UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **DECLARATION OF DR. AMELIA HUNTSBERGER**

DECLARATION OF DR. AMELIA HUNTSBERGER IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Amelia Huntsberger, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a board-certified Obstetrician-Gynecologist (Ob/Gyn) physician at Bonner General Health, a critical access hospital in Sandpoint, Idaho. Bonner General Health is a small, rural hospital that provides Labor and Delivery services. The nearest Neonatal Intensive Care Unit (NICU) is 45 miles from Sandpoint.

2. In 2008, I graduated from the University of Washington School of Medicine which is the regional medical school for Washington, Idaho, Wyoming, Montana and Alaska. I completed my residency in Obstetrics and Gynecology at the University of Michigan in Ann Arbor in 2012. I am board certified in General Obstetrics and Gynecology since 2015.

3. I was invited to join the Idaho Perinatal Project advisory board in 2018. Improving pregnancy outcomes by reducing maternal and infant morbidity

and mortality is the mission of the Idaho Perinatal Project. I am a member of the Idaho Maternal Mortality Review Committee. I am currently the Idaho Section Chair of the American College of Obstetricians & Gynecologists.

4. I moved to Sandpoint, Idaho in 2012 and began working as an Ob/Gyn at Bonner General Health.

5. I grew up in a rural area and feel patients in rural areas deserve high quality, compassionate health care just like patients in more populated areas. Serving a rural community has been my goal since I was a medical student.

6. I have reviewed declarations prepared by Kraig White, M.D., Tammy Reynolds, M.D., Richard Scott French, M.D., and Prosecuting Attorney Grant Loebs, which I understand were submitted by Idaho in this case. I submit this declaration in response. The facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

Abortion Is Sometimes Medically Necessary Even When It Is *Not* Necessary to Prevent the Mother's Death.

7. The physician declarations from Drs. White, Reynolds, and French seem to suggest that whenever abortion is medically necessary, it is necessary to prevent the mother's death. That is simply not the case.

8. At Bonner General Health, we do not perform purely "elective abortion." However, I have personally treated patients whose health condition requires abortion as stabilizing care—even if those patients were not necessarily facing death in the absence of an abortion.

9. A relatively common example of this is ectopic pregnancy. Not every patient with an ectopic pregnancy will die without an abortion. But terminating an ectopic pregnancy is the standard of care to prevent serious risks to the mother, including internal bleeding, injury to the fallopian tube or other organs in the abdominal cavity, impaired fertility, and in some cases, death.

10. I have reviewed the declaration of Dr. Reynolds stating that termination of ectopic pregnancy is not an abortion. While Dr. Reynolds may not consider the termination of ectopic pregnancy to be abortion, she does not acknowledge how Idaho law defines abortion. Unlike Dr. Reynolds, who practices in Las Vegas, Nevada, I practice medicine in Idaho. I have reviewed Idaho law and it defines abortion as "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child except that, for the purposes of this chapter, abortion shall not mean the use of an intrauterine device or birth control pill to inhibit or prevent ovulations, fertilization or the implantation of a fertilized ovum within the uterus." An ectopic pregnancy is a "clinically diagnosable pregnancy" even if the fetus is not viable, and Idaho law has no exceptions for lethal anomalies. There are various means to terminate an ectopic pregnancy, all of which are intended to cause the death of the fetus and all of which are performed with knowledge that they will cause the death of the fetus.

11. For example, I treated a patient in her mid-30s who presented to the hospital with spotting and pelvic pain. An ultrasound showed an ectopic pregnancy

with a fetal heartbeat. Free fluid, presumed to be blood, was seen on the pelvic ultrasound. I counseled the patient about the risks, benefits, and alternatives available to her and she elected and consented to undergo laparoscopy with removal of the ectopic pregnancy. At the time of surgery, there was 750 mL of blood in her abdomen despite normal blood pressure and pulse. A patient with stable vital signs like this one is experiencing a health emergency—her health is in "serious jeopardy" within the meaning of EMTALA. However, a patient with stable vital signs may not appear to be near death. If I had let her condition deteriorate before performing a life-saving abortion, however, she would have faced increased pain, risk of further hemorrhage inside the abdomen, anemia, possible development of disseminated intravascular coagulopathy (DIC), need for blood transfusion and other blood products. She also could have died had we waited too long and been unable to manage the complications that may have arisen. Ectopic pregnancy is a potentially life-threatening diagnosis. The timeline for it to develop into an acutely life-threatening condition is difficult to precisely predict, even for a medical expert. Stabilizing treatment with abortion as defined by Idaho law was necessary to prevent a life-threatening situation from evolving.

Waiting Until Abortion Is Necessary to Prevent the Patient's Death Will Cause Serious Harm.

12. With ectopic pregnancies and pregnancy of unknown location, waiting until an abortion is necessary to prevent death is harmful and dangerous. In some ectopic pregnancies and pregnancies of unknown location, treatment with methotrexate may be offered. Methotrexate is a chemotherapy drug used to kill

rapidly dividing cells (which therefore targets pregnancy). Methotrexate can be used 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" (the Idaho definition of abortion). If we must wait until a patient's death is imminent to terminate her ectopic pregnancy or pregnancy of unknown location, we can no longer use methotrexate and must provide surgical intervention. Surgical intervention carries its own risks, including potential loss of a fallopian tube, damage to nearby abdominal structures (like bladder, bowel, uterus, ovary, ureter and/or blood vessels), infection, bleeding and potential loss of the patient's ability to become pregnant naturally in the future.

13. I have personally treated patients who sadly experienced this outcome. One patient had the devastating experience of having both tubes removed for separate instances of ruptured ectopic pregnancy. As a result, she has no option for spontaneous pregnancy and would require in vitro fertilization (IVF) or adoption to grow her family. Appropriate use of methotrexate when the patient first presents with ectopic pregnancy, if successful (which it typically is), may avoid the need for surgical intervention and increase likelihood of successful future pregnancy. The total abortion ban will cause doctors to hesitate before using methotrexate, putting their patients' health and fertility at risk.

14. Another example shows the consequences of delaying an abortion. This patient was a female in her 40s with 3 living children who presented to the hospital via ambulance with heavy vaginal bleeding. She reported that she was

approximately 14 weeks gestation. She had been experiencing very heavy bleeding at home. She initially declined care including bloodwork, pelvic ultrasound and/or Ob/Gyn consultation in the ER. She was not unstable at this time, and I could not say an abortion was necessary at that time to prevent her death. However, she continued bleeding profusely in the ER until she was unable to stand due to hemorrhage causing symptomatic anemia. After a syncopal episode, she agreed to be seen by an Ob/Gyn and I was emergently called. She was pale and unable to sit up in bed due to her anemia at the time of my evaluation. She was bleeding heavily from the vagina making visualization during pelvic exam very difficult. I removed products of pregnancy from the open cervix in the ER, however, very brisk bleeding continued and she was counseled to undergo emergent D&C in the Operating Room (OR) for a second trimester incomplete abortion. I reviewed the risks, benefits and alternatives of D&C (dilation and curettage- a procedure to remove the products of pregnancy from the uterus) in addition to the risks, benefits and alternatives of blood transfusion and she consented to both. I took her to the OR for D&C. She was hypotensive and tachycardic; she was unstable at that time. She received 2 liters of IV fluids, transfusion of 3 units of packed red blood cells in the OR, another unit of packed red blood cells in the Recovery Room immediately following her surgical procedure. She received 2 units of fresh frozen plasma given her large volume blood loss. I had to order platelets from Spokane, Washington, which did not arrive until several hours later via taxi and were transfused into the patient. She stayed in the

hospital for 2 days. She received another transfusion of 2 units of blood for ongoing symptomatic anemia prior to her discharge home.

15. I provide these details regarding this patient's case because her case shows what can happen when we delay an abortion that would otherwise be the recommended medical intervention. In this case, the patient chose to delay the abortion but if Idaho Section 622 takes effect, physicians in Idaho will be forced to wait until the abortion is necessary to prevent death of the patient. Patients may experience serious complications, have negative impact on future fertility, require additional hospital resources including blood products, and some patients may die.

The Idaho Law Will Have Serious Negative Effects on Medical Care in Idaho.

16. While Drs. White, Reynolds and French suggest that the law is clear to them, it certainly is not clear to me. The goal in medicine is to effectively identify problems and treat them promptly so patients are stabilized *before* they develop a life-threatening emergency. The Idaho law requires doctors to do the opposite—to wait until abortion is necessary to prevent the patient's death. One impact on medical care may be a reluctance to use effective, evidence-based treatments like methotrexate for ectopic pregnancy or pregnancy of unknown location.

17. Most rural hospitals in Idaho, like my own institution, were not offering "elective terminations" of pregnancies prior to the *Dobbs* decision. Yet those of us who treat pregnant patients are deeply worried about what these abortion laws will mean for the practice of routine reproductive care given the Legislature's broad definition of "abortion."

18. In rural areas, patients may live 30-60 miles or more away from medical care. There is less access to specialty care, less blood stocked in the blood bank, less access to other blood products. At the critical access hospital where I work, we don't have platelets in the blood bank as previously described. If necessary, platelets come via taxi from a neighboring state and may take hours to arrive. Most rural hospitals do not have interventional radiology (can provide additional treatment option for maternal hemorrhage), Maternal Fetal Medicine expert (high risk pregnancy doctor), nor a dedicated Critical Care doctor that manages the Intensive Care Unit (ICU). Rural hospitals, like my own, may not have dialysis capabilities. As per EMTALA, some patients will need to be transferred to a hospital that can offer a higher level of care. If there is bad weather, it is not possible to use a helicopter and then a patient will travel by ambulance 45 to 60 miles away depending on which hospital accepts the patient and/or which hospital has the resources that the patient needs. We work with the resources that we have to the best of our ability, but we don't have the same staff, equipment and resources as larger and/or urban centers. For rural patients in particular, delaying medical care until we can say an abortion is necessary to prevent death is dangerous. Patients will suffer pain, complications, and could die if physicians comply with Idaho law as written when it conflicts with EMTALA.

19. I hope that the Court takes into consideration how physicians actually practicing in Idaho and treating Idahoans perceive the law and its effect of criminalizing evidence-based medical care. A doctor practicing in Las Vegas or Honolulu does not have the same experience and does not face the same potentially life-altering dilemma that we will face if this law is allowed to take effect.

20. I have also reviewed the declaration of the attorney, Mr. Loebs, and it does not make me feel any better about how the law will negatively affect patients and physicians in Idaho. How can I trust that every prosecutor in the State has exactly the same beliefs, much less every *future* prosecutor? If the law allows prosecution, it is not reassuring that I can simply rely on the good faith of prosecutors. A prosecutor may believe that they have an obligation to enforce the law as it is written. I have a career and a family of my own so I cannot just hope that all prosecutors will exercise discretion in exactly the same way as Mr. Loebs.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 18th day of August 2022, in Sandpoint, Idaho.

8/18/2022
Date

Amelia Huntsberger, M.D.