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 ST. LUKE'S HEALTH SYSTEM AS AMICUS CURIAE IN SUPPORT OF RESPONDENT

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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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Idaho Code § 18-622(2)(a)(i) 3, 9, 13

OTHER AUTHORITIES

Ada County Medical Society, *Idaho Physician Retention Survey – May 2023*, https://bitly.ws/3fnbV (last visited Mar. 8, 2024) 19

Christopher L. Bennett et al., *United States 2020 Emergency Medicine Resident Workforce Analysis*, 80 Annals Emergency Med. 3 (2022), https://bit.ly/3QM50pB 17

Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, *Natality on CDC WONDER Online Database*, https://bit.ly/3ZE4rEh 1

Christopher Cheney, *Rural Areas Experiencing Emergency Medicine Workforce Shortage*, Rural Health Info. Hub (June 29, 2022), https://bit.ly/3QqHcIm 17

Kelly Gooch & Marissa Plescia, *States Ranked by Active Physicians Per Capita*, Becker's Hosp. Rev. (Mar. 9, 2022), http://bit.ly/49VrkHM 17

Idaho Dep't Health & Welfare, *Bureau of Rural Health & Primary Care Brief* (Jan. 2023), https://bitly.ws/WoWZ 17

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 20

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Sarah Varney, *After Idaho's Strict Abortion Ban, OB-GYNs Stage a Quick Exodus*, Salt Lake Trib. (May 2, 2023), https://bit.ly/467ocGB 18

INTEREST OF *AMICUS CURIAE*

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; in 2022, 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

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[1] No party or party's counsel authored the brief in whole or in part, and no party or party's counsel contributed money that was intended to fund the preparation or submission of the brief. No person other than 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 https://bit.ly/3ZE4rEh on Feb. 26, 2024. Data is not yet published for 2023.

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 § 18-622 risks 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 § 18-622 imperils 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

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[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.

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 already taking place in Idaho's emergency departments, with dire consequences for the affected physicians, patients, and their families.

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 emergency medical care, it has that effect. And that remains true even after the amendments adopted by the Idaho Legislature, which may permit termination of pregnancy when "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 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 files this brief in support of the United States.

INTRODUCTION AND SUMMARY OF ARGUMENT

Amicus previously explained to this Court in its brief opposing the State's emergency application that permitting § 18-622 to take effect would have grave consequences. Since this Court's vacatur of the district court's injunction, that is exactly what has happened.

In Idaho's hospitals, healthcare providers today are confronted with a conflict between 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. Today, those patients suffer as physicians' best option is often to transfer the patients out of state—thereby delaying care and creating additional risks for patients. These delays can cause not only pain and suffering, but also more permanent effects such as organ failure, loss of reproductive organs, and other forms of disability.

While the patients are most directly impacted by § 18-622's implementation, they are not alone: the law's unintended consequences also harm medical professionals, the Idaho healthcare system, and Idaho residents more broadly. Fearful that they will be compelled to violate federal or state law as a result of the conflict between EMTALA and § 18-622, physicians are

fleeing from Idaho and/or refusing to take jobs in the state. Today, only three full-time and two part-time maternal fetal medicine doctors remain in all of Idaho—less than half of the number who practiced in Idaho as of May 2022. The consequences for patient care are grave. And the Legislature's recent amendments do not avoid any of these harms.

As the state's largest private employer and the entity responsible for treating more patients on the ground in Idaho than any other (more than 235,000 emergency department visits in 2023), *Amicus* respectfully submits this brief in support of the United States.

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 2023 alone, Medicare-covered services accounted for more than 40% 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 Petitioners argue that EMTALA does not require "any particular procedure," State Br. at 14; *see also* Moyle Br. at 6, 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.[4] St. Luke's physicians submitted declarations[5] in the district court describing several examples: two patients with preeclampsia with severe features, Cooper Decl. ¶ 6, J.A. 367-68; Seyb Decl. ¶¶ 9-10, J.A. 374; two patients with HELLP syndrome, Cooper Decl. ¶¶ 8, 10, J.A. 368-69; a patient with septic abortion, Seyb Decl. ¶¶ 7-8, J.A. 373-74; and a patient in hypovolemic shock due to blood loss, *id.* ¶¶ 11-12, J.A. 374-75. 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. Petitioners' interpretation of EMTALA stands in

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[4] To be clear, EMTALA does not, under any circumstance, require "on-demand," elective abortion care. For EMTALA to apply, patients must present with emergent conditions, for which stabilizing treatment (including, in some cases, abortion care) is necessary to prevent "material deterioration" of the patient's health. 42 U.S.C. § 1395dd(e)(3)(A).

[5] *See* Declaration of Kylie Cooper, M.D., J.A. 365-70 (hereinafter "Cooper Decl."); Declaration of Stacy T. Seyb, M.D., J.A. 371-76 (hereinafter "Seyb Decl.").

marked contrast to the decades of experience in Idaho's hospitals and emergency departments.[6]

These cases also illustrate something critical the Petitioners overlook: 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 patient's health and, with the patient's informed consent, is therefore required by EMTALA.[7] 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

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[6] 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.

[7] Petitioners wrongly argue that the only specific care the statute demands is "to deliver [an] unborn child and placenta" is incorrect. State Br. at 32 (citing 42 U.S.C. § 1395dd(e)(3)(A)); *see* Moyle Br. at 6. 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). Petitioners overlook 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.

obligations of St. Luke's 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(2)(a)(i). But there is still no exception to preserve the mother's underlying health, bodily organs, fertility, or the other irreparable harms women may experience. EMTALA requires stabilizing treatment for *any* "emergency medical condition," not just those treatments intended to prevent death.[8] 42 U.S.C. § 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, J.A. 373-74, stroke, seizure, pulmonary edema, and kidney failure, Cooper Decl. ¶¶ 6, 10, J.A. 367-69.

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[8] 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").

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 prohibits it, unless "necessary to prevent the death of the pregnant woman."

Now that § 18-622 has taken effect, health care providers in Idaho face an impossible choice. They can terminate a pregnancy where necessary to prevent serious jeopardy to a patient's health, but they may risk 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 the risks to the patients' health become life-threatening. Or, they can transfer their patients out of state, delaying care while transport is arranged and distancing patients from their support networks, including the medical providers they know and trust.

In addition to the harm suffered by the directly-impacted patients, a physician's choice 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," *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43 (1963), or second, if the state law is "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress," *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941). *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.

II. Section 18-622 Will Cause—and Is Causing—Extraordinary Harm to the People of Idaho.

A. Section 18-622 Is Harming Emergency Patient Care and Causing Patients to Suffer Debilitating Pain and Other Consequences.

Prior to § 18-622 taking effect, when a pregnant patient presented to an emergency room with serious complications, physicians would follow their training and federal law. If termination was necessary to stabilize a patient whose health was in serious jeopardy, their training and federal law indicated that a termination should be performed upon the patient's consent.

Idaho Code § 18-622 has disrupted that care, criminalizing what previously had been mandated. By its terms, § 18-622 chills health care providers from administering care necessary to stabilize pregnant patients whose health is in jeopardy. And notwithstanding the limited exception to prevent the

death of the patient, the law 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, J.A. 368-69. And often, it is patients with wanted pregnancies who must make the heart-wrenching decision to terminate to avoid these complications—including, in some cases, to preserve their future ability to have children.

When these situations arise, they are agonizing for the patient, as their joy in expecting a new baby turns to tragedy. This tragedy is compounded when they learn the care that is needed cannot be provided in their own state, making it likely they will suffer irreparable health consequences in addition to the loss of their expected child. Moreover, the health consequences of delayed care can also be long term, making it difficult for them to care for any existing children they have at home.

In an emergency, time matters. Even if a patient is ultimately provided the medically necessary care, Idaho Code § 18-622 may 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(2)(a)(i), 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 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.

These harms are not hypothetical. Section 18-622 is already causing considerable harm to the Idaho public by delaying and disrupting patient care. Since the Court vacated the district court's injunction in January, Idaho providers have been all but paralyzed by legal uncertainties—and patients' health has suffered. Several patients have presented with previable, preterm, premature rupture of membranes—i.e., spontaneous rupture of the membrane containing a fetus before 22 weeks of gestation. This is a life-threatening condition with high risk of infection, sepsis, and bleeding from placental abruption, and for which the standard of care includes termination. Prior to 22 weeks of gestation, a neonatal intensive care unit (NICU) would not even attempt to resuscitate, as the fetus could not survive. Given the legal uncertainty surrounding § 18-622, however, these patients are now being transferred out of state unless they are at imminent risk of death.

Amicus's physicians have expressed that this practice has put patients at risk due to significant delays in care while arranging medical transport out of state. And if those delays create a situation where the patient is no longer stable enough that the benefits of transfer outweigh the risks, then Idaho physicians are left to wait until termination is necessary to prevent the patient's death, knowing that the wait could have severe health consequences, including damage to the patient's future reproductive health. St. Luke's physicians have described a constant fear that patients will present in an emergency room who are not stable enough to transfer, yet the medically indicated stabilizing care—termination—cannot be provided because it is not yet needed to prevent the patient's *death*.

By way of example, one St. Luke's patient had her first planned pregnancy in early 2022, before § 18-622 took effect. She and her husband were ecstatic—until approximately 20 weeks into the pregnancy when she developed severe abdominal pain and was rushed to the emergency department. The patient was diagnosed with HELLP syndrome, a potentially life-threatening condition that affects the blood and liver and, in some cases, fetal development. In this patient's case, the fetus would not develop lungs and was therefore non-viable. The following day, the patient underwent a procedure to terminate the pregnancy. The high-risk OB-GYN physician who performed the procedure no longer practices in Idaho due to § 18-622. The patient is pregnant again, and her physician is concerned that should the patient re-develop HELLP syndrome, she would need to be transferred out of Idaho for care, away

from family and the doctors she trusts, and that the delay may have permanent consequences for her health.

B. Section 18-622 Is Also Harming Medical Professionals in Idaho, Which in Turn Harms the Idaho Public.

Though pregnant patients bear the brunt of § 18-622's consequences, they do not bear them alone. Since the law took effect, health care providers have found themselves mired in legal debates and living with the fear of criminal proceedings should they need to terminate a pregnancy for the sake of their patient's health.

The exception for abortions necessary to "prevent the death" of the mother does not avert these consequences. 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 § 18-622 took effect, Idaho physicians could provide stabilizing care without trying to decipher the line between health and death. Now, they must waste precious minutes trying to parse where one obligation begins and another ends. Their patients suffer accordingly.

Making matters worse, Idaho law also exposes those who assist physicians in terminating a pregnancy 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 may be some cases where a physician may be comfortable

proceeding but has no nurse or other staff to assist. This too, means at best delayed care and at worst deficient or no care at all. And, again, the patients necessarily suffer.

This legal landscape has deterred—and will continue to deter—physicians and nurses from practicing in Idaho, thereby compounding existing provider shortages. Medical providers in Idaho are already stretched thin. Idaho has the lowest number of physicians per capita of all fifty states.[9] 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.[10] Idaho also has a shortage of emergency physicians.[11] And Idaho is one of the states most affected by the nationwide OB-GYN shortage.[12] This shortage is both caused and exacerbated by the lack of a single OB-GYN residency program in the State of

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[9] Kelly Gooch & Marissa Plescia, *States Ranked by Active Physicians Per Capita*, Becker's Hosp. Rev. (Mar. 9, 2022), http://bit.ly/49VrkHM.

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

[11] *See* Christopher L. Bennett et al., *United States 2020 Emergency Medicine Resident Workforce Analysis*, 80 Annals Emergency Med. 3 (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.

[12] 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).

Idaho: that gap means that every OB-GYN physician must be recruited to Idaho from out of state.

Unfortunately, Idaho Code § 18-622 worsens these provider shortages by deterring medical professionals from practicing in Idaho. *See* Seyb Decl. ¶14, J.A. 376; Declaration of Dr. Emily Corrigan ¶ 32, J.A. 362 (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"). Since the Legislature passed § 18-622, the shortages have become dire. In 2023, St. Luke's lost two Maternal Fetal Medicine ("MFM") specialists—Dr. Kylie Cooper and Dr. Lauren Miller, both declarants in the district court proceedings—due to § 18-622. Another declarant, Dr. Huntsberger, left Idaho due to the uncertainties surrounding § 18-622.[13] Now, there are only three full-time and two part-time MFM specialists left in the entire state—less than half from before § 18-622 took effect.[14] Moreover, ten of the OB-GYNs in the Panhandle region of Idaho alone have left the state or resigned; several OB-GYNs in Boise have transitioned to GYN-only practice, meaning they will no longer provide obstetric care; three midwives have resigned or relocated out of state; and many of St. Luke's remaining providers are seriously considering reducing their practice, moving, or retiring early. This mirrors the pattern statewide: in the

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[13] *See* Sarah Varney, *After Idaho's Strict Abortion Ban, OB-GYNs Stage a Quick Exodus*, Salt Lake Trib. (May 2, 2023), https://bit.ly/467ocGB.

[14] As of May 2022, there were nine MFM specialists practicing in Idaho.

fifteen months after § 18-622's enactment, 22% of Idaho obstetricians have stopped practicing in the state.[15] Now, there is one obstetrician per 8,510 Idahoans.[16] And the problem may worsen still: Over half of Idaho OB-GYNs surveyed in 2023 were considering leaving Idaho; of those, 96% said they would reconsider or very likely stay if a health exception was added to the state's abortion law.[17]

Recruitment for St. Luke's has likewise been fraught: Since § 18-622's enactment, St. Luke's has had markedly fewer applicants for open physician positions, particularly in obstetrics.[18] And several out-of-state candidates have withdrawn their applications upon learning of the challenges of practicing in Idaho, citing § 18-622's enactment and fear of criminal penalties. Program directors in other states have said they will no longer recommend to any of their fellows that they consider job opportunities in Idaho. Again, this mirrors the pattern statewide: As the president of the Idaho Hospital Association explained in an interview with the Statesman, physicians are refusing in droves to come to

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[15] Angela Palermo, *Boise-area Hospital Will Close Labor, Delivery Units. What It's Saying – and Not Saying*, Idaho Statesman (Feb. 22, 2024), https://bitly.ws/3eWBR.

[16] *See id.*

[17] *See* Ada County Medical Society, *Idaho Physician Retention Survey – May 2023*, https://bitly.ws/3fnbV (last visited Mar. 8, 2024).

[18] For 2024, St. Luke's received a record-low 57 applications for open obstetrics positions—a 39% and 47% decrease from 2022 and 2021, respectively.

a state that criminalizes physicians' efforts to safeguard their patients' health.[19]

As a result of provider shortages, hospitals are simply shutting down their labor and delivery services. Dr. Huntsberger's hospital, Bonner General Health, no longer provides any obstetrical care.[20] Valor Health, the only hospital in Emmett, closed its obstetrics program as well.[21] And West Valley Medical Center has announced the closure of its labor and delivery and neonatal intensive care units effective April 1, 2024.[22] These sorts of closures can only be expected to proliferate as more doctors leave and few, if any, are willing to move to Idaho to take their places.

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 burnout and—in a vicious cycle—deterring others from entering the medical field or practicing here, which only compounds the shortages going forward. Again, these consequences are 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,

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[19] *See* Palermo, *supra* note 15.

[20] *See* 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.

[21] *See* Palermo, *supra* note 15.

[22] *Id.*

family practitioners, emergency physicians, maternity nurses, and other medical providers, Idaho Code § 18-622 harms public health statewide.

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

The Legislature's recent amendments—which, *inter alia*, set forth exceptions 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 makes 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 reinstate the district court's injunction.

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