IN THE CIRCUIT COURT OF ST. LOUIS COUNTY
STATE OF MISSOURI

SOUTHAMPTON COMMUNITY HEALTHCARE, formerly known as SOUTHAMPTON HEALTHCARE, INC.; KELLY STORCK; A.S., as next friend and on behalf of her minor child R.S.; N.F., as next friend and on behalf of his minor child A.F.; and LOGAN CASEY;

Plaintiffs,

v.

ANDREW BAILEY, in his official capacity as Attorney General for the State of Missouri,

207 West High Street,
Jefferson City, MO 65102,

Defendant.

Case No. _____

Division: _____

PLAINTIFFS' MEMORANDUM IN SUPPORT
OF MOTION FOR TEMPORARY RESTRAINING ORDER

Plaintiffs seek a temporary restraining order preventing Defendant from violating Sections 536.014, 536.021 and 536.025 of the Revised Missouri Statutes by implementing, making effective, enforcing, or applying the Missouri Attorney General's recent emergency rule, codified at 15 CSR 60-17.010 and titled, "Experimental Interventions to Treat Gender Dysphoria," which is attached as Exhibit A to the Petition (the "Emergency Rule" or "Rule").

As set forth in the Petition, Missouri's new, politically-appointed Attorney General, is attempting to expand and transform the Missouri Merchandising Practices Act, Chapter 407, RSMo, from a prohibition on fraudulent sales or advertisements—*e.g.*, a car dealership selling a car without providing the title, a hardware store failing to honor a warranty on a vacuum, or a lawn service for not fertilizing as invoiced—to essentially outlaw, on less than two weeks' notice,

virtually all medically-necessary treatment for gender dysphoria in Missouri, treatment that is supported by every major medical association in the United States. The Attorney General's action violates Missouri's constitutionally established separation of powers and is an attempt to legislate behind closed doors through Missouri's limited emergency rulemaking procedures set forth in RSMo § 536.025, without any input from the Missourians the Rule will affect most.

Notwithstanding that, for years, responsible medical professionals in Missouri have provided gender-affirming care to treat gender dysphoria in accordance with widely accepted and recognized evidence-based clinical practice guidelines as part of their overall treatment for adolescents and adults, the Attorney General now insists there is an "emergency" necessitating the suspension of long-standing procedural legislative safeguards to protect against poorly-drafted, ill-considered, one-sided, impracticable ideas becoming law. This end run around public comment and the separation of powers not only violates the emergency rule-making provisions in the first instance, but also results in a rule that conflicts with other Missouri statutes, including Chapter 538, which provides a remedy for medical malpractice,[1] and Section 334.020, et seq., pertaining to the Missouri Board of Registration for the Healing Arts. The Emergency Rule is so arbitrary and capricious that it creates substantial inequity and unreasonable burdens on thousands of Missourians, *i.e.*, transgender adolescents and adults in Missouri, seeking medically necessary health care.

Absent interim equitable relief, the Emergency Rule could be enforced as soon as Thursday, April 27, 2023. It places draconian restrictions on the ability of, and, in many circumstances

[1] In fact, the Missouri Merchandising Practices Act [Mo. Rev. Stat. § 407.025, et seq.]("MMPA"), which the Attorney General through the Emergency Rule improperly seeks to amend, specifically prohibits actions thereunder where "a claim can be brought under chapter 538." RSMo § 407.025.3. This section, added to the MMPA in 2020, effectively moots case law prior to that date that may be cited by Defendant Bailey in arguing that the MMPA reaches such claims.

categorically prohibits Missourians from receiving necessary, effective and safe gender-affirming medical care. These restrictions are entirely divorced from and in contravention of the expert opinions of learned medical providers and the treatment protocols for gender dysphoria recognized by the leading medical associations in the United States.

A temporary restraining order preserving the status quo and staying the effectiveness of the Emergency Rule—and prohibiting the Attorney General from enforcing it—is needed to protect Missourians, including certain of the Plaintiffs, from the irreparable harms concomitant with limitations to and denials of clinically appropriate and medically necessary health care, and to preserve their rights and interests under the laws of the State of Missouri.

BACKGROUND

A. Gender-Affirming Medical Care is the Established Medical Protocol for Treatment of Transgender Individuals with Gender Dysphoria.

"Gender identity" refers to a person's internal, innate and immutable sense of belonging to a particular gender. (*See* Declaration of Dr. Shumer ("Shumer Decl.") ¶28; Declaration of Dr. Janssen ("Janssen Decl.") ¶¶33, 37). For some, their gender identity aligns with the sex they were assigned at birth based on external genitalia, but others have a gender identity that does not align with their sex assigned at birth. (Shumer Decl. ¶¶28, 38; Janssen Decl. ¶32). The term "gender dysphoria" is the distress related to the incongruence between one's gender identity and one's sex assigned at birth. (Shumer Decl. ¶¶38, 39; Janssen Decl. ¶¶41-42).

Gender dysphoria is a serious medical condition characterized by the clinically significant distress a transgender person feels because of the incongruity between their gender identity and their assigned sex. (Shumer Decl. ¶¶38, 39; Janssen Decl. ¶42). Left untreated, gender dysphoria can lead to serious negative health outcomes including severe anxiety and depression, eating

disorders, substance abuse, self-harm, and, in many instances, suicidality.[2] (Shumer Decl. ¶43; Janssen Decl. ¶50).

Gender dysphoria, however, is highly treatable, and Missouri doctors use well-established guidelines to diagnose and treat minors and adults with gender dysphoria. (*See* Shumer Decl. ¶43; Janssen Decl. ¶¶51, 53-54). When properly diagnosed and treated with gender-affirming care, those with gender dysphoria can live consistently with their gender identity, allowing them to survive and thrive. (*See* Shumer Decl. ¶44; Janssen Decl. ¶50). Undergoing treatment to alleviate gender dysphoria is commonly referred to as transition[3] (*See* Shumer Decl. ¶59).

Leading medical organizations, including the Endocrine Society [4] and the World Professional Association for Transgender Health ("WPATH")[5] have studied gender dysphoria and transition-related care (also known as "gender-affirming care") for more than four decades. (Shumer Decl. ¶¶49-55; Janssen Decl. ¶¶51-56). As a result of their medical expertise developed over many years of training and diligent study, some medical organizations like WPATH and the Endocrine Society have published evidence-based clinical practice guidelines for the medical treatment of transgender patients. (Shumer Decl. ¶57; Janssen Decl. ¶56). These publications have been endorsed and recognized as authoritative by the major professional medical and mental health associations in the United States. (*Id.*). These guidelines confirm that gender-affirming care,

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[2] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 452-53 (5th ed. 2013).

[3] Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey*, NAT'L CTR. FOR TRANSGENDER EQUAL. (Dec. 2016), https://perma.cc/FC9M- 4QZJ.

[4] Wylie C. Hembree *et al.*, "Endocrine Treatment of Gender Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," *The Journal of Clinical Endocrinology & Metabolism*, Volume 102, Issue 11, 1 November 2017, Pages 3869-3903, https://doi.org/10.1210/jc.2017-01658 ("Endocrine Society Guideline").

[5] World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Conforming People* (7th Version) (2012), https://www.wpath.org/publications/soc ("Standards of Care").

including puberty-delaying treatment and hormone therapy where appropriate, is safe, effective, and medically necessary.[6] (*See* Shumer Decl. ¶¶78-91; Janssen Decl. ¶¶80-85).

The precise aspects of a person's treatment plan for their gender dysphoria, as with all medical care, may differ based on individualized considerations, such as whether the person is pre-pubertal, an adolescent, or an adult, and whether a particular treatment is indicated for that person. (*See* Shumer Decl. ¶¶46-48, 59; Janssen Decl. ¶¶67-79, 87-88). None of the recognized clinical practice guidelines for treatment of gender dysphoria recommend medical treatment for prepubertal children, meaning *no medical treatment is recommended until after the onset of puberty*. (Shumer Decl. ¶60; Janssen Decl. ¶55). For transgender adolescents, the plan and treatment components are determined based on the individual's medical and mental health needs. (*See, e.g.*, Shumer Decl. ¶¶64-77; Janssen Decl. ¶¶61-79).

For many transgender adolescents, going through puberty in accordance with the sex assigned to them at birth can cause extreme distress. (*See* Shumer Decl. ¶63). To relieve this distress and delay the permanent physical changes that would come with puberty, healthcare providers may prescribe puberty-delaying medication to these patients. (*See* Shumer Decl. ¶¶62-71; Janssen Decl. ¶¶62-63, 80-82). Medical treatments for adolescents are provided in consultation with qualified mental health professionals. (Shumer Decl. ¶¶40, 45; Janssen Decl. ¶¶65, 68). Puberty-delaying medications pause endogenous puberty, limiting the influence of endogenous hormones on the body. (Shumer Decl. ¶65; Janssen Decl. ¶¶62-63). Such interventions afford the

[6] Rafferty J, AAP *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, Pediatrics, 2018 Volume 142 No. 4 https://pediatrics.aappublications.org/content/pediatrics/142/4/e2018 2162.full.pdf; *AACAP Statement Responding to Efforts to Ban Evidence-Based Care for Transgender and Gender Diverse Youth*, American Academy of Child and Adolescent Psychiatry, https://www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx.

adolescent time to better understand their gender identity, while delaying the development of secondary sex characteristics. (Janssen Decl. ¶62-63).

For some adolescents, their healthcare provider may determine it is medically necessary and appropriate to initiate puberty consistent with a patient's gender identity through gender-affirming hormone therapy (testosterone for transgender boys and testosterone suppression and estrogen for transgender girls). (*See* Shumer Decl. ¶¶72-77; Janssen Decl. ¶¶64, 80, 83-84). Transgender adolescents who receive gender-affirming hormones after having received puberty-delaying treatment do not go through puberty in accordance with the sex assigned to them at birth. Instead, they go through puberty that matches their gender identity. (*See* Shumer Decl. ¶72-73). Treatment can drastically minimize dysphoria later in life and may eliminate the need for surgery. (*See* Shumer Decl. ¶¶68-69). Adolescents who first receive treatment later in puberty also go through a puberty consistent with their gender identity, however, they will have undergone physical changes associated with their endogenous puberty that may not be wholly reversed by hormone therapy. (*See* Shumer Decl. ¶73). For adults, hormone therapy may also be medically necessary. (Shumer Decl. ¶¶72, 75; Janssen Decl. ¶51). For some transgender adults and rarely some older transgender adolescents, surgery may be indicated. (Janssen Decl. ¶¶51, 85).

Due to the robust evidence of its safety and efficacy for the treatment of gender dysphoria, gender-affirming care, including the use of puberty-delaying medications and hormone treatment in adolescents, and hormone treatment in adults, is the current standard of care – it is not experimental. (Shumer Decl. ¶91; Janssen Decl. ¶110).

Accordingly, every major medical association in the country agrees: gender-affirming care, consistent with evidence-based clinical practice guidelines such as those published by WPATH and the Endocrine Society, is safe, effective, and medically necessary treatment for gender

dysphoria that improves the health and wellbeing of transgender people. (Shumer Decl. ¶57; Janssen Decl. ¶56). In fact, the protocols set forth by the WPATH Standards of Care and the Endocrine Society Guidelines are endorsed and cited as authoritative by the major professional medical and mental health associations in the United States, such as American Medical Association, American Academy of Pediatrics, American Psychiatric Association, American Psychological Association, Pediatric Endocrine Society, and the Endocrine Society, among others. (Shumer Decl. ¶57; Janssen Decl. ¶56).

B. The Plaintiffs

i. R.S.

R.S. is a girl in eighth grade from Boone County, Missouri. She lives on a farm, likes video games, plays tennis, and is an excellent student who consistently earns straight As. (Affidavit of A.S. ("A.S. Aff.") ¶¶4, 6-7). R.S. is in Science Olympiad and is a member of her school's Student Council. (*Id.* ¶7). R.S. is also transgender. (*Id.* ¶7).

R.S. has struggled with anxiety since a young age, but began seeing a local psychologist at age 7 who specialized in treating young adolescents. (*Id.* ¶8). She was diagnosed with anxiety and Attention-Deficit Hyperactivity Disorder ("ADHD") and has been successfully managing her symptoms with medication ever since. (*Id.*).

At the age of 13, R.S. came out to her family as a transgender girl. (*Id.* ¶9). Her family searched for options for her medical care and support, found the Washington University Transgender Center (the "Center"), but were initially put on a waitlist. (*Id.* ¶10). Over the next several months, R.S. came out to her friends and school. She also adopted a new name, pronouns, and dress habits. (*Id.* ¶11). When R.S. first came out, a local teacher refused to continue teaching R.S. and her sister because R.S. was transgender. (*Id.* ¶13). When R.S. went to get her hair trimmed

in a more traditionally feminine style, the hair stylist told the family that she would not have any openings for R.S. (*Id.*).

R.S. had her first appointment at the Center in May of 2021, and, because of her anxiety and ADHD, she was referred to and received a full psychological evaluation. (*Id.* ¶14-15). In September of 2021, R.S. was formally diagnosed with gender dysphoria. (*Id.* ¶18).

R.S. began to experience worsened gender dysphoria as her friends entered adolescence and began visibly showing signs of pubertal development, and became interested in exploring gender-affirming care in the form of puberty-delaying treatment to slow puberty and allow her time to decide whether to pursue hormone therapy. (*Id.* ¶19). In January of 2022, R.S. was prescribed puberty-delaying medication in the form of a Supprelin implant. (*Id.* ¶21). To preserve her fertility, an issue R.S. cares deeply about, R.S., her parents, and her medical team – including a fertility specialist at the Center – developed a plan in which R.S.'s implant would be removed in March 2023. (*Id.* ¶¶23-24). Then, after the recommended three-month waiting period, the plan was for R.S. to take steps to preserve fertility and decide whether to pursue hormone replacement therapy. (*Id.*). Three weeks later, Defendant Bailey adopted the Emergency Rule. (*Id.* ¶25).

R.S.'s existing anxiety and ADHD, which may never be completely resolved, mean that she will not be permitted to access hormone therapy under the Emergency Rule. (*Id.* ¶¶26-27). This places R.S. and her family in an impossible position: in order to preserve the possibility that R.S. could access hormone therapy under the Rule's continuing care provision, R.S. and her family would have to abandon plans to preserve fertility, which requires waiting at least another two months to begin hormone therapy. (*Id.* ¶29).

ii. A.F.

A.F. is a 13-year-old girl who lives in Missouri. (Affidavit of N.F. ("N.F. Aff.") at ¶5). A.F.'s parents first noticed A.F.'s feminine gender expression when she was as young as 2 years old. (*Id.*). A.F. would regularly wear her sister's clothes and put bows in her hair, feeling envious of her cisgender sister receiving Disney princess dresses while she received Batman costumes. (*Id.* ¶6). There are countless photos of A.F. playing with toys traditionally for girls and wearing dresses, even at events like family reunions. (*Id.* ¶7). As A.F. grew older, she began to express more and more discomfort with dressing in a way that led others to perceive her as a boy. (*Id.* ¶9). On the eve of her 9th birthday, A.F. first expressed to her parents that she thought that "something got mixed up" when she was "in [her mother's] belly [she] was supposed to be a girl." (*Id.* ¶10).

In 2019, between her third and fourth grade years, A.F. and her family decided that A.F. would begin a social transition, and would openly live as the girl she is. (*Id.* ¶¶17-20). A.F. spent that summer "practicing" with her family what it would be like as a transgender girl and began the next school year fully transitioned. (*Id.* ¶¶19-20). A.F. began therapy for gender dysphoria in 2019, seeing a therapist every week. (*Id.* ¶22). As part of therapy, A.F. discussed feeling symptoms of anxiety and depression. (*Id.* ¶23). As A.F.'s transition progressed, however, her symptoms lessened and she had less of a need to see her therapist, scaling back to semi-annual check-ins and periodic as-needed appointments. (*Id.* ¶¶22, 24). Just prior to seeking therapy, in late 2018, A.F's family reached out to the Center, attending their first appointment at the Center in July 2019. (*Id.* ¶¶25-26).

In the Fall of 2021, A.F. began experiencing symptoms of endogenous puberty that were distressing and exacerbated her gender dysphoria (*Id.* ¶28). This coincided with her cisgender girl classmates beginning to go through puberty as well, further aggravating her gender dysphoria and

worsening her anxiety and depression. (*Id.* ¶¶31-32). Following this, A.F. underwent further tests to determine if she met the requirements to start puberty-delaying medications, which, after the tests results indicated she was, she began in October 2021. (*Id.* ¶¶29-30). In late 2022, as A.F. continued to witness her classmates undergoing puberty, her gender dysphoria worsened, as did her feelings of depression. (*Id.* ¶32).

The next step in A.F.'s treatment plan is to begin hormone replacement therapy in the summer of 2023. (*Id.* ¶¶34-35. 38, 40). A.F. is excited to begin hormone treatment so that her physical body can feel even more aligned with her gender identity. (*Id.* ¶35).

On April 13, 2023, however, A.F. and her family learned of the Emergency Rule. (*Id.* ¶36). A.F.'s parents have reviewed her records and believe she has undergone eleven visits with her licensed therapist or psychiatrist over the last 18 months. (*Id.* ¶40). Because she falls short of the Emergency Rule's requirement of fifteen visits in eighteen months, and because of her existing mental health comorbidities, A.F. would not be permitted to receive hormone therapy under the Emergency Rule. A.F.'s parents view the Emergency Rule as the greatest threat to her mental health. (*Id.* ¶43). When asked how that makes her feel, she stated she "would not want to be on this planet anymore." (*Id.* ¶42).

iii. Logan Casey, Ph.D.

Logan Casey, Ph.D., is a 36-year-old transgender man living in St. Louis, Missouri. (Affidavit of Logan S. Casey, Ph.D. ("Casey Aff.") at ¶¶3-4). Mr. Casey was born in Ferguson, grew up in the St. Louis area, and attended Truman State University for his undergraduate education. (*Id.* ¶5). While at Truman State, Mr. Casey was diagnosed with ADHD, which is now well managed with medication. (*Id.* ¶6). In 2007, during his senior year at Truman State, Mr. Casey began experiencing worsening distress, which he would later realize was gender dysphoria. (*Id.*

¶8). He began seeing a therapist for his gender dysphoria in 2009 and continued in some form of therapy until 2020. (*Id.* ¶9).

In 2010, Mr. Casey began gender-affirming hormone therapy under the supervision of his doctor and obtained gender-affirming "top" surgery later that same year while living in Michigan, where Mr. Casey was pursuing a graduate education. (*Id.* ¶¶7, 10). He also legally changed his name that year. (*Id.*). In 2012, Mr. Casey obtained a hysterectomy. (*Id.*). After a short stint in Ohio, Mr. Casey moved back to Missouri in 2021, and has lived here since. (*Id.* ¶13).

Mr. Casey is concerned that, under the Emergency Rule, although he is more than a decade into his transition, he will be required to prove that for the last three years he has medically documented gender dysphoria in order to access his testosterone treatments. (*Id.* ¶15). Mr. Casey is also concerned because he has been living with ADHD for nearly twenty years, and his symptoms, thought well-managed, can never be fully resolved. (*Id.* ¶16). He also does not understand the requirement to screen for "social contagion," and is worried that his work as a researcher frequently focusing on LGBTQ+ people and interconnections with other transgender people will be weaponized against him in order to deny him access to a medically necessary medication that he has taken for more than a decade. (*Id.* ¶20).

iv. Kelly Storck, LCSW

Kelly Storck, LCSW, is a licensed clinical social worker with an active practice in St. Louis, where she lives. (Affidavit of Kelly Storck, LCSW "Storck Aff". at ¶3). Ms. Stork obtained her Missouri license in 1999. (*Id.*). Ms. Storck has 25 years of clinical experience working with people of all ages, and 15 years specifically working with transgender and other LGBTQ+ young people. (*Id.* ¶4). She estimates that she sees between 75 and 100 clients a year, and about 20 of those are transgender or gender-diverse people under the age of 18. (*Id.* ¶5). In a given month, approximately

60 to 70 percent of her clients are transgender, non-binary, or queer, or those who love and support LGBTQ+ people. (*Id.*). Ms. Storck has extensive experience working with young transgender people, and occasionally assesses clients for gender-affirming care and, where appropriate, provides letters of support for clients seeking to access gender-affirming care consistent with the WPATH Standards of Care. (*Id.* ¶6-7).

The Emergency Rule would significantly and immediately interfere with Ms. Storck's day-to-day practice, which substantially involves providing counseling for transgender people of many ages, including assessments for those seeking gender-affirming care. (*Id.* ¶9). According to the Emergency Rule, her assessments must deviate from the WPATH guidelines that she strictly follows, and must involve needless and nonsensical screenings. (*Id.*). She must impose a mandatory three-year waiting period and a requirement of 15 therapy sessions in 18 months, which are inappropriate, unnecessary, and arbitrary. (*Id.* ¶11-12). In addition, they will "absolutely" create severe negative mental health consequences for many of her clients. (*Id.*).

The Emergency Rule also requires that she ensure that mental health comorbidities are "resolved" prior to providing letters of support for gender-affirming care, forcing Ms. Storck to withhold from her clients the very treatments available to lower anxiety and depression that arise out of gender dysphoria. (*Id.* ¶¶13-14). Further, the Emergency Rule will forbid Ms. Storck from providing letters of support for many of her clients, even when that will result in negative mental health consequences. (*Id.* ¶20). Without access to gender-affirming care, many of Ms. Stork's clients will endure serious mental health consequences including a "very real risk of death by suicide." (*Id.*).

v. Southampton Community Healthcare

Southampton Healthcare is a primary care medical provider that has been providing affirming medical care to the LGBTQ+ community since 1986. (Donovan Decl. ¶10; Tochtrop Decl. ¶9). Providers at Southampton Healthcare provide primary care with an LGBTQ-focus, treatment and prevention of HIV, treatment related to sexual and reproductive health, and gender-affirming hormone care and treatment. (Donovan Decl. ¶¶6, 10-12; Tochtrop Decl. ¶¶6, 10-11). Southampton Healthcare accepts private insurance, Medicaid, and also treats the uninsured. (Donovan Decl. ¶¶11-12; Tochtrop Decl. ¶11).

Southampton Healthcare provides care to between 6,000-7,000 patients, primarily adults, close to 1,000 of whom are receiving a form of hormone care. (Donovan Decl. ¶10; Tochtrop Decl. ¶10). Southampton Healthcare treats patients with hormone therapy who are transgender as well as cisgender. (Donovan Decl. ¶¶18, 23; Tochtrop Decl. ¶15). For example, menopausal cisgender women receive hormone therapy. (Donovan Decl. ¶23; Tochtrop Decl. ¶15). The safety profile of hormone treatment does not change based upon the population of the patient, meaning the likelihood of adverse effects is the same among cisgender and transgender patients. (Donovan Decl. ¶23; Tochtrop Decl. ¶15) Southampton Healthcare providers rely on the widely accepted and evidence-based clinical practice guidelines published by the Endocrine Society, WPATH, and UCSF Center of Excellence for Transgender Care at the University of California - San Francisco in their treatment of transgender patients. (Donovan Decl. ¶¶20-21; Tochtrop Decl. ¶14). Physicians at Southampton Healthcare know firsthand, through their academic and clinical experience, that gender-affirming medical care is safe and effective, and when medically indicated, how it leads to substantial improvements in the health, wellbeing, and quality of life of their patients. (Tochtrop Decl. ¶16).

If the Emergency Rule is allowed to take effect, its restrictions, regulations, and prohibitions on care will stigmatize, unduly restrict, and in many respects, completely prohibit gender-affirming treatment for Southampton Healthcare's transgender patients. (Donovan Decl. ¶¶24-28; Tochtrop Decl. ¶¶17-18). If patients do not feel they can be honest about their symptoms and medical needs, Southampton Healthcare is concerned it will miss serious health issues that could increase morbidities and cause negative health outcomes, including suicidality. (Donovan Decl. ¶¶24-35).

A full report of a patient's symptoms and medical needs is especially critical to providers at the beginning of a person's social transition, when their symptoms of depression and anxiety may be higher due to fears of being mis-gendered when they begin presenting in society as their true gender (*Id*). Patients will likely also suffer generally, Southampton fears, due to the Emergency Rule heightening the stigmatization of mental health issues and disintegrating the trust between patients and providers necessary for proper, effective care. (Donovan Decl. ¶34).

Further, the Emergency Rule contrives significant barriers to obtaining gender-affirming care that are unsupported by medical science. (Tochtrop Decl. ¶¶17-18). For instance, the mental health therapy requirement constructs an unnecessary and insurmountably-high barrier for many because of a dearth of LGBTQ-affirming therapists in their region, and because of the expense. (Donovan Decl. ¶37; Tochtrop Decl. ¶¶19-20). The requirement may also further stigmatize transgender patients by forcing them to undergo unnecessary medical treatment which can, in turn, cause increased harm. (Tochtrop Decl. ¶22).

The mental health comorbidities restriction will also prohibit Southampton Healthcare physicians from effectively treating patients who experience issues of gender dysphoria and other mental health disorders. (Donovan Decl. ¶¶31-32; Tochtrop Decl. ¶21). Many mental health

disorders are chronic and cannot be resolved. (Tochtrop Decl. ¶27). If the Emergency Rule goes into effect, Southampton Healthcare will be forced to refuse or discontinue care for some patients. (Tochtrop Decl. ¶¶28-29).

The medical professionals at Southampton Healthcare know from personal experience treating hundreds of Missourians with gender dysphoria that delaying treatment for a patient's gender dysphoria risks not only exacerbating the patient's gender dysphoria but also increasing the risk of depression, anxiety and suicidality. (Tochtrop Decl. ¶23). Further, hormone treatment will often resolve symptoms of anxiety and depression and lead to a patient not needing separate treatment for those diagnoses. (Donovan Decl. ¶39; Tochtrop Decl. ¶24). These symptoms could return if hormone treatment is stopped, causing mental and physical harm. (Tochtrop Decl. ¶30). Moreover, when forced to abruptly stop gender-affirming health care, symptoms including fatigue and cardiac events may result. (*Id.*).

The medical professionals at Southampton Healthcare also know from personal experience that the Emergency Rule, if permitted to take effect, will significantly and severely compromise the health of their patients. (Donovan Decl. ¶24; Tochtrop Decl. ¶¶18, 38-39). Southampton Healthcare has already received calls from numerous families, panicking because their adolescents are severely distressed by the Emergency Rule threatening their loss of the health care they rely on for their well-being. (Donovan Decl. ¶¶24-25; Tochtrop Decl. ¶¶17-18).

The Emergency Rule will force Southampton Healthcare to deny patients medically necessary, potentially lifesaving care, violating the tenets of the medical profession by directly conflicting with the oath of those professionals: do no harm. (Donovan Decl. ¶¶50-52, 54, 57; Tochtrop Decl. ¶¶36-37). The Emergency Rule places the medical professionals at Southampton Healthcare in the untenable position of having to decide between fulfilling their oaths by providing

patients with the evidence-based medical care that they need, or risking criminal liability. (Donovan Decl. ¶¶61-63; Tochtrop Decl. ¶¶36-37). Southampton Healthcare has grave concerns about its patients' ability to survive, much less thrive, if the Emergency Rule takes effect. (Donovan Decl. ¶36).

Patients must be confident and comfortable speaking honestly with their medical providers without the interference of a state official, such as the Attorney General. (*See* Donovan Decl. ¶¶24-35). Despite this necessity, the Emergency Rule attempts to regulate health care through its broad requirements and directives to both patients and providers, designating who is permitted to receive care, when they may receive care, and what care they are permitted to receive. (*See id.*).

C. There is no Emergency Justifying Emergency Rule 15 CSR 60-17.010

The Missouri legislature's consideration of proposed laws affecting gender-affirming health care is nothing new.[7] Missouri lawmakers have been discussing such laws since at least 2020. In late 2022, both the Missouri Senate and House of Representatives pre-filed currently pending legislation concerning gender affirming health care. Any alleged concerns related to the appropriate standard of care for gender dysphoria in Missouri have been well known, or at least reasonably available, to the Office of the Attorney General for decades; there is no new "emergency."

Not only that, the MMPA, under which Defendant Bailey seeks to promulgate this new law, was enacted in 1967. In the intervening 56 years, no previous Attorneys General have sought

[7] *See, e.g.*, in April 2022, the Missouri House of Representatives debated House Bill 2649, which was sponsored by Representative Suzie Pollock and officially titled the "Save Adolescents from Experimentation (SAFE)" act. The bill would have prevent health care providers from providing or referring transgender health care to anyone under 18, and waives insurance providers the responsibility of covering transgender health care. See also HB 2210 (2020), provisions in SB 848 (2020), SB 842 (2020), HB 1721 (2020), and HB 2051 (2020).

to coopt this consumer protection law to restrict gender-affirming health care in Missouri. Again, there is simply no "emergency" justifying this unprecedented departure from legislative norms.

On March 20, 2023, Defendant Bailey announced he would issue an emergency rule to temporarily enact strict limits on transgender medical treatment for adolescents.[8] Defendant's office specifically noted many of the restrictions that would eventually be included in the Emergency Rule, including the minimum therapy requirement, the requirement that all mental health comorbidities be treated prior to care, and certain additional consent disclosures.[9] At the time, Defendant stated he was "dedicated to using every legal tool at [his] disposal to stand in the gap and protect children . . . ."[10] Defendant Bailey finally promulgated the Rule on April 13, 2023, more than three weeks after his announcement.[11]

This can only be seen as a contrived "emergency," in view of the decades of successful and established gender-affirming treatment in Missouri and elsewhere, Defendant's dilatory conduct, the Rule's heavy reliance on a single affidavit to justify creating a radically new healthcare law by co-opting a merchandising practices statute, and the Rule's *sua sponte* deprivation of Missourians' access to essential health care.

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[8] *See* Summer Ballentine, *Missouri to restrict gender-affirming care for minors*, AP NEWS (Mar. 20, 2023), https://apnews.com/article/minors-gender-affirming-care-attorney-general-missouri-7332d7baee1580d1aec122cc4210792c.

[9] *Id.*

[10] *Id.*

[11] The Emergency Rule defines "Covered Gender Transition Intervention" or "Intervention" to mean "the provision or prescription of any puberty-blocking drugs, cross-sex hormones, or surgery, for the purpose of transitioning gender, decreasing gender incongruence, or treating gender dysphoria." The Rule then declares that it is an unfair, deceptive, fraudulent, or otherwise unlawful practice for "any person or health organization to provide a covered gender transition intervention to a patient (or refer a patient for such an intervention)" if the person or health organization does not abide by several vague, overbroad, and unreasonably burdensome restrictions – restrictions which have the obviously intended effect of systemically denying care to innumerable transgender Missourians. A violation of the Rule is a Class E felony punishable by up to four years imprisonment and fines of up to $10,000 ($20,000 for corporate violators). RSMo. §§ 407.020; 557.021; 558.002.

In creating the Emergency Rule, Defendant Bailey circumvented the traditional agency rule-making process. Traditional procedure provides for public notice and the opportunity to comment on the Rule. Rather than allow for public notice and comment, Defendant fast-tracked the Rule, behind closed doors, consequently depriving the public of this opportunity.

The Emergency Rule also includes significant expansions in the scope of Missourians that it impacts and the breadth of conduct it proscribes. Most significantly, these expansions restrict access to gender-affirming health care of not just minors, which was the focus of Defendant's original stated concern, but of all Missourians. By imposing severe restrictions on gender-affirming care for *adults*, the Rule represents an outrageous and shocking deviation from the overwhelming consensus of the medical community, a deviation that Defendant attempts to institute with the stroke of a pen. Unless enjoined under Missouri Supreme Court Rule 92.02, these restrictions and deviations will go into effect. If effective, medical professionals and their patients will be forced to grapple not only with the Rule's requirements that defy successful and established medical treatment, but also with the impracticability of compliance for those the Rule affects.

It is not surprising that an expansive health care law of such import created without input from all stakeholders will be nearly impossible to implement. As set forth in more detail below, the Emergency Rule does not provide patients, health care professionals, pharmacists, regulators, or insurance providers any reasonable guidance on how life-saving medical care can be provided, starting at 12:01 am on Thursday, April 27, 2023. Even if it were validly implemented procedurally, the Emergency Rule is arbitrary and capricious and cannot withstand even cursory scrutiny.

Finally, it is indisputable the Emergency Rule will cause immediate, irreparable harm to thousands of innocent adolescents and adults in need of widely-accepted, safe health care. The Emergency Rule, with just 13-days' notice, would impose an immediate, expansive government

intrusion into one of society's most essential, protected interests—the private health care decisions between citizens and their medical providers. The innocent Missourians singled out by the Emergency Rule will be denied access to something so basic it is easy to take for granted—the freedom to seek safe, competent medical advice to ensure their physical and emotion wellbeing. Such a gross deprivation of this right cannot be compromised by the procedurally infirm Emergency Rule. Based on Missouri law, good governance, common sense, and fundamental fairness, Defendant should be enjoined from making effective and enforcing the Emergency Rule.

ARGUMENT

I. Legal Standard

Missouri Supreme Court Rule 92.02 and RSMo § 526.030 allow for the issuance of injunctive relief where "immediate and irreparable injury, loss, or damage will result in the absence of relief." Mo. R. Civ. P. 92.02(a); RSMo § 526.030 ("The remedy by writ of injunction or prohibition shall exist in all cases . . . to prevent the doing of any legal wrong whatever, whenever in the opinion of the court an adequate remedy cannot be afforded by an action for damages."). A Court need not, and in fact should not, wait until some identifiable injury occurs before granting immediate temporary relief. *See e.g.*, *Osage Glass, Inc. v. Donovan*, 693 S.W.2d 71, 75 (Mo. banc 1985).

"The primary objective of a temporary restraining order is to maintain the status quo until the need for a permanent injunction can be adjudicated." *Hemme v. Evans,* 866 S.W.2d 922, 923 (Mo. App. 1993); *see also, St. Louis Cnty. v. Village of Peerless Park,* 726 S.W.2d 405, 410 (Mo. App. 1987). Maintaining the status quo "is taken to mean not merely freezing the situation as the court now finds it but to mean figuratively the restoration of the parties to the last actual, peaceable,

non-contested condition which preceded the pending controversy." *State ex rel. Schoenbacher v. Kelly*, 408 S.W.2d 383, 389 n.2 (Mo. App. 1966) (internal citations and quotation marks omitted).

A court is to consider four factors in deciding whether to issue a temporary restraining order and subsequent injunction: (1) the likelihood of success on the merits; (2) whether the injunction will prevent irreparable injury; (3) whether the injunction will harm others; and (4) whether the public interest will be served. *See State ex rel. Director of Revenue, State of Mo. v. Gabbert*, 925 S.W.2d 838, 839 (Mo. 1996) (relying on *Dataphase Sys., Inc. v. C.L. Sys. Inc.*, 640 F.2d 109, 114 (8th Cir. 1981) (en banc)); *see generally* Mo. R. Civ. P. 92.02. No single factor is dispositive; rather, each factor must be considered to determine whether the balance of equities weighs toward granting the injunction. *Furniture Mfg. Corp. v. Joseph*, 900 S.W.2d 642, 648 (Mo. App. 1995). Further, the balance-of-harms and public-interest factors "merge when the Government is the opposing party." *Nken v. Holder*, 556 U.S. 418, 435 (2009).

II. Plaintiffs are Entitled to a Temporary Restraining Order Preventing Enforcement of the Emergency Rule.

A. Plaintiffs are Likely to Succeed on the Merits.

i. The Emergency Rule was improperly adopted as an emergency rule in contravention of RSMo Section 536.025.1.

a. *The Emergency Rule fails to identify an immediate danger to the public health, safety, or welfare requiring emergency action.*

There is no state of emergency or exigent circumstances that justifies immediate implementation of the Emergency Rule. Treatment of gender dysphoria with gender-affirming care has been around for more than 80 years.[12]

[12] *See* Genny Beemyn, *Transgender History in the United States*, *in* TRANS BODIES, TRANS SELVES (Laura Erickson-Schroth ed., 2014), available at https://www.umass.edu/stonewall/sites/default/files/Infoforandabout/transpeople/genny_beemyn_transgender_history_in_the_united_states.pdf; *History and Epidemiology*, American Psychiatric

WPATH published its original Standards of Care in 1979, articulating the professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria and help professionals understand the parameters within which they may offer assistance to those with these conditions.[13] The Standards of Care have been updated eight times, most recently in 2022.[14] In 2009, the Endocrine Society issued peer-reviewed clinical practice guidelines that cover diagnosis, treatment, and preventive care needs for transgender patients[15] The Endocrine Society's Guidelines were revised in 2017.[16] The WPATH Standards of Care, Version 8 and the Endocrine Society's Clinical Practice Guidelines are both based on the best available evidence; are peer-reviewed publications in scientific, medical journals; and their recommendations were graded using a modified GRADE (Grading of Recommendations, Assessment, Development, and Evaluations) methodology considering the available evidence supporting interventions, risks and harms, and feasibility and acceptability.

In other words, far from a new emergency requiring immediate rulemaking, gender-affirming medical care is an established and well-documented practice that dates back decades and is backed by an exceedingly large body of evidence and clinical experience. Defendant appears to

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Association (Nov. 2017), https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/history-and-epidemiology; Farah Naz Khan, *A History of Transgender Health Care*, Scientific American (Nov. 16, 2016), https://blogs.scientificamerican.com/guest-blog/a-history-of-transgender-health-care/.

[13] E. COLEMAN, ET AL., STANDARDS OF CARE FOR THE HEALTH OF TRANSGENDER AND GENDER DIVERSE PEOPLE, VERSION 8, (8th ed., 2022), available at https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644

[14] *Id.*

[15] *See, e.g.*, Farah Naz Khan, *supra* note 12.

[16] Hembree WC, Cohen-Kettenis PT, Gooren L, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, J CLIN. ENDOCRINOL. METAB. (Nov. 1, 2017).

acknowledge as much, citing to numerous studies and articles published more than ten years ago.[17] Notwithstanding the many years gender-affirming care has existed, political and legislative attacks on this care suddenly exploded amidst a tsunami of attacks against the LGBTQ community. In total, 249 bills targeting transgender health care have been introduced in the past five years, seeking to accomplish similar goals as the Emergency Rule. The Rule fails to explain how medical care that has existed for decades now suddenly constitute an emergency demanding immediate non-legislative action.

Moreover, the justification that Defendant offered in his initial announcement of the Emergency Rule—to "protect children"[18]—is not descriptive of the text and effect of what he ultimately promulgated. Instead, the Rule impacts gender-affirming care for *all* transgender people, including *adults*. Recently, when promoting his Rule to the press, Defendant Bailey acknowledged that the Emergency Rule exceeds the scope of its purported justification. While the motivations for the Rule may have "started with protecting children," Defendant said, he admits its true purpose and effect is to apply to "all patients."[19]

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[17] For instance, Defendant Bailey cites to articles published as early as 2006, *see*, Emergency Rule at 9 n. 32 (citing to Delemarre-van de Waal et al., "Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects," Euro. J. of Endo., 155, S131-S137, 2006) and routinely cites to studies published in the early 2010's, *see, e.g.*, Emergency Rule at 7 n. 11 (citing to Dhejne et al., "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," PLoS ONE, 6(2): e16885, 2011, and Asscheman, "A Long-Term Follow-Up Study of Mortality in Transsexuals Receiving Treatment with Cross-Sex Hormones," Euro. J. of Endocrinol., 2011); p. 10 n. 35 (citing to Pantic, "Online Social Networking and Mental Health," Cyberpsychology, Behavior, and Social Networking, Vol. 17, 10 (2014)).

[18] *See* OFFICE OF MISSOURI ATTORNEY GENERAL, MISSOURI ATTORNEY GENERAL ANDREW BAILEY ANNOUNCES EMERGENCY REGULATION ON GENDER TRANSITION INTERVENTIONS FOR MINORS (Mar. 20, 2023), available at https://ago.mo.gov/home/news/2023/03/20/missouri-attorney-general-andrew-bailey-announces-emergency-regulation-on-gender-transition-interventions-for-minors

[19] Jason Rosenbaum, *Att'y General Andrew Bailey's Restrictions on Gender-Affirming Care Will Affect Adults,* St. Louis Public Radio (Apr. 20, 2023), available at https://bityl.co/IKDP.

Gender-affirming care for transgender adults is an even longer-standing practice than that of minors, and so characterizing it as an emergency is even less reasonable. Defendant has not identified any protracted issue, much less an emergent one, in the provision of gender-affirming care to transgender people of *all ages*. (*See* Shumer Decl. H. (demonstrating fatal flaws in the Rule's cited medical evidence)).

Instead, Defendant promulgated the Rule nearly three months after beginning a politically motivated and carefully choreographed investigation, and more than three weeks after announcing his plan to promulgate the Rule. Given its effective date, should the Rule go into effect, it will be effective 5 weeks after its press release. This prolonged build-up belies any such emergency demanding immediate action. If immediate action was required, one would expect Defendant's office to have acted more expeditiously to, at the very least, promulgate the Rule at the time he announced his intention to do so. Defendant, however, waited almost a month. This timing gives the Emergency Rule the maximum effective period permitted by statute—30 legislative days[20] or 180 calendar days. R.S.Mo. § 536.024.7. By waiting until April 13 to promulgate the rule and setting the effective date for April 27, 2023, two weeks later, fewer than 30 legislative days will remain before the end of the 2023 legislative session. Consequently, if the Rule goes into effect it would remain effective until the remainder of the 30 days elapsed in the 2024 legislative session—*i.e.*, on February 6, 2024. This extends the effectiveness of the bill to 285 days, far exceeding any reasonable timeframe contemplated by the spirit of the statute.

Again, as one would expect in reaction to a legitimate emergency requiring immediate action, Defendant could have acted weeks ago to adopt and make the Rule effective before the end

[20] "Legislative days" are statutorily defined as "each Monday, Tuesday, Wednesday and Thursday beginning the first Wednesday after the first Monday in January and ending the first Friday after the second Monday in May, regardless of whether the legislature meets." § 536.025.7 R.S.Mo.

of March. Instead, weeks passed before the Defendant promulgated the Rule, during which Defendant could have engaged in the traditional notice and comment rule-making pursuant to R.S.Mo. § 536.021. Rather, from behind closed doors, Defendant Bailey now attempts to usurp legislative authority to both enact and enforce one of the most restrictive health care regulations in the nation, for the maximum period of time possible.

b. *Defendant failed to follow procedures best calculated to ensure fairness to all interested person and parties, instead usurping legislative authority and excluding the public, interested persons and parties from giving input.*

Defendant Bailey issued the Emergency Rule purportedly pursuant to the emergency rule-making procedure set out in RSMo § 536.025, and in so doing excluded the public from the process. The power of agencies to issue rules and regulations, traditionally the sole purview of the legislative branch, is limited in deference to the notions of separation of powers and the public's role in electing their legislative representatives. To preserve the public's role in the agency rule-making process, the statutory authorization to make rules is traditionally accompanied by a requirement that the public have notice of the proposed rule and an opportunity to submit comments in support of or opposition to the rule for consideration prior to promulgation. This important protection for the public's role is codified in Section 536.021, which requires giving a notice of the proposed rulemaking, including the text of the rule and "[n]otice that anyone may file a statement in support of or in opposition to the proposed rulemaking at a specified place and within a specified time . . . ." RSMo § 536.021.2. Section 536.021's notice and comment protections apply to every rule-making process, except in narrow circumstances where there is an emergency demanding immediate action. RSMo §§ 536.021.7; 536.025.1(1). Defendant's Rule attempts to improperly exploit this exception.

By excluding the public entirely, Defendant did not consider important opinions from key stakeholders in this issue. Defendant did not hear from medical professionals about how gender-affirming care is an evidence-based and widely-accepted treatment for gender dysphoria, how untreated gender dysphoria results in severe mental and physical distress, or how immediate cessation of hormone treatment leaves transgender individuals at higher risks for a multitude of harms. Nor did Defendant Bailey hear from providers on how the Emergency Rule would conflict with healthcare providers' medical, ethical, and legal obligations, and impose significant costs on their practices. Instead, the Defendant's actions denied public comment from medical experts and promulgated a Rule disregarding the overwhelming consensus of the medical community, which supports gender-affirming care. (Shumer Decl. ¶¶95-130; Janssen Declaration ¶¶28, 89).

Likewise, Defendant did not to hear from parents of transgender adolescents about their first-hand experience of the incredible difference that gender-affirming care has made, or their terror that, without it, their loved one may not survive.

And, most concerning, not only does Defendant attempt to effect the Emergency Rule without public comment from medical experts or the parents of transgender adolescents, Defendant did not hear from a single transgender individual.

Indeed, Defendant did not hear from any Missourian who will be personally, dramatically and irreparably harmed by the Emergency Rule. Defendant did not hear from them about the importance of gender-affirming care, about their experience with gender dysphoria, or about their distress and panic with the vague wording and expansive scope of the rule.

Because the text of the Rule would drastically expand the restrictions on access to gender-affirming care beyond what Defendant initially announced on March 20, the "announcement" itself served to mislead the transgender people of Missouri. In the interim, between this misleading

announcement and Defendant's promulgation of the Emergency Rule, transgender people, parents, medical providers, allies, indeed, *everyone* was in the dark about what was prohibited and permitted in the Rule and, worse, were unable to provide Defendant Bailey's office with formal comments for consideration prior to adoption of the Emergency Rule.

Defendant's lack of notice threatens to have devastating effects on the lives of transgender people. For example, R.S. and her family had only just stopped puberty-delaying treatment at the end of March, and had a plan, in consultation with their doctors, to wait at least three months to preserve fertility and then pursue hormone therapy in the Fall. (*See* A.S. Aff. ¶¶23-24). The promulgation of the Emergency Rule wreaks havoc on that plan; now, to avail themselves of the clause allowing for continuation of a specific intervention once started, R.S. and her family must choose between fertility preservation and access to hormone therapy. (*See id.* ¶¶25-29).

In sum, Defendant's procedure for enacting the Emergency Rule excluded those most directly impacted by the Rule from commenting on what would be a grossly improper intrusion by the government into their private medical decisions, and knowingly extends the effectiveness of the Rule to the fullest extent permitted by statute. In marked contrast to the statutory requirement that Defendant Bailey follow procedures "best calculated to assure fairness," Defendant's process was best calculated to and did in fact ensure discrimination and prejudice.

c. *The Emergency Rule violates both the United States and Missouri Constitutions.*

The Emergency Rule is unconstitutionally vague, and for that reason, void and in violation of both the United States and Missouri Constitutions. "It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined." *Cocktail Fortune, Inc. v. Supervisor of Liquor Control*, 994 S.W.2d 955, 957 (Mo. banc 1999) (citing *State v. Mahan*, 971 S.W.2d 307, 312 (Mo. banc 1998)). The void for vagueness doctrine "serves two essential

functions." *State ex rel. Cook v. Saynes*, 713 S.W.2d 258 (Mo. 1986). First, it "ensures that laws give fair notice of proscribed conduct," and, second, it "protects against arbitrary and discriminatory enforcement." *Cocktail Fortune*, 994 S.W.2d at 957.

The test for enforcing the void for vagueness doctrine is "whether the language conveys to a person of ordinary intelligence a sufficiently definite warning as to the proscribed conduct when measured by common understanding and practices." *Id.* (citing *State v. Schleiermacher*, 924 S.W.2d 269, 276 (Mo. banc 1996)). The Emergency Rule fails to provide any guidance for proper enforcement and leaves the public unable to determine proscribed conduct from permitted conduct.

For instance, the Emergency Rule contains a narrow exception for continuing care; however, the provision is internally incongruous and unclear, and, therefore, incapable of being applied consistently. The Emergency Rule prohibits provision of or referrals regarding a covered gender transition intervention, which is defined as "the provision or prescription of any puberty-blocking drugs, cross-sex hormones, or surgery." Excepted from that definition is "continuing prescription or provision of a specific intervention that has already begun, *so long as the person or health organization promptly seeks to initiate the treatments and assessments called for by these subparagraphs* [providing for specific prohibitions]." For those who do not meet the various subparagraphs of the rule, it is not clear how long care can continue under the exception: as long as they are continuously receiving care, or only until the provider implements a subparagraph-requirement they do not meet. Nor does this imprudently-drafted exception give clarity on whether care must remain static, or if, as an example, transgender minors with mild unresolved anxiety on puberty-delaying treatment will be allowed to transition to hormone therapy as they enter adolescence, consistent with recommended medical practices. Educated legal scholars, let alone

persons of ordinary intelligence or the minors being regulated by the Rule, would be hard-pressed to make sense of this.

Similarly, the Emergency Rule requires that any psychiatric symptoms from existing mental health comorbidities of a patient be treated and resolved prior to provision of gender affirming care. However, while the Attorney General has positioned his office to both define medical clinical practice guidelines and enforce their compliance, the Rule provides no guidance as to what is meant by "existing mental health comorbidities" or what is required to treat and resolve them. Would this require a person with existing depression caused by gender dysphoria to somehow cure their depression before receiving the gender-affirming care necessary to treat and resolve their depression? That is nonsensical—further demonstrating the lack of study, understanding, and thought that went into crafting the Rule. Indeed, this lack of clarity has already created confusion amongst medical professionals as they attempt to determine whether they are in compliance with the Rule. (*See* Shumer Decl. ¶101; Donovan Decl. ¶42; Tochtrop Decl. ¶24). Violation of the Rule is a Class E felony, yet providers are left without fair notice as to what conduct is permissible. This lack of clarity opens the door to uneven application of the Rule across different medical professionals at the whim of the Attorney General.

d. *The Emergency Rule is overly broad and not limited to the circumstances purportedly creating the alleged emergency.*

The Emergency Rule extends far beyond the narrow set of circumstances Defendant cites in support of the Rule. First and foremost, the concerns Defendant lists in the Emergency Rule focus largely, if not entirely, on transgender minors. Defendant admits that "at the end of the day

[the Emergency Rule] started with protecting children," but that its purpose and effect is to apply to "all patients."[21]

Further, in his explanation of the allegedly emergency circumstances and beyond citation to the WPATH Standards of Care, which are applicable to both transgender adolescents and adults, Defendant cites primarily to opinion pieces and unpublished, non-peer-reviewed reports pertaining to the topic of gender-affirming health care for transgender adolescents, instead of the large body of scientific, peer-reviewed literature supporting provision of this care.[22] In addition, the only other purported reasons for emergency action, Ms. Reed's statement and the Missouri Attorney General's post-hoc investigation based thereupon, similarly pertain only to transgender adolescents and in any event have been thoroughly debunked.[23] Not only did an investigation fail to substantiate the allegations in Ms. Reed's statement, but it showed that "physicians and staff at the Center follow appropriate policies and procedures and treat patients according to the currently

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[21] Jason Rosenbaum, *Att'y General Andrew Bailey's Restrictions on Gender-Affirming Care Will Affect Adults,* St. Louis Public Radio, (Apr. 20, 2023) https://bityl.co/IKDP.

[22] *See* Socialstyrelsen NBHW, "Care of Children and Adolescents With Gender Dysphoria," 2022, p. 3, https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf; Gean, "Topic Brief: Treatments for Gender Dysphoria in Transgender Youth," AHRQ, Nom. No. 0928, Jan. 8, 2021, p. 2, https://effectivehealthcare.ahrq.gov/get-involved/nominated-topics/treatments-gender-dysphoriatransgender-youth; "Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance In Minors," PALVELUVALIKOIMA, p. 8; See generally, Abbruzzese et al., "The Myth of 'Reliable Research' in Pediatric Gender Medicine: A Critical Evaluation of the Dutch Studies—And Research That Has Followed," J. of Sex & Marital Therapy, Jan. 2, 2023.

[23] Colleen Schrappen, *Parents push back on allegations against St. Louis transgender center. 'I'm baffled.'*, ST. LOUIS POST DISPATCH (Mar. 5, 2023), available at https://www.stltoday.com/news/local/metro/parents-push-back-on-allegations-against-st-louis-transgender-center-i-m-baffled/article_a94bc4d2-e68b-535f-b0c7-9fefb9e8e9f4.html; Annelise Henshaw, *Families dispute whistleblower's allegations against St. Louis transgender center*, MISSOURI INDEPENDENT (Mar. 1, 2023), available at https://missouriindependent.com/2023/03/01/transgender-st-louis-whistleblower/.

accepted standard of care, as recommended by the American Academy of Pediatrics and other nationally recognized organizations."[24]

Nevertheless, without any further justification, the Emergency Rule extends its prohibitions to both transgender adolescents and adults. Defendant did not proffer a single reason to extend the scope of the Emergency Rule to adults. The stunningly broad scope of the Emergency Rule lacks any nexus to the circumstances giving rise to the alleged emergency: concern with the provision of gender-affirming care to transgender adolescents, and whether providers were obtaining proper consent for such care. The Emergency Rule is an improper, extra-legislative overreach by an un-elected political appointee, who purports to distort and weaponize the MMPA, an act purposed on making sure that cars are sold with titles and that hardware stores abide by a warranty on a vacuum, in order to dictate what medical care is available to adults Missourians. There is no justification for this contrived emergency: the Rule extends far beyond its purported original purpose, and its implementation and enforcement must be stopped, at the very least for failing to conform with the statutory procedures for emergency rule-making.

ii. <u>The Emergency Rule is invalid as lacking statutory authority, conflicting with state law, and being arbitrary and capricious in contravention of RSMo Section 536.014</u>

a. *Defendant acted without and in contravention of statutory authority for the Emergency Rule.*

For the reasons stated *supra* Section II.A.i., Defendant Bailey acted without and in contravention of statutory authority under RSMo Sections 536.021 and 536.025 by not abiding by the procedures set out in RSMo Section 536.025.1.

[24] *Washington University Transgender Center Internal Review Summary of Conclusions*, WASHINGTON UNIVERSITY OF ST. LOUIS (Apr. 21, 2023), available at https://source.wustl.edu/wp-content/uploads/2023/04/Washington-University-Summary-of-Conclusions.pdf.

b. *The Emergency Rule conflicts with Missouri laws, including those on medical malpractice claims.*

The MMPA does not provide the Attorney General with authority to investigate or pass rules concerning patient medical care. The MMPA was "clearly designed…to aid in the discovery and prevention of fraudulent and deceptive practices in the advertisement and sale of any merchandise." *State ex rel. Ashcroft v. Goldberg*, 608 S.W.2d 385, 386 (Mo. banc 1980) (emphasis supplied). The words of a statute are to be construed in their plain and ordinary meaning in determining the intent of the legislature. *Howard v. City of Kansas City*, 332 S.W.3d 772, 787 (Mo. banc 2011).

The MMPA defines "unlawful" practice thusly:

> The act, use or employment by any person of any deception, fraud, false pretense, false promise, misrepresentation, unfair practice or the concealment, suppression, or omission of any material fact in connection with the sale or advertisement of any merchandise in trade or commerce.

RSMo § 407.020.1 (emphasis supplied). *See, e.g., Ward v. West County Motor Co., Inc.* 403 S.W.3d 82-83 (Mo. banc 2013) (MMPA action relating to auto sales); *Chochorowski v. Home Depot, U.S.A.*, 404 S.W.3d 220, 223 (Mo. banc 2013) (garden tillers); *Huch v. Charter Communications, Inc.*, 290 S.W.3d 721, 722 (Mo. banc 2009) (cable television). The Emergency Rule, however, does not allege what "merchandise" is being sold or offered in violation of the MMPA. *See* § 407.020.1.

Further, regulating essential community providers ("ECPs") is expressly prohibited from the Attorney General's enforcement powers. *See* § 407.020 ("Nothing contained in this section shall apply to … [a]ny institution, company, or entity that is subject to chartering, licensing, or regulation by the director of the department of commerce and insurance under chapter 354 ….). Nevertheless, the Emergency Rule makes no exception for ECPs.

RSMo § 407.025.3 (added by the Legislature in 2020) provides that "[N]o action may be brought under this section . . . in which a claim can be made under chapter 538." Chapter 538, in turn, provides the remedy for medical malpractice, creating a "statutory cause of action for damages against a healthcare provider for personal injury or death arising out of rendering or failure to render health care services." RSMo § 538.210.1. The MMPA is sensibly distinguished from Chapter 538, inasmuch as the former is designed to promote "fundamental honesty, fair play, and right dealings in public transactions." *Conway v. CitiMortgage, Inc.*, 438 S.W.3d 410, 414 (Mo. banc 2014) (citation omitted) (emphasis supplied). There is nothing "public" about the personal, private relationship between physician and patient.

Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive personal information to enable their physician to effectively provide needed services. Physicians, in turn, have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient. *See* American Medical Association Code of Ethics, Opinion 3.2.1, "Confidentiality."

There is no indication that the legislature intended for the MMPA to be used to regulate the practice of medicine. To the contrary, the Missouri Board of Registration for the Healing Arts was created to do so in this State. RSMo § 334.020. That Board is empowered to commence administrative action against medical providers, including those engaging in "misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the function or duties of any profession licensed or regulated by this chapter . . . ." RSMo § 334.100.2(4). Such acts include, among others, "[w]illfully and continually performing inappropriate or unnecessary treatment . . . or medical or surgical services" and "[a]ny other conduct that is unethical or unprofessional involving a minor." This can result in censure,

suspension or restriction of license, denial of application for a license, of permanent withholding of issuance of a license among others." RSMo § 334.100.4(f) & (s).

c. *The Emergency Rule is arbitrary, capricious, and creates such a substantial inequity as to be unreasonably burdensome on persons affected.*

Promulgation of a regulation must conform with the rule-making procedures of RSMo § 536.021. *NME Hosps., v. Dep't of Soc. Servs., Div. of Med. Servs.*, 850 S.W.2d 71, 74 (Mo. banc 1993). The exception for an emergency rule requires an agency finding that "an immediate danger to the public health, safety, or welfare requires emergency action or the rule is necessary to preserve a compelling governmental interest that requires an early effect date." RSMo § 536.025.1. The agency must follow "procedures best calculated to ensure fairness to all interested persons and parties under the circumstances." *Id*. "The test of whether an emergency exists is whether the factual situation is such that there is actually a crisis or emergency which requires immediate action for the preservation of the public peace, property, health, safety or morals." *State ex rel. Tyler v. Davis*, 443 S.W.2d 625, 631 (Mo. banc 1969). The specific facts, reasons, and findings that support the agency's compliance with the requirements of subsection 1 must be included in a written statement filed with the Secretary of State. RSMo § 536.025.2.

In the context of rules and regulations, "arbitrary and capricious" has been defined as "willful and unreasoning action, without consideration of and in disregard of the facts and circumstances." *Beverly Enters.-Mo. Inc. v. Dep't of Soc. Servs., Div. of Med. Servs.*, 349 S.W.3d 337, 345 (Mo. App. W.D. 2008). "Moreover, an agency which completely fails to consider an important aspect or factor of the issue before it may also be found to have acted arbitrarily and capriciously." *Barry Serv. Agency Co. v. Manning*, 891 S.W.2d 882, 892 (Mo. App. W.D. 1995) (citation omitted).

Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which [the legislature] has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. *Prime Healthcare Servs.-Kan. City, LLC v. Dep't of Health and Senior Servs.*, 653 S.W.3d 638, 645 (Mo. App. W.D. 2022); *see also Missouri Corr. Off. Assoc., Inc. v. Missouri Office of Administration*, 2002 WL 1742253 (Mo. App. W.D. 2022) (affirming decision to find OA's decisions to suspend automatic payroll deductions as an employee association and denying payroll deductions as being unlawful, arbitrary, capricious, and unreasonable).

Defendant's first-of-its-kind, dramatic overreach into the purview of the medical licensing board's authority to regulate the practice of medicine to specifically dictate to medical professionals how they must assess, obtain consent, and treat a single, specific condition bespeaks how truly arbitrary and capricious the Emergency Rule is. Even more concerning, the Rule dictates the assessment and treatment of gender dysphoria in a way contrary to the current, evidence-based clinical practice guidelines. This forces medical professionals to treat patients in ways inconsistent to best practice and will cause harm to their patients. (*See* Shumer Decl. ¶95; Donovan Decl. ¶¶24, 28, 38; Tochtrop Decl. ¶¶18, 28, 36-37; Storck Decl. ¶9).

For example, the Emergency Rule's requirement for three years of medically-documented gender dysphoria is completely arbitrary, especially contrasted with the clinical criteria for gender dysphoria requiring only 6 months of symptoms. (*See* Shumer Decl. ¶99; Tochtrop Decl. ¶28; Storck Decl. ¶¶11-12). Coleman, et al., cited by Defendant as purportedly supporting the Rule, mentions neither three years nor adult care. (*See* Shumer Decl. ¶99).

Additionally, the Rule includes a number of false, out-of-context, and misleading assertions based on citations that are speculative at best, and outright spurious at worst. (Shumer Decl. ¶¶95-125; Donovan Decl. ¶¶89-99). Item 4 asserts that gender-affirming care results in an increased rate of mortality; however, the article cited for that proposition, while noting an increase in mortality among *transgender people*, does not state or otherwise even imply that gender-affirming care is the cause. (Shumer Decl. ¶110; Donovan Decl. ¶99(d)). Item 5 focuses on data regarding the persistence of gender dysphoria in young adolescents, ignoring that pre-pubertal adolescents *are not eligible for medical intervention*. (Shumer Decl. ¶111; Donovan Decl. ¶99(e)).

Item 6 quotes directly from an opinion piece—not a scientific article. (Shumer Decl. ¶112; Donovan Decl. ¶99(f)). Item 9 refers to a highly-criticized study, the criticism of which requiring multiple post-publication corrections. (Shumer Decl. ¶114; Donovan Decl. ¶99(g)). The Krishna, et al. article cited primarily for support of Item 16's statement on the preservation of fertility explicitly states: "this paper is explicitly not intended to evaluate what is recommended in terms of the best use of GnRHa, based on evidence and expert opinion." (Shumer Decl. ¶119; Donovan Decl. ¶99(m)). Item 17, again, cites an opinion piece, not a scientific study. (Shumer Decl. ¶121; Donovan Decl. ¶99(n)).

The Emergency Rule employs a one-size-fits-all approach that fails to take into account the unique medical needs and circumstances of particular patients and medical evidence demonstrating the significance of timely and appropriate care for dysphoria, is misleading, based on shoddy evidence, including more than one opinion piece by noted opponents of transgender health care, and runs contrary to the legislature's intent. Defendant has used the MMPA to usurp authority of Missouri Board of Registration for the Healing Arts and create arbitrary barriers to critical patient care. It is deeply troubling that Defendant is attempting to redefine standard medical

practices, and in a manner that wholly fails to consider the unique needs of the individual patient. The Rule runs contrary to the legislature's expressed intent and places medical decisions in the hands of non-medical professionals.

B. The Emergency Rule will Cause Immediate, Irreparable Harm to Plaintiffs.

Without the injunctive relief sought, the Emergency Rule will cause Plaintiffs to suffer serious, extensive, and irreparable harm. "Irreparable harm" exists when pecuniary remedies fail to provide adequate reimbursement for improper behavior. *City of Greenwood v. Martin Marietta Materials, Inc.*, 311 S.W.3d 258, 266 (Mo. App. 2010) (citing *City of Kansas City v. N.Y.-Kan. Bldg. Assoc., L.P.*, 96 S.W.3d 846, 855 (Mo. App. W.D. 2002)). The myriad harms that the Emergency Rule will cause are precisely the type of injuries that cannot be redressed by pecuniary remedies, and strongly militate in favor of granting temporary relief to maintain the status quo until the merits of Plaintiffs' claims can be determined.

i. <u>The Emergency Rule will result in the denial of medically indicated care for transgender people with gender dysphoria, including transgender Plaintiffs and Provider Plaintiffs' patients.</u>

If the Emergency Rule is allowed to go into effect, many transgender Missourians will be unable to obtain medically indicated gender-affirming care recommended by their providers. They will be forced to stop the necessary medical care for their gender dysphoria that they have already undertaken on the advice of their health providers. This will inevitably lead to recurrence or worsening of their gender dysphoria. (*See* Donovan Decl. ¶28; Tochtrop Decl. ¶¶17-18, 25-30; Shumer Decl. ¶¶42-43; Janssen Decl. ¶¶50, 74, 102). Among those who stand to be affected are people like Plaintiffs R.S., A.F., and Mr. Casey, as well as the patients of the Provider Plaintiffs, Southampton Healthcare and Ms. Storck.

For example, people with gender dysphoria will often be unable to meet the Emergency Rule's requirement that patients undergo "not fewer than 15 separate, hourly sessions (at least 10

of which must be with the same therapist) over the course of not fewer than 18 months" in order to initiate medical treatment for gender dysphoria, or that they do so "promptly" in order for them to continue medical treatment they have already initiated on the advice of their healthcare providers. Given the arbitrary nature of this requirement, which is wholly divorced from any clinical practice guidelines, and that therapy is not necessary nor recommended for every person (*See* Shumer Decl. ¶100; Janssen Decl. ¶92), transgender people like Plaintiff A.F. and Provider Plaintiffs' patients will be unable to initiate or continue medical treatment recommended by their providers. (*See* N.F. Aff. ¶40; Donovan Decl. ¶37; Tochtrop Decl. ¶¶19-20; Shumer Decl. ¶96). What is more, aside from the cost-prohibitive nature of this requirement, there is a dearth of mental health therapists in Missouri, which will make compliance with this requirement virtually impossible. (*See* Donovan Decl. ¶37; Tochtrop Decl. ¶20; Shumer Decl. ¶96; Janssen Decl. ¶92).

Similarly, the Emergency Rule's requirement that, to initiate medical treatment for gender dysphoria, any psychiatric symptoms from "existing mental health comorbidities" of people with gender dysphoria be "treated and resolved" will result in the denial of medically necessary treatment for gender dysphoria for countless transgender people throughout Missouri. This includes not only Provider Plaintiffs' patients, but also transgender people such as Plaintiffs R.S., A.F., and Mr. Casey, all of whom live with well-managed comorbidities, the symptoms of which may not always be capable of complete resolution. (N.F. Aff. ¶¶37-38; A.S. Aff. ¶27; Casey Aff. ¶16; *see also* Donovan Decl. ¶¶38-46; Tochtrop Decl. ¶27; Storck Aff. ¶14). Indeed, many mental health comorbidities are chronic, and may not or cannot be resolved. (Donovan Decl. ¶42; Tochtrop Decl. ¶27; Shumer Decl. ¶101; Janssen Decl. ¶¶76, 93). It is contrary to well-known and widely-accepted practices of medicine that mental health comorbidities must be resolved before a person can obtain care for another condition. (Donovan Decl. ¶¶38, 41-42; Janssen Decl. ¶¶77-78).

Ending or precluding treatment comes with dire consequences. For one, the denial of medical treatment for gender dysphoria will lead to the development of physical and physiological characteristics that may be irreversible, undesirable, or necessitate otherwise-avoidable medical interventions in the future, such as surgery. Taking away puberty-delaying treatment or denying hormone treatment may harm transgender minors forever. There is no "undo" button for puberty when it conflicts with your gender identity. The physical characteristics that occur during puberty will stay with the adolescents denied care for the rest of their lives. (*See* Shumer Decl. ¶¶65 (describing physical changes that occur during puberty)). For another, abruptly stopping ongoing hormone medical treatment can result in fatigue as well as potential cardiac effects. (*See* Tochtrop Decl. ¶30).

Furthermore, untreated gender dysphoria can and will "result in severe anxiety and depression, eating disorders, substance abuse, self-harm, and suicidality." (Shumer Decl. ¶43; Janssen Decl. ¶50; Tochtrop Decl. ¶23; Donovan Decl. ¶46). Indeed, "[t]he denial of medically indicated care to transgender adolescents and adults not only . . . results in the prolonging of their gender dysphoria, but also causes additional distress and poses other health risks, such as depression, trauma, self-harm, and suicidality." (Janssen Decl. ¶102; *see also* Storck Aff. ¶20 ("Without access to gender-affirming care, I have no doubt that many of my clients will endure serious mental health consequences including a very real risk of death by suicide.")).

Such "[e]motional distress, anxiety, depression and other psychological problems can constitute irreparable injury." *Hicklin* v. *Precynthe*, 2018 WL 806764, at *9 (E.D. Mo. Feb. 9, 2018) (quoting *Norsworthy* v. *Beard*, 87 F.Supp.3d 1164, 1192 (N.D. Cal. 2015)); *cf. Braggs v. Dunn*, 383 F.Supp.3d 1218, 1243 (M.D. Ala. 2019) ("[T]he immediate and substantial risk of suicide [absent an injunction] satisfies the irreparable harm inquiry."). To be clear, this is not

hypothetical. "When asked how she would feel if she could no longer get the medical care supporting her transition, A.F. said she 'would not want to be on this planet anymore.'" (N.F. Aff. ¶42). Hearing their daughter say this, "pains and scares" A.F.'s parents. (*Id.*).

As such, courts recognize that the denial of medically necessary health care constitutes irreparable harm for which there is no other adequate legal remedy. *See Bowen v. City of New York*, 476 U.S. 467, 483-84 (1986) (finding denial of benefits caused irreparable injury by exposing plaintiffs to "severe medical setback[s]" or hospitalization); *Brandt v. Rutledge*, 47 F.4th 661, 671 (8th Cir. 2022) (finding irreparable harm where plaintiffs "would be denied access to hormone treatment (including needing to stop treatment already underway), undergo endogenous puberty—a process that cannot be reversed—and suffer heightened gender dysphoria"); *Planned Parenthood S. Atl. v. Baker*, 941 F.3d 687, 707 (4th Cir. 2019); *Eknes-Tucker v. Marshall*, 2022 WL 1521889, at *12 (concluding "Plaintiffs will suffer irreparable harm absent injunctive relief" because "without transitioning medications, [] Plaintiffs will suffer severe medical harm, including anxiety, depression, eating disorders, substance abuse, self-harm, and suicidality"); *Flack v. Wis. Dep't of Health Servs.*, 328 F.Supp.3d 931, 942-46 (W.D. Wis. 2018) (finding likelihood of irreparable harm to transgender Medicaid beneficiaries denied coverage for gender dysphoria treatments); *Edmunds v. Levine*, 417 F.Supp.2d 1323, 1342 (S.D. Fla. 2006) ("The denial of medical benefits, and resultant loss of essential medical services, constitutes an irreparable harm to these individuals."); *Karnoski v. Trump*, 2017 WL 6311305, at *9 ("[M]onetary damages proposed by Defendants will not . . . cure the medical harms caused by the denial of timely health care."); *Smith v. W. Elec. Co.*, 643 S.W.2d 10, 13 (Mo. App. 1982) (finding exposure to conditions deleterious to one's health is an irreparable harm "particularly . . . where the harm has not yet resulted in full-blown disease or injury").

In addition, the Emergency Rule threatens a particular irreparable harm upon Plaintiff R.S., as it forces her to choose between preserving her fertility and continuing the treatment plan for her gender dysphoria that her doctors have created, in consultation with her and her parents. Given that preserving fertility is important to R.S., R.S.'s treatment plan involved the carefully timed removal of her puberty-delaying implant before starting gender-affirming hormones in a few months. (*See* A.S. Aff. ¶23). Accordingly, R.S.'s puberty-delaying implant was removed in late March 2023 to allow for fertility preservation before starting gender-affirming hormones in the fall. (*See* A.S. Aff. ¶24). The Emergency Rule has wreaked havoc on these plans, as R.S. is now faced with the Hobson's choice of choosing to preserve her fertility or start hormones immediately. (*See* A.S. Aff. ¶¶25, 28-29). The Emergency Rule similarly interferes with Plaintiff A.F.'s treatment plan under which she would start gender-affirming hormones in July. This type of "deprivations of temporally isolated opportunities, are exactly what [injunctive relief is] intended to relieve." *D.M. by Bao Xiong v. Minnesota State High School League*, 917 F.3d 994, 1003 (8th Cir. 2019).

As such, the harms the Emergency Rule will cause are serious, irreparable, and potentially life-threatening. (*See* Janssen Decl. ¶100-08; Shumer Decl. ¶92-94; Tochtrop Decl. ¶¶25, 30; Donovan Decl. ¶¶46, 61). Injunctive relief becomes "easier to obtain as the plaintiff faces progressively graver harm," and as the Eighth Circuit noted in *Henderson v. Bodine Aluminum*, "[i]t is hard to imagine a greater harm than losing a chance for potentially life-saving medical treatment." 70 F.3d 958, 962 (8th Cir. 1995).

ii. <u>The Emergency Rule irreparably harms Provider Plaintiffs by threatening criminal and civil liability, frustrating their missions, and imposing non-compensable costs.</u>

The Provider Plaintiffs likewise face irreparable harm. These Plaintiffs will be unable to serve their patients not only as the patients need, but also in a manner consistent with the Providers'

medical, ethical, and legal duties. When healthcare providers are forced to abandon their patients, it violates the tenets of their professions, causing them great distress.

The Emergency Rule will inflict irreparable harm on Plaintiff Southampton Healthcare, whose providers will face the possibility of criminal prosecution or civil liability should they continue to provide medical treatment for gender dysphoria consistent with evidence-based guidelines and the tenets of their professions. (Donovan Decl. ¶50 ("The Emergency Rule is in direct conflict with the oath that I swore as a doctor and many of the rules, regulations, and statutes that I am required to follow.")); *id.* at ¶54 ("[T]he Emergency Rule imposes requirements that are inconsistent with the practice of medicine and medical ethics."); Tochtrop Decl. 37 ("The Emergency Rule is … completely at odds with clinical practice guidelines and the practice of medicine more generally" and "is in direct contradiction with our obligations as physicians and health care providers" as providers "have an obligation to treat all patients in a manner consistent with their best interests to achieve the best possible health results for our patients.")).

This places Provider Plaintiffs in the ethically untenable position of deciding between committing a felony or harming their patients by refusing care. *See Brandt,* 551 F.Supp.3d at 891-92 (finding healthcare provider plaintiffs proved irreparable harm when Arkansas medical ban would force them to "choos[e] between breaking the law and providing appropriate guidance and interventions for their transgender patients"). The threat of imprisonment and civil penalties is more than sufficient to constitute irreparable harm. *See, e.g.*, *VanDerStok v. Garland*, No. 4:22-CV-00691-O, 2022 WL 4809376, at *5 (N.D. Tex. Oct. 1, 2022); *Chamber of Com. of United States v. Becerra*, 438 F. Supp. 3d 1078, 1103–04 (E.D. Cal. 2020), *aff'd sub nom. Chamber of Com. of the United States of Am. v. Bonta*, 62 F.4th 473 (9th Cir. 2023).

In addition, an organization is irreparably "harmed if the actions taken by the defendant have perceptibly impaired the organization's programs." *League of Women Voters of United States v. Newby*, 838 F.3d 1, 8 (D.C. Cir. 2016) (cleaned up). "Obstacles that unquestionably make it more difficult for an organization to accomplish its primary mission provide injury for purposes of irreparable harm." *Open Communities All. v. Carson*, 286 F.Supp.3d 148, 177 (D.D.C. 2017) (cleaned up); *see also Santa Cruz Lesbian & Gay Cmty. Ctr. v. Trump*, 508 F. Supp. 3d 521, 546 (N.D. Cal. 2020) ("The frustration of Plaintiffs' ability to carry out their core missions is itself irreparable harm."). Southampton Healthcare's mission is to provide high quality health care to its patients, and to do so with state-of-the-art medical knowledge and compassionate care. (Tochtrop Decl. ¶38). "The Emergency Rule frustrates this mission and prevents [Southampton Healthcare] from providing the compassionate and affirming care that [its] patients deserve." (*Id.*)

In addition, "[t]he health-provider Plaintiffs have demonstrated that they will likely experience an array of financial and operational burdens as a result of the [Emergency Rule] at issue." *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Hum. Servs.*, 485 F.Supp.3d 1, 56 (D.D.C. 2020). "[T]he health-provider Plaintiffs will be forced to provide increasingly difficult treatment for LGBTQ patients who arrive with more acute conditions, either because they refrain from being fully transparent with their external providers given their heightened fears of discrimination, or because such apprehension causes them to delay seeking necessary care entirely." *id.*; (*see also* Tochtrop Decl. ¶¶22-23; Donovan Decl. ¶¶29-31, 33-34). Provider Plaintiffs will also have to undergo significant costs in order to comply with the Emergency Rule, which are not recoverable. (Tochtrop Decl. ¶32). These "injuries are unrecoverable because the present suit arises under the APA, which does not allow for recovery of monetary damages." *Whitman-Walker Clinic*, 485 F.Supp.3d at 59.

* * *

In light of the severe and irreparable harms the Plaintiffs face under the Emergency Rule, a temporary restraining order is appropriate and necessary.

C. The Public Interest Favors the Plaintiffs, as Defendant has no Interest in Enforcing an Unlawful Rule He Lacked Authority to Adopt.

The serious and irreparable harms that Plaintiffs will face should the Emergency Rule take effect far outweigh Defendant's interest in the issuance and enforcement of the Emergency Rule. Further, preserving Plaintiffs' rights and precluding Defendant from enforcing an unlawful and invalid rule are in the public's interest. A temporary restraining order and, ultimately, preliminary and permanent injunctions are warranted where, as here, the balance of equities strongly favors the moving party. As noted above, when the non-moving party is the government, consideration of the balance-of-equities and public-interest factors is co-extensive. *Nken*, 556 U.S. at 435.

The public interest is undoubtedly served by preserving the status quo ante and preventing Missouri's medical providers from being thrown into chaos by an interlocking set of arcane, indecipherable rules lacking of rhyme and reason. The Rule's requirements are vague, confusing, and contradictory, and undoubtedly would lead to widely variant practices at different providers. Some will likely give up on providing gender-affirming care entirely for fear of straying outside an broad and burdensome set of requirements punishable as a felony; in fact, when the Rule was filed, at least one provider reacted by signalling they would no longer provide gender-affirming care.[25]

The balance of equities strongly favors equitable relief here. As discussed at length above, the harms to Plaintiffs from enforcement of the Emergency Rule are tangible, immediate, durable,

[25] Orion Rummler, *New restrictions in Missouri would make gender-affirming care nearly impossible*, The 19th (Apr. 18, 2023), available https://19thnews.org/2023/04/missouri-transgender-health-care-rule-attorney-general/.

and extensive. Plaintiff-Adolescents will, in many cases, abruptly lose or be refused essential gender-affirming care, and, as a result, undergo irreversible physical and physiological changes and experience extreme distress and suffering. Indeed, because of the impending effective date of the Rule, R.S. faces an impossible and permanent choice between pursuing hormone therapy or preserving fertility, where no choice is necessary. (A.S. Aff. ¶29).

Plaintiff-Parents will be left in the horrifying position of watching their child suffer from lack of access to necessary medical care, or, if they are able, packing up their family and moving to another state. Plaintiff-Providers will be under constant threat of imprisonment or fine and will be incentivized to inflict harm on vulnerable patients by not providing the medical care consistent with the recognized standard of care that they believe to be in their patients' best interest.

In marked contrast, Defendant is seeking to enforce a discriminatory, invalid, unlawful, and unconstitutional rule, and, therefore, is not harmed by maintenance of the status quo by issuance of the temporary restraining order. *See Lankford v. Sherman*, 2007 WL 689749, at *3 ("[T]he comparative harm to the Defendant, however, is small. Plaintiffs' injunction seeks only that Defendant comply with federal law. Compliance with the law does not pose a burden on a defendant." (Internal citations omitted)); *White v. Martin*, 2002 WL 32596017, at *9 (W.D. Mo. 2002) ("Enforcement of laws passed by Congress is in the public interest, even when that means enjoining allegedly illegal actions by another government body."); *Glenwood Bridge, Inc. v. City of Minneapolis*, 940 F.2d 367, 372 (8th Cir. 1991).

An injunction would simply maintain the status quo while Plaintiffs pursue their claims. Parents can continue to meet their children's medical needs; transgender Missourians can continue to receive recommended, evidence-based, medically necessary treatment for their gender dysphoria; and healthcare providers can continue to treat patients without fear of prosecution.

D. Defendant Will Suffer No Harm from the Temporary Restraining Order, so no Surety Bond or Deposit is Required.

Given the rights at stake in this case and the fact that Defendant will not suffer harm from the imposition of a temporary injunction, the Missouri Supreme Court Rule 92.02(d) bond should be waived. *See State ex rel. Ideker, Inc. v. Grate*, 437 S.W.3d 279, 287 (Mo. App. W.D. 2014) (acknowledging the right of courts to not require bonds for injunctive relief where "it does not appear that [the non-moving party] will suffer harm as a result of this temporary restraining order"); *Phelps-Roper v. Cnty. of St. Charles, Mo.*, 780 F. Supp. 2d 898, 904 (E.D. Mo. 2011) (granting injunctive relief without a security bond where Defendant would "suffer no financial harm if found to be wrongfully enjoined"). A bond is neither appropriate nor necessary in this case.

CONCLUSION

For these reasons, Plaintiffs request the Court to grant their motion for a temporary restraining order and enjoin Defendant from implementing, making effective, enforcing, or applying the Emergency Rule, as set forth in the Proposed Order grating the Temporary Restraining Order filed herewith.

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Respectfully submitted,

By: /s/ *J. Bennett Clark*

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