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

DISTRICT COURT OF 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,	)	Case No. DG-2025-CV-000241
Plaintiffs,	)	
v.	)	
STATE OF KANSAS, *ex rel.* KRIS KOBACH, Attorney General of the State of Kansas,	)	Division 7
Defendant.	)	

Order Granting Temporary Injunction

Plaintiffs move the Court for a temporary injunction against the State of Kansas *ex rel.* Kris Kobach, Attorney General of the State of Kansas. Plaintiffs request an order enjoining Defendant from enforcing Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63 until further order of this Court.[1] After considering the evidence from the hearing held November 19–20, 2025, and the parties' arguments, the Court grants the temporary injunction requested by Plaintiffs.

I. Overview

The Court heard extensive testimony over the course of two days regarding the personal history of Plaintiffs, as well as experts in the field of gender-affirming care, and science and medicine more generally. The Court also reviewed thousands of pages of exhibits that were offered as substantive evidence for the injunction

[1] Section 3 of S.B. 63 is now codified at K.S.A. 65-28,139.

hearing. After closely reviewing all of this evidence, the Court grants the temporary injunction requested by Plaintiffs and issues a temporary order enjoining Defendant from enforcing Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63—which are now set out in K.S.A. 65-28,139(a)(2), (a)(3), (b)(2), and (b)(3).

This temporary injunction is not a final determination of any claim. But it is intended to prevent the Plaintiffs from suffering irreparable injury during the pendency of this lawsuit while Plaintiffs' claims are being litigated.

II. Findings of Fact

A. Procedural History

1, On May 28, 2025, Plaintiffs filed a Petition and Motion for Temporary Injunction.

2. On July 5, 2025, Defendant filed a Response in Opposition to Plaintiffs' Motion for Temporary Injunction and a Motion to Dismiss.

3. On August 8, 2025, the Court granted the parties' Joint Motion for Temporary Injunction Hearing and set the hearing for November 18–19, 2025.

4. On August 21, 2025, Plaintiffs filed a Response in Further Support of Motion for Temporary Injunction and an Opposition to Defendant's Motion to Dismiss.

5, On September 5, 2025, Defendant filed a Reply in Support of the Motion to Dismiss.

6. On November 3, 2025, the Court held a status conference regarding the scheduled evidentiary hearing on Plaintiffs' Motion for Temporary Injunction.

7. On November 18, 2025, the Court entered an Order permitting Plaintiffs to proceed via pseudonyms during the pendency of this case.

8. On November 18–19, 2025, the Court held an evidentiary hearing on Plaintiffs' Motion for Temporary Injunction.

9. On December 2, 2025, the parties filed their joint exhibits from the evidentiary hearing.

10. On December 16, 2025, the Court held oral argument on Defendant's Motion to Dismiss.

B. Plaintiff Loe Family

11. Plaintiff Lily Loe is 14 years old. Tr. 43:16–17.

12. Plaintiff Lily Loe provided testimony via affidavit (Ex. 2) but did not testify at the evidentiary hearing and was not subject to cross-examination. The Court finds Lily Loe's affidavit to be credible.

13. Plaintiff Lisa Loe is Lily's mother. Tr. 42:7–8.

14. Plaintiff Lisa Loe provided testimony via affidavit (Ex. 1), testified at the evidentiary hearing, and was subject to cross-examination. The Court finds Lisa Loe's testimony via affidavit and at the hearing to be credible.

15. The Loe Family lives in Douglas County, Kansas. Tr. 42:9–10.

16. Lily Loe was assigned male at birth; but her gender identity is female. Tr. 43:22–25.

17. Lily began to express a female gender identity when she was eighteen months old and was drawn to dolls, make-up, and traditionally feminine toys as a

young child. Tr. 44:5–13.

18. As a young child, Lily consistently expressed discomfort with wearing traditionally masculine clothing and only wanted to shop in the girls' section of stores. Tr. 44:22–45:9; Ex. 2 at ¶ 5.

19. Lily's persistent distress regarding her gender identity motivated Lisa to seek professional care for Lily. Tr. 47:15–48:20.

20. In January 2019, Lisa brought Lily to an appointment at the Gender Pathways Services Clinic that operates through Children's Mercy Hospital in Kansas City. Tr. 48:21–49:1. Lily's father and Lily's elementary school teacher also attended this appointment. Tr. 49:2–8. Lily was seven years old at the time of this appointment. Tr. 50:2–3.

21. At that first appointment, Lily and her family met with a psychologist for five hours. Tr. 49:9–19. Lily was diagnosed with gender dysphoria during this appointment. Tr. 49:20–23.

22. After Lily was diagnosed with gender dysphoria, she began having yearly consultations at the Gender Pathways Clinic with an endocrinologist. Tr. 50:11–18. As Lily grew older and got closer to the beginning of puberty, these appointments became more frequent. Tr. 50:19–22.

23. At these appointments, Lily spoke with doctors about her feelings towards her body and expressed anxiety about the possibility of beginning male puberty. Tr. 51:2–13; Ex. 2 at ¶ 9-11. Lily became increasingly anxious about puberty starting, and became hyper-vigilant for any changes, like body odor or hair

on her face. Ex. 1 at ¶ 21.

24. In late 2023, Lily's doctors presented Lisa and Lily with the option of Lily beginning puberty blockers. Lily began taking puberty blockers in late 2023. Tr. 51:13–20. Lily was relieved to begin taking puberty blockers as she did not want to undergo male puberty. Ex. 2 at ¶ 11–12.

25. At the time Lily began taking puberty blockers, she had been living full-time as a girl for at least five years. Tr. 51:21–24. This included using she/her pronouns, using the girl's restroom at school, and wearing traditionally feminine clothing. Tr. 51:25–52:7.

26. Lisa Loe spoke with Lily's endocrinologist, their family doctor, and a fertility specialist at the Gender Pathways Clinic before Lily began taking puberty blockers to understand how the treatment may affect Lily, including any potential side effects. Tr. 52:18–55:2.

27. Lily was ecstatic when she begun taking puberty blockers in late 2023. Tr. 55:3–5. She has not experienced any negative side effects to date. Tr. 55:13–15.

28. Lily's mental health and feelings about her body improved significantly after she had begun taking puberty blockers. She is scared that she will no longer be able to access her current treatment, nor will she be able to consider further treatment options that could alleviate her gender dysphoria. Ex. 2 at ¶ 13–15.

29. When S.B. 63 was passed into law by the Kansas Legislature earlier this year, Lisa and Lily were informed by the Gender Pathways Clinic that they would no longer offer puberty blockers or hormone therapy for Lily. Tr. 55:18–24.

Without access to puberty blockers and estrogen, Lily would commence endogenous puberty, which would cause her permanent, unwanted, and distressing physical changes that would in turn cause negative mental health outcomes. Tr. 51:11–14; Ex. 1 at ¶ 20–23, 25, 32.

30. After S.B. 63 was passed into law, Lisa began researching out-of-state providers so that Lily could continue receiving treatment. Tr. 55:25–56:10. Lisa was not able to secure an appointment for Lily that was covered by her insurance until late May 2025, and since Lily would not receive treatment at her first visit at a new clinic, her next round of treatment was overdue by the time she could make a second appointment. Ex. 1 at ¶ 31.

31. The passage of S.B. 63 has caused logistical and financial difficulties for the Loe family. Lisa and Lily must drive more than seven hours to Minneapolis for Lily to continue receiving the same treatment she previously received at the Gender Pathways Clinic. Tr. 56:7–10. Because of the distance, Lisa and Lily must pay for a hotel room and stay overnight in Minneapolis when Lily has an appointment. Tr. 56:11–21. As a single mom, Lisa must take time off work to bring Lily to her appointments. Because Lily's care must now take place out-of-state, Lisa has needed to place Lily on her employer's medical insurance instead of KanCare, causing additional financial and logistical strain. Tr. 56:22–57:2.

32. The passage of S.B. 63 has caused emotional difficulty for the Loe family. They have considered moving out-of-state so that Lily may continue to access care. Tr. 57:11–58:2. Lisa Loe has lived in Kansas for nearly her entire life.

Her three children have all lived in Kansas their entire life. The Loe family has a strong connection to their community in Kansas and do not wish to move. Tr. 42:14–43:2, 57:11–58:2.

C. Plaintiff Roe Family

33. Plaintiff Ryan Roe is 16 years old. Tr. 68:24–69:1.

34. Plaintiff Ryan Roe provided testimony via affidavit (Ex. 4), but did not testify at the evidentiary hearing and was not subject to cross-examination. The Court finds Ryan Roe's affidavit to be credible.

35. Plaintiff Rebecca Roe is Ryan Roe's mother. Ex. 3 at ¶ 2.

36. Plaintiff Rebecca Roe provided testimony via affidavit (Ex. 3), testified at the evidentiary hearing, and was subject to cross-examination. The Court finds Rebecca Roe's testimony via affidavit and at the hearing to be credible.

37. The Roe family lives in Overland Park, Kansas. Tr. 68:7–8.

38. Ryan Roe was assigned female at birth; but his gender identity is male. Tr. 70:2-4.

39. Ryan began expressing a male gender identity from a young age. Rebecca Roe explained that Ryan rejected wearing traditionally feminine clothes and loved dressing up as pirates, princes, and other traditionally masculine characters. Tr. 70:20–71:12.

40. When he was six years old, Ryan told his mother that he was a boy. Tr. 72:6–14. Ryan expressed fear and anxiety during that conversation because he thought his parents would be disappointed and that they did not want him to be a

boy. Tr. 73:4–15.

41. Rebecca Roe described how Ryan was perceived as a boy by many of his peers, and even teachers. Tr. 74:21–22. She described multiple instances where teachers explicitly characterized Ryan as a boy. Tr. 74:22–75:15.

42. The Roe family moved from Texas to Overland Park, Kansas in the spring of 2022, when Ryan was thirteen years old. Tr. 77:12–13, 78:14–15.

43. Shortly after beginning the eighth grade, Ryan expressed to his parents that he wanted to change his pronouns and live full-time as a boy. Tr. 78:16–20. Ryan felt that the community in Kansas was more welcoming, and he felt more comfortable expressing his gender. Ex. 4 at ¶ 7.

44. At the time, Ryan was experiencing ongoing distress related to his gender identity and the onset of puberty. Tr. 78:21–25. Ryan was distressed that the physical changes to his body in relation to female puberty did not align with his gender identity. Tr. 79:1–19; Ex. 4 at ¶ 8.

45. In the fall of 2022, Ryan began seeing a therapist, who diagnosed him with gender dysphoria after several sessions together. Tr. 79:20–80:3. At the time of his diagnosis, Ryan had been consistently expressing to his parents that he was a boy for at least seven years. Tr. 80:4–10.

46. After Ryan was diagnosed with gender dysphoria, Rebecca set up an appointment for him with the Gender Pathways Clinic at Children's Mercy Hospital. Tr. 80:11–18.

47. At the first appointment, Ryan and Rebecca met with a series of people

over the course of five hours, including a psychologist, an endocrinologist, a general practitioner, and a chaplain. Tr. 80:23–81:6. These doctors agreed that Ryan was suffering from gender dysphoria. Tr. 81:7–9.

48. The doctors at the Gender Pathways Clinic told Rebecca that Ryan was a candidate for testosterone. Tr. 81:10-13. The doctors explained how starting testosterone may change Ryan's body. Tr. 81:14–23. They also educated Rebecca and Ryan on potential negative side effects, including potential hair loss and potential effects on Ryan's fertility. Tr. 81:24–82:6.

49. After discussing as a family, Rebecca and Ryan decided to start him on a low dose of testosterone. Tr. 82:21–24.

50. Rebecca described how Ryan has benefited greatly since beginning testosterone. Ryan has felt better about himself and feels his body now is in stronger alignment with his identity. Tr. 83:3–13. Ryan's academic performance and mental health have improved significantly since he began taking testosterone. Tr. 84:11–18; Ex. 4 at ¶ 10.

51. In recent months, Ryan has begun experiencing elevated cholesterol levels in connection with his testosterone treatment. Tr. 83:14–17. Ryan has been meeting regularly with a pediatric cardiologist to monitor his treatment. Tr. 83:18–22. Rebecca asked Ryan's doctors whether he should cease taking testosterone and his doctors recommended that Ryan continue taking testosterone to treat his gender dysphoria while finding other ways to address this side effect. Tr. 83:23–84:10.

52. When S.B. 63 was passed by the Kansas legislature earlier this year,

Ryan's endocrinologist told his family that they would no longer be able to provide care for Ryan. Tr. 84:21–85:6. Rebecca became very concerned about the effects of the loss of testosterone on Ryan's physical and mental wellbeing. Ex. 3 at ¶ 27.

53. After that appointment, Rebecca began researching out-of-state providers so that Ryan could continue receiving treatment for his gender dysphoria. Tr. 85:7–14.

54. Ryan has begun receiving care at a clinic in Colorado. Tr. 85:15–19.

55. The passage of S.B. 63 has caused logistical and financial difficulties for the Roe family. Tr. 85:20–23. Rebecca and Ryan must drive more than nine hours for Ryan to continue receiving the same treatment he previously received at the Gender Pathways Clinic. Tr. 85:24–86:5. Because of the distance, Rebecca and Ryan must pay for a hotel room and stay overnight in Colorado when Ryan has an appointment. Ryan must also take time off school to attend his appointments, even though he is in a rigorous academic program, and one of his parents must miss work to take him to Colorado. Tr. 86:6–10, 87:8–12.

56. Since the passage of S.B. 63, Ryan has experienced significant anxiety about his physical and mental health if he is no longer able to access treatment. Ex. 4 at ¶ 14.

57. The Roe family has considered moving to a state where Ryan's care is more accessible, but they do not wish to. The Roe family is invested in their community in Overland Park. They have friends, family, and jobs in Kansas. Tr. 86:11–22. They remain concerned about S.B. 63's impact on their physical,

financial, and mental wellbeing.

D. The Gender Pathways Services Clinic in Kansas

58. The Gender Pathways Services Clinic ("GPS") is the primary provider of gender-affirming medical care for minors in Kansas and the surrounding area. Ex. 8 at ¶ 26.

59. Other gender-affirming medical care providers in Kansas primarily treat adolescents aged 16 years or older. Ex. 8 at ¶ 26.

60. 60. In 2014, in response to the needs of current patients, doctors at Children's Mercy, including Dr. Angela Turpin, founded the GPS Clinic. Tr. 265:25–266:12.

61. At the time, there were no options for minors to obtain gender-affirming medical care in Kansas—or Missouri. Tr. 266:13–18. The closest clinics that provided that care were in Denver and Chicago, respectively. Tr. 266:19–21.

62. GPS is a multi-disciplinary clinic, meaning "there are a variety of care providers from a number of different disciplines that are all essential to caring for that particular diagnosis." Tr. 266:22–267:4.

63. GPS staffs PhD-level clinical psychologists that specialize specifically in pediatrics, adolescent medicine specialists, social workers, pediatric endocrinologists, a chaplain, and a nurse clinical-care coordinator. Tr. 267:5–11.

64. As of May 2025, the clinic had 522 total patients, 320 of whom are under the age of 18. "On average the clinic sees 150–160 new patients per year all of whom are under 18 as the [the] clinic does not take new referrals for those age 18 or

older." Ex. 8 at ¶ 15.

65. Those numbers include many patients who travel from out of state to receive care, as bans in other states have forced families to travel from as far away as Texas or North Carolina. Ex. 8 at ¶ 53.

66. Gender-affirming medical care for adolescents has been available in Kansas since 2014. Tr. 265:25–266:16; Ex. 8 at ¶ 5.

67. The State has identified no concern about the safety of this care provided in Kansas during these past 11 years.

68. The GPS Clinic's policies and procedures align with the Endocrine Society Clinical Practice Guideline. Ex. 8 at ¶ 6.

69. If anything, GPS is more conservative in initiating gender-affirming medical care. For example, a gender dysphoria diagnosis—a prerequisite of medical treatment—requires at least six months of psychological distress related to gender incongruence. Ex. 6 at ¶ 32 (Antommaria); Ex. 13 at 12 (Turban *et al.*). GPS is more conservative, "typically requiring a year of symptoms." Tr. 269:16–20 (Turpin).

70. Gender-affirming medical treatments that GPS may provide to minor patients include puberty blockers (gonadotropin releasing hormone agonists, or GnRH agonists) or androgen receptor blockers (together, "puberty blockers"), and testosterone or estrogen (together, "hormone therapy"). Ex. 8 at ¶ 36.

71. GPS does not offer, nor does it refer minors for surgery for the treatment of gender dysphoria. Tr. 312:13–17.

72. Even if there were no external prohibition on offering or referring

minor patients for surgery, GPS would not do so. Tr. 314:10–12.

73. Before providing gender-affirming medical care, GPS conducts "a rigorous, multi-step process that holistically considers the adolescent, their family context, their existing mental and physical health, and other criteria to ensure that care is provided appropriately and when medically necessary." Ex. 8 at ¶ 28.

74. That holistic, multi-step process begins when GPS receives a referral form from the potential patient's licensed mental-health provider. Ex. 8 at ¶ 29. A referral is required to receive an appointment at GPS. Ex. 8 at ¶ 29.

75. The referral form must be filled out by a mental-health provider who "typically deals with kids and who has some knowledge of gender dysphoria." Tr. 268:10–12. The provider must be an outpatient therapist, psychiatrist, or clinical psychologist—GPS does not accept referrals from emergency departments or inpatient psychiatry. Ex. 12 at ¶ 8.

76. The referral form is extensive. It includes questions on: how long the referring licensed mental-health provider has been treating the potential patient; whether the potential patient has a diagnosis of gender dysphoria; whether the potential patient is mentally capable of assenting to care; whether the provider believes the potential patient would benefit from gender-affirming medical care; whether the potential patient has "any other confounding issues, whether psychosocial or mental health" and, if so, "are those well-controlled, such that they could undertake care"; and other areas designed to determine "readiness for possible medical interventions." Ex. 8 at ¶ 29; Tr. 267:14–268:6.

77. The median length of time that GPS patients have experienced gender-dysphoria symptoms before seeking treatment at GPS is four years. Guardians of GPS patients have known about their child's gender-dysphoria symptoms for a median time of 2.4 years. Tr. 268:20–269:6.

78. GPS patients have a median time of having socially transitioned for 14 months before receiving gender-affirming medical care (guardians report the time period as 12 months). Tr. 269:10–13.

79. After receiving a referral, GPS clinical staff review the referral form to determine whether the young person will be accepted as a patient. Tr. 269:23–270:25.

80. If the patient is accepted, GPS schedules the patient for an initial four-hour appointment. Ex. 8 at ¶ 30.

81. Before the initial appointment, the patient and their guardian complete separate intake surveys for review by a clinical psychologist at their first appointment. Ex. 8 at ¶ 30. The survey screens for eating disorders, substance use, sexual activity, sexual abuse, functioning in school, functioning in their family, and any learning disabilities (such as attention deficit hyperactivity disorder, or ADHD) that may have required accommodations in school. Tr. 269:23–270:25.

82. At the initial appointment, the patient and their guardian meet with a clinical psychologist, social worker, adolescent-medicine provider (if over the age of 12), chaplaincy (if desired), and potentially a pediatric endocrinologist. Ex. 8 at ¶ 30–35.

83. At the initial meeting with a clinical psychologist, any comorbidities are evaluated in detail. The psychologist also screens for any previously undiagnosed comorbidities. Ex. 12 at ¶ 10, 12.

84. The psychologist also reviews the gender-dysphoria criteria to ensure they agree with the diagnosis given by the referring provider. Tr. 309:21–310:22.

85. GPS does not find that all of their patients are eligible under the Endocrine Society Clinical Practice Guideline for gender-affirming medical care. Tr. 273:17–274:7; Ex. 8 at ¶ 34; Ex. 12 at ¶ 13. For those patients for whom GPS does not believe gender-affirming medical care would be appropriate, they plan for follow up and continued evaluation. Ex. 8 at ¶ 34.

86. If GPS believes that a patient meets eligibility criteria for medical treatment of gender dysphoria under the Endocrine Society Clinical Practice Guideline, including that the benefits of puberty blockers or hormone therapy may outweigh the risk for a given patient, then GPS will share with the patient and their guardian detailed information about the potential risks and benefits of medical intervention, and will provide written materials with that information. Ex. 8 at ¶¶ 35, 37. Families may take written materials home to reflect on whether treatment is right for them, and GPS encourages them to schedule follow-up appointments for any questions or concerns that may arise. Ex. 8 at ¶ 37.

87. GPS physicians do not recommend gender-affirming medical care—but rather tell patients and their guardians if the patient is eligible for it. Tr. 276:9–20. They do this so that the family can make a decision without actual or perceived

pressure from their doctors. Ex. 12 at ¶ 22.

