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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'S HEALTH NORTHERN CALIFORNIA, LLC; 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: December 10, 2025 Time: 9:15 a.m. Dept.: 4 Judge: Hon. Timothy Canning Action Filed: September 30, 2024

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INTRODUCTION

If you go to an emergency room, you will receive emergency care. For a generation, that simple promise has been a fundamental element of healthcare 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. But at Providence St. Joseph Hospital in Eureka (SJH), now the only hospital in Humboldt County with a labor and delivery unit, pregnant women are unable to access time sensitive, potentially lifesaving care—in violation of the ESL. The stories of two SJH patients—Jane Roe and Anna Nusslock—clearly and painfully illustrate the human costs of this policy. Jane Roe has suffered from a condition known as Previable Preterm Premature Rupture of Membranes (Previable PPROM) three times: once in 2021, then again in April 2022 and once more in December 2022. Previable PPROM is an emergent, potentially life-threatening pregnancy complication that almost always results in pregnancy loss. The standard of care for Previable PPROM is to provide an abortion, either through induced labor or a Dilation and Evacuation procedure (D&E). Each time Jane Roe had Previable PPROM she sought care at SJH—each time she was denied care because SJH's policy prohibited her physicians from terminating her pregnancy because she was not close enough to death, or at least not yet. As a consequence, she suffered needless pain and complications—including a serious hemorrhage.

Knowing that it was only a matter of time before another patient suffered the same fate or worse, Jane Roe's doctor reached out to SJH's leadership in July of 2023, asking them to reconsider or clarify the policy on emergency abortion care. But despite a promise to follow up on the issue, SJH never responded. While SJH failed to act, the clock began to tick down to the next tragedy, which was less than a year away. In the early morning hours of February 23, 2024 Anna Nusslock—fifteen weeks pregnant, bleeding, leaking amniotic fluid, and in agonizing pain—arrived at the SJH emergency department (ED). Like Jane Roe, Anna had Previable

PPROM, and soon received the heartbreaking news that her (desperately wanted) pregnancy was doomed and that she was at high risk for further complications, especially hemorrhage and infection. Once again though, SJH refused to allow Anna's doctors to treat her. The physicians could only offer the standard of care once the mother's life was at immediate risk, a high threshold which Anna apparently did not yet reach. Only at some unknown point in the future, when SJH judged that Anna was close enough to death, would the hospital permit her doctors to intervene. Until then, Anna and her physicians could do nothing but wait, worry, and hope.

With one exception. Just before Anna was discharged and instructed to drive to another hospital that would provide her with the emergency care she needed, a SJH nurse offered her a bucket and towels "in case something happen[ed] in the car."

SJH's policy puts pregnant patients' health and safety at risk and violates its 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 terminate a pregnancy until a patient is about to code, there is no guarantee that doctors will be able to pull the patient back from the brink of death, let alone do so without permanent injury. SJH's policy violates this clear mandate by delaying and denying pregnant patients the emergency care they need. SJH 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.

Jane Roe and Anna Nusslock were not the first patients harmed by SJH's illegal policy. Absent judicial intervention, they will not be the last. Plaintiff, the People of the State of California (the People) therefore ask this Court for an injunction requiring SJH to meet its obligations under the ESL.

BACKGROUND

I. 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, subd. (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. (*Id.* at § 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." (*Id.* § 1317.2, subd. (b).)

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"].)

II. 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

[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).)

PPROM, infection, severe hypertension and/or preeclampsia, placental disorders such as placental abruption, accreta, and previa, 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[2] 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. (*Id.* at ¶ 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.)

[2] This brief describes pregnancy using medical terminology, unless describing a particular person's pregnancy, in which case, consistent with principles of medical ethics, it adopts the terminology preferred by the individual patient.

