Nos. 23-726, 23-727

# In the Supreme Court of the United States

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, ET AL., PETITIONERS,

*v.*

UNITED STATES

STATE OF IDAHO, PETITIONER,

*v.*

UNITED STATES

*ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT*

## BRIEF OF *AMICUS CURIAE* IDAHO COALITION FOR SAFE HEALTHCARE, INC. IN SUPPORT OF RESPONDENT

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## CORPORATE DISCLOSURE STATEMENT

Idaho Coalition for Safe Healthcare, Inc. is an Idaho nonprofit corporation. It has no parent corporation. No publicly held corporation, or any other person or entity, owns stock in Idaho Coalition for Safe Healthcare, Inc.

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## IDENTITY AND INTEREST OF AMICUS CURIAE

Idaho Coalition for Safe Healthcare, Inc. ("the Coalition")[1] is an Idaho-based non-profit organization dedicated to ensuring Idahoans have safe, legal, and equitable access to evidence-based medical care, that physicians and other healthcare professionals are able to provide services that comply with accepted standards of care, and that healthcare decisions made within a patient-provider relationship are honored and preserved.

One of the Coalition's primary goals is to educate the public and public officials about the measurable impacts of Idaho's statutes regulating healthcare, in particular the true harms to patients and physicians of Idaho's reproductive healthcare laws. In that vein, the Coalition has closely tracked the effect these laws have had on physician retention and motivations in Idaho. Armed with this and other data, the Coalition seeks to partner with legislators, legal organizations, and healthcare provider advocacy groups to craft future legislation and policy that will facilitate the best possible care for all Idahoans.

The Coalition consists of 678 physicians and providers from all over the state of Idaho. These professionals work on the ground every day in hospitals, emergency rooms, and independent practices, trying their best to provide Idahoans with access to safe healthcare. The members of

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[1] No party or party's counsel authored the brief in whole or in part, and no party or party's counsel contributed money that was intended to fund the preparation or submission of the brief. No person other than Idaho Coalition for Safe Healthcare, Inc. or its counsel has made a monetary contribution to fund the preparation or submission of this brief.

the Coalition are diverse. They come from different backgrounds and medical specialties, they hold beliefs that span the political spectrum, and they serve every corner of Idaho, from populous urban centers to remote hamlets. Many of the Coalition's members are obstetricians, gynecologists, labor and delivery nurses, and emergency room doctors. Many work for hospitals that participate in Medicare. These are the individuals who day-in and day-out struggle with how to comply with Idaho's abortion laws, EMTALA, and their professional obligations to provide the safest, highest standard of care to their patients. The members of the Coalition are among the individuals who will be affected most on a daily basis by this Court's decision in this case.

The Coalition submits this amicus brief in support of the United States to inform the Court about what it is like to be a doctor on the ground in Idaho, facing the conflicts presented by EMTALA and Idaho's total abortion ban. The Coalition describes the acute challenges these doctors face and the larger impact this conflict is having on doctors and patients across Idaho.

## SUMMARY OF ARGUMENT

Obstetricians in Idaho live in constant fear. Always at the back of their minds is the worry that a pregnant patient will arrive at their hospital needing emergency care that they will not be able to provide. For some emergencies threatening the life or the health of a pregnant patient, the prescribed standard of care is to terminate the pregnancy. Before Idaho's total abortion ban—Idaho Code § 18-622—went into effect, Idaho doctors could, and did, regularly perform this procedure when necessary to protect the pregnant patient without fear of repercussion. Now, under § 18-622, Idaho doctors face two to five years in prison, plus the loss of their medical license, for following the exact same protocol, unless the emergency condition is so far advanced that the patient is face-to-face with death.

Until January 5, 2024, the Emergency Medical Treatment and Labor Act ("EMTALA") quelled that ever-present fear for many Coalition members. These members work for hospitals in Idaho that participate in Medicare. These hospitals, and the providers they employ, are bound to comply with EMTALA. This federal law requires Medicare-participating hospitals to provide necessary stabilizing care to any patient experiencing an emergency, and they must do so before transferring the patient to another hospital. Again, for some pregnant patients, abortion care is the necessary stabilizing care. Yet Idaho Code § 18-622 bars Idaho healthcare providers from providing this care until the patient is on the brink of death. As the district court in this case correctly recognized, EMTALA's requirement that these hospitals provide necessary stabilizing care directly conflicts with

Idaho's total abortion ban.

Since this Court lifted the district court's injunction in January, Coalition doctors all across the state of Idaho have been at a loss for what to do. When presented with a pregnant patient in an emergency, they are unsure whether to comply with EMTALA—and risk spending two to five years in prison for providing what the State deems an unnecessary abortion—or comply with Idaho law by delaying stabilizing care or transferring the patient out of state—and risk losing the ability to participate in Medicare, and risk harming the patient or losing their life altogether.

