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

AUGUST DEKKER, et al., *Plaintiffs*, v. JASON WEIDA, et al., *Defendants*.	Case No. 4:22-cv-00325-RH-MAF

REBUTTAL EXPERT REPORT OF QUENTIN VAN METER, M.D.

I, Quentin Van Meter, M.D., declare that the facts contained herein are true and correct to the best of my knowledge and belief, and that the opinions expressed herein represent my own.

Introduction

1. I have been asked by counsel for the Defendants to respond to the expert report of Dr. Johanna Olson-Kennedy.

2. I received my B.A. in Science from the College of William and Mary and my M.D. from the Medical College of Virginia, Virginia Commonwealth University. I am currently a pediatric endocrinologist in private practice in Atlanta, Georgia. I am the President of Van Meter Pediatric Endocrinology, P.C. I am on the clinical faculties of Emory University School of Medicine and Morehouse College of Medicine, in the role of adjunct Associate Professor of Pediatrics. I am board certified in Pediatrics and Pediatric Endocrinology. I have been licensed to practice medicine in Georgia since 1991. I have been previously licensed to practice medicine in California, Louisiana, and Maryland.

3. I did my Pediatric Endocrine fellowship at Johns Hopkins Hospital from 1978-1980. The faculty present at that time had carried on the tradition of excellence established by Lawson Wilkins, M.D. Because of the reputation of the endocrine program as a center for exceptional care for children with disorders of sexual differentiation, I had well-above average exposure to such patients. As a Pediatric Fellow, I was also exposed to adults with Gender Identity Disorder, then called Trans-Sexuality, and received training from John Money, Ph.D., in his

Psycho-hormonal Division. Over the past 44 years, I have closely followed the topic of incongruent gender in children, adolescents, and adults, but I am focusing this report on working with children and adolescents.

4. The bases for my opinions expressed in this report are my review of Dr. Olson-Kennedy's report dated February 16, 2023, my professional experience as a pediatric endocrinologist, and my knowledge of the pertinent scientific literature, including those publications listed in the attached bibliography.

5. A list of my publications is included in my curriculum vitae, which is attached as Exhibit "A" hereto.

6. Over the past four years, I have testified at trial and/or deposition in the following cases:

- 2019: Multiple Plaintiffs v. State of Ohio Bureau of Records, Columbus, Ohio, deposed.
- 2020: Loughman v. Loughman, Harris County, Texas, deposed, court testimony.
- 2021: Spahr v. Spahr, St Louis County, Missouri, court testimony.
- 2021: Laura Cauthen v. James Cauthen, Cobb County, Georgia, court testimony.

7. I am being compensated at an hourly rate for actual time devoted, at the rate of $350 per hour including report drafting, travel, testimony, and consultation. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

Response to Dr. Olson-Kennedy

8. In paragraph 1 on page 8 of her report, Dr. Olson-Kennedy wrongly states that gender identity "has a strong biological basis." To the contrary, there is no biologic basis for gender identity.[1] Genetic markers have been evaluated but there is no statistical significance between genomic sequences in trans-identified individuals compared to the sequences of non-trans humans of the same sex.[2,3] MRI studies on human adults do not show an identifiable female or male brain.[4] A study purporting to show a female configuration of the brain in trans female patients was marred by the small sample size and inability to reproduce the findings[5] and the differences reported can be explained by neuroplasticity.[6]

9. The term gender has crept into the vernacular as a replacement for the word sex. Gender originally was a linguistic term describing nouns as either masculine or feminine in a number of languages. It was actually John Money who introduced the term gender identity as the internal sexed self in 1955.[6] This contradicts this statement in paragraph 1 of Dr. Olson-Kennedy's opinion, suggesting that it was coined by Robert J. Stoller some 9 years later. Dr. Olson-Kennedy states that gender identity and gender are the same, when that is not the case if sex and gender are used interchangeably.

10. Contrary to the suggestion in paragraph 8 of the report, there is absolutely no spectrum to biologic sex. Sex is binary. Individuals with disorders of sexual differentiation are not a third sex.[8] Mosaicism can occur in varying degrees, but the patient remains either male or female, not both. In my clinical

experience over 42 years of practice, none of my hundreds of DSD patients have experienced any gender identity confusion. The same Endocrine Society whose guidelines say "biologic sex" is a term that should not be used subsequently published a statement that biologic sex is a necessary determinant of human propensity for disease, and that it is necessary to understand the response to therapeutic interventions.[9]

11. In paragraph 10 on page 12 of her report, Dr. Olson-Kennedy refers to the World Professional Association of Transgender Health's (WPATH's) Standards of Care version 8 (SOC 8). However, "SOC 8" are not indeed standards of care, by definition, since there is clearly no consensus of opinion For example, Drs. Kenneth Zucker and Paul McHugh are internationally recognized experts in the field of human sexuality and yet their contrary viewpoints were not discussed or included in "SOC 8".

