No. 23-5110

In the United States Court of Appeals for the Tenth Circuit

PETER POE, by and through his parents and next friends, PAULA POE and PATRICK POE, *et al.*,

Plaintiffs-Appellants,

v.

GENTNER DRUMMOND, in his official capacity as Attorney General of the State of Oklahoma, *et al.*,

Defendants-Appellees.

On Appeal from the U.S. District Court for the Northern District of Oklahoma, No. 4:23-cv-00177, Honorable John F. Heil, III, District Judge

OPENING BRIEF FOR PLAINTIFFS-APPELLANTS

Megan Lambert
AMERICAN CIVIL LIBERTIES UNION OF OKLAHOMA FOUNDATION
P.O. Box 13327
Oklahoma City, OK 73113
(405) 524-8511
mlambert@acluok.org

Omar Gonzalez-Pagan
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, NY 10005-3919
(646) 307-7406
ogonzalez-pagan@lambdalegal.org

Harper S. Seldin
Chase Strangio
AMERICAN CIVIL LIBERTIES UNION
125 Broad Street, 18th Floor
New York, NY 10004
(212) 549-2500
hseldin@aclu.org
cstrangio@aclu.org

Laura J. Edelstein
JENNER & BLOCK LLP
455 Market Street, Suite 2100
San Francisco, CA 94105
(628) 267-6800
LEdelstein@jenner.com

Counsel for Plaintiffs-Appellants
(Additional counsel listed on signature block)

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STATEMENT OF RELATED CASES

There are no prior or related appeals.

STATEMENT OF JURISDICTION

Plaintiffs' claims arise under the Fourteenth Amendment. Plaintiffs sought relief under 42 U.S.C. § 1983. The district court had jurisdiction under 28 U.S.C. §§ 1331, 1334. The district court denied Plaintiffs' preliminary injunction motion in an opinion and order issued October 5, 2023, and Plaintiffs timely filed a notice of appeal on October 6, 2023. This Court has jurisdiction under 28 U.S.C. § 1292(a)(1).

STATEMENT OF ISSUES

1. Does SB613 likely violate the Fourteenth Amendment's Equal Protection Clause?

2. Does SB613 likely violate the Fourteenth Amendment's Due Process Clause?

3. Did the district court abuse its discretion in denying Plaintiffs-Appellants' preliminary injunction motion?

INTRODUCTION

Right now, Peter Poe, Daphne Doe, Brandon Boe, Lydia Loe, and Ryan Roe–five transgender adolescents who just want to enjoy their childhoods and grow into young adults–cannot receive potentially lifesaving medical care in their home state of Oklahoma. These Minor Plaintiffs all suffer from severe, clinically significant distress without access to gender-affirming medical care to treat their gender dysphoria. Before treatment, they were withdrawn and depressed, several struggled with suicidality or self-harm, and they all struggled to envision a future for themselves. Their parents and guardians decided, after careful reflection and consultation with medical professionals, that the benefits of evidence-based treatment, which their doctors recommended and all major U.S. medical organizations support, outweighed the risks, and they provided the requisite informed consent for this treatment. With care, Peter, Daphne, Brandon, Lydia, and Ryan began to thrive.

But Oklahoma now bans all interventions "for the purpose of attempting to affirm the minor's perception of his or her gender or biological sex, if that perception is inconsistent with the minor's biological sex," including the pubertal suppression and hormone therapy prescribed to the Minor Plaintiffs. SB613 does not prohibit those medications generally, or even for all minors. Clinicians may continue to prescribe pubertal suppression and hormone therapy for any other purpose, to

anyone of any age, *except* for people like the Minor Plaintiffs: transgender adolescents with gender dysphoria. SB613 thus takes aim at one class of people who need treatment for one purpose: to align their bodies with their gender identity.

Because Oklahoma's ban classifies on the basis of an individual's sex and transgender status, it triggers heightened scrutiny. The district court erred by applying a lower standard of review and then, in dicta, making clearly erroneous factual findings based on Defendants' discredited and unqualified experts. The district court further erred by failing to recognize the Parent Plaintiffs' fundamental right to direct their children's medical care, a right not constrained by medical interventions available at the Fourteenth Amendment's ratification.

Accordingly, the Court should reverse the district court's decision and order, issue a preliminary injunction to preserve the status quo, and protect Plaintiffs from irreparable harm.

STATEMENT OF THE CASE

A. Medical Guidelines for Treating Transgender Adolescents with Gender Dysphoria

Gender identity refers to a person's core sense of belonging to a particular gender. J.A.(Vol.2).0179; J.A.(Vol.2).0217. Gender identity has biological roots and cannot be changed voluntarily, by external forces, or through medical or mental health intervention. J.A.(Vol.2).0179-80; J.A.(Vol.2).0217-18. A person's gender identity does not always match the sex an individual was designated at birth.

J.A.(Vol.2).0179; J.A.(Vol.2).0218. People whose gender identity aligns with their sex designated at birth are cisgender (or non-transgender), while those whose gender identity differs from their sex designated at birth are transgender. J.A.(Vol.2).0179; J.A.(Vol.2).0218.

Being transgender is not a condition to be cured. But many transgender people suffer from gender dysphoria, a serious medical condition characterized by clinically significant distress arising from the incongruence between a transgender person's gender identity and sex designated at birth. If left untreated, gender dysphoria can result in severe anxiety, depression, self-harm, and suicide. J.A.(Vol.2).0183; J.A.(Vol.2).0218-19.

Treatment for gender dysphoria is well-established and has been provided for decades using evidence-based clinical guidelines. J.A.(Vol.2).0178; J.A.(Vol.2).0219-21. The World Professional Association for Transgender Health ("WPATH") and the Endocrine Society publish these widely used clinical practice guidelines (the "Guidelines"). J.A.(Vol.2).0184-85; J.A.(Vol.2).0222-26. Under these Guidelines, gender-affirming medical care is provided to adolescents only when an adolescent has: (i) gender incongruence that is both marked and sustained over time; (ii) a gender dysphoria diagnosis; (iii) sufficient emotional and cognitive maturity to provide informed consent; (iv) provided informed consent with their parents after being informed of the potential risks of treatment, including potential

reproductive side effects; and (v) no mental health concerns that would interfere with diagnosis or treatment. J.A.(Vol.2).0187; J.A.(Vol.2).0222-24.

For some adolescents with gender dysphoria, pubertal suppression may be medically indicated *after the onset of puberty*. Pubertal suppression is only indicated when, among other diagnostic criteria, the adolescent has "a long-lasting and intense pattern of gender nonconformity or gender dysphoria [that has] . . . worsened with the onset of puberty." J.A.(Vol.2).0223. Pubertal suppression prevents gender dysphoria from worsening by pausing the development of secondary sex characteristics that are inconsistent with the patient's gender identity. J.A.(Vol.2).0222. It is reversible and has no effect on fertility: once treatment stops, endogenous puberty resumes. J.A.(Vol.2).0222, 0226, 0231-32.

For some older adolescents, gender-affirming hormone therapy (i.e., testosterone for transgender boys and a combination of testosterone suppression and estrogen for transgender girls) may be medically indicated. J.A.(Vol.2).0223-24. Hormone therapy alleviates gender dysphoria by facilitating physiological changes consistent with an adolescent's gender identity. J.A.(Vol.2.)0227-28. Under the Guidelines, treatment is provided only after rigorous assessments of the minor's gender dysphoria and capacity to understand treatment's risks and benefits and with the informed consent of parents or guardians. J.A.(Vol.2).0187-89; J.A.(Vol.2).0225-26.

These medical interventions are provided to allow transgender adolescents to undergo puberty within the typical age range for puberty. J.A.(Vol.5).1004-05. These interventions greatly improve the health and wellbeing of transgender adolescents, as demonstrated by a substantial body of evidence, including cross-sectional and longitudinal studies and decades of clinical experience. J.A.(Vol.2).0189-90; J.A.(Vol.2).0258. Delaying treatment can result in significant distress, including anxiety and escalating suicidality, along with physical changes that can be difficult or impossible to reverse. J.A.(Vol.2).0219; J.A.(Vol.2).0258; J.A.(Vol.2).0376. Interventions in adolescence, however, can dramatically minimize gender dysphoria later in life and eliminate the need for surgery. J.A.(Vol.2).0228, 0233. By contrast, the risks and side-effects of these interventions are rare or easily managed. J.A.(Vol.2).0232-33. The evidence supporting gender-affirming medical care is comparable to the evidence supporting other pediatric care, which is often provided without randomized controlled trials. J.A.(Vol.2).0364-66.

B. Oklahoma's Ban

On May 1, 2023, Governor Kevin Stitt signed into law SB613, categorically banning medical care for gender dysphoria for transgender adolescents in Oklahoma. SB613 prohibits any "health care provider" from "knowingly provid[ing] gender transition procedures to any child," defined as "any person under eighteen (18) years of age." Okla. Stat. tit. 63 § 2607.1(A)(1), (B).

"Gender transition procedures" are defined by an enumerated list of "medical or surgical services performed for the purpose of attempting to affirm the minor's perception of his or her gender or biological sex, if that perception is inconsistent with the minor's biological sex." *Id.* § 2607.1(A)(2)(a). Prohibited procedures include "puberty-blocking drugs, cross-sex hormones, or other drugs to suppress or delay normal puberty or to promote the development of feminizing or masculinizing features consistent with the opposite biological sex," and "surgical procedures that alter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex." *Id.*

SB613 excludes from its prohibition, *inter alia*, "medications prescribed . . . specifically for the purpose of treating precocious puberty or delayed puberty in that patient," "services provided to individuals born with ambiguous genitalia, incomplete genitalia, or both male and female anatomy, or biochemically verifiable disorder[s] of sex development," and treating conditions "caused by or exacerbated by" "gender transition procedures." *Id.* § 2607.1(A)(2)(b).

Healthcare providers who violate SB613 can be convicted of a felony and disciplined for unprofessional conduct by their licensing board. *Id.* § 2607.1(C)-(D).

