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,
Respondent.

IDAHO,
Petitioner,
v.
UNITED STATES,
Respondent.

On Writs of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF AMICUS CURIAE PHYSICIANS FOR HUMAN RIGHTS IN SUPPORT OF RESPONDENT

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INTEREST OF AMICUS CURIAE[1]

For more than 35 years, Physicians for Human Rights ("PHR") has used science and medicine to document and call attention to severe human rights violations around the world. PHR, which has shared in the Nobel Peace Prize, utilizes its expertise to investigate and speak out against attacks on health care workers and health care, prevent torture, document mass atrocities, and ensure accountability for human rights violations.

Through PHR's longstanding efforts to address human rights violations, PHR has developed an extensive network of partnerships with clinicians throughout the United States, including within the state of Idaho. PHR's clinician partners are deeply committed to ensuring respect for human rights for their patients and have expertise in conducting forensic medical examinations for survivors of human rights violations, and researching the impacts of national and state policies on patient health and rights.

Since this Court reversed *Roe v. Wade*[2] in *Dobbs v. Jackson Women's Health Organization*, 597 U.S., (2022) [hereinafter *Dobbs*], PHR has been conducting rigorous and ongoing research to gain an understanding of the impacts of the implementation of state-level abortion bans on health care providers and

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[1] Counsel for amicus curiae state that no counsel for a party authored this brief in whole or in part and that no person other than amicus curiae, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

[2] 410 U.S. 113 (1973) [hereinafter Roe].

hospitals, particularly in states with restrictive abortion legislation, including Idaho. It is PHR's belief that the combination of our medical expertise, extensive clinician network, and rigorous research uniquely positions us to present guidance to this Court and submit this amicus brief to share the results of our research.

PHR's research supports the conclusion that there is a clear conflict between physician compliance with Idaho Code §18-622 ("The Idaho Act") and 42 U.S.C. §1395 ("EMTALA") as to what is required to treat pregnant patients in emergency rooms. Therefore, PHR presents this brief to explain why the holding issued by the District Court is critical to ensuring that emergency room physicians can treat patients in a way that is consistent with medical standards of care and adheres to professional ethical principles as well as the requirements of EMTALA, all for the ultimate benefit of their patients and the citizens of Idaho.

SUMMARY OF ARGUMENT

Idaho Code §18-622 ("The Idaho Act") and 42 U.S.C. §1395 ("EMTALA") are demonstrably in conflict. EMTALA requires stabilizing treatment, including pregnancy termination, where clinically indicated to preserve the health of the pregnant patient, whereas under the Idaho Act the pregnant patient's health is an insufficient consideration. And even though a pregnant patient may suffer severe pregnancy-induced health conditions, such as preeclampsia, PPROM, HELLP syndrome, placental abruption, uncontrollable uterine hemorrhage, and infection, all warranting immediate treatment under EMTALA to avoid the deterioration of the patient's condition, termination of pregnancy under the Idaho Act is not permitted until necessary to prevent the death of the pregnant patient.

Thus, diligent emergency room physicians face an impossible choice of either following the Idaho Act, but jeopardizing their patients' health, or acting in accordance with basic medical standards of care and professional ethics. The difficulties of this choice are only exacerbated by the harsh civil, criminal, and professional penalties clinicians may face for violating the Idaho Act, while they are placed in a "double bind" where they may face a medical malpractice suit if they follow the law by delaying treatment or not treating at all.

Research, including studies conducted by PHR, reveals that the Idaho statute has led to delays in necessary medical care and resulted in the material deterioration of the health of pregnant patients. Patients in desperate and urgent need of health care

have been forced to undergo long-distance and dangerous journeys for treatment that further jeopardize their health, which is contrary to the core purpose of EMTALA. Such delays and denials of care have already caused health harms to pregnant patients, and risks causing maternal death. Pregnant patients diagnosed with fatal fetal impairments may be forced to continue their pregnancies and denied the care necessary to prevent deterioration of their condition, adversely impacting their physical and mental health and violating their human rights.

The devastating results for the citizens of Idaho will escalate with time. In Idaho and nationally, maternal mortality and morbidity are increasing to record levels and will continue to increase. A growing number of areas of Idaho are "maternity care deserts," increasing the risk of poor pregnancy outcomes. At the same time, the safety net of emergency room care is crumbling absent adherence to the requirements of EMTALA.

ARGUMENT

I. THE IDAHO ACT AND EMTALA CONTAIN MARKEDLY DIFFERENT REQUIREMENTS FOR EMERGENCY ROOM CARE

The Idaho Act, which restricts the care that can be provided by all health care professionals in Idaho, including emergency room[3] personnel, became effective after this Court's *Dobbs* decision gave states the authority to regulate abortion. As currently understood, the Idaho Act limits permissible abortions to: 1) those "necessary to prevent the death of the pregnant woman," §18-622(2)(a)(i); 2) those necessary to terminate "an ectopic or molar pregnancy," §18-604(1)(c); and 3) those that terminate pregnancies resulting from rape or incest if reported to police in the first trimester, §18- 622(2)(b)(ii). Beyond these three limited exceptions, Idaho makes performing or assisting in performing an abortion a felony punishable by two to five years' imprisonment, as well as by suspension or revocation of a health care provider's professional license. The law broadly defines "abortion" as "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child." Id. §18-604(1).

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[3] For purposes of the issues before the Court, this brief is limited to emergency rooms and emergency room personnel, although the problems affect physicians beyond the emergency room.

There is, therefore, no exception to allow clinicians to act to preserve a pregnant patient's health, including preventing harm to bodily organs or fertility, unless it can be reasonably determined that an abortion is necessary to prevent death. Idaho Code §18-622(2)(a)(i) does not permit the termination of a pregnancy even when necessary to stabilize serious and debilitating health conditions being suffered by pregnant patients seeking emergency services.