88. As part of the discussion regarding potential effects of medication, GPS doctors discuss possible impacts on fertility, a conversation they revisit "at least annually." They will also discuss potential ways to preserve future fertility, such as egg/sperm banking. Ex. 8 at ¶ 38.

89. GPS creates individualized treatment plans tailored to the particular comorbidities (if any), needs, and goals of the patient and their guardian, among other factors. Ex. 12 at ¶ 5.

90. Both the patient and their guardian must sign a consent/assent form setting forth all known effects or side effects of the medication before it is prescribed. No gender-affirming medical care is provided unless both consent from the guardian and assent from the patient is received. Ex. 8 at ¶ 38.

91. The parents or guardians of GPS patients are involved throughout the assessment and treatment process. *See, e.g.*, Ex. 8 at ¶¶ 30–35; Tr. 279:6–18.

92. GPS has regular follow-up appointments with its patients. For patients receiving gender-affirming medical care, those follow-up appointments include checking in with the patient as to any desired or undesired outcomes of the medication and whether they would like to continue, adjust, or discontinue treatment. Ex. 8 at ¶ 42; Ex. 12 at ¶¶ 27–32. Regular medical testing is also done to monitor for any potential adverse side effects, such as scanning for bone density for patients on puberty blockers and blood draws to screen for "treatment associated side effects." Ex. 8 at ¶¶ 41–42.

93. GPS follows up with their patients after they leave or age out of care in the pediatric clinic. This follow-up has revealed that 99.2% of GPS patients who received gender-affirming medical care continue to identify as transgender into adulthood. Of the remaining 0.8%, most did not regret the medical treatment they received. Ex. 8 at ¶ 50. Some of that 0.8% "reverted to identifying with their sex assigned at birth again" but "the greater majority tend to be what we call nonbinary individuals" who report that they "have settled on . . . someplace in the middle [between female and male gender identities]." Tr. 287:7–21.

94. Because of S.B. 63, Kansans and residents of other states who have travel to Kansas for care are forced to either forego gender-affirming medical care or—if they can afford it—miss work and school to travel to Minnesota or Illinois (the closest locations that offer such care). Ex. 8 at ¶ 53.

95. Absent S.B. 63, GPS would continue to provide gender-affirming medical care to minor patients. Tr. 289:15–18.

E. S.B. 63

96. The Kansas Legislature made no legislative findings of fact in S.B. 63. *See* Ex. 101. S.B. 63 is codified at K.S.A. 65-28,137 through K.S.A. 65-28,142.

97. S.B. 63 defines "sex" as "the biological indication of male and female in the context of reproductive potential or capacity, including sex chromosomes, naturally occurring sex hormones, gonads and nonambiguous internal and external genitalia present at birth, without regard to an individual's psychological, chosen or subjective experience of gender." S.B. 63, § 1(b)(9) (Ex. 101). This definition of "sex"

has since been amended to "the biological indication of male and female in the context of reproductive potential or capacity, including sex chromosomes, naturally occurring sex hormones, gonads and nonambiguous internal and external genitalia present at birth." K.S.A. 65-28,137(b)(8) (eff. Feb. 26, 2026).

98. S.B. 63 defines "gender" as "the psychological, behavioral, social and cultural aspects of being male or female." S.B. 63, § 1(b)(3) (Ex. 101). The Legislature subsequently removed this definition of "gender" from the statutory scheme. *See* K.S.A. 65-28,137(b) (eff. Feb. 26, 2026).[2]

99. S.B. 63 defines "perceived sex" as an "individual's internal sense of such individual's sex." S.B. 63, § 1(b)(7) (Ex. 101); K.S.A. 65-28,137(b)(6) (eff. Feb. 26, 2026).

100. S.B. 63 also defines "perceived gender" as "an individual's internal sense of such individual's gender." S.B. 63, § 1(b)(8) (Ex. 101); K.S.A. 65-28,137(b)(7) (eff. Feb. 26, 2026).

101. S.B. 63 defines "social transitioning" as "acts other than medical or surgical interventions that are undertaken for the purpose of presenting as a member of the opposite sex, including the changing of an individual's preferred pronouns or manner of dress." S.B. 63, § 1(b)(10) (Ex. 101); K.S.A. 65-28,137(b)(9) (eff. Feb. 26, 2026).

102. S.B. 63 provides: "Except to the extent required by the first

[2] There have been no other 2026 substantive changes to S.B. 63, other than the amendment to the definition of "sex" and the removal of the definition of "gender."

amendment to the United States constitution, a state property, facility or building shall not be used to promote or advocate the use of social transitioning, medication or surgery as provided in section 3, and amendments thereto, as a treatment for a child whose perceived gender or perceived sex is inconsistent with such child's sex." S.B. 63, § 2(d) (Ex. 101); K.S.A. 65-28,138(d).

103. S.B. 63 provides: "A state employee whose official duties include the care of children shall not, while engaged in those official duties, promote the use of social transitioning or provide or promote medication or surgery as provided in section 3, and amendments thereto, as a treatment for a child whose perceived gender or perceived sex is inconsistent with such child's sex." S.B. 63, § 2(f) (Ex. 101); K.S.A. 65-28,138(f).

104. S.B. 63 provides: "Except as provided in subsection (c) or (d), a healthcare provider shall not knowingly perform the following surgical procedures or prescribe, dispense or administer the following medications to a 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 . . . (2) supraphysiologic doses of testosterone or other androgens; or (3) puberty blockers such as GnRH agonists or other synthetic drugs that suppress the production of estrogen and progesterone to delay or suppress pubertal development in female children." S.B. 63, § 3(a)(2), (3) (Ex. 101); K.S.A. 65-28,139(a)(2), (3).

105. S.B. 63 also provides: "Except as provided in subsection (c) or (d), a healthcare provider shall not knowingly perform the following surgical procedures

or prescribe, dispense or administer the following medications to a 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 . . . (2) supraphysiologic doses of estrogen; or (3)puberty blockers such as GnRH agonists or other synthetic drugs that suppress the production of testosterone or delay or suppress pubertal development in male children." S.B. 63 § 3(b)(2), (3) (Ex. 101); K.S.A. 65-28,139(b)(2), (3).

106. S.B. 63 provides: "The treatments prohibited by subsections (a) and (b) shall not apply to treatment provided for other purposes, including: (1) Treatment for individuals born with a medically verifiable disorder of sex development, including: (A) An individual born with external biological sex characteristics that are irresolvably ambiguous, including an individual born with 46 XX chromosomes with virilization, 46 XY chromosomes with under virilization or having both ovarian and testicular tissue; or (B) an individual whom a physician has otherwise diagnosed with a disorder of sexual development that the physician has determined through genetic or biochemical testing that such individual does not have normal sex chromosome structure, sex steroid hormone production or sex steroid hormone action for a male or female; and (2) treatment of any infection, injury, disease or disorder that has been caused or exacerbated by the performance of a procedure listed in subsections (a) or (b)." S.B. 63, § 3(c) (Ex. 101); K.S.A. 65-28,139(c).

107. S.B. 63's provision regarding previously initiated care only allows existing treatment to continue subject to a "plan to systematically reduce" medication, and that provision expired on December 31, 2025. S.B. 63, § 3(d); K.S.A.

65-28,139(d).

108. Plaintiffs seek a temporary injunction only as to S.B. 63, §§ 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3). These provisions are codified at K.S.A. 65-28,139.

F. Credentials and Credibility of Plaintiffs' Experts

1. Dr. Jack Turban

109. Dr. Jack Turban is a child, adolescent, and adult psychiatrist. Tr. 103:11–12. Dr. Turban is an assistant professor of child and adolescent psychiatry at the University of California, San Francisco (UCSF) School of Medicine, and affiliate faculty at the Philip R. Lee Institute for Health Policy Studies at UCSF. Tr. 103:13–19; Ex. 7 at ¶ 4. At UCSF, Dr. Turban serves as director of the Gender Psychiatry Program in the Division of Child & Adolescent Psychiatry—he also serves as an attending psychiatrist in the adult LGBT psychiatry clinic, and in the eating disorders program. Tr. 104:13–18; Ex. 7 at ¶ 4.

110. Dr. Turban has published over 40 peer-reviewed articles on gender dysphoria and transgender youth. Tr. 105:14–17; Ex. 7 at ¶ 8. Dr. Turban's research focuses on the determinants of mental health for young people with gender dysphoria, including outcomes following gender-identity conversion efforts and following puberty blockers and gender-affirming hormones, as well as the general development of gender identity and gender dysphoria. Tr. 105: 21–106:7. Dr. Turban has served as a co-editor of a textbook about pediatric gender identity and served as lead textbook chapter author on gender dysphoria for child and adolescent-psychiatry textbooks. Tr. 106:8–19; Ex. 7 at ¶ 7. Dr. Turban presents

nationally and internationally on gender dysphoria, including at the annual meetings of the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the International Academy of Child and Adolescent Psychiatry. Tr. 107:2–10; Ex. 7 at ¶ 6. Dr. Turban has received awards for excellence in public health from the U.S. Accredited Health Services for his work on the mental health of transgender youth. Tr. 106:22-24; Ex. 7 at ¶ 6.

111. Plaintiffs proffered Dr. Turban as an expert witness in the field of child and adolescent psychiatry and the treatment of youth with gender dysphoria. Tr. 107:22–25.

112. Dr. Turban is qualified to offer testimony as an expert in the field of child and adolescent psychiatry and the treatment of youth with gender dysphoria. His testimony was credible.

2. Dr. Armand Antommaria

113. Dr. Armand Antommaria is a pediatric hospitalist and bioethicist. Tr. 156:9–13. He is the Director of the Ethics Center and Lee Ault Carter Chair of Pediatric Ethics at Cincinnati Children's Hospital Medical Center, where he is also an attending physician, and a professor of pediatrics and surgery at the University of Cincinnati College of Medicine. Tr. 157:16–22; Ex. 6 at ¶ 11. Dr. Antommaria has been licensed to practice medicine since 2001 and is currently licensed to practice medicine in Ohio. Tr. 157:9–11; Ex. 6 at ¶ 13.

114. As Director of the Ethics Center at Cincinnati Children's Hospital Medical Center, Dr. Antommaria provides approximately 25 clinical ethics

consultations per year and works with a variety of medical teams to address ethical issues in the care they provide. Tr. 158:7–21; Ex. 6 at ¶ 14. These consultations include those within the Medical Center's transgender health clinic, with which Dr. Antommaria has been involved since its establishment in 2012. Tr. 158:22–25; Ex. 6 at ¶ 14. He is familiar with the latest research on treatment for gender dysphoria and has taught courses and given lectures on bioethics. Tr. 159:1–8.

115. Dr. Antommaria has published 45 peer-reviewed articles, including on the topics of the strength of recommendations in clinical-practice guidelines, guidelines for shared decision making regarding treatment for differences of sex development, guidelines for shared decision making for adolescents with gender dysphoria, and pediatric decision making. Ex. 6 at ¶ 4, A-12–A-16.

116. Plaintiffs proffered Dr. Antommaria as an expert witness in bioethics and pediatrics. Tr. 160:3–5.

117. 117. Dr. Antommaria is qualified to offer testimony as an expert in bioethics and pediatrics. His testimony was credible.

3. Dr. Sarah Corathers

118. Dr. Sarah Corathers is a pediatric and adult endocrinologist. Tr. 202:21–24. Dr. Corathers is a professor in the College of Medicine at the University of Cincinnati, the Clinical Director of the Division of Pediatric Endocrinology at Cincinnati Children's Hospital, and the Associate Chief of Staff for Ambulatory Services at Cincinnati Children's Hospital. Tr. 203:12–17; Ex. 5 at ¶ 7. Dr. Corathers has been licensed to practice medicine in Ohio since 2006. Ex. 5 at ¶ 8.

119. Dr. Corathers works as one of the primary endocrinologists at an interdisciplinary clinic for the treatment of gender dysphoria in Ohio. Tr. 203:21–204:2; Ex. 5 at ¶ 12. In over ten years of practice as an attending physician, she has treated between 200 and 300 transgender youth and young adults with gender dysphoria and consulted as a member of the interdisciplinary team providing care to many more patients. Tr. 204:15–205:1; Ex. 5 at ¶ 13. She is familiar with the latest medical science and treatment protocols related to gender dysphoria and differences of sex development (DSDs). Ex. 5 at ¶ 16. Dr. Corathers supervises the education of pediatric endocrinology fellows in the care of transgender youth through lectures and clinical practice. Ex. 5 at ¶ 14.

120. Dr. Corathers has published over 70 articles on endocrine disorders and treatments, including on the topics of interdisciplinary care for transgender youth, shared decision making around gender-affirming hormone therapy, hormonal contraceptive choices for transgender adolescents and adults, and bone health among transgender youth undergoing pubertal suppression. Tr. 205:2–16; Ex. 5 at ¶ 15.

121. Plaintiffs proffered Dr. Corathers as an expert witness in the field of endocrinology and the treatment of gender dysphoria in adolescents and young adults. Tr. 206:15–19; Ex. 5 at ¶ 2; Ex. 9 at ¶¶ 5–11.

122. Dr. Corathers is qualified to offer testimony as an expert in the field of endocrinology and the treatment of gender dysphoria in adolescents and young adults. Her testimony was credible.

4. Dr. Angela Turpin

123. Dr. Angela Turpin is a pediatric endocrinologist. Tr. 262:3–7; Ex. 8 at ¶ 4. Dr. Turpin is an attending physician at Children's Mercy Hospital – Kansas City in pediatric endocrinology, an assistant professor of pediatrics at the University of Missouri – Kansas City School of Medicine, and the medical director for the Gender Pathways Services Clinic at Children's Mercy Hospital – Kansas City. Tr. 262:18–24; Ex. 8 at ¶¶ 4, 8. Dr. Turpin has been licensed to practice medicine in Missouri since 2001 and Kansas since 2002. Ex. 8 at ¶ 10.

124. 124. As the medical director of the GPS Clinic, Dr. Turpin oversees the policies and procedures surrounding the prescription of medications and the medical education of medical students, residents, and fellows with respect to gender-affirming care in pediatrics and endocrinology. Tr. 263:2–11; Ex. 8 at ¶ 13. Dr. Turpin was also one of the founders of the GPS Clinic. Ex. 8 at ¶ 5. Dr. Turpin has been treating patients with gender dysphoria since 2014 and served as the medical director for the past three years. Ex. 8 at ¶ 15. Over the past 11 years, she has treated approximately 350 adolescents or young adult patients with gender dysphoria and participated in or overseen the care of many more. Tr. 263:11–16; Ex. 8 at ¶ 15. Dr. Turpin's practice includes treating many endocrine conditions, as well as puberty-related disorders, differences of sex development, and gender dysphoria. Ex. 8 at ¶ 14.

125. Dr. Turpin has published peer-reviewed articles and presented on topics such as treatment protocols for gender dysphoria, including medication

management, issues specific to rural populations, eating disorders, the prevalence of differences of sex development, and growth charts. Tr. 263:17–25; Ex. 8 at ¶ 11.

126. Plaintiffs proffered Dr. Turpin as an expert witness in the field of pediatric endocrinology and treatment of gender dysphoria in adolescents and young adults. Tr. 264:24–265:4; Ex. 8 at ¶¶ 4–7; Ex. 12 at ¶ 4.

127. Dr. Turpin is qualified to offer testimony as an expert in the field of pediatric endocrinology and the treatment of gender dysphoria in adolescents and young adults. Her testimony was credible.

G. Credibility of Defendant's Witnesses

1. Dr. James Cantor

128. Dr. James Cantor is a psychologist and neuroscientist. Tr. 385:19–20. He is not a physician. Tr. 410:18–19.

129. The focus of Dr. Cantor's clinical work is on adult sex and couple's therapy. Tr. 410:20–23. Dr. Cantor is not licensed to treat individuals under the age of 16. Tr. 411:4–8. He has never diagnosed an individual under the age of 16 with gender dysphoria. Tr. 411:9–11.

130. Dr. Cantor has not conducted any original scientific research on the efficacy or safety of gender dysphoria treatments. Tr. 412:19–22.

131. Despite his lack of experience in the area, Defendant proffered Dr. Cantor to speak on the medical impacts of puberty blockers and hormone therapies for the treatment of gender dysphoria in minors. *See, e.g.*, Ex. 102 at ¶ 40.

132. The Court does not credit the testimony of Dr. Cantor as to the actual

or potential effects of puberty blockers or hormone therapies because he lacks the qualifications to offer his opinions and failed to support them.

133. Defendant also proffered Dr. Cantor for his opinion on the quality, quantity, and results of studies pertinent to the provision of gender-affirming medical care to minors. Tr. 391:7–409:21.

134. The Court does not credit Dr. Cantor's opinions on the quality, quantity, and results of studies for the reasons articulated by Plaintiffs' experts. His opinions are supported only by cherry-picked information, conjecture, and research taken out of context. The Court, thus, finds that his opinions do not accurately or reliably report and summarize the state of research regarding gender-affirming care in minors. This is shown by, among other things:

i. Dr. Cantor stated that "peer-review is the line between acceptable and not" but himself relied on non-peer reviewed sources to support his position. Ex. 11 at ¶ 21 (Turban Rebuttal Decl.).

ii. Dr. Cantor uses survey-based reports to support his position, but dismisses higher-quality studies out of hand. Ex. 11 at ¶ 55 n. 71 (Turban Rebuttal Decl.).

iii. Dr. Cantor states that certain systematic reviews support his views, but ignores that the authors of those reviews stated that their work should not be used to prevent the provision of gender-affirming medical care. Ex. 11 at ¶ 22 (Turban

Rebuttal Decl.).

iv. Dr. Cantor makes several statements which have no scientific support. *See, e.g.*, Ex. 11 ¶ 44 (Turban Rebuttal Decl. re Dr. Cantor's suggestion, without evidence, that gender dysphoria might be a misdiagnosis for borderline personality disorder in some cases); Ex. 9 at ¶ 44 (Corathers Rebuttal Decl. re Dr. Cantor's suggestion, without providing evidence, that transgender boys receiving gender-affirming medical care may be at an increased risk of parkinsonism).

135. The Court gives Dr. Cantor's testimony little weight when compared to the testimony of Plaintiffs' expert witnesses.

2. Dr. Daniel Weiss

136. Dr. Weiss is an endocrinologist who has treated adult patients with gender dysphoria through the provision of hormone therapies. Tr. 425:6–11. He has no clinical experience in treating minors with gender dysphoria, nor has he published research on the subject. Tr. 444:23–445:17.

137. Dr. Weiss opined that neither puberty blockers nor hormone therapy for minors with gender dysphoria are safe and effective. Tr. 443:10–444:15.

138. The Court does not credit Dr. Weiss's testimony because—unlike Plaintiff's endocrinology experts Dr. Corathers and Dr. Turpin—he lacks qualifications and experience regarding the provision of gender-affirming medical care to minors.

139. Despite the potential side effects Dr. Weiss spoke about in his testimony, Tr. 438:19–441:16, he admitted on cross-examination that of the approximately 100 adult patients he has treated with hormone therapy for gender dysphoria, Ex. 103 at ¶ 10, the only negative side effects he observed in his practice were high hemoglobin and worsening sleep apnea. Tr. 446:3–11.

140. Dr. Weiss also spoke at length about potential negative side effects of puberty blockers. Tr. 432:22–438:18. But, despite their side effects, he does not object to their use to treat central precocious puberty. Tr. 446:12–15.

141. Dr. Weiss admitted on cross-examination his personal belief that children of same-sex couples are more likely to have significant pathology and that he is personally opposed to the social transition of children with gender dysphoria. Tr. 452:1–8.

142. Given all of this testimony— but, most importantly, Dr. Weiss's lack of experience or research of the medical treatment care of minors with gender dysphoria—this Court gives Dr. Weiss's testimony little weight when compared to the testimony of Plaintiffs' expert witnesses.

3. Dr. Farr Curlin

143. Dr. Curlin is a doctor and a medical ethicist. Tr. 453:15–24. He is not a pediatrician, nor is he a psychiatrist or endocrinologist. Tr. 475:6-13. He has never treated anyone for gender dysphoria. Tr. 475:20–476:2.

144. Dr. Curlin offered his opinion that gender-affirming medical care is "ethically problematic" because it is not, in his view, aimed at "bringing about a

health benefit that corresponds to a genuine problem with the patient's health. . . ." Tr. 456:11–19.

145. Dr. Curlin believes that, to the extent that gender-affirming care may have the side effect of reducing fertility, it "prevents the realization of the basic good of marriage, since sexual capacities make possible the one flesh union of marriage." Tr. 484:24–485:6.