C. Plaintiffs' Background and Harms Imposed by SB613

Peter Poe is a twelve-year-old transgender boy who lives in Oklahoma with his parents, Paula and Patrick Poe. J.A.(Vol.2).0283-84. Peter asked to use a boy's

name when he was seven and came out to his parents when he was ten. J.A.(Vol.2).0284. As a child and young adolescent, Peter struggled with anxiety, thoughts of self-harm, and even suicide. He hid his body and avoided engagement with the world. J.A.(Vol.2).0284. Peter's parents found him a therapist, and he was eventually diagnosed with gender dysphoria. J.A.(Vol.2).0289. For the past 18 months, Peter has been receiving pubertal suppression to treat his gender dysphoria, J.A.(Vol.2).0289-90, and because of that treatment, he has bloomed: he is happier and more excited, outgoing, and social. J.A.(Vol.2).0290. When Peter's medication was delayed for insurance reasons, his gender dysphoria worsened. J.A.(Vol.2).0290. Peter is surrounded by a supportive community, church, and family. J.A.(Vol.2).0290-91. But his parents worry that without treatment, he will once again struggle with suicidality and thoughts of self-harm. J.A.(Vol.2).0291.

Daphne Doe is a fifteen-year-old transgender girl who lives in Oklahoma with her grandmother and legal guardian, Donna Doe. J.A.(Vol.2).0294-95. She has always known she was a girl: she "cannot imagine trying to be a boy for the rest of [her] life." J.A.(Vol.2).0295. Before puberty, Daphne experienced severe anxiety at the prospect of undergoing changes that would make her look like a boy. J.A.(Vol.2).0302. She told her grandmother and her therapist that she did not want to go through puberty as a boy and wanted everyone to see her as a girl. J.A.(Vol.2).0301. When her endogenous puberty began, the changes in her body

made her depressed, anxious, and withdrawn, and sent her on a downward spiral. J.A.(Vol.2).0301-02. Daphne has been diagnosed with gender dysphoria for which she received pubertal suppression and later estrogen, which she has been taking for almost two years. J.A.(Vol.2).0302. Daphne has persevered through the suicidal thoughts she had before receiving this medical care; she is thriving in school and avoids harassment by not being public about being transgender. J.A.(Vol.2).0302-03. Her grandmother worries that being forced to go through male puberty will make her depressed, anxious, and suicidal again. J.A.(Vol.2).0303. Daphne is grateful she started hormones as a teenager. Not only has she experienced immediate relief from her dysphoria, but she also feels hopeful about the future and is relieved she may not have to worry about other people assuming she is transgender based on her appearance. J.A.(Vol.2).0297.

Brandon Boe is a seventeen-year-old transgender boy who lives in Oklahoma with his parents, Benjamin and Bethany Boe. J.A.(Vol.2).0307-08. Even as a young child, Brandon insisted he was a boy. J.A.(Vol.2).0308. Brandon's parents found him mental health counseling after he came out as transgender, and he was diagnosed with gender dysphoria. J.A.(Vol.2).0314. Brandon's parents initially wanted him to wait for hormones until he turned eighteen, but Brandon's increasing isolation made them realize that Brandon could not wait until he was an adult for medical treatment for his gender dysphoria. J.A.(Vol.2).0309, 0314-15. Still, Brandon was

in therapy for more than a year before starting testosterone. J.A.(Vol.2).0309. Brandon is much more confident after being on testosterone for over a year. He has a job and goes out with his friends, neither of which he could do before. J.A.(Vol.2).0309. Brandon's parents are cautious, conservative, and religious people: they deliberated for a long time and did extensive research before allowing Brandon to start testosterone. J.A.(Vol.2).0315-16. They are involved in this case because they believe they must do everything they can to protect their son. J.A.(Vol.2).0316.

Lydia Loe is a seventeen-year-old transgender girl who lives in Oklahoma with her mother, Lauren Loe. J.A.(Vol.2).0320-21. She was raised in foster care and experienced significant rejection because she is transgender. J.A.(Vol.2).0321. Lauren became Lydia's foster parent (and now mother) when Lydia was thirteen, and after a year Lydia felt comfortable enough to share who she was. J.A.(Vol.2).0321. After two years of counseling and over a year after she first talked to a doctor about hormones, Lydia started estradiol and spironolactone to treat her gender dysphoria. J.A.(Vol.2).0321-22, 0328. Lydia has been taking hormones for almost a year, and she feels better about herself and her appearance: without the constant fear of being misgendered, she can leave the house and feel confident. J.A.(Vol.2).0322. She has worked hard to be her true self, and just wants to keep being herself. J.A.(Vol.2).0323. Lydia's mental health drastically declines when

she does not have access to her medication, however, and Lauren is worried that her daughter will return to suicidality and self-harm without hormone therapy. J.A.(Vol.2).0329.

Ryan Roe is a fourteen-year-old transgender boy who lives in Oklahoma with his parents, Rachel and Richard Roe. J.A.(Vol.2).0338. Ryan never felt comfortable with gendered expectations, and as puberty approached, he became distressed, anxious, and uncomfortable. Even alone in his room, existing in his body felt "horrible" because of the conflict between his physiological characteristics and his identity. J.A.(Vol.2).0339. His parents found him a therapist; he was ultimately diagnosed with gender dysphoria. J.A.(Vol.2).0334, 0339. Based on his diagnosis and medical team's recommendation, Ryan started pubertal suppression, which has alleviated his gender dysphoria and allowed him to thrive. J.A.(Vol.2).0334, 0339-40. Living as a boy brings Ryan joy and happiness; he is terrified about being forced to live in a body inconsistent with his identity. J.A.(Vol.2).0340. His mother Rachel, a mental health professional, has ensured that Ryan has the support of therapists, but it is the medical treatment for her son's gender dysphoria that dramatically and positively improved his wellbeing. J.A.(Vol.2).0334. Because the family cannot leave Oklahoma, Rachel is considering sending Ryan to live on the East Coast with relatives if he cannot access medical care. J.A.(Vol.2).0335.

PROCEDURAL HISTORY

Plaintiffs filed their Complaint and Motion for Preliminary Injunction on May 2, 2023. J.A.(Vol.1).0034; J.A.(Vol.1).0115; J.A.(Vol.1).0119. On May 18, 2023, the State Defendants agreed to "not enforce any provision of SB 613 in relation to conduct that occurs while Plaintiffs' Motion for Preliminary Injunction is pending before this Court or otherwise enforce any provision of SB 613 during the pendency of Plaintiffs' Motion for Preliminary Injunction," thereby "negat[ing] Plaintiffs' need for expedited briefing." J.A.(Vol.2).0418-19. The district court denied Plaintiffs' Motion for Preliminary Injunction on October 5, 2023 (corrected on October 6, 2023). J.A.(Vol.6).1230.; J.A.(Vol.6).1266. On October 6, 2023, Plaintiffs timely filed a Notice of Appeal. J.A.(Vol.6).1302.

STANDARD OF REVIEW

"To obtain a preliminary injunction, the movant must show: (1) a substantial likelihood of success on the merits; (2) irreparable harm to the movant if the injunction is denied; (3) the threatened injury outweighs the harm that the preliminary injunction may cause the opposing party; and (4) the injunction, if issued, will not adversely affect the public interest." *Gen. Motors Corp. v. Urb. Gorilla, LLC*, 500 F.3d 1222, 1226 (10th Cir. 2007).

This Court "review[s] a district court's denial of a preliminary injunction under an abuse of discretion standard," *id.*, and "examine[s] the [district] court's

factual findings for clear error and its legal conclusions de novo." *Free the Nipple-Fort Collins v. City of Fort Collins*, 916 F.3d 792, 796–97 (10th Cir. 2019). The Court will disturb the trial court's decision if it "has a definite and firm conviction that the lower court made a clear error of judgment or exceeded the bounds of permissible choice in the circumstances." *Moothart v. Bell*, 21 F.3d 1499, 1504 (10th Cir. 1994) (citation omitted).

SUMMARY OF THE ARGUMENT

The district court abused its discretion by failing to issue a preliminary injunction. The court made several legal and factual errors.

First, the district court applied the wrong level of scrutiny to Plaintiffs' equal protection claim. Heightened scrutiny applies because SB613 classifies based on sex and transgender status and seeks to enforce gender conformity. Reviewed under the appropriate standard, SB613 is unconstitutional because it is not substantially related to an important government interest. Decades of scientific study and clinical experience establish the efficacy of gender-affirming medical care to treat adolescent gender dysphoria. The treatment's benefits outweigh its risks, which are comparable to those present in many other types of pediatric medicine. And there is no legitimate state interest, let alone an exceedingly persuasive justification, in seeking to enforce gender conformity. SB613 fails any level of review.

Second, the district court erred in holding that SB613 did not impinge upon Parent Plaintiffs' fundamental right to direct their children's medical care, which is neither procedure-specific nor limited to the state of medicine in 1868.

Though the district court did not address the other preliminary injunction factors, Plaintiffs will be irreparably harmed by the deprivation of their constitutional rights and the interruption in Minor Plaintiffs' medical care. The balance of the equities and public interest both favor a preliminary injunction.

ARGUMENT

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THEIR EQUAL PROTECTION CLAIM.

All sex classifications warrant heightened scrutiny. *See United States v. Virginia*, 518 U.S. 515, 555 (1996) ("*VMI*"). By singling out for prohibition all treatment related to "gender transition," SB613 classifies based on sex and transgender status and therefore triggers heightened equal protection scrutiny.

Under the appropriate level of scrutiny, it is evident that Plaintiffs are likely to succeed on their equal protection claim. But under any standard of review, Oklahoma has failed to explain how banning only this form of care advances the interests it claims to serve. The evidentiary support for and risk associated with this care are comparable to many other forms of pediatric treatment.

A. SB613 Triggers Heightened Scrutiny.

SB613 is subject to heightened scrutiny for three independent reasons. First, SB613 facially classifies based on sex. Second, it facially classifies based on transgender status. And third, it purposely seeks to enforce gender conformity by singling out transgender people for disfavored treatment.

1. SB613 classifies based on sex.

SB613 classifies based on sex in at least two separate ways: (a) it facially classifies based on sex designated at birth, and (b) it facially classifies based on a person's failure to identify with their sex designated at birth, i.e., their transgender status.

(a) SB613 prohibits treatment based on a person's sex designated at birth.

SB613 "necessarily rests on a sex classification," *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 608 (4th Cir. 2020), *cert. denied*, 141 S. Ct. 2878 (2021), by prohibiting medical care when it is provided in a manner the state deems "inconsistent with the minor's biological sex." Okla. Stat. tit. 63 § 2607.1(A)(2)(a).[1] Every person to whom SB613 applies is subjected to a sex classification because their sex designated at birth determines whether they can receive the medical care.

[1] In this respect, SB613 is no different from the bathroom policies in *Adams by & through Kasper v. School Board of St. Johns County*, 57 F.4th 791, 803 (11th Cir. 2022) (en banc), and *Grimm*.

See Brandt v. Rutledge, 47 F.4th 661, 669 (8th Cir. 2022); *K.C. v. Individual Members of Med. Licensing Bd. of Ind.*, 2023 WL 4054086, at *8 (S.D. Ind. June 16, 2023), *appeal filed*, No. 23-2366 (7th Cir. July 12, 2023).

The district court rejected the notion that SB613 "is discriminatory on its face because it makes distinctions in 'explicit gendered terms.'" J.A.(Vol.6).1276. In its view, "[t]he use of these 'gendered terms' reflects the nature of the procedure being regulated, not an intention to discriminate between people of different sexes," and thus does not classify based on sex. J.A.(Vol.6).1276. But a law or policy that "deals in explicitly gendered terms," *Kadel v. Folwell*, 620 F. Supp. 3d 339, 375 (M.D.N.C. 2022) (cleaned up), cannot be facially neutral. Indeed, SB613's use of "gendered terms" is critical to *how SB613 operates*.

SB613 does not just incidentally mention sex. It explicitly imposes differential treatment based on an individual's sex designated at birth. Whether a specific treatment is prohibited depends exclusively on whether the treatment is deemed consistent or inconsistent with the minor's sex designated at birth. For example, an adolescent in Oklahoma designated male at birth may be prescribed testosterone because he is a "late bloomer" and feeling alienated from his peers. Brandon Boe, in contrast, cannot because he was designated female at birth. In other words, the law "penalizes" a person designated female at birth for the same "action[]" of seeking masculinizing medical treatment that it "tolerates" in persons

designated male at birth. *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1741 (2020).[2] If the legislature cannot "writ[e] out instructions" for determining whether treatment is permitted "without using the words man, woman, or sex (or some synonym)," the law classifies based on sex. *Bostock*, 140 S. Ct. at 1746;[3] *see also Dekker v. Weida*, 2023 WL 4102243, at *11 (N.D. Fla. June 21, 2023) ("If one must know the sex of a person to know whether or how a provision applies to the person, the provision draws a line based on sex."), *appeal pending*, No. 23-12155 (11th Cir. filed June 27, 2023). SB613 necessarily classifies based on sex.

In response, Defendants argue there are physical differences between men and women and that because SB613 deals with medicine (which they contend must consider such differences), it does not discriminate based on sex. J.A.(Vol.3).0529. Defendants put the cart before the horse. Their argument goes to whether SB613 *survives* heightened scrutiny, not whether it *classifies* on the basis of sex in the first instance. The existence of "medical and biological realities" may provide reasons

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[2] For example, SB613 contains an explicit exception allowing for irreversible, sterilizing surgery on intersex infants with differences of sex development if the purpose of the surgery is to make the infant's body conform to their sex designated at birth. *See* Okla. Stat. tit. 63 § 2607.1(A)(2)(b)(4).

[3] It does not matter that *Bostock* was a Title VII case because its reasoning applies. Lower courts are "bound by more than just the express holding of a case"; their decisions "must comport with the 'reasoning or theory,' not just the holding, of Supreme Court decisions." *Thompson v. Hebdon*, 7 F.4th 811, 827 (9th Cir. 2021) (citation omitted).

why a particular classification survives heightened scrutiny, *see Nguyen v. INS*, 533 U.S. 53, 73 (2001), but it cannot be a basis for refusing to apply heightened scrutiny in the first place. *See Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 n.9 (1982) ("While the validity and importance of the objective may affect the outcome of the analysis, the analysis itself does not change."). The very purpose of heightened scrutiny is "to assure that the validity of [a sex] classification is determined through reasoned analysis rather than through the mechanical application of traditional, often inaccurate, assumptions." *Id.* at 726. As this Court has explained, "in some cases, . . . such differences justify differential treatment. But not always." *Fort Collins*, 916 F.3d at 801.

The district court reasoned that "[t]he Act does not use sex as a means to distinguish between groups" because "treatments allowed by SB 613 are allowed for *all* minors, regardless of sex," and "*all* minors, regardless of sex, are prohibited from undergoing certain procedures for the purpose of gender transition." J.A.(Vol.6).1277. But there is no exception to heightened scrutiny for sex-based classifications that apply equally to men as a group and women as a group. Explicit facial classifications "do not become legitimate on the assumption that all persons suffer them in equal degree." *Powers v. Ohio*, 499 U.S. 400, 410 (1991) (citing *Loving v. Virginia*, 388 U.S. 1 (1967)). We do not compare the relative burdens the law places on people of differing sexes. *Peltier v. Charter Day Sch., Inc.*, 37 F.4th

104, 125 n.13 (4th Cir. 2022), *cert. denied*, 143 S. Ct. 2657 (2023). Indeed, the Supreme Court squarely rejected this argument when it held that peremptory challenges could not be used to strike individual jurors based on sex. *See J.E.B. v. Alabama*, 511 U.S. 127, 141–42 (1994).

SB613 facially classifies based on sex.

(b) SB613 classifies based on a person's transgender status, which is a sex-based classification.

SB613 also classifies based on sex because the prohibition is based on a person's transgender status—that is, the incongruence between a person's sex designated at birth and their gender identity. A transgender person, by definition, is someone whose sex designated at birth is different from their gender identity. J.A.(Vol.2).0179; J.A.(Vol.2).0218. And "discrimination based on . . . transgender status necessarily entails discrimination based on sex." *Bostock*, 140 S. Ct. at 1747; *see also Tudor v. Se. Okla. State Univ.*, 13 F.4th 1019, 1028 (10th Cir. 2021) ("[T]ransgender discrimination . . . is discrimination 'because of sex[.]'").

SB613 explicitly bars "gender transition procedures" for minors. Okla. Stat. tit. 63 § 2607.1(B). This prohibition operates by determining whether a particular medical intervention is "inconsistent" with a person's sex designated at birth. To know whether any given procedure is "inconsistent" with a person's sex, a medical provider must know and act based on an individual's sex as designated at birth. As

such, this line is based both on a person's sex at birth, *see supra* section I.A.1.a, and the incongruence between a person's sex designated at birth and gender identity.

By prohibiting "gender transition," SB613 necessarily classifies based on transgender status: only transgender people undergo "gender transition" to treat gender dysphoria. And "a person cannot suffer from gender dysphoria without identifying as transgender." *Fain v. Crouch*, 618 F. Supp. 3d 313, 325 (S.D. W.Va. 2022); *see also C.P. v. Blue Cross Blue Shield of Ill.*, 2022 WL 17788148, at *6 (W.D. Wash. Dec. 19, 2022); *Kadel v. Folwell*, 2022 WL 11166311, at *4 (M.D.N.C. Oct. 19, 2022). SB613 therefore singles out medical care that only transgender people need or seek. *See Fain*, 618 F. Supp. 3d at 327; *Toomey v. Arizona*, 2019 WL 7172144, at *6 (D. Ariz. Dec. 23, 2019); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 950 (W.D. Wis. 2018); *see also* J.A.(Vol.6).1281 (finding SB613 "restrict[s] a specific course of treatment that only transgender individuals would normally request"). By doing so, it classifies based on transgender status and therefore based on sex.

The district court refused to apply the reasoning of *Bostock* (and *Tudor*) because "this case … concerns a materially different governing law, materially different language, and materially different facts." J.A.(Vol.6).1278; J.A.(Vol.3).0529. But the question is not whether to import Title VII's liability

standard to the Equal Protection Clause; it is whether *Bostock*'s reasoning as to the threshold classification question applies. It does.

Bostock did not say its reasoning applies only to Title VII or suggest its assessment of sex classifications could not apply in other contexts. The district court's limitation of *Bostock* "is reading quite a bit into a statement that says, in essence, 'we aren't reaching this point.'" *A.C. v. Metro. Sch. Dist. of Martinsville*, 75 F.4th 760, 769 (7th Cir. 2023). Neither the district court nor Defendants can provide an answer for how a classification based on a failure to identify with one's sex designated at birth simultaneously can be a facially sex-based classification under Title VII and a facially sex-neutral classification under the Equal Protection Clause.

The differences between Title VII and the Equal Protection Clause center on whether sex discrimination is *permissible*,[4] not whether a sex classification exists in the first place. The district court thus erred as it cannot "explain why or how any difference in language requires different standards for determining whether a facial classification exists in the first instance." *L.W. v. Skrmetti*, 83 F.4th 460, 503 (6th

[4] Sex discrimination under Title VII is categorically prohibited, but a sex classification may be permissible under the Equal Protection Clause if it satisfies heightened scrutiny. *Cf. Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181, 308-09 (2023) (Gorsuch, J., concurring) (distinguishing between Title VI and Title VII's categorical prohibitions on race and sex discrimination and the Equal Protection Clause's application of strict and intermediate scrutiny).

Cir. 2023) (White, J., dissenting). "Indeed, Supreme Court decisions under Title VII and the Equal Protection Clause imply the opposite, often citing one another." *Id.* The Supreme Court's reasoning as to the *classification* identified in *Bostock* applies in full force here.

Moreover, the district court's reliance on the "different language" of Title VII and the Fourteenth Amendment overlooks that both unambiguously focus on discrimination against individuals, not groups. *Compare Bostock*, 140 S. Ct. at 1740–41 (noting Title VII's application to "any individual"), *with J.E.B.*, 511 U.S. at 152 (Kennedy J., concurring), *and Mojo Built, LLC v. City of Prairie Vill.*, 2022 WL 288139, at *2 (10th Cir. Feb. 1, 2022) ("[I]t is well-settled the Equal Protection Clause protects persons, not groups." (cleaned up)).

Even if *Bostock*'s reasoning could be limited to Title VII (it cannot), Defendants cannot explain how to consider transgender status without considering sex. As other courts have found in the equal protection context, "discrimination on the basis of transgender status is a form of sex-based discrimination." *Hecox v. Little*, 79 F.4th 1009, 1026 (9th Cir. 2023). Before *Bostock,* the Seventh Circuit explained that discrimination based on transgender status discriminates based on sex under the Equal Protection Clause because it treats people "who fail to conform to the sex-based stereotypes associated with their assigned sex at birth" differently from others. *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d

1034, 1051 (7th Cir. 2017), *abrogated on other grounds as recognized by Ill. Republican Party v. Pritzker*, 973 F.3d 760, 762 (7th Cir. 2020).

