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IN THE CIRCUIT COURT OF JACKSON COUNTY, MISSOURI
AT KANSAS CITY

COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, et al., Plaintiffs, v. JOSHUA D. HAWLEY, in his official capacity as Attorney General of Missouri, et al., Defendants.	CASE NO. 1716-CV24109 Division 13

PLAINTIFFS' SUGGESTIONS IN SUPPORT OF MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Plaintiffs seek immediate injunctive relief prohibiting enforcement of portions of Senate Bill 5, 99th General Assembly, 2nd Extraordinary Session (2017 Mo.) ("S.B. 5"), to be codified at Mo. Rev. Stat. § 188.027.6 ("the Act"), which will take effect on October 24, 2017 absent relief from this Court. See Mo. Const. art III, § 29. In support of their motion, Plaintiffs submit these suggestions demonstrating that a temporary restraining order, followed by a preliminary injunction, should issue.

I. INTRODUCTION

Absent relief from this Court enjoining the Act from taking effect, women will be subject to an extreme set of requirements that they and their physicians must overcome so that women can exercise their right to have an abortion in the state of Missouri. Existing law already forces all women, regardless of how certain they are in their decision to have an abortion, to make an additional and medically unnecessary trip to a health center at least 72 hours before they can obtain an abortion, at which they must be given orally and in writing certain state-mandated

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information. The Act adds an extremely burdensome layer of medically unnecessary regulation by now mandating, not that any new information be imparted to patients, but rather that the *same* physician or physicians who will "perform or induce" a woman's abortion must be the person(s) to, orally and in person, at least 72 hours in advance of her procedure, describe certain state-mandated information to patients (hereinafter "same-physician requirement"). The same-physician requirement is either impossible to implement, for some types of abortion care, or for others will dramatically reduce patients' access to care and delay the care that can be provided. It provides no exceptions for when the patient or the physician must reschedule, provides no exception for how far a woman must travel to the health center, does not take into account that often multiple physicians on different days can be involved in a woman's abortion care, and does not contain a medical emergency exception on its face. No other state in the nation imposes a similar requirement, and Missouri imposes no similar requirement for any medical procedure other than abortion.

The Act conflicts with other provisions of existing Missouri law, and additional amendments made by S.B. 5, that—consistent with accepted medical practice—provide for the same, state-mandated information to be provided to the patient by a physician who is to perform or induce the abortion, *or* by a referring physician, *or* by certain licensed, qualified professionals. The Act also leaves undefined certain terms which are critical to understanding the Plaintiffs' obligations and limitations when providing abortions. As a result of the conflicting requirements, it is unclear what the Act requires and allows. Noncompliance with the Act carries serious criminal, licensing, and other penalties.

The Act is additionally unenforceable because it violates article III, section 21 of the Missouri Constitution, which prohibits legislative changes to a bill that are unrelated to the bill's

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original purpose. The passage of the Act, and other provisions in S.B. 5, have resulted in a bill that unconstitutionally deviates from the original (and sole) purpose of S.B. 5, as it was introduced, which was to expand the Attorney General's jurisdiction, but now enacts a diverse set of unrelated changes to Missouri's code.

If the same-physician requirement takes effect it will irreparably harm Plaintiffs and their patients by imposing significant burdens on patient care such that, for whole categories of patients, abortion care would no longer be available, and for virtually all other abortion patients, it would be either unavailable or so delayed that they would experience harmful delays which carry increased medical risk and financial costs. To prevent these harms and maintain the status quo, this Court should enter preliminary injunctive relief.

II. FACTUAL BACKGROUND & STATUTORY FRAMEWORK

A. Abortion Background

Abortion is a safe and common medical procedure. Ex. 3, Affidavit of David Eisenberg ¶¶ 13–14 (hereinafter "Eisenberg Aff."); Ex. 4, Affidavit of George Macones ¶ 6 (hereinafter "Macones Aff."). Approximately 30% of women have an abortion by the age of 45. Eisenberg Aff. ¶ 15; Macones Aff. ¶ 6. Many are mothers already who have decided that they cannot parent another child at this time. Eisenberg Aff. ¶ 15; Ex. 5, Affidavit of Sheila Katz ¶ 33 (hereinafter "Katz Aff."). Women may, for example, plan instead to have children (or additional children) when they are older, financially able to provide necessities for them, and/or in a supportive relationship with a partner so that their children will have two parents. See Eisenberg Aff. ¶ 15. In both the first and second trimester, abortion is safer than carrying a pregnancy to term, as to both morbidity and mortality. Macones Aff. ¶ 6; see also Eisenberg Aff. ¶ 14. While legal abortion is very safe, the medical risks do increase as pregnancy progresses. Macones Aff. ¶ 6;

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Eisenberg Aff. ¶ 92. Delay in accessing abortion thus increases the risks a woman faces, including (but not only) if that delay pushes her from the first to the second trimester, when abortion typically requires a more complex procedure. Eisenberg Aff. ¶¶ 13, 21–25; Macones Aff. ¶ 6.

During the first trimester, there are two methods of abortion. Eisenberg Aff. ¶¶ 16–17, 19. For pregnancies through 10 weeks, dated from the first day of a patient's last menstrual period ("lmp"), a patient may have an abortion using medications alone. Id. ¶ 17. In a medication abortion, the patient takes first one medication and then a second one 24-48 hours later, and then passes the products of conception, usually in her home, in a process similar to an early miscarriage. Id. The other method of first trimester abortion is a suction (or aspiration) procedure in which the physician uses instruments to open the cervix and suction out the contents of the uterus. Id. ¶ 19.

During the beginning of the second trimester, a suction procedure may continue to be a possibility. Id. In addition, throughout the second trimester, there are two other methods of abortion: dilation and evacuation ("D&E") and induction; the vast majority of abortions performed in the second trimester are D&Es, though the induction method is an important one for those patients for whom it is appropriate. Id. ¶¶ 21, 25–26; Macones Aff. ¶¶ 9–11. D&E abortions early in the second trimester are performed as a one-day procedure, but in Missouri, by 18 weeks lmp, a D&E requires two appointments on consecutive days. Eisenberg Aff. ¶¶ 22–23. In induction abortions, which require hospitalization, medication is used to induce labor and, after an unpredictable period that may last up to 72 hours or more, the patient delivers the non-viable fetus. Macones Aff. ¶¶ 13–16; Eisenberg Aff. ¶ 25. On occasion, though not typically, a patient may need to have a second procedure to ensure that the abortion is completed and any

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further medical risks avoided. Eisenberg Aff. ¶ 28. This second procedure typically is performed by a different physician, with a different method, than initially treated the patient. Id.

There are currently only two, and soon to be three, dedicated abortion facilities in Missouri. Due to onerous legal restrictions, until recently, there was only one. Ex. 2, Affidavit of Mary Kogut ¶ 9 (hereinafter "Kogut Aff."). That one, Plaintiff Reproductive Health Services of Planned Parenthood of the Saint Louis Region ("RHS"), provides medication abortion as well as aspiration and/or D&E abortions through 21 weeks, 6 days lmp at its St. Louis Center. Kogut Aff. ¶ 9, 22; Eisenberg ¶¶ 18, 20, 24. In 2016, RHS provided close to 4500 abortions. Kogut Aff. ¶ 5. Nearly 70 percent of the second-trimester procedures that are performed at RHS are two-day procedures. Id. ¶ 22. Plaintiff Comprehensive Health of Planned Parenthood of Great Plains ("Comprehensive Health") recently resumed providing only medication abortion at its Midtown-Kansas City Center, and this month will resume providing medication abortion and surgical abortion at its Columbia health center. Ex. 1, Affidavit of Aaron Samulcek ¶ 5 (hereinafter "Samulcek Aff."). In addition to these dedicated facilities, a small number of abortions are also performed in a hospital and general outpatient clinic setting. See Eisenberg Aff. ¶¶ 20, 24.