III. HEALTH CARE IN EUREKA

There are only two hospitals near Eureka: SJH in Eureka and Mad River Community Hospital (Mad River) in Arcata, California. SJH is licensed as a general acute care hospital and maintains and operates an ED to provide emergency services to the public.[3] SJH 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. (Decl. of Elizabeth Micks, MD ISO Mot. for Prelim. Inj. ("Micks Decl.") ¶ 7.) Mad River, located approximately 12 miles away from SJH, is a smaller facility that operates an ED and, until October 2024, operated a L&D unit. (*Ibid.* ¶ 16.) In October of 2024, Mad River suspended its L&D services; without on call obstetric services the hospital is accordingly unable to treat emergent conditions related to pregnancy on any kind of reliable basis. (*Id.*)

A. The Case of Jane Roe

In June of 2021, Jane Roe and her partner found out that she was pregnant, for the first time. (Decl. of Jane Roe ISO Mot. for Prelim. Inj. ("Roe Decl.") ¶ 1.) They were thrilled. (*Ibid.*) Throughout her pregnancy, she received care at Open Door's Redwood Community Health Center Family Medicine and pregnancy Services ("Open Door"), located in Eureka, California. (Roe Decl. ¶ 6.) She was diagnosed with gestational diabetes early in her pregnancy, which, along with her age, made her pregnancy high risk. (Roe Decl. ¶ 7.)

On September 4, 2021, Jane Roe was 17 weeks into her pregnancy when she woke up to her water breaking. (Roe Decl. ¶ 8.) She immediately called Open Door, who told her to go to SJH's birth center. (Roe Decl. ¶ 9.) Upon arrival at SJH, Dr. Simon Stampe, who evaluated her, told her that she was in labor, miscarrying, and that there was no possibility her baby would survive. (Roe Decl. ¶ 11.) She later learned that she had a condition called Previable preterm premature rupture of membranes ("Previable PPROM"). (Roe Decl. ¶ 12.)

[3] (See SJH Website, https://www.providence.org/locations/norcal/st-joseph-hospital-eureka/emergency-department, (last accessed 10/3/25).)

Dr. Stampe told her that she needed a dilation and curettage ("D&C") to terminate her nonviable pregnancy, but that SJH had a policy[4] that prevented him from performing the procedure if there was still a heartbeat that could be detected. (Roe Decl. ¶ 14-15.) Because SJH's policy prohibited Dr. Stampe from providing Jane Roe with the medical care she needed, he advised her to go immediately to UCSF or to Mad River Hospital, in Arcata for a dilation and curettage ("D&C") procedure. (Roe Decl. ¶ 17.) Because she knew she was facing a serious emergency and because Mad River was a small hospital, she and her partner drove 5.5 hours to San Francisco, where she was admitted for a D&C and delivered after 17.5 hours of labor. (Roe Decl. ¶ 18-23.) Jane Roe was left traumatized by her experience at SJH. (Roe Decl. ¶ 24.)

In early 2022, Jane Roe discovered that she was pregnant for a second time. (Roe Decl. ¶ 30.) Tragically, though, on April 22, 2022, at around 17 weeks of pregnancy, her water broke again. (Roe Decl. ¶ 32.) Jane Roe immediately called Open Door and was told to go SJH. (Roe Decl. ¶ 33.)

After waiting to be admitted at SJH, Jane Roe was taken for tests and an ultrasound. (Roe Decl. ¶ 34.) The ultrasound showed critically low amniotic fluid. (*Ibid*.) The medical record indicates that she was losing amniotic fluid and that placenta previa was suspected, which is a major risk factor for postpartum hemorrhage and can lead to mortality and morbidity of the mother. (Roe Decl. ¶ 34-35.) For some reason, Jane Roe was unable to see a doctor – instead, a nurse called Open Door (the outpatient clinic where Jane Roe had been receiving prenatal care), and she spoke with a midwife. (Roe Decl. ¶ 36.) The SJH nurse then told her that she would be discharged to go home on bedrest and instructed her to follow up with Open Door the next morning. (*Ibid*.) She was never treated by anyone at SJH. (Roe Decl. ¶ 37.)