146. Dr. Curlin's medical ethics philosophy disfavors many treatments the public commonly enjoys. For example:

i. Dr. Curlin views the prescription of birth control for contraception as "ethically problematic" because "a feature of health for women of reproductive age is the capacity for reproduction" such that "blocking the capacity for reproduction seems contrary to the purposes of health." Tr. 486:18–25.

ii. Dr. Curlin also views in vitro fertilization (or IVF) as "ethically problematic." Tr. 488:7–19.

147. By his own admission, Dr. Curlin's views are out-of-step with those of "many" medical ethicists. Tr. 477:6–9. He believes that medical ethics in general has "overemphasized autonomy to a detrimental degree[.]" Tr. 477:1–5. Indeed, his views are, in his words, "radically counter to current medical orthodoxy." Tr. 488:20–489:6.

148. Dr. Curlin's opinions are inconsistent with the weight of medical

research in his field, and his opinion appears motivated by his personal views as opposed to a methodology applicable in the field of medical ethics.

149. For these reasons, the Court gives Dr. Curlin's opinion testimony little-to-no weight.

4. Dr. Patrick Lappert

150. Dr. Lappert is a plastic surgeon. Tr. 370:5–7. He acknowledges that he is not an expert in the treatment of gender dysphoria. Tr. 378:18–379:8.

151. Dr. Lappert offered opinions on the ethics of gender-affirming surgery for minors with gender dysphoria. Tr. 376:7–377:6.

152. S.B. 63's prohibition on surgery is not challenged by Plaintiffs' Motion for Temporary Injunction, and thus Dr. Lappert's testimony is not relevant to the issue before the Court at this time.

5. Dr. Stephen Levine

153. Defendant did not present Dr. Stephen Levine at the evidentiary hearing, and he was not subject to cross-examination. Thus, it is difficult for the Court to determine the credibility of Dr. Levine's affidavit (Ex. 107).

154. The Court gives some weight to Dr. Levine's testimony via affidavit. Dr. Levine appears to be the only expert proffered by Defendant with any experience treating adolescent patients with gender dysphoria, although most of his experience has been with adults. Ex. 107 at ¶¶ 4, 8.

155. Even Dr. Levine has, under certain circumstances, provided documentation to support his patients' future efforts to begin hormone therapy. Ex.

107 at ¶ 8.

156. Dr. Levine has also previously testified that it would be "shocking" and "devastating" to require youth who are currently receiving estrogen or testosterone to stop. *Brandt v. Rutledge*, 677 F. Supp. 3d 877, 910 (E.D. Ark. 2023), *rev'd and remanded sub nom. Brandt by & through Brandt v. Griffin*, 147 F.4th 867 (8th Cir. 2025).

6. Jamie Reed

157. Defendant did not present Jamie Reed at the evidentiary hearing, and she was therefore not subject to cross-examination by Plaintiffs. Thus, it is difficult for the Court to determine the credibility of Jamie Reed's affidavit (Ex. 106). In addition, the affidavit cites attachments that were not made part of the record. This, again, makes it difficult to assess the weight to give to this affidavit.

158. The Court gives thus Jamie Reed's affidavit little weight, given that she is not a medical provider or mental-health professional. In addition, her affidavit primarily addresses her experiences with a clinic operating outside of Kansas—thus, it does not rebut or refute the credible, uncontroverted testimony about clinical practice within the state of Kansas. *See, e.g.*, Ex. 8, Ex. 12; Tr. 262:1–333:8, 500:1–515:10 (Turpin).

7. Chloe Cole

159. Ms. Cole testified about her personal experience receiving puberty blockers and hormone therapy for a diagnosis of gender dysphoria when she was a minor in California, both via affidavit and at the evidentiary hearing. Tr. 335:16–

367:21; Ex. 108. She was subject to cross-examination.

160. While Ms. Cole credibly testified as to her experience in California, she admittedly did not receive care in Kansas. Tr. 363:19–364:4. Moreover, she believes her care did not align with medical guidelines and constituted medical malpractice. Tr. 366:1–4.

161. Plaintiff's expert witness Dr. Turpin also testified that Ms. Cole's care, as Ms. Cole described it during the evidentiary hearing, would not have occurred in Kansas and would be inconsistent with the GPS Clinic's implementation of the Endocrine Society Clinical Practice Guideline. Tr. 500:3–511:10.

162. Ms. Cole's testimony, while credible, is given less weight because her care did not take place in Kansas and because the care she received does not reflect care in Kansas or the accepted practices for gender-affirming medical care more generally.

8. Corinna Cohn

163. Defendant did not present Corinna Cohn at the hearing and therefore this witness was not subject to cross-examination. Thus, it is difficult for the Court to determine the credibility of Corinna Cohn's affidavit (Ex. 109).

164. In addition, Ex. 109 does not address medical treatments provided to an individual under the age of 18 or treatments that are used within the state of Kansas. *See, e.g.*, Ex. 109 at ¶ 5 (describing care accessed as an adult), ¶ 6 (describing care in Wisconsin). Thus, this affidavit is given little weight for the issue before the Court.

H. Background on Gender Identity and Transgender Persons

165. As used by the expert witnesses in this case and the applicable medical research and literature, "gender identity" refers to one's fundamental inner psychological sense of self as female, male, a combination of both, or neither distinctly male nor female. Ex. 5 at ¶ 19 (Corathers); Tr. 109:7–9 (Turban).

166. "Sex assigned at birth" refers to the designation of sex generally noted at birth based on the observation of external physical attributes, like genitalia. Ex. 5 at ¶¶ 21–22 (Corathers). The term "biological sex" is less precise than "sex assigned at birth." This is because "biological sex" does not account for the complex, multi-step nature of sex development, which includes numerous physiologic attributes, including chromosomes, gonads (glands that produce hormones), other anatomy (reproductive parts both inside and outside of the body), secondary sex characteristics that usually develop during puberty, as well as gender identity, and which may all vary within a particular person. Ex. 5 at ¶ 22 n.1 (Corathers); Ex. 9 at ¶¶ 13, 26, 31 (Corathers).

167. Medical conditions known as Differences of Sex Development (DSD), or Intersex conditions describes a group of conditions in which biological sex development does not follow a typical path. Ex. 9 at ¶ 14 (Corathers).

168. There is considerable scientific evidence demonstrating a durable biological element underlying gender identity. Ex. 9 at ¶ 35 (Corathers).

169. Although most people have a gender identity that aligns with their sex assigned at birth, transgender persons have a gender identity that differs from their

sex assigned at birth. Ex. 5 at ¶¶ 22–23 (Corathers).

170. Being transgender is not a mental-health condition to be treated or cured. Ex. 5 at ¶ 27 (Corathers). But Transgender people may experience gender dysphoria, the medical condition marked by clinically significant distress that can arise from the incongruence between a person's gender identity and their sex assigned at birth. Ex. 5 at ¶¶ 25–26 (Corathers); Ex. 7 at ¶ 12 (Turban); Ex. 6 at ¶ 32 (Antommaria).

171. There is medical consensus that gender identity is innate and that efforts to change a person's gender identity are unethical and harmful to a person's health and well-being. Ex. 9 at ¶ 34 (Corathers). Once a transgender youth begins puberty, it is rare for them to later identify as cisgender. Ex. 7 at ¶ 30, 32 (Turban).

I. The Diagnosis of Gender Dysphoria

172. "Gender dysphoria" is a diagnosis included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, or DSM-5. It refers to when a person's gender identity is incongruent from their sex assigned at birth, and that incongruence creates significant emotional distress or impairment in social, occupational, or other important areas of functioning. Tr. 108:22–109:4 (Turban); Ex. 9 at ¶ 36 (Turban). In addition to the clinically significant impairment in function, the diagnosis of gender dysphoria requires that the incongruence between a person's gender identity and sex assigned at birth must have persisted for at least six months. Ex. 9 at ¶ 38 (Corathers).

173. The impairment in social, occupational, or other area of functioning

may present differently in different people, however some individuals are so distressed about physical changes of puberty that they are unable to shower, some have trouble going to school and interacting with their peers, and some become very depressed or suicidal regarding the way their bodies develop through puberty. Tr. 112:1–10 (Turban).

174. Gender dysphoria is a medically verifiable condition—it is diagnosed, like other psychiatric conditions, based on criteria set out in the DSM-5 and using information collected via mental-health assessments. Ex. 7 at ¶¶ 12–14 (Turban); Ex. 11 at ¶ 5 (Turban); Tr. 109:20-110:18 (Turban). This reliance on patient self-report is not unique to a gender-dysphoria diagnosis or even psychiatry generally—for example, migraine headaches are diagnosed via self-report and do not have confirmatory laboratory studies. Ex. 10 at ¶ 66 (Antommaria).

175. Gender dysphoria "has scientifically acceptable interrater reliability—meaning that if one professional concludes that a patient meets criteria for the diagnosis, another is reasonably likely to agree." Ex. 107 at ¶ 33 (Levine).

176. Clinical-practice guidelines are summaries of evidence and recommendations for treatment developed by professional associations to guide clinicians based on the best available evidence. Tr. 163:1–20 (Antommaria).

177. The Court primarily heard testimony about the Endocrine Society Clinical Practice Guideline as used for the treatment of gender dysphoria in adolescents and young adults; however, two professional associations, the World Professional Association for Transgender Health (WPATH) and the Endocrine

Society, have published widely accepted clinical-practice guidelines or protocols for the treatment of adolescents with gender dysphoria. Tr. 112:16–21 (Turban). WPATH's Standards of Care (SOC) is currently in its 8th version, and the Endocrine Society's guidelines were first published in 2009 and most recently updated in 2017. Ex. 6 at ¶ 34 (Antommaria). These clinical-practice guidelines are followed by clinicians and are generally consistent with one another. Tr. 164:6–16, 170:4–9 (Antommaria).

178. Under the Endocrine Society Guideline, medical interventions are never indicated for children who have not yet entered puberty. Tr. 114:9–12 (Turban). The earliest medical intervention that would be considered under the guidelines is a puberty blocker, or pubertal suppression, which is not considered until the early stages of puberty have begun. Tr. 114:13–18 (Turban).

179. Under the Endocrine Society Guideline, the first step for evaluating whether a child or adolescent has gender dysphoria is conducting a comprehensive psychiatric or mental-health evaluation, also called a biopsychosocial evaluation. Tr. 109:20–110:4, 113:9–19 (Turban).

180. The biopsychosocial evaluation involves obtaining a biological, psychological, and social history from the young person, as well as their parents or guardians and educators, about their gender development and other mental-health concerns. Ex. 7 at ¶ 15 (Turban); Ex. 13 (Turban e*t al.*). These evaluations collect biological information about the young person, such as their individual and family medical history; psychological information such as their common thought patterns,

whether they have rigid thinking, and their ability to conceptualize abstract concepts; and social information regarding their social environment, including their family functioning, and their relationships with peers and communities. Tr. 109:20–110:4, 113:16–114:6 (Turban); Ex. 7 at ¶ 15 (Turban); Ex. 13 (Turban *et al.*).

181. Biopsychosocial mental-health assessments also include screening for other mental-health conditions, including autism spectrum disorder, major depressive disorder, and a wide range of other mental-health conditions. Tr. 110:13–16, 115:17–24 (Turban). If there is any indication from the screening that a co-occurring mental-health condition may be present, more information must be collected to ensure the correct diagnosis. Tr. 115:24–116:2 (Turban).

182. This process of ruling out other possible diagnoses in the diagnostic process is referred to as "differential diagnosis," which is practiced in all of medicine. Tr. 110:19–111:3 (Turban). The DSM-5 specifically requires consideration of several other diagnoses when evaluating for gender dysphoria, including body dysmorphic disorder, in which one has an obsessive discomfort with a certain body part, as well as autism spectrum disorder, which can cause rigid thinking or different thought processes regarding gender. Tr. 111:4–17 (Turban).

183. The most common co-occurring mental-health conditions for adolescents with gender dysphoria are major depressive disorder and anxiety disorders, such as generalized anxiety disorder or social anxiety disorder. Tr. 116:3–12 (Turban). The Endocrine Society Guideline makes clear that if a co-occurring mental-health condition is present, treatment must be provided for that condition,

including psychotherapy or medication where indicated. Tr. 116:13–23 (Turban).

184. The diagnostic assessment may also be extended in certain circumstances, including if certain co-occurring conditions like autism spectrum disorder are present, to ensure the patient understands the difference between concepts like gender identity, gender expression, and sexual orientation. Tr. 117:7–23 (Turban); Ex. 7 at ¶ 15 (Turban). Although these concepts must be discussed more thoroughly with patients with autism, the Endocrine Society Guideline requires that they be discussed with every patient. Tr. 119:4–12 (Turban).

185. Before any medical interventions being considered, the Endocrine Society Guideline requires that other mental-health conditions be reasonably well controlled, that a young person is able to provide informed assent to the treatment, and that their parents or guardians provide informed consent. Tr. 120:9–121:1 (Turban). Patients and their parents or guardians must be informed about all risks, including potential fertility risks, of medical interventions, along with the benefits and potential side effects. Tr. 118:7–13 (Turban); Ex. 7 at ¶ 15 (Turban).

186. "Social contagion" is a term used in psychiatric epidemiology to describe phenomena where a certain mental-health condition or psychological manifestation is spread from one person to another through social contact. Tr. 128:10–14 (Turban). There is no convincing evidence that "social contagion" is a valid phenomenon with respect to gender dysphoria. Tr. 129:1–3 (Turban).

187. "Rapid onset gender dysphoria" is not a recognized mental-health condition—it is a theory that originated from a study that derived its information

from an anonymous survey of parents of transgender youth, recruited from several websites targeting parents who believed the theory that their children developed gender dysphoria suddenly, due to social contagion, peer pressure or social media, including one website called "Transgender Trend." Tr. 129:4–24 (Turban); Ex. 11 at ¶¶ 51–52 (Turban). The original study was corrected to note that the study did not collect data from the adolescents and young adults with gender dysphoria themselves. Tr. 130:2-5 (Turban); Ex. 11 at ¶¶ 51–52 (Turban).

188. Young persons with gender dysphoria often report that they have hidden their transgender identities from their parents for a long time, such that once they do inform their families of their identities—so their parents may believe that their identity developed all of a sudden. Tr. 130:9–20 (Turban). One study found that among transgender people who first understood their gender identity in childhood waited a median of 14 years before sharing this with another person. Ex. 11 at ¶ 53 (Turban).

189. Even though neither social contagion nor rapid onset gender dysphoria are recognized phenomena with respect to transgender young people, the Endocrine Society Guideline nonetheless requires clinicians to screen for evidence of social contagion or peer pressure leading to the gender dysphoria presentation. Tr. 131:2–11, 129:1–3 (Turban). The GPS Clinic also screens for those phenomena but does not encounter it. Tr. 273:1–16 (Turpin).

190. Following the conclusion of the diagnostic process for gender dysphoria, the Endocrine Society Guideline requires that young people continue

mental-health treatment so that the mental-health provider can evaluate their response to treatment and continually evaluate if continued treatment is appropriate or not. Tr. 118:1–6 (Turban).

J. Medical Treatments for Gender Dysphoria

191. Endocrinology is a medical subspecialty focused on hormones and metabolism. Tr. 208:14–19 (Corathers). Endocrinologists are involved in the treatment of gender dysphoria because the field specializes in the function of hormones, regulation of hormones, and feedback system of hormones—the use of GnRH agonists (pubertal suppression), estrogen, and testosterone is within that clinical subspecialty. Tr. 208:18–209:4 (Corathers); Ex. 5 at ¶ 35 (Corathers).

192. Endocrinologists rely on the Endocrine Society Clinical Practice Guideline for the Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons (Ex. 14) when providing pubertal suppression or hormone therapy to adolescents with gender dysphoria. Tr. 210:14–211:8 (Corathers); Ex. 5 at ¶¶ 36, 37 (Corathers). The Endocrine Society is a professional organization of more than 18,000 endocrinologists. Ex. 5 at ¶ 37 (Corathers). The Guideline is generally accepted in the medical community and is endorsed by the Pediatric Endocrine Society and the American Academy of Pediatrics. Tr. 210:14–18, 211:10–13 (Corathers); Ex. 5 at ¶ 37 (Corathers). The Guideline is comparable to the other clinical-practice guidelines issued by the Endocrine Society and used by endocrinologists. Tr. 211:14–212:3 (Corathers).

193. Medical treatment for adolescents with gender dysphoria primarily

includes GnRH agonists, otherwise known as puberty blocker medications, and gender-affirming hormone treatment, generally estrogen or testosterone. Tr. 212:8–14 (Corathers); Ex. 5 at ¶¶ 39, 44 (Corathers).

194. No medical treatments are provided to patients with gender dysphoria before puberty. Tr. 212:15–24 (Corathers); Ex. 5 at ¶ 54 (Corathers).

195. Under the Endocrine Society Clinical Practice Guideline (Ex. 14), transgender adolescents with gender dysphoria may be eligible for pubertal suppression if:

1. A qualified mental-health provider has confirmed that:
    - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
    - gender dysphoria worsened with onset of puberty,
    - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
    - the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment, and
2. The adolescent:
    - has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone

treatment) and options to preserve fertility,

- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent through the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment:

- agrees with the indication for GnRH agonist treatment,
- has confirmed that puberty has started in the adolescent, and
- has confirmed that there are no medical contraindications to GnRH agonist treatment.

Ex. 14 at 421 (Endocrine Society Guideline); Ex. 5 at ¶ 42 (Corathers).

196. Under the Endocrine Society Clinical Practice Guideline (Ex. 14), transgender adolescents may be eligible for gender-affirming hormone therapy if:

1. A qualified mental-health professional has confirmed:

- the persistence of gender dysphoria,
- any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
- the adolescent has sufficient mental capacity to estimate the consequences of this (partly) irreversible treatment, weigh

the benefits and risks, and give informed consent to this (partly) irreversible treatment,

2. And the adolescent:

    - Has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility) and options to preserve fertility,

    - Has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation), and the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent through the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:

    - agrees with the indication for sex hormone treatment,

    - has confirmed that there are no medical contraindications to sex hormone treatment.

Ex. 14 at 421 (Endocrine Society Guideline); Ex. 5 at ¶ 47 (Corathers).

197. The GPS Clinic relies on these Endocrine Society Guideline criteria to determine eligibility for medical treatment. Ex. 8 at ¶ 25 (Turpin); Tr. 276:4–20 (Turpin).

198. The GPS Clinic provides GnRH agonists and hormone therapy consistent with the Endocrine Society Guideline. Tr. 502:24–503:3, 506:10–13 (Turpin); Ex. 8 at ¶ 38–39 (Turpin).

199. Dr. Corathers's description in court of the use of pubertal suppression and hormone therapy for treating gender dysphoria in adolescents is consistent with the provision of that care at the GPS Clinic. Tr. 275:9–15 (Turpin).

200. Before providing either GnRH agonists or hormone therapy, clinicians obtain written and verbal informed consent from parents and assent from adolescent patients, as well as confirming the diagnosis of gender dysphoria from a qualified mental-health professional. Ex. 5 at ¶ 59 (Corathers); Tr. 267:12–268:19, 271:1–15, 275:18–24 (Turpin). That informed consent process includes discussing what is unknown about the treatments. Tr. 509:6–16 (Turpin).

201. For transgender youth, the development of secondary sexual characteristics associated with their endogenous puberty can be very distressing and contribute to or severely exacerbate gender dysphoria. Ex. 5 at ¶ 38 (Corathers).

202. Puberty is the process of physical changes between childhood and adulthood associated with secondary sexual characteristics, including breast development or increasing testicular volume. Tr. 209:5–24 (Corathers); Ex. 5 at ¶ 28 (Corathers). There are five stages of puberty, known as "Tanner stages," and no medical interventions are indicated until the second stage of puberty, also called "Tanner 2." Tr. 212:15–213:15 (Corathers); Ex. 5 at ¶ 29 (Corathers). Puberty typically starts between the ages of 8–14. Ex. 5 at ¶ 29 (Corathers). Common variations in puberty include both "early bloomers" and "late bloomers." Ex. 5 at ¶ 30 (Corathers). There are also medical conditions associated with hypogonadism

that may prevent someone from spontaneously beginning puberty. Tr. 209:25–210:9 (Corathers).

203. Treatment with GnRH agonists temporarily suppresses or pauses endogenous puberty. Ex. 5 at ¶ 39 (Corathers).

204. The primary goal of GnRH agonists to treat gender dysphoria in adolescents is to alleviate the significant distress associated with physical changes of puberty that are incongruent with the youth's gender identity. Tr. 214:18–215:1 (Corathers). A temporary pause in puberty also allows youth with gender dysphoria to continue socially presenting in their affirmed gender, provides more time for gender-identity exploration (*see, e.g.*, Tr. 257:23–259:4 (Corathers)), and preserves an opportunity to proceed in the future with a puberty that is congruent with the adolescent's gender identity. Ex. 5 at ¶ 39 (Corathers).

205. Long-term benefits of GnRH agonists include preventing permanent physical changes that do not align with a transgender person's gender identity, such as a deepened voice in transgender women or breast development in transgender men. Tr. 215:2–22 (Corathers); Ex. 5 at ¶ 41 (Corathers). By preventing the development of unwanted secondary sexual characteristics, puberty blockers reduce lifelong gender dysphoria and allow transgender individuals the option of passing as cisgender, making it easier to concentrate on aspects of life other than medical or safety concerns. Ex. 8 at ¶ 48 (Turpin); Tr. 285:5–286:20 (Turpin).

206. Puberty starts when a gland in the brain, called the hypothalamus, sends signals to the pituitary gland, and then the pituitary gland then sends signals

through the bloodstream to the gonads (ovaries or testes) in a pulsatile fashion. Tr. 213:16–214:9 (Corathers); Ex. 5 at ¶ 30 (Corathers). GnRH agonists work by interrupting that pulsatile pattern, and when that signal from the brain is no longer pulsing, the gonads no longer make estrogen or testosterone. Tr. 213:16–214:9 (Corathers); Ex. 5 at ¶ 32 (Corathers).

207. GnRH agonists are reversible: once the medication is discontinued, the pulsatile signal from the brain resumes, and puberty resumes. Tr. 214:10–17; (Corathers) Ex. 5 at ¶¶ 30, 68 (Corathers).

208. Medical treatment with a GnRH agonist or puberty blocker is considered when medically indicated for an adolescent with gender dysphoria at Tanner 2 or Tanner 3 stages of puberty. Ex. 5 at ¶¶ 53–54 (Corathers).

209. Before medical treatment using GnRH agonists or puberty blockers, clinicians discuss the Endocrine Society Guideline indications for treatment, as well as the risks, benefits, limitations, and potential side effects, including considerations for fertility and bone health. Ex. 5 at ¶ 55 (Corathers); Ex. 8 at ¶ 35, 38 (Turpin). Clinicians will also conduct baseline labs and conduct follow-up visits to determine whether the patient wants to continue, adjust, or discontinue treatment. Ex. 5 at ¶¶ 57, 59–62 (Corathers); Ex. 8 at ¶ 42 (Turpin).

210. GnRH agonists are used for other conditions beyond gender dysphoria, including the treatment of central precocious puberty, to protect fertility during cancer treatments, for endometriosis, and for prostate cancer. Tr. 216:21–217:8 (Corathers); Ex. 5 at ¶ 31 (Corathers).

211. The potential side effects of pubertal suppression are the same regardless of whether they are used to treat gender dysphoria or other conditions like precocious puberty. Ex. 5 at ¶ 56 (Corathers).

212. Puberty blockers do not have common, severe side effects: the most common side effects of puberty blockers—injection site reaction, emotional lability, headache, general pain, rash, vaginal bleeding, and weight gain—are infrequent and manageable when they occur. Ex. 9 at ¶ 58 (Corathers). Uncommon side effects, such as increased brain pressure, are exceedingly rare, with almost all reported cases in literature arising from their use in treating central precocious puberty. Ex. 9 at ¶¶ 59–60 (Corathers); Tr. 220:20–221:18 (Corathers); Ex. 12 at ¶ 37 (Turpin).

213. Pubertal suppression does not harm bone density, though it does delay the more rapid accrual of bone density that occurs during puberty as a result of increased levels of estrogen or testosterone. Ex. 9 at ¶ 61 (Corathers); Tr. 217:7–218:25, 245:19–246:7 (Corathers). But the primary concern with bone density is increased risk of fracture, and there are no outcome studies documenting increased risk of fracture as a result of GnRH agonists. Tr. 219:1–219:6, 246:9–13 (Corathers). The delay in bone density accrual among patients treated with GnRH agonists is similar to children who naturally experience puberty later than usual, and once puberty begins, they tend to catch up with bone mineral density. Tr. 245:1–245:19 (Corathers). The potential risks of delayed bone density accrual must be weighed against the benefit of pubertal suppression, which is significant in the context of gender dysphoria. Ex. 9 at ¶ 63. Bone-health considerations are not unique to

GnRH agonists when used for gender dysphoria, and the informed consent process covers other ways to mitigate potential risks to bone health, including Vitamin D and exercise. Ex. 9 at ¶¶ 65–66 (Corathers); Ex. 12 at ¶ 38 (Turpin).

214. Pubertal suppression affects fertility while the medication is being used because it prevents the progression toward fertility associated with puberty. Tr. 219:9–19 (Corathers). Pubertal suppression as a single medication without sex hormones (estrogen and testosterone) is not provided past the age of 15–16 years because the latest age of normal pubertal onset is 15–16 years. Ex. 8 at ¶ 40 (Turpin).

215. Pubertal suppression alone does not have a long-term impact on fertility. Tr. 219:7–10 (Corathers). When GnRH agonists are stopped, if there is no other intervention, then endogenous puberty resumes, and a person's fertility potential will be as it otherwise would have been. Tr. 219:20–220:2 (Corathers). Several studies demonstrate that individuals treated with GnRH agonists for central precocious puberty experience normal fertility once the medication is withdrawn. Ex. 9 at ¶ 67 (Corathers).

216. For the subset of individuals who initiate GnRH agonists at an early stage of puberty (Tanner 2) and proceed directly to gender-affirming hormone therapy, fertility is impaired and infertility may result. Ex. 9 at ¶ 70 (Corathers). Patients and their parents are counseled on this risk and options to preserve fertility, including allowing endogenous puberty to progress sufficiently for the retrieval of eggs or sperm. Ex. 9 at ¶ 70 (Corathers); Tr. 256:2–257:12 (Corathers).

217. There is no support in the literature or clinical experience showing any negative cognitive or emotional effects from GnRH agonists in humans. Ex. 9 at ¶¶ 73–75 (Corathers); Tr. 326:17–327:18 (Turpin). Studies demonstrate that transgender adolescents who receive pubertal suppression had fewer emotional and behavioral problems than their non-transgender peers. Ex. 9 at ¶ 75 (Corathers).

218. For transgender youth with gender dysphoria in later adolescence, hormone therapy may be clinically indicated. Ex. 5 at ¶¶ 43–44 (Corathers); Tr. 212:8–14, 221:19–222:9 (Corathers). The goal of hormone therapy to treat gender dysphoria is to develop the physical characteristics associated with the person's gender identity and alleviate distress. Tr. 222:10–21 (Corathers). Hormone therapy improves symptoms of gender dysphoria, depression, and anxiety. Ex. 5 at ¶ 46 (Corathers).

219. Transgender girls may be prescribed estrogen, which has feminizing effects, including breast growth, redistribution of body fat, and decrease in terminal hair growth. Ex. 5 at ¶ 45 (Corathers). Transgender boys may be prescribed testosterone, which has masculinizing effects, including deepening of the voice, increased muscle mass, and increased growth of facial and body hair. Ex. 5 at ¶ 45 (Corathers).

220. For transgender adolescents who are already on GnRH agonists, hormone therapy is provided to initiate puberty around age 14–16 years, similar to the timing of puberty in peers. Ex. 5 at ¶ 56 (Corathers); Tr. 221:19–222:9 (Corathers); Ex. 8 at ¶ 40 (Turpin); Tr. 502:1–18 (Turpin).

221. For adolescents or adults who do not begin treatment until after puberty has started or substantially progressed, gender-affirming hormone therapy may be the first indicated medical intervention. Ex. 5 at ¶ 44 (Corathers); Tr. 501:5–16 (Turpin).

222. Hormone therapy is provided via a slow titration process to mimic changes of the cadence of endogenous puberty. Ex. 5 at ¶ 57 (Corathers). Before providing hormone therapy, clinicians review the risks, benefits, and alternatives; the expected changes associated with hormones and the timeframe when they are most often experienced; which aspects of treatment are fully reversible, partly reversible, and not reversible; the impact on growth; the impact on future fertility and the need for reliable contraception, as well as the option for fertility preservation; family medical history to protect against cardiovascular risks; and that treatment can be slowed or discontinued at any time. Ex. 5 at ¶ 57 (Corathers).

223. The potential unwanted side effects from hormone therapy are comparable when used to treat patients with gender dysphoria and when used for other purposes. Ex. 5 at ¶ 58 (Corathers); Tr. 224:8–225:24 (Corathers). Most of the potential side effects from hormone therapy are related to genetic and behavioral risk factors, not the medications themselves, and many of the potential risks and side effects are the same or similar for non-transgender and transgender patients. Ex. 5 at ¶ 66 (Corathers); Ex. 9 at ¶ 83 (Corathers).

224. Patients are counseled on the potential cardiovascular risks associated with hormone therapy, which are manageable; for example, the cardiovascular risks

associated with testosterone in transgender men are akin to the ordinary cardiovascular risks associated with men who produce testosterone endogenously. Tr. 331:2–333:1 (Turpin).

225. Patients are also counseled on the need to continue to screen for cancer even after hormone therapy, and the potential increased risk of breast cancer if there is increased breast tissue resulting from estrogen treatment, in the same way that women who endogenously produce estrogen are also at increased risk of breast cancer. Tr. 328:24–331:1 (Turpin).

226. While there is a difference with respect to the potential impact on fertility, that is thoroughly discussed, fertility preservation is offered, and it is not unique to gender-affirming hormone therapy, as other pediatric treatments may also impair fertility. Ex. 5 at ¶ 58 (Corathers); Tr. 227:6–228:6 (Corathers). Moreover, adolescents are cautioned that hormone therapy is not contraception. Tr. 227:6–228:6 (Corathers).

227. Transgender persons can achieve fertility in adulthood even after hormone therapy. Ex. 9 at ¶ 69 (Corathers).

228. For hormone therapy, clinicians will also conduct baseline labs and conduct follow-up visits to determine whether the patient wants to continue or discontinue treatment. Ex. 5 at ¶¶ 57, 59–62 (Corathers); Ex. 8 at ¶ 42 (Turpin); Tr. 279:19–282:15 (Turpin).

229. There are several mechanisms for delivering testosterone or estrogen, some of which depend on patient preference. Ex. 5 at ¶¶ 63–64 (Corathers).

230. Hormone replacement therapy is a cornerstone of endocrinology, and undergoing hormone treatment to sustain health is not unique to the treatment of gender dysphoria. Ex. 5 at ¶ 71 (Corathers). Compared to other hormone treatments endocrinologists routinely prescribe, testosterone and estrogen have a wide safety profile. Ex. 5 at ¶ 71 (Corathers).

231. Many people with gender dysphoria have been on hormone therapy for decades, and there is no evidence of any negative health outcomes that would outweigh the substantial benefit of the treatment. Ex. 5 at ¶ 72 (Corathers).

232. Many non-transgender individuals also undergo hormone treatment for hypogonadism for most of their lives, and it is well-managed; this includes Turner syndrome, Klinefelter syndrome, premature ovarian failure, and the consequences of cancer treatments. Ex. 5 at ¶ 72 (Corathers).

233. Testosterone and estrogen are also used in pediatric endocrinology to treat non-transgender adolescents for social-emotional or gender-affirming purposes, including using testosterone to jumpstart puberty in boys with constitutional delay of growth, and use of estrogen and androgen receptors for girls with polycystic ovarian syndrome to minimize unwanted facial and body hair. Ex. 5 at ¶ 73 (Corathers); Ex. 9 at ¶ 79 (Corathers); Tr. 222:22–224:3, 250:13–253:23 (Corathers). Testosterone and estrogen are also used to allow an adolescent who is intersex or who has a difference of sex development to undergo the puberty that is congruent with their gender identity. Tr. 506:14–509:5 (Turpin).

234. Adolescent patients treated with GnRH agonists and hormone therapy

are able to achieve sexual function and participate in romantic relationships. Tr. 328:3–23 (Turpin).

235. Surgery is not part of the Endocrine Society Clinical Practice Guideline for gender dysphoria in adolescents. Tr. 240:18–241:13 (Corathers). Surgery is not part of the clinical practice in Kansas for adolescents. Tr. 283:14–17, 312:12–313:7 (Turpin).

236. The Court did not permit testimony regarding gender-affirming surgery for the treatment of gender dysphoria in transgender adolescents and makes no findings about its safety or efficacy.

K. Informed Consent for the Treatment of Gender Dysphoria

237. The Endocrine Society Guideline and WPATH Standards of Care have provisions for informed consent for gender-affirming medical care that are consistent with principles of informed consent and assent used throughout the field of pediatric medicine. Tr. 120:22–121:7 (Turban); Ex. 6 at ¶ 42 (Antommaria); Ex. 9 at ¶ 96 (Corathers). The informed-consent process for gender-affirming medical care for adolescents does not differ from the informed-consent process for pediatric medicine generally. Tr. 172:9–16 (Antommaria).

238. In general, before any medical treatment is provided to a patient, the health care provider must obtain informed consent. Ex. 6 at ¶ 42 (Antommaria). Informed consent means patients—and in the case of minors, their parents or guardians—are informed of the nature of the treatment and the potential risks, benefits, and alternatives to treatment (including the alternative of not undergoing

the treatment) so that they can weigh them and decide whether to pursue treatment. In the informed-consent process, the provider discloses information, elicits the patient's and their family's preferences, offers medical advice, and seeks explicit authorization. Ex. 6 at ¶¶ 42–43 (Antommaria). The informed-consent process also includes discussion of what is known and what is not known about a given course of treatment. Tr. 509:6–16 (Turpin); Ex. 9 at ¶¶ 62, 108 (Corathers).

239. As minors become older, they should participate more actively in medical decision making. In general, adolescents have the capacity to understand the risks, benefits, and alternatives (including declining treatment) to a medical intervention, as well as their own identity and individual values and preferences. The assent of adolescents—meaning their agreement with the proposed course of treatment—should be obtained before starting treatment. Tr. 172:15–16 (Antommaria), 511:7–13 (Turpin); Ex. 6 at ¶ 44 (Antommaria); Ex. 10 at ¶ 62 (Antommaria).

240. Even when adolescents are able to understand the risks, benefits, and alternatives to treatment and assent to treatment, their parents or guardians must generally still provide informed consent. Parents and guardians are afforded substantial, although not unlimited, discretion in making medical decisions for their minor children based on their understanding of their children's best interests, as they generally care about their children and understand their needs. Tr. 121:2–7 (Turban), 172:15–16 (Antommaria); Ex. 6 at ¶ 43 (Antommaria); Ex. 10 at ¶ 55 (Antommaria); Ex. 9 at ¶ 98 (Corathers).

241. Informed consent is an ongoing process. Patients and their families engage in ongoing conversations with healthcare providers both about whether to start treatment and whether to continue treatment should they choose to start it, so that they can continue to make informed choices regarding the benefits and risks associated with a particular treatment or not receiving that treatment. Tr. 319:2–5 (Turpin); Ex. 9 at ¶¶ 99–100, 102, 108 (Corathers); Ex. 12 at ¶ 28 (Turpin).

242. The Endocrine Society Guideline provides that, before gender-affirming medical care is provided to adolescent patients, the patient and their parents or guardians must be informed of the potential risks, benefits, and alternatives to treatment, and consent must be provided by the parents or guardians. The Endocrine Society Guideline extensively discusses the potential risks, benefits, and alternatives to treatment, and it advises delaying gender-affirming hormone therapy until an adolescent is developmentally capable of providing informed consent. Ex. 6 at ¶ 45 (Antommaria); Ex. 9 at ¶ 101 (Corathers); Ex. 12 at ¶ 26 (Turpin).

243. For hormone therapy, the Endocrine Society Guideline specifically provides that patients and their parents must be informed of the potential implications of treatment for fertility and counseled on options for fertility preservation. Ex. 6 at ¶ 45 (Antommaria); Tr. 227:11–18 (Corathers), 438:13–17 (Weiss).

244. In some cases, a mental-health diagnosis may impair an individual's medical decision-making capacity, in which case treatment would be delayed. Ex. 11

at ¶ 11 (Turban). However, having a mental-health diagnosis does not necessarily mean that an individual lacks decision-making capacity. An individualized assessment of a patient's capacity to make medical decisions is always required. Tr. 120:12–121:1 (Turban); Ex. 10 at ¶ 64 (Antommaria).

245. The potential risks of gender-affirming medical care are comparable to or lesser than the risks to which parents regularly consent on behalf of their minor children in many other treatment decisions. Tr. 171:15–24 (Antommaria); Ex. 10 at ¶ 55 (Antommaria); Ex. 9 at ¶ 66 (Corathers); For instance, not all gender-affirming medical care has an impact on fertility—but S.B. 63 explicitly authorizes treatment of differences of sex development, which may include parents choosing to have their child's gonads surgically removed, thus permanently causing sterility. Tr. 171:25–172:4 (Antommaria); Ex. 9 at ¶ 108 (Corathers); Ex. 10 at ¶ 55 (Antommaria). *See also* K.S.A. 65-28,139(c)

L. Benefits, Efficacy, and Safety of Puberty Blockers and Hormone Therapy

246. When appropriately treated, gender dysphoria can be effectively managed. Tr. 162:6–13 (Antommaria), Tr. 283:18–24 (Turpin); Ex. 5 at ¶ 37 (Corathers), Ex. 7 at ¶¶ 11, 16 (Turban).

247. Decades of clinical experience have shown that adolescents with gender dysphoria experience significant positive benefits to their health and well-being from gender-affirming medical care. Tr. 284:4–285:4 (Turpin), 207:3–7, 208:8–13, 228:7–229:20 (Corathers); Ex. 8 at ¶ 44–49 (Turpin); Ex. 5 at ¶¶ 48, 67, 69 (Corathers); Ex. 9 at ¶¶ 6, 112 (Corathers).

248. Clinical experience has shown that, for many adolescents, gender-affirming medical care provides significant relief from gender dysphoria and decreases depression, anxiety, suicidality, and thoughts of self-harm. Tr. 284:9–15 (Turpin); Ex. 8 at ¶ 46 (Turpin); Ex. 5 at ¶ 74 (Corathers).

249. Clinical experience has shown that adolescents with gender dysphoria who had once been withdrawn and unable to attend school or develop interpersonal relationships were able, after treatment, to return to school and flourish both academically and socially. Tr. 284:16–25 (Turpin); Ex. 8 at ¶¶ 46–47, 49 (Turpin); Ex. 5 at ¶¶ 48, 69; (Corathers); Ex. 9 at ¶ 110, 112 (Corathers).

250. Clinical experience shows the long-term effectiveness of gender-affirming medical care for adolescents with gender dysphoria. Tr. 229:11–20 (Turpin); Ex. 8 at ¶¶ 49–50 (Turpin).

251. Dr. Corathers has observed that the overwhelming majority of her approximately 200 adolescent patients who pursue gender-affirming medical care with support from their families are thriving at subsequent visits and that negative mental-health outcomes improve with the provision of gender-affirming medical care and a supportive social structure. Tr. 204:16–20, 239:13–19; Ex. 5 at ¶¶ 13, 69, 74. She has seen patients become more comfortable, more confident, and more willing to engage as they begin and continue gender-affirming medical care. Tr. 229:3–20; Ex. 5 at ¶ 48. For instance, Dr. Corathers has seen them become more active with peers, feel more like themselves, and exhibit improved academic performance, as the physical changes from gender-affirming medical care coincide

with noticeable positive impacts on mood and wellbeing. Ex. 5 at ¶ 48.

252. Dr. Turpin has observed in treating approximately 350 adolescent patients for gender dysphoria that gender-affirming medical care decreases gender dysphoria and increases mental health and quality of life. Tr. 263:11–14, 283:18–24; Ex. 8 at ¶¶ 15, 44. She has seen patients become more comfortable with their bodies, become integrated with their peers, cease self-harm, and drastically improve their self-esteem. Tr. 284:4–25; Ex. 8 at ¶¶ 45–47. Dr. Turpin has observed her patients later complete advanced degrees, pursue fulfilling artistic careers, and start families. Tr. 328:10–23; Ex. 8 at ¶ 49.

253. In addition to substantial clinical experience, there is also a body of scientific research demonstrating the effectiveness of gender-affirming medical care in treating adolescents with gender dysphoria. The currently available body of medical research, as a whole, shows that gender-affirming medical care is effective at improving mental-health outcomes for adolescents with gender dysphoria. Tr. 134:24–135:4 (Turban), 160:20–161:6, 161:13–16, 175:22–176:2 (Antommaria), 207:3–8, 216:14–17, 228:7–13 (Corathers), 265:12–13 (Turpin); Ex. 7 at ¶ 24 (Turban); Ex. 9 at ¶ 75 (Corathers).

254. There are over 20 scientific studies assessing the efficacy or effectiveness of puberty blockers and hormone therapy to treat adolescents with gender dysphoria, and this body of research has found that these treatments are effective at alleviating gender dysphoria and improving a variety of mental-health outcomes, including anxiety, depression, and suicidality. Tr. 124:21–125:12

(Turban); Ex. 7 at ¶¶ 18, 20, 22 (Turban); Ex. 6 at ¶ 47 (Antommaria). These studies have substantially long follow-up periods, especially as compared to other commonly used medications in pediatrics. Tr. 126:12–127:5 (Turban); Ex. 7 at ¶ 23 (Turban).

255. The studies evaluating the use of puberty blockers to treat gender dysphoria saw improvements in mental health or that patients did not experience worsening of mental health, as is typically the case when children with gender dysphoria go through their endogenous puberty. Tr. 125:13–25 (Turban); Ex. 7 at ¶ 21 (Turban); Ex. 11 at ¶ 29 (Turban); Ex. 6 at ¶¶ 37, 39 (Antommaria).

256. The studies evaluating the use of hormone therapy to treat adolescents with gender dysphoria had findings similar to the results of dozens of studies of gender-affirming hormones for adults, as both sets of studies found significant improvements in mental health. Tr. 126:1–7 (Turban); Ex. 7 at ¶ 22 (Turban).

257. While both clinical experience and research demonstrate that gender-affirming medical care can significantly improve the mental health of patients, that care does not necessarily fully resolve all psychological comorbidities, which may persist due to the harassment, stigma, and discrimination experienced by transgender people in society. Tr. 127:20–25 (Turban); Ex. 11 at ¶ 28 (Turban).

258. The evidence base supporting gender-affirming medical care for adolescents is comparable to the evidence base supporting other medical treatments for minors. Tr. 170:13–171:3, 176:3–7 (Antommaria); Ex. 6 at ¶¶ 36–39 (Antommaria); Ex. 10 at ¶ 18 (Antommaria). For example, GnRH agonists that are used to delay puberty for treatment for gender dysphoria are also used to treat

other conditions, such as central precocious puberty, which is when a minor starts puberty earlier than is normal. Tr. 170:21–171:03 (Antommaria), Tr. 216:21–217:4 (Corathers); Ex. 5 at ¶ 31 (Corathers); Ex. 6 at ¶ 38 (Antommaria); Ex. 10 at ¶ 18 (Antommaria). The use of GnRH agonists for this purpose was approved by the FDA based on prospective observational studies, not randomized controlled trials. Tr. 170:25–171:3 (Antommaria); Ex. 6 at ¶ 38 (Antommaria).

259. The quality of the evidence supporting gender-affirming medical care for adolescents is comparable to the quality of evidence supporting many other medical treatments, including many other pediatric medical treatments. Tr. 176:3–7, 165:20–166:19, 170:13–20 (Antommaria); Ex. 6 at ¶¶ 36–39 (Antommaria).

260. Adolescent patients and their parents frequently make decisions to undergo treatments supported by evidence bases that are comparable to the evidence base for gender-affirming medical care. Tr. 171:4–9 (Antommaria); Ex. 5 at ¶ 71 (Corathers).

261. The Endocrine Society and WPATH have each published a clinical-practice guideline for the treatment of gender dysphoria in adolescents. Tr. 162:18–25 (Antommaria), Tr. 112:14–21 (Turban); Ex. 6 at ¶ 34 (Antommaria). Under these guidelines, no medical treatments are provided to pre-pubertal children with gender dysphoria. Tr. 114:9–18 (Turban), 212:14–25, 211:10–13 (Corathers); Ex. 7 at ¶ 31 (Turban); Ex. 5 at ¶ 54 (Corathers). These guidelines are based on evidence that demonstrates the safety and efficacy of gender-affirming medical care for adolescents with gender dysphoria. Tr. 169:16–19, 170:4–9 (Antommaria); Ex. 6 at

¶¶ 37, 39 (Antommaria).

262. In clinical-practice guidelines, such as the Endocrine Society's, evidence may be graded, with randomized controlled trials (where participants are randomly assigned to either an intervention group or a control group) generally constituting the highest quality of evidence. Tr. 169:1–3 (Antommaria); Ex. 6 at ¶¶ 20, 22 (Antommaria); Ex. 10 at ¶ 8 (Antommaria); Ex. 7 at ¶ 22 (Turban). All other types of evidence, including observational studies such as cross-sectional studies (evaluating individuals who received treatment and those who did not at one point in time) and longitudinal studies (evaluating participants both before and after treatment over time), are generally categorized as low or very-low-quality evidence. Tr. 168:5–7 (Antommaria); Ex. 6 at ¶ 23 (Antommaria).

263. The Endocrine Society uses the GRADE system to evaluate the quality of evidence. This is a widely used system in medicine. Ex. 6 at ¶ 20 (Antommaria); Ex. 10 at ¶ 8 (Antommaria). Low-quality evidence under the GRADE system refers to the degree of certainty that evidence supports a recommendation. Tr. 200:2–10 (Antommaria); Ex. 6 at ¶ 21 (Antommaria). For instance, low-quality evidence can be sufficient to justify strong recommendations under the GRADE system. Tr. 166:7–11 (Antommaria); Ex. 6 at ¶¶ 21, 25, 28 (Antommaria); Ex. 10 at ¶ 14 (Antommaria). Additionally, under the GRADE system, the quality of a study or group of studies may be moved up or down based on other considerations beyond study design, such as the risk of bias, patient values and preferences, and resource use. Ex. 6 at ¶¶ 24, 28 (Antommaria); Ex. 10 at ¶ 8 (Antommaria). Under the

GRADE system, strong recommendations indicate a high confidence in the balance between desirable and undesirable consequences, and weak recommendations mean there is less confidence. Ex. 10 at ¶ 28 (Antommaria).

264. The majority of the recommendations in all of the Endocrine Society's clinical practice guidelines for pediatric conditions are based on low-quality or very-low-quality evidence or are ungraded good practice statements. Ex. 6 at ¶¶ 35–36 (Antommaria).

265. The labels "high" and "low" quality evidence do not correspond to colloquial understandings of "high" or "low" quality. Tr. 200:11–19 (Antommaria); Ex. 6 at ¶¶ 21, 25 (Antommaria); Ex. 10 at ¶ 8 (Antommaria). Evidence need not be considered high quality for a treatment to be considered non-experimental. Ex. 6 at ¶ 25 (Antommaria).

266. The evidence supporting gender-affirming medical care for adolescents with gender dysphoria includes prospective observational studies, including uncontrolled longitudinal studies and controlled cross-sectional studies, as well as clinical experience. Tr. 168:4–10, 160:20–161:1 (Antommaria), 125:2–12 (Turban); Ex. 7 at ¶ 18 (Turban). This is the best available evidence. Tr. 168:8–10 (Antommaria). These types of studies are well-accepted in medical research and often relied upon in medicine. Ex. 7 at ¶ 19 (Turban).

267. It is common for clinical-practice guidelines, especially in pediatric medicine, to rely and make recommendations based on low-quality or very-low-quality evidence, such as prospective observational studies. Tr. 165:20–166:19

(Antommaria); Ex. 6 at ¶¶ 27, 29–31 (Antommaria); Ex. 10 at ¶¶ 11, 15–16 (Antommaria). Clinical research focusing on children is generally less likely to use randomized controlled trials than clinical research focusing on adults. Ex. 6 at ¶ 27 (Antommaria). In medicine, clinicians frequently rely on low-quality evidence in making treatment decisions because it is the best available type of evidence. Tr. 166:12–19, 175:22–176:2 (Antommaria).

268. There are no randomized controlled trials evaluating the efficacy of gender-affirming medical care for adolescents. Such research would not be ethical because it is not ethical to conduct a study in which a control group is not provided treatment that is known from clinical experience and research to benefit patients. Tr. 168:11–23 (Antommaria); Ex. 6 at ¶¶ 26, 40 (Antommaria); Ex. 10 at ¶ 20 (Antommaria); Ex. 7 at ¶ 19 (Turban); Ex. 11 at ¶ 35 (Turban). Additionally, it would not be possible to blind the studies to researchers and participants given the obvious physical effects of the treatments. Tr. 169:6–15 (Antommaria); Ex. 6 at ¶¶ 26, 41 (Antommaria); Ex. 7 at ¶ 19 (Turban). It would also likely be difficult to recruit participants to any such study given the risk of being randomized to receive no treatment. Ex. 6 at ¶ 26, 40 (Antommaria); Ex. 7 at ¶ 19 (Turban).

269. Limiting clinical practice guidelines to only those supported by randomized controlled trials would significantly limit the amount of clinical practice guidelines that could be developed and would make it more difficult for clinicians to practice. Tr. 166:20–167:2, 164:6–16 (Antommaria).

270. When patients are suffering, it is necessary to make treatment

decisions based on the best available evidence. Patients who are suffering cannot wait until more evidence is accumulated. Ex. 6 at ¶ 31 (Antommaria).

271. The treatments banned by S.B. 63 are widely recognized in the medical community, including by the major professional medical associations, as effective treatments for adolescents suffering from gender dysphoria, based on clinical experience and scientific research. Tr. 115:3–14 (Turban); Ex. 6 at ¶ 34 (Antommaria); Ex. 7 at ¶ 17 (Turban); Ex. 9 at ¶ 5 (Corathers).

272. There are no other evidence-based treatments besides those prohibited by S.B. 63 that are known to alleviate gender dysphoria in adolescents. Tr. 128:1–2 (Turban), 201:9–15 (Antommaria); Ex. 7 at ¶ 25 (Turban); Ex. 11 at ¶ 36 (Turban). While adolescents with gender dysphoria may benefit from psychotherapy to support their social transition and other mental health conditions, clinical experience has shown that psychotherapy alone does not improve gender dysphoria. Tr. 127:16–25 (Turban); Ex. 7 at ¶¶ 25–26 (Turban); Ex. 11 at ¶¶ 36, 40 (Turban); Ex. 10 at ¶ 54 (Antommaria).

M. Potential Risks and Side Effects of Puberty Blockers and Hormone Therapy

273. All medications have risks and benefits. Tr. 162:1–3 (Antommaria); Ex. 6 at ¶ 48 (Antommaria); Ex. 7 at ¶ 42 (Turban).

274. As with other medical treatments, gender-affirming medical care entails potential risks and side effects that must be weighed by patients and their parents against the potential benefits of this treatment, after being informed of those risks and side effects by their doctors. Tr. 135:5–9 (Turban), 161:23–162:5

(Antommaria), 207:13–17 (Corathers); Ex. 6 at ¶¶ 48, 57, 59 (Antommaria).

275. The risks of gender-affirming medical care are not categorically different from the risks or types of risks that other types of pediatric healthcare pose. Tr. 135:6–9 (Turban), 171:15–21, 172:9–16 (Antommaria); Ex. 6 at ¶¶ 48, 51, 57–58 (Antommaria); Ex. 5 at ¶ 58 (Corathers).

N. Puberty Blockers

276. Decades of clinical experience and research on puberty blockers, both for the treatment of central precocious puberty and gender dysphoria, have shown this treatment to be safe. Ex. 5 at ¶ 31 (Corathers); Ex. 6 at ¶¶ 38, 48 (Antommaria); Ex. 9 at ¶ 67 (Corathers).

277. GnRH agonists that are used to delay puberty as treatment for gender dysphoria are also used to treat other conditions, such as central precocious puberty, fertility preservation during cancer treatment, endometriosis, and prostate cancer. Tr. 170:21–25 (Antommaria), 216:21–217:4 (Corathers); Ex. 5 at ¶ 31 (Corathers); Ex. 6 at ¶ 38 (Antommaria); Ex. 10 at ¶ 18 (Antommaria).

278. The expected side effects of puberty blockers are the same side effects as when GnRH agonists are used to treat these other conditions, such as central precocious puberty. Ex. 5 at ¶ 56 (Corathers).

279. Patients on puberty blockers as treatment for central precocious puberty are, on average, treated for a longer period of time than patients on puberty blockers as treatment for gender dysphoria. Patients receiving puberty blockers as treatment for central precocious puberty may begin treatment as early as three

years old. Tr. 220:12–19 (Corathers); Ex. 5 at ¶ 56 (Corathers).

280. GnRH agonists do not have common side effects that are severe; instead, the most common side effects are infrequent and manageable when they occur. Ex. 9 at ¶ 58 (Corathers). Uncommon side effects such as increased cranial pressure are exceedingly rare, with almost all reported cases arising from their use in treating central precocious puberty. Tr. 220:20–221:18 (Corathers); Ex. 9 at ¶¶ 59–60 (Corathers); Ex. 12 at ¶ 37 (Turpin); Ex. 10 at ¶ 50 (Antommaria).

281. Although puberty blockers do not harm bone density, one expected effect of puberty blockers is slower rates of bone acquisition compared to peers who are undergoing puberty. Tr. 217:18–218:5 (Corathers); Ex. 9 at ¶ 61 (Corathers). To address this risk, doctors conduct bone-density studies before prescribing medication, Vitamin D levels are screened and regularly reviewed, calcium levels are regularly reviewed, and puberty blockers are not prescribed in isolation past the age of 15 or 16 years. Tr. 246:2–8 (Corathers), 327:10–17 (Turpin); Ex. 5 at ¶¶ 55, 60, 62 (Corathers); Ex. 9 at ¶ 62 (Corathers); Ex. 8 at ¶ 42 (Turpin); Ex. 12 at ¶ 38 (Turpin). Other variables, such as weight, height, and diet, also impact bone density. Tr. 218:7–16 (Corathers). The primary concern with bone density is risk of fracture, and there are no outcome studies documenting increased risk of fracture as a result of puberty blockers. Tr. 21:1–219:6 (Corathers).

282. The rates of bone mineral density accrual increase after initiation of puberty, either through endogenous puberty or gender-affirming hormone therapy. Tr. 245:13–18 (Corathers); Ex. 9 at ¶ 61 (Corathers). Any delay in bone density

accrual in patients treated with GnRH agonists is similar to children who naturally experience puberty later than usual, both of whom tend to catch up once puberty begins. Tr. 245:1–19 (Corathers).

283. Puberty blockers are fully reversible. Tr. 214:10–17 (Corathers); Ex. 5 at ¶¶ 30, 68 (Corathers). If an adolescent discontinues such treatment, endogenous puberty will resume. Ex. 5 at ¶ 68 (Corathers).

284. Puberty blockers have no long-term impact on fertility. Tr. 219:7–10 (Corathers). When they are stopped, if there is no other intervention, endogenous puberty resumes, and a person's fertility potential will be as it otherwise would have been. Tr. 219:20–220:2 (Corathers); Ex. 9 at ¶ 71 (Corathers). Several studies demonstrate that patients who receive GnRH agonists as treatment for central precocious puberty experience normal fertility once the treatment is stopped. Ex. 9 at ¶ 67 (Corathers).

285. Puberty blockers impact fertility in the short term since they pause pubertal progression, meaning that patients will not be reproductively fertile while receiving this medication. Adults who used this medication would also have their reproductive capacity interrupted. Tr. 219:9–19 (Corathers).

286. For the subset of patients who initiate puberty blockers at Tanner 2, an early stage of puberty, and proceed directly to hormone therapy, fertility is impaired, and infertility may result. Patients and their families are counseled on these potential risks and their options for preserving fertility. Tr. 227:6–21 (Corathers); Ex. 9 at ¶ 70 (Corathers). If maintaining fertility is important to

patients and their families, there are ways to manage treatment to preserve fertility, such as by allowing endogenous puberty to progress sufficiently for the retrieval of sperm or eggs. Ex. 9 at ¶¶ 70, 101 (Corathers).

O. Hormone Therapy

287. Most potential side effects from hormone therapy are tied to genetic and behavioral risk factors rather than the medications themselves. Accordingly, much of the counseling regarding hormone therapy involves ensuring appropriate oversight and monitoring. Ex. 5 at ¶ 65 (Corathers).

288. Testosterone is used to treat cisgender adolescent male patients for a number of conditions, including hypogonadism, constitutional delay of growth and puberty, and gynecomastia (unwanted breast tissue). Tr. 222:21–223:20 (Corathers); Ex. 9 at ¶ 54 (Corathers).

289. Estrogen is used to treat cisgender adolescent female patients for a number of conditions, including polycystic ovarian syndrome. Tr. 223:20–224:3 (Corathers); Ex. 9 at ¶ 54 (Corathers).

290. Risks associated with taking testosterone, regardless of the condition it is treating or the patient's sex assigned at birth, include increased risks of blood clots, elevated hemoglobin levels, and cardiovascular disease. Tr. 224:17–225:2 (Corathers), 332:3–5 (Turpin); Ex. 5 at ¶ 66 (Corathers). To address these risks, patients' blood pressure and hormone levels are regularly monitored. Tr. 225:8–24 (Corathers), 332:3–10 (Turpin); Ex. 12 at ¶ 35 (Turpin). The cardiovascular risks associated with testosterone for transgender men are akin to the ordinary

cardiovascular risks associated with men who produce testosterone endogenously. Tr. 331:2–333:2 (Turpin).

291. Risks associated with taking estrogen, regardless of the condition it is treating or the patient's sex assigned at birth, include increased risks of blood clots and breast cancer. Tr. 225:3–7 (Corathers); Ex. 5 at ¶ 66 (Corathers). To address this risk, patients' blood pressure and hormone levels are regularly monitored, and patients are counseled on the importance of regular mammograms. Tr. 225:8–24 (Corathers), 330:12–331:1 (Turpin); Ex. 9 at ¶ 85 (Corathers). The increased risk of breast cancer associated with estrogen for transgender women is akin to the increased risk of breast cancer associated with women who endogenously produce estrogen. Tr. 328:24–331:1 (Turpin).

292. When patients assigned female at birth are treated with testosterone or patients assigned male at birth are treated with estrogen, it can impact fertility. Patients and their families are advised of this risk and fertility preservation options are discussed. Tr. 227:11–18 (Corathers); Ex. 5 at ¶ 57 (Corathers); Ex. 9 at ¶¶ 69–70 (Corathers); Ex. 8 at ¶ 38 (Turpin).

293. Treatment with testosterone or estrogen does not necessarily cause infertility. Some transgender men conceive children while taking testosterone, and many transgender men are able to conceive after temporarily stopping hormone therapy (one option for fertility preservation). Ex. 9 at ¶ 69 (Corathers); Ex. 10 at ¶ 49 (Antommaria). Many transgender women are able to achieve spermatogenesis after cessation of estrogen therapy (an option for fertility preservation). Ex. 9 at ¶

69 (Corathers). Patients are therefore also advised on contraception. Tr. 227:19–228:6 (Corathers); Ex. 5 at ¶ 57 (Corathers); Ex. 9 at ¶ 69 (Corathers).

294. The potential risks and side effects of hormone therapy to treat gender dysphoria are comparable to the risks and side effects of other treatments regularly provided to adolescent patients. For instance, other pediatric treatments may impair fertility. Adolescents who have lupus nephritis (a type of kidney disease) may be treated with a medication that can result in infertility, and treatment for pediatric cancers may also impair fertility. Patients and their families are counseled accordingly. Tr. 171:18–24 (Antommaria); Ex. 5 at ¶ 58 (Corathers); Ex. 9 at ¶ 71 (Corathers).

295. Additionally, children with certain differences of sex development—which S.B. 63 specifically permits—may undergo gonadectomy (removal of testes or ovaries), which results in sterility. Tr. 171:25–172:4 (Antommaria); Ex. 6 at ¶ 58 (Antommaria).

296. Detransition and transition regret are distinct concepts, and transition regret is uncommon. Ex. 7 at ¶ 33 (Turban). The term "detransition" is used inconsistently in literature and may sometimes refer to simply the stopping of medical interventions. Ex. 7 at ¶ 34 (Turban).

297. Individuals who choose to stop receiving gender-affirming medical treatment choose to do so for a variety of reasons, many of which do not mean they regret treatment or now identify with their sex assigned at birth. Ex. 7 at ¶ 34 (Turban). These reasons may include that they have experienced enough physical

changes that their gender dysphoria is alleviated, or that they have experienced stigma, harassment, bullying, or inability to find a job as a result of their medical transition, or that they have lost insurance coverage. Tr. 131:21–132:4 (Turban); Ex. 7 at ¶ 34 (Turban).

298. Studies that focus specifically on regret indicate that regret is extremely rare—one study of 220 youth who had access to pubertal suppression and/or gender-affirming hormones during adolescence showed that only 9 (4%) expressed any kind of regret, and only 4–5 (1.8%–2.3%) stopped treatment. Tr. 132:5–10 (Turban); Ex. 7 at ¶ 35 (Turban). The fact that many individuals who express "any kind of regret" nonetheless continue treatment suggests that the benefits of treatment they have experienced outweighed negative aspects of treatment. Tr. 132:10–14 (Turban); Ex. 7 at ¶ 35 n.43 (Turban). By contrast, 38% of caregivers of infants with congenital adrenal hyperplasia (a DSD) reported some level of regret about their child's genital surgery. Ex. 6 at ¶ 62 (Antommaria).

299. At Children's Mercy's GPS Clinic, if a patient chooses to stop receiving hormone therapy, then medical providers continue to follow those patients for at least one year to ensure that they are well-supported both psychosocially and medically. Tr. 503:7–24 (Turpin).

300. GPS also collects data on their patients even as they grow into adults, which shows that over 99% of their patients continue living as the gender that they identified with when they were receiving treatment at the clinic. Tr. 286:21–287:6 (Turpin); Ex. 8 at ¶ 50 (Turpin). Of the less than 1% that have not continued to

identify as transgender, only a minority re-identified with their sex assigned at birth; a greater majority of those individuals now identify as nonbinary, such that they do not identify as either their sex assigned at birth or as a transgender man/transgender woman. Tr. 287:9–21 (Turpin); Ex. 8 at ¶ 50 (Turpin). Of the less than 1% who no longer identified as transgender, most did not regret the medical treatment they received. Tr. 287:22-24 (Turpin); Ex. 8 at ¶ 50 (Turpin).

P. Assertions on Various Government Authorities' Approach to Gender-affirming Medical Care for Adolescents

301. Defendant's experts suggested that systematic reviews from European countries show that the science does not support the provision of gender-affirming medical care for adolescents, citing specifically to systematic reviews issued by government health authorities in the United Kingdom, Sweden, Finland, Germany, and Norway. Tr. 33:4–5 (Defendant opening statement); Defendant's Temporary Injunction Resp. Br. 10–11; Ex. 102 at ¶¶ 190–204, 349, 363–379 (Cantor); Ex. 104 at ¶¶ 19–20, 24–26 (Curlin); Ex. 107 at ¶¶ 103, 111–122, 228 (Levine).

302. The Court finds that the evidence shows none of these systematic reviews recommend categorically banning gender-affirming medical care for adolescents. The Court further finds that the United Kingdom, Sweden, Finland, Germany, and Norway have not categorically prohibited gender-affirming medical care for minors.

303. Systematic reviews provide an overview of the scientific literature in a field, but do not make recommendations regarding the provision of care. Tr. 133:5–6 (Turban), 165:3–6 (Antommaria); Ex. 10 at ¶ 12 (Antommaria).

304. The methodology used by the authors of the Cass Report from the United Kingdom raises questions about the report's reliability. The authors changed their methodology from the methodology they said they would use in their preregistration, which is a deviation from standard academic publishing practices designed to minimize bias. Tr. 141:7–23 (Turban); Ex. 11 at ¶¶ 15–16 (Turban). The authors of the Cass Report also used idiosyncratic standards in scoring and thus excluded studies that had made important contributions to the field. Tr. 145:5–13 (Turban); Ex. 11 at ¶ 17 (Turban).

305. The methodology used by the authors of the Swedish systematic review also raises questions about the review's reliability. The authors did not publish their preregistration on a neutral database, which is a deviation from standard academic publishing practices, and excluded studies that their methodology should have included without justification. Tr. 147:25–148:10, 148:21–25, 155:1–9 (Turban); Ex. 11 at ¶¶ 18–20 (Turban).

306. The Norwegian systematic review referenced by Defendant's experts is not available in English, which makes it difficult to assess its reliability. Ex. 11 at ¶ 23 (Turban).

307. None of the European countries referenced by Defendant's experts categorically prohibit puberty blockers and hormone therapy as treatment for minors with gender dysphoria. Tr. 173:6–9 (Antommaria); Ex. 6 at ¶ 65 (Antommaria); Ex. 10 at ¶¶ 34–35, 41 (Antommaria). Moreover, a systematic review of European Union countries conducted as part of the Cass Report showed that the

example countries picked by Defendant's experts are not representative of the European Union members countries' general position toward gender-affirming medical care for adolescents. Ex. 10 at ¶ 38 (Antommaria).

308. European countries uniformly call for at least an exception for further research on gender-affirming medical care for adolescents, which S.B. 63 lacks. Ex. 10 at ¶ 37 (Antommaria).

309. The Cass Report does not recommend banning gender-affirming medical care for adolescents and instead reaches conclusions that are similar to those in the Endocrine Society Guideline and WPATH Standards of Care. It concludes that there are young people who absolutely benefit from gender-affirming care, for whom it is essential to ensure continued access to this care. Tr. 133:6–9, 139:15–17 (Turban); Ex. 7 at ¶ 40 (Turban); Ex. 11 at ¶ 9 (Turban).

310. The United Kingdom does not categorically ban gender-affirming medical care for adolescents. Instead, it makes puberty blockers available through clinical studies and allows hormone therapy for patients aged 16 and older. Tr. 174:5–21 (Antommaria); Ex. 6 at ¶ 67 (Antommaria); Ex. 10 at ¶ 36 (Antommaria).

311. Sweden does not categorically ban gender-affirming medical care for adolescents. Instead, it allows this care when permitted by the Dutch protocol, on which the Endocrine Society Guideline and WPATH Standards of Care are based, and in the context of research. Tr. 173:3–5 (Antommaria); Ex. 6 at ¶ 66 (Antommaria).

312. Finland does not categorically ban puberty blockers and hormone

therapy for adolescents. Tr. 172:25–173:2 (Antommaria).

313. Germany's recent guideline endorses the provision of gender-affirming medical care. Tr. 173:10–19 (Antommaria); Ex. 6 at ¶ 68 (Antommaria).

314. Defendant's experts also suggest that the United States Department of Health and Human Services (HHS) has followed in Europe's footsteps by issuing a systematic review counseling against the provision of gender-affirming medical care to minors. TI Resp. Br. 11; Tr. 33:4–7; Ex. 107 at ¶ 130 (Levine). But the Court finds that HHS's report does not recommend categorically banning gender-affirming medical care for adolescents.

315. The HHS report does not recommend categorically banning medical care for adolescents and in fact makes no policy or legislative recommendations at all. Tr. 133:9–10 (Turban); Ex. 11 at ¶ 13 (Turban); Ex. 6 at ¶ 69 (Antommaria); Ex. 10 at ¶ 43 (Antommaria).

316. The methodology used by the HHS report raises questions about its reliability. For instance, the report failed to initially disclose its contributors, whether they had potential conflicts of interest, and how any potential conflicts were managed. Ex. 6 at ¶ 70 (Antommaria); Ex. 10 at ¶ 44 (Antommaria). HHS only disclosed its contributors on November 19, 2025, after publishing the report in May 2025. Tr. 490:14-18 (Defendant's expert Curlin). The report criticized certain scholars who participated in the development of the WPATH Standards of Care because they are paid expert witnesses but nonetheless cited studies by other scholars who are also paid expert witnesses. Ex. 6 at ¶ 70 (Antommaria). The report

also claims that gender dysphoria is unique because its diagnosis is based on self-reports and behavioral observations, when that is true of all psychiatric conditions, and makes claims based on the lack of data on completed suicide, which is not a commonly relied-upon variable in psychiatry given the technical difficulties of studying that outcome. Ex. 11 at ¶ 12 (Turban).

Q. Harm from Withdrawing or Denying Puberty Blockers or Hormone Therapy When Medically Indicated

317. It is harmful to transgender adolescents with gender dysphoria to remove the option of receiving gender-affirming medical care because that is the treatment with the most evidence of being helpful to treat gender dysphoria. Tr. 135:12–18 (Turban).

318. It is harmful to withhold medical treatment or withdraw medical treatment in progress that is safe, effective, and medically indicated. Tr. 207:18–208:7, 230:24–231:13 (Corathers).

319. In addition to the harms of withholding this medical treatment, transgender youth feel threatened, unwelcome, and targeted by laws that prohibit their medical care, and families without the financial means to travel are under tremendous stress. Ex. 5 at ¶ 85 (Corathers).

320. The risks of not providing puberty blockers or hormone therapy when medically indicated for an adolescent with gender dysphoria include exacerbated distress from gender dysphoria and significant mental-health consequences, including worsening depression and anxiety and social isolation. Tr. 229:21–230:21 (Corathers).

321. Specifically with respect to puberty blockers, the "[a]bsence of treatment [where medically appropriate] is not benign. Absence [of] treatment means that endogenous puberty progresses, and the distress [of gender dysphoria] continues. And that has significant deleterious effects." Tr. 230:7–11 (Corathers). "Development of physical secondary sexual characteristics inconsistent with gender identity is known to cause significant psychological distress among youth who meet the diagnostic criteria for gender dysphoria. In summary, premature discontinuation of puberty blockers among eligible youth who meet the criteria for gender dysphoria will be predictably harmful." Ex. 5 at ¶ 79 (Corathers).

322. If hormone therapy is stopped, transgender girls will resume producing endogenous testosterone and experience voice deepening and facial hair, while transgender boys will resume producing endogenous estrogen and may experience additional breast growth and resumed menstruation. Tr. 231:14–232:20 (Corathers). The resumed development of secondary sexual characteristics that are inconsistent with gender identity will result in worsening gender dysphoria and increased psychological distress. Ex. 5 at ¶ 80–82 (Corathers).

323. Transgender adolescents who receive puberty blockers and gender-affirming hormone therapy grow into adults who do not have the physical secondary sex characteristics associated with their sex assigned at birth, and therefore are at lower risk of targeted bullying or abuse based on their transgender status or appearing gender non-conforming. Ex. 5 at ¶ 83 (Corathers). Transgender adults who underwent endogenous puberty and began gender-affirming hormone therapy

later in life, particularly those who continue to have physical secondary sex characteristics associated with their sex assigned at birth and are therefore perceived as transgender or gender non-conforming, often report bias, discrimination, and hostility at work and in public. Ex. 5 at ¶ 83 (Corathers).

324. If individuals are required to wait until the age of 18 to receive gender-affirming medical care, they will have already experienced endogenous puberty and have the physical secondary sex characteristics of their sex assigned at birth; while they will benefit from hormone therapy, they will still need to overcome the physical changes that have already taken place, which will require higher doses of medication. Tr. 233:7–23 (Corathers). Many transgender adults wish they had the ability to access this medical care when they were younger. Tr. 233:24–234:11 (Corathers).

325. The State has identified no other medical care that Kansas has restricted only to adults.

326. As a result of S.B. 63, the GPS Clinic has been unable to prescribe puberty blockers to transgender adolescents with gender dysphoria in Kansas since February 2025. Tr. 287:25–288:15 (Turpin).

327. For testosterone and estrogen, the GPS Clinic has been required to gradually taper down prescriptions of those medications since February 2025 and was required to discontinue the mediations altogether by December 31, 2025. Tr. 287:25–288:15 (Turpin).

328. Transgender adolescents who have remained patients of the GPS

Clinic since S.B. 63 went into effect are experiencing mental-health crises—their anxiety and depression have returned, and they feel society has rejected them and does not value them as individuals. Tr. 288:16–25 (Turpin); Ex. 8 at ¶ 51 (Turpin). The patients that remained at the GPS Clinic did so because they did not have the means to travel elsewhere for care. Tr. 289:1–4 (Turpin). The GPS Clinic had to discontinue those patients' medications effective December 31, 2025. Tr. 289:5–11 (Turpin).

329. Patients who cannot continue puberty blockers or hormone therapy because of S.B. 63 may face years of untreated gender dysphoria, and that constant stress of living in a body incongruent with one's gender adversely affects all aspects of life, including education, relationships, and functioning in society. Ex. 8 at ¶ 52 (Turpin). The inability to access care where medically indicated is likely to increase self-harm and suicidality. Ex. 8 at ¶ 52 (Turpin).

330. If S.B. 63 were no longer in effect, the GPS Clinic would continue to provide gender-affirming medical care to transgender adolescents in Kansas. Tr. 289:15–18 (Turpin).

331. S.B. 63's prohibition on pubertal suppression and hormone therapy to treat gender dysphoria in adolescents will cause harm to those individuals. Tr. 234:12–24 (Corathers). It will push minors with gender dysphoria and their families deeper into crisis. Ex. 8 at ¶ 54 (Turpin).

332. Prohibitions on gender-affirming medical care adversely impact clinical care and require physicians to compromise their standard of care or offer

substandard medical care. Ex. 5 at ¶ 76 (Corathers).

333. There are no clinical guidelines to direct the reduction of doses and discontinuation of gender-affirming medical care as described in section 3(d) of S.B. 63 because discontinuation of a safe and effective treatment will predictably exacerbate gender dysphoria and cause harm. Ex. 5 at ¶ 77 (Corathers).

334. Arbitrary discontinuation of a beneficial treatment is contrary to medical ethics and standards of care. Ex. 5 at ¶ 77 (Corathers).

335. Legislation like S.B. 63 results in moral injury to providers who are left in the impossible position of not being able to follow standards of medical practice and the law. Ex. 5 at ¶ 86 (Corathers).

336. Defendant's expert Dr. Levine has acknowledged the harm to patients from laws like S.B. 63. *See Brandt*, 677 F. Supp. 3d at 910, *rev'd and remanded sub nom. Brandt by & through Brandt v. Griffin*, 147 F.4th 867 (8th Cir. 2025).

R. Harm to Plaintiffs from S.B. 63

337. After S.B. 63 went into effect, Plaintiff Lily Loe was unable to receive her next puberty-blocker shot, which was supposed to happen in May 2025, and she lost access to her doctor of seven years, with whom she and her mother, Plaintiff Lisa Loe, had a strong and trusting relationship. Tr. 55:18–56:6; Ex. 1 at ¶¶ 25, 27.

338. Both Lisa and Lily have sought to continue care in their home state of Kansas and at Children's Mercy, from doctors they know and trust and have been seeing for years. Ex. 1 at ¶ 30.

339. Without puberty blockers, Lily would begin male puberty, which would

be alarming and upsetting to her: she is terrified of developing a deep voice, Adam's apple, and facial hair, and is constantly worried that something will happen to her body that she will not be able to correct when she is an adult. Ex. 1 at ¶¶ 26–27, 32. Puberty blockers mean Lily does not have to worry every day about these changes happening to her body or making her gender dysphoria worse. Ex. 2 at ¶ 12.

340. The closest provider that Lisa Loe found for Lily Loe is in Minneapolis, which is a seven-and-a-half-hour drive. Tr. 56:7–10. The GPS Clinic was 35 minutes from the Loe family home. Tr. 56:11–21.

341. Traveling to Minneapolis requires Lisa Loe to miss work and Lily Loe to miss school. It is too far to drive in one day, so the trip takes two days and requires an overnight stay in a hotel. Tr. 56:11–21. Lisa and Lily Loe have had to travel there four times since June 2025, and they will need to continue traveling there a little more often than every six months. Tr. 59:21–60:19.

342. Lisa Loe also had to switch Lily Loe's insurance provider from KanCare to her employer's insurance, which is expensive. Tr. 56:22–57:2; Ex. 1 at ¶ 30.

343. Lily Loe has experienced fear and anxiety as a result of the loss of her medical care. Tr. 57:3–10. Lily worries for her future and how she will be treated if she is not allowed to continue to develop into a young woman, which would have a negative effect on her mental health and social life: she just wants to be treated like a normal teenage girl and not be so scared of what might happen in the future. Ex. 2 at ¶ 14. Her fear and anxiety have dimmed her light, and S.B. 63 put

immeasurable stress on the Loe family. Ex. 1 at ¶ 33. The Loe family has discussed the potential need to uproot their family for Lily's safety and medical care, but that is not a realistic option for them. Tr. 57:11–58:2; Ex. 1 at ¶ 29. Lisa Loe worries for Lily's safety. Tr. 58:3–13.

344. After S.B. 63 went into effect, Ryan Roe's doctors at the GPS Clinic told him and his mother Rebecca Roe that his next visit would be his last appointment. Tr. 84:21–85:6.

345. Rebecca and Ryan were informed that there was an "off-ramp" for Ryan's testosterone treatment under S.B. 63, Tr. 92:9–18; but that off-ramp would not work for Ryan because there was no lower dose he could take. Tr. 97:5–13.

346. S.B. 63 has caused the Roe family extreme amounts of stress and anxiety, and they spent significant time and resources looking for out-of-state options to maintain Ryan's care. Ex. 3 at ¶ 25–26.

347. After spending a lot of time researching and looking, Rebecca Roe found a clinic for Ryan in Colorado. Tr. 85:7–19. Telemedicine is not an option unless the Roes drive six hours to cross the border into Colorado. Tr. 93:3–12.

348. Ryan has to go to the clinic every six months, and it is at least a nine-hour drive to get there, requiring at least one overnight stay. Tr. 85:20–86:10. In addition to the cost of traveling there, Ryan has to miss school, which is a setback given that he is doing well academically in a rigorous program. Tr. 86:6–10, 87:11. Rebecca Roe and Ryan's father have to miss work. Tr. 87:8–12. The Roe family has considered moving but does not want to uproot their family. Tr. 86:11–22; Ex. 3 at ¶

26.

349. In addition to the cost of traveling to Colorado and the disruption to Ryan's school schedule and the Roe family's lives, the need to travel chips away at Ryan's mental health and confidence. Tr. 86:23–88:1, 88:13–18. Ryan cannot even imagine being unable to continue his care. Tr. 87:20–88:1; Ex. 4 at ¶ 14. Ryan has had consistent anxiety about losing access to his healthcare and is worried about his physical and mental health if he is forced to stop. Ex. 4 at ¶ 15. He has been so much happier and healthier on testosterone, and Rebecca worries about the mental and physical toll the loss of testosterone would place on Ryan. Ex. 3 at ¶ 27.

III. Conclusions of Law

The "purpose of a temporary or preliminary injunction is not to determine any controverted right, but to prevent injury to a claimed right *pending a final determination of the controversy on its merits*." *Steffes v. City of Lawrence*, 284 Kan. 380, 394, 160 P.3d 843, 853 (2007) (emphasis in original). Plaintiffs' motion is brought pursuant to K.S.A. 60-901 and K.S.A. 60-905, which allow for the issuance of a temporary injunction after notice and a hearing.

To obtain temporary injunctive relief, the movant must show: (1) A substantial likelihood of eventually prevailing on the merits; (2) a reasonable probability of suffering irreparable future injury; (3) the lack of obtaining an adequate remedy at law; (4) the threat of suffering injury outweighs whatever damage the proposed injunction may cause the opposing party; and (5) the impact of issuing the injunction will not be adverse to the public interest. *Hodes & Nauser,*

MDs, P.A. v. Schmidt, 309 Kan. 610, 619, 440 P.3d 461 (2019) (*Hodes I*) (citing *Downtown Bar and Grill, LLC v. State*, 294 Kan. 188, 191, 273 P.3d 709 (2012)). To obtain injunctive relief, Plaintiffs must meet each these factors. *Idbeis v. Wichita Surgical Specialists*, P.A., 285 Kan. 485, 491, 173 P.3d 642 (2007) (citing *Steffes,* 284 Kan. at 395).

Plaintiffs allege three rights that they are attempting to preserve with this motion: (1) the natural right to personal autonomy established by Section 1 of the Kansas Constitution Bill of Rights; (2) the right to equal protection of the law established by Sections 1 and 2 of the Kansas Constitution Bill of Rights; and (3) the right to make parenting decisions established by Section 1 of the Kansas Constitution Bill of Rights.

Plaintiffs have made a successful showing on all five prongs of the test for a temporary injunction. The appropriate relief is a facial, statewide injunction against Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63, *i.e.*, the portions of S.B. 63 that prohibit the provision of GnRH agonists (also known as puberty blockers) and hormone therapy (testosterone and estrogen) to adolescent minors for the treatment of gender dysphoria. *See* K.S.A. 65-28,139(a)(2), (a)(3), (b)(2), and (b)(3).

Plaintiffs Lisa Loe, Lily Loe, Rebecca Roe, and Ryan Roe have standing to seek a facial, statewide injunction of Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63. *See Mirabelli*, 146 S. Ct. at 803 (2026) ("the parents protected by the injunction very likely have standing because they are objects of the challenged exclusion policies"). For the reasons stated herein, the Court grants Plaintiffs'

motion for temporary injunction. Specifically, the Court concludes that Plaintiffs are likely to prevail on the Third Claim, based on the right to personal autonomy set out in Section 1 of the Kansas Constitution Bill of Rights and a parent's fundamental right to make medical decisions for their children.

A. There is a substantial likelihood that Plaintiffs will have success on the merits for at least one of their claims.

A plaintiff seeking a temporary injunction must show "a substantial likelihood of eventually prevailing on the merits." *Hodes I*, 309 Kan. at 619. Plaintiffs seeking a temporary injunction are not required to establish to a certainty that they will prevail on the merits, but only that they are substantially likely to prevail . . . ." *Id*. The purpose of a temporary or preliminary injunction is not to determine any controverted right, but to prevent injury to a claimed right pending a final determination of the controversy on its merits. *Idbeis v. Wichita Surgical Specialists, P.A.*, 285 Kan. 485, 492, 173 P.3d 642 (2007). "[A] reasonable probability of success is a much lower hurdle than meeting the applicable burden of proof at trial." *Id*.

Plaintiffs need only demonstrate a substantial likelihood of eventually prevailing on the merits of one of their claims to satisfy the first prong of the five-part test for a temporary injunction. Plaintiffs have shown a substantial likelihood of eventually prevailing on the merits of at least one of their three claims—the Third Claim for Relief— which is Parent Plaintiffs Lisa Loe and Rebecca Roe's claim that S.B. 63 violates their fundamental right to parenting contained in Section 1 of the Kansas Bill of Rights.

Section 1 of the Kansas Bill of Rights provides—"All men are possessed of equal and inalienable natural rights, among which are life, liberty, and the pursuit of happiness." This provision "has no textual counterpart in the U.S. Constitution and therefore has its own meaning and effect." *Rivera v. Schwab*, 315 Kan. 877, 893, 512 P.3d 168 (2022). In addition, the Kansas Supreme Court has noted that "allowing the federal courts interpret the Kansas Constitution seems inconsistent with the notion of state sovereignty." *State v. Lawson*, 296 Kan. 1084, 1091–92, 297 P.3d 1164 (2013) (explaining that "the wholesale, automatic adoption of federal constitutional jurisprudence does not produce such desired stability in the law for Kansans.").

Here, Plaintiffs are likely to eventually succeed on the merits of the Third Claim because the Kansas Constitution protects personal autonomy in Section 1 of the Kansas Bill of Rights; this personal autonomy includes the fundamental right of parents to the care, custody, and control of their minor children; S.B. 63 infringes on that fundamental parenting right, which triggers strict scrutiny; and S.B. 63 fails strict scrutiny. Defendant has failed to carry its burden to demonstrate that S.B. 63's prohibitions on puberty blockers and hormone therapy are narrowly tailored to a compelling government interest.

1. The Court reviews Plaintiffs' challenge to S.B. 63 under the strict-scrutiny standard because it involves the fundamental right of parents to make medical decisions for their children.

Plaintiffs have demonstrated to this Court a substantial likelihood of succeeding on the merits of their Third Claim for Relief in the Petition— that

Parent Plaintiffs Lisa Loe and Rebecca Roe's claim that S.B. 63 violates their fundamental right to parenting contained in Section 1 of the Kansas Bill of Rights.

Section 1 of the Kansas Constitution Bill of Rights "protects the core right of personal autonomy—which includes the ability to control one's own body, to assert bodily integrity, and to exercise self-determination." *Hodes I*, 309 Kan. at 660. "[S]ection 1 encompasses a natural right to make decisions about parenting and procreation." *Id.* at 644. "This right allows Kansans to make their own decisions regarding their bodies, their health, their family formation, and their family life." *Id.* at 660. The Kansas Supreme Court has held that the right to parent one's child is also a fundamental right that is protected by the Kansas Constitution. *In re Adoption of Baby Girl P.*, 291 Kan. 424, 430, 242 P.3d 1168 (2010).

Plaintiffs Lisa Loe's and Rebecca Roe's parental-rights claim is made under Section 1 of the Kansas Constitution. To determine whether an asserted right is entitled to protection under Section 1, courts "include an analysis of natural rights, Lockean principles, the caselaw of Kansas, the rationale and holdings of court decisions from other jurisdictions reviewing broad constitutional natural rights provisions or other provisions similar to ours, and [in the context of abortion] the history of early statutes limiting abortion in Kansas." *Hodes I*, 309 Kan. at 660.

Parents who have assumed their parental responsibilities have a fundamental right, protected by the United States Constitution and the Kansas Constitution, to the care, custody and control of his or her child. *In re Adoption of Baby Girl P.*, 291 Kan. at 430; *Sheppard v. Sheppard*, 230 Kan. 146, 154, 630 P.2d

1121d (1981); *In re Creach*, 37 Kan. App. 2d 613, 618, 155 P.3d 719 (2007); *State, Dep't of Soc. & Rehab. Servs. v. Paillet*, 270 Kan. 646, 650, 16 P.3d 962 (2001).

Kansas statutes, passed by the legislature, also recognize this fundamental parenting right. *See* K.S.A. 38-141(b) ("It shall be the public policy of this state that parents **shall retain the fundamental right** to exercise primary control over the care and upbringing of their children in their charge. It is further the public policy of this state that children shall have the right to protection from abuse and neglect.") (emphasis added). Parents are presumed to act in the best interests of their children, and it is only when parents are unfit that the state steps in as *parens patriae*. *Sheppard*, 230 Kan. at 149.

The U.S. Supreme Court recently reiterated that "[u]nder long-established precedent, parents—not the State—have primary authority with respect to 'the upbringing and education of children.'" *Mirabelli v. Bonta*, 146 S. Ct. 797, 803 (2026) (quoting *Pierce v. Society of Sisters*, 268 U.S. 510, 534–535, 45 S. Ct. 571, 69 L. Ed. 1070 (1925)). The *Mirabelli* opinion explained that "[g]ender dysphoria is a condition that has an important bearing on a child's mental health," and under these longstanding parental-rights cases, "[t]he right protected by these precedents includes the right not to be shut out of participation in decisions regarding their children's mental health." *Id.*

Kansas also recognizes a fundamental state constitutional right under Section 1 to seek specific medical treatment for oneself (specifically abortion), as part of "an inalienable natural right of personal autonomy with profound and

unique attributes." *Hodes & Nauser, MDs, P.A. v. Stanek*, 318 Kan. 995, 1006, 551 P.3d 62 (2024) (*Hodes III*). Section 1 goes beyond the protections in the U.S. Constitution—it protects "natural rights," words that do not appear in the federal Constitution. *Hodes I*, 309 Kan. at 624–25.

Other state courts interpreting language similar to the "natural rights" language found in Section 1 have also held that such language includes parents' rights to direct their children's medical care. *See Huffman v. State*, 204 P.3d 339, 345–46 (Alaska 2009) (holding that the guarantee that "all persons have a natural right to life, liberty, the pursuit of happiness" found in Art. I, § 1 of the Alaska Constitution includes "the right to make decisions about medical treatments for oneself or one's children"); *see also Happel v. Guilford Cnty. Bd. of Educ.*, 387 N.C. 186, 200 (2025) (holding that the North Carolina Constitution protects a parent's fundamental right to control her child's upbringing and remanding to district court to determine whether right was violated by the administration of a COVID-19 vaccine without parental consent).

In *Huffman*, the Supreme Court of Alaska interpreted Article I, Section 1 of the Alaska Constitution, which provides: "[t]his constitution is dedicated to the principles that all persons have a natural right to life, liberty, the pursuit of happiness, and the enjoyment of the rewards of their own industry; that all persons are equal and entitled to equal rights, opportunities, and protection under the law; and that all persons have corresponding obligations to the people and to the State." The Alaska Supreme Court also considered Article I, Section 22, "The right of the

people to privacy is recognized and shall not be infringed . . . ." 204 P.3d 339, generally.

In *Huffman*, the Supreme Court of Alaska considered a parental challenge to a law requiring that public schools test for tuberculosis using a purified protein derivative (PPD) test. 204 P.3d at 341. The Court considered "the threshold question" of "whether the Huffmans are asserting a fundamental right," and the Court held that the Alaska Constitution "protects as fundamental rights the ability of every individual to control her hairstyle and to make her own reproductive choices. We believe controlling one's medical treatment falls into the same category of personal physical autonomy. We now hold that the right to make decisions about medical treatments for oneself or one's children is a fundamental liberty and privacy right in Alaska." *Id*. at 346.

Even courts adhering more closely to the federal articulation of parental rights have found a fundamental parental right to direct their children's medical care. *See Happel*, 387 N.C. at 196 ("Our state constitution and caselaw have long implied the existence of the precise right plaintiffs claim here. We directly recognize it today.").

In *Happel*, the Supreme Court of North Carolina considered a parent and child's state constitutional claim after his school's medical provider inoculated the child with the COVID-19 vaccine against the parent and child's wishes. 387 N.C. at 187. Article I, Section 19 of the North Carolina Constitution contains the "Law of the Land Clause"—which provides, "No person shall be taken, imprisoned, or

disseized of his freehold, liberties, or privileges, or outlawed, or exiled, or in any manner deprived of his life, liberty, or property, but by the law of the land." The Law of the Land Clause is considered North Carolina's "analogue to the Due Process Clause of the Fourteenth Amendment." *Id.* at 192. And the liberties "protected under our Law of the Land Clause include a few fundamental rights not mentioned elsewhere in the constitution[.]" *Id.* at 193.

Earlier decisions of the Supreme Court of North Carolina explained that "North Carolina law 'fully recognized' the natural and substantive rights of parents to 'the custody and control of their infant children.'" *Id.* at 195. The court, while considering the U.S. Supreme Court's decision regarding the federal Due Process Clause as "instructive in construing the scope of the rights plaintiffs claim under our Law of the Land Clause[,]" held that "the state constitution protects a parent's right to control her child's upbringing, including her right to make medical decisions on her child's behalf. At this point, there can be little doubt that our State and Nation have each fiercely guarded parental rights and consider them integral to the preservation of liberty and justice." *Id.* at 194.

The *Happel* court also held that the parental right extended to consenting on the child's behalf: "[i]ndeed, the constitutional right to full 'custody and control' over one's minor children would ring hollow if it did not include the right to consent on the child's behalf, as well as the right to seek a constitutional remedy when the State disregards the absence of that consent." 387 N.C. at 196.

In *Moe v. Yost*, 2025-Ohio-914, 265 N.E.3d 158, *appeal allowed*, 2025-Ohio-2537, 179 Ohio St. 3d 1425, 263 N.E.3d 360 (10th Dist. Ohio Ct. App. Mar. 18, 2025), the Ohio Tenth District Court of Appeals held that parents have a fundamental right to seek medical care for their children, which naturally includes the right of parents to, in conjunction with their minor child's consent and their medical providers' recommendation, make a judgment that such medical care is necessary. *Id.* at ¶ 102.

The *Moe* court considered the plaintiffs' challenge to Ohio H.B. 68, which prohibited puberty blockers and hormone therapy for transgender minor adolescents with gender dysphoria. 2025-Ohio-914, at ¶¶ 4–6. The court explained that the Ohio Constitution was a "document of independent force," that state courts "are unrestricted in according greater civil liberties and protections to individuals and groups" under state constitutions, and that even "coextensive provisions under the Ohio and United States Constitutions do not foreclose the possibility that in some circumstances, rights afforded to people under the Ohio Constitution are greater than those afforded under the United States Constitution." *Id.* at ¶¶ 41–42 (cleaned up).

Article I, Section 16 of the Ohio Constitution states in part, "All courts shall be open, and every person, for an injury done him in his land, goods, person, or reputation, shall have remedy by due course of law, and shall have justice administered without denial or delay." Section 16 is "equated" to the Fourteenth Amendment's Due Process Clause, and "unless there is a compelling reason to

separately analyze the federal and state constitutional provisions, Ohio courts generally look to decisions of the United States Supreme Court to give meaning to Ohio's Due Course of Law Clause." 2025-Ohio-914, at ¶ 79.

After considering federal caselaw, the Ohio appellate court concluded that the parent plaintiffs "assert a long-recognized and well-established fundamental liberty interest protected by the federal Due Process Clause and Ohio's Due Course of Law Clause: the right of parents to make decisions concerning the care, custody, and control of their children." 2025-Ohio-914, at ¶ 93. The court "decline[d] to hold that parents' fundamental right to direct their children's medical care is limited to those treatments existing as of 1851, 1868, or 1912." *Id.* at ¶ 98. "Holding otherwise would not just be detrimental for the parents of transgender minors. It would be disastrous for ***all*** parents seeking access to modern medical care for their children." *Id.* at ¶ 99 (emphasis in original).

The Kansas Constitution Bill of Rights and the caselaw of our State suggest a similar result in this case. Section 1 of the Kansas Bill of Rights protects the fundamental right of parents to the care, custody, and control of their children, which includes the right to consent to medical care that their children need and desire and which is recommended by a clinician.

Under this umbrella of constitutional rights, Parent Plaintiffs are substantially likely to prevail in their claim that S.B. 63 infringes on Section 1's guarantee of personal autonomy by prohibiting parents from exercising medical decision-making authority on behalf of their minor children made in accordance

with their children's wishes and doctor's recommendations, including the decision to treat gender dysphoria with puberty blocking medication or hormone therapy. *See Moe*, 2025-Ohio-914, at ¶ 191.

In addition, Parent Plaintiffs are substantially likely to prevail in their claim that S.B. 63 infringes on their fundamental rights by usurping the aligned judgment of parents, adolescents, and doctors and replacing it with the government's preference. Because S.B. 63 infringes on a fundamental right, the law must be tested under strict scrutiny. *Hodes I*, 309 Kan. at 663.

2. Plaintiffs are substantially likely to prevail in their claim that S.B. 63 violates Section 1 of the Kansas Constitution Bill of Rights.

Plaintiffs are substantially likely to show that Defendant has failed to carry its burden to demonstrate that S.B. 63 satisfies strict scrutiny. "Under strict scrutiny, the initial burden is on the plaintiff to prove a challenged law actually infringes on a constitutionally protected fundamental right under Section 1. Any degree of actual infringement, however slight, triggers strict scrutiny. Once a plaintiff proves a statute infringes on a constitutionally protected fundamental right under section 1, the court presumes the law is unconstitutional and the burden shifts to the State to defend the law under strict scrutiny. Strict scrutiny requires the State to prove (a) the existence of a compelling government interest, (b) its actions further that compelling interest, and (c) its actions do so in a way that is narrowly tailored." *Hodes III*, 318 Kan. at 1005 (citing *Hodes I*, 309 Kan. at 669).

Plaintiffs are substantially likely to prevail in their claim that S.B. 63 actually infringes on a constitutionally protected fundamental right under Section 1, Parent Plaintiffs' fundamental parenting right, by taking away their medical decision-making authority and giving the government the sole authority to decide how to treat a serious medical condition in their minor adolescent children.

Section 1 of the Kansas Constitution Bill of Rights, by its independent protection for natural rights and personal autonomy, protects this fundamental parenting right regarding medical decision-making authority.

Because the Plaintiffs have proven that S.B. 63 likely infringes on a constitutionally protected fundamental right, the burden shifts to the Defendant to defend S.B. 63 under strict scrutiny by providing (a) the existence of a compelling government interest, (b) its actions further than compelling interest, and (c) its actions do so in a way that is narrowly tailored.

With respect to the existence of a compelling government interest, Defendant argues that S.B. 63 protects children from experimental or harmful medical interventions. *See*, *e.g.*, Defendant's Response in Opposition to Plaintiffs' Motion for Temporary Injunction at p. 23–24; Tr. 27:5–14 (Defendant's opening statement). Defendant argued elsewhere that another legitimate interest is the protection of the integrity of the medical profession. *See* Defendant's Motion to Dismiss at p. 15.

For purposes of strict scrutiny, a compelling interest is "not only extremely weighty, possibly urgent, but also rare—much rarer than merely legitimate interests and rarer too than important interests." *Hodes & Nauser, MDs, P.A. v.*

Kobach, 318 Kan. 940, 952, 551 P.3d 37 (2024) (*Hodes II*). It must be "concrete and exhibit some level of specificity, rather than broad and open to wide interpretation and inclusion of a great array of concerns," because to determine whether a law is narrowly tailored, it is "difficult, if not impossible, to effectively regulate in the interest of something that is amorphous or capable of encompassing countless sub-interests." *Id.* at 952–53.

The "welfare of children is, of course, a matter of state concern," *Sheppard*, 230 Kan. at 149—but a "broadly stated aspirational interest" like "promoting the value and dignity of human life, born and unborn," is insufficiently specific to satisfy the constitutional inquiry of strict scrutiny. *Hodes II*, 318 Kan. at 957–58.

Protecting children and regulating the medical profession are likely legitimate and important state interests—but such broad articulations are likely insufficiently specific to satisfy the strict-scrutiny standard.

To the extent that Defendant instead argues that there is a compelling state interest in "protect[ing] children from experimental gender-transition interventions that lack scientific support and cause irreversible harm" and "shield[ing] vulnerable children from procedures that permanently sterilize them, damage their bodies, and offer no proven mental health benefits," Defendant's Response in Opposition to Plaintiffs' Motion for Temporary Injunction at p. 1, this Court can assume without deciding for purposes of this temporary injunction motion that such an interest is compelling and sufficiently specific.

But even assuming that Defendant has articulated a compelling and sufficiently specific government interest, Defendant has failed to carry its burden to demonstrate that S.B. 63 furthers that compelling interest in a way that is narrowly tailored.

Plaintiffs have shown a substantial likelihood to prevail on their claims that S.B. 63 is not narrowly tailored to further any compelling interest, *see Hodes II*, 318 Kan. at 952, and thus S.B. 63 is likely unconstitutional.

Based on the evidence and argument before the Court, Defendant has not shown that S.B. 63 is narrowly tailored to further a compelling state interest. The protection of children and of the integrity of the medical profession are legitimate government interests, and likely important interests. However, the Defendant also failed to meet its burden to demonstrate that S.B. 63 substantially furthers either objective.

There is no relationship between S.B. 63's restrictions on state support for social transition, which is specifically defined as non-medical, *see* S.B. 63 § 1(b)(10), and a state interest in protecting children from medical interventions or protecting the integrity of the medical profession.

Plaintiffs are also likely to prevail in their claim that S.B. 63 does not substantially further Defendant's interest in protecting children or the medical profession. This is because the evidence presented to the Court demonstrated that puberty blockers and hormone therapy are not experimental. Plaintiffs presented reliable and credible testimony from Dr. Turban, Dr. Antommaria, Dr. Corathers,

and Dr. Turpin that these interventions are not experimental in the technical or colloquial sense, that the Endocrine Society Clinical Practice Guideline is based on scientific and reliable evidence of efficacy, that the scientific literature demonstrates safety and efficacy, and that clinical experience demonstrates safety and efficacy. Defendant's witnesses did not provide sufficiently credible or reliable evidence to the contrary, even if they may have personally disagreed with the choice to pursue these interventions or believed that more research would be beneficial.

Plaintiffs are also likely to prevail in their claim that S.B. 63 does not substantially further Defendant's interest in protecting children or the medical profession. This is because the evidence presented to the Court demonstrated that puberty blockers and hormone therapy have scientific support for use in the treatment of gender dysphoria in adolescents. Plaintiffs presented reliable and credible testimony from Dr. Turban, Dr. Antommaria, Dr. Corathers, and Dr. Turpin that there are many studies of various kinds demonstrating the safety and efficacy of these interventions, that the scientific evidence base is comparable to the evidence base supporting other kinds of medical interventions provided in pediatric medicine, and that clinical experience is consistent with the findings in the literature about safety and efficacy. Defendant's witnesses did not provide sufficiently credible or reliable evidence to the contrary, even if they may have personally disagreed with the choice to pursue these interventions or believed that more research would be beneficial to the field. Defendant's experts' reliance on

systematic reviews from European and other countries did not undermine Plaintiffs' experts' evidence of scientific support.

Thus, Plaintiffs are also likely to prevail in their claims that S.B. 63 does not substantially further Defendant's interest in protecting children or the medical profession because the evidence submitted to the Court demonstrated that puberty blockers do not cause irreversible changes or harm when used to treat gender dysphoria in adolescents. Plaintiffs presented reliable and credible testimony from Dr. Corathers and Dr. Turpin that puberty blockers are fully reversible, do not cause long-term negative effects for bone health, fertility, or cognitive function, and have side effects that are manageable, even for the more serious side effects, which are nonetheless very rare. Plaintiffs' experts as well as Plaintiffs Lisa Loe (via live testimony and affidavit) and Lily Loe (via affidavit) provided credible testimony of the benefits of puberty blockers where medically indicated to treat gender dysphoria in Lily's individual experience. Defendant's experts did not provide credible or reliable evidence to the contrary. None of Defendant's witnesses who testified at the two-day evidentiary hearing diagnose gender dysphoria in minors or treat gender dysphoria in adolescents.

Plaintiffs and their experts also provided reliable and credible testimony that allowing a transgender adolescent with gender dysphoria to experience their endogenous puberty when puberty blockers are medically indicated according to the Endocrine Society Clinical Practice Guideline is highly likely to result in irreversible physical changes that create enormous short- and long-term distress

and gender dysphoria. Thus, there was substantial evidence that S.B. 63 not only fails to protect minors, but also endangers them, by prohibiting the use of GnRH agonists when medically indicated.

Plaintiffs are likely to prevail in their claim that S.B. 63 does not substantially further Defendant's interest in protecting children or the medical profession because the evidence submitted to the Court demonstrated that testosterone and estrogen do not cause bodily damage when used to treat gender dysphoria in adolescents. Plaintiffs presented reliable and credible testimony that no medical intervention is without risks or potential side effects, but that those risks and potential side effects must be balanced against the potential benefits of treatments and downsides to forgoing treatment. Plaintiffs presented reliable and credible testimony from Dr. Corathers and Dr. Turpin that hormone therapy has effects that are fully reversible, partially reversible, and irreversible, that patients and their parents are counseled on these effects (many of which are desired and expected and not unwanted or unexpected), that this care is only medically indicated when the potential benefits outweigh the risks, and that patients can stop or reduce their dose at any time. Dr. Corathers and Dr. Turpin also provided reliable and credible testimony that, except with respect to fertility, the risks and side effects of hormone therapy are not different when prescribed to treat gender dysphoria in adolescents as compared to other treatments that non-transgender or intersex adolescents may desire and need. Plaintiffs also presented credible and reliable testimony from Plaintiff Rebecca Roe (via live testimony and affidavit) and

Plaintiff Ryan Roe (via affidavit) of the benefits of hormone therapy via testosterone when medically indicated, and that even when there are unwanted side effects, the risks of stopping an effective treatment for gender dysphoria must be weighed against the other options for addressing such side effects. Defendant's witnesses did not provide sufficiently credible or reliable evidence to the contrary. None of Defendant's witnesses who testified at the two-day evidentiary hearing diagnose gender dysphoria in minors or treat gender dysphoria in adolescents.

Plaintiffs and their experts also provided reliable and credible testimony that prohibiting a transgender adolescent with gender dysphoria from using hormone therapy when medically indicated according to the Endocrine Society Clinical Practice Guideline is highly likely to result in untreated, continued, or worsening gender dysphoria. Thus, the evidence submitted to the Court demonstrated that S.B. 63 not only fails to protect minors, but also endangers them, by prohibiting the use of hormone therapy when medically indicated.

Plaintiffs are likely to prevail in their claim that S.B. 63 does not substantially further Defendant's interest in protecting children or the medical profession because the evidence presented to the Court demonstrated that puberty blockers and hormone therapy do not permanently sterilize adolescents when used to treat gender dysphoria. Dr. Corathers and Dr. Turpin provided reliable and credible testimony that puberty blockers do not cause permanent infertility and that once the medication is withdrawn, fertility resumes. Dr. Corathers and Dr. Turpin provided reliable and credible testimony that hormone therapy may have an

effect on fertility, but that it is not sterilizing, that transgender individuals may still be fertile while taking hormone therapy (such that adolescents are counseled on the need for contraception), and that there are fertility preservation options available both before starting hormone therapy and upon temporary cessation of hormone therapy. Dr. Corathers and Dr. Turpin provided credible and reliable testimony that individuals who proceed directly from puberty blockers to hormone therapy without experiencing their endogenous puberty will not be fertile without undergoing at least some endogenous puberty, but that patients and parents are regularly counseled on this risk, as well as options for fertility preservation. Defendant's witnesses did not provide sufficiently credible or reliable evidence to the contrary.

Plaintiffs are likely to prevail in their claim that S.B. 63 does not substantially further Defendant's interest in protecting children or the medical profession because the evidence presented to the Court demonstrated that puberty blockers and hormone therapy offer proven mental-health benefits when used to treat gender dysphoria in adolescents. Plaintiffs presented credible and reliable testimony from Dr. Turban, Dr. Antommaria, Dr. Corathers, and Dr. Turpin that both the scientific literature and clinical experience demonstrate improved mental health in adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy, including reduced gender dysphoria, depression, anxiety, and suicidality, as well as increased well-being and functioning in family, school, and social life. Plaintiffs also provided reliable and credible testimony (via live

testimony and affidavit) of the benefits to Minor Plaintiffs Lily Loe and Ryan Roe resulting from their receipt of these treatments over the past two years. Defendant's witnesses did not provide sufficiently credible or reliable evidence to the contrary.

Plaintiffs are likely to prevail in their claim that S.B. 63 does not substantially further Defendant's interest in protecting children or the medical profession because the evidence presented to the Court highlighted that the rates of regret around gender-affirming medical care are very low. Plaintiffs presented credible and reliable testimony from Dr. Turban, Dr. Antommaria, Dr. Corathers, and Dr. Turpin that both the scientific literature and clinical experience demonstrate that even though some small percentage of patients may later choose to stop treatment, most people who choose to stop do not regret their treatment, and in any event the rates of regret are between 1% and 4%. Moreover, 99% of the patients seen in the GPS Clinic continue living in their gender identity into adulthood, and of the less than 1% who do not, the greater majority have a nonbinary identity as opposed to re-identifying with the sex assigned at birth, and they typically do not regret their treatment.

Plaintiffs are likely to prevail in their claim that S.B. 63 does not substantially further Defendant's interest in protecting children or the medical profession because the evidence presented to the Court demonstrated that there is no difference or defect in the informed-consent process that parents and patients undertake before receiving puberty blockers or hormone therapy as compared to ordinary informed-consent process in pediatrics. Plaintiffs presented credible and

reliable testimony (via live testimony and affidavit) and from Dr. Turban, Dr. Antommaria, Dr. Corathers, and Dr. Turpin that this care is only provided after a rigorous informed-consent process that requires initial and ongoing informed consent from parents and assent from the adolescent. The informed-consent process specifically in Kansas at the GPS Clinic involves multiple conversations, supported by written materials, about the risks, benefits, and alternatives of treatment; that patients and their parents are given as much time as they need to review those materials and ask follow up questions; that parents are not pressured or coerced into consenting to treatment, and their consent is required before any treatment can proceed; that adolescents are not provided treatment unless there is both parental consent and the adolescent's own assent; and that at follow up appointments, patients are asked whether they want to stop, reduce, continue, or progress treatment.

Plaintiffs are substantially likely to prevail in their claim that S.B. 63 does not further and is not narrowly tailored to a compelling government interest, and thus does not survive strict scrutiny. For this reason, Parent Plaintiffs have shown a substantial likelihood of eventually prevailing on the merits of their claim that S.B. is a violation of their parental rights under Section 1 of the Kansas Constitution Bill of Rights.

B. There is a reasonable probability of Plaintiffs suffering an irreparable injury.

For the second requirement for a temporary injunction, Plaintiffs must show a reasonable probability of irreparable future injury or harm. *Bd. of Cnty. Comm'rs*

of Leavenworth Cnty. v. Whitson, 281 Kan. 678, 684, 132 P.3d 920 (2006); *see also Steffes*, 284 Kan. at 395; *Hodes I*, 309 Kan. at 619. Here, Plaintiffs have shown a reasonable probability of irreparable future injury or harm.

Once a plaintiff shows that a constitutional right will be abridged, no further showing of irreparable harm is required—a deprivation of a constitutional right is in and of itself irreparable harm. *Mirabelli*, 146 S. Ct. 797, 803 (2026) ("The denial of plaintiffs' constitutional rights during the potentially protracted appellate process constitutes irreparable harm."). *ACLU v. Johnson*, 194 F.3d 1149, 1163 (10th Cir. 1999); *Adams By & Through Adams v. Baker*, 919 F. Supp. 1496, 1505 (D. Kan. 1996) ("A deprivation of a constitutional right is, itself, irreparable harm."). *See also Bonner Springs Unified Sch. Dist. No. 204 v. Blue Valley Unified Sch. Dist. No. 229*, 32 Kan. App. 2d 1104, 1118, 95 P.3d 655 (2004) (citing federal cases as persuasive authority for the nature-of-harm analysis); *Trust Women Found. Inc. v. Bennett*, 509 P.3d 599, at *7 (Kan. Ct. App. 2022) (unpublished) ("courts presume that irreparable injury results when a constitutional right is violated").

Because Plaintiffs Lisa Loe and Rebecca Roe have demonstrated a reasonable likelihood of success on the merits of their claim under Section 1 of the Kansas Constitution for violation of their fundamental rights as parents, they have demonstrated sufficient irreparable harm for entry of a temporary injunction against Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63.

In addition to the presumption of irreparable harm that flows from constitutional injuries, Plaintiffs have shown a reasonable probability of irreparable

future injury or harm based on the disruptions to Lily Loe and Ryan Roe's medical care and corresponding disruptions to Plaintiffs' lives, employment, and education resulting from Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63.

The effects from medical care that is delayed, drawn out, or canceled due to the burdens imposed by travel constitute irreparable harm for purposes of a temporary injunction, even if the travel required is only in-state. *See Trust Women Found. Inc.*, 509 P.3d 599, at *8 (unpublished) (explaining that "evidence regarding the reasonable probability of harm related to delays in appointments . . . , length of appointments—again requiring delays if a patient could not be away from home or work that long—and cancelations due to the inability of physicians to travel" established irreparable harm for purposes of temporarily enjoining Kansas law requiring all abortion care to be provided in person).

Plaintiffs provided uncontroverted evidence that, as a result of S.B. 63, they have had GPS medical appointments canceled, resulting in treatment delays, that they have been required to travel out of state to continue medical care, and that they will continue to need to travel out of state for medical care so long as S.B. 63 is in effect and until Lily and Ryan turn 18 years old. This constitutes irreparable injury.

The loss of access to puberty blockers and hormone therapy for Lily Loe, and hormone therapy for Ryan Roe, also constitutes irreparable harm. To continue with their current medical treatment, Lily Loe and Ryan Roe will continue to need puberty blockers and/or hormone therapy in the immediate future, and they cannot

wait until they turn 18 years old to resume their care without experiencing worsening gender dysphoria, negative physical side effects, and negative mental health consequences, including a more limited ability to participate in their education and social lives. This constitutes irreparable injury.

Plaintiffs provided unrebutted and credible testimony that, without access to puberty blockers and estrogen, Lily Loe will experience endogenous male puberty, resulting in permanent, unwanted, and distressing changes to her physical body that will follow her into adulthood and will also cause immediate negative mental-health consequences from worsening gender dysphoria. This constitutes irreparable injury.

Plaintiffs provided unrebutted and credible testimony that, without access to testosterone, Ryan Roe will stop developing masculine characteristics and may begin resuming the development of feminizing changes that will result in unwanted and distressing changes to his physical body that will also cause negative mental health consequences from worsening gender dysphoria. This constitutes irreparable injury.

Plaintiffs provided unrebutted evidence that, as a result of S.B. 63, they have had to incur substantial costs to find, obtain, and maintain care out of state, including burdensome travel to Colorado or Minnesota. Those burdens have included Lily and Ryan missing school, Ryan missing work, Lily and Ryan's parents missing work, and additional disruptions to their mental well-being and family life. While the financial costs of that travel are compensable, the remaining burdens are

not, and these burdens constitute irreparable injury for purposes of a temporary injunction. And here, the damages related to S.B. are not completely compensable with financial damages. Thus, injunctive relief is appropriate.

C. There is no adequate legal remedy for Plaintiffs' injuries.

As the third requirement for temporary injunctive relief, Plaintiffs must demonstrate the lack of an adequate legal remedy, such as damages. *Hodes I*, 309 Kan. at 619. Generally, if a constitutional right will be abridged, no further showing of irreparable harm is required—a deprivation of a constitutional right is and of itself irreparable harm. *See Johnson*, 194 F.3d at 1163; *Adams*, 919 F. Supp. at 1505 ("A deprivation of a constitutional right is, itself, irreparable harm.").

There is no adequate remedy at law where plaintiffs seek only injunctive and declaratory relief, and as here, the violation to be addressed is a continuous or ongoing deprivation of legal rights. *See Wing v. City of Edwardsville*, 51 Kan. App. 2d 58, 64, 341 P.3d 607 (2014).

Plaintiffs provided unrebutted and credible evidence that, as a result of S.B. 63, they have had to incur and will continue to incur substantial costs to find, obtain, and maintain care out of state, including burdensome travel to Colorado or Minnesota, as well as other non-compensable injuries. Those burdens have included missing school and work and additional disruptions to mental well-being and family life. While the financial costs of travel are compensable, the remaining burdens are not, and there is no adequate remedy at law.

Only equitable relief can address the constitutional injuries and other risks of irreparable harm that flow from Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63.

D. The threat of suffering injury outweighs whatever damage the proposed injunction may cause Defendant.

Plaintiffs have shown that the threat of injury to them from the continued operation of Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63 outweighs whatever harm the injunction may cause Defendant. *Hodes I*, 309 Kan. at 619.

The threat of injury to Plaintiffs includes irreparable harm flowing from likely constitutional injuries and loss of access to medical care. Conversely, the threat of injury to Defendant is limited to being unable to enforce a portion of S.B. 63, a law which was passed by a supermajority of the Kansas Legislature over Governor Kelly's veto.

Defendant will face little, if any, injury from issuance of an injunction, which will impose no affirmative obligations and will preserve the status quo. For purposes of a temporary injunction, the status quo is "the last actual, peaceable, noncontested position of the parties which preceded the pending controversy." *State v. Alston*, 256 Kan. 571, 579, 887 P.2d 681 (1994).

The relevant status quo for purposes of this temporary injunction motion is prior to S.B. 63's effective date of February 20, 2025. Before S.B. 63's effective date, parents could consent to, minor patients could assent to, and healthcare providers in Kansas and at the GPS Clinic could provide puberty blockers and hormone

therapy where medically indicated under the Endocrine Society Clinical Practice Guideline to treat gender dysphoria in adolescents.

Defendant will face little, if any, injury from a temporary injunction against Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63, which does not impose any affirmative obligation on Defendant and will preserve the pre-enactment status quo before February 20, 2025.

Defendant has no equitable interest in enforcing a law or a portion thereof that is likely unconstitutional.

The timing of Plaintiffs' complaint and motion for temporary injunction also do not change the balance of the equities. "[T]here is no categorical rule that delay bars the issuance of an injunction[.]" *Fish v. Kobach*, 840 F.3d 710, 753 (10th Cir. 2016). Defendant has not provided evidence of any prejudice or disadvantage from the timing of Plaintiffs' complaint or the scheduling of the evidentiary hearing on the preliminary injunction, which also allowed Defendant to fully brief the legal arguments and present live witnesses at the evidentiary hearing. *See also Kan. Health Care Ass'n, Inc. v. Kan. Dep't of Soc. & Rehab. Servs.*, 31 F.3d 1536, 1544 (10th Cir. 1994) (holding that a delay in filing did not alter the finding of irreparable harm).

Plaintiffs are not required to demonstrate their complete inability to access care out of state to establish imminent and irreparable harm from its unavailability in state.

Given all the circumstances found herein, the balance of hardships in this case suggest irreparable harm without temporary injunctive action. The ongoing injury to Plaintiffs "outweighs whatever damage the preliminary injunction may cause Defendant['s] inability to enforce what appears to be an unconstitutional statute." *See Johnson*, 194 F.3d at 1163.

E. The impact of issuing the injunction will not be adverse to the public interest.

The public's interest in not suffering a potential constitutional limitation is served more by maintaining the status quo than by permitting a law which may be unconstitutional to go into effect.

It is not in the public interest to allow Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63 to remain in effect during the pendency of these proceedings. Rather, it is in the public interest to maintain the status quo that existed before the enactment of S.B. 63, *i.e.*, before February 20, 2025.

It is also in the public interest to temporarily enjoin Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63 because of the harm to the medical profession. Physicians, including those like Dr. Angela Turpin and at the GPS Clinic, are harmed from being required to abandon their patients and stop providing medically necessary care with no evidence-based alternative treatment to offer, both of which violate medical ethics and may cause moral injury.

It is also in the public interest to temporarily enjoin Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63 because of the harm to transgender adolescents with gender dysphoria and their parents in Kansas. Such minors and their parents are

harmed by being unable to maintain access to puberty blockers and/or hormone therapy in Kansas. This harm is particularly acute for families without the means to travel out of state to maintain care and who will be left without any treatment options after December 31, 2025. These harms also extend to those families in Kansas, like the Plaintiffs, who are only able to continue accessing care out of state at great expense and with significant disruption to education, employment, and family life.

It is in the public interest to temporarily enjoin Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63 even though some small percentage of patients may later choose to stop receiving puberty blockers or hormone therapy.

It is in the public interest to temporarily enjoin Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63 even though some very small percentage of patients may later regret receiving puberty blockers or hormone therapy. Rates of regret are between one and four percent, Ex. 8 at ¶ 50, Tr. 132:5–14, and it is not in the public interest to prohibit the overwhelming majority of patients from receiving medically necessary care based on some instances of regret.

It is in the public interest to temporarily enjoin Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63 even though some very small percentage of patients may not continue to experience a binary transgender identity in adulthood. Ninety-nine percent of the patients seen in the GPS Clinic continue living in their gender identity into adulthood. Tr. 286:23–287:6. Of the one percent who do not, the greater majority have a nonbinary identity as opposed to re-identifying with the sex

assigned at birth, and they typically do not regret their treatment. Tr. 287:13–24. It is not in the public interest to prevent all transgender adolescents with gender dysphoria from receiving medically necessary treatment during adolescence based on some very small percentage of those adolescents later experiencing a different understanding of their gender.

F. Scope of Relief

Having held that Plaintiffs are entitled to a temporary injunction, the Court must determine the appropriate scope of that relief. For the reasons stated below, a statewide, facial injunction against Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63 is both necessary and appropriate.

Kansas district courts have the equitable authority to issue statewide injunctions of unconstitutional state laws. *See, e.g.*, *Hodes I*, 309 Kan. at 614 (affirming the trial court's injunction temporarily enjoining the enforcement of S.B. 95); *Bennett*, 509 P.3d 599, at *1 (holding that district court erred in denying the plaintiffs' request for statewide injunction against a statute that would prevent abortion providers from providing services via telehealth).

For this issue, a statewide injunction is appropriate regarding the prohibitions of Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63. This would redress Plaintiffs' harm because Kansas physicians, including Minor Plaintiffs' doctors at the GPS Clinic, would resume providing puberty blockers and hormone therapy to transgender adolescents with gender dysphoria in the absence of that law. An injunction limited only to the Plaintiffs would substantially limit the GPS

Clinic's practice in this field of medicine, which may ultimately affect the clinic's ability to serve Plaintiffs. A statewide temporary injunction of Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63 more adequately upholds the status quo while the Plaintiffs' claims are pursued in this lawsuit.

Plaintiffs have not requested any temporary injunctive relief with respect to S.B. 63's prohibitions on surgery for minors, nor is that part of clinical practice in Kansas for transgender adolescents with gender dysphoria, so the scope of relief does not include any injunction with respect to S.B. 63's surgical prohibitions.

A facial injunction with statewide effect is the appropriate scope of relief for the temporary injunction. This is because only a facial injunction with statewide effect can fully redress the irreparable harm, including the constitutional injuries, imposed by Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63.

Although Defendant argues that Plaintiffs' facial challenge requires Plaintiffs to demonstrate that "no set of circumstances exist under which [S.B. 63] would be valid," Tr. 36:6–16, by reference to *Injured Workers of Kansas v. Franklin*, 262 Kan. 840, 850, 942 P.2d 591 (1997), that portion of *Franklin* references *United States v. Salerno*, 481 U.S. 739, 745, 107 S. Ct. 2095, 95 L.Ed.2d 697 (1987). More recent federal jurisprudence explains that the "proper focus of the constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *City of Los Angeles, Calif. v. Patel*, 576 U.S. 409, 418, 135 S. Ct. 2443, 192 L. Ed. 2d 435 (2015).

The Kansas Supreme Court has cited *Patel* with approval. *State v. Ryce*, 303 Kan. 899, 915, 368 P.3d 342 (2016), *adhered to on reh'g*, 306 Kan. 682, 396 P.3d 711 (2017) ("*Patel* emphasizes that the scope of circumstances we examine is determined and limited by the application of the statute—we do not consider the entire universe of possible scenarios, we must instead look to the circumstances actually affected by the challenged statute.").

The group for whom S.B. 63 is relevant are transgender minors with gender dysphoria who meet eligibility criteria for puberty blockers or hormone therapy under the Endocrine Society Clinical Practice Guideline, as well as parents of these youth—as these are the only persons in Kansas burdened by the law's prohibitions. That other youth who do not meet those criteria are also prohibited from receiving those treatments, and their parents, do not change the likely facial unconstitutionality of S.B. 63's prohibitions on puberty blockers and hormone therapy. For these youth, and the parents of these youth, for which the prohibitions of Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63 are relevant, a statewide injunction is appropriate.

IV. Conclusion

For these reasons, Plaintiffs' Motion For Temporary Injunction is GRANTED. Defendant IS ENJOINED from enforcing Sections 3(a)(2), 3(a)(3), 3(b)(2), and 3(b)(3) of S.B. 63—which are now set out in K.S.A. 65-28,139(a)(2), (a)(3), (b)(2), and (b)(3)—until further order of this Court.

IT IS SO ORDERED.

Carl Folsom, III
District Judge