No. 23A763

In the Supreme Court of the United States

RAÚL LABRADOR,
IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF IDAHO,
Applicant,

v.

PAM POE,
BY AND THROUGH HER PARENTS AND NEXT FRIENDS, *et al.*,
Respondents.

To the Honorable Elena Kagan, Associate Justice of the United States Supreme Court and Circuit Justice for the Ninth Circuit

On Emergency Application to Stay Pending Appeal Injunction Entered by the United States District Court for the District of Idaho

BRIEF OF ALABAMA AND 18 OTHER STATES AS *AMICI CURIAE* IN SUPPORT OF IDAHO'S STAY APPLICATION

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

Cleveland Clinic, *Orchiectomy*,
https://my.clevelandclinic.org/health/procedures/orchiectomy
(accessed Feb. 16, 2024) 8

Cleveland Clinic, *Perineoplasty*,
https://my.clevelandclinic.org/health/treatments/23183-perineoplasty
(accessed Feb. 16, 2024) 10

Cleveland Clinic, *Phalloplasty*,
https://my.clevelandclinic.org/health/treatments/21585-phalloplasty
(accessed Feb. 16, 2024) 9, 10

Cleveland Clinic, *Vaginectomy*,
https://my.clevelandclinic.org/health/treatments/22862-vaginectomy
(accessed Feb. 16, 2024) 10

Craig Alter et al. (eds.), *Precocious Puberty*, ENDOCRINE SOCIETY
(Jan. 24, 2022), https://perma.cc/6Q3E-PEMP 11

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(Sept. 15, 2022), https://perma.cc/Y9G6-TP3M 9, 14, 18

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https://perma.cc/RFU9-S72N (last accessed Dec. 10, 2023) 5, 10

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Jenny Jarvie, *This Abortion Doctor is Not Ready to Leave Alabama*,
L.A. TIMES (Apr. 28, 2023), https://perma.cc/G5KZ-J7TB 20

Karen O. Klein, *Review of Hormone Replacement Therapy in Girls and Adolescents with Hypogonadism*,
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https://apnews.com/article/health-business-tennessee-nashville-vanderbilt-university-6deb93f7dea92f1b2082c39f72b59766 19

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Maria Vogiatzi et al., *Testosterone Use in Adolescent Males: Current Practice and Unmet Needs*, 5 J. ENDOCRINE SOC'Y (2021), https://perma.cc/SZ3D-QE2A 12

Nat'l Inst. for Health & Care Excellence, *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria* (Mar. 11, 2021), https://perma.cc/93NB-BGAN 11, 12

Nat'l Inst. for Health & Care Excellence *Gender-affirming hormones for children and adolescents with gender dysphoria* (Mar. 11, 2021), https://perma.cc/M8J5-MXVG 12, 13

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Sarah O'Neill et al., *The role of penectomy in penile cancer—evolving paradigms*, TRANSLATIONAL ANDROLOGY & UROLOGY 3191 (2020), http://dx.doi.org/10.21037/tau.2019.08.14 8

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INTEREST OF *AMICI CURIAE*

The States of Alabama, Alaska, Arkansas, Florida, Georgia, Indiana, Iowa, Louisiana, Mississippi, Missouri, Montana, Nebraska, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Virginia, and West Virginia respectfully submit this brief as *amici curiae* in support of Idaho's stay application.

Like Idaho, Amici are concerned that a devastating medical scandal is at hand: the medical establishment's fast-tracking of vulnerable youth suffering from gender dysphoria—and, almost aways, a host of other psychiatric ailments—for hormonal and surgical sex-modification procedures that can leave them sterilized and permanently harmed. In response, over twenty States have joined Idaho in generally requiring children to reach the age of majority before undergoing medicalized sex-change procedures.[1]

"State[s] plainly ha[ve] authority, in truth a responsibility, to look after the health and safety of [their] children." *L.W. v. Skrmetti*, 73 F.4th 408, 419 (6th Cir. 2023) (staying injunction of Tennessee's similar law). Governments have done so "from time immemorial"—regulating the medical profession, restricting access to potentially dangerous medicines, and banning treatments that are unsafe or unproven. *Dent v. West Virginia*, 129 U.S. 114, 121-24 (1889); *see Abigail All. For Better Access*

[1] *See* Ala. Code § 26-26-4; Ark. Code Ann. 20-9-1502; Fla. Admin. Code Ann. R.64B8-9.019; Ga. Code Ann. § 31-7-3.5; Ind. Code § 25-1-22-13; Iowa Code § 147.164; Ky. Rev. Stat. Ann. § 311.372; La. Stat. Ann. § 40:1098; Miss. Code Ann. § 41-141-1-9; Mo. Rev. Stat. Ann. § 191.1720; S.B. 99, 68th Leg., 2023 Sess. (Mont. 2023); Neb. Rev. Stat. § 72-7301-07; H.B. 808, 2023 Sess. (N.C. 2023); N.D. Cent. Code. § 12.1-36.1-02; H.B. 68, 135th General Assembly (Ohio 2024) (effective Apr. 24, 2024); Okla. Stat. tit. 63, § 2607.1; H.B. 1080, 98th Leg. Sess. (S.D. 2023); Tenn. Code Ann. § 68-33-101; S.B. 14, 2023 Sess. (Tex. 2023); Utah Code Ann. § 58-68-502(1)(g); W. Va. Code § 30-3-20.

to Developmental Drugs v. von Eschenbach, 495 F.3d 695, 703-05 (D.C. Cir. 2007) (en banc). And when it comes to "areas where there is medical and scientific uncertainty," States have particularly "wide discretion." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). States like Idaho can "choose fair-minded caution and their own approach to child welfare" before subjecting their children to irreversible transitioning treatments. *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 488 (6th Cir. 2023) (reversing preliminary injunctions of similar laws in Tennessee and Kentucky). "Absent a constitutional mandate to the contrary, these types of issues are quintessentially the sort that our system of government reserves to legislative, not judicial, action." *Eknes-Tucker v. Governor of Ala.*, 80 F.4th 1205, 1231 (11th Cir. 2023) (vacating preliminary injunction of Alabama's similar law).

Yet rather than accord Idaho's "health and welfare laws" a "strong presumption of validity," *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2284 (2022) (citation omitted), the district court inverted the constitutional standard and enjoined enforcement of the law. In its entirety. Against everyone. Even though Plaintiffs lack standing to challenge parts of the law. Even though Plaintiffs do not represent a class. Even though Idaho's requirements in some circumstances are consistent with the (activist-drafted) guidelines on which the district court relied. And even though this Court has instructed time and again that injunctions must be limited to providing relief to individual plaintiffs, not the world at large.

Amici thus write in support of Idaho's application to narrow the injunction pending appeal. Universal injunctions inflict profound harms on States. They provide

plaintiffs nearly "boundless opportunity … to secure a win," while State defendants must retain a perfect litigation record—regardless of the individual facts of each case—just to enforce the challenged law against non-parties. *See Dep't of Homeland Sec. v. New York*, 140 S. Ct. 599, 601 (2020) (Gorsuch, J., concurring in grant of stay, joined by Thomas, J.). And an injunction prohibiting enforcement of a State's law "clearly inflicts irreparable harm on the State." *Abbott v. Perez*, 585 U.S. 579, 602 n.17 (2018) (citing *Maryland v. King*, 567 U.S. 1301 (2012) (Roberts, C.J., in chambers)). The harm is exponentially greater when the State cannot "enforce its duly enacted" safeguards *at all*. *Id.* Absent relief from this Court, Idaho will be unable to protect its children from experimental, sterilizing sex-change procedures, harming both the State's vulnerable youth and Idaho's sovereign interest in enforcing its law.[2]

SUMMARY OF ARGUMENT

The Court should grant Idaho's application. The universal injunction cannot stand, for all the reasons Idaho states in its application and this Court has stated so many times before. The normal rule is that "neither declaratory nor injunctive relief can directly interfere with the enforcement of contested statutes or ordinances except with respect to the particular federal plaintiffs." *Doran v. Salem Inn, Inc.*, 422 U.S. 922, 931 (1975). The district court flouted that rule when it entered a universal injunction precisely *so that* it could grant relief to non-parties. App.A.53 (lamenting

[2] Alabama recently supported Tennessee and Kentucky in opposing certiorari in cases arising from preliminary injunctions that had, before the Sixth Circuit reversed them, enjoined enforcement of laws similar to Idaho's. *See L.W. v. Skrmetti*, No. 23-466 (docketed Nov. 2, 2023); *United States v. Skrmetti*, No. 23-477 (docketed Nov. 6, 2023), and *Doe v. Kentucky*, No. 23-492 (docketed Nov. 9, 2023). This brief, arguing that the injunction of Idaho's law should be limited to the individual plaintiffs and the procedures they seek, is not to the contrary.

that "a plaintiffs-only injunction" would not reach "similarly situated" third parties). This was a gross abuse of discretion. The two plaintiffs "in this case do not represent a class, so they could not seek to enjoin" Idaho's law "on the ground that it might cause harm to other parties." *Monsanto Co. v. Geertson Seed Farms*, 561 U.S. 139, 163 (2010). "[P]arty-specific relief" is the norm, and to the extent a court's "remedial order affects nonparties, it" should do "so only incidentally," not intentionally. *United States v. Texas*, 599 U.S. 670, 693 (2023) (Gorsuch, J., concurring in judgment, joined by Thomas & Barrett, JJ.).

Amici write to explain *why* the district court erred as it did. In addition to the obvious errors—its desire to provide relief to non-parties and its recognition of a new Article III loophole for plaintiffs proceeding under pseudonyms—the court fundamentally misunderstood Idaho's law. That misunderstanding infected both its merits analysis—a topic for another day—and the remedy it crafted.

Idaho's Vulnerable Child Protection Act prohibits physicians from providing specific sex-modification procedures to minors. Idaho Code § 18-1506C(3). The Act's prohibitions range from over a dozen separate transitioning surgeries to three different hormonal interventions to a general proscription on "[r]emoving any otherwise healthy or nondiseased body part or tissue." *Id.* Yet rather than construing each prohibition and procedure individually, the district court lumped them all together for a drive-by finding that Idaho "allows the same treatments for cisgender minors that are deemed unsafe and thus banned for transgender minors." App.A.38.

The court's construction makes no sense. For instance, a vaginoplasty for a woman brings "separated muscles together" to restore normal vaginal functioning following trauma,[3] while a "vaginoplasty" for a transitioning male "involves removing the penis, testicles and scrotum" and creating a faux-vagina using "skin graft[s] from the abdomen or thigh."[4] These are not even remotely the "same treatments." Yet having viewed the procedures from too high a level, the court granted a remedy that was equally expansive: It enjoined Idaho from enforcing its law against *anyone* under *any* circumstance. App.A.52-53.

This was error. When crafting its injunction, the court should have (1) determined which of the Act's prohibitions the two plaintiffs had standing to challenge, and (2) examined whether there are circumstances in which those prohibitions could be lawfully enforced. These steps were necessary because even a victorious plaintiff is entitled only to a "remedy" that is "limited to the inadequacy that produced the injury in fact that the plaintiff has established." *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 353 (2006) (quoting *Lewis v. Casey*, 518 U.S. 343, 357 (1996)). And if "circumstances exist[] under which the Act would be valid," *United States v. Salerno*, 481 U.S. 739, 745 (1987), the injunction should obviously not extend that far.

Relief is warranted for an additional reason. Universal injunctions promote inequitable behavior like judge shopping that harms both litigants and the judiciary.

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[3] *See* American Society of Plastic Surgeons, *Aesthetic Genital Plastic Surgery Surgical Options: What Is A Vaginoplasty?*, https://perma.cc/5WFH-57QP.

[4] *See* Fan Liang, Johns Hopkins Medicine, *Vaginoplasty for Gender Affirmation*, https://perma.cc/RFU9-S72N.