B. The Current Law And Plaintiffs' Compliance With It

The Act is the most recent in a long line of attempts by the legislature to impose severe restrictions on access to abortion in Missouri. See Mo. Rev. Stat. tit. XII ch. 188; Mo. Rev. Stat. § 188.010 ("It is the intent of the general assembly of the state of Missouri … to regulate abortion to the full extent permitted by the Constitution . . . ."). The state subjects abortion providers to inspections, licensing, reporting obligations, and detailed requirements for providing care to minors. Separate from this case, ongoing litigation challenges a number of other Missouri restrictions, similar to those enacted by Texas and recently struck down by the U.S. Supreme

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Court, which unduly interfere with the Planned Parenthood Plaintiffs' ability to provide accessible abortion services throughout the state. Kogut Aff. ¶ 9; Samulcek Aff. ¶¶ 3, 5.

All medical providers are bound by their ethical obligations and professional standards of care to ensure that all patients receive relevant information and provide their voluntary, informed consent before treatment. See Eisenberg Aff. ¶ 29; Macones Aff. ¶ 22. Abortion providers take that obligation very seriously. See Eisenberg Aff. ¶ 31; Macones Aff.¶¶ 22–25, 39–42; Kogut Aff. ¶ 12; Samulcek Aff. ¶¶ 9–10. Missouri's abortion law codifies the need for voluntary, informed consent. See Mo. Rev. Stat. § 188.027.1 ("no abortion shall be performed or induced … without [patient's] voluntary and informed consent, given freely and without coercion."); see also §188.027.3, .5; § 188.039 (interpreted by Missouri Supreme Court to codify duty to obtain informed consent, see Reprod. Health Servs. of Planned Parenthood of St. Louis Region, Inc. v. Nixon, 185 S.W.3d 685, 691 (Mo. 2006)).

Missouri law then goes further to mandate that specific information be provided and in exactly what manner, including when it must occur: at least 72 hours prior to any abortion procedure, see Mo. Rev. Stat. §§ 188.027, 188.039, a requirement imposed in 2014 that tripled the previous 24-hour mandatory delay.[1] Among the information a patient must receive is: a description of the "immediate and long-term medical risks associated with the proposed abortion method" and the "immediate and long-term medical risks. . . in light of the anesthesia and medication that is to be administered [and other factors]." Id. § 188.027.1(1)(b)b-c. This information, and other information required by §§ 188.027, 188.039, must be provided orally, in

[1] This suit challenges the 72-hour waiting period as a medically unnecessary obstacle to patients' abortion care, but that count of the Complaint is not relied upon here, on the motion for immediate injunctive relief.

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person, and in a private setting with the patient.[2] The patient must certify, on a written checklist, that she has received the state-mandated information and must further certify her free and voluntary consent. Section 188.039.2 also states that—to satisfy that section's requirements—"[o]nly one such conference shall be required for each abortion."

Under existing law, either a physician who will perform or induce the abortion *or any other "qualified professional"* can provide the above required information and obtain a patient's required written consent. Id. §§ 188.027.1(1), (3); 188.039.2-.6. The term "qualified professional" includes "a physician, physician assistant, registered nurse, licensed practical nurse, psychologist, licensed professional counselor, or licensed social worker," licensed or registered under the relevant chapters of Missouri law, "acting under the supervision of the physician performing or inducing the abortion, and acting within the course and scope of his or her authority provided by law." Id. § 188.027.9 (amended by Act to be codified at § 188.027.10).

In accordance with the current law, abortion providers in Missouri have a licensed registered nurse or other qualified professional (as defined by law) provide the state-mandated information, who ensures that the prospective patient has all required information orally and in writing, answers any questions she may have, and obtains the written checklist and consent from the patient, if she decides to proceed. Kogut Aff. ¶ 12; Samulcek Aff. ¶ 9; Eisenberg ¶ 33. These licensed, qualified professionals are trained and well-versed in this role, and acting under the

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[2] Current law further specifies that the patient must receive "[m]edically accurate information that a reasonable patient would consider material to the decision of whether or not to undergo the abortion," including a description of the abortion methods "relevant to the stage of pregnancy, as well as the immediate and long-term medical risks commonly associated with each abortion method . . . ." Mo. Rev. Stat. § 188.027.1(3); see also id. § 188.039.2 (requiring discussion of a patient's "indicators and contraindicators, and risk factors including any physical, psychological, or situational factors for the proposed procedure …."). This information must also be provided in written form, through documents created by the state itself. id. §§ 188.027.1(2)-(3), (5)-(7); see also id. § 188.027.2.

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supervision of the physicians on the facility's staff. Id. These professionals, as is common across many areas of modern medical practice, also undertake similar counseling and consenting roles for non-abortion procedures, such as the insertion of an IUD or a surgical procedure for miscarriage management. Eisenberg ¶ 33; Kogut Aff. ¶ 12. This model allows physicians to fully and efficiently allocate their resources, providing patients with ongoing access to care and effectively spreading those resources among not only abortion care, but also their gynecological and other care for patients and their other professional obligations. Eisenberg Aff. ¶¶32, 62, 65; Macones Aff. ¶¶ 25–27.

By providing the required information and consultation appointment through nurses and other qualified professional staff, RHS and Comprehensive Health are able to see local patients for their initial appointment in one location close to their home, and then have the patient travel farther only for the actual abortion procedure. Kogut Aff. ¶¶ 11, 42; Eisenberg ¶ 34. This can save a patient from having to make two lengthy trips to the abortion facility; for example, a patient who lives close to Springfield can avoid a second 400+ mile trip. Kogut Aff. ¶¶ 11, 41–42. In addition, the use of qualified professionals saves limited physician resources for treating patient's gynecological needs or performing the abortions. See Kogut ¶¶ 38–39; Eisenberg ¶ 34; Samulcek Aff. ¶¶ 17; 21.

C. The Act Adds Conflicting, Unclear Requirements

The Act leaves each of the above requirements of existing law in place, but then adds a new subsection 6 to Section 188.027. The new subsection 6 adds a requirement that "the physician performing or inducing the abortion" must meet with the patient, in person, at least 72 hours before the start of the procedure, to orally describe "the immediate and long-term medical risks to the women associated with the proposed abortion method" and the "immediate and long-

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term medical risks . . . in light of the anesthesia and medication that is to be administered"—the very same information, verbatim, that is already covered by the existing requirement in Section 188.027.1(1)(b)b-c. Thus, the Act provides no new information to abortion patients, but instead duplicates the law's pre-existing information requirements.

The Act also leaves unchanged the ability of "any qualified professional" to provide that same information (in addition to other mandated information) under subsection 1 of Section 188.027, and does not explain whether subsection 1 or subsection 6 takes precedence—creating confusion and leaving clinicians uncertain of how to proceed. Moreover, the Act and S.B. 5 as a whole not only keep in place the option to have a "qualified professional" provide the state-mandated information and obtain written consent, but also *adds* the option of a "referring physician," who need not be affiliated at all with the physicians or other clinicians who will eventually provide the patient's abortion care, to provide this same medical risk information and obtain written consent.

The result is an extreme lack of clarity as to who must provide the information and what the legislature truly intended. Eisenberg Aff. ¶¶73–76; Macones Aff. ¶¶ 35–36; Kogut Aff. ¶¶ 18–20; Samulcek Aff. ¶¶ 11–12. Because medical professionals and facilities face serious penalties for any abortion that does not fully comply with state legal requirements, however, clinicians must err on the side of reading these conflicting and confusing provisions as requiring the most stringent, same-physician counseling to occur: that is, that any physician who will perform or induce an abortion must himself or herself meet in person with the patient 72 hours ahead of time, and relay the specified risk information, and that the use of another physician, whether referring or otherwise, or another qualified professional is insufficient. Eisenberg ¶ 76; Macones Aff. ¶ 36.

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There is also lack of clarity about what conduct constitutes "performing" or "inducing" an abortion, and whether, in the context of abortion methods that often involve multiple steps, days, and/or physicians, more than one physician must participate in providing the specified information to the patient, in person, at least 72 hours before the start of the procedure. Eisenberg Aff. ¶ 77; Macones Aff. ¶ 35; Kogut Aff. ¶ 21. Neither "perform" nor "induce" are defined. It is unclear, what, if any, medical emergency exception might apply to this new section. See Eisenberg Aff. ¶ 78. In addition, the Act has no exigent circumstances exception, nor any other apparent means of sparing a patient from having to repeat both the state-mandated in person meeting and the minimum 72-hour delay, if the physician who provided the state-mandated information to a patient ultimately cannot perform her abortion. Eisenberg Aff. ¶ 79. For example, this situation may arise if the patient ends up needing or choosing a different method of abortion than that physician can provide, if the patient and physician schedules simply cannot be coordinated once the mandatory information is provided, or if some last-minute obstacle arises either for the physician or the patient. Eisenberg Aff. ¶ 79; Kogut Aff. ¶ 36; Samulcek Aff. ¶ 15. Section 188.039 continues to state that only one pre-procedure conference for purposes of providing information and obtaining informed consent is necessary for a given abortion, but the new same-physician requirement would make it highly likely that, in numerous common scenarios, two or more such in-person meetings would have to take place before a patient's abortion could begin (assuming the attendant delays had not pushed her past the cutoff for her procedure). As explained below, this is just one aspect of the lack of feasibility of a same-physician requirement and the harms that the Act threatens, if allowed to take effect.

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D. The Impact of the Act on Plaintiffs' and Their Patients

As the attached sworn affidavits in support of this application describe in detail, Plaintiffs already struggle to provide adequate abortion access to Missouri women. See Eisenberg Aff. ¶¶ 41–54; Kogut Aff. ¶ 7; Samulcek Aff. ¶¶ 3, 5. There are no Missouri physicians who work full time in abortion care. Eisenberg Aff. ¶ 44; Kogut Aff. ¶ 7. Instead, the limited care available takes place at a few facilities through a rotating patchwork of coverage by dedicated physicians who have many other obligations, and can devote only discrete, finite hours each month—scheduled long in advance and typically *not* the same hours each week or month for the same physician at the same facility—to treating abortion patients. Eisenberg Aff. ¶¶ 48–62; Kogut Aff. ¶¶ 7, 29–34; Samulcek Aff. ¶¶ 6–7. In addition to their varied clinical duties, many of the physicians providing these services have numerous other responsibilities, including teaching, research, and administration, and treat abortion patients on certain days—all according to complex schedules set for months-long periods and finalized months in advance. Eisenberg Aff. ¶¶ 49–52; Kogut Aff. ¶¶ 30-33; Samulcek Aff. ¶ 7. RHS, for example, must fill in other coverage at its St. Louis Center with multiple Missouri physicians, plus some physicians who live out of state, all of whom can devote only a limited number of hours to abortion care. Kogut Aff. ¶¶ 30–33; Eisenberg ¶¶ 53–54. It is a constant struggle to secure and maintain physician coverage there. Id. At the Midtown-Kansas City Center, only one physician is able to provide medication abortions. Samulcek Aff. ¶ 6. The shortage of abortion physicians in Missouri follows from the harassment, threats, and hyper-regulation associated with abortion practice. Kogut Aff. ¶ 8; Eisenberg Aff. ¶¶ 46–47.

At the same time as these facilities and physicians must stretch to maintain even the current, limited availability of abortion options in Missouri, women seeking abortions, who tend

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disproportionately to be of very limited means, struggle to schedule care with, pay for, and travel to these providers. Kogut Aff. ¶¶ 43–44; Samulcek Aff. ¶ 18; Katz Aff. ¶¶ 19–38. These women often have limited options for transportation, time off work, child care, and ways to manage or pay for other logistical requirements to access abortion care, and that may only be available far from their homes. See Katz Aff. ¶¶ 22-38. In 2014, 49% of women having abortions in the United States had incomes below the federal poverty level, and another 25.7% had incomes below 200% of the federal poverty level. Id. ¶ 20. Missouri's poverty rate is higher than in the United States as a whole, and poverty is particularly concentrated in the southern part of the state. Id. ¶ 12. More than 70% of the patients who obtain abortions at RHS are low-income. Kogut Aff. ¶44. As the affidavit of Sheila M. Katz, Ph.D., shows, the majority of prospective abortion patients in Missouri face significant financial, logistical, and social psychological challenges in reaching providers, paying for abortion, and completing their desired care. Katz Aff. ¶¶ 19-38. Even without the new same-physician requirement, it is often the case that a procedure initially scheduled for one day may have to be rescheduled because of the practical constraints that Plaintiffs' patients face. Id. ¶ 41.

The Act will greatly exacerbate these scheduling difficulties—for both Plaintiffs and their patients—resulting in increased travel distances and extraordinarily long delays for patients which will in turn subject them to greater medical risks, if they can access care at all. While Plaintiffs will do their best to accommodate women in need, because of the limited availability of physicians, the two separate visits may need to be, not 72 hours apart, but *weeks* apart. Samulcek Aff. ¶ 16; Kogut Aff. ¶¶ 34–37. As a result, some women will not succeed in making it through all these hoops to actually receive an abortion. See Samulcek Aff. ¶ 19; Kogut Aff. ¶¶ 28, 40, 46. Other women will be forced to attempt to travel much farther distances because they cannot

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receive timely care at a health center that only provides abortions up to a certain point in pregnancy. Samulcek Aff. ¶ 18–19. In addition, women will lose the ability to do the state-mandated information visit with a qualified professional at a health center closer to their home, meaning that some women will be forced to make two lengthy trips (each trip hundreds of miles): one trip to receive the state-mandated information from the physician who will perform the abortion and a second trip, which must be at least 72 hours later, to have the abortion. See Kogut Aff. ¶ 42; Samulcek Aff. ¶ 20. Moreover, because the Act will require all providing physicians to split their time between abortion procedures and counseling, much more limited physician time will be available for the procedures themselves. See Kogut Aff. ¶ 38; Samulcek Aff. ¶ 17; Eisenberg Aff. ¶¶ 81–82. For induction abortions, which unpredictably span over days in the hospital, there is no possible means of using a "same physician" approach, and the Act would effectively bar those procedures. Eisenberg Aff. ¶ 83; Macones Aff. ¶¶ 31–34. The Act also cannot be reconciled at all with those circumstances where a medication or induction abortion is incomplete, and the patient needs a prompt suction or D&E procedure performed by a different doctor than originally contemplated in her care. Eisenberg Aff. ¶ 28; Macones Aff. ¶ 14. All of these burdens, and the costs associated with them, will mean that more women in Missouri will be unable to access abortion at all.

At the same time as the Act would impose these burdens, its same-physician requirement is a medically-unnecessary requirement that departs from modern medical practice and standards of care. Eisenberg Aff. ¶¶ 66–72; Macones Aff. ¶¶ 37–43. The practice of having one qualified professional meeting in person with a prospective abortion patient, counseling her about her options, informing her of all relevant medical information, and answering her questions, as practiced by Plaintiffs, already fully complies with medical and ethical best practices. Id. The

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structuring of modern medical practice in this way, which involves a team approach to delivering health care, avoids patient delays, limits physicians and other clinicians to physically manageable shifts, and provides effective continuity of patient care. Id. Indeed, no similar Missouri law applies to any other area of medicine. That is to say, in no other area of medicine, even for procedures that carry far higher risks, is a physician in Missouri prohibited from enlisting qualified staff or another physician to aid in providing information to a patient prior to the patient providing voluntary and informed consent. Id.

F. The Act's Passage

When S.B. 5 was introduced, the two-page bill's initial title was: "An Act [t]o repeal section 188.075, RSMo, and to enact in lieu thereof one new section relating to the jurisdiction of the attorney general to enforce state abortion laws, with penalty provisions." The bill contained one new subsection: § 188.075.3. True to its title, the new subsection 3 gave the Missouri Attorney General original jurisdiction, concurrent with that of each prosecuting or circuit attorney in the state, to prosecute violations of existing state laws that regulate abortion providers. After passing out of committee in its original form, S.B. 5 underwent numerous expansions on the Senate floor, with a variety of disparate provisions added, in the House Children and Families Committee, and finally on the floor of the House. The House's amended version of the House Committee's Substitute for the Senate Substitute for S.B. 5 was then passed by the Senate and became the version of S.B. 5 truly agreed to and finally passed by the General Assembly and signed by Governor Greitans.

The final title of S.B. 5 was "An Act [t]o repeal sections 188.021, 188.027, 188.030, 188.039, 188.047, 188.075, 192.665, 192.667, 197.150, 197.152, 197.158, 197.160, 197.162, 197.165, 197.200, 197.205, 197.215, 197.220, 197.225, 197.230, 197.235, 197.240, 197.285,

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197.287, 197.289, 197.293, 197.295, and 595.027, RSMo, and to enact in lieu thereof thirty-one new sections relating to abortions, with penalty provisions." As explained in more detail below, see infra Part III.A.3, the final version of S.B. 5 is replete with sections, including the Act, that do not share the limited original purpose of S.B. 5 as it was introduced: to give the Missouri Attorney General jurisdiction to prosecute violations of existing state laws that regulate abortion providers.

III. ARGUMENT

PLAINTIFFS ARE ENTITLED TO A TEMPORARY RESTRAINING ORDER AND A PRELIMINARY INJUNCTION

The purpose of a temporary injunction is "to preserve the status quo until the trial court adjudicates the merits of the claim for a permanent injunction." State ex rel. Myers Mem'l Airport Comm., Inc. v. City of Carthage, 951 S.W.2d 347, 350 (Mo. Ct. App. 1997). In deciding a motion for a temporary restraining order or a preliminary injunction, the trial court weighs "the movant's probability of success on the merits, the threat of irreparable harm to the movant absent the injunction, the balance between this harm and the injury that the injunction's issuance would inflict on other interested parties, and the public interest." State ex rel. Dir. of Revenue v. Gabbert, 925 S.W.2d 838, 839 (Mo. 1996) (internal quotation marks and citations omitted); see also Minana v. Monroe, 467 S.W.3d 901, 907 (Mo. Ct. App. 2015). Although "[n]o single factor in itself is dispositive," United Indus. Corp. v. Clorox Co., 140 F.3d 1175, 1179 (8th Cir. 1998), some showing of probability of success is required, Gabbert, 925 S.W.2d at 839; CitiMortgage, Inc. v. Just Mortg., Inc., No. 4:09 CV 1909 DDN, 2013 WL 6538680, at *3 (E.D. Mo. Dec. 13, 2013). In addition, the movant must supply some evidence supporting each of these considerations, however, the inquiry is "'flexible'" and should not be accomplished with "'mathematical precision.'" Gabbert, 925 S.W.2d at 840 (quoting Dataphase Sys., Inc. v. C L

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Sys., Inc., 640 F.2d 109, 113 (8th Cir. 1981)). As explained below, all of these factors weigh in Plaintiffs' favor.

A. PROBABILITY OF SUCCESS ON THE MERITS WEIGHS IN FAVOR OF AN INJUNCTION

1. COUNT 1: Plaintiffs Are Likely to Succeed in Demonstrating that a Same-Physician Requirement Violates Their Patients' Due Process Rights Under the Missouri Constitution

"Claimed violations of a right to personal privacy, to procreate, and similar rights not specifically set out in the constitution but inherent in the concept of ordered liberty are analyzed under substantive due process principles." Doe v. Phillips, 194 S.W.3d 833, 843 (Mo. 2006) (citing *inter alia* Albright v. Oliver, 510 U.S. 266, 272 (1994) (generally applied to "matters relating to marriage, family, procreation, and the right to bodily integrity") (citing Planned Parenthood of Se. Pennsylvania v. Casey, 505 U.S. 833, 850 (1992))). The Missouri Supreme Court has previously declined the invitation to interpret the due process clause more broadly than the comparable federal constitutional provision in the context of the cases that were before them. See Phillips, 194 S.W.3d at 841 ("The Court rejects the Does' invitation to interpret the Missouri due process, equal protection or ex post facto clauses more broadly than comparable federal constitutional provisions *here*." (emphasis added)); Reprod. Health Servs., 185 S.W.3d at 692 ("There is no reason, *within the context of this case*, to construe this language from the Missouri constitution more broadly than the language used in the United States constitution." (emphasis added)). Rather, in prior cases, the Court has chosen to apply the due process clause "consistently with [its] interpretation under federal law." Phillips, 194 S.W.3d at 841; see also Reprod. Health Servs., 185 S.W.3d at 691–92 (rejecting challenge under the Missouri Constitution to a 24 hour mandatory delay law (citing Casey, 505 U.S. at 877)); cf. Kansas City Premier Apartments, Inc. v. Mo. Real Estate Comm'n, 344 S.W.3d 160, 169 n.4 (Mo. 2011).

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Although Plaintiffs maintain that the Missouri Constitution confers greater privacy and liberty rights than are conferred by the United States Constitution, it is not necessary for this Court to decide that question at this stage because it is plain that the Act fails even if the Court applies the due process clause "consistently with [its] interpretation under federal law."[3]

As the Missouri Supreme Court has recognized, "[a] state may not impose an 'undue burden' on a woman's decision to have an abortion before fetal viability." Planned Parenthood of Kansas v. Nixon, 220 S.W.3d 732, 743 (Mo. 2007) (citing Casey, 505 U.S. at 876–77)). An undue burden exists if a state "place[s] a substantial obstacle in the path of a woman seeking an abortion." Id. In Whole Woman's Health v. Hellerstedt, the U.S. Supreme Court recently stressed that the undue burden standard requires a court to balance "the burdens a law imposes on abortion access together with the benefits those laws confer." 136 S. Ct. 2292, 2309 (2016) (citing Casey, 505 U.S. at 887). Moreover, in assessing the benefits as well as the burdens, a court must consider the actual evidence and not merely defer to legislative findings or the government's speculation. Whole Woman's Health, 136 S. Ct. at 2309 (it "is wrong to equate the judicial review applicable to the regulation of a constitutionally protected personal liberty with the less strict review applicable where, for example, economic legislation is at issue").

Under these principles, cf. Phillips, 194 S.W.3d at 841, the Act's same-physician requirement does not provide women any benefits. As current law reflects, and as it has for a number of years, see Mo. Rev. Stat. §§ 188.027, 188.039, abortion patients—like patients receiving other medical treatment—need not receive pre-procedure information about risks from

[3] Plaintiffs reserve their right to argue at the permanent injunction stage that Missouri Constitution's far-reaching right to liberty and privacy affords more protection to the right to choose an abortion than afforded by the United States Constitution. Cf. Ambers-Phillips v. SSM DePaul Health Ctr., 459 S.W.3d 901, 911 (Mo. 2015) ("[F]undamental rights normally include free speech, freedom of travel, the right to personal privacy . . . .").

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the exact same clinician(s) who will be involved in subsequent stages of their care. On the contrary, it is common and within the standard of care in many types of patient care, including much riskier types of care than abortion, for one qualified professional to counsel and obtain informed consent from a patient, and then for other clinicians to subsequently provide the chosen procedure. See Eisenberg Aff. ¶¶ 66–72. Nor is there any evidence of the need for the Act, as women having abortions in Missouri have been able to give full and informed consent after receiving information about risks from a qualified and licensed professional other than the same physician who will induce or perform their abortion. Cf. Whole Woman's Health, 136 S. Ct. at 2311–12 (noting the absence of evidence demonstrating the existence of a problem the challenged statute would solve); see also Planned Parenthood of Ind. & Ky., Inc. v. Comm'r, Ind. State Dep't of Health, No. 1:16–cv–01807, 2017 WL 1197308, at *20 (S.D. Ind. Mar. 31, 2017) ("The relevant question is whether the . . . law provides the asserted benefits *as compared to the prior law*." (citing Whole Woman's Health, 136 S. Ct. at 2311, 2314)). Indeed, the challenged Act appears to recognize that other qualified professionals including referring physicians are fully capable of both providing patients with information regarding the medical care they are seeking *and* obtaining a woman's informed and voluntary consent. See supra Part II.C.[4] No other state in the nation imposes as extreme a requirement as the challenged Act, and Missouri imposes no similar requirements on any other medical care, including procedures that carry far more risks, see Macones Aff. ¶¶ 37–41; Eisenberg Aff. ¶ 71.

[4] While Plaintiffs maintain that abortion patients can and should be able to provide informed consent in the same manner as patients seeking all other medical procedures—on the same day as the procedure and without state-mandated information—those issues are not presented in this motion. Plaintiffs at this time request the Court only to maintain the status quo and enjoin the same-physician requirement.

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On the other side of the balance, the same-physician requirement will impose enormous burdens on abortion access. As an initial matter, a same-physician requirement for counseling and performance of the abortion would be literally impossible to fulfill for induction abortions and lead to outright denial of that care. The requirement would also severely cripple the provision of other abortion services in Missouri. See supra Part II.D. The Act would diminish both the number of physicians available to perform abortions, already scarce due to other legal restrictions, and the resources of the physicians who continue to provide abortion in Missouri, who would have to divert a portion of their limited time away from the provision of abortion and other gynecological procedures. See Kogut Aff. ¶ 38; Samulcek Aff. ¶ 17; Eisenberg Aff. ¶¶ 81–82. This will both raise the cost of the procedure and lead to significant delays (beyond the 72 hour mandatory delay). If the Act is allowed to take effect, it is foreseeable that it will routinely cause delays of *two to four weeks* for some patients, if compliance is possible at all, a length of time that certainly increases the medical risk (and in many cases, the cost) of the procedure.[5] Samulcek Aff. ¶ 16; Kogut Aff. ¶¶ 34–37; Eisenberg Aff. ¶ 83; Macones Aff. ¶¶ 31–34. Delays of this length will mean, for example, that some women will be unable to access medication abortion, despite preferring that method, and others will find themselves past the time when they can legally obtain an abortion at all.

Some of Plaintiffs' patients, who currently are able to go to a health center closer to their home to meet with a qualified professional at least 72 hours before an abortion, Kogut Aff. ¶ 42; see also Samulcek Aff. ¶ 20, will be particularly burdened. They will now be forced to travel instead to the health center where they will have their abortion to receive the state-mandated

[5] The Act does not contain a medical emergency exception, and therefore puts certain patients' health at particularly high risk. See Eisenberg Aff. ¶ 78.

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information from the physician who is to perform their abortion. This will require some women to make two round trips of hundreds of miles to have an abortion because, due to other legal restrictions, abortion services are currently only offered at limited health centers, and not all health centers provide both medication and surgical abortion services, Samulcek Aff. ¶ 18; indeed, surgical abortions through 22 weeks are performed only in St. Louis. Kogut Aff. ¶ 41–42. Thus, for example, whereas currently women in the Joplin and Springfield areas are only required to make one 400+ mile round-trip to St. Louis by doing their first visit at RHS's Springfield Center, under the Act these women would have to travel a minimum of 800 miles total to have an abortion. Kogut Aff. ¶ 42. This will impose an enormous burden on a woman's ability to exercise her right to have an abortion.

The burdens caused by the Act will disproportionately impact the Plaintiffs' low-income patients, who constitute a significant portion of patients receiving abortion services, women who are victims of abuse, and those with medical conditions. See Katz Aff. ¶¶ 19–21; Kogut Aff. ¶¶ 44–45; Samulcek Aff. ¶ 18.

Other courts have recognized that these sorts of burdens (especially when they are so unjustifiable) are undue. See, e.g., Whole Woman's Health, 136 S. Ct. at 2313 (holding abortion restrictions led to scheduling constraints, longer wait times, and increased driving distance, which supported finding of undue burden); Planned Parenthood of Wis., Inc. v. Schimel, 806 F.3d 908, 920 (7th Cir. 2015), cert. denied, 136 S. Ct. 2545 (2016) (holding abortion restriction endangered women's health by increasing wait time and causing women to delay abortions); Planned Parenthood of Ind. & Ky., Inc., 2017 WL 1197308 at *7, *25 (preliminarily enjoining law that would require many women to travel hundreds of miles to their informed-consent appointments and that such travel is especially difficult for low-income women); Planned

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Parenthood Se., Inc. v. Strange, 33 F. Supp. 3d 1330, 1377–78 (M.D. Ala.), as supplemented, 33 F. Supp. 3d 1381 (M.D. Ala. Oct. 20 2014), and amended, 2014 WL 5426891 (M.D. Ala. Oct. 24, 2014) (permanently enjoining restriction in part because it would force women to travel farther, which would cause some women to forgo abortion and others to delay their abortions, while imposing significant financial and other costs on remaining women).

While the Missouri Supreme Court upheld under Casey a challenge to a prior version of section 188.039, which required that a patient be provided certain state-mandated information at least 24 hours prior to having an abortion, see Reprod. Health Servs., 185 S.W.3d at 691, the Act challenged here is far more extreme. **First**, the Act requires the *same* physician who is later to perform or induce the abortion to provide certain state-mandated information to a patient, *and* to do so in person, at the beginning of the mandatory delay period, while the law at issue in Reproductive Health Services, 185 S.W.3d at 687–88, required only that "*a* treating physician" provide the relevant information. **Second**, the Act requires that the state-mandated information be provided by the physician who is to perform or induce the abortion at least **72** hours before the abortion—which is far more onerous than the 24-hour mandatory delay requirement that was at issue in Reproductive Health Services. The existing 72-hour mandatory delay is burdensome in and of itself, but, as Plaintiffs have demonstrated, the Act's same-physician restriction will greatly increase this mandatory delay period, further delaying or preventing women from obtaining abortions. See supra Part II.D. **Third**, and relatedly, Plaintiffs have presented evidence of significant additional burdens, including that the Act would substantially reduce access to not only surgical abortion, but to the noninvasive option of medication abortion as well, and would end induction abortion procedures. Id.

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Indeed, *no court in the country* has upheld a law as extreme as the Act. Plaintiffs are only aware of two other states, Texas and South Dakota, that require the "same physician" to provide the relevant state-mandated information.[6] Texas's law not only has only a 24-hour waiting period, but the requirement is also reduced to two hours if the woman travels from more than 100 miles away. Tex. Health & Safety Code Ann. § 171.012(a)(4). And South Dakota's law has an exception for "serious unforeseen circumstances" that prevent the same physician from taking the consent and performing the abortion. S.D. Codified Laws § 34-23A-57. In short, the burdens that the Act imposes are wholly unprecedented and medically unnecessary, and impermissibly burden access to abortion. Plaintiffs are therefore likely to succeed in demonstrating that the Act violates patients' rights guaranteed by the Missouri Constitution.

2. COUNT 2: Plaintiffs Are Likely to Succeed in Demonstrating that the Act is Void for Vagueness

The Act also violates the constitutional rights of Plaintiffs and their staff because it is impermissibly vague. A statute is unconstitutionally vague if it fails to provide (1) notice to the ordinary person of what conduct is prohibited or (2) standards to those enforcing the law so as to prevent arbitrary and discriminatory enforcement. City of Festus v. Werner, 656 S.W.2d 286, 287 (Mo. Ct. App. 1983) (holding municipal ordinance "too vague to be enforceable or constitutional"). "Where . . . the statutory terms are of such uncertain meaning, or so confused that the courts cannot discern with reasonable certainty what is intended, the statute is void." Bd. of Educ. of St. Louis v. State, 47 S.W.3d 366, 369 (Mo. 2001) (holding statute unconstitutionally void for vagueness) (citation omitted). Moreover, a law that "threatens to inhibit the exercise of constitutionally protected rights," State ex rel. Nixon v. Telco Directory Publ'g, 863 S.W.2d 596,

[6] The only court to have considered a same-physician, 72-hour mandatory delay restriction, preliminarily enjoined it. See Planned Parenthood of Minn., N.D., S.D. v. Daugaard, 799 F. Supp. 2d 1048 (D. S.D. 2011), claim dismissed on other grounds.

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600 (Mo. 1993) (en banc) (citation and quotation marks omitted), and imposes criminal penalties on individual behavior for noncompliance, State v. Shaw, 847 S.W.2d 768, 774 (Mo. 1993) (en banc), requires greater clarity. See also id. ("[t]he possibility of criminal sanctions heightens the stakes and necessarily sharpens the focus of the constitutional analysis.").

The challenged Act is void for vagueness because it imposes conflicting requirements on physicians who provide abortions, under the threat of criminal and licensing penalties, and fails to provide sufficient guidance as to what is required of them under the Act in the following ways:

First, existing law states that a physician may not perform an abortion unless a patient has provided informed consent as specified in Missouri Revised Statutes Section 188.027. As discussed above, supra Part II.C., the Act amends existing law and adds conflicting language regarding who is allowed to provide a woman with the state-mandated information in order to comply with the Missouri law. Namely, the Act adds a new subsection 6 to Missouri Revised Statutes Section 188.027, which states that the physician who will "perform or induce" a woman's abortion must be the same person(s) to, orally and in person and at least 72 hours in advance of her procedure, provide information about "the immediate and long term risks to the woman," Pet. Ex. A at 8, yet the Act leaves unchanged subsection 1 which allows a referring physician, *or* a qualified professional, *or* the physician who is to induce or perform the abortion to provide this exact same information, id. at 3. Thus, it is unclear what the Act requires and allows, and specifically whether it is legally sufficient for a qualified professional or a referring physician to provide information about risks to the woman at the state-mandated visit.[7]

[7] The Act's changes to Missouri Revised Statutes Section 188.039 cause further confusion. The Act amends Section 188.039 to *add* that a referring physician (in addition to a qualified professional, or the physician who is to perform or induce the abortion) may provide the woman

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Second, the Act lacks clarity as to what is required when an abortion involves more than one provider and multiple steps over the course of more than one day, which is a common occurrence for second trimester abortions and absolutely necessary for inductions, which can span numerous days. Neither "perform" nor "induce" are defined, and thus Plaintiffs are left to guess as to their meaning as applied to the Act's same-physician requirement. For example, in the context of procedures that require dilation over the course of one or two days, must the physician who begins the dilation of the cervix be the person who provided the woman with the state-mandated information at least 72 hours prior? Or must it be the physician who performs the abortion? Or both? And if the abortion spans numerous days, as is the case for inductions, must every physician involved in the woman's care have provided her with the state-mandated information 72 hours before the beginning of her procedure? The Act provides zero guidance as to which physician must have provided the patient with the information in these common scenarios. Similarly, the Act is silent as to whether a physician who, training under the supervision of an attending physician, may also be involved in a patient's abortion procedure, which is the case at least once a week at RHS, must also be present during the state-mandated information visit with the attending physician. Nor does the Act provide any guidance as to how physicians should handle the very common scenario where a patient must reschedule her

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with the state-mandated information required by Section 188.039. This statute, as stated above, has been interpreted by the Missouri Supreme Court to codify the duty to obtain a patient's informed consent, which necessarily involves providing information about risks. See Reprod. Health Servs., 185 S.W.3d at 693. Thus, Section 188.039 and subsection 1 of Section 188.027 both suggest that information about risks may be provided to the woman by a qualified professional, *or* a referring physician, *or* the physician who is to perform or induce the abortion.

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procedure appointment or a physician becomes unable to perform a specific patient's previously scheduled procedure.[8]

The Act thus fails to provide Plaintiffs with "notice . . . of what is prohibited" so that Plaintiffs and their staffs may act accordingly. City of Festus, 656 S.W.2d at 287. "[T]he statutory terms are of such uncertain meaning, [and] so confused" that it cannot be "discern[ed] with reasonable certainty what is intended . . . ." Bd. of Educ. of St. Louis, 47 S.W.3d at 371 (internal quotations and citations omitted). Because Plaintiffs cannot determine what conduct will incur the Act's severe criminal and licensing penalties and what conduct will not, Plaintiffs will be chilled in their conduct in providing abortions. For all these reasons, Plaintiffs are likely to succeed in demonstrating that the Act is unconstitutionally vague. See Telco Directory Publ'g, 863 S.W.2d at 600 (most important factor affecting the clarity that the Constitution demands of a law, is "whether [the law] threatens to inhibit the exercise of constitutionally protected rights" (citation omitted)).

3. COUNT 3: Plaintiffs are Likely to Succeed in Demonstrating that S.B. 5 was Unconstitutionally Amended to Change Its Original Purpose

Because the final version of S.B. 5 includes numerous provisions that stray far beyond the bill's original purpose, Plaintiffs are likely to succeed in demonstrating that the bill, and specifically the Act, was passed in violation of the Missouri Constitution. Article III, Section 21 of the Missouri Constitution prohibits the General Assembly from passing a bill that has been

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[8] Tellingly, not even the sponsor of S.B. 5 (which was later amended to add the same-physician restriction see infra), seems to have understood the bill to require that the ***same*** physician provide both the abortion and the state-mandated information. See Jason Rosenbaum, "New Abortion Regulations Headed to Missouri Governor, Ending 2nd Special Session," KCUR St. Louis Public Radio (July 25, 2017) (http://kcur.org/post/new-abortion-regulations-headed-missouri-governor-ending-2nd-special-session#stream/0) ("'Requiring ***a*** doctor to meet the 72-hour waiting period is something that's common sense. It's common medical practice to do that,' [Senator] Koenig said after the bill passed." (emphasis added)).

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"so amended in its passage through either house as to change its original purpose." "Original purpose refers to the general purpose of the bill." Mo. Ass'n of Club Execs. v. State, 208 S.W.3d 885, 888 (Mo. 2006). Section 21 "prohibits the introduction of a matter that is not germane to the object of the legislation or that is unrelated to its original subject." Lebeau v. Comm'rs of Franklin Cnty., Mo., 422 S.W.3d 284, 289 (Mo. 2014) (internal quotation omitted). As the Missouri Supreme Court has explained, amendments are "clearly and undoubtedly not germane" if they are not "relevant to or closely allied with a bill's original purpose." Trout v. State, 231 S.W.3d 140, 144 (Mo. 2007) (internal quotation and alteration omitted).

To determine whether a bill violates section 21, a court must first identify the bill's original purpose as "established by the bill's 'earliest title and contents' at the time the bill is introduced." Legends Bank v. State, 361 S.W.3d 383, 386 (Mo. 2012) (quoting Club Execs., 208 S.W.3d at 888). "The second analytical step is to compare the original purpose with the final version of [the bill]." Id.

S.B. 5 started as a simple, two-page bill aimed at bringing an area of existing law within the ambit of the Missouri Attorney General's original jurisdiction. Bill sponsor Senator Andrew Koenig had previously introduced an identical version of the bill as S.B. 196 at the start of the 2017 regular session of the General Assembly.[9] After the bill failed to advance during the regular session, Senator Koenig reintroduced it with identical language as S.B. 5 during the second

[9] In fact, Senator Koenig has been pursuing extension of the Attorney General's jurisdiction since before he was sworn in as a first-term senator. On December 8, 2016—even before the first day of the General Assembly's 99th Session—then-Representative Koenig prefiled S.B. 196, entitled "an Act to repeal section 188.075, RSMo, and to enact in lieu thereof one new section relating to the jurisdiction of the attorney general to enforce state abortion laws, with penalty provisions." S.B. 196, 99th Gen. Assemb., Reg. Sess. (Mo. 2017). S.B. 196 was formally introduced on the first day of the session, on January 4, 2017. But for the bill number, Senator Koenig's S.B. 5 as introduced mirrors S.B. 196 *verbatim*. Compare Pet. Ex. B, with S.B. 196, 99th Gen. Assemb., Reg. Sess. (Mo. 2017).

special session. His remarks in a hearing before the Missouri Senate Seniors, Families and Children Committee on the day S.B. 5 was introduced clearly explain the bill's goal. Senator Koenig noted his bill would simply add another area of law to the list of narrow subjects in which the attorney general has original jurisdiction – including gaming violations, Medicaid fraud, and hazardous waste among other subjects. See Travis Zimpfer, "Senate committee passes abortion bills; action on floor set for Wednesday," The Missouri Times (June 13, 2017) (http://themissouritimes.com/41596/senate-committee-passes-abortion-bills-action-floor-set-wednesday).

Indeed, the title and contents of S.B. 5 as introduced leave no room for question about the bill's original purpose. First, the title: the original title of the bill was "An Act [t]o repeal section 188.075, RSMo, and to enact in lieu thereof one new section relating to the jurisdiction of the attorney general to enforce state abortion laws, with penalty provisions." See S.B. 5, 99th Gen. Assemb., 2nd Extraordinary Sess. (as introduced, June 12, 2017), Pet. Ex. B; see also Stroh Brewery Co. v. State, 954 S.W.2d 323, 326 (Mo. 1997) (concluding that although bill title "an act to amend chapter 311, RSMo, by adding one new section relating to the auction of vintage wine, with penalty provisions" did not clearly convey exclusive purpose as to the auction of vintage wine without further limitation, it did convey "that the amendment of Missouri's liquor control law, chapter 311, was the purpose of the bill."). And, true to the title of the bill, the contents of S.B. 5 as introduced proposed the enactment of one new provision of law regarding the attorney general's jurisdiction, making no changes to the prior version of § 188.075 other than to add the following:

> 3. The attorney general shall have concurrent original jurisdiction throughout the state, along with each prosecuting attorney and circuit attorney within their respective jurisdictions, to commence actions for a violation of any

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> provision of this chapter, for a violation of any state law on the use of public funds for an abortion, or for a violation of any state law which regulates an abortion facility or a person who performs or induces an abortion. The attorney general, or prosecuting attorney or circuit attorney within their respective jurisdictions, may seek injunctive or other relief against any person who, or entity which, is in violation of any provision of this chapter, misuses public funds for an abortion, or violates any state law which regulates an abortion facility or a person who performs or induces an abortion.

Pet. Ex. B. Both the title and contents of S.B. 5 match exactly, leaving no space from which to divine an alternative original purpose other than to expand the Attorney General's powers to include the prosecution of violations of existing abortion laws.

In contrast to the original version of the bill, the final version of S.B. 5 is a 40-page hodgepodge of provisions that not only change the prosecutorial powers of the Attorney General, but also impact a wide array of disparate areas of law. These provisions are not germane to the objective of expanding the attorney general's original jurisdiction and are unrelated to S.B. 5's original purpose. For instance, S.B. 5 wades deep into the serious topics of preemption and home rule by creating Section 188.125, which preempts the law-making powers of political subdivisions in various ways. Section 188.125.2 blocks political subdivisions from, *inter alia*, enacting or enforcing an ordinance that "adversely affects an alternatives to abortion agency's operations or speech," Pet. Ex. A at 17, maintaining a policy that has the effect of indirectly requiring a person to "participate in abortion" against the person's moral or religious beliefs, adopting an ordinance requiring a property owner to rent to an abortion facility if contrary to that property owner's religious or moral beliefs, or adopting a regulation requiring a health care provider "to provide coverage for or to participate in a health plan that includes benefits that are not otherwise required by state law," id. at 18. Clearly, the overarching purpose of Section 188.125 is to limit the powers of political subdivisions of Missouri.

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As another example, the final version of S.B. 5 newly creates section 188.160, which requires entities "involved in abortion" to maintain a written policy relating to whistleblower protections for employees who disclose actual, potential, or alleged violations of *any* "applicable federal or state laws or administrative rules, regulations, or standards." Id. at 19. While section 188.160 may represent another step in the 99th General Assembly's project of remaking Missouri law on whistleblower protections, see S.B. 43, 99th Gen. Assemb., Reg. Sess. (Mo. 2017), codified at Mo. Rev. Stat. § 285.575, also known as the "Whistleblower's Protection Act," it in no way revises the original jurisdiction of the attorney general and thus has a different purpose than the original purpose of S.B. 5. In addition, S.B. 5 contains provisions which create new obligations for the Department of Health and Senior Services related to licensing abortion facilities—a far cry from granting new powers to the Attorney General. These obligations range from requiring the Department to create a new licensing category of "abortion facility" and complete annual inspections, Pet. Ex. A at 33, to a mandate to submit annual reports to the General Assembly related to pathology tissue reports, id. at 15–16. Nor does the challenged same-physician requirement relate to the bill's original purpose. As introduced, S.B. 5 did not touch upon the subject of informed consent; indeed, the Act altered neither the conduct of abortion providers nor the operations of the health care settings in which they work, as it was strictly related to the Attorney General's powers.

Section 21 does not prohibit legislators from extending the scope of a bill after it has been introduced, so long as the original purpose is maintained. See Jackson Cnty. Sports Complex Auth. v. State, 226 S.W.3d 156, 160 (Mo. 2007). The General Assembly would have been within its bounds to add additional provisions relating to the expansion of the attorney general's original jurisdiction over existing laws. Arguably, the bill could have been subsequently changed to add

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provisions more broadly related to the prosecution and enforcement of, and punishment for, violations of the state's existing abortion laws, (e.g., increasing the criminal penalties for violations or creating a civil cause of action for private citizens). But the later amendments to S.B. 5 went far beyond the bill's original purpose of granting the Attorney General concurrent jurisdiction along with each prosecuting attorney and circuit attorney within their respective jurisdictions. There is no indication from either the title or the contents of the original version of S.B. 5 that it had anything to do with imposing numerous additional obligations and restrictions on various entities, including the Department of Health, abortion providers, and political subdivisions.

The Missouri Constitution's original purpose provision "provide[s] the citizens of Missouri with necessary and valuable legislative accountability and transparency," Legends Bank, 361 S.W.3d at 389, by "facilitat[ing] orderly procedure, avoid[ing] surprise, and prevent[ing] 'logrolling,' in which several matters that would not individually command a majority vote are rounded up into a single bill to ensure passage," id.; Lebeau, 422 S.W.3d at 289 (internal citation omitted). The passage of S.B. 5, including the Act, directly contravenes these goals and results in an unconstitutional mismatch between the narrow purpose of the original version of S.B. 5, which was to revise Missouri Revised Statutes § 188.175 to expand the attorney general's jurisdiction over existing laws, and the wide-ranging amendments made to the bill during its passage, which make numerous non-germane alterations and additions to unrelated areas of law. The Act, in particular, is not germane to the original purpose of S.B. 5 and Plaintiffs are therefore likely to succeed on this claim as well.

B. THE REMAINING FACTORS FOR PRELIMINARY INJUNCTIVE RELIEF ALL FAVOR PLAINTIFFS

1. Plaintiffs and Their Patients Face Irreparable Injury

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Irreparable harm is established if monetary remedies cannot provide adequate compensation for improper conduct. Peabody Holding Co., Inc. v. Costain Grp. PLC, 813 F. Supp. 1402 (E.D. Mo. 1993). The term "adequate remedy at law" generally means that damages will not adequately compensate the plaintiff for the injury or threatened injury, or that the plaintiff would be faced with a multiplicity of suits at law. Snelling v. City of St. Louis Dep't of Pub. Utils. - Water Div., 897 S.W.2d 642 (Mo. Ct. App. 1995).

Plaintiffs have plainly demonstrated that absent an injunction they and their patients will suffer irreparable harm for which there is no adequate remedy at law. If allowed to take effect, the Act will prevent whole categories of women from accessing an abortion, and delay other women up to 2-4 weeks from being able to have an abortion, which will increase medical risks. This unquestionably constitutes an irreparable injury for which there is no adequate remedy at law. See Mo. State Med. Ass'n v. State, No. 07AC-CC00567, 2007 WL 6346841 (Mo. Cir. Ct. for Cole Cnty., July 3, 2007) (granting temporary restraining order against law that restricted practice of midwifery and would impose irreparable injury on physicians and their pregnant patients); Harris v. Bd. of Supervisors, L.A. Cnty., 366 F.3d 754, 766 (9th Cir. 2004) (plaintiffs established likelihood of irreparable harm where evidence showed they would experience pain, complications, and other adverse effects due to delayed medical treatment); Planned Parenthood of Kan. & Mid-Mo. v. Lyskowski, No. 2:15-CV-04273-NKL, 2015 WL 9463198, at *4 (W.D. Mo. Dec. 28, 2015) (any period during which plaintiff could not perform abortions because of the loss of its license constitutes irreparable injury), appeal dismissed (May 12, 2016).

In addition, the violation of Plaintiffs' and their patients' constitutional rights caused by the Act itself constitutes irreparable injury. See Elrod v. Burns, 427 U.S. 347, 373 (1976); Deerfield Med. Ctr. v. City of Deerfield Beach, 661 F.2d 328, 338 (5th Cir. Unit B. Nov. 1981)

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(threatening the fundamental right to privacy mandates a finding of irreparable injury); Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action, 558 F.2d 861, 867 (8th Cir. 1977) (holding that plaintiff's showing of interference "with the exercise of its constitutional rights and the rights of its patients supports a finding of irreparable injury").

2. Preliminarily Enjoining The Act Will Not Harm Defendant and Will Serve the Public Interest

Finally, the balance of equities also weighs heavily in favor of maintaining the status quo. As set forth above, Plaintiffs and their patients will suffer serious harm if the law takes effect, whereas Defendants only stand to lose the ability temporarily to enforce a law that is likely to be held unconstitutional, where there is no evidence that that law will help even one woman. Moreover, the public interest will be served by injunctive relief. The public interest is not served by putting women's health at risk nor by allowing an unconstitutional government action. See Hill v. Mo. Conservation Comm'n, No. 15OS-CC00005-01, 2016 WL 8814770 at *18 (Mo. Cir. Ct. Gasconade Cnty. Nov. 17, 2016) ("[T]here can be no public interest in enforcement of an unauthorized government action."); Mo. State Med. Ass'n, 2007 WL 6346841 ("[B]alancing of the harms favors immediate injunctive relief, because a restraining order will not harm the State of Missouri and will actually further its interests in ensuring the health and safety of its citizens."); see also Saint v. Neb. Sch. Activities Ass'n, 684 F. Supp. 626, 628 (D. Neb. 1988) (noting "no discernable harm" to defendant in losing the ability to enforce potentially unconstitutional regulations); Reinert v. Haas, 585 F. Supp. 477, 481 (S.D. Iowa 1984) (public interest "is always well served by protecting the constitutional rights of all its members"); see also Kirkeby v. Furness, 52 F.3d 772, 775 (8th Cir. 1995) (public interest favored injunction against unconstitutional ordinance).

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C. BOND IN THIS CASE

Plaintiffs respectfully submit that bond be set at no more than the nominal amount of $100. See Planned Parenthood of Kan. and Mid-Mo. v. Nixon, No. 0516-CV25949, 2005 WL 3116528, at *1, *2 (Mo. Cir. Ct. 2005) (maintaining $100 bond for TRO and subsequent preliminary injunction in case challenging law creating civil cause of action related to minors' abortions). Because a preliminary injunction in this case would merely maintain the status quo, Defendants are not at risk of harm should they later prevail in this litigation.

CONCLUSION

For these reasons, the Court should grant Plaintiffs' Motion for a Temporary Restraining Order, followed by a Preliminary Injunction, and enjoin Defendants from enforcing the Act.

Dated: October 10, 2017

Respectfully submitted,
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** Pro hac vice motion forthcoming*

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