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CLERK OF THE DOUGLAS COUNTY DISTRICT COURT
CASE NUMBER: DG-2025-CV-000241
PII COMPLIANT

IN THE SEVENTH JUDICIAL DISTRICT
DOUGLAS COUNTY, KANSAS

LILY LOE, by and through her parent and next friend Lisa Loe; LISA LOE; RYAN ROE, by and through his parent and next friend Rebecca Roe; REBECCA ROE,

Plaintiffs,

v.

STATE OF KANSAS, *ex rel.* KRIS KOBACH, Attorney General of the State of Kansas,

Defendants.

Case No. DG-2025-CV-000241
Division No. 7

PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

Currently before the Court is Plaintiffs' Motion for Temporary Injunction, filed May 28, 2025. In connection with that Motion, Plaintiffs and Defendants, represented by their respective counsel, appeared for a hearing held on November 19 and 20, 2025, during which time the Court heard opening statements, received witness and expert witness testimony, received evidence, and heard closing arguments from both parties. At the conclusion of the hearing, the Court ordered the parties to submit proposed findings of fact and conclusions of law by December 19, 2025.

In making its decision below, the Court has considered the following: (1) Plaintiffs' Motion for Temporary Injunction, filed on May 28, 2025 including the accompanying briefs and declarations; (2) Defendants' opposing brief, filed on July 10, 2025,

including the accompanying declarations; (3) Plaintiffs' Response in Further Support of the Injunction, filed on August 21, 2025, and the accompanying rebuttal declarations; and (4) the testimony, evidence, statements, and arguments submitted during the hearing, including Exhibits 1–14, 101–113 and 115, which were admitted into evidence by the Court. All such matters being duly considered, the Court, pursuant to KSA 60-252, DENIES the motion for temporary injunction and makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

I. The Help Not Harm Act.

1. On February 18, 2025, the Kansas Legislature enacted the Help Not Harm Act (SB 63), which took effect on February 20, 2025, and is codified as K.S.A. §§ 65-28,137 through 65-28,142.

2. The Help Not Harm Act contains certain prohibitions on the medicalized gender transition of minors. Three of those prohibitions are relevant to Plaintiffs' motion for a temporary injunction.

3. First, K.S.A. § 65-28,139(a)(3) prohibits healthcare providers in Kansas from "prescrib[ing], dispens[ing] or administer[ing]" puberty blockers to any female child "for the purpose of treatment for distress arising from such female child's perception that such child's gender or sex is not female." K.S.A. § 65-28,139(b)(3) contains a corresponding prohibition for male children. For females, puberty blockers are defined as "GnRH agonists or other synthetic drugs that suppress the production of estrogen and progesterone to delay or suppress pubertal development in female children." K.S.A. § 65-28,139(a)(3). For males, puberty blockers are defined as "GnRH agonists

or other synthetic drugs that suppress the production of testosterone or delay or suppress pubertal development in male children." K.S.A. § 65-28,139(b)(3).

4. Second, K.S.A. § 65-28,139(a)(2) prohibits healthcare providers in Kansas from "prescrib[ing], dispens[ing] or administer[ing]… supraphysiologic doses of testosterone or other androgens" to any female child "for the purpose of treatment for distress arising from such female child's perception that such child's gender or sex is not female."

5. Third, K.S.A. § 65-28,139(b)(2) prohibits healthcare providers in Kansas from "prescrib[ing], dispens[ing] or administer[ing]… supraphysiologic doses of estrogen" to any male child "for the purpose of treatment for distress arising from such male child's perception that such child's gender or sex is not male."

6. The Help Not Harm Act has a sunset period that allows healthcare providers to continue administering the proscribed interventions through December 31, 2025, as long as a provider develops a plan to systematically reduce the child's use of the intervention and determines that immediately terminating the intervention would harm the child.

7. Violation of the Help Not Harm Act constitutes unprofessional conduct and may result in a healthcare provider's license being revoked under K.S.A. § 65-28,140(a)(1). The Act also renders healthcare providers strictly liable for any harm to a child from proscribed treatments. *See* K.S.A. § 65-28,140(b). The Act also creates private rights of action against healthcare providers who violate its terms. K.S.A. § 65-28,140(c)–(d).

II. The Parties.

A. Plaintiffs.

8. Plaintiff Lily Loe[1] is a thirteen-year-old child who resides in Douglas County, Kansas. Loe is a biological male and has been prescribed puberty blockers since 2024.

9. Plaintiff Ryan Roe is a sixteen-year-old child who resides in Johnson County, Kansas. Roe is a biological female and has been prescribed testosterone since 2023.

10. Plaintiff Lisa Loe is the mother of Lily Loe.

11. Plaintiff Rebecca Roe is the mother of Ryan Roe.

B. Defendant.

12. Defendant Kris Kobach is the Attorney General of Kansas, sued in his official capacity.

C. The Claims.

13. Plaintiffs bring three claims for relief.

14. First, they allege that the Act violates the Kansas Constitution's guarantee of equal protection of the law, because, according to Plaintiffs, the Act discriminates on the basis of sex. Plaintiffs allege that the Help Not Harm Act prohibits certain interventions based on a child's sex and is therefore subject to heightened judicial scrutiny, which they allege it fails.

15. Second, Plaintiffs allege that the Act violates the Kansas Constitution's guarantee of equal protection of the law, because, according to Plaintiffs, the Act discriminates on the basis of transgender status. Plaintiffs claim that the Help Not Harm

[1] Plaintiffs are proceeding pseudonymously at their request and as permitted by the Court in its November 18, 2025, Order.

Act prohibits certain interventions based on a child's transgender status. This, they claim, amounts to invidious discrimination against a protected class, subjecting the Act to heightened scrutiny, which they allege it fails.

16. Finally, Plaintiffs assert that the Help Not Harm Act violates the right of parents to direct the care and upbringing of their children under Section 1 of the Kansas Constitution. They allege that the Act prohibits parents from exercising decision-making on behalf of their child to treat certain psychological distress with puberty blockers and cross-sex hormones. They allege that this violates a fundamental parental right, subjecting the Act to strict scrutiny, which they allege it fails.

17. Along with their Petition, Plaintiffs filed a motion for a temporary injunction.

18. That motion asks the Court to facially enjoin Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of the Help Not Harm Act, which are codified as K.S.A. § 65-28,139(a)(2)–(3) and as K.S.A. § 65-28,139(b)(2)–(3). These are the sections of the Help Not Harm Act that ban prescription of puberty blockers and cross-sex hormones for the treatment of psychological distress in minors. Plaintiffs do not seek an injunction on the Act's proscription of surgical interventions or its regulation of government property.

III. The Witnesses.

19. The parties collectively provided oral testimony and sworn written declarations from thirteen witnesses.

A. Plaintiffs' Witnesses.

20. The Plaintiffs provided both oral testimony at the preliminary injunction hearing and sworn declarations from Rebecca Roe, Lisa Loe, Dr. Jack Turban, Dr. Armand

Antommaria, Dr. Sarah Corathers, and Dr. Angela Turpin. The Plaintiffs provided sworn declarations from Lily Loe and Ryan Roe.

21. Lily Loe is a 14-year-old[2] who identifies as a girl and is biologically male. Loe receives puberty blockers to prevent male puberty. Loe wrote in a sworn declaration that the puberty blockers enhance Loe's wellbeing. Loe also expressed concern about experiencing male puberty because it would harm Loe's mental health and social life. (Lily Loe Decl. ¶ 14).

22. Ryan Roe is a 16-year-old who identifies as a boy and is biologically female. Roe takes doses of testosterone and wrote in a sworn declaration that the testosterone enhanced Roe's personal confidence and supported Roe's mental health. (Ryan Roe Decl. ¶ 11).

