Nos. 23-35440, 23-35450

In the United States Court of Appeals for the Ninth Circuit

UNITED STATES OF AMERICA

Plaintiff-Appellee,

v.

STATE OF IDAHO,

Defendant-Appellant,

and

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES; CHUCK WINDER, PRESIDENT PRO TEMPORE OF THE IDAHO SENATE; THE SIXTY-SEVENTH IDAHO LEGISLATURE,

Movants-Appellants.

On Appeal from the United States District Court
for the District of Idaho
Case No. 1:22-cv-00329-BLW

BRIEF OF AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AMERICAN MEDICAL ASSOCIATION, ET AL. AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFF-APPELLEE AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 26.1 and 29(a)(4)(A), the undersigned counsel certifies that none of the amici curiae are nongovernmental entities with a parent corporation or a publicly held corporation that owns 10% or more of its stock.

/s/ Kaitlyn Golden
Kaitlyn Golden

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INTEREST OF *AMICI CURIAE*[1]

Amici are leading professional medical organizations; ensuring access to evidence-based health care and promoting health care policy that improves patient health are central to their missions. *Amici* believe all patients are entitled to prompt, complete, and unbiased emergency health care that is medically and scientifically sound and provided in compliance with the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"). *Amici* submit this brief to explain how EMTALA is understood and applied in the practice of medicine and the role of abortion care as stabilizing treatment required by EMTALA. A full list of the 19 participating medical organizations is provided as an appendix to the brief. Among them are:

American College of Obstetricians and Gynecologists (ACOG): Representing more than 90% of board-certified OB/GYNs in the United States, ACOG is the nation's premier professional membership organization for obstetrician-gynecologists dedicated to access to evidence-based, high-quality, safe, and equitable obstetric and gynecologic care.

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[1] No party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund this brief, and no person other than amici curiae, their members, and their counsel contributed money to fund this brief. All parties have consented to the filing of this brief.

ACOG maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access for all people to the full spectrum of evidence-based quality reproductive health care, including abortion care, and is a leader in the effort to confront the maternal mortality crisis in the United States.

American College of Emergency Physicians (ACEP): ACEP is the nation's leading medical society representing emergency medicine. Through continuing education, research, public education, and advocacy, ACEP advances emergency care on behalf of its approximately 38,000 emergency physician members and the more than 150 million people they treat on an annual basis. Both by law and by oath, emergency physicians must care for all patients seeking emergency medical treatment. ACEP members represent a diverse array of personal and political beliefs, yet they are united in the belief that emergency physicians must be able to practice high-quality, objective, evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship.

American Medical Association (AMA): The AMA is the largest

professional association of physicians, residents, and medical students in the United States. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every specialty and in every state.

INTRODUCTION

Idaho's abortion ban, Idaho Code § 18-622 (the "Idaho Law"), endangers patients by interfering with patient-clinician relationships and medical ethics and by preventing medically indicated care. For nearly four decades, EMTALA has ensured that patients with statutorily defined emergency medical conditions receive the care they require—but the Idaho Law conflicts with EMTALA and prohibits that emergency care even when it is dictated by well-established clinical guidelines and medical ethics. This forces clinicians to disregard their patients' clinical presentations, their own medical expertise and training, and EMTALA's requirements—or else face criminal prosecution. This double bind has compelled clinicians to leave Idaho for states where they will not face criminal liability for responsibly practicing medicine, depriving many Idahoans—including people who are not pregnant—of access to even routine OB/GYN care. The Idaho Law puts clinicians in the untenable position of either violating their

moral and ethical obligation to avoid harming patients (and potentially facing claims of malpractice), or risking criminal prosecution. Simply put, the law affords them no meaningful option.

ARGUMENT

I. Pregnant Patients Frequently Face Emergency Medical Situations.

A. Nature of Emergency Care for Pregnant Patients

Clinicians regularly treat pregnant patients for emergent conditions. Those conditions may arise from the many risks associated with pregnancy[2] or from other trauma that implicates the patient's or the pregnancy's safety or viability, like car accidents.[3] In providing care,

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[2] The U.S. mortality rate associated with live births was a staggering 32.9 per 100,000 live births in 2021, up from 23.8 in 2020. *See* Donna Hoyert, *Maternal Mortality Rates in the United States, 2021*, Nat'l Ctr. For Health Stats. 1 (Mar. 2023), https://tinyurl.com/mrb6avsh. Pre-existing conditions and comorbidity with other illnesses further increase the likelihood of pregnancy complications. *See*, *e.g.*, Cleveland Clinic, *High-Risk Pregnancy*, https://tinyurl.com/3scffvzr (last reviewed Dec. 14, 2021) (describing how preexisting conditions exacerbate the pregnancy risks). *See infra*, Section IV.

[3] Kimberly A. Kilfoyle et al., *Non-Urgent and Urgent Emergency Department Use During Pregnancy: An Observational Study*, PubMed Central, at 1, 2 (Feb. 1, 2018), https://tinyurl.com/3hay25dw. Am. Coll. of Emergency Physicians (ACEP), *Definition of Emergency Medicine* (Jan. 2021), https://tinyurl.com/46a37m56; *see also* ACOG Comm. Op. No. 667, *Hospital-Based Triage of Obstetric Patients* (July 2016), https://tinyurl.com/yp83c3rn.

clinicians use their medical judgment—honed through years of education, training, and experience—to provide evidence-based care consistent with clinical guidance and responsive to patients' individualized needs.

Pregnant patients with emergency conditions may receive care in an emergency department (ED) or in labor and delivery units from obstetrician-gynecologists, family physicians, or other medical specialists.[4] Hospital-based obstetric units collaborate with EDs because "labor and delivery units frequently serve as emergency units for pregnant women."[5]

Speed is essential when providing emergency care. Rapid treatment improves patient outcomes, while delayed treatment increases risk of complications, permanent injury, or death.[6] "Patients often arrive at the emergency department with acute illnesses or injuries that require immediate care . . . there is a presumption for quick action guided by predetermined treatment protocols."[7] For pregnancy-related emergencies, "[e]arly diagnosis and treatment are paramount to reducing maternal

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[4] ACEP, *Definition of Emergency Medicine*, *supra* n.3, at 1; *see also* ACOG Comm. Op. No. 667, *supra* n.3.

[5] *See* ACOG Comm. Op. No. 667, *supra* n.3, at 1.

[6] *See*, *e.g.*, Robert W. Neumar, *The Zerhouni Challenge: Defining the Fundamental Hypothesis of Emergency Care Research*, 49 Annals Emergency Med. 696 (2007).

[7] ACEP, *Code of Ethics for Emergency Physicians* 4 (Oct. 2023), https://tinyurl.com/4z4twrj3; *see also infra* Section V.

morbidity and mortality, especially because of the risk of rapid deterioration."[8]

B. Emergency Care for Pregnant Patients Sometimes Includes Abortion Care

Pregnant patients frequently visit EDs.[9] Most emergency providers see pregnant patients in virtually every shift, treating conditions like abdominal pain, vaginal bleeding, or other pregnancy-related issues,[10] some of which require emergency intervention. Pregnant patients may present with a range of serious issues, including:

- **Preterm prelabor rupture of membranes** ("PPROM"), where the amniotic sac ruptures early, presenting a major maternal risk of infection, abruption, and sepsis;[11]

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[8] Katherine Tucker et al., *Delayed Diagnosis and Management of Second Trimester Abdominal Pregnancy*, BMJ Case Rep. 1 (Sept. 2017), https://tinyurl.com/3mea7hns; *see also* Ashley N. Battarbee et al., *Society for Maternal-Fetal Medicine Consult Series #71: Management of Previable and Periviable Preterm Prelabor Rupture of Membranes*, 231 Am. J. Obstetrics & Gynecology B2, B7 (2024) (for PPROMS "once infection was identified, the median time to death was only 18 hours").

[9] In 2019, over 3.5 million women visited EDs for pregnancy-related reasons (other than delivery), with 216,981 additional pregnant women visiting for reasons not primarily related to pregnancy. Agency for Healthcare Rsch. & Quality, *Emergency Department and Inpatient Utilization and Cost for Pregnant Women: Variation by Expected Primary Payer and State of Residence, 2019*, Healthcare Cost & Utilization Project 30 (Dec. 14, 2021), https://tinyurl.com/mpcfjrjk.

[10] *Id.*

[11] ACOG Prac. Bull. No. 217, *Prelabor Rupture of Membranes*, 135 Obstetrics & Gynecology e80, e80 (2020).

- **Miscarriage or early pregnancy loss**, which occurs in approximately 10% of clinically recognized pregnancies.[12] Pregnant patients seek hospital-based care with miscarriage-related concerns hundreds of thousands of times annually.[13] A miscarriage may put a patient at risk of excessive blood loss and serious infection.

- **Gestational hypertension and preeclampsia** (high blood pressure), which complicate 2–8% of pregnancies and are among the leading global causes of maternal mortality.[14] Preeclampsia prior to viability presents a risk of serious health consequences including seizure, stroke, multiple organ failure, and death.[15]

- **Excessive bleeding**, which can be caused by placenta accreta spectrum and other conditions;[16]

- **Placental abruption**, where the placenta separates from the inner wall of the uterus, causing potentially uncontrollable

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[12] ACOG Prac. Bull. No. 200, *Early Pregnancy Loss* (Nov. 2018), https://tinyurl.com/ympwyp7v.

[13] Carolyn A. Miller et al., *Patient Experiences with Miscarriage Management in the Emergency and Ambulatory Settings*, 134 Obstetrics & Gynecology 1285, 1285 (2019), https://tinyurl.com/fx44fz93 ("Patients with concerns about a potential miscarriage . . . present for care in [EDs] at a rate of approximately 500,000 each year in the United States."); Lyndsey S. Benson et al., *Early Pregnancy Loss in the Emergency Department, 2006–2016*, 2 J. Am. Coll. Emergency Physicians, no. 6, Aug. 2021, at 1–2, https://tinyurl.com/2p5ar74a ("EPL-related care accounts for over 900,000 ED visits in the United States each year.").

[14] ACOG Prac. Bull. No. 222, *Gestational Hypertension and Preeclampsia*, 135 Obstetrics & Gynecology e237, e237 (2020), https://tinyurl.com/54xvzju3; *see also* 1-ER-11 (discussing situations in which high blood pressure or preeclampsia might occur).

[15] ACOG Prac. Bull. No. 222, *supra* n.14, at e245.

[16] *See* ACOG, *FAQs: Bleeding During Pregnancy* (Aug. 2022), https://tinyurl.com/mpah8eh; ACOG Obstetric Care Consensus No. 7, *Placenta Accreta Spectrum*, https://tinyurl.com/387vurry (last updated 2021).

> bleeding. It results in stillbirth in up to 10% of cases and can result in serious complications for the patient, like cardiac arrest or kidney failure.[17]

These are just a few of the emergencies that can arise during pregnancy. The American Board of Emergency Medicine's *Model of Clinical Practice of Emergency Medicine*, the definitive source for the core content found on emergency physicians' board examinations, contains an entire section devoted to "Complications of Pregnancy."[18] Nearly all are graded as "critical" or "emergent," meaning that they "may progress in severity or result in complications with a high probability for morbidity if treatment is not begun quickly."[19]

Clinicians who provide emergency care understand that the stabilizing treatment for pregnant patients experiencing complications might abortion care. Abortion care may be necessary to prevent severe health consequences, like loss of uterus (and future fertility), seizures, stroke, vital organ damage and failure, and death.

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[17] See *United States v. Idaho*, 623 F. Supp. 3d 1096, 1104 (D. Idaho 2022) (discussing placental abruption complications); ACOG Obstetric Care Consensus No. 10, *Management of Stillbirth* (Mar. 2020), https://tinyurl.com/4cc7fnjj.

[18] Michael S. Beeson et al., *2022 Model of the Clinical Practice of Emergency Medicine*, 64 J. Emergency Med. 659, 679 (2022), https://tinyurl.com/5dwb65k.

[19] *Id.* at 661–662.

For many emergency medical conditions requiring abortion care, pregnancy loss is inevitable. When a pregnant patient experiences PPROM prior to viability, continuing the pregnancy risks serious health consequences including sepsis and death—and the fetus is unlikely to survive regardless.[20] An inevitable or incomplete abortion—commonly called a miscarriage—can cause excessive bleeding and risk of hemorrhage or infection and fetal or embryonic cardiac activity may remain. Other emergency situations—like molar or ectopic pregnancy—occur precisely because a pregnancy will not progress and result in a live birth.[21] In these and other cases, abortion care may be required to stabilize the patient.[22]

II. EMTALA Has Always Required Clinicians to Provide Stabilizing Treatment to Pregnant Patients—Including Termination of Pregnancy in Some Situations.

Since its passage over 35 years ago, EMTALA has required hospitals that accept Medicare to provide treatment to any patient who presents

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[20] ACOG Prac. Bull. No. 217, *supra* n.11, at 81.

[21] ACOG Prac. Bull. No. 193, *Tubal Ectopic Pregnancy* (Mar. 2018); Neil Horowitz et al., *Epidemiology, Diagnosis, and Treatment of Gestational Trophoblastic Disease: A Society of Gynecologic Oncology Evidenced-Based Review and Recommendation*, 163 Gynecologic Oncology 605 (2021), https://tinyurl.com/5yeda2ds. *See also* ACOG, *Facts Are Important: Understanding and Navigating Viability*, https://tinyurl.com/y3chewc5 (last visited Oct. 21, 2024).

[22] *See, e.g.*, ACOG Prac. Bull. No. 217, *supra* n.11, at 88.

with an emergency condition "until the emergency condition is resolved or stabilized."[23] And since that time, that care has included abortion care when it is the medically indicated treatment to stabilize a pregnant patient.

EMTALA does not specify particular treatments. Instead, when a clinician determines that an individual has an emergency medical condition, the clinician must provide "such treatment as may be required to stabilize the medical condition."[24] EMTALA properly relies on clinicians' medical judgment to determine how to achieve stabilization in each specific case.[25] That determination, in turn, is informed by training and experience, and based on established clinical guidelines that are painstakingly developed and regularly updated according to the latest expert reviews of medical evidence.[26] And it is also grounded in the strong ethical guidelines that apply to clinicians and a fundamental commitment

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[23] ACEP, *Understanding EMTALA*, https://tinyurl.com/4k36btsk (last visited Oct. 20, 2024).

[24] 42 U.S.C. § 1395dd(b)(1)(A) (emphasis added).

[25] While EMTALA requires clinicians to make available appropriate medical care, patients retain the ultimate authority to accept or decline care. 42 U.S.C. § 1395dd(b)(2); *see also* ACOG Comm. Op. No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021), https://tinyurl.com/265ppjwz.

[26] ACOG, *Clinical Practice Guideline Methodology*, 138 Obstetrics & Gynecology 518 (2021).

to the welfare of the patient.[27]

Defendant-Appellant's suggestion that EMTALA's coverage of abortion care makes "doctors a law unto themselves" is a red herring and a "blame the doctors" approach to excusing the real-world impact of abortion bans. Doctors are subject to licensing requirements, state medical board review, medical society grievance procedures, and the threat of medical liability litigation. And EMTALA does not require the treatments Defendant-Appellant describes because, unlike abortion care, those treatments are not stabilizing care for an emergency medical condition.[28]

III. The Idaho Law Criminalizes Care EMTALA Requires.

The Idaho Law directly conflicts with providers' ability to provide care required by EMTALA. The Idaho Law takes an essential medical practice and criminalizes it, even in emergency situations that endanger patients.

In some emergencies, providers may be unable to comply with both the Idaho Law and EMTALA, for two related reasons. The Idaho Law

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[27] ACOG, *Code of Professional Ethics* 2 (Dec. 2018), https://tinyurl.com/2jkaruud.

[28] *See* Def.-Appellant's Br. 37 (suggesting EMTALA could authorize providers to offer medical marijuana, opioids, or a lobotomy in violation of state law in an ED).

allows for abortion care only in the most narrow and limited situations: when "necessary to prevent the death" of the pregnant patient.[29] EMTALA, in contrast, requires stabilizing treatment in a broader set of circumstances to ensure the patient's *health* is not jeopardized.[30] Contrary to Defendant-Appellant's assertions, there are many situations where providers will be unable to comply with both EMTALA and the Idaho Law, given the level of severity and the delayed timing of intervention the Idaho Law requires.

First, the level of severity. By its plain terms, the Idaho Law sets a higher threshold for treatment: the patient must be facing death. EMTALA, on the other hand, requires stabilizing care when "the absence of immediate medical attention" would place the patient's health in "serious jeopardy" or cause serious bodily impairment or dysfunction.[31] This is appropriate given the course of many pregnancy complications, since delaying care can result in severe maternal morbidity as well as mortality.[32] What's more, even if a pregnant patient is at risk of death, the

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[29] Idaho Code § 18-622(2)(a)(i); *see also Idaho*, 623 F. Supp. 3d at 1109–1112.
[30] 42 U.S.C. § 1395dd(e)(1)(A).
[31] *Id.*
[32] One *amicus* has relied on a selective interpretation of statistics to

Idaho Law's requirement that the procedure be "necessary" to prevent death requires a level of certainty inconsistent with actual medical practice and thus will delay stabilizing treatment past where EMTALA and medical ethics require intervention.

This presents the second issue, timing. The Idaho Law encourages providers to delay treatment until the patient's condition reaches the required level of severity—but no clinical bright line defines when these conditions are met. At what point does the condition of a patient with a uterine hemorrhage deteriorate from health-threatening to where abortion care is "necessary" to prevent death? When is it certain she will die absent intervention? How many units of blood does she have to lose? One? Five? How fast does she have to be bleeding? Soaking through two pads an hour?

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suggest that maternal mortality rates have fallen following *Dobbs v. Jackson Women's Health Organization*. Br. American Association of Pro-Life Obstetricians & Gynecologists 34. This conclusion relies on a misunderstanding of underlying data: that *amicus* relies on a rolling 12-month mortality count, and the decline in that count that began in the summer of 2022 reflects decreasing maternal mortality over the course of 2021—nearly a full year before the decision and after the initial phase of the COVID pandemic. Amanda Jean Stevenson & Leslie Root, *Do Abortion Bans Somehow Save Pregnant People's Lives? A Cautionary Research Note on Trends in Maternal Death Post-Dobbs* 6 (2024), https://tinyurl.com/mrxcycek. "[D]ata with which to examine the relationship between post-Dobbs abortion bans and trends in maternal death will take years to become available." *Id.*

Three? How low does her blood pressure need to be? 90 over 60? 80 over 50? And when does the condition of a patient with sepsis from a uterine infection deteriorate from health threatening, to life-threatening, to necessarily about to die? If the standard treatment of IV fluids does not stabilize her, is her condition now life-threatening? Even if life-threatening, when is care "necessary" to prevent her death? Is it when she is unconscious, and any further treatment has become more fraught with risk and further complications? The Idaho Law requires clinicians to make these judgments only in the context of state laws restricting access to abortion care and under threat of severe criminal penalties.[33]

As the District Court recognized, "medicine rarely works in absolutes."[34] Life and health exist on a fragile and shifting continuum, and in emergent situations, providers must act quickly. Consider a patient who presents with previable or periviable PPROM. Defendant-Appellant incorrectly argues that these conditions present an easy case for expectant

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[33] Even under the Idaho Supreme Court's decision that the Idaho Law incorporates a "subjective" standard, *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132, 1203-1204 (Idaho 2023), a provider must believe an abortion is "necessary" to save their patient—an unworkable standard inconsistent with actual medical practice and the nuanced situations clinicians face.

[34] *Idaho*, 623 F. Supp. 3d at 1112.

management under the Idaho Law.[35] Defendant-Appellant's position blithely dismisses the known and extremely serious risks of PPROM in favor of Defendant-Appellant's preferred approach.

A significant number of patients whose membranes have ruptured at the previable and periviable stage of pregnancy will deteriorate quickly and unpredictably, and for many, the only sure way to halt this progression is an abortion.[36] While expectant management, or the "wait and see approach," can sometimes be used with stable pregnant individuals without signs of infection, hemorrhage or other potential complications who make an informed decision to continue the pregnancy despite the

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[35] Defendant-Appellant relies on misleading data, suggesting that 90 percent of patients who experience PPROM, and their fetuses, will survive. Def.-Appellant's Br. 42-43. This statistic reflects only a certain subset of patients who remained pregnant for at least 7 days following rupture—among other exclusions, it did not include data on medically indicated terminations, and the study thus recognized the "potential for selection bias." Jane E. Brumbaugh et al., *Neonatal Survival After Prolonged Preterm Premature Rupture of Membranes Before 24 Weeks of Gestation*, Obstetrics & Gynecology, at 1 (2014), https://tinyurl.com/b83zcpva. A more recent study suggests that only 39 percent of neonates survive, and that figure is far lower the earlier in pregnancy the condition occurs. Battarbee et al., *Society for Maternal-Fetal Medicine Consult Series #71*, *supra* n.8, at B6.

[36] Battarbee et al., *Society for Maternal-Fetal Medicine Consult Series #71*, *supra* n.8, at B4 ("Other contraindications to expectant management, including hemorrhage and fetal demise, should prompt abortion care or delivery and evacuation of uterine contents.").

risks,[37] abortion is still the most common stabilizing treatment needed to address the critical risk of maternal mortality or morbidity. In Defendant-Appellant's imagining, clinicians should ignore the needs of and risks to their patient, let their patient deteriorate, and wait until some arbitrary sign of adequate deterioration and then attempt to act quickly enough to save the patient's life within a narrow time window—despite facing a strong likelihood of rapid progression of symptoms and risk.[38] In no other clinical scenario in medicine or surgery is such a "wait and see" approach mandated, risking the lives of patients who present for emergent care.

Providers cannot be expected, and should not be compelled, to delay stabilizing treatment until a legislatively imagined but medically nonexistent line has been crossed.

IV. The Idaho Law Has Devastating Consequences for Idahoans.

The Idaho Law prevents clinicians from performing abortions in emergencies. Any provider treating a patient when abortion care is indicated—even when the pregnant patient's life is clearly threatened—faces the possibility of looming prosecution. Providers must consult with

[37] *Id.* at B5, B9.

[38] *Id.* at B7 (for patients experiencing PPROM "once infection was identified, the median time to death was only 18 hours").

legal counsel in their institutions and consider the risk of criminal investigation and indictment on this politically polarized issue; the attendant cost of retaining counsel; the risk of losing their medical license, livelihood, or reputation; and even conviction, if a lay jury decides that they erred in their medical judgment. These considerations inevitably delay necessary care and result in an untenable situation for Idaho clinicians, some of whom are leaving Idaho for states where they do not face these threats simply for practicing medicine.

A. Pregnant People Are Already Experiencing and Will Continue to Experience Negative Consequences as a Result of the Idaho Law

The Idaho Law endangers patients. Maternal mortality is a crisis in Idaho and nationwide, even though most maternal deaths—four out of five according to a recent study—are preventable.[39] Only the preliminary injunction presently blocks the Idaho Law from preventing care to patients facing obstetrical emergencies and worsening their health outcomes.

In states with abortion bans—including Idaho—nearly 40 percent of

[39] Ctrs. for Disease Control & Prevention, *Four in 5 Pregnancy-Related Deaths in the U.S. Are Preventable* (Sept. 19, 2022), https://tinyurl.com/n3x46dy; *see also* Susanna Trost et al., Ctrs. for Disease Control and Prevention, *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States*, *2017–2019* (2022), https://tinyurl.com/4sc2s3c6.

OB/GYNs surveyed have been constrained in providing care for pregnancy-related emergencies.[40] Under the Idaho Law, to avoid potential criminal liability, physicians would be forced to wait until abortion care becomes "necessary to prevent the [patient's] death."[41] Providers describe delaying care until "labor start[s] or when they experience[] signs of infection."[42] This is precisely what Idaho says providers should do, despite patients' needs and the clear EMTALA requirement that a clinician "act prior to the patient's condition declining."[43] The alternative is to send patients out of state for necessary and potentially life-saving abortion care.

The immense danger of delaying care is not hypothetical. A recent study of Texas's similar abortion ban concluded that "expectant management of obstetrical complications [at the border of viability] was

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[40] Brittni Frederiksen et al., *A National Survey of OBGYNs' Experiences After Dobbs*, Kaiser Fam. Found. (June 21, 2023), https://tinyurl.com/mr3d3ev8.

[41] Idaho Code § 18-622(2)(a)(i).

[42] Daniel Grossman et al., *Care Post-Roe: Documenting Cases of Poor-Quality Care Since the Dobbs Decision*, Advancing New Standards in Reproductive Health 7 (Sept. 2024), https://tinyurl.com/499b4a8j.

[43] Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations Specific to Patients Who Are Pregnant or Are Experiencing Pregnancy Loss* 4, https://tinyurl.com/yjeaaaau (last updated Aug. 25, 2022).

associated with significant maternal morbidity."[44] "Expectant management resulted in 57% of patients having a serious maternal morbidity compared with 33% who elected immediate pregnancy interruption under similar clinical circumstances reported in states without such legislation."[45] The study documented a significant increase in maternal morbidity among patients with preterm labor who would have been promptly offered abortion care before the law but now cannot be offered such treatment until their physicians determined that an emergent condition poses "an immediate threat to maternal life."[46] Considering such situations, the study concluded that "state-mandated expectant management" is associated with "significant maternal morbidity."[47]

These statistics reflect devastating consequences for individual people. Jennifer Adkins, an Idaho mother, was "very excited" to be

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[44] Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 Am. J. Obstetrics & Gynecology 648, 649 (2022), https://tinyurl.com/5xtct689.

[45] *Id.* The study followed patients with PPROM and pregnancy tissue prolapsed into the vagina. Among these patients, 43% experienced maternal morbidity such as infection or hemorrhage; 32% required intensive care admission, dilation and curettage, or readmission; and one patient required a hysterectomy. *Id.*

[46] *Id.* at 648–49.

[47] *Id.*

pregnant, until learning that her pregnancy was likely not viable, and that she faced a high risk of mirror syndrome, also known as Ballantyne syndrome—a rare condition where maternal edema (abnormal fluid accumulation in a pregnant person), placentamegaly (an abnormally enlarged placenta) and fetal hydrops (abnormal fluid buildup in the fetus) are all present.[48] "Timely intervention is needed to prevent fetal and maternal morbidity"[49] for patients with mirror syndrome. If Jennifer remained in Idaho, her only option would have been to continue carrying a non-viable fetus until her mirror syndrome or other conditions worsened enough that terminating the pregnancy was deemed "necessary" to prevent her death. Fearful for her well-being, Jennifer felt that she "needed to stay alive for her two-year-old son," but doing so depended on her ability to get appropriate medical care—abortion care—in another state.[50] With the assistance of two abortion funds, she and her husband traveled to Oregon and she received care.[51] Idahoans will continue either to be forced out of

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[48] Pl.'s Compl. for Declaratory J. and Inj. Rel. 8, *Adkins v. Idaho*, CV01-23-14744 (Idaho Fourth Jud. Dist. Sep. 11, 2023); Caroline Mathias & Carmela Rizvi, *The Diagnostic Conundrum of Maternal Mirror Syndrome Progressing to Pre-Eclampsia – A Case Report*, 23 Case Reps. Women's Health 1, 2 (2019), https://tinyurl.com/j4329k5s.
[49] Mathias & Rizvi, *supra* n.48, at 2.
[50] Pl.'s Compl. for Declaratory J. and Inj. Rel. 10, *Adkins*, *supra* n.48.
[51] *Id*.

state or to suffer the devastating consequences of pregnancy complications under the impossible bind created by the Idaho Law.

B. The Idaho Law Has Directly Caused an Exodus of Critical Health Care Clinicians from Idaho, Further Worsening Its Impact on Pregnant People and People Who May Become Pregnant

The Idaho Law is driving clinicians out of state. Idaho healthcare leaders note that the law has "had a profound chilling effect on recruitment and retention" of providers and "smaller hospitals in Idaho have been unable to withstand the strain."[52] At least three Idaho hospitals have closed their labor and delivery units since the Idaho Law took effect; "one of them, Bonner General Health, a 25-bed hospital in northern Idaho, cited the state's 'legal and political climate' and the departure of 'highly respected, talented physicians' as factors that contributed to its decision." [53]

These closures are unsurprising amidst the current exodus of providers. In the fifteen months following the Idaho Law taking effect,

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[52] Sheryl Stolberg, *As Abortion Laws Drive Obstetricians from Red States, Maternity Care Suffers,* N.Y. Times (Sept. 7, 2023).

[53] *Id.*; Kelcie Moseley-Morris, *Idaho Doctor Who Worked at Closed Maternity Ward Says Abortion Ban Harmed Recruiting*, Idaho Cap. Sun (Apr. 22, 2024), https://tinyurl.com/2cz2fk3t.

Idaho lost a net total of 58 of 268 obstetricians (21.6 percent).[54] During the same period, five of the state's nine maternal-fetal medicine experts—obstetricians with additional training specific to high-risk pregnancies—have either retired or moved away. [55] These doctors are not being replaced: in that same fifteen-month period, only two new obstetricians moved to Idaho.[56] As one maternal-fetal medicine specialist explained her decision to leave, "the risk was too big for me and my family."[57] They needed to be "where we felt that reproductive health care was protected and safe." [58] Another maternal-fetal health specialist who left noted that she was "very anxious being on the labor unit, just not knowing if somebody else was going to second-guess my decision. That's not how you want to go to work every day." [59] The choice to leave a restrictive state is an inherently ethical responses for clinicians facing the impossibility of providing care.

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[54] Idaho Physician Well-Being Action Collaborative, *A Post Roe Idaho Data Report* 3 (Feb. 2024), https://tinyurl.com/2bwe5yw3.
[55] *Id*. at 5; Stolberg, *supra* n.52.
[56] Idaho Physician Well-Being Action Collaborative, *supra* n.54, at 4.
[57] Stolberg, *supra* n.52.
[58] Laura Ungar, *Why Some Doctors Stay in US States with Restrictive Abortion Laws and Others Leave*, Assoc. Press (June 22, 2023), https://tinyurl.com/yw25zwwm.
[59] Stolberg, *supra* n.52.

This mass exodus endangers pregnant people. One half of Idaho counties (22 out of 44) have no practicing obstetricians.[60] There are an estimated 2.22 obstetricians per 10,000 Idaho women, compared to a 2016 national average of 5.5 obstetricians per 10,000 women of reproductive age.[61] Simply put, Idaho does not have enough clinicians to meet the needs of its citizens. The rapid departures of clinicians have worsened Idaho maternity care deserts, leaving primary care clinicians to provide care that should, ideally, be administered by specialists. As a result, many pregnant patients are unable to see specialists, many patients with high-risk pregnancies are forced to rely on "consult services from more urban areas where coverage is already stretched thin,"[62] and OB/GYNs are often unavailable for labor and delivery. The exodus of clinicians also reduces gynecological care for Idaho patients who are not pregnant. In short, "[t]his isn't an issue about abortion. This is an issue about access to comprehensive obstetric and gynecologic care."[63]

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[60] Idaho Physician Well-Being Action Collaborative, *supra* n.54, at 4.
[61] *Id.* at 5; ACOG, *Graduate Medical Education*, https://tinyurl.com/bdek6hh8 (last visited Oct. 20, 2024).
[62] Idaho Physician Well-Being Action Collaborative, *supra* n.54, at 4.
[63] Stolberg, *supra* n.52.

C. The Idaho Law Has and Will Continue to Have a Disproportionately Negative Impact on Rural and Poor Pregnant People and Pregnant People of Color in Idaho

Reversal of the injunction would especially devastate underserved populations, including rural and low-income patients. As one obstetrician explained, "[f]or rural patients in particular, delaying medical care until we can say an abortion is necessary to prevent death is dangerous. Patients will suffer pain, complications, and could die if physicians comply with Idaho law as written when it conflicts with EMTALA."[64] As a result of structural inequities and social determinants of health, these populations are "more likely to face barriers in accessing routine health care services," including prenatal care.[65] This is especially true in Idaho, where 31.8% of counties are "maternity care deserts,"[66] and the number of birthing hospitals decreased 12.5% from 2019 to 2020, even before the Idaho Law took effect.[67]

This particularly endangers the over 500,000 (or 30.8% of) Idaho

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[64] 3-ER-210.

[65] Benson, *supra* n.13, at 2.

[66] *14 Idaho and 8 Washington Counties Lack Maternity Care, Report Finds*, KLEW (Sept. 12, 2024), https://tinyurl.com/3fphvuv7.

[67] Jazmin Fontenot et al., *Where You Live Matters: Maternity Care Access in Idaho*, March of Dimes 1 (May 2023), https://tinyurl.com/27u22t2y.

residents in rural areas.[68] "[R]ural Americans are more likely to be living in poverty, unhealthy, older, uninsured or underinsured, and medically underserved."[69] Rural hospitals and EDs are "the safety net" for rural Americans, including pregnant patients.[70] Rural women are "more likely to be poor, lack health insurance, or rely substantially on Medicaid and Medicare" and "must travel longer distances to receive care."[71] Pregnant rural patients accordingly are less likely to seek prenatal care,[72] and the initiation of prenatal care in the first trimester is lower for rural pregnant patients than suburban patients.[73] Unsurprisingly, "rural women experience poorer maternal outcomes compared to their non-rural counterparts, including higher pregnancy-related mortality."[74] Because access to blood, antibiotics and other supportive care measures is limited

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[68] U.S. Census Bureau, *Urban and Rural* (June 28, 2023), https://tinyurl.com/2uwf32nm.

[69] Ctrs. for Medicare & Medicaid Servs., *CMS Rural Health Strategy* 2 (2018), https://tinyurl.com/2j3yth7u (choose "State-level Urban and Rural Information for the 2020 Census and 2010 Census").

[70] Anthony Mazzeo et al., *Delivery of Emergency Care in Rural Settings* 1 (July 2017), https://tinyurl.com/yh689fnh.

[71] ACOG Comm. Op. No. 586, *Health Disparities in Rural Women* 2 (Feb. 2014), https://tinyurl.com/4mjkdmry.

[72] *Id.* at 1.

[73] *Id.*

[74] Ctrs. for Medicare & Medicaid Servs., *Advancing Rural Maternal Health Equity* 1 (2022), https://tinyurl.com/ycyptkn2.

in rural settings acting well ahead of clinical deterioration can save lives. Waiting may put the care of these patients outside the realm of possible for some rural hospitals, requiring likely futile patient transfers when appropriate interventions required by EMTALA would have saved their lives.

Pregnant patients of color similarly will be disproportionately harmed by the Idaho Law. People of color often have worse access to care and higher rates of ED visits.[75] Pregnant women of color are also less likely to receive prenatal care, resulting in increased risk for complex health issues in pregnancy.[76] As a result, women of color experience higher rates of severe maternal morbidity and are more likely to die from pregnancy-related complications.[77] Women of color are also more likely to

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[75] *See generally* Agency for Healthcare Rsch. & Quality, *2022 National Healthcare Quality and Disparities Report* (Oct. 2022), https://tinyurl.com/2p8k57fk; Off. of the Assistant Sec'y for Plan. & Evaluation, U.S. Dep't of Health & Hum. Servs., *Trends in the Utilization of Emergency Department Services, 2009-2018*, at 22 (Mar. 2021), https://tinyurl.com/4aca6rrd.

[76] Benson, *supra* n.13, at 2; *see also* Juanita J. Chinn et al., *Health Equity Among Black Women in the United States*, 30 J. Women's Health 212, 215 (2021) (explaining that "Black women are at a disadvantage regarding the protective factor of the early initiation of prenatal care").

[77] *See* Agency for Healthcare Rsch. & Quality, *supra* n.75, at 4; *see also* Chinn, *supra* n.76, at 215 (Black and Latina women "are at greater risk of poor pregnancy outcomes").

experience miscarriage, for which standard treatment can include abortion care, and to visit an ED for miscarriage-related care.[78]

Each of these categories of pregnant patients is more likely to experience emergency medical conditions when pregnant and thus more likely to need critical care the Idaho Law obstructs. The Idaho Law not only limits these populations' ability to access the full spectrum of OB/GYN care, but will "undoubtedly deter physicians from providing abortions in some emergency situations."[79] This will only exacerbate poor outcomes, thereby "obviously frustrat[ing] Congress's intent to ensure adequate emergency care for all patients."[80]

V. The Idaho Law Undermines Principles of Medical Ethics that Have Long Been Protected by EMTALA.

The Idaho Law contradicts core principles of medical ethics that have been implicitly ensured by EMTALA for nearly 40 years. EMTALA's requirement that a clinician provide "stabilizing treatment [to] prevent material deterioration" to any patient with an emergency medical condition, and "act prior to the patient's condition declining"[81] codifies the

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[78] Benson, *supra* n.13, at 5–7.
[79] *Idaho*, 623 F. Supp. 3d at 1112.
[80] *Id.*
[81] Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations*, *supra* n.43, at 4.

medical ethics principles of beneficence, non-maleficence, and respect for patient autonomy. In direct contrast, the Idaho Law violates these long-established principles by exposing providers to criminal penalties for providing evidence-based treatment, thus compelling them to deny necessary and appropriate care.

As EMTALA reflects, the core of medical practice is the patient-clinician relationship. ACEP's Code of Ethics for Emergency Physicians states that "[e]mergency physicians shall embrace patient welfare as their primary professional responsibility" and "shall respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care."[82] ACOG's Code of Professional Ethics similarly states that "the welfare of the patient must form the basis of all medical judgments" and that obstetrician-gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[83] The AMA Code of Medical Ethics likewise places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[84]

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[82] ACEP, *Code of Ethics for Emergency Physicians*, *supra* n.7, at 3.
[83] ACOG, *Code of Professional Ethics*, *supra* n.27, at 2.
[84] AMA Council on Ethical & Jud. Affs. Op. 1.1.1, *Patient-Physician Relationships* 1, https://tinyurl.com/7p4hkf36 (last updated 2017).

Beneficence and non-maleficence, respectively the obligations to promote the well-being of others and to do no harm, are not only ensured by EMTALA, but are cornerstone principles of the medical profession.[85] Patient autonomy, the respect for patients' right to control their bodies and make meaningful choices when making medical decisions, is another cornerstone.[86] Clinicians ensure patient autonomy through providing information about risks and benefits of potential courses of treatment and engaging in joint decision-making with their patients.[87] These principles are the natural result of the foundation of medical ethics: the welfare of the patient forms the basis of all medical decision-making. Taken together, they provide a clear approach that physicians—including those whose hands are tied by the Idaho Law—must follow: provide patient-centered, evidence-based care, equipping patients with information about

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[85] Am. Med. Ass'n, *AMA Principles of Medical Ethics*, https://tinyurl.com/3xy8rzsn (last updated June 2001); ACOG Comm. Op. No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, at 1, 3 (Dec. 2007), https://tinyurl.com/24nj94hr.

[86] *See* ACOG, *Code of Professional Ethics*, *supra* n.27, at 1 ("[R]espect for the right of individual patients to make their own choices about their health care (*autonomy*) is fundamental."). Consistent with both the principle of patient autonomy and EMTALA, 42 U.S.C. § 1395dd(b)(2), a patient may decline necessary care, including a necessary abortion.

[87] ACOG Comm. Op. No. 819, *supra* n.25; AMA Council on Ethical & Jud. Affs. Op. 2.1.1, *Informed Consent*, https://tinyurl.com/mr43szbz (last updated 2017).

options, risks, and benefits, and ultimately empowering patients to make autonomous decisions and obtain care informed by medical science.

Requiring EMTALA and the longstanding history of ethically informed care to yield to the decisions of anti-abortion legislators obliterates these principles. Where an Idaho clinician providing emergency care concludes that abortion care would be the appropriate stabilizing care to prevent severe harm to a patient's health, beneficence, non-maleficence, and respect for patient autonomy require the clinician to recommend abortion care and provide information about risk, benefits, and options. If an informed patient decides that abortion care is the best course of action, those principles require that the patient be provided the care. Under the Idaho Law, a clinician who concludes that abortion care is the appropriate stabilizing care instead faces a dilemma: they can (1) provide the best and most appropriate medical care, consistent with principles of medical ethics, and in so doing, risk substantial penalties, including the loss of their liberty and livelihood; or (2) they can follow the Idaho Law, violating basic principles of medical ethics and unnecessarily endangering their patient and suffering the attendant moral injury themselves. In short, the Idaho Law prevents physicians from heeding the central tenet of the Hippocratic Oath: do no harm.

CONCLUSION

The Idaho Law endangers the lives and well-being of pregnant patients. For the foregoing reasons, this Court should affirm the district court's injunction.

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Respectfully submitted,

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APPENDIX A—LIST OF *AMICI CURIAE*

***Amici Curiae* are:**

- American College of Obstetricians and Gynecologists
- American College of Emergency Physicians
- American Medical Association
- Society of Family Planning
- Society for Maternal-Fetal Medicine
- American Academy of Family Physicians
- American Academy of Nursing
- American Academy of Pediatrics
- American College of Chest Physicians
- American College of Medical Genetics and Genomics
- American College of Physicians
- American Gynecological and Obstetrical Society
- American Medical Women's Association
- American Thoracic Society
- Association of Women's Health, Obstetric and Neonatal Nurses
- GLMA: Health Professional Advancing LGBTQ+ Equality
- National Association of Nurse Practitioners in Women's Health
- National Medical Association
- Society of General Internal Medicine