That was the case in Alabama, where lawyers challenging the State's similar child protection law (some of whom represent Plaintiffs here) dismissed their lawsuits when the cases were assigned to a particular judge they seemed eager to avoid. No matter: some of the lawyers found new clients and filed in a different district, knowing that their former clients would benefit from the universal injunction they might secure in their new case—which they did.[5] It is hard to imagine such chicanery taking place if courts were bound by traditional equitable principles. For this reason, too, the Court should grant the application and narrow the injunction pending appeal.

ARGUMENT

I. The District Court's Misconstruction Of Idaho's Law Led To Its Overly Broad Injunction.

Idaho's Vulnerable Child Protection Act prohibits medical providers from "engag[ing] in" listed procedures "upon a child for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex." Idaho Code § 18-1506C(3). The Act lists 18 procedures that are prohibited when used to transition a child: (1) "castration," (2) "vasectomy," (3) "hysterectomy," (4) "oophorectomy," (5) "metoidioplasty," (6) "orchiectomy," (7) "penectomy," (8) "phalloplasty," (9) "clitoroplasty," (10) "vaginoplasty," (11) "vulvoplasty," (12) "ovariectomy, or reconstruction of the fixed part of the urethra with or without metoidioplasty," (13) "phalloplasty," (14) "scrotoplasty, or the implantation of erection or testicular prostheses," (15) "mastectomy," (16) "[p]uberty-blocking medication to stop or delay normal puberty,"

[5] The Eleventh Circuit later reversed. *See Eknes-Tucker*, 80 F.4th 1205.

(17) "[s]upraphysiological doses of testosterone to a female," and (18) "[s]upraphysiological doses of estrogen to a male." *Id.* The Act also prohibits other surgeries "that sterilize or mutilate, or artificially construct tissue with the appearance of genitalia that differs from the child's biological sex," as well as "[r]emoving any otherwise healthy or nondiseased body part or tissue." *Id.*

Plaintiffs challenged every single one of the Act's prohibitions. *See* App.A.6. Yet in crafting its remedy, the district court did not even attempt to construe the individual prohibitions, mentioning only a few of them in its opinion. *E.g.*, App.A.11-12 (referring broadly to "puberty blockers, hormone therapy, and surgeries"). Rather, the court lumped all the prohibited procedures together under the rubric "gender-affirming care" and construed the Act as prohibiting *only* minors who identify as transgender from accessing those procedures. *Id.* According to the court, all other children in Idaho retain ready access to the "same treatments" the Act otherwise banned. *E.g.*, App.A.38 (the Act "allows the same treatments for cisgender minors that are deemed unsafe and thus banned for transgender minors"); App.A.47 ("The classified group (transgender minors) cannot have medical treatments that the similarly situated group (cisgender minors) can."); App.A.3 (the Act "bars certain medical procedures to treat gender dysphoria, while those same procedures are left freely available for the treatment of other medical conditions"); App.A.12 ("the medical treatments banned by [Idaho] have a long history of safe use in minors for various conditions"). Having interpreted Idaho's law in such a flat and sweeping way, the district court entered an equally sweeping injunction.

But Idaho's law is not so far reaching. Begin with the crux of the court's reasoning: that most minors in Idaho can access the "same treatments" listed in the Act because the underlying drug or procedure can be used to treat conditions other than gender dysphoria. Even when true, that fact alone does not make the "treatments" the same. It only makes the drug or procedure at issue the same. And a physician can use the same drug or procedure to treat different conditions with different risk profiles without making the two "treatments" the same. This should have been obvious. Appendectomies, C-sections, and quadruple bypasses are all treatments that involve a scalpel, but in no meaningful sense are they the "same treatments." The same is true with medications. To the diabetic patient, injecting insulin is lifesaving. To the hypoglycemic patient, it can be life ending. Same drug, different treatments. States routinely authorize drugs for some treatments (morphine to treat a patient's pain), but not others (morphine to assist a patient's suicide).

Now consider some of the sex-modification procedures Idaho prohibits for minors. Castration and orchiectomy (the surgical removal of a male's testicles) and penectomy (the surgical removal of the penis) are normally performed only when necessary to treat otherwise-unresponsive cancers or to remove damaged testicles following trauma.[6] These are medical procedures that only one sex can undergo, for the simple reason that females do not have testicles or a penis to remove. And there

[6] *See* Cleveland Clinic, *Orchiectomy*, https://my.clevelandclinic.org/health/procedures/orchiectomy (accessed Feb. 16, 2024); Sarah O'Neill et al., *The role of penectomy in penile cancer—evolving paradigms*, TRANSLATIONAL ANDROLOGY & UROLOGY 3191, 3191-94 (2020), http://dx.doi.org/10.21037/tau.2019.08.14.

is a world of difference between removing a boy's testicles to save his life from cancer and castrating a child because his gender identity is "eunuch," as the World Professional Association for Transgender Health (WPATH) recommends[7]—or, for that matter, because parents want their son to prolong his time with the boys' choir. These are not the "same treatments."

Next, metoidioplasty is the surgical creation of a "neophallus, literally a 'new penis,'" using tissue from a woman's clitoris.[8] This is also a surgery only one sex can undergo. And the surgery apparently has no application outside the context of gender transition, so it is unclear how the district court concluded that the procedure was "freely available" to other children, App.A.3, much less how it had a "long history of safe use in minors for various conditions," App.A.12. Neither statement is true.

Phalloplasty is similar to metoidioplasty in that it also creates a neophallus; the difference is that it uses tissue from a patient's arm, thigh, or back to craft the faux-penis.[9] Other than that general definition, "[p]halloplasty is not a homogenous procedure," but "a patient and surgeon-specific combination of" many "sub procedures that are used to meet the patients goals."[10] For males, a phalloplasty is typically used

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[7] *See* E. Coleman et al., *WPATH Standards of Care for the Health of Transgender & Gender Diverse People, Version 8*, 23 INT'L J. OF TRANSGENDER HEALTH S88-89 (Sept. 15, 2022), https://perma.cc/Y9G6-TP3M ("WPATH Standards of Care 8") (explaining that "castration" may be "medically necessary gender-affirming care" for individuals who identify as "eunuchs"—i.e., individuals "assigned male at birth" who "wish to eliminate masculine physical features, masculine genitals, or genital functioning").

[8] Cleveland Clinic, *Metoidioplasty*, https://my.clevelandclinic.org/health/treatments/21668-metoidioplasty (accessed Feb. 16, 2024).

[9] Cleveland Clinic, *Phalloplasty*, https://my.clevelandclinic.org/health/treatments/21585-phalloplasty (accessed Feb. 16, 2024).

[10] Aaron L. Heston et al., *Phalloplasty: techniques and outcomes*, TRANSLATIONAL ANDROLOGY & UROLOGY 254-265 (June 2019), https://doi.org/10.21037%2Ftau.2019.05.05.

to reconstruct a penis following trauma or due to a congenital abnormality.[11] For transitioning females, the procedure can include a perineoplasty ("a surgical procedure to repair the perineum and external organs of [the] vagina"[12]); a vaginectomy ("a surgical procedure to remove all or part of the vagina"[13]); and a hysterectomy and/or oophorectomy (removal of the uterus and ovaries, respectively).[14] Suffice it to say, a phalloplasty performed on members of different sexes for different purposes that necessitate different, sex-specific procedures are not the "same treatments."

Vaginoplasty generally refers to "a procedure designed to tighten the vagina" by surgically "bring[ing] the separated muscles together," typically following trauma like childbirth.[15] But the term has also been used to refer to a surgery for transitioning males that "involves rearranging tissue in the genital area to create a vaginal canal (or opening) and vulva (external genitalia), including the labia."[16] The surgery begins by "removing the penis, testicles, and scrotum."[17] These are obviously not the "same treatments," either.[18]

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[11] Cleveland Clinic, *Phalloplasty*, https://my.clevelandclinic.org/health/treatments/21585-phalloplasty (accessed Feb. 16, 2024).

[12] Cleveland Clinic, *Perineoplasty*, https://my.clevelandclinic.org/health/treatments/23183-perineoplasty (accessed Feb. 16, 2024).

[13] Cleveland Clinic, *Vaginectomy*, https://my.clevelandclinic.org/health/treatments/22862-vaginectomy (accessed Feb. 16, 2024).

[14] Heston, *supra* note 10, at 255.

[15] American Society of Plastic Surgeons, *supra* note 3.

[16] Liang, *Vaginoplasty for Gender Affirmation*, *supra* note 4.

[17] *Id.*

[18] Lest the Court think these are absurd examples, pending before the Eleventh Circuit is a case in which the United States advances the "same treatments" argument to claim that Title VII requires an employer's health insurance carrier to cover transitioning "vaginoplasties" for men if it covers reparative vaginal surgery for women. *See* Brief for the United States as Amicus Curiae at 3, 6, 18, *Lange v. Houston Cnty.*, No. 22-13626 (11th Cir. Mar. 17, 2023).

Moving to the hormonal interventions at issue, puberty blockers—GnRH agonists—are typically prescribed to children to treat precocious puberty, a condition where a child begins puberty at an unusually early age.[19] When puberty blockers are used for that purpose, the aim is to ensure that children go through pubertal development at the normal age.

Puberty blockers can also be used to treat gender dysphoria. When used for that purpose (or any other), the child's sex does not affect the dosage—in stark contrast to most other treatments at issue. *See L.W.*, 83 F.4th at 483.[20] When used to treat gender dysphoria, the purpose of the puberty blockers is to *block* normally timed puberty—the exact opposite goal for when the blockers are used to treat precocious puberty. This distinction changes the risk-benefit analysis. Using puberty blockers beyond the normal pubertal age can, at minimum, risk a child's bone growth, social and cognitive development, and—particularly when followed by cross-sex hormones—fertility and sexual function.[21] The risks are much more serious when puberty blockers are used to treat gender dysphoria than when they are used to treat precocious puberty. The benefits differ, too. When used for precocious puberty, the benefit is clear: the child goes through naturally timed puberty. When used to treat

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[19] Craig Alter et al. (eds.), *Precocious Puberty*, ENDOCRINE SOCIETY (Jan. 24, 2022), https://perma.cc/6Q3E-PEMP.

[20] This is one reason why Idaho's law does not run afoul of this Court's decision in *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020). At the core of the Court's reasoning in that case was a "simple test": "if changing the employee's sex would have yielded a different choice by the employer," the employer has treated the employee differently "because of sex." *Id.* at 1741. Because puberty blockers work the same for boys and girls, changing the child's sex changes nothing.

[21] *See* Nat'l Inst. for Health & Care Excellence (NICE), *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria* (Mar. 11, 2021), https://perma.cc/93NB-BGAN, at 26-32 ("NICE Puberty Blocker Evidence Review"); *see also* App.D.108-15.

gender dysphoria, systematic reviews of the evidence reveal that the claimed benefits are utterly unproven.[22] These are not the "same treatments," any more than using puberty blockers to prolong a boy's singing career would be.

The story is similar for testosterone therapy. "Testosterone therapy is routinely prescribed in adolescent males with constitutional delay of growth and puberty or hypogonadism."[23] In the case of delayed puberty, testosterone is "applied for a limited time, typically 3 to 6 months," to "initiate sexual changes" and "increase growth."[24] "Testosterone replacement in adolescents with primary or secondary hypogonadism is a long-term therapy" to bring and maintain a boy's testosterone levels at a normal range for his age.[25] The aims of both treatments are generally the same: restore healthy biological functioning, promote pubertal development, and alleviate infertility and sexual disfunction caused by insufficient testosterone.[26]

Using testosterone to transition an adolescent girl is altogether different. Here, the aim is to "induce the development of the physical sex characteristics" of males.[27] Doctors do that by pushing testosterone levels far *outside* the healthy biological range for females, intentionally creating the diseased state of hyperandrogenism and thereby causing the patient's risk of heart attack to triple, the risk of stroke to double,

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[22] *See* NICE Puberty Blocker Evidence Review, *supra* note 21; App.D.82-107.

[23] Maria Vogiatzi et al., *Testosterone Use in Adolescent Males: Current Practice and Unmet Needs*, 5 J. ENDOCRINE SOC'Y 1, 2 (2021), https://perma.cc/SZ3D-QE2A (parentheticals omitted).

[24] *Id.* at 2.

[25] *Id.*

[26] *Id.*

[27] Nat'l Inst. for Health & Care Excellence, *Gender-affirming hormones for children and adolescents with gender dysphoria* 3 (Mar. 11, 2021), https://perma.cc/M8J5-MXVG ("NICE Cross-Sex Hormone Review").

and the likelihood of breast cancer to increase significantly.[28] High levels of testosterone in natal females can also cause infertility,[29] particularly when the transitioning patient begins testosterone immediately following puberty blockers.[30] And the benefits when used to treat gender dysphoria are unproven. According to Britain's National Institute for Health and Care Excellence, *all* the studies shedding light on the safety and efficacy of testosterone transitioning treatment are "uncontrolled observational studies," "subject to bias and confounding," with results of "very low certainty."[31] Sweden's National Board of Health and Welfare concluded that "the risk" of such treatments for youth "currently outweigh the possible benefits."[32] As with the other treatments at issue, administering testosterone to bring a boy's levels into a normal range is not the same treatment as ramping up a young girl's testosterone levels to that of a healthy boy, which is ten times that of a healthy girl.[33] Nor, for that matter, is it the "same treatment" as providing the hormone to a Tour de France cyclist seeking a yellow jersey. Indeed, the Department of Justice has

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[28] App.D.61-62.

[29] Jayne Leonard, *What Causes High Testosterone in Women?*, MEDICAL NEWS TODAY (Jan. 12, 2023), https://perma.cc/BT38-L79X.

[30] Stephen B. Levine et al., *Reconsidering Informed Consent for Trans-identified Children, Adolescents, and Young Adults*, 48 J. OF SEX & MARITAL THERAPY 706, 713 (2022), https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2046221 ("[P]uberty blockage followed by cross-sex hormones lead to infertility and sterility."); *accord* Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLIN. ENDOCRINOL. METAB. 3869, 3880 (2017), https://doi.org/10.1210/jc.2017-01658 ("Endocrine Society Guideline") ("In females with [gender dysphoria]/gender incongruence, the effect of prolonged treatment with exogenous testosterone on ovarian function is uncertain.").

[31] NICE Cross-Sex Hormone Review, *supra* note 27 at 47.

[32] Sweden National Board of Health and Welfare Policy Statement, Socialstyrelsen, *Care of Children and Adolescents with Gender Dysphoria: Summary* 3 (2022), https://perma.cc/FDS5-BDF3.

[33] While there may be some instances in which administering testosterone to a female could be necessary—say, to treat symptoms of menopause or a gland disorder—doing so would not be the "same medical treatment" as that given to a male.

prosecuted people for distributing testosterone when the purpose is to promote athletic performance.[34] Same drug. Different treatment.

The same rationale applies to estrogen, which is generally prescribed to females to treat problems with sexual development. "Girls with either hypo- or hypergonadotropic hypogonadism need treatment with estrogens to initiate puberty and maintain a normal hormonal milieu."[35] The aim—and effect—is to restore normal bodily functioning and alleviate infertility. That is neither the aim nor the effect when estrogen is provided as a transitioning treatment. Instead, transitioning estrogen treatment *causes* infertility, inhibits normal pubertal development, and significantly raises the risk of breast cancer, stroke, and blood clots.[36] In fact, when transitioning estrogen treatment is prescribed to a natal boy who started puberty blockers at the first signs of puberty—as both WPATH and the Endocrine Society recommend[37]—the effect is nearly always infertility because the boy's sperm will never mature.[38]

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[34] *See, e.g.*, U.S. Attorney's Office, Southern District of Florida, *South Florida Residents Charged In Conspiracy To Distribute Performance Enhancing Drugs To Underage High School And Professional Athletes* (Aug. 5, 2014), https://www.justice.gov/usao-sdfl/pr/seven-south-florida-residents-charged-conspiracy-distribute-performance-enhancing-drugs; *see also* U.S. Attorney's Office, Northern District of Ohio, *Former Pittsburgh Physician Convicted of 180 Counts, Including Conspiracy to Distribute Steroids, Human Growth Hormone, Oxycodone and Oxycontin* (May 2, 2017), https://www.justice.gov/usao-ndoh/pr/former-pittsburgh-physician-convicted-180-counts-including-conspiracy-distribute.

[35] Karen O. Klein, *Review of Hormone Replacement Therapy in Girls and Adolescents with Hypogonadism*, 32 J. PEDIATRIC & ADOLESCENT GYNECOLOGY 460 (2019), https://www.sciencedirect.com/science/article/abs/pii/S1083318819301834.

[36] Anna Smith Haghighi, *What To Know About Estrogen in Men*, MEDICAL NEWS TODAY (Nov. 9, 2020), https://perma.cc/B358-S7UW; App.D.63.

[37] Endocrine Society Guideline, *supra* note 30, at 3870; WPATH Standards of Care 8, *supra* note 7, at S64.

[38] *See* Endocrine Society Guideline, *supra* note 30, at 3879 (noting that "[f]or those designated male at birth with [gender dysphoria]/gender incongruence and who are in early puberty, sperm production and the development of the reproductive tract are insufficient" to preserve fertility through "the cryopreservation of sperm" and that "[r]estoration of spermatogenesis after prolonged estrogen treatment has not been studied").

Dr. Tandy Aye, the Medical Director of Stanford's Pediatric and Adolescent Gender Clinic, matter-of-factly recounted these effects from her treatment of "Avery," a natal male. In her 2019 Ted Talk, Dr. Aye described how, after "pubertal blockers were added, and then estrogen was added to her therapy, Avery's testes never developed. In fact, she does not make any sperm. And her reproductive capability to be a biological parent has been eliminated."[39] In Dr. Aye's view, that was reason to go further still: "Her testes are non-functional, and in medicine, don't we often recommend the removal of non-functional organs, like an appendix?"[40] Thus, the fundamental purpose and the evidence of risks and benefits of estrogen transitioning treatment is once again radically different. As the World Health Organization recently stated when it determined that it would not promulgate treatment guidelines for gender dysphoric adolescents, "the evidence base for children and adolescents is limited and variable regarding the longer-term outcomes of gender affirming care," including estrogen transitioning treatment.[41]

One final note on testosterone and estrogen transitioning treatments. Both are treatments that only one sex can undergo. Based purely on biology, only females can use testosterone for the purpose of gender transition—never males. *See L.W.*, 83 F.4th at 481. Although a male could use testosterone for other types of treatment, no amount of testosterone will cause a male to develop female characteristics. The

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[39] Tandy Aye, *Is the Surgical World Ready for Adolescent Gender Surgery?* TEDX TALKS (Mar. 12, 2019), https://www.youtube.com/watch?v=L240CPOJ6FM at 5:59-6:20.

[40] *Id.* at 6:20-30.

[41] World Health Organization, *Frequently Asked Questions – WHO Development of a Guideline on the Health of Trans and Gender Diverse People* (Jan. 15, 2024), https://perma.cc/L39M-MH7N.

inverse is true for estrogen transitioning treatment. Biology dictates that estrogen can be used for transition *only* in males, never the reverse. *Id.*[42]

II. The Court Should Narrow The Injunction Pending Appeal.

Had the district court carefully construed Idaho's law, it would have—or should have—crafted a far narrower injunction, if it crafted one at all.

First, a focus on the individual treatments would have shown that Plaintiffs lack standing to challenge most of the Act's prohibitions. This is not only because Plaintiffs themselves seek access only to estrogen transitioning treatment, App.D.139, 144, but because the Plaintiffs could not challenge many of the Act's provisions even if they wanted to. Both Plaintiffs are natal males. App.A.7-8. As a result, they lack standing to challenge Idaho's prohibition on testosterone transitioning treatment because Plaintiffs could not take testosterone *to transition*. The same is true of many of the surgeries the Act prohibits, including metoidioplasty, phalloplasty, hysterectomy, and oophorectomy, all of which are surgeries only females can undergo. Because Plaintiffs cannot be injured by these prohibitions, the district court lacked jurisdiction to enjoin Idaho from enforcing them. As the Court

[42] The fact that only one sex can undergo these treatments also shows why the district court was wrong on the merits. A State's medical regulation does not become "a sex-based classification" merely by mentioning sex or recognizing biology. *Dobbs*, 142 S. Ct. at 2245. That is because the fact that a patient's sex affects the nature of a treatment does not mean anyone is denied equal protection. There is no sex-based classification simply because a provider must know a patient's sex to know what treatment she is receiving—e.g., a pelvic exam for a male is not the same as a pelvic exam for a female. And the Constitution does not look askance at a hospital offering testicular exams only to boys or pap smears only to girls. This is also why the reasoning of *Bostock* does not apply to testosterone or estrogen transitioning treatments: the test for determining discrimination in the workplace cannot apply to medicine, where males and females are not similarly situated. Per *Dobbs*, a fertility clinic does not discriminate on the basis of sex by implanting fertilized eggs only in females, even though "changing the [patient's] sex would have yielded a different choice by the [clinic]." *Bostock*, 140 S. Ct 1741. There is no stereotype or inequality in the clinic's policy. The same is true of Idaho's law.

stated in *Lewis*, Article III requires that a court-crafted remedy "be limited to the inadequacy that produced the injury in fact that the plaintiff has established." 518 U.S. at 357. Otherwise, the "actual-injury requirement would hardly serve the purpose" "of preventing courts from undertaking tasks assigned to the political branches" "if once a plaintiff demonstrated harm from one particular inadequacy in government administration, the court were authorized to remedy *all* inadequacies in that administration." *Id.*; *see DaimlerChrysler*, 547 U.S. at 351-53.

Second, a better understanding of the Act's prohibitions sheds light on the many circumstances in which Idaho could enforce its law consistent with the district court's (erroneous) legal and factual conclusions. Even the district court did not find the law "unconstitutional in all of its applications." *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008); *see Salerno*, 481 U.S. at 745. It concluded only that sex-modification procedures for minors are safe for "some adolescents" "when provided in accordance with the guidelines published by WPATH and the Endocrine Society." App.A.12.

The court was obviously wrong to outsource the regulation of medical procedures to interest groups whose members are financially dependent on providing the procedures at issue; the Constitution puts States, not medical socities, in charge of regulation for a reason. But even WPATH and the Endocrine Society recognize that sex-modification procedures should not administered to just anyone. For instance, WPATH does not recommend phalloplasty "be considered in youth under 18."[43] The

[43] WPATH Standards of Care 8, *supra* note 7, at S66.

district court enjoined Idaho's prohibition of that surgery anyway. WPATH does not recommend any hormonal or surgical interventions for pre-pubescent children.[44] The district court enjoined Idaho's prohibitions as to such children anyway.

Likewise, WPATH recommends that "health care professionals working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns" and that an "adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and/or gender-affirming medical treatments have been addressed" before starting hormonal or surgical interventions.[45] No matter; the district court enjoined Idaho from enforcing its law even when a doctor medically transitions a child who has never had any kind of mental health assessment *at all*.

The overbroad injunction thus puts children's health and safety in danger. And these risks are not theoretical. As Dr. Laura Edwards-Leeper, the former head of the Child and Adolescent Committee for WPATH, recently told the *New York Times*, "[m]any providers are completely missing" the "step" of conducting a thorough mental health assessment of their gender dysphoric patients.[46] Dr. Edwards-Leeper "find[s] evidence every single day, from [her] peers across the country and concerned parents who reach out, that the field has moved from a more nuanced, individualized, individualized and developmentally appropriate assessment process to one where

[44] *Id.* at S69.

[45] *Id.* at S50, S62.

[46] Pamela Paul, *As Kids, They Thought They Were Trans. They No Longer Do.*, N.Y. TIMES (Feb. 2, 2024), https://www.nytimes.com/2024/02/02/opinion/transgender-children-gender-dysphoria.html.

every problem looks like a medical one that can be solved quickly with medication or, ultimately, surgery."[47]

These anecdotal assessments have been confirmed all too many times. A 2017 survey revealed that a majority of *WPATH's own plastic surgeons* in the United States had performed transitioning "vaginoplasties" on minors, "contravening" the WPATH standards that at the time restricted such surgeries to adults.[48] "[A] few highly experienced surgeons" noted their "alarm" at the "absence of surgical standards and the ease of entering the subspeciality without any documented training."[49]

More recently, a doctor at Vanderbilt's gender clinic bragged that transitioning services are "huge money makers."[50] And a surgeon profiled by the *New York Times* "has built a thriving top surgery specialty" by advertising her services to children on social media.[51] Dr. Sidhbh Gallagher in Miami "frequently posts photos, FAQs and memes on Facebook, Instagram and TikTok" to "connect[] with hundreds of thousands of followers."[52] "Her feeds often fill with photos tagged #NipRevealFriday, highlighting patients … whose bandages were just removed."[53]

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[47] Laura Edwards-Leeper & Erica Anderson, *The Mental Health Establishment Is Failing Trans Kids*, WASHINGTON POST (Nov. 24, 2021) https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/.

[48] Christine Milrod & Dan H. Karasic, *Age is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States*, 14 J. SEXUAL MED. 524, 626 (2017), https://pubmed.ncbi.nlm.nih.gov/28325535/.

[49] *Id.*

[50] Kimberlee Kruesi, *Vanderbilt to Review Gender-Affirming Surgeries for Minors*, ASSOCIATED PRESS (Oct. 7, 2022), https://apnews.com/article/health-business-tennessee-nashville-vanderbilt-university-6deb93f7dea92f1b2082c39f72b59766.

[51] Azeen Ghorayshi, *More Trans Teens Are Choosing "Top Surgery,"* N.Y. TIMES (Sept. 26, 2022), https://www.nytimes.com/2022/09/26/health/top-surgery-transgender-teenagers.html.

[52] *Id.*

[53] *Id.*

Dr. Gallagher regularly provides surgeries to minors as young as 13 and initially told the *Times* that she didn't "know of a single case of regret" and assumed that reports of her patients detransitioning were "a hoax."[54] She "amended her stance" when confronted with a patient who detransitioned 16 months after surgery. The patient said the surgery "had been a mistake born out of a mental health crisis."[55]

Even in *amicus*'s home state of Alabama physicians have jettisoned the WPATH standards in favor of quicker "care." Dr. Leah Torres, an OB-GYN in Tuscaloosa, started "provid[ing] hormone therapy to transgender patients, including minors," after her abortion practice dried up.[56] Though admitting that "'this area of medicine is pretty new to [her]'" and "is a relatively experimental area of medicine without a lot of data," Dr. Torres has already rejected WPATH's recommendations, "not believ[ing] [that] adolescents seeking hormones require mental health evaluations."[57] At her first meeting—via telehealth—with a teenaged girl with "a history of depression and anxiety," Torres told the patient "straight up that she would prescribe a low dose of testosterone"—something "the teen's pediatrician and staff at a psychiatric hospital" had refused to do.[58]

While Dr. Torres practices alone, the care does not seem to be much better at the academic clinics that purport to practice with multidisciplinary teams. The endocrinologist head of Washington University's pediatric gender clinic recently

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[54] *Id.*

[55] *Id.*

[56] *See* Jenny Jarvie, *This Abortion Doctor is Not Ready to Leave Alabama*, L.A. TIMES (Apr. 28, 2023), https://perma.cc/G5KZ-J7TB.

[57] *Id.*

[58] *Id.*

admitted he had "no idea how to meet" "intensive interpretations" of the WPATH standards and "worried that his clinic would not be able to adjust" to them.[59] So it didn't. As one patient told the *New York Times*, the doctor prescribed her testosterone "after one appointment."[60] "There was no actual speaking to a psychiatrist or another therapist or even a case worker," the patient said.[61] The clinic is currently under investigation by the Missouri Attorney General after a whistleblower detailed ways "doctors at the clinic had hastily prescribed hormones with lasting effects to adolescents with pressing psychiatric problems."[62] Another whistleblower in Washington recently described the pressure she felt as a therapist "simply to affirm that the patient was transgender, and even approve the start of a medical transition," "[n]o matter the patient's history or other mental health conditions that could be complicating the situation."[63]

The district court's injunction prohibits Idaho from intervening in any of these circumstances. The fact that children may be permanently harmed as a result of the court's eagerness to extend its "remedy" to *all* minors and *all* circumstances is a stark reminder of the wisdom of the rule that "injunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs." *Madsen v. Women's Health Center, Inc.*, 512 U.S. 753, 765 (1994) (quoting

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[59] Azeen Ghorayshi, *How a Small Gender Clinic Landed in a Political Storm*, N.Y. TIMES (Aug. 23, 2023), https://www.nytimes.com/2023/08/23/health/transgender-youth-st-louis-jamie-reed.html.

[60] *Id.*

[61] *Id.*

[62] *Id.*; *see* Affidavit of Jamie Reed, Missouri Attorney General's Office (Feb. 7, 2023), https://perma.cc/QE9Q-K2QP.

[63] Tamara Pietzke, *I Was Told to Approve All Teen Gender Transitions. I Refused.*, THE FREE PRESS (Feb. 5, 2024), https://www.thefp.com/p/i-refused-to-approve-all-teen-gender-transitions.

Califano v. Yamasaki, 442 U.S. 682, 702 (1979)). Here, as-applied relief would afford Plaintiffs complete relief while allowing Idaho to protect other vulnerable children.

III. Universal Injunctions Encourage Judge Shopping.

It is bad enough that universal injunctions allow one or two individual plaintiffs to obtain class-wide relief without meeting the burdens of class certification or facing the preclusive effect of losing on behalf of a class. But that asymmetry harms both States and the judiciary in other ways, too: It promotes judge shopping. That's just what happened in Alabama when the State first set out to defend its similar child protection law. After years of planning, two sets of plaintiffs—some represented by the same counsel and organization representing Plaintiffs here—immediately challenged Alabama's law and moved for emergency injunctive relief. Then they dropped their suits just hours after their cases were consolidated before a judge they apparently didn't expect to see, and one set of lawyers "refiled" a few days later in a different district, safe in the knowledge that, if they won, their former clients would be covered by the facial and universal injunction they sought.

Alabama's law was enacted on April 8, 2022. *See Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1140-41 (M.D. Ala. 2022), *vacated sub nom. Eknes-Tucker v. Governor of Ala.*, 80 F.4th 1205 (11th Cir. 2023). The law was immediately challenged by two sets of plaintiffs, who filed near-identical complaints in separate districts, enabling them to drop whichever case was assigned to a judge they disliked. Gender clinician Dr. Morissa Ladinsky led one suit filed in Birmingham (in the Northern District of Alabama), *see Ladinsky v. Ivey*, No. 5:22-cv-447 (N.D. Ala. 2022 filed April

8, 2022), while her patient and patient's father, Jeff Walker, filed suit in Montgomery (in the Middle District), *Walker v. Marshall*, No. 22-cv-480 (M.D. Ala. filed April 11, 2022). This is a common judge-shopping tactic. *See, e.g.*, *In re Fieger*, 191 F.3d 451 (6th Cir. 1999) (table op.) (involving similar manipulation); *Barragan v. Clarity Servs., Inc.*, No. 22-cv-876, 2021 WL 1226537, at *7 (D. Nev. Mar. 31, 2021) (same).

The *Walker* case was assigned to Chief Judge Marks, who ordered the parties to show cause why it should not be transferred to the Northern District, where *Ladinsky* had already been filed and was pending before Judge Axon. *Walker*, Doc. 3. The *Walker* Plaintiffs—represented by at least one ACLU attorney who represents the Idaho plaintiffs here—consented to the transfer. *Walker*, Doc. 18. They insisted their "interest is in the expeditious injunction of the unconstitutional law they challenge, and Plaintiffs will seek to pursue their motion for this preliminary relief expeditiously in the Northern District, assuming transfer." *Id.* at 3.

The next day, *Walker* "was randomly assigned to" Judge Burke in the Northern District. *Eknes-Tucker*, 603 F. Supp. 3d at 1140. By 4:20pm that day, the parties agreed to move to consolidate both cases before Judge Axon, who had the first-filed case. *See Eknes-Tucker*, Doc. 69-40 at 3. About twenty minutes later, Judge Axon sua sponte transferred Dr. Ladinsky's case to Judge Burke. *See Ladinsky v. Ivey*, 2:22-cv-00447, Doc. 14. That's when things got strange. Less than two hours later, "at 6:24 p.m. CDT, the *Walker* plaintiffs," who only the day before had professed their desire to pursue their motion for preliminary relief expeditiously in the Northern District, "filed a notice of voluntary dismissal." *Eknes-Tucker*, 603 F. Supp. 3d at 1140.

Stranger still, "[t]he *Ladinsky* plaintiffs voluntarily dismissed their case nine minutes later." *Id.*

Had the Southern Poverty Law Center, the ACLU, and their clients realized the State's law was valid? It doesn't appear so, because "counsel for *Ladinsky* informed the press" the day after dismissal: "We do plan to refile imminently." *Id.* Sure enough, a few days later, new plaintiffs represented by the *Ladinsky* lawyers "refiled" in the Middle District. All 17 attorneys listed on the new *Eknes-Tucker* complaint were the same as on the *Ladinsky* complaint (which had been filed in the Northern District). The complaint was nearly identical, other than the new plaintiffs, a throwaway First Amendment claim, and the switcheroo of the once-lead plaintiff, Dr. Ladinsky, to the role of expert. The *Walker* plaintiffs and lawyers (who had originally filed in the Middle District) never refiled, but apparently handed off their expert to the United States, who intervened in the "refiled" *Eknes-Tucker* case. *Compare Eknes-Tucker*, Doc. 62-2, with *Walker*, Doc. 10-3.

As Judge Burke noted: "At the risk of stating the obvious, Plaintiffs' course of conduct could give the appearance of judge shopping—'a particularly pernicious form of forum shopping'—a practice that has the propensity to create the appearance of impropriety in the judicial system." *Walker*, Doc. 24 at 3; *cf. Nat'l Treasury Emps. Union v. IRS*, 765 F.2d 1174, 1177 (D.C. Cir. 1985) ("The semblance of judge shopping … is also a concern when a litigant discontinues a fray, only to start over again on another day."). On May 10, 2022, the chief judges of the three district courts in Alabama convened a special three-judge panel to investigate whether the *Walker*

and *Ladinsky* lawyers "inten[ded] to circumvent the practice of random case assignment in the District Courts for the Northern and Middle Districts of Alabama." *In re Amie Adelia Vague*, No. 2:22-mc-3977 (M.D. Ala.), Doc. 1 at 2. The panel's final report of inquiry remains under seal and has been provided to Judge Burke for further proceedings. *In re Vague*, No. 2:22-mc-3977, Doc. 99.

The conduct above—of lawyers claiming an urgent need for judicial relief for their clients and then dropping those clients' claims with even greater urgency—is hard to imagine in a world without universal injunctions. Dr. Ladinsky still clearly opposed Alabama's law after she dropped her suit—she showed up as an expert in the "refiled" case. So why did she feel comfortable dropping her challenge? Apparently because some other plaintiff could "refile" it and maybe get a different judge who could grant universal relief for current and former plaintiffs alike.

"Every court considering attempts to manipulate the random assignment of judges has considered it to constitute a disruption of the orderly administration of justice." *In re BellSouth Corp.*, 334 F.3d 941, 959 (11th Cir. 2003). The availability of universal injunctions like the one entered against Idaho make the playbook all the more attractive. For that reason too, this Court should narrow the injunction to only those plaintiffs who have sought and have standing to obtain judicial relief.

CONCLUSION

The Court should grant the stay application.

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