At the same time, as a condition of participating in Medicare, Congress has required these same emergency room personnel and hospitals to comply with the provisions of EMTALA. See 42 U.S.C. §1395cc(a)(1)(I)(i). Under EMTALA, there is a requirement that emergency personnel "stabilize" a patient in the emergency room, which means emergency room physicians must "provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result" if the patient is discharged or transferred. U.S.C. §1395dd(e)(3)(A). Thus, pursuant to EMTALA, emergency room physicians and hospitals are required to offer "stabilizing treatment"[4] where: 1) "the health" of a patient is "in serious jeopardy"; 2) a condition could result in a "serious impairment to bodily functions"; or 3) a condition could result in a "serious dysfunction of any bodily organ or part." 42 U.S.C. §1395dd(e)(1)(A)(i)-

[4] Letter to Health Care Providers, DHHS, (Jul. 11, 2022), https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf.

(iii). As such, EMTALA expressly extends beyond lethal harms.[5] Stabilizing treatment can include medical and/or surgical interventions, such as removal of one or both fallopian tubes, anti-hypertensive therapy, antibiotics, or abortion.

Conflict between the Idaho Act and EMTALA arises when a pregnant patient presents with an emergency medical condition that is not imminently life-threatening but where the only care that will stabilize the condition is the termination of the pregnancy. EMTALA by its terms requires emergency room personnel to undertake this medically necessary intervention pursuant to the appropriate standard of care in response to such emergencies. The Idaho Act forbids it. Of course, if care is delayed long enough, pregnancy termination may eventually become necessary to prevent the death of pregnant patients as their condition deteriorates. However, waiting until that point would violate EMTALA, which would have already required stabilizing treatment to avoid "material deterioration of the condition," 42 U.S.C. 1395dd(e)(3), and not wait for the delay to have devastating consequences.[6]

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[5] In these circumstances, EMTALA directs that the hospital "must provide" that treatment if the patient chooses to receive it. 42 U.S.C. 1395dd(b)(1).

[6] Until January 2024, Idaho Code Section 18-622 was enjoined by lower courts as they considered the law's inconsistency with EMTALA. In January 2024, this Court allowed Idaho's law to go into effect for the first time since August 2022.

II. THE CONSEQUENCES OF RESTRICTING TREATMENT UNTIL A PREGNANT PATIENT'S LIFE IS AT RISK

The theoretical and legal arguments put forward by Petitioner and its amici ignore how emergency rooms work in practice as well as the human consequences of the lack of timely medical action.

When patients go to the emergency room, the initial challenge for the emergency room staff is to determine if someone is very sick and needs complex or immediate medical care. In a fast-paced environment, often teeming with patients, it can be hard to tell immediately if someone is very sick and in need of urgent treatment or really not that sick at all. At the same time, hesitation in treatment can itself be a significant risk.

An important aspect of this initial evaluation is determining whether a patient is pregnant. Indeed, many patients first learn about their pregnancy at the emergency room, often because they are experiencing early pregnancy complications, such as bleeding or pelvic pain. It is essential to determine pregnancy, because many medications and treatments may harm pregnant patients and their fetuses or even be abortifacients.

If a pregnancy is confirmed, the emergency room physician has to quickly do a differential diagnosis to determine whether the patient is suffering a pregnancy complication that, if left unaddressed, will result in harm. An entire line of clinical investigation must be conducted. What is the conception date or last menstrual period? What might the due date be? Is this

a healthy pregnancy? Are there any underlying conditions that complicate the diagnosis? Properly diagnosing the pregnant patient requires taking a good history, reviewing records if available, conducting a comprehensive physical exam, and, if believed to be warranted, ordering ultrasound, CT, MRI, blood tests, or other diagnostic tests.

Treating conditions in these pregnant patients then can take many shapes. For some, pregnancy could be the direct or indirect cause of the condition that prompted the patient to seek medical care. But for virtually every condition in the emergency room, managing the patient's condition can require medications or other treatments that may put a pregnancy at risk. The question that must quickly be assessed is, what does the medical standard of care call for and is termination of the pregnancy a necessary treatment modality that must be considered?

Emergency room physicians are trained to diagnose and manage a variety of severe conditions and illnesses related to pregnancy. However, the Idaho Act fundamentally upends standard clinical practice by introducing non-evidence-based legal restrictions that force clinicians to make arbitrary determinations between "life-saving" and "health-saving" and that call on clinicians to abandon patients who are suffering but not about to die. If the standard of care to treat the pregnant patient requires the termination of the pregnancy, which is a treatment offered by most emergency rooms, Idaho law does not give treating physicians the authority to follow the guidelines of their medical training unless necessary

to prevent the death of the pregnant patient. When consulted, emergency room physicians and obstetrician-gynecologists have no option but to continue the pregnancy until the patient's health deteriorates enough to be fatally endangered, despite the fact that their pregnant patient may presently be at risk of serious health complications, including, but not limited to, systemic bleeding, overwhelming infection (sepsis), loss of reproductive organs and fertility, permanent disability, severe pain, liver hemorrhage and failure, kidney failure, stroke and other brain damage from hypotension, seizure, and severe pulmonary problems.

The exclusion of a health exception in the Idaho Act has created an additional step for physicians in emergency departments, often already working feverishly to stabilize patients. They must immediately determine if the termination of pregnancy is necessary to prevent death rather than to preserve the health of the patient. Before the law, Idaho physicians could provide all necessary stabilizing care without trying to decipher this uncertain line between adverse health and death. Now, as a final extra step in this evaluation, they are forced to spend precious minutes trying to parse whether death is imminent before acting in the best interests of the health of their pregnant patients.

The harm caused by the additional restrictions imposed under the Idaho Act has been clearly articulated by physicians who either currently practice or formerly practiced in Idaho or who practice in surrounding states and have treated pregnant patients from Idaho who were transferred to their

state because the Idaho facility where the patient initially sought care determined treatment was no longer allowable under the state's abortion laws.

A. The Idaho Act is Inhibiting the Proper Treatment of Very Severe Pregnancy Complications – Treatment Formerly Required by EMTALA

Physicians who PHR spoke with consistently shared that their capacity to deal with serious pregnancy conditions has been significantly hampered and that the medical treatment they are able to provide in these cases is substandard. (*See* PHR Report: "In Clinicians' Own Words: How Abortion Bans Impeded Emergency Medical Treatment for Pregnant Patients in Idaho," March 2024,[7] (hereinafter Idaho p 2); see also, PHR Report: "Criminalized Care: How Louisiana's Abortion Bans Endanger Patients and Clinicians," March 2024,[8] (hereinafter Louisiana pp.4-6).[9]

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[7] URL: https://phr.org/wp-content/uploads/2024/03/PHR-Brief-EMTALA-Idaho-2024.pdf.

[8] URL: https://phr.org/wp-content/uploads/2024/03/PHR-Report-Criminalized-Care-March-2024.pdf.

[9] The abortion ban in Idaho is substantially similar to laws enacted in Louisiana, Oklahoma, and Texas. Like Idaho, these laws include complete bans on abortions with limited exceptions for threats to the life of the pregnant person. If an abortion is performed and is not within the limited exceptions, clinicians would face criminal and civil penalties. As such, the negative outcomes observed in various studies and reports are worth noting, as these can be expected to occur in Idaho.

1) Pre-eclampsia or HELLP

Preeclampsia is a condition of pregnancy diagnosed by dangerously high blood pressure and includes protein in the urine. Some experts consider Hemolysis, Elevated Liver enzyme levels, and Low Platelet levels ("HELLP") a severe form of pre-eclampsia. These conditions can cause severe health complications, including hemorrhage or excessive bleeding, the onset of seizures, and hypoxic brain injury. Although treatment may include intravenous anti-hypertensive medications and blood transfusions, the ultimate treatment for both HELLP and pre-eclampsia is prompt delivery to remove the fetus and the placenta, or, if the fetus is previable, abortion. HELLP has been found to have up to a 24 percent maternal mortality rate.[10]

Following the lifting of the injunction on enforcement of the Idaho Act, clinicians have reported patients being unable to access termination for this condition while experiencing significant deterioration of their health due to the denial of definitive treatment. One Oregon ob-gyn had a patient from Idaho with a twin pregnancy at 18 weeks' gestation who had gone to an Idaho emergency room. The patient, who had already had a renal transplant, was diagnosed with HELLP syndrome. She was bounced between different hospitals in Idaho without being provided with the medically appropriate treatment: an abortion. With signs of hemolysis, uncontrolled

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[10] *HELLP Syndrome Overview*, YALE MEDICINE, (2024), https://www.yalemedicine.org/conditions/hellp-syndrome.

bleeding, and worsening renal function, the patient was transferred to Oregon after significant delay. By the time she got there, she had severe anemia from bleeding, severe acute renal failure, dangerously low platelets, altered mental status secondary to magnesium toxicity as the amounts of magnesium she was given to delay delivery were too much for her body to process, and both of her fetuses had died in utero. Despite the fact that she had asked doctors in Idaho to terminate her pregnancy after her first fetus died, her doctors felt that they could not terminate her pregnancy under Idaho law before finally transferring her to Oregon for termination (Idaho p.4).

2) Preterm Premature Rupture of Membranes (PPROM)

PPROM occurs when the amniotic membrane surrounding the fetus ruptures before 37 weeks of gestation. A pregnant patient suffering from PPROM is likely not at risk of death "at the point of diagnosis" in the emergency room. Yet, "immediate treatment through termination of pregnancy may be necessary because delaying treatment would allow the condition to progress, thereby threatening other bodily organs and functions."[11] A major risk of PPROM is the development of a serious infection of the placental tissues called chorioamnionitis. While antibiotics are given to treat this condition, the definitive treatment is immediate delivery or, if previable, abortion.

Physicians in Idaho have noted that PPROM is one of the major challenges for current care, whereas standard of care treatment options were previously

[11] Declaration of Lee A. Fleisher, M.D. at J.A.594-595.

protected by EMTALA. As one clinician stated, "with the EMTALA injunction lifted, we're back to that gray area. Do we wait for them to get chorioamnionitis? How sick does a mom have to be before we can declare its life threatening and offer her the national standard of care?" (Idaho p.6)

One Utah clinician recounted receiving a patient from Idaho with PPROM who was sent home in Idaho for expectant management despite the risk of infection. Unsurprisingly, she developed sepsis and returned to the hospital where she was again denied the required care she needed – evacuation of the uterus and IV antibiotics. She was then transferred to Utah while experiencing a medical emergency. (Idaho pp. 5-6)

Under Louisiana's similar ban, a clinician described PPROM patients receiving more invasive procedures than would have been previously provided to meet the standard of care in response to their medical emergencies; before the ban, the standard of care would have only required the termination of the pregnancy. For example, clinicians were more frequently performing hysterotomies instead of less invasive dilations and evacuations (D & Es). According to one emergency medicine physician, the obstetrician-gynecologist consulted on the case performed a C-section on a patient with PPROM at 20 weeks' gestation just to preserve the appearance of not doing an abortion, even though this was not a pregnancy that could result in a live birth. As a result, the patient underwent a far more invasive surgery than the recommended standard of care, likely will not be able to deliver again vaginally at most hospitals,

and is at greater risk of complications (Louisiana p. 23).

Attempting to minimize the clear danger that PPROM poses for pregnant patients, the amicus curiae brief of the American Association of Pro-life Obstetricians and Gynecologists states:

> A significant proportion of women can give birth without suffering any significant negative health impacts, even when the membranes rupture at very early stages of pregnancy. See, e.g., Ariel Sklar et al., Maternal Morbidity After Preterm Premature Rupture of Membranes at <24 Weeks' Gestation, A M . J. OBSTETRICS & GYNECOLOGY, 226:558.e1-11 (Apr. 2022) (noting that 15.7 percent of women "avoided morbidity and had a neonate who survived to discharge").

But which E.R. doctor would be justified in failing to treat a condition causing 84.3 percent morbidity and four times the risk of developing chorioamnionitis?

3) Infection and Sepsis

Serious infection is a persistent risk faced in the E.R., including infection after the amniotic sac surrounding the fetus has ruptured, which, absent abortion care, could lead to "sepsis"—a serious condition in which the infection-fighting processes turn on the body, causing death if not treated expeditiously.

Nearly every clinician interviewee who had treated patients in or from Idaho relayed an account in which

they and/or their colleagues delayed abortion care until complications worsened to the point where the patient's life was irrefutably at risk due to infection. As one Idaho clinician stated: "[I]t has caused delays in care. And often while we're waiting and trying to figure out what we're allowed to do in the interim, patients, they'll become infected, and it becomes more clear that we need to deliver them. But it saddens me that we're waiting for pregnant women to become infected before we intervene." (Idaho p.8).

4) Conditions Not Directly Caused By Pregnancy But a Necessary Part of an E.R. Physician's Evaluation and Treatment

The Idaho ban, as well as the bans in states with similar laws, have increased the use of medical procedures and treatments that do not meet the standard of care due to fear of impacting pregnancies—heightening risk to patients that could have been avoided if clinicians had been able to provide abortion care. E.R doctors treat pregnant patients suffering from uterine aneurysm, pelvic infections, heart conditions, abscesses, gastrointestinal infections or pathology, brain damage, severe trauma, and other issues that require critical care. Some patients may need to start treatment immediately, which may include termination of the pregnancy.

Dr Jennifer Chin, a physician in Washington state, treated an out-of-state patient from Idaho who was suffering with pulmonary hypertension. She noted the reluctance of Idaho clinicians to provide necessary medical care, concluding that her Idaho patient would

have died if the patient did not receive abortion care in Washington.[12]

In Louisiana, a maternal fetal medicine specialist described a situation where a patient with a severe cardiac condition was forced to remain pregnant and try multiple medications to mitigate the added stress of pregnancy on her heart before clinicians advised her of options for abortion care: "At what point can you act? How many cardiac meds have to fail? Okay, you failed ten cardiac meds, so now we can talk about it?" (Louisiana p.23)

B. The Consequences of the Limitation on Care

1) Waiting Until Patients Become Sicker

Idaho "[p]hysicians stated that attempting to adhere to the criteria of state abortion restrictions is resulting in delays of care. To avoid the risk of criminal penalties under the bans, nearly every physician relayed an account in which they and/or their colleagues delayed abortion care until complications worsened to the point where the patient's life was irrefutably at risk." (Idaho p.8)

This dangerous delay is being reported throughout the country where strict bans are in place. A Texas physician shared the following experience about

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[12] Mary Murphy, *Protection for Abortion Doctors Proposed*, THE CHRONICLE, (Jan. 31, 2024), https://www.chronline.com/stories/protection-for-abortion-doctors-proposed,333726.

trying to perform a medically indicated abortion after the Texas ban was enacted:

> For the patients that we do have, who maybe come in as inevitable [abortions], we sit and we wait until they get infected or have some other reason that will allow us to intervene. So, it definitely, like knowing that the inevitable conclusion to this story will be a pregnancy loss, it's hard that you have to then wait for them to then develop a complication like infection in order to do anything.[13]

Another Texas doctor, Dr. Elissa Serapio, explained that her "colleagues were forced to watch their patients' health deteriorate before providing abortions due to the narrow exceptions for legal abortion where the 'life of the mother' is at risk."[14] In the words of a Texas maternal fetal medicine specialist, "people have to be on death's door to

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[13] Whitney Arey, et. al., *Abortion Access and Medically Complex Pregnancies Before and After Texas Senate Bill 8*, 141, Obstetrics & Gynecology, 995 (May 2023), https://journals.lww.com/greenjournal/fulltext/2023/05000/abortio n_access_and_medically_complex_pregnancies.20.aspx.

[14] PHR, et al., *Human Rights Crisis Following the United States Supreme Court Decision in Dobbs v. Jackson Women's Health Org.*, GLOBAL JUSTICE CENTER, (Mar. 2, 2023), at 6, https://www.globaljusticecenter.net/wp-content/uploads/2023/06/20230413_UN_SR_briefingPaper_FINAL.pdf.

qualify" for medical exceptions to Texas's abortion bans.[15]

Similar devastating consequences of abortion bans are occurring in Oklahoma. When Jaci Statton, an Oklahoma woman, sought treatment, the hospital staff shockingly recommended that Ms. Statton "sit in the parking lot" until something else happened, because they could not help her unless she was "crashing in front of [them] or [her] blood pressure [went] so high that [she was] fixing to have a heart attack."[16]

2) Transferring Patients Out of State Due to Idaho's Abortion Ban Causes Unnecessary Delays of Care and Increased Patient Morbidity

Physicians in states surrounding Idaho describe patients from Idaho arriving in unstable medical condition and needing additional treatments due to delay, thereby increasing longer term health risks:

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[15] Whitney Arey, et al., *A Preview of the Dangerous Future of Abortion Bans — Texas Senate Bill 8*, 387, New. Eng. J. Med., (Jun 22, 2022), https://www.nejm.org/doi/full/10.1056/NEJMp2207423

[16] Selena Simmons-Duffin, *In Oklahoma, a Woman Was Told to Wait Until She's 'Crashing' for Abortion Care*, NPR, (Apr. 25, 2023), https://www.npr.org/sections/health-shots/2023/04/25/1171851775/oklahoma-woman-abortion-ban-study-shows-confusion-at-hospitals.

"We had a previable preeclampsia patient transferred to us…If she had her care wherever she was coming from, she wouldn't have needed to be persistently on IV antihypertensive[s]. She didn't have to have that prolonged risk of stroke." (Idaho p.11) Other clinicians treating patients from Idaho highlighted risks from travel delays, including isolation from support systems during long hospital stays resulting from delays in treatment, lack of access to the patient's prior medical records, and increased costs to the patient: "You're just adding trauma to trauma." (Idaho p.11).

Patients report experiencing this compounded trauma when left no option but to travel to access abortion. A Texas patient, who was diagnosed with a rupture of membranes before fetal viability, was "angry and sad" to learn that she had to travel outside of Texas for abortion care. The patient reported that her clinician told her, "If you labor on the plane, leave the placenta inside of you. You're going to have to deal with a 19-week fetus outside of your body until you land."[17]

But not everyone has the funds and ability to travel for an abortion. All too often, people of lower income or from historically marginalized groups are simply unable to travel due to costs or heightened risks of criminalization. (Louisiana p. 23)

A heartbreaking example of someone who could not afford to travel to another state is Mayron Hollis, a

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[17] Arey et al., *supra* note 15 at 389.

resident of Tennessee. Hollis learned that her pregnancy was "endangering her life," prompting her to seek an abortion, the appropriate medical treatment for her condition. Nonetheless, after being denied treatment in her home state and unable to travel elsewhere, "Hollis was forced to endure a dangerous pregnancy and birth, where she ultimately suffered severe hemorrhaging and lost her uterus, destroying her ability to give birth to any more children."[18]

3) Forced Pregnancy with a Fetal Condition Incompatible with Life

One Idaho specialist expressed her frustration at not being able to perform abortions when pregnancies were forced to continue even though fetuses would not survive: "Some of their fetuses had lethal chromosome abnormalities, like a triploid situation. So those are situations where not only is the patient's life and health and future fertility at risk, but the fetus is also nonviable because it has a lethal chromosome disorder. And so, yeah, I mean, the only way to treat that is going to be no longer continuing the pregnancy and abortion." Yet, despite having a fatal fetal diagnosis with a heightened risk of maternal morbidity and postpartum hemorrhage, this patient was ultimately denied care in Idaho and counseled to

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[18] Payal Shah, Akila Radhakrishnan, *It's Time to Call Abortion Bans What They Are —Torture and Cruelty*, THE NATION, (Jun. 9, 2023), https://www.thenation.com/article/society/abortion-bans-torture-cruelty/.

seek care in Utah. Once there, her insurance did not cover her care. (Idaho p.8)

As a maternal-fetal medicine specialist in Texas described her experience counseling patients: "You really can barely imagine what it's like for a woman or a couple to be faced with a devastating diagnosis for the fetus that they've just learned about maybe days or weeks before. They have grappled with this terrible, heart-breaking decision. And then they're told by the doctor, 'Well, good luck to you. Jump on Google and see where you can find a place to get your termination."[19]

Florida resident Deborah Dorbert's fetus was diagnosed with "Potter syndrome, a rare and lethal condition." Although the state of Florida "has an exception for fatal fetal abnormalities," doctors refused to provide care because they detected a heartbeat. Deborah was forced to "wait for labor to be induced at 37 weeks" and watch her baby struggle to breathe for 99 tortuous minutes.[20]

Nancy Davis, a Louisiana resident, "was about 10 weeks pregnant" when her fetus was diagnosed with acrania, a rare and fatal condition in which the fetus

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[19] Arey, et al., *supra* note 15.

[20] Frances Stead Sellers, et al., *The Short Life of Baby Milo*, WASHINGTON POST, (May 19, 2023), https://www.washingtonpost.com/health/interactive/2023/florida-abortion-law-deborah-dorbert/.; Maya Yang, *Florida Couple Unable to Get Abortion Will See Baby Die After Delivery*, THE GUARDIAN, (Feb. 18, 2023), https://www.theguardian.com/world/2023/feb/18/florida-abortion-law-couple-birth.

does not develop a skull.[21] Though initially told she was a candidate for abortion in her home state based on a list of conditions that constituted a "medically futile" fetus, she was later informed that she would need to carry her pregnancy to term or travel out of state.[22]

III. CONFLICTING LOYALTY AND OBLIGATIONS FACING IDAHO EMERGENCY ROOM PHYSICIANS

A. Conflict Between the Idaho Act, EMTALA, and the Standard of Care

Describing EMTALA, an Idaho clinician stated:

> *You're going to have somebody who's hemorrhaging, someone with potentially early onset preeclampsia, or somebody who has sepsis or an infection in their uterus. And I think EMTALA covers not just emergency, your life is at risk, but it covers threat to bodily organs, long term function, things like that." (Idaho p. 7).*

And another Idaho physician stated:

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[21] Ramon Antonio Vargas, *Louisiana Woman Carrying Unviable Fetus Forced to Travel to New York for Abortion*, THE GUARDIAN, (Sept. 14, 2022), https://www.theguardian.com/us-news/2022/sep/14/louisiana-woman-skull-less-fetus-new-york-abortion.

[22] Ray Sanchez, Melissa Alonso, *Louisiana Woman Who Alleges she was Denied Abortion after Fetus' Fatal Diagnosis Says 'It Should Not Happen to Any Other Woman'*, CNN, (Aug. 26, 2022), https://www.cnn.com/2022/08/26/us/louisiana-abortion-nancy-davis-fatal-condition/index.html.

> *We know, as physicians and health care providers, we don't wait until somebody's in kidney failure. We want to do the things to prevent them from ever getting there and to fix things, if we can, or treat it appropriately. It's not how medicine is practiced to wait till somebody's having the worst case scenario situation. And so that's the main issue with these bans, is that they're so strict that they're in conflict with our EMTALA obligations*." (Idaho p. 7)

Prior to the passage of the Idaho Act, E.R. physicians were able to make good-faith determinations about whether abortion care was necessary based both upon an individualized assessment of a pregnant patient's medical needs and their medical knowledge and experience. Also, under EMTALA, the treating physician could conclude that the requisite stabilizing treatment for patients experiencing certain conditions required pregnancy termination—that is, termination was the only care that would assure, within reasonable medical probability, that no material deterioration of the patient's condition was likely to result. If so, EMTALA required that such treatment be offered and provided upon informed consent. 42 U.S.C. 1395dd(b)(1)(A), (2).

After the passage of the Idaho Act, E.R. physicians became unable to determine whether their good faith assessment of medical need was sufficient to legally provide medically necessary care. Instead of making decisions based on experience and their advanced medical training, particularly when faced with the sudden onset of symptoms, experienced physicians

"report that the restrictive legal landscape means that they are generally unsure if and when medically necessary, and even lifesaving, abortions are legal."[23]

B. Dual Loyalty: The Conflict Between Idaho Law and a Physician's Ethical Obligations

Idaho's medical exceptions present physicians the impossible choice of "dual loyalty"[24]—that is, a situation where physicians are unable to fully comply with both the law and their ethical obligations as medical practitioners. In many situations, an emergency room physician is ethically obligated to perform an abortion in line with medical necessity, and yet it is entirely unclear whether Idaho's law permits it. Idaho, on the other hand, mandates that the physician's first obligation is to comply with its statutes. At times, it is impossible to comply with both.

As a result, the Idaho abortion ban can prevent emergency room physicians from complying with two fundamental recognized principles for the provision of quality medical care: (i) beneficence, or the duty to provide beneficial care to their patients; and (ii) nonmaleficence, or "do no harm," seeking to ensure that a patient will be no worse off physically,

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[23] Human Rights Crisis: *Abortion in the United States after Dobbs*, HUMAN RIGHTS WATCH, (Apr.18, 2023), https://www.hrw.org/news/2023/04/18/human-rights-crisis-abortion-united-states-after-dobbs.; PHR, et al., *supra* note 14.

[24] Int'l Dual Loyalty Working Grp., *Dual Loyalty & Human Rights In Health Professional Practice*, PHR, (2002), at 16, https://phr.org/wp-content/uploads/2003/03/dualloyalties-2002-report.pdf.

emotionally, or otherwise after treatment than before.[25] As stated by the American College of Emergency Physicians, physicians assume a fundamental duty to serve the best interests of their patients, and the welfare of their patients should form the basis of any physician's medical judgments.[26] But, under abortion bans like Idaho's, a specialist commented, "It's almost like we're just rolling the dice on someone's life."[27]

C. The Conflict Caused by Harsh Criminal and Civil Penalties

The Idaho Act carries a criminal penalty of two to five years imprisonment. In addition, Idaho E.R. physicians face the risk of losing their medical licenses

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[25] Jacob P. Olejarczyk, Michael Young, *Patient Rights and Ethics*, (Nov. 28, 2022), https://www.ncbi.nlm.nih.gov/books/NBK538279/#:~:text=In%20healthcare%2C%20justice%20refers%20explicitly,be%20treated%20fairly%20and%20equitably.

[26] American College of Emergency Physicians, *Code of Ethics for Emergency Physicians*, ACEP, (Oct. 2023), at 6, https://www.acep.org/siteassets/new-pdfs/policy-statements/code-of-ethics-for-emergency-physicians.pdf.; American College of Obstetricians and Gynecologists, *Code of Professional Ethics*, ACOG, (Dec. 2018), at 2, https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf.

[27] Charlie McCann, A*bortion Bans in America are Corroding Some Doctors' Souls*, ECONOMIST, (Oct. 6, 2023), https://www.economist.com/1843/2023/10/06/abortion-bans-in-america-are-corroding-some-doctors-souls.

and the ability to practice medicine, as well as reputational harm, steep fines, and other professional penalties. Ultimately, these fines and penalties mean physicians can lose the ability to support themselves—often after a decade or more of education.

Each time that an Idaho physician terminates a pregnancy believing it to be necessary to prevent serious jeopardy to a patient's health, they are exposed to criminal investigation and prosecution and the revocation of their license. Because a physician administering an emergency termination in Idaho would be risking their professional license, livelihood, personal security, and freedom, it is natural that they will hesitate even while their patients may suffer and their patients' conditions may deteriorate.

As one clinician who left Idaho stated, "I think we all live in fear of an attorney general or the prosecutors who are just looking to charge someone with this. And I think there's just that constant threat …. You worry all the time. Like, when are they going to try to come after me for this …. And for me, having a family, being a mother, a wife, you know, in addition to being a physician, and this is my career, it was just way too much for me to bear." (Idaho p.16). This was echoed by Dr. Kylie Cooper, a maternal-fetal medicine specialist in Idaho, who remarked: "My husband and I would talk about this every day. It was consuming us. What if I lost my license? What would happen to our

kids if I went to jail? What about my guilt if I didn't help a sick patient to my fullest ability?"[28]

Dr. Amelia Huntsberger, who like Kylie Cooper was one of several doctors that submitted a declaration in support of the Government's case against Idaho, said she was forced to leave Idaho: "I'm in the [operating room] dry heaving. I'm not dry heaving because of this surgery. I know how to do this surgery. I trained for this surgery …. I did not train for, I am not ready for thinking about, 'Is this the case that's gonna make me a felon?'"[29]

D. The Conflict Caused by the Potential for Civil Malpractice Suits

The medical exceptions to the Idaho Act also subject physicians to potential legal injuries beyond those provided for by statute. This situation, recognized as the "Abortion Double Bind," refers to when abortion bans trap clinicians between the risk of criminal penalty for ending a pregnancy that is not perilous enough to qualify for the state's medical exceptions, and the risk of malpractice liability for not

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[28] Stacy Weiner, *The Fallout of Dobbs on the Field of OBGYN*, AAMC, (Aug. 23, 2023), https://www.aamc.org/news/fallout-dobbs-field-ob-gyn.

[29] Erika L. Sabbath, et al., *U.S. Obstetrician-Gynecologists' Perceived Impacts of Post–Dobbs v Jackson State Abortion Bans*, JAMA, (Jan. 17, 2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2814017.

ending a pregnancy that is dangerous[30] and results in injuries or death to the pregnant patient that is argued to have been preventable. As a result, physicians are faced with two draconian options: either leave their patients to suffer harm and risk civil liability or perform an abortion and risk criminal and civil prosecution.[31]

Dr. Lauren Miller, head of the Idaho Coalition for Safe Reproductive Health, said of the murkiness of the Idaho abortion laws, "We have a death exception and that is it without any other guidelines .... If I don't act fast enough to save your life, prevent you from getting septic, I could be liable for civil cases … malpractice. But if I act too quickly and I'm not 100 percent certain that the patient is going to die from the complication she's sustaining, then I could be guilty of a felony."[32]

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[30] Dov Fox, *The Abortion Double Bind*, 113, American J. of Public Health, 1068, (Oct. 1, 2023), https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2023.307369?role=tab.; Harris Meyer, *Malpractice Lawsuits Over Denied Abortion Care May Be on the Horizon*, KFF HEALTH NEWS, (Jun. 23, 2023), https://kffhealthnews.org/news/article/malpractice-lawsuits-denied-abortion-care/., note that H.B. 3058 has passed.

[31] PHR, et al., *supra* note 14 at 6.

[32] Randi Kaye, Stephen Samaniego, *Idaho's Murky Abortion Law is Driving Doctors Out of the State*, CNN, (May 13, 2023), https://www.cnn.com/2023/05/13/us/idaho-abortion-doctors-drain/index.html.

IV. THE CRIMINALIZATION OF ABORTION, INCLUDING WHEN IT IS NECESSARY FOR TREATMENT OF A PREGNANT PATIENT, CONSTITUTES A HUMAN RIGHTS VIOLATION

The criminalization of abortion in the United States, including when it is the necessary standard of care treatment, is causing a human rights crisis. International human rights law explicitly states that governments cannot legislate abortion in such a way that risks the life, health, equality, and privacy of pregnant patients.[33] Yet, the retraction of EMTALA's protection for abortion where necessary to preserve the health of a pregnant patient leads to precisely such risks. EMTALA's requirement of stabilizing care for pregnant patients is necessary to prevent grave violations of human rights that the United States has committed to upholding in treaties it has signed and ratified.

A. Right to Life

As a party to the International Covenant on Civil and Political Rights ("ICCPR"), the United States is obligated to protect the right to life of pregnant people by ensuring they are free from restrictions on abortions that jeopardize the life or health of a pregnant person. Further, state parties to the ICCPR must not apply criminal sanctions either to such pregnant patients who need to undergo abortion or the clinicians who assist them. In 2023, the United

[33] Human Rights Comm. Gen. Comment 36, U.N. Doc. CCPR/C/GC/36 (Sep. 3, 2019).

Nations Human Rights Committee, which is tasked with reviewing and upholding compliance with the ICCPR, called on the United States to address the "profound impact" of post-*Dobbs* abortion legislation and "redouble its efforts to prevent and combat maternal mortality and morbidity."[34]

B. Right to Freedom from Torture and Ill Treatment

Human rights bodies have recognized that being left no option but to travel to access necessary abortion care can constitute torture or ill-treatment due to the psychological, physical, and financial burdens that pregnant patients undertake when they travel out of state to obtain this care.[35] Therefore, the U.S. failure to ensure access to abortion to save the health of a pregnant patient gives rise to violations of the right to be free from torture and ill treatment. Indeed, U.N. bodies that monitor the ICCPR and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment have recognized that the denial of abortion care in certain cases can

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[34] Human Rights Committee, *Concluding Observations on the Fifth Periodic Report of the United States of America*, U.N. Doc. CCPR/C/USA/CO/5, at 7, (Dec. 7, 2023), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2FC%2FUSA%2FCO%2F5&Lang=en.

[35] *See Mellet. v. Ireland*, U.N. Doc. CCPR/C/116/D/2324/2013, at 16, ¶ 7.7 (Nov. 17, 2016); *Whelan v. Ireland*, U.N. Doc. CCPR/C/119/D/2425/2014, at 14, ¶ 7.9 (July 11, 2017).

result in physical and mental suffering so severe in pain and intensity as to amount to torture.[36]

C. Right to Equality and Nondiscrimination

State bans fundamentally change the standard of medicine enshrined in EMTALA by essentially creating different standards of care for pregnant and nonpregnant patients. Prohibiting emergency medical care to a pregnant woman that would be legal for a nonpregnant woman, constitutes discrimination. Under the ICCPR, laws criminalizing abortion in situations that cause harm to pregnant women reflect "a gender-based stereotype of the reproductive role of women primarily as mothers" in violation of the right to equal protection of the law.[37]

As clinicians above shared, this different standard of care will most acutely impact historically marginalized populations. In 2022, the UN Committee on the Elimination of Racial Discrimination called on

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[36] *See, e.g.*, Comm. Against Torture, *Concluding Observations on the Seventh Periodic Report of Poland,* U.N. Doc. CAT/C/POL/CO/7 (Aug. 29, 2019), https://www.ohchr.org/en/documents/concluding-observations/catcpolco7-committee-against-torture-concluding-observations; Comm. Against Torture, *Concluding Observations on the United Kingdom of Great Britain and Northern Ireland*, U.N. Doc. CAT/C/GBR/CO/6 (Jun. 7, 2019), https://www.ohchr.org/en/documents/concluding-observations/catcgbrco6-concluding-observations-sixth-periodic-report-united.

[37] *Mellet. v. Ireland*, U.N. Doc. CCPR/C/116/D/2324/2013, at 16, ¶ 7.11 (Nov. 17, 2016); see also ICCPR art. 26;; *Whelan v. Ireland*, U.N. Doc. CCPR/ C/119/D/2425/2014, at 14, ¶ 7.12 (July 11, 2017).

the United States to address the increased maternal morbidity and the "profound disparate impact" of *Dobbs* on racial and ethnic minorities and indigenous and low-income people by ensuring legal access to abortion as required under IHRL and ensuring women seeking abortion and health providers are not subject to criminal penalties.[38]

V. RESEARCH DEMONSTRATES THAT THE ALREADY ADVERSE EFFECTS OF THE IDAHO ABORTION REGIME WILL ONLY MULTIPLY WITH TIME

The Idaho Act and similar laws have exacerbated maternal mortality and morbidity. The United States already has the highest maternal mortality rate of all high-income countries, and its maternal death rate has climbed from 20.1 deaths per 100,000 live births in 2019, to 23.8 in 2020, to 32.9 in 2021.[39] Additionally,

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[38] Committee on Elimination of Racial Discrimination, *Concluding Observations on the Combined Tenth to Twelfth Periodic Report of the United States of America*, U.N. Doc. CERD/C/USA/CO/10-12 (Sep. 21, 2022), https://www.ohchr.org/en/documents/concluding-observations/cerdcusaco10-12-concluding-observations-combined-tenth-twelfth.

[39] *No One Could Say: Accessing Emergency Obstetrics Information as a Prospective Prenatal Patient in Post-Roe Oklahoma*, PHR, (Apr. 2023), https://phr.org/wp-content/uploads/2023/04/Oklahoma-Abortion-Ban-Report-2023.pdf.; *The State of Reproductive Health in the United States: The End of Roe and the Perilous Road Ahead for Women in the Dobbs Era*, GENDER EQUITY POLICY INSTITUTE, at 6, (Jan. 19, 2023), https://thegepi.org/wp-content/uploads/2023/06/GEPI-State-of-Repro-Health-Report-US.pdf.; Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2021*, CDC, (Mar.

for every person in the United States who dies as a consequence of pregnancy or childbirth, up to 70 suffer hemorrhages, organ failure or other significant complications, amounting to more than 1 percent of all births.[40]

Across the United States, there have been numerous cases of pregnant patients who have suffered preventable harm of trauma, including nearly dying or in fact dying, because physicians have either delayed providing abortion care or outright denied it.[41] A national study conducted in the wake of *Dobbs* found that "health care providers have seen increased morbidity, exacerbated pregnancy complications, an inability to provide time-sensitive care, and increased delays in obtaining care for patients in states with abortion bans."[42]

16, 2023), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm.

[40] Katherine Ellison, Nina Martin, S*evere Complications for Women During Childbirth Are Skyrocketing — and Could Often Be Prevented*, PRO PUBLICA, (Dec. 22, 2017), https://www.propublica.org/article/severe-complications-for-women-during-childbirth-are-skyrocketing-and-could-often-be-prevented.

[41] Daniel Grossman, et al., *Care Post-Roe: Documenting Cases of Poor- Quality Care Since the Dobbs Decision,* UCSF, (May 2023), https://sites.utexas.edu/txpep/files/2023/05/ANSIRH-Care-Post-Roe-Report-Embargoed-until-15-May-23.pdf.

[42] How post-Roe laws are obstructing clinical care, UCSF, May 16, 2023, https://www.ansirh.org/research/research/how-post-roe-laws-are-obstructing-clinical-care; Brittni Frederiksen, et. al., *A National Survey of OBGYNs' Experiences After Dobbs*, KFF HEALTH NEWS, (Jun. 21, 2023), https://www.kff.org/womens-

Findings from a different study established that changes in practice "were associated with a doubling of severe morbidity for patients presenting with pre-labor rupture of membranes and other complications before 22 weeks' gestation."[43]

Overall, infant mortality rose in 2022 for the first time in two decades, with the rise most prominently seen in four states: Georgia, Iowa, Missouri, Texas — all of which have instituted criminal abortion bans since the overturning of *Roe*.[44] These rates will undoubtedly worsen.

Research affirms that states that restrict abortion also have fewer doctors providing care to pregnant people, creating "maternity care deserts." Thirteen of Idaho's forty-four counties are maternity care

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health-policy/report/a-national-survey-of-obgyns-experiences-after-dobbs/.

[43] 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*, 78, Obstetrical & Gynological Survey 194 (Apr. 2023), https://journals.lww.com/obgynsurvey/abstract/2023/04000/maternal_morbidity_and_fetal_outcomes_among.4.aspx.

[44] Aria Bendix, *Infant Mortality Rose in 2022 For the First Time in Two Decades*, NBC, (Nov. 1, 2023), https://www.nbcnews.com/health/health-news/infant-mortality-rose-2022-first-time-two-decades-rcna122995.

deserts.[45] Citing Idaho's "legal and political climate,"[46] all four ob-gyns that practiced at Bonner General Hospital left Idaho in 2023 for states where abortion is legal.[47] Valor Health, another Idaho hospital, discontinued labor and delivery services because of staff shortages in March 2023 and stopped providing care in June 2023.[48] Idaho already has the fewest number of active physicians per capita of any state.[49] As Jim Souza, the chief physician executive at St.

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[45] *Where You Live Matters: Maternity Care Deserts and the Crisis of Access and Equity in Texas*, MARCH OF DIMES, (2023), https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Texas.pdf.

[46] Danielle Campoamor, *Idaho Hospital Closes its Maternity Ward, Citing the State's 'Political Climate'*, TODAY, (Mar. 22, 2023), https://www.today.com/parents/pregnancy/idahos-bonner-general-hospital-closes-maternity-ward-rcna75776; Sharon Zhang, *Idaho Hospital Will Stop Delivering Babies as Providers Flee After Abortion Bans*, TRUTHOUT, (Mar. 21, 2023), https://truthout.org/articles/idaho-hospital-will-stop-delivering-babies-as-providers-flee-after-abortion-bans/.

[47] Julianne McShane, *Pregnant With No OB-GYNs Around: In Idaho, Maternity Care Became a Casualty of its Abortion Ban*, NBC NEWS, (Sept. 30, 2023), https://www.nbcnews.com/health/womens-health/pregnant-women-struggle-find-care-idaho-abortion-ban-rcna117872.

[48] Staci Carr, *Discontinuation of Labor and Delivery Services*, VALOR HEALTH, (2023), https://www.valorhealth.org/discontinuation-of-labor-delivery-services/.

[49] Kelly Gooch, Marissa Plescia, *States Ranked by Active Physicians Per Capita*, Becker's Hospital Review, (Mar. 9, 2022), https://www.beckershospitalreview.com/workforce/this-state-has-the-most-physicians-per-capita.html.

Luke's Medical Center in Boise, said, "We're at the beginning of the collapse of an entire system of care."[50]

The overall effect has been borne out by medical studies. The difference in pregnancy outcomes in states with "extreme" abortion bans has been compared with outcomes in states without such bans. Those with such bans have: a 32 percent lower rate of obstetricians to births; a 62 percent higher proportion of people giving birth with no or late prenatal care; and a 62 percent higher maternal death rate across states.[51]

CONCLUSION

The judgment of the District Court should be affirmed.

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[50] Randi Kaye**,** *supr*a

[51] Callie Cox Bauer, et al., *Turning Rage Into Action: Abortion Care and Residency Training in the United States,* NATIONAL LIBRARY OF MEDICINE, (Jun. 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10286934/.

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