



Physicians for
Human Rights

In Clinicians' Own Words: How Abortion Bans Impede Emergency Medical Treatment for Pregnant Patients In Idaho

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Introduction

The Emergency Medical Treatment & Labor Act (EMTALA) was enacted by Congress in 1986 to ensure patients' access to emergency services regardless of a person's ability to pay.¹ EMTALA requires hospitals with emergency departments (EDs) to take a range of measures when presented with a person who comes to the department, including providing a medical screening examination if the individual requests one; "necessary stabilizing treatment for emergency medical conditions and labor within the hospital's capability and capacity"; and, where necessary, "appropriate transfer of an unstabilized individual to another medical facility" if circumstances permit.² EMTALA prohibits hospitals with emergency departments from refusing to examine or treat people with emergency medical conditions. The provisions of EMTALA apply to all people who seek emergency care from a hospital with such a designated facility; it is not limited to Medicare beneficiaries.

In June 2022 the U.S. Supreme Court ruled in *Dobbs v. Jackson Women's Health Organization* to overturn nearly 50 years of legal precedent recognizing the constitutionally protected right to an abortion. Following growing confusion post-*Dobbs* about whether emergency medical care could be provided in states with newly enforceable or enacted abortion bans, the U.S. Centers for Medicare and Medicaid Services issued guidance to affirm that, "Emergency medical conditions involving pregnant patients [under EMTALA] may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features."³ The course of treatment

¹ 42 USC §1395dd: Examination and treatment for emergency medical conditions and women in labor (2024), [https://uscode.house.gov/view.xhtml?req=\(title:42%20section:1395dd%20edition:prelim\)%20OR%20\(granuleid:USC-prelim-title42-section1395dd\)&f=treesort&edition=prelim&num=0&jumpTo=true](https://uscode.house.gov/view.xhtml?req=(title:42%20section:1395dd%20edition:prelim)%20OR%20(granuleid:USC-prelim-title42-section1395dd)&f=treesort&edition=prelim&num=0&jumpTo=true).

² Ibid.

³ "Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-21-22-Hospitals)," Centers for Medicare & Medicaid Services, July 11, 2022, last modified August 25, 2022, <https://www.cms.gov/files/document/qso-22-22-hospitals.pdf>.

necessary to stabilize such emergency medical conditions is also under the purview of the physician or other qualified medical personnel. The guidance further stated that stabilizing treatment could include medical and/or surgical interventions (for example, abortion, removal of one or both fallopian tubes, anti-hypertensive therapy, methotrexate therapy), irrespective of any state laws or mandates that apply to specific procedures.⁴ In addition, Health and Human Services Secretary Xavier Becerra sent a letter to health care providers to reiterate that EMTALA federal law preempts state law restricting access to abortion in emergency situations.⁵

Federal courts have also been presented with cases considering whether EMTALA preempts state abortion bans that were passed in the wake of *Dobbs*. In January 2024, following separate but related lower court proceedings in both Texas and Idaho, the Supreme Court agreed to hear the case of *Idaho v. United States*, which aims to clarify whether EMTALA preempts state laws that prohibit abortions, including laws like Idaho's Defense of Life Act.⁶ The Idaho Defense of Life Act criminalizes anyone who performs or assists in performing an abortion except to prevent the death of the pregnant woman, in cases of rape and incest when reporting to law enforcement in the first trimester, and in cases of ectopic and molar pregnancy.⁷ Violation of this law is considered a felony and subjects clinicians – including nurses, lab techs, or anesthesiologists involved – with a minimum of two years in prison; providers also face having their professional licenses suspended a minimum of six months for the first offense and then permanently revoked upon a subsequent offense.⁸ The Supreme Court allowed Idaho's law to go into effect after scheduling to hear the case, for the first time since August 2022 when it had been enjoined by a lower court after the Biden administration sued to block the law.⁹

Following the Supreme Court's decision to hear this case, Physicians for Human Rights (PHR) undertook fact-finding interviews from January through February of 2024 with nine physicians who either currently practice or formerly practiced in Idaho, or who practice in surrounding states. Of the latter group, these physicians have treated pregnant patients from Idaho who were transferred out of state because the Idaho facility where the patient initially sought care determined treatment was no longer allowable under the state's abortion laws.¹⁰

⁴ Ibid.

⁵ Xavier Becerra, "Emergency medical care letter to health care providers," Secretary of Health and Human Services, Letter to Health Care Providers, July 11, 2022, <https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf>.

⁶ U.S. Supreme Court, *Idaho v. United States*, case No. 23-727, January 5, 2024, <https://www.supremecourt.gov/qp/23-00727qp.pdf>.

⁷ ID Code § 18-622 (2023), <https://legislature.idaho.gov/statutesrules/idstat/title18/t18ch6/sect18-622/#:~:text=Search%20Idaho%20Statutes&text=18%2D622..the%20crime%20of%20criminal%20abortion>.

⁸ "Brief of St. Luke's Health System as Amicus Curiae in Opposition to Emergency Application for Stay Pending Appeal," *Idaho v. United States*, No. 23A470, November 29, 2023, https://www.supremecourt.gov/DocketPDF/23/23A470/290825/20231129150826460_23A470%20Amicus%20St.%20Lukes%20Opposition%20to%20Emergency%20Application.pdf

⁹ Nina Totenberg, "Supreme Court allows Idaho abortion ban to be enacted, first such ruling since *Dobbs*," *NPR*, January 5, 2024, <https://www.npr.org/2024/01/05/1216284896/supreme-court-allows-idaho-abortion-ban-to-be-enacted-first-such-ruling-since-do>.

¹⁰ Participants were recruited through professional networks, professional listservs, and through snowball sampling. Interviews were conducted by two researchers with expertise in qualitative research and abortion policy. Interviews were audio recorded with participants' consent, transcribed, and de-identified. ERB approval was determined to not be required for this research.

The purpose of these interviews was to document whether and how Idaho's abortion bans have impeded the provision of care required under EMTALA.

In speaking with PHR, clinicians described multiple cases in which Idaho's abortion ban caused delays in pregnant patients receiving the recommended standard of care, including, in some cases, as a result of the necessity of being transferred to out-of-state facilities, which resulted in increased morbidity among these patients. Their experiences are recounted below.¹¹

Medical conditions where treatment has been delayed or denied due to state abortion bans, but would be covered by EMTALA

There is a range of medical conditions requiring treatment that may be considered by clinicians to be "emergency medical conditions" as defined under EMTALA, including: Hemolysis, Elevated Liver enzyme levels, and Low Platelet levels Syndrome (HELLP Syndrome) preeclampsia, preterm premature rupture of membranes (PPROM), cardiomyopathy, placental abruption, cervical insufficiency, pulmonary hypertension, infection, incomplete miscarriage, cancers, mirror syndrome, placenta previa, ischemic heart disease, placenta accreta spectrum disorder (PASD), uterine hemorrhage, and mental health concerns.¹² Physicians that PHR spoke with described cases where they would have been able to treat patients with these conditions prior to *Dobbs* and also post-*Dobbs* while the Idaho ban was enjoined by the U.S. District Court of Idaho and the 9th U.S. Circuit Court of Appeals. These physicians shared that now their capacity is significantly hampered and the medical treatment they are able to provide in these cases is substandard.