While in active labor and losing amniotic fluid, Jane Roe was shocked to be discharged from the ED without receiving monitoring or care, despite possessing numerous factors that made her pregnancy high-risk, including her prior miscarriage, advanced maternal age, and gestational diabetes. (Roe Decl. ¶ 39.) Nobody at SJH spoke to Jane Roe about the other risk factors she

[4] As discussed in Part II.G. *infra*, the relevant SJH policy was unwritten. Accordingly, different providers used slightly different language at various times to articulate its requirements.

presented with that day, including critically low amniotic fluid, suspected placenta previa, and high blood pressure. (Roe Decl. ¶ 40.)

After suffering active labor at home all night, Jane Roe saw Dr. Stampe at Open Door the first thing in the morning. (Roe Decl. ¶ 41-42.) He told her that, based on her ultrasound images, she had Previable PPROM again. (Roe Decl. ¶ 42.) He informed her that she had the same choice of going to Mad River or UCSF for a D&C. (*Ibid.*) He checked for a heartbeat, before she attempted to make another 5.5-hours-long drive to San Francisco after laboring all night. (*Ibid*.) Dr. Stampe did not detect a heartbeat, and Roe's cervix was dilated. (Roe Decl. ¶ 43.) Dr. Stampe instructed Jane Roe to start pushing immediately to deliver the baby in the examination room. (*Ibid*.) She was shocked because the examination room was not set up for a delivery. (Roe Decl. ¶ 44.) It was not sterile and did not even have medical supplies beyond gloves. (*Ibid*.)

Jane Roe's repeat nightmare rapidly worsened. Though she delivered the nonviable fetus after approximately 21 hours of labor, the placenta did not follow. (Roe Decl. ¶ 45-46.) She began to hemorrhage at Open Door to the point where she thought she was going to die there. (*Ibid.*) Meanwhile, the Open Door staff could not even find scissors to cut the umbilical cord and were trying to call for an ambulance to transport Jane Roe to SJH's ED. (*Ibid*.)

After Jane Roe was transported to SJH's ED, a doctor performed an emergency D&C to deliver the placenta. (Roe Decl. ¶ 47.) She had lost tremendous amounts of blood and was given two units of blood, i.e., a double blood transfusion. (*Ibid*.) She ultimately developed acute blood loss anemia and needed treatment to reestablish her blood levels. (*Ibid*.)

In Fall of 2022, Jane Roe found out that she was pregnant again. (Roe Decl. ¶ 54.) To increase the odds of her carrying this baby to term, she received a cerclage, which involved sewing a portion of her cervix shut to prevent it from weakening, once cause of preterm labor. (Roe Decl. ¶ 55.)

Tragically, on December 12, 2022, Jane Roe's water broke again around 17 weeks into her pregnancy. (Roe Decl. ¶ 58.) She rushed to the SJH's ED and tried to be admitted as quickly as possible because, if the cerclage was not removed before her cervix dilated in labor, the sutures

would rip and tear her cervix. (Roe Decl. ¶ 59.) Jane Roe was admitted in the afternoon, and her cerclage was removed at around 6:00 pm. (*Ibid*.)

What came next was devastatingly familiar. Jane Roe was diagnosed with Previable PPROM and told her baby would not survive. (Roe Decl. ¶ 60.) Her medical notes documented "risk of infection" and "[h]igh risk of postpartum hemorrhage due to retained placenta," given her prior experience. (*Ibid*.) The notes reflected that the medical team would "plan for possible D&C." (Roe Decl. ¶ 60.) The same doctor who had performed Jane Roe's emergency D&C in April 2022 was on duty. (Roe Decl. ¶ 62.) The doctor and the nurses repeatedly apologized to Jane Roe for not being able to immediately render lifesaving care—solely because SJH had a policy of denying even medically necessary emergency abortion care unless the mother was "actively dying." (Roe Decl. ¶ 62.)

