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 **SUPPLEMENTAL DECLARATION OF KYLIE COOPER, M.D.**

SUPPLEMENTAL DECLARATION OF KYLIE COOPER, M.D. IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

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

1. I have read the briefs submitted by the State of Idaho and the Idaho Legislature and the supporting Declarations. I submit this supplemental declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, 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.

2. As stated in my Declaration (Dkt.17-7), pregnancy is not always straight forward and complication free. If I terminate a "clinically diagnoseable pregnancy" the affirmative defense available to me under Idaho Code §18-622 requires me to prove that in my medical judgment and based on the facts known to me, the termination was necessary to prevent the death of the pregnant woman. The vast majority of patients do not present at death's door. For those patients who are clearly suffering from a severe pregnancy related illness and for which there is a clear indicated

treatment, but death is not imminent, it is unclear whether I should provide the appropriate treatment because the circumstances may not justify the affirmative defense.

3. My patient Jane Doe 1 is just one of countless patients whom I have treated with a diagnosis of preeclampsia with severe features. Medical standard of care dictates that expectant management, or continued observation without treatment of a pregnancy with a diagnosis of preeclampsia with severe features is contraindicated in the setting of a fetus not expected to survive including those at a pre-viable gestational age. The reason for this is because preeclampsia with severe features places a patient at risk for both acute and long-term complications and the clinical course involves progressive deterioration of the maternal and fetal condition. Patients with preeclampsia with severe features may present with varying symptoms. For some it is severe hypertension, for others it is evidence of kidney or liver damage on laboratory assessment. Others present with severe intractable headache pulmonary edema and some at the extreme end of the spectrum with HELLP syndrome (hemolysis, elevated liver enzymes, low platelets). The definitive medical treatment for pre-viable preeclampsia with severe features is termination of pregnancy. The medical rationale to treat preeclampsia with severe features once it has been diagnosed is not always to prevent death; in the majority of cases it is to avoid further deterioration, physical harm, and threat to future fertility and long-term health.

4. Maternal death remains relatively uncommon which is due to contemporary and evidence based medical practices and protocols which we use to treat the patient in an appropriate and timely manner rather than waiting until they experience the anticipated and severe complications of their illness.

5. Preterm pre-labor rupture of membranes (PPROM) is a circumstance in which the amniotic sac has ruptured too early. I have treated countless patients with PPROM and for some

patients this occurs in the pre-viable or peri-viable time frame. This condition carries a multitude of risks including intra-amniotic infection, endometritis, placental abruption, and retained placenta. It can also lead to maternal sepsis, acute kidney injury, hemorrhage, need for blood transfusion, and hysterectomy. Maternal deaths due to infection do occur. The clinical presentation of PPROM can vary. In addition to abnormal leakage of amniotic fluid, some may also experience bleeding from an abruption or labor. For others, they may present with signs and symptoms of intraamniotic infection. In the pre-viable and peri-viable setting the chance of pregnancy loss is very high. The clinical course for patients with PPROM can be unpredictable. They may be stable at one moment and bleeding profusely or demonstrating systemic signs of infection the next. Having PPROM places them at risk for hemorrhage which can be further compounded by an intraamniotic infection or sepsis. Hemorrhage, if significant and unresponsive to first line therapies can necessitate a hysterectomy which would eliminate future fertility. The treatment for intraamniotic infection or hemorrhage related to PPROM is to remove the products of conception from the uterus. It is my opinion these are the types of scenarios where the condition may not meet the "necessary to prevent the death of the pregnant woman" requirement for the affirmative defense under I.C. §18-622 but I would be required under EMTALA to stabilize a condition that without immediate medical attention would place the patient's health in jeopardy.

6. I have read the declarations of Dr. White and Dr. Reynolds. As a maternal-fetal medicine physician I provide direct care for high-risk pregnant patients and also serve as a subspecialist consultant for other medical providers. In my role as a subspecialist physician I am consulted regularly and from around the state of Idaho by a variety of physicians including generalist OB/Gyn, family practice, and emergency medicine for assistance in managing pregnant patients and pregnancy complications. As a subspecialist physician at a tertiary care center who

receives pregnancy related patient transports regularly from around the state, I frequently see conditions that threaten the health of the patient. The three examples in my initial declaration were all cared for within the past year. Even if it is just one patient's health being severely impacted or life lost related to the inability of her medical providers to care for her, that is unacceptable.

7. Dr. Reynolds states that "any effort to redefine abortion to include treatment of ectopic pregnancies is medically baseless and, in my judgment, inexcusable." Idaho Code §18-622 defines an abortion as the termination of a "clinically diagnosable pregnancy". Medically speaking, the healthcare community would not classify treatment of an ectopic pregnancy as an abortion. This statute was not written using medically accepted definitions or terminology. Therefore, providers are left with the plain language of the law and because an ectopic pregnancy is a clinically diagnosable pregnancy this leads to provider fear of prosecution for providing the evidence-based and medically indicated treatment for those patients. Dr. Reynolds, who practices in Nevada, states that Idaho physicians, "may proceed without the kinds of subjective 'fears' and 'chillings' suggested in the declarations of the three Idaho doctors" and "[t]he doctor-declarants' comments about 'fears' and 'chillings' of doctors already in Idaho and of Ob-Gyn doctors considering relocating to Idaho do not ring true to me." As a physician who is practicing in Idaho and through my personal interactions with health care providers around the state as well as through my positions with ACOG, the Idaho Perinatal Project advisory board, and the Idaho Coalition for Safe Reproductive Healthcare, provider fear and unease is real and widespread.

8. I have read the declaration of Dr. French who states "the 'life-saving' abortion that results in the death and dismemberment of a fetus in the uterus can cause an entire cascade of reactions that would in fact worsen many of the scenarios that are presented as life-saving." Surgical abortion is a safe treatment. The risk of death associated with childbirth is 14 times higher

than that with abortion. For those complications related directly to the pregnancy itself such as HELLP syndrome, preeclampsia with severe features, severe hemorrhage, and intraamniotic infection, this safe surgical procedure is the definitive treatment that will stop the progression and reduce risks of bodily harm.

9. I have read the declaration of Mr. Loebs. A single prosecutor, from a different jurisdiction from where I practice medicine stating that he would not prosecute a physician based on a few patient examples does not alleviate my fear of criminal prosecution. Similarly, his speculation that all prosecuting attorneys in Idaho would interpret these scenarios the same way he does gives me no security. Implicit in prosecutorial discretion, is the fact that each prosecutor will decide for themselves whether to prosecute these cases, leaving medical providers unable to predict or know how each prosecuting attorney will proceed.

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 19th day of August 2022, in Boise, Idaho.

8/19/22
Date

/s/ Kylie Cooper
Kylie Cooper MD