23. Lisa Loe is Lily Loe's mother. She testified that Lily was diagnosed with gender dysphoria at the age of seven. (Hearing Tr. 49:20–50:10). Lisa Loe testified in her sworn declaration that she has allowed Lily to dress in girls' clothes, use the girls' restroom, and avoid using her birth name since Lily was "six or seven" years old. (Lisa Loe Decl. ¶ 11). Lisa Loe further testified that puberty blockers have made Lily happier and alleviated Lily's anxiety about undergoing male puberty. (Lisa Loe Decl. ¶ 24).

24. Rebecca Roe is Ryan Roe's mother. She testified in her sworn declaration that Ryan has believed Ryan was a boy since Ryan was "about six years old." (Rebecca Roe

[2] Lily was 13 years old at the time of Lily's declaration but has since turned 14. (Hearing Tr. 43:16–17).

Decl. ¶ 7). Rebecca Roe testified that Ryan was diagnosed with gender dysphoria in 2022. (Rebecca Roe Decl. ¶ 19). She further testified that Ryan has been taking testosterone since April 2023 and it has made Ryan "more comfortable" and "all-around happier." (Rebecca Roe Decl. ¶ 23).

25. Dr. Jack Turban is a psychiatrist and Assistant Professor of Child & Adolescent Psychiatry at the University of California, San Francisco School of Medicine. He testified that prescription of puberty blockers and cross-sex hormones for the treatment of gender dysphoria in minors is consistent with the guidelines of the Endocrine Society and the World Professional Association for Transgender Health ("WPATH"). (Hearing Tr. 112:14–21). Dr. Turban explained the requirements of those guidelines, (Hearing Tr. 112:14–121:17), and testified that, when administered in accordance with those guidelines, he believes puberty blockers and cross-sex hormones are safe and effective. (Hearing Tr. 124:25–127:5).

26. Dr. Armand Antommaria is a pediatrician and bioethicist who directs the Ethics Center at Cincinnati Children's Hospital Medical Center. He testified that he believes puberty blockers and cross-sex hormones are a safe and effective treatment for gender dysphoria in minors. (Hearing Tr. 161:17–162:13). Dr. Antommaria testified that recommendations supporting the use of puberty blockers and cross-sex hormones are only supported by low or very-low quality evidence, but that many clinical practice guidelines are supported by such evidence. (Hearing Tr. 165:20–166:19).

27. Dr. Sarah Corathers is a pediatric endocrinologist who prescribes puberty blockers and cross-sex hormones to children to treat gender dysphoria. She testified

that "families can best decide" whether the benefits of puberty blockers and cross-sex hormones outweigh the risks and that withholding those interventions can be harmful. (Hearing Tr. 207:8–23). She wrote in her sworn declaration that puberty blockers and hormones are administered to treat other conditions in the field of endocrinology. (Corathers Decl. ¶¶ 71–73).

28. Dr. Angela Turpin is a pediatric endocrinologist who, until passage of the Help Not Harm Act, prescribed puberty blockers and cross-sex hormones for the treatment of gender dysphoria in minors in Kansas. Dr. Turpin wrote in her sworn declaration that her clinic performs evaluations of each patient and administers these interventions in what she believes is a safe way. (Turpin Decl. ¶¶ 17–33). She further testified that these interventions have improved the mental health of some of her patients. (Hearing Tr. 283:18–284:25).

B. Defendant's Witnesses.

29. Defendant presented the oral testimony and written declarations of Chloe Cole, Dr. James Cantor, Dr. Daniel Weiss, Dr. Farr Curlin, and Dr. Patrick Lappert. Defendant also presented the sworn declarations of Jamie Reed, Corinna Cohn, and Dr. Stephen Levine.

30. Chloe Cole is a 21-year-old woman who was diagnosed with gender dysphoria and identified as a boy from the ages of 13 to 16 (Cole Decl. ¶¶ 6–12). She testified that she took puberty blockers and testosterone during that time. (Hearing Tr. 348:17–22). Cole testified that the puberty blockers and testosterone have caused her lasting physical and mental health struggles, including pelvic pain, urinary tract

issues, depression, joint pain, and post-traumatic stress. (Hearing Tr. 349:1–354:10). She testified that she does not believe she at age 13, or any child, could understand the consequences of puberty blockers and cross-sex hormones sufficiently to make an informed choice about them. (Hearing Tr. 360:22–361:16).

31. Dr. James Cantor is a clinical psychologist, neuroscientist, and Director of the Toronto Sexuality Center. He testified that research about the efficacy of puberty blockers and cross-sex hormones has failed to produce any dependable evidence that they are an effective treatment for gender dysphoria in minors. (Hearing Tr. 391:12–392:2). He testified that every organization to systematically review the available scientific evidence has concluded that there is insufficient evidence to show puberty blockers and cross-sex hormones are effective treatments for minors. (Hearing Tr. 397:21–398:8).

32. Dr. Daniel Weiss is an endocrinologist. At one point in his practice, he prescribed hormones to transgender patients. (Hearing Tr. 425:4–16). Dr. Weiss testified that puberty blockers and cross-sex hormones carry serious health risks for children. (Hearing Tr. 443:10–444:15). Among other things, Dr. Weiss wrote in his sworn declaration that males who receive estrogen are twenty-two times more likely to develop breast cancer, twice as likely to develop thyroid cancer, thirty-six times more likely to suffer a stroke, and are at increased risk for cardiovascular events. (Weiss Decl. ¶¶ 189–199). He also wrote that females who receive testosterone are three-and-a-half times more likely to suffer heart attack, twice as likely to suffer a stroke, and at increased risk for reproductive tract cancers. (Weiss Decl. ¶¶ 185–188).

33. Dr. Farr Curlin is a doctor, medical ethicist, and the Josiah C. Trent Professor of Medical Humanities at Duke University. Dr. Curlin testified that the use of puberty blockers and cross-sex hormones to treat gender dysphoria is contrary to widespread standards of medical ethics. (Hearing Tr. 462:20–463:14). He testified that, when presented with a patient whose belief about their body does not match objective reality (for example, obsessive-compulsive disorder or anorexia nervosa), a doctor cannot ethically attempt to change the patient's physiology to match the disordered perception. (Hearing Tr. 460:25–463:13). Dr. Curlin wrote in his sworn declaration that children and parents cannot provide informed consent to the interventions at issue. (Curlin Decl. ¶¶ 89–126).

34. Dr. Pattrick Lappert practiced as a plastic surgeon and has performed the same reconstructive surgical techniques prohibited by the Help Not Harm Act in other contexts not involving gender transitions. (Hearing Tr. 370:16–371:9). Dr. Lappert testified that gender transition surgeries are cosmetic, not reconstructive, procedures that universally result in the loss of function in the recipient. (Hearing Tr. 382:17–384:25).

35. Dr. Stephen Levine is a clinical professor of psychiatry at Case Western Reserve University School of Medicine and the founder of the Case Western Reserve University Gender Identity Clinic. Dr. Levine has been a member of WPATH and chaired the committee that developed the fifth version of WPATH's standards of care. Dr. Levine wrote in his sworn declaration that there is no consensus among medical professionals as to how to treat children with gender dysphoria (Levine Decl. ¶¶ 68–

77, 95–130). He further wrote that gender transition is an experimental intervention for children. (Levine Decl. ¶¶ 177–200, 222–254).

36. Jamie Reed is the former case manager for the Washington University Pediatric Transgender Center at St. Louis Children's Hospital. She wrote in her sworn declaration that the current cohort of transgender youths are meaningfully different than those considered when developing modern treatment protocols. (Reed Decl. ¶¶ 24–26). She further wrote that recent decades have seen a precipitous rise in children experiencing adolescent gender dysphoria and that there has been insufficient research into whether these children can be treated with existing protocols. (Reed Decl. ¶¶ 27–34).

37. Corinna Cohn is a biological male who began taking estrogen at age 18 and had a penectomy and vaginoplasty at age 19. Cohn wrote in a sworn declaration that "[a]s a teenager, I was unprepared to understand the consequences of my decision to medicalize my transition despite the rigorous controls that were then in place to ensure that patients would not be harmed from gender affirming care." (Cohn Decl. ¶ 9). Cohn wrote that hormones and surgery did not help Cohn's depression and anxiety and that "there is no reason why this irreversible decision needs to be made in adolescence." (Cohn Decl. ¶¶ 8, 11).

IV. Gender Transition Interventions.

38. Central to Plaintiffs' motion for preliminary injunction are puberty blockers and cross-sex hormones, which Plaintiffs collectively refer to as "gender-affirming care" and Defendant refers to as "gender transition interventions".

39. "Puberty blockers" refers broadly to a group of chemicals that act to block the secretion of luteinizing hormone and follicle stimulating hormone from the human pituitary gland. (Weiss Decl., ¶¶ 124–127; Corathers Decl., ¶ 30). These hormones stimulate the initiation of human puberty. By blocking their secretion, puberty blockers act to stop the initiation of puberty and attending production of testosterone or estrogen. (Weiss Decl., ¶¶ 124–127; Corathers Decl., ¶ 30).

40. "Cross-sex hormones" refers to the prescription of testosterone or other androgens to biological females and estrogen to biological males. Administration of cross-sex hormones can cause the body to undergo physical changes associated with puberty of the other biological sex. (Corathers Decl., ¶ 43).

41. Some healthcare providers prescribe puberty blockers and cross-sex hormones to children in an attempt to alleviate distress arising from gender dysphoria. (Corathers Decl. ¶¶ 39–43). Gender dysphoria is a mental health diagnosis where there is a perceived incongruence between one's gender identity and biological sex. (Cantor Decl., ¶ 60; Turban Decl., ¶¶ 13–14).

42. "Gender identity" in this context refers to "a person's deeply felt, internal, intrinsic sense of their own gender." (Weiss Decl. ¶ 54). No evidence presented to the Court defined "gender" in a way that further explains or contradicts this definition.

43. Some healthcare providers prescribe cross-sex hormones to induce physical changes in a child's body that will align their physical appearance and voice pitch with the child's gender identity or "embodiment goals." (Corathers Decl., ¶ 43; Hearing Tr. 233:6–22). By aligning a child's physical appearance and voice pitch with their

"embodiment goals," providers hope to alleviate the distress attending gender dysphoria. (Hearing Tr. 233:23–234:10).

44. Some healthcare providers prescribe puberty blockers to children who suffer from gender dysphoria in an attempt to delay the physical changes that accompany puberty because those providers believe such changes will increase the distress associated with gender dysphoria. (Corathers Decl., ¶¶ 39–40).

45. Whether puberty blockers and cross-sex hormones are safe and effective treatments for gender dysphoria in minors was the primary factual dispute between the parties at the temporary injunction hearing. The parties disputed the meaning of certain studies identified by the parties' experts, whether the interventions improve mental health for recipients, and whether the interventions have dangerous side effects.

A. The Lack of Evidence of Efficacy.

46. The Court finds that the evidence presented, in the form of expert testimony and scientific studies, demonstrates that there is, at a minimum, substantial doubt about the efficacy of puberty blockers and cross-sex hormones as treatments for gender dysphoria.

47. The Plaintiffs presented the testimony of Dr. Jack Turban, who testified that there are "over a dozen" cohort studies evaluating the efficacy and effectiveness of puberty blockers and cross-sex hormones to treat gender dysphoria. (Turban Decl., ¶ 18). Dr. Turban testified that "[w]hile each of these studies—as with all studies in medicine—has strengths and limitations, and no one study design can answer all

questions regarding an intervention, taken together, these studies indicate that gender-affirming medical care improves mental health for adolescents who require such care." (Turban Decl., ¶ 20).

48. Dr. Turban testified that studies have found that puberty suppression and cross-sex hormones are associated with improved mental health in minors. (Turban Decl., ¶ 21–22).

49. The Defendant presented the testimony of Dr. James Cantor, who testified that there have been 18 cohort studies on the efficacy of puberty blockers and cross-sex hormones. (Cantor Decl. p. 117). He also testified that there have been eight systematic reviews of the available scientific evidence. (Cantor Decl. ¶¶ 184–209).

50. Dr. Cantor testified that the studies of puberty blockers and cross-sex hormones as treatments for pediatric gender dysphoria are "very preliminary" and have not demonstrated clinical benefit "in any conclusive way." (Hearing Tr. 391:21–392:2).

51. Dr. Cantor testified that, of the 18 cohort studies on the efficacy of puberty blockers and cross-sex hormones, seven found "little to no improvement in mental health" (Cantor Decl. p. 119), seven others confounded medical treatment with mental health services (Cantor Decl. ¶¶ 236–248), two found no advantage to puberty blockers and cross-sex hormones over psychotherapy (Cantor Decl. ¶¶ 249–250), and two failed to report whether psychotherapy was provided to participants (Cantor Decl. ¶¶ 251–254).

52. Dr. Cantor further testified that the longitudinal studies cited by Dr. Turban have, "without exception not accounted for the fact that patients were in mental health treatment at the same time they received puberty blockers or cross-sex hormones." (Hearing Tr. 393:14–17). This, he testified, makes it impossible to conclude whether any mental health benefits came from the puberty blockers and cross-sex hormones or from the mental health treatment. (Hearing Tr. 392:14–393:2).

53. Dr. Cantor also testified regarding systematic reviews, which are efforts by scientists to survey all research on a topic, evaluate its reliability, and produce a conclusion regarding the research within a given field on a given topic. (Cantor Decl. ¶¶ 129–131). Dr. Cantor testified that systematic reviews are "by far the most reliable method we have available" for "evaluat[ing] a body of scientific literature on a given topic." (Hearing Tr. 396:24–397:4).

54. Dr. Cantor testified that, with respect to the use of puberty blockers and cross-sex hormones to treat pediatric gender dysphoria, "every organization which has used the systematic review process has come up with exactly the same conclusion: That we have relatively reliable evidence demonstrating the harms, because we can measure them objectively, but only ambiguous, inconclusive evidence that there's any benefit to it." (Hearing Tr. 397:24–398:5).

55. Dr. Cantor provided detailed testimony regarding all eight systematic reviews, with a focus on the review conducted by the English National Health Service. (Cantor Decl. ¶¶ 98–209; Hearing Tr. 397:21–398:22). This review is also known as the "Cass Review" or "Cass Report" and was the focus of much testimony during the hearing.

56. The Cass Review comprises seven separate systematic reviews, each focused on a separate topic. (Cantor Decl. ¶ 199). One of the reviews focused on the research surrounding puberty blockers and another on the research surrounding cross-sex hormones. (*Id.*).

57. The other systematic reviews identified by testimony were conducted by the United States Department of Health and Human Services, the national health bodies of Sweden and Finland, McMaster University, and an independent group of scholars from Sweden and the United Kingdom. (Cantor Decl. ¶¶ 187–209).

58. The results of these reviews have caused at least four nations, the United Kingdom, Sweden, Finland, and New Zealand, to restrict the use of puberty blockers and cross-sex hormones to treat gender dysphoria in children. (Cantor Decl. ¶¶ 363–373; Hearing Tr. 153:5–154:14 (Test. of Turban)).