This time, Jane Roe initially could not travel to UCSF because, initially, she was waiting for her cerclage to be removed. (Roe Decl. ¶ 63.) Once it was removed, she was in too much pain and felt too weak to endure the 5.5-hour trip. (*Ibid*.)

Jane Roe was checked every hour to determine if fetal cardiac activity was no longer detectable so that she could receive the D&C her doctors had planned. (Roe Decl. ¶ 64.) In the meantime, Jane Roe remained in active labor aided only by occasional nitrous oxide for minimal pain relief and was instructed not to eat. (*Ibid*.) She passed small blood clots and, especially in light of her experience with retained placenta and life-threatening hemorrhaging, was at risk of fatally bleeding. (*Ibid*.) The next morning, Jane Roe delivered her nonviable fetus on the toilet after approximately 19 hours of labor. (Roe Decl. ¶ 66.) She was heartbroken to lose another baby. (*Ibid*.)

B. Dr. Stampe Seeks Answers

After Jane Roe's third pregnancy loss, Dr. Stampe reached out to SJH's leadership. On July 17, 2023, Dr. Stampe met in person with several hospital executives including both the regional and local ethics leaders. (Stampe Decl. ¶ 6.) Dr. Stampe told them about Jane Roe's experience and the consequences of delaying and denying her care. (*Id.*) Later that day, Dr. Stampe followed up with an e-mail message describing Jane Roe's case. (*Ibid* at ¶ 7, Ex. A) But

Dr. Stampe's appeal fell on deaf ears. Despite being confronted with the consequences of its policy, SJH took no action. (*Ibid* at ¶ 6.) It was only a matter of time before another patient would suffer a similar fate.

C. 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, 2024, 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 SJH ED in the early morning hours of February 23, 2024. (*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.[5] (*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.)

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

2. SJH 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 SJH had adequate personnel and facilities, the same policy which prohibited Dr. Stampe from caring for Jane Roe now blocked Dr. McGraw from providing care to Anna Nusslock. Only once 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.) Anna's records show that Dr. McGraw specifically confirmed the scope of SJH's policy only to find her hands firmly tied:

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.) More than seven months after Dr. Stampe had alerted hospital leadership to Jane Roe's case and asked them to shift policy, nothing had changed, and another patient was about to be faced with the same agonizing choices.

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.[6] (*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 SJH asked Anna whether she wanted an ambulance to

[6] 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.)

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.) SJH 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.* ¶ 22.)

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.) But on the way into the Mad River operating room, she spontaneously delivered Twin A on the hospital gurney. (Nusslock Decl. ¶¶ 27-28, Ex. F; Micks Decl. ¶ 12.) And by the time Anna was on the operating table, she was "actively hemorrhaging." (Nusslock Decl. ¶ 28, Ex. F; Micks Decl. ¶¶ 12-13.) Dr. Elizabeth Micks performed a D&E on Anna. (Micks Decl. ¶¶ 11-13.) 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 SJH. (Micks Decl. ¶¶ 8, 14; Hedriana Decl. ¶ 32.) Anna's ordeal stands as vivid illustration of the risks in delaying care.

For Dr. Micks, Anna's case was shocking but not surprising, as Mad River treated one to two patients per year who, like Anna, were discharged from SJH without receiving definitive care for an obstetric emergency. (Micks Decl. ¶¶ 5-6.) Indeed, Anna's case happened less than a year after Dr. Stampe, motivated by his experience caring for Jane Roe, sought to change SJH's policy to no avail. (Stampe Decl. ¶ 6, Ex. A.) SJH has failed to implement a lawful, humane policy and there is every reason to believe that, absent judicial intervention, these scenarios will play out again in the future. (Hedriana Decl. ¶ 36 ["In Humboldt County, a case like Anna Nusslock is going to happen again"].)