Because of this irreconcilable conflict, the Coalition urges this Court to find § 18-622 is preempted by EMTALA and reinstate the district court's injunction. First, as a practical matter, it is impossible for doctors on the ground, working in Idaho's emergency rooms and labor and delivery units to comply with both EMTALA's requirements and Idaho's total abortion ban. This reality is made plain through real stories of doctors dealing with the conflict between the two laws. Second, the culture of fear surrounding Idaho's abortion laws has only exacerbated the struggle to try to reconcile the two laws. At nearly every turn, Idaho's doctors have been warned that they are being tracked and scrutinized and they should fear prosecution for providing an abortion under any circumstances—even when medically necessary. Finally, the irreconcilable conflict between the two laws, and Idaho's abortion laws more generally, are having a devastating impact on physician retention, the availability of obstetric and gynecological care in the state, and the quality of the care that is available. The Coalition's own studies show that allowing Idaho doctors to provide abortion care when

necessary to stabilize a patient, as required by EMTALA, without fear of prosecution under § 18-622, would significantly benefit the healthcare system in Idaho and all who are served by it.

## ARGUMENT

### I. For doctors on the ground, it is impossible to comply with both Idaho law and EMTALA.

Idaho doctors working in Medicare-participating hospitals are being pulled in two opposite directions. On the one hand, EMTALA requires doctors to stabilize all pregnant patients with an emergency medical condition. Thus, under EMTALA, these hospitals cannot deny the patient stabilizing care. Nor can they transfer the patient to another hospital to receive necessary stabilizing care. Idaho Code § 18-622, on the other hand, requires doctors to deny patients available,[2] stabilizing care until the last possible moment.

Crystallizing this conflict, several Coalition members are now advising their patients who are or are trying to become pregnant to obtain and maintain life flight insurance—insurance that would specifically cover the cost of medical transport to another state, even when not medically necessary—for the duration of their pregnancies. In short, these doctors are preparing to do exactly what EMTALA forbids: Transfer their patients with emergency medical conditions that threaten their health, their bodily

[2] Contrary to the State's argument, *see* Idaho Br. 24, abortion care is "available" care under EMTALA. *See* 42 U.S.C. 1395dd(b)(1)(A). It is neither experimental or untested. It is a procedure nearly every emergency room is equipped to provide and nearly every obstetrician is trained to perform. And even under Idaho law abortion care is on the "menu," Idaho Br. 17, for certain patients.

functions, or their fertility—but not clearly their life—to out-of-state hospitals to receive the emergency, stabilizing care they desperately need. As one Coalition doctor explained, they do not want to "add insult to injury" by denying their patients necessary, standard care, flying them to neighboring states to receive that care, and then charging them tens of thousands of dollars for the flight. If this Court were to correctly find EMTALA preempts § 18-622, these transfers, and life flight insurance, would be unnecessary for these patients.[3]

The following real-world stories of doctors working on the ground in Idaho illustrate the inherent conflict in these two laws, particularly when viewed through the lens of the culture of fear and intimidation surrounding abortion in Idaho. As the examples illustrate, the conflict at issue here implicates a narrow set of cases, but one that looms large in the hearts and minds of Idaho's doctors.

### A. The first-hand experiences of Coalition members demonstrate the excruciating conflict between EMTALA and Idaho's abortion laws.

Coalition doctors have been confronted with the direct

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[3] Congress's purpose in passing EMTALA was to ensure that *all* individuals, "particularly the indigent and underinsured, receive adequate emergency medical care." *Arrington v. Wong*, 237 F.3d 1066, 1073-74 (9th Cir. 2001) (citation omitted). Idaho Code § 18-622 is directly impeding that goal by segregating care between the haves and the have nots. Those who can afford life flight insurance or who have the means to pay for a trip out of state on their own can obtain an abortion that will protect their health, their major organs, and their fertility. But those who cannot afford such expenses are left waiting in Idaho hospitals until they are in the throes of death to receive the care they need.

conflict between EMTALA and Idaho Code § 18-622 numerous times in the last 18 months since Idaho's total abortion ban went into effect. For the first 16 months, the Idaho law was present and worrying, but the district court's injunction provided some relief. However, since this Court lifted the injunction in January, physician anxiety over the conflict has risen to a fever pitch. As these firsthand stories illustrate, the conflict is real and Idaho's doctors must agonize over how to handle the irreconcilable conflict. These excruciating decisions are negatively impacting emergency room care, and patient and physician well-being.

**1.** A Coalition doctor was presented with a pregnant patient whose membranes had ruptured at just 15-weeks gestation. For most pregnant patients, the membranes rupture just before or during labor, approximately 25 weeks later. The risk of infection, sepsis, or other complications is extremely high with a premature rupture of the membranes as early as this one. Another hospital had already turned the patient away—effectively, in Petitioner's words, "dumping" the patient, *e.g.* Idaho Br. 36—citing its inability to provide care under Idaho's total abortion ban.

After evaluation, the Coalition doctor determined the fetus was at least eight weeks away from viability. And even if delivered at 23-weeks gestation, it was unclear whether the fetus's lungs would be sufficiently developed to survive. The lack of amniotic fluid in the womb, caused by the ruptured membranes, would severely inhibit the development of the fetus's lungs in the following weeks. In short, the chance that the fetus would survive was next to none.

In light of the high risk of infection and low chance of the fetus's survival, the standard of care prescribed offering termination of the pregnancy. Idaho's total abortion ban barred the doctor from providing that care.

When the patient was told that a second doctor could not provide her with the necessary, standard care, the patient was distressed, mentally and emotionally. She understood the doctors could not treat her until she was near death. She feared that she would not survive to take care of her existing child. She also understood an infection could harm her fertility and her chances of having another child in the future.

The patient did not have the option to travel out of state to obtain abortion care. She feared she could not afford the travel and she feared her insurance would not cover her care in another state. The doctor also advised against travel. The closest hospital that could provide the necessary care and manage the potential complications was a six-hour drive away through remote country roads lacking medical resources and, at times, cell phone service. The risk was high that the patient would begin to deliver the fetus or hemorrhage en route. So the patient stayed put and waited.

The patient's condition deteriorated. She showed symptoms of an intrauterine infection called chorioamnionitis, which include fever, fast heart rate in the mother and fetus, and a sore or painful uterus. The doctor provided standard care for the infection, but the patient's condition did not improve. When the infection treatment failed, the standard of care again prescribed offering termination of the pregnancy. Indeed, at that point, that was the only possible treatment left. And yet, Idaho's total

abortion ban required the doctor to wait until any further delay in care would put the patient face-to-face with death. Again, they waited. Eventually, when the infection advanced far enough, the pregnancy was terminated and the patient survived.

This experience was traumatic for the patient and torture for the doctor. The doctor both felt she had violated her medical ethics by delaying necessary, standard care, and feared the repercussions from the State if she didn't wait quite long enough. Experiences like these are driving doctors out of the state and creating a shortage of essential healthcare. *See infra* Part II.

**2.** Another patient, this one 18-weeks pregnant, presented to a Coalition doctor in an emergency room with a condition called "hourglassing membranes." This condition occurs when there is a prolapse of the amniotic sac through the cervix, which has dilated. Upon assessment, it was determined that the fetus had cardiac activity, but would not survive. The patient's condition was so advanced that spontaneous abortion—miscarriage—was inevitable and would happen far before the fetus was developed enough to survive outside of the womb.

At this point in the treatment, the standard of care dictated that the doctor provide the patient with medication to induce an abortion. The risk of infection in the patient and fetus was extremely high and it was known the fetus would not survive. Idaho's abortion laws dictated the opposite. The doctor could not induce an abortion under Idaho law because the patient was not yet at risk of dying. There was no care the Coalition doctor could provide to the patient.

As with the first patient, the second patient was counseled on potential transfer out of state for care. Again, this was not an option. Financial and language barriers made this travel challenging. But the definitive factor was the high likelihood that the patient would begin to miscarry and bleed out en route. In other words, the doctor determined that "material deterioration of the condition is likely to result from or occur during the transfer of the individual."42 U.S.C. § 1395dd(e)(3)(A). Again, the patient and the doctor waited.

The patient remained pregnant for several more days before her membranes ruptured. When she presented in the emergency room the fetus was partially delivered and the patient had a rapidly developing infection. The physician augmented the labor and the patient delivered a stillborn baby. In addition, because of the acute infection, the patient remained hospitalized for several days. This infection could easily have spread, infecting areas of the pelvic region and abdomen or causing sepsis or blood clots in the pelvis or lungs. Luckily, the infection was controlled, but the patient experienced an unnecessary high risk of major complications that threatened her life, her organs, and her fertility.

Again, this experience was traumatic for both the patient and the doctor. The patient feared for her life and well-being. The doctor was caught between Idaho abortion law on one hand and EMTALA (and her medical ethics, her training, and the standard of care) on the other.

**3.** A third patient presented to one of Idaho's few maternal fetal medicine specialist ("MFMs") 19-weeks pregnant with twins. This patient had a host of unique complications. She had previously suffered from end-stage

chronic kidney disease and had received a kidney transplant. When she presented to her regular OB-GYN several days earlier in distress, she was hospitalized with what her doctor believed was a kidney infection. But as her condition worsened, it became clear there was something else going on. Needing more specialized care, the patient was transferred to the closest MFM—a three and a half hour drive away—for his expertise in handling complex pregnancy conditions.

The MFM determined that the patient did not just have a kidney infection, but was experiencing full-on kidney failure. She also had HELLP (Hemolysis, Elevated Liver enzymes and Low Platelets) syndrome—a rare, potentially life-threatening pregnancy condition that can cause, among other things, bleeding and blood clotting, kidney and liver failure, and fluid buildup in the lungs. It was also determined that one of the two fetuses no longer had a heartbeat.

The patient was in critical condition, but was not yet on death's doorstep. In the MFM's words, she was "stably unstable." Nevertheless, the writing was on the wall: If her condition was permitted to advance any further her kidney would fail. The patient and her nephrologist (kidney specialist) had worked hard for years to improve her health, first through dialysis and then through her kidney transplant. If her kidney failed, the patient would lose all that progress, she would have to resume kidney dialysis, and she would go back to the bottom of the kidney transplant list. And, if she survived, it would take *years* for the patient's health to improve to the point where she would be able to become pregnant again and carry a fetus to term.

The standard of care for any patient experiencing this array of complications was immediate termination of the pregnancy. No medical journal or medical organization would counsel otherwise. And yet, Idaho Code § 18-622 stood in the way of providing the patient with this stabilizing, standard care.

After the patient was counseled on her options, she was prepared for medical transport as quickly as possible. Over the course of two hours, she was loaded on a plane with an emergency medical team, and flown to a hospital in another state that could provided the termination procedure she needed. The MFM knew that at any moment during travel the patient could have a stroke or begin hemorrhaging. However, because the health consequences of waiting any longer—complete kidney failure—were so high, and the medical transport team would be able to provide some emergency care in flight if needed, the MFM determined that transfer out of state was the only appropriate option.[4] The standard of care and the doctor's training, experience, medical ethics, and Hippocratic oath simply could not tolerate waiting until the patient was on the brink of death before terminating the pregnancy.

Like many pregnant patients experiencing medical emergencies in Idaho, this patient was overwhelmed by

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[4] Since Idaho's total abortion ban went into effect, Coalition doctors have relied on the willingness of hospitals in surrounding states that have less restrictive abortion laws to take and treat their patients. These hospitals may not always be so willing. There is a very real possibility that these hospitals may refuse to take Idaho patients, in which case Idaho patients will be left with no options to receive an abortion to protect their health before they are on the brink of death.

the entire experience. As the MFM explained, these patients are nearly always shocked that they cannot receive the standard medical care that they need, even in Idaho's most advanced, comprehensive care centers. They are astonished when they learn they have to be shipped out of state, away from their families and support networks, to receive that standard medical care. Some patients are so stunned that, like this patient, they are almost unable to process or participate in the life-changing medical decisions that need to be made almost instantaneously.

* * *

These are just a few examples of the types of circumstances that are implicated by the conflict between EMTALA and Idaho's total abortion ban. But these examples are far from exhaustive. Rather, there are a multiplicity of circumstances in which termination of a pregnancy is the standard, offered treatment to stabilize a patient and stave off permanent organ failure and loss of fertility well before death of the patient is imminent. These circumstances include when a patient has or is experiencing any of the following: a severe hemorrhage; a severe infection or sepsis; a pregnancy-related or pregnancy-exacerbated heart condition; a clotting complication (thromboembolic disease); a hypertensive disorder of pregnancy including preeclampsia with severe features or HELLP syndrome; and kidney failure due to an underlying or pregnancy-related condition.

No matter which of these circumstances is present, as the above stories show, Idaho's total abortion ban forces doctors to deny and delay standard medical care. This not only causes physical harm, but is traumatic and stressful for the patients and their families and their entire

healthcare team. With the protections of EMTALA, obstetricians and MFMs will be able to provide their patient's the prescribed, standard care without transferring them to another state and without putting their lives, their major organs, or their family's wellbeing on the line.

### B. The overwhelming culture of fear in Idaho targeting healthcare workers makes it even more difficult to reconcile EMTALA and Idaho's total abortion ban.

Petitioners and their *amici* would have this Court believe that it is easy for Idaho doctors to know the moment when a patient is close enough to death that abortion suddenly becomes a tool that is "available" to them. They would also have this Court believe that the statute gives doctors wide latitude to make this determination and that their subjective assessment will be recognized and honored. In practice, these characterizations couldn't be farther from the truth.

At every turn, public officials in Idaho's Legislature and Executive Branch have warned doctors and other healthcare providers not to provide abortion care and not to help a patient obtain an abortion *under any circumstances*. They've created an atmosphere of fear, where providers feel every decision they make will be questioned and potentially punished. Doctors working in this space carry an extra burden. They carry both their own fear of retribution and that of the nurses and other staff who work at their direction whose freedom may also be compromised if they make the "wrong" choice.

**1.** This culture of fear has long been brewing. Idaho's Legislature introduced and adopted the total abortion ban in 2020. It specified the law would become effective when

a "decision of the United States Supreme Court" or "an amendment to the United States constitution . . . restores to the states their authority to prohibit abortion." Idaho Code § 18-622(1) (effective July 1, 2020, to June 30, 2023). The law's enforcement scheme targeted healthcare workers alone. Under this new law medical professionals would face two to five years in prison for "perform[ing] or attempt[ing] to perform an abortion." *Id.* § 18-622(2).

The law's sponsors considered banning all abortions, with no exceptions at all. Instead, they settled on providing a set of narrow "affirmative defense[s] to prosecution." *Id.* § 18-622(3). These affirmative defenses included that "[t]he physician determined, in his good faith medical judgment . . . that the abortion was necessary to prevent the death of the pregnant woman." *Id.* Provided however, that "[t]he physician performed . . . the abortion in the manner that . . . provided the best opportunity for the unborn child to survive." *Id.* Because of this legal framing, a doctor who performed an abortion to save the life of the mother could still be arrested, charged, and forced to endure the costs and emotional toll of a jury trial, at which the doctor would carry the burden of proving the affirmative defense. S*ee Smith v. United States*, 568 U.S. 106, 112 (2013) (the burden of proving an affirmative defense is on the criminal defendant).

That the abortion was necessary to protect the *health* of the pregnant woman was not included as an affirmative defense. The bill's sponsor, Senator Todd Lakey, made clear that the reason the law included an exception only to protect the life, but not the health, of the mother, is because in his mind the pregnant patient's health carries less "weigh[t]"—i.e. is less important—than the life of the fetus. Idaho House State Affairs Committee Meeting

(March 16, 2020), https://bit.ly/3x7JuHo (1:06:45-07:30) (in questions over total abortion ban, when asked if a women's health is irrelevant in context of abortion law, Senator Lakey stated a pregnant women's life and health "weighs less, yes, than the life of the child").

The very next year, 2021, the Legislature passed, and the Governor signed, another abortion ban: Idaho's "Fetal Heartbeat Preborn Child Protection Act." Again targeting doctors and healthcare workers, this law would punish any "licensed health care professional who" "performs or induces an abortion" after detection of a fetal heartbeat. Idaho Code § 18-8805(2), (3). Again, the punishment for violating the law was two to five years in prison and revocation of the professional's medical license. *Id.*

If these two laws were not enough, the next year, 2022, the Idaho Legislature passed, and the Governor signed, another anti-abortion law that again targeted healthcare professionals. This law allowed civil lawsuits to be filed against medical professionals who perform abortions after fetal cardiac activity is detected. Idaho Code § 18-8807. The law provides a hefty civil penalty of "not less than" $20,000. *Id.* The aim of this law was to "effectively prohibit almost all abortions in the State of Idaho beginning at about six weeks gestational age" without governmental enforcement. Kelcie Moseley-Morris, *Idaho governor signs bill effectively banning most abortions*, IDAHO CAPITAL SUN (Mar. 23, 2022), https://bit.ly/3PsoUrw.

**2.** This Court decided *Dobbs v. Jackson Women's Health Organization* in June 2022. This event triggered Idaho's new abortion laws, which went into effect later that summer. After that, the atmosphere of fear that had been brewing amongst healthcare workers in Idaho for

over two years immediately escalated.

**a.** Doctors were particularly fearful of the brand-new total abortion ban, § 18-622, that was vague, had yet to be tested, and carried significant penalties. The law provided no guidance on what "good faith medical judgment" meant or how it would be gauged. Idaho Code § 18-622(3)(a)(ii)-(iii) (effective July 1, 2020, to June 30, 2023). Doctors did not know how to apply this standard, which is not a medical term and is not taught in medical school. The law also provided no guidance to determine the exact point an abortion becomes "necessary to prevent the death of the pregnant" patient. *Id.* Again, this is not a recognized medical marker. Instead, physicians are taught to intervene far before a patient's life is on the line. Finally, the law provided no guidance to determine if the abortion was performed "in the manner that . . . provided the best opportunity for the unborn child to survive." *Id.* This requirement was particularly confusing for early abortions where the fetus has no chance of survival under any circumstances. In short, the law was fraught with uncertainty and yet the consequences were high enough that there was no room for error.

A group of providers challenged the new law in Idaho state court on various grounds, including on the ground that it was "unconstitutionally vague because it gives no guidelines on whether the risk of death must be 'imminent' or 'substantial' in order to perform the abortion." *Planned Parenthood Great NW. v. Idaho*, 522 P.3d 1132, 1203 (2023). A divided panel of the Idaho Supreme Court rejected this argument, concluding that the law provides a "subjective standard" that "leaves wide room for the physician's 'good faith medical judgment' on whether the

abortion was 'necessary to prevent the death of the pregnant woman.'" *Id.* The Court also concluded the law requires no "particular level of immediacy[] before the abortion can be 'necessary' to save the woman's life." *Id.*

Far from assuaging doctors' fears, this decision only generated more uncertainty. Yet again doctors were given no guidance on how to apply non-medical standards to their medical practice. After this decision doctors still had no idea how to determine the moment in time when termination of a pregnancy changes from "unnecessary" to "necessary" to save the patient's life. And although the majority insisted that doctors' "good faith" decisions would be honored, the structure and high consequences of law, combined with the political climate, which demonized all forms of abortion and the doctors who provide them, sent the opposite message. As one of the dissents aptly pointed out, doctors' exercise of their independent medical judgment had already been and would continue to be "chill[ed]." *Id.* at 1225 (Zahn, J., dissenting).

**b.** The political actions surrounding the implementation of the law only exacerbated this chilling effect. Just weeks before the law was to take effect, the Idaho Republican Party—the party that controls more than 80% of the Idaho Legislature and all of Idaho's elected executive branch positions—announced its new party platform. *See* Idaho Republican Party Platform, Art. XIV § 3 (adopted July 16, 2022), https://bit.ly/3IIADPc. The party made clear that its position was that all abortion—with no exceptions for the life of the mother, rape, or incest—is murder and any doctor who performs any abortion should be severely punished. *Id.* While the party platform certainly does not carry the weight of law, it still contributed to the culture of fear as prominent politicians announced their

plans to pass laws eliminating *all* exceptions to the total abortion ban and with them all protections for physicians. *See* Kelcie Moseley-Morris, *OBGYNs speak out: Doctors say Idaho's abortion laws will cause harm to patients*, IDAHO CAPITAL SUN (Aug. 19, 2022), https://bit.ly/3vc7vN5.

Around the same time, there were inklings that *one* Idaho city might choose not to "prioritize" enforcement of the new law, so as to "not invade the privacy of individuals and doctors who are making really tough decisions." Joe Parris, *Boise resolution on abortion creates questions surrounding law enforcement and Idaho's new abortion laws*, KTVB (July 21, 2022), https://bit.ly/3TnhdEh. The Idaho Legislature lashed out in response. At the beginning of the next session, the Legislature quickly passed a bill that would punish local entities who refused to investigate potential violations of or enforce Idaho's criminal abortion laws. *See* Clark Corbin, *Idaho House to vote on bill to strip cities of state funding for refusing to enforce state felonies*, IDAHO CAPITAL SUN (Jan. 26, 2023), https://bit.ly/3TicZOl; Idaho Code § 63-3642 (withholding sales and use tax revenue from any "city or county governmental entity" that refuses to investigate or enforce felonies in Idaho, including Idaho's abortion laws). The message to local government was clear: Keep a close eye on doctors who might perform abortions in your jurisdiction, *or else*. The message to doctors was also clear: Every enforcement authority with jurisdiction over you will be watching and questioning your every move.

The message only became worse from there. Just weeks later, Idaho Attorney General Raul Labrador issued a legal opinion stating that Idaho healthcare profes-

sionals who "*assist*[] in performing or attempting to perform an abortion"—and thereby violate Idaho Code § 18-622—when they simply refer a patient to a doctor or facility out of state to access abortion care—even medically necessary abortion care. *Letter from Idaho Attorney General Raul Labrador to Representative Brent Crane Re: Request for AG Analysis* (March 27, 2023), https://bit.ly/3Tid5Wd ("Idaho law prohibits an Idaho medical provider from . . . referring a woman across state lines to access abortion services . . . ."). The District of Idaho blocked enforcement of the legal interpretation as unconstitutional, *Planned Parenthood Greater NW. v. Labrador*, _ F.Supp.3d. _, 2023 WL 4864962, at *2 (D. Idaho July 31, 2023), but again the message to doctors from the executive branch was clear: Idaho's abortion laws would be construed broadly against doctors and anything they do to help a patient receive an abortion will be questioned.

Within days thereafter, the Legislature passed, and the Governor signed, Idaho's so-called "abortion trafficking" statute. This statute, the first of its kind in the country, tells doctors—and other members of the public—that if they help a minor patient travel out of state to obtain an abortion—again, even a medically necessary one—they face two to five years in prison. *Idaho governor signs 'abortion trafficking' bill into law*, THE ASSOCIATED PRESS (April 6, 2023), https://bit.ly/3TxcNed; Idaho Code § 18-623; *Matsumoto v. Labrador*, No. _ F.Supp.3d _, 2023 WL 7388852 (D. Idaho Nov. 8, 2023) (granting preliminary injunction blocking implementation of § 18-623).

At the same time these events were happening, the Legislature disbanded Idaho's Maternal Mortality Review Committee ("MMRC"), the state committee tasked

with "investigat[ing] pregnancy-related deaths and severe complications to gain a deeper knowledge of how to improve healthcare systems in Idaho." Andrew Baertlein, *Idaho disbands Maternal Mortality Review Committee*, KTVB (July 5, 2023), https://bit.ly/43jlIo3. With the committee's dissolution, Idaho became the only state without a maternal mortality review committee. *Id.* While still in operation, the MMRC determined that maternal deaths in Idaho had increased more than 50 percent from 2019 to 2021, and nearly all of the deaths were preventable. Maternal Mortality Review Committee, *2021 Maternal Deaths in Idaho, A report of findings by the Maternal Mortality Review Committee* at 44, IDAHO DEPARTMENT OF HEALTH & WELFARE (June 2023), https://bit.ly/3TVdcs8; Rachel Cohen, *Idaho dissolves maternal mortality review committee, as deaths remain high*, BOISE STATE PUBLIC RADIO NEWS (July 7, 2023), https://bit.ly/3x2tSVS. And yet, the Legislature apparently saw no need for the committee's work to continue.

The timing of the dissolution could not have been worse. The MMRC could have helped Idaho doctors and policymakers determine, among other things, if the lack of a health exception in Idaho's total abortion ban was contributing to maternal deaths. But the MMRC never had the chance to review any data after the total abortion ban went into effect.

Just weeks after the MMRC disbanded, the Idaho Freedom Caucus, a group of state legislators, sent a letter to numerous Idaho hospitals—including many hospitals where Coalition doctors are employed—questioning the accuracy of their abortion reporting. Rachel Sun, *UPDATED: Idaho Freedom Caucus asked hospitals for abortion records*, NORTHWEST PUBLIC BROADCASTING

(Aug. 3, 2023), https://bit.ly/43m3xOm. The letter threateningly reminded the hospitals that Idaho mandates that all "induced abortions" must "be reported to the Idaho Department of Health and Welfare," and that the failure to report an abortion could be punished with a $1,000 fine and imprisonment. *Id.* The letter demanded to know whether each "hospital performed any of the induced abortions that are required to be reported" and whether they failed to comply with the reporting law. *Id.* Again the message to doctors and hospitals was clear: Legislators are watching and scrutinizing each and every abortion you perform. And when juxtaposed with the dissolution of the MMRC, these Legislators also made clear that while every abortion would be scrutinized, every maternal death would be ignored.

These messages have continued into 2024. For example, the very first bill introduced in a committee during Idaho's 2024 Legislative session proposed to replace the term "fetus" everywhere it appears in Idaho Code—more than 70 times—with the term "preborn child." Kyle Pfannenstiel, *House Bill 381 would replace the term 'fetus' with 'preborn children' in Idaho law*, IDAHO CAPITAL SUN (Jan. 9, 2024), https://bit.ly/3TFZVnl. Although pitched as a non-substantive "change in policy," *id.*, the bill indicates the Legislature will continue to prioritize legislation that uses vague, non-medical terms to regulate the medical field and that creates room for the further criminalization of abortion care by opening the door to giving a fetus the same rights as a "child."

**3.** The collective effect of all these (and other), communications and actions is an immense amount of fear surrounding what should be standard healthcare decisions. Healthcare workers fear that every decision they

make that is in any way related to abortion is being scrutinized and potentially distorted. Doctors fear prosecutors are waiting in the wings to bring charges under § 18-622 at any moment. And doctors have been repeatedly told that the mother's life should matter less in their decision-making than the fetus.

One consequence of all this fear is an even further delay in patient care. Some physicians worry they must consult with attorneys before rendering necessary care. As a practical matter that means administrators must get hospital counsel on the phone for legal consultations at all hours of the day and night while patients wait for emergency care. Most doctors are also "over-ordering tests" and "over-ordering ultrasounds to try to protect [them]selves," because they "don't want to have any possible way that a doctor could be scrutinized and sent to jail." Rebecca Boone, *Hypothetical situations or real-life medical tragedies? A judge weighs an Idaho abortion ban lawsuit*, THE ASSOCIATED PRESS (Dec. 14, 2023), https://bit.ly/3wRwnKk. Indeed, the culture of fear is so acute that "there is fear among [healthcare workers] . . . about treating an ectopic pregnancy"—even though terminating an ectopic pregnancy has been explicitly declared legal—"[b]ut nobody believes" those assurances. *Id.*

All this fear has also made it increasingly difficult for doctors to try to reconcile EMTALA and Idaho Code § 18-622. In situations where EMTALA requires hospitals to provide abortion care to stabilize a patient, physicians are denying or delaying care later and later. They are wasting critical minutes consulting with an attorney, over-ordering and scrutinizing tests, and fretting over the incredibly consequential decision of when a patient is close enough

to death to intervene. And in some cases physicians are doing exactly what EMTALA tells them not to do: They are transferring emergency patients to other hospitals out-of-state when they do not think they can provide the patient the care they need to save both their life and health.

## II. The public interest strongly favors enforcing the district court's injunction and finding EMTALA preempts Idaho law.

The traumatic experiences of treating pregnant patients experiencing medical emergencies, *supra* Part I.A., as well as the culture of fear surrounding abortion care in Idaho, *supra* Part I.B., is driving obstetricians out of the state. As detailed below, this exodus is causing an ever-increasing shortage of obstetricians, which is hurting all pregnant patients, not just those experiencing medical emergencies.

### A. Idaho doctors are leaving in droves because of Idaho's total abortion ban. Failing to reinstate the injunction will only exacerbate this exodus.

The Idaho Coalition for Safe Healthcare in collaboration with the Idaho Physician Well-Being Action Collaborative has closely tracked the impact of Idaho's abortion laws on the availability of healthcare in Idaho. *See A Post Roe Idaho*, IDAHO COALITION FOR SAFE HEALTHCARE (Feb. 2024), https://bit.ly/4cdGhq5. The results are dismal.

Since August 2022, when Idaho's total abortion ban went into effect, until November of 2023—a period of just 15 months—60 actively practicing obstetricians have left. *Id.* at 4. This is nearly a quarter of all obstetricians in the

state. *Id.* This exodus is not typical turnover. Just *two* obstetricians moved to Idaho in the same period. *Id.* The vast majority of obstetric openings have remained vacant for months and medical students are declining to complete obstetric residencies in the state. As a result, there are now only 210 obstetricians in Idaho, and not all of them work full-time. *Id.* Idaho needs more than 250 full-time obstetricians to serve its population. *Projections of Supply and Demand for Women's Health Service Providers: 2018-2030*, U.S. DEPT. OF HEALTH & HUMAN SERVICES, at 18 (March 2021), https://bit.ly/3VBjRc7. Thus, at present, Idaho has less than 84% of the obstetricians its residents need. *Id.* That percentage will only decrease as Idaho's population continues to rapidly increase and doctors continue to leave or stop practicing.

Perhaps the real canary in the coal mine is the exodus of maternal fetal medicine doctors ("MFMs"). MFMs are obstetricians who specialize in taking care of women having complicated or high-risk pregnancies. More than any other specialist, their practice is impacted by the conflict between EMTALA and § 18-622. Prior to Idaho's total abortion ban going into effect in 2022, Idaho had nine MFMs. Five of these specialists have since left the state or their practice because of the effects of Idaho's total abortion ban, and just one has moved to Idaho since 2022. That leaves just five MFMs, not all of whom full time, to serve the entire state of Idaho. *Supra A Post Roe Idaho* at 5. For context, each year approximately 22,500 babies are born in the state of Idaho. Michelle J. K. Osterman, et al., U.S. DEPT. OF HEALTH & HUMAN SERVICES, *Births: Final Data for 2021*, NAT'L VITAL STAT. REP. Vol. 72, No. 1, at 21 (Jan. 31, 2023), https://bit.ly/3TURlRB. Approximately 6-8% of those involve high-risk complications.

*MFM: High-Risk Pregnancies*, UCSF DEPARTMENT OF OBSTETRICS, GYNECOLOGY & REPRODUCTIVE SCIENCES, https://bit.ly/4cdGDwV. That leaves less than five full-time MFMs to serve the expected 1,800 high-risk, complicated pregnancies in the state each year.

In case there was any doubt as to their motivations, the Idaho Coalition for Safe Healthcare collected data from Idaho doctors who are impacted by Idaho's abortion laws to understand what was making them leave or consider leaving. *Idaho Physician Retention Survey*, ADA COUNTY MEDICAL SOCIETY (May 2023) , https://bit.ly/3TIynOg (data supplied by Idaho Coalition for Safe Healthcare). Of the 116 doctors initially surveyed, 64% reported that they were "considering relocating out-of-state in the next year." *Id.* Of that 64%, a staggering 97% reported that "Idaho's restrictive abortion laws [were] contributing to [their] consideration of leaving medical practice in Idaho." McKay Cunningham, *Survey shows Idaho's maternal health doctors are leaving the state, or soon will*, IDAHO CAPITAL SUN (April 7, 2023), https://bit.ly/3IGGd4r. Of the OBGYNs who reported they "were considering leaving Idaho, 96% stated they would 'consider staying' or would 'very likely stay' if" the Idaho Legislature "modified the existing abortion laws to allow exceptions to preserve the health of the patient (not just 'prevent death')." *Supra Idaho Physician Retention Survey*.

### B. The exodus of doctors is harming all pregnant patients in Idaho.

The mass exodus of doctors is having devastating effects. Since Idaho's total abortion ban went into effect, two hospital labor and delivery units have closed because

they simply do not have the necessary personnel to staff the programs. *See supra A Post Roe Idaho*, IDAHO COALITION FOR SAFE HEALTHCARE at 3. These closures have left large swaths of the state without access to obstetric or gynecologic care. *Id.* at 4. Another Idaho hospital obstetrics program plans to close in just days, on April 1, 2024, and a fourth is in serious jeopardy of closing in the near future. *Id.*

For rural Idahoans, the impact of this exodus is especially scary. Currently, 22 of Idaho's 44 counties—half of the state—do not have access to a *single* practicing obstetrician. *Id.* Only 10 counties—less than a quarter—have more than three. *Id.* at 5. It takes a bare minimum of three obstetricians serving the same hospital to ensure someone is on call to provide delivery or emergency care services to pregnant patients 24 hours a day, 7 days a week, 365 days a year. *Id.* In other words, only a small handful of urban locations in Idaho have a sufficient number of obstetricians to ensure the necessary care for pregnant patients will be available at any time. This means many pregnant patients living in remote or rural counties will likely have to drive tens or even hundreds of miles to receive necessary care in an emergency.

The doctor shortage is now also having a real impact on *all* pregnant patients in Idaho, not just those living in rural areas or experiencing an emergency. Doctors recommend that patients who suspect they are pregnant should see a healthcare professional as soon as possible for prenatal care. *Having a Baby*, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGIST, https://rb.gy/c93uf9. This early "prenatal care can help prevent complications and inform women about important steps they can take to protect their infant and ensure a

healthy pregnancy." *Pregnancy*, EUNICE KENNEDY SHRIVER NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, https://bit.ly/43ofdjH. Because of Idaho's doctor shortage, in many cases Idaho patients now cannot obtain an appointment to see their OB-GYN as soon as they suspect they are pregnant. Instead, some patients are now waiting weeks or months to have their first pre-natal visit. Coalition doctors in certain locations have reported that some patients have not been able to obtain an initial pre-natal visit until they are well into the second trimester. By missing these important early appointments, patients may not receive vital information regarding, *inter alia*, how to follow a safe, healthy diet during pregnancy; how to avoid exposure to substances that may be harmful to the fetus, including through medications the pregnant patient may normally use; how to promote fetal health and development; and how to reduce the risk of pregnancy complications and health complications for the fetus. *Id.* Patients may also miss the window to obtain a non-emergency, yet wanted or needed, abortion in another state. Patient wait times, and the attendant harms, will only worsen unless obstetricians feel they can safely practice in Idaho.

* * *

Idaho's abortion laws have made it dangerous to be pregnant in Idaho. EMTALA's protections, when given full force and effect, significantly reduce the dangers pregnant patients face, improve patient care and well-being, and reduce physician fear and anxiety. By finding EMTALA preempts Idaho Code § 18-622, and reinstating the district court's injunction, this Court will make Idaho a safer place to be pregnant. It will also reduce a significant amount of patient suffering and improve physician

retention by giving doctors the confidence that they will be able to provide their pregnant patients with the care necessary to stabilize their health in an emergency without fear of repercussion.

## CONCLUSION

The Court should reinstate the district court's injunction.

Respectfully submitted.

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