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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF HUMBOLDT

THE PEOPLE OF THE STATE OF CALIFORNIA,

Plaintiff,

v.

ST. JOSEPH HEALTH NORTHERN CALIFORNIA, LLC AND DOES 1-10,

Defendants.

Case No. CV2401832

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF THE PEOPLE OF THE STATE OF CALIFORNIA'S MOTION FOR PRELIMINARY INJUNCTION

Date: October 25, 2024
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I. INTRODUCTION

If you go to an emergency room, you will receive emergency care. For a generation, that simple promise has underlain much of medicine in the U.S. and has provided a crucial safety net for anyone in a medical crisis. In California, this guarantee was codified as the Emergency Service Law, Health & Safety Code section 1317, *et seq.* (ESL), which requires all hospitals with emergency rooms in the state to treat anyone with an emergency medical condition without regard for their ability to pay, or their race, sex, pregnancy status, sexual orientation, or other protected characteristic. So when Anna Nusslock—fifteen weeks pregnant, bleeding, leaking amniotic fluid, and in agonizing pain—arrived at the emergency department (ED) of Providence St. Joseph Hospital (Providence or Providence Hospital) in the early morning hours of February 23, 2024, she had every reason to believe that whatever happened, her doctors would at least treat her to the limits of their ability. Anna was soon diagnosed with previable Premature Prelabor Rupture of Membranes (Previable PPROM) and received the heartbreaking news that her (desperately wanted) pregnancy was doomed. Worse still, she then learned that absent intervention, she was at high risk for further complications, especially hemorrhage and infection. The standard of care in her case—and the only treatment that resolves the underlying condition—is to provide an abortion, either through induced labor or a Dilation and Evacuation procedure (D&E). However, Providence refused to allow Anna's doctors to treat her, as the hospital's policies prohibited them from terminating a pregnancy so long as they could detect fetal heart tones. The only exception was if the mother's life was at immediate risk, a high threshold which Anna apparently did not yet reach. Only at some poorly defined point in the future, when Anna was close enough to death, would Providence permit her doctors to intervene. Until then, Anna and her physicians could do nothing but wait, worry, and hope.

Well, not quite nothing. Just before Anna was discharged and instructed to drive to another hospital that would provide her with the emergency care she needed, a Providence nurse offered her a bucket and towels "in case something happen[ed] in the car."

Providence's policy puts pregnant patients' health and safety at risk and violates Providence's obligations under the ESL. Under the law, a hospital must act not merely to save a

patient from imminent death, but also when a patient's health is in serious jeopardy and, when necessary to *prevent* medical hazards from developing. Nor should it be any other way: if a hospital waits to intervene until a patient is about to code, there is no guarantee that doctors will be able to pull the patient back from the brink, let alone do so without permanent injury. Providence's policy violates this clear mandate by delaying and denying pregnant patients the emergency care they need. Providence also violates the ESL when it transfers these unstable patients for treatment at other facilities, the exact kind of patient dumping the ESL was originally created to stop.

As long as Providence's policy remains in effect, it gambles with the lives of pregnant patients. Plaintiff, the People of the State of California (the People) therefore ask this Court for an injunction requiring Providence to meet its obligations under the ESL.

II. BACKGROUND

A. California's Emergency Services Law

The ESL guarantees that anyone with an "emergency medical condition" shall be treated at any hospital that operates an emergency room. (Health & Saf. Code, § 1317, subd. (b); Civ. Code, § 51(e).) The ESL defines an "emergency medical condition" as a medical condition that "in the absence of immediate medical attention, could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy; (2) Serious impairment to bodily functions; (3) Serious dysfunction of any bodily organ or part." (Health & Saf. Code, § 1317.1, subd. (b).) Anyone with an emergency medical condition is entitled to receive "the care, treatment, and surgery . . . necessary to relieve or eliminate the emergency medical condition" from any ED in the state. (*Ibid.* § 1317.1, subd. (a)(1).[1] Though a hospital may, in limited instances, transfer the patient to another facility for a nonmedical reason, the hospital may only do so after providing sufficient care "so that it can be determined within reasonable medical probability, that the transfer or delay caused by the transfer will not create a medical hazard to the person." (*Ibid.* § 1317.2, subd. (b).)

[1] The only qualifications on a hospital's obligation to treat patients with emergency medical conditions are the scope of the practitioners' licenses and the capability of the facility. (Health & Saf. Code, § 1317.1, subd. (a)(1).)

Critically, the ESL requires hospitals not merely to treat a patient on the brink of death but also to intervene whenever there is a reasonable probability that delaying treatment will put the patient's health in "serious jeopardy" or create a "medical hazard." (Health & Saf. Code, §§ 1317.1, subd. (b), 1317.2, subd. (b).) That means hospitals cannot shut their eyes to the impending complications a patient faces, even if those complications have not yet fully taken hold or the patient appears temporarily stable. Indeed, it would be irresponsible for the ESL to work any differently: to wait until an infection sets in or a patient begins to hemorrhage is to wager with human life. (Decl. of Herman Hedriana, M.D. ISO Mot. for Prelim. Inj. ("Hedriana Decl.") ¶ 29 ["Deterioration of the critical condition can occur rapidly and unpredictably"]); Decl. of Elizabeth Micks, M.D. ISO People's Mot. for Prelim. Inj. ("Micks Decl.") ¶ 14 ["there is never a guarantee that doctors will be able to address and reverse the damage once a patient begins to deteriorate"].)

B. Emergency Medical Conditions Related to Pregnancy

Pregnancy is an extraordinarily complex process which comes with a wide range of serious medical risks. Unfortunately, some conditions both pose a grave threat to the health of the patient and can only be adequately treated by terminating the pregnancy. These include Previable PPROM, infection, severe hypertension and/or preeclampsia, placental disorders such as placental abruption or accreta, certain types of cancer, and other conditions. (Hedriana Decl. ¶ 7.) These conditions, and others like them, share three crucial characteristics. First, when they occur before the fetus is viable, the only way to treat them is via abortion. (*Ibid.* ¶¶ 10-12 ["termination of a previable pregnancy in this scenario is the only treatment that avoids life threatening maternal complications"].)

Second, left untreated, these conditions all pose a high risk of serious injury—including damage to the patient's reproductive organs—and even death. (Hedriana Decl. ¶¶ 7-8, 12, 28.) In the case of Previable PPROM for instance, the primary risks are infection and hemorrhage. (*Ibid.* ¶ 28.) These in turn can lead to other complications such as sepsis and can cause permanent injury to the reproductive organs, brain, other parts of the body, and, in extreme cases, death. (*Ibid.*)

Third, patients with these conditions can deteriorate rapidly and with little warning. (*Ibid.* ¶¶ 7, 28-29, 36 ["Because everything in Obstetrics with ongoing complications is unpredictable, a few minutes of delay can rapidly deteriorate an otherwise clinical stable scenario"].) A patient with Previable PPROM "can progress from asymptomatic and seemingly uninfected to floridly sepsis within minutes to a few hours." (*Ibid.* ¶ 28.) There is virtually no way to predict when a patient may take a turn for the worse and the only sure bet is that the risks will increase as time passes. (*Ibid.* ¶ 29 ["any delay in treatment . . . increases the likelihood of maternal morbidity that is uncalled for in the standard of care"].) Though expectant management (or the "wait and see" approach) may be a viable option in some circumstances—if for instance there is no sign of bleeding, infection, or labor—it necessarily increases the risk of complications, permanent injury, or death. (*Ibid.* ¶¶ 7-8, 11-12, 28.) Accordingly, while a patient may have a range of options, the standard of care for any of these conditions is to offer immediate pregnancy termination. (*Ibid.* ¶ 33.)

C. Health Care in Eureka

There are only two hospitals near Eureka: Providence Hospital in Eureka and Mad River Community Hospital ("Mad River") in Arcata, California. Providence is licensed as a general acute care hospital and maintains and operates an ED to provide emergency services to the public. *See* Providence Hospital Website, https://www.providence.org/locations/norcal/st-joseph-hospital-eureka/emergency-department, last accessed 9/27/24. Providence also maintains and operates a Labor and Delivery (L&D) unit, with at least one obstetrician-gynecologist available, that is open 24 hours a day, seven days a week. (Micks Decl. ¶ 7.) Mad River, located approximately 12 miles away from Providence Hospital, is a smaller facility that operates an ED and, until October 2024, will operate a L&D unit. (*Ibid.* ¶ 16.)

D. The Case of Anna Nusslock

1. Anna becomes pregnant with twins but develops Previable PPROM.

Anna Nusslock lives in Eureka, California with her husband, Daniel. (Decl. of Anna Nusslock ISO People's Mot. for Prelim. Inj. ("Nusslock Decl.") ¶ 2.) In November 2023, Anna and Daniel found out they were pregnant with twins. (*Ibid.* ¶ 3.) On February 22, approximately

15 weeks into her pregnancy, Anna felt a sudden gush of fluid from her vagina while she was making dinner. (*Ibid.* ¶ 7.) Her symptoms worsened over the next few hours, and after repeatedly consulting with the doctor on call that night, Dr. Sarah McGraw, Anna and her husband went to the Providence ED in the early morning hours of February 23. (*Ibid.* ¶¶ 7-8.) By the time she arrived, she was in so much pain from contractions that she could barely walk and had passed several golf ball sized blood clots. (*Ibid.* ¶¶ 9-10.)

Dr. McGraw ordered an ultrasound and soon confirmed Anna's worst fear—Twin A's amniotic sac had broken.[2] (*Ibid.* ¶ 10, Ex. B at p. 13.) Dr. McGraw diagnosed Anna with Previable PPROM and told Anna that, although Twin A still had heart tones, there was no chance of survival. (*Ibid.* ¶¶ 10-11.) Anna then asked whether there was any chance of saving Twin B. (*Ibid.* ¶ 12.) Dr McGraw consulted with a maternal-fetal medicine (MFM) specialist at UCSF who quickly confirmed that there was not. (*Ibid.* ¶¶ 12-13, Ex. C; Ex. D at pp. 16, 18.) Given that any delay in treatment would increase the risk of hemorrhage or infection, UCSF recommended immediately terminating Anna's pregnancy, either through induced labor or a D&E. (*Ibid.* ¶ 13, Ex. C; Ex. D. at pp. 16, 18.) Dr. McGraw passed this recommendation on to Anna and indicated that she agreed with UCSF's assessment. (*Ibid.* ¶ 13.) Anna, though devastated, agreed to proceed with termination. (*Ibid.* ¶ 14.)

2. Providence refuses to treat Anna and dumps her on Mad River.

Despite UCSF's recommendation, despite Dr. McGraw's concurrence, despite Anna's wishes, and despite the uniformly recognized standard of care for these cases, Dr. McGraw could not treat Anna. Though Providence Hospital had adequate personnel and facilities, hospital policy prohibited Dr. McGraw from terminating Anna's pregnancy unless there was a sufficient risk to Anna's life—that is, one that was *more* serious and *more* immediate than what she was already experiencing. (Nusslock Decl. ¶ 15; Ex. D at p. 18; Micks. Decl. ¶ 7.) As Dr. McGraw wrote in Anna's records, Dr. McGraw had specifically confirmed the scope of Providence's policy only to find her hands firmly tied:

[2] As is standard in multiple pregnancies, Anna's doctors designated the developing fetuses as Twin A and Twin B. (Nusslock Decl. ¶ 5.)

> Please note that discussion with patient regarding "expectant management" versus "active management" of fetuses with heart beats in Catholic Faith Affiliated hospital. Specifically, we discussed that I cannot offer her Dilation and evacuation unless her life is at risk (including hemorrhage or vital sign instability or infection) and I cannot offer her induction of contractions/provoke delivery with misoprostol while the fetuses have a heart rate. This was discussed with charge nurse overnight who confirmed policy.

(Nusslock Decl., Ex. D at p. 18.) Until Anna was, in Providence's judgment, close enough to death, all Dr. McGraw could offer Anna was expectant management. (*Ibid.*)

Anna and Dr. McGraw discussed her options. At first, they considered using a helicopter ambulance to fly Anna down to UCSF. (*Ibid.* ¶ 17.) But this option was not feasible because Anna knew her insurance would not cover the $40,000 cost of the flight.[3] (*Ibid.*) When Anna asked if she should simply start driving to UCSF, Dr. McGraw immediately told her not to, saying "you will hemorrhage and die before you get to a place that can help you." (*Ibid.* ¶ 18.)

Dr. McGraw then contacted Mad River and told Anna that she could go there for care. (*Ibid.* ¶ 20.) When medical staff at Providence Hospital asked Anna whether she wanted an ambulance to take her to Mad River (without explaining to her the risks of declining), Anna decided to have her husband drive her instead because of the added cost and time she presumed an ambulance would involve. (*Ibid.* ¶¶ 21-22.) Providence had one final insult for Anna though—as Anna was leaving, a nurse offered her a bucket and towels, saying she should have them "in case something happens in the car." (*Ibid.* ¶ 23.)

By the time Anna presented to Mad River's L&D, she was bleeding at a worryingly high rate and needed surgery on an emergency basis. (Micks Decl. ¶¶ 12-13.) Dr. Elizabeth Micks performed a D&E on Anna. (*Ibid.* ¶¶ 11-13.) But on the way into the Mad River operating room, she spontaneously delivered Twin A on the hospital gurney. (Nusslock Decl. ¶¶ 28-29, Ex. F; Micks Decl. ¶ 12.) And by the time Anna was on the operating table, she was "actively hemorrhaging." (Nusslock Decl. ¶ 29, Ex. F; Micks Decl. ¶¶ 12-13.) While Anna was able to physically recover, this was far from assured and she experienced far greater risks and threats to her health than she would have had she received prompt treatment at Providence. (Micks Decl.

[3] Anna's husband would also not be allowed to accompany her on the helicopter, leaving her alone with nobody to advocate for her care. (Nusslock Decl. ¶ 17.)

¶¶ 8, 14; Hedriana Decl. ¶ 32.) Anna's ordeal stands as vivid illustration of the risks in delaying care.

Anna's case was not an isolated incident. Due to Providence's policy, Mad River treats one to two patients per year similar to Anna. (Micks Decl. ¶¶ 5-6.) And even if Providence had a spotless record before now, the fact that the hospital's policy prohibits doctors from providing the standard of care means there is every reason to believe this scenario will play out again in the future. (Hedriana Decl. ¶ 36 ["In Humboldt County, a case like Anna Nusslock is going to happen again"].)

III. LEGAL STANDARD

Generally, courts should consider whether to grant an injunction based on "two interrelated factors: the likelihood that the plaintiff will prevail on the merits, and the relative balance of harms that is likely to result from the granting or denial of interim injunctive relief." (*White v. Davis* (2003) 30 Cal. 4th 528, 554.) This two-prong test does not apply, however, where a government entity is seeking to enjoin a violation of a statue that specifically authorizes injunctive relief. (*IT Corp. v. Cnty. of Imperial* (1983) 35 Cal. 3d 63, 72.) In such public enforcement cases, once the government shows a "reasonable probability of prevailing on the merits" the Court presumes "that the potential harm to the public outweighs the potential harm to the defendant." (*Ibid.*; *see also Water Replenishment Dist. of S. Cal. v. City of Cerritos* (2013) 220 Cal. App. 4th 1450, 1462-63.) Only if "the defendant shows that it would suffer grave or irreparable harm from the issuance of the preliminary injunction" does the Court perform the traditional weighing of equities. (*Water Replenishment Dist.*, 220 Cal. App. 4th at p. 1463.)

IV. ARGUMENT

A. The People Have a Reasonable Probability of Prevailing on the Merits

1. Providence's policy violates the ESL by prohibiting treatment of emergency medical conditions.

a. Previable PPROM and other conditions are "emergency medical conditions" under the ESL

There are numerous medical conditions like Previable PPROM that can arise during pregnancy that pose an immediate and serious threat to the health and potentially the life of the

mother. (Hedriana Decl. ¶ 7.) Under California law, they clearly constitute "emergency medical conditions" under the ESL as, absent swift intervention, (1) they place the patient's "health in serious jeopardy"; and (2) there is a high risk of "[s]erious impairment to bodily functions" and "[s]erious dysfunction of [a] bodily organ or part." (Health & Saf. Code, § 1317.1, subd. (b); Hedriana Decl. ¶ 12.) In the case of Previable PPROM for instance, infections and hemorrhage can permanently damage a patient's reproductive organs, lead to kidney failure, sepsis, and other serious injuries. (*Ibid.* ¶ 28.) And in Anna's case, there was no question that she presented to Providence with an "emergency medical condition," as she was bleeding, in severe pain, leaking amniotic fluid, actively miscarrying, and already exhibiting signs of infection. (Nusslock Decl. ¶¶ 8-13, 25-29; Hedriana Decl. ¶ 21 ["Anna had an emergency medical condition that posed risks of infection, hemorrhage, or possibly, hysterectomy with all the attendant complications of blood transfusion, AKI, ARDS, ICU admission, and possible loss of her reproductive future."].)

b. Frequently, the only treatment for Previable PPROM and comparable conditions is an abortion

As Dr. Hedriana explains, the only effective treatment for Previable PPROM and comparable conditions is usually an abortion. (Hedriana Decl. ¶¶ 10-12 ["termination of a previable pregnancy in this scenario is the only treatment that avoids life threatening maternal complications"].) This is not a controversial finding: numerous courts have also recognized that many conditions pose an imminent threat to the life and health of the mother and can *only* be effectively treated via abortion care. (*See Moyle v. United States* (2024) 144 S. Ct. 2015, 2024 (Jackson, K., concurring) [noting the parties now agree that there are a "host of emergency medical conditions that require stabilizing abortions . . . include[ing] pre-eclampsia, preterm premature rupture of the membranes (PPROM), sepsis, and placental abruption"]; *Texas v. Zurawski* (Tex. S. Ct. 2024) 690 S.W.3d 644, 665 [holding that under Texas law, "abortion is recommended to prevent a woman's death or serious bodily injury if she develops [PPROM]"]; *Wrigley v Romanick* (N.D. 2023) 988 N.W 2d 231, 242 ["Preserving the life or health of the woman necessarily includes providing an abortion when necessary to prevent severe, life altering damage"].) Under the ESL then, an abortion will frequently be "necessary to relieve or

eliminate" these conditions and required under the law. (Health & Saf. Code, § 1317.1, subd. (a)(1); Hedriana Decl. ¶¶ 10-12; Micks Decl. ¶¶ 5-6, 8; *see also U.S. v. Idaho* (D. Id. 2022) 623 F. Supp. 3d 1096, 1101 ["if the physician does not perform the abortion (on a patient with serious complications) the pregnant patient faces grave risks to her health—such as severe sepsis requiring limb amputation, uncontrollable uterine hemorrhage requiring hysterectomy, kidney failure requiring lifelong dialysis, hypoxic brain injury, or even death"].)

c. Providence violates the ESL by refusing to provide abortions in an emergency

Instead of offering treatment that would actually relieve the threat posed by these conditions, Providence only allows for expectant management until a sufficiently grave threat to the patient's life materializes. This violates the ESL for two distinct reasons.

First, the ESL requires that Providence act not merely to preserve the patient's life but to prevent any serious jeopardy to or dysfunction of their overall health and wellbeing. (Health & Saf. Code, § 1317.1, subd. (b) [must act to prevent organ or bodily dysfunction].) The ESL's broad definition of "emergency medical condition" represents a deliberate—and humane—policy judgment that emergency rooms should treat all serious medical conditions; a patient need not be at death's door before they receive care. (*C.f. Idaho*, 623 F. Supp. at p. 1109 [federal emergency care law "demands abortion care to prevent injuries that are more wide-ranging than death"].) By allowing active treatment only when the patient's very life is at stake, Providence plainly contravenes California law and needlessly exposes its patients to a wide range of serious risks short of death.

Second, by offering only expectant management, which entails delaying or withholding intervention, Providence necessarily fails to provide care that will "relieve or eliminate" the underlying condition. (Health & Saf. Code, § 1317.1, subd. (a)(1).) Care delayed is often care denied. (*See* Hedriana Decl. ¶ 24 ["By delaying definitive treatment pursuant to the standard of care . . . Anna ran the risks of sepsis/septic shock; placental abruption given the bleeding and low-lying placenta, hemorrhage and the downstream severe medical disorders of chronic kidney disease, hypertensive crisis/stroke since she has chronic hypertension, and ARDS"].) And as the

federal District Court for Idaho explained:

> [D]elayed care worsens patient outcomes . . . A recent study of maternal morbidity in Texas confirms this. When a pregnant woman with specific pregnancy complications was treated with "the standard protocol of terminating the pregnancy to preserve the patient's life or health," the rate of serious maternal morbidity was 33 percent. That rate reached 57 percent, nearly doubling, when providers used "an expectant management approach."

(*Idaho*, 623 F. Supp. 3d at p. 1114.) And in the vast majority of preventable maternal deaths from sepsis or hemorrhage—the two greatest risks in cases of Previable PPROM— the main reason was due to "delayed response to clinical warning signs." (Hedriana Decl. ¶ 29.)

These risks were partially born out in Anna's case, where the delay caused by Providence's policy meant that she was actively hemorrhaging by the time she received adequate care and was exposed to heighted—and needless—risks of permanent injury. (Micks Decl. ¶¶ 10-14; Hedriana Decl. ¶ 24 ["At the extreme, Anna may have died of the complications discussed above"].) Indeed, Dr. Hedriana believes that Anna may have come very close to suffering permanent injuries or worse. In his opinion "[i]f the standard of care was delayed by a few more minutes or hours . . . Anna would have had massive hemorrhage and would be in florid sepsis with all the attendant severe maternal morbidities." (Hedriana Decl. ¶ 32.)

Far from relieving or eliminating their patients' emergency medical conditions, Providence's policy virtually guarantees they will worsen.

2. Providence violates the ESL by improperly transferring patients.

To counteract the scourge of "patient dumping" the ESL only allows a hospital to transfer a patient for nonmedical reasons after meeting numerous conditions. Key among these is that before any transfer, the initial hospital must provide "emergency services and care so that it can be determined, within reasonable medical probability, that the transfer or delay caused by the transfer will not create a medical hazard to the person." (Health & Saf. Code, § 1317.2, subd. (b).)[4] Providence fails to meet this standard with respect to pregnant patients. Patients with PPROM and similar conditions can deteriorate rapidly and with little warning. (Hedriana Decl. ¶

[4] "Medical hazard" is defined as "a material deterioration in medical condition in, or jeopardy to, a patient's medical condition or expected chances for recovery." (Health & Saf. Code, 1317.1, subd. (f).)

26 [it is "not possible to know how and when the condition will worsen"].) In many of these cases it is impossible to say with "reasonable medical certainty" that the delay caused by transferring a patient with an emergency medical condition related to pregnancy will not put their health in jeopardy. (*Ibid.* ¶ 30 ["there was no adequate time to judge if transferring Anna to another hospital or the delay of care would not create a medical hazard"]; Micks Decl. ¶¶ 5-6, 8-11.)

Anna's case is a vivid illustration of Providence's shortcomings. Not only did Providence improperly transfer her when it was clear a delay could create a medical hazard at the time she was discharged, *Anna was already deteriorating*. Though her vital signs may have been stable, "her clinical presentation was visibly in rapid decline and she was in significant pain, infected, and in active labor." (Hedriana Decl. ¶ 31.) Rapid intervention at Mad River may have averted an even more tragic outcome, but this does not change the fact that she "should not have been discharged" in the first place and should have been treated immediately. (*Ibid.*)

Providence's policy meant that Providence did not offer Anna—and will not offer any similarly situated patient—sufficient care to prevent them from deteriorating to the point that they are literally hemorrhaging by the time they receive care at another hospital. *See* Micks Decl. ¶¶ 10-11. Having failed to properly treat her, Providence then did not properly coordinate her transfer to another hospital. Instead, it discharged her to the street and offered her a bucket and towels on her way out in case *something* happened during her drive to Mad River. Nusslock Decl. ¶ 23. The ESL requires far more.

3. Providence has no religious liberty defense to the ESL.

Providence may argue that it need not comply with the ESL where doing so would violate its religious beliefs as a Catholic-affiliated hospital. This defense is squarely foreclosed by existing precedent. Neutral laws of general applicability may be enforced even when doing so substantially burdens an individual's religious exercise. (*Emp. Div. Or. Dep't of Humans Res. v. Smith* (1990) 494 U.S. 872, 885; *Fulton v. City of Phila.* (2021) 593 U.S. 522, 533 ["laws incidentally burdening religion are ordinarily not subject to strict scrutiny under the Free Exercise Clause so long as they are neutral and generally applicable"].) The ESL is unambiguously such a

law because it applies equally to all EDs licensed in California and contains no exceptions. (*Fulton*, 593 U.S. at p. 533 ["A law is not generally applicable if it 'invite[s]' the government to consider the particular reasons for a person's conduct by providing '"a mechanism for individualized exemptions"'"].)

This outcome does not change under California law. The California Supreme Court has never directly addressed the standard of review under the California Constitution for a neutral law of general applicability that incidentally burdens religious exercise. However, the Court has upheld laws that require hospitals to provide medical care, even when doing so is at odds with religious beliefs. (*See North Coast Women's Care Med. Grp., Inc. v. Super. Ct.* (2008) 44 Cal. 4th 1145, 1158 [physicians had to assist lesbian couple with IVF treatment notwithstanding the doctors' objections]; *see also Cath. Charities of Sacramento, Inc. v. Super. Ct.* (2004) 32 Cal. 4th 527, 549 [Catholic non-profit had to provide contraception coverage to its employees despite its religious objections]; *Minton v. Dignity Health* (2019) 39 Cal. App. 5th 1155, 1165 [burdens on religious beliefs are "justified by California's compelling interest in ensuring full and equal access to medical treatment for all its residents"].)

North Coast is particularly instructive. There, a lesbian couple sued a fertility clinic after the physicians refused to provide them with IVF treatment. (44 Cal. 4th at pp. 1150-551.) Though the parties disputed the exact reason for the doctors' refusal, there was no question that assisting the plaintiffs would violate the defendants' religious beliefs. (*Ibid.* at pp. 1152-53.) The couple sued under the Unruh Civil Rights Act, and the California Supreme Court held that the doctors had to comply with the act's non-discrimination requirements. (*Ibid.* at pp. 1156-59.) The Court first found that "the First Amendment's right to the free exercise of religion does not exempt defendant physicians here from conforming their conduct to the Act's antidiscrimination requirements even if compliance poses an incidental conflict with defendants' religious beliefs." (*Ibid.* at p. 1156.) The Court then found that California's interest in preventing discrimination in medical care meant that the Unruh Act, as applied to the physicians, could survive strict scrutiny. (*Ibid.* at p. 1158 ["The Act furthers California's compelling interest in ensuring full and equal access to medical treatment irrespective of sexual orientation, and there are no less restrictive

means for the state to achieve that goal."].) The state's interest in ensuring free and equal access to medicine outweighed the incidental burden on religious expression. (*Ibid.*)

In *North Coast*, *Catholic Charities*, and *Minton*, the courts upheld requirements that defendants provide non-emergent healthcare and services despite religious objections. These holdings apply with special force here because this case deals not with outpatient care, but with lifesaving treatment for emergency medical conditions. (*C.f. People v. Coyle* (Cal. Ct. App. 1988) 251 Cal. Rptr. 80, 82 ["the state has a compelling interest in saving lives and promoting the welfare of its citizens"].) This clear, controlling precedent forecloses any religious liberty defense, and requires a finding that the People will prevail on the merits.

B. There is a Presumption in Favor of an Injunction

In this action, the People seek to enjoin violations of state laws that specifically provide for injunctive relief. The ESL states that that "the Attorney General, may bring a civil action against the responsible hospital . . . to enjoin the violation." (Health & Saf. Code, § 1317.6, subd. (j).) As unlawful conduct, Providence's violations of the ESL are also predicates for an injunction under Business and Professions Code sections 17200 and 17204.[5] Accordingly, there is a rebuttable presumption "that the potential harm to the public outweighs the potential harm to the defendant." (*IT Corp.*, 35 Cal. 3d at p. 72.) This Court therefore does not need to weigh competing claims of equity and must only determine whether the People are reasonably likely to prevail on the merits. (*Ibid.*) The People have more than met this burden, and the Court should enter the injunction.

C. The Balance of Equities Heavily Favors an Injunction

Even if the Court were to weigh the comparative harms, there is no question which way the scale tips in this case. Initially, California courts have repeatedly held *as a matter of law* that a defendants' interest in religious liberty is outweighed by the state's need to guarantee equal access to medical care. (*See North Coast*, 44 Cal. 4th at p. 1158 ["that burden [on religious

[5] The People's preliminary injunction motion is based on their First Cause of Action (violation of the ESL, *i.e.*, Health. & Safety Code section 1317, *et seq.*) and Third Cause of Action (violation of Business and Professions Code section 17200). The People do not seek an injunction based on their Second Cause of Action under the Unruh Act. (*See Lam v. Ngo* (2001) 91 Cal. App. 4th 832, 844 ["A single cause of action can sustain a preliminary injunction."].)

exercise] is insufficient to allow them to engage in such discrimination"]; *Catholic Charities*, 32 Cal. 4th at p. 564 [contraception requirement imposed on Catholic organization passed strict scrutiny]; *Minton*, 39 Cal. App. 5th at p. 1165 [burdens on religious beliefs are "justified by California's compelling interest in ensuring full and equal access to medical treatment for all its residents"].) Here, the People's interest is higher still, as the ESL ensures that all of California's residents receive the emergency care they need during their worst moments, when they are in danger of serious injury or illness and even death. (*Idaho*, 623 F Supp. 3d at p. 1116 ["we should not forget the one person with the greatest stake in the outcome of this case—the pregnant patient, laying on a gurney in an emergency room facing the terrifying prospect of a pregnancy complication that may claim her life. . . . From that vantage point, the public interest clearly favors the issuance of a preliminary injunction"].)

Ensuring that nobody else experiences what Anna Nusslock went through is more than enough then to justify an injunction. But the need for immediate relief is about to intensify. On August 22, Mad River announced that it will be closing its L&D unit in October 2024, leaving Providence Hospital with the only L&D unit in all of Humbolt County. (Micks Decl. ¶ 16.) Unless Dr. Micks or one of her colleagues is available to take a patient on an ad hoc basis, any future patient in Anna's shoes may face an even more agonizing choice than she did. On the one hand, they can stay at Providence, wait until they are close enough to death to receive care, and hope that Providence's decision to intervene does not come too late. On the other, they can travel for hours to another hospital outside the county and pray that they do not critically deteriorate on the road.[6] Either option presents unacceptable risks to patient health and safety. Unfortunately, it is a medical certainty that very soon, someone in Humbolt County will find themselves in this situation. (Hedriana Decl. ¶ 36 ["In Humboldt County, a case like Anna Nusslock is going to happen again, and without the maternity services offered by Mad River Hospital, the likelihood of severe maternal morbidity will increase for people who cannot be provided with emergency therapeutic abortion care, and the rate of pregnancy associated maternal mortality among these

[6] A lucky few who can afford a $40,000 air ambulance ride may have that as a third option.

people will be high."].) The balance of equities therefore tips overwhelmingly in favor of an injunction at this stage.

V. CONCLUSION

The Court should grant the People's motion for preliminary injunction to prevent Providence Hospital from violating the ESL, Health and Safety Code section 1317, *et seq.* and from engaging in unlawful business conduct, as defined in Business and Professions Code section 17200, specifically, violating the ESL.

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