D. SJH's New Unlawful Policy

Before this lawsuit was filed, SJH only permitted its physicians to terminate a pregnancy when the patient "was clinically unstable and maternal life was in jeopardy." (Harrison Tr. 45:11-14.) While this was notably an unwritten policy (*ibid* at 108:9-19), the physicians working for SJH nevertheless understood it to be clear and binding. Dr. Stampe, the physician who treated Jane Roe, knew that unless a patient was "actively dying" he could not

terminate a pregnancy, on pain of having his admitting privileges revoked. (Stampe Decl. ¶¶ 3-5.) Dr. McGraw noted in Anna Nusslock's medical records that the hospital policy prohibited her from terminating even a non-viable pregnancy "unless her life is at risk." (Nusslock Decl., Ex. D at p. 18.)

One critical aspect of SJH's policy though was left undefined—precisely how close must death be before a physician may terminate a pregnancy? (*e.g.,* Stampe. Decl. ¶ 5.) SJH has now clarified this in writing for the first time. In prior briefing, SJH submitted a letter from the Most Reverend Robert F. Vasa, Bishop of Santa Rosa, detailing when SJH may terminate a pregnancy consistent with the Ethical and Religious Directives (ERDs) that apply to care at Catholic hospitals. (Hewitt Decl. Ex. 1.) SJH asserted that this letter was binding on the hospital and accordingly, absent an injunction or other order from the Court, represents the hospital's policy. (Opp'n to Mtn. to Enforce at p. 11.) The letter states that SJH is only permitted to perform an abortion where doing so is "the **only alternative to the certain death** of both the mother and the child." (Hewitt Decl. Ex. 1 at 3, emphasis original.) This is an extreme standard with devastating implications for the women of Humboldt County. As Dr. Hedriana explains, waiting until death was "certain" would mean delaying care until the patient was in cardiac arrest or suffering from septic shock—i.e. multiple organ failure. (Hedriana Decl. ¶¶ 39-40.) The statistics are grim: as many as 60% of the women who deteriorate to this point would not survive, and most of those that did would be left with permanent, lifelong injuries and disabilities. (*Ibid.* at ¶ 41-43.)

There are therefore two policies now at issue in this case. The former—under which Jane Roe and Anna Nusslock were treated—allowed the physicians to intervene once the patient's "life is at risk." (Nusslock Decl., Ex. D at p. 18.) For both Jane Roe and Anna Nusslock, delaying care until this undefined risk actually manifested resulted in serious, and entirely avoidable consequences. Both women suffered serious hemorrhages, in addition to the psychological anguish of being denied care during one of the most personal and painful moments of their lives. (Micks Decl. ¶¶ 12-13; Nusslock Decl. ¶ 32 (Nusslock diagnosed with PTSD as a result of her experience at SJH; Roe Decl. ¶ 26 (Roe diagnose with PTSD as a result of her

experience at SJH.) But under SJH's newly announced policy, even a substantial risk to the patient's life would not be enough: a physician may only perform an emergency abortion if it is the "**only alternative to the certain death**" of the mother. (Hewitt Decl. Ex. 1 at 3, emphasis original.) This new policy requiring certainty before intervention has not been implemented due to the prior Stipulation and Order entered by the Court. (Stipulation and Order.) However, as SJH has repeatedly announced that it must comply with this directive, absent injunctive relief the hospital will *not* even return to the standard which governed Roe and Nusslock's care: it will implement something far worse.

IV. 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.)

V. ARGUMENT

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

1. SJH'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 which 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.) Anna's case was particularly severe 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 (acute kidney injury), ARDS (acute respiratory distress syndrome), ICU (intensive care unit) 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 . . . includ[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 is 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. SJH violates the ESL by refusing to provide abortions in an emergency

Under both the old and new versions of its policy, SJH does not immediately offer treatment that relieves the threat posed by PPROM and similar conditions. Instead, SJH only allows for expectant management until a sufficiently grave threat to the patient's life materializes (or, under the new policy, once death is "certain"). Both versions of the policy violate the ESL for two distinct reasons.