12. As Dr. Olson-Kennedy notes in paragraphs 11 and 12, the WPATH "SOC 7" served as the template for the recommendations of the Endocrine Society, the Pediatric Endocrine Society, the UCSF guidelines and the position statement of the American Academy of Pediatrics. However, she fails to note that all of the recommendations were essentially the product of authors in leadshipe positions within WPATH. The recommendations are not uniformly supported by members of those other organizations. The American Academy of Pediatrics' 67,000 members were not consulted. The Endocrine Society sent their standards out for comment to membership before approval, but they did not

acknowledge the input or make any changes based on our objections. The Pediatric Endocrine Society requested input from membership with a warning that suggestions like those we made to the Endocrine Society would not be considered. The leadership of the American Academy of Pediatrics called to question the wisdom of that organization's 2018 policy statement.[10]

13. The vast amount of publications which exist, including the DSM-V[1] and the Handbook of Human Sexuality published by the American Psychological Association indicate gender identity is fluid and can change.[11] There are over 11 published studies which clearly prove that desistance occurs in children who have been allowed to proceed uninterrupted through natural puberty ranging 50-98 percent of the time.[1,12,13,14,15,16,17,18,19,20,21] In-depth mental health evaluation of the patient, the family, and those in close contact with the patient and subsequent counseling to resolve pathology is truly beneficial and most often effective.[22]

14. In paragraph 14 on pages 13-14 of her report, Dr. Olson-Kennedy incorrectly suggests that my report attached to the GAPMS determination somehow endorsed what she calls "conversion," "redirection," and "corrective" therapy. Nowhere in my report do I state that I endorse conversion or redirection therapy. Those are her terms, not mine. Instead, I outline the use of extensive in-depth evaluation of the mental health of the patient, parents, and siblings and assessment of the adverse childhood events to which the patient was exposed. The term conversion therapy is used pejoratively to suggest that allowing the patient to examine their underlying mental health issues is somehow converting

a male or female patient, when recommended counseling is indeed just addressing the mental health morbidities to facilitate healing the patient.

15. In paragraph 16 of her report, Dr. Olson-Kennedy expands on a topic never mentioned by me and refers to "people like me" who advocate "redirection" therapy. But my report never mentions "redirection" therapy. She refers to my statement on the recommended use of counseling as unethical and ineffective. In doing so, she refuses to acknowledge the consequential body of literature in peer-reviewed journals which shows the beneficial outcomes that result from counseling.[22,23,24,25,26] She also stands against her own referenced documents (Endocrine Society Guidelines and WPATH SOC 7) which state that first and foremost, mental health evaluations and counseling must be done before any social, medical, or surgical interventions are considered. The American Academy of Pediatrics' policy statement does clearly state that any kind of counseling is unethical, but it came under fire for that.[27,28]

16. In paragraph 17 on pages 15-16 of her report, Dr. Olson-Kennedy's version of wait-and-see suggests that once puberty starts, medical intervention follows immediately, whereas wait-and-see has been used by others to describe waiting until *completion* of puberty at the age of consent, since by that time the vast majority of patients have desisted.

17. In paragraphs 18, 19, and 20 on pages 16-18 of her report, Dr. Olson-Kennedyattempts to make her treatment plans sound compassionate and other treatment plans sound barbaric. She is wrong in stating that there is no goal to

affirm any specific outcome. Why would anyone socially transition a child if their goal were not to follow on with medical, and then surgical transition. The director of the transgender clinic in Columbus, Ohio stated, under oath, that she was unaware of any patients who dropped out from that pathway.[29] Dr. Olson-Kennedy's statement that there is no data to support the automaticity of the intervention cascade is true because there is no transparency of full data from any of the transgender care centers. Her theory that social affirmation in pre-pubertal patients does not lead to medical and surgical interventions during puberty is false.[13]

18. Dr. Olson-Kennedy's claim in paragraph 21 on page 18 of her report that treatment is individualized is not substantiated by data from each transgender center, again with a complete lack of transparency.

19. Dr. Olson-Kennedy refuses to recognize that patients with gender dysphoria have undercurrent mental health issues. Patients referred to me with the diagnosis of gender dysphoria have undercurrent depression and/or anxiety that historically preceded the gender dysphoria. The published literature suggests that a conservative estimate for undercurrent mental health issues is 70%. Data are hard to extract because there is no uniformity or transparency to the protocols used in the transgender clinics in the United States. The recent published data from the NIH study clearly point that out. Each of the four study centers had different consent forms and the study design was an observation of the response to interventions at four independent sites.[30] This was the explanation used to

explain why there was no central uniform design or accountability to an Institutional Review Board (IRB).

20. GnRH super-agonists (puberty blockers) interrupt signaling to the gonads and thereby suppress the innate gonadal steroid production. The "Dutch protocol" (cited in paragraph 24 on page 20 of Dr. Olson-Kennedy's report) started pubertal suppression in Tanner stage III (average age 14 years), but never before age 12 (which is the average age of onset of menstruation in females). This intervention is suggested to be used as a "pause" at the very onset of puberty (stage II) by the Endocrine Society Guidelines.[13] However, the pause in U.S. transgender clinics is often for as little as a month.[31] Delayed puberty is a reason why adolescents seek endocrine consultation because of the social consequences that surround delay. It is the most common reason we see adolescent boys for evaluation of short stature.

21. In paragraph 24 on page 20 of her report, Dr. Olson-Kennedy refers to the use of GnRH super-agonist therapy in the FDA-approved indication for precocious puberty and cites the safety data and the reversible nature of such treatment. That is comparing apples to oranges. Stopping puberty in the adolescent age range and then overlapping cross-sex hormones in supraphysiologic dosing is a completely different circumstance. It is an open-ended experiment involving minors with no competent oversight or control. The release of data from Australian and European centers has shown no diminution of gender dysphoria and worsening of mental health, causing their governments

to intervene and stop such therapy[32,33,34,35,36,37,38]. As for using age as a criteria for any intervention, the most recent version of guidelines from WPATH ("SOC 8") eliminates use of age as a determinant of when to intervene socially, medically or surgically.[39]

22. As to paragraphs 25-32 on pages 21-24 of Dr. Olson-Kennedy's report, the "growing body of evidence" of purported benefits of pubertal suppression in regard to the mental health of the adolescents comes from studies of what is called convenience sampling. This describes using survey data obtained by advertising through advocacy sites such as the Trevor Project or the U.S. Transgender Survey to anyone with an interest in the survey subject matter. This inherently biases the nature of the survey participants. People who experienced significant regret or who died as a result of their efforts to transition are not likely to respond. Those who do respond provide answers that cannot be verified. These data bases show potential correlation at best, but prove no direct causation.[40] Unlike blocking precocious puberty, blocking puberty during the adolescent time frame causes irreversible loss of calcium accretion to the skeleton and affects the development of the brain and the gonads.[41] Without knowing if these latter two issues are reversible if the patient chooses to cease suppression of puberty later on, continued use is, once again, an uncontrolled experiment involving minors who cannot ethically consent. The "dark places of despair" she describes are just buried deeper as a result of the false sense of security. The frontal lobe of the teen brain is unable to see the folly of short term gains that

result in long-term losses.[38] Blocking puberty does indeed change the landscape: it leads the patients to cross-sex hormones 100% of the time in the Dutch transgender clinics.[43] The N.I.C.E. review highlighted a clear lack of scientific proof of any benefit from suppressing natural puberty during adolescence, and the UK banned the general use of puberty blockers due to documented worsening of mental health.[44]

23. Beginning with paragraph 32 on page 24 of her report, Dr. Olson-Kennedy discusses cross-sex hormones. Cross-sex hormones are indeed used to transform the appearance of the body to look like the opposite sex. Again, the fact that 100% of children who have puberty blocked also go on the cross-sex hormones points out clearly that the "case-by-case" assessment is really not that at all. The adolescent cannot really consent to a process that induces life-long medical morbidity, including sterilization. The only full population study that has been published indicated that medical intervention did not reduce mental health morbidity after extended periods of time.[45] It is clearly not surprising that there is initial euphoria in females treated with testosterone. There is an increase in physical and emotional energy and a sense of reaching a goal as the physical changes begin to occur. But those who detransition are left with these subsequently unwanted and irreversible physical changes. What starts out as euphoric energy can easily turn into extreme anxiety. The clear risk of cancers, strokes, and heart disease among other pathologies, not to mention infertility, is

widely known. An adolescent minor cannot fully understand or consent to the long-term problems caused by seeking short term "gains."

24. The study referenced in paragraph 39 of Dr. Olson-Kennedy's report included two years of data and is flawed by the death of three patients by suicide.[30] Any independent review board would have halted the study in its tracks with such serious adverse events as death of study participants, especially with a study population already suffering from depression and anxiety. It is also flawed because regret and detransition is known to occur much later than two years after interventions begin. The only truly valid data from long-term studies comes from the two population studies which showed no improvement in mental health over the long run.[45,46]

25. Dr. Olson-Kennedy's opinions about surgical intervention in paragraphs 44 to 46 on pages 28-29 of her report are belied the Branstrom and Djheine studies, which clearly demonstrated that when followed for long-enough periods of time, surgical intervention did not improve mental health.[45,46,47]

26. The "SOC 8" referenced in paragraph 47 on page 30 of her report clearly states that its recommendations are merely guidelines. They are not true standards of care in the legal sense.

27. In paragraph 48 on page 32 of her report, Dr. Olson-Kennedy states that gender-affirming medical interventions are recognized as "medically necessary" by many major medical organizations. However, the guidelines were written by special interest groups within medical organizations, mostly members

of WPATH (8 of the 9 authors of the 2017 revision), reflecting the opinion of WPATH and not the whole of the membership of those organizations. Contrary opinions are suppressed or ignored.[11] Good science involves evolution of thought which considers all data, not just selected, affirming data.

28. In paragraph 40 on page 27 of her report, Dr. Olson-Kennedy simply dismisses the influence of social media. In my experience, patients were convinced they had gender dysphoria because of the online influence to which they were exposed. A Google search that I performed identified 482,000,000 entries on the subject. Troubled adolescents, struggling for acceptance by peers or for some sense of celebrity have existed forever, but social media now presents them with a one-size-fits-all solution which offers acceptance and celebrity instantly. Before the advent of social media, transgender teens turned to parental support and counseling, which resolved their gender identity confusion 60-98% of the time.[22]

29. At least half of my patients were recruited by transgender or non-binary individuals. There is no published data because, once again, there is no transparency about data collection protocols in the transgender centers in the U.S. The studies Dr. Olson-Kennedy cites to "prove" a biologic basis are limited by small numbers and no ability to prove causation.

30. In paragraph 52 on page 32 of Dr. Olson-Kennedy's report, the actual data reported by Zucker, collected before any exposure to medical or social

interventions, showed desistance if the patients were followed through completion of puberty.[22]

31. In paragraph 54 on pages 33-34 of her report, Dr. Olson-Kennedy attempts to draw a distinction between Gender Identity Disorder and Gender Dysphoria to discredit certain studies cited in the GAPMS report. Like Gender Dysphoria, Gender Identity Disorder was based on mental health morbidity as a key part of the diagnostic criteria. Failing to recognize this, Dr. Olson-Kennedy wrongly suggests that these patients did not suffer from gender dysphoria. The name change was just that—a name change.

32. In paragraphs 57 on pages 34-35 and paragraph 64 on page 38 of Dr. Olson-Kennedy's report, she mentions a subset of patients who do not present until adolescence, but then turns around in paragraph 58 and denies that Dr. Lisa Littman's cohort of studied patients could possibly exist and be called, instead, adolescent-onset patients. In fact, upwards of 80% of children presenting with gender incongruence are female (compared to 30% ten years ago) and that of those, the majority are teenagers with no history of gender incongruence in young childhood. Although she dismisses Littman's 2019 study[48,49], the data that Littman collected was not retracted in the accepted revision of her article—the conclusions were the same, but the terminology was revised.

33. In paragraph 65 on page 39 of her report, Dr. Olson-Kennedy explains that the increased incidence of gender incongruence is due to the increased social acceptance from reduction of social stigma. The overwhelming

increase in the number of patients presenting to Tavistock is what caused the NHS to take a deeper look at what caused the rise, and lessening social stigma was clearly shown not to be the cause.[50] What makes data collection nearly impossible in the U.S. is the utter lack of transparency about what goes on behind closed doors. The magnitude of increase in incidence can only be truly ascertained by opening the files of the transgender treatment centers at which time data can be obtained by independent monitors.

34. In paragraph 70 on page 42 of her report, Dr. Olson-Kennedy recognizes the need for longitudinal studies, which have been called for by the original and revised version of the Endocrine Society Guidelines.[13] More importantly, such studies should be rigorous and have a control group. She incorrectly assumes that any random controlled trial is blinded, which clearly is not possible or necessary. She expresses dismay about the probable dropout potential, but does not mention the high dropout rates in the Dutch protocol study which is the foundation upon which transgender clinic protocols are ostensibly built.[51] There has been recent criticism by one of the authors or the Dutch protocol that what he gleaned from having a glimpse inside the U.S. clinics was that his protocol was not actually being followed.[52] Dismissing the need for a randomized control group based on the theory that patients in the control arm will die from suicide is insupportable, since there is published evidence that counseling alone is highly effective in resolving gender dysphoria.[22] It is also obvious that no IRB would even consider allowing a treatment arm in a study that

would include reported complications such as sterility and decreased sexual function, let alone increased risk of heart disease, stroke, and cancer.[53]

35. In response to paragraphs 87-89 on pages 49-50 of Dr. Olson-Kennedy's report, evidence-based medicine is practiced when all sides of a medical issue are researched, and the results graded independently. Evidence-based medicine supports standards of care. It is abused when only some evidence is used, and especially when that evidence is indirect opposition to existing evidence and subsequently published evidence. The GRADE system interprets data to determine the degree to which the recommendations are evidence-based medical practices. The Endocrine Society Guidelines in both iterations failed miserably. SOC7 failed the evidence-based test entirely.[54]

36. Dr. Olson-Kennedy's discussion in paragraphs 91 to 93 on pages 50-51 of her report regarding off-label use of medication compares apples to oranges. There are medications which are used off label because of published studies showing benefit and clear lack of harm, but there is no desire for the manufacturer to apply for FDA approval due to the complexity and cost of doing so, especially when there is no future compensatory return on investment. Puberty blockers were studied for safety and efficacy and their ability to prevent progression of secondary sex characteristics and stall bone maturation in patients with precocious puberty. The drugs passed muster in their ability to do such and were therefore approved by the FDA, with a proviso that the study patients be followed longitudinally indefinitely to monitor for any signals of harm. One such signal

was announced recently and has been added to the product insert of puberty blocking medications used for treatment of precocious puberty.[55] The manufacturers of puberty blockers have not engaged in clinical research studies about the safety and efficacy of puberty blockers in gender incongruent children and adolescents despite the fact that they would profit if these drugs were FDA-approved for such.

37. In response to paragraph 96 on pages 53-54 of Dr. Olson-Kennedy's report, it is a bit self-serving that WPATH recommends multidisciplinary staffing for transgender clinics, all of whom follow its recommended guidelines. It is clear from the history of the Tavistock Clinic that if you do not follow the WPATH protocol or if you call out the harm the WPATH protocol generates, you are not considered to be a part of "the team."[56]

38. In response to paragraphs 99 to 100 on pages 54-55 of Dr. Olson-Kennedy's report, the "growing body of evidence" of purported benefits of pubertal suppression in regard to the mental health of the adolescents comes from studies of convenience sampling involving the retrospective memories of those who chose to answer the surveys. These data bases have been used repeatedly by the authors who cherry pick the recalled memories of participants in an attempt to prove a point. The surveys failed to verify the mental health status of the participants at any point in time by independent examination. They show no direct causation.[57,58,59,60,61] Heretofore, no reputable editor would accept such studies for publication in peer-reviewed journals.

39. Paragraphs 104 to 105 on pages 56-57 of Dr. Olson-Kennedy's report provide another case of apples vs. oranges: the studies of young people with precocious puberty show full recovery of function after two years off therapy. Dr. Olson-Kennedy mentions not using the puberty blockers for longer than two years, thereby admitting the relentless continuum of puberty blockers followed by cross-sex hormones in the U.S. gender clinics—once again proving the pause theory to be mythical. The precocious puberty patients are not in adolescence, which is when calcium accretion is critical.

40. In response to paragraph 108 on page 59 of Dr. Olson-Kennedy's report, supraphysiologic levels of hormones are always prone to cause severe side effects, regardless of whether the patient is experiencing gender dysphoria or not. That proves that they are never appropriate.

41. In response to paragraph 112 on page 60 of her report, Dr. Olson-Kennedy completely ignores the phenomenal published experience of Kenneth Zucker's behavioral interventions because they do not fit the narrative reflected in her report. In fact, desistance has been documented with behavioral health interventions in Canada and Europe since the 1980s. [1,12,13,14,15,16,17,18,19,20,21]

I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct.

Executed this 10th day of March 2023.

/s/ Quentin Van Meter

Quentin Van Meter, M.D.

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Exhibit A

QUENTIN L. VAN METER, M.D. **updated 5 March, 2023**
1800 Howell Mill Road NW, Suite 475
Atlanta, Georgia 30318 **(678) 961-2100**

PERSONAL

Home Address:	26 Paces West Drive NW, Atlanta GA 30327
Home Phone:	(404) 963-5618
Date of Birth:	September 13, 1947
Place of Birth:	Laramie, Wyoming
Citizenship:	USA

EDUCATION:

Undergraduate:	College of William & Mary, 1969 B.S. – 1969
Medical School:	Medical College of Virginia, 1973 M.D. – 1973

CLINICAL TRAINING:

Institution:	The University of California, San Francisco
Hospital:	Naval Regional Medical Center, Oakland
Position:	Pediatric Intern – 1973 – 1974 Pediatric Resident – 1974 – 1976
Institution:	Johns Hopkins University
Hospital:	Johns Hopkins Hospital
Position:	Fellow, Pediatric Endocrinology 1978 – 1980 Fellowship Program Director: Claude Migeon, M.D.
Current Position:	Pediatric Endocrinologist Van Meter Pediatric Endocrinology, P.C. 1800 Howell Mill Road, Suite 475 Atlanta, Georgia 30318

PROFESSIONAL CERTIFICATION & SOCIETIES:

Diplomate, National Board of Medical Examiners, 1974

American Board of Pediatrics, certified in general pediatrics, 1978, sub-board certified in Pediatric Endocrinology, 1983

Fellow:	American Academy of Pediatrics, Georgia Chapter 1975 -present President, Uniformed Services West Chapter, 1987 – 1990 District VIII member, AAP Committee on Awards for Excellence in Research, 1990-1994 Editor, The Georgia Pediatrician, 1994 – 1998
	Chairman, Georgia Chapter Legislative Committee, 1996 – 2006
Fellow:	The American College of Pediatricians, 2007 – present Member of the Board of Directors, 2008- present Immediate Past President
Member:	Pediatric Endocrine Society, 1989 – present
Member:	American Diabetes Association Professional Section, 1988 – present
Member:	Endocrine Society, 1994-present
Member:	Southern Pediatric Endocrine Society, 1992 – Present
Member:	American Association of Clinical Endocrinologists, 2005 – 2022
Licensure:	Georgia, #34734

FACULTY POSITIONS:

Institution:	Morehouse School of Medicine
Position:	Associate Clinical Professor, Pediatrics, 2004 – present
Institution:	Emory University School of Medicine
Position:	Adjunct Associate Professor, Pediatrics, 1991 – 2020
Institution:	University of California, San Francisco
Position:	Associate Clinical Professor, Pediatrics, 1989 – 1991
Institution:	University of California, San Diego, School of Medicine
Position:	Assistant Clinical Professor, Pediatrics, 1980 – 1986
Institution:	LSU School of Medicine, Clinical Instructor, Pediatrics, 1977 – 1978

MILITARY SERVICE:

Commission:	Medical Corps, United States Navy, August 1971
Rank:	Captain, retired
Duty Stations:	Health Professional Scholarship Student, 1971 – 1974
	Intern and Resident, Pediatrics, Naval Regional Medical Center, Oakland, 1973 – 1976
	Staff Pediatrician, Naval Regional Medical Center, Oakland, 1976

Staff Pediatrician, Naval Regional Medical Center,
New Orleans, 1976 – 1978

Full time out-service fellow in Pediatric Endocrinology,
Johns Hopkins Hospital, 1978 – 1980

Staff Pediatric Endocrinologist, Naval Hospital San Diego,
1980 – 1986

Chairman and Director, Residency Training, Department of Pediatrics
Naval Hospital Oakland, 1986 – 1991

OTHER PROFESSIONAL ACTIVITIES:

Consultant, Pediatric Endocrinology,
Nellis Air Force Base Hospital, Las Vegas, Nevada
1981 – 1991

Consultant, Pediatric Endocrinology,
Naval Hospital Lemoore, CA
1986 – 1991

Consultant, Pediatric Endocrinology,
Letterman Army Medical Center, Presidio of San Francisco, CA
1990 – 1991

Consulting Endocrinologist,
Columbus Regional Medical Center, Columbus, GA
1991 – 1994

Pediatrician and Pediatric Endocrinologist, partner
Fayette Medical Clinic
Peachtree City, Georgia 30269
September 1991 – October 2003

Speaker's Bureau
Novo Nordisk
Eton Pharamceuticals
AAP Eqipp course on Growth- development committee- 2012

PUBLICATIONS: (Articles in Peer Reviewed Journals)

Riddick, JR, Flora R., Van Meter, QL:
"Computerized Preparation of Two-Way Analysis of Variance Control Charts for Clinical Chemistry," Clinical Chemistry, 18:250, March 1972.

Van Meter, QL, Gareis FJ, Hayes, JW, Wilson, CB:
"Galactorrhea in a 12 Year Old Boy with Chromophobe Adenoma," J. Pediatrics 90:756, May 1977.

Plotnick, LP, Van Meter, QL, Kowarski, AA, "Human Growth Hormone Treatment of Children with Growth Failure and Normal Growth Hormone Levels by Immunoassay: Lack of Correlation with Somatomedin Generation: Pediatrics 71:324, March 1983.

Brawley, RW, Van Meter, QL, "Mebendazole Ascaris Migration," W.J. Med, 145:514015, October 1986.

Van Meter, QL, "The Role of the Primary Care Physician in Caring for Patients with Type-1 Diabetes," Comp Ther 1998; 24(2):93–101

Midyett LK, Rogol AD, Van Meter QL, Frane J, and Bright GM, "Recombinant Insulin-Like Growth factor (IGF)-I Treatment in Short Children with Low IGF-I Levels: First-Year Results from a Randomized Clinical Trial," J Clin Endocrinol Metab, 2010;95:611–619.

Laidlaw MK, Van Meter QL, Hruz PW, Von Mol A, and Malone WJ, Letter to the Editor: "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," J CLin Endo Metab 2019;104: 1-2.

Van Meter QL, Bringing Transparency to the Treatment of Transgender Persons, Issues in Law and Medicine 2019:34;147-152.

Laidlaw, MK Von Mol A,Van Meter Q, and Hansen JE, Letter to the Editor from Laidlaw et al: "erythrocytoisis in a large cohort of thansgender Men using testosterone: a long-term follow-up study on prevalence, determinants, and exposure years" J Clin Endocrinol Metab, 2021 December 2021, e5275-35276 Https://doi/10.1210/clinem/dg ab514

ABSTRACTS/LETTERS:

Van Meter,Q L, & Lee, PA: "Evaluation of Puberty in Male and Female Patients with Noonan Syndrome," Pediatric Research 14:485, 1980.

Van Meter, QL, et al: "Characterization of Pituitary Function in Double Bolus GnRH Infusion as a Diagnostic Tool," Pediatric Research 32:111, 1984.

Van Meter, QL, Felix, SD, Lin, FL: "Evaluation of the Pituitary-Adrenal Axis in Patients Treated with nasal Beclomethasone," (Presented at the 1991 Annual Meeting of the Endocrine Society and the 6th Annual Naval Academic Research Competition, Bethesda, MD, 17 May, 1991).

Rogol AD Midyett LK Van Meter Q, Frane J, Baily J, and Bright GM, Recombinant Human IGF-1 for Children with Primary IGF-1 Deficiency (IGFD): Safety Data from Ongoing Clinical Trials (presented at the PAS 2007, Toronto).

Van Meter Q, Midyett LK, Deeb L et al, Prevalence of primary IGFD among untreated children with short stature in a prospective, multicenter study (Poster POO715) ICE Rio de Janeiro, Brazil 2008.

G.M. Bright[1], W.V.Moore[2], J.Nguyen[3], G. Kletter[4], B. S. Miller[5], Q. L. Van Meter[6], E. Humphriss[1], J.A. Moore[7] and J.L. Cleland[1] Results of a Phase 1b Study of a new long-acting human growth hormone (VRS-317) in pediatric growth hormone deficiency (PGHD). PAS 2014 May 2014

Van Meter Q, Welstead B and Low J, Characteristics of a Population of Obese Children and Adolescents: Suggesting a New Paradigm, presented at ESPE meeting, Dublin 2014.

Wayne V. Moore[1], Patricia Y. Fechner[2], Huong Jil Nguyen[3], Quentin L. Van Meter[4], John S. Fuqua[5] , Bradley S. Miller[6], David Ng[7], Eric Humphriss[8], R. W. Charlton[8], George M. Bright[8,] Safety and Efficacy of Somavaratan (VRS-317), a Long-Acting rhGH, in Children with Growth Hormone Deficiency (GHD): 3-Year Update of the VERTICAL & VISTA Trials, presented at the 2017 Endocrine Society meeting in Orlando FL

Bradley S. Miller[1], Wayne V. Moore[2], Patricia Y. Fechner[3], Huong Jil Nguyen[4], Quentin L. Van Meter[5], John S. Fuqua[6], David Ng[7], Eric Humphriss[8], R. W. Charlton[8], George M. Bright[8], 3-Year Update of the Phase 2a and Long-term Safety Studies (VERTICAL and VISTA) of Somavaratan (VRS-317), a Long-acting rhGH for the Treatment of Pediatric Growth Hormone Deficiency, presented at the 2017 IMPE meeting in Washington D.C.

ADDITIONAL PRESENTATIONS/LECTURES:

Pediatrics Update, CME Associates, San Diego – Orlando Annual Conferences: Lectures on Pediatric Endocrine Subjects – 1986 – 2001. Course Moderator, 1997, 1998, 1999, 2000, 2001

Endocrine and Gastroenterology Update, CME Associates, Maui HI Nov 2001, Lecturer and Course Moderator

Lecture on Panhypopitutarism, Pharmacia Conference, Nashville TN April 2002.

Family Medicine Review Course, Orlando, FL, 1992 – 2001

Pediatric Grand Rounds, Tanner Medical Center, October 1997

Pediatric Grand Rounds, Hughes Spaulding Children's Hospital, September, 2003

Pediatrics in the Park, Fall CME meeting for the Georgia Chapter of the American Academy of Pediatrics, November 2003

Pediatric Grand Rounds, Columbus Regional Medical Center, January 2004

Frontiers in Pediatrics CME Course, sponsored by the Atlanta Children's Health Network, Atlanta, March 2004.

Pediatric Grand Rounds, Eggleston Children's Hospital, May 2004.

Sue Schley Matthews Pediatric Conference, Columbus Regional Medical Center, September 2004

56th Annual Scientific Assembly and Exhibition of the Georgia Academy of Family Physicians, Nov 2004

Program Co-Chairman: Southern Pediatric Endocrine Society Annual meeting, Nov 2004, November 2014

Presentations on Diabetes, Growth Failure, and Thyroid Disease to the Postgraduate Pediatric Nurse Practitioner Program, Georgia State University, Nov 2005, June 2006, May 2007

Issues in Medicine, US Medical Congress Conference and Exhibition, Las Vegas, meeting planner and speaker, June, 2006

CME Presentations for the Georgia Chapter of the American Academy of Pediatrics Spring and Fall Meetings 2004-present

Pediatric Grand Rounds, Columbus Regional Medical Center, Columbus, GA, 2011-present

Human Growth Foundation Regional CME Conference, Atlanta GA March 2013, February 2014 Columbus Georgia

International Federation of Therapeutic Counseling Choice: Transgender Medicine, IFTCC Launch, October 15, 2018 London, Third International Congress, October 25 2018 Budapest.

Southern Pediatric Endocrine Society, Orlando FL, Feb 2019

Matthew Bulfin Conference, Indianapolis IN April 2019

CMDA annual conference, Ridgecrest NC, May 2019

Support 4 Family conference, London, UK June 2019

Audio Digest Pediatrics - ① v. 41, no. 4; ② v. 41, no. 20; ③ v. 43, no. 17

Audio Digest Family Practice - ① v. 42, no. 5; ② v. 44, no. 11; ③ v. 44, no. 44; ④ v. 45, no 15

Audio Digest Otolaryngology - ① v. 32, no. 14

CURRENT HOSPITAL APPOINTMENTS:

Eggleston/Scottish Rite Children's Hospitals, active staff, Pediatric Endocrinology

PAST AND CURRENT CLINICAL RESEARCH:

2006	Sanofi-Aventis HMR1964D/3001	study completed 2007
2006	Tercica MS301-	study completed 2008
2007	Tercica MS310-	study completed 2008
2007	Tercica MS306-	study completed 2010
2007	Tercica MS316-	study completed 2012
2008	EMD Serono 28358	study completed 2009
2012	Versartis 12VR2	study completed 2014
2012	Debiopharm 8206-CPP-301	study started July 2012
2013	Versartis 13 VR3	study started Dec 2013
2014	Novo-Nordisk Elipse	study started 2014
2015	Versartis 14 VR4	study completed 2017
2017	Mannkind MKC-TI-155	study completed 2019
2018	Abbvie M16-904	study started 2018
2019	Novo-Nordisk Real-4	study started 2019
2019	Lilly 18B-MC-ITSB	study started 2019
2021	Pfizer PROGRES	study started 2021

2021	Lumos OragrowtH210	study started July 2021
2022	Novo-Nordisk Real-8	study started July 2022

LEGAL EXPERT WITNESS:

2017	North Carolina Legislature- transgender bathroom bill
2018	Jessica Siefert transgender case, Cincinnati, OH
2018	Alberta, Canada school system transgender case
2018	Decatur GA School Board transgender case
2019	British Columbia transgender case
2019	Gavin Grimm transgender case, Gloucester County, VA
2019	Rowe vs Isle of Wight School Board, UK
2019	Younger transgender case, Dallas, TX
2020	Alabama State House and Senate committee hearings
2020	Pennsylvania State House Health Subcommittee hearings
2020	Iowa State House committee hearing
2020	California State House committee hearing
2020	Harris County TX custody case
2021	Missouri State House committee hearing
2021	NAACP *v* State of Arkansas
2022	Seifert Civil Suit affidavit
2022	development of Florida GAPMS
2022	testimony before Florida State Medical Board
2023	testimony before Idaho legislative hearing
2023	testimony prepared for Kansas state legislative hearing