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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

KATIE ROBINSON, et al.,

Plaintiffs,

v.

RAÚL LABRADOR, et al.,

Defendants.

Case No. 1:24-cv-00306-DCN

PLAINTIFFS' REPLY ISO MOTION FOR EIGHTH PRELIMINARY INJUNCTION

This Court has granted seven preliminary injunctions to maintain the status quo until it can determine on a full evidentiary record whether Idaho Code § 18-8901 violates the Eighth Amendment. In granting each of these injunctions, this Court concluded that Plaintiffs have raised "serious questions" going to the merits that "cannot be resolved one way or the other at the hearing

on the injunction because they require more deliberative investigation." Dkt. 186 at 7, 5; *accord* Dkt. 58 at 9; Dkt. 95 at 9; Dkt. 120 at 7; Dkt. 137 at 6; Dkt. 150 at 6-7; Dkt. 180 at 7; Dkt. 186 at 7. Despite their lengthy opposition, Defendants have not identified any changes in law or fact that alter this Court's previous conclusions. *Cf. Mayweathers v. Terhune*, 136 F. Supp. 2d 1152, 1154 (E.D. Cal. 2001) (issuing successive preliminary injunction after 90-day expiration under PLRA because "defendants have failed to identify substantially different evidence, a change in the controlling legal authority, or any error in the court's prior decision").

Defendants have not identified any change in the law. They assert that the Eighth Amendment does not apply when prison officials are carrying out state law. But, as this Court recognized in granting Plaintiffs' motion for a stop-gap TRO, "courts across the country have declined to immunize individuals for acting pursuant to an unconstitutional policy." Dkt. 200 at 4-5. Binding Ninth Circuit precedent—and indeed the case law on which Defendants rely—makes clear, compliance with state law does not immunize prison policies from Eighth Amendment scrutiny, and courts may grant injunctive relief to prevent such policies from being enforced. *Cf. Peralta v. Dillard*, 744 F.3d 1076 (9th Cir. 2014) (en banc) (distinguishing personal capacity suits for damages and official capacity suits for injunctive relief).

Defendants have also not identified any change in the facts. The expert declarations they attach to their opposition present no material changes in the science or relevant professional fields since the most recent preliminary injunction was issued. Defendants appear eager to skip past discovery and cross-examination of their evidence and fast-forward to a decision on the merits. As this Court has now recognized seven times, such a decision would be premature. *See, e.g.*, Dkt. 95 ("The injunction . . . ensures no violation of class members' Eighth Amendment rights *pending a final decision on the merits*.") (emphasis added); *accord* Dkt. 120 at 9; Dkt. 137 at 7-8; Dkt. 150

at 7-8; Dkt. 180 at 8-9; Dkt. 186 at 7-8; *see also* Dkt. 58 at 11 ("*[U]ntil the Court can make a more informed decision*, the public is best served if the Court steers clear of potential constitutional impingement.") (emphasis added). As demonstrated by the rebuttal expert reports of Dr. Karasic and Dr. Hamnvik, there is no medical or scientific basis for a blanket ban on hormone replacement therapy (HRT), and Defendants' evidence at most creates a disputed factual question to be resolved after discovery.[1]

Defendants also rely on medical records that largely predate the most recent preliminary injunction and have not been produced to Plaintiffs. For instance, Defendants only produced medical records for plaintiffs Robinson and Singer [redacted]. However, they now rely on more recent, unproduced medical history for Robinson and Singer exclusively in Defendants' possession. *See, e.g.*, Dkt. 191 at 12 (referring to Plaintiff Robinson's medical history [redacted]); Dkt. 191-2 ¶¶ 222, 224, 228 (referring to Plaintiff Singer's [redacted]). Notably, discovery is stayed in this case pending resolution of several motions, *see* Dkt. 176, including two dispositive motions, *see* Dkts. 72, 75, and indeed one motion based on Defendants' previous failure to provide complete discovery, *see* Dkt. 153.

[1] Plaintiffs' position is that the Court should not consider Defendants' expert reports, pursuant to the "law of the case doctrine," which "requires that when a court decides on a rule, it should ordinarily follow that rule during the pendency of the matter." *Mayweathers*, 136 F. Supp. 2d at 1153-54. The Court has previously reviewed substantially similar contentions from Defendants in their July 2024 submissions, *see* Dkts. 24-1, 24-2, and issued a preliminary injunction, despite them. *See* Dkt. 58; *see also Mayweathers*, 136 F. Supp. 2d at 1154 (law of the case doctrine weighed in favor of successive injunction because "[a]ll of the defendants' contentions were previously argued and rejected when the court issued the first and second preliminary injunction" and "[g]rounds justifying departure from the law of the case include substantially different evidence, a change in controlling authority or the need to correct a clearly erroneous decision which would work a manifest injustice") (citing *White v. Murtha*, 377 F.2d 428, 431-32 (5th Cir. 1967)). To the extent the Court considers any new evidence—such as new opinions or citations in Defendants' expert reports or the medical records Defendants are only now introducing—in deciding whether to grant Plaintiffs' instant motion, Plaintiffs have submitted rebuttal expert declarations and exhibits detailing Defendants' productions to Plaintiffs prior to the stay order.

Defendants may not rely on cherry-picked medical records to oppose the preliminary injunction while Plaintiffs are prevented from taking any discovery to rebut Defendants' arguments.[2]

For the reasons further explained below, Plaintiffs are entitled to an eighth preliminary injunction that mirrors the seven others previously granted.

ARGUMENT

A preliminary injunction remains necessary to ensure class members receive HRT when medically indicated. Defendants cannot escape Eighth Amendment scrutiny by hiding behind the state law. Nor have they shown that HRT is never medically necessary, which they must do to enforce a categorical ban. At minimum, there is still a serious question going to the merits of this case—counseling in favor of, not against, an eighth preliminary injunction.

I. Legal Standard.

Courts in the Ninth Circuit apply a "sliding scale" standard in evaluating the preliminary-injunction factors, "allowing a stronger showing of one element to offset a weaker showing of another." *Doe v. Snyder*, 28 F.4th 103, 111 (9th Cir. 2022) (citing *All. for Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011)). Thus, an injunction is proper where there are "serious questions going to the merits" and the balance of hardships "tips sharply toward the plaintiff." *Cottrell*, 632 F.3d at 1132. Plaintiffs demonstrate such a "serious question" where they raise questions "that cannot be resolved one way or the other at [debate over] the injunction because they require more deliberative investigation." *All. for the Wild Rockies v. Petrick*, 68 F.4th 475, 490-91, 497 (9th Cir. 2023) (cleaned up) (citing *Winter v. Nat'l Res. Def. Council, Inc.*, 555

[2] Defendants failed to produce complete discovery even prior to the stay order. Production demonstrated that IDOC decision makers conducted official business through their mobile phones during the implementation of HB 668. *See* Dkt. 153-1 at 4. These text messages, call logs, and voicemails likely included conversations about expected side effects of tapering, concerns of IDOC providers, and potential waivers to HB 668. *Id.* But State Defendants failed to preserve this evidence in violation of their obligations. *Id.* at 15.

U.S. 7, 20, 22-23 (2008)); *see also Fellowship of Christian Athletes v. San Jose Unified Sch. Dist. Bd. of Educ.*, 82 F.4th 664, 684 (9th Cir. 2023) (showing of "serious questions" is "a lesser showing than likelihood of success").

II. Plaintiffs Have Established, at Minimum, Serious Questions Going to the Merits.

It is well-established that "[d]eliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (internal citation omitted). A plaintiff establishes deliberate indifference by showing (1) a serious medical need such that failure to treat the condition could result in further significant injury or the unnecessary and wanton infliction of pain, and (2) that defendants' chosen course of treatment was medically unacceptable under the circumstances and pursued in conscious disregard of an excessive risk to the plaintiff's health. *Edmo v. Corizon, Inc.*, 935 F.3d 757, 785-86 (9th Cir. 2019).

A. Deliberate Indifference.

A prison official acts with deliberate indifference when they "knowingly and unreasonably disregard[] an objectively intolerable risk of harm." *Farmer v. Brennan*, 511 U.S. 825, 846 (1994). Though "Eighth Amendment liability requires consciousness of a risk," *id.* at 840, "an Eighth Amendment claimant need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official failed to act despite his knowledge of a substantial risk of serious harm[.]" *Id.* at 842.

Defendants do not contest the actual elements of deliberate indifference: knowledge of and an action taken in conscious disregard of an unreasonable risk. Defendants do not argue that prison

officials are unaware of the risk of denying prescribed medical care to the class members.[3] Nor do they dispute that prison officials enacted policies to cut off access to this medicine.[4]

Instead, Defendants dismiss these acts taken in conscious disregard of risk as merely "obeying a state statute[.]" Dkt. 191 at 7. But Defendants are not immunized from suit because their denial of care was the result of a blanket policy. *See* Dkt. 200 at 4-6.

Defendants' argument has no basis in precedent and, indeed, conflicts with the very precedent Defendants purport to rely on. *See Fields v. Smith*, 653 F.3d 550, 556 (7th Cir. 2011) ("It is well established that the Constitution's ban on cruel and unusual punishment does not permit a state to deny effective treatment for the serious medical needs of prisoners. . . . Surely, had the Wisconsin legislature passed a law that DOC inmates with cancer must be treated only with therapy and pain killers, this court would have no trouble concluding that the law was unconstitutional."); *Cordellioné v. Comm'r, Indiana Dep't of Corr.*, No. 3:23-cv-00135-RLYCSW, 2024 WL 4333152, at *18-19 (S.D. Ind. Sept. 17, 2024) (finding that state law "violates the Eighth Amendment as it *requires* deliberate indifference" on the part of DOC officials and that DOC officials' "denial of surgery to [plaintiff] *because of the challenged statute* . . . represents deliberate indifference to her serious medical need") (emphasis added); *Marcum v. Crews*, No. 5:25-cv-00238-GFVT, 2025 WL 2630922 at *6 (E.D. Ky. Sept. 12, 2025)

[3] Prior to the stay of discovery, evidence suggested that IDOC officials were [redacted]. *See* Croston Decl. Ex. B (Dr. Wilks e-mail "[redacted]; Ex. C (Dr. Wilks e-mail regarding potential [redacted], Ex. D (Dr. Wilks e-mail listing [redacted]; Ex. E (e-mail from Chad Page, noting [redacted]

[4] Prior to the stay of discovery, evidence suggested that IDOC officials were [redacted]. *See* Croston Decl. Ex. B (Dr. Wilks e-mails discussing [redacted]

(applying the deliberate indifference standard to prison officials if they knew of a serious medical need but refused to provide hormone therapy because of the law); *Benjamin v. Oliver*, No. 1:25-cv-04470-VMC, 2025 WL 3900855 (N.D. Ga. Dec. 3, 2025) (same). The subjective requirement of deliberate indifference does not require an examination of *why* a particular actor is inflicting punishment. The state defendants may be merely "obeying a state statute prohibiting the treatment Plaintiffs seek," Dkt. 191 at 7, but they are doing so, despite their awareness of a substantial risk of serious harm. As this Court recognized when granting Plaintiffs' motion for a stop-gap TRO "[w]here a defendant has subjective knowledge that a course of action or inaction required by policy creates or fails to address a serious risk to an inmate's health or safety, he may not escape constitutional liability by disregarding such risk in compliance with the policy." Dkt. 200 at 5-6 (quoting *Johnson v. Sanders*, 121 F.4th 80, 92 (10th Cir. 2024)). If taken to its logical conclusion, Defendants' position would mean that states could evade Eighth Amendment scrutiny for physically torturing prisoners or for execution by drawing and quartering simply by codifying those cruel and unusual punishments as part of state statutes. That is not the law.

Controlling Ninth Circuit precedent makes clear that the existence of a state statute does not prevent courts from remedying ongoing constitutional violations. For example, in *Peralta v. Dillard*, the Ninth Circuit permitted the jury to consider whether state legislative constraints negated a prison dentist's deliberate indifference where he was unable to provide adequate medical care due to inadequate funding. *Peralta*, 744 F.3d at 1076. However, the court was specific that this defense based on constraints outside of the provider's control was specific to whether he could be liable for retrospective damages when sued in his personal capacity. *Id.* at 1083. The court noted that a case seeking injunctive relief against the provider in his official capacity would be treated differently. *See id.* ("Lack of resources is not a defense to a claim for prospective relief because

prison officials may be compelled to expand the pool of existing resources in order to remedy continuing Eighth Amendment violations."); *id.* at 1082 ("For example, although prisoners can't sue states for monetary relief, they can sue for injunctions to correct unconstitutional prison conditions." (*citing Brown v. Plata*, 563 U.S. 493 (2011)). "*Peralta* holds that in a suit for injunctive relief prison officials must remedy ongoing constitutional violations of which they are aware. *Peralta* is binding and it ensures adherence to constitutional standards." *Jensen v. Shinn*, 609 F. Supp. 3d 789, 873 (D. Ariz. 2022), *amended*, No. CV-12-00601-PHX-ROS, 2022 WL 2910835 (D. Ariz. July 18, 2022); *see also Colwell v. Bannister*, 763 F.3d 1060, 1070 (9th Cir. 2014) (holding that prison director was a proper defendant for a claim for injunctive relief "because he would be responsible for ensuring that injunctive relief was carried out, even if he was not personally involved in the decision giving rise to [the plaintiff's] claims") (quoting *Pouncil v. Tilton*, 704 F.3d 568, 576 (9th Cir. 2012)).

Denial of care due to a blanket policy "is the paradigm of deliberate indifference." *Colwell*, 763 F.3d at 1063. That is true, regardless of whether the deliberate indifference has been codified into statute. Defendants' contrary argument has no basis in law and should be rejected.

B. Substantial Risk of Serious Harm.

Defendants argue that this Court should not issue an eighth preliminary injunction because HRT is never a medically necessary treatment for gender dysphoria. To support this argument, Defendants cite expert reports which make arguments and rely on evidence that has either already failed to convince the Court to deny a preliminary injunction or has not been produced to Plaintiffs. But, as Plaintiffs have repeatedly shown and the Court has found seven times over, there is at least a serious question as to whether categorically denying HRT to incarcerated people with gender

dysphoria without consideration of their individual medical needs puts them at "substantial risk of serious harm." *Farmer*, 511 U.S. at 834.

This is all Plaintiffs must show to prevail at this juncture. As this Court explained in granting the second preliminary injunction, "if upon individual evaluation by a medical professional, hormone therapy is determined to be medically necessary for the treatment of that individual's gender dysphoria," to "deny[] that treatment under the Act . . . puts each inmate with gender dysphoria at substantial risk of irreparable harm because they are automatically precluded from seeking a recognized gender dysphoria treatment, even if it is determined to be medically necessary." Dkt. 95 at 10-11. Defendants are well aware of this risk. *See, e.g.*, Croston Decl. Ex. C [redacted] Ex. D at 4 [redacted]; Ex. E at 2 [redacted]

Defendants argue that HRT is not medically necessary for any prisoners with gender dysphoria, Dkt. 191 at 9, because—according to Defendants' proposed experts—there is a genuine debate in the medical community about its necessity and efficacy, and it is risky and unproven. But, as demonstrated by the rebuttal expert reports of Dr. Karasic and Dr. Hamnvik, there is no medical or scientific basis for a blanket ban on HRT, and Defendants' evidence at most creates a disputed factual question to be resolved after discovery.

The evidence Defendants rely upon does not support their argument that HRT is never medically necessary for a prisoner with gender dysphoria. To support their claim that there is a

"genuine debate" within the field, they largely rely on statements made about treatment for minors—not adults. *Compare* Dkt. 191 at 9 (relying on Dr. Laidlaw's declaration, Dkt. 191-2, at ¶¶ 147-58 to suggest there is live "debate" about HRT generally) *with* Dkt. 191-2 at ¶¶ 150-53, 156-58 (referring respectively to other countries' and scientists' research on "minors," "youth under 18 years," "young people," and "children," and a report that only "relates to minors").

Defendants further attempt to prove this debate by citing *Dana v. Campbell*, No. 1:18-CV-00298-DCN, 2025 WL 1827042 (D. Idaho July 1, 2025), and *United States v. Skrmetti*, 605 U.S. 495 (2025), which are inapposite. Just as this Court has ruled before, these cases do not "definitively resolve the question of medical necessity of gender-affirming care." Dkt. 150 at 6. *Skrmetti* only concerned gender-affirming care for youth and did not evaluate any evidence about adult care; indeed, the statute at issue explicitly permitted the provision of HRT to adults. 605 U.S. at 511. And not only is the language Defendants quote from *Dana* dicta, but *Dana* is easily distinguishable: it concerns an individual's challenge to a discrete decision (not a blanket policy), a higher standard that is distinct from the preliminary-injunction factors (qualified immunity), and an altogether differently situated plaintiff. *See* Dkt. 148 at 2-3 (explaining *Dana* plaintiff failed to receive gender dysphoria diagnosis, but class here is defined by that diagnosis).

