that person's osteoporosis?

A. No.

Q. You would agree with me that -- that many teenagers who are not -- do not suffer from gender dysphoria and don't take puberty blockers can have osteoporosis, correct?

A. Yes.

Q. And yet you chose to suggest to the Health and Human Services committee that this one individual, because they had osteoporosis, it was in some way related to puberty blockers, even though you had absolutely no basis to make that statement; isn't that correct?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: Are we -- are you referring to the English child that I mentioned or the Swedish child?

BY MS. ALTMAN:

Q. The 15-year-old child. I don't have -- I can pull up your audio from the Health and Human Services. I honestly don't remember if she was Swedish or English. But regardless, you didn't do any investigation whatsoever to determine whether or not there was a pre-existing condition or reason for the osteoporosis; isn't that right?

A. The Swedish clinicians were so concerned about this case that it changed their policy on giving puberty blockers. So the Swedish had made that determination.

Q. Did you understand my question?

A. Yes.

Q. Did you understand my question?

A. Yes.

Q. Do you need me to ask it again?

A. Sure.

Q. Okay. My question is, you didn't do any independent research or analysis to determine whether or not the 15-year-old that you referenced in your testimony before the Health and Human Services committee had any pre-existing condition or other reason that she suffered from osteoporosis; isn't that right?

A. I did not, no. I was repeating what the Swedish clinicians had found.

Q. Right. You were repeating somebody else's research, correct?

A. Yes.

Q. Okay. And you didn't do any independent study or analysis to determine whether or not that particular individual that you represented to the Health and Human Services committee in a way as to suggest that the osteoporosis was derived from giving the puberty blockers. You did not do any independent analysis to determine whether that's correct; isn't that right?

A. Yes.

MR. BEATO: Object to form.

But, Dr. Biggs, you can answer the question.

BY MS. ALTMAN:

Q. I think he said I was right, correct?

A. Yes.

Q. As you sit here today, you don't have any basis to testify under oath that the individual you noted to the committee was diagnosed with osteoporosis because of receiving puberty blockers; isn't that true?

A. I was reporting what the Swedish -- the Swedish doctors had found.

Q. Right. And so what I said was true, correct, you have no basis under which to testify to this

Court or to have testified before the committee under oath that the individual you noted was diagnosed with osteoporosis as a result of receiving puberty blockers, correct?

A. No, I disagree with that characterization. I did have a basis for my statement. The statement -- the basis was based on the -- the conclusions drawn from the -- by the Swedish clinicians.

Q. And you don't know, as you sit here today, whether or not anyone, whether it is in the Swedish clinicians or the English ones, whether or not they did any independent analysis to determine whether or not the 15-year-old's osteoporosis was caused from factors other than or in addition to puberty blockers; isn't that correct?

A. Yes.

Q. And, sir, even though -- well, strike that.

You would agree with me that there is no consensus on any long-term impact on bone density with regards to the use of GnRH alone or with cross-sex hormones; isn't that correct?

A. No, there is a consensus.

Q. Of the long-term impact? What is the consensus, sir, in your opinion?

A. Well, the consensus is that puberty

blockers will reduce bone density or bone density will not accrue as fast as it should, so it will reduce relative to the age and sex. And then in some cases it will increase again with cross-sex hormones. But it will not increase -- it will remain below the level relative to age and sex than it was at the commencement.

Q. Okay. And other than what you just said, do you have any other opinions on that subject?

A. No.

Q. And so if I understood you correctly, you agree with me that providing cross-sex hormones, at that point an individual's bone density would accrete, perhaps not at the same level, but would continue to accrete while they are taking cross-sex hormones, correct?

A. Yes, but they do not reach the level at which they -- they remain below where they were in terms of relevant to age and sex.

Q. Okay. And you don't know -- as you sit here today, you have no ability to opine or provide an opinion on whether or not that will have any long-term detrimental impact on any individual's life, correct?

A. Well, we know that the lower your Z-score, typically below 2.5, the more likely you are to have osteoporosis in later life.

Q. And as you sit here today, sir, you can't

testify or provide an opinion on how many individuals who took puberty blockers and then cross-sex hormones will suffer with osteoporosis later in life, correct?

A. Correct.

Q. You have no basis to provide an opinion in this court on that subject, correct?

A. Well, this is -- if we know that people that -- that have a Z-score minus 2.5 are very high -- are very likely to have a very high risk of osteoporosis than -- in -- later in life, then we know that if we have a group of people with a large number below minus 2.5, then the risk of them developing osteoporosis later in life is elevated.

Q. Okay. And my question is, as you sit here today, do you know how many people with a Z of less than minus 2.5, who took puberty blockers and cross-sex hormones, suffer from osteoporosis?

A. No, there is no published study on that.

Q. Okay. Have you taken any steps to conduct a published -- conduct and then publish a study on that?

A. No.

Q. But it sounds like it is something important to you, correct?

A. Yes, yes.

Q. And you are espousing that concern in the

Health and Human Services committee and in your report in this case, correct?

A. Yes.

Q. Well, sir, what have you done to study it?

A. I don't have access to the patients to study it. But I believe that that's an -- that is an urgent thing for, for example, the Tavistock gender clinic to have -- to study.

Q. Okay. And what have you done to try and create interest in studying this issue?

A. Publishing a letter to the editor in the journal of pediatric and endocrinology and metabolism showing that the -- that the initial results of puberty suppression after two years are very -- unusually high number of children have low bone density.

Q. And anything else that you've done other than publish your letter to the editor?

A. That's the main thing I've done, yes.

Q. And you haven't independently studied this, correct?

A. Correct.

Q. Sir, you would agree with me that it is a medical doctor, not a sociologist, who determines whether or not GnRH should be used with a patient, correct?

A. For an individual patient, yes.

Q. Sir, what is the basis of your statement that you made at the Health and Human Services committee, what is the scientific basis for the statement that the purpose of treating someone with puberty suppressors who has been diagnosed with gender dysphoria is, and I quote, "to begin taking cross-sex hormones for the rest of their lives."

What is the scientific basis for that statement that you made to the committee?

A. Because that is the explicit stages of the -- in the Dutch protocol. First stage is puberty suppression, second stage is cross-sex hormones, and the third stage is surgery.

Q. Well, sir, that's not the statement you made. And I just want to make sure we unpack it. You told the committee that the purpose of someone taking puberty suppressors for gender dysphoria is to begin taking cross-sex hormones for the rest of their lives. What is your scientific basis for that statement?

A. This is the rationale that was advocated by the Dutch clinicians, like Peggy Cohen-Kettenis and Gooren and Henrietta Delemarre-van de Waal -- quite a mouthful -- of why puberty blockers were -- why they advocated for puberty blockers.

Q. But I didn't ask what their scientific

basis is. I asked what yours was. What is your scientific basis for making that statement to the Health and Human Services committee?

A. Reading the explicit statements by the advocates for puberty blockers.

Q. The Dutch Protocol?

A. Yes.

Q. And that was how long ago?

A. Well, the -- that was in -- well, that -- published many things from the 1990s to -- down to today.

Q. Okay. And -- but your specific rationale for that statement was the Dutch Protocol, correct?

A. Yes.

Q. Okay. And that's one study, correct?

A. The Dutch Protocol is a generic term to describe the use of puberty -- early puberty suppression followed by cross-sex hormones.

Q. Right. And you --

A. When it was adopted in America, it was known as the Dutch Protocol. When it was adopted in Britain, it was known as the Dutch Protocol. That's the generic name for it.

Q. I got that. And so my question, though, sir, is a little more nuance. And that is, you made a statement that the purpose of taking puberty suppressors

in those -- in those diagnosed with gender dysphoria, is to begin taking cross-sex hormones for the rest of their lives. That's what you said.

And, sir, you would not be in a position to determine for any specific patient on any specific day in any -- with any specific doctor what the purpose that they were prescribed puberty suppressors was; isn't that right?

MR. BEATO: Object to form.

But, Dr. Briggs, you can answer that.

BY MS. ALTMAN:

Q. Do you understand the question?

A. Yes, but the -- the rationale of this is to enable the individual to pass better to prevent the development of secondary sex characteristics. So --

Q. Sir, you don't know what anyone's individual purpose is in taking puberty suppressors; isn't that right? That's between an individual, their family, if they are a minor, and their physician; isn't that correct? You can't jump into the mind of any particular person and determine what their purpose for taking puberty blockers is; isn't that right?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: I certainly can't jump into

the mind of any particular person, correct.
BY MS. ALTMAN:
Q. And so you make these broad sweeping statements that the purpose of taking puberty blockers is to take -- is so that they can take cross-sex hormones for the rest of their life. But that's up to the individual, isn't that correct, and their physician and their family; isn't that right?
MR. BEATO: Object to form.
But, Dr. Biggs, you can answer that question.
THE WITNESS: Yeah, I mean, we know that not -- from 93, 95, 97, 98 percent of children who go on puberty blockers will continue to cross-sex hormones.
BY MS. ALTMAN:
Q. Did you understand my question?
A. Yes, and I answered it.
Q. No. You told me the percentages of people that you believe will go on to cross-sex hormones. You didn't answer my question, which was, the decision of whether or not to take puberty blockers and the decision whether or not to take cross-sex hormones is not one for you to make. It is between a patient, their physician, and their parents; isn't that correct?

A. Correct.

Q. And you would agree with me that the purpose of taking puberty blockers at a time when a person is experiencing distress due to gender dysphoria is actually to alleviate the distress for the child; isn't that correct?

A. That's possibly the short-term aim, yes.

Q. Sir, have you reviewed any studies that attributed a greater than 1 percent death rate in healthy teenagers for those taking puberty blockers?

A. No.

Q. What is the death rate of children diagnosed with gender dysphoria who are prohibited from receiving gender-affirming care?

A. I don't believe we know that -- those figures.

Q. Sorry about that.

What research have you performed on the impact of children with gender dysphoria who are prevented from reading -- from receiving gender-affirming care?

A. I've not conducted such research.

Q. Since you professed to be interested in the subject matter, why have you not undertaken any independent research into what medical interventions can

assist those with -- those suffering from gender dysphoria?

A. Can you repeat the question, sorry.

Q. Sure. You seem to be interested in -- if I understand what your report is in this case and your testimony before the Health and Human Services committee, and the two cases in which you indicate in your report that you participated in, you seem to be interested in puberty suppressors and those with gender dysphoria.

Did I get that right?

A. Yes.

Q. Okay. And so, since you seem to be interested in the subject matter, why have you not undertaken any independent research into what medical interventions can assist those suffering from gender dysphoria?

A. I'm concerned about puberty blockers and that's the thing that I've been focused on.

Q. But we talked about -- talked about it earlier. You are very concerned about puberty blockers but only as it pertains to gender dysphoria, not as it pertains to precocious puberty, correct?

A. Yes.

Q. What is the death rate of children diagnosed with gender dysphoria?

A. I don't think we have figures -- any figures -- any sort of figures that would be, you know, generalizable across different situations.

Q. In your testimony before the Health and Human Services committee, you acknowledge that "puberty suppressors for gender dysphoria have been provided for more than a quarter of a century," that's a quote; isn't that correct?

A. Yes.

Q. As you sit here today, are you aware of a single death caused by an individual who was diagnosed with gender dysphoria and was also taking puberty suppressors?

A. Well, the individual we discussed earlier who died of the necrotizing fasciitis, that I would -- I think that was an indirect consequence of puberty blockers.

Q. Anyone else?

A. No.

Q. And what about, as you sit here today, are you aware of a single death caused by anyone who initially took puberty blockers and then cross-sex hormones and that their death was a consequence of taking cross-sex hormones and puberty blockers?

A. No.

Q. Now, you told the committee that one of the more serious concerns of taking puberty suppression medication along with cross-sex hormones is the impact on sexual function, correct?

A. Yes.

Q. Sir, again, you are not qualified to render an opinion on whether or not puberty suppressors impact sexual function; isn't that correct?

A. Well, I can render an opinion by quoting Dr. Marci Bowers, for example.

Q. So you can -- it is your opinion that you can give an opinion based on someone else's opinion?

A. Well, that's Marci Bowers' experience, yes. Not just --

Q. Well, it is not your experience, is it, sir?

A. No.

Q. And you don't have any basis under which you can provide any testimony to this Court that taking puberty blockers impacts sexual function; isn't that correct?

A. That would -- basis for that would be my reading of the literature, again.

Q. Okay. Have you conducted any studies or research with regard to sexual function other than

reading Marci Bowers?

A. No.

Q. Conducted any peer-reviewed studies?

A. No.

Q. And I think you also mentioned in your testimony before the Health and Human Services committee that there is an unknown impact on emotional, cognitive development, do you recall saying that?

A. Yes.

Q. And you say that in your report as well, correct?

A. Yes.

Q. And so this unknown emotional, cognitive development, if it's unknown, it means you don't know whether there is such an impact; isn't that right?

A. Correct.

Q. So you are just kind of throwing it out there for open discussion?

A. Well --

(Simultaneously speaking.)

BY MS. ALTMAN:

Q. -- whether or not that might be the case?

A. The Dutch clinicians have continued to emphasize that they have known -- no idea of what the cognitive and emotional effects will be. And they can --

they state that many times over -- in many articles.

Q. They do. And so you've repeated that, and I appreciate that. But as we sit here today, sir, "they have no idea" means there could be none, right?

A. Correct.

Q. But, nonetheless, you include that in your report and you talked about it at the Health and Human Services committee, right?

A. Yes, but I think randomized clinical trials on animals provide good evidence. And this is the best evidence because it is based on randomized clinical -- randomized trials, that there are broad -- broad impacts of puberty suppression on emotional, cognitive development in nonhuman animals.