59. In particular, the Cass Review of puberty blockers surveyed the available evidence and concluded that, with respect to puberty blockers, "[n]o conclusions can be drawn about the effect on gender-related outcomes, psychological and psychosocial health, cognitive development, or fertility" and that "bone health and height may be compromised during treatment." (Cantor Decl. ¶ 201).

60. The Cass Review of cross-sex hormones surveyed the available evidence and concluded that, with respect to cross-sex hormones, "[n]o conclusions can be drawn about the effect on gender-related outcomes, body satisfaction, psychosocial health, cognitive development or fertility" and that "[u]ncertainty remains about the outcomes for health/growth, cardiometabolic and bone health." (Cantor Decl. ¶ 201).

61. The conclusions of every other systematic review to be conducted by a national health body are in accord with these conclusions. (Hearing Tr. 397:21–398:8 (Test. of Cantor)).

62. Dr. Turban criticized the Cass Review for the way in which it registered its methodology and for using a customized scoring methodology. (Turban Rebuttal Decl. ¶¶ 16–17). Under cross examination, Dr. Turban testified that he was not aware of any professional standards for registering systematic review methodologies. (Hearing Tr. 142:8–143:7).

63. Dr. Cantor testified that there are clear standards for registration of methodologies and that the Cass Review complied with relevant standards "to the letter." (Hearing Tr. 404:2–405:19). He also testified that the scoring methodology used by the Cass Review was legitimate and caused it to have greater scope than other reviews. (Hearing Tr. 405:20–406:20).

64. Every witness to address the issue agreed that clinical guidelines recommending the use of puberty blockers or cross-sex hormones for the treatment of gender dysphoria in children are based on "low" or "very low" quality evidence. (Hearing Tr. 178:5–21 (Test. of Antommaria); p. 447:18–448:2 (Test. of Weiss); Cantor Decl. ¶¶ 38, 165).

65. Dr. Antommaria testified that clinical practice guidelines are often based on low-quality evidence. (Hearing Tr. 165:20–166:11).

66. Dr. Cantor testified that, while Evidence-Based Medicine standards allow some recommendations on low-quality evidence, they only do so where the

recommendation itself is weak, where the recommendation is against a certain treatment, or where a patient's life is threatened. (Cantor Decl. ¶¶ 167–172).

67. Dr. Cantor testified that none of these situations apply to puberty blockers or cross-sex hormones, rendering inappropriate any recommendation in favor of treatment based on low-quality evidence. (Cantor Decl. ¶ 172).

68. Defendants also presented the testimony of Dr. Stephen Levine, a professor of psychiatry who has treated patients with gender dysphoria for more than 50 years. Dr. Levine supports the use of cross-sex hormones and transition surgery in some patients but testified that they are not appropriate for children. (Levine Decl. ¶¶ 13–21).

69. Dr. Levine testified that "[a]mong practitioners in the field, there are currently widely varying views concerning both the causes of and appropriate therapeutic response to gender dysphoria in children or adolescents." (Levine Decl. ¶ 13). He further testified: "There are no studies that show that affirmation of transgender identity in young children reduces suicide or suicidal ideation, or improves long-term outcomes, as compared to other therapeutic approaches." (Levine Decl. ¶ 18). He set out at length the widely varying opinions and practices in the field with respect to puberty blockers and cross-sex hormones in children. (Levine Decl. ¶¶ 99–110).

70. Dr. Levine described the use of cross-sex hormones in children as "unproven, experimental, and dangerously uncertain in the long run." (Levine Decl. ¶ 20).

71. Like Dr. Cantor, Dr. Levine provided an in-depth review of the available scientific studies and explained that puberty blockers and cross-sex hormones are best

understood as "experimental" in the context of children with gender dysphoria. (Levine Decl. ¶¶ 177–255).

72. The Court finds that this evidence demonstrates, at a minimum, that the medical and scientific communities have not reached a consensus about the efficacy of puberty blockers and cross-sex hormones. The available evidence as to the efficacy or benefits of puberty blockers and cross-sex hormones is inconclusive and the Court has heard directly contrary opinions from highly qualified experts.

B. The Potential Harms to Children.

73. The Court finds that the evidence demonstrates a substantial risk of harm to children from puberty blockers and cross-sex hormones.

i. Puberty Blockers.

74. The evidence presented to the Court demonstrated that puberty blockers can cause infertility, reduced bone density, loss of sexual function, and other potentially harmful conditions, most of which are irreversible.

75. Defendants presented the testimony of Dr. Daniel Weiss to demonstrate the harms associated with puberty blockers. Dr. Weiss testified that puberty blockers can cause irreversible loss of fertility, (Hearing Tr. 437:24–438:18), permanent loss of sexual function, (Hearing Tr. 442:1–7), and lasting reductions in bone density, which is linked to an increased risk of bone fractures, (Weiss Decl. ¶¶ 140–145).

76. Dr. Weiss also testified that puberty blockers can cause seizures, pseudotumor cerebri (intracranial high blood pressure), fatigue, weight gain, and hot flashes. (Weiss Decl. ¶¶ 133–135).

77. Defendants presented the testimony of Chloe Cole, who described the side effects of receiving puberty blockers and cross-sex hormones. Cole is not able to attribute particular side effects to particular drugs, but she described experiencing lasting physical and mental health struggles, including pelvic pain, urinary tract issues, depression, joint pain, and post-traumatic stress. (Hearing Tr. 349:1–354:10).

78. Plaintiffs presented the testimony of Dr. Sarah Corathers.

79. Dr. Corathers testified that puberty blockers decrease the acquisition of bone density in children and can have long-term effects on bone density. (Hearing Tr. 217:8–219:5; 244:24–245:12). She also testified that puberty blockers can cause pseudotumor cerebri. (Hearing Tr. 220:19–221:17).

80. Dr. Corathers also testified that puberty blockers could cause distress to a child by delaying puberty, causing them to fall behind their peers. (Hearing Tr. 250:12–251:17). When asked if it was possible to evaluate how puberty blockers affect the development of any specific individual, Dr. Corathers responded that "there's certain things that are unknowable." (Hearing Tr. 248:19–249:18).

ii. Cross-Sex Hormones.

81. The evidence presented to the Court demonstrated that administration of cross-sex hormones dramatically increases the risk of cancer, increases the risk of heart attack, increases the risk of stroke, causes lasting infertility, and carries other potentially harmful side effects.

82. Dr. Weiss testified, for example, that males who receive estrogen are twenty-two times more likely to develop breast cancer, twice as likely to develop thyroid

cancer, thirty-six times more likely to suffer a stroke, and are at increased risk for cardiovascular events. (Weiss Decl. ¶¶ 189–199).

83. Dr. Weiss testified that randomized controlled trials have found that administration of estrogen to males increases risk of heart attacks, strokes, and cancers. (Hearing Tr. 440:20–441:16; Weiss Decl. ¶¶ 198–201).

84. Dr. Weiss also testified that estrogen causes permanent infertility in males, especially if they have taken puberty blockers. (Weiss Decl. ¶¶ 146, 195–96).

85. Dr. Weiss testified that females who receive testosterone are three-and-a-half times more likely to suffer a heart attack, twice as likely to suffer a stroke, and at increased risk for reproductive tract cancers. (Weiss Decl. ¶¶ 185–188).

86. Dr. Weiss also testified that testosterone causes permanent infertility in females, especially if they have taken puberty blockers. (Weiss Decl. ¶¶ 146, 176).

87. He further testified that testosterone provided to biological females can cause erythrocytosis (thickening of the blood), clitoral enlargement, pelvic pain, acne, and baldness. (Weiss Decl. ¶¶ 174–180).

88. Plaintiffs presented the testimony of Dr. Sarah Corathers and Dr. Angela Turpin.

89. Dr. Corathers testified that estrogen administered to males causes increased risk of blood clots, (Hearing Tr. 225:2–6), and reduced fertility (Hearing Tr. 227:5–17).

90. Dr. Turpin testified that she counsels her patients that administration of testosterone to females carries the risks of psychological dependance, loss of fertility,

increased risk of blood clots, increased risk of strokes, increased risk of heart attack, increased risk of cancer, increased difficulty in detecting cervical cancer, pelvic pain, clitoral enlargement, and blood thickening. (Hearing Tr. 278:4–279:5) (Referencing Roe testimony at Hearing Tr. 89:7–92:4).

91. Dr. Turpin also testified that she "discuss[es] at length" with patients the risks of fertility loss, neurological harm, cancer, heart attack, and strokes and her clinic included these risks on its informed consent documents. (Hearing Tr. 293:8–294:11).

92. The Court finds that experts from both parties agree that administration of cross-sex hormones increases a child's risk of, among other things, heart attack, stroke, cancer, blood clots, and loss of fertility. These are serious side effects that pose a danger to the health of children.

C. Informed Consent.

93. Defendant offered the testimony of Dr. Farr Curlin and Dr. James Cantor that minors and their parents are unable to give informed consent to puberty blockers and cross-sex hormones. They further testified that puberty blockers may actually impair the ability of children to understand the consequences of other medical treatments, like cross-sex hormones.

94. Dr. Curlin testified that children are unable to understand puberty blockers and cross-sex hormones because the interventions have lifelong consequences related to features of adult life, like sexuality and family formation. (Hearing Tr. 464:23–465:8). He further testified that puberty blockers interfere with the ability of a child to understand the implications of cross-sex hormones because they "block the

physical, mental, and emotional maturation that allows an adolescent to become adult and along the way, to develop the capacity to generally understand the implications of interventions like these." (Hearing Tr. 465:9–16).

95. Dr. Curlin also testified that parents and children could not render truly informed consent to puberty blockers or cross-sex hormones because doctors "do not inform children and their parents that these interventions are deeply contested and controverted across medicine." He described this omission as "a really striking violation of the ethical principle of a rational person standard for informed consent." (Hearing Tr. 467:13–468:9).

96. Dr. Cantor testified that "by slowing or preventing stages of neural development, puberty blockers may impair precisely the maturing of cognitive capabilities that would be necessary to evaluation of, and meaningful informed consent to, the type of life-changing impacts that accompany cross-sex hormones." (Cantor Decl. ¶ 285).

97. Dr. Cantor further testified that the majority of children who report gender dysphoria stop experiencing gender dysphoria after puberty, but that there's currently no method to predict whether gender dysphoria will persist. (Hearing Tr. 420:10–421:23). There is therefore no way to predict which children, if any, will be helped by puberty blockers or cross-sex hormones. (Hearing Tr. 421:2–23).

98. Dr. Weiss testified that puberty blockers do not "buy time to think" for children with gender dysphoria. (Weiss Decl. ¶ 166). Though gender dysphoria will not persist

through puberty for many of them, 95% of children prescribed puberty blockers are later prescribed cross-sex hormones. (Weiss Decl. ¶ 166).

99. Plaintiffs offered the testimony of Dr. Armand Antommaria, who testified that the "current treatment paradigm for treating gender dysphoria in minors is consistent with general ethical principles instantiated in the practice of informed consent and assent." (Antommaria Decl. ¶ 45).

D. Plaintiffs' Access to the Interventions.

100. Both minor Plaintiffs currently have access to the medical interventions they seek.

101. Lisa Loe testified that Lily Loe is receiving puberty blockers from a doctor in Minnesota. (Hearing Tr. 59:13–20).

102. Lily Loe travels to Minnesota just twice a year to receive puberty blockers. (Hearing Tr. 59:21–60:12 (Test. of Loe)).

103. Treatment options are available that would allow Loe to receive puberty blockers only once a year. (Hearing Tr. 431:24–432:11 (Test. of Weiss)).

104. Rebecca Roe testified that Ryan Roe is receiving testosterone from a clinic in Colorado. (Hearing Tr. 92:19–93:2).

105. Ryan Roe travels to Colorado just twice a year to receive testosterone. (Hearing Tr. 93:3–93:5 (Test. of Roe)).

CONCLUSIONS OF LAW

1. To obtain a temporary injunction, Plaintiffs must demonstrate "(1) a substantial likelihood of eventually prevailing on the merits; (2) a reasonable probability that

the plaintiff will suffer irreparable injury without an injunction; (3) the lack of an adequate legal remedy, such as damages; (4) the threat of injury to the plaintiff outweighs whatever harm the injunction may cause the opposing party; and (5) the injunction will not be against the public interest." *Downtown Bar & Grill, LLC v. State*, 294 Kan. 188, 191, 273 P.3d 709, 713 (2012).

2. Based on the evidence and the Court's review of the applicable law, it holds, as discussed below, that the Plaintiffs are unlikely to succeed on their claims, they will not suffer irreparable harm, they have adequate remedies at law, and the harm to the public from an injunction outweighs any threat of injury from enforcement.

I. Plaintiffs are unlikely to succeed on the merits of their claim.

3. Plaintiffs bring a facial challenge to the Help Not Harm Act, asking the Court to hold that the law is unconstitutional in all of its applications.

4. To succeed in their challenges, Plaintiffs must prove that "no set of circumstances exist" in which the law could be constitutionally applied. *Injured Workers of Kansas v. Franklin*, 262 Kan. 840, 850, 942 P.2d 591, 601 (1997).

5. Plaintiffs must meet this burden beyond a reasonable doubt. *See State v. Engles*, 270 Kan. 530, 531, 17 P.3d 355, 357 (2001); *State v. Robinson*, 303 Kan. 11, 278, 363 P.3d 875, 1050 (2015).

6. Further, because the Help Not Harm Act does not involve any suspect classifications, the Court must presume it is constitutional. *Barrett ex rel. Barrett v. Unified Sch. Dist. No. 259*, 272 Kan. 250, 256, 32 P.3d 1156, 1162 (2001),

7. Facial challenges like those brought by the Plaintiffs are disfavored. *See Moody v. NetChoice, LLC*, 603 U.S. 707, 744 (2024). They are "the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid." *State v. Jones*, 313 Kan. 917, 931, 492 P.3d 433, 445 (2021).

8. In keeping with the facial nature of their claims, Plaintiffs ask the Court to issue a facial injunction of the Help Not Harm Act, permitting children across the state, not just the Plaintiffs, to access puberty blockers and cross-sex hormones.

9. Plaintiffs are unlikely to succeed on their underlying claims because the Help Not Harm Act is subject to rational basis review and would pass constitutional muster under any applicable standard.

10. Additionally, Plaintiffs have not provided the Court with evidence sufficient to show that facial injunction of the Help Not Harm Act may be warranted here.

11. The evidence demonstrates broad uncertainty with respect to how puberty blockers and cross-sex hormones may affect a particular child. Plaintiffs have offered evidence regarding how the Help Not Harm Act affects them, but they have not proven how the law affects others.

12. In addition to being unlikely to succeed on their claims, therefore, Plaintiffs have not demonstrated that the Help Not Harm Act should be facially enjoined.

A. The Help Not Harm Act is subject to rational basis review.

13. Plaintiffs' Equal Protection claim is resolved by the Supreme Court's holding and reasoning in *United States v. Skrmetti*, 605 U.S. 495 (2025). This Court is bound

by Kansas precedent to follow that case and, even if it was not, *Skrmetti*'s reasoning is persuasive here.

14. The Help Not Harm Act is subject to rational basis review because it does not regulate a suspect class or burden a fundamental right.

15. Plaintiffs' parental rights claim is not cognizable under any provision of the Kansas Constitution. The Kansas Constitution does not create a fundamental right for parents to override the state's regulations of medical practice.

i. *Skrmetti* applies.

16. Plaintiffs' equal protection claim is properly evaluated under Section 2 of the Kansas Constitution (not Section 1, as alleged by Plaintiffs) because "the textual grounding of equal protection guarantees contained in the Bill of Rights of the Kansas Constitution is rooted in the language of section 2." *Rivera v. Schwab*, 315 Kan. 877, 894, 512 P.3d 168, 180 (2022).

17. Courts employ a three-part analysis to assess whether a statute violates the equal protection guarantees of Section 2.

18. At step one, the court must determine "the nature of the legislative classifications and whether the classifications result in arguably indistinguishable classes of individuals being treated differently." *Miami Cnty. Bd. of Comm'rs v. Kanza Rail-Trails Conservancy, Inc.*, 292 Kan. 285, 315, 255 P.3d 1186, 1207 (2011).

19. At step two, the court must select the appropriate level of scrutiny. A court must apply rational basis review unless the law "target[s] a suspect class or burden[s]

a fundamental right." *Downtown Bar & Grill, LLC v. State*, 294 Kan. 188, 194, 273 P.3d 709, 715 (2012).

20. At step three, the court must evaluate whether the classification's link to the legislative goal withstands the applicable scrutiny. *Miami Cnty. Bd. of Comm'rs*, 292 Kan. at 316, 255 P.3d at 1208.

21. The proper analysis under all three of these steps is informed by *Skrmetti*. This is because the Kansas Supreme Court's decision in *Rivera v. Schwab* requires this Court to apply *Skrmetti* here. *Rivera* held that "the equal protection guarantees found in section 2 [of the Kansas Constitution] are coextensive with the equal protection guarantees afforded under the Fourteenth Amendment to the United States Constitution. *Rivera*, 315 Kan. at 894, 512 P.3d at 180. Because the guarantees are coextensive, "Kansas courts shall be guided by United States Supreme Court precedent interpreting and applying the equal protection guarantees of the Fourteenth Amendment of the federal Constitution when we are called upon to interpret and apply the coextensive equal protection guarantees of section 2 of the Kansas Constitution Bill of Rights." *Id.*

22. Plaintiffs argue that their equal protection claims are properly evaluated under Section 1 of the Kansas Constitution, not section 2. For this proposition, they cite the standards identified in *Hodes & Nauser, MDs, P.A. v. Schmidt*, 309 Kan. 610, 622, 440 P.3d 461, 470 (2019) (*Hodes I*). However, *Rivera* expressly held that *Hodes I* is not an equal protection case and that its language does not apply to equal protection claims. The *Rivera* Court wrote, "[a]fter our decision in *Hodes* (giving a

substantive rights effect to section 1), it is clear that the textual grounding of equal protection guarantees contained in the Kansas Constitution Bill of Rights is firmly rooted in the language of section 2." *Rivera*, 315 Kan. at 894, 512 P.3d at 180. The Court went on, "[e]ven though *Hodes* changed the way in which we interpret section 1, it has not changed our historical and fundamental interpretation of the scope of equal protection found in section 2." *Id.* The Kansas Supreme Court has recently re-affirmed *Rivera*'s interpretation of the Kansas Constitution Bill of Rights in *League of Women Voters of Kansas v. Schwab*, 318 Kan. 777, 805, 549 P.3d 363, 383 (2024) that "[w]e are 'guided by United States Supreme Court precedent interpreting and applying the equal protection guarantees of the Fourteenth Amendment of the federal Constitution when we are called upon to interpret and apply the coextensive equal protection guarantees of section 2 of the Kansas Constitution Bill of Rights.'"

23. This Court therefore "shall be guided" in its equal protection analysis by decisions of the United States Supreme Court interpreting the Fourteenth Amendment's equal protection clause, including its decision in *Skrmetti*. *Rivera*, 315 Kan. at 894, 512 P.3d at 180.

24. Applying the reasoning of *Skrmetti* leads to the conclusion that Plaintiffs' claim is subject to rational basis review. In *Skrmetti*, the Supreme Court considered a Tennessee law identical in all relevant respects to the Kansas Help Not Harm Act.

25. Plaintiffs contend that the social transition provisions in the Help Not Harm Act set it apart from the Tennessee law at issue in *Skrmetti*, but those provisions are not at issue in this case. The allegedly differentiating provisions of the Help Not

Harm Act cited by the Plaintiffs concern the use of state buildings and resources. *See* K.S.A. § 65-28,138(d)–(f).

26. As Plaintiffs admitted at the hearing on Defendant's motion to dismiss, none of the Plaintiffs in this case allege harm from the denial of state facilities or state resources. Moreover, the temporary injunction request before the Court does not concern the social transition provisions as the Plaintiffs do not seek to enjoin them.

27. The *Skrmetti* Court addressed provisions of the Tennessee law materially indistinguishable from the provisions of the Kansas Act at issue in this case and concluded that the Tennessee law did not "classify on any bases that warrant heightened review." *Skrmetti*, 605 U.S. at 510. The Court therefore applied rational basis review. *See id.* at 522–25. That holding controls here.

ii. *Skrmetti*'s Reasoning is Sound.

28. Even if *Skrmetti* did not directly control, its reasoning is sound: the Help Not Harm Act does not classify on any bases that warrant heightened review. It only classifies on the basis of age and medical use.

29. The Help Not Harm Act first classifies on the basis of age. The law prohibits interventions for minors but says nothing about adults. *See generally* S.B. 63.

30. The Help Not Harm Act also classifies on the basis of medical use. The Act prohibits clinicians from "knowingly perform[ing] … [certain] surgical procedures or prescrb[ing], dispens[ing], or administer[ing] [puberty blockers and cross-sex hormones] to a [] child for the purpose of treatment for distress arising from such [] child's perception that such child's gender or sex[does] not" match their biological sex. S.B.

63 § (3)(a)–(b). On the other hand, the Act allows clinicians to provide children with these interventions for "treatment provided for other purposes." S.B. 63 § (3)(c).

31. In classifying by medical use, the Help Not Harm Act mentions sex, but only because the proscribed interventions depend on it. *See* S.B. 63(3)(a)-(b) (prohibiting vaginoplasties and "supraphysiologic doses of estrogen" for "male child[ren]" and phalloplasties and "supraphysiologic doses of testosterone" for "female child[ren]").

32. "Some medical treatments and procedures are uniquely bound up in sex." *Skrmetti*, 605 U.S. at 512. A medical procedure is not merely the substance administered to the patient; it also includes the condition being treated. For example, giving Aspirin to alleviate a heart attack is a different medical treatment from giving Aspirin to alleviate a headache. *See Skrmetti,* 605 U.S. at 513 ("The Food and Drug Administration approves drugs and requires that they be labeled for particular indications—the diseases or conditions that they treat, prevent, mitigate, diagnose, or cure.").

33. The sex-based language in the Help Not Harm Act is necessary because the interventions it addresses are bound up in sex. But "the mere use of sex-based language does not sweep a statute within the reach of heightened scrutiny." *Id*. at 512.

34. In other words, under the Help Not Harm Act, "*no* minor may be administered puberty blockers or hormones to treat gender dysphoria, gender identity disorder, or gender incongruence; minors of *any* sex may be administered puberty blockers or hormones for other purposes." *Skrmetti*, 605 U.S. at 515 (emphases in original). In

Kansas, puberty blockers and cross-sex hormones may not be prescribed to minors to treat gender dysphoria. That is not a sex classification.

35. Nor does the Help Not Harm Act discriminate on the basis of transgender status. The Help Not Harm Act "divides minors into two groups: those who might seek puberty blockers or hormones to treat the excluded diagnoses, and those who might seek puberty blockers or hormones to treat other conditions. Because only transgender individuals seek puberty blockers and hormones for the excluded diagnoses, the first group includes only transgender individuals; the second group, in contrast, encompasses both transgender and nontransgender individuals." *Skrmetti*, 605 U.S. at 519 (internal citation omitted).

36. Just as regulations concerning pregnancy are not sex discrimination, *see Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974); *Harder v. Kan. Comm'n on Civ. Rts.*, 225 Kan. 556, 559–60, 592 P.2d 456, 459–60 (1979), so regulations on treatment of gender dysphoria are not discrimination against transgender people.

37. Thus, the Help Not Harm Act would be subject only to rational basis review even if *Skrmetti* were not binding.

iii. There is No Parental Right to Particular Medical Interventions.

38. Plaintiffs' parental rights claim does not trigger heightened scrutiny because there is no Kansas Constitutional right to obtain particular medical treatments for one's child.

39. There is no Kansas case recognizing the right that Plaintiffs claim. Plaintiffs rely on cases regarding the right to refuse treatment. *See, e.g., Stockwell v. State*, 54

Kan. App. 2d 325, 328, 399 P.3d 873, 875 (2017) ("Stockwell's right to refuse unwanted medical treatment is well-established and constitutional in nature."); *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 278 (1990) ("At common law, even the touching of one person by another without consent and without legal justification was a battery."). But the right to *refuse* medical treatment is fundamentally different than the right to *access* medical treatment that Plaintiffs advocate. Nonconsensual treatment implicates bodily autonomy and the common law of informed consent in a way that the right to access a particular medical treatment does not. If Kansas *required* puberty blockers for minors diagnosed with gender dysphoria, Plaintiffs' cases would be relevant.

40. There are numerous examples across the United States of previously available medical treatments that are now banned, even if a child's parent otherwise wishes to access that treatment for their child. For example, after decades of permitting the sterilization of young people with intellectual disabilities, many states now restrict the practice and a number ban it outright. *See, e.g.,* 18 V.S. § 8705(a) (Vermont's absolute ban on sterilizing minors with intellectual disabilities); C.R.S. § 25.5-10-231(4) (Colorado's ban on sterilizing minors with intellectual disabilities absent a court order). Similarly, after lobotomy fell out of favor medically, many states passed laws restricting so-called "psychosurgeries," including a number of states completely banning them. *See* Roland Nadler & Jennifer A. Chandler, *Legal Regulation of Psychosurgery: A Fifty-State Survey*, 39 J. Legal Med. 335, 354–364 (2020). The federal government has enacted many similar bans, including every drug currently listed as

Schedule I by the Controlled Substances Act. *See* 21 CFR parts 1308.11–1308.15 (totally banning many drugs that have seen medical use, such as cannabis and methaqualone).

41. Plaintiffs' claim the Help Not Harm Act should be analyzed under strict scrutiny because it prohibits parents from choosing to allow their child to take puberty blockers or cross-sex hormones. This theory, if accepted, would subject many otherwise valid medical regulations to strict scrutiny. Such a theory cannot be correct. Even if sincerely held, a parent's say-so is not enough to subject medical regulations to strict scrutiny. "If parents could veto legislative and regulatory policies about drugs and surgeries permitted for children, every such regulation—there must be thousands—would come with a springing easement: It would be good law until one parent in the country opposed it." *L. W. by & through Williams v. Skrmetti*, 83 F.4th 460, 475 (6th Cir. 2023). The Help Not Harm Act is therefore subject to, at most, rational basis review under Plaintiffs' parental rights claim.

B. The Help Not Harm Act Passes Constitutional Muster Under Any Standard.

42. The Help Not Harm Act "clearly meets" the applicable rational basis review. *Skrmetti*, 605 U.S. at 522.

43. The conclusions of the United States Supreme Court in *Skrmetti* on this point apply with equal force here.

44. Kansas "concluded that there is an ongoing debate among medical experts regarding the risks and benefits associated with administering puberty blockers and hormones to treat gender dysphoria, gender identity disorder, and gender

incongruence. [The Help Not Harm Act's] ban on such treatments responds directly to that uncertainty." *Id.* at 523.

45. Like the United States Supreme Court, this Court "decline[s] the plaintiffs' invitation to second-guess the lines that [the Help Not Harm Act] draws. It may be true, as the plaintiffs contend, that puberty blockers and hormones carry comparable risks for minors no matter the purposes for which they are administered. But it may also be true, as [Kansas has] determined, that those drugs carry greater risks when administered to treat gender dysphoria, gender identity disorder, and gender incongruence." *Id.* at 524.

46. Even without *Skrmetti*, the Help Not Harm Act passes rational basis review.

47. A law must be upheld under rational basis review if there is "any state of facts which rationally justifies the classification." *Peden v. State*, 261 Kan. 239, 258, 930 P.2d 1, 14 (1996).

48. The findings of fact above demonstrate that there is meaningful scientific debate over the merits of puberty blockers and cross-sex hormones to treat gender dysphoria in children.

49. The efficacy of the interventions is in question, with many doctors and studies concluding that they do not improve the mental health of children to whom they are administered.

50. The side effects of the interventions are serious. They include life-threatening events like heart attacks, strokes, and cancer as well as life-altering effects like loss of fertility and loss of sexual function.

51. In the face of medical and scientific uncertainty like this, courts grant legislatures wide discretion to act. *See Gonzales v. Carhart*, 550 U.S. 124, 163 (2007) ("The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty."); *Kansas v. Hendricks*, 521 U.S. 346, 360 (1997) ("In fact, it is precisely where such disagreement [among medical professionals] exists that legislatures have been afforded the widest latitude in drafting such statutes.").

52. "In reviewing questions of constitutionality courts are not to be concerned with the wisdom, expediency, necessity or desirability of a legislative enactment." *City of Wichita v. White*, 205 Kan. 408, 409, 469 P.2d 287, 288 (1970).

53. The Kansas legislature is free to take sides on policy disagreements where the scientific evidence is uncertain, but the courts should not constitutionalize policy disputes, especially where the evidence is ambiguous.

54. "[T]he fact the line might have been drawn differently at some points is a matter for legislative, rather than judicial, consideration." *Skrmetti*, 605 U.S. at 524.

55. The importance of the government interests at stake here and the state of the available evidence means that the law would also pass muster under heightened scrutiny, which requires that the law "substantially further a legitimate legislative purpose." *Farley v. Engelken*, 241 Kan. 663, 669, 740 P.2d 1058, 1062 (1987).

i. The Law Directly Furthers an Important Interest in Protecting Children from Unproven Medical Interventions.

56. The Help Not Harm Act directly furthers the state's interest in protecting children.

57. The state has a compelling interest in protecting children. *State v. Wilson*, 267 Kan. 550, 559, 987 P.2d 1060, 1067 (1999).

58. The state also has a "quasi-sovereign interest in [preserving] the health and well-being—both physical and economic—of its residents," by protecting children from potentially dangerous medical interventions. *Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel., Barez*, 458 U.S. 592, 607 (1982).

59. The evidence presented to the Court demonstrated that the side effects of puberty blockers and cross-sex hormones are serious. The likelihood of cancer, heart attack, and stroke are orders of magnitude greater for children receiving these drugs. For example, Dr. Weiss testified that boys on estrogen are twenty-two times more likely to develop breast cancer and girls who receive testosterone are three-and-a-half times more likely to suffer a heart attack.

60. Plaintiffs' experts largely agreed with Defendant's account of the risks: Dr. Turpin testified that she informs all of her patients of the above risks.

61. Protecting children from strokes, heart attacks, cancer, and permanent loss of fertility is an important government interest.

62. The concern of national health bodies across the world confirms that the legislature's concern is not ill-founded. The decisions of other nations are non-binding here, but they show that the Kansas legislature's concerns are reasonable.

63. Protecting children from life-threatening and life-altering medical conditions is an important government interest that is implicated by puberty blockers and cross-sex hormones.

ii. A restriction on dangerous medical care is a valid means of furthering that interest.

64. Proscribing puberty blockers and cross-sex hormones for the treatment of gender dysphoria in minors is substantially related to the government's interest in protecting children from life-threatening and life-altering medical conditions.

65. The serious side-effects identified above are directly caused by puberty blockers and cross-sex hormones.

66. There is substantial debate in the medical and scientific communities about whether puberty blockers and cross-sex hormones carry any meaningful benefit when administered for the treatment of gender dysphoria in minors.

67. A statute is substantially related to a government interest if it substantially furthers that interest. *See In re K.M.H.*, 285 Kan. 53, 74, 169 P.3d 1025, 1039 (2007).

68. In light of the clear evidence of harm and the ambiguous evidence of benefit, a restriction on the prescription of puberty blockers and cross-sex hormones for the treatment of gender dysphoria in children substantially furthers the state's interest in protecting those children from harm.

69. The Help Not Harm Act is therefore substantially related to its interest in protecting minors from harm.

II. Plaintiffs will not suffer irreparable harm from an injunction and they have adequate remedy at law.

70. Plaintiffs will not suffer irreparable harm without an injunction because they currently have access to puberty blockers and cross-sex hormones.

71. A harm is not irreparable if it can be remedied with money damages. *See Persimmon Hill First Homes Ass'n v. Lonsdale*, 31 Kan. App. 2d 889, 894, 75 P.3d 278, 283 (2003).

72. Lisa Loe testified that Lily Loe has access to puberty blockers but must visit a clinic in Minnesota twice a year. And there are interventions available that would only require Loe to visit the clinic once a year. (Hearing Tr. 431:24–432:11 (Test. of Weiss)).

73. Rebecca Roe testified that Ryan Roe has access to testosterone but must visit a clinic in Colorado twice a year.

74. The unavailability of treatment in Kansas is not itself irreparable harm because both Plaintiffs have alternative means of access. *See, e.g., Smith & Nephew, Inc. v. Synthes (U.S.A.)*, 466 F.Supp.2d 978, 982 (W.D. Tenn. 2006) ("The irreparable harm requirement contemplates the inadequacy of alternate remedies available to the plaintiff."); *Curtis 1000 v. Youngblade*, 878 F. Supp. 1224, 1248 (N.D. Iowa 1995) ("Irreparable harm will not be found where alternatives already available to the plaintiff make an injunction unnecessary.").

75. While both Plaintiffs have to travel to obtain these treatments, travel costs are compensable via damages and are therefore not irreparable. *See Persimmon Hill*, 31 Kan. App. 2d at 894, 75 P.3d at 283.

76. Many medical treatments require a patient to incur costs, travel time, and other inconveniences, which may be substantial depending on the nature of the condition being treated. Plaintiffs have not presented evidence to indicate that their

travel, or the time or costs to obtain treatment, is substantially different than other patients who must travel for medical care. Nor have they shown that their time, travel, or inconvenience in obtaining out-of-state treatment has resulted in irreparable harm.

77. Plaintiffs' delay in seeking a temporary injunction also cuts against their claim of irreparable harm. The Help Not Harm Act took effect in February 2025. Plaintiffs filed their suit three months later and subsequently did not seek to expedite the hearing on the temporary injunction request, which took place on November 19th and 20th, 2025, nine months after the law went into effect.

78. During those nine months, Plaintiffs continued to receive medical care via out-of-state providers, which further undercuts their claim that their ability to obtain such care in Kansas has resulted in irreparable harm.

79. This delay counsels against finding irreparable harm here. *See Kan. Health Care Ass'n, Inc. v. Kan. Dep't of Soc. & Rehab. Servs.*, 31 F.3d 1536, 1543–44 (10th Cir. 1994) ("[D]elay in seeking preliminary relief cuts against finding irreparable injury."); *Wreal, LLC v. Amazon*, 840 F.3d 1244, 1248 (11th Cir. 2016) ("A delay in seeking a preliminary injunction of even only a few months—though not necessarily fatal—militates against a finding of irreparable harm.").

80. Aside from the burdens of travel, Plaintiffs have provided no other evidence of harm from a temporary injunction in this case.

81. To the extent Plaintiffs have offered any evidence of harm as a result of the inability to administer these medical treatments to children under the age of 18, it

would run only the Plaintiffs in this case. They have not offered evidence of harm to other parties, who may be differently situated under the Help Not Harm Act's phase-out provision, may have obtained alternative care under different circumstances, and may have had different experiences with puberty blockers and/or cross-sex hormones.

82. Plaintiffs therefore have not demonstrated sufficient evidence of a likelihood of irreparable harm.

III. An injunction would be adverse to the public interest

83. The equities and public interest in this case do not favor an injunction.

84. "Subject to specific constitutional limitations, when the legislature has spoken, the public interest has been declared in terms well-nigh conclusive." *White*, 205 Kan. at 409, 469 P.2d at 288.

85. The legislature has declared that it is in the public interest in this case to restrict access to puberty blockers and cross-sex hormones.

86. There is no "specific constitutional limitation" here, as Plaintiffs are unlikely to succeed on their claim.

87. The evidence demonstrates that the legislature's declaration is a reasonable one: there are real threats to the health of children from these medical interventions.

88. Enjoining the Help Not Harm Act would allow more children to access puberty blockers and cross-sex hormones.

89. Based on the record before the Court it is unclear whether those children would benefit from these interventions.

90. Based on the record before the Court, it is clear that these children would be at risk of serious side effects from these interventions.

91. While the Court has evidence related to Loe and Roe's diagnosis and treatment, it has no evidence related to the diagnosis and treatment of other children in Kansas. The only evidence before the Court with respect to those children is evidence of ambiguous benefit and clear harm.

92. To the extent the Court has any concrete evidence of harm, it runs only to the Plaintiffs. In contrast, the evidence of harm is generalizable; every child who is subject to the interventions is exposed to the side effects. This counsels strongly against a facial injunction of the statute.

93. Therefore, the Court concludes that an injunction would be adverse to the public interest. It would contravene the legislature's valid declaration of the public interest and it would expose children to harmful side effects for uncertain benefit.

CONCLUSION

For the reason stated herein, the Court denies Plaintiffs' motion for a temporary injunction. This order is effective as of the date and time shown on the electronic file stamp.

SO ORDERED.

Proposed order submitted by:

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CERTIFICATE OF SERVICE

I certify that the foregoing was filed via the Kansas Courts eFiling system, which will automatically serve an electronic copy upon Plaintiffs Lily Loe, Lisa Loe, Ryan Roe, and Rebecca Roe, via their attorneys of record who have registered with that system. In addition, the foregoing was e-mailed to the following attorneys for Plaintiffs:

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