HELLP Syndrome/Preeclampsia

One particularly dangerous condition is HELLP syndrome, which is a life-threatening complication of pregnancy.¹³ The condition can cause health complications, such as hemorrhage or excessive bleeding. Up to 24 percent of pregnant women with HELLP syndrome and up to 34 percent of babies die from the condition. While about 70 percent of cases occur during the third trimester, it can occur earlier in pregnancy. Some experts consider HELLP a severe form of preeclampsia. Preeclampsia is a pregnancy condition diagnosed by dangerously high blood pressure and includes protein in the urine. Supportive treatment includes intravenous anti-hypertensive medications and blood transfusions. The only definitive treatment for both HELLP and preeclampsia is prompt delivery to remove the fetus and the placenta, or if the fetus is pre-viable, abortion.¹⁴

Physicians that PHR spoke with described having to decide between providing the necessary treatment of abortion or waiting until patients developed even more severe life-threatening health complications from continuing the pregnancy. One ob-gyn described a case

¹¹ Some quotes have been edited for conciseness and clarity. This is indicated by brackets or ellipses.

¹² These conditions reflect those described by clinicians throughout our interviews on abortion ban impacts in Idaho and Louisiana.

¹³ Daniel Grossman, et al., "Care Post-Roe: Documenting cases of poor-quality care since the *Dobbs* decision," University of California San Francisco, May 2023,

<https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf>.

¹⁴ "HELLP Syndrome," Yale Medicine, accessed March 13, 2024,

<https://www.yalemedicine.org/conditions/hellp-syndrome#:~:text=Up%20to%2024%25%20of%20pregnant,arise%20during%20labor%20and%20deliver%20the%20fetus%20and%20the%20placenta,or%20if%20the%20fetus%20is%20pre-viable,abortion.>

involving a patient from Idaho who was received at their academic medical center in Oregon.¹⁵ The patient was pregnant with twins at 18 weeks' gestation. The patient initially presented at an Idaho hospital with abdominal pain and was diagnosed with HELLP syndrome. In this case, the patient already had a history of renal issues and although she had a renal transplant previously, at baseline she still had impaired renal function. As the physician described the case, the patient went to the emergency department of a hospital in Idaho and *"different hospital settings in Idaho without them providing the necessary termination, which is the appropriate treatment. And then she was diagnosed with demise of one of the fetuses still inside her and had pretty significant lab abnormalities, high LFTs.¹⁶ There were signs of hemolysis,¹⁷ all the things that come with HELLP syndrome. She had worsening renal function. So, the patient herself was pretty sick. And then she ultimately got transferred to us and even the transfer itself took time, with a delay of even more hours. So, it took time as she came by air, as they were figuring out the logistics of what they could and couldn't do."*

The physician in Oregon recounted the physical and emotional state of the woman when their health center received her. Besides the patient having severe anemia from blood loss due to her dangerously low platelets and worsening renal function:

When she got to us, she was on magnesium, but because her creatinine had worsened in that interim period, she came with [toxicity from the magnesium given to delay delivery] She was somnolent¹⁸ with altered mental status [from being given supra-therapeutic amounts of magnesium that did not account for her worsening renal function]. She was in a terrible state. So, I was the overnight person and started the process, [the] cervical preparation, so she could have the procedure first thing in the morning. It can take a while to prepare the cervix. And in the morning, when the morning team came, the second fetus had demised.

Anyway, she was young and the whole thing was incredibly traumatic for her. After we removed the two dead fetuses, she had to stay with us for a while. After all this we had to coordinate transport back afterwards, after she had not gotten appropriate treatment for a long time and was in a terrible state, and the fetuses died even though no Idaho hospital would terminate, and was with us [hospitalized] for a while just to make sure everything was trending back in the right direction, but then [she] had to drive, like, several hours back home.

The physician stated that if the patient had initially presented to their medical center in Oregon, they would have recommended immediate termination at the outset:

So, given her gestational age of 18 weeks, in Oregon the earliest we would try to deliver and resuscitate is 21 weeks. If she had presented to us with the lab values that she had, and then just having pretty bad baseline renal function and her already having transplant graft rejection and the possibility of that sort of worsening, we would have recommended termination at that point, which she was amenable to. She had said she had told the doctors in Idaho that she wanted them to do whatever they had to, including termination, as she was so scared, especially after the first fetus died. It was her understanding that they just felt they couldn't terminate, and that ultimately was the reason she went to wherever she went and they

¹⁵ Citations for Idaho interviews will be updated once the stories are published.

¹⁶ LFTs refers to liver function tests.

¹⁷ Hemolysis means an accelerated rate of red blood cell destruction.

¹⁸ Somnolent is defined as a state of drowsiness.

hospitalized her, but they just watched her again. They sent her to us because they did not want to terminate.

In discussing her horror about the high risk of severe health harms and even death that this pregnant patient faced by her physicians in Idaho fearing legal consequences if they provided the standard of care for HELLP, the physician in Oregon reiterated: *She would be a patient that we would not sit on, not for an hour let alone up to 24 hours. We would pretty quickly get things going, because sort of, regardless of the mode of termination, it will take some time for the cervix to dilate. And the faster that you can get, like, mifepristone on board or dilators in place or start the induction process, the better for somebody in her situation.*

Preterm Premature Rupture of Membranes

The most common condition that physicians described difficulties in treating under Idaho state abortion bans is preterm premature rupture of membranes. PPRM is when the amniotic membrane surrounding the fetus ruptures before the 37th week of pregnancy. In 50 percent of patients, delivery occurs within one week.¹⁹ A major risk of PPRM is the development of a serious infection of the placental tissues called chorioamnionitis. While antibiotics are given to treat, the definitive treatment is delivery, or if preivable, abortion. This is particularly problematic, as noted by a physician in Utah who discussed the patients they had been receiving from Idaho and other states with abortion bans:

So, in my experience and in the experience of most of my colleagues as well, we're seeing an increase in the delay of care and inappropriate management of women who have been diagnosed with pre viable PPRM, because it is a condition that is particularly, I think, prone to influence in care based on legislation. So, there is still a fetus with cardiac activity. Often the morbidity that results from pre viable PPRM is one that doesn't necessarily develop right away but can develop very quickly after its diagnosis. So, the American College of Obstetricians and Gynecologists recommend offering, and actually recommend, termination of pregnancy for women who are diagnosed with pre viable PPRM, because the rates of morbidity can be very high, up to that 60 percent for folks who are diagnosed prior to viability.