Q. Is that the mice study that you referred to in your report?

A. Mice, sheep, and also there is a primate study as well. I don't remember exactly which -- what type of primate --

Q. Did you rely on that primate study in forming your opinions in this case?

A. Not the prime -- the primate study I know about from one of the rebuttals.

Q. Right. Again, you didn't rely on that in rendering your opinions in this case, correct?

A. Correct.
Q. You have not personally performed any studies on any impact on the emotional, cognitive development, correct?
A. Correct.
Q. And there is no studies, that you are aware of, that there is any impact on cognitive IQ, either, right?
A. There are some studies on cognition.
Q. What studies are you referring to?
A. There was one by the Dutch clinicians about the tower of London exercise and the tower -- and they showed that puberty blocked -- children with puberty blockers did perform less well on executive functioning than the controlled group. But it was a very small sample.
Q. How small?
A. I don't remember off the top of my head. It wasn't significant. But it was a...
Q. It was not significant -- statistically significant, correct?
A. It was statistically significant.
Q. It was significant, okay. And you say you don't recall the name of the study?
A. The first author was Stufforsus (Phonetic),

I think some Dutch name like that.

Q. Is it cited in your report?

A. I can't remember whether I cited that particular article.

Q. Did you rely on it for your opinions in this case?

A. Yes, because I've cited it in the -- I believe I've cited it in my article with the Dutch Protocol. I've certainly known about that study for a while.

Q. Okay. Now, as you sit here today, sir, you are not qualified and cannot render an opinion to this Court that GnRH has any negative impact on cognitive development; isn't that right?

It's just a question, it's an open question, right?

A. I believe that the animal studies strongly are suggestive that blocking normal puberty for quite a few years will have cognitive and emotional effects. Effects on --

Q. You believe that based on reading other people's work, right?

A. Yes.

Q. Not any independent research of your own, correct?

A. Correct.
Q. Sir, have you reviewed the Tower of London study?
A. I've read it, yes.
Q. Have you read Dr. Edmiston's rebuttal report in this case?
A. Yes.
Q. And you would agree with me that he says that the Tower of London study shows no effect on -- of GnRH on executive function, do you agree with that?
A. No, I disagree.
Q. No, did you see that in his report, is my question?
A. I did see it, yes.
Q. Okay. So you two have a difference of opinion, right?
A. Yes.
Q. Okay. And you would agree with me, reasonable people can disagree, correct?
A. No. I went back to look at the abstract and the abstract says very clearly that there was a difference.
Q. You would agree with me, Dr. Edmiston is a medical doctor?
A. Yes.

Q. And you are not, right?
A. Correct.
Q. And you would agree with me that the impact on emotional, cognitive development would be the same whether it is prescribed for precocious puberty or gender dysphoria; isn't that right?
A. Well, it's -- it's prescribed at completely different ages for those two conditions.
Q. Do you understand my question?
A. I don't believe the two are directly comparable because precocious -- GnRH for precocious puberty is prescribed much -- at much younger ages than GnRH for --
Q. Fair enough. What impact does GnRH have on the emotional, cognitive development with those precocious puberty?
A. I don't think we have -- well, I think there are a few studies that -- again, very small, that suggest that may be deleterious effects on IQ for precocious puberty.
Q. Okay. But doctors haven't stopped prescribing GnRH for those with precocious puberty because of those studies you just mentioned, have they?
A. I believe there is more caution now, but I'm not an expert, so I wouldn't like to really state my

claim on that.

Q. You don't know one way or another, right?

A. Correct.

Q. And you haven't analyzed it, correct?

A. Correct.

Q. And as you just said, you are not an expert, right?

A. Not -- I have not reviewed extensively the literature on precocious puberty, no.

Q. Right. Or on the impact of GnRH on individuals who were diagnosed with gender -- with precocious puberty who are taking it, correct?

A. For precocious puberty, correct, yes.

Q. I think I said that, precocious puberty, correct, okay.

Now, you mentioned a recent randomized test on mice that were -- GnRH was provided to mice and it showed high level of stress and anxiety, correct?

A. Yes.

Q. You didn't perform that study, did you, sir?

A. No.

Q. Have you ever asked an individual diagnosed with gender dysphoria what psychological impact taking puberty blockers has had on him or her?

A. Yes.
Q. And is that the one individual you mentioned earlier from the Dutch Protocol, I forget their name?
A. Yes.
Q. Anyone else?
A. Yes.
Q. Who? I think it was -- [redacted] was the one you mentioned earlier?
A. Yes. Keira Bell.
Q. Okay. Anybody else?
A. No.
Q. So two people, right?
A. Yes.
Q. Has anyone stopped you from speaking to individuals with gender dysphoria who are taking puberty suppressors, which you profess to be interested in, from finding out the specific impact that it's had on them?
A. No.
Q. Now, if I understood your testimony before the Health and Human Services committee, you said that "puberty blockers should only be offered in a proper randomized controlled trial," do you recall saying that?
A. Yes.
Q. Do you believe that's true for those with

precocious puberty also?

A. Yes. In fact, there have been some randomized control trials used for precocious puberty.

Q. And what were the results of those?

A. The results were that it has very -- the only rationale for treatment for precocious puberty is the effect on height. And unless you start very young, that the -- the actual gains in height from block -- stopping -- from stopping precocious puberty are minimal.

Q. Okay. Anything else?

A. No. Not --

Q. Now, sir, could you explain to me how can you conduct a -- to use your words, a proper randomized control trial if the medical care has been prohibited?

A. You can't.

Q. But you think that's what's necessary in order to utilize puberty blockers for those with gender dysphoria, is a proper randomized control trial, right, that's what you told the Health and Human Services committee?

A. Yes. I believe that puberty blockers should be offered only as part of a randomized control trial, yes.

Q. Uh-huh. And in order to do a proper randomized control trial, you need to be able to provide

such care, correct?

A. Yes.

Q. Sir, you also spoke at the Florida Board of Medicine meeting relating to the development of rules regarding gender-affirming care on October 28, 2022, correct?

A. Yes.

Q. And I don't know if you saw the agenda for that meeting, but you are identified as an MD?

A. That was not my -- that was a mistake, yeah.

Q. Right. I just -- did you correct them on that? Did you --

A. This is the first time I've heard -- the first time I've heard of it.

Q. Okay. And you were listed on that agenda, if you are aware, as a subject matter expert, do -- are you aware of that?

A. I did not -- I don't believe I saw the agenda.

Q. Okay. But do you consider yourself a subject matter expert?

A. Yes, based on my publications, yes.

Q. And the subject matter which you are an expert is reading other people's research and then

reporting on it, is that the subject matter in which you are an expert?

MR. BEATO: Object to form.

But, Dr. Biggs, you can answer that question.

THE WITNESS: I wouldn't agree with that characterization. I believe that I've done original research on, for example, suicide and on bone density. And I believe that my, you know, publications stand on their own.

BY MS. ALTMAN:

Q. Sir, who invited you to attend the Florida Board of Medicine meeting?

A. I believe it was Patrick. I thought we covered that. Did we not cover that?

Q. Well, you said that he invited you to the Health and Human Services committee. Did he also invite you to the Florida Board of Medicine meeting?

A. I don't -- I don't believe that I said that. I believe that I said that he invited me to the board of medicine. But I -- for the Health and Human Services, I just got an e-mail from whoever was organizing that, I believe. Maybe --

Q. Okay. So just to make sure I'm on the same page with you, Patrick Hunter invited you to the Florida

Board of Medicine meeting, and you got an e-mail for the Health and Human Services committee meeting, but you don't recall who it is from?

A. Correct.

Q. Were you paid for your time at the Florida Board of Medicine?

A. I believe I've already said no.

Q. What expertise do you have with regard to the medical treatment of gender dysphoria?

A. The expertise is the articles that I've published.

Q. Well, that's -- that's with regard to puberty blockers?

A. Yes. And suicide.

Q. My question was broader. What expertise do you have with regard to the medical treatment of gender dysphoria?

A. Well, my expertise is concentrated in those areas.

Q. And at the meeting, do you recall you provided a statement in research on gender dysphoria, according to the meeting minutes, do you agree with that?

A. Yes.

Q. And your statement at the Florida Board of Medicine meeting essentially, if not verbatim, mirrored

the testimony that you gave at the Health and Human Services committee; isn't that correct?

A. Yes.

Q. And it's essentially mirrored your report in this case, correct?

A. Similar, yes.

Q. And I didn't do a side-by-side comparison, but based upon my review of both of your testimony at the committee and your testimony, which I heard the audio of at the Florida Board of Medicine, it appeared as though you were reading from the identical script in both instances; is that correct?

A. Yes. That's probably roughly correct, yes.

Q. Prior to your statement at the Florida Board of Medicine meeting, had you performed any independent research with regard to gender dysphoria that you were asked to speak about at the meeting?

A. No.

Q. And, again, I'm not asking you to repeat anything we've talked about on the record. But you didn't perform any independent research on gender dysphoria for your statements that you made at the Florida Board of Medicine meeting, did you?

A. Correct.

Q. And all of your research is merely

reviewing the research of others and then opining on it, isn't that correct, other than we'll get back to your suicidality report and your bone density, correct?

A. Correct.

Q. And your letter to the editor, okay.

Is there any instance in which you believe in individual suffering with gender dysphoria should receive GnRH? Do you have an opinion on that?

A. Well, do you mean under 18 or in general?

Q. I'm asking if you have an opinion on that.

A. For those under 18, I believe that they should -- or under 16, they should have -- they could access GnRH as part of a proper randomized clinical trial.

Q. So under 16, part of a proper randomized trial, correct?

A. Clinical trial, yes.

Q. Right, okay. Older than 16, do you have an opinion on that?

A. Well, possibly -- over 18, GnRH is sometimes used as a -- it's called a testosterone blocker but it -- to go with estrogen. And, as I said, I don't have any opinions on, you know, what adults can consider.

Q. So we kind of got lost in the question there. And I apologize, I'm sure it is my fault. You

said less than 16, proper randomized control trial, right? Clinica trial, correct?

A. Yes.

Q. Yes, you've got to answer out loud. Sorry about that.

A. Yes.

Q. And then my question was 16 -- between 16 and one, not over 18, what about the people -- the sloth of people between 16 and 18, what do they get? If under 16 has to be part of a randomized controlled clinical trial, what about the people between 16 and 18?

A. I believe that in some circumstances they may be able to access if they have -- if they are told, you know, about the cost as well as the benefits of that treatment.

Q. Okay. So you would agree with me then that someone between the age of 16 and 18, so long as their medical provider consults with them, along with their parents, and discusses the risks versus the rewards of that treatment, that they should be entitled to receive that treatment, correct?

A. Yes.

Q. All right.

MS. ALTMAN: Now is probably a good time for a lunch break. I know for you it is probably

a dinner break. We can try -- let's see, it is four hours. It's 1 o'clock here so it's 5 o'clock there, am I right?

THE WITNESS: Yes.

MS. ALTMAN: Okay.

Michael, how long would you like to take?

MR. BEATO: Oh, gosh, I defer to Dr. Biggs, what do you think an appropriate time would be?

THE WITNESS: Half an hour.

MS. ALTMAN: Fine with me. So it's 1 o'clock here, 5 o'clock there. So 5:30, 1:30 for the rest of us.

(A lunch recess is taken at 12:58 p.m. to 1:33 p.m.)

BY MS. ALTMAN:

Q. Sir, did you have a nice short break?

A. Yes, yes, good to have a break.

MS. ALTMAN: Okay. Michael, and I know you had asked -- I should have probably said this before we got back on the record, but you had asked how long I think I'll go. I think on the outside, like the longest would probably be two hours.

MR. BEATO: Oh, okay. Okay.

MS. ALTMAN: Fingers crossed. Trying to be

as efficient as possible. All right. Well, let's see.

BY MS. ALTMAN:

Q. Sir, before -- during the break, did you speak with anyone?

A. My girlfriend to ask her for a coffee.

Q. Other than that, did you speak with anyone about your testimony or about this case?

A. No.

Q. Okay, good. And did she bring you the coffee?

A. She did indeed, yes, yes.

Q. Okay, excellent. Excellent. So you are ready to go. Good.

So I think you mentioned, if I understood you correctly, that there were randomized controlled trials relating to central precocious puberty, and in particular with regard to the impact on height, do you recall that?

A. Yes.

Q. What study specifically have you reviewed on that subject?

A. I don't have that information to hand.

Q. Do you know when those studies were published?

A. In the last ten years, I believe.
Q. Would they postdate 2019?
A. I couldn't say but possibly not.
Q. Are you familiar with a study Treatment of Central Precocious Puberty?
A. What's the author?
Q. I will tell you one second. Erica E-U-G-S-T-E-R?
A. That author is not familiar.
Q. And that study, sir, was published in 2019 -- one second. I just lost my e-mail. And in that study, the author, who -- it was a survey of the literature up in to 2019.

And I'll quote what she says, "The main goal of treatment in children with CPP is the preservation of height potential. Although this sounds straightforward, any consideration of height outcomes must acknowledge several limitations."

"One is no randomized control studies examining the effect of treatment versus no treatment on height in CPP has ever been conducted, to this author's knowledge."

Does that impact your testimony, sir, where you testified that there were indeed random controlled trials?

A. No, because --

MR. BEATO: Object to form.

Dr. Biggs, you can answer that.

THE WITNESS: I did cite them in the Dutch -- I did cite at least one randomized control trial on height in my Dutch Protocol article.

BY MS. ALTMAN:

Q. Okay. We'll get to that. So you would take issue with this author's statement?

A. Or perhaps it was an article since 2019.

Q. And as you sit here today, you don't know?

A. No.

Q. Okay. Sir, you appeared on the podcast, Gender: A Wider Lens, do you recall that?

A. Yes.

Q. And the title of the program in which you appeared was called Medicalization of Children With Gender Identity: Impact of Puberty Blockers, and that was in February of 2023, correct?

A. Yes.

Q. And that podcast, Gender: A Wider Lens, is supported by Genspect, correct?

A. Yes.

Q. And Genspect is an organization that holds

itself out as an alternative to WPATH; isn't that right?

A. That sounds correct, yes.

Q. And Genspect believes that gender identity ideology has caused damage and harm; isn't that right?

A. Probably, yes. I could -- yes.

Q. Do you believe that?

A. I believe in many cases, yes.

Q. And those cases are, as we've discussed today, nothing different, correct?

A. Sorry, could you repeat the question.

Q. Yeah, my -- my point was -- and my question was unartful, I apologize. The bases on which you believe gender identity ideology has caused damages and harm are those that you have elucidated in your report?

A. Yes.

Q. Okay. Nothing other than that is what I'm trying to understand, correct?

A. Well, I believe -- there are some other issues, for example, putting rapists in women's prisons that may be under the umbrella of gender identity -- gender ideology, but I think that's -- yeah, I didn't know if that's what you were...

Q. Well, what do you understand gender identity ideology to be referring to?

A. Well, it's not a phrase that I myself use,

but I believe it would be suggesting that, for example, that people have a certain -- a gendered soul, which is more important than their biological physical body. And that that gendered soul sort of takes precedence over their -- the reality of their -- of the sex body.

Q. Sir, are you suggesting that it is lesser than?

A. Well, it's certainly unobservable, like a soul. I'm not saying that -- yeah...

It is like a soul, right, it is not observable.

Q. Well, not observable to you but it's observable to the person that's experiencing it, isn't that correct, sir?

A. Yes, yes.

Q. So the fact that you don't see it doesn't mean it doesn't exist, right?

A. Yes, exactly. Just as I don't see a Christian soul and I don't know if the Christian soul exists but it is very real to the Christian.

Q. Sir, during the podcast, you refer to F.G., the letters of F.G., and you said was previously identified as B., who was part of an original study and who was followed up on in her 30s.

Do you recall giving that statement during

your podcast -- during the podcast?

A. Yes.

Q. And if I understood you correctly, you indicated she did not have a good outcome. That she was ashamed of her genitals and could not hold a relationship, referencing a 2014 follow-up study, do you recall that?

A. Yes.

Q. And I believe you also referenced that in your report, correct?

A. Yes.

Q. But that -- that was one person out of an entire group, correct?

A. That was the first individual, that was the first individual who had ever been given puberty blockers as a treatment for gender dysphoria, yes.

Q. Right. But did you do anything to follow up on any of the others to determine what their outcomes were?

A. Well, that person was the only person who was the subject of the case study, which made puberty blockers -- made puberty -- introduced puberty blockers to the -- to their medical community.

Q. Right. But I'm asking what steps you took, since you are interested in the subject matter of puberty

blockers, to understand what the case studies would be of the other individuals, what specific actions have you taken to undertake that analysis?

A. Well, there is only -- that's the one individual who was the subject of a case study. The others are -- come in groups, like the cohort of 17, which was discussed earlier, referred to in de Vries, et al., 2011 and 2014.

Q. You would agree with me, would you not, that one example can't be extrapolated to an entire group, correct, that wouldn't be statistically sound?

A. Yes.

Q. Now, during the podcast and before the Florida Human Health and Services Committee, you said that GnRH for the treatment of gender dysphoria would only be appropriate after proper clinical trials and randomized control group. Remember, we talked about that a little bit earlier, correct?

A. (Nodding head yes.)

Q. Yes? You have to answer out loud.

A. Yes.

Q. Sorry.

Has any organization that you are a part of attempted to perform such randomized -- proper clinical trials with randomized control groups?

A. No, but I know that the Cass inquiry were -- is looking into that.

Q. Okay. And why haven't you urged any of the groups that you are a part of to conduct clinical trials with randomized control groups?

A. Well, the -- SEGM is probably the most relevant example, we don't have the resources to. But, of course, we advocate. Or many of us would advocate.

Q. Well -- and, again, maybe I missed it, but did you -- when you were testifying or speaking at the Florida Board of Medicine, did you encourage them not to ban gender-affirming care so that they could conduct clinical trials with randomized control groups? Because I listened to your statement, I didn't hear that. Did you do it off the record and maybe I missed it?

A. I think the implication of saying that puberty blockers should be offered only as part of a clinical trial is a recommendation that those doctors and institutions that are currently offering puberty blockers should do so as part of a clinical -- randomized clinical trial.

Q. But you understood, sir, at the time that you were testifying before the board of medicine that Florida had already imposed a ban on gender-affirming care; isn't that correct?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: The rule that was being discussed, as I understood it, was to mean that -- that would remove the license of somebody who was doing -- providing these kinds of treatments outside of the kind of research that would be constituted as a randomized clinical trial.

BY MS. ALTMAN:

Q. Have you -- did you -- have you read the rule at issue in this case?

A. Issue in this case now, Dekker versus --

Q. The case for which you are providing expert opinion, have you read that -- the rule that's at issue?

A. I have read the reports on the rule but I don't think I've read the rule itself.

Q. Okay. And so you don't know one way or another what the impact of the rule is, correct?

A. I don't know the details, no.

Q. Okay. Well, would it surprise you that -- that the rule prohibits those who receive Medicaid from receiving any kind of gender-affirming care whatsoever, whether they are a child or an adult, does that surprise you?

A. No. No, that's my understanding.

Q. Right. And so when you were before the Florida medicine, you understood that the rule in place was prohibiting the payment for care for those who are on Medicaid for gender-affirming care of any kind, whether they are a child or an adult, correct?

A. I was not aware of that Florida rule when I presented to the board of medicine because I was addressing the proposition before the Florida Board of Medicine.

Q. Okay. And do you understand that -- well, strike that.

What do you understand the board of medicine rule now is with regard to providing such care?

A. It enables -- it means that doctors can lose their license if they provide this care outside of a research setting.

Q. And are you aware of any clinical trials and randomized control groups that the state of Florida, the Agency for Health Care Administration has undertaken?

A. No, but I would not -- I presume it wouldn't be up to the Agency. It would be up to university clinicians to undertake these trials.

Q. And is it your understanding that they could undertake these trials without any risk whatsoever to their license, is that your understanding?

A. Yes.

Q. Are you aware that there is research indicating that there are benefits to treating individuals with gender dysphoria with puberty blockers?

A. Yes.

Q. So as you sit here today, you understand that there are both risks and benefits to taking GnRH, correct, for gender dysphoria?

A. Yes.

Q. And you would agree with me that it is incumbent upon a medical professional, dealing with each individual patient, to explain to that patient the risks and rewards of taking puberty blockers, correct?

A. I believe that that sort of discussion must be based on a rigorous review of the costs and the benefits, yes.

Q. Okay. And -- but you would agree with me, that's not for you to opine on, correct?

A. Well, I believe it is up to me not to opine on but to publish articles or to uncover the results of experiments, like at the Tavistock, which was suppressed by the clinicians. And I believe that it is the duty -- incumbent upon somebody like me to publish the results of those -- of those investigations to inform the way that patients and their parents and clinicians undertake

there.

Q. And you did that, right, you -- you put out your Freedom of Information Act request and you published on the subject, correct?

A. Yes.

Q. And -- and the import of your publication is that a medical professional, a parent, and a child can read that research and draw their own conclusions as to how they want to proceed, correct?

A. Yes.

Q. Now, sir, during the podcast, the Gender: A Wider Lens podcast, you acknowledge that suicide rates are five to six times higher for transgender teenagers than non-transgender teenagers, do you recall making that statement?

A. Yes, that's based on -- I should say that's based the -- on my research that was done on the Tavistock, yes.

Q. Okay. And I just want to juxtapose that with, you don't say that in your report, do you, sir, to the Court?

A. I believe I do -- I believe I do. I can --

Q. You think your report -- you say somewhere that suicide rates for transgender teenagers is five to six times higher than non-transgender teenagers?

A. If I don't in my report, it was with one of the exhibits that was with the report.

Q. And, sir, in your report, what you do say is that individuals who -- who report suicide attempts or suicidal ideation don't really want to kill themselves. They are just crying out for help, isn't that what you say?

A. I don't believe that's a fair characterization of what I say. What I say is that it would be -- you cannot just simply take suicidal ideation, extrapolate to that suicide intelligence.

Q. Sir, it is not within your wheelhouse to diagnose somebody who has suicidal ideation, is it?

A. No.

Q. And it is not within your wheelhouse to determine whether or not someone who -- who reports a suicide attempt really means it or not, correct?

A. Not in the individual case, no.

Q. Well, not in any individual case, correct, sir?

A. Not in the individual case, no.

Q. Not in any individual case, correct, sir?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: Yes.

BY MS. ALTMAN:

Q. And you -- you didn't mean to imply in your expert report that you, as a sociologist, have any complications to opine on the mental state of an individual and whether they really want to kill themselves or not; isn't that right?

A. Correct.

Q. And you would agree you have no such qualifications, correct?

A. Correct.

Q. What was the -- what is the point in your report of -- of that -- that, for lack of a better word, opinion -- of that opinion that most who suffer from gender dysphoria who -- who report a suicide attempt don't really want to kill themselves, what is the basis for you to provide that opinion?

A. The point is to combat a particular argument that is often used to advocate for medicalization, saying that -- rather cliche, is it is better to have a live son than a dead daughter or vice versa.

And so by exaggerating, the possibility of suicide, it means that individuals or patients and their families more -- have an exaggerated degree of the risk of suicide if they don't take the medication that

influences their views on whether they should or shouldn't take the medication.

Q. Well, regardless of whether or not you think it is exaggerated, you've acknowledged that transgender individuals have a five or six times greater risk of suicide; isn't that right?

A. Yes, there is a difference between absolute rates and relative rates. Absolute rate, fortunately, is very low. The relative rate is, as you say -- at least what I've calculated from the Tavistock, five or six times higher.

Q. Okay. And in that regard, sir, I hope you would agree with me that -- that even one suicide is bad, right?

A. Yes, absolutely.

Q. And you are not suggesting to the Court that we don't pay attention to whether a child is transgender or not to any inclination that they might commit suicide. You are not suggesting we just disregard it because we think they don't really mean it, are you?

A. No, absolutely correct.

Q. So I guess I'm just trying to understand what the import of including that opinion in your report is, what does it add to your conclusions in this case?

A. It adds, as I said, an important caveat to

an argument that is often made to push for the medicalization of children, which is they would kill themselves unless they get these drugs. What I was pointing out, based on my research, is that the absolute rate of suicide is thankfully low, at least from what I've -- from the Tavistock clinic.

Q. From one study in one jurisdiction, right?

A. It's the largest pediatric clinic in the world, but yes, one -- one clinic.

Q. You understood my question?

A. Yes.

Q. Yeah, okay. It's one clinic, correct?

A. Yes.

Q. Based on data from one fixed period of time?

A. Yes, a span over ten years, right.

Q. Right. And when was that published?

A. Sorry?

Q. When was the results finalized?

A. When was my article published?

Q. Uh-huh.

A. I believe it's 2021, I think.

Q. Okay. And, sir -- well, strike that.

Do you believe that medical doctors who are providing gender-affirming care, that they are attempting

to convert cisgender individuals to be transgender?

A. No. But I don't know quite what a cisgender individual is.

Q. You don't know what, I'm sorry?

A. I don't know what you mean by a cisgender individual. That's why it took a while to answer that question.

Q. A non-transgender individual, a non -- not homosexual, not lesbian, a heterosexual person, do you believe that doctors who render gender-affirming care are trying to convert cisgender individuals to be transgender?

A. No.

Q. Do you think that they are trying to convert those who are gay or lesbian to be transgender?

A. I don't believe they are intending to do that, no.

Q. Okay. Now, sir, on your website you include a blog post that you author, and I'm going to read the title of it. "The astonishing admission in the health research authority report the purpose of puberty blockers is to commit children to permanent physical transition."

Do you recall that blog post?

A. Yes, yes.

Q. And we talked about this a little earlier in connection with another similar statement that you've made. But in this case, you made it on a blog post on your website.

And in your blog post, you state that the researchers made what you referred to as "an astonishing admission," and you go on to state that "the admission is the purpose -- that the purpose of puberty blockers is to commit children to permanent physical transition."

That's what you say, do you recall that statement?

A. Yes.

Q. And we talked about it in another context earlier, but I want to then read to you this statement from which you drew that conclusion on your blog post. So I'm going to read that to you.

The actual statement that you quote in your blog post says, "It would have reduced confusion if the purpose of the treatment had been described as being offered specifically to children demonstrating a strong and persistent gender identity dysphoria at an early stage in puberty, such that suppression of puberty would allow subsequent cross-sex hormone treatment without the need to surgically reverse or otherwise mask the unwanted physical effects of puberty in the birth gender."

Do you recall that quote?

A. Yes.

Q. Now, that quote, sir, does not say that the purpose of puberty blockers is to ensure transition to cross-sex hormones, correct?

A. Well, the purpose is to enable or allow.

Q. No, sir, what it says is, for those individuals that persist and are transgender, allowing them to not have fully developed, which would require more complex surgery, is a benefit to those individuals; isn't that what it says?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that.

THE WITNESS: Yes, they -- the -- what I was pointing to is that that statement is a clear statement that the purpose of puberty blockers is the first stage in a course of treatment that will continue on to cross-sex hormones.

