The Honorable Maureen McKee

SUPERIOR COURT OF THE STATE OF WASHINGTON
FOR KING COUNTY

J. DOE A, in their individual capacity and on behalf of their minor child; JANE DOE B and JANE DOE C, in their individual capacities and on behalf of their minor child; JANE DOE D, in their individual capacity and on behalf of their minor child; JANE DOE E and JOHN DOE F, in their individual capacities and on behalf of their minor child; JOHN DOE G, in their individual capacity and on behalf of their minor child; TRANSFAMILIES, a nonprofit organization; and WASHINGTON EDUCATION ASSOCIATION, a nonprofit organization,

Plaintiffs,

v.

STATE OF WASHINGTON,

Defendant.

No. 26-2-37399-0 SEA

BRIEF OF WASHINGTON STATE MEDICAL ASSOCIATION, WASHINGTON CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, WASHINGTON ACADEMY OF FAMILY PHYSICIANS, WASHINGTON CHAPTER OF THE AMERICAN COLLEGE OF PHYSICIANS, WASHINGTON STATE PSYCHIATRIC ASSOCIATION, WASHINGTON CHAPTER OF THE NATIONAL ASSOCIATION OF PEDIATRIC NURSE PRACTITIONERS, WASHINGTON STATE NURSES ASSOCIATION, APRNS OF WASHINGTON STATE, AND ASSOCIATION OF ADVANCE PRACTICE PSYCHIATRIC NURSES AS AMICI CURIAE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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I. INTRODUCTION

Initiative Measure No. 638 (the "Initiative" or "I-638") imposes legal obligations without clinical standards. Amici—a collection of Washington State's leading medical and nursing associations and organizations, together representing thousands of family-medicine doctors, pediatricians, obstetrician-gynecologists, internists, psychiatrists, physician assistants, nurses, and other providers dedicated to providing safe, evidence-based healthcare to all Washingtonians[1]—submit this brief to bring to the Court's attention the practical risks and consequences of the Initiative's implementation.

The Initiative requires girls seeking to participate in school sports to "provide a health examination and consent form or other statement signed by the student's personal health care provider that verifies the student's biological sex," relying only on "reproductive anatomy, genetic makeup, or normal endogenously produced testosterone levels." I-638 § 3(2). But the Initiative defines none of these terms in clinical language, identifies no governing standard, and says nothing about what providers must do to comply with its verification requirement—effectively putting healthcare providers on the field without a playbook.

The sort of examination contemplated by the Initiative is not part of a routine sports physical and—critically from a provider standpoint—is *not medically necessary* to determine whether a child can safely participate in athletics. Sports physicals follow a model form developed by the nation's leading pediatric and sports-medicine organizations, and the American Medical Association ("AMA") opposes both medically unnecessary interventions *and* physician participation in athletic sex-verification requirements. Requiring providers to

[1] A more thorough description of Amici and their interests is included in their motion for leave to submit this brief, filed concurrently.

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perform these examinations not only forces them to operate outside the standard of care and without clinical guidelines but also compromises the clinician-patient relationship to an irreparable degree.

These harms extend beyond the examination room. Faced with a medically unnecessary and potentially intrusive examination, some girls will simply stop playing—and will lose the well-documented mental health, academic, and developmental benefits of sports. And because laboratory alternatives are costly and unlikely to be covered by insurance, the Initiative creates a two-tiered system: Families with means can afford a less-intrusive path to eligibility while families with fewer resources cannot.

Amici and their members hold as their paramount objective the health and wellbeing of their patients. They should not be enlisted to participate in an untested legal regime that lacks any recognizable clinical grounding or purpose. Unless the Initiative is enjoined, providers will face significant compliance risks and girls who want to play sports will be left waiting for a clinician to certify something the Initiative fails to define. For these reasons and those that follow, Amici respectfully urge the Court to issue a preliminary injunction.

II. ARGUMENT

A. Requiring medically unnecessary sex-verification examinations departs from the established standard of care for sports physicals.

Physicians and other clinicians have a professional and ethical responsibility to recommend and perform only those examinations and tests that are medically necessary. Unnecessary procedures that are not medically indicated undermine the physician-patient

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relationship and erode patient trust—a particular concern at a time when trust in physicians and medical providers is declining and medical misinformation is on the rise.[2]

For many children and adolescents, pre-participation physical evaluations (commonly known as "sports physicals") are formative interactions with doctors and other clinicians, critical to building clinician-patient trust. These evaluations are designed to identify conditions that could put young athletes at risk of serious injury, illness, or other health complications that might arise during physical activity, and they typically include an examination of the patient's vital signs, cardiovascular and musculoskeletal systems, and, at the physician's or clinician's discretion, a medical-history review.

These examination categories derive from the model physical-examination form (the "Model Form") developed by the American Academy of Pediatrics in conjunction with the American Academy of Family Physicians, the American College of Sports Medicine, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine.[3] The Washington Interscholastic Activities Association ("WIAA") has long used the Model Form for these evaluations, and for good reason—it reflects the consensus of the nation's leading pediatric and sports-medicine organizations and follows established medical standards.[4] Its authors describe the evaluation's goals as follows:

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[2] *See* Marcella Alsan & David M. Cutler, *Prescription for Division—Healing the Growing Gap in Physician Trust*, 6 JAMA Health Forum e256765 (2025), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2843194; Roy Perlis et al., *Trust in Physicians and Hospitals During the COVID-19 Pandemic in a 50-State Survey of U.S. Adults*, 7(7) JAMA Network Open e2424984 (2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2821693.

[3] *Preparticipation Evaluation: Physical Examination Form*, Am. Acad. of Pediatrics, http://aap.org/en/patient-care/preparticipation-evaluation (last visited Nov. 20, 2026).

[4] *See Official WIAA Forms*, WIAA, https://www.wiaa.com/forms (last visited Nov. 20, 2026). WIAA has additionally added a biological-sex attestation addendum to comply with the Initiative's requirements. *See An Update on the WIAA's Implementation of I-638*, WIAA (Nov. 18, 2026), https://www.wiaa.com/an-update-on-the-wiaas-implementation-of-i-638.

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(1) Promote optimal and safe physical activity;

(2) Provide a framework to assess, promote, and discuss physical and psychological health related to physical activity;

(3) Encourage use and/or establishment of a medical home for continuity-based healthcare;

(4) Identify conditions that may be life-threatening or disabling; and

(5) Provide an opportunity for discussion of health and lifestyle issues.[5]

These goals reflect two core purposes: ensuring the child's safety and building a trusted relationship between the child and their physician or other healthcare provider. A requirement that physicians or clinicians verify "biological sex" as a part of these examinations serves neither goal and represents a significant departure from accepted medical practice. Notably, such verification requirements conflict with the AMA's guidance that "*physicians should only recommend and provide interventions that are medically appropriate*"[6] and with AMA policy opposing "satisfying third-party requirements to certify or confirm an athlete's gender through physician participation."[7]

None of the methods for verifying "biological sex" authorized by the Initiative is routinely necessary or medically appropriate for a sports physical. In particular, genital or "reproductive anatomy" examinations are not routine. Rather, they are sensitive procedures that might cause distress or discomfort and often require special precautions.[8] Physicians

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[5] *Preparticipation Evaluation*, Am. Acad. of Pediatrics, http://aap.org/en/patient-care/preparticipation-evaluation (last visited Nov. 20, 2026).

[6] *Medically Ineffective Interventions*, AMA, https://code-medical-ethics.ama-assn.org/ethics-opinions/medically-ineffective-interventions (last visited Nov. 20, 2026) (emphasis added).

[7] *Opposition to Requirements for Gender-Based Treatment for Athletes H-470.951*, AMA, https://policysearch.ama-assn.org/policyfinder/detail/H-470.951?uri=%2FAMADoc%2FHOD.xml-H-470.951.xml (last visited Nov. 20, 2026).

[8] *See* Abeba Berhane et al., *Use of Chaperones for the Pediatric and Adolescent Encounter: Policy Statement*, 155(6) Pediatrics e2025071810 (2025), https://publications.aap.org/pediatrics/article/155/6/e2025071810/201949/Use-of-Chaperones-for-the-Pediatric-and-Adolescent.

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must "protect patient privacy in all settings to the greatest extent possible," including by minimizing intrusions on a patient's privacy.[9] For these reasons, such examinations should be performed only when medically indicated. Performing them for any other reason conflicts with physicians' ethical obligations and could compromise the clinician-patient relationship and erode the very trust that sports physicals can otherwise build.

The Initiative's contemplated alternatives—genetic or chromosomal testing and hormone testing through a blood draw—present their own challenges. Chromosome-based sex verification of athletes was discredited decades ago as discriminatory and scientifically unsound.[10] Blood-based testing is also physically uncomfortable and can lead to follow-up testing that is itself medically unnecessary. For these reasons, among others, the AMA opposes the use of hormonal assessments to determine gender classifications for participation in sports.[11]

Requiring physicians and other providers to verify "biological sex" solely to satisfy an athletic-eligibility rule therefore raises serious ethical, privacy, and cost concerns, and it pushes clinicians well outside the accepted standard of care. These consequences reach beyond a single visit: For many children, the sports physical is one of their first independent encounters with the medical system, an annual rite of passage that marks the start of a new season. The Initiative turns that encounter into an occasion for a state-mandated, potentially intrusive examination unrelated to the child's health. A child subjected to that experience learns that the examination room is not a place that prioritizes their interests. That lesson

[9] *Privacy in Health Care*, AMA, https://code-medical-ethics.ama-assn.org/ethics-opinions/privacy-health-care (last visited Nov. 20, 2026).

[10] *See, e.g.*, Louis Elsas et al., *Gender Verification of Female Athletes*, 2 Genetics in Med. 249 (2000), https://pubmed.ncbi.nlm.nih.gov/11252710.

[11] *See Opposition to Requirements for Gender-Based Treatment for Athletes*, *supra* note 7.

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erodes the relationship between patients and clinicians and makes patients less willing to seek care or speak candidly with their providers.[12]

B. The Initiative requires physicians to verify sex using nonclinical criteria and provides no standards.

The Initiative makes a student's healthcare provider the gatekeeper for girls' school athletics, yet it gives that provider no workable clinical standard to apply. To participate in competition activities "intended for female students only," a student must submit "a health examination and consent form or other statement signed by the student's personal health care provider that verifies the student's biological sex, relying only on one or more of the following: The student's reproductive anatomy, genetic makeup, or normal endogenously produced testosterone levels." I-638 § 3. The Initiative leaves basic questions unanswered: What clinical standard governs verification? What testing is required or permitted? How is informed consent obtained? How is patient privacy protected? And what happens when a student has a difference in sex development? By leaving these questions open, the Initiative ultimately demands that physicians and clinicians act outside standard clinical practice, without established clinical guidelines and the professional protections that accompany them and on which physicians ordinarily rely.

1. The Initiative's operative terms are undefined or lack clinical meaning.

Each element of the Initiative's verification requirement uses language that does not reflect how medicine or nursing is practiced. The Initiative relies on generalized terms that

[12] Courts have long recognized that this kind of injury cannot be undone. Disrupting the physician-patient relationship is as irreparable as any harm can be—the trust destroyed cannot be restored with money damages. *See, e.g.*, *Fairfield Cnty. Med. Ass'n v. United Healthcare of New Eng.*, 985 F. Supp. 2d 262, 271–72 (D. Conn. 2013) (noting that several courts found that "disruption of the physician-patient relationship can cause irreparable harm that justifies issuing preliminary injunctive relief, particularly when the patient belongs to a vulnerable class"), *aff'd as modified*, 557 F. App'x 53 (2d Cir. 2014).

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lack clinical specificity, leaving physicians and clinicians to guess at what compliance requires. The Initiative's problematic terminology includes the following:

- **"Health examination"** and **"consent form or other statement."** The Initiative defines neither term. *See* I-638 § 3(2). Providers are left to guess what they must do to comply or whether the verifications they sign satisfy the law.
- **"Reproductive anatomy."** This is a lay term, not a clinical one. It could mean an external genital examination, an internal genital examination, or imaging of reproductive organs. Each is an intimate procedure, and none would ordinarily be performed on a healthy child who simply wants to join a sports team. Physicians and other providers must therefore choose between an examination that might be legally inadequate and one that is clinically unjustified.
- **"Normal endogenously produced testosterone levels."** This criterion assumes a test that does not exist. No blood test isolates "endogenous" testosterone, and those in existence instead only measure circulating testosterone levels.[13]

Nor does the Initiative define "normal," specify a reference range, or account for differences in age or physical maturity. These differences are critical for younger athletes because, before puberty, circulating testosterone levels do not differ significantly by sex, *see* Compl. for Declaratory J. & Injunctive Relief ("Compl.") ¶¶ 5.30, 5.43—meaning this

[13] *See, e.g.*, David J. Handelsman, *Toward a Robust Definition of Sport Sex*, 45 Endocrine Reviews 709, 728 (2024), https://academic.oup.com/edrv/article/45/5/709/7641481 ("The specified measurement technology for testosterone recognizes that testosterone immunoassays have unacceptably limited sensitivity, specificity, and reproducibility at the low circulating levels in women at any age[.]"); Ruth I. Wood & Steven J. Stanton, *Testosterone and Sport: Current Perspectives*, 61 Hormones & Behav. 147 (2012), https://pmc.ncbi.nlm.nih.gov/articles/PMC3264812/pdf/nihms-334274.pdf (explaining that, "[d]ue to the dynamic regulation of endogenous testosterone production … testosterone concentrations may vary considerably within and among individuals," making it "difficult to establish a threshold separating endogenous testosterone from exogenous sources").

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criterion cannot meaningfully distinguish biological sex for many younger students. Organized medicine has also consistently rejected this approach: As noted above, the AMA opposes the use of hormonal assessments to determine gender classifications in athletics. The Initiative would thus require Washington physicians and healthcare providers to engage in the very practices their profession's policymaking bodies have deemed inappropriate.

2. For girls with differences in sex development, verification might be clinically impossible.

The Initiative assumes that anatomy, genetics, and hormones always point to the same answer. They do not. For girls with differences in sex development (sometimes called intersex traits), chromosomal makeup, hormone levels, and anatomy might diverge.[14] In those cases, a physician may be unable to "verify" sex under *any* permitted method—a significant problem considering that the Initiative says nothing about how to resolve conflicting results.

3. A physician's existing knowledge of the patient does not satisfy the Initiative's requirements.

One might expect that a student's longtime pediatrician could simply attest to what the physician already knows about the patient, but the Initiative's text specifically forecloses that option: A physician's general knowledge of the sex a child was assigned at birth is not, by itself, one of the three enumerated criteria on which a physician may base their attestation. *See* I-638 § 3(2). Even the provider who knows the child best must therefore

[14] *See, e.g.*, Syed Faisal Ahmed et al., *Differences of Sex Development*, 11 Nature Revs. Disease Primers 54 (2025), https://pubmed.ncbi.nlm.nih.gov/40744924 (explaining that "there may be many scenarios where a simple classification is not applicable" because sex development "may vary depending on the person's age, and variants of a single gene may be associated with several different phenotypes").

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conduct an examination or order a test that serves no clinical or medically indicated purpose whatsoever.

4. Implementing the Initiative midyear, without guidance, compounds these problems.

Without time to develop statewide clinical guidance, physicians and other clinicians will be left to resolve on their own difficult professional and ethical questions about how to comply with the Initiative: whether to order tests that are not medically indicated, how to obtain informed consent from minors and their parents, how to document and protect sensitive results, and what to do when results are indeterminate. Imposing these requirements in the middle of the school year, as students prepare for winter sports, places needless burdens on students, families, schools, and a healthcare system already facing a well-documented, endemic shortage of primary-care physicians.[15] Pediatric and primary-care practices would have to absorb a sudden demand for verification visits that serve no clinical purpose, with no protocol to follow and no assurance that their judgments will be accepted.

C. The Initiative will discourage girls from playing sports and create cost and access barriers that fall hardest on families with the fewest resources.

Faced with a choice between a medically unnecessary and potentially intrusive examination and giving up sports altogether, some girls will choose not to play. That loss is substantial. Participation in youth sports is associated with lower rates of anxiety, depression, and suicide and with higher grades and graduation rates. *See* Compl. ¶¶ 5.4–5.6

[15] *See* Kevin McKeough, *Building a Strong Primary Care Physician Workforce*, AMA (Oct. 22, 2026), https://www.ama-assn.org/practice-management/physician-health/building-strong-primary-care-physician-workforce ("The U.S. doesn't have enough primary care physicians to meet patient needs and that the problem is getting worse … Along with making it difficult for patients to obtain healthcare, the primary care shortage affects the care patients do obtain.").

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(citing, e.g., Molly C. Easterlin et al., *Association of Team Sports Participation with Long-Term Mental Health Outcomes Among Individuals Exposed to Adverse Childhood Experiences*, 173 JAMA Pediatrics 681–88 (2019)). Girls in particular experience gains in academic achievement and self-esteem. *Id.* ¶ 5.9. Leading pediatric authorities recognize these benefits and encourage participation in organized sports for that reason.[16] A measure that drives girls off the field in the name of protecting girls' athletics defeats its own purpose and denies children benefits that last well beyond any single season.

The Initiative also imposes costs, delays, and access barriers that will fall hardest on families with limited financial resources. The Initiative's three verification options—examination of "reproductive anatomy," testing of testosterone levels, or genetic testing—raise concerns about unequal access. Families who can afford laboratory testing might choose that option to spare their children a medically unnecessary genital examination. But those tests can be expensive and, because they are not medically necessary, are unlikely to be covered by insurance. The result is a two-tiered system, where families with means can buy their children a less-intrusive route to eligibility while families without means are left with needless genital examinations—or no sports at all.

III. CONCLUSION

For these reasons, Amici respectfully urge the Court to grant Plaintiffs' motion for preliminary injunction.

[16] *See* Kelsey Logan & Steven Cuff, *Organized Sports for Children, Preadolescents, and Adolescents*, 143 Pediatrics 1, 6–7, 13 (2019), https://pubmed.ncbi.nlm.nih.gov/31110166 (reaffirmed July 11, 2023).

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RESPECTFULLY SUBMITTED this 20th day of November, 2026.

I certify that this brief contains 2,803 words.

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