The district court's observation that "Plaintiffs do not argue that the original fixed meaning of . . . the equal protection guarantee covers their claims," has no place in equal protection analysis. J.A.(Vol.6).1271. Heightened scrutiny applies to all sex classifications, regardless of whether they were commonplace at the time the Fourteenth Amendment was ratified. *See Sessions v. Morales-Santana*, 582 U.S. 47, 57 (2017); *Frontiero v. Richardson*, 411 U.S. 677, 685 (1973) (plurality opinion). Under the district court's view of equal protection, no sex-based classification would be subject to heightened scrutiny under the Fourteenth Amendment.

2. Heightened Scrutiny Is Required for Classifications Based on Sex and Transgender Status.

Because SB613 discriminates based on sex and transgender status, SB613 is subject to heightened scrutiny.

First, "all gender-based classifications . . . warrant heightened scrutiny." *VMI*, 518 U.S. at 555 (quotations omitted).

Second, SB613 is independently subject to heightened scrutiny because it discriminates against transgender persons, a quasi-suspect class. Heightened scrutiny is required where the government targets a class that: (1) has been historically "subjected to discrimination," *Bowen v. Gilliard*, 483 U.S. 587, 602

(1987); (2) has a defining characteristic bearing no "relation to ability to perform or contribute to society," *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440–41 (1985); (3) has "obvious, immutable, or *distinguishing characteristics* that define them as a discrete group," *Bowen*, 483 U.S. at 602 (emphasis added); and (4) is "a minority or politically powerless," *id*. Not all considerations need point toward heightened scrutiny; the first two alone may be dispositive. *See Windsor v. United States*, 699 F.3d 169, 181 (2d Cir. 2012), *aff'd sub nom. United States v. Windsor*, 570 U.S. 744 (2013). All four factors are present here.

The district court refused to apply heightened scrutiny because neither the Supreme Court nor this Court have recognized transgender status as a suspect class. J.A.(Vol.6).1279-80.[5] "But the lack of binding precedent does not require this Court to only apply rational basis review, nor does it prevent this Court from relying on well-reasoned opinions of non-binding courts to inform its opinion here." *Ray v. McCloud*, 507 F. Supp. 3d 925, 938 (S.D. Ohio 2020). The failure to perform that analysis was error. This Court should join the Fourth and Ninth Circuits (as well as

[5] Defendants argued below that *Brown v. Zavaras*, 63 F.3d 967, 971 (10th Cir. 1995), forecloses this argument. J.A.(Vol.3).0526. But *Brown* disclaimed any answer to the heightened scrutiny question because the *pro se* prisoner's allegations were "too conclusory to allow proper analysis." *Id.* at 971. *Brown* made clear the question remained open, including because of "[r]ecent research concluding that sexual identity may be biological." *Id*. *Druley v. Patton*, 601 F. App'x 632 (10th Cir. 2015), confirms this understanding, observing that this Court had not held that transgender people constitute a suspect class "[t]o date." *Id.* at 635.

the majority of district courts) in concluding that transgender persons constitute a quasi-suspect class. *See, e.g.*, *Grimm*, 972 F.3d at 608; *Karnoski v. Trump*, 926 F.3d 1180, 1200–01 (9th Cir. 2019); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017); *Adkins v. City of N.Y.*, 143 F. Supp. 3d 134, 139 (S.D.N.Y. 2015); *cf. Brandt*, 47 F.4th at 670 n.4.

As to the first and second factors, "[t]here is no denying that transgender individuals face discrimination, harassment, and violence because of their gender identity." *Whitaker*, 858 F.3d at 1051. This discrimination is unrelated to transgender people's ability to contribute to society. *See Grimm*, 972 F.3d at 612.

As to the third factor, though gender identity is innate, has a biological underpinning, and cannot be voluntarily changed, *id.* at 612–13; J.A.(Vol.2).0179-80, "the test is broader" than immutability. *Windsor*, 699 F.3d at 183. It includes "distinguishing characteristics that define [individuals] as a discrete group." *Bowen*, 483 U.S. at 602.[6] Transgender people are a distinguishable and discrete group.

As to the fourth and final factor, transgender people are a politically powerless and vulnerable group. In 2023, state legislatures entertained 500+ anti-LGBTQ laws, over eighty-four of which became law, including prohibitions against mentioning transgender people in schools, accessing sex-designated facilities,

[6] For example, illegitimacy and alienage are quasi-suspect or suspect classifications notwithstanding that they are not immutable. *See Mills v. Habluetzel*, 456 U.S. 91, 98–99 (1982); *Nyquist v. Mauclet*, 432 U.S. 1, 9 n.11 (1977).

obtaining corrected identity documents, and, as here, the provision or coverage of gender-affirming medical care.[7] *See also Grimm*, 972 F.3d at 612.

3. SB613 Engages in Purposeful Discrimination by Seeking to Enforce Sex Stereotypes.

Independently, SB613 is subject to heightened scrutiny because it was passed "because of," not "in spite of," its effect of enforcing generalizations about sex. *See Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 279 (1979). "By definition, a transgender individual does not conform to the sex-based stereotypes of the sex that he or she was assigned at birth." *Whitaker*, 858 F.3d at 1048; *see also Hecox*, 79 F.4th at 1033.

SB613 explicitly enforces sex stereotypes and gender conformity by prohibiting medical care intended to "affirm the minor's perception of his or her gender or biological sex, if that perception is *inconsistent* with the minor's biological sex." Okla. Stat. tit. 63 § 2607.1(A)(2)(a) (emphasis added). In other words, SB613 purposely discriminates against transgender people by imposing traditional sex stereotypes. *See, e.g.*, *Bostock*, 140 S. Ct. at 1742–43.[8] Under SB613, a transgender

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[7] ACLU, *Mapping Attacks on LGBTQ Rights in U.S. State Legislatures*, https://www.aclu.org/legislative-attacks-on-lgbtq-rights (Nov. 9, 2023).

[8] Imposing sex stereotypes is another reason why SB613 discriminates based on sex. *See Smith v. Avanti*, 249 F. Supp. 3d 1194, 1201 (D. Colo. 2017) (agreeing that "discrimination based on applying gender stereotypes to someone who was assigned a certain sex . . . at birth, constitutes discrimination based on sex"); *Fort Collins*, 916 F.3d at 805 ("[E]qual protection law should be particularly alert to the

adolescent "is required effectively to maintain [their] natal sex characteristics." *Boyden v. Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018).[9]

"[D]isapproving [of] transgender status," "discouraging individuals from pursuing their honest gender identities," and "[d]issuading a person from conforming to the person's gender identity rather than to the person's natal sex," are "plainly illegitimate purposes" that demonstrate a law was adopted for its "purposeful discrimination against transgender[] [people]." *Dekker*, 2023 WL 4102243, at *14; *see also* Order Granting Pls.' Mot. Prelim. Inj. at 33–34, *Van Garderen v. Montana*, No. DV-23-541 (Missoula Cnty. Dist. Ct., Mont. Sept. 27, 2023) ("It seems more likely that the SB 99's purpose is to ban an outcome deemed undesirable by the Montana Legislature veiled as protection for minors.").[10]

The district court erred in concluding that "[t]he law does not further gender stereotypes by taking adverse actions against those who fail to conform to them." J.A.(Vol.6).1279. SB613 prohibits minors from obtaining necessary medical care

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possibility of sex stereotyping in contexts where 'real' differences are involved, because these are the contexts in which sex classifications have most often been used to perpetuate sex-based inequality." (citation omitted)).

[9] SB613 enforces the notion that gender is limited to genitalia observed at birth. But this is not universally true. *See Zzyym v. Pompeo*, 958 F.3d 1014, 1024 (10th Cir. 2020) (recognizing that while most people are male or female, "some people are neither," as in the case of an intersex person).

[10] Available at: https://www.documentcloud.org/documents/23993157-montana-order-granting-plaintiffs-motion-for-preliminary-injunction (Nov. 9, 2023).

because it is "*inconsistent* with the minor's biological sex," alters "characteristics or features that are *typical* for the individual's biological sex," or "promote[s] the development of feminizing or masculinizing features *consistent with the opposite* biological sex." Okla. Stat. tit. 63 § 2607.1(A)(2)(a) (emphasis added). SB613 "tethers Plaintiffs to sex stereotypes which, as a matter of medical necessity, they seek to reject." *Kadel v. Folwell*, 446 F. Supp. 3d 1, 14 (M.D.N.C. 2020).

SB613 also was adopted within a broader context of Oklahoma legislation targeting transgender people, *see supra* section I.A.2, far beyond the fifteen other bills that sought to limit access to gender-affirming medical care. *Contrast* J.A.(Vol.1.)0139-40 (referring to and citing J.A.(Vol.1).0062-65) *and* J.A.(Vol.3).0447-49 *with* J.A.(Vol.6).1280-81. In addition to SB 3, which Plaintiffs also challenge (though not part of this appeal), Oklahoma passed "laws making it more difficult for transgender and nonbinary people to obtain identity documents, laws restricting transgender youth's ability to participate fully in schools, and laws banning transgender students in public and charter schools from using the restrooms and locker rooms that align with their gender identity." J.A.(Vol.1).0064.

Oklahoma legislators' "contemporary statements" also reveal an impermissible legislative purpose. *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 268 (1977); J.A.(Vol.2).0139. Lawmakers claimed transgender adolescents were "delusional play acting" and "misguided children,"

J.A.(Vol.1).0064; J.A.(Vol.1).0139, and compared gender-affirming care to "starving your child to death." J.A.(Vol.1).0064. Below, the United States filed a Statement of Interest documenting the purposeful discrimination behind SB613. *See* J.A.(Vol.3).0447-49.

Given SB613's explicit terms, legislative history, and context surrounding its adoption, disapproving of transgender people and enforcing state-mandated gender conformity was not an incidental effect of SB613; it was its purpose.