First, the ESL requires that SJH 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 (and potentially irreversibly so) 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 withholding definitive care until the patient's very life is at stake, SJH 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, SJH 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 both Nusslock and Roe's cases, where the delay caused by SJH's policy meant that both patients suffered hemorrhages by and were exposed to heightened—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 Nusslock 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, SJH's policy virtually guarantees they will worsen.

SJH's newly articulated policy requiring "certain death" before terminating a pregnancy violates the ESL in a third way. The ESL requires a hospital to act whenever a person "is in ***danger*** of loss of life or serious injury or illness." (Health & Saf. Code, § 1317, subd. (a), emphasis added.) Acting immediately once danger is apparent is the only sensible rule because from a medical perspective, it is difficult to predict the course of any illness and if physicians wait until death (or other serious injury) is imminent, they will frequently be unable to pull a patient back from the brink. (Hedriana Decl. ¶¶ 41-42 [obstetric septic shock has a mortality rate of 50-60%].) SJH's policy requiring actual certainty before a physician may offer definitive treatment

accordingly violates this rule, and guarantees that absent an injunction, patient outcomes at SJH will be even worse than before.

2. SJH 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).)[7] SJH 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. ¶ 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 SJH's shortcomings. Not only did SJH 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.*) Similarly, Jane Roe was improperly discharged from SJH twice. The first time she was fortunately able to avoid serious physical complications despite the five hour drive to San Francisco. (Roe Decl. ¶¶ 21-23.) But the second time once again illustrated the risks of delayed care—she was forced to

[7] "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).)

endure active labor alone, and by the time she made it to her outpatient appointment the next morning, it was too late to avoid a hemorrhage. (*Ibid.* at ¶¶ 42-47.)

SJH's policy meant that it did not and will not offer Anna, Jane, or any similarly situated patient sufficient care to prevent them from seriously deteriorating by the time they might receive definitive care at another hospital. *See* Micks Decl. ¶¶ 10-11. SJH's conduct shows it is fully aware of this risk: after discharging Anna to the street, SJH offered her a bucket and towels in case *something* happened during her drive to Mad River. (Nusslock Decl. ¶ 23.) The ESL requires far more.

3. SJH's policy violates the bar on the corporate practice of medicine.

SJH's policy is also unlawful because it violates the bar on the corporate practice of medicine. In California, "corporations and other artificial legal entities shall have no [medical] professional rights, privileges, or powers." (Bus. & Prof. Code, §§ 2400, 2052.) The doctrine exists to ensure the professional independence of physicians and prevent "a secondary and divided loyalty to the patient." (*Steinsmith v. Med. Bd. of Cal.* (2000) 85 Cal.App.4th 458, 466; *see also Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.* (C.D. Cal. 2015), 121 F. Supp. 3d 950, 977 ["Courts have said that the ban on the corporate practice of medicine is intended to ameliorate the evils of divided loyalty and impaired confidence" which accompany non-physician control of medicine."].) This prohibition applies with equal force to for-profit and non-profit corporations because the fundamental danger of allowing non-doctors to make medical decisions "attends all types of corporations." (*Cal. Physicians Service v. Aoki Diabetes Research Institute* (2008), 163 Cal.App.4th 1506, 1515-16.) SJH's policy has the hospital second guess the professional judgment of treating physicians—in an emergency situation no less—and actually prohibits doctors from implementing the standard of care in many cases. (Hedriana Decl. at ¶¶ 33, 44.) This kind of policy, which fundamentally undermines the physician-patient relationship, is precisely why corporations are barred from medical decision making, and is all the more reason why the People are likely to prevail on the merits. (*Steinsmith*, 85 Cal.App.4th at 466 [corporate bar exists to ensure only doctors and patients make medical decisions free from corporate interference].)

4. SJH has no first amendment defense.

In prior motion practice, SJH contended that its religious liberty rights under the First Amendment preclude the People's claims. These arguments are all meritless and do not dent the People's chance of success on the merits.

The ESL is a neutral law of general applicability. 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; *Civil Right Dept v. Cathy's Creations, Inc.* (2025) 109 Cal.App.5th 204, 262 ["[A]n individual's religious beliefs do not excuse him from compliance with an otherwise valid law prohibiting conduct that the State is free to regulate. Thus, 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."] (citation and quotation marks omitted).) As this Court previously found, "the ESL is neutral as to religion and is a statute of general applicability" and therefore "the ESL is not an unconstitutional infringement of [SJH]'s right to free religious expression." (Order on Demurrer at p. 10.) The People's claims are accordingly only subject to rational basis review, a threshold they easily clear. (*Ibid.*) And even if enforcing the ESL triggered strict scrutiny, the Court already ruled that this is the rare case where the government can meet this burden. (*Ibid.* at pp. 10-12 [the ESL "serves a specific and identified compelling government interest" and is narrowly tailored to promote that interest].).

No animus. SJH has asserted that while the ESL may be neutral on its face, the Attorney General's decision to enforce it against a Catholic hospital shows anti-religious animus. But the only evidence SJH has mustered to support this argument are a handful of statements from a press conference characterizing its policy as "extreme." But courts consistently find that this kind of conduct is insufficient to overcome a law's facial neutrality or to trigger strict scrutiny. (*Yelp, Inc. v. Paxton* (9th Cir. 2025) 137 F.4th 954, 956 [the "commonplace stridency of prosecutorial press releases" are not enough to show bad faith or animus]; *Cath. League for Religious and Civil Rights v. City and Cnty of San Francisco* (9th Cir. 2009) 567 F.3d 595, 605 [statements which "taken in isolation, may be said to convey disparagement towards the Catholic Church" were not

sufficient to show an outright motivation to discriminate].) As a litigant and elected official, the Attorney General "is entitled to mount a zealous and forceful legal challenge" and nothing in the record comes close to showing hostility to SJH's faith.

Church Autonomy does not apply here. The Church Autonomy Doctrine provides that civil courts "may not adjudicate the correctness of an interpretation of canonical text or some decision making relating to government of the religious polity." (*Burri Law PA v. Skurla* (9th Cir. 2022) 35 F.4th 1207, 1212, citing *Paul v. Watchtower Bible & Tract Soc.* (9th Cir. 1987) 819 F.2d 875, 878, fn. 1.) The doctrine is intended to allow religious institutions to determine "matters of church government as well as those of faith and doctrine" free from secular interference. (*Zinski v. Liberty Univ., Inc.* (W.D.Va. 2025) 777 F. Supp. 3d 601, 648, quoting *Kedroff v. St. Nicholas Cathedral of Russian Orthodox Church in N. Am.* (1952) 344 U.S. 94, 116.) The People's claim turns on a straightforward, and entirely secular question: does SJH's policy on emergency abortion care violate the ESL? Resolving this dispute does not impact the internal governance of the Catholic Church nor must the Court weigh the "correct" interpretation of Christian dogma. Church Autonomy therefore simply does not apply to this case.

SJH's true argument seems to run deeper, contending that because its policies on abortion are rooted in the tenants of the Catholic Church, it cannot be held liable, even if those policies contravene the ESL. But that is not the law—Church Autonomy "does not mean that religious institutions enjoy a general immunity from secular laws." (*Kentucky v. Beshear* (6th Cir. 2020) 981 F.3d 505, 510, quotation marks and citation omitted; *see also Belya v. Kapral* (2nd Cir. 2022) 45 F.4th 621, 630 ["simply having a religious association on one side of the 'v' does not automatically mean a district court must dismiss the case"]; *Smith,* 494 U.S. at 885 [secular laws may be enforced notwithstanding religious burdens].) So long as enforcing the ESL does not involve an "internal church dispute" or competing "interpretations of religious doctrine," Church Autonomy poses no obstacle to the People's case. (*Roman Cath. Archbishop of L.A. v. Super Ct.* (2005), 131 Cal.App.4th 417, 432.)

5. The 2015 conditions of consent do not allow SJH to violate the ESL

SJH has previously contended that the 2015 Conditions of Consent, under which the Attorney General approved the merger of SJH and Providence, bar this action. This argument—that the Conditions of Consent preclude enforcement of the ESL—is without merit, for two reasons. First, the Conditions of Consent contain no explicit reference to the ESL, or emergency abortion services. The Attorney General may "impose" conditions on a transaction and enforce them to the fullest extent provided by law—including by seeking "specific performance, injunctive relief, and other equitable remedies." (Corp. Code, § 5926.) Once the transaction is executed, the purchaser is subject to the Attorney General's conditions. (Corp. Code, §§ 5914, 5926.) As such, the Conditions of Consent are subject to the rules of statutory interpretation. The canons of statutory construction prevent this Court from reading language into a statute that is not there, or importing a requirement into a statute that does not exist. (*Midwest Motor Supply Co. v. Superior Court* (2020) 56 Cal.App.5th 702, 710 [courts cannot read into a law a provision that does not exist and is not shown to be the intent of the lawmakers].) The Conditions of Consent do not contain any reference to emergency abortion or the ESL; therefore, they cannot preclude the Attorney General's enforcement of the ESL here.

Second, the Attorney General could not have implicitly agreed to waive future enforcement of any law, including the ESL, because "[a] state is without power to enter into binding contracts not to exercise its police power in the future." (*Interstate Marina Dev. Co. v. County of Los Angeles* (1984) 155 Cal.App.3d 435, 448, citations omitted.) Such powers include those that "are necessary for the general good of the public." (*Mendly v. County of Los Angeles* (1994) 23 Cal.App.4th 1193, 1204, quotations omitted.) Therefore, the Conditions of Consent do not allow SJH to violate the ESL, a law intended to ensure that the public receives emergency medical treatment.

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 "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, SJH's violations of the ESL are also predicates for an injunction under Business and Professions Code sections 17200 and 17204.[8] 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 the state's need to guarantee equal access to medical care outweighs a defendants' interest in religious liberty. (*North Coast Women's Care Med Grp v. Super Ct.* (2008), 44 Cal.4th 1145, 1158 ["that burden [on religious exercise] is insufficient to allow them to engage in such discrimination"]; *Catholic Charities v. Super Ct.* (2004), 32 Cal.4th 527, 564 [contraception requirement imposed on Catholic organization passed strict scrutiny]; *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"].) 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 Jane Roe and Anna Nusslock went through is more than enough to justify an injunction. But there is a demonstrable need for

[8] 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."].)

preliminary relief here. Mad River closed its L&D unit in October 2024, leaving SJH with the only L&D unit in all of Humboldt County, and the only reliable source of care in an obstetric emergency. (Micks Decl. ¶ 16.) Any future patient in Anna or Jane's shoes may face an even more agonizing choice than she did. On the one hand, they can stay at SJH, wait until they are close enough to death to receive care, and hope that SJH'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.[9] Either option presents unacceptable risks to patient health and safety. Unfortunately, it is virtually certain that very soon, someone in Humboldt 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 people will be high."].)

The balance of equities tips particularly strongly in favor of an injunction because absent immediate relief, Humboldt County will not return to the pre-litigation status quo: it will see something much worse. Not only will Mad River no longer be able to serve as a partial safety net, SJH will be following a far harsher and dangerous policy than before. Rather than its prior, unwritten policy which allowed physicians to intervene once there was a substