Court of King's Bench of Alberta

Citation: Egale Canada v Alberta, 2025 ABKB 394

Date: 20250627
Docket: 2401 17719
Registry: Calgary

Between:

Egale Canada, Skipping Stone Scholarship Foundation, Applicant Doe 1 by their litigation representative Parent Doe 1, Applicant Doe 2 by their litigation representative Parent Doe 2, Applicant Doe 3 by their litigation representative Parent Doe 3, Applicant Doe 4 by their litigation representative Parent Doe 4, and Applicant Doe 5 by their litigation representative Parent Doe

Applicants

- and -

His Majesty the King in Right of Alberta and His Majesty's Attorney General in and for the Province of Alberta

Respondent

Reasons for Decision
of the
Honourable Justice Allison G. Kuntz

I. Introduction

[1] The Applicants have applied for an interim and interlocutory injunction enjoining the Lieutenant Governor in Council of Alberta from proclaiming into force amended provision of the ***Health Professions Act***, RSA 2000, c H-7 (the ***HPA***) that would prohibit doctors from prescribing certain drugs, including puberty blockers and hormone replacement therapy (collectively, **Hormone Therapy**), to persons under the age of 18 for the treatment of gender dysphoria or gender incongruence except as authorized by the Minister (the **Ban**).

[2] The Applicants commenced this proceeding by Originating Application to challenge the constitutionality of the amended provisions and seek: (a) a declaration that the amended provisions violate rights guaranteed in the *Canadian Charter of Rights and Freedoms* and the *Alberta Bill of Rights*, and (b) an order striking down the amended provisions. The Applicants seek an injunction until such time as the Originating Application has been adjudicated on its merits.

[3] For the reasons that follow, I will grant the injunction as requested by the Applicants. I also find that the Doe applicants have private interest standing, and I exercise my discretion to grant public interest standing to Egale Canada (**Egale**) and Skipping Stone Scholarship Foundation (**Skipping Stone**).

II. The Parties

[4] The Applicants are five gender diverse young Albertans and their parents, as well as Egale and Skipping Stone, two leading 2SLGBTQI[1] organizations.

[5] The Respondents are His Majesty the King in the Right of Alberta, and His Majesty's Attorney General in and for the Province of Alberta.

III. The Impugned Legislation

[6] Bill 26, the ***Health Statutes Amendment Act, 2024 (No. 2)*** (the ***HSAA***) was assented to on December 5, 2024. The ***HSAA*** amended, *inter alia*, the ***HPA***. At issue in this application is section 9(3) of the ***HSAA*** which added sections 1.92 and 1.93 to the ***HPA***:

> Prohibition of certain drug prescriptions for minors
>
> 1.92(1) A regulated member shall not prescribe a Schedule 1 drug within the meaning of the *Pharmacy and Drug Act*, or any other drug identified in the regulations, to a minor for the purposes of hormone therapy, including puberty suppression and hormone replacement therapy, for the treatment of gender dysphoria or gender incongruence except in accordance with an order of the Minister under section 1.93.
>
> (2) The Minister may make regulations identifying any drug as a drug for the purposes of this section.
>
> Orders
>
> 1.93 The Minister may make orders
>
> (a) authorizing the prescription of a Schedule 1 drug within the meaning of the *Pharmacy and Drug Act*, or any other drug identified in the regulations made under section 1.92(2), to a minor for the purposes of hormone therapy, including puberty suppression and hormone

[1] Two Spirit (2S), Lesbian, Gay, Bisexual, Trans, Queer and Intersex.

replacement therapy, for the treatment of gender dysphoria or gender incongruence, and

(b) respecting any such authorization, including any terms, conditions or limits that apply to an authorization.

[7] Section 9(2) of the ***HSAA*** added the following definitions to section 1 of the ***HPA***:

(o.1) "gender dysphoria" means a person's distress caused by a marked incongruence between that person's gender identity or gender expression and that person's sex assigned at birth;

(o.2) "gender incongruence" means a marked and persistent incongruence between a person's gender identity and that person's sex assigned at birth;

(v.1) "minor", except in sections 53.4(3) and 120(2) and section 8.7(i) of Schedule 21, means a person under the age of 18 years;

[8] Sections 1.92 and 1.93 are not yet in force, they come into force on proclamation: ***HSAA***, s 23. No date has been set for proclamation.

[9] The Respondents advised that the prohibition under section 1.92 and the authority to make Ministerial Orders under section 1.93 are intended to come into force concurrently with a Ministerial Order setting out exceptions to the prohibition. This procedure is not prescribed in the legislation. Section 1.93 is permissive, thus sections 1.92 and 1.93 could be proclaimed in the absence of a Ministerial Order.

[10] The Respondents state that the Ministerial Order is "under development" but it is "expected" to at least provide for an exemption for: (i) those already taking puberty blockers and hormone therapy for the treatment of gender dysphoria and gender incongruence, and (ii) minors aged 16 or 17 who have parental, physician and psychologist approval.

IV. Preliminary Issues – Prematurity & Standing

A. Is the injunction application premature?

[11] The Respondents submit that courts generally lack jurisdiction to enjoin the proclamation of legislation because this impermissibly interferes with the legislative process, and that in this case the injunction application is premature. The Respondents argue that the application is premature because sections 1.92 and 1.93 are meant to come into force concurrently with the issuance of a Ministerial Order, which will set out exemptions, further defining the scope of the prohibition. The Respondents submit that at this point, the timing and the scope of the Ministerial Order are unknown such that the court cannot adequately assess the injunction application.

[12] Further, the Respondents argue that proclamation is the final, mandatory step in the legislative process and is a step in which courts have "no right to interfere", relying on: ***Criminal Law Amendment Act, Reference***, [1970] SCR 777 at 783 and 801 [***Criminal Law Amendment***]; ***Hogan et al v Newfoundland (Attorney General) et al*** (1998), 156 DLR (4th) 149, 1998 CanLII

18727 at paras 39, 57-59 and 66-68 (NLSC) [***Hogan***]; and ***Galati v Canada (Governor General)***, 2015 FC 91 at para 35 [***Galati***]. The Applicants argue the legislative process ended with royal assent of the ***HSAA*** on December 5, 2024, and the court has jurisdiction to grant injunctive relief, relying on ***Galati*** at paras 34-35 and 44.

[13] As for the pending Ministerial Order, the Applicants submit that the Respondents cannot rely on speculation about a possible Ministerial Order to evade constitutional scrutiny of enacted legislation. The authority to make a Ministerial Order under section 1.93 of the ***HPA*** is discretionary. But in any event, the Applicants submit that sections 1.92 and 1.93 of the ***HPA*** are unconstitutional regardless of the scope of any ministerial order, relying on: ***Harm Reduction Nurses Association v British Columbia (Attorney General)***, 2023 BCSC 2290 at paras 52-56, leave to appeal to BCCA refused, 2014 BCCA 87 [***Harm Reduction***]; and ***Reference re Impact Assessment Act***, 2023 SCC 23 at para 74 citing ***R v Hydro-Québec***, [1997] 3 SCR 213 at para 73.

[14] The law is well-established that courts should not grant an injunction if doing so would interfere with the legislative process: Robert J Sharpe, *Injunctions and Specific Performance* (Toronto: Thomson Reuters) (loose-leaf updated 2024, release 1) at §3:26.

[15] The Respondents' argument that this court does not have jurisdiction to grant an injunction enjoining proclamation was addressed by Justice Côté sitting as a single judge in ***Alberta v Lac La Biche***, 1993 ABCA 104 [***Lac La Biche***]. There, like here, the applicant sought injunctive relief enjoining proclamation of legislation that had been given royal assent but not yet proclaimed. And there, like here, the respondent argued that enjoining proclamation would unduly interfere with the legislative process. The injunction application was ultimately dismissed because the applicant refused to provide an undertaking as to damages. But Justice Côté was not persuaded that granting an injunction at that point in time would interfere with the legislative process. He reasoned that an injunction would not "force the Legislature to do or not do anything" and if the applicants were correct that the legislation was void for being contrary to the *Charter*, "proclaiming it would not achieve anything": ***Lac La Biche*** at para 23.

[16] The Applicants point to a number of cases where courts have found that they had jurisdiction to grant an injunction to stay the effect of a statute that had been assented to but had not yet come into force: ***Harm Reduction***; ***Tłı̨chǫ Government v Canada (Attorney General)***, 2015 NWTSC 9 [***Tłı̨chǫ***]; and ***Manitoba Federation of Labour et al v the Government of Manitoba***, 2018 MBQB 125 [***Manitoba Federation of Labour***].

[17] The Respondents say ***Manitoba Federation of Labour*** is distinguishable because in that case the impugned law was effectively being applied although it had not been proclaimed. I am not convinced that this argument goes to the issue of jurisdiction. Injunctions may be granted before any harm has actually been suffered. This argument is better addressed under the merits of the application.

[18] ***Hogan*** does not assist the respondents. ***Hogan*** concerned a fundamentally different type of proclamation than what is being discussed here. Indeed, Orsborn J held that the proclamation the applicants sought to enjoin in that case (a proclamation under section 48 of the *Constitution Act, 1982*) was equivalent to royal assent: ***Hogan*** at paras 50, 57-58. ***Hogan*** is entirely consistent with the holding in ***Galati*** that a court cannot interfere until a law has received royal assent.

[19] ***Criminal Law Amendment*** also does not assist the Respondents. That case was decided pre-*Charter* and rests on legal principles that have since been overtaken by the *Charter* and subsequent jurisprudence: see ***Tłı̨chǫ*** at paras 46-49.

[20] Having reviewed the authorities, I agree with the Applicants that this court has jurisdiction to grant an interlocutory injunction once a law has been enacted (i.e. assented to).

[21] All that remains is for the executive branch to act under the authority it has been granted under section 23 of the ***HSAA*** to bring the amendments to the ***HPA*** into force. The exercise of that authority is reviewable by the courts: ***Operation Dismantle v The Queen***, [1985] 1 SCR 441 at 455 [***Operation Dismantle***]; ***Canada Christian College and School of Graduate Theological Studies v Post-Secondary Education Quality Assessment Board***, 2023 ONCA 544 at para 53.

[22] As for the question of the effect, of a potential Ministerial Order that may change the scope of the prohibition, I find ***Harm Reduction*** instructive. In ***Harm Reduction*** the prohibition in the statute (prohibiting consumption of certain illegal substances in public areas) was subject to the Lieutenant Governor in Council's broad discretionary powers to make regulations with exemptions. Hinkson CJ held that in deciding whether to grant an injunction, the possibility of forthcoming regulations was not a bar to injunctive relief. The proper approach was to determine the injunction application on the statute as it was currently written, without any regulations, as that is what was before the court. Hinkson CJ recognized that in cases where regulations have been promulgated, the proper approach is to look at the regulations and the statute together as a "single legislative unit": ***Harm Reduction*** at para 54.

[23] The Respondents submit that I ought not follow ***Harm Reduction*** or ***Tłı̨chǫ*** because, unlike those cases, here the deliberative process is ongoing, and the scope of the statutory prohibition is in an active state of development. The Respondents argue that both cases are distinguishable: in ***Harm Reduction*** the government had proposed to bring the impugned law into force without any regulations, and in ***Tłı̨chǫ*** no further regulations defining the scope of the law were contemplated.

[24] Taking the Respondents' argument to its logical end, this court could only review the legislation once a Ministerial Order is issued under section 1.93. But as the Respondents concede, that may never happen. Regulations can be created or amended at any time subject to the scope of authority of the enabling statute. The evidence from the Respondents' affiant Ms. Fulsom is that the Minister of Health has not yet decided to issue a Ministerial Order under section 1.93, there may never be a Ministerial Order issued under section 1.93, and the scope of any potential Ministerial Order is unknown.

[25] Hinkson CJ's observation in ***Harm Reduction*** at para 56 is apt:

> I conclude that I must determine the application before me on the *Act* as it is presently written; that is, without any regulations, as that is the form that the Province proposes to bring into force. Unless the [Lieutenant Governor in Council] were to, in effect, exempt from the *Act* so as to render it moot entirely, the *Charter* implications pleaded by the plaintiff would remain attendant, and the issues to be tried would remain serious. Just because the [Lieutenant Governor in Council] may have the authority to tailor the application of the *Act* does not

> guarantee the form that any such tailoring may take, nor does it guarantee that any such tailoring will occur at all.

[26] I adopt the same approach as the Hinkson CJ. The injunction application must be decided on the basis of the ***HSAA*** as it reads today without any Ministerial Order.

[27] To conclude, I find that I have jurisdiction to grant an injunction at this stage.

B. Do the Applicants have standing?

[28] The Respondents submit that there are no appropriate applicants before the Court. The Respondents argue that Egale and Skipping Stone do not meet the test for public interest standing and the Doe applicants have neither private interest standing (as none are currently impacted by the ***HSAA***), nor do they have public interest standing.

[29] I have already rejected the Respondents' arguments related to prematurity, and to the extent they are relied on for the standing argument, I similarly reject them.

[30] I am satisfied that the individual Doe applicants have private interest standing.

[31] The general rule for private interest standing is summarized in Peter Hogg & Wade Wright, *Constitutional Law of Canada*, 5th ed (Toronto: Thomson Reuters, 2007) at §59:3:

> In the context of a challenge to the validity of a statute, this rule denies standing to an individual who is affected by the statute no differently from any other member of the public. If, however, an individual is "exceptionally prejudiced" by the statute — that is, the statute applies to the individual differently from the public generally — then the individual has standing to bring a declaratory action to challenge the validity of the statute.

[32] The impugned provisions will apply differently to the Doe applicants than to the public generally. The Doe applicants will be denied medication that they either already have a prescription for but are not yet taking or that they are already taking. The prohibition will cause the Doe applicants to go through puberty that does not align with their identity.

[33] I also exercise my discretion to find that Egale and Skipping Stone have public interest standing as they represent the points of view of those most affected by the issues. I have considered the three factors identified in ***Canada (Attorney General) v Downtown Eastside Sex Workers United Against Violence Society***, 2012 SCC 45 (serious justiciable issue, the nature of the plaintiff's interest, and other reasonable and effective means). Having already rejected the Respondents' prematurity argument, the Respondents' argument rests on the third factor: that the proposed suit is not a reasonable and effective means of bringing the case to court.

[34] I understand the Respondents' arguments to be that if the Doe applicants are appropriate, then there is no need for Egale and Skipping Stone to be granted standing, or in the alternative, only one organization should be granted standing to avoid duplication.

[35] In the circumstances of this case, where all the Doe applicants and the organizations have presented a single set of submissions through one set of counsel, I am not concerned about efficiency or scarcity of judicial resources. Neither organization is a "mere busybody" litigant. I am satisfied that given the nature of their work, both organizations have a real stake in the proceedings and a continuing interest in the claim.

[36] There is some merit to the Respondents' arguments that if the Doe applicants are granted standing, then granting standing to the organizations is duplicative. But with the passage of time or changing circumstances the Doe applicants may "age out" or may not be affected by the impugned provisions, which could bring the proceedings to an end. I am satisfied that granting both organizations standing will ensure that the courts have the benefit of the contending points of view to allow this court to play its proper role and will improve access to justice by ensuring that the merits of this application are decided.

[37] As this court stated in ***WV v MV***, 2024 ABKB 174 at para 129:

> Courts should not be parsimonious in granting public interest standing where a justiciable issue important to the public has been raised and the proposed litigant is the best or only capable party willing to take the matter forward. Professor Kennedy, writing in the context of public interest standing in constitutional cases, observed that public interest litigants should not necessarily expect to succeed, but ***Council for Canadians with Disabilities*** is a message to lower courts that there should be an "expectation that merits-based resolution of civil claims will be the norm": Gerard J. Kennedy, "*Council of Canadians with Disabilities*: Another Reminder to Resolve Cases on the Merits" (2023) 115 SCLR (2d) 25 at 25 (forthcoming).

[38] To conclude, I find that the Doe applicants have private interest standing and I exercise my discretion to grant Egale and Skipping Stone public interest standing.

V. The Affiants & Experts

A. The Applicants' Fact Witnesses

[39] Each minor Applicant has provided affidavit evidence, as have their parents as litigation representatives. Egale and Skipping Stone have also provided affidavit evidence.

[40] The Applicant Doe affiants are children between the ages of 6 and 12. These children describe their interests and lives in the same manner you would expect of any other child their age (e.g. sports, girl guides, and favourite foods). They and their parents also describe that from the age of kindergarten and before they expressed a gender that was different from the sex they were assigned at birth. These children describe their experience with gender affirming care as including multiple appointments with different professionals and ultimately a prescription for puberty blockers with their assent and their parents' consent. These children are very concerned about what the Ban will mean for their ability to develop in a manner that aligns with their gender identity.

[41] The Managing Director of Skipping Stone explains that Skipping Stone is a Calgary-based society and registered charity that serves trans and gender diverse youth, adults and their families across Alberta. Its mission is to provide trans and gender diverse individuals and their families with comprehensive and low-barrier access to community support, programming, and mental health and medical services, including health care support, counselling services, system navigation, therapy, peer mentor support, and family interventions. The Director states that healthcare provided to gender diverse adults and youth is individualized and tailored to the individuals' unique needs and circumstances. Because of the individualized nature of the care, the Director states that the Ban will significantly and detrimentally impact the healthcare services that trans and gender diverse youth receive in Alberta to varying degrees depending on the individual's specific circumstances.

[42] The Executive Director of Egale echoed the themes from the Skipping Stones affidavit as it relates to the individualized nature of trans healthcare and the variable impact that the Ban will have on gender diverse youth.

[43] The Applicants have also filed the following two affidavits from doctors who work with transgender and gender diverse youth:

(a) **Dr. Jake Donaldson.** Dr. Donaldson is a family physician. Dr. Donaldson was a founding physician and the medical lead of a clinic in California where over the course of 7-years he worked with about 400 transgender and gender diverse patients. He has lived in Calgary since 2021 working at Foothills Medical Clinic and other places in Calgary with a focus on transgender and gender diverse patients, including those under 18; and

(b) **Dr. Daniele Pacaud.** Dr. Pacaud is a pediatric endocrinologist and has been practicing pediatric medicine for over 27 years. Dr. Pacaud is a professor at the University of Calgary and was the chief of the Division of Pediatric Endocrinology at the Alberta Children's Hospital (Calgary) for over 14 years. Dr. Pacaud began working with gender diverse patients in 2012 and helped to establish the Gender Clinic at the Alberta Children's Hospital (the **Metta Clinic**) in 2014.

B. The Respondents' Fact Witnesses

[44] The Alberta Government has filed an affidavit sworn by Catherine Fulsome, the Executive Director of the Strategic Policy and Legislative Services branch of Alberta Health (the **Fulsome Affidavit**). Exhibit I to the Fulsome Affidavit is the Cass Review. The Cass Review is defined and described more fully below, but it is a recent systematic review of the science of the issue of gender-affirming care. The Respondents rely on the Cass Review to argue that the science surrounding the risks and benefits of puberty blockers and hormone replacement therapy is speculative at best, such that the precautionary measures in the Ban are necessary and do not infringe the Applicants' rights under the *Charter*.

[45] The Respondent Doe Affiants are a youth and two adults who have de-transitioned and two parents, one of a youth who has transitioned and another of a youth who has de-transitioned. The two adults speak to the regrets they have surrounding their transitions. The youth who socially

transitioned and was prescribed puberty blockers speaks to the difficulties faced during the transition and detransition and describes being scared about how close they came to causing "severe and permanent damage" to their body. One parent describes how their child, who transitioned without parental consent, has filed for emancipation. That parent believes the outcome would have been different if the youth had been given psychiatric treatment as opposed to hormone therapy.

[46] The Respondents have also filed the following five affidavits from doctors who work with youth, including transgender and gender diverse youth:

(a) **Dr. Jacob Les**. Dr. Les is an emergency pediatrician, and a Clinical Assistant Professor at the Cumming School of Medicine. Dr. Les has practiced as a pediatrician for approximately 20 years. Dr. Les' practice primarily involves front-line urgent clinical assessment of sick, injured, and psychiatrically unwell minors.

(b) **Dr. Timothy Ehman**. Dr. Ehman is a Child and Adolescent Psychiatrist, registered to practice in the province of Alberta. Dr. Ehman's current practice is entirely based within Alberta Health Services community mental health clinics. In his over 10 years of practice, Dr. Ehman estimates that he has completed psychiatric assessments of over 3000 children and youth and has followed about one third of them for 18-24 months.

(c) **Dr. Roxanne Goldade**. Dr. Goldade is a community pediatrician who has been practicing in Calgary for almost 30 years. Dr. Goldade primarily treats child and adolescent mental health.

(d) **Dr. Darrell Palmer**. Dr. Palmer is a general pediatrician and has been practicing for 30 years. For his entire career he has practiced in Alberta.

(e) **Dr. Ian Mitchell**. Dr. Mitchell is a pediatric respirologist and has practiced in Alberta since 1982. Dr. Mitchell's practice involved caring for children with chronic lung disease, and Dr. Mitchell has dedicated a significant portion of his career to research and ethics in the pediatric profession.

C. The Expert Evidence

1. Admissibility of Respondents' Expert Reports

[47] The Applicants have asked the Court to strike some of the Respondents' expert reports either in part or in whole. The Applicants argue that they are biased and speak to matters that are well-beyond the authors' expertise. I decline to strike any of the Respondents' expert evidence. I have considered the requirements for the admission of expert evidence as set out in ***R v Mohan***, [1994] 2 SCR 9 and ***White Burgess Langille Inman v Abbott and Haliburton Co***, 2015 SCC 23 and, without limiting the trial judge in any way, I find the evidence is admissible for the purposes of this application, which includes only a limited review of the case on its merits.

2. The Applicants' Expert Witnesses

[48] The Applicants have filed the following four expert reports to explain the nature and safety of gender affirming care in Canada and Alberta:

(a) **Dr. Mark Palmert**. Dr. Palmert is a Pediatric Endocrinologist and the Associate Chair of Paediatrics, Ambulatory Care, The Hospital for Sick Kids in Toronto. For 25 years, Dr. Palmert has actively researched and worked in the area of regulation and disorders of pubertal timing in cisgender youth, which involves extensive use of puberty blockers as well as hormones, such as estradiol and testosterone. Dr. Palmert co-founded the Transgender Youth Clinic at the Hospital for Sicks Kids in 2013 and has been a staff endocrinologist in that clinic for 11 years as well as a member of its Executive Committee;

(b) **Dr**. **Suzanne Zinck**. Dr. Zinck is a child and adolescent psychiatrist and Associate Professor, Department of Psychiatry, Dalhousie University. Dr. Zinick has been practicing for about 25 years, and she became a WPATH (defined below) certified provider in 2018. Dr. Zinick has had an active clinical practice of 17 years in gender identity treatment and assessment. Dr. Zinck's practice includes assessment of gender dysphoria and incongruence; treatment or referrals for any mental health disorders; readiness assessment for pubertal suppression, cross-sex hormones and surgeries. Dr. Zinck collaborates with social workers, psychologists, pediatricians, pediatric and adult endocrinologists, and primary care practitioners;

(c) **Dr. Elizabeth Saewyc**. Dr. Saewyc is a Professor & Distinguished University Scholar, Director, School of Nursing, University of British Columbia. Dr. Saewyc has decades of experience in multidisciplinary, multi-university youth health research and in large-scale, province-wide B.C. Adolescent Health Surveys. Dr. Saewyc's clinical background is primarily working with marginalized adolescents and young adults including 2SLGBTQ+ young people; and

(d) **Dr. Alice Virani**. Dr. Virani is a bioethicist with over 20 years of experience. Over the past 10-years, Dr. Virani has worked closely with the gender teams and trans youth to navigate the ethical issues that arise in the context of gender-affirming healthcare, including decision-making capacity, the best interest of youth, and parental consent.

3. The Respondents' Expert Witnesses

[49] The Respondents have tendered the following four experts in response to the Applicants' evidence:

(a) **Dr. James Cantor**. Dr. Cantor is a clinical psychologist, and a sexual behaviorist scientist. Dr. Cantor is recognized for studying the development of human sexualities and the research methodology of sexuality. Dr. Cantor is not a clinician like the Applicants' experts. Dr. Cantor's view is that while clinicians have expertise in applying general principles to the care of an individual patient, experts like himself are better suited to opine on clinical standards;

(b) **Dr. Farr Curlin**. Dr. Curlin is a Professor of Medical Humanities in the Trent Centre for Bioethics, Humanities, and History of Medicine, and Professor in the Department of Medicine at Duke University. He is also a professor of biomedical ethics. Dr. Farlin is an internist with a board certification in Internal medicine, as well as subspecialty board certification in Hospice and Palliative Medicine;

(c) **Dr. Daniel Weiss**. Dr. Weiss is a practicing physician, with a specialty in Internal Medicine and a subspecialty in of Diabetes/Endocrinology and Metabolism. Dr. Weiss has been a principal investigator for 90 clinical research trials, and has offered endocrine care to adults with gender dysphoria; and

(d) **Dr. Stephen Levine**. Dr. Levine is a Clinical Professor of Psychiatry at the Case Western Reserve University School of Medicine in Clevland, Ohio. Since 1973, his specialities have included psychological problems and conditions relating to individuals' sexuality and sexual relations, among others. In 1974, he founded a Gender Identity Clinic and has served as its co-director since that time, working with hundreds of transgender patients along the way.

VI. The Evidence

A. Terminology

[50] Gender dysphoria and gender incongruence are defined, respectively, in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (**DSM-5-TR**), and the International Classification of Diseases Eleventh Revision (**ICD-11**). The definition of these terms in the ***HSAA*** tracks the DSM-5-TR and the ICD-11 definitions. The terms are defined as follows:

(a) **Gender dysphoria** refers to the distress that can arise from a marked incongruence between an individual's experienced gender and their sex assigned at birth; and

(b) **Gender incongruence** refers to a person's marked and persistent experience of an incompatibility between their gender identity and the sex assigned to them at birth.

[51] The two drugs that are specifically prohibited in the Ban are puberty blockers and hormone replacement therapy (collectively referred to herein as **Hormone Therapy**).

[52] The most commonly used puberty blocker is Lupron, which is a gonadotropin-releasing hormone agonist (**GnRHa**). GnRHA works by suppressing the production of sex steroids in the body and pausing further pubertal development.

[53] Hormone replacement therapy is also called gender-affirming hormone treatment or GAHT. When used as part of gender-affirming care, GAHT induces development of physical characteristics that align with an individual's gender identity versus the sex they were assigned at birth.

[54] The parties have different views about the benefits and risk of Hormone Therapy.

B. Prevailing sources of clinical guidance in Alberta

[55] The parties agree that the prevailing sources of clinical guidance in Alberta regarding Hormone Therapy for transgender and gender diverse youth are:

(a) The Endocrine Society Clinical Practice Guideline (**Endocrine Society Guidelines**);

(b) World Professional Association for Transgender Health (**WPATH**) Standards of Care version 8 (**WPATH Guidelines**); and

(c) The Canadian Pediatric Society (**CPS**) position statement (1), which advocates for care that is consistent with the Endocrine Society Guidelines and the WPATH Guidelines.

[56] The parties have different views on the value of these guidelines.

C. Summary of the Applicants' Medical Evidence

[57] The Applicants' evidence is that gender cognition emerges early in life, and that by the age of three most children can distinguish between sexes and have a felt sense of their gender. For example, they may align themselves closely with those of the same gender and may express preferences for toys or activities that are stereotypically associated with a particular gender. By the age of 6 or 7, it is common for children to show preferences for gender-typed toys and clothing. Children who feel their gender identity is different from their sex assigned at birth may experience increased anxiety because while they want to be like their peers they realize they do not feel the same way that their peers do in relation to their assigned gender.

[58] As a child grows and transitions into puberty and adolescence, they become more aware of their gender identity. As secondary sex characteristics develop, the misalignment may become more concerning.

[59] The Applicants' experts speak to the very small number of youths who identify as transgender or gender diverse. As a group, they are a marginalized, disenfranchised population with high levels of minority stress, which may impact their mental health and well-being. The Applicants' experts state that it is important for care providers to recognize, accept and value transgender and gender diverse identities as an integral part of humanity, and that conversion therapy is harmful and unethical.

[60] The Applicants' experts explain that not all transgender and gender diverse youth want or seek medical care, and state that youth should never be pressured to make rapid decisions or pursue medical intervention. The use of medication requires discussion with the youth (and parents when possible), and understanding of pros/cons, risk/benefits and uncertainties associated with its use.

[61] The Canadian and international practice is to only prescribe puberty blockers and gender affirming hormones where it is relevant to an individual's goals and to youth who have begun Tanner stage 2 puberty. They are not indicated to pre-pubertal children/youth.

[62] The Applicants' experts explain that there are several important benefits of puberty blockers, including that if they are started before puberty is too far a long, they will pause further pubertal development and prevent unwanted physical development that is not aligned with the individual's gender identity and is a component of their gender dysphoria.

[63] The Applicants' expert evidence is that puberty blockers are reversible, and once discontinued the body will resume production of hormones in the same manner as prior to the medication. Lupron has been used for over 25 years as a component for gender-affirming care for youth, and even longer for treatments that are not related to gender identity such as precocious puberty.

[64] The Applicants' experts state that puberty blockers can afford a youth with gender dysphoria time to further explore their gender identity, free from the distress of ongoing gendered experiences. They also state that puberty blockers have other compelling benefits such as preventing the irreversible development of secondary sex characteristics that will have life-long impacts and that can make subsequent medical and/or surgical transitions more difficult for those who wish to pursue them.

[65] The Applicants' experts state that there are many studies linking puberty blockers as a component of gender-affirming care to improved mental health, psychosocial functioning and reduced risk of suicidal ideation. Their use may also result in a person needing lower doses of gender affirming hormones later in life, if the person decides to take that path.

[66] The Applicants' experts also speak to the risks of such treatments. GnRHa can result in hot flashes and irritability and temporarily impact fertility. Fertility will return to its base line functioning once the medication is stopped, and notably GnRHa medications are in fact used in the context of in vitro fertilization for cisgender females. For males, the medication may affect options for future feminizing bottom surgeries.

[67] The Applicants' experts also speak to longer term risks that must be discussed and considered as the youth, parents/caregivers and the medical team make decisions about the youth's care. There may be a decrease in bone mineral density. However, this does not necessarily mean that there will be adverse outcomes. Several studies also indicate that bone mineral density improves when youth are re-exposed to sex steroids (resuming puberty or other hormones that are a part of gender-affirming hormone treatment).

[68] The Applicants' experts state that concerns about cognitive impacts have not been substantiated: IQ scores and executive functions in youth are not impacted by exposure to puberty blockers. Dr. Palmert states:

> For those youth who express a desire to initiate puberty blockers, the [...] benefits and risks should be-and in my experience, are- reviewed and time provided for reflection on these considerations. Those youth who proceed to start GnRHa therapy will do so after engaging in such reflection and having concluded that for them the benefits outweigh the risks. This is a reasonable conclusion given the available evidence.

[69] The Applicants' experts opine that GAHT is associated with significant positive impacts for youth desiring this intervention. GAHT is associated with improved appearance congruence and reduced gender dysphoria. Additional benefits include improved well-being, global functioning, lower rates of depression, decreased body dissatisfaction, and decreased suicidality. GAHT is considered to be a partially reversible intervention, with both reversible and irreversible changes. GAHT has been used safely to induce puberty in cisgender populations for decades.

[70] Dr. Palmert's evidence is that similarly to the use of puberty blockers, youth who wish to initiate GAHT review and reflect on the risks and benefits of the medication. His evidence is that the vast majority of recipients of GAHT report high rates of satisfaction and exceedingly low levels of regret.

[71] The Applicants' experts speak to the Endocrine Society Guidelines, and the WPATH Guidelines. Their evidence is that these guidelines are supported by 22 other medical associations in North America, who not only support the guidelines but are actively opposing government-imposed restrictions as harmful to transgender and gender diverse youth. One of these organization alone, the American Academy of Pediatrics, has 67,000 members.

[72] The Endocrine Society Guidelines and the WPATH Guidelines support a team approach to treating transgender and gender diverse youth. The Applicants' experts support this approach and confirm that as per the WPATH Guidelines, transgender and gender diverse youth must meet the following criteria for treatment:

- gender incongruence is marked and sustained over time;
- young person demonstrates emotional and cognitive maturity required to provide informed consent/assent for treatment;
- mental health concerns that may interfere with diagnosis, capacity, or treatment have been addressed;
- informed consent has been provided (e.g. risks related to fertility);
- if puberty blockers are being started, confirming that the patient is at least at Tanner Stage 2;
- efforts have been made to involve the patient's parents unless there is a concern that parental involvement may be harmful to the patient; and
- social support and family dynamics are also important considerations.

[73] Dr. Donaldson states that when providing care to young people he adheres to the Alberta Health Policy PRR-01-03 entitled "Consent to treatment/Procedure(s): Minor/Mature Minors". In Dr. Donaldson's experience, his young patients have been grateful for the gender-affirming care he provides, and he has seen the consequences of not having that care as a young person in adults who take steps to transition. The Ban would prevent Dr. Donaldson from helping his patients.

[74] The Applicants' expert reports speak to what considerations inform whether a young person has the capacity to make a medical decision, and how ethical considerations should be weighed when considering the youth's best interest and the possibility of regret. The Applicants' experts state that the capacity required to decide will vary with the complexity, nature and potential consequences of the decision. However, it is well-established that with proper support and guidance – including from medical professionals and parents/guardians when appropriate, youth can and should be involved in decisions related to health care.

[75] The Applicants' experts state that informed healthcare decisions should align with the individual's values, preferences, and goals, and that it is critical for patients to have an accurate understanding of the potential risks, benefits and alternatives of a proposed treatment. The Applicants' experts state that information about the risks and benefits should be delivered in a non-directive manner to ensure that decisions are made voluntarily. To determine whether an individual has the capacity to make a healthcare decision, clinicians consider the patient's ability to understand, appreciate and reason.

[76] In the context of her understanding that puberty blockers are generally reversible and can be adjusted and reassessed during a course of treatment, Dr. Virani is of the view that the level of decision-making required around puberty blockers is less as compared to a decision where adjustments and reassessments are not possible. Dr. Virani states that generally speaking clinicians have a higher degree of confidence in patient decisions that are made on a non-urgent basis because the individual has time to reflect on and consider their life experiences and values. Because decisions around gender affirming care are generally not made on an urgent basis, decision making capacity should be higher around such decisions.

[77] The Applicants' experts state that denying competent youth the right to make decisions about their healthcare can have significant consequences, such as eroding trust in the healthcare system, pushing youth towards unsafe, unregulated alternatives and perpetuating societal and healthcare inequalities. For transgender and gender diverse youth, this can result in inequitable treatment, placing higher burdens on transgender youth when it comes to healthcare decisions.

[78] The Metta Clinic uses the Endocrine Guidelines and WPATH Guidelines in their work. As a pediatric endocrinologist, Dr. Pacaud does not diagnose gender dysphoria or incongruence, but rather relies on the in-house mental health professionals at the Metta Clinic who include three psychiatrists, and adolescent medicine physician, and a family therapist. Dr. Pacaud states that this approach is consistent with the multidisciplinary approach for the treatment of adolescents recommended by the WPATH Guidelines.

[79] Dr. Pacaud describes the process at the Metta Clinic as requiring adolescents and their families to first be seen by mental health professionals who conduct a comprehensive intake and make any appropriate diagnosis. The mental health team will see patients for routine follow-ups, often for a year or more, before they are seen by a pediatric endocrinologist (meaning Dr. Pacaud, or another trained hormone prescriber within the Metta Clinic).

[80] Dr. Pacaud's main role is prescribing puberty blockers and gender affirming hormones, as appropriate, while also monitoring and overseeing the care of adolescents receiving treatment. Dr. Pacaud's evidence is that she always discusses the potential risks, side effects, and benefits of each

medical intervention with the adolescent and their parent(s). Dr. Pacaud's evidence is that she always discusses the potential impacts on fertility and provide referrals for fertility preservation as needed.

[81] Dr. Pacaud's evidence is that treatment at the Metta Clinic is evidence based, informed, individualized and voluntary. Treatment decisions are made with parental consent save for in rare circumstances, and where parental consent is an issue, the clinic discuss the matter at multi-disciplinary meetings before hormonal therapy is initiated.

[82] Dr. Palmert commented on the Cass Review. Dr. Palmert agrees with some aspects of the review, but in his view its methodology, and the literature upon which it is based have many biases and flaws. Dr. Palmert states:

> It is important to recognize that the Cass Review is a critique written by one person presenting a perspective on current practices and making recommendations for future care within the [National Health Service England]. It should and will inform care. However, it is not an international guideline and should not be viewed as such.

[83] Dr. Palmert states that unlike the singular perspective in the Cass Review, the Endocrine Society Guidelines and the WPATH Guidelines were both developed through extensive involvement of experts from around the world (e.g. more than 18,000 Endocrine Society members had an opportunity to comment on guidelines drafts before publication), robust methodology and consensus building.

[84] Dr. Palmert highlights the following commonalties in the care recommended in the Cass Review and the care recommended in the Endocrine Society Guidelines and the WPATH Guidelines. Dr. Palmert opines that these commonalities already underscore the care of transgender and gender diverse youth in Canada:

- no medical interventions be undertaken until youth have entered puberty;
- call for provision of holistic, comprehensive care;
- call for provision of mental health and community support for youth, parents, caregivers;
- completion of biopsychosocial evaluation prior to medical intervention;
- recognition that provision of medical intervention is not enough to address the co-occurring mental health or psychosocial issues. If theses issues are present, they must also be addressed;
- assurance that youth are told and understand the pros and cons of any decisions they make; and
- assessment of youth's capacity to make informed medical decisions.

[85] Dr. Palmert criticizes the Cass Review for the following statement, among other things: "For the majority of young people, a medical pathway may not be the best way to manage their gender-related distress." Dr. Palmert states that there is no robust evidence to support this assertion and that it wrongly encourages a one size fits all approach to treatment, which is not the standard in Canada.

[86] Dr. Palmert's evidence is that the Endocrine Society Guidelines, the WPATH Guidelines, and the CPS call for individualized treatment that supports and does not try and alter an individual's gender identity. Dr. Palmert states: "Efforts to change a youth's gender identity are harmful and unethical and should not be undertaken."

[87] In this light, Dr. Palmert's view is that puberty blockers and GAHT may be warranted for some youth. Dr. Palmert reiterates that the decision to use either is made after prescribers work to ensure that its use fits with the youth's goals and that youth (and families/caregivers when appropriate) are informed about the pros and cons, its risks and benefits, and uncertainties related to its use. Prescribers also assess the capacity of the youth to consent to the treatment by determining that the youth understands and appreciates these considerations. Dr. Palmert notes that the Endocrine Society Guidelines and WPATH Guidelines also offer details on dosing and formulations.

[88] Dr. Palmert's evidence is that a final important tenet of care in Canada is recognition that medical intervention does not in any way replace appropriate mental health supports/treatments for co-occurring mental health conditions. On-going supports are considered where warranted.

[89] The Applicants see two types of harm that will arise from the Ban: (i) harms that derive from withholding the benefits that accrue from care; and (ii) harms that derive from the anti-trans environment and increased minority stress that result from restricting care.

[90] The Applicants' experts' evidence is that withholding gender-affirming care will deny transgender and gender diverse youth the opportunity to experience the full scope of intended therapeutic effects at developmentally appropriate ages. Dr. Palmert's evidence is that the age of pubertal onset for assigned females is between 8 and 13 years, and for assigned males is between 9 and 14 years. Puberty development is most rapid within the 2.5 years post initiation, meaning that denying youth access to puberty blocking medications until age 16 will cause irreparable harm by precluding the majority of youth from deriving the main benefit of pubertal suppression (i.e., prevent irreversible development of undesirable physical characteristics which will impact other gender-affirming care options; deny them an effective treatment to alleviate gender dysphoria and have a better quality of life).

[91] The Applicants' experts are also concerned that withholding treatment will deny transgender and gender diverse youth autonomy to make decisions around their bodies and medical care in conjunction with health care providers and in coordination with family and caregivers where appropriate. The Applicants' experts' disagree with the Respondents that the Ban is protecting youth, and state that impeding access to the benefits conferred by the gender-affirming care is inherently harmful.

[92] The Applicants' evidence challenges the assertion that youth are identifying as transgender or gender diverse because it is cool (i.e. for social acceptance):

> …they are transgender and gender diverse because that is who they are. Withholding medical care will further exacerbate the distress and mental health challenges faced by these youth while also intensifying the discrimination and feelings of societal exclusion they often experience.

[93] The Applicants' experts are not alone in their concerns about the Ban: on October 25, 2024, the Society for Adolescent Health and Medicine released a statement arguing for access to appropriate medical care for transgender and gender diverse youth and against the Ban; on November 1, 2024, Children's Health Care Canada issued a statement strongly opposing the legislation, which it states "will negatively impact the physical, mental and sexual health of children and youth in the province…"; and on November 4, 2024, the Alberta Medical Association's Section of Pediatrics released a statement about the Ban, stating, among other things, that they "unequivocally oppose the singling out to this population" and that "there is no place for the government in the medical decisions being made by parents and their children in conjunction with physicians…"

D. Summary of the Respondents' Medical Evidence

[94] The Respondents submit that the Cass Review is the most comprehensive review of the current science and that it is critical to understanding the state of the science with respect to the use of puberty blockers and GAHT in minors. Accordingly, while its author was not an expert in this proceeding or subject to cross-examination, I will start the review of the Respondents' expert evidence with the Cass Review.

[95] In 2020, the English National Health Service (the **NHS**) commissioned an independent review of the use of puberty blockers in children and cross-sex hormones in adolescents. The review was commissioned in response to: (i) an increase in the number of adolescent referrals to England's Gender Identity Development Service, (ii) a concern that there had been a move from a psychosocial and psychotherapeutic model of treatment to one that prescribes medical interventions as a first-line treatment, and (iii) legal action against the U.K. by a person who had chosen to detransition.

[96] Dr. Hillary Cass was retained to conduct the review. Dr. Cass is a well-known pediatrician, but she does not work with gender diverse minors. Over a four-year period, Dr. Cass conducted an appraisal of existing international guidelines (including the WPATH Guidelines and the Endocrine Society Guidelines, which are used in Canada and elsewhere) and commissioned a number of systematic reviews to assess the evidence base associated with puberty blockers and GAHT. Dr. Cass published an Interim Report in February 2022, and the Final Report on April 10, 2024 (the **Cass Review**).

[97] The aim of the Report is stated as follows:

> The aim of this Review is to make recommendations that ensure that children and young people who are questioning their gender identity or experiencing gender

> dysphoria receive a high standard of care. Care that meets their needs, is safe, holistic, and effective….

[98] These are some of the findings in the Cass Review:

- The original rationale for using puberty blockers was that it would buy 'time to think' by delaying onset of puberty and also improve the ability to 'pass' later in life. Subsequently it was suggested that they may also improve body image and psychological wellbeing;

- No changes in gender dysphoria or body satisfaction were demonstrated with the use of puberty blockers, and there was insufficient/inconsistent evidence about the effects of puberty suppression on psychological or psychological well-being, cognitive development, cardio-metabolic risk or fertility;

- The vast majority of young people who start on puberty blockers proceed to masculinizing/feminizing hormones, such that there is some concern that they may change the trajectory of psychosexual and gender identity development;

- Because puberty blockers only have clearly defined benefits in quite narrow circumstances, and because of the potential risks to neurocognitive development, psychosexual development, and longer-term bone health, they should only be offered under a research protocol;

- There is a lack of high-quality research assessing the outcomes of hormone interventions in [transgender and gender diverse adolescents], and few studies that undertake long-term follow-up. No conclusions can be drawn about the effect on gender dysphoria, body satisfaction, psychological health, cognitive development, or fertility. Uncertainty remains about the outcomes for height/growth, cardiometabolic and bone health. There is suggestive evidence from mainly pre-post studies that hormone treatment may improve psychological health, although long-term follow-up is needed;

- The evidence does not support that hormone treatment reduces risk of death by suicide;

- The rate of detransition is unknown; and

- Research on psychosocial interventions and longer-term outcomes for those who do not access endocrine pathways is as weak as research on endocrine treatment, leaving a major gap in knowledge regarding what is the best treatment.

[99] The Cass Review also made findings regarding how healthcare and other professionals should care for gender dysphoric minors with a view to the WPATH Guidelines and the Endocrine Society Guidelines. Some of Dr. Cass's findings about the guidelines were that: (i) they describe insufficient evidence about the risks and benefits of medical interventions but go on to recommend the interventions; (ii) they rely on circular reasoning to show consensus despite the underlying

evidence being poor; (iii) recommendations were not linked to robust evidence; (iv) WPATH Guidelines rely on studies which are admittedly of low quality; (v) WPATH did not admit the extent to which its recommendations were based on clinical consensus; (vi) only the more conservative Swedish and Finish guidelines follow international standards for guideline development and could therefore be recommended for use in practice.

[100] In response to the Cass Review, the UK government implemented policies which indefinitely prohibit the provision of puberty blockers, cross-sex hormones, and surgery to minors to treat gender dysphoria and gender incongruence. Other jurisdictions such as Finland, Sweden, Denmark, and Australia have also recently implemented similar restrictions. The Respondents state that additional systematic reviews published after the Cass Review have generally confirmed the results in the Cass Review and dismiss criticism of the review as biased and indicative of the toxic environment that surrounds this issue.

[101] The Respondents argue that in light of the Cass Review and the response of other governments to the Cass Review, it cannot reasonably be argued that there is a broad consensus supporting the approach taken by the Applicants. The Respondents ask the court to rely on the Cass Review and the views and actions of other governments to conclude that that the Ban is a necessary precaution for the use of puberty blockers and GAHT.

[102] The Respondents' expert evidence is consistent with the Cass Review. The Respondents' experts state that the WPATH Guidelines and the Endocrine Society Guidelines have not followed procedures or principles of evidence-based medicine. They state that the studies relied upon by the Applicants are not reliable because they demonstrate the lower tier of evidence, and there is little reliable evidence of transition improving the mental well-being of children.

[103] The Respondents' experts state there is substantial documentation indicating high levels of poor mental health and poor social functioning in those who report gender dysphoria, but no evidence suggesting that transphobia is the cause of their poor mental health.

[104] The Respondents' experts state there is highly reliable, consistently replicated evidence that childhood-onset gender dysphoria/incongruence resolves with puberty for the large majority of children. The Respondents' experts opine that this indicates that puberty blockers block the very process of maturation that would naturally resolve the dysphoria/incongruence. They opine that puberty blockers eliminate the possibility of desistance in juveniles, and that the decision to put a young person on puberty blockers is a decision to put them on GAHT.

[105] The Respondents' experts have found a link between rapid onset of gender dysphoria with the "social contagion" hypothesis and are concerned that people are transitioning because people in their friend groups, for example, are transitioning. Dr. Cantor states that this finding is inconsistent with claims that transgender identity is innate and immutable. Dr. Levine states that it points to a social or psychosocial cause not a biological one.

[106] The Respondents' experts state that there is no substantial evidence upon which to conclude that puberty blockers and GAHT are safe for adolescents. They opine that statements that puberty blockers are reversible are not supported by evidence and even if puberty is unblocked, the youths who take puberty blockers have irreversibly lost the opportunity and experience of developing

with their peers. The Respondents' experts state that gender-affirming care is experimental and not medically necessary, in part because it relies on the subjective views and self-reporting of a patient.

[107] The Respondents' experts state that systematic reviews find transition is not associated with reductions of suicide, and that the mental health benefits that are claimed to justify gender affirming treatment to minors are unproven and disputed. Dr. Weiss agrees with Dr. Palmert that suicide in people with gender dysphoria is increased compared to those without, but states that the suicide risk is related to co-morbidities such as depression and not with gender dysphoria, *per se*.

[108] The Respondents' experts state that the Applicants are downplaying the risks of gender affirming care. The Respondents' experts state that the known or anticipated harms from gender affirming treatment are substantial and serious (e.g., fertility problems, issues with sexual response, brain development, and bone density), and that there is no consensus that medicalized gender treatment is beneficial and suitable for minors.

[109] The Respondents' experts state that there are no systematic studies of the effect of GnRH blocking puberty on judgment, cognition and emotional development. Essentially, there is not enough information on the impact on brain development and more study is needed. Further, GAHT comes with significant medical risk such as higher risk of cancer, blood clots, and autoimmune disorder. Dr. Weiss states that it is neither safe nor effective to prescribe opposite sex hormones to youth or to block their puberty.

[110] The Respondents' state that it is not at all clear that meaningful informed consent for gender affirming treatment can be obtained from minors, because, in part, youth cannot understand the long-term implications of the treatments they are receiving and gender affirming care contradicts bodily health.

[111] The Respondents' experts state there is a growing consensus that comprehensive psychiatric assessment should be followed by psychotherapy before medical intervention is contemplated. They suggest that the clinician who uses traditional methods of psychotherapy does not endlessly focus on a patient's gender identity but instead works to help the patient address the actual sources of their discomfort. They suggest that success in this effort may remove or reduce the desire for a redefined identity. The Respondents' experts also see psychotherapy as the best method for preventing suicide.

[112] The medical doctors who have sworn affidavits in support of the Respondents' position also have serious concerns about the gender affirming model of care, and some feel silenced by the culture of fear that they say has surrounded this issue. Some feel they have lost clinical autonomy to assess and diagnose to a rigorous standard, and that children and adolescents are suffering as a result.

[113] Some of these doctors also feel unfairly compelled to refer to the Metta Clinic, frustrating their ability to assist with other approaches to care. There is a suggestion that gender affirming care physicians are exaggerating the risk of suicide to place pressure on parents, and that referrals to the Metta Clinic are contrary to a doctor's oath to do no harm. Their evidence also echoes the concerns of the Respondents' experts that more rigorous research needs to be done.

[114] These doctors speak to a sharp increase in the number of patients they see that are reporting gender dysphoria and/or gender congruence. Dr. Goldade states that some come in with a very strong conviction that gender identity is the source of their unhappiness, and a strong view that they require puberty blockers or GAHT. Dr. Goldade has referred a number of patients to the Metta Clinic but has grown concerned with the high rate of medicalization for the patients she has referred there. Dr. Les is equally as concerned about an increase in the number of patients with gender dysphoria presenting for emergency care. Dr. Ehman and Dr. Palmer are concerned as well.

[115] Dr. Mitchell has observed a (1) aversion and hostility towards producing a research base required to support gender affirming care; and (2) politicization of medical associations and an abdication of their core values. Dr. Mitchell refers to a growing hostility to any questioning of what seems to have solidified into what can only be described as an orthodoxy.

[116] Dr. Goldade co-published a letter to the editor in the Journal of Paediatrics & Child Health entitled: "Response to the Canadian Paediatric Position Statement on transgender and gender-diverse youth". In the article, Dr. Goldade and others urged CPS to urgently revise their position in accordance with the Cass Review.

[117] Dr. Les refers to a letter that a group of 30 physicians, including Dr. Les, recently wrote to the Canadian Medical Association in response to its position statement against the Ban. In the letter, the authors urged caution in light of a growing body of literature that gender affirming care is neither safe nor ethical. Dr. Les also authored a letter in the National Post on the topic, and feels he was ignored and chastised in response to both.

[118] Against the backdrop of the Cass Review, Dr. Mitchell has reviewed various position statements issued by, the Alberta Medical Association, Canadian Paediatric Society, and the Canadian Medical Association in relation to gender affirming care. Dr. Mitchell's evidence is that statements from these group in opposition to the Ban do not support his views and contain misinformation about the state of the science (i.e. in Dr. Mitchell's view that there is no certainty in the research regarding puberty blockers helping with suicidal ideation).

[119] Dr. Mitchell states that there was no consultation with the membership regarding the statement made by the Alberta Medical Association. Dr. Mitchell and others have written to these organizations expressing their concerns and asking that gender affirming care be urgently revised to consider the findings in the Cass Review.

VII. The Legal Test for an Interim Injunction

[120] The test for an interlocutory injunction, in constitutional cases and otherwise, is the three-part test laid out by the Supreme Court of Canada in ***RJR-MacDonald Inc v Canada (Attorney General)***, [1994] 1 SCR 311 at 348-49 [***RJR***] as confirmed in ***AC and JF v Alberta***, 2021 ABCA 24, leave to appeal to SCC refused, 2021 CanLII 54465 [***AC***]:

(a) Is there a serious issue to be tried;

(b) Will there will be irreparable harm if the injunction is not granted; and

(c) Does the balance of convenience favour granting the injunction?

[121] The components of the tripartite test are not "water-tight compartments" or individual hurdles. Rather, the relative strength of an applicants' claim is a relevant consideration in the overall assessment of whether to grant the injunction, as is the nature of the harm the applicants will suffer if interim relief is not granted: ***AC*** at para 27.

[122] Whether there is a serious issue to be tried is determined "on the basis of common sense and an extremely limited review of the case on the merits": ***RJR*** at 348. The threshold is "deliberately low" (***AC*** at paras 21) and asks the Court to decide whether the case is: (a) arguable, or (b) frivolous or vexatious: ***RJR*** at 348; ***AC*** at para 39.

[123] When considering irreparable harm, the question is "whether a refusal to grant relief could so adversely affect the applicants' own interests that the harm could not be remedied if the eventual decision on the merits does not accord with the result of the interlocutory application": ***RJR*** at 341. "Irreparable" refers to the nature of the harm, and not its magnitude: ***RJR*** at 341. It is "harm which either cannot be quantified in monetary terms or which cannot be cured...": ***RJR*** at 341.

[124] The burden is on the applicants to provide evidence of irreparable harm that is "clear and not speculative": ***Modry v Alberta Health Services***, 2015 ABCA 265 at para 82. The focus is on the harm suffered by the applicants; alleged harm to the respondent or to the public interest are weighed in the balance of convenience: ***RJR*** at 341.

[125] When considering the balance of convenience, the question is whether the granting or withholding of interlocutory relief would occasion greater harm pending a decision on the merits: ***Manitoba (AG) v Metropolitan Stores Ltd***, [1987] 1 SCR 110 at 129. In ***Harper v Canada (Attorney General)***, 2000 SCC 57 [***Harper***] at para 5, the Supreme Court identified the competing interests engaged at this leg of the test in cases like this one:

> Applications for interlocutory injunctions against enforcement of still-valid legislation under constitutional attack raise special considerations when it comes to determining the balance of convenience. On the one hand stands the benefit flowing from the law. On the other stand the rights that the law is alleged to infringe. An interlocutory injunction may have the effect of depriving the public of the benefit of a statute which has been duly enacted, and which may in the end be held valid, and of granting effective victory to the applicant before the case has been judicially decided. Conversely, denying or staying the injunction may deprive plaintiffs of constitutional rights simply because the courts cannot move quickly enough: R. J. Sharpe, *Injunctions and Specific Performance* (loose-leaf ed.), at para. 3.1220.

[126] There is a presumption that the impugned law is in the public interest and has that effect: ***RJR*** at 348-49; ***AC*** at para 36. As explained by the Supreme Court in ***Harper*** at para 9:

> Courts will not lightly order that laws that Parliament or a legislature has duly enacted for the public good are inoperable in advance of complete constitutional review, which is always a complex and difficult matter. It follows that only in clear cases will interlocutory injunctions against the enforcement of a law on grounds of alleged unconstitutionality succeed.

[127] While there is a presumption that laws passed are directed towards the public good and serve a public purpose, the government "is not the exclusive representative of a monolithic 'public' in *Charter* disputes" and the applicant can also claim to represent the "public interest": ***RJR*** at 343; ***AC*** at paras 33-34. The presumption that the law is in the public interest is rebuttable and the Applicants bear the burden of demonstrating that "the suspension of the legislation would itself provide a public benefit": ***RJR*** at 348-49; ***PT v Alberta***, 2019 ABCA 158 at paras 75-76.

[128] There is no presumption that the law is constitutional: ***AC*** at paras 35-36.

[129] Relevant considerations at this stage include the nature of the relief sought, the number of people affected and how they are affected, the nature and extent of the irreparable harm, the strength of the applicants' claim, the nature of the impugned legislation, and where the public interest lies: ***RJR*** at 350; ***AC*** at paras 66-69.

[130] Ultimately, for an injunction to be granted in this case, the balance of convenience must clearly favour the applicant. This does not mean that the Court will reassess the merits at this stage and hold them to a higher standard than under the first leg of the test. It means only that a strong case on the merits may tip the balance in favour of that party in the overall result, and that the Court will consider the overall balance in the case when determining whether an injunction should be granted: ***AC*** at para 37; ***Black v Alberta***, 2023 ABKB 123 at paras 67-68 [***Black***].

VIII. Serious Issue to be Tried

A. Section 7 – Deprivation of Life, Liberty and Security of the Person

[131] The Applicants submit there is a serious issue to be tried regarding whether the Ban unreasonably limits the section 7 *Charter* rights of gender diverse Albertans under the age of 18 by infringing their right to security of the person.

[132] Section 7 of the *Charter* states:

> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

[133] An analysis under section 7 requires the Court to answer two questions (***Carter v. Canada (Attorney General)***, 2015 SCC 5 at para 55 [***Carter***]; ***Black*** at para 71):

> 1. Does the law interfere with, or deprive the claimant of, their life, liberty, or security of the person?
>
> 2. Is the deprivation in accordance with the principles of fundamental justice?

[134] There are three principles of fundamental justice that are central to determining the second question: "laws that impinge on life, liberty or security of the person must not be arbitrary, overbroad, or have consequences that are grossly disproportionate to their object": ***Carter*** at para 72. The analysis of whether the Ban is arbitrary, overbroad and grossly disproportionate is qualitative not quantitative: "a grossly disproportionate, overbroad or arbitrary effect on one

person is sufficient to establish a breach of s. 7": ***Canada (Attorney General) v Bedford***, 2013 SCC 72 at para 123 [***Bedford***].

1. Is there a serious issue re interference with security of the person?

[135] The Applicants submit that the Ban interferes with the psychological integrity of transgender and gender diverse youth. To establish an infringement of security of the person on this basis, the Applicants must demonstrate on a balance of probabilities that the Ban will have a "serious and profound effect" on the psychological integrity of transgender and gender diverse youth. The effects of the Ban must be assessed objectively, with a view to its impact on the psychological integrity of a person of reasonable sensibility, based on fundamental elements of their personal identity: ***New Brunswick (Minister of Health and Community Services) v G(J)***, [1999] 3 SCR 46 at paras 60-61 [***G(J)***].

[136] The Applicants argue that gender identity – i.e. a persons' internal, psychological sense of their own gender – is fundamental to personal identity. The Applicants argue that the Ban will have a serious and profound effect on the psychological integrity of transgender and gender diverse youth because it will: (a) take away medically necessary gender affirming care for gender incongruence and gender dysphoria; (b) take away a young person's option to delay puberty (and the associated stress and fear) so that they can have more time to consider their gender identity and options; (c) subject them to the irreversible changes associated with puberty, which may result in more difficulty transitioning at a later date; (d) deny gender diverse young people autonomy over their own bodies; and (e) make it more likely that others will identify them as trans, increasing the risk of bullying, discrimination, violence, depression, suicidal ideation and self-harm.

[137] The Respondents argue that each of the Applicants' claims are speculative or based on a right to health care, which is not recognized by the *Charter*. The case law is clear that the *Charter* does not confer a "freestanding" right to healthcare nor does it protect the right to access one's preferred form of treatment: ***Chaoulli v Quebec (Attorney General)***, 2005 SCC 35 at para 104 and ***Ontario Health Coalition and Advocacy Centre for the Elderly v His Majesty the King in Right of Ontario***, 2025 ONSC 415 at para 247. The Respondents submit that even if the court were to find a *Charter* infringement, given the "state of the science", any infringements are reasonable justified under section 1 of the *Charter*. For these reasons, the Respondents say there is no serious issue to be tried under section 7.

[138] The Applicants dispute that they are advancing a right to healthcare. They submit the issue is not whether the government must make any particular form of health care available to gender diverse young people, but rather whether the government may constitutionally prohibit regulated professionals from providing certain forms of health care to transgender and gender diverse youth when it is available to others (albeit for a different purpose). In ***Canada (Attorney General) v PHS Community Services Society***, 2011 SCC 44 at para 93 [***PHS***], the Supreme Court of Canada held: "Where a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out."

[139] The Applicants' evidence shows that some transgender and gender diverse youth have benefitted from Hormone Therapy. The Respondents' evidence challenges the benefits of Hormone Therapy but does not preclude Hormone Therapy as a viable treatment for some. The

Applicants' evidence shows that preventing access to Hormone Therapy could damage the health and well-being of some transgender and gender diverse youth by causing, for example, increased anxiety and depression, unwanted and irreversible changes to their bodies, or outing them as trans and thereby subjecting them to (even more) bullying and discrimination. In light of this evidence, it is arguable that the Ban will create a risk to health by preventing access to health care. As per the decision in ***PHS***, that would be a deprivation of the right to security of the person. There is a serious issue to be tried in this regard.

[140] The Respondents compare this situation to the one in ***Lewis v Alberta Health Services***, 2022 ABCA 359 [***Lewis***] where the panel held that a requirement "deemed medically necessary to protect Ms. Lewis and others in the transplant context" (i.e. a covid vaccine requirement), did not amount to "serious state-imposed psychological stress" or a violation of section 7 of the *Charter*: ***Lewis*** at para 60. The Respondents highlight the panel's finding that Ms. Lewis did not have a right to insist on "medical treatment while refusing to abide by medically appropriate clinical pre-conditions". The Respondents submit that the Ban is a decision to create "medically appropriate" pre-conditions to accessing Hormone Therapy and does not, therefore, violate section 7 of the *Charter*. The situation in ***Lewis*** is different than the one here.

[141] In ***Lewis***, the panel upheld the decision of the chambers judge that the vaccine requirement did not engage the *Charter* because the vaccine requirement was not a government act. Rather, it was the decision of treating physicians exercising their clinical judgment in formulating pre-conditions for organ transplants. *Charter* engagement aside, this is not a case where the Applicants are refusing to follow medical pre-conditions. Medical pre-conditions are already in place for the treatment of gender dysphoria and gender incongruence. The issue is whether the medical pre-conditions are adequate. The Applicants' evidence is that they are, and the Respondents' evidence is that they are not.

[142] The Applicants are seeking the right to continue to follow the medical pre-conditions that are already in place for prescribing Hormone Therapy until the parties' dispute about their safety and efficacy can be resolved. The Applicants are challenging a legislative prohibition that would prevent them and their doctors from doing so. I agree with the Applicants that the issue in this case is like the issue in ***Black***, at para 70:

> The question before the Court in the present application is not whether Ms. Black has a standalone right to a particular form of treatment that is protected by the *Charter* s. 7. [...] The question in the present application is whether there is a serious issue to be tried that the limits on Ms. Black's treatment regime imposed by the *Regulation* and the *Standards* comply with the *Charter* [emphasis added].

[143] The Applicants argue that Hormone Therapy is medically necessary not just because it will, in some cases, alleviate the stress, anxiety and suicidal ideation of a young person facing endogenous puberty, but because some people are capable of determining that they are transgender or gender diverse at a young age and may require Hormone Therapy to reach gender congruence. The Applicants have filed evidence to support these arguments. The Respondents do not deny that some youth are transgender and gender diverse, and state that they want to support youth in whatever path they end up taking, so long as there are appropriate safeguards in place.

[144] The Respondents argue that Hormone Therapy cannot be medically necessary because gender identity is self-assessed, and because Hormone Therapy is prescribed to meet a patient's personal goals for gender identity. While gender identity is and must be self-assessed, a diagnosis of gender dysphoria or gender incongruence, and the resulting treatment, is not self-assessed. Rather, medical professionals make the diagnosis and treatment recommendations in accordance with protocols. Those protocols include assessing the person's needs and wants. While the parties disagree on the safety of the protocols, and the rigour with which doctors are making the diagnoses, the formal diagnoses and established treatment protocols suggest that Hormone Therapy could be considered medically necessary.

[145] Further, while gender identity is self-assessed, that does not mean it is choice. As discussed further below, gender identity is an immutable characteristic. Currently, there is health care in place that allows transgender and gender diverse to access Hormone Therapy in order to align themselves with their gender identity. This suggests that Hormone Therapy could be considered medically necessary. There is a serious issue to be tried in this regard.

[146] The Respondents argue that there cannot be a serious issue to be tried under section 7 of the *Charter* because the government has a duty and a wide latitude to set health policy, including the removal of treatments based on patient health and safety. The Respondents' evidence is that there is no strong evidence that puberty blockers reduce depression or suicidal ideation, and that given the state of the science, the risk of allowing Hormone Therapy is greater than the risk of denying it. The Applicants disagree and state that the science supports the current treatment protocols for transgender and gender diverse youth.

[147] The merits of the parties' respective expert evidence cannot, nor should it, be resolved on this application. I can appreciate the Respondents' reliance on the Cass Review, and their submission that it is prudent to follow its recommendations, especially given the steps that some other countries have taken in response to it. However, the Applicants' evidence challenges many aspects of the Cass Review, and that challenge may well be resolved in their favour at trial. I do not find the Cass Review or the Respondents' expert evidence to be so overwhelming as to preclude a finding that there is a serious issue to be tried regarding whether the Ban interferes with rights protected by section 7 of the *Charter*. Further, while the government does have wide latitude to set health and other policy, the courts have an obligation to step in where a proposed policy may or will infringe a person's *Charter* rights.

[148] The Applicants argue that the Ban will undermine gender diverse young people's security of person by denying them autonomy over their own bodies, contrary to the Supreme Court of Canada's holding in ***Carter*** at para 64 (citations omitted): "[s]ecurity of the person encompasses 'a notion of personal autonomy involving....control over one's bodily integrity free from state interference'...and it is engaged by state interference with an individual's physical or psychological integrity".

[149] The Applicants' evidence is that the Ban will interfere with personal autonomy and bodily integrity by forcing transgender and gender diverse youth to experience unwanted changes to their body that do not align with their gender identity. The Respondents' evidence is that the Ban preserves autonomy by preserving the choice to grow in accordance with the sex you were assigned at birth and to possibly have biological children.

[150] The Ban is not necessary to preserve the choice advanced by the Respondents. That choice is available without government intervention. The Ban takes away choice in favour of preserving a very specific choice that some youth may not want to preserve, or that some youth may want to approach differently than the Ban assumes. Accordingly, there is a serious issue to be tried in respect of whether the Ban denies gender diverse youth personal autonomy over their body contrary to section 7 of the *Charter*.

[151] The Respondents argue that the psychological harm that is allegedly being caused by the Ban is too remote to infringe the *Charter* because the cause of the psychological harm is endogenous puberty, and not the Ban itself. The Respondents rely on ***Operation Dismantle*** where the Supreme Court held that state action or inaction will frequently affect the lives and security of its citizens, and ***G(J)*** where the Supreme Court held that the right to security of the person does not protect the individual from ordinary stresses and anxieties: ***Operation Dismantle*** at 488-89; and ***G(J)*** at paras 59-60.

[152] Endogenous puberty may be the starting point for the harm, but that is no different than the situation in, for example, ***Black*** where the starting point for the harm was a drug addiction, or ***Chaoulli***, where the starting point was an illness. The starting point for an alleged harm might not be caused by government action, but government action may impact an individual's ability to address the harm in a way that infringes their *Charter* rights and causes further harm. In addition, the Applicants' evidence is that for transgender and gender diverse youth, endogenous puberty is something beyond an ordinary stress.

[153] In ***G(J)***, the Supreme Court held that it is the quality of the injury that dictates whether the *Charter* will be engaged. In that case the issue was whether indigent parents have a constitutional right to be provided with state-funded counsel when a government seeks a judicial order suspending such parents' custody of their children. The Supreme Court held that section 7 of the *Charter* was engaged because the state action impugned the parents' status by usurping their role and prying into the intimacies of the parent-child relationship. This constituted interference with the psychological integrity of the parent as a parent: ***G(J)*** at paras 63-64. The Respondents submit that the Ban is not directly interfering with the psychological integrity of the Applicants as was the case in ***G(J)***, and that it is only concerned with their health and safety.

[154] Interference with psychological integrity and a concern for health and safety are not mutually exclusive concepts. It could be that the Respondents' concerns have caused them to overstep and infringe section 7 of the *Charter*. The Applicants' evidence is that Hormone Therapy is safe and that it can be necessary. Their evidence is that Hormone Therapy is medically supervised and subject to an accepted protocol that encourages the youth's family to be consulted and involved. The doctors that practice in this area are already subject to oversight by their regulatory body and the courts. The Ban proposes to take away, or make subject to government control, a very personal decision that is already subject to a number of safeguards. That being the case, it is possible that the Ban could be viewed as, to use the language in ***G(J)***, the government prying into the intimacies of the lives of the youth and families who will be impacted by the Ban.

[155] Having considered the parties' evidence and arguments, I find the Applicants have raised a serious issue to be tried as to whether the Ban will interfere with the Applicants' section 7 *Charter* right to security of the person. Without limiting the trial judge in any way, I find there is a serious

issue to be tried in respect of whether the Ban will have a serious and profound effect on the psychological integrity of transgender and gender diverse youth by preventing and/or unduly limiting their access to health care (including by denying them access to treatments that are medically necessary) and their having to experience the consequences of that limitation (e.g. high levels of depression/anxiety and irreversible changes to their bodies, discrimination), and by denying them autonomy over the bodies.

[156] Having found there is a serious issue to be tried regarding whether the Ban interferes the Applicants' rights under section 7 of the *Charter*, the next question is whether there is a serious issue to be tried on whether the interference is in accordance with the principles of fundamental justice: arbitrariness, overbreadth, and gross disproportionality.

2. Is there a serious issue re whether the Ban is arbitrary?

[157] A law is arbitrary if it is "not capable of fulfilling its objectives" (***Carter*** at para 83) and if it limits life, liberty and security of person in a way that "bears *no connection* it its objective" (***Bedford*** at para 111, emphasis in original).

[158] The Respondents describe the purpose of the Ban as follows: "to protect the health, safety and long-term choices of children and youth with gender dysphoria or gender incongruence". The Respondents say the Ban is precautionary in light of uncertain science, a sharp increase in the number of youths presenting for Hormone Therapy, and the toxic environment surrounding the issue which has prevented open, honest and rational dialogue. The Respondents submit that the Ban reflects the government's view that medical interventions for youth must be evidence based, especially where there is risk of long-term harm. The Respondents submit that the Ban will prevent youth from making life-changing decisions which they might later regret before they have reached an appropriate stage of development and maturity and that it is, therefore, rationally connected to its objective.

[159] The Applicants argue that the Ban cannot accomplish its objective to preserve choice because it takes away the choice of Hormone Therapy. The Respondents criticize the Applicants for unduly narrowing the purpose of the Ban to "preserving choice" and then broadening its scope by ignoring the exceptions that the Government intends to proclaim by Ministerial Order. As mentioned above, the injunction application must be decided on the basis of the ***HSAA*** as it reads today and today it does not include a Ministerial Order. Accordingly, I will not consider the argument that the Applicants are unduly broadening the scope of the Ban by ignoring the potential Ministerial Order.

[160] The Ban does not seek to preserve choice generally. Rather, it seeks to preserve a certain choice (i.e., the choice to develop in accordance with the sex assigned at birth and to possibly have biological children) by removing another choice (i.e., the choice to confirm gender identity with Hormone Therapy at a young age). In that light, the Ban does bear a rational connection to its objective by prohibiting doctors from prescribing Hormone Therapy to minors for gender dysphoria and gender incongruence. Therefore, I am not satisfied that there is a serious issue on whether the Ban is arbitrary.

3. Is there a serious issue re whether the Ban is overbroad?

[161] "A law is overbroad when it is so broad in scope that it includes some conduct that bears no relation to its purpose, making it arbitrary in part": ***R v Ndhlovu***, 2022 SCC 38 at para 77 citing ***Bedford*** at para 112. In other words, a law is overbroad when it impacts more people than is necessary to accomplish its purpose: ***Black*** at para 90.

[162] The Applicants argue that the Ban is overbroad in the manner it will impact older youths versus younger youth. The Applicants argue that the Ban puts the mature minors in the same position as the younger minors, taking away their ability to make decisions, their agency and autonomy. It assumes that no gender diverse young person under the age of 18 – even with the supportive involvement of their parents or guardians – has capacity to make medical treatment decisions concerning gender affirming care. The Applicants rely on Abella J's statement in ***AC v Manitoba (Director of Child and Family Services)***, 2009 SCC 30 at para 108 where, writing for the majority, she held that: "it would be arbitrary to assume that no one under the age of 16 has capacity to make medical treatment decisions."

[163] The Applicants' expert evidence explains that youth can make different decisions about their health depending on their maturity, the nature of the treatment, and the consequences of the treatment. The Respondents' evidence is not entirely at odds with this assertion and one of the studies the Respondents rely on concludes that "adolescents presenting for endocrine treatment were generally thought to be able to consent to treatment and demonstrated many of the necessary elements to make an informed decision." The Applicants argue that the Ban fails to recognize that individual youth have different levels of understanding and maturity and lumps them altogether as children who are not capable of informed consent.

[164] The Respondents state that the Ban is not overbroad and that all aspects of the Ban are tied to its objective because of the significant unknowns about the risks, benefits and outcomes associated with puberty blockers as a treatment for gender dysphoria and gender congruence. The Respondents' experts state that given the state of the science, it is impossible for doctors to give minors and parents sufficient information for informed consent, and that it is not possible for minors who have not gone through puberty to develop sufficient capacity to understand the implications of Hormone Therapy.

[165] Further, the Respondents argue that the Ban is not overbroad because there is no way to reliably predict which children or adolescents will benefit from these interventions, and which will be unnecessarily harmed. As such, the Ban must protect them all. The Respondents point to their evidence that many children and adolescents desist and even de-transition as they age.

[166] The Applicants' evidence is that an extremely small number of people (who are already a part of a very small group) de-transition. I agree with the Applicant's submission that a person who gave informed consent to a treatment they later regret, is not a reason to deny that treatment to others.

[167] Finally, the Respondents argue that all minors must be included in the Ban because of an overeagerness among physicians to designate youth as mature minors, and to prescribe Hormone Therapy on demand. The Applicants' evidence is to the contrary and suggests that youth are

assessed in accordance with a protocol and only prescribed Hormone Therapy if certain conditions are met, including long-term persistence regarding their gender identity.

[168] The common law recognizes that minors have capacity to make important decisions, and also that their choices may be overridden where life or health are endangered: ***JI v Alberta (Child, Youth and Family Enhancement Act, Director)***, 2023 ABCA 169, paras 17-18.

[169] I find there is a serious issue to be tried in respect of whether the Ban is overbroad to the extent it includes mature minors and prevents them from accessing Hormone Therapy because there is evidence to support the Applicants' position that mature minors are more capable of making serious decisions about their bodies than are younger or less mature minors. Further, there is evidence to support the Applicants' position that doctors are treating gender diverse minors in accordance with established science and accepted protocols that account for the Respondents' concerns. Accordingly, there is an arguable case that the Ban is overbroad, and the Applicants' arguments are neither frivolous nor vexatious.

4. Is there a serious issue re whether the Ban is grossly disproportionate?

[170] A law is grossly disproportionate when its effects on the security of the person are "so disproportionate to its purpose that they cannot be rationally supported" (***Bedford*** at para 120), or "so extreme as to be disproportionate to any legitimate government interest" (***PHS*** at para 133). A grossly disproportionate effect on one person is sufficient to violate the norm: ***Bedford*** at para 122.

[171] The Applicants argue that the Ban is grossly disproportionate to its purpose because it comes at the expense of forcing gender diverse youth to experience irreversible body changes and acute harm across multiple domains of mental health and well-being. The Applicants' evidence also suggests that the Ban will have the adverse effect of aggravating the "anti-trans environment" and increasing minority stress among gender diverse persons.

[172] The Respondents' response is as described above – the state of the science is so uncertain that there is a blanket need to protect minors from Hormone Therapy. If there is a blanket need to protect transgender and gender diverse minors from Hormone Therapy, then the impact of the Ban cannot be grossly disproportionate to its purpose.

[173] I have already determined that the merits of the parties' respective expert evidence regarding the safety and efficacy of Hormone Therapy cannot be, nor should they be, resolved on this application. Until that matter is resolved, it cannot be said that the Ban is necessary to protect transgender and gender diverse minors. The Applicants' evidence suggests the Ban is not necessary to protect gender diverse youth, and that the Ban will cause them serious harm. Accordingly, I find there is a serious issue to be tried in respect of whether the Ban is necessary or whether its effect on security of person is so disproportionate to its purpose that it cannot be rationally supported.

B. Section 15 – Equal Protection and Benefit of the Law

[174] Section 15 of the *Charter* states:

> 15(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[175] The goal of section 15(1) is to achieve substantive equality by "preventing discriminatory distinctions that impact adversely on members of groups identified by the grounds enumerated in s. 15 and analogous grounds": ***R v Kapp***, 2008 SCC 41 at para 16; ***Black*** at para 107. According to ***Withler v Canada (Attorney General)***, 2011 SCC 12 at para 39, the focus of the analysis under s. 15 is "on the actual impact of the impugned law, taking full account of social, political, economic and historical factors concerning the group."

[176] To prove a *prima facie* violation of section 15, a claimant must first demonstrate that the impugned law creates a distinction on an enumerated or analogous ground, either on its face or in its impact. A law may create a distinction in its impact "when a seemingly neutral law has a disproportionate impact on members of groups protected on the basis of an enumerated or analogous ground": ***R v Sharma***, 2022 SCC 39 at para 29 citing ***Fraser v Canada (Attorney General)***, 2020 SCC 28 at para 30.

[177] Second, a claimant must show that the law imposes burdens or denies benefits to the identified group "in a manner that has the effect of reinforcing, perpetuating or exacerbating their disadvantage.": ***Sharma*** at para 28. A law may perpetuate an arbitrary disadvantage if it fails to account for the "actual capacities and needs of the members of the group": ***Black*** at para 111 citing ***Kahkewistahaw First Nation v Taypotat***, 2015 SCC 30 at para 20.

1. Is there a serious issue re infringement of section 15?

[178] Gender identity is an analogous ground under section 15 of the *Charter*. Gender identity is an "immutable personal characteristic" or a characteristic that can only be changed at an unacceptable cost: ***Centre for Gender Advocacy v Attorney General of Quebec***, 2021 QCCS 191 at paras 104-111 cited with approval in ***Hansman v Neufeld***, 2023 SCC 14 at para 88. Also see ***CF v Alberta (Vital Statistics)***, 2014 ABQB 237 at paras 58-60. The conclusion that gender identity is an immutable characteristic worthy of protection under section 15 the *Charter* is supported by the case law and the fact that conversion therapy is a criminal offence in Canada: *Criminal Code*, RSC 1985, c C-46, ss. 320.102 to 320.104.

[179] The Applicants argue that the Ban creates a distinction based on gender identity because the only group that will be impacted by the Ban are transgender and gender diverse youth. The Applicants argue that the Ban will have a disproportionate impact on gender diverse youth because they will not receive medically indicated treatment (i.e. Hormone Therapy) for their diagnoses, but their cisgender counterparts will.

[180] The Applicants argue that the Ban will have an adverse impact on gender diverse youth because it will prevent medically indicated treatment for an already vulnerable group. The Applicants' expert evidence is that gender diverse youth routinely rate their mental health at a lower level than their cisgender peers and that they are more likely to report extreme hopelessness and engage in self-harm. In addition to facing these challenges, gender diverse youth face greater

challenges accessing health care, and experience higher rates of violence and bullying. The Applicants' evidence is consistent with the Supreme Court of Canada's findings in ***Hansman***.

[181] In ***Hansman***, the Supreme Court of Canada recognized that gender diverse persons are "undeniably a marginalized group in Canadian society", that they "occupy a unique position of disadvantage", and that "harmful...therapy" has historically (and wrongly) been imposed on them to try and force conformity with their gender assigned at birth." Further the Supreme Court of Canada recognized, at paras 85-86:

> [85] ... As the British Columbia Human Rights Tribunal has recognized, "[u]nlike other groups..., transgender people often find their very existence the subject of public debate and condemnation" [citations omitted]. ...
>
> [86] Transgender people have faced discrimination in any facets of Canadian society. Statistics Canada has concluded that they are at increased risk of violence, and report higher rates of poor mental health, suicidal ideation, and substance abuse as a means to cope with abuse or violence they have experienced...

[182] The Applicants' expert evidence is that banning or delaying Hormone Therapy will prolong or worsen the gender dysphoria, distress, prejudice against, and mental health challenges of gender diverse youth. On this basis, the Applicants submit that the Ban imposes burdens and denies benefits in a manner that reinforces and perpetuates prejudice, and that the second step of the section 15 test is met.

[183] The Respondents dispute that the Ban draws a distinction based on gender identity. Rather, the Respondents submit that the Ban draws a narrow distinction on the basis of a mental health diagnosis of either gender incongruence or gender dysphoria. The Respondents argue that because the Applicants say gender diversity is "never a psychological or medical condition", the Applicants cannot argue that the Ban draws a distinction based on gender diversity.

[184] The Respondents argue that the Ban cannot have an adverse impact on gender diverse youth because the Ban is meant to ameliorate, rather than worsen, the situation of minors who have been diagnosed with gender dysphoria or gender incongruence. The Respondents reiterate their serious concerns about the science, and their view that Hormone Therapy for gender diverse youth is controversial and experimental.

[185] The Respondents argue that like the Applicants' claim under section 7, their claim under section 15 relies on the incorrect assertion that Hormone Therapy can be medically necessary to treat gender dysphoria and gender incongruence. The Respondents reiterate their argument that Hormone Therapy is not medically necessary and argue that there is no discriminatory distinction on an enumerated ground where the government refuses to fund an emergent or uncertain treatment, relying on ***Auton (Guardian ad litem of) v British Columbia (Attorney General)***, 2004 SCC 78 [***Auton***]. The Respondents argue that there is no discrimination because the medical interventions at issue are based on low certainty evidence

[186] I find there is a serious issue to be tried in respect of whether the Ban infringes the Applicants' rights under section 15 of the *Charter*. The Ban prohibits doctors from prescribing Hormone Therapy to any minor for the purposes of treating gender incongruence and gender

dysphoria. The only minors who are prescribed Hormone Therapy to treat gender incongruence and gender dysphoria are transgender and gender diverse youth. Under the Ban, cisgender youth will have access to Hormone Therapy for medically indicated reasons, but gender diverse youth will not.

[187] At trial, the Respondents can argue that the Ban does not distinguish based on gender diversity but on the basis of a mental health diagnosis such that there is no infringement of section 15. However, in my view, raising that argument does not diminish the fact that there is a serious issue to be tried regarding the nature of the distinction for three reasons.

[188] First, perhaps the Respondents' distinction is too technical and does not consider the equality issue substantively and contextually: ***Auton*** at para 25.

[189] Second, to find an infringement of section 15, the distinction made by the Ban does not have to be true in respect of every single person in the protected group.

[190] Finally, it seems that the question of how to properly understand and characterize a diagnosis of gender dysphoria and gender congruence will be an issue at trial. Findings in that regard may inform how the trial judge considers the extent to which Hormone Therapy should be made available to transgender and gender diverse youth.

[191] For the purposes of this application, I find there is a serious issue as to whether the Ban creates a *prima facie* distinction between gender diverse youth (or a subset of gender diverse youth) and cisgender youth on its face and in its effect by denying gender diverse youth medically indicated Hormone Therapy which was previously available to them and remains available to others.

[192] Regarding the second leg of the test, I appreciate the Respondents' argument that Hormone Therapy is not a benefit provided by law and the Applicants cannot, therefore, rely on section 15 of the *Charter*. I also appreciate their evidence and concern regarding the safety of Hormone Therapy and their argument that the Ban cannot adversely impact gender diverse youth because it is there to protect them. However, I have already decided that the evidence regarding medical necessity, denial of health care, and safety cannot be resolved on this application, and that the Applicants' evidence in that regard suggests there is a serious issued to be tried under section 7. Those findings are equally applicable here.

[193] For the purposes of this application, the Applicants' evidence makes it sufficiently clear that there is a serious issued to be tried in respect of whether the Ban will adversely impact gender diverse youth in a manner that perpetuates disadvantage and prejudice by denying them access to medically indicated treatment that remains available to others, thereby prolonging or worsening gender dysphoria, distress, prejudice, and mental health challenges of gender diverse youth.

C. Section 1 – Is there justification?

[194] Section 1 of the *Charter* must also be considered when determining whether there is a serious issue to be tried under section 7 and section 15. Section 1 reads:

> 1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

[195] While the Applicants bear the onus of establishing a *Charter* violation, the Respondents bear the onus under section 1 of proving that the limitation is justified: ***R v Oakes***, [1986] 1 SCR 103 at 136-37 [***Oakes***]. There is a particularly heavy burden as it relates to section 7 because the rights protected by section 7 are fundamental and "cannot ordinarily be overridden by competing social interests": ***G(J)*** at para 99.

[196] The Respondents must show that: (1) the Ban's objective is pressing and substantial; and (2) the means chosen to further that objective are proportionate: ***Oakes*** at 138-39. In order to show that the Ban is proportionate to its objective, the Respondents must show there is: (1) a rational connection between the government's objective and the means chosen to achieve that objective; (2) that the Ban minimally impairs the right in question; and (3) that the salutary effects of the Ban outweigh its deleterious effects: ***Carter*** at para 94.

1. Is there a serious issue re justification?

[197] The Respondents argue that the courts must show deference to legislative choices because they involve a complex assessment of risks and benefits, scientific uncertainty, consideration of public welfare and safety, among many other things. Further, the Respondents submit that states are not barred from taking precautionary action, particularly where human life and safety is in issue and there is scientific uncertainty, and that the court should take an especially deferential stance in this case because the Ban seeks to protect minors. The Respondents rely on their evidence that Hormone Therapy is experimental and of minimal efficacy to argue that the Ban is clearly justified under section 1.

[198] I have already addressed this evidence and the Respondents' arguments in the context of the section 7 and section 15 analyses. There is a serious issue to be tried in respect of all of these matters, and the same conclusions apply under this leg of the test. Further, while the legislature is entitled to deference, the courts are required to assess their decisions for compliance with the *Charter*. In my view, the Respondents' evidence and arguments are not enough to preclude a finding that there is a serious issue to be tried in respect of whether the Ban is justified under section 1.

D. Conclusion on Serious Issue

[199] I find there are serious issues to be tried as it relates to the Applicants' rights claims under sections 7 and 15 of the *Charter* as well the justification arguments under section 1 of the *Charter*. I find the Applicants have an arguable case that is neither frivolous nor vexatious.

IX. Irreparable Harm

[200] The Applicants submit that if the injunction is not granted, gender diverse youth in Alberta will suffer irreparable harm because they will: (i) be forced to undergo unwanted and irreversible bodily changes; (ii) be deprived of their autonomy to make personal health care decisions; and (iii) suffer serious, and potentially life-threatening, psychological harm.

[201] The Applicants rely on ***Cambie Surgeries Corporation v British Columbia (Attorney General)***, 2018 BCSC 2084 at paras 169-170, leave to appeal to BCCA refused, 2019 BCCA 29 as authority for the proposition that delayed access to health care constitutes irreparable harm. The Respondents say ***Cambie*** does not apply because here the treatments are not medically necessary like in ***Cambie***, rather they are "desired treatments".

[202] The Applicants submit that timing is a critical factor in this case and argue that ***Lowrey (Litigation Guardian of) v Ontario*** (2003), 64 OR (3d) 222, 2003 CanLII 2436 (SCJ), leave to appeal refused, [2003] OJ No 2009, 2003 CarswellOnt 1934 (SCJ) is analogous. In ***Lowrey*** an injunction was granted requiring the government to maintain funding for programming for children with autism partly on the basis that the "window of opportunity" for a young person to learn and develop may have closed by the time that matter went to trial. The Applicants say the same consideration applies here – there is a short "window of opportunity" for gender diverse young people to receive puberty blockers when they can be fully effective. I note, however, that in ***Lowrey*** the Crown Respondents did not press the argument that the applicant in that case would not suffer irreparable harm if he did not complete his treatment, rather, that decision turned on balance of convenience.

[203] The Respondents say that the harms articulated by the Applicants are speculative. The Respondents assert that the purpose of the Ban is to protect the health, safety, and long-term choices of gender diverse youth in Alberta. The Respondents say the Ban is a precautionary response to scientific uncertainties and harms and reflects the Government's view that medical interventions for children and youth must be evidence-based.

[204] Where the nature of relief sought is to prevent prospective harm, the applicant must establish with a "high degree of probability that the harm will in fact occur": ***Operation Dismantle*** at para 35.

[205] I find that there will be irreparable harm to gender diverse youth if an injunction is not granted. The evidence shows that the Ban will cause irreparable harm by causing gender diverse youth to experience permanent changes to their body that do not align with their gender identity. There is nothing speculative about this evidence.

[206] Further, the evidence shows that singling out health care for gender diverse youth and making it subject to government control will cause irreparable harm to gender diverse youth by reinforcing the discrimination and prejudice that they are already subjected to. Intentionally or not, the Ban will signal that there is something wrong with or suspect about having a gender identity that is different than the sex you were assigned at birth. Gender diverse youth will bear the entire burden of that speculation. Further, the Ban will cause irreparable harm by denying gender diverse youth the benefit of: (i) receiving direct care from a medical community that has expertise in this area, and (ii) being able to make informed decisions based on the advice of their doctors and often with the guidance and support of their parents and guardians, in the very narrow window of opportunity they have to act on such advice.

[207] I find that that the Applicants have established irreparable harm.

X. Balance of Convenience

[208] The Applicants submit that this is one of the clear cases where the balance of convenience favours granting the injunction. They contend that an injunction is necessary to ensure that Albertans under the age of 18 who want medical treatment are not denied the protection of their constitutional rights while the case works its way through trial.

[209] The Applicants argue that even if the law is presumed to be for the public good, there is an "infinitesimally small" fraction of the public who will stand to benefit from the Ban: those who have been prescribed and chosen to take Hormone Therapy before the age of 18, who experience irreversible physical changes, and who later regret their decision to have pursued such treatment. The Applicants point to evidence that only 1% of individuals who received gender affirming hormone treatments for at least six months later discontinued treatment because they re-identified with the gender associated with their sex assigned at birth. The Respondents point to evidence that the percentage is closer to 10-20%.

[210] The Applicants say the Ban does not provide for a benefit to the broader public at large, and this distinguishes this case from cases like ***Moms Stop the Harm Society v Alberta***, 2022 ABCA 35 (impugned law required users to provide personal health numbers before accessing supervised consumption services) and ***Black*** (impugned law stopped certain narcotics from being prescribed to individuals for opioid dependence outside treatment facilities).

[211] The Respondents say that in the face of "heavily disputed and highly uncertain scientific evidence" the public interest is served by taking precautionary steps and imposing the Ban. The Respondents rely on ***Trest v British Columbia (Minister of Health)***, 2020 BCSC 1524 at para 91 where the court held that the balance of convenience was best served by permitting the government to continue to rely on guidance and advice "firmly rooted in current scientific knowledge and best practices. The fact that some of this advice is not universally accepted is insufficient to conclude that the government has clearly chosen the wrong approach in terms of the public interest." The underlying claim in ***Trest*** concerned the constitutionality of policies related to return to in-class instruction in schools during the Covid-19 pandemic.

[212] The Respondents argue that the proper approach to assessing balance of convenience was set out by Pomerance J, as she then was, in ***Ontario v Trinity Bible Chapel et al***, 2022 ONSC 1344, aff'd 2023 ONCA 134, leave to appeal to SCC refused, 2023 CanLII 72135 [***Trinity Bible***]. Pomerance J held that in cases where there is scientific debate and the medical experts disagree, it is not the role of the court to determine whether certain experts are right or wrong: ***Trinity Bible*** at paras 6, 127, 129 and 144. Instead, the question is "whether it was open to [the respondents] to act as [they] did, and whether there was scientific support for the precautionary measures that were taken": ***Trinity Bible*** at para 6.

[213] I note that the Respondents rely on the above passage from ***Trinity Bible*** notwithstanding that Pomerance J was discussing whether the impugned law failed the minimal impairment test for justification under section 1 of the *Charter*. The balance of convenience stage of the ***RJR*** test is focused on whether the granting or withholding of interlocutory relief would occasion greater harm pending a decision on the merits and not on whether "the law falls within a range of reasonable alternatives" which is the focus of the minimal impairment test: see ***RJR-MacDonald Inc v***

Canada (Attorney General), [1995] 3 SCR 199 at 342. That said, I acknowledge, as do both parties, that there is a presumption that the law is directed at the public interest and the burden is on the applicants to overcome that presumption.

[214] The law requires me to assume that an injunction will harm the public interest, and to assess the gravity of that harm when considering the balance of convenience. An injunction will harm the public interest by denying protection to gender diverse youth in accordance with the objective of the legislation. I find that the harm to the public interest does not outweigh the benefit that the injunction will afford.

[215] The evidence shows that the only group that will be directly impacted by the Ban are gender diverse minors for whom Hormone Therapy is medically indicated. The evidence of both parties shows that the Ban will benefit an even smaller subset of this already very small group of people and those are the individuals that are prescribed Hormone Therapy and later regret it. The harm that this group might suffer would arise only after they made an informed choice to obtain Hormone Therapy.

[216] Again, I appreciate that the ability to make an informed choice, and the state of the science are in issue, but the evidence supports that informed choice is possible and that the doctors who prescribe Hormone Therapy do so with a careful eye to the needs of the patient and the risks of the treatment. I accept that some patients and their parents may have had a different experience and believe that treatment was initiated hastily and without a full understanding of the consequences. However, based on my assessment of the evidence it would be a stretch to conclude that because that may have been the experience of some, every doctor who practices gender affirming care has abdicated their responsibilities and are choosing to ignore the strength of the science regarding gender affirming care such that the Ban is necessary to protect the public good.

[217] The evidence shows that there is a benefit to the public in issuing the injunction because it will allow this marginalized group to continue receiving medical care from trusted doctors and a broader team of health professionals thereby avoiding the adverse consequences the Ban will have on them, including interference with their autonomy, unwanted and permanent development, serious stress and anxiety and further discrimination, until the issues are decided on a full record at trial.

[218] In conclusion, I find that the professional standards of Alberta's health care professions will protect the public interest while an interlocutory injunction is in effect. I agree with the Applicants that in this case, the *status quo* protects the public interest through a web of public law and private law constraints on the provision of gender affirming care, which the injunction would leave fully in place.

[219] I am satisfied the balance of convenience favours the granting of an injunction.

XI. Conclusion

[220] I am satisfied, in respect of the grounds raised under sections 7 and 15 of the *Charter*, that there are serious issues to be tried, that irreparable harm will be caused if the Ban comes into force, and that the balance of convenience weighs in favour of granting the injunction.

[221] I grant the requested injunction enjoining the Lieutenant Governor in Council of Alberta from proclaiming into force section 1.92 of the ***HPA*** until the Applicants' Originating Application has been finally adjudicated.

[222] Given the *Charter*-based nature of the claim, I dispense with any requirement that the Applicants file an undertaking as to damages.

XII. Costs

[223] Costs will be in the cause.

Heard on the 10th and 11th day of March, 2025.
Dated at the City of Calgary, Alberta this 27th day of June, 2025.

Allison G. Kuntz
J.C.K.B.A.

Appearances:

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