B. Neither *Geduldig* nor *Dobbs* Forecloses the Application of Heightened Scrutiny to SB613.

Relying on *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974), and *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228, 2235 (2022), the district court and Defendants say it does not matter that SB613 uses sex to prohibit treatment only transgender people need or seek. J.A.(Vol.6).1280-81; J.A.(Vol.3).0526. But neither case saves SB613 from heightened scrutiny.[11]

As to equal protection, *Dobbs* merely restated the Supreme Court's conclusion in *Geduldig* that classifications based on pregnancy do not automatically trigger heightened scrutiny even if they exclusively affect women. That conclusion does not resolve the level of scrutiny here. On its face, SB613 requires that a person's

[11] *Dobbs* did not create new equal protection law; it simply reiterated *Geduldig*'s holding that facially neutral regulations of medical procedures do not always receive heightened scrutiny simply because they disparately impact members of one sex.

sex at birth be known and used to determine whether treatment is prohibited. SB613 expressly "reference[s] a minor's sex and gender conformity . . . and use[s] these factors to determine the legality of procedures." *L.W.*, 83 F.4th at 502 (White, J., dissenting). For example, under SB613's express terms, an adolescent can be prescribed testosterone to affirm a male gender identity if the minor's sex designated at birth was male but not if it was female. *Dobbs* did not immunize all facial sex classifications in the healthcare context and direct that all are subject to deferential review. Nor did *Dobbs* overrule *VMI*'s command that all sex classifications warrant heightened scrutiny. Lower courts must follow controlling Supreme Court precedent "even if the lower court thinks the precedent is in tension with 'some other line of decisions.'" *Mallory v. Norfolk S. Ry. Co.*, 600 U.S. 122, 136 (2023) (quoting *Rodriguez de Quijas v. Shearson/Am. Express, Inc.*, 490 U.S. 477, 484 (1989)).

The centrality of gender transition to transgender identity further distinguishes this case from *Geduldig*. Unlike *Geduldig*'s pregnancy exclusion, SB613 is purposefully drawn to reach transgender individuals only. Pregnancy is not the defining characteristic of a woman, and the line in *Geduldig* was not drawn to limit care for women. But living in accord with one's gender identity rather than sex designated at birth is the defining characteristic of a transgender person and the very thing SB613 targets: gender transition.

The Supreme Court has "declined to distinguish between status and conduct" in analogous contexts. *Christian Legal Soc'y Chapter of the Univ. of Cal., Hastings Coll. of the L. v. Martinez*, 561 U.S. 661, 689 (2010); *see also Lawrence v. Texas,* 539 U.S. 558, 583 (2003) (O'Connor, J., concurring) (Where "the conduct targeted by th[e] law . . . is closely correlated" with the status of being gay, the law "is targeted at more than conduct," "[i]t is instead directed toward gay persons as a class."); *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993) ("A tax on wearing yarmulkes is a tax on Jews."). As such, laws singling out "gender transition" for differential treatment treat transgender people differently "as a class." *Williams v. Kincaid*, 45 F.4th 759, 772 (4th Cir. 2022).

Finally, *Geduldig* recognized that where distinctions are "mere pretexts designed to effect an invidious discrimination against the members of one [protected class] or the other," they are unconstitutional. 417 U.S. at 496 n.20; *see also Hecox*, 79 F.4th at 1025. Here, the legislature's intent to treat transgender minors differently pervades SB613's legislative history. *See supra* section I.A.3. Moreover, "[s]ome activities may be such an irrational object of disfavor that, if they are targeted, and if they also happen to be engaged in exclusively or predominantly by a particular class of people, an intent to disfavor that class can readily be presumed." *Bray*, 506 U.S. at 270. Although the district court found "there is no evidence of pretext for

discrimination," J.A.(Vol.6).1281, this *legal* conclusion was in error.[12] SB613 is plain: care is prohibited only for purposes of "gender transition." That is enough to show intent without any additional finding of animus.

C. Tested Under the Proper Legal Standards, SB613 Fails to Survive Scrutiny.

Because SB613 is subject to heightened scrutiny, Defendants must, at a minimum, provide an "exceedingly persuasive justification" for SB613's classifications. *VMI*, 518 U.S. at 531. Oklahoma must demonstrate a "close means-end fit" that does not "classify unnecessarily and overbroadly by gender when more accurate and impartial lines can be drawn." *Sessions*, 582 U.S. at 63 n.13, 68. The "burden of justification is demanding"—not "deferential"—and it "rests entirely on the State." *VMI*, 518 U.S. at 533, 555. Oklahoma cannot satisfy this standard.

The district court erred in finding that SB613 likely survives equal protection scrutiny. The record does not support the State's justifications for SB613. The district court's findings to the contrary, which were dicta given the court's application of the incorrect legal standard, were clearly erroneous.

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[12] To the extent the Court considers that finding to be factual, which is clearly erroneous given the evidence, it is a legislative fact that this Court can assess *de novo*. *See infra* section I.C.1.

1. This Court should not defer to the district court's factual findings.

This Court should not defer to the district court's factual findings for three independent reasons. First, the court's discussion of the facts is dicta. Second, the district court abused its discretion by failing to properly consider the evidence. Third, this Court can independently make findings as to legislative facts without the typical deference afforded to a lower court's factfinding.

(a) The district court's factual findings were dicta.

The district court's factfinding is dicta because the court used the wrong legal standard. The court explained that under rational basis review, the law would be constitutional based on "nothing more than [the court's] own rational speculation." J.A.(Vol.6).1293. The district court's subsequent discussion of the facts is dicta as it was "not necessarily involved nor essential to determination of the case at hand." *Rohrbaugh v. Celotex Corp.*, 53 F.3d 1181, 1184 (10th Cir. 1995) (citation omitted). Once the court conceded that *any* factual findings were extraneous to its ultimate holding that SB613 satisfied rational basis review, *all* its factual findings became superfluous. *See*, *e.g.*, *United States v. Weeden*, 117 F.3d 1429 (Table), 1997 WL 375345, at *1 n.1 (10th Cir. 1997) (determining that a statement was dicta based on the prior court's "caveat" in its decision that the approach discussed was not urged by either party).

(b) The district court failed to properly consider and weigh the evidence proffered by Plaintiffs' experts and gave improper weight to Defendants' experts.

In addition, the district court abused its discretion by ignoring the evidence Plaintiffs submitted and relying exclusively on the evidence Defendants presented. This error permeates the entire opinion and infects most, if not all, of the court's factual findings.

Circuit courts, including this one, have explained in a variety of contexts that failing to consider or overlooking evidence amounts to an abuse of discretion. *See*, *e.g.*, *James v. Eli*, 889 F.3d 320, 328 (7th Cir. 2018); *Shardar v. Att'y Gen.*, 503 F.3d 308, 315 (3d Cir. 2007); *Golub v. Sec'y of Health & Hum. Servs.*, 243 F.3d 561 (Table), 2000 WL 1471643, at *3 (Fed. Cir. 2000); *Dulane v. INS.*, 46 F.3d 988, 996 (10th Cir. 1995).

Plaintiffs presented ample evidence from qualified experts who have collectively worked with over a thousand youths with gender dysphoria and conducted extensive research in this area: Dr. Deanna Adkins, a pediatric endocrinologist; Dr. Aron Janssen, a child and adolescent psychiatrist; Dr. Jack Turban, a child and adolescent psychiatrist and researcher; and Dr. Armand Antommaria, a pediatrician and bioethicist. *See* J.A.(Vol.2).0173; J.A.(Vol.2).0214; J.A.(Vol.2).0253; J.A.(Vol.2).0356; J.A.(Vol.5).0980; J.A.(Vol.5).1000; J.A.(Vol.5).1019; J.A.(Vol.5).1043. These experts have been found to be qualified

and relied upon by numerous courts. *See*, *e.g.*, *Dekker*, 2023 WL 4102243, at *8 (crediting the testimony of Drs. Antommaria and Janssen and finding them to be "well-qualified"); *Brandt v. Rutledge*, 2023 WL 4073727, at *27 (E.D. Ark. June 20, 2023) (finding Drs. Adkins, Turban, and Antommaria to "have deep knowledge of the subject matter of their testimony," to be "fully qualified," and to "have provided credible and reliable testimony"); *Adams by & through Kasper v. Sch. Bd. of St. Johns Cnty.*, 318 F. Supp. 3d 1293, 1298 n.12 (M.D. Fla. 2018) (finding Dr. Adkins qualified and her testimony reliable), *vacated on other grounds*, 57 F.4th 791. No court has found their testimony to lack credibility.

By contrast, Defendants provided declarations from individuals with no experience providing or even studying gender-affirming medical care for transgender minors. *See* J.A.(Vol.3).0541; J.A.(Vol.4).0727; J.A.(Vol.5).0802; J.A.(Vol.5).0882; J.A.(Vol.6).1137; J.A.(Vol.6).1169; J.A.(Vol.6).1222; J.A.(Vol.6).1227. Indeed, multiple courts have discredited or given little to no weight to several of the State's purported experts based on their lack of clinical or research experience treating gender dysphoria. *See*, *e.g.*, *Koe v. Noggle*, 2023 WL 5339281, at *21 n.28 (N.D. Ga. Aug. 20, 2023) (assigning "Dr. Cantor's views less weight" in part because "[h]e is not a physician and has no experience treating gender dysphoria in youth as such"); *L.W. v. Skrmetti*, 2023 WL 4232308, at *20 (M.D. Tenn. June 28, 2023) (same), *rev'd and remanded on other grounds*, 83 F.4th

460; *id.* at *20 n.40, 25 n.48 (noting courts' skepticism about Dr. Laidlaw's testimony and finding his testimony "unpersuasive"); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1142–43 (M.D. Ala. 2022) (giving Dr. Cantor's "testimony regarding the treatment of gender dysphoria in minors very little weight"), *vacated on other grounds*, 80 F.4th 1205 (11th Cir. 2023); *C.P. v. Blue Cross Blue Shield of Ill.*, 2022 WL 17092846, at *4 (W.D. Wash. Nov. 21, 2022) (noting it was a "close question" as to whether Dr. Laidlaw was qualified given his lack of clinical and research experience). Defendants' other purported experts (Drs. Harris and Thompson) fare no better as they similarly have no experience treating or diagnosing gender dysphoria in adolescents or adults. *See* J.A.(Vol.5).0967-68.

Despite their lack of clinical and research experience, which Plaintiffs raised below (*see* J.A.(Vol.5).0967-68), and without making any credibility determinations, the district court relied solely upon the testimony of Defendants' purported experts to make its purported factual findings and ignored the evidence Plaintiffs submitted, even after determining that no courtroom factfinding was necessary because rational basis would apply.[13] Although a court has discretion to

[13] The district court cited to Defendants' experts over thirty times. *See generally* J.A.(Vol.6).1266. In contrast, the district court cited to Plaintiffs' experts only four times and only for basic propositions like "gender dysphoria is a psychological diagnosis" and "being transgender or gender nonconforming is not a medical condition or pathology to be treated." J.A.(Vol.6).1295, 1299. This is not meaningful engagement with or consideration of Plaintiffs' evidence, especially

ascertain the credibility of experts and reject or accept expert testimony, it may not arbitrarily fail to engage with such testimony or ignore it. *See Quintana-Ruiz v. Hyundai Motor Corp.*, 303 F.3d 62, 76–77 (1st Cir. 2002); *In re Wolverton Assocs.*, 909 F.2d 1286, 1296 (9th Cir. 1990) (factfinder "may not act arbitrarily in disregarding entirely probable testimony of expert witnesses whose judgments have not been discredited"); *see also Allfirst Bank v. Progress Rail Servs. Corp.*, 521 F. App'x 122, 129 (4th Cir. 2013).

In sum, the district court's approach to the evidence was "arbitrary, capricious, whimsical, [and] manifestly unreasonable." *Planned Parenthood of Kan. v. Andersen*, 882 F.3d 1205, 1223 (10th Cir. 2018). As such, it abused its discretion and made erroneous factual findings, albeit in dicta.

(c) This Court can make independent findings as to legislative facts.

Finally, this Court can independently find or judicially notice that WPATH and the Endocrine Society promulgate guidelines supported by clinical experience and research and that every major U.S. medical association publicly supports providing such care to adolescents with gender dysphoria. J.A.(Vol.2).0220; J.A.(Vol.2).0185; J.A.(Vol.5).1021. *See United States v. Iverson*, 818 F.3d 1015, 1031 (10th Cir. 2016) (O'Brien, J., concurring). The status and reliability of certain

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absent explanation as to why the court relied upon Defendants' far less qualified or experienced experts.

scientific evidence are appropriate subjects of legislative factfinding and not contested here. *See United States v. Hunt*, 63 F.4th 1229, 1250–51 (10th Cir. 2023) (noting in the context of firearm toolmark examinations' reliability, "[w]hen the resolution of a dispute turns on legislative facts, courts regularly relax the restrictions on judicial inquiry"). Legislative facts "are established truth, facts or pronouncements that do not change from case to case but apply universally." *United States v. Wolny*, 133 F.3d 758, 764 (10th Cir. 1998) (citation omitted). "[W]henever a tribunal engages in the creation of law or of policy, it may need to resort to legislative facts, whether or not those facts have been developed on the record." *Iverson*, 818 F.3d at 1030 (O'Brien, J., concurring) (quoting *United States v. Gould*, 536 F.2d 216, 219–20 (8th Cir. 1976)).

2. None of the State's Proffered Justifications Amounts to an Exceedingly Persuasive Justification for the Law's Categorical Ban on Treatment.

SB613 fails heightened scrutiny because it does not substantially advance any important governmental interest. None of the Defendants' criticisms justifies singling out only gender-affirming medical treatment for transgender adolescents for categorical prohibition. The district court's citations do not support the propositions for which they are used, and the district court's findings, which are dicta in any event, are manifestly incorrect considering the full record below and Defendants' putative experts' comparative lack of credibility. To the extent the district court's

factual findings are subject to clear error review, the Court can and should conclude that "a mistake has been committed." *Anderson v. City of Bessemer City*, 470 U.S. 564, 573 (1985) (citation omitted).

(a) SB613 is not justified by claims that the prohibited treatment is "experimental."

The record does not support Defendants' claim that gender-affirming medical care to treat gender dysphoria in minors is "experimental" treatment that justifies a categorical prohibition. And even if the banned care were experimental in nature (which it is not), that does not explain why Oklahoma bans *only* this treatment.

The "level of evidence supporting clinical practice guidelines recommendations regarding gender-affirming medical care for adolescents is comparable to the level of evidence supporting many other pediatric medical treatments." J.A.(Vol.2).0366. It is not "new, novel, or unproven," and it "is intended to benefit individual patients and is modified based on individual patients' responses." J.A.(Vol.2).0366-67. That is the difference between clinical practice, where the goal is to "benefit individual patients and [the] method is individualized decision-making," and research or experimentation, where the goal "is to contribute to generalizable knowledge" through "formal protocols that describe [the] objectives and procedures." J.A.(Vol.2).0361. Treatments are not considered "experimental" even if the clinical guidelines recommending those treatments are not based on randomized controlled trials: for example, the use of GnRHa to treat precocious

puberty is not considered experimental—it is FDA approved and widely used in clinical practice—but that use is based entirely on observational studies and not randomized controlled trials. J.A.(Vol.5).1046-48.

It was clear error for the district court to find that "the experimental phase has truly not yet begun" for gender-affirming care, and it is therefore not "proven" or "established." J.A.(Vol.6).1291. The district court invented a new definition of "experimental" that the record does not support. The banned care "is not experimental in either the colloquial or the technical sense." J.A.(Vol.2).0366. Defendants complain there are insufficient long-term studies documenting the evidence of efficacy of treatment. That assertion is not accurate, and the district court erred in concluding there is "scant information" about the long-term use of the banned treatment. J.A.(Vol.6).1298 (citing J.A.(Vol.4).0746, 0752; J.A.(Vol.5).0840).

Although Defendants criticize the evidence supporting the efficacy of the banned care, they offer no alternative treatment supported by any evidence, let alone evidence comparable to that supporting gender-affirming medical interventions. Doctors must make decisions today about how to treat individual patients. Defendants do not dispute that (1) every major medical association in the United States supports the banned care; (2) multiple observational and cross-sectional

studies support the care; and (3) the banned care is the only evidence-based treatment available.

(b) SB613 is not justified by the existence of potential risks and side effects of the proscribed treatment.

That the banned treatment carries potential side effects and risks does not materially distinguish it from other treatments and cannot justify SB613. The overwhelming weight of the evidence shows that the potential risk of harm from pubertal suppression and hormone therapy is rare when provided under medical supervision. The district court clearly erred in concluding otherwise.

The record evidence conclusively demonstrates that gender-affirming medical treatment for adolescents with gender dysphoria is not uniquely risky. Though Defendants' putative experts highlight a litany of possible side effects of treatment, they never quantify the prevalence of those risks. What is more, they lack first-hand knowledge: none have meaningful clinical experience treating youth with gender dysphoria or relevant original research experience. Plaintiffs' experts, however, have treated a thousand adolescent patients with gender dysphoria and explain that side effects are rare. *See*, *e.g.*, J.A.(Vol.5).1012-13. Further, that the treatments at issue carry risk is not sufficient to justify SB613. J.A.(Vol.2).0268-69; J.A.(Vol.2).0358, 0379-80. All medical care carries risks, but SB613 targets certain established treatments when used by a particular population for a particular purpose. Indeed, SB613 is grossly underinclusive in this regard because the same treatments

remain available for other purposes and carry comparable risks. J.A.(Vol.2).0230-31; J.A.(Vol.5).1009, 1013; J.A.(Vol.5).1061.

The district court's specific factual findings about risk are clearly erroneous. The court found that minors with gender dysphoria "face risks that are different and more extensive than those minors who would use the same protocols for other diagnoses." J.A.(Vol.6).1296. But the court offered no record citation in support of this finding, and there is none. Rather, the evidence demonstrates that the risks related to pubertal suppression do not vary based on the conditions they are prescribed to treat, and youth with gender dysphoria use pubertal suppression for a comparably shorter period than those treated for precocious puberty. J.A.(Vol.2).0228, 0231.

Timing of Puberty. The use of pubertal suppression to treat gender dysphoria does not cause puberty to occur beyond what is typical, and the medication is not used for longer periods of time to treat gender dysphoria than other conditions. There is no factual support for the conclusion that pubertal suppression for gender dysphoria is prescribed "with the intent and effect of undergoing puberty later than it would be physically appropriate to do so" or "later than the typical range." J.A.(Vol.6).1296 (citing J.A.(Vol.4).0576). Pubertal suppression is not used to delay puberty in adolescents with gender dysphoria beyond the typical age range, which already has a "very wide age variation among individuals." J.A.(Vol.5).1004.

Gender dysphoria treatment protocols would tend to put adolescents in the latter third but "nothing outside of the typical range" for puberty. J.A.(Vol.5).1004-05; J.A.(Vol.2).0227-28. The district court erred in relying on the unsupported (and incorrect) assertion that pubertal suppression is used to "push[]" adolescents with gender dysphoria "away from the mean age of the healthy population" or turn them into "very late-bloomers." J.A.(Vol.4).0576. Rather, "[m]any peers will have comparably timed or later puberty" than adolescents treated for gender dysphoria, and no data supports the assumption that there are short- or long-term social and developmental consequences for delaying puberty until the latter third of the typical range. J.A.(Vol.5).1005.

Bone Health. Though Defendants' putative experts suggest that using pubertal suppression to treat gender dysphoria poses a substantial risk to bone health, the record does not support such claims. To the contrary, adolescents on pubertal suppression continue to accrue bone density, just at a pre-pubertal rate, and once a patient begins endogenous puberty or hormone therapy, their bone structure and strength increases. J.A.(Vol.5).1006-07. The district court deferred to an unqualified expert's parroting of a *New York Times* article—not even a summary of an article in a medical journal—that incorrectly suggested the effects of pubertal suppression on bone density are unknown. J.A.(Vol.4).0641-43. The district court also erred in relying on another unqualified expert's speculation that pubertal

suppression uniquely predisposes adolescents with gender dysphoria to future osteoporosis. J.A.(Vol.4).0748-49. There is no evidence for this assertion. Dr. Adkins explained that "we have been using puberty blockers to treat patients with precocious puberty for over 30 years and have not observed these long-term effects" that Defendants' purported experts hypothesize. J.A.(Vol.5).1007. That during treatment, patients prescribed pubertal suppression accrue bone density at a lower rate does not justify a ban on such treatment, particularly given that there is no evidence of long-term harm from this reduced bone density accrual rate, while there is substantial evidence of the benefits of treatment and the harm from withholding treatment.

Executive function. The district court further erred when it found that pubertal suppression carries "a range of risks, including impaired brain development and poorer psychosocial and educational development." J.A.(Vol.6).1296 (citing J.A.(Vol.4).0639-40; J.A.(Vol.4).0751; J.A.(Vol.5).0808; J.A.(Vol.4).0641). Over thirty years of data support the safety and efficacy of using pubertal suppression to treat precocious puberty, and more than twenty years of data support treatment for gender dysphoria. J.A.(Vol.2).0229; J.A.(Vol.5).1004. No scientific evidence shows short- or long-term negative effects on patients that outweigh the benefits of treatment. J.A.(Vol.2).0229. The district court erred in relying on speculation to the contrary, such as studies of "non-transsexual males" and "adult biological women"

and correlations between naturally occurring very late puberty and some negative health metrics, J.A.(Vol.4).0640-41, or "animal models" for alleged effects on IQ and spatial memory. J.A.(Vol.5).0807-08. The district court clearly erred in relying on those suppositions instead of the decades of data showing the safety and efficacy of this treatment for patients with precocious puberty or gender dysphoria. J.A.(Vol.5).1004.

Fertility. Though Defendants' purported experts attempt to justify SB613 through incendiary claims about sterilization, the reality is that "[p]ubertal suppression on its own has no impact on fertility" and the argument that "treatment is automatically sterilizing . . . is not accurate." J.A.(Vol.2).0231. It was clear error to find that puberty suppression causes "immediate[] . . . infertility." J.A.(Vol.6).1298 (citing J.A.(Vol.4).0746, 0748; J.A.(Vol.5).0840). The district court clearly erred in relying on the assertion that "continuous administration of GnRHa makes the full maturation of the gametes impossible" to support its finding regarding infertility. J.A.(Vol.1).083. First, pubertal suppression is reversible. J.A.(Vol.2).0222. Second, it pauses puberty "only for the duration of the treatment," i.e., until an adolescent resumes endogenous puberty or, if medically indicated, begins gender-affirming hormone therapy. J.A.(Vol.2).0222. Third, adolescents may, even after pubertal suppression, resume their endogenous puberty if generating gametes is of particular importance. *See*, *e.g.*, J.A.(Vol.5).1014-15.

Desistance. The district court clearly erred in determining that the banned treatment "altered natural desistance rates, such that puberty blockers, rather than operating as a 'pause button,' are instead a 'pathway towards future sterilizing surgeries.'" J.A.(Vol.6).1298 (citing J.A.(Vol.4).0752). The only support for that clearly erroneous factual finding is the declaration of Dr. Laidlaw, who purported to rely on the de Vries, et al. studies from 2011 and 2014. J.A.(Vol.6).1298. But those studies demonstrate that "given the comprehensive biopsychosocial mental health assessment that is done prior to starting gender-affirming medical interventions under current guidelines, the adolescents who started pubertal suppression were those who were, through medical and mental health screening, determined, prior to starting pubertal suppression, to have a low likelihood of future desistence in their transgender identity." J.A.(Vol.5).1033-34. In other words, most adolescents who begin treatment continue treatment because it is prescribed to the right group of people, not because it is making people transgender.

(c) SB613 is not justified by gender dysphoria's diagnostic process.

The district court clearly erred when it found "there is no evidence that a diagnosis of gender dysphoria can be confirmed by any objective measurement or testing protocol." J.A.(Vol.6).1294 (citing J.A.(Vol.4).0666-67 and purporting to cite J.A.(Vol.5).1046). Psychiatric diagnoses like gender dysphoria indisputably rely on objective diagnostic criteria. Gender dysphoria is a diagnosis, like other

psychiatric diagnoses, made using objective criteria set forth in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR). J.A.(Vol.2).0181-82; J.A.(Vol.5).1045. The district court erroneously conflated gender dysphoria—a recognized diagnosis that can be ascertained by a qualified clinician using objective criteria—with gender identity, which is a person's core understanding of their gender. J.A.(Vol.2).0176-77.

To support its erroneous finding, the district court pointed to Dr. Antommaria's acknowledgement that gender dysphoria is a diagnosis in the DSM-5-TR. J.A.(Vol.6).1294 (citing J.A.(Vol.5).1045). That does not support finding a lack of objective diagnostic criteria. To the contrary, inclusion in the DSM-5-TR necessarily means that clinicians can apply diagnostic criteria in their practice. The district court erroneously relied on the assertion that psychiatric conditions lack "any measurable, physical features to distinguish it objectively from a healthy state." J.A.(Vol.4).667. Psychiatric diagnoses, like gender dysphoria, are no "less real" or "any less severe" merely because their "physical" location is the brain. J.A.(Vol.5).1045. That a psychiatric condition lacks a physical manifestation does not mean that it lacks objective criteria for diagnosis. The district court's error was compounded by the erroneous distinction between "physiological condition[s]" and "psychological one[s]." J.A.(Vol.6).1294. Although "most mental health

conditions," including gender dysphoria, rely on "patients' reports of their symptoms and [are] not confirmed by laboratory or radiographic testing," that is also true of "some non-mental health conditions," including migraine headaches. J.A.(Vol.5).1046. No laboratory test can prove whether someone suffers from gender dysphoria or migraine headaches, but a clinician can objectively diagnose gender dysphoria or migraine headaches based, *inter alia*, on a patient's report, a patient's history, and clinical interviews.

(d) Gender conformity is not an important state interest sufficient for heightened scrutiny.

Finally, Defendants essentially claim that the government has a legitimate interest in ensuring that adolescents assigned female at birth will develop and retain the secondary sex characteristics typically associated with women and vice versa for those assigned male. The district court erred in two separate ways by crediting this interest.

First, the district court conflated transgender identity (a naturally occurring variation in gender identity) with gender dysphoria (a serious medical condition). *Compare* J.A.(Vol.6).1299 *with* J.A.(Vol.2).0219. The court found that "[t]he legislature's decision to permit minors to have access to the Treatment Protocols for medical disorders that can be cured or corrected, but not to permit the same protocols (with greater associated risk) to *treat a condition for which no "cure" is sought*, is a rational one." J.A.(Vol.6).1299 (emphasis added). But the court's phrasing betrays

the flaw in its analysis. Being transgender is not a condition to be cured. But gender dysphoria, a serious medical condition that transgender people can have, can be treated or ameliorated through the banned treatment. J.A.(Vol.2).0234; J.A.(Vol.2).0186, 0191-92. That is the whole point of Plaintiffs' lawsuit: Oklahoma banned the only evidence-based interventions for gender dysphoria, a serious condition that *can be treated and even cured*.

Second, the district court impermissibly credited gender conformity as a legitimate or important state interest by finding that SB613 only permitted comparable interventions for "diseased or disordered" states, when in fact SB613 allows non-transgender adolescents to undertake "cosmetic" treatments so long as the phenotypic results are consistent with a person's assigned sex. SB613 is not rationally related to a limitation on treating physical diseases or disorders. J.A.(Vol.6).1299. SB613 contains no such limitation:[14] it does not prohibit any interventions "for the purpose of attempting to affirm the minor's perception of his or her gender or biological sex" when that perception *aligns* with the minor's biological sex, only when it is "inconsistent." Okla. Stat. tit. 63 § 2607.1(A)(2)(a). Although SB613 contains an explicit carve-out for certain disorders of sex development, *see id.* § 2607.1(A)(2)(b)(4), the prohibition is based on congruence

[14] To the extent that the district court's finding was a conclusion of law, this Court owes it no deference and may decide the issue *de novo*. *See Stokes v. United States*, 967 F.3d 1034, 1043 (10th Cir. 2020).

or incongruence, not healthy or diseased states. For example, natural development processes for non-transgender adolescents may result in being short, being a late bloomer, having small breasts, or having a patchy beard. Under SB613, those are all matters for which an adolescent could seek hormonal treatment or surgery to address, even if there was no disease or disorder. Non-transgender adolescents can, under SB613, use pubertal suppression, estrogen, testosterone, or surgery to alter their appearances, even if they suffer from no medical condition but merely wish to appear more stereotypically feminine or masculine. It is only transgender adolescents who are prevented from altering their appearances to relieve the clinically significant distress resulting from the incongruence between their secondary sex characteristics and their gender identity, even when they have been diagnosed with gender dysphoria, a serious medical condition.

SB613 fails heightened scrutiny, as it is grossly underinclusive, lacks a rational relationship with Oklahoma's asserted interests, has no evidentiary basis, and is improperly aimed at enforcing gender conformity.

D. SB613 Fails Any Level of Review.

Although SB613 is properly subject to heightened scrutiny, it ultimately fails any level of review. There is no rational basis for concluding that allowing adolescents with gender dysphoria to receive gender-affirming medical care that they, their parents, and their doctors agree is medically necessary "would threaten

legitimate interests of [Oklahoma] in a way that" allowing other types of care "would not." *Cleburne*, 473 U.S. at 448; *see also Eisenstadt v. Baird*, 405 U.S. 438, 452 (1972) (health risks of birth control pills not a rational basis for banning access for unmarried people only); *Bd. of Trs. of Univ. of Ala. v. Garrett*, 531 U.S. 356, 366 n.4 (2001).

SB613 furthers no legitimate interest. What the law does is "so far removed from [the asserted] justifications that … it [is] impossible to credit them." *Romer v. Evans*, 517 U.S. 620, 635 (1996). Rather than protect children, SB613 harms them. SB613's improper motive of gender conformity arose, at a minimum, from "insensitivity caused by simple want of careful, rational reflection or from some instinctive mechanism to guard against people who appear to be different in some respects from ourselves." *Garrett*, 531 U.S. at 374 (Kennedy, J., concurring). SB613 therefore fails any level of review.

II. PLAINTIFFS ARE LIKELY TO SUCCEED ON THEIR SUBSTANTIVE DUE PROCESS CLAIM.

SB613 impinges on Parent Plaintiffs' fundamental right to make medical decisions for their minor children, particularly when supported by the independent judgment of a consulting physician and with the minor's consent. Furthermore, SB613 is not a narrowly tailored means of vindicating a compelling state interest. Fundamental parental rights include "some level of protection for parents' decisions regarding their children's medical care." *PJ ex rel. Jensen v. Wagner*, 603 F.3d

1182, 1197 (10th Cir. 2010) (citing *Parham v. J.R.*, 442 U.S. 584, 604 (1979)); *see also Dubbs v. Head Start, Inc.*, 336 F.3d 1194, 1203 (10th Cir. 2003). In upholding a statute permitting parents to involuntarily commit their children to psychiatric institutions, the Supreme Court held that parents, not the government, have "plenary authority" in the usual course to make decisions concerning their children's healthcare and to "recognize symptoms of illness and to seek and follow medical advice" for their children. *Parham*, 442 U.S. at 602. "Neither state officials nor federal courts are equipped to review such parental decisions." *Id.* at 604.

