

The Honorable Lauren King

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**UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE**

STATE OF WASHINGTON, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official
capacity as President of the United States,
et al.,

Defendants.

NO. 2:25-cv-00244-LK

PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION

NOTE ON MOTION CALENDAR:
February 28, 2025, at 2:00 p.m.

ORAL ARGUMENT REQUESTED

TABLE OF CONTENTS

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26

I. INTRODUCTION..... 1

II. STATEMENT OF FACTS..... 2

 A. Gender-Affirming Care Is Life-Saving Medical Treatment Overwhelmingly Supported by Medical Professionals and Protected by Plaintiff States 2

 B. The Orders Unilaterally Defund Medical Institutions and Threaten Criminal Prosecution for Providers and Families 5

 C. This Court Granted Plaintiffs’ Motion for Temporary Restraining Order 7

III. ARGUMENT 7

 A. Legal Standard 7

 B. Plaintiffs Have Standing to Challenge the Orders 8

 C. Plaintiffs Are Likely to Succeed on the Merits..... 8

 1. The Orders discriminate against transgender children 8

 a. The Orders are subject to heightened scrutiny because they discriminate based on transgender status and sex..... 8

 b. The Orders fail heightened equal protection scrutiny..... 10

 c. The Orders fail any level of review 13

 2. Defunding medical schools, providers, and hospitals for providing gender-affirming care and recognizing transgender identity violates the separation of powers..... 14

 3. The Denial-of-Care Order’s criminalization of gender-affirming care violates the Tenth Amendment and separation of powers 17

 4. The Orders are unconstitutionally vague 20

 D. Plaintiffs Will Suffer Irreparable Harm if the Orders Are Not Enjoined 20

 E. The Balance of Equities Weigh in Plaintiffs’ Favor, and a Preliminary Injunction Is in the Public Interest..... 24

I. INTRODUCTION

1
2 With two Executive Orders, the President unlawfully intruded into the personal medical
3 decisions of transgender youth, their families, and their doctors. The Orders target vulnerable
4 transgender youths by directing federal agencies to “immediately” defund programs that
5 recognize the existence of transgender and gender-diverse people and medical institutions that
6 provide necessary and often life-saving gender-affirming care. The President also weaponized a
7 criminal statute to threaten providers and parents for providing care. Lest there be any doubt
8 about the President’s intent, the White House bragged that his action is “already having its
9 intended effect” with “hospitals around the country . . . taking action to downsize or eliminate”
10 gender-affirming care programs.

11 These Orders have unleashed unbridled fear and irreparable harms. They force State
12 medical institutions and providers into an impossible choice between following their ethical
13 obligations to provide necessary care or risk immediately losing hundreds of millions of dollars
14 in federal funding. Doctors and families must now risk criminal prosecution or watch their young
15 patients and children suffer. And for transgender youth singled out by the President’s Orders,
16 pausing treatment can cause irreversible impacts to their bodies that dramatically increase their
17 risk of depression, anxiety, self-harm, and suicide. Simply put, if the Orders stand, transgender
18 children will die.

19 The Orders are unconstitutional several times over. They violate the constitutional
20 guarantee of equal protection because they discriminate against transgender youth on the basis
21 of their transgender status and sex. They violate the constitutional separation of powers because
22 the President has seized Congress’ spending and lawmaking power by rewriting the law to
23 defund medical institutions. They violate the Tenth Amendment and separation of powers
24 because they rob states of their core police power to regulate medicine by dictating what
25 constitutes medically necessary care, conflict with Congress’s decision not to regulate the
26 practice of medicine, and contravene Congress’s direction not to discriminate in the provision of

1 medical care. Finally, they are impermissibly vague because their nonsensical definitions of
 2 “sex”, “male,” and “female” provide no way to determine a person’s sex, a necessary first step
 3 in attempting to apply them.

4 The Court must enjoin these flagrant and discriminatory abuses of power.

5 II. STATEMENT OF FACTS

6 A. Gender-Affirming Care is Life-Saving Medical Treatment Overwhelmingly 7 Supported by Medical Professionals and Protected by Plaintiff States

8 Gender dysphoria is a serious medical condition marked by a persistent mismatch
 9 between a person’s assigned sex and gender identity, causing severe distress or impairment.
 10 Dkt. #19 ¶39. Left untreated, it can result in severe anxiety and depression, eating disorders,
 11 substance abuse, self-harm, and, far too often, suicide. *Id.* ¶46. Fortunately, it is treatable.

12 Gender-affirming care is overwhelmingly supported by the evidence and broadly
 13 endorsed by the medical community, including the American Academy of Pediatrics, American
 14 Medical Association, American Psychological Association, American Psychiatric Association,
 15 and American Academy of Family Physicians. *Id.* ¶¶50-58. It is governed by (1) Standards of
 16 Care published by the World Professional Association for Transgender Health (WPATH), a non-
 17 profit professional and educational organization devoted to transgender health, (2) guidelines
 18 published by the Endocrine Society, an organization representing endocrinologists, and (3) the
 19 American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders
 20 (DSM-5). *Id.* ¶¶, 40, 50-58. Gender-affirming care covers a spectrum of treatments, including
 21 talk therapy, social transition, puberty-blocking medications, hormone replacement therapy, and
 22 other care, based on individual need. *Id.* ¶¶59-60, 62, 64-79.

23 Transgender children and their parents do not make the decision to start gender-affirming
 24 care lightly. Dkt. #111 ¶¶14-15; Dkt. #93 ¶9; E.L. ¶9. Children often endure extended and
 25 debilitating periods of depression, self-hatred, hopelessness, anxiety, self-harm, and suicidality
 26 before families seek gender-affirming care. *See* Dkt. #11 p.4 n.2 (citing declarations); *see also*

1 Dkt. #47 ¶4; C.F. ¶7; E.L. ¶11; S.T. ¶4; L.D. ¶¶7-8; M.M. ¶12; Mischo ¶9; Dkt. #89 ¶6. L.L., a
2 Seattle-area teen, would, for years, “rot in [] bed” all day, with no friends, struggling even to
3 shower in a body he “hated.” Dkt. #21 ¶9. S.F., a teen in southwest Washington, spent days
4 “curled up in the fetal position on the floor,” with his mother feeling helpless to do anything but
5 sit and share his pain. Dkt. #68 ¶6. Some adolescents showered in a bathing suit or in the dark
6 so they didn’t have to see their own body. Dkt. #102 ¶6; Dkt. #34 ¶8. Others engaged in self-
7 harm, “cutting” or “burning” themselves or developing eating disorders so they could “feel in
8 control of their body.” Dkt. #99 ¶13.

9 Meanwhile, parents experience profound “grief” seeing their children’s pain, while
10 fearing others will “harm their child.” Dkt. #91 ¶16; C.D. ¶15. Those with resources often seek
11 extensive therapy before engaging in gender-affirming hormonal treatment. Dkt. #83 ¶¶8-9. To
12 qualify for gender-affirming care, adolescents must “consistently, persistently, and insistent-
13 ly express their desire for a body that reflects a non-binary gender or a gender different than the
14 sex they were assigned at birth.” *Id.* ¶9; *see also* Dkt. #19 ¶63.

15 When families seek gender-affirming care, clinicians follow settled guidelines to ensure
16 accurate diagnoses and that patients understand their options. *E.g.*, Dkt. #13 ¶¶8-16; Dkt. #14
17 ¶¶6, 11-13; Dkt. #15 ¶¶14-17; Nelsen-Barbosa ¶¶6-7. Physician Plaintiffs, for example, do not
18 see patients until after a thorough mental screening confirming the dysphoria diagnosis. Dkt. #13
19 ¶¶10-11; Dkt. #14 ¶9; Dkt. #15 ¶17. Clinicians independently confirm the diagnosis and spend
20 extensive time with families discussing the adolescent’s experiences, goals and expectations, the
21 risks and benefits of different options, and obtaining informed consent from the patient and
22 parent. Dkt. #13 ¶¶10-15; Dkt. #14 ¶¶11-15; Dkt. #15 ¶¶14-18. Clinicians generally start with
23 gradual, readily reversible treatments that mimic natural puberty processes. Dkt. #13 ¶16;
24 Dkt. #14 ¶¶19-21. They provide regular follow-up care to adjust treatment as needed and monitor
25 the patient’s mental and physical health. Dkt. #13 ¶16; Dkt. #14 ¶20; Dkt. #95 ¶¶14-15.
26

1 The evidence supporting gender-affirming care for adolescents is as robust as the
2 evidence supporting other pediatric treatments. Dkt. #18 ¶¶43-45; Dkt. #19 ¶¶78-102. Clinicians
3 have used puberty blockers for decades to treat gender dysphoria. *Id.* ¶66. Patients receiving
4 gender-affirming care have high rates of satisfaction and extremely low incidence of regret. *E.g.*,
5 *Id.* ¶101; Dkt. #13 ¶¶19-22. Studies show rates of regret for gender-affirming care are
6 exceptionally low, between about 0.3 and 1.1 percent—much lower than, for example, knee
7 replacements (10%), tattoos (16%), or having children (7%). Dkt. #18 ¶71; Dkt. #112 ¶22. Most
8 providers have never had a patient regret gender-affirming care. *E.g.*, Dkt. #15 ¶26; *see also*
9 Dkt. #11 p.6 (citing declarations); Leggett ¶¶18-19. If anything, patients regret not starting
10 earlier. *Id.*; Dkt. #111 ¶12; Dkt. #81 ¶13; Dkt. #27 ¶7. Beyond the extremely low incidence of
11 regret, the risks to fertility are likewise mischaracterized. Puberty blockers do not permanently
12 impair fertility. Children experiencing medically precocious puberty are routinely treated with
13 puberty blockers and have typical fertility in adulthood, and such medications are used to
14 preserve fertility in patients with cancer and treat other pediatric conditions. Dkt. #14 ¶22;
15 Dkt. #76 ¶14; Dkt. #18 ¶60. Moreover, the current treatment paradigm is consistent with general
16 ethical principles and the informed consent practices for other pediatric medical care. *Id.* ¶56.
17 For example, UW Medicine requires consent from a parent or guardian for a minor patient to
18 receive gender-affirming medical care. Dkt. #16 ¶16.

19 And it works. Transgender youths who receive gender-affirming care see their rates of
20 anxiety and depression dramatically improve to mirror those of their cisgender peers. *See*
21 Dkt. #11 p.4 n.2 (citing declarations); *see also* Dkt. #90 ¶¶15-16; A.D. ¶8; C.S. ¶9; J.K. ¶11; J.V.
22 & P.V. ¶13; K.B. ¶17; M.S. ¶¶15-17; S.W. ¶7; B.P. ¶12. Parents report similarly transformative
23 changes, with kids experiencing “a profound sense of relief” when their “outsides” finally
24 “match their insides,” making them feel like “their true and authentic selves” for the first time in
25 their young lives. Dkt. #29 ¶13; Dkt. #28 ¶10; Dkt. #33 ¶10; Dkt. #17 ¶11.

1 Nothing reveals the profundity of this transition better than kids’ and parents’ own words.
2 Youth receiving treatment “blossom[ed] in every way,” and experience newfound confidence
3 that helps them “flourish,” and live “joyful,” lives. Dkt. #68 ¶7; Dkt. #38 ¶8; Dkt. #39 ¶6;
4 Dkt. #82 ¶13; C.D. ¶10; C.F. ¶9. They “go from socially isolating themselves, engaging in
5 negative internal dialogue, not going to school” and avoiding people, to joining clubs, playing
6 sports, and seeking out community. Dkt. #74 ¶11; Dkt. #30 ¶9; Dkt. #72 ¶12. Treatment makes
7 youth feel “like something inside of them is lighter” when “they no longer hate themselves.”
8 Dkt. #76 ¶11. They feel “happier” and “more confident.” Dkt. #129 ¶9; J.T. ¶8; S.T. ¶13. And it
9 brings “a sense of security in identity without which [they] would not have survived.” Dkt. #23
10 ¶8. Parents describe the transformation “like flipping a light switch,” with their kids having
11 increased energy and a renewed sense of self that reveals just “how much their child must have
12 been suffering.” Dkt. #85 ¶¶13-16. When children are “relieved of the need to mask, hide, or
13 cover who she was,” they stop self-harming. Dkt. #44 ¶8. “Passing” or “being seen as the gender
14 they identify” often “makes life worth living.” Dkt. #83 ¶7. It allows them to “walk through the
15 world without being discriminated against or harassed.” *Id.* Not spending “every moment of their
16 day” thinking about “how their body looks and how it does not align with their identity” gives
17 children the freedom to “learn better at school and proactively engage and prepare for their future
18 careers and lives.” Dkt. #99 ¶16. The benefits of gender-affirming care are literally “life-giving.”
19 Dkt. #77 ¶12.

20 **B. The Orders Unilaterally Defund Medical Institutions and Threaten Criminal**
21 **Prosecution for Providers and Families**

22 On January 20, 2025, President Trump issued Executive Order 14,168, titled “Defending
23 Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal
24 Government” (Gender-Ideology Order); 90 C.F.R. §8615 (cited as E.O. 14,168). And on January
25 28, 2025, President Trump issued Executive Order 14,187, titled “Protecting Children from
26 Chemical and Surgical Mutilation” (Denial-of-Care Order); 90 C.F.R. §8771 (cited as E.O.

1 14,187). These Orders follow a decade of President Trump scapegoating transgender people and
2 threatening to criminalize their medical care. In the first three weeks of this presidential term,
3 President Trump has targeted all aspects of transgender lives, halting their passport applications,
4 ordering transfer of incarcerated transgender women to men’s prisons, initiating a ban on
5 transgender military service claiming transgender soldiers are not “honorable, truthful, or
6 disciplined,” erasing references to “gender” from federal websites and forms, barring female
7 transgender student-athletes from “compet[ing] with or against” other women and girls, and
8 making the denial of transgender existence a cornerstone of executive policy. Dkt. ## 17-1, 17-
9 2, 17-3, 17-15; *see also* McGinty Decl. ISO Mot. for Prelim. Inj. Decl. Ex. 4 (E.O. 14,190).

10 The Orders continue this ruthless persecution. The Gender-Ideology Order strictly
11 defines “sex,” “female,” and “male” in non-scientific and nonsensical ways and strips federal
12 funding from any program that supposedly “promote[s] gender ideology” by accepting that
13 transgender people exist. E.O. 14,168 §§2(a), (d), (e), (f), 3(e), (g). The Centers for Disease
14 Control and Prevention (CDC), for instance, directed grant recipients at the UW School of
15 Medicine and the Washington State Department of Health to “terminate, to the maximum extent”
16 all activities “inculcating gender ideology at every level.” Dellit Supp. ¶3; Fehrenbach-
17 Marosfalvy ¶6. The administration has likewise terminated grants to medical clinics for
18 purportedly violating the Gender-Ideology Order. *See* Dkt. #149-1.

19 The Denial-of-Care Order, in cruel and dehumanizing terms, redefines all gender-
20 affirming care—including the use of medications like puberty blockers—as “chemical and
21 surgical mutilation” and a “stain” on the Nation’s history.. Among other directives, Section 4 of
22 the Order requires “[d]efunding” gender-affirming care by ordering each executive department
23 or agency providing research or education grants to medical institutions to “*immediately . . .*
24 ensure that institutions receiving Federal research or education grants end” gender-affirming
25 care for youths. E.O. 14,187 §4 (emphasis added). Section 8(a) of the Denial-of-Care Order, in
26 turn, directs the Attorney General to prioritize “enforcement of protections against female genital

1 mutilation” under 18 U.S.C. §116, which it equates with gender-affirming care. E.O. 14,187 §§1,
2 8(a). These provisions are already causing immediate, irreparable harm to the Plaintiffs.

3 **C. This Court Granted Plaintiffs’ Motion for Temporary Restraining Order**

4 After holding a hearing, this Court granted a temporary restraining order, finding that the
5 Denial-of-Care Order was “aimed at erasure of transgender individuals.” TRO Hearing Tr.
6 35:22-23 (Feb. 14, 2025). The Court found that Plaintiffs were likely to succeed on the merits of
7 their equal protection, separation of powers, and Tenth Amendment claims, and that the
8 remaining *Winter* factors favored a TRO. *See generally* Dkt. #161.¹ The Court’s Order provided
9 immediate benefits, affording temporary relief to physicians and providers in the Plaintiff States
10 to provide gender-affirming care without risking criminal prosecution or loss of federal grant
11 funds. Dellit Supp. ¶¶4-5; Physician Plaintiff 1 Supp. ¶4 (“After the TRO was issued, I felt like
12 I could finally breathe again.”); Physician Plaintiff 2 Supp. ¶4 (Physician Plaintiff 2 was
13 “immediately relieved for [themselves] and [their] patients” after issuance of the TRO);
14 Physician Plaintiff 3 Supp. ¶6 (“I felt immediate relief upon learning about this Court’s order”);
15 Ojemann Supp. ¶¶3-6. And it resulted in resumed care for patients: immediately after this Court
16 announced its order, a Seattle teen whose gender-affirming procedure had been cancelled by a
17 Seattle-area hospital in response to the Denial-of-Care Order, received a call notifying him that
18 care had been resumed and rescheduling his procedure. Hillinger, Aumann, & E.H. ¶¶3-5.

19 **III. ARGUMENT**

20 **A. Legal Standard**

21 A preliminary injunction is warranted where the moving party establishes that (1) it is
22 likely to succeed on the merits; (2) irreparable harm is likely in the absence of preliminary relief;
23 (3) the balance of equities tips in the movant’s favor; and (4) an injunction is in the public
24

25 ¹ The District of Maryland entered a nationwide TRO restraining federal defendants from conditioning or
26 withholding federal funding based on the fact that a healthcare entity or professional provides gender-affirming
medical care to a patient under the age of 19 under Section 3(g) of the Gender-Ideology Order and Section 4 of the
Denial-of-Care Order. *PFLAG, Inc. v. Trump*, No. 1:25-cv-00337-BAH, Dkt. #61 (D. Md. Feb. 13, 2025).

1 interest. Fed. R. Civ. P. 65(c); *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008);
 2 Fed. R. Civ. P. 65(b)(1). All four factors strongly favor the Plaintiffs.

3 **B. Plaintiffs Have Standing to Challenge the Orders**

4 As this Court previously determined, Plaintiffs face imminent, direct injuries because of
 5 the Denial-of-Care Order. Dkt. #161 pp.7-13. These include the (1) choice between losing
 6 federal funds or being forced to stop “providing medical services they would otherwise provide,”
 7 (2) a “credible and substantial” threat of federal prosecution; (3) third-party standing by
 8 Physician Plaintiffs on behalf of their patients; and (4) constitutional injuries from federal
 9 officials exceeding their powers. *Id.* Plaintiffs face similar injuries with respect to the Gender-
 10 Ideology Order, because it too strips federal funding related to gender-affirming care.
 11 E.O. 14,168 §§3(e), (g); Dkt. #149-1. Because these injuries are imminent and would be
 12 occurring now but for this Court’s TRO, the Plaintiffs have standing and this matter is ripe for
 13 review. *See* Dkt. #161 p.12 n.4.

14 **C. Plaintiffs Are Likely to Succeed on the Merits**

15 **1. The Orders discriminate against transgender children**

16 Both the Gender-Ideology Order and the Denial-of-Care Order target transgender
 17 children and their medical care based on transgender status and sex, triggering heightened equal
 18 protection scrutiny. The Orders cannot survive this “exacting” test. *United States v. Virginia*,
 19 518 U.S. 515, 533 (1996) (cited as *VMI*). Given their rejection of the scientific consensus, they
 20 couldn’t even survive rational basis review.

21 **a. The Orders are subject to heightened scrutiny because they**
 22 **discriminate based on transgender status and sex**

23 Heightened scrutiny applies to classifications based on transgender status and sex. *See*
 24 *Doe v. Horne*, 115 F.4th 1083, 1102 (9th Cir. 2024); *Karnoski v. Trump*, 926 F.3d 1180, 1200-01
 25 (9th Cir. 2019) (applying heightened scrutiny to discrimination based on transgender status); *see*
 26 *also Hecox v. Little*, 104 F.4th 1061, 1080 (9th Cir. 2024) (applying heightened scrutiny to

1 discrimination based on sex and transgender status). Because the Orders discriminate based on
2 transgender status and sex, they are subject to heightened scrutiny.

3 First, the Orders expressly classify based on transgender and gender-diverse status. *See*
4 Dkt. #161 p.17 (holding the Denial-of-Care Order “facially discriminates on the basis of
5 transgender status”). The Gender-Ideology Order defunds any program that supposedly
6 “promote[s] gender ideology,” simply by acknowledging the scientific consensus that
7 transgender people exist. E.O. 14,168 §§2(f), 3(e), (g). The Denial-of-Care Order similarly
8 classifies based on transgender and gender-diverse status by penalizing and criminalizing
9 healthcare only when provided to “an individual who does not identify as his or her sex,” “to
10 align an individual’s physical appearance with an identity that differs from his or her sex,” or to
11 “transform an individual’s physical appearance to align with an identity that differs from his or
12 her sex or that attempt to alter or remove an individual’s sexual organs to minimize or destroy
13 their natural biological functions.” E.O. 14,187 §2(c).

14 Second, the Denial-of-Care and Gender-Ideology Orders draw a classification based on
15 sex. *See* Dkt. #161 p.18; *see also PFLAG, Inc., v. Trump*, No. 25-cv-337-BAH, 2025 WL 510050
16 (D. Md. Feb. 14, 2025) (“[T]he Executive Orders discriminate on the basis of transgender
17 identity, and therefore on the basis of sex.”). The purported biological sex of the patient is the
18 basis on which the Denial-of-Care Order distinguishes between medical interventions restricted
19 and criminalized versus those that are not. *See Bostock v. Clayton Cnty.*, 590 U.S. 644, 660
20 (2020) (“[I]t is impossible to discriminate against a person for being . . . transgender without
21 discriminating against that individual based on sex[.]”). Thus, “discrimination against
22 transgender individuals constitute[s] sex-based discrimination for purposes of the Equal
23 Protection Clause because such policies punish transgender persons for gender non-conformity,
24 thereby relying on sex stereotypes.” *Hecox*, 104 F.4th at 1080 (quoting *Grimm v. Gloucester*
25 *Cnty. Sch. Bd.*, 972 F.3d 586, 608 (4th Cir. 2020)); *see also Brandt ex rel. Brandt v. Rutledge*,

1 47 F.4th 661, 670-71 & n.4 (8th Cir. 2022) (applying heightened scrutiny to law prohibiting
2 “gender transition procedures” because the law discriminated on the basis of sex).²

3 The Orders explicitly and coercively enforce gender conformity by targeting medical
4 care when used to affirm a gender that is different from one’s sex as defined in the Orders.
5 E.O. 14,168 §§3(e), (g); E.O. 14,187 §2(c). Thus, a mastectomy for a cisgender boy with
6 gynecomastia (swollen breast tissue) to conform his chest to his male gender is not penalized.
7 See Dkt. #112 ¶¶26-28. Nor is testosterone therapy to a cisgender boy who wants to “jumpstart”
8 puberty. See Dkt. #14 ¶22; see also Dkt. #161 pp.17-18 (explaining under the Denial-of-Care
9 Order, federally-funded medical institutions can provide certain treatments to cisgender
10 individuals but not to individuals ‘who does not identify as his or her sex’” (quoting Dkt. #17-1
11 p.2)). By allowing and disallowing care based on sex as defined in the Orders, the Orders facially
12 classify based on transgender status and sex and trigger heightened scrutiny.

13 **b. The Orders fail heightened equal protection scrutiny**

14 To survive heightened scrutiny, the Orders must provide an “exceedingly persuasive
15 justification” for their classifications and a “close means-end fit.” *Sessions v. Morales-Santana*,
16 582 U.S. 47, 58, 68 (2017). Neither exists here. The “burden of justification is demanding”—
17 not “deferential”—and “rests entirely on the [federal government].” *VMI*, 518 U.S. at 533, 555.
18 Heightened scrutiny is an “extremely fact-bound test,” requiring courts to “examine the ‘actual
19 purposes’” of the governmental action and “carefully consider the resulting inequality to ensure
20 that our most fundamental institutions neither send nor reinforce messages of stigma or second-
21 class status.” *SmithKline Beecham Corp. v. Abbott Labs.*, 740 F.3d 471, 483 (9th Cir. 2014).

22 The Orders harm adolescents and young adults by restricting their access to the only
23 medically necessary treatments for gender dysphoria. Gender dysphoria is a serious medical
24 condition, and all major medical associations recognize that gender-affirming care is necessary

25 ² The “Court’s approach to Fifth Amendment equal protection claims has always been precisely the same
26 as to equal protection claims under the Fourteenth Amendment.” *Weinberger v. Wiesenfeld*, 420 U.S. 636, 638 n.2
(1975).

1 to alleviate the significant distress of adolescents facing gender dysphoria. Dkt. #19 ¶¶51, 110.
2 There is no non-discriminatory justification for singling out and criminalizing the medical
3 decisions made by transgender youth, their parents, and their doctors. Untreated gender
4 dysphoria can result in severe anxiety and depression, self-harm, and suicidality. *Id.* ¶46; *see*
5 *also, e.g.*, Dkt. #76 ¶13; Dkt. #29 ¶12; Dkt. #86 ¶¶9, 11. Gender-affirming care dramatically
6 improves the health and well-being of adolescent patients, is well-accepted in the medical field,
7 and is supported by substantial clinical and research evidence demonstrating its effectiveness.
8 Dkt. #19 ¶¶45-102; Dkt. #13 ¶7. The quality of evidence supporting this care is comparable to
9 the quality of evidence supporting countless other medical treatments provided to minors.
10 Dkt. #18 ¶¶45-47. And it is supported by decades of clinical experience and research
11 demonstrating the often life-saving results of treatment. *Id.* ¶¶41-42; Dkt. #13 ¶¶19-24; Dkt. #14
12 ¶¶8, 16-22; Dkt. #15 ¶¶17-26. And last but certainly not least, the personal experiences of
13 transgender youths and their families reflect just how such treatment positively transforms the
14 lives of the adolescents who need it. *See supra* 4-5. By penalizing and criminalizing this
15 necessary care, the Orders will harm kids across the country.

16 Gender-affirming care is not uniquely risky. Dkt. #19 ¶¶80-84; Dkt. #18 ¶¶60-63, 67-69;
17 *Poe v. Labrador*, 709 F. Supp. 3d 1169, 1182 (D. Idaho 2023). The same medications and
18 treatments used in gender-affirming medical care—including puberty blockers, testosterone,
19 testosterone suppression, and estrogen—are widely used to treat cisgender adolescents and pose
20 the same potential risks. Dkt. #14 ¶22; Dkt. #112 ¶¶26-28. For example, GnRHa medications
21 are used to treat precocious puberty; testosterone is used to treat cisgender boys with delayed
22 puberty; and estrogen is used to treat cisgender girls for ovarian failure, regulation of
23 menstruation, and contraception. Dkt. #18 ¶¶47, 63, 80. Again, in many cases, this treatment is
24 *also used to affirm* the cisgender adolescent’s gender—but the Orders say not a word about it.
25 Dkt. #112 ¶¶26-28.
26

1 The Gender-Ideology Order’s stated purpose is rebutted by the evidence. It purports to
2 align national policy with “biological reality,” (Section 1) but advances unscientific and false
3 definitions of “sex,” “male,” and “female.” *See generally* Shumer Supp.; *see also* Dkt. #18 ¶¶18-
4 22; Dkt. #19 ¶¶27-37, 103-105. It says that it seeks to defend women from “erasure of sex in
5 language and policy,” but the order is grossly overbroad because it defines transgender people
6 out of existence altogether and defunds any program that merely accepts the idea that transgender
7 people exist. E.O. 14,168 §§3(e), (g).

8 The Denial-of-Care Order’s purported concern over potential “sterilization” of youths
9 (Section 1) is similarly unpersuasive. While some types of gender-affirming medical care may
10 impair fertility, this risk is discussed in the informed consent process, as with other medical
11 treatments that can impact fertility. Dkt. #18 ¶¶58, 61-62. And there are ways to adjust treatment
12 to protect fertility if that is important to the patient and family. *Id.* ¶62. And concerns about the
13 low risks of permanent side effects ring hollow when youth denied treatment far too often make
14 permanent decisions with much more tragic consequences. Dkt. #19 ¶107. Given the extensive
15 evidence supporting gender-affirming care, no “exceedingly persuasive justification” exists for
16 treating gender-affirming medical care differently than all other medical treatment for minors.
17 To the contrary, the President’s goal in issuing the Order “was not to ban a treatment. It was to
18 ban an outcome that [he] deems undesirable.” *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 891
19 (E.D. Ark. 2021), *aff’d* 47 F.4th 661 (8th Cir. 2022).

20 “Even assuming . . . that the Executive Order’s stated purpose . . . constitutes an
21 important government interest, there is no substantial relationship between this purported goal
22 and Section 4’s blunderbuss approach to achieving it.” Dkt. #161 pp.19-20; *id.* 21 (Denial-of-
23 Care Order is “insufficiently tailored” to survive heightened scrutiny); *see also Hecox*, 104 F.4th
24 at 1086 (law lacked means-end fit between categorical ban of transgender female athletes and
25 purported interest in athletic equality based on law’s broad enforcement mechanism). Although
26 the Denial-of-Care Order suggests in Section 1, without support, that people who receive gender-

1 affirming care will regret that care, the undisputed evidence shows that regret is exceedingly
2 uncommon for transgender youth receiving gender-affirming care. *See* Dkt. #19 ¶¶77, 107;
3 Dkt. #99 ¶17; Dkt. #15 ¶26; Dkt. #112 ¶22. And in any event, the Order doesn't explain why
4 this small risk justifies banning care for all transgender adolescents. Nor does the order weigh
5 the purported risk of regret against the benefits of gender-affirming care—which is particularly
6 troublesome given the consensus of the medical community that this care is medically
7 appropriate and life-saving for certain transgender youth. *Id.* ¶¶22-23. The Denial-of-Care Order
8 discusses fertility risks associated with gender-affirming care, but targets treatments, like puberty
9 blockers, that have no impact on fertility. Dkt. #18 ¶60. And as the Court acknowledged, many
10 patients receiving hormone therapy remain fertile and can be provided with fertility-preserving
11 options. Dkt. #161 pp.21-22; Dkt. #19 ¶¶82-84. And similar or greater risks attend other pediatric
12 treatments, but the Order singles out only gender-affirming care. Dkt. #18 ¶80.

13 Neither Order survives heightened scrutiny.

14 **c. The Orders fail any level of review**

15 Heightened scrutiny should be applied for the reasons described above. But both Orders
16 would fail any level of scrutiny because they “[are] so far removed from” their purported goals,
17 “it [is] impossible to credit” them. *Romer v. Evans*, 517 U.S. 620, 635 (1996). There is no rational
18 basis to disregard the scientific consensus and conclude that allowing minors with gender
19 dysphoria to receive gender-affirming medical care that they, their parents, and their doctors
20 agree is medically necessary “would threaten [the federal government’s] legitimate interests in
21 a way that” allowing other types of medical care “would not.” *City of Cleburne v. Cleburne*
22 *Living Ctr.*, 473 U.S. 432, 448 (1985). *Eisenstadt v. Baird*, 405 U.S. 438, 452 (1972) (health
23 risks of birth control pills not a rational basis for banning access for unmarried people while
24 allowing access for married people). The Orders’ insistence that transgender people do not and
25 cannot exist is simply false as a matter of fact, and there is no legitimate interest in insisting
26 otherwise.

1 Nor is animus a rational basis, *see Romer*, 517 U.S. at 632: “a bare desire to harm a
 2 politically unpopular group cannot constitute a legitimate governmental interest.” *Id.* (cleaned
 3 up); *U.S. Dep’t of Ag. v. Moreno*, 413 U.S. 528, 534 (1973) (same). While the Orders purport to
 4 “protect[]” “vulnerable” youth, the President’s actions—indeed, the language of the Orders
 5 themselves—show that their real purpose was to erase transgender people. This is another reason
 6 the Orders fail any level of review. *See Bd. of Trs. of Univ. of Ala. v. Garrett*, 531 U.S. 356, 374-
 7 75 (2001) (Kennedy, J., concurring); *see, e.g., Doe v. Ladapo*, 676 F. Supp. 3d 1205, 1220 (N.D.
 8 Fla. 2023), *appeal dismissed sub nom. Doe v. Surgeon Gen., Fla.*, No. 23-12159-JJ, 2024 WL
 9 5274658, at *1 (11th Cir. July 8, 2024) (concluding “there is no rational basis, let alone a basis
 10 that would survive heightened scrutiny,” for prohibiting gender-affirming treatment for minors);
 11 *Dekker v. Weida*, 679 F. Supp. 3d 1271, 1293 (N.D. Fla. 2023) (“disapproving transgender status
 12 and discouraging individuals from pursuing their honest gender identities” are “plainly
 13 illegitimate purposes” demonstrating state law was adopted for “purposeful discrimination”
 14 against transgender people).

15 **2. Defunding medical schools, providers, and hospitals for providing gender-**
 16 **affirming care and recognizing transgender identity violates the separation**
 17 **of powers**

18 The Orders also violate the separation of powers by unilaterally ordering federal agencies
 19 to cut off federal funding to medical institutions that provide gender-affirming care or that
 20 recognize transgender identity. *See* Dkt. #161 pp.14-16; *PFLAG*, 2025 WL 510050, at *1 (“The
 21 challenged provisions of the Executive Orders place conditions on federal funding that Congress
 22 did not prescribe.”). President Trump should know from his failed efforts to defund States and
 23 municipalities during his first term that Congress alone holds the “power of the purse” and that
 24 he cannot set conditions on appropriated funds that Congress did not authorize. But he did it
 25 again anyway.

26 *City and County of San Francisco v. Trump* controls. There, the Ninth Circuit struck
 down an Executive Order from President Trump’s first term ordering agencies to broadly defund

1 “sanctuary cities” without congressional authorization. 897 F.3d 1225 (2018). The Court held
2 that, because the United States Constitution “exclusively grants the power of the purse to
3 Congress, not the President,” “the Administration may not redistribute or withhold properly
4 appropriated funds in order to effectuate its own policy goals.” *Id.* (citing U.S. Const. art. I, §9,
5 cl. 7 (Appropriations Clause); U.S. Const. art. I, §8, cl. 1 (Spending Clause)). Rather, given the
6 President’s obligation to “take Care that the Laws be faithfully executed,” the President is
7 affirmatively obligated to distribute funds appropriated by Congress without adding
8 unauthorized conditions. *Id.* Because Congress had not “authorize[d] withholding of funds” to
9 sanctuary cities, President Trump and the executive branch “violate[d] the constitutional
10 principle of the Separation of Powers” by claiming “for itself Congress’s exclusive spending
11 power” and attempting to “coopt Congress’s power to legislate.” *Id.*

12 So too here. Section 4 of the Denial-of-Care Order directs every federal agency to
13 “immediately” “ensure that institutions receiving Federal research or education grants end”
14 gender-affirming care. And while Section 4 purports to direct only actions “consistent with
15 applicable law” and “in coordination with the Director of the Office of Management and
16 Budget,” similar caveats did not save the order at issue in *San Francisco*, 897 F.3d at 1240 (“If
17 ‘consistent with law’ precludes a court from examining whether the Executive Order is
18 consistent with law, judicial review is a meaningless exercise, precluding resolution of the
19 critical legal issues.”). The “clear and specific language,” *id.* at 1239, of the Denial-of-Care
20 Order is obvious. It directs the “defunding” of medical institutions that provide gender-affirming
21 care. The Gender-Ideology Order similarly directs federal agencies to “end the Federal funding
22 of gender ideology,” and to “assess grant conditions and grantee preferences and ensure grant
23 funds do not promote gender ideology.” E.O. 14,168 §§3(e), (g). Just as in *San Francisco*,
24 President Trump did not even attempt to identify any federal laws conditioning the receipt of
25 federal funds on denying transgender youth gender-affirming care or a refusing to recognize
26 transgender identity. No such law exists, much less in unambiguous terms required for a valid

1 exercise of congressional spending power. The Supreme Court has likened Congress’s power to
2 condition federal funds as “much in the nature of a contract: in return for federal funds, the States
3 agree to comply with federally imposed conditions.” *Pennhurst State Sch. & Hosp. v.*
4 *Halderman*, 451 U.S. 1, 17 (1981). The “legitimacy” of such conditions “rests on whether the
5 State voluntarily and knowingly accepts the terms of the ‘contract.’” *Id.* (citations omitted). As
6 such, “if Congress intends to impose a condition on the grant of federal moneys, it must do so
7 unambiguously.” *Id.*

8 Congress did not do so. For example, medical institutions in the Plaintiff States receive
9 federal research grants authorized by Congress under dozens of federal statutes, not one of which
10 conditions receipt of such funds on depriving patients of gender-affirming care or recognizing
11 transgender identity. Dkt. #16 ¶122; Dkt. #116 ¶15; Dkt. #92 ¶16; Dkt. #97 ¶16.³

12 Indeed, Congress has passed numerous laws *prohibiting* federal interference in the
13 practice of medicine and patients’ private medical decisions and prohibiting sex-based
14 discrimination in medicine. For example, the Social Security Act (Medicare and Medicaid)
15 forbids federal interference in medical decisions by practitioners and guarantees individuals the
16 right to make their own choices about needed medical care. *See, e.g.*, 42 U.S.C. §1395
17 (“[n]othing in this subchapter shall be construed to authorize any Federal officer or employee to
18 exercise any supervision or control over the practice of medicine or the manner in which medical
19 services are provided”); *id.* §1396a(a)(23) (providing individuals freedom of choice to obtain
20 health services from any institution, agency, or person qualified to participate). Similarly, the
21 Affordable Care Act prohibits discrimination on the basis of sex by any health program receiving

22 ³ Indeed, no appropriations bill in the last decade has included a condition requiring denial of gender-
23 affirming care or prohibiting recognition of transgender identity. *See* House Bill 4366,
24 <https://www.congress.gov/bill/118th-congress/house-bill/4366/text>; House Bill 2617,
25 <https://www.congress.gov/bill/117th-congress/house-bill/2617/text>; House Bill 2471,
26 <https://www.congress.gov/bill/117th-congress/house-bill/2471/text>; House Bill 1158,
<https://www.congress.gov/bill/116th-congress/house-bill/1158/text>; House Bill 1625,
<https://www.congress.gov/bill/115th-congress/house-bill/1625/text>; House Bill 1244,
<https://www.congress.gov/bill/115th-congress/house-bill/244/text>; House Bill 2029,
<https://www.congress.gov/bill/114th-congress/house-bill/2029/text>.

1 federal assistance. *Id.* §18116; *see Kadel v. Folwell*, 100 F.4th 122, 164 (4th Cir. 2024) (en banc)
2 (state Medicaid plan’s categorical exclusion of coverage for gender-affirming care violated the
3 ACA’s anti-discrimination requirement).

4 By attaching conditions to federal funding that were not only unauthorized by Congress
5 but that contravene laws prohibiting federal interference and discrimination in the practice of
6 medicine, the Orders usurp Congress’s spending, appropriation, and legislative powers.
7 *Clinton v. City of New York*, 524 U.S. 417, 438 (1998) (“There is no provision in the Constitution
8 that authorizes the President to enact, to amend, or to repeal statutes.”). This Court should enjoin
9 Defendants’ implementation and enforcement of the Orders.

10 **3. The Denial-of-Care Order’s criminalization of gender-affirming care**
11 **violates the Tenth Amendment and separation of powers**

12 By attempting to criminalize gender-affirming care, the Denial-of-Care Order usurps the
13 States’ reserved powers to regulate the practice of medicine, in violation of the
14 Tenth Amendment. The Tenth Amendment provides that “[t]he Powers not delegated to the
15 United States by the Constitution, nor prohibited by it to the States, are reserved to the States,
16 respectively, or to the people.” The President has no enumerated power to regulate the practice
17 of medicine or to criminalize medical practices. Nor has he been authorized by Congress to do
18 so. The Order thus encroaches on powers reserved to the States.

19 It is long-established that the “direct control of medical practice in the states is beyond
20 the power of the federal government.” *Linder v. United States*, 268 U.S. 5, 18 (1925). States have
21 historically regulated the field of healthcare and set medical standards of care as a quintessential
22 exercise of their police power. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387 (2002);
23 *Dent v. West Virginia*, 129 U.S. 114, 122 (1889) (recognizing the state’s powers to regulate
24 medical professions from “time immemorial”). Throughout the nation’s history, states have
25 exercised such police powers to protect the health and safety of their citizens as primarily
26 “matter[s] of local concern.” *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996); *see also*

1 *Gonzales v. Oregon*, 546 U.S. 243, 270 (2006) (holding that the Controlled Substance Act did
2 not manifest intent to “regulate the practice of medicine,” which has traditionally fallen within
3 core state police powers).

4 Here, each of the Plaintiff States has exercised their police powers to authorize and
5 protect gender-affirming care, including for transgender youth. Washington, for example, makes
6 clear that the provision of or participation in any gender-affirming treatment consistent with the
7 standard of care in Washington by a license holder does not constitute unprofessional conduct
8 subject to discipline. Wash. Rev. Code §18.130.450; *see also* Dkt. #117 ¶5. It also enacted the
9 Gender Affirming Treatment Act to protect the rights of insured individuals seeking coverage
10 for gender-affirming medical treatment. Wash. Rev. Code §74.09.675. Washington has also
11 enacted a shield law protecting providers and patients in providing or obtaining gender-affirming
12 treatment. Wash. Rev. Code §7.115. As part of the regulation of practice of medicine, Oregon,
13 Minnesota, and Colorado likewise do not treat the gender-affirming care meeting standards of
14 care as unprofessional conduct. Dkt. #103 ¶¶5-7; Dkt. #104 ¶9; Colo. Rev. Stat.
15 §12-30-121(2)(a). The Plaintiff States further ensure insurance coverage for gender-affirming
16 care. *See* Dkt. #114 ¶10; Dkt. #94 ¶9; Dkt. #87 ¶9; 3 Code Colo. Regs. 702-4, Regulation 4-2-
17 42, §5(A)(1)(o). And this Court need not determine if Congress would have authority to preempt
18 these laws because Congress has never outlawed gender-affirming care.

19 The President, in contrast, has no enumerated power to regulate the practice of medicine
20 or to criminalize medical care. But this is exactly what the Denial-of-Care Order does. It broadly
21 redefines gender-affirming care—including non-surgical options like puberty-blocking
22 medications and hormone therapy—as “mutilation,” in a bad-faith effort to bring this necessary,
23 life-saving care within the federal prohibition on “female genital mutilation” under
24 18 U.S.C. §116. And it directs the Department of Justice to “prioritize” these baseless
25 prosecutions. But 18 U.S.C. §116 applies only to “procedure[s] performed for *non-medical*
26 *reasons* that involve[] partial or total removal of, or other injury to, the external female genitalia.”

1 *Id.* §116(e) (emphasis added). It has nothing to do whatsoever with non-surgical treatments—
2 which are generally the only treatments minors can receive. And it explicitly excludes any
3 “surgical operation” that is “necessary to the health of the person on whom it is performed, and
4 is performed by a person licensed in the place of its performance as a medical practitioner[.]”
5 *Id.* §116(b). The statute cannot apply to gender-affirming care provided by state medical
6 providers and authorized under the law of Plaintiff States.

7 Courts will not construe a statute to “alter the federal-state framework by permitting
8 federal encroachment upon a traditional state power,” unless “Congress conveys its purpose
9 clearly.” *United States v. Bass*, 404 U.S. 336, 349 (1971); *see also Gonzales*, 546 U.S. at 274
10 (“Just as the conventions of expression indicate that Congress is unlikely to alter a statute’s
11 obvious scope and division of authority through muffled hints, the background principles of our
12 federal system also belie the notion that Congress would use such an obscure grant of authority
13 to regulate areas traditionally supervised by the States’ police power.”); *Solid Waste Agency of*
14 *N. Cook Cnty. v. U.S. Army Corps of Eng’rs*, 531 U.S. 159, 174 (2001) (invalidating agency
15 interpretation of federal statute where it “would result in a significant impingement of the States’
16 traditional and primary power over land and water use”). Here, 18 U.S.C. §116 clearly respects
17 the States’ historic authority to govern the practice of medicine.

18 Even though 18 U.S.C. §116 clearly does not prohibit gender-affirming care lawfully
19 provided in the Plaintiff States, Defendants have not disavowed weaponizing the statute in
20 exactly this way. Dkt. #136 pp.25-26; TRO Hearing Tr. 18:14-21. The Denial-of-Care Order
21 thus terrorizes medical providers and parents with threats of investigation and prosecution for
22 medical care that is lawful in the Plaintiff States. Physician Plaintiff 1 Supp. ¶¶12-13; Physician
23 Plaintiff 2 Supp. ¶9; Physician Plaintiff 3 Supp. ¶7; Dellit Supp. ¶5. It usurps the Plaintiff States’
24 authority in violation of the Tenth Amendment and subverts 18 U.S.C. §116’s specific exclusion
25 of medical care in violation of separation of powers.
26

1 **4. The Orders are unconstitutionally vague**

2 The Orders are facially vague because they seek to enforce a definition of “sex” that is
3 nonscientific, nonsensical, and cannot apply to anyone.

4 Executive Orders are subject to the same vagueness standards as statutes. *See*
5 *Humanitarian Law Project v. Dept. of Treasury*, 463 F.Supp.2d 1049, 1057-1064 (applying
6 statutory vagueness standard to executive order). “A statute is void for vagueness when it does
7 not sufficiently identify the conduct that is prohibited.” *United States v. Wunsch*, 84 F.3d 1110,
8 1119 (9th Cir. 1996). “A law is unconstitutionally vague if it fails to provide a reasonable
9 opportunity to know what conduct is prohibited, or is so indefinite as to allow arbitrary and
10 discriminatory enforcement.” *United States v. Mincoff*, 574 F.3d 1186, 1201 (9th Cir. 2009); *see*
11 *also United States v. Williams*, 553 U.S. 285, 304 (2008) (cleaned up).

12 Here, the Gender-Ideology Order in Section 2 provides the definition of “sex,” that
13 governs the Denial-of-Care Order as “an individual’s immutable biological classification as
14 either male or female.” E.O. 14,168 §2(a). The Gender-Ideology Order further defines “Female”
15 as “a person belonging, *at conception*, to the sex that produces the large reproductive cell.” *Id.*
16 §(2)(d) (emphasis added). It defines “Male” as “a person belonging, *at conception*, to the sex
17 that produces the small reproductive cell.” *Id.* §2(e) (emphasis added).

18 But zygotes do not produce reproductive cells “at conception.” Shumer Supp. ¶8; *see*
19 *also* Dkt. #18 ¶¶18-23; Dkt. #19 ¶¶27-37, 103-105. The labels “male” and “female” “cannot be
20 assigned at conception prior to the process of sex differentiation.” Shumer Supp. ¶8. These
21 “inaccurate definitions” “make the Order nonsensical.” *Id.* ¶22. The Denial-of-Care Order
22 requires determination of an individual’s sex. *See* Dkt. #161 pp.18-19. But the Orders define
23 these terms in pure gobbledygook and are unconstitutionally vague.

24 **D. Plaintiffs Will Suffer Irreparable Harm if the Orders Are Not Enjoined**

25 If the Orders are not blocked, Plaintiffs will suffer serious and irreparable harm. *See*
26 *Brandt*, 47 F.4th at 672; *see also* Dkt. #161 pp.26-27. As discussed above, the Orders violate the

1 constitutional rights of the Plaintiffs and their medical institutions, providers, and adolescent
2 patients, which is, in and of itself, irreparable harm. *See, e.g., Hecox*, 104 F.4th at 1088;
3 *Hernandez v. Sessions*, 872 F.3d 976, 994-95 (9th Cir. 2017).

4 If they stand, the Orders will dramatically reduce if not eliminate the availability of
5 gender-affirming care for transgender adolescents, causing them catastrophic harm. Dkt. #19
6 ¶¶113, 115; Dkt. #15 ¶¶33-35; Dkt. #102 ¶¶9-13; Dkt. #113 ¶¶9-10; Dkt. #119 ¶5. Transgender
7 adolescents are already vulnerable, facing higher risks of suicide, eating disorders, anxiety, and
8 depression. Dkt. #76 ¶13; Dkt. #77 ¶11; Dkt. #86 ¶¶9, 11; Dkt. #69 ¶4; Dkt. #68 ¶6; Dkt. #102
9 ¶7. With treatment, these youth experience an “overwhelming sense of relief”—a type of “gender
10 euphoria” that allows them to “plug into life, “flourish,” become “outgoing,” and “willing to try
11 new things,” even gaining the confidence to become class president. Dkt. #13 ¶¶20-21; Dkt. #77
12 ¶13; Dkt. #86 ¶10; Dkt. #106 ¶13; Dkt. #39 ¶6. For most adolescents this takes “many months,
13 and often years, of careful medication titration and medical monitoring to get them to that
14 healthy, thriving place.” Dkt. #13 ¶26.

15 If transgender and gender-diverse youth are unable to access gender-affirming care, even
16 temporarily, they can quickly develop secondary sexual characteristics inconsistent with their
17 gender identity, potentially “causing lifelong gender dysphoria,” and “prolonged negative mental
18 health outcomes.” Dkt. #86 ¶13; Dkt. #15 ¶¶33-35; Dkt. #88 ¶15; *see also* CEO-MN-1 ¶13
19 (“Stopping gender-affirming medical for youth with forcibly detransition youth against their
20 wishes.”). Transgender children and their parents are afraid to return to the anguish of gender
21 dysphoria, in which children suffered “severe depression,” “suicidal ideation,” and felt “trapped”
22 in bodies that “felt foreign.” Dkt. #69 ¶4. Some “cannot go back to the way they felt before they
23 received gender-affirming care”—“their world would close in and go dark.” Dkt. #76 ¶15;
24 Dkt. #43 ¶10. Many transgender adolescents have already experienced trauma from harassment
25 and violence and losing access to care will only expose them to “more violence as their outward
26

1 appearance changes and they no longer ‘pass.’” Dkt. #74 ¶17; Dkt. #83 ¶13; Dkt. #46 ¶¶10-11;
2 Dkt. #121 ¶7; Dkt. #122 ¶6.

3 Legal uncertainty itself is already wreaking havoc. Providers have been “deluged” with
4 “frantic” calls and emails from patients and parents “terrified at the prospect of losing access to
5 this care.” *E.g.*, Dkt. #13 ¶25; Dkt. #14 ¶¶24-25; Dkt. #116 ¶16. After the Order, providers have
6 witnessed increased “anxiety, depression, despair, and suicidal ideation” among their patients,
7 many of whom tie it to their “feeling hopeless about their existence, or their child’s existence,
8 as transgender.” Dkt. #108 ¶10. Providers are worried patients may seek treatment options on
9 the internet or through other illicit sources. Dkt. #96 ¶5; Dkt. #98 ¶19. Organizations supporting
10 gender-diverse youth have likewise seen a spike in crisis calls from transgender youth who are
11 suicidal or considering self-harm, and transgender youth have started to crisis plan for access to
12 medications, including through dangerous methods. Dkt. #118 ¶¶10-12; Dkt. #115 ¶15;
13 Dkt. #120 ¶6; Dkt. #78 ¶¶4-6. Some children’s reaction to the orders was “they should end their
14 life” and should “no longer exist after learning that the ‘leader of our country hates them,’” and
15 even young transgender kids now fear being murdered. Dkt. #108 ¶11; Dkt. #13 ¶26; Dkt. #111
16 ¶¶16-17.

17 Many parents of transgender youth are considering moving out of the country, with
18 children asking if they can move to Canada, and preparing to split up their families if necessary.
19 *See* Dkt. #11 p.24 n.9 (citing declarations); *see also* Dkt. #32 ¶15; C.C. ¶13; C.D. ¶14; C.S. ¶20;
20 Caitlin P. ¶17; G.K.L. ¶17; J.L. ¶14; J.T. ¶15; Mischo ¶18; S.M. ¶10; S.T. ¶20. They are facing
21 the difficult choice between staying in the home and State they love or keeping their children
22 safe and healthy. Dkt. #41 ¶13. Parents have packed “emergency bags” in case they “need to
23 suddenly flee the country.” *Id.* Other parents have avoided international travel out of fear their
24 child’s passport or even their child themselves could be taken from them at the border. Dkt. #63
25 ¶15; S.T. ¶17. They “fear even mentioning” their child’s “need for gender affirming care.”
26 Dkt. #60 ¶13. Transgender kids are now scared to go to school and families “feel boxed in from

1 every angle.” Dkt. #41 ¶13. Parents are struggling to shield their young children from their
2 growing fear about losing access to gender-affirming care.

3 If this care is lost or even interrupted temporarily, transgender children will predictably
4 suffer severe anxiety, depression, and suicidal ideation, making children’s “worst nightmares” a
5 reality. Dkt. #69 ¶9; Dkt. #70 ¶11; Dkt. #14 ¶30; Dkt. #15 ¶¶34, 36; Dkt. #85 ¶19; Leggett ¶21;
6 N.B. ¶12; S.G. ¶14; T.D. ¶11. Indeed, numerous doctors have already lost young transgender
7 patients to suicide. Dkt. #14 ¶31; Dkt. #77 ¶11; Dkt. #99 ¶21; Prince ¶7. Shortly after the
8 election, one provider’s 18-year-old patient—who had not previously been suicidal—took her
9 own life “rather than continue to live in a country where she was being told she should not exist.”
10 *Id.* Another Washington teen, Kai, a “bright and gentle soul” who loved game club, knowledge
11 bowl, and Japanese club, took her own life shortly before President Trump was inaugurated,
12 overwhelmed by the hate directed at transgender people. Dkt. #55 ¶¶4-12. If gender-affirming
13 care disappears, Washington doctors have no doubt that “transgender adolescents will die.”
14 Dkt. #13 ¶26. They are “certain” that “there are going to be young people who are going to take
15 their lives if they can no longer receive this care.” *Id.* Dkt. #80 ¶12; Dkt. #111 ¶16;
16 Dkt. #100 ¶16.

17 Moreover, the threat of prosecution and loss of funding has already caused practitioners
18 to stop providing gender-affirming care. *E.g.*, N.V. ¶8; D.Z. & A.Z. ¶11. The White House itself
19 has touted that the Denial-of-Care Order has forced hospitals around the country to shut down
20 their gender-affirming care programs. Dkt. #17-9. Seattle Children’s, for example, is “facing
21 immense pressure from the federal government to stop providing gender-affirming care” and is
22 “caught in [an]” emergency caused by the Order. Dkt. #116 ¶16. Immediately after the Order
23 issued, a clinician in Seattle halted all care due to fear of the DOJ, requiring other providers to
24 scramble to cover the providers’ appointments. Dkt. #13 ¶29. Other providers in the Plaintiff
25 States reasonably fear being prosecuted if they continue to provide gender-affirming care.
26 Dkt. #14 ¶33; Dkt. #15 ¶32; Dkt. #112 ¶38; Dkt. #33 ¶12; Dkt. #108 ¶¶13-14; Dkt. #80 ¶15;

1 E.L. ¶3; Chun ¶8. Washington already faces a shortage of providers offering gender-affirming
2 care, with clinicians having months- or years-long wait lists, and patients driving three to four
3 hours to meet with appropriate medical providers. Dkt. #76 ¶4; Dkt. #112 ¶¶9, 22. Absent an
4 injunction, the Denial-of-Care and Gender-Ideology Orders’ funding restrictions will only
5 intensify this shortage, making this necessary, often life-saving care all but impossible to access.
6 Dkt. #122 ¶8. These injuries are irreparable. *See Edmo v. Corizon, Inc.*, 935 F.3d 757, 797-98
7 (9th Cir. 2019).

8 The loss of hundreds of millions of dollars in funding also constitutes irreparable harm.
9 UW School of Medicine alone would lose nearly half a billion dollars in research grants annually,
10 putting the University and its providers in the untenable position of either violating the integrity
11 of their medical judgment and ethical obligation to provide evidence-based care for their
12 patients, or risk their and their colleagues’ research, practices, and livelihoods. Dkt. #16 ¶20;
13 Dkt. #13 ¶33; Dkt. #14 ¶32; Dkt. #15 ¶39; Dkt. #77 ¶18; Dkt. #76m¶15; Dkt. #82 ¶¶14, 16;
14 Catherine Doe ¶17. If enforced, the Order would eliminate all manner of research and treatment,
15 including for cancer, AIDS, diabetes, drug abuse, mental health treatment, autism, aging,
16 cardiovascular diseases, maternal health, and so much more. Dkt. #16 ¶9; Dkt. #116 ¶13. These
17 institutions are relied on by their surrounding communities to train doctors, provide medical care,
18 and conduct research into life-saving medications and procedures. *See id.*

19 **E. The Balance of Equities Weigh in Plaintiffs’ Favor, and a Preliminary Injunction**
20 **Is in the Public Interest**

21 The equities and public interest, which merge when the government is a party, tip sharply
22 in favor of the Plaintiffs. *Wolford v. Lopez*, 116 F.4th 959, 976 (9th Cir. 2024); *see also* Dkt. #161
23 pp.27-28. The threat of harm to Plaintiffs far outweighs the federal government’s interests in
24 immediately enforcing the Orders, and preserving Plaintiffs’ constitutional rights is in the public
25 interest. *See Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (“[I]t is always in the
26 public interest to prevent the violation of a party’s constitutional rights.”) (citation omitted)).

1 The balance of equities decidedly supports a preliminary injunction, and the Court should
2 preserve the status quo until the case can be decided on the merits.

3 Whatever interest the federal government may have in cutting off treatment to
4 transgender kids during the pendency of this case pales in comparison to Plaintiffs’ irreparable
5 harm. In contrast to the personal and irreparable harms faced by the Plaintiffs, a preliminary
6 injunction would not harm the federal government at all, but merely maintain the status quo.
7 Gender-affirming care has been provided safely for many years. And the Orders fail to identify
8 any harm to the federal government from the provision of such care. “[B]y establishing a
9 likelihood that [the government’s] policy violates the U.S. Constitution,” Plaintiffs “have also
10 established that both the public interest and the balance of the equities favor a preliminary
11 injunction.” *Ariz. Dream Act Coal. v. Brewer*, 757 F.3d 1053, 1069 (9th Cir. 2014).

12 **VI. CONCLUSION**

13 The Court should grant the Plaintiffs’ Preliminary Injunction Motion.

14 DATED this 19th day of February 2025.

15 I certify that this memorandum contains 8,377
16 words, in compliance with the Local Civil Rules.

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The Honorable Lauren King

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**UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE**

STATE OF WASHINGTON, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official
capacity as President of the United States,
et al.,

Defendants.

NO. 2:25-cv-244

ORDER GRANTING PLAINTIFFS’
MOTION FOR PRELIMINARY
INJUNCTION

[PROPOSED]

NOTE ON MOTION CALENDAR:
February 28, 2025, at 2:00 p.m.

ORAL ARGUMENT REQUESTED

I. INTRODUCTION

This matter came before the Court on the Motion for a Preliminary Injunction filed by the States of Washington, Minnesota, Oregon, and Colorado (collectively, Plaintiff States) and Physician Plaintiff 1, Physician Plaintiff 2, and Physician Plaintiff 3 (all collectively, Plaintiffs). Plaintiffs challenge Executive Order 14,187, issued January 28, 2025, by President Trump entitled “Protecting Children from Chemical and Surgical Mutilation” and Executive Order 14,168 issued on January 20, 2025, entitled “Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government.” Having considered the motion, Defendants’ response, if any, and the argument of the parties, if any, the Court GRANTS Plaintiffs’ Motion for a Preliminary Injunction effective immediately which shall continue until

1 further order from the Court. The Court enters the following findings of fact and conclusions of
2 law.

3 **II. FINDINGS OF FACT**

4 1. This Court granted a 14-day temporary restraining order against Defendants in
5 this matter on February 14, 2025, and set the hearing for this preliminary injunction motion at
6 that time. Defendants had notice of the prior motion for temporary restraining order and were
7 heard at the hearing on that motion. They were provided notice of this motion for preliminary
8 injunction.

9 2. Plaintiffs face irreparable injury as a result of the signing and implementation of
10 Executive Orders 14,187 and 14,168. The Orders harm Plaintiffs by forcing medical institutions
11 and providers within the Plaintiff States to choose between exercising their medical judgment
12 and ethical obligations in providing gender-affirming medical care to their adolescent patients
13 or risking losing substantial federal funding. Under the Orders, physicians and providers face
14 the risk of criminal liability for providing gender-affirming medical care. The threats to defund
15 research and education grants and applying 18 U.S.C. § 116 to medical professionals providing
16 gender-affirming care and families receiving such care will reduce the provision of
17 gender-affirming care to individuals suffering from gender dysphoria in the Plaintiff States. The
18 White House has agreed that the Order has caused hospitals to downsize or eliminate
19 gender-affirming care programs.

20 3. These harms are immediate, ongoing, and significant, and cannot be remedied in
21 the ordinary course of litigation.

22 4. A preliminary injunction against Defendants, as provided below, is necessary to
23 preserve the status quo and prevent irreparable harm during the pendency of this case.

24 **III. CONCLUSIONS OF LAW**

25 5. The Court has jurisdiction over Defendants and the subject matter of this action.

26 6. The Defendants had notice sufficient under Fed. Rule Civ. Pro. 65(a)(1).

1 7. The Court deems no security bond is required under Fed. R. Civ. Pro. Rule 65(c)
2 because Defendants will not suffer any costs from the preliminary restraining order.

3 8. To obtain a preliminary injunction, Plaintiffs must establish (1) they are likely to
4 succeed on the merits; (2) irreparable harm is likely in the absence of preliminary relief; (3) the
5 balance of equities tips in the Plaintiffs' favor; and (4) an injunction is in the public interest.
6 *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008); Fed. R. Civ. P. 65(b)(1).

7 9. Plaintiffs are likely to succeed on the merits of their claims. Plaintiffs are likely
8 to succeed in demonstrating that both Executive Order 14,168 and 14,187 facially discriminate
9 based on transgender status and sex and are thus subject to heightened scrutiny. *Doe v. Horne*,
10 115 F.4th 1083, 1102 (9th Cir. 2024); *Hecox v. Little*, 104 F.4th 1061, 1080 (9th Cir. 2024), *as*
11 *amended* (June 14, 2024) (applying heightened scrutiny to discrimination based on sex and
12 transgender status). Order 14,168 expressly classifies based on transfer status and sex by
13 prohibiting federal funding to programs that “promote[] gender ideology” by accepting the fact
14 that transgender and gender diverse people exist, including programs that provide gender-
15 affirming care to transgender and gender diverse people. Order 14,187 expressly classifies based
16 on transgender status and sex by penalizing and criminalizing healthcare only when provided to
17 “an individual who does not identify as his or her sex,” “to align an individual’s physical
18 appearance with an identity that differs from his or her sex,” or to “transform an individual’s
19 physical appearance to align with an identity that differs from his or her sex or that attempt to
20 alter or remove an individual’s sexual organs to minimize or destroy their natural biological
21 functions.” Executive Order 14,187, § 2(c). Plaintiffs are also likely to succeed in demonstrating
22 that there is no non-discriminatory justification for singling out and criminalizing the medical
23 decisions made by transgender youth, their parents, and their doctors, given that gender-
24 affirming care is supported by all major medical associations as medically appropriate and often
25 life-saving care for alleviating the significant distress of adolescents facing gender dysphoria.
26

1 10. Plaintiffs are likely to succeed in showing that the Executive Orders violate the
2 constitutional separation of powers by attaching conditions to funds appropriated by Congress
3 without authorization by Congress. *City & Cnty. of San Francisco v. Trump*, 897 F.3d 1225,
4 1245 (2018).

5 11. Plaintiffs are likely to succeed in showing that the Executive Orders thus intrude
6 on rights reserved by the Plaintiff States to regulate the practice of medicine in their own states
7 in violation of the Tenth Amendment. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387
8 (2002); *Dent v. West Virginia*, 129 U.S. 114, 122 (1889) (recognizing the state’s powers to
9 regulate medical professions from “time immemorial”).

10 12. Plaintiffs are likely to succeed in showing that the Executive Orders are
11 unconstitutionally vague in violation of the Fifth Amendment because they define “sex,” “male,”
12 and “female” in non-scientific, nonsensical, and impossible to apply ways such that no person
13 would be “male” or “female” under their terms. It is thus impossible to know what the Executive
14 Orders prohibit, and a person of ordinary intelligence would be unable to comply with the Orders
15 rendering them unconstitutionally vague. *See United States v. Williams*, 553 U.S. 285, 304
16 (2008).

17 13. Plaintiffs have also shown that they are likely to suffer irreparable harm in the
18 absence of preliminary relief. The Executive Orders directly impact Plaintiffs, immediately
19 risking substantial federal research and education grants and threaten prosecution for the
20 provision of medical care that is lawful in the Plaintiff States. The Order also irreparably harms
21 transgender and gender-diverse residents in the Plaintiff States, depriving them of their
22 constitutional right to equal protection.

23 14. The balance of equities tips sharply toward Plaintiffs and the public interest
24 strongly weighs in favor of entering temporary relief.

1 **IV. PRELIMINARY INJUNCTION**

2 Now, therefore, it is hereby ORDERED that:

3 1. Defendants and all their respective officers, agents, servants, employees and
4 attorneys, and any person in active concert or participation with them who receive actual notice
5 of this order are hereby fully enjoined from the following:

6 a. Enforcing or implementing Section 4 of Executive Order 14,187 within
7 the Plaintiff States or against health care providers for gender-affirming care provided in
8 Plaintiff States:

9 b. Enforcing or implementing Section 8(a) of Executive Order 14,187 within
10 the Plaintiff States, against health care providers for gender-affirming care provided in
11 Plaintiff States, or against families receiving health care provided in Plaintiff States to
12 the extent that Section 8(a) of Executive Order 14,187 purports to redefine “female
13 genital mutilation” under 18 U.S.C. § 116 as “chemical and surgical mutilation” as
14 defined in Section 2(c) of Executive Order 14,187;

15 c. Enforcing 18 U.S.C. § 116 against health care providers for gender-
16 affirming care provided in Plaintiff States or against families receiving health care
17 provided in Plaintiff States to the extent that Section 8(a) of Executive Order 14,187
18 purports to redefine “female genital mutilation” under 18 U.S.C. § 116 as “chemical and
19 surgical mutilation” as defined in Section 2(c) of Executive Order 14,187;

20 d. Enforcing Sections 3(e) or 3(g) of Executive Order 14,168 to condition or
21 withhold federal funding based on the fact that a health care entity or health professional
22 provides gender-affirming care within the Plaintiff States or against health care providers
23 for gender-affirming care provided in Plaintiff States;

24 e. Defendants’ attorneys shall provide written notice of this Order to all
25 Defendants and agencies and their employees, contractors, and grantees by March ____,
26 2025. Defendants shall file a copy of the notice on the docket at the same time.

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2. This preliminary injunction remains in effect pending further orders from this Court.

DATED this this ____ day of February 2025.

THE HONORABLE LAUREN KING
United States District Court Judge

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