Defendants' attempt to rely on *Gibson v. Collier*, 920 F.3d 212, 224 (5th Cir. 2019) also fails. *Edmo*, which is binding on this Court, specifically rejected *Gibson*'s reasoning—primarily because "*Gibson* relies on an incorrect, or at best outdated, premise: that '[t]here is no medical consensus that [gender-affirming surgery] is a necessary or even effective treatment for gender dysphoria.'" 935 F.3d at 795 (quoting *Gibson*, 920 F.3d at 223). As the *Edmo* court observed, *Gibson* is an outlier in suggesting a treatment's failure to be "universally accepted" in the medical field precludes a deliberate indifference claim, regardless of "evidence of [plaintiff's] personal

medical need" for the treatment. *See Gibson*, 920 F.3d at 225. This standard is unsupported by any precedent and is instead "an unfounded qualification to the well-known deliberate indifference standard." *Id.* at 229, 235 (Barksdale, J., dissenting).[5]

Simply put: There is no such debate regarding gender-affirming HRT for adults. Karasic Decl. ¶¶ 39-41. Instead, decades of research and clinical experience have shown that gender-affirming HRT is safe and effective treatment for gender dysphoria. Karasic Decl. ¶¶ 30-32; Hamnvik Decl. ¶ 23. In their original preliminary injunction motion, Plaintiffs submitted substantial evidence that HRT is well-accepted as treatment for gender dysphoria in the medical field, *see* Dkt. 2-1 at 7-10, including its support from every major medical association in the United States, *see* Dkt. 2-5 at 10-11. Since that first preliminary injunction, Plaintiffs have introduced additional evidence that this care is essential, *see* Dkts. 114-5, 114-6, 114-7, which this Court has credited. *See* Dkt. 120 at 7. Plaintiffs' experts provide further evidence to that effect here. Karasic Decl. ¶¶ 30-32; Hamnvik Decl. ¶ 23. Even though the PLRA contemplates that district courts may evaluate whether to renew a preliminary injunction based on new information from the past 90 days, Defendants offer nothing of the sort.[6] That Defendants can name some individual doctors

[5] The *Gibson* court reached this conclusion by mischaracterizing a different out-of-circuit case, *Kosilek v. Spencer*, 774 F.3d 63 (1st Cir. 2014). It suggested that *Kosilek* held the Eighth Amendment permits categorical bans on treatment without regard to individual need if the medical community lacks consensus about the treatment's appropriateness. But, as the *Edmo* court recognized, *Kosilek* said no such thing. Instead, the prison's denial of gender-affirming surgery there was based on an individualized evaluation, and the court's decision was not "a de facto ban against [gender-affirming surgery] as a medical treatment for any incarcerated individual," since such a "blanket policy" "would conflict with the requirement that medical care be individualized based on a particular prisoner's serious medical needs." *Id.* at 90-91; *see also Edmo*, 935 F.3d at 797 (*Gibson* "contradicts and misconstrues the precedent it purports to follow: *Kosilek*" and "disregarded [*Kosilek*'s] words of warning" against reading it as supporting blanket bans); *Flack v. Wis. Dep't of Health Servs.*, 395 F. Supp. 3d 1001, 1017 (W.D. Wis. 2019) (similar).

[6] Defendants cite only one study from the past 90 days. *See* Dkt. 191-1 ¶ 74 (Cantor) (citing Zhang, et al. study in string cite to support same argument as in previous declaration about WPATH's lack

who disagree with the prevailing treatment protocols for adults with gender dysphoria does not constitute a genuine debate. If that were so, it would apply to all medical treatment.

Indeed, Defendants and their own experts have recognized that HRT for gender dysphoria can be medically indicated. *See* Dkt. 25 at 2-3 (collecting examples of testimony to this effect from both Drs. Cantor and Laidlaw in other cases). IDOC's own policy, which had been in place since 2002, prior to the passage of this law, recognized that [redacted] *Id.* at 2. Bizarrely, Dr. Cantor's updated expert declaration defends the methodology used to develop WPATH's SOC-6, *see* Dkt. 192-5 ¶¶ 35, 113, 115-117, 120-121, but criticizes the development of SOC-7 and SOC-8, *id.* ¶¶ 35, 113, 122, 165, 168-169. *See also* Karasic Decl. ¶¶ 39, 42-43. If Defendants were to follow SOC-6, based on Dr. Cantor's own declaration, they would provide HRT based on the following eligibility criteria: "a DSM diagnosis, indications that hormones will be used responsibly, and three months of either psychotherapy or three months of documented 'real-life experience' (RLE), fully adopting the new gender role in everyday life." Dkt. 192-5 ¶ 115 (emphasis removed). This is a far cry from Defendants' stated position of banning HRT, for any class member, no matter the level of medical need. To justify the blanket policy imposed by Idaho Code § 18-8901, Defendants must show that HRT is *never* medically necessary. They cannot.

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of rigor and conflict of interest management in developing the SOC-8), Dkt. 191-2 ¶ 109 (Laidlaw) (citing same study for similar proposition). The Response does not cite this study directly at all. *See* Dkt. 191. Notably, Dr. Zhang was one of the authors of the May 2025 HHS report on gender dysphoria that has itself been critiqued by major medical associations for its lack of transparency and scientific rigor—for instance, by failing to disclose the names of the authors until months after its publication. *See, e.g.*, *APA Statement on Access to Treatment for Transgender, Gender Diverse, and Nonbinary People*, AM. PSYCHOLOGICAL ASS'N (May 1, 2025), https://updates.apaservices.org/statement-on-access-to-treatment-for-transgender-gender-diverse-and-nonbinary-people ("The lack of transparency regarding authorship, expertise, and methodology in the recent HHS report undermines scientific rigor and contradicts standards for evidence-based policymaking. Policies should be developed through open scientific discourse rather than opaque processes that prevent proper evaluation of potential biases.").

Defendants' other expert, Dr. Laidlaw,[7] argues that HRT is an unproven treatment for gender dysphoria. But—as explained by Plaintiffs' rebuttal experts—the evidence supporting the efficacy of HRT as treatment for gender dysphoria in adults is of the same quality as the evidence that supports numerous other medical interventions. *See* Karasic Decl. ¶¶ 33-34; Hamnvik Decl. ¶¶ 24-30; *cf.* Hamnvik Decl. ¶¶ 31-33.[8] HRT is also not "riskier" than other standard medical treatments. The risks of HRT are comparable to many other medical treatments that are widely used—including when the same medications are used to treat cisgender people for other conditions. Hamnvik Decl. ¶¶ 34-49 (testosterone), 50-62 (estrogen). For instance, the risk of venous thromboembolism is actually higher when estrogen is taken as birth control by cisgender women than as gender-affirming HRT by transgender women. *Id.* ¶ 57. Indeed, all medical treatments carry risks, which doctors weigh in consultation with their patients in deciding how to address a condition. There is nothing unique about gender-affirming HRT that warrants deviating from this approach. Hamnvik Decl. ¶¶ 62, 66.[9]

[7] Dr. Laidlaw is a prolific witness, but as other courts have noted, his expertise is a "close question" raising questions about his reliability. *C.P. by and through Pritchard v. Blue Cross Blue Shield of Illinois*, No. 3:20-CV-06145-RJB, 2022 WL 17092846, at *4 (W.D. Wash. Nov. 21, 2022) (noting that "[h]e has done no original research on gender identity," and has only seen two patients with gender dysphoria); *see also Koe v. Noggle*, 688 F. Supp. 3d 1321, 1351 n.26 (N.D. Ga. 2023) (finding Laidlaw's "contrary conclusions" regarding treatment regret "unreliable").

[8] Defendants seek to discredit HRT by attacking WPATH and other major medical and mental health organizations that endorse it. But Defendants cannot change the underlying science by shooting the messenger. The medical necessity of gender-affirming care is established by the decades of research and clinical experience, which have shown that HRT is an effective treatment for gender dysphoria. Karasic Decl. ¶ 54. And as explained in Dr. Karasic's report, the attack on WPATH is baseless. Karasic Decl. ¶¶ 54-60; *see also* Dkt. 192-5 ¶¶ 35, 113, 115-17, 120-21 (Dr. Cantor defending WPATH's SOC-6).

[9] Defendants also suggest that HRT increases the risk of suicide. But this conflates causation with correlation. *See* Karasic Decl. ¶ 38. Rates of suicide are overall higher in the transgender population than in comparator populations, especially when they are unable to access gender-affirming care, such as HRT, not *because* of HRT. *See* Dkt. 2-5, Ettner Decl. ¶ 47.

At minimum, Defendants have not provided anything to contradict the Court's longstanding determination that there is a serious question going to the merits of the case, which counsels in favor of—not against—issuing an eighth preliminary injunction. *See* Dkt. 95 at 9 ("Until the parties present the Court with more definitive evidence one way or another as to the medical necessity of hormone therapy to individuals with gender dysphoria, there continues to be a serious question as to the merits of this case, and this factor weighs in favor of granting another preliminary injunction."); *accord* Dkt. 58 at 9; Dkt. 120 at 7; Dkt. 137 at 6; Dkt. 150 at 6-7; Dkt. 180 at 7; Dkt. 186 at 7; *see also* Dkt. 200 at 6 (granting TRO in part because "the Court does not find State Defendants' newly-disclosed report dispositive on its face").

C. Use of Individual Medical Histories.

The Court should also reject Defendants' attempt to demonstrate HRT's lack of safety and efficacy by pointing to select portions of three individuals' medical histories. First, with discovery stayed, now is not an appropriate time for Defendants to introduce new evidence that has not been produced to Plaintiffs—let alone for this Court to resolve this case on the merits. Plaintiffs deserve the opportunity to seek discovery and cross-examine Defendants' evidence before this Court relies upon it. Second, as with their expert reports, the vast majority of the medical records Defendants cite was available to them long before the most recent preliminary injunction. *See* Dkt. 191-2 ¶¶ 172-76, 178-97 (referencing aspects of plaintiff Robinson's medical history [redacted], *id.* ¶¶ 208-28 (same for plaintiff Singer [redacted], *id.* ¶¶ 160-64 (same for class member [redacted]. Third, this case is a challenge to a blanket policy that prohibits the provision of HRT to *any* individual with gender dysphoria in IDOC custody, regardless of their particular medical need. The experiences of three individuals say nothing about whether HRT is medically necessary for anyone else.

For instance, Defendants point to one class member [redacted]—the fact that one person experienced an adverse effect does not mean the treatment is never medically necessary for anyone. All medical care has risks and, as Dr. Hamnvik explains, estrogen and testosterone carry most of the same risks whether provided to transgender people to treat gender dysphoria or to cisgender people for other conditions. Hamnvik Decl. ¶¶ 34-49 (testosterone), 50-62 (estrogen). Indeed, the cardiovascular risk for transgender men taking testosterone is the same risk level as that seen in cisgender men taking testosterone. *Id.* ¶ 43. Similarly, transgender women taking estrogen do not exhibit any significant changes in their cardiovascular risk. *Id.* ¶¶ 57, 58. If one cisgender woman has a stroke due to estrogen therapy provided to treat menopausal symptoms or autoimmune conditions that destroy the ovaries, it would not be a basis to conclude that estrogen therapy is never medically necessary for any women with those conditions. Nor does the fact that one plaintiff has certain risk factors mean HRT is not medically necessary for anyone. It just means that, as with all medical care, risks and benefits must be considered and weighed. *Id.* ¶¶ 62, 66; *cf. id.* ¶¶ 64-65.

The same goes for Defendants' contentions about Plaintiff Singer.[11] Again, as with all medical care, risks and benefits must be considered and weighed. Singer's medical provider, Dr. Alviso, currently provides this individualized evaluation and supervision of treatment for Singer and other class members. In contrast, Defendants' expert, Dr. Laidlaw, would not

[10] Moreover, this class member's medical history, as produced to Plaintiffs, indicates that [redacted]. *See* Croston Decl. Ex. G.

[11] Plaintiff Singer's medical records that have been produced to Plaintiffs indicate that Dr. Alviso [redacted] *See* Croston Decl. Ex. H.

understand how this process works for patients like Plaintiff Singer, having never treated patients with gender dysphoria. He has no experience at all in this realm, save for one refill of one patient's prescription. *See* Croston Decl. Ex. A at , 37:4-6, 87:19-20, 88:1-5. Under Dr. Laidlaw's logic, HRT is *never* appropriate treatment for gender dysphoria. *See id.* at 89:15-18, 90:13-24; 91:12-22. His absolute position does not account for the benefits of HRT. Accordingly, he cannot do the requisite weighing, since one cannot weigh a treatment's risks against the benefits without assessing its benefits. Hamnvik Decl. ¶ 66; Karasic Decl. ¶ 43.

Finally, [redacted]

Again, Defendants have not produced the records on which they rely with respect to this claim, preventing Plaintiffs from assessing [redacted].

[redacted]

[redacted]

III. Irreparable Harm.

This Court has found in seven consecutive orders "that the irreparable harm prong continues to 'tip sharply' in favor of the Plaintiffs." *See* Dkt. 186 at 7; *accord* Dkt. 180 at 8; Dkt. 150 at 7; Dkt. 137 at 6-7; Dkt. 120 at 8; Dkt. 95 at 10-11; Dkt. 58 at 9-10. Defendants' strategy of focusing on two plaintiffs and one class member implies that Plaintiffs must demonstrate that each class member would experience irreparable harm, but—as this Court has held—this is not Plaintiffs' burden. Rather, "an individualized showing of irreparable harm to each class member is not necessary here because the blanket prohibition on hormone therapy for any incarcerated individual diagnosed with gender dysphoria presents primarily the same Eighth Amendment concerns for each class member." Dkt. 95 at 10. Accordingly, "each inmate with gender dysphoria" is "at substantial risk of irreparable harm because they are automatically precluded from seeking a recognized gender dysphoria treatment, even if it is determined to be medically necessary." *Id.* at 10-11.

The record confirms that the risk of this harm is concrete, not speculative. This Court credited Dr. Wall's expert opinion that "discontinuation of hormone therapy will lead to severe psychological distress for both [named plaintiffs], up to and including possible suicidal attempts."

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Dkt. 120 at 7-8. That finding has been incorporated into every subsequent order. *See* Dkt. 137 at 6; Dkt. 150 at 7; Dkt. 180 at 8; Dkt. 186 at 7. These conclusions apply to any class member whose HRT is discontinued, not merely the named plaintiffs. Karasic Decl. ¶¶ 45, 49. None of the concerns Defendants raise about the three individuals' medical histories change the fact that discontinuation of HRT at IDOC facilities would result in class-wide irreparable harm. *See* Dkt. 120 at 7-8 (observing "emotional stress, depression, and a reduced sense of well-being can all be categorized as irreparable harm" and "such effects seem inevitable if the class members' hormone therapy is discontinued"); *see also* Dkt. 200 at 7 (granting TRO in part because "State Defendants do not dispute that some of the class members are continuing to take hormone therapies at the direction of their physicians").

IV. Balance of the Equities and Public Interest.

Because the government opposes the injunction, the balance-of-equities and public-interest inquiries merge. *See Porretti v. Dzurenda*, 11 F.4th 1037, 1047 (9th Cir. 2021). This Court has consistently found both factors favor Plaintiffs, and the present record confirms that conclusion. *See* Dkt. 58 at 10-11; Dkt. 95 at 11-12; Dkt. 120 at 8-9; Dkt. 137 at 7; Dkt. 150 at 7; Dkt. 180 at 8; Dkt. 186 at 7. Defendants continue to "remain silent on the potential burden of continuing to provide hormone therapy to" the class, Dkt. 186 at 7, while the Plaintiff class faces severe physiological and psychological harm if medically necessary HRT is discontinued. *Id.* at 7 (citing Dkt. 120 at 7-8); *see also* Dkt. 200 at 7 (similar). Because the threatened harm to the Plaintiff class is devastating and the burden on the State is negligible, the balance of hardships "tips sharply" in Plaintiffs' favor. *Petrick*, 68 F.4th at 490-91.

The public interest likewise favors Plaintiffs. "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir.

2012) (quoting *Sammartano v. First Jud. Dist. Ct.*, 303 F.3d 959 (9th Cir. 2002)). A preliminary injunction remains warranted, so that the Court may "continue to steer clear of potential constitutional impingement." Dkt. 186 at 7; *accord* Dkt. 180 at 8; Dkt. 150 at 7; Dkt. 137 at 7; Dkt. 120 at 9; Dkt. 95 at 12; Dkt. 58 at 11; Dkt. 200 at 7.

CONCLUSION

Plaintiffs have made the requisite showing that a preliminary injunction against enforcement of Idaho Code § 18-8901 continues to be necessary in this case. Plaintiffs respectfully request that the Court issue an eighth preliminary injunction prior to the temporary restraining order's expiration on June 15, 2026.

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