In the light of parents' broad right to make medical decisions for their minor children, the district court erred when it adopted Defendants' hyper-specific framing of the right as "a fundamental right for parents to choose for their children to use puberty blockers, cross-sex hormones, and surgeries for the purposes of effectuating a gender transition." J.A.(Vol.6).1288. Fundamental rights are "carefully defined," J.A.(Vol.6).1288-89 (citing *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997)), but not microscopically so. *See Obergefell v. Hodges*, 576 U.S. 644, 671 (2015) ("*Loving* did not ask about a 'right to interracial marriage'; *Turner* did not ask about a 'right of inmates to marry'; and *Zablocki* did not ask about a 'right of fathers with unpaid child support duties to marry.' Rather, each case inquired about the right to marry in its comprehensive sense . . . ."); *Kitchen v. Herbert*, 755 F.3d 1193, 1209–10 (10th Cir. 2014). The district court's narrow definition cannot be reconciled with

parents' plenary "authority to decide what is best for the child" in the medical context *generally*. *Parham*, 442 U.S. at 602, 604 (parents have the right "to recognize symptoms of illness and to seek and follow medical advice" on behalf of their children, including procuring "a tonsillectomy, appendectomy, or other medical procedure").

Relying on *Dobbs*, the district court demanded that Parent Plaintiffs demonstrate they have a "deeply rooted" right tethered to a specific *treatment.* This is inconsistent with *Parham*'s framing of the parental right as one to make medical *decisions* on behalf of their children.[15] The district court's reliance on *Dobbs* is further erroneous because the Supreme Court's instruction is unambiguous: "Nothing in this opinion should be understood to cast doubt on precedents that do not concern abortion." *Dobbs*, 142 S. Ct. 2228 at 2277–78 (2022); *id.* at 2309 (Kavanaugh, J., concurring).

The district court purported to distinguish *Parham* on the grounds that it involved procedural due process, not a substantive due process claim. But the

[15] A condition-specific interpretation would circumscribe the right based on whether the intervention was available and widely recognized at the time of the Fourteenth Amendment's ratification. *See Timbs v. Indiana*, 139 S. Ct. 682, 687–89 (2019) (examining whether the right to be free from excessive fines was widely recognized in 1868); *Glucksberg*, 521 U.S. at 711, 722–25 (same with respect to assisted suicide). That would leave parents with the fundamental right to vaccinate their children against smallpox, but not polio; to amputate infected limbs, but not to treat with antibiotics; and categorically exclude treatments for illnesses like ADHD, childhood cancer, diabetes, and asthma.

Parham court framed parents' liberty interest in choosing the best course of treatment for their children by reference to other substantive due process cases, *see* 442 U.S. at 602 (collecting cases), and this Court relies on *Parham* in the substantive due process context. *See Jensen*, 603 F.3d at 1197 (framing the substantive due process right as the "right to make decisions about the child's medical care" and citing *Parham*); *United States v. White*, 782 F.3d 1118, 1138–39 & n.20 (10th Cir. 2015) ("The liberty interest parents have in the care, custody, and control of their children is a substantive due process right protected by the Fourteenth Amendment" (citing *Parham*)); *see also Dubbs*, 336 F.3d at 1203 (discussing "the right to consent to medical treatment for oneself and one's minor children" in the substantive due process context). *Accord Cook v. Gates*, 528 F.3d 42, 53 (1st Cir. 2008); *Anspach v. City of Phila.*, 503 F.3d 256, 261 (3d Cir. 2007); *Wallis v. Spencer*, 202 F.3d 1126, 1141 (9th Cir. 2000).

To justify supplanting this fundamental right in the case of transgender adolescents with gender dysphoria, the State must show that the "infringement is narrowly tailored to serve a compelling state interest." *Reno v. Flores*, 507 U.S. 292, 302 (1993) (citations omitted); *accord Reed v. Town of Gilbert*, 576 U.S. 155, 171 (2015). Only "the most exact connection between justification and classification survives" this test. *Kitchen*, 755 F.3d at 1219 (cleaned up).

With respect to the tailoring requirement, the State has not come close to meeting its burden. Safeguarding minors' health and wellbeing is a compelling interest. *See Globe Newspaper Co. v. Super. Ct. for Norfolk Cnty.*, 457 U.S. 596, 607 (1982). But SB613 *harms*, rather than protects, transgender adolescents by denying them access to the only evidence-based treatment for their gender dysphoria. *See* J.A.(Vol.2).0173; J.A.(Vol.2).0214; J.A.(Vol.2).0253; J.A.(Vol.2).0356; J.A.(Vol.5).0980; J.A.(Vol.5).1000; J.A.(Vol.5).1019. The State has not demonstrated that SB613 survives such scrutiny. *See supra* section I.C.2. At most, the State points to the possibility of risks, but "risk[] does not automatically transfer the power to make [the healthcare] decision from the parents to some agency or officer of the state." *Parham*, 442 U.S. at 603. Parent Plaintiffs do not seek access to otherwise unavailable medical procedures: the banned treatments are still permitted for adults with gender dysphoria and for minors with any other condition (or no condition at all).

There is no justification for imposing a one-size-fits-all ban on care where parents, adolescents, and doctors all agree that treatments are medically appropriate. Denying access to this treatment exposes Minor Plaintiffs to severe distress and risk to their health and wellbeing. J.A.(Vol.2).0291; J.A.(Vol.2).303; J.A.(Vol.2).0329; J.A.(Vol.2).0340. The State has not advanced a compelling state interest to justify

this harm to the adolescents it purports to protect. The decision below must be reversed.

III. THE OTHER PRELIMINARY INJUNCTION FACTORS FAVOR PLAINTIFFS.

A. Plaintiffs Will Be Irreparably Harmed Absent a Preliminary Injunction.

If SB613 is not blocked, Plaintiffs will suffer serious and irreparable harm with no adequate remedy at law. *See Fort Collins*, 916 F.3d at 805–06. "[W]hen an alleged constitutional right is involved, most courts hold that no further showing of irreparable injury is necessary." *Awad v. Ziriax*, 670 F.3d 1111, 1131 (10th Cir. 2012) (citation omitted); *see Fort Collins*, 916 F.3d at 806 (claim that city ordinance discriminated based on sex in violation of equal protection necessarily satisfied irreparable harm).

But the irreparable harm here is far greater than just the deprivation of Plaintiffs' constitutional rights. SB613 prohibits the initiation or continuation of lifesaving medical care, forces families either to watch their children suffer or incur the significant expense of travel or relocation out-of-state to access care, and compels medical providers to abandon their patients by threatening their medical licenses. *See* J.A.(Vol.2).0140-42. Losing access to medical treatment constitutes irreparable harm. *See Andersen*, 882 F.3d at 1236–37.

B. The Balance of the Equities and Public Interest Favor Plaintiffs.

The balance of the harms and the public interest, which "merge when, like here, the government is the opposing party," both favor an injunction. *Aposhian v. Barr*, 958 F.3d 969, 978 (10th Cir. 2020) (citation omitted). The harms to Plaintiffs from SB613 are tangible, immediate, and irreparable. Whatever interest the State may have in enforcing SB613 during the pendency of this case pales compared to Plaintiffs' certain and severe harm. Oklahoma has little to no cognizable interest in immediately enforcing a "likely unconstitutional" law. *Citizens United v. Gessler*, 773 F.3d 200, 218 (10th Cir. 2014). In contrast, preserving Plaintiffs' constitutional rights is in the public interest. *See Verlo v. Martinez*, 820 F.3d 1113, 1127 (10th Cir. 2016). A preliminary injunction is warranted: this Court should preserve the status quo until a final decision on the merits.

CONCLUSION

Oklahoma has withdrawn potentially lifesaving care from the Minor Plaintiffs. Only this Court can restore it. The denial of Plaintiffs' motion for preliminary injunction should be reversed, and this Court should order the issuance of a preliminary injunction enjoining enforcement of SB613.

Dated this 9th day of November 2023.

Respectfully submitted,

/s/ Omar Gonzalez-Pagan

Megan Lambert
AMERICAN CIVIL LIBERTIES UNION OF OKLAHOMA FOUNDATION
P.O. Box 13327
Oklahoma City, OK 73113
(405) 524-8511
mlambert@acluok.org

Harper S. Seldin
Chase Strangio
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, 18th Floor
New York, NY 10004
(212) 549-2500
hseldin@aclu.org
cstrangio@aclu.org

Luke C. Platzer
Madeleine V. Findley
JENNER & BLOCK LLP
1099 New York Ave., NW, Suite 900
Washington, DC 20001
(202) 639-6094
LPlatzer@jenner.com
MFindley@jenner.com

Lillian McGuire
Jocelyn A. Sitton
JENNER & BLOCK LLP
353 N. Clark Street
Chicago, IL 60654
(312) 840-7484
LMcGuire@jenner.com
JSitton@jenner.com

Omar Gonzalez-Pagan
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, NY 10005
(646) 307-7406
ogonzalez-pagan@lambdalegal.org

Sasha Buchert
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, NW, 8th Floor
Washington, DC 20006
(202) 804-6245
sbuchert@lambdalegal.org

Laura J. Edelstein
JENNER & BLOCK LLP
455 Market Street, Suite 2100
San Francisco, CA 94105
(628) 267-6800
LEdelstein@jenner.com

Remi J.D. Jaffre
JENNER & BLOCK LLP
1155 Avenue of the Americas
New York, NY 10036
(212) 891-1600
RJaffre@jenner.com

Counsel for Plaintiffs-Appellants

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This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f), this brief contains 12,818 words.

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/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan

STATEMENT REGARDING ORAL ARGUMENT

Plaintiffs' counsel believes that oral argument would aid this Court in its consideration of this appeal. The disposition of this appeal will impact others beyond the parties, including transgender youth in Oklahoma, their parents or guardians, and their providers, both with respect to the matter of access to gender-affirming medical care for transgender adolescents with gender dysphoria in Oklahoma as well as larger issues concerning the level of scrutiny applicable to discrimination against transgender people and the scope of parents' fundamental right to direct the upbringing of their children, particularly as it pertains to medical decisions.

/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan

CERTIFICATE OF SERVICE

I hereby certify that on November 9, 2023, I filed a true and correct copy of the foregoing with the Clerk of the United States Court of Appeals for the Tenth Circuit by using the appellate case filing CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan

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/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan