No. 23A470

IN THE
Supreme Court of the United States

STATE OF IDAHO,
Applicant,

v.

UNITED STATES OF AMERICA,
Respondents.

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

BRIEF OF ST. LUKE'S HEALTH SYSTEM AS AMICUS CURIAE IN OPPOSITION TO EMERGENCY APPLICATION FOR STAY PENDING APPEAL

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CORPORATE DISCLOSURE STATEMENT

St. Luke's Health System, Ltd. is an Idaho nonprofit corporation. St. Luke's Health System, Ltd. has no parent corporation. No publicly held corporation, or any other person or entity, owns stock in St. Luke's Health System, Ltd.

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STATEMENT OF INTEREST

St. Luke's Health System, Ltd. ("St. Luke's" or "Amicus")[1] is the only Idaho-based, not- for-profit, community-owned and community-led health system. Its mission is to improve the health of people in the communities it serves. To fulfill that mission, St. Luke's operates hospitals, clinics, and other health facilities across Southwest and South-Central Idaho, including nine hospital emergency departments. St. Luke's employs more than 16,000 people and is the largest private employer in the State of Idaho. St. Luke's physicians and nurses treat patients millions of times each year, including over one million hospital visits, 224,000 emergency department visits and 1.9 million clinic visits in 2022 alone. Many of those patients are pregnant women; just last year, St. Luke's helped welcome more than 8,735 newborns, representing 39% of live births in the state of Idaho.[2]

Hospitals in Idaho participate in Medicare pursuant to agreements with the United States Department of Health and Human Services and are required to comply with the Emergency Medical Treatment and Labor Act ("EMTALA"). Because Idaho Code § 18-622 creates a direct conflict with EMTALA, it places hospitals, including St. Luke's, in the precarious position of risking the criminal liability and medical licenses of their providers simply for complying with federal law. Alternatively, complying with

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

[2] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2016-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/natality-expanded-current.html on Oct 4, 2023 10:16:56 AM.

§ 18-622 could risk violating EMTALA and the ability to participate in Medicare. As a result, physicians in Idaho, and the institutions in which they work, are faced with an irreconcilable conflict. Foreseeing the potential for such conflict, Congress expressly stated that EMTALA preempts such conflicting state law requirements.

In this brief, St. Luke's offers first-hand insight into what transpires in Idaho's emergency departments[3] and how a grant of the emergency application—which would permit § 18-622 to take full effect for the first time—would imperil patient care. Health care providers in Idaho's emergency departments treat all kinds of health conditions experienced by pregnant patients. In some critical cases, termination of a clinically diagnoseable pregnancy is the standard of care necessary to stabilize a patient's emergency medical condition. In many such cases, absent termination, the patient may experience severe consequences short of death that are nonetheless irreparable. These include loss of reproductive organs and fertility, loss of other organs, permanent disability, and severe pain, among others. Idaho Code § 18-622 prohibits health care providers from doing what is needed to stabilize their patients and prevent these harms. This conflict is not hypothetical: It is very real, and the consequences of § 18-622 will be grave.

St. Luke's understands the Idaho Legislature's reasons for enacting this law and appreciates the Legislature's obligation to enact laws that reflect the needs and values of Idahoans. Although the law does not expressly state an intention to impact

[3] Patients with emergency pregnancy-related conditions are frequently triaged and treated in a hospital's labor & delivery department, which is considered part of the "emergency department" under EMTALA.

emergency medical care, it will have that effect. And that remains true even after the amendments adopted by the Idaho Legislature this year, which may permit termination of pregnancy where "necessary to prevent the [mother's] death," Idaho Code § 18-622(2)(a)(i), but do not permit termination of pregnancy when necessary to stabilize other serious and debilitating health conditions. Unfortunately, the law's unintended consequences will harm patients, medical professionals, the Idaho healthcare system, and Idaho residents more broadly. Because St. Luke's is dedicated to improving the health and well-being of Idahoans and supporting its physicians, and because § 18-622 undermines those goals, *Amicus* respectfully urges that the application for a stay pending appeal be denied.

INTRODUCTION AND SUMMARY OF ARGUMENT

The emergency application seeks a stay of the Ninth Circuit's *en banc* decision granting reconsideration of a panel's order that stayed a district court injunction of Idaho Code § 18-622. That injunction preserved the status quo: § 18-622 had never been permitted to take full effect in Idaho's emergency rooms. Should the Court grant the emergency application, thereby reinstating the panel's stay order, it would allow § 18-622 to take effect for the first time when the Ninth Circuit is scheduled to rehear the panel's decision in less than two months, on January 23, 2024.

The resulting consequences would be grave. Should § 18-622 go into effect, healthcare providers will be forced to choose between compliance with state and federal law: while § 18-622 prohibits termination except to *prevent the death* of the mother, EMTALA requires providers to offer stabilizing care even when an emergency medical

condition poses severe health risks short of death. This can and does occur with some pregnant patients who suffer an emergency that threatens severe consequences and for which the standard of care includes termination of the pregnancy. Those patients will be most impacted by § 18-622's implementation, but they will not be alone: the law's unintended consequences will harm medical professionals, the Idaho healthcare system, and Idaho residents more broadly. These consequences will be especially serious if the law is permitted to take effect now, when Idaho's winter weather will make it treacherous if not entirely impossible for patients to travel out of state to receive needed emergency care. Moreover, the Legislature's recent amendments do not avoid these harms. As the largest private employer providing medical care on the ground in Idaho, *Amicus* respectfully urges this Court to deny the stay.

ARGUMENT

I. Idaho Code § 18-622 Imposes Conflicting State and Federal Obligations on Idaho's Health Care Providers.

From the perspective of Idaho's physicians and hospital systems, Idaho Code § 18-622 and EMTALA irreconcilably conflict. To start, consider the stakes: Idaho's medical providers depend on Medicare to care for their patients. In 2021 alone, Medicare-covered services accounted for more than 30% of St. Luke's patient encounters. If Idaho's hospitals were to lose their ability to participate in Medicare, many patients who rely on them, not only those covered by Medicare, would not be able to receive the care they need. Nor are they likely to easily find care elsewhere: Idaho suffers from a hospital resource crisis in which there are often not enough hospital staff or beds, and facilities

are forced to transfer patients to other facilities for care. Participation in Medicare is essential to health care operations and Idahoans.

As a condition of participating in Medicare, hospitals must agree to comply with EMTALA. *See* 42 U.S.C. § 1395cc(a)(1)(I)(i). Under EMTALA, hospitals must offer stabilizing treatment where "the health" of a patient is "in serious jeopardy" or where a condition could result in a "serious impairment to bodily functions" or a "serious dysfunction of any bodily organ or part." *Id.* § 1395dd(e)(1)(A)(i)-(iii). To "stabilize" a patient, the hospital 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. *Id.* § 1395dd(e)(3)(A).

While the panel's stay order suggests that EMTALA does not require any particular treatment, that is not the experience of trained medical providers who comply with the law. In some cases, "stabilization" under EMTALA does require a physician to recommend termination of a patient's clinically diagnosable pregnancy because that is the standard of care appropriate under the circumstances. Specifically, termination is sometimes necessary to prevent serious jeopardy to the health of a pregnant patient; in those cases, so long as the patient consents, a provider under EMTALA *must* perform that procedure. St. Luke's physicians submitted declarations[4] describing several recent examples: two patients with preeclampsia with severe features, Cooper Decl. ¶ 6; Seyb

[4] *See* Declaration of Kylie Cooper, M.D., Dkt. 17-7 (hereinafter "Cooper Decl."), Declaration of Stacy T. Seyb, M.D., Dkt. 17-8 (hereinafter "Seyb Decl."), *United States v. Idaho*, 623 F. Supp. 3d 1096 (D. Idaho 2022).

Decl. ¶¶ 9-10; two patients with HELLP syndrome, Cooper Decl. ¶¶ 8, 10; a patient with septic abortion, Seyb Decl. ¶¶ 7-8; and a patient in hypovolemic shock due to blood loss, *id.* ¶¶ 11-12. In each case, a fetal heartbeat was detected when the patient presented in the emergency department. In each case, the health of the patient was in serious jeopardy. In each case, physicians determined that termination of the clinically diagnosable pregnancy was the standard of care "necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result." 42 U.S.C. § 1395dd(e)(3)(A). As a result, in each case, physicians were compelled by EMTALA to recommend termination of the pregnancy (with patient consent) knowing that the termination would result in fetal death. The interpretation of EMTALA advanced in the panel's stay order stands in marked contrast to the decades of experience in Idaho's hospitals and emergency departments.[5]

These cases illustrate something critical the stay overlooks: termination of a clinically diagnoseable pregnancy is sometimes necessary to stabilize a patient's *health*. And these cases are just a few examples: pregnant patients also present with early incomplete miscarriage as well as other conditions that can occur concurrent with, or because of the pregnancy, such as cancer, pulmonary hypertension, and heart failure. In some of these cases, physicians determine that termination is necessary to stabilize the

[5] The notion that Congress *excluded* abortion as stabilizing treatment in EMTALA would stun the vast majority of medical providers who have provided emergency care to pregnant patients over the last several decades.

patient's health and, with the patient's informed consent, is therefore required by EMTALA.[6]

Because EMTALA sometimes requires physicians to perform a termination that would fit the definition of an abortion under Idaho law, the criminal ban on abortions in Idaho Code § 18-622 creates a conflict between the state and federal obligations of our healthcare providers. Under § 18-622(1), "[e]very person who performs or attempts to perform an abortion . . . commits the crime of criminal abortion," a felony punishable by two to five years imprisonment. *Id.* The statute defines "[a]bortion" 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). The Legislature created an exception for terminations that are "necessary to prevent the death of the pregnant woman." *Id.* § 18-622. But there is still no exception to preserve the mother's underlying health, bodily organs, fertility, or the other irreparable harms women will experience if the application is granted. EMTALA requires stabilizing treatment for *any* "emergency medical condition," not just those treatments intended to prevent death.[7] 42 U.S.C.

[6] The State's argument that "the only specific care the statute demands is to deliver—not abort—the child of a woman in labor" is incorrect. *See* State Br. at 4 (citing 42 U.S.C. § 1395dd(e)(1)(A)). EMTALA requires stabilizing treatment as "necessary to assure, within reasonable medical probability, that no material deterioration of the [emergency medical] condition is likely to result." 42 U.S.C. § 1395dd(e)(3)(A). The State overlooks the fact that EMTALA applies not only to patients "in labor," *see id.* § 1395dd(c)(2)(A), but also to patients with "emergency medical conditions," *id.* § 1395dd(b)—which can include pregnant patients who are not in labor.

[7] EMTALA does not require termination, or any other stabilizing treatment, where a patient refuses to consent to the treatment. *See* 42 U.S.C. § 1395dd(b)(2) (acknowledging that "the individual" with an emergency medical condition, after being informed "of the risks and benefits" of treatment, may "refuse[] to consent to the . . . treatment").

§ 1395dd(e)(1)(A). As both Dr. Seyb and Dr. Cooper explained, some of their patient examples may have survived without a termination but would have been at risk for severe health problems, including renal failure and clotting disorder, Seyb Decl. ¶¶ 7-8, stroke, seizure, pulmonary edema, and kidney failure, Cooper Decl. ¶¶ 6, 10. Thus, in many cases where termination is necessary to "stabilize" a patient under EMTALA because the life or health of the mother is in serious jeopardy, Idaho Code § 18-622 appears to prohibit it. Unfortunately, the panel's stay order overlooks these patients entirely and thereby misses how and why EMTALA preempts § 18-622 even as amended.

If § 18-622 takes effect, health care providers in Idaho will be faced with an impossible choice. They can terminate a pregnancy where necessary to prevent serious jeopardy to a patient's health, but they may face criminal prosecution and the revocation of their licenses; their malpractice insurance is unlikely to cover them for criminal acts or the defense of a criminal prosecution, and the consequences of facing such prosecution may be ruinous. Alternatively, Idaho physicians may decline or simply hesitate to perform a termination until it may be too late, putting their patients' health in jeopardy and violating EMTALA. In addition to the harm suffered by the directly-impacted patients, this could place the hospital's participation in Medicare in danger, with devastating results for *all* patients.

The example of St. Luke's is illustrative. In the entire State of Idaho, there are only 43 critical access and acute care hospitals with emergency departments or services. Eight of those hospitals are operated by St. Luke's. Ending participation in Medicare

would threaten the health care of hundreds of thousands of Idahoans, whether pregnant or not.

In 1986, Congress foresaw this dilemma and preempted laws like Idaho Code § 18-622 precisely so that health care providers would not be forced to choose between Scylla and Charybdis. Specifically, EMTALA provides that "any State or local law requirement" is preempted "to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). "A state statute directly conflicts with federal law in either of two cases: first, if 'compliance with both federal and state regulations is a physical impossibility,' or second, if the state law is 'an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993) (citations omitted) (per curiam); *see also PLIVA, Inc. v. Mensing*, 564 U.S. 604, 618 (2011) ("We have held that state and federal law conflict where it is 'impossible for a private party to comply with both state and federal requirements.'" (citation omitted)).

Here, both kinds of direct conflict exist. First, compliance both with EMTALA and Idaho Code § 18-622 is impossible: one statute requires stabilizing care to be performed, even if it involves termination of a pregnancy, while the other prohibits many terminations that are necessary to stabilize a patient's health. *See PLIVA*, 564 U.S. at 618 (holding state law was preempted when "[i]t was not lawful under federal law for the Manufacturers to do what state law required of them" and "even if they had fulfilled their federal duty…, they would not have satisfied the requirements of state law"). Second, Idaho Code § 18-622 is an obstacle to EMTALA's purpose "to ensure that patients,

particularly the indigent and underinsured, receive adequate emergency medical care." *Arrington v. Wong*, 237 F.3d 1066, 1073-74 (9th Cir. 2001) (quotation marks and alterations omitted).

Because of the Supremacy Clause, "[w]here state and federal law 'directly conflict,' state law must give way." *PLIVA*, 564 U.S. at 617 (citation omitted). Here, the Supremacy Clause requires that Idaho Code § 18-622 give way to the conflicting obligations of EMTALA. By overlooking how § 18-622 functions on the ground in Idaho's emergency departments, the stay order erred in its preemption analysis.

II. Staying the Ninth Circuit's En Banc Order, Therefore Allowing § 18-622 to Take Full Effect, Will Cause Irreparable Harm to Idaho.

A showing of irreparable harm does not require proof "that irreparable harm is certain or even nearly certain[,]" only that it is "likely." *Small v. Avanti Health Sys., LLC*, 661 F.3d 1180, 1191 (9th Cir. 2011). That standard is certainly met here. If the stay is reinstated, Idaho Code § 18-622 will cause irreparable harm to the Idaho public by delaying and disrupting patient care. By its terms, the law will chill health care providers from administering care necessary to stabilize pregnant patients whose health is in jeopardy. And though pregnant patients will bear the brunt of those consequences, they will not bear them alone. Health care providers will be mired in legal debates and/or criminal proceedings, removing them from patient care and further overburdening an already overburdened system. Because this legal landscape will deter physicians and nurses from practicing in Idaho, § 18-622 will compound existing provider shortages, and everyone in Idaho will suffer. Finally, the Legislature's recent amendments exempting

abortions that are necessary to "prevent the death" of the mother, will not avert the disastrous consequences of § 18-622.

A. The Stay Will Irreparably Harm Patient Care and Increase Suffering.

Today in Idaho, when a pregnant patient presents with serious complications, physicians follow their training and federal law. Both presently advise that a termination should be performed where necessary to stabilize a patient whose health is in serious jeopardy. Idaho Code § 18-622 disrupts that care. By criminalizing this necessary care, § 18-622 hinders a provider's ability to do their job and protect their patients' health.

The Idaho statute is designed to prohibit health care providers from terminating pregnancies, and—notwithstanding the limited exception to prevent the death of the patient—it does not permit termination where necessary to otherwise stabilize the patient's health. In those situations, if a patient has no option but to continue their pregnancy, they will suffer—potentially gravely. The conditions that call for termination can be extremely painful. If untreated, they can cause serious health complications, including systemic bleeding, liver hemorrhage and failure, kidney failure, stroke, seizure, pulmonary edema, and more. *See, e.g.*, Cooper Decl. ¶¶ 8, 10.

In an emergency, time matters. Even if a patient is ultimately provided the medically necessary care, Idaho Code § 18-622 will delay that care until a debate—likely had among physicians and non-physician attorneys—determines whether it is truly "necessary to prevent the death" of the patient, Idaho Code § 18-622, or whether it is "only" necessary to avert a serious but non-lethal threat to the patient's health—which is not permitted under Idaho law. Because a physician administering an emergency

termination in Idaho would be risking their professional license, livelihood, personal security, and freedom, it is only natural that physicians may hesitate and seek assurance, to the extent possible, before proceeding. In the meantime, their patients may suffer, and their conditions may deteriorate, perhaps materially. These delays will ultimately harm the critically ill pregnant patient along with other patients in the Emergency Department whose providers must scramble to cover additional patients as other providers debate with lawyers as to whether the indicated care is permissible under Idaho law and when it may be administered.

A stay granted now would be especially dangerous. During the winter months, Idaho's roads can be treacherous. Whereas physicians in Idaho sometimes may be able to transfer a patient out of state to receive necessary care prohibited by § 18-622, that may not be possible in the winter when roads may be impassable, require travel at extremely low speeds, or may simply be too dangerous to traverse with a precarious medical condition. Knowledge that treatment out of state may not be an option only compounds the conflict physicians in Idaho would feel if § 18-622 were to take effect in Idaho's emergency rooms.

The Supreme Court of Idaho did not solve this problem by interpreting the law to provide a subjective standard requiring the doctor, in their good faith medical judgment, to believe it necessary to terminate the pregnancy to prevent the patient's death. *See Planned Parenthood Great Nw. v. Idaho*, 522 P.3d 1132, 1203 (Idaho 2023). From a physician's perspective, it is not always easy to tell—even subjectively and in good faith—when a patient's life, as opposed to her health, is imperiled. Before the stay, Idaho

physicians could provide stabilizing care without trying to decipher the line between health and death. Now, they will waste precious minutes trying to parse where one obligation begins and another ends. Patients will suffer accordingly.

Furthermore, Idaho law not only prohibits physicians from terminating a clinically diagnosable pregnancy but also exposes those who assist them to criminal and license-suspension risk. *See* Idaho Code § 18-204 (criminal accessory statute); *id.* § 18-622(1) (license suspension provision). As a result, there will be some cases where a physician may be comfortable proceeding but has no nurse or other staff to assist. This too will mean at best delayed care and at worst deficient or no care at all. And, again, it is the patients who will suffer irreparably.

B. The Stay Will Also Harm the Idaho Public by Deterring Nurses and Physicians from Practicing in Idaho.

Medical providers in Idaho are already stretched thin. Idaho trails far behind other states regarding its number of physicians per capita.[8] A January 2023 report by the Idaho Department of Health and Welfare shows that 98.2% of areas in Idaho have a primary care professional shortage.[9] Idaho also has a shortage of emergency physicians.[10] And

[8] *States Ranked by Active Physicians Per Capita*, Becker's Hospital Review, http://bit.ly/49VrkHM (last visited Nov. 28, 2023).

[9] Idaho Dep't Health & Welfare, *Bureau of Rural Health & Primary Care Brief* (Jan. 2023), https://bitly.ws/WoWZ.

[10] *See* Christopher L. Bennett et al., *United States 2020 Emergency Medicine Resident Workforce Analysis*, 80 Annals Emergency Med. 3 (July 1, 2022), https://bit.ly/3QM50pB; *see also* Christopher Cheney, *Rural Areas Experiencing Emergency Medicine Workforce Shortage*, Rural Health Info. Hub (June 29, 2022), https://bit.ly/3QqHcIm.

Idaho is one of the states most affected by the nationwide OB-GYN shortage.[11] This shortage is both caused and exacerbated by the lack of a single OB-GYN residency program in the State of Idaho: that gap means that every OB-GYN physician must be recruited to Idaho from out of state.

Unfortunately, Idaho Code § 18-622 will inevitably worsen these provider shortages by deterring medical professionals from practicing in Idaho. *See* Seyb Decl. ¶ 14. Indeed, one of the physician declarants confirmed this is already happening, as OB-GYNs around the country have rejected offers to work in states with restrictive abortion laws so as to avoid the risks of liability that may result if they follow the standard of care.[12] *See* Declaration of Dr. Emily Corrigan ¶ 32, Dkt. No. 17-6 (stating that "at least one of my colleagues has already decided to stop her part-time work at our hospital due to the stress of complying with this law"). Another declarant, Dr. Huntsberger, has already left Idaho due to the uncertainties surrounding § 18-622.[13]

The consequences of provider shortages are serious. Without enough physicians and nurses to provide medical care to a community, the quality of care suffers, wait times for an appointment increase, and practitioners become overworked and stressed, causing

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[11] U.S. Dep't of Health & Human Servs., *Projections of Supply and Demand for Women's Health Service Providers: 2018-2030* (Mar. 2021), https://bit.ly/3PhGagh (projecting demand of OB-GYNs to exceed supply in Idaho).

[12] Christopher Rowland, *A Challenge for Antiabortion States: Doctors Reluctant to Work There*, Wash. Post (Aug. 6, 2022), https://wapo.st/3w1ujfC.

[13] *See, e.g.*, Sarah Varney, *After Idaho's Strict Abortion Ban, OB-GYNs Stage a Quick Exodus*, Salt Lake Trib. (May 2, 2023), https://bit.ly/467ocGB; Kathleen McLaughlin, *No OB-GYNs Left in Town: What Came After Idaho's Assault on Abortion*, The Guardian (Aug. 22, 2023), https://bitly.ws/WoZy. Maternal Fetal Medicine ("MFM") specialists, who are relied upon by OB-GYNs and family practitioners statewide—are also leaving Idaho. In the past year, St. Luke's lost two MFM specialists—Dr. Kylie Cooper and Dr. Lauren Miller—which brings the *statewide* total of MFMs down to 5.

burnout and—in a vicious cycle—deterring other people from entering the medical field or practicing here, which only compounds the shortages going forward. Again, these consequences will be felt by far more than just the pregnant patients most directly affected by § 18-622. By making it materially more difficult to attract and retain OB-GYNs, family practitioners, emergency physicians, maternity nurses, and other medical providers, Idaho Code § 18-622 will harm the public interest. *See Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 512 F.3d 1112, 1126 (9th Cir. 2008) (granting stay because "the general public has an interest in the health of San Francisco residents and workers").

C. The Legislature's Amendments Do Not Avoid These Harms.

The Legislature's recent amendments—which, *inter alia*, set forth exemptions for abortions that physicians deem necessary to prevent the death of the mother—do not forestall the harms to patients, physicians, or the people of Idaho.

First, the "prevent the death" exception does not mitigate the law's chilling effect on medical providers who could be criminally prosecuted if they are found to have violated the law. The exception is sufficiently narrow—covering threats to life, but not to other serious (though nonfatal) health complications—that providers can take no comfort that they will escape prosecution if their patient will survive, yet suffer, absent termination.

Second, and relatedly, the limited exception leads to prolonged suffering. Because it allows termination of a clinically diagnosable pregnancy only where necessary to prevent death, it encourages providers to delay medically-necessary treatment until the

patient is close to death, even though the provider understands that the condition will inevitably worsen and even though the patient suffers in the meantime. Said differently, even if the health of the pregnant patient is in serious jeopardy—where she may suffer a lifetime of debilitating complications and excruciating pain if she does not receive an emergency termination—so long as the suffering is short of death, even the amended § 18-622 provides no exception. EMTALA exists to prevent this deterioration. *See* 42 U.S.C. § 1395dd(e)(3).

Third, the amendments do not ameliorate the law's harmful effects in discouraging health care providers from practicing in Idaho. The exception does not change the fact that, by forcing physicians to allow their patients to suffer, § 18-622, and any stay allowing it to take full effect, make Idaho an unwelcome home for OB-GYNs, family practitioners, emergency physicians, and other providers seeking to minimize patient suffering consistent with their professional assessments.

CONCLUSION

The Court should deny the Application.

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