IN THE DISTRICT COURT OF DOUGLAS COUNTY, KANSAS

CIVIL COURT DEPARTMENT

DANIEL DOE, et al
Plaintiff,
vs.
STATE OF KANSAS, ex rel KRIS KOBACH, et al
Defendant.

Case No. 2026-CV-112

TRANSCRIPT OF TEMPORARY INJUNCTION
VOLUME II-part 1

BE IT REMEMBERED that on the 30th day of September, 2026, the above-entitled matter comes on for hearing before the Honorable JAMES McCABRIA, Judge of Division No. 4 of the Seventh Judicial District of the State of Kansas, at Lawrence, Kansas.

APPEARANCES

For the Plaintiff: Mr. Harper Seldin
Ms. Heather St. Clair
Mr. Doug Dalgleish
Mr. Joshua Block
Ms. Aditi Fruitwala
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For the Defendant: Mr. Kris Kobach
Mr. James Rodriguez
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Reported by Nina Copeland Official Reporter, CCR

THE COURT: Are we expecting General Kobach?

MR. RODRIGUEZ: Yes, any minute.

THE COURT: No worries, I will go ahead and call the case, 26-CV-112. Doe v. State of Kansas. state the appearances.

MR. SELDIN: Good morning, Your Honor. Harper Seldin for the plaintiffs.

MR. BLOCK: Joshua Block for plaintiffs.

MR. DALGLEISH: Doug Dalgleish for plaintiff.

MS. FRUITWALA: Aditi Fruitwala, plaintiffs.

THE COURT: Say the name again. I'm sorry.

MS. FRUITWALA: Aditi Fruitwala.

THE COURT: Thank you.

MR. SELDIN: Your Honor, we have a housekeeping matter.

THE COURT: Let me go ahead and take these appearances real quick.

MR. RODRIGUEZ: Good morning, Your Honor, James Rodriguez for the State.

MR. NUSSBAUM: Good morning, Your

Honor, Andrew Nussbaum on behalf of the State.

MR. COMPTON: James Compton on behalf of the State.

MS. GUST: Erin Gust on behalf of the State.

MR. CARSWELL: Dwight Carswell for the State.

THE COURT: Last name?

MR. CARSWELL: Carswell.

MR. BREWER: Good morning, Your Honor, Jordan Brewer for Department of Administration and Secretary Proffitt.

MS. BAKKER: Good morning, Your Honor, Lynette Bakker for Department of Administration and Secretary Proffitt.

MR. SMITH: Your Honor, Ted Smith for the Kansas Department of Revenue.

THE COURT: Thank you. Okay, housekeeping matters?

MR. SELDIN: Yes, Your Honor. I believe at the end of Court yesterday, we reported the time and we should not have done that, we should've checked our math before we did so.

We have subsequently gone back and we had recorded directs, crosses, redirects. Having

then done that review, we believe the correct time is that plaintiffs have spent three hours and 58 minutes and defendants have spent two hours and 43 minutes.

We provided in an e-mail last night once we realized that we had given the wrong time with the itemized list explaining how we came to that total.

We provided that to counsel for defendant and I believe we also copied Ms. Baker, so the Court would be aware.

Again, I apologize, we will not report until we've checked out math for today. It's my understanding that the State may dispute that time somehow, but I just wanted to report that that was the total that we had. We're happy to further share our recordings, but that's been shared via e-mail with counsel and the Court.

THE COURT: I'm sorry, repeat the new totals again.

MR. SELDIN: Plaintiffs have used three hours and 58 minutes, and defendant has used two hours and 43 minutes.

THE COURT: Okay. Who is keeping time, do we have one individual?

MR. SELDIN: We have two counsel on our side who have been keeping time, and my understanding is that yesterday, when we gave the total, lawyers were trying to add on their phones and we should not have been doing that.

So then we went yesterday and recorded and it, and we realized we made an error, for which we apologize.

THE COURT: I appreciate double checking and updating. Mr. Rodriguez, any thoughts or concerns with that time?

MR. RODRIGUEZ: Yesterday, we agreed to an aggregate number on both sides. We didn't dispute the numbers. We think we should abide by what we agreed to yesterday. We didn't see any breakdown yesterday. And we did not agree to the new numbers, particularly for our side.

THE COURT: Started at 8:30, and went to 6:00 o'clock, so six and four is ten. And we had, say, two hours for our lunch and the docket that I took up.

I don't have a timekeeper, so I'm going to rely on the due diligence and professionalism of counsel to keep track. And if we get to a point where we have strong disputes over

that, just be prepared to put up your numbers and that will be for either side.

Other housekeeping?

MR. SELDIN: None from plaintiffs, Your Honor.

THE COURT: State?

MR. RODRIGUEZ: None from the State.

THE COURT: The record should reflect that General Kobach joined. And General, sorry, I just wanted to take up the housekeeping matters as quickly as we could. We haven't started anything of substance, sounds like we've attended to housekeeping matters. Unless there's more, we'll start evidence.

MR. SELDIN: Thank you, Your Honor.

Plaintiffs call Dr. Angela Turpin.

THE COURT: Dr. Turpin, come forward and be sworn.

ANGELA TURPIN, being duly sworn by the court reporter, testified as follows:

DIRECT EXAMINATION

BY MR. SELDIN

Q. Good morning, Dr. Turpin. Can you please state and spell your name for the court reporter?

A. My name is Ms. Angela Turpin, A-N-G-E-L-A,

last name Turpin, T-U-R-P-I-N.

Q. And Dr. Turpin, what is your profession?

A. Pediatric endocrinologist.

Q. And where are you licensed?

A. The states of Kansas and Missouri.

Q. As a pediatric endocrinologist, do you also treat adults?

A. Yes, I do.

Q. In what context?

A. Typically when we start seeing children in our clinic, they will often stay through young adulthood, and so typically we see our patients through the age of 22.

Q. Can you please briefly summarize your educational background for the Court?

A. Sure. I received my combined BA and MD through the medical school at the University of Missouri in Kansas City. After medical school, I did a pediatric residency at Children's Mercy Hospital in Kansas City. And then stayed to do a fellowship in pediatric endocrinology also at Children's Mercy where upon completion of the fellowship, I stayed on as an attending.

Q. So how long have you been a doctor?

A. Oh, 27 years.

Q. And have you been a pediatric endocrinologist for most of that time?

A. Most of that time.

Q. And what was your most recent position?

A. My most recent position was as a pediatric endocrinologist at Children's Mercy Hospital.

Q. And until when did you hold that position?

A. Until last Friday.

Q. And when you were employed there, did you have other roles?

A. Yes, I did.

Q. What were those roles?

A. I was also the medical director for our Gender Pathways clinic.

Q. And how long were you in that role?

A. Gosh, for the last approximately five years.

Q. And how long have you been involved in that clinic?

A. Since its inception in 2014.

Q. And what is the Gender Pathways clinic?

A. The Gender Pathways clinic was a multidisciplinary clinic. We had a pediatric endocrinology, adolescent medicine, clinical psychology, social work, a clinical nurse

coordinator, and a chaplain who all helped give multi-disciplinary care to children and adolescents and adults with gender dysphoria.

Q. As the medical director, what was your specific role?

A. My specific role was to make sure that everybody was on the same page with practicing medication administration, so overseeing, you know, prescription or puberty blockers, testosterone, estrogen.

We also teach medical students, residents and fellows in that clinic as well.

Q. And over the course of your career, how many adolescents or young adults have you treated for gender dysphoria?

A. Approximately 350 or so.

Q. And over how long?

A. Over the last 12 or 13 years.

Q. Can you give the Court some context please, for what percentage of your patient load that was?

A. About 25 percent.

Q. What other kinds of -- what was the other 75 percent of your patient load like?

A. Yeah, diabetes, thyroid disease,

precocious puberty and other puberty disorders, adrenal disease, pituitary, those sorts of things.

Q. And in your work as a pediatric endocrinologist, do you treat intersex individuals?

A. Yes.

Q. And how many intersex patients do you estimate you've treated or seen in your career?

A. Over a hundred.

Q. And have you published peer-reviewed articles on the treatment gender dysphoria in adolescents?

A. Yes, I have.

Q. And what were those articles about?

A. I was involved in one article that looked at our patient, patient population with gender dysphoria to look for undiagnosed differences in sex development, and then also a paper looking at access to gender affirming care in the rural areas.

Q. And you said differences of sex development, what is that?

A. Yeah, differences in sex development is when, I think traditionally we think of sex is like very binary buckets. You are either the determinants of sex, such as sex chromosomes, internal gonads, or sex organs, external genitalia

hormone milieu, gender identity. These things all align with each other in a traditionally masculine or what we would call a cisgender male bucket, or they would align in a traditionally female or cisgender female bucket.

When all of those things align, that's great, that's nice. But oftentimes we find that there are crossing over, and that things don't align perfectly, whether that is sex hormones, or chromosomes or appearances of external genitalia.

When these things don't align, there is some additional work to be done there.

Q. So are DSD, or differences of sex development, is that another term for intersex conditions?

A. Yes, it is.

Q. Did you --

THE COURT: What was the acronym? I missed it.

MR. SELDIN: DSD.

THE WITNESS: DSD.

THE COURT: Thank you.

MR. SELDIN: I apologize.

BY MR. SELDIN

Q. Dr. Turpin, there should be a white binder

that says plaintiff's exhibits there. If you could please turn to tab six.

I'm just going to ask you if you recognize this document and if you could identify it for the Court.

A. Yes, I do, this is my declaration that I submitted to the Court.

Q. And is that your signature there at the end?

A. Yes, it is.

MR. SELDIN: Plaintiffs would move to admit Dr. Turpin's declaration.

MR. NUSSBAUM: No objection, Your Honor.

THE COURT: Without objection, Exhibit 6 is admitted. And there is, it says declaration and exhibits, so we're admitting the entire thing.

(Plaintiff's Exhibit 6 was admitted.)

MR. SELDIN: Thank you, Your Honor.

BY MR. SELDIN

Q. Dr. Turpin, have you testified as an expert witness before?

A. Yes, I have.

Q. In what context?

A. In SB 63 regarding gender affirming care in the state of Kansas.

Q. Was that here in Douglas County?

A. Yes, it was.

THE COURT: Dr. Turpin, I'm sorry to have to ask you, can you crank that microphone, the very top of the microphone down --

THE WITNESS: Yes. Down?

THE COURT: -- a little bit. It's directional, I think it will pick up better.

THE WITNESS: Sorry about that.

THE COURT: No, you're fine. I'm sorry to interrupt. Go ahead.

BY MR. SELDIN

Q. And Dr. Turpin, have you been retained as an expert in this case?

A. Yes, I have.

Q. Are you being compensated for your time?

A. Yes, I am.

Q. Does your compensation depend on the content of your testimony?

A. No, it does not.

MR. SELDIN: Your Honor, at this time, plaintiff's would tender Dr. Turpin as an expert witness in the field of endocrinology, the

treatment of gender dysphoria, provision of gender affirming medical care to adolescents and young adults and the diagnosis and treatment of DSDs.

THE COURT: I caught, expert of endocrinology, gender dysphoria, DSDs, what was the other?

MR. SELDIN: Providing gender affirming medical care.

THE COURT: State?

MR. NUSSBAUM: Your Honor, we do object to Dr. Turpin's being offered as an expert in this matter. Among other things, her declaration in this case does not concern endocrinology, it does not concern the treatment of gender dysphoria or gender affirming medical care, it is primarily in the form of psychiatric and psychological conclusions.

I'm happy to voir dire the witness right now, or I can address it on cross-examination, and you can address the objection later.

THE COURT: I'm interested in your voir dire, I'll let you do that and it'll help me assess everything better.

VOIR DIRE OF THE EXPERT WITNESS

BY MR. NUSSBAUM

Q. Good morning, Dr. Turpin.

A. Good morning.

Q. You just testified that you're a pediatric endocrinologist; is that right?

A. Yes, that's correct.

Q. And tell me what endocrinology is.

A. Endocrinology is the study of the endocrine system, so anything that is affected by hormone transmission.

Q. Okay, so it primarily concerns hormone disorders?

A. Yes, that's correct.

Q. So things like diabetes?

A. Among other things.

Q. And tell me what the pediatric part of that means?

A. Pediatrics will continue to care for patients from birth through young adulthood.

Q. And your patients range from newborns to about age 22 --

A. That's correct.

Q. -- is that right? You don't see any patients beyond that age, typically.

A. Occasionally we will see patients beyond

that age, depending on individual circumstances.

Q. And we talked about that in your deposition and you said that's in extenuating circumstances; is that correct?

A. That's correct.

Q. So you've only seen a couple of patients past beyond age 22 in your career?

A. I would describe it as significantly more than a couple, because I've been practicing for 25 years, but the bulk of my patients we transition on at about age 22.

Q. So do you recall being deposed in this matter?

A. Yes, I do.

Q. I'm going to show you a copy of your deposition. And you recall being under oath in that deposition?

A. Yes, I was.

Q. And you've been deposed before, or was that your first time?

A. No, that was the first time.

Q. But you understand that oath was the same oath you took today in court to tell the whole truth?

A. Yes, yes.

Q. All right. If you can go to page nine with me tell me when you're there.

A. I'm there.

Q. If you start on line 17. I asked you, do you see any patients older than 24. You answer, only in extenuating circumstances typically.

A. Yeah.

Q. There are situations where a patient is a very complex patient and that traditionally may not have survived through young adulthood, so there are not necessarily a lot of adult doctors who know how to take care of that particular diagnosis, and so sometimes we have had patients stay until thirty.

You keep going, and you say, so those are rare instances, but only -- I'm sorry, am I on the wrong page here? Only rarely.

So it says rare instances, but occasionally something like that will happen. And I asked, how often, and you said I don't now, like, statistically speaking. Like in my career, I've had only a couple of those patients. Did I read that correctly?

A. No, it says I've had a couple of those patients. And I guess in my mind --

Q. And I'm sorry, I just asked you if I read

that correctly --

A. Yes, you did not. And I didn't say only, I said a couple.

Q. So let me say it again. In my career, I've had a couple of those patients. Did I read that --

A. That's correct, yes.

Q. Okay. And only a quarter of your clinical expertise or practice concerns treatment of gender dysphoria; is that right?

A. Yes, but I would say that's actually quite a few patients, given the rarity of that diagnosis.

Q. And I appreciate that clarification --

MR. SELDIN: Your Honor, at this point, he is cutting off the witness during voir dire.

MR. NUSSBAUM: They are yes or no questions, Your Honor, and I'm trying to move through this quickly.

MR. SELDIN: Your Honor, if it's not a yes or no answer --

THE WITNESS: It's, it's --

THE COURT: Here's my -- here's how I address this. I know for most people nerve-racking to be on the stand, having what you've said

questioned and those sorts of things. Listen carefully to the question, answer just what's being asked.

Certainly Mr. Seldin can have the opportunity to get up and if there's issues that he feels needs to be followed up on, he'll have that opportunity.

That is not a criticism of you, just an encouragement of how we can efficiently go through this.

BY MR. NUSSBAUM

Q. All right. So my question for you was a quarter of your clinical practice involves the treatment of gender dysphoria, correct?

A. That's correct.

Q. And the other three quarters concerns unrelated endocrinology issues, like thyroid disorders, diabetes, correct?

A. That's correct.

Q. You hold only one board certification and that's in pediatric endocrinology, correct?

A. That's correct.

Q. You hold no board certification, degree or certification in psychiatry or psychology, correct?

A. That's correct.

Q. You do not consider yourself an expert in psychiatry or psychology, correct?

A. No, I do not.

Q. You've never conducted a study in psychiatry or psychology, correct?

A. Correct.

Q. You've never conducted a study of the mental health effects of restroom restrictions or identity document policies in the patient population you treat, correct?

A. That's correct.

Q. You've never --

THE COURT: Repeat, repeat the question you just asked.

BY MR. NUSSBAUM

Q. Of course. You've never conducted a study of the mental health effects of restroom restrictions or identity document policies on the population you treat, correct?

A. That's correct.

Q. You've never conducted a study on social transition, correct?

A. That's correct.

Q. You have no degree, certification, or training in public-policy, sociology, criminology or

statistics, correct?

A. That's correct.

Q. You are not an expert in human biology?

A. I guess I'm not sure what that question means.

Q. Let me be more specific here. We talked about it in your deposition, you're not an expert in human sexual development, correct?

A. I don't think that I would agree with that. I don't agree with that.

Q. You are not an expert in biology, correct?

A. Again, I'm not sure what you mean by that question.

Q. You're not an expert in human anatomy, correct?

A. Again, I'm not sure what you mean by that question.

Q. Could you go to your deposition for me at page 145. I asked you, line 17 -- are you there?

A. Yes, I'm there.

Q. All right. You're not an expert in biology. And you said, answer, no, I'm not. Did I read that correctly?

A. Yes, you did.

Q. And you did not offer any qualification in

your deposition --

A. I did not.

Q. And then I said, you're not an expert in anatomy. And you said, no, I'm not. Did I read that correctly?

A. Yes, you did.

Q. And you didn't offer any qualification in your deposition, did you?

A. No, I did not.

Q. You are not an expert in feminist studies, correct?

A. No.

Q. Or gender studies?

A. No.

Q. You're not an expert in the privacy concerns of a person who encounters someone of the opposite sex in a restroom or locker room, correct?

A. No.

Q. And you offer no testimony, no testimony in this case about those privacy concerns, correct?

A. That's correct.

Q. So I want to talk to you about your CV briefly. And I think that is in tab six that Mr. Seldin was discussing with you.

So this is Exhibit A, a document of

your report. If you want to go to page 21.

A. Page 21 doesn't correlate with what I have.

Q. It's Exhibit A and maybe I'm looking at a different document. Let me see here, I can do it in my version. Let's do it in Exhibit 174 of the defendants, just so we're looking at the same thing.

May I approach?

MR. SELDIN: Your Honor, that hasn't been admitted.

THE COURT: Yeah --

MR. NUSSBAUM: And I'll --

THE COURT: Well, it's helpful for the record if we stick with the exhibit that we started with rather than two exhibits reflecting the same thing.

MR. NUSSBAUM: Fair enough. One moment.

BY MR. NUSSBAUM

Q. So I think it says page 97, but there's also a 24 on that page as well in tab six?

A. Yes, there is.

Q. And I'm looking at -- if you go to your section of CV on research. Do you see that?

A. Yes, I do.

Q. None of that research concerns gender dysphoria; is that correct?

A. That's correct.

Q. You received a grant regarding histamine responsiveness, do you see that?

A. Yes, I do.

Q. That's not gender dysphoria, correct?

A. No, that's correct. That is not.

Q. And none of that research concerns psychiatry or psychology, correct?

A. No, it does not.

Q. Or human sexual development?

A. That's correct.

Q. And your publications, your first two publications, Allergic Manifestations and Frequency of Mealtime Insulin Bolus Predicts, do you see those?

A. Yes, I do.

Q. Neither of those concern gender dysphoria?

A. That's correct.

Q. Or human sexual development?

A. That's correct.

Q. You do have two publications, one called Gender Affirming Care in the Midwest, Reaching World Populations. Did I read that correctly?

A. That's correct.

Q. And I apologize, Dr. Turpin, I stumbled a bit there. But let me finish my question before you answer, just so we have a clean record. So that concerns access to gender affirming care in rural populations; is that correct?

A. Yes, that's correct.

Q. But it's not about human sexual development, right?

A. It is not.

Q. And it's not about psychology, right?

A. That's correct.

Q. Or psychiatry?

A. That's correct.

Q. And the Prevalence of Intersex Differences in Sex Development. That last article, that's about the DSDs or intersex conditions, correct?

A. In transgender populations.

Q. And it's about gonadal insufficiency?

A. That was just one of the differences in sex development that was identified within that --

Q. But it's about endocrine issues, right?

A. In transgender persons.

Q. Right, but not psychology or psychiatry?

A. That's correct.

Q. Your book chapters, fluid, electrolytes and metabolism. That's not about gender dysphoria?

A. No, it's not.

Q. It's not about human sexual development?

A. That's correct.

Q. It's not about psychology or psychiatry?

A. That's correct.

Q. You have many presentations listed here, the vast majority of them -- and you can take your time and look at them -- concern topics related to other issues in endocrinology than gender dysphoria -- let me strike that. That was a confusing question.

In your presentations listed, the vast majority of them do not concern treating gender dysphoria, correct?

A. That's correct.

Q. And none of them concern psychiatry or psychology, correct?

A. That's correct.

Q. None of them concern human sexual development?

A. That's correct.

Q. I want to talk to you a little bit about the declaration itself, which is in front of you.

And this is the declaration you submitted in this case; is that correct?

A. Yes, correct.

Q. And this contains all the opinions you intend to offer in this case, right?

A. I believe so.

Q. Okay. Would you agree with me that the meat of the analysis starts at paragraph 17 of your declaration, and that's when you get into the detail about your opinions?

A. Yes.

Q. And your first opinion is essentially that SB 244 doesn't align with biological understanding of sex and gender?

A. Yes, yes.

Q. And your second opinion, which starts on page 47, concerns the impacts of not being able to use a restroom congruent with gender identity, correct?

A. Yes.

THE COURT: I'm sorry, I don't have a page 47.

MR. NUSSBAUM: Paragraph 47, Your Honor.

THE COURT: Paragraph 47.

BY MR. NUSSBAUM

Q. Okay. If you would go with me to paragraph 40?

A. Did you say paragraph 40?

Q. Yes. You would agree with me that your opinions about the effects of SB 244 are couched primarily in psychological and psychiatric terms, correct?

MR. SELDIN: Your Honor, at this point I think we're exceeding the scope of voir dire and starting to get into cross. I also think some of this could be cleaned up with further qualifications of the expert, which I'm happy to do.

MR. NUSSBAUM: The reason I'm laying the foundation, Your Honor, is that her opinions are primarily about psychology and psychiatry, and she's clearly been -- she's not qualified to offer that testimony.

MR. SELDIN: Your Honor, we'd dispute that characterization of the expert testimony that she's going to offer. And again, I'm very happy to continue qualifying the expert, in addition to which I think some of these can be question by question objections, or dealt with on cross.

MR. NUSSBAUM: Which is precisely why

I was going to go through the declaration here and show the Court where she's talking about psychiatric issues.

MR. SELDIN: And again, I think that's better suited for cross.

THE COURT: I do think there's a couple of ways we can approach it.

And if I -- here's what I'm going to do I'm going to end up hearing the testimony. This has been helpful in terms of me understanding where you're going to be coming from with your objections to qualifications.

If there's other general areas you want to address Dr. Turpin at this time, I'll let you do that, then I'll let Mr. Seldin address what you've asked about.

I'm going to take the issues of her qualifications under advisement. But I want to hear the testimony and make the decision post-testimony.

So you can certainly raise objections then on a question-by-question basis, and I think our record is more complete then, does that make sense --

MR. NUSSBAUM: So that was my only question, I wonder if we could just have a standing

objection to any psychological, psychiatric, or testimony around human sexual development.

THE COURT: I like standing objections for efficiency reasons. I'm not a fan of them for record purposes and for helping me understand what your ultimate argument will be. So I prefer the objections.

MR. NUSSBAUM: Fair enough, Your Honor.

THE COURT: Okay. So Mr. Seldin, if there's issues you want to address on the voir dire that just occurred.

MR. SELDIN: Your Honor, I will do that, and then continue into my direct, if that's --

THE COURT: Let me know when you've completed your voir dire.

BY MR. SELDIN

Q. Dr. Turpin, as an endocrinologist, do you assist your patients in managing chronic conditions?

A. Yes, we do.

Q. What kinds of chronic conditions do you help your patients manage?

A. Type one diabetes, pituitary abnormalities, and gender dysphoria are ones that are fairly weighty and are managed chronically.

Q. Can you please explain to the Court as an endocrinologist, what it means to help a patient manage a chronic condition, like the ones you just listed?

A. Yes, managing a chronic condition means taking care of the whole person. And so any person that has an ongoing medical condition that is at risk for comorbidities --

THE COURT: For?

THE WITNESS: Comorbidities.

A. And psychological comorbidities are part of that. So like for instance, let's take my type one diabetics, they are at a much higher risk for depression and anxiety and other things as a result of their type one diabetes, their chronic health condition.

And so with every visit we're assessing those things. We do depression and suicide screening. We do general questions about their health and well-being, how they are functioning in society, how they are functioning in their mental health because those things will directly affect their ability to be able to take care of their chronic condition.

And so diabetes is just one example, but

gender dysphoria is another one, where those individuals don't take care of their chronic health condition in a vacuum. They are out in society functioning in the world, and I'm their touch point most often with the medical community, so it's up to me to be assessing their mental health and how they're functioning in society.

So if we're doing an assessment and I notice there's a change in their mental health or how they're functioning in society, that we can help get them the appropriate resources to help deal with that.

Q. Dr. Turpin, in the context of those patients, can you walk me through how that might develop in one of your appointments with them?

A. Yes, absolutely. So every visit, and again, my type one diabetics and my gender dysphoria patients are the ones that are most at risk.

And I have a checklist for those patients that I go through, where I ask about school functioning, I ask about job or employment. I ask about, just mental health in general, how they think things are going, how they are able to deal with their chronic health condition as they go about their lives, but I have a various checklist that I

go through in addition to those screening tools that we use.

THE COURT: Type one is insulin-dependent?

THE WITNESS: That's correct, yes.

BY MR. SELDIN

Q. So if you've done those assessments and those checklists with your patients, if you discover that there is some kind of issue, what happens next?

A. Yeah, we have a social worker who is embedded in our clinic every day, and I touch base with my social worker and we work on a plan for that patient, what resources we can make available to them and we make a follow-up plan for patient.

Q. So for example, might the follow-up be something like therapy--

A. Absolutely. Yes, yes. It might be community support, it could be a referral to a therapist, it could be a referral to a psychiatrist. Yes, absolutely.

Q. So would it be fair to say that you are assessing those issues, and referring, even if you are not directly treating?

A. Yes, absolutely.

Q. And how many times have you done that over

the course of your career for any patient?

A. More times than I can remember over 25 years. Again, with our type one diabetics and gender dysphoria, bothof them have very likelihood of having psychosocial comorbidities.

And so that's actually why, our clinic is one of the few where we have a social worker embedded in our clinic on a daily basis. There are other clinics that don't have that.

Q. And so I think you said that you estimated over 12 years you had treated maybe 350 patients with gender dysphoria?

A. That's correct.

Q. How about how many times have you had a doctors appointment like we just described where you're doing, assessing social and mental functioning and then providing resources and referrals?

A. Hundreds of times.

Q. For over 350 patients over 12 years, about how many would you do in a year?

A. Oh goodness. And you know it depends, the same patient might require an intervention, you know, more than once in a year. So it's difficult to do that assessment, but again, it is something

that I've done hundreds of times over the course of my career.

With that specific patient population, it's at least a couple hundred times.

Q. And Dr. Turpin, in the field of endocrinology generally, what percentage of the patient population would you estimate is people with diabetes?

A. In the patient population that I take care of, it's about 50 percent.

Q. And you said the patient population that you saw for gender dysphoria was approximately?

A. 25 percent.

Q. Do most endocrinologists have that kind of split?

A. No.

Q. What's the usual split for your average pediatric endocrinologist you've met in your career?

A. So the typical split, in fact, many of my colleagues don't see gender dysphoria at all. We actually try and concentrate that among just a few providers so that those providers see a large number of those patients, so that they become the experts on those specific patients.

It's kind of like we have one of our

physicians who specializes in thyroid nodules because we want them to see every thyroid nodule and be the best that they can with seeing the thyroid nodules.

We do the same thing with gender dysphoria. We limit that to a certain number of physicians so they see enough patients that they are the experts on that condition.

Q. And does being an expert on that condition include being able to assess and refer social, emotional, and mental health and well-being?

A. Yes, it does.

Q. It's more than just reading lab values?

A. That's correct.

Q. I want to talk about another couple topics. With respect to treating patients with differences of sex development, can you explain the context in which you would care for such patients?

A. Yes. Typically individuals with differences in sex development would be either identified shortly after birth, because their external genitalia are not quickly identifiable as looking traditionally masculine or traditionally feminine, so we have difficulty assigning a sex at birth to that baby.

Or we will assign a sex baby to a baby, and as that baby grows up and they come to an age where they should be going through puberty, and things happen where either they are not going through puberty or they're not going through the puberty that we expected, and so an evaluation would be completed at that time.

Q. And have you done such evaluations?

A. Yes.

Q. How many do you estimate you've done over the course of your career.

A. Over a hundred.

Q. Imagine -- are you ever on service?

A. Yes, do inpatient service for infants and children and young adults that are hospitalized.

Q. And when might you be called in the context of a patient who might have a DSD?

A. Yeah, any time a baby is born where they are not sure what sex to assign the baby, we receive a consultation on that.

Q. And when you say "we", do you mean you?

A. Yes, me. Yes, me as an endocrinologist. Yes, me or my colleagues.

Q. You as Dr. Turpin, endocrinologist. Walk me through what your role is in the context where

you get that call because you're on service.

A. Yes, absolutely. So we receive a call that there's been a consultation for a baby with ambiguous genitalia.

And it is our job to go meet with the family, you know, hey congratulations on your baby, we notice that things may have looked a little bit different than we expected and so your pediatric team has called us to consult in helping to determine, helping you with assigning a sex to the baby.

And so we walk through with the family on how we help make that determination. That determination is made with the help of lab values, and imaging, chromosomes. And so the things that we look at will be chromosomes, sex chromosomes. We will look at imaging, so internal organs, whether someone has a uterus or ovaries or undescended testes.

We will look at their external genitalia, we will look at lab values for hormonal milieu. And ultimately, initially using those tools and in consultation with the family, we can typically come up with what the differences in sex development, where that lies, and I can give some examples if

that's helpful.

And then we help the family determine what we think might be the best sex of -- but through that process, we also talk about gender identity because we can do our best guess based on these tangible things that we have right now, but those things may not align with the individual's gender identity as they get older and they are able to tell us how they feel, and if they feel like the gender that we have assigned to them.

And so we talk with the parents about that and then we actually have a clinic dedicated to these individuals, one that has urology, gynecology, genetics, pediatric endocrinology, and clinical psychology that we all work together with those families as those babies age and grow up to help them through that.

Q. And Dr. Turpin, did you have a role in that clinic at Children's Mercy?

A. Yes.

Q. What was that role?

A. I was the pediatric endocrinologist that dealt with some of those cases; all of them were my colleagues.

Q. And so within the medical field, in terms

of the diagnosis of differences of sex development, what specialty does that lie in?

A. I'm sorry, can you repeat the question?

Q. Within the field of medicine, with respect to identifying or diagnosing differences of sex development, what field does that lie in?

A. Typically pediatric endocrinology.

Q. And that's a role that you performed over the course of your career?

A. Yes, that's correct.

Q. And in the course of, I think you were talking about how to help parents make a decision about what the sex assigned at birth will be, those factors that you listed, chromosomes, internal and external internal anatomy, what we know about gender identity, are those all things that you are directly involved in assessing?

A. Yes, that's correct.

MR. SELDIN: Your Honor, on the basis of that experience that Dr. Turpin has just laid, we would, again, tender her as an expert in the topics that I mentioned earlier with respect to diagnosing and treating gender dysphoria, pediatric endocrinology itself, diagnosis and treatment of differences of sex development.

I understand there was request for a standing objection with respect to psychological opinions. Dr. Turpin is not a psychologist or psychiatrist, but she will be offering an opinion on the management of chronic conditions, to the extent that that has an element of managing, of helping patients manage those aspects of their treatment.

THE COURT: Is there an objection to her qualifications as an expert for pediatric endocrinology?

MR. NUSSBAUM: No, Your Honor, there's no objection. There is an objection in so far as she's going to testify on what's in her report that does not concern pediatric endocrinology.

So she's not qualified to offer opinions about what's in her report, that's the objection.

MR. SELDIN: Your Honor, I think she is qualified based on her experience with hundreds of patients over the course of her career, to offer opinions about her role in their treatment, what her patients tell her, how that fits within pediatric endocrinology, and the management of these chronic conditions.

Again, I think this can be dealt with better on a case-by-case basis, you know, as we go forward.

THE COURT: She's offered as an expert in pediatric endocrinology, gender dysphoria. There's an objection to that?

MR. NUSSBAUM: To the extent it concerns the psychological or psychological aspects.

THE COURT: To differential sex diagnosis, is she an expert in that?

MR. NUSSBAUM: No objection there, Your Honor. Again, I don't think that's in her report, but no objection.

THE COURT: And management gender medical care? Is there an objection?

MR. NUSSBAUM: To the extent it concerns the physiatric or psychological aspects.

THE COURT: Okay. I'm going to take the request to qualify her as an expert under advisement, I'm going to hear all the testimony. It's going to be a standing objection on those grounds, but if you hear a question that you think invades or steps into that subject area, I would want the objection noted for the record.

MR. NUSSBAUM: Thank you, Your Honor.

THE COURT: Okay. Does that make sense, Mr. Seldin?

MR. SELDIN: Yes.

THE COURT: Dr. Turpin, we've finished with the legal contours there, and we're going to proceed to your questioning.

BY MR. SELDIN

Q. Dr. Turpin, we started to talk about this a little bit earlier, but in your field of endocrinology, how do endocrinologists define sex?

A. An endocrinologist defines sex as a -- it's a constellation of things. These include chromosomes, sex chromosomes, they include internal sex organs, external genitalia, hormonal milieu, gender identity.

Q. Does that also include secondary sex characteristics?

A. Yes, it does.

Q. Why did you include gender identity in your list of characteristics of sex?

A. We include gender identity because ultimately your brain has to be happy with how you're functioning.

So I can assign somebody, let's say I assign somebody a female sex assigned at birth, and

that individual is being reared as a female. But if they, as they age, their brain does not align with the sex assigned at birth, we ultimately have to go with what your brain has been wired.

And so if that person's brain was actually wired masculine, then that is ultimately going to trump all of those other things.

MR. NUSSBAUM: And Your Honor, I would just state for the record my objection to the psychiatric aspects, psychological aspects of that testimony. And just to clarify the Court's request, should I offer my objections at the end of testimony or interrupt the witness?

THE COURT: Sorry, there's -- there's terms being used that the Court doesn't understand. So when you make an objection, I don't know how to assess it in that light.

You see what I'm saying? Like, for example, I think I have some understanding of the phrase gender identity, but I don't know what she means by that, and so therefore, I don't know what's included within the scope of what she's testifying to.

So with that said, the standing objection to her qualifications to offer testimony

outside the scope of what you said you don't have an objection to, is going to remain.

What I want assistance with is when you believe you hear a question that you think falls within the scope of that, you can say, Judge, that is outside of her expertise and then I know that's a question that you have that particular objection to, you don't need to elaborate.

MR. NUSSBAUM: Thank you, Your Honor. And is it fine to object at the end of her testimony, rather than interrupting her?

THE COURT: I'm assuming there is questions that you may not find objectionable --

MR. NUSSBAUM: Yes. Yes.

THE COURT: So I want -- you can just, objection, scope. And I will interpret that as you think it's exceeding the scope of any expertise that she's qualified to offer.

MR. NUSSBAUM: I apologize, Your Honor. I'm just trying to get a sense of timing, and I would prefer not to interrupt her, so I'm wondering if at the end of her answer, I might offer the objection.

THE COURT: I thought when you said end of her testimony, I thought you meant not during

her testimony. Yes, at the end of her question --

MR. NUSSBAUM: Thank you, Your Honor.

THE COURT: You should make the objection.

BY MR. SELDIN

Q. And Dr. Turpin, in your list of traits within sex, you listed gender identity. What is gender identity?

A. Gender identity is someone's internal sense of being masculine or feminine.

MR. NUSSBAUM: Objection --

THE COURT: Go ahead.

MR. NUSSBAUM: Objection, scope.

BY MR. SELDIN

Q. Do your intersex patients have gender identities?

A. Yes, they do.

Q. Do your transgender patients have gender identities?

A. Yes, they do.

Q. Do your patients with diabetes have gender identities?

A. Yes, they do.

Q. Does everyone have a gender identity?

A. Yes, they do.

Q. Is gender identity directly observable?

MR. NUSSBAUM: Objection, scope.

A. No -- well, it's a little bit tricky. We do think there are specific underlying biological underpinnings, right? We know that if you have identical twins, so twins who are of the, where the fertilized egg splits, and you get identical twins, we know that those individuals have a much higher likelihood of having gender dysphoria, if one -- I should say, those individuals, if one has gender dysphoria identical twin, the other identical twin has a much higher likelihood of having gender dysphoria.

We know that, for instance, a couple of the differences in sex development that I take care of, one is a type of adrenal gland enzyme defect, wherein babies that have XX chromosomes, so they otherwise might have developed along a more feminine pathway, these babies, because of this enzyme defect in utero, they are exposed to high levels of testosterone.

Those babies, we counsel the parents that those individuals have a much higher likelihood of having a masculine gender identity, even though they have XX chromosomes, they have ovaries, they have a

uterus, but again, that exposure to those higher levels of testosterone, we know is likely responsible for the increased rate of those individuals having gender dysphoria.

And what I mean by that, is that the general population, there's about .5 to one percent, kind of depending on what studies you look at of the population that is transgender.

And in people with this specific form of congenital adrenal hyperplasia or with this enzyme defect, their potential for having gender dysphoria is in the neighborhood of five to 20 percent, depending on which studies you look at.

There's another example, too, with individuals who have partial androgen insensitivity. Used to be that all of those individuals, we raise them as females, now what we realize is about up to 10 percent, again, depending on studies that you look at, actually still had male gender identities, which again, is different from the general population. And so we do think there are biological things at play.

And a final example would be looking at functional MRIs. So you can look at MRIs that show kind of as the brain is thinking and working,

different areas will light up.

And so for a cisgender woman, where kind of everything lines up, all biological markers and gender identity, and these things all line up in a female bucket, and compares those to a cisgender male where everything lines up perfectly in a male bucket, and there are differences that you can see in the workings of those individuals' brains.

And when they have done functional MRI on trans women and trans man, what they have found is that there are similarities in how a trans woman's brain works to the cisgender women's.

And that there are similarities in how the trans man's brain works to the cisgender man's brain, things that we would not expect to see otherwise, if their gender identity aligned with their sex assigned at birth.

So there are definitely biological underpinnings that overlap in this area or what we take care of in endocrinology, and it is definitely something that we consider when we are taking care of these patients.

Q. And in that context when you're talking about gender identity -- actually I want to take a step back. Is gender identity different than gender

dysphoria?

MR. NUSSBAUM: Objection, scope.

A. Yes, gender identity is different than gender dysphoria.

Q. What is gender dysphoria?

MR. NUSSBAUM: Objection, scope.

A. Gender dysphoria is when you receive, let's say the sex assigned at birth is female, but you feel like your brain is wired as a male, that that creates severe distress for you functioning in your day-to-day life.

And oftentimes those individuals will seek out medical care to align their bodies and make them more congruent with their gender identity.

Q. Is gender dysphoria a diagnosis within the medical field?

MR. NUSSBAUM: Objection, scope.

A. Yes, it is. In the Endocrine Society guidelines, in our general textbooks that we use for pediatric endocrinology there are divided criteria for gender dysphoria.

Q. And what is the Endocrine Society guideline that you just referenced?

A. The Endocrine Society guideline is the tool that we use to help assess whether individuals

with gender dysphoria meet general qualifications where medical treatment would be reasonable and then it walks through the steps of potential medical treatment.

THE COURT: I'm going to ask a question. Do you make -- have you made the diagnosis of gender dysphoria?

THE WITNESS: We do make the diagnosis of gender dysphoria in our clinic.

THE COURT: And that's a decision that you make?

THE WITNESS: Yes, it is. I am the one making the decision on whether somebody needs, can get medical treatment. These guidelines are outlined in our medical society guideline.

THE COURT: So give me a sense of how often you've been involved in making a determination that a person should be diagnosed with gender dysphoria.

THE WITNESS: We work together in our clinic as a team, so we all work -- I'm not making it by myself.

THE COURT: Okay.

THE WITNESS: It is a team effort, I should say. So it's the adolescent,

(indiscernible.) person, it's myself, it's the clinical psychologist, it's all of us talking about all of the different facets that we each bring to the table in making that determination on whether somebody meets the indications for treatment.

THE COURT: Thank you.

THE WITNESS: I'm not making it in a vacuum, I guess.

BY MR. SELDIN

Q. Dr. Turpin, earlier we talked about diagnosing differences of sex development in infants. Is that another situation where there is a team helping to make a diagnosis?

A. We do involve geneticists, we do involve urology as well as clinical psychology. Yes, overall, we do work as a team.

Q. So even if it's different specialties within your clinic, is it similar, a group of different kinds of professionals helping to make a team decision about --

A. Yes, yes, it is.

THE COURT: And what was the example, Mr. Seldin?

MR. SELDIN: I think Dr. Turpin and I were discussing her role in diagnosing differences

of sex development in infants, and that team as compared to the team that makes diagnoses of gender dysphoria within her clinic.

THE COURT: Thank you.

BY MR. SELDIN

Q. So do those diagnoses of gender dysphoria be made without your consultation, in your clinic?

A. In our clinic, the diagnosis of gender dysphoria?

Q. Correct.

A. It could be someone came from an outside clinic, and they came in with a diagnosis of gender dysphoria, which oftentimes does happen in our clinic. But occasionally we will have people who we are already seeing in our clinic that will express gender dysphoria and that process --

Q. That's a diagnosis you and your team could confirm independently though --

A. Yes, yes, it is. That's correct.

Q. Even if someone else might've agreed with you earlier?

A. Yes, yes. That's correct.

Q. So gender dysphoria, what -- can you run a blood test for that?

MR. NUSSBAUM: Objection, scope.

A. No, you cannot.

Q. Then how do you assess it, as an endocrinologist?

MR. NUSSBAUM: Objection, scope.

A. The assessment is based on patient report, their report on their feelings about their gender, about how they are functioning in society.

It is similar to other things that we rely on for patient report, whether that's things such as irritable bowel, or migraine headaches, or chronic fatigue syndrome. There's many things that we rely on patient support and that we can't necessarily do a blood test for.

Q. And so Dr. Turpin, if you can believe it, we started out with what is sex. My next question is how is sex different than sex assigned at birth?

A. Yeah, sex assigned at birth is essentially what we do when a baby is born, and all we're doing is looking at external genitalia and what it appears to look like. So if it appears more masculine or aligns to match with masculine, we're going to give the baby a sex assigned at birth male.

If the external genitalia appear female, then we are going to give that baby a sex assigned at birth female. But in doing that, we could be

wrong.

For example, I recently had an individual come to my clinic who was six years old. This six-year-old had a surgery because she had a hernia in her groin. So when they went in to repair the hernia, they realized that the hernia was not just a little bit of bowel that had herniated, that it was actually a testicle.

And so this individual who had been assigned sex at birth a female, who is now six years old, who we now discover has undescended testes, she has no uterus, and her chromosomes are XY.

And so in that instance, if you're just looking biological markers, as far as her organs or sex chromosomes, you might think this person is assigned male because they have XY chromosomes, they don't have a uterus, they have undescended testes.

This individual actually had an enzyme defect that caused them to be unable to make any sex hormones. And so this individual is going to require some sort of sex hormone replacement.

For this individual, their reported and lived and experienced gender identity was always female. And so in this individual, she will start estrogen in the next couple of years.

Q. So is that a case where someone's sex assigned at birth might be different than what their sex would be if you were to tally up all of the different characteristics we just talked about?

A. Yes, that's correct. And if this, the caveat would be, too, yes, we assigned this individual female at birth because that's just what their external genitalia, we had no other reason to believe that things might be different at that point in time.

But if that individual as they grew and developed reported to us that they had a masculine gender identity, then again, this person is unable to make any sex hormone, the replacement hormone option would have been testosterone for that individual.

MR. NUSSBAUM: Objection, scope.

BY MR. SELDIN

Q. Dr. Turpin, I apologize. Is there -- I guess we started with sex, sex assigned at birth. We've talked about intersex people and DSDs. What does it mean to be transgender?

MR. NUSSBAUM: Objection, scope.

BY MR. SELDIN

Q. In the context of your -- just for

purposes of the record -- in your work as an endocrinologist, how is the term transgender relevant to your practice?

A. It's relevant to our practice in that, in transgender, for the patients that I see in my clinical practice on a day-to-day, these are patients that their gender identity does not align with their sex assigned at birth, and so they are interested in making their bodies more congruent with the gender that they identify with.

Q. Is transgender a medical diagnosis?

MR. NUSSBAUM: Objection, scope.

A. Transgender is not a medical diagnosis, but gender dysphoria is.

BY MR. SELDIN

Q. I think with that individual that you just mentioned, didn't make any sex hormones, you said that at some point later in life, to go through puberty they would need one sex hormone or another?

A. Yes, correct.

Q. Why do people need to go through puberty?

A. Sex hormones are critical for normal development, particularly bone health. If someone does not have any sex hormones, they'll develop early osteopenia or brittle bones, so it is critical

for that.

Also, other things, just like mood, muscle mass, heart health, those things, sex hormones also play a role.

Q. In the context of -- what is secondary sex characteristics?

A. Secondary sex characteristics would be things like breast development, pubic hair development.

Q. Are those things as a pediatric endocrinologist that you deal with?

A. Daily.

Q. If a person doesn't go through puberty, what happens with their secondary sex characteristics?

A. They don't develop secondary sex characteristics as expected.

Q. And so in your practice as an endocrinologist, do you treat patients who are intersex with respect to their development of puberty?

A. Yes, we do.

Q. Okay. And what kinds of treatments might you provide someone who is intersex to assist them with puberty?

A. We provide estrogen or testosterone.

Q. How do you determine which of those you are providing?

A. Based on their gender identity.

Q. Do you assist transgender individuals, or rather do you assist individuals with gender dysphoria in developing secondary sex characteristics?

A. Yes, we do.

Q. How does that work? In what context would you do that?

A. Also with testosterone or estrogen based on their gender identity.

Q. And so for individuals who have a sex assigned at birth of female, and a gender identity of male, what treatment would you provide so that they develop male secondary sex characteristics?

A. It would be testosterone.

Q. And what happens?

A. So when we give an individual testosterone, the idea is essentially to have that individual progress just like anybody who would make testosterone on their own is going to progress through puberty.

So I say we take a low and slow approach,

so we start with a small amount -- excuse me. We will start with a really small amount -- will start -- oh, my goodness, something is there.

MR. SELDIN: May I give her a mint?

THE COURT: You sure can.

THE WITNESS: Sorry.

THE COURT: Compose yourself, don't stress.

MR. SELDIN: I'll mark this mint as exhibit --

THE WITNESS: Thank you.

A. So typically we will start with what I call the low and slow approach where we'll start with a really small dose of testosterone or estrogen, depending on the hormone, the gender identity of the individual and the effects that we're trying to get. And we will start with a small dose and very gradually work up to, you know, adult doses over the course of about, you know, 18 months to two years, depending on the age of the patient, to mimic that normal puberty that that individual would go through.

Q. And how does providing testosterone to induce those secondary sex characteristics, how does that treat gender dysphoria?

A. By aligning the individual's body with the way that their brain is wired. It can alleviate those feelings of distress and allow them to go though their lives in society presenting and appearing as the gender that their brain is wired to be.

MR. NUSSBAUM: Objection, scope.

BY MR. SELDIN

Q. When you are providing testosterone to patients with gender dysphoria to induce secondary sex characteristics that match their gender identity, how do you know it's working?

A. So we regularly see those patients for follow-ups. If I am starting someone on testosterone or estrogen for gender dysphoria, we will see those patients back every three to six months.

So they will come to my clinic, I will do an assessment, you know, how are you feeling? How is this affecting how you're going through your daily lives? Are you having any side effects from your medication? Are you taking it regularly as prescribed? We will go through all of these things and again, through my checklist. School, work, metal health in general and all these different

aspects of their various functioning, and see if those are feeling better or improving with the medication that I have prescribed.

So the idea is, if this is the right prescription, if this is the right medication for you, you're going to come back every three to six months telling me, yeah, this is right, this is better, I'm getting some hair growth now, I'm a trans man, and I'm loving it, feeling great.

If you come back and you tell me, I don't know, this doesn't -- let's reassess. Let's either stop your medication, let's pause, let's reassess where we're at.

You know the vast majority of people that we treat with gender dysphoria with testosterone or estrogen, you just see these continued improvements in their lives. They are feeling well, and this definitely helps alleviate that gender dysphoria that they feel.

MR. NUSSBAUM: Objection, scope.

BY MR. SELDIN

Q. Dr. Turpin, were you in the courtroom yesterday when the plaintiffs testified?

A. Yes, I was.

Q. Did you hear the testimony of Nicholas

Noe, Cameron Broyles, Kyle Koe, and Daniel Doe?

A. Yes, I did.

Q. Did you hear them testify about medical transitions between the ages of 17 and their early 20s/

A. Yes, I did.

Q. Is that a patient population you are familiar with?

A. Yes, it is.

Q. Is that the patient population you treat?

A. Yes, it is.

Q. Did you hear them testify about the effect of their medical transitions on their lives?

A. Yes.

Q. Are those reports -- do you have those kinds of conversations with your patients?

A. Yes, everyday.

Q. If you're an endocrinologist, and you deal with hormones, why do you care how they are doing in school?

THE COURT: Why do you care about what?

MR. SELDIN: I said, if you are an endocrinologist, and are a specialist in hormones, why do you care how they're doing in work, in

school?

MR. NUSSBAUM: Objection, scope.

A. Again, our patients don't exist in a vacuum. And the medications that I'm prescribing, the testosterone or the estrogen are supposed to have an effect on their daily lives, so I'm doing those assessments to make sure that the medications aren't just getting physical effects, I need to know how they are processing those physical effects in their daily lives.

And so we are constantly doing those, doing those assessments better. I want to make sure that the medication that I have prescribed is having the desired result for those patients.

Q. You said you also treat patients with diabetes?

A. Yes, I do.

Q. Do you have similar concerns about how the medication is affecting their daily lives?

A. Yes, exactly. It's very similar. You know going out into the world, having diabetes, you know, patients will have the more touch points, so to speak, you have to deal with a chronic medical condition, the work can kind of weigh on you.

With diabetes, it's a very labor intensive

disease, and so again, we are also assessing, how are you able to take care of this at school, how does this -- are you doing this with your sports, or is this affecting your mental health. Again, always do a depression and suicide screenings in all of these patients.

We know that these patients, there is a burden in functioning in society with a chronic medical condition, whether it is diabetes or gender dysphoria, so we're constantly assessing how that is going.

For example, I had a patient, I'm using diabetic as an example, was being bullied. You know, if you just didn't just eat a cookie, if you just weighed a little bit less, you wouldn't have diabetes.

Unfortunately, type one diabetes isn't caused by cookies or weight, so that was unfortunate. But that individual, that weighed enough on that individual that they quit taking their insulin and ended up hospitalized and in a life-threatening condition called diabetic ketoacidosis.

So if we don't assess, like, those things and we aren't figuring out, okay, how can we help

this person function better out in society, there can and will be negative health outcomes.

Q. Dr. Turpin, I think at the start of your answer, you talked about a touch point for their chronic condition. Is that what you meant by like being bullied because of their condition?

A. Also just the more that chronic condition has to be at the forefront of your brain, rather than just living your life -- so for my diabetics, it's every time that you eat, you have to think about the fact that you have diabetes, that can really weigh on individuals, and start to increase depression and anxiety, these sorts of things?

The same could be said for somebody with gender dysphoria. I've seen that in my clinic where if they're forced to have additional touch points with being confronted with their gender dysphoria as they're going through their daily lives, that will start to negatively weigh on their, on them and it can increase, you know, depression and anxiety symptoms.

MR. NUSSBAUM: Objection, scope.

BY MR. SELDIN

Q. Dr. Turpin, in the context of a patient with diabetes, I think you said, the impetus in

their social life was like at mealtime, being bullied --

A. Yes.

Q. -- for your, people eat over the course of that day --

A. Right.

Q. What is the equivalent, or is there an equivalent daily activity for your patients with gender dysphoria, with respect to sort of one of those friction touch points that we talked about?

A. Yes, using the restroom is one of those. Also, if they have to produce an identification, that also can be. But daily, it would be, restroom use would be the primary one.

MR. NUSSBAUM: Objection, scope.

THE COURT: I'm sorry, I didn't hear --

A. Sorry, restrooms are kind of that chronic touch point or can be a chronic touch point for individuals who have gender dysphoria, where they get that reminder and that weighs on them.

MR. NUSSBAUM: Objection, scope.

BY MR. SELDIN

Q. How many times a day does the average person need to use the restroom?

A. They are using the restroom three to five times a day.

MR. NUSSBAUM: Objection, scope.

BY MR. SELDIN

Q. Do you ask your patients about how often they use the restroom?

A. I ask them about just restroom use in general. Are you able to access restrooms that you feel comfortable using, is a question that we typically ask our individuals with gender dysphoria.

MR. NUSSBAUM: Objection, scope.

BY MR. SELDIN

Q. Why do you care whether the patients you are treating for gender dysphoria are using the restroom --

MR. NUSSBAUM: Objection, scope.

A. Because we've had patients, I've had patients come in and especially, like, for example, there is for our trans women, so sex assigned at birth is male, they identify as female, those women do not want facial hair or other hair growth that would be seen as masculine.

There is an oral medication called Spironolactone that it blocks the testosterone receptor, and so it prevents that person from

developing additional hair growth.

So a lot of trans women will be on this medication called Spironolactone. A side effect of it though, is that it is a weak diuretic, meaning it increases your need to go to the restroom. And I've had trans girls, trans women who have been on Spironolactone, that are afraid to use the men's restroom or they don't have access to a restroom.

So what they will do is, one, not drink, but two, they're going to the bathroom more. So I've had people with syncopal episodes or fainting episodes because they're not taking in enough fluid and they are on a medication that works as a diuretic, so it's really important to make sure that they are having effects of these medications that I'm prescribing, along with social behaviors that might exacerbate the side effects of those.

THE COURT: Spironolactone.

THE WITNESS: Spironolactone. I can spell --

THE COURT: Spell --

THE WITNESS: -- it.

S-P-R-I-N-O-L-A-C-T-O-N, Spironolactone.

BY MR. SELDIN

Q. And I think you were just talking about

transgender women. For transgender women, what is their sex assigned at birth?

A. For transgender women, sex assigned at birth would be male.

Q. And what is their gender identity?

A. Female.

Q. Do your patients, who are transgender men meaning they have a sex assigned at birth as female and a gender identity of male, have they ever reported restroom avoidance to you?

A. Yes, actually recently I had a patient who came in, and this was after this bill that we were discussing, SB 244 was passed. And so in general, I was trying to just assess, has anything changed for you since this bill has passed. And I had one individual, he said, well --

MR. NUSSBAUM: Your Honor, I would object to the hearsay here. It is not within any hearsay exception. This is not the kind of material that an expert would usually rely upon in their report.

It's not a learned treatise or anything along those lines.

MR. SELDIN: Your Honor, she is testifying in part based on her clinical experience

treating patients. We've established that she's done that hundreds if not thousands of times over the course of her career.

A. I could make it more generalized --

THE COURT: Stop.

THE WITNESS: Because it's not --

THE COURT: Please, stop.

I'm taking it as an example of her experience, not for the literal words it is being stated for, so it's not for the truth of the matter asserted, it's for the purpose of the question. Objection's overruled.

MR. NUSSBAUM: Thank you, Your Honor.

A. This is just an example of something that has come up other times as well. But in this particular instance, the individual had said, you know, I just try to not use the bathroom at all. It's kind of okay.

And the person had a parent with them for that visit. And the parent said, well, do you want to tell her the truth. And you could see at that point, the patient, you know, head dropped and they felt kind of ashamed, and they said, well, yeah, but when I don't use the bathroom, then I get severely constipated and then I have to deal with that whole

situation. And that's not the only patient that's reported that or that is just the one that was recent.

So there are other issues that patients have reported as well.

Q. And Dr. Turpin, with respect to -- Dr. Turpin, were you in the courtroom when Ms. Dakota West testified?

A. Yes, I was.

Q. And I believe earlier we were discussing partial androgen insensitivity syndrome. What does the treatment for that look like in an intersex patient who has a gender identity female?

A. Yes, so in that instance that person has -- so a complete androgen insensitivity, your testosterone receptors don't respond at all to testosterone.

Those individuals are typically completely feminine looking, but there are varying degrees of androgen insensitivity. Some are partial, so with partial androgen insensitivity, you might have a phallus that is larger than a clitoris, but not a typical looking male penis.

You might have a tiny bit of pubic hair growth, or you may have none. Oftentimes those

individuals, as they go through a time where puberty should occur, testosterone levels will increase, but the body is not able to respond to that. You do get an effect though where testosterone levels will start to, its hard to describe, but they start to spill over, so to speak.

There's an enzyme that takes testosterone and converts it to estrogen, so some of those people will get a little bit of breast budding, but ultimately, they are kind of left in a limbo land, and the majority -- majority of those people will identify as female and go on estrogen replacement, but not all.

Q. Are there some individuals with androgen insensitivity syndrome, who have a gender identity of male?

A. Yes, studies have shown up to 10 percent of individuals with partial androgen insensitivity will identify as male.

Q. And who does that 10 percent figure compare to the rate of persons who are transgender in the general population?

MR. NUSSBAUM: Objection, scope.

A. General population, the studies have shown about .5 to 1 percent of the general population is

transgender.

Q. For an individual who is intersex, who has androgen insensitivity syndrome, partial, if they have a gender identity of female, would you prescribe them testosterone?

A. No.

Q. Why not?

A. Because we need to, we need to make our hormone replacement congruent with their gender identity.

If I can give another example of a patient I saw with Turner syndrome. So in Turner syndrome, normally there's two sex chromosomes, an X, either you're XX, which would typically align with female, if everything goes as planned. Or there is XY, which would go with male if everything goes as planned.

In Turner's syndrome, the non-mosaic form, one of those, the second sex chromosome is missing, so you just have an X, and nothing else. On those individuals, they will typically develop a uterus, they will develop external genitalia that appear female, and more often than not, their gender identity is female.

They don't -- the research I've seen --

have a higher incidence of having gender dysphoria, but the issue is, in these individuals that only have one X chromosome, once they get to the time of puberty, they do not go through puberty. They have ovaries, but they're not functional most of the time.

And so in those individuals, ultimately, we have to decide, are we going to estrogen or are we going to do testosterone. I think if you're just looking at the markers that we discussed earlier, that you can tick a box on and say, X chromosome, uterus, external genitalia, appear female, you would say, okay, we're going to go ahead with estrogen in this individual, but it doesn't always align that way.

And in fact, I've had two Turner syndrome patients where it came down to do replacement hormone therapy who had masculine gender identities, and ultimately, you have to go with the way that the brain is wired, even though all of these other things make it likely that you would say, okay, feminine gender identity.

MR. NUSSBAUM: Your Honor, I need to interrupt here. Your Honor, none of this was in Dr. Turpin's report, the treatment of Turner syndrome,

the diagnosis of DSDs. It's not anywhere in her report. It's never been disclosed to us. We've never had the opportunity to depose her about it, nor do I think it has any relevance to the issues in this case.

But at this point, I've never heard this testimony before, and never heard these opinions.

MR. SELDIN: Your Honor, if I may?

BY MR. SELDIN

Q. Dr. Turpin, can you turn to paragraph 44 of your declaration.

A. Yes.

MR. SELDIN: Your Honor, I don't want to annoy the Court, but it might be helpful if I read this paragraph, or the witness read this paragraph. Would that be acceptable?

THE COURT: Paragraph 44? What would be the purpose of having her read it?

MR. SELDIN: I think the purpose of having her read it would be to demonstrate that this is, in fact, part of her report and I think I could maybe address some of the concerns about how the testimony she's just offered relates to the opinion that she's expressing here in her report.

THE COURT: I think the objection was Turner syndrome. I don't think there was an objection that she hadn't testified to the intersex and the percentages we heard about in voir dire and just now. Is that right?

MR. NUSSBAUM: Yes, Your Honor.

THE COURT: Just the Turner syndrome aspect.

MR. SELDIN: I may be able to clean this up a little bit, if that would help.

THE COURT: I'm going to overrule the objection.

BY MR. SELDIN

Q. Dr. Turpin, we started this conversation talking about what is sex and what is gender identity. What has your education, and clinical experience with both intersex patients -- excuse me, what has your education and experience with intersex patients taught you about the nature of gender identity, in the context of your practices as an endocrinologist?

A. That there are definitely biological underpinnings for gender identity, that gender identity is real, and that gender dysphoria is real. And that ultimately, when we are making clinical

decisions regarding sex hormones, that we need to rely on gender identity.

Q. Okay. And I think we started this conversation also talking about your role in diagnosing differences of sex development in infants to help assign a sex at birth. Why do we need to assign sex at birth?

A. We live in a binary society in general, and so parents are typically raising their children, there's we call it sex rearing, either male or female. And that again, in a binary society that's just how we function.

MR. NUSSBAUM: Objection, scope.

THE COURT: Mr. Seldin, can we take a short recess?

MR. SELDIN: Yes, Your Honor.

THE COURT: Fifteen minutes.

(A recess was taken.)

THE COURT: Back on the record. Dr. Turpin, you're still under.

The appearances are the same as before the recess. A couple things to address.

One, I have a better sense, Mr. Nussbaum, of the nature of your objections and I'm going to allow as a standing objection, so I'm

going to making this decision after I hear all of the testimony, in any event.

Number two, my court reporter has a cup that says 225 WPM. I don't know if that is her actual limit, but I know that when you're going through hills and curves, the speed limit is not a max, and we're talking about phrases and terms that I'm having to think about and she's having to process.

So everybody's been going fast, I know we want to get to the finish line, but please be mindful of our speed.

And both were sort of stepping on the answer and stepping on the question. Let everybody finish completely the question and answer before we start again. So just reminders of what everybody knows, I know.

But the court reporter asked me if I was keeping up, and I said not always, and I'm not sure how she is, so help us all do that. Go ahead.

MR. NUSSBAUM: I just want to make sure the record's clear, so I don't need to offer my objections as I have been, I have a standing objection.

THE COURT: Standing objection.

MR. NUSSBAUM: Thank you, Your Honor.

MR. SELDIN: Thank you for letting us off with a warning on the speed. We will be more careful.

THE COURT: It's only fair to warn, I don't think anybody was doing anything intentionally. Let's proceed.

BY MR. SELDIN

Q. Dr. Turpin, returning the discussion with the patient population that you treated over the course of your career with gender dysphoria within your clinic, how would you describe the number of -- how would you describe the gender identity of most of your patients, of your patient population overall?

A. The patients that we see are almost uniformly binary, trans men or trans women.

Q. And I want to unpack that just a little bit. When you say a binary trans man, what do you mean?

A. I mean a person whose sex assigned at birth is female, their gender identity is masculine. And in every way, shape, or form possible in their lives, they would like to be seen and present as masculine.

And then the opposite of that would be somebody whose sex assigned at birth is male, their gender identity is female and in every way, shape, and form in their lives, they would like to be seen as female.

Q. And if you think about your patient population, what percentage would you estimate are either binary trans men or binary trans women?

A. I would say about 95 percent.

Q. And how would you describe the gender identity of that other five percent?

A. The other five percent I would describe as either gender nonbinary or someone describes themselves as what they consider as more gender fluid.

Q. And you were in the courtroom yesterday when the plaintiffs testified?

A. Yes, I was.

Q. You heard the five transgender men testify?

A. Yes.

Q. The experiences that they've related, how would you typically understand that kind of patient report in terms of the identity terms we just talked about?

A. I might not understand the question.

Q. Sorry, you said that a binary trans man is a man who seeks to live in every aspect of his life as a man. Would you consider the male, the transgender men who testified yesterday, is that consistent with your understanding?

A. Oh, yes.

MR. NUSSBAUM: Your Honor, I would offer an objection to this. This is beyond the scope of her report. She didn't evaluate the patients as part of her reports has never been disclosed to us.

MR. SELDIN: I'm not asking her to evaluate, I'm asking if it's consistent. Experts routinely comment on facts that are elicited during a hearing.

THE COURT: It was elicited during the hearing, she was present. She is offering an opinion, I assume, consistent with her other expert testimony, and that is something you can cross-examine her about.

BY MR. SELDIN

Q. Dr. Turpin, for your patients who are --

THE COURT: Let me interrupt. I'm sorry. I'm talking about, as asked. If you feel

like we're getting into too much detail, I don't want you to feel like you can't renew an objection.

Go ahead, Mr. Seldin.

BY MR. SELDIN

Q. For your patients who are binary trans men, who seek to live as men in all aspects of their lives, we've talked today about one of the different ways that patients like that try to effectuate living in every aspect of their lives. What do you help them do?

A. My patients traditionally will make a social transition where they will start dressing, wearing their hair, in a -- the identity, and if we're using masculine as the example, in a more masculine way, they will adapt if they want a more masculine sounding name.

And in certain instances they will use masculine pronouns. They, in our clinics, they typically will desire testosterone to make their body congruent to develop body hair, facial hair, they will get a deeper voice, they will get enlargement of the clitoris, all of those things to make their body more congruent with their gender identity.

And then in public, being addressed as he

or him or sir by a stranger, or using the men's restroom, those things also affirm that gender identity.

Q. Dr. Turpin, when we were talking earlier about things like school and work and restrooms, do those fall within the ambit of what you call social transition?

A. Yes, they do.

Q. In addition to social and medical transition are there other ways that your patients who are binary transgender men seek to effectuate living their lives as men?

A. You said in addition to social --

Q. Medical --

A. I'm sorry, what was that?

Q. In addition to social and medical transition, are there other steps that binary trans men patients that you treat, are there other things they do to live their lives as men that you may have assisted with?

A. That I may have assisted with. Oh, they will typically get to the point where they would also like the identification that they carry to match their gender identity, and so I will write letters saying that they've had the appropriate

medical treatment to change their gender markers to the gender identity that they have.

Q. And prior to SB 244, were you involved in writing such letters?

A. Yes, I was.

Q. And do you know why you had to write such letters?

A. Yes, because I had to verify that the individuals had actually had medical intervention, which I deem to mean, you know, testosterone or estrogen, surgery, those kinds of thing.

Q. And did you ever write those letters for someone who hadn't had that kind of clinical treatment?

A. No.

Q. Did other people within your clinic?

A. No.

Q. And typically at what stage -- typically, when would, for example, your binary transgender men patient request you write such a letter?

A. After they felt like they could pass in the community as the gender that they identify with. So if that's a masculine person, they were on testosterone for a year or two and felt like they were not fully presenting in society.

Masculine strangers would see them as a masculine person, and so they wanted their IDs to reflect that as well.

Q. And for your patients who are binary transgender women, so people whose sex assigned at birth is male, but who live in all aspects of their lives as female, when do they typically seek such letters and what would they do with them?

A. In a similar fashion, those trans women would typically seek out to change on their identification once they had been on medical treatment for a year or two, and felt like they were able to fully pass as much as possible in society. As women, that they would ask for a gender marker change letter.

Q. So we've talked about 95 percent of your patient population being in one of those two categories, binary trans men or binary trans women. For the remaining patients who are nonbinary or gender fluid, did they seek such letters?

A. No.

Q. Why not?

A. Most of our nonbinary or gender fluid individuals, they are coming in kind of feeling in between and that's what they will voice.

I'm not sure, I was assigned male, but I'm not sure that that fits me. And so sometimes there might be a time where they're kind of trying to figure out, so I've used puberty blockers in those individuals on occasion where they're trying to figure out where exactly their gender identity is.

And occasionally I've had people, you know, I don't feel like I have a specific gender, that's fine, eventually we will discontinue the puberty blocker and they'll have to feel comfortable with whichever, either the sex hormone that their body makes or maybe they do want to use an opposite sex hormone.

But those individuals, the function where they typically, more often than not, they will use the bathroom of the sex assigned at birth because they look most congruent with that.

And that's in general what we see, that those individuals are going to use the restroom that they look most congruent with, which most often is their sex assigned at birth.

Q. And with respect to things like driver's licenses, what do your nonbinary patients typically do, if anything?

A. We don't write letters for nonbinary

people. Again, even if you use a puberty blocker, that's not forever. You do that for a year or two while someone is kind of trying to figure things out, and then you let things go. But I've never written a letter for a nonbinary individual.

Q. And Dr. Turpin, before patients for whom you have written these letters, do you follow up with them, you know, to see what happens?

A. Yeah, typically we see patients back. I mean, I feel like the time that most of these individuals will do this is around 17 or 18, maybe 19. Again, they've been on medication for a year or two, and then we do see them back in clinic after they've had their IDs changed.

Q. And then you talked earlier about how you check in on their well-being at these visits. Do patients report anything to you about what happens after they've changed their driver's licenses?

A. Yes, patients are super excited after they've changed their driver's license. They feel, they're like, yes, I can drive now, and I don't worry about, you know, if I get pulled over, somebody is going to see this gender marker that doesn't look like the person that's driving the car.

People are more excited about getting

employment, and they have to show their identification, whether they are applying or accepting a job.

They definitely feel like, you know, more doors have opened for me, for the vast majority of the patients.

Q. And since SB 244 went into effect, and just up until Friday when you retired, were you seeing patients?

A. Yes, I was.

Q. Did you see patients with gender dysphoria diagnoses who you had been treating since then?

A. Yes.

Q. Had any of those patients received medical letters from you supporting their changed driver's licenses?

A. Yes.

Q. Did you ask any of your patients about what had happened to their driver's licenses?

A. Yes, I did.

Q. What were those conversations like?

A. Patients were very disappointed that their identification had to be changed. I have one patient who was planning to get a graduate degree here in Kansas, but since her identification has had

to be changed, she is planning to seek her degree elsewhere.

I had another patient who was planning to obtain a driver's license --

MR. NUSSBAUM: Your Honor, I'd like to interrupt and object to the hearsay in this answer. It is not within any exception of the hearsay rule, it's not learned.

MR. SELDIN: Your Honor, it falls in the same scope of the testimony we were talking about before, part of the basis for her clinical experience is her experience with patients, it is not being offered for the truth of the matter asserted, it's part of the foundation for expert testimony.

THE COURT: Overruled.

A. I had another patient who was planning to obtain a driver's license, and who has now decided that they just won't get one.

And unfortunately, that person is now, you know, telling me now, I don't know what I'm going to do. I can't get a job without my driver's license, but I can't look at that gender marker, which is understandable.

Q. And why do you care if your patients can't

drive or where they go to graduate school?

A. Yeah, it makes their worlds smaller, is what I have found.

Another patient, going back to the bathroom where it's, you know, this individual works at a public pool, and they go to a public university.

And one person, kind of going back to yesterday, where they have decided if they're going to go to Quiktrip to go to the bathroom in this class, and so what I found what happens when you don't have access to the things that the rest of us have access to, you are making the decision to go to class or go to Quiktrip to use the bathroom.

Ultimately, those things will drive people to drop out of school or, you know, quit their jobs, or live smaller lives that are marked isolated. They tend to become more depressed, more anxious, is what I've seen when they are not able to fully live in society as the gender they identify with.

Q. And are those things like, you know, decreased social life or education --

A. Yes, absolutely.

Q. We're going to get in trouble. Sorry because. Are those -- I guess, sorry. As an

endocrinologist, why are those facts in their lives and those potential increased in depression and anxiety, why are they relevant to your practice?

A. Because again, we're taking care of the whole person. And so when those things start to happen, those patients are coming into their clinic visits where we're doing medication check-ins and assessing how things are going, and it's, it's important that those individuals are able to live fully as the gender they identify with to avoid some of those comorbidities.

Q. And Dr. Turpin, you gave us some illustrative examples. Are those anomalous within the patient population you were seeing?

A. No.

Q. Dr. Turpin, I want to pivot very briefly back to something you were talking about earlier. Within the field of pediatric endocrinology, are there any authoritative treatises?

A. Yes, there are. There is.

Q. What is it?

A. Sperling Endocrinology --

Q. What is --

A. I'm so sorry, Sperling, S-P-E-R-L-I-N-G. It's the basic book of pediatric endocrinology that

we use for instructional purposes, for medical students, residents, and mostly for pediatric endocrinology fellows, because it's more detailed.

Q. And within the field of pediatric endocrinology, broadly speaking, what kinds of topics does a cover?

A. It covers all the basics that we expect somebody who is doing a fellowship in pediatric endocrinology to understand.

MR. NUSSBAUM: Your Honor, I'm going to object right now.

Dr. Turpin has a bibliography attached to her declaration. No where is the Sperling referenced in that declaration. I specifically asked her about this in her deposition. It's never been disclosed to us.

MR. SELDIN: Your Honor, as part of voir dire, I think there were some concerns about whether the things she was talking about were within the scope of her field. We believe it is relevant as part of her clinical education or medical residence and her own training as an endocrinologist, what is typical to rely on in her field, just generally as an endocrinologist.

THE COURT: And that's the purpose of

the discovery and the disclosures.

MR. SELDIN: And in fact, at her deposition when Mr. Nussbaum asked her if there was, like, an authoritative textbook, she said it was Sperling.

MR. NUSSBAUM: I don't recall that specifically, Your Honor, but it hasn't been disclosed to us.

MR. SELDIN: Your Honor, I have a page and line.

THE COURT: I'm inclined to sustain the objection. I don't want her to go on at length about a topic that should have been disclosed and they don't have the opportunity to examine about.

MR. SELDIN: Your Honor, it's very brief, just about moving back to things we've already talked about. I'm not opening a new topic.

THE COURT: I think what she's discussed is the, it's her view that it's the basic book in the field of pediatric endocrinology for medical students, fellows and the types of topics that it covers.

I will allow that testimony, but if you go beyond that, I'll hear objections.

MR. SELDIN: For purposes of the

record, can I just ask one more questions?

THE COURT: Yes.

BY MR. SELDIN

Q. Dr. Turpin, the topics that we've covered today with respect to differences of sex development, with respect to the treatment of gender dysphoria, are those topics covered in Sperling?

A. Yes, they are.

MR. NUSSBAUM: Same objection, Your Honor.

MR. SELDIN: That's my last question, Your Honor.

THE COURT: And the answer was, yes, they are.

MR. SELDIN: That's all I have, Your Honor.

THE COURT: Mr. Nussbaum, need a minute or are you ready to proceed?

MR. NUSSBAUM: I'm ready to proceed, Your Honor.

THE COURT: Dr. Turpin, you have water or anything else? Are you doing okay?

THE WITNESS: I do. Thank you.

CROSS-EXAMINATION

BY MR. NUSSBAUM

Q. Good morning, again, Dr. Turpin.

A. Good morning.

Q. So on the brief time we had to speak earlier this morning, we were talking a little bit about your qualifications, do you recall that?

A. Yes.

Q. And in your conversation with Mr. Seldin, you were also talking about qualifications and your role on your team at the Gender Pathways clinic; is that right?

A. Yes.

Q. And is it fair to describe your team at the Gender Pathways clinic as an interdisciplinary team?

A. Yes, it is.

Q. And I think you talked about if you were assigning sex at birth, there might be a geneticist involved, a urologist involved, a psychologist involved. Do I recall that correctly?

A. So let me correct myself there. So we do, when we are assigning sex at birth, the, the, the role of the clinical psychologist is not necessarily to help assign the sex at birth, it's to be ongoing support for the family.

Q. And I apologize, my time is limited --
A. Okay.
Q. -- and I'm just trying to understand briefly. So there might be geneticist or a urologist involved in that process?
A. That's correct.
Q. And you've repeatedly used the term we throughout your testimony; is that fair?
A. Yes, it is.
Q. But for example, you don't, you personally don't assign sex at birth, right, as part of practice?
A. Yes, we do.
Q. You do personally?
A. Yes, I personally do.
Q. And a geneticist has a specific role on that team. What is the geneticist role?
A. The geneticist role is to interpret chromosome analysis.
Q. And what is a urologist?
A. The urologist takes care of your genital disorders that, typically, that might need surgery.
Q. And you're generally familiar with urology as a field of study because you work with urologists, right?

A. Yes.

Q. And you are generally familiar with the study of genetics, because you work with geneticist, right?

A. Yes.

Q. And that's same for psychologist, it's part of your practice, you talk to them regularly, you are generally familiar with it, right?

A. Yes.

Q. But you're not an expert in genetics, right?

A. Correct.

Q. You're not a urologist? You're not an expert in urology?

A. No.

Q. And you're not an expert in psychology, are you?

A. Correct.

Q. Okay. You agree with me, and you talked about your role in thinking about mental health issues in your practice, on your direct examination, do you recall that?

A. Yes.

Q. And you agree with me that when a patient goes to see a primary physician, that primary care

physician is trained to screen for mental health issues, right?

A. Yes.

Q. So that can be a family nurse practitioner or family doctor, or a PA, they will screen for mental health issues, right?

A. Yes.

Q. But you wouldn't call a family doctor, or a family nurse practitioner, or a physician's assistant, I think is the other one I said, an expert in psychiatry or psychology, would you?

A. No.

Q. Or an expert in human sexual development, right?

A. I guess -- again, I don't think so. It depends on what their training and background is. But in general, no.

Q. But -- thank you. So even though a typical family doctor probably has some training in human sexual development in medical school, right?

A. Yes.

Q. And psychiatry, right?

A. Yes.

Q. They might even do a rotation on the psychiatry board?

A. Yes.

Q. But they're not experts in psychiatry, correct?

A. Correct.

Q. You agree with me that your role is limited as it pertains to psychiatry or psychology is limited to screening and referral, right?

A. Yes. I would like to point out, that it's, there's a difference I think between giving them like a screening for, like an isolated screening for depression, like a general screening for depression, or general screening for suicidal ideation to be used, and then talking in depth about psychosocial things that are affecting their lives that may not trigger a screen for depression or suicide.

Q. Fair enough. So like a PHQ9 is what you're talking about with regards to suicidal ideation?

A. There are various screens, but that's one of them.

Q. And you have a number of checklists, where you ask certain questions that help you understand what you're going to screen a patient for with regard to psychiatric issues.

A. So again, any patient who has diabetes or gender dysphoria is going to get actual, specific depression and SI screenings. But then I'll ask more in-depth questions in general.

Because just because somebody didn't screen positive for depression screening, doesn't mean that they are struggling to take care of their diabetes in their general lives because of psychosocial things.

Q. So you --

A. Same thing with gender dysphoria.

Q. You ask follow-up questions?

A. Yes.

Q. I want to talk to you a little bit more about your report.

Well, before we jump into that, in your conversation with Mr. Seldin, you said that 95 percent of your patient population that suffers from gender dysphoria, and fill in the blank for me, what is that 95 percent?

A. I said they are binary transgendered individuals, meaning that they were, I'll use an example, you're assigned female at birth, and your gender identity is male and you want to live and be presented, present to society in all aspects of your

life as -- excuse me -- male, oftentimes again with medical intervention as well.

Q. So the other five percent is nonbinary and gender fluid; is that fair?

A. Yes.

Q. And I just want to make sure I understand the scope of the population we're talking about. Three quarters of your practice concerns nothing -- strike that question.

Three quarters of your practice, those patients have no diagnosis or gender dysphoria and aren't seen for treatment for gender dysphoria, correct?

A. Yes.

Q. And 25 percent concerns gender dysphoria, or have a diagnosis for some (indiscernible.) related to gender dysphoria, correct?

A. Correct.

Q. And the patient population you specifically see is pediatric, right?

A. As we discussed earlier, it's pediatric to young adults.

Q. And with almost no exceptions, you have a couple in your background that you've treated beyond 22 or 23, but almost all of your patient population

is under the age of 22 or 23?

A. Yes.

Q. And you've conducted no study of your patient population to determine if what you testify today is scientifically valid, right?

A. That's correct.

Q. It's purely patient self-report?

A. It's based on clinical experience.

Q. But you haven't done anything to look at the data and validate it consistent with, for example, the grade system, correct?

THE COURT: For example what?

MR. NUSSBAUM: The grade system, G-R-A-D-E.

BY MR. NUSSBAUM

Q. What is the grade system, Doctor?

A. The grade system is a system that's used to analyze scientific literature to determine the quality of the evidence and it goes from higher grade to very low grade evidence and that's how scientific literature is often evaluated.

Q. And you haven't undertaken that analysis of this case, of your patient population?

A. That's correct.

Q. You can't make any causal claims related

to identity documents or bathrooms because you haven't undertaken that analysis, right?

A. I can only do so based on my experience with patients.

Q. The statements patients have made to you?

A. That's correct.

Q. Is that fair to describe that anecdotal evidence?

A. You know, in, in medicine, we are oftentimes left to make clinical decisions based on patient experience and our own experiences and practices.

We don't always have medical literature to heavily rely on in making clinical decision-making -- especially in pediatrics where, you know, you look at 50 percent of the medications that we prescribe for kids aren't actually FDA-approved for kids, and yet we're still prescribing them.

So we oftentimes are left to do the best that we can with the information that we have available to us.

Q. You've never studied the effects of Senate Bill 244, correct?

A. That's correct.

Q. And you've never studied the effects of restroom restrictions in Kansas or in any other jurisdiction, right?

A. That's correct.

Q. You haven't studied the effects of having identity documents consistent with one's gender identity, have you?

A. That's correct.

Q. And you've never examined or treated any of the plaintiffs in this case, right?

A. Personally?

Q. Personally.

A. No.

Q. You had reviewed their medical records?

A. No.

Q. You testified in the Lily Loe case previously last year, right?

A. Yes, I did.

Q. And you volunteered to testify in that, didn't you?

A. Yes, I did.

Q. Reached out to the ACLU and said, I would like to help?

A. Yes, I did.

Q. You consider yourself an advocate for

transgender individuals?

A. I consider myself an advocate for my patients.

Q. You testified before the Kansas Legislature regarding the bill in Lily Loe, right?

A. Yes, I did.

Q. And you signed a physician's letter to the Missouri Legislature opposing Missouri's bill of the same topic, right?

A. Yes, I did.

Q. You've previously donated to advocacy organizations for LGBTQ individuals?

A. I did donate $20 to PROMO in Missouri.

Q. I want to talk to you a little bit about sex and gender.

Can you define the term sexual dimorphism for me?

A. Sexual dimorphism is when we talk about basically how when a human develops typically, they are going to go down one path or another. They're either going to go down a masculine path or they are going to go down a feminine pathway. And that's the sexual dimorphism.

Q. I think you described it at your deposition as that developing fetuses, humans are

supposed to go down one chute or another. Do you recall that?

A. Yes.

Q. And sexual dimorphism, that concept applies to the human species, doesn't it?

A. In most cases it does, but there are, particularly in my line of work, we see a lot of people who do not follow down one chute or the other and they end up stuck in between.

Q. You agree with me that the Y chromosome starts the pathway that produces male gonads?

A. Yes.

Q. Male external genitalia?

A. Yes.

Q. And the male hormonal milieu?

A. Yes, in most instances, but not all. Y chromosome does not do that in all instances.

Q. And that would be an intersex or DSDs, right?

A. That's correct.

Q. And two X chromosomes produce the female pathway to sexual development, correct?

A. Again, if things go as typical, that would be the expectation, but that does not always happen.

Q. What's your estimate of the population

that suffers from DSDs or intersex condition?

A. It's around two percent.

Q. You agree with me that a disorder of sex development is by definition a condition which those typical components, the hormonal milieu, the secondary sexual characteristics, those kinds of things do not line up, correct?

A. That is correct.

Q. Other than the DSDs and intersex conditions, there are no instances in which a person's chromosomes, gonads, internal reproductive anatomy, external genitalia, secondary sex characteristics, and hormonal profile do not align with that person's biological sex, or what you call sex assigned at birth, as opposed to their gender identity, correct?

A. I'm not sure I'm understanding what you're asking. Sorry.

Q. I'll restate it for you. Other than DSDs and intersex conditions --

A. Okay.

Q. -- people with DSDs and intersex conditions there are no instances in which a person's chromosomes, gonads, internal reproductive anatomy, external genitalia, secondary sex

characteristics, and hormonal profile do not align with that person's biological sex, correct?

A. It depends on how you define biological sex. Again, in my line of work, you can make a determination and find that that person's gender identity does not match up with all these other things.

So I would say in transgender individuals, and individuals with differences in sex development, that's where those determinates don't all line up, because I would typically include gender identity in that, because it's really important, especially when you're trying to assign a sex to take into account potential gender identity.

Q. You anticipated my next question, so that was helpful. Thank you. You agree with me that gender identity in your view is a person's internal sense of self as being potentially masculine or feminine or neither or somewhere in between, correct?

A. Yes.

THE COURT: Can you repeat, I'm sorry.

BY MR. NUSSBAUM

Q. You agree with me that in your view,

gender identity is a person's internal sense of self as being potentially -- I'm having trouble talking -- potentially masculine or feminine or neither or somewhere in between, correct?

A. Yes.

Q. There is no scientific or medical way for a clinician to determine a patient's gender identity, right?

A. I would disagree with that. They're clear and -- the endocrine society guidelines, there are clear criteria for diagnosing gender dysphoria.

Just like in other illnesses, or chronic medical conditions, I should say, where we rely on a constellation of symptoms, or patient-reported events.

This could include irritable bowel, ADHD, depression, migraine headaches, chronic fatigue syndrome. There is not a lab test or radiology study that you can do, but there are certainly recognized diagnostic criteria in the medical community for these particular chronic health conditions or health conditions in general.

Q. So you just answered a different question. I asked about gender identity, and you used the phrase gender dysphoria, do you recall that?

A. I did not, sorry.
Q. So --
A. I didn't recall that.
Q. The question I asked is, there's no medical or scientific way for a clinician to determine a patient's gender identity, correct?
A. Yes, that's correct.
Q. And you talked about gender dysphoria, which has a very specific definition --
A. That's correct.
Q. But for gender identity itself, there's no medical or scientific meaning to that term?
A. That is correct.
Q. And you just said there's no blood test or x-ray or other objective scientific measure for gender identity, right?
A. That is correct.
Q. There's now medical diagnosis for gender identity?
A. Again, we use gender dysphoria, that would be -- I think we're confusing gender identity with requiring --
Q. I don't mean to cut you off, Dr. Turpin, I just have limited time here, and I think you're going to have an opportunity to clarify yourself on

redirect.

But for gender identity specifically?

A. Yes.

Q. There is no medical diagnosis for it, right?

A. No.

Q. And the reason I'm asking about it is because you've reviewed the petition in this case, right?

A. Yes.

Q. Plaintiffs seek relief on the basis of gender identity, not gender dysphoria, do you understand that --

MR. SELDIN: Objection, calls for a legal conclusion.

MR. NUSSBAUM: I'll move on.

THE COURT: Thank you.

BY MR. NUSSBAUM

Q. One cannot go to a biology textbook or a medical textbook and find a scientifically verifiable definition of gender identity, right?

A. Not to my knowledge.

Q. And yet in your view, as you just said, it is impossible to define the term male in biological terms without referring to gender identity, isn't

it? That's your view?

A. That's -- yes. I mean, again, it's the internal sense of self that helps us determine if they have gender dysphoria.

Q. Same question for female. It's impossible to define the term female in biological terms without referring to gender identity, right?

A. Again, for us, yes. We still use that as the term to refer to the individual, because the gender identity can cause gender dysphoria. And then it's the gender dysphoria that requires the treatment.

Q. In your practice, you treat quote unquote "nonbinary" and gender fluid gender identities, right?

A. Yes, we see those patients sometimes.

Q. In your view a nonbinary identity is a gender identity that's not definitively masculine, not definitively feminine, but somewhere in between, correct?

A. Yes.

Q. In your view, gender fluid is an identity where someone sometimes feels more feminine, and sometimes feels more masculine, and sometimes lives in between?

A. Correct.

Q. You agree with me though that nonbinary has no medical or scientific meaning, correct?

A. Again, as a term in and of itself, no, but if it creates gender dysphoria, then it absolutely does.

Q. The medical is gender dysphoria, right?

A. Correct.

Q. But one doesn't need a diagnosis of gender dysphoria to be transgender, correct?

A. So in my experience, in the bulk of the people that I see the, their being transgender creates gender dysphoria.

Q. In your 25 percent of your practice --

A. So that's my experience, is the transgender people that we see, they have gender dysphoria and so we treat the gender dysphoria, which is improved or alleviated with treatment.

Q. My question is a little bit different. You don't need a diagnosis of gender dysphoria to be transgender, correct?

A. That is correct.

Q. You don't need a diagnosis of gender dysphoria to be nonbinary, right?

A. That's correct.

Q. You don't need a diagnosis of gender dysphoria to be gender fluid, correct?

A. That's correct.

Q. You never diagnose a patient as transgender, right?

A. We diagnosis gender dysphoria.

Q. You use the ICD 10 code for gender dysphoria, correct?

A. That's correct.

Q. There's no transgender diagnosis, correct?

A. Correct.

Q. You submitted two reports in this case, correct?

A. Yes.

Q. I want to talk about your previously submitted report. And this is in, if I may approach, Your Honor --

THE COURT: Standing permission.

BY MR. NUSSBAUM

Q. I just want to make sure that we're on the same page. I think, I know it's here.

MR. SELDIN: Mr. Nussbaum, where is it in the binders for counsel?

MR. NUSSBAUM: Just one moment here. I believe it's Exhibit 174. Of course, my notes are

all over the place.

BY MR. NUSSBAUM

Q. It is in volume three of the blue binder in front of you, Dr. Turpin. I'll help you out here.

So what I've shown you there is Exhibit 74, 174. Let me make sure. Exhibit 174, which has been pre-marked.

And do you recognize this as a copy of the report that you submitted in this case on February 26, 2026?

A. Yes.

Q. And you submitted this report under penalty of perjury, correct?

A. Yes.

Q. And it accurately reflects your opinions in this case, correct?

A. Yes.

Q. I want to turn to paragraph 26 of that report. Tell me when you're there.

A. I'm there.

Q. And if you go to the second, or third sentence -- excuse me -- of that report. You write, all individuals have a gender identity, and an individual's understanding or articulation of that

identity may evolve over time. Did I read that correctly?

A. Yes, you did.

Q. Yet in the very next sentence, you write, gender identity is immutable, and cannot be voluntarily altered. Did I read that correctly?

A. Yes, you did.

Q. You cannot point the Court to any medical textbook, study, medical school course, for the proposition that gender identity is immutable, correct?

A. The course of my clinical practice, again, what we have found, and I think it does apply as far as pediatric endocrinology, in the examples I used earlier -- so for example, the individuals --

Q. Dr. Turpin, I don't mean to cut you off. I have my limited time --

A. Okay.

Q. But my question was different. My question was, you cannot point this Court to any medical textbook, study or medical school course for the proposition you put in your declaration, that gender identity is immutable, correct?

A. I don't know that I agree with the premise of that question.

Q. You don't have to agree with the premise of the question, but I would ask that you answer it.

A. Because I do think that there is medical history that shows that us assigning somebody female at birth, because most of the things line up that would be, and then their gender identity is masculine later on, we can't change that for those people.

I can't take that person with congenital adrenal hyperplasia and say, nope, most of the boxes line up and you will be, we will treat you as a woman, and you are going to be on estrogen and you have to take this medication.

I -- and so in my clinical experience is that, again, going back to the patient with Turner syndrome, that patient doesn't make any sort of hormones at all and they're saying, absolutely that their gender identity is masculine. Am I -- I can't change that, I can't make them think that that's different. I can't make them take estrogen.

So in that way, in my practice, it is immutable. That person is willing to forgo all hormones in general, knowing that that would be extremely detrimental to their health, rather than use an estrogen patch.

Q. So I'm asking a yes or no question, and I need an answer so the record is clear here --

A. I --

Q. Dr. Turpin, let me finish, please?

A. Okay.

Q. You cannot point the Court to any medical textbook, study or medical school course for the proposition that gender identity is immutable, correct? Can you or can't you?

A. I don't know that I know the answer to that question.

Q. All right. Do you recall being deposed in this case?

A. Yes.

Q. Do you recall being asked that --

A. I don't --

Q. -- in your deposition?

A. -- I don't.

Q. You do recall being under oath though, right?

A. Yes, I do.

Q. And you understand that that deposition was my time to explore your expertise, correct?

A. Yes.

Q. I'd like you to go to page 164 of your

deposition, if you would.

A. I'm there.

Q. You're there?

A. Yes.

Q. If you go to line 14, I'm going to read to you. Where would I find support for the proposition that gender identity is immutable in scientific or medical texts? Mr. Seldin objected, and you said, again, I cannot give you a specific resource. I wrote, I said, would it appear in a medical textbook. Again, I cannot tell you off the top of my head, but generally agreed upon in the medical community, gender is not immutable, or gender is not immutable. Did I read that correctly?

A. Yes.

Q. You agree with me that in your view, everyone is born with a gender identity, right?

A. Yes.

Q. Even a baby can be born with a gender identity, right? I guess that's the same question. Let me strike that.

A baby could be born with a nonbinary identity?

A. Babies aren't able to express a gender identity, but eventually as that child grows and

develops, they will typically express a gender identity.

Q. But that baby from the moment of birth is born with their nonbinary identity, right?

A. Yes, they are.

Q. You'd agree with me that you've had patients who started down the road toward one gender identity, and then realized they were more in between, correct?

A. Yes.

Q. Nonbinary patients in your experience are trying to figure out maybe where they feel most comfortable, correct?

A. Yes, that's correct.

Q. Some of your patients on a particular medical pathway to a particular medical gender identity changed course, come off their medication, and changed their minds about the gender identity they were moving towards, correct?

A. Yes.

Q. And you believe that those patients should be allowed to change their sex marker on their license back to their previous gender identity, right?

A. I actually have not had anybody who's

gotten to the point where they've changed a gender marker on their license, who has then wanted to change it back.

Q. Okay, but you're offering opinions in this case about -- opinions in this case about the transgender population in general?

A. Yes.

Q. Not just your patients. So you would agree with me that patients who have gone down the pathway to one gender identity and then reversed course should be allowed to change the sex marker on their license, correct?

A. Yes, if they were to stop their medications and make those changes, then yes. There's a variety of reasons someone might do that and they may or may not have to do with their gender identity.

Q. You have no opinions on how many times someone should be allowed to change their gender identity back and forth, correct?

A. Again, in my experience, I don't see flip-flopping of gender identity. It's not what I see.

Q. And Dr. Turner, it's a yes or no question --

A. I --

Q. Do you have an opinion on that?

A. I believe that someone should be able to change their gender marker if they desire.

Q. As many times as they want?

A. Yes.

Q. For a nonbinary person deciding which marker to put on a license, the choice would be up to the individual, correct?

A. Yes. Again, as a clinician, I don't see value in putting gender markers on driver's licenses because of the patient population I take care of, I know that those give very minimal information. And if there is a photograph on the driver's license.

And so I'm not sure, we don't use photographs, because again, particularly in taking care of patients who have differences in sex development, the M or F doesn't really mean anything to me in clinical practice.

Q. It has no meaning?

A. Not for my clinical practice.

Q. We're been using the word gender marker throughout this conversation, right?

A. Yes.

Q. And you understand that SB 244 refers to

it as a sex marker, correct?

A. Yes.

Q. You just said you don't think it is particularly helpful to have what you call a gender marker on a driver's license?

A. Not when it can be inaccurate. If it falls with a binary individual, so everything lines up, all of those things that we were talking about earlier, as far as chromosomes and hormonal milieu and all those things, it could be helpful in that aspect.

If it's all aligned male and it has an M, that could be helpful. If it all aligns as female and it has an F, but the problem is when you go to get your license, they don't have any of your medical history.

And so you could have XY chromosomes and no uterus, and have a female external appearing genitalia. And put an F on your --

Q. Dr. Turpin, I apologize, I'm not trying to be rude here. But I have very limited time in my cross-examination and we're held to a strict time limit, so when I ask a yes or no question, I would ask that you limit yourself to yes or no.

And Mr. Seldin, if he feels it's necessary

can clarify your answer on redirect. Does that sounds good?

A. Yes.

Q. You would support adding an X as possible gender markers for license, correct?

A. Yes.

Q. And you would support potentially adding other gender markers to licenses in Kansas, right?

A. I don't know what the other ones would be, but sure.

Q. I want to talk to you a little bit more about your original report in this case. Going back to 174. And I think this is your same opinion you offer in your subsequent report.

So if you go to paragraph 43.

A. I'm sorry, was this in my declaration?

Q. It's in your declaration that was submitted on February 26th or so, 2026. It's Exhibit 174.

A. You said 43?

Q. Yes.

A. Yes, I'm there.

Q. You write, from a medical perspective, denying access to facilities consistent with a person's gender identity constitutes a form of

social non affirmation. Did I read that correctly?

A. Yes, that's correct.

Q. And the basis for that assertion is your patient's self-report to you, correct?

A. That's correct.

Q. You go to the next page, paragraph 44, you write, when transgender individuals are required to use facilities inconsistent with their gender identity, or are segregated into single-user facilities not required of their peers, the message conveyed is that their gender identity is invalid or that they are fundamentally other, correct?

A. Yes.

Q. And that assertion, too, is based only on patient self-report?

A. That's correct.

Q. And you've undertaken no effort to validate that data?

A. That's correct.

Q. No scientific study?

A. That's correct.

Q. You've done no analysis to determine how many of your patients experience that message, correct?

A. No, but the vast majority of them report

concerns about those things because it is part of the checklist on the things that I ask about.

Q. But you have no numbers for the Court?

A. No.

Q. And you've undertaken no effort to ensure there's not other confounding factors, right?

A. That's correct.

Q. So it's purely what your patients tell you?

A. That's correct.

Q. Out of that 25 percent of your practice that concerns gender dysphoria?

A. Yes.

Q. Of people under 22?

A. Correct.

Q. Do you understand that SB 244 applies to the entire population, every age range in the state of Kansas?

A. Yes, I do.

Q. You use the word stigmatizing or stigma in your report?

A. Yes.

Q. There is no scientific or medical definition of that, correct?

A. Correct.

Q. You describe social non affirmation, that's the message that's conveyed by SB 244 in your view, right?

A. Yes.

Q. Social non affirmation in your view is not always conveyed though, correct?

A. I am not sure what you're asking.

Q. Let me give you a little bit more meat on the bones there. For example, you had a patient assigned female at birth, who socially transitioned to male, who kept using the women's locker room at his high school -- I'm sorry, assigned female at birth, socially transitioned to male -- strike that question, not a good one.

For example, you had a patient who was assigned female at birth, socially transitioned to male and continued to use the women's locker room at his high school, correct?

A. Yes.

Q. And he was comfortable with doing so, correct?

A. Only until he graduated from high school because he knew all of the people in his small high school, and was comfortable with that. After he graduated and started testosterone, he did not

use --

Q. And I apologize, Dr. Turpin, again, I'm on very limited time. The answer to my question was, yes, correct?

A. Yes.

Q. Okay. So that message of social non affirmation is not always conveyed by sex segregated space, right?

A. That can be true.

Q. There is no medical or scientific test for when the other message that you described is conveyed and when it is not, correct?

A. That's correct.

Q. Paragraph 47 of your report that was submitted in February, the first sentence there -- I'm sorry, the second sentence. You're writing about restroom access, and you say first, it generates acute psychological distress. Did I read that correctly?

A. Yes, you did.

Q. That is a causal claim, isn't it?

THE COURT: It's a what?

MR. NUSSBAUM: Causal.

BY MR. NUSSBAUM

Q. You use the word cause, the verb cause,

correct?

A. Yes.

Q. So that is a causal claim, isn't it?

A. Yes.

Q. And the basis for that sentence, that assertion, is that your patient self-report?

A. That's correct.

Q. Paragraph 49, you write to avoid misgendering harassment or force disclosure, many transgender individuals restrict or entirely avoid restroom-use in public settings, correct?

A. Yes.

Q. You can't tell the Court how many transgender individuals do not, right?

A. No.

Q. You have undertaken no study to offer statistics around that?

A. That's correct.

Q. Some do, correct?

A. Yes.

Q. Some don't?

A. Correct.

Q. You don't know how many of your patients have ever been subject to a restroom policy like SB 244's, correct?

A. No, correct.

Q. You've done no analysis of your patients who experience alleged psychological harm from the bathroom policy --

A. Correct.

Q. For the driver's license provision of SB 244, you cannot identify the number of your patients who have or will suffer harm from that provision, correct?

A. That's correct.

Q. And you've undertaken no analysis to identify the number --

A. That's correct.

Q. I apologize, Dr. Turpin, let me finish my question so the record's clean. You have undertaken no analysis to identify that number, correct?

A. That's correct.

Q. Back to social affirmation, and your opinion about social affirmation. There's no medically verified tool or diagnostic instrument for determining the appropriate form of social affirmation for a given patient, correct?

A. No, other than the patient self-report.

Q. There is no diagnostic tool for determining when a patient should begin using

restrooms consistent with their gender identity, correct?

A. That's correct.

Q. Your declaration says the driver's license provision of the SB 244 will cause harassment at work, being fired, bad encounters with the police. Do you recall that?

A. Yes.

Q. To your knowledge, none of that has occurred, right?

A. I'm sorry, can you repeat the question one more time?

Q. Sure, it's a yes or no question.

A. Okay.

Q. So do you know about it or not? Your declaration says that the driver's license portion of SB 244 will cause harm, cause harassment at work, being fired, bad encounters with the police.

To your knowledge, none of that has happened, right?

A. The driver's license portion, I have not had feedback of that nature yet.

Q. Okay. You treat patients from Missouri, right?

A. I treat some patients from Missouri, yes.

Q. Missouri changed its driver's license rule in 2024 to require surgery before a marker change?

A. Yes, it did.

Q. And you know of no Missouri patient who has lost a job, has been harassed, or had a bad police interaction because of the marker on a license, right?

A. That's correct.

Q. You also treat patients from Texas, Oklahoma, and Nebraska, don't you?

A. I have --

Q. And none --

A. -- a very small handful.

Q. None of your patients from those states have experienced harassment, job, or police issues because their licenses reflect their biological sex, correct?

A. Not to my knowledge.

Q. Can you just verify for me, Dr. Turpin, the bibliography in your February report and your July report, those are the same, right?

A. Yes.

Q. Was that a yes?

A. Yes.

Q. And so I want to talk to you about

Exhibit 174, and I want to talk to you about the bibliography provision of that report.

And just before we jump into it, as I understand it, the basis for your testimony is really twofold. It's your clinical experience and your patient self-report on the one hand, and the information you cite in your bibliography?

A. Yes.

Q. Anything else?

A. No.

Q. All right. Let's talk about that bibliography. So this is Exhibit B to your February report. And just for the record, it is also Exhibit B to your July 15th report. So let's take those one at a time.

The first one, the archival review is from the Police Foundation, correct?

A. Yes.

Q. The Police Foundation, that's not a medical journal?

A. No, it's not.

Q. It's not a scientific journal?

A. No.

Q. This wasn't peer-reviewed?

A. No.

Q. And it's not about Kansas, correct?
A. That's correct.
Q. Item two, do you know how to pronounce that name, is it Bagdadli?
A. Yes.
Q. Does that sound right?
A. Yes.
Q. And I want to show you a copy of that, if I can find it. It is Exhibit 184. It's tab 84 in that volume three, Dr. Turpin, in that blue binder in front of you?
A. Yes.
Q. Can you identify this document for me, Dr. Turpin?
A. Yes, it's the document in my bibliography that you just referenced.
Q. And this is from a journal called Frontiers in Sociology, right?
A. That's correct.
Q. And you relied on it in forming your opinions in this case?
A. Yes.
Q. Frontiers in Sociology is not a medical journal?
A. No.

Q. It's not a scientific journal?
A. No.
Q. It's not peer-reviewed?
A. I cannot speak to whether it's peer-reviewed.
Q. You didn't look that up?
A. I did not look that up.
Q. You don't think that's relevant?
A. It probably is relevant.
Q. I want to go to page three of that document.
A. Yes, I'm there.
Q. You agree with me that the authors there, if you're in the first column, in the second full paragraph, they state there what their methodology they use in this study. They write, in our theoretical course --
A. I'm sorry, I'm not where you are.
Q. Page three?
A. Yes, page three?
Q. First column.
THE COURT: On the left.
MR. NUSSBAUM: May I approach, Your Honor?
THE COURT: Yes.

THE WITNESS: Sorry.

MR. NUSSBAUM: You're good. It's right there.

THE WITNESS: Okay.

BY MR. NUSSBAUM

Q. So on page three at the first column, second full paragraph, the authors states their methodology in this study. They write in our theoretical course, we seek to foster possible dialogues between the field of materialist discourse analysis, and feminist and gender studies. Did I read that correctly?

A. Yes, you did.

Q. This article reports no data on any patient or population, correct?

A. No, there is population. There is date, once you get past the introduction.

Q. I think you maybe misunderstood my question. It is not a medical or patient population data that's reported in this report, right?

A. I guess I'm struggling with what you mean by medical?

Q. It's a sociological study, right?

A. It does discuss data about, it references data that does talk about, again, restroom

withholding and things of that nature. Yes, in a societal aspect, but --

Q. Let's talk about that analysis. So if you go to page two?

A. Okay.

Q. Second column.

A. Yes.

Q. This is the kind of analysis that this study offers. First full paragraph, the bathroom is part of the exclusion operation of cities, and as presadio points out, it's necessary to think of the historicity of a public bathroom as a bourgeois institution responsible for the management of bodily waste. Did I read that correctly?

A. Yes, you did.

Q. And it goes on, in the 20th century, bathrooms became authentic public inspection cells, in which the adequacy of each body, with the current codes of masculinity and femininity is evaluated. Did I read that correctly?

A. Yes, you did.

Q. It is as if an unwritten law authorizes people going to the bathroom to inspect the bodies of those who choose to cross the border that separates the inside and the outside of the door of

gender. Did I read that correctly?

A. Yes, you did.

Q. That's the analysis of this paper, isn't it?

A. What the paper is describing --

Q. It's a yes or no question, Dr. Turpin -- that's --

A. It is -- that is part of the introduction --

Q. Fair enough --

A. It is not, it is not inclusive of what the whole paper is about. It's just part of the introduction.

Q. So let's talk a little bit more about what the paper's about then.

If you go to the next page, page three. Footnote 10, the authors write, the arguments that supported racial segregation during the Jim Crow laws in the United States are analogous to arguments in favor of trans exclusionary positions as they both harbor similar fears about the need to protect women and children from a group of people perceived as capable to corrupt public morals, health, and order. Did I read that correctly?

A. Yes, you did.

Q. You agree with the authors, you believe that the Kansans who supported SB 244 use arguments similar to those that supported racial segregation during Jim Crow, don't you?

A. What I agree with is the premise, the comparison of othering human beings. So with Jim Crow, it was the other people based on the color of their skin. With this law, we are othering people by making them use the restroom that does not align with their gender identity, which is not something that individual can change.

Their gender identity is their gender identity, and so by othering them, again, we cause them to live smaller lives, they have increased depression and increased anxiety. These other things happen, but the comparison is in othering of human beings.

Q. So the answer to my question is yes?

A. Yes.

Q. You believe, along with the authors of that study that SB 244 ghetto-izes Kansas's transgender population, correct?

A. The concern, again, is by having people live smaller lives, they are not able to access as gainful employment as they might if they were

confident in using their identification.

Q. And I apologize, Dr. Turpin --

A. So the answer is, yes.

Q. Okay. I want to go back to one thing, you said that two percent of the population are intersex?

A. Correct.

Q. And I just want to qualify one thing. Is that two percent of the general population or two percent of the patients at your clinic?

A. Two percent of the general population.

Q. All right. Back to your bibliography. So this is Exhibit 174, and tell me when you're there?

A. I'm there.

Q. And I want to zoom down. We talked about items one and two. I want to talk to you about number nine, the one, the Scheim study from 2025?

A. Yes, yes.

Q. Do you see that?

A. I do.

Q. And you relied on that in writing your report, correct?

A. Yes.

Q. And the report is described as a systematic review and meta-analysis. Do you see

that?

A. Yes, I do.

Q. What is a systematic review and meta-analysis?

A. A systematic review takes into account as many possible studies as they can about a particular topic and analyzes the -- analyzes the accuracy -- accuracy is not the right word.

I guess going back to grade system. Goes back to analyzing the quality of the literature.

Q. So is it fair to say this takes all the studies on a given topic; is that right?

A. All the studies that they were able to find, yes, and that met their criteria for doing the meta-analysis.

Q. And determines what those studies say and how valid their data; is that correct?

A. That's correct.

Q. And let me finish my question. So it takes all those studies and determines how valid the data and conclusions of those studies are, correct?

A. Yes, it does.

Q. So is this the only meta-analysis on your bibliography?

A. Yes, it is.

Q. And the reason I wanted to go to it next is it encompasses several of the other of your studies on your bibliography.

So let's first talk about the overall conclusion of this study. Well, first you've mentioned the grade system briefly, we've talked about it several times.

And the grade system ranks scientific evidence as very low, low, moderate, and high, correct?

A. That's correct.

Q. And a study with a grade rating of high means we are very confident that the true effect lies close to the estimate of the effect, correct?

A. Yes, that's correct.

Q. Can you put that in layman's terms, Dr. Turpin?

MR. SELDIN: I'm going to object, Your Honor. Ask this witness -- it's outside the scope of her opinion.

MR. NUSSBAUM: Your Honor, she relied on this study in her bibliography and her declaration?

THE COURT: And expressed familiarity with the grade system. It's a fair question for her

to the extent she has an understanding of what he is asking her. And he's allowed to ask her that.

MR. SELDIN: Thank you.

BY MR. NUSSBAUM

Q. So let me go back a step, Dr. Turpin. We just talked about a grade rating of high means we are very confident that the true effect lies close to the estimate of that affect. Do you recall that?

A. Yes.

Q. Put that in layman's terms for us?

A. To put this in layman's terms for us?

THE COURT: How would you explain it?

THE WITNESS: Basically that we can fairly, confidently rely on the evidence in that study.

BY MR. NUSSBAUM

Q. By contrast, under the grade system, a study rated very low certainty means we have very little confidence in the effect estimate, correct?

A. That's correct.

Q. The true effect is likely to be substantially different from the estimate of the effect, correct?

A. That is true.

Q. So let's go back to Dr. Scheim's

systematic review here. And if you go with me to page three.

THE COURT: Is that a separate exhibit?

MR. NUSSBAUM: That is Exhibit 134, Your Honor. And I'll wait for you to get there.

THE WITNESS: I'm sorry, what number did you say?

BY MR. NUSSBAUM

Q. And I apologize, Dr. Turpin, we're flipping back and forth between.

And I probably should lay some foundation, can you identify this document, Dr. Turpin?

A. Yes, it's a Legal Gender Recognition and Health of Transgender and Gender Diverse People, a Systematic Review and Meta-analysis.

Q. This is what appears as number nine on your bibliography, right?

A. Yes, that's correct.

Q. If you go to page three for me, bottom of the second column, very last sentence that starts at the bottom of that.

A. Which paragraph?

Q. It's the bottom of the second column on page three that begins under 3.1, effectiveness

review. Are you on page three?

A. I'm on page three.

Q. If you go to the bottom of the second column?

A. Yes.

Q. Under 3.1, do you see that?

A. Oh, yes, yes.

Q. Effectiveness review?

A. Yes.

Q. And this is in the introductory section to the results of the meta-analysis, right?

A. Yes.

Q. And so in this section, the authors are talking about their overall conclusions; is that right?

A. That's correct.

Q. If you to go to the bottom of that page, the first full sentence, the authors write, the overall certainty of evidence was very low for all five outcome categories and low or very low for sub outcomes, according to the grade system. Did I read that correctly?

A. Yes, you did.

Q. What were they studying in the study?

A. In this particular study, they were -- I

need to review and make sure.

Q. Let me refresh your recollection, they use the term LGR, do you know what that is?

A. The legal gender recognitions, yes.

Q. And this study is titled Legal Gender Recognition and the Health of Transgender and it goes on.

A. Yes, I'm looking at the use of legal identification in trans individuals.

Q. So basically things like --

A. Driver's licenses --

Q. Bathrooms. So for the study for those kinds of interventions, and the affect on transgender health, the author's bottom line conclusion is that the overall certainty of evidence was very low for all five outcome categories and low or very low for sub outcomes.

A. That's correct.

Q. And this is the study of studies?

A. That's correct.

Q. I want to talk about a few of those specifically, because we've discussed them in this trial.

Well, first, before we do that, I just want to call your attention to a few things. So if

you go to the next page, page 4, under 3.3 mental-health and substance use?

A. Yes.

Q. That refers to Scheim et al 2020, do you see that?

A. Yes.

Q. So that's one of the studies on your bibliography, correct?

A. Correct.

Q. Sorry, let me state that again. That's one of the studies on your bibliography?

A. Correct.

Q. That's encompassed in the author's overall conclusion that the evidence was very low for all five outcome categories, correct?

A. That's correct.

Q. And if you go to the next page, he is listing a number of the studies here, correct?

A. Yes.

Q. Look at the bottom of that page on page five, it refers to the Shantz et al, 2022. Did I read that correctly?

A. Yes.

Q. And that's the number three on your bibliography?

A. Yes, it is.

Q. So that, too, and if you go over to the right-hand column, study risk of bias. Do you see that?

A. Yes, I do.

Q. It says the study risk of bias for the Schantz 2022 was high?

A. Yes.

Q. If you go to page nine? And it says Seal men at al, 2021.

A. Yes.

Q. That's your bibliography number 10, isn't it?

A. Yes.

Q. And if you go over into the right-hand column where it says study risk of bias, it says high, doesn't it?

A. Correct.

Q. If you go to the next page. Tell me when you're there.

A. I'm there.

Q. Page 10, Under 3.3.1, it's discussing Legal Gender Recognitions Effects on Suicidal Ideation, Planning, and Attempts. Did I read that correctly?

A. Yes, you did.

Q. If you go to the bottom of that first paragraph, this outcome was graded as low certainty. Did I read that correctly?

A. Yes, you did.

Q. Next paragraph, for suicide planning, this outcome was graded as low certainty. Did I read that correctly?

A. Yes.

Q. And I'm going to skip through here a bit, but 3.3.2, serious psychological distress. Do you see that?

A. Yes, I do.

Q. We heard a lot about serious psychological distress, haven't we?

A. Yes.

Q. And at the bottom there, it says this outcome was graded as very low certainty. Do you see that?

A. Yes, I do.

Q. Other mental-health outcomes, 3.3.3. These outcomes were graded as very low certainty, do you see that?

A. Yes, I do.

Q. And they go on, if you go to 3.5 on page

12. Tell me when you're there.

A. Yes, I'm there.

Q. Stigma, discrimination and violence. These outcomes were graded as very low certainty. Did I read that correctly?

A. Yes, you did.

Q. Physical health, 3.6, these outcomes were graded as very low certainty. Do you see that?

A. Yes.

Q. None of the grading or the outcome certainties from the study were included in your declaration, were they?

A. No, they were not.

Q. I want to go back to your bibliography and that's Defendant's Exhibit 174. We discussed one and two. We've discussed three, nine and 10, correct?

A. Yes.

Q. And also eight?

A. Yes.

Q. So that leaves four, five, six, and seven, right?

A. Correct.

Q. Four here, Discrimination as a Social Determinative of Health. Do you see that?

A. Yes, I do.
Q. That is a case report about a single 17-year-old patient, correct?
A. That is correct.
Q. The patient is not from Kansas?
A. That's correct.
Q. And a single case report cannot be generalized to a population, correct?
A. That's correct.
Q. And it cannot support a causal claim?
A. That's correct.
Q. Item number five, the Pediatric Study on Sexual Assault. Do you see that?
A. Yes.
Q. You agree with me that its authors expressly could not determine if restroom and locker room caused the observed differences in sexual assault risk, correct?
A. Correct.
Q. Item number six doesn't concern Kansas, correct?
A. That's correct.
Q. And item number seven on your bibliography, this is the bathroom discrimination study, do you see that?

A. Yes, I do.
Q. It's not from Kansas?
A. That's correct.
Q. And its authors determined that conclusions related to prevalence cannot be drawn from this data, correct?
A. That's correct.
Q. So the first two studies on your bibliography are in peer-reviewed journals?
A. Yes.
Q. One is a sociological study about feminist and gender studies, correct?
A. Correct.
Q. Number nine is the only meta-analysis, correct?
A. That's correct.
Q. And it says that is determinations for the interventions are low or very low?
A. That's correct.
Q. And it addresses number three, eight and 10 on your bibliography?
A. Yes, that's correct.
Q. And grades those all as low or very low quality evidence?
A. Yes, that's correct.

Q. And four, five, six, seven, and eight can't make causal claims for them, right?

A. That's correct.

MR. NUSSBAUM: Nothing further, Your Honor.

MR. SELDIN: Your Honor, if I could have two minutes to confer with counsel?

THE COURT: Why don't we all take a five-minute break.

MR. SELDIN: I will take it, thank you.

(A recess was taken.)

THE COURT: Dr. Turpin, you're still under oath. We're back on record and the appearances are the same. Or at least materially and substantially, and if you're ready to proceed, Mr. Seldin, you may.

REDIRECT EXAMINATION

BY MR. SELDIN

Q. Dr. Turpin, I believe you were talking with counsel just now about an article that you included in your bibliography from the Police Foundation. Why did you include that in your bibliography?

A. When I was contacted about this case I

felt like it was very important to look into what the State side was. So from my opinion and in practice, I absolutely knew the effect that this bill would have on my patients, because I had seen patients who were denied restroom access or weren't able to access appropriate IDs and what that did to those patients. And then seeing when they were able to access those things, how it significantly improved their lives.

And in my general day-to-day, I never had any of my cisgender patients ever be concerned about using the bathroom with trans patients.

I do some community education about what is gender affirming care, and I had not encountered issues with that.

So I wanted to make sure that first, I was doing no harm in taking this case. And so I did some looking into that side of things, by me advocating for my patients. And in doing that research I couldn't find any evidence that when trans patients used the restroom with individuals that cisgender patients were being harmed.

But I wanted to make sure that I did that before I took this case.

Q. Dr. Turpin, you also talked to counsel

about where your patients are from. Where are most of your patients from?

A. Kansas.

Q. How long have you been treating patients in Kansas?

A. Since I started practicing, since I finished my school. I've been a pediatric endocrinologist since 2005.

Q. You also talked to counsel about levels of certainty on some studies. Based on your education, your clinical experience, including your interactions with your patients who have gender dysphoria, what is your level of certainty that restrictions on the restroom use and driver's licenses will make their lives worse?

A. I've absolutely seen it in my practice. Limiting restroom use, not allowing for proper identification has and will continue to make the lives of my patients worse.

Q. Have your patients told you that?

A. Yes, they have.

MR. SELDIN: That's all, Your Honor.

MR. NUSSBAUM: If I may have just a moment, Your Honor? Nothing further, Your Honor.

THE COURT: Doctor, give me just a

minute, I want to go back and read through my notes and make sure I don't have questions for you. If I do, I will allow counsel to follow up, but give me just a moment.

I don't have any questions for you. Thank you very much.

And we discussed two other witnesses for today? I think it makes sense to take our lunch recess? Tell me when we should start back that you would feel reasonably confident getting through both of those witnesses. Or a different question, is 1:30 too late?

MR. SELDIN: I think 1:15 just to play it a little safe, Your Honor.

THE COURT: Okay. Let's recess until 1:15.

(A recess was taken.)

C E R T I F I C A T E

STATE OF KANSAS)
) SS
DOUGLAS COUNTY)

I, Nina Copeland, Certified Court Reporter, do hereby certify that I am the regularly appointed, qualified, and acting Official Reporter for Division No. 6 of the Seventh Judicial District, Douglas County, Kansas, duly certified under and by virtue of the laws of the State of Kansas. I further certify that on the 30th day of September, 2026, I was present at and reported in voice shorthand the proceedings in the aforementioned case before the Honorable James McCabria, Judge of Division 4 of the District Court of Douglas County, Kansas, and that the foregoing transcript is a true and correct transcript of the proceedings as revealed by my voice notes so taken.

IN TESTIMONY WHEREOF, I have hereunto set my hand and official seal at Lawrence, Douglas County, Kansas, this 3rd day of October, 2026.

__\s\Nina Copeland_____
Nina Copeland, CCR
Official Court Reporter