An ob-gyn practicing in a state near Idaho described a PPRM case she had treated in her hospital:

This is a woman who, this was her first pregnancy. She was in her mid 20s. She lived in Idaho. She had initially presented to a hospital in Idaho that was not a tertiary care center when she had ruptured membranes. So she had noticed loss of fluid at about 18 weeks and went into her local hospital where she was diagnosed with preivable PPRM. So they had done a test that confirmed that the fluid was amniotic fluid. There's actually no documentation about whether or not she was counseled about different options at that point. She was sent home for expectant management, which is something that, in terms of clinical care, can be offered, but it should always be done in the setting of counseling around other options and the recommendation for termination of pregnancy. Three days later, she actually called her local midwife because she was starting to feel ill. So she was starting to have some symptoms of infection, [the midwife] recommended she go to a large hospital in the area. She presented

¹⁹ "Prelabor Rupture of Membranes: ACOG Practice Bulletin, Number 217," *Obstetrics & Gynecology* 135, No. 3 (March 2020): e80-97, <https://pubmed.ncbi.nlm.nih.gov/32080050/>; Brian M. Mercer, "Preterm premature rupture of the membranes," *Obstetrics & Gynecology* 101, No. 1 (January 2003): 178-193, <https://pubmed.ncbi.nlm.nih.gov/12517665/>.

there, where she was diagnosed with sepsis. So she had elevated white count, she was tachycardic, she was febrile to 101 and was clinically unwell, appearing. So sepsis in the setting of previable PPROM is a medical emergency does require evacuation of the uterus and iv antibiotics, which is something that I know for a fact this hospital that she presented to has the capacity to perform, and instead she got transferred to Utah, predominantly because of Utah state law. So she was transferred to us via vic swing, came to our labor and delivery, where she remained septic. She did deliver pretty rapidly thereafter, and her postpartum course was complicated by both a postpartum hemorrhage requiring an emergency surgery in order to remove her retained products of conception. She was also persistently hypotensive in the postpartum period, requiring multiple blood products as well as multiple rounds of antibiotics. She did, fortunately, avoid needing an ICU admission, but she was pretty close to that. And I do think that the delay in care, potentially from her original presentation, but certainly from the transport, contributed to the morbidity that she experienced postpartum. So she was with us for about four days and then went back to Idaho, where she had ongoing care from her team. And I don't know how she's done sort of subsequently because we don't have access to those records.

The other PPROM case that I was mentioning is a patient who was transferred in septic shock and ended up having kidney failure, requiring dialysis for about six months after her delivery. So we are seeing those sorts of morbidities as well.

Physicians who spoke with PHR noted that PPROM was one of the major challenges for emergency medical care. One Idaho physician stated:

I think the biggest challenge that we've had clinically is for a situation called pre viable preterm rupture of membranes, or PPROM, that has been really difficult because our national standard of care is that if a woman's water breaks prior to the gestational age of viability, that we include offer of immediate delivery as a treatment option after counseling the patient carefully as to the baby's prognosis. And with the change in Idaho law, there's been a lot of questions as to what we are allowed to do. We do know that women with pre viable PPROM can go on to develop infection, hemorrhage, and even death. So, we're worried about waiting for them to develop a sign of an additional complication besides their water breaking before we offer them immediate delivery. The EMTALA injunction we had was quite helpful because Secretary Becerra, I think it was in the late April or early May of 2023, provided clarification through the Department of Health and Human Services that pre viable PPROM was, in fact, considered an emergency medical condition and gave us clarity there. But now, 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 it's life threatening and offer her the national standard of care?

Another Idaho physician described having to wait until a patient with PPROM developed chorioamnionitis before being able to treat the patient under the state's abortion ban.²⁰ This physician noted the devastating consequences of not being able to provide standard medical care to patients. In this case, an abortion could not be provided to the patient before complications like chorioamnionitis developed during preterm labor.

[The patient] was a political refugee who had undergone significant sexual abuse in her home country and had immigrated here, who went into preterm labor with her water breaking

²⁰ Chorioamnionitis refers to acute inflammation of the membranes of the placenta, typically due to bacterial infection after rupture of the membranes.

Here we've got a baby in the vagina who can't completely be delivered and a mom that won't push, who's been sexually abused. And we can't do anything to augment this patient before the patient gets chorioamnionitis, gets sick and potentially septic. And the reason that sepsis in these patients has been so low is because we've been treating them the right way for so many years. Infection rates of 30 percent to 60 percent, depending on which article you want to look at. Here's a lady with significant issues. We have language barriers, and unfortunately, we can't do the right thing to treat her, one from a psychosocial aspect or, and from a medical aspect.

While abortion in the case of rape is allowed in Idaho as an exception during the first trimester, this patient was seen after 20 weeks (the start of preterm labor), and thus unable to legally access abortion care. Additionally, this history of sexual abuse complicated medical care, with care options already limited by Idaho's abortion restrictions.

A maternal-fetal medicine specialist whom PHR interviewed had practiced medicine in Idaho for 10 years before leaving the state following the imposition of the abortion bans. This specialist described clinical situations where, without EMTALA protections, physicians could not provide emergency medical care for pregnant patients in Idaho:

The most common situations are patients who come into the ED, their water is broken early, and they have sepsis, or they have a bad infection in their uterus, which, of course, can lead to hemorrhage, it can lead to loss of their uterus, loss of their fertility. If they're in septic shock, that's incredibly dangerous to them. That can have long term implications and death We had patients where they come in and they are bleeding so heavily that you need to go immediately to an operating room to provide the treatment, which may be like a D&C or a D&E to stop their uterus from bleeding while you're treating them for their hypovolemic shock or massive transfusion protocol or whatever. So those are the treatments that you need to do. And I think my other patients, which is more rare, but certainly comes up, are those patients that have really early onset preeclampsia or HELLP syndrome. And the other aspect of that, not only are they really sick, and it's very dangerous to them, preeclampsia, right, like stroke, seizure, liver damage, kidney failure, bleeding, complications.

I mean, there's so many things that can happen with preeclampsia. 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. And so those, to me, are the big three. 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.

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.

Waiting until patients become sicker (delays/denials of care)

Physicians 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. One physician in Idaho said:

So, I think in most of those cases, this perseveration we're having about it 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, because we've been lucky so far and nobody's died. But I'm sure other physicians have shared with you, too, the way medicine works. We don't typically watch a patient get sicker and sicker until we intervene. Good medicine means offering treatment when we find sickness. And in this situation, we're forced to watch a sickness until it becomes worse before we're offering the appropriate medical intervention. So, I worry that a patient's going to become septic, that I'm not going to intervene in time to save her life. And that makes it really hard to practice in Idaho and makes me worry every time I get one of these cases.

Fetal conditions can result in maternal health risks and morbidities such as a condition called mirror syndrome, where pregnant person develops symptoms such as preeclampsia. An ob-gyn practicing in a state near Idaho described a case of a pregnant woman who developed severe symptoms from a fatal fetal anomaly:

Triploid? Again, I'll just do a little bit of summary into the medical, the medicine behind it. So triploid is a type of fetal anomaly where there are three copies of the entire genome. So entire genome is copied three times. So it is a lethal diagnosis. It is not compatible with life. And from a maternal perspective, it is associated with significantly increased risks of morbidity in pregnancy. So it is associated with early onset preeclampsia. It is associated with postpartum hemorrhage. It is associated with preterm labor and other severe maternal morbidities. In addition, there's something called Mirror syndrome, where you can have essentially maternal response to preeclampsia, which is life threatening. So she had been diagnosed with triploid on genetic testing in Idaho and was counseled about options in the recommendation for termination of pregnancy. However, because of Idaho, law, was unable to receive it there. So she was referred by her providers to us for care, and we helped arrange for her to come to Utah for her to get her cervical prep, and she had elected a dilation evacuation, so she had one there. She did not have maternal morbidity, but the part that was really hard for her is that her insurance didn't cover her care. So all of this was out of pocket. And it was very difficult to explain to her why she wasn't able to receive the care that she was needing, especially in the context of she had been told appropriately about these risks for morbidity and the sort of futility of continuing the pregnancy.

A general ob-gyn described the incompatibility of EMTALA and the Idaho laws—and the medical impossibility of knowing when a patient's death was so imminent that they would be allowed to act:

The Idaho laws says you can act to save the life of the mother but there is no health exception. And that's the friction with EMTALA. EMTALA compels us to protect organ function. EMTALA should protect us, compels us to take action, it's not a guideline. It's like you have to stabilize the patient and provide care that protects their organ function, that protects their organs. Whereas in Idaho, no, you can only act to prevent their death. But how close, how close to death do they need to be? Are we doing CPR or where's the line? Anyone in medicine knows how

ridiculous it is to think that, oh, well, when they're within 2 hours of death, you can proceed. Nobody knows. How can you tell? This isn't how we practice medicine. In ob-gyn we're taking care often of very healthy people who will compensate for a while. Compensate, compensate, compensate. But then by the time their vitals are looking abnormal, they're about to die. You have used all their reserves. You don't have any time anymore. So, this nebulous language and the laws of, like, prevent the death, what does that mean? Like, nobody knows.

Physicians noted that Idaho's laws lack language that allows for protecting health and this has resulted in uncertainties about when physicians could intervene to provide the necessary care to their patients. By contrast, under EMTALA, physicians would be protected in their ability to intervene earlier and prevent patients from developing pregnancy complications. An Idaho physician described this problem in terms of a recent patient, saying:

I mean, with cervical insufficiency, for example, if somebody has a bag of water sitting in their vagina and fetal parts already in the vagina, we are thinking that's an inevitable abortion. The patient under EMTALA, I think, would be considered potentially in labor having a miscarriage. And I think we're provided at least more legal security in making those decisions that wouldn't be something that resulted in a felony charge for the physician. And now it's unclear. And I know our state's attorney general, his office has at least made some comments about, we don't have to be certain that it can result in maternal death, but they're not really adequately addressing this question of maternal health. Can I say that situation is likely to cause harm to maternal health? Yes, absolutely, I can. Is that situation going to cause her death? Well, if it progressed far enough and if she developed an infection, became septic, certainly it could. But there's just these gray areas in medicine where when the consequence is potentially five years in prison and as a felony charge, physicians want more certainty when making that call. I mean, they've just hung such a heavy consequence around our necks when we're making this decision that it is causing delays in decision making. And then no matter what decision we make, we're in a bad position, because I think if we proceed with delivery, we worry about this risk for a felony charge. And if we don't, if we have delay and we don't take care of a patient in the way that's consistent with the national standards, then we worry that we've made a decision that's self-protective rather than in the best interest of the patient. And that also causes great moral distress for us as physicians. Well, for me personally, I should say.

The uncertainty of how medical practice translates into compliance with Idaho's state abortion restrictions means that physicians have different interpretations about when they are allowed to treat patients, and the resulting confusion equates to delays in care. One physician shared the following experience:

I remember one patient that came in with like a 14- or 15-week PPRM (rupture of membranes) and kind of kept her in OBs and EMTALA status, but she was still pretty clinically stable at that point. And there was still cardiac activity. So actually, even though when it eventually went through the hospital ethics committee, they were like, yes, this is appropriate to go ahead and start an induction. When she first came initially, it was like, okay, we're going to wait and see if cardiac activity goes away. And then the next OB-hospitalist that came on and was like, oh, maybe we should just send you out of state right now. You're kind of stable. Maybe we should just discharge you and have you drive and leave. And then the next one that came on was like, no, hold on. So, it took like a couple of days before we were able to really start anything. And the patient was just told this and then this. Even with general hospital guidance, every case felt like there was a lot of uncertainty, like where that line really was.

A physician in a neighboring state also noted a case where fears of clinicians in Idaho impacted diagnosis as well as treatment of patients, and that some patients might be inappropriately transferred because some of the experts capable of caring for them have left the state.

One case was a patient who was being told she had what's called a heterotopic pregnancy, which is a pregnancy in the uterus and a pregnancy not in the uterus, and that the second pregnancy was in her cornua, which is sort of that space between the tube and the uterus. And if it grows, then it can cause the uterus to rupture and can have catastrophic bleeding. And she was told, we can't handle this here. We can't do anything about this. Go find, you know, go someplace else. And then she was also told, you know, don't be more than 30 minutes from a hospital. And so, she, first of all, was just extremely confused and scared out of her mind and had gotten very conflicting advice. And I think her fears were heightened by the fears of her clinicians around whether or not they could treat her - because she actually didn't end up having a heterotopic pregnancy. So, I think that all got problematic because of physician fear [and] the person who was told she had a heterotopic pregnancy and didn't, is that because experts have moved out of state and so they no longer have people who can appropriately interpret that? Or, like, even the radiologists are so worried about getting it wrong that they're, like, calling it a heterotopic when it was a fibroid or there were a number of things that were confusing about that to us because it didn't all hang together.

Transferring patients out of state due to Idaho's abortion ban cause unnecessary delays of care and increase patient morbidity

When patients are deemed unable to receive treatment under state abortion laws, physicians often decide to transfer patients to states without or with less abortion restrictions. A physician in Idaho discussed trying to decide when to transfer patients out of state:

Well, since the law has changed again, I think there's been a lot further discussion ... about who do we transfer out of state for care. And I think that has made me very uncomfortable because it is never simple. For example, if we have a patient whose water is broken, but she's already dilated, but she's not infected, but she's had many other babies before. If she starts to go into labor, she could deliver very quickly. So, do I have enough time to get her to Salt Lake City or no? We are a large rural state, and we are surrounded by rural parts of other states. So, to get a patient to a city with a big medical center that would be capable and have adequate resources to take care of the complications that come along with some of these pregnancy emergencies means potentially six hours of transport. Even if we fly the patient, it takes some time to get that helicopter coordinated, get the accepting physician in order. We have complications regarding weather, fire. There are a lot of issues with air transport, and ground transport makes me even more nervous because patients are traversing hundreds of miles with minimal medical resources. So, to think about a patient in that scenario who may appear stable at the moment, getting on an airplane or getting in a car, she could go into labor, start bleeding, have the baby en route and be hemorrhaging and become quickly unstable. So those transport decisions are not easy.²¹

²¹ Abruptio placentae (placental abruption) complicates 2–5 percent of PPRM pregnancies and can increase the risk of hemorrhage. See “Prelabor Rupture of Membranes,” *Obstetrics & Gynecology*.

Transferring patients across state lines is complicated, with logistical issues such as arranging air transport. Transferring patients also creates additional costs for patients and takes patients away from their social support systems. Another physician from Idaho said:

It's one thing to say you're going to transfer people out of state for care, but it's another thing to have the patient leave family support groups and then the expense. There's some risk of putting somebody on a jet and flying them for 5 hours. And one of our transports recently took 8 hours to get somebody to Salt Lake City because the weather wasn't great. They didn't have a pilot So, are you going to do medical malpractice, potentially, and say, this patient's really stable, which is going to be questionable, especially in the court of law, or do you want to get arrested for trying to do the right thing for the patient?

And I know of a hospital [in Idaho] that literally sent somebody out, flew them out of state because they were afraid early on with a severe preeclamptic that she was going to go into renal failure, and they couldn't treat. They could treat the renal failure, but they couldn't treat the cause of it [the pregnancy], which is why they were doing that. And the expense of that – the whole thing is obscene that I'm going to fly somebody out of state. The cost, the emotional things. I mean, you're just adding trauma to trauma. It's bad enough you have to lose your child, and then you compound it with this. Yeah, it's cruel. Our hospital is more likely to try to be sympathetic to the patients and the emotional stress that they're going through and the trauma they're going through. But that's not been the case. One of the other hospitals in the system flies people out almost immediately.

Physicians seeing patients from Idaho described the increased health complications they are observing, which would not need to be incurred if patients were treated in Idaho under EMTALA. A physician in Utah described the following case, where they received a patient who had been transferred to their facility from Idaho and the journey amounted to a prolonged risk of stroke:

We're also seeing women with previable preeclampsia or HELLP syndrome who are coming via transfer. And this is where the question of clinical stability is so tricky. It's something that we think a lot about, which is, what constitutes stability sufficient for transfer? What constitutes stability sufficient for instability, sufficient for sort of overriding these laws in the state that you're at? We had a previable preeclampsia patient transferred to us with platelets of 40 who had blood pressures that were requiring constant IV administration of antihypertensives. And, yes, we can run antihypertensives in an airplane, but she didn't need to do that. If she had her care wherever she was coming from, she wouldn't have needed to be persistently on IV antihypertensive. She didn't have to have that prolonged risk of stroke, and she probably would have delivered with more platelets than she did.

Patients presenting with symptoms that were not yet life-threatening in Idaho experienced worsening symptoms during transport. A physician in Washington State described one such case where a patient who was not in an immediate life-threatening situation before transfer, developed sepsis after arriving at their hospital: *"There was another one who had kind of a similar thing with twins that had both demised. And this may just be like, there was nobody who could do that procedure in Idaho. And I don't recall how she was referred or if she just showed up and she actually ended up having sepsis, and she ultimately did fine, but was quite sick. [When she was transferred, sepsis] was, like, brewing, maybe, but not florid. She wasn't, like, super sick. But there were some signs of concern."*

Physicians receiving patients from Idaho also noted how multiple factors in transferring patients from other states had compounding harms on patient care, including health risks from delays, increased costs which may or may not be covered by insurance, confusion and logistical hurdles of the process of transfer, and increased emotional trauma. A physician in Washington seeing Idaho patients noted that all of the factors in transferring a patient added up to an increased burden on the patients:

It's just like anytime you're transferring, you're adding so many different risks, and there's a couple sets of mountains in between if they have to come all the way to Seattle. There's so many things that can delay transfers, that can delay care, and even when it's timely, it's still a delay if you're getting to another state, it's not appropriate to make patients have to go away from their doctors and the care that they know, the family that can support them and be alone or with maybe one support person miles and miles away. And then the cost for patients to potentially have to pay for a long ambulance to get over to another state and then stay there, recovery time, get themselves back, is just such a huge hurdle and burden. That is a big concern. And then I think patient confusion driving further, putting more cost or burden on themselves than they didn't necessarily have to.

A physician in Oregon, describing the aforementioned Idaho patient who needed to be transferred out of state to receive treatment for PPROM complicated by renal disease, discussed how the process of transfer meant that the patient's care would be delayed:

[The case] was like twins with ruptured membranes. And also, she had renal disease that was quite serious, and she was starting to get infected and compromise her kidney. She was transferred from Idaho to us, and the transfer took a while, as it does, because even by plane, it takes a little while to get that going. And by the time she got here, she wasn't prepped to be able to have a procedure right away. So, we had to do that prep. That took some time. By the time [of] her procedure, the second twin had already died, and then she needed to go to the ICU because she was really sick. So, the implication for this particular twin patient was that the second twin was going to die. Everyone knew that except her. That it was going to be soon, that she was probably going to have that happen before she got settled in the new location, that it would take more than 24 hours to get her settled before she could actually undergo the next step, and that in that time she was at risk for infection, she was at risk for losing her transplanted kidney, and that she would incur thousands of bazillions of dollars because her insurance wouldn't cover it, because she was out of state, out of network. And I think nobody puts those costs or the fact that she wasn't even with her family and she was hours away.

While this process of formally transferring care caused inherent delays for patients, some patients were not waiting to be formally referred; rather, they were traveling to states without abortion bans like Washington or Oregon and simply presenting at hospital emergency rooms. A physician in Oregon said:

I think because some of these are not really formal referrals or transfers of care, some of these patients are like transporting themselves, sometimes driving far distances, etcetera, and there's an opportunity for them to get pretty sick along the way. So far, we haven't had anybody die en route. But that's a real concern. I think I worry also just about the delays. So, if there isn't a formal referral process, then it's just going to take longer potentially for patients to get into care somewhere. And whether they need an abortion or not, that can create challenges. We certainly are seeing globally a later gestational age at presentation for patients seeking abortion, but it

could have negative impacts on delayed care for even a pregnancy where they desire continuation.

Not having a formal referral from the hospital that a patient was seen at in Idaho means that care is often delayed as tests are repeated that may have already been done at the previous hospital. This intervening time also means increased health risks for patients while waiting for tests to be taken and results to come in and increased costs of duplicate testing. A physician in Oregon said:

One of the biggest deals, I don't know if you're aware, but when you have a referral, it allows you to get the records, right? If you don't have a referral, it's incumbent on the patient to send you the records. And we can't just cold call patients. They have to call us. And so, it creates this problem of getting even the genetic counseling information, so many times there's a major cardiac anomaly identified, and then we have to repeat everything because we couldn't get all of the assessments to know what had been done already, and so that incurs extra cost to the patient.

Disproportionately affected patient populations

Physicians also described how the disproportionate costs to patients were not fully being accounted for in the decisions to transfer patients. A physician in Oregon discussed how costs of and care for the patient were the sending hospital's responsibility until the transfer was complete. However, patient preference might not get taken into this decision in terms of where they were being transferred to. This physician was concerned about the unintended, associated costs of a transfer, where people's families might not be able to travel to this location for support during the procedure and recovery period:

I think the other thing to stress, which is in EMTALA to some degree, but doesn't really quite get stressed with hospital to hospital transfers very much, is that it is well known among those of us receiving the transfer that the initiating hospital is responsible for the patient's health and welfare until they are accepted in our hands and they have to incur that cost and et cetera. If there was some measure of increased cost to the patient included in that would be useful as well as having her family travel also, because where you send the patient to is your choice. So, it's like here, I'm going to just take this patient and I'm going to do this punitive thing to you, which is send you a whole 500 miles away to where I think is good for you but isn't actually the closest place where you could get care.

Additionally, physicians discussed how patients belonging to marginalized populations were disproportionately impacted by abortion restrictions, and these harms were exponentially felt by those who needed to be transferred out of state. One Idaho physician said:

And we have a special population in Boise. I don't know if anybody's talked to you about it, but it is a refugee resettlement center, so a large number of the patients that we care for don't speak English as their primary language. So that adds just an extra layer of complication. I also know that there have been patients in our state who have been transferred out of state for previsible delivery and then end up getting large bills and denials from their insurance companies to cover that mean it's exceedingly complicated. [We need to] know the burdens we're putting on pregnant women in the state of Idaho right now as a result of our law.

Health care workers are experiencing moral distress, and many are leaving Idaho

Physicians described experiencing moral distress due to Idaho's abortion restrictions as they attempt to provide their patients with standard medical care during pregnancy. A maternal fetal medicine (MFM) specialist who had practice partners leave the state in part or wholly because of Idaho's abortion laws said:

When the law was passed, everybody, even my genetic counselor, was afraid to give people a paper with just sites for pregnancy termination, for lethal anomalies, for fear of getting arrested. So, the anxiety was palpable in these offices. So, it's hard enough doing what we do. But to add this on top of it, you've seen people's mental health as physicians and staff just deteriorate over the last year, and certainly I'm burned out, and that's a big component of it.

The psychological trauma to the team and its care of people should not be underestimated. People don't sleep at night. They're afraid to come to work. EMTALA really protected people, and everybody felt better. But once that was removed, and when the attorney general got the removal of EMTALA protection, everything changed in a severe way, and it's really hurt people's lives, nursing staff in particular, and the physicians. It's so unacceptable.

This moral distress has resulted in burnout and in physicians leaving the state. A general ob-gyn, who left Idaho six months ago because of the abortion laws, described ways she had experienced moral distress practicing in Idaho:

And that's the thing. And that's what I mean about it's a ticking time bomb. It's like you're screwed no matter what. If you act and you help somebody, which then the prosecutor decides was too soon, they weren't close enough to death, then you're in hot water. If you allow things to progress before you take care of them yourself or before you're able to get them somewhere else or they become unstable en route to another state, you have to live with that. You have to live with how you participated in the harm. When you knew better. So again, for the people who are still there and what terrified me, it was not a matter of when am I going to be in the crosshairs? It will happen. It's just a matter of time.

And why would I, as a mom, allow my kids to have the potential that one or both parents could end up facing felony charges for providing health care like that. We would be thinking, we need to call a lawyer before we do what we trained for years to mean. How can you practice? Like, again, like, you're going to have to live with your own choices. And none of this is promoting the health of our patients.

Workforce impacts of physicians leaving Idaho

According to an MFM specialist, who left Idaho because of its harsh post-*Dobbs* abortion bans and now practices in a state without abortion restrictions, in the whole state of Idaho there had been nine MFM specialists before *Dobbs*, including her. After *Dobbs*, she and four other MFM specialists have since left the state. She had provided care at an urban hospital where they frequently cared for pregnant patients who came to their ED or were transferred from all over the state facing medical emergencies. She explained that the weight of not being able to provide all medically indicated care in those situations “*was just so much. And I couldn't sleep at night I would worry about these patients that I had treated, and you knew it wasn't like if, but when they're going to come in and just like, what are we going to do? And so it was just so overwhelming. And so, I left because I was like, this is not a place I can continue to work and live in.*”

Ten general ob-gyns in the panhandle region of Idaho have left or resigned since 2022.²² In a study, one clinician said, “pitting my own livelihood against patient well-being, that was not a situation I was willing to be in anymore.”²³ Valor Health, another Idaho hospital, also announced it was discontinuing labor and delivery services because of staff shortages in March 2023, and stopped providing care in June 2023.²⁴ Jim Souza, the chief physician executive at St. Luke’s Medical Center in Boise, Idaho, said, “We’re at the beginning of the collapse of an entire system of care.”²⁵

Currently, 13 of Idaho’s 44 counties are considered “maternity care deserts,” areas where “access to maternity care services is limited or absent, either through lack of services or barriers to a woman’s ability to access that care within counties.”²⁶ Sandpoint, Idaho is not yet considered one because of the presence of a birth center and local midwives. But Idaho’s ban has nonetheless had a significant impact on maternity care there. The city previously had a maternity ward at Bonner General Health, the local hospital, that delivered hundreds of babies yearly. The ward shuttered in March 2023, however, citing Idaho’s “legal and political climate.”²⁷ All four ob-gyns that practiced at Bonner General left Idaho to practice in states where abortion is legal.²⁸ Sandpoint had been a medical hub for a rural region of 50,000 in north Idaho, Montana, and Washington. Hospital-based pregnancy care in town is no longer an option. Krista Haller, a therapist who specializes in working with pregnant people and new parents, said of the bans *“It’s about the medical rights that women have – that’s really what comes up. Women are feeling very scared about the care they’re going to get. They’re unsure about their medical care and whether they can trust the medical system.”*²⁹

²² Abigail Abrams, “It’s demoralizing’: Idaho abortion ban takes toll on medical providers,” *The Guardian*, July 16, 2023, <https://www.theguardian.com/us-news/2023/jul/16/idaho-abortion-ban-ob-gyn-doctors>.

²³ Erika L. Sabbath, et al., “US Obstetrician-Gynecologists’ Perceived Impacts of Post-Dobbs v Jackson State Abortion Bans,” *JAMA Network Open* 7, No. 1 (2024): e2352109. doi:10.1001/jamanetworkopen.2023.52109.

²⁴ Staci Carr, “Discontinuation of Labor and Delivery Services,” Valor Health, accessed March 13, 2024, <https://www.valorhealth.org/discontinuation-of-labor-delivery-services/>.

²⁵ Randi Kaye, “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>.

²⁶ “Where You Live Matters: Maternity Care in Idaho,” March of Dimes, 2023,

<https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Idaho.pdf>.

²⁷ Sharon Zhang, “Idaho Hospital Will Stop Delivering Babies as Providers Flee After Abortion Bans,” *Truthout*, March 21, 2023, <https://truthout.org/articles/idaho-hospital-will-stop-delivering-babies-as-providers-flee-after-abortion-bans/>; Danielle Campoamor, “Idaho hospital closes its maternity ward, citing the state’s ‘political climate,’” *TODAY*, March 22, 2023, <https://www.today.com/parents/pregnancy/idahos-bonner-general-hospital-closes-maternity-ward-rcna75776>.

²⁸ Julianne McShane, “Pregnant with no OB-GYNs around: In Idaho, maternity care became a casualty of its abortion ban,” *NBC*, Sept. 30, 2023, <https://www.nbcnews.com/health/womens-health/pregnant-women-struggle-find-care-idaho-abortion-ban-rcna117876>.

²⁹ Kathleen McLaughlin, “No OB-GYNs left in town: what came after Idaho’s assault on abortion,” *The Guardian*, August 22, 2023, <https://www.theguardian.com/us-news/2023/aug/22/abortion-idaho-women-rights-healthcare>; Gloria Oladipo, “Idaho hospital to stop delivering babies as doctors flee over abortion ban,” *The Guardian*, March 20, 2023, <https://www.theguardian.com/us-news/2023/mar/20/idaho-bonner-hospital-baby-delivery-abortion-ban>.

In rural counties without access to maternal health care, women are more likely to face negative health consequences, including a higher risk of preterm birth,³⁰ which is associated with asthma, hearing loss, intellectual disabilities, and other lifelong impacts for children. An analysis published in 2019 found that rural residents had a 9 percent greater chance of maternal morbidity and mortality compared to urban residents, in part because of limited access and longer travel times to obstetrics care. Women of color had at least 33 percent higher odds of those negative outcomes than white women regardless of where they lived, according to the research.³¹

A physician in Idaho said that it was clear that Idaho's abortion restrictions were causing physicians to leave the state:

I think that our attorney general's stance and our legislative stance that this state law is clear enough is not what I'm experiencing in practice. And I do think that the stress and lack of clarity is causing my colleagues to leave. That was another thing I've seen in a communication by the attorney general that they don't think there's any empiric evidence that people are leaving for this reason. And the OBs in Idaho that have left are ones who did elective abortions, and that is false. We had a maternal fetal medicine colleague that left here at our Catholic health system to go to a nonrestrictive state to also work in a Catholic health system who did not have elective termination as part of her practice. And yet the stress of providing obstetric care in our state under these circumstances was really contributory to her decision because it was quite stressful. And she left along with her husband, who is a non-obstetric physician. I have considered leaving. Ultimately, I've decided that this is my home. I've worked here for 10 years. I really care about my patients. Our patient population deserves to have obstetricians, but I can't work here and not speak out about this.

This same physician also pointed out that recruitment of physicians to Idaho has been impacted by state abortion restrictions, saying:

I would say the other parallel impact has been on recruiting because physicians, we do not have an ob-gyn program and residency program in Idaho, so we do have to recruit from out of state because we don't have those services here. And my group has been short now for 20 months. We have been short staffed, and the last interview we had was in 2022. I have not had somebody to interview for the open position in my group in that long. It's just the recruiting is drying up.

One MFM specialist who had left Idaho when asked if there was any level of support her health care system could provide under the current bans that would make her feel she could return to the state to live and practice in a way consistent with best evidence-based medicine and ethical practice:

I think my short answer is no. I think there's just too many variables. Anytime you try to put legislation on top of medical care, things that are written by nonmedical personnel that don't

³⁰ Katy B. Kozhimannil, et al., "Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States," *JAMA Network* 319, No. 12 (March 27, 2018): 1239-1247, <https://jamanetwork.com/journals/jama/article-abstract/2674780>.

³¹ Katy B. Kozhimannil, et al., "Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007–15," *Health Affairs* 38, No. 12 (December 2019), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00805>.

understand your specialty or your world, it's impossible to know how they're going to interpret that because it's not based in medicine. So for me, I think if we could have had some more protections for the health of the patient, not just averting their death or fetal anomalies, like other things that where I think it would better. But at the end of the day, especially in certain states, there's this aggressive push that 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. My answer is no, because I think you worry. You worry all the time. Like, when are they going to try to come after me for this, despite all the documentation and all the support, legal support and all the things that we do on the front end, but you just don't know. 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.

The same doctor described how different it was now to practice in a state that protects abortion rights:

I'm thankful to be in a state where I can just care for patients the way that I always, you know, you don't realize what a weight you have on your shoulders, even though you're trying to do the best. But when you leave a state like Idaho and you're like, I can just go into this room and I can talk to this person and I can do the things I'm trained to do and offer evidence-based medicine, standard of care. And it's this freeing feeling, which is just so wrong. Why is that? The situation that we're in? So, it is really sad. We were happy there. And honestly, if this would have never come up, we would still be there, 100 percent, because I was very happy with my job, my colleagues, my community, children, and a partner.

Another general ob-gyn had practiced in a small town in rural Idaho for many years, but left the state with their spouse (an ED doctor) due to fear of providing emergency medical care under the abortion bans.

So, after the laws go into effect, [the regional center in Idaho where they usually would send more serious medical emergencies such as a patient with previable PPROM or HELLP] would not be able to manage these patients due to the Idaho law. So, you're going to have to get them out of the state. And then how are you safely going to do that? What if it's an ice storm? What if there's wind? No helicopters can go. It could be two hours or more. Plus, you have to wait for vehicles. We don't have that much EMS. So, what if they're out on a run headed toward western Montana and you don't have a crew and you don't have an ambulance?

[We knew] it was just a matter of time before something where there was some sort of crisis where you could not get the patient where they needed to be, and so you were going to have to provide care that is not okay according to Idaho law. And that's the thing, is to sit in that situation of just being like every time you're on call, like, okay, is this it? Is this the time? I can't live like that. How am I supposed to?

She further described what happened in her town right after she and her husband gave notice:

Well, get this. My husband and I gave our notice, and a week later, our critical access hospital announced its intention to close labor and delivery. So my partners who were planning to stay, and they knew that it would be very difficult to recruit, so they were like, oh, man. Now we're going to have to do the work of four with three of us, but we're going to dig in and do this. All of a sudden, their job imploded, and all of my partners are now practicing outside of Idaho. None of us

looked at jobs within Idaho. One of my partners had been practicing there for 14 years. Another for eight. One of my partners who had been there for eight years, built her forever home. They didn't intend to go anywhere, but her job was blown up. And so now everybody else is in a state without restrictions on health care. There are no ob or gynecological practices in our town now at all. [Patients] have to drive two hours to [XX, regional center.]

And then as the workforce dwindles, I mean, there's an estimate that just came out from Idaho Coalition for Safe Reproductive Health Care. There's an estimate that 40 to 60 ob-gyns left the state. Idaho is one of the states with the lowest per capita physicians before all of this business. So to lose 40 to 60 ob-gyns and all of that pressure that puts on the rest of the system, people will suffer. Families will suffer.

Conclusion: Health care workers need EMTALA protections to provide care under state abortion bans

Health care workers need protection from EMTALA in order to continue to provide the national standard of evidence-based medical care for their patients, without risking fear of criminal charges. Physicians who spoke with PHR described a marked difference between when the injunction was in place, allowing them to provide care under EMTALA, as compared with their experiences since the injunction has been lifted due to the pending U.S. Supreme Court case. An Idaho physician stated:

You know, we felt extremely comfortable taking patients, knowing that EMTALA and the federal government was supporting us in the practice of medicine. I mean, it was huge. We went from staff members being petrified to going, okay, now we can do our jobs again. This is great. Now we can take care of patients, we can prevent morbidity. So, they said abortion is not part of EMTALA, but emergency care is. And as a labor delivery unit, we are considered an emergency room, and we should not be hindered to provide care in emergency situations. And that is for the mother's health, because the last thing I want is my mother to go to the ICU and have complications because she's septic. And again, they'll go, well, the septic rates are really low. Well, yeah, that's because we treat people expediently, and if you don't, things aren't going to go the way you want them to. So, it means the world to us to have intelligent protection and allowing us to do the things that we train for and really protecting women and women's rights.

Knowing that there's a support system, if someone has a case, attempted to prosecute against them. And that was one of the things our hospital system was really hesitant, very reluctant to say that they would support us from a financial standpoint [if] we have been charged with a felony. And I've not seen it in writing, but I've heard it verbally from them. So, I think all of us, and there were some of us that did things that early on – we did the right thing, so to speak. And there were some of us going, I don't know what would happen if we got arrested under those circumstances, but it was kind of like, damn it, excuse the expression, we're going to do the right thing. But the pressures increased. Now everybody is on edge, and unfortunately, that edge doesn't leave. So, we really need that infallible protection. We really need defense protection if something does happen to us. (ID-009)

Another physician noted the need for EMTALA protections considering the uncertainty around what they are able to do medically under Idaho's abortion laws:

Yeah, I think it would be a sense of safety for both providers to be able to provide the standard of care and for patients to know that they are getting offered the standard of care and

not have information withheld because we're afraid or unsure how to act. And then just consistency for patients, the one that I remember so vividly, it was such a painful experience for her already to be going through this and then to be hearing multiple different things and wondering if she now needs to, in this very vulnerable state, be driving across state lines. I think being able to kind of know that everyone in the hospital has the same understanding of if this is what we would normally do, this is still what we can normally do, regardless of whether or not the patient is septic and actively crashing or just has that potential would be helpful. And then I think because Idaho, their law is so strict and their politicians are so utterly bonkers and have made all sorts of ridiculous claims about what will and won't count, that kind of knowing that we can continue to have EMTALA will be really important for that. Patient safety allowed under the Idaho law is going to be a lot harder. (ID-004)

PHR's interviews with physicians provide examples of how Idaho's abortion ban is delaying or preventing the treatment of patients with medical conditions that had been covered by EMTALA. Physicians in Idaho noted that since the injunction has been lifted, inappropriate and substandard care has been provided to patients, who they do not feel they can treat under the state's abortion bans without the protection of EMTALA. Hospitals are handling the risk of legal liability for their physicians differently, with some transferring patients immediately out of state for care and other hospitals waiting until patients develop complications that enable them to be treated under the narrow exception for abortions "necessary to prevent the death of the pregnant woman."³² These delays and denials of care result in increased maternal morbidity, as described throughout these narratives.

Additionally, some physicians who are finding themselves in situations where they are unable to provide the full spectrum of pregnancy care to their patients have left the state, with impacts on the health care and workforce in Idaho. Physicians discussed difficulties of recruiting and facilities being understaffed, drawing direct links between Idaho's abortion laws and the moral distress that they and their colleagues have experienced from being unable to provide immediate medical care to patients. Idaho's restrictive abortion laws are having an immediate impact on, and will potentially have long-term consequences for, Idaho's health care system, and for the state's residents who seek reproductive and pregnancy care, their partners, and their families.

In order to address these concerns, what is needed is a full decriminalization of abortion, including "removing abortion from all penal/criminal laws, not applying other criminal offences (for example, murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors."³³ Ensuring physicians and health care workers can provide evidence-based standard of care to all their pregnant patients is essential to patient-centered care, and a shared decision-making model that allows patients to make the best decision for their individual circumstances. However, in locations like Idaho where criminal penalties for abortion exist, physicians need protections like EMTALA in order to continue effectively treating patients in line with their medical ethics.

³² ID Code § 18-622 (2023).

³³ "Abortion Care Guideline," World Health Organization, March 8, 2022, <https://www.who.int/publications/i/item/9789240039483>.