BY MS. ALTMAN:

Q. Sir, that is not what it says. What it says is, for those individuals that choose to go on to cross-sex hormones, puberty blockers will ensure that they have less surgical intervention than those that don't have their puberty blockers; isn't that what the import of the paragraph is?

A. Yes. And we know that in that particular study, I believe you are referring to the 44 children in the Tavistock trial, 40 -- out of the 44, 43 went on cross-sex hormones.

Q. But that isn't the point, sir, is it? Of the 43, that was their choice because they were -- by choice I mean they were transgender, not that that is a choice. But those individuals that were transgender chose to go on to cross-sex hormones, which would be expected if you are transgender, correct, sir?

A. Well, they were diagnosed with gender dysphoria. I don't believe that in the protocol there was any mention of them being transgender. I think the diagnosis was gender dysphoria or gender identity disorder, whichever was the one prevailing.

Q. Do you know whether or not the 43 individuals you referred to are indeed transgender, sir?

A. I would assume so but I wouldn't know. But I --

Q. You've not undertaken any analysis to understand that, have you?

A. Well, this was a treatment this was intended to treat gender dysphoria.

Q. Correct. And for those individuals that -- that were indeed transgender, they would go on to

cross-sex hormones.

But there was nothing in that paragraph that I read to you that said the purpose of puberty blockers is to make their way for a lifelong, you know, experience on cross-sex hormones; isn't that correct, sir?

A. I don't agree with that interpretation.

Q. Well, sir, I'm not interpreting it. You're actually the one that interpreted it. I'm reading these -- the written word, as it is written.

You have extrapolated from that a purpose of giving gender -- puberty blockers that is nowhere in the paragraph that you reference?

A. I believe that's an unfair characterization of the way that even clinicians would describe the benefits of puberty blockers.

Q. Well, it may be a benefit of puberty blockers but that's not what you said, sir. You said the purpose of puberty blockers, not that a side benefit of puberty blockers is, that for those that go on to cross-sex hormones, the surgical intervention may be lessoned. That's not what you said.

What you said on your blog post, and you've said it at other times, is that the purpose of puberty blockers is essentially only to transition someone to

cross-sex hormones, correct?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: Yes. And that's why I use the -- that's why the first articles refer to juvenile transsexuals. Precisely the logic was you give puberty blockers, you stop the development of secondary sex characteristics, and then the patient will go on to cross-sex hormones and surgeries.

BY MS. ALTMAN:

Q. No, the patient may go on, correct, sir, may go on. You don't know?

MR. BEATO: Object to form.

BY MS. ALTMAN:

Q. It is individual specific, correct?

A. Individual specific but 93, 95, 97, 98 percent will go on --

Q. Which is it, 93, 95 or 97?

A. It depends on which studies you look at. I cite I think four of them from different clinics, Australian, Britain, the Netherlands, and Belgium in my witness statement -- report, I believe.

Q. And, indeed, that section goes on to say -- of the paragraph that you quote, it specifically says,

"For children demonstrating a strong and persistent gender identity dysphoria at an early age in puberty, such that the suppression of puberty would allow subsequent cross-sex hormone treatment without the need to surgically reverse or otherwise mask unwanted physical effects of puberty."

The language is very clear. It's for those children demonstrating a strong and persistent gender identity dysphoria, isn't that what it says?

A. Yes.

Q. Now, you say in your report, sir, that there is no objective physical diagnosis for gender dysphoria, do you recall making that statement?

A. Yes.

Q. Are you suggesting to the Court that you don't believe gender dysphoria exists?

A. No.

Q. And you'd agree with me that there are many medical conditions for which there is no objective physical diagnosis; isn't that right?

A. Yes.

Q. And that doesn't mean the condition doesn't exist, does it?

A. No.

Q. Since you are opining on what treatment

transgender adolescents should not receive, do you have an opinion on what treatment they should receive, are you offering such an opinion in this case?

A. I don't -- I mean, I did not offer an opinion in my expert report, no.

Q. Okay. Are you aware of any research that demonstrates the negative impact on adolescents when they are not prescribed treatment for gender dysphoria?

A. Yes.

Q. Are you offering an opinion on that in this case? Have you been asked to offer an opinion in this case on that?

A. Specifically on puberty blockers, yes.

Q. That's not what I said. Let me read my question again.

Are you aware of any research that demonstrates negative -- the negative impact on adolescents when they are not prescribed treatment for gender dysphoria? My question was not limited to puberty blockers.

A. I'm aware of studies that attempt to demonstrate that, yes.

Q. Have you been asked to offer an opinion in this case on that?

A. No, I don't believe -- no.

Q. You are not providing an opinion in this case on the GAPMS report, are you?
A. No.
Q. You are not providing an opinion on the rule in this case, correct?
A. No. Correct.
Q. You are not -- you are not providing an opinion about the process that AHCA followed when arriving at its rule, are you?
A. Correct.
Q. You are not providing an opinion on the diagnosis of those specific plaintiffs in this case, correct?
A. Correct.
Q. You don't have an opinion about the proper medical treatment for the plaintiffs in this case, correct?
A. Correct.
Q. You haven't reviewed their medical records, correct?
A. Correct.
Q. And you don't review medical records as part of your job as a sociologist generally, correct, sir?
A. Yes.

Q. Yes; that's correct, right?
A. Correct. Yes, correct.
Q. You've never met with any of the plaintiffs in this case?
A. No.
Q. You've never asked to meet with any of the plaintiffs in this case, correct?
A. Correct.
Q. You've never met or asked to meet any of the medical providers of any of the plaintiffs in this case, correct?
A. Correct.
Q. And you are not offering an opinion on the qualification of any of the medical providers that treat any of the plaintiffs in this case, correct?
A. Correct.
Q. As a sociologist, generally speaking, do you -- do you utilize the standards of care for gender-affirming care? Is that part of what you would do, generally speaking, as a sociologist?
A. No.
Q. And the same question about the American Medical Association's position on the standard of care, is that something you would generally utilize as a sociologist in your work?

A. No.
Q. And the same is true, sir, with regard to the WPATH standard of care and the Endocrine Society guidelines. Those are not things that you would typically utilize in your work as a sociologist, correct?
A. Correct.
Q. And you had no role in drafting the WPATH standards of care, correct?
A. Correct.
Q. You've never provided a diagnosis of gender dysphoria, correct?
A. Correct.
Q. You've never provided a diagnoses for any medical condition, correct, sir?
A. Correct.
Q. You've never provided a treatment plan for any medical condition whatsoever, correct?
A. Correct.
Q. And you are not qualified to provide a medical diagnosis for any medical condition, correct?
A. Correct.
Q. You've never prescribed drugs of any kind to anyone who is experiencing gender dysphoria, correct?
A. Correct.
Q. What did you do to prepare your report?

A. I read the literature and -- I mean, the report was the culmination of quite a few years of research in this area that was -- resulted in the -- my publications. And so I prepared a report I believe is the evidence for or against the use of puberty blockers for gender dysphoria.

Q. Does the report contain all the opinions you intended to provide in this matter?

A. Yes.

Q. You indicated a moment ago that you read the literature and that the report is a culmination of reviewing all the literature.

Is there any literature that you reviewed that you have not identified in your report as having been a basis for the opinions you are offering?

A. I don't believe so, no.

Q. Does the report contain all the work you needed to render your opinions in this case?

A. Yes.

Q. Were you provided or did you otherwise have all of the things that you needed to render your opinions in this case?

A. Yes.

Q. If not, what else would you have needed?

A. I said I had everything I needed.

Q. I know and I'm asking you to think if there is anything else that you would have needed, could have considered in order to render full, complete, and robust opinions in this case?

A. I don't believe so, no.

Q. So you don't believe, by example, having conducted any research yourself or -- or spoken to any transgender individuals or people from WPATH or people who have the guidelines published from the endocrine society, none of those things would have helped you inform your opinions in this case?

A. No, I don't believe so, no.

Q. Is there any work left undone to finalize your opinions in this case?

A. No.

Q. Any work that you wanted to do that you haven't done?

A. No, not for this case, no.

Q. Have you been engaged in any other case as a testifying expert?

A. No. Well, apart from the two I mentioned, the one in Australia and the one in the UK.

Q. Without telling me what case, regardless, without disclosing, have you been engaged as a consulting expert in any other cases on gender dysphoria or puberty

blockers?

A. No.

Q. Other than what's identified, is there anything else that you reviewed in connection with rendering your opinions?

A. No.

Q. Was there any information that you got from defense counsel, either related to the individual plaintiffs or their caregivers, or any information that you got from defense counsel that you did not otherwise have for review?

A. No. The only thing I had was -- the only thing they sent me is some -- about three or -- maybe five rebuttals which mentioned my evidence.

Q. Did you review those?

A. Yes, I looked at those.

Q. Okay. Thank you. When did you write your report?

A. January, Feb -- February, I think.

Q. Of 2023?

A. Yes.

Q. And you testified already you did not show a draft of your report to anyone, correct?

A. Correct.

Q. What did you learn about the lawsuit for

which you have been retained as an expert?

A. I'm not sure. It must have been -- yeah, I -- to be honest, I can't recall now. Possibly November, but...

Q. Well, you testified or spoke at the board of medicine meeting in October of 2022. Does that orient you as to when you may have been contacted about providing expert testimony in this case?

A. Perhaps in January, yeah -- yeah, I'm really not clear about the date.

Q. Do you have -- regardless of whether you are clear about the date, do you have any kind of approximation for how long ago was it, a year ago, six months ago, eight months ago?

A. It was a few -- I think it was either sort of -- either the end of last year or the beginning of this year.

Q. Okay. So if I understand you correctly, you believe you were contacted to provide testimony in this case sometime in the late fall of 2022 or early 2023; is that correct?

A. Yes.

Q. Yeah, you can't nod. Yeah, okay.

A. Yes, that's right.

Q. Thank you. Okay.

And who contacted you about being an expert in this case?

A. It was one of the lawyers at Holtzman Vogel.

Q. Do you know how they got your name?

A. I -- no, I don't know but I would assume it was from my appearances in Florida to the Florida Board of Medicine.

Q. Do you recall who from the law firm contacted you?

A. It might be Gary Perko.

Q. Did they ask you your opinions before having you testify in this case?

MR. BEATO: So, Mr. Biggs, I'm going to instruct you not to answer any other questions regard -- excuse me, regarding our communications. That's privileged information.

I'm instructing him not to answer that question.

MS. ALTMAN: Hold on, Michael. My question only called for a yes or no. It wasn't the substance of the conversation.

MR. BEATO: Still, I think that verges into the substance of the conversation. I'm instructing him not to answer any more questions

relating to that.

MS. ALTMAN: Okay. We can talk about it later.

MR. BEATO: Sure.

BY MS. ALTMAN:

Q. You already testified you were not involved with the rulemaking of the GAPMS process, correct?

A. Correct.

Q. But what you say in your report is, "After reading the scientific literature, I became increasingly concerned about the lack of robust evidence."

A. Yes.

Q. Do you recall putting that in your report at paragraph 5?

A. Yes.

Q. Okay. And what specific literature did you review that caused you to be concerned?

A. Well, the -- my initial concern was reading the case study of the individual B. or F.G. And the second was reading the sort of gold standard Dutch study of de Vries, et al., at 2011 and 2014, which I was very surprised to see how little evidence there was to justify puberty blockers. That was many years ago. But that was what initially interested me.

Q. Anything else that caused you to have great

concern?

A. Yes. The fact that I discovered that the Tavistock clinic in London had done an experiment or study -- wasn't a proper experiment -- it was a study of early puberty suppression that was designed to replicate the Dutch study, and that they had never published any of the results.

Q. Anything else?

A. No, those are the main things that led me into this.

Q. Okay. And we've already talked about you are aware of literature studies, findings that have a different conclusion than the ones you rely on, correct?

A. Yes.

Q. In paragraph 6 you state, and I quote, "I have conducted original research on the use of GnRH puberty suppressors," do you recall making that statement in your report?

A. Yes.

Q. And what original research did you conduct?

A. Well, I was the first to publish the results of the -- that English study into -- designed to replicate the Dutch -- the Dutch study.

Q. But you didn't conduct the original research, sir, you just wrote about what someone else

did, correct?

A. It was only due to my efforts that that research saw the light of day. And I was the first person to publish on it.

Q. And congratulations. I'm not trying to undermine or demean what you've done, I just want to make sure the record is clear. Because the statement you made in your report is you conducted original research. And you, in fact, did not conduct original research, sir. Someone else conducted original research and you wrote about it, correct?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: I believe that what I've done constitutes original research.

BY MS. ALTMAN:

Q. And the sole original research that you believe you've conducted is publishing the English study that was trying to mimic the Dutch study, correct?

A. That's one -- that was one. Another one would be the analysis of bone density.

Q. Which, again, you were reporting on someone else's work, correct?

A. I was doing original analysis based on data that I myself had elicited -- elicited from the

Tavistock.

Q. No, sir. Someone else created the data and then you provided your analysis of that data, correct?

(Simultaneously speaking.)

MR. BEATO: Object to form.

Dr. Biggs, you can answer the question.

BY MS. ALTMAN:

Q. Go ahead, sir.

MR. BEATO: What's the answer to the question, Mr. Biggs, just for the record?

THE WITNESS: Yes, I conducted the statistical analysis, correct.

BY MS. ALTMAN:

Q. Right, of someone else's data, correct?

A. Yes.

Q. Have you engaged in any kind of clinical study with patients that involved GnRH treatments?

A. Sorry, what do you mean by "critical study" -- oh, you are saying clinical study?

Q. Yes, sir.

A. No.

Q. Have you been involved directly in any longitudinal studies?

A. No.

Q. Any observational studies?

A. No.

Q. Is there any study whatsoever where you have been the primary investigator of data that you collected?

A. No.

Q. Have you published an original article that underwent a peer-review process analyzing data from a clinical study that you performed with patients treated by GnRH analogs?

A. No.

Q. So we've kind of gone over this, and I don't want to retread it. I just want to point out in paragraph 7 of your report, you make the same similar statement about "puberty suppression is designed to stop normal puberty in order to prepare the child for taking hormones of the opposite sex."

Do you recall making that statement in your report?

A. Yes.

Q. And we've kind of gone back and forth, debated what that means and whether or not that's an accurate statement. I'm assuming your testimony isn't going to be any different about what you wrote in paragraph 7 than what it is going to be about what you said on your blog post and what you said to the Health

and Human Services division, right -- committee, rather?

A. Yes.

Q. Okay. I just don't want to go over things that we don't need to.

In -- in -- in paragraph 9, you say, "GnRH is never tested in any randomized clinical trial," do you recall saying that?

A. Yes.

MR. BEATO: Would it be helpful -- I apologize for interjecting -- would it be helpful to, when we're quoting Dr. Biggs' report, to put it on the screen just so everyone sees what's being said?

MS. ALTMAN: We can, if you want. He said he had it there, so I wasn't going to --

THE WITNESS: As long as I can refer to it, then that's fine.

MS. ALTMAN: Sure, if you want.

But, Michael, if you want it to put on the screen, we're happy to do that too.

MR. BEATO: I would prefer that. It just makes things easier so we're all looking at one screen --

MS. ALTMAN: You are making me wake Ana up.

Ana, are you out there? Thank you.

MR. BEATO: Thank you, Ana.

MS. ALTMAN: Paragraph 9. There you go.

BY MS. ALTMAN:

Q. Do you see this statement, sir, paragraph 9, "Puberty suppression as a treatment for gender dysphoria was never tested in any randomized clinical trial, nor were there any preliminary experiments on nonhuman animals"?

A. Yes.

Q. What specifically did you rely upon in making that -- those two statements?

A. The fact that there has -- that there has never been published any -- any randomized clinical trials using puberty suppression as a treatment for gender dysphoria. And the fact that the Dutch endocrinologist, Henrietta Delemarre-van de Waal, actually worked in the laboratory with rats, but she did not do any permanent experiments with rats even though she had the laboratory there.

Q. Anything else that you rely upon in making those two statements?

A. No.

Q. And in paragraph 10, which is on the next page, you make this statement, "The reported improvement in gender dysphoria is flawed because the researchers

switched the questionnaire used to construct the measure."

Did I read that right?

A. Paragraph 10 or paragraph 11?

Q. Let's see. I thought it was in ten.

A. No, it is not in ten.

Q. All right. Hold on. Let me put that one to the side and I'll go back to that in a minute, how about that?

But regardless -- and I'm going to go back to the report in a second -- switching the questionnaires doesn't explain how -- that the conclusion would be wrong or improper, does it, sir?

A. Yes, it does, because if you ask -- if you start off with a male, a boy who says he's -- one of the questions will be, "Are you distressed about having erections?" And he'll say, "Yes, I am because I'm gender dysphoric," that makes sense, right, so he's gender dysphoria.

And then after surgery you say, "Do you hate menstruation?" Now, of course, whether -- if you ask me whether I hate menstruation, I would say no. But it's not because I've been cured of gender dysphoria, it's just because I don't menstruate. So the question is -- obviously can be answered in the negative.

That's the kind -- those are the -- that's the reason why the scales -- switching the scales makes a huge difference.

Q. Well, but you don't know, sir, do you, whether or not -- switching the scales, whether or not the individual recipient even answered that question, do you? You didn't look at the actual survey results, did you?

A. But that is one of the questions that are used in making their gender dysphoria scale.

Q. But that wasn't my question. My question is, you didn't go back and look at the underlying questionnaires to determine whether or not individuals properly and correctly responded to questions that would be associated with their specific gender, did you?

A. Well, the Dutch clinicians asked males a series of questions, including "are you uncomfortable or does" -- "are you very bothered by menstruation?"

Q. Right. My question to you is, you don't know whether or not any particular individual answered that question or how they answered that question, correct?

A. I know they would have answered that question because that was required to -- for the scale. I don't know how any particular individual answered that

question, no.

Q. Right. And what I'm just trying to get at is you didn't go back and look at the underlying results, you relied upon somebody else's reporting of these results, correct?

A. Yes, I relied upon the published articles by de Vries, et al., yes.

Q. And you didn't conduct any of your own, correct?

A. Correct.

Q. Meaning that if you thought it would be more appropriate to ask the questions in a different way, you've not taken upon yourself to engage in a study that asks the questions in a way that you believe would have been more appropriate, correct?

A. Correct.

Q. And I think it is in paragraph 13 but let's just go down there. Hopefully I have it right.

In paragraph 13 do you say, "The suspicion must be that at least some of these children could have grown up to be typical gays and lesbians without requiring lifetime medical treatment, and without loss of fertility and sexual function"?

Do you recall making that statement?

A. Yes.

Q. Okay. And you base your opinion on your suspicion; isn't that right, sir?

A. Yes, that's what the sentence reads, yes.

Q. Right. It's your suspicion. You have no evidence whatsoever to make that statement; isn't that correct?

A. The evidence is in the preceding sentence, the first 70 adolescents, the vast majority were homosexual, and only one was heterosexual. The others were bisexual.

Q. Well, but that doesn't necessarily eliminate the fact that they could be transgender, correct?

A. Correct.

Q. Right. And so I go back to my point, which is throughout your report, you were -- you used words like -- and we'll get to it -- "suspicion," "belief," words that are not scientific. They are your musings about what may or may not be.

That particular quote is the last sentence on paragraph 13 where you say, "The suspicion must be at least some of these individuals could have grown up to be typical gays and lesbians." But that's your musings about it, that's not science, correct, sir?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: I think that's synonymous with a credible hypothesis or, you know, potential hypothesis. The word "suspicion" is just saying that, yeah, I'm -- I cannot prove it. There is no proof, but I believe it is a plausible conjecture or plausible hypothesis.

BY MS. ALTMAN:

Q. So it is conjecture and hypothesis, not opinion, right, sir?

A. Yes, I -- yes.

Q. Are you aware of any study that's ever demonstrated that gender affirmation in childhood leads to a child being transgender who otherwise may not have been?

A. Well, that would be unobservable because we wouldn't know what the outcome was.

Q. So you would agree with me that you have no evidence to support that, correct?

You are not aware of any study that supports that, correct?

A. Correct.

Q. That gender affirmation in childhood leads to a child being transgender who otherwise may not have been, correct?

A. Correct.

Q. And you are not opining, sir, that puberty blockers somehow make someone transgender and prevents them from being a typical gay or lesbian, are you?

A. Yes, I am.

Q. You are? That's your testimony, sir, under oath, that if you take puberty blockers, by definition, you won't become a typical gay or lesbian?

A. Well, in some cases I believe that children who are taking puberty blockers and turned into what was originally called juvenile transsexuals could have grown up to be feminine boys, gay men, or butch lesbians. That's -- that's my belief, yes.

Q. And your -- that's your -- that's what I think you called conjecture, right, your speculation because you have no evidence to support that, correct?

A. There is evidence to support that. There is not proof. There is not demonstration. But I would also say -- point out that the Dutch clinicians in an article by Anacker, et al. 2023 acknowledged that possibly gonadotropin-releasing hormone agonists can become a self-fulfilling prophecy. That's not the exact words but that's what they acknowledge as one -- as a credible possibility.

Q. A credible possibility?

A. Yes.
Q. But that's not science, sir, it's just a hypothetical, correct?
A. No. This was a statement in -- by the Dutch clinicians in a published and a peer-reviewed journal. I don't remember off the top of my head what journal it was. So they were entertaining this as a possibility.
Q. As a possibility, correct?
A. Yes.
Q. Not a scientific truism, correct, sir?
A. How science deals with possibilities.
Q. Okay.
A. And probabilities.
Q. Sir, in paragraph 13 of your report, you also make the following statement: "All this evidence predates the promotion of transgenderism in health care and schools and on social media."
Do you see where you wrote that?
A. Yes.
Q. Okay. And you go on to refer to "the manifesto for the Dutch Protocol fails to mention homosexuality and does not cite any of the studies of feminine boys."
Did I read that right?

A. Yes.

Q. Now, it -- starting with the first sentence, "All this evidence predates the promotion of transgenderism in health care and schools and on social media." What evidence do you have that transgenderism is being promoted in health care, schools, and on social media, what specific evidence do you rely upon for that statement?

A. Well, social media was not around then, so clearly there was no promotion on social media. Schools, there is widespread evidence, for example, the use of the book about Jazz Jennings. And on media, you could use Jazz Jennings as perhaps the best example of that.

In terms of health care, more and more of the possibility of being transgender in, for example -- and the growth of the gender clinics -- of the gender clinics like the gender clinic in Tavistock.

Q. Well, how is that promoting transgenderism?

A. Well, it's -- it's suggesting to children that this is a possible and perhaps even a desirable way of being.

Q. Isn't it just, sir, accepting those who are transgender for who they are?

Nobody is converting people to be transgender, are they?

MR. BEATO: Object to the form.

Dr. Biggs, you can answer that question.

THE WITNESS: I would -- I'm quite happy with the phrase that I use there. I do believe that there is more and more publicity to being given -- to being a transgender identity as a potential way of being and a -- and perhaps even a desirable way of being.

BY MS. ALTMAN:

Q. Well, do you think it is an undesirable way of being?

A. I believe that there are -- what is undesirable is becoming a lifelong medical patient.

Q. And what is the basis, the medical basis for your statement, the scientific basis for the statement you just made?

A. Well, I don't think -- I don't -- who wants to be a lifelong medical patient? I don't think -- yeah, I don't think that's a desirable -- a desirable outcome, if it can be avoided.

Q. So that's just more of your suspicions and musings and conjecture. I'm asking whether or not you have actual -- any scientific support for the statements that are in your report?

MR. BEATO: Object to the form.

Dr. Biggs, you can answer that question.

THE WITNESS: That statement, I don't believe, is in my report. It is just simply what you've asked me -- asked me about now.

BY MS. ALTMAN:

Q. Well, no, I read to you the statement that's in your report, that there is -- apparently, there is -- people are promoting transgenderism in health care, schools, and on social media. And I asked you for the evidence that you have to support that statement?

A. Yes, I've said that I think -- believe there is abundant evidence in -- for example, if you look at searches on Google trans. If you look at the --

Q. What specific searches -- sir, what specific searches, what specific evidence did you rely upon when you made that statement in your report. I'm asking you the specific evidence that you relied upon?

A. If you search for various combinations and permutations of the word "transsexual child," "transgender child," "trans child," "trans kid," "trans children" and so on, you can see a massive peak in that, particularly after 2005 but more particularly after 2010.

Q. Okay. So, sir, it is not my responsibility to conduct these searches. I'm asking you what specific scientific basis do you have before you made that

statement in this report, what -- did you do those searches, if so, are they -- are the results listed in your bibliography?

MR. BEATO: Object to form.

Dr. Biggs, you can answer those questions.

THE WITNESS: I did do those searches. The results are not listed in my -- in the bibliography because I thought it was --

BY MS. ALTMAN:

Q. Why not?

A. It was so obvious that the increase in the prominence of transgenderism in health care and schools and social media would be obvious.

Q. Sir, did you look at all of the possible reasons why being transgender is more at the forefront today, like perhaps US states that are banning transgender health care -- just as an example, throwing it out there -- and then putting that in the media. Did you look at that, maybe that's the reason why people are more frequent to be discussing the issue?

A. Well, bans on health care have only been around for a couple of years. I'm talking about a long -- long-term trend from -- I think I did 1990 to 2020. So it's -- yeah, that's the basis of it.

Q. So other than your Google searches, is

there anything else that you relied upon in making that statement in your report?

A. Just to clarify, it wasn't a Google search. It was a search of Google's corpus and the entire body of printed material in -- in the English language.

Q. Right. The one -- the things that you did not list in your report as resources, correct?

A. Yes.

Q. Sir, do you believe it's -- that it is easy to be transgender, it is appealing to be transgender?

A. I believe in some cases it can be appealing, yes.

Q. What about in others?

A. In other cases, it is not.

Q. You are not making a -- you are not providing a general opinion that people are jumping on the transgender bandwagon because it is so easy and it is being promoted, are you?

A. No. I believe that sometimes it makes sense of an individual's predicament of suffering or distress about their body, about their gender roles.

Q. And it might make sense just because they are transgender, right?

A. Yes, it might.

Q. Right. And you don't know in any

particular case whether that's true, right?

A. Not in any individual case, no.

Q. Now, sir, in paragraph 14 of your report, you spend a lot of time talking about that -- the overlap between gender dysphoria and autistic spectrum conditions, do you recall writing about that in your report?

A. Yes.

Q. Sir, you would agree with me that being transgender and being on the spectrum are not mutually exclusive, correct?

A. Correct.

Q. Sir, on the studies pertaining to feminine boys, you agree that all of those studies pertain to preadolescence, mostly prepubertal children under the age of 12, correct?

A. Yes.

Q. And you would also agree that being gender nonconforming is not the same thing as being transgender, correct?

A. It's not necessarily the same, no.

Q. And you would also agree by definition those studies don't indicate a desistance rate for people who are actually transgender abandoning a transgender identity, correct?

A. Well, the study by Green on Sissy Boys that I cite was -- they specifically identified children, boys, who they thought were going to be transsexual, they -- they refer to pre-transsexual. So they are trying to find the most feminine, most dysphoric children, dysphoric male children.

Q. Well, that doesn't mean that they were though, correct, sir?

A. Well, the -- they were identifying the most feminine boys they could find who were -- who they thought would be certain to develop into transsexuals or very highly likely to develop into transsexuals.

Q. Right. But, again, that's subjective, correct, sir? It is somebody else's, you know, views on whether or not they may or may not be, correct?

A. Yes.

Q. Now, sir, again, back to your opinions or musings about gender dysphoria and autistic spectrum conditions. As I just asked you, being autistic and having gender dysphoria are not mutually exclusive, correct?

A. Correct.

Q. And you make this statement, "Children on the autistic spectrum are more likely to face difficulties fitting in with their same sex peers, which

makes a transgender identity obviously appealing as both an explanation and a solution." And that's at -- the bottom of page 9 and goes on to page 10.

Do you recall making that statement?

A. Yes.

Q. Is it -- have you done any studies, sir, as to whether or not autistic children or children on the spectrum have difficulty fitting in with both their same sex peers and opposite sex of peers -- peers?

A. That was reporting the article that was in the previous sentence. So I'm having -- do we have the right page there?

Q. Yeah. Well, that's --

A. In the previous -- the last -- yeah, I was reporting on something that was quoted on a literature reviewed by van der Miesen, Hurley and de Vries, 2016, that quotes -- I'm paraphrasing the evidence that this literature review was producing.

Which said, essentially, particularly de Vries is one of the clinicians who emphasized this, that children on the autistic spectrum are more likely to face difficulties fitting in with their same sex peers. And the original study was, I think, de Vries -- de Vries, et al., 2010, the original article that I don't cite that -- because I'm citing the literature review.

Q. Right. So a couple things. Number one, it is not quoted, correct, there is no quotes around that. It's a statement by you, correct?

A. It's a -- but it's a paraphrase of the evidence that I provided.

Q. Well, it is not attributed to anyone, correct, sir? At the end of the sentence, there's not a footnote, there is not a quote or reference to anybody else's study, right?

MR. BEATO: Object to the form.

Dr. Biggs, you can answer that question.

THE WITNESS: Yes.

BY MS. ALTMAN:

Q. And, sir, my question is, you make this statement, you make this statement, not anybody else, "Children on the autistic spectrum are more likely to face difficulties fitting in with their same sex peers."

And my question to you is, have you done any analysis whatsoever into whether or not children on the autistic spectrum have difficulty fitting in with anyone, whether it is their same sex peers or their opposite sex peers?

A. No, I haven't conducted an original research on that -- on that question, no.

Q. Okay. And so, sir, you don't know whether

or not the fact that -- whether it is same sex or opposite sex peers, that children on the autistic spectrum are, air quotes, becoming transgender because they don't -- they don't feel that they fit in with their peers. You don't have any evidence to support that, correct, sir?

A. Well, apart from my reading of the Dutch clinicians like de Vries, correct.

Q. Right. But I'm asking you, though, what research or studies you've done to support the statement in this report? Other than --

A. I haven't done my own original research on that, no.

Q. And perhaps I'm misreading what you are saying. But, I mean, the implication of what you are saying is that autistic spectrum individuals are pretending to be transgender to fit in.

Is that what you are trying to convince this Court?

MR. BEATO: Object to the form.

Dr. Biggs, you can answer that question.

THE WITNESS: No, that's not -- that's not how I would characterize it at all. I don't believe they're pretending. I believe they're making sense, as we all do, of their experiences.

And that this label helps them make sense of their experiences, and also to provide a potential solution for them.

BY MS. ALTMAN:

Q. Well, is being transgender a label?

A. Yes, among other things, yes.

Q. And so label for what, sir?

A. Well, it is a label for a particular identity, just like Christian or British or sociologist, these are the ways in which we interact with the social world.

Q. Now, you go on to say in the end of that paragraph, "From a sample of over 700 referrals to the G-I-D-S, GIDS, in 2012" -- so ten years ago -- "and 2015" -- so less than ten years ago -- "14 to 15 percent were diagnosed with autism" -- you say ASC -- but autism spectrum conditions -- "and this was more than ten times greater than the rate for students in England," which you then cite to.

Do you recall that statement in your report?

A. Yes.

Q. And you go on to say, "The proportion among those subjected to GnRH could be even higher." What's the scientific basis or the evidence for that statement?

A. Can I -- I think this may be on page 10. Can we scroll forward --

Q. It is on page 10, yes.

A. The evidence for that is in the -- the next sentence, because in the first study that was done by the Tavistock kids, of the first 30 patients, almost half of them had autistic spectrum traits.

Q. Well, again, we discussed a few minutes ago, they are not mutually exclusive, right, somebody could be both -- have autistic spectrum disorder and also be transgender, correct?

A. Yes, yes.

Q. In -- in paragraph 20 of your report, you say, "Because of the risk of suicide" -- "because the risk of suicide increases greatly from prepubescence to late adolescence, altering normal cognitive and emotional development with GnRH could reduce the risk of suicide by preventing the child from maturing."

Did I read that right?

A. Yes.

MR. BEATO: Let me just pause here.

Ana, could you please scroll down --

MS. GONZALEZ: Okay. Sorry.

(Simultaneously speaking.)

MR. BEATO: Page 13, please. Thank you.

Sorry for the interruption, just wanted to...

MS. ALTMAN: No, no worries.

BY MS. ALTMAN:

Q. "Because of the risk of suicide," do you see that, sir, second sentence in paragraph 20?

A. Yes.

Q. What's the basis, the evidential basis for that statement, sir?

A. Well, that's an inference from the way that suicide is much higher, for example, in a 18-year-old than it is in a 10-year-old. We're talking about sort of the general population. So if we're able to sort of -- if you, like, freeze a 12-year-old at a sort of mental state of being 12, then one of the logical consequences of that will be less likely to -- to commit suicide than they would be otherwise.

Q. So the answer to my question is that you don't have any evidential basis for that statement in your report, correct?

A. Correct.

Q. It is just an inference that you've drawn?

A. Yes. Yes. And, in fact, the next says, "As yet, there is no evidence; however," so exactly, that's the case.

Q. But you were engaged to provide opinions in this case, not -- not inferences or musings or suspicions. You were engaged to provide opinions based on scientific evidence, correct, sir?

MR. BEATO: Object to form.

Dr. Biggs, you can answer the question.

THE WITNESS: I mean, the way science works is by entertaining different possibilities and different probabilities.

In that case, I think quite fairly, I said that it could be the case. It is not implausible on a theoretical basis that puberty blockers do reduce suicidality. However, there was no robust empirical evidence that that is the case.

So I think that gives the full panel of potential impacts of puberty blockers.

BY MS. ALTMAN:

Q. Sir, you would agree with me that your opinions are contrary to the WPATH standards of care?

A. Yes.

Q. And they are contrary to the American Medical Association?

A. Yes.

Q. And they are contrary to the American Academy of Pediatrics?

A. Yes.
Q. And they are contrary to the Endocrine Society guidelines?
A. Yes.
Q. And are you aware that your opinion is contrary to the standards of care for gender-affirming care in the United States generally?
A. Established clinical practice as its developed, yes.
Q. And you don't know, in this particular case, whether the treatments that the plaintiffs were receiving have been helpful or not, correct?
A. Correct.
Q. And I hope you would agree that the efficacy of puberty suppressors is best left to the experts in the field, meaning, endocrinologists, psychiatrists, and psychologists, correct?
MR. BEATO: Object to form.
Dr. Biggs, you can answer that question.
THE WITNESS: I believe that there should be a robust empirical debate in the literature, signed literature that robustly scrutinizes the evidence for the efficacy and safety of puberty blocks.
BY MS. ALTMAN:

Q. And I get that. And the robust empirical discussion should occur between medical practitioner, endocrinologist, psychiatrist, psychologist, correct?

A. No. It should occur between everybody who has something to say about this, including -- and can publish their work in a peer-reviewed journal.

Q. Including yourself; is that right?

A. Correct.

Q. And I think I asked you this earlier, but just in case, you don't have any clinical experience with puberty blockers, do you?

MR. BEATO: Objection to form, asked and answered.

Dr. Biggs, you can respond.

THE WITNESS: Correct.

BY MS. ALTMAN:

Q. Yeah, I wasn't trying to ask you the same question again, so I apologize if I did.

Now, sir, you've been quoted as making this statement, and I just want to understand it. This is a direct quote. It was in sex and gender. "I do not, however, believe that gender identity supersedes sex any more than I believe that Jesus was the son of God."

"Therefore, I oppose any attempt by the university to establish an official doctrine on gender,

just as I would oppose the imposition of a single religion or one particular position on Israel, Palestine."

Did I read -- do you remember making that statement?

A. Yes.

Q. Okay. And what does that mean, "I do not, however, believe that gender identity supersedes sex"?

A. I do not believe that gender identity or someone's subjectively perceived understanding of themselves should be -- weigh more in society than -- than their physical sex.

Q. Well, would you agree that it should at least be weighed the same?

A. No -- well, depends on the case -- depends on cases -- depends on the case. If you are talking about, for example, should a rapist be put in a women's prison -- a male who has used his penis to rape a woman should be put in a women's prison because his gender identity is that of a woman. I would say, in that case, for example, no. His physical biological sex should take precedence.

Q. Sir, have you ever been a prison warden?

MR. BEATO: Object to form.

Dr. Biggs, you can answer the question.

THE WITNESS: No, I haven't.

BY MS. ALTMAN:

Q. And have you done any research into whatever standards and guidelines are utilized by prisons in determining where prisoners are placed?

A. Yes.

Q. You have? And is any of that published literature referenced in your bibliography?

A. Of this -- of my expert report, no, because it wasn't relevant to the -- what I was being asked to do.

Q. And where would that published literature be that you've written on this subject?

A. The article is in the -- is in the general controversial ideas.

Q. Okay.

A. It is specifically about England, England and Wales.

Q. Okay. And when was that published?

A. I believe 2022.

Q. Okay. Sir, you wrote a chapter in a book titled, "Inventing transgender children and young people." Do you recall that?

A. Yes.

Q. Do you think that you can invent

transgender people or children?

A. Well, I believe that these labels or social categories are -- vary across cultures and over -- vary over time, like being lesbian or being African American versus, you know, other -- other sorts of identities. So, yes, I believe, in a manner of speaking, that identities are invented, like sociologist or lesbian or so on.

Q. You think being a lesbian is invented?

A. I believe that the -- the identifying as a lesbian as such is -- is a social construct, and that those have genealogies which we can explore, yes.

Q. And you think being transgender is invented?

A. In a way that is very common parlance in the social sciences, we talk about the way that constructs change over time and they vary across cultures.

Q. Well, what does that mean, sir? I mean, you've testified earlier you agree that transgender people exist, so what does it mean, that they are being invented?

A. Well, I believe Christians exist but I -- there is also societies in which there was no such thing as a Christianity, right, there's no such thing as a

Christian.

So there was nobody in 1900 identified as transgender because that -- that label had -- that category had not been created yet.

Q. Uh-huh. So your -- if I understand you correctly, you are just suggesting that the name for it has changed?

A. And the way it is theorized, the way -- the conceptualization of it, yes.

Q. Well, how are we conceptualizing it, how are you conceptualizing it?

A. Well, I'm conceptualizing it as a -- kind of a -- as a social identity, which -- which involves, in many cases, a medical physical intervention.

Q. Well, as a social identity, is that different from an actual identity?

A. Identities are generally social.

Q. So all identities are social?

A. Yes.

MR. BEATO: Counsel, I know we're approaching upon the one hour and 30-minute point. Would it be best --

MS. ALTMAN: Happy to take a break, Michael.

MR. BEATO: Perfect.

MS. ALTMAN: As long as you want.
MR. BEATO: So how about we meet -- I don't know --
MS. ALTMAN: As long as you want. 3:10?
MR. BEATO: I'm sorry?
MS. ALTMAN: 3:10 on -- I have 2:57. So 3:10. You want to do 13 minutes, you want to do 15 minutes, what do you want to do?
MR. BEATO: How about 3:05, if that works with you, Dr. Biggs.
MS. ALTMAN: 3:05.
THE WITNESS: 3:05, yep, that's good.
MR. BEATO: I didn't mean to interrupt your train of thought. Just want to get a quick little break.
MS. ALTMAN: No problem.
MR. BEATO: Thank you very much.
(A brief recess was taken from 2:57 p.m. to 3:04 p.m.)
BY MS. ALTMAN:
Q. So, sir, in paragraph 22 you say, "There are anecdotal reports of children experiencing increased suicidal feelings after GnRHa," did I read that correctly?
Do you need for us to pull it up on the

screen or do you recall making that statement?

A. I recall that.

Q. Okay.

MR. BEATO: And for my benefit, can we -- Ana, could you put that on the screen again for my benefit?

MS. GONZALEZ: I'm sorry, what paragraph was that? I was copying her e-mail.

MS. ALTMAN: P 2, 22.

MS. GONZALEZ: Page 22?

MS. ALTMAN: Yes, ma'am.

MR. BEATO: Paragraph 22.

MS. GONZALEZ: Oh, paragraph 22.

MS. ALTMAN: I'm sorry, yes, paragraph 22.

MR. BEATO: Thank you, Ana.

MS. GONZALEZ: You are welcome.

BY MS. ALTMAN:

Q. All right. Dr. Biggs, first of all, anecdotal reports of children experience increased suicidal feelings of -- feelings after GnRHa is not scientific evidence, can we agree on that?

A. Reports of adverse events are part of the medical -- part of the important documentation and medical -- medical research.

Q. Well, sir, you are not -- the only thing

you cite to that is this Brik 2020, correct, of one --

(Simultaneously speaking.)

BY MS. ALTMAN:

Q. Let me just finish.

Of one teenager who stopped treatment because of the increase in mood problems and suicidal thoughts and confusion attributed to GnRH treatment, correct?

A. There is a -- in the next -- I think -- believe the subsequent sentence, there is another case.

Q. Right. So there is two instances. And -- and in the first instance, the child was obviously monitored, which is what you would do when you put someone on any medication, correct?

You would -- as a medical practitioner, you would evaluate how that person is -- is doing clinically on the medication, correct?

MR. BEATO: Object to the form.

(Simultaneously speaking.)

MR. BEATO: Dr. Biggs, can you please repeat your answer?

THE WITNESS: Yes. So medical practitioners certainly should be monitoring children who are on puberty blockers, definitely.

BY MS. ALTMAN:

Q. Okay. But that's -- so that's a reason to monitor care, not to ban it; isn't that right, sir?

A. Yes.

Q. Now, sir, in paragraph 24 on page 16, and going on to page 17, as well, in paragraphs 26 and 27, so paragraphs 24, 26, 27, you consistently use your -- your interpretation rather than science.

For example, in paragraph 24 you refer to "One obvious explanation is that clinicians were following the WPATH health recommendations against commencing medical intervention when an adolescent is experiencing an acute mental health crisis."

And so you are providing your explanation but that doesn't make it the actual explanation, does it, sir?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: Correct. Though, that was not my explanation. It would be the -- of any scientist worth -- any scientist worth his or her salt would suggest that that is a potential explanation.

BY MS. ALTMAN:

Q. It's one explanation, not necessarily the explanation, correct?

A. Absolutely correct.

Q. Right. And in paragraph 26, the first sentence, "The Dutch pioneers warned at the outset that patients 'could' end up with a decreased bone density, which is associated with a high risk of osteoporosis."

So, again, it could happen, that doesn't mean it will happen, correct?

A. Yes.

Q. And then further down in the paragraph you say, "In addition, children given GnRHa already have unusually low bone density, perhaps due to the high prevalence of eating disorders."

So now, if I read your statement, which is not referencing any evidence whatsoever, now you are musing about whether or not people have low -- already have low bone density because they have a high prevalence of eating disorders, right, sir?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: My apologies for not providing a citation. I thought that this would have been sort of common knowledge.

One citation I could have used is Olson-Kennedy, who states in her NIH -- Olson-Kennedy is not the first author but one of

the coauthors of this article which is on bone density on 95 children who were given GnRH, and they're in an NIH-funded study.

And suggested that they -- the data were from this 95, that they have unusually low bone density due to -- probably due to eating disorders.

BY MS. ALTMAN:

Q. "Probably" was the word you just used?

A. I couldn't -- I cannot quoting what they are saying, but one of the recommendations was that clinicians must always ask about eating disorders because they suggested that calorific deficiency was what was causing this usually low bone density.

Q. And that would be part of a clinician's job, right, before they put an individual on any medication, they should do a thorough clinical examination of the patient, correct?

A. They certainly should do a thorough clinical examination, yes, you are correct.

Q. Right. And that, again, is a reason to do a thorough clinical analysis but not to ban care, correct?

MR. BEATO: Object to form.

You can answer that, Dr. Biggs.

THE WITNESS: Well, this is one of the reasons why, in this particular population of children with -- starting out with on average -- a lower bone density than average, the risks of decreasing that density is going to be more pronounced.

So it's -- it's a statistical fact that's important -- is very important in evaluating the costs and the benefits of the treatment.

BY MS. ALTMAN:

Q. Which is why the clinicians and medical professionals should monitor the care, correct?

A. Certainly, they -- clinicians should monitor the care, yes.

Q. Right. That's not a reason to ban care, correct, sir?

A. It's not -- by itself, it does not say that the care should be banned, correct.

Q. And at the bottom of page 17, paragraph 7, again, you use the word "Anecdotally, a British female patient who started GnRH at age 12 then experienced four broken bones at the age of 16," correct?

A. Correct.

Q. Did I read that right? Right?

A. Yes.

Q. And, sir, as you sit here today, you don't know why this one individual at the age of 16 had four broken bones, do you?

A. No.

Q. And, again, on page 19, paragraph 29, you said, second or third sentence, referring to the Dutch -- "Dutch clinicians initially promoted puberty suppression as providing space for therapeutic exploration of gender identity without the pressure of physical changes accompanying puberty."

Did I read that right?

A. Yes.

Q. And that makes sense, does it not, sir?

A. It was one -- it was a plausible outcome, yes, yes.

Q. And the bottom of paragraph 30, again, you use the word "suspicion." "The suspicion is that puberty suppression reinforced gender dysphoria." Do you recall making that statement in your report?

A. Yes.

Q. Whose suspicion are you referring to there, sir?

A. Can I see -- let me --

Q. Page 20, the first -- there you go.

A. I'm just looking at what comes -- precedes

that.

Q. Sure.

MR. BEATO: Ana, could you go to page 19, please.

THE WITNESS: That's okay. No, I've seen it on my paper copy.

That is I think any reasonable observer -- or any scientific observer would suspect that is one -- one potential possibility, yes.

BY MS. ALTMAN:

Q. Not to the exclusion of other possibilities, correct, sir?

A. Absolutely.

Q. So this is just, again, one possible scenario, a hypothetical, but it could be something else completely, correct?

A. Yes.

Q. And, sir, we talked about social constructs earlier, and you would agree with me that being male or female is also a social construct, correct?

A. No, I disagree on that.

Q. You do. How so?

A. I believe what male and female are biological -- are biological concepts, not sociological concepts.

Q. And what's your basis for that statement?
A. Reading of the literature around sex.
Q. What literature specifically are you referring to?
A. Evolutionary literature on the evolution of sex.
Q. Is that a specific periodical that you are referring to, the evolution of sex?
A. No, I'm referring to a sort of literature, a large scientific --
(Phone interruption.)
(Reporter asks for clarification.)
THE WITNESS: Literature about why sex evolved.
BY MS. ALTMAN:
Q. And what specific literature are you referring to?
A. Well, I'm not -- I'm not going to cite particular articles, but the reason. This is a -- there's a huge literature on why sex evolved. And sex has been around for many millions of years. And it so long predates humans and long predates culture, human culture.
Q. Based on your -- that's your reading of this sex evolution history, that's your conclusion from

it; is that correct?

A. Correct.

Q. Now, sir, you've been linked to some transphobic tweets, you -- are you aware of that?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: Yes.

BY MS. ALTMAN:

Q. And it's correct, sir, have you been tweeting under the pseudonym Henry Wimbush?

A. I used -- that was a student of my Twitter account, yes -- or my -- yes.

Q. And I know you talked a lot today about how you want a free and open discourse and people should be able to, you know, give their opinions on various matters. And in keeping to that, why did you hide behind a pseudonym, why didn't you use your name?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: Because I believe that evidence shouldn't be based on who -- on the status or the credentials of the person saying it. It should be based on the logic and empirical evidence of the statement -- incorporating the statement.

BY MS. ALTMAN:

Q. Well, why would you think it would be any less impactful or important if you used your own name versus Henry Wimbush?

A. As I said, I don't believe that views should be judged by the -- the identity of the person or the credentials of the person making those statements but on the content of the statement themselves.

Q. So you believe -- it's most appropriate to hide behind a keyboard, is that what I'm hearing you say?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: I think there is a long history of pseudonymity. I mean, the federalist -- I believe The Federalist Papers, the authors of The Federalist Papers chose to hide behind a keyboard, as you might say.

BY MS. ALTMAN:

Q. Well, is there any particular reason why you didn't use your real name, sir?

A. I think I've already explained why I have -- why I made that decision.

Q. Now, you were exposed in an article in The Oxford Student, right?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: Correct.

BY MS. ALTMAN:

Q. And I just want to ask you about some of your tweets. One of them is, and I'm quoting, "Transphobia is a word created by fascists and used by cowards to manipulates morons."

Do you recall sending out that tweet?

A. Yes.

Q. What does that mean?

A. So it is a very famous quote by Peter Hitchens, an atheist. And he used the -- originally, of course, the quote was about Islamophobia. And as an atheist, he was objecting to the way his atheism -- or his criticism, let's say, of Islam would be denounced as being Islamophobic.

And I was -- I think the tweet indicates that a similar -- there can be a similar silencing of discourse around using the word "transphobia."

Q. Well, so you changed the quote. It is not a direct quote, correct, sir?

A. No. Exactly. But it's obviously -- to the learned audience, it's obvious what the reference is. I'm ripping off. It's ripping off somebody else's very famous quote.

Q. Right. No, and I apologize. Perhaps I'm not the learned audience that you were trying to reach, but I still have some questions about it because I don't understand.

What is it you were trying to communicate to the reader, sir, by saying -- are you concerned that people perceive -- would perceive you or anyone else as transphobic?

MR. BEATO: Object to form.

Dr. Biggs, you can answer that question.

THE WITNESS: I believe that important public policy debates around sex and gender are sometimes stifled by accusations of transphobia, yes.

BY MS. ALTMAN:

Q. Well, has anyone accused you of being transphobic?

A. Yes.

Q. Who has accused you of that?

A. Well, I believe that The Oxford Student article you mentioned does. I can't quote chapter and verse but I believe that's the -- at least the -- the implication.

Q. Well, sir, that -- the tweet that you -- that they wrote about occurred before the article, right?

A. Yes.

Q. Right. So they were only interpreting what you were -- you or Mr. Wimbush was putting out into the universe, correct?

A. Yes.

Q. So they had no reason -- they were not predetermined to be against your tweets. You put that information out into the universe, correct?

A. Yes.

Q. And so why is "transphobia" a word created by fascists?

A. Well, it is a play on words suggesting that there is an authoritarian streak in some forms of the transgender movement, and that includes the short-circuiting of important debates, such as the one I mentioned earlier about sort of, for example, should a rapist be put in a women's prison by short-circuiting of that proper democratic debate through accusations of transphobia.

Q. Well, you would agree with me, sir, I assume, that for every opinion that the person that holds the opinion -- strike that.

You would agree with me, a actual debate or discussion isn't one-sided. And so the fact that one person believes a person who is a transgender female

should not be put in a women's prison, there is someone else that might feel differently, correct?

MR. BEATO: Object to form.

You can answer, Dr. Biggs.

THE WITNESS: Yes.

BY MS. ALTMAN:

Q. Right. And both can coexist, meaning the person that has the opposite opinion is entitled to that opinion, correct?

A. They should be entitled.

Q. Right. You are not trying to stifle the debate that you claim you want, are you?

A. No, of course not.

Q. Okay. Now, I believe you've also made a tweet that claims "transitioning makes you LESS attractive," do you recall that?

A. I don't recall that. But if you've read it, I -- that may be the case.

Q. And the less is in all caps. Do you believe that transitioning makes somebody less attractive?

A. I believe transitioning is likely to reduce your potential pool of sexual partners or romantic partners, yes.

Q. Well, that's not what this says. This

doesn't say transitioning reduces your pool of potential sexual partners, does it?

MR. BEATO: Object to form.

You can answer, Dr. Biggs.

THE WITNESS: I really do not recall the particular reply or the Twitter thread that -- that that was -- that tweet was embedded in. But I believe that my -- to my -- best of my interpretation now, that is the import of that -- of that statement.

BY MS. ALTMAN:

Q. Okay. So is it your testimony here today you weren't trying to imply that transitioning makes someone physically less attractive, all caps?

A. It reduces their chance that that individual will find -- reduces the potential pool of romantic and sexual partners to that individual.

Q. Why?

A. Because, for example, if I'm a heterosexual man and I transition into a woman, if I have breast augmentation and I take estrogen, and I want to find lesbians, female homosexuals to have sex with, that's going to be a relatively small proportion of the lesbian population who will be interested in me as a potential wife or girlfriend.

Q. Why would you assume that that would be the only pool of people that might be your opportunity for a sexual partner?

A. I believe that that would be one obvious -- not the only pool but a significant pool that one would -- might be hoping that one could, you know, swim in, as it were.

Q. Well, based on what is your analysis of what pool a transgender female wants to swim in?

A. I couldn't cite particular chapter and verse of literature, but I believe there are surveys of who trans people -- their ideal partner would be or what kind of person they are looking for. And a very large number of males who transition, particularly later in life, are looking for lesbian -- lesbian partners.

Q. What particular important social commentary were you trying to make with this tweet, I mean, why were you concerned --

MR. BEATO: Object to form.

BY MS. ALTMAN:

Q. Why are you concerned with what sexual partners a person has who has transitioned?

MR. BEATO: Object to form.

You can answer, Dr. Biggs.

THE WITNESS: I'm afraid I genuinely can't

remember the context of that tweet.
BY MS. ALTMAN:
Q. Okay. Well, do you recall a tweet generally about many cis-gay youth have inappropriately transitioned to become straight?
A. I can't remember the particular one but I understand what -- what you are getting at.
Q. Well, no, what -- what are you getting at?
A. The suspicion that I think is in my report, that children who could grow up without being medicalized to become either feminine boys, gay boys, or masculine lesbians have been -- adopted a transgender identity which puts them on the path to -- for lifelong medicalization. An example would be the very first patient who took gender -- GnRH, B. or F.G.
Q. Sir, do you believe gender-affirming care is akin to eugenics?
MR. BEATO: Object to form.
You can answer, Dr. Biggs.
THE WITNESS: I believe that it is -- yeah, within a robust debate in public policy, that -- that's not an unfair characterization.
BY MS. ALTMAN:
Q. Well, I don't know -- I didn't ask about robust public policy. I asked you if you believe that

gender-affirming care is akin to eugenics?

MR. BEATO: Object to form.

You can answer, Dr. Biggs.

THE WITNESS: Certainly it is creating, particularly when -- it is creating a class of individuals who are not -- who are going to have either no chance or very little chance of giving -- of having children. So it is essentially like sterilizing some individuals.

BY MS. ALTMAN:

Q. Well, when you say "no chance" or "very little chance" of having children, are you specifically referring to whether or not they can physically carry a child as opposed to having children through other means, surrogate, adoption, fill in the blank?

A. Yes, exactly, yes.

Q. And so if I understand you correctly, you think that because someone may not be able to -- to have a child, if they were to go through transition, that that is in some way akin to eugenics, is that your testimony?

MR. BEATO: Object to form.

THE WITNESS: Yes. Could we -- could we remove the deposition so I can just see -- see you a bit better? It just helps me to pick up the questions.

MS. ALTMAN: Sure.

MR. BEATO: The expert report.

THE WITNESS: Sorry, the expert witness statement, yes.

MS. ALTMAN: Ana -- she's got it. There you go. Okay. And I'm almost done, if that helps, so...

THE WITNESS: Yes.

BY MS. ALTMAN:

Q. So in what way -- I'm just trying to understand, in what way this is like eugenics, sir?

MR. BEATO: Object to form.

You can answer, Dr. Biggs.

THE WITNESS: So eugenics was a program of sterilizing certain people who are seen as inferior in order to promote the health of the race. And the analogy that was being drawn here is that contemporary medical practices are also sterilizing some children, or putting them on a path to sterilization, in which case they wouldn't be -- ironically, treating them is almost like an inferior type of individual who shouldn't be allowed to reproduce.

And that was banned, that's why it was being objected to.

BY MS. ALTMAN:

Q. Well, you would agree with me, sir, that people who are transgender are choosing their own path, whereas eugenics is someone else charting a course for them, correct?

MR. BEATO: Object to form.

BY MS. ALTMAN:

Q. Someone else made a decision that they are in some way inferior and making a decision for that person or group of people versus being transgender, which is, we all agree, I think you -- yourself agree, is something that's innate to the person, correct?

MR. BEATO: Object to form.

You can answer, Dr. Biggs.

THE WITNESS: I never believe -- and I do not believe I stated that transgen- -- being a transgender was innate. I don't believe I've ever said that.

BY MS. ALTMAN:

Q. Well, you believe people can be transgender, correct?

A. Correct.

Q. You've testified to that earlier, correct?

A. Correct.

Q. Okay. And so are you now suggesting it's

not innate, that somebody is superimposing it on someone?

MR. BEATO: Object to form.

You can answer, Dr. Biggs.

THE WITNESS: Well, I believe someone can be a Christian. I don't believe that Christianity is innate in the individual.

BY MS. ALTMAN:

Q. Well, sir, are you -- are you correlating Christianity with being transgender, I just want to make sure I'm following?

MR. BEATO: Object to form.

THE WITNESS: I'm just giving you analogy on how to explain -- how I can -- obviously, transgender people exist without necessarily claiming that being transgender is an innate property of the individual.

BY MS. ALTMAN:

Q. Right. And I'm just trying to understand. Is it your testimony under oath that you believe that's a correct analogy?

MR. BEATO: Object to the form.

BY MS. ALTMAN:

Q. That neither of the two things are innate?

MR. BEATO: Object to form.

THE WITNESS: Yes, it's a helpful analogy.

I mean, like any other analogy, it has limitation.
BY MS. ALTMAN:
Q. Well, I thought we went through this earlier. And, again, I don't want to retread. But, sir, I thought we agreed that -- and I'm going to give you the benefit of your testimony -- you thought that in some instances transgender could be a choice, but that in many other instances, it is not a choice, correct, do you recall that testimony?
A. Yes.
Q. Okay. And you -- that's your testimony, right?
A. Yes.
Q. And so at least in your world, there is at least some subset of people that are transgender and it is not a choice, correct?
A. Well, it may not be their choice, it may be the choice, for example, of their parents, for example.
Q. But it may be their choice and it may not be their choice, it may be innate, correct?
MR. BEATO: Object to form.
You can answer, Dr. Biggs.
THE WITNESS: I mean, a child who is brought up in a pious Christian home and Christian school and sent to Bible every -- Bible study and

church and very -- given a very religious upbringing, I would say that child did not really have a choice to be a Christian. But I don't believe that Christianity is somehow sort of physically innate in them in the way that blue eyes would be, for example.

BY MS. ALTMAN:

Q. Well, sir, we want to -- you keep focusing on children. Let's try and unpack it a little by not talking about children for a minute.

You would agree with me that there are adults that -- that live their life as one gender and ultimately come to terms with the fact that they have a gender identity different from their gender at birth, correct?

A. Yes, yes.

Q. So let's not talk about parents and Christians and whatever else you want to talk about. I'm talking about adults now.

Would you agree with me, sir, that there are transgender individuals, that it is not a choice, it is innate to them?

A. I think maybe we have a different understanding of innate.

Q. Okay. Well, what's your understanding of

innate, sir?

A. Innate is something that would -- would be -- would arise regardless of the cultural context.

Q. What does that mean, sir? Are you trying to say that every transgender person arises because of the cultural context, is that your testimony?

MR. BEATO: Object to the form.

BY MS. ALTMAN:

Q. Whatever that means?

MR. BEATO: Object to form.

THE WITNESS: I'm suggesting that there are different societies. Different cultures have different ways of understanding gender. And, obviously, our society, our culture at this moment has an understanding which is encapsulated in the label "transgender." But that is not universal or across -- across different societies, different cultures.

BY MS. ALTMAN:

Q. Meaning what? That it is your testimony under oath that there are people in other societies and other cultures that -- that have no individuals that are transgender, is that what you want this Court to believe?

MR. BEATO: Object to form.

THE WITNESS: They might understand

their -- their experience in quite different ways. For example, they would not be seeking cross-sex hormones, for example.

BY MS. ALTMAN:

Q. Who is the they in your sentence?

A. No individuals and -- before 1900 were seeking cross-sex hormones.

Q. Sir, you are here to provide your opinions today. I'm happy to talk to you at length if you'd like during your deposition about the 1900s. But I'm just trying to understand your testimony here today about what -- what it is today.

Is it your opinion under oath that being transgender is a choice?

MR. BEATO: Object to form.

You can answer, Dr. Biggs.

THE WITNESS: In some cases, yes.

BY MS. ALTMAN:

Q. And in some cases?

A. In some cases no.

Q. Okay. Thank you very much. And I think I asked you this earlier, but just in case, other than talking to -- to Michael for five minutes, did you discuss your deposition testimony with anyone else?

A. No.

Q. And I think you also answered you've not read any of the other depositions in this case, correct?
A. Correct. Expert witness -- yeah, expert reports.
Q. Yes, sir.
A. Correct.
Q. Do you --
A. Except the rebuttals, except the five rebuttals to -- five rebuttals to expert reports.
Q. Right. And my question, I'm sorry, was about deposition transcripts. Have you read any deposition transcripts?
A. No.
Q. No. Did hormone treatments exist before the 1900s?
A. No.
Q. Did we even understand hormones before the 1900s?
A. No.
Q. So using your analogy before in referencing that before the 1900s, you know, transgender was not a thing, that really isn't a good analogy because it didn't exist, correct, the use of cross-sex hormones?
MR. BEATO: Object to the form.
You can answer, Dr. Biggs.

THE WITNESS: Yes, I think medical -- certain medical technologies make certain -- certain identities more -- more likely or more -- more attractive.

MS. ALTMAN: Let me just look at the report real quick, sir, and make sure I don't have any other questions. I'm either just about done or done. So just give me one second.

BY MS. ALTMAN:

Q. Sir, on the bottom of page 13 of your report, I don't think we need to bring the report up, I just have a quick question.

You cite to -- it says, "In the Belgian clinic which experienced the exceptionally high suicide rate," then there is a period and a lowercase, "subsequent correspondence reveals that suicide was" -- and I'm quoting -- "suicide was related to many more psychological problems than G.D., and occurred mostly a few years after the start of hormonal treatment."

And you cite to an e-mail from Gaia Van Cauwenberg, C-A-U-W-E-N-B-E-R-G, to Avi, A-V-I, Ring, R-I-N-G, an e-mail dated May 27, 2022.

Is that your evidence that you are relying upon for that statement, is an e-mail from this one individual to another, or did you have other evidence for

that proposition?

A. That's the evidence. And that -- the -- Van Cauwenberg is one of the authors of that articles -- of the article that talks about the high suicide rate in the Belgian clinic.

Q. Okay.

MS. ALTMAN: I don't have any more questions, sir.

Michael.

MR. BEATO: And thank you again, Dr. Biggs, for your -- for your testimony. I just have two questions for you.

CROSS-EXAMINATION

BY MR. BEATO:

Q. The first question is, do you think that the subject matter of gender-affirming care is controversial?

A. Yes.

Q. Then why did you decide to weigh in and opine into this controversial subject matter?

A. Because I believed that the empirical evidence did not justify the kind of certainty that was being presented in the practice of gender clinics, like the Tavistock in London, and in the sort of media discussion of the care for transgender children and

adolescents.

MR. BEATO: No further questions.

MS. ALTMAN: You want to tell him his right to read or waive or do you want me to do it?

MR. BEATO: You can do it.

MS. ALTMAN: So you have the right to read your transcript. Can't make substantive changes but you can read it. Maybe you said yes, the court reporter wrote no or something else. So you have the right to read or waive your transcript.

THE WITNESS: How long would I have to do -- to read and -- and approve that transcript?

MS. ALTMAN: 30 seconds -- no, I think it's 30 days.

THE WITNESS: I will take -- I would rather -- I probably would like to read it, then.

MS. ALTMAN: Okay.

And then I just have one real quick redirect question.

REDIRECT EXAMINATION

BY MS. ALTMAN:

Q. Have you weighed in on whether surgeries should be provided to intersex infants?

A. No, I haven't, but I have a strong view that they shouldn't be unless absolutely medically

necessary.

MS. ALTMAN: So, Ms. Bush, he is going to read it, I think. Did I get that right?

THE WITNESS: Yes. Yes, please.

MS. ALTMAN: Okay. I believe we are ordering on an expedited basis. So we will take a copy -- the original, I guess. And we want it on an expedited basis.

MS. REPORTER: And when is that, when do you want it by? As soon as I can get it to you?

MS. ALTMAN: Right, but faster than that.

MS. REPORTER: Do you have a specific time frame in mind?

MS. ALTMAN: Well, I mean, we're -- I mean, as soon as possible. As soon as you can humanly get it here.

MS. REPORTER: That's fine.

And then, Michael, do you want a copy?

MR. BEATO: Yes, please.

(The proceeding is adjourned at 3:44 p.m.)

CERTIFICATE OF NOTARY PUBLIC

STATE OF FLORIDA

COUNTY OF _____

I, MICHAEL BIGGS, PH.D., certify that I have read the foregoing transcript of my deposition and that the statements contained therein, together with any additions or corrections made on the attached Errata Sheet are true and correct.

Dated this _____ day of _____, 20__.

_____

MICHAEL BIGGS, PH.D.

The foregoing certificate was subscribed to before me this _____ day of _____, 20__, by the witness who has produced a _____ as identification and who did not take an additional oath.

_____

NOTARY PUBLIC

ERRATA SHEET

IN RE: DEKKER VS. WEIDA, ET AL.

DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE:

Page No.	Line No.	Change	Reason
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I have read my deposition in this matter and entered any changes in form or substance as reflected above.

_____ _____

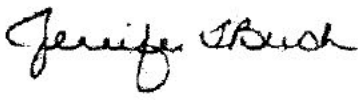
DATE MICHAEL BIGGS, PH.D.

CERTIFICATE OF OATH OF WITNESS

STATE OF FLORIDA)
COUNTY OF ST. LUCIE)

I, the undersigned Notary Public, in and for the State of Florida, hereby certify that MICHAEL BIGGS, PH.D. personally appeared before me and was duly sworn.

WITNESS MY HAND and official seal in the City of Fort Pierce, County of St. Lucie, State of Florida this March 24, 2023.



Jennifer L. Bush, RPR, FPR
Notary Public
State of Florida at Large.
My Commission: #HH 002112
My commission expires: 9/24/24

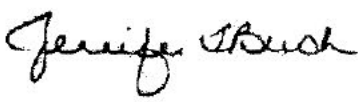
CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF ST. LUCIE)

I, Jennifer L. Bush, Registered Registered Registered Professional Reporter, do hereby certify that I was authorized to and did stenographically report the deposition of MICHAEL BIGGS, PH.D.; and that a review of the transcript was requested; and that pages 1 through 243, inclusive, are 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, attorneys or counsel connected with the action, nor am I financially interested in the action.

Dated this March 24, 2023.



Jennifer Bush, RPR, FPR

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March 24, 2023

MICHAEL BIGGS, PH.D.
C/O Michael Beato, Esquire
Holtzman Vogel Barantorchinsky & Josefiak PLLC
119 S Monroe Street, Suite 500
Tallahassee, FL 32301

RE: DEKKER VS. WEIDA, ET AL.
Deposition of MICHAEL BIGGS, PH.D.
Dear Dr. Biggs:

This letter is to advise you that the transcript of the deposition listed above is completed and is awaiting reading and signing. Depending on the length of the transcript, you should allow yourself sufficient time.

If the reading and signing has not been completed prior to the time of trial, we shall conclude that you have waived the reading and signing of the deposition transcript.

Your prompt attention to this matter is appreciated.

Sincerely,

Jennifer L. Bush, RPR, FPR
CC: All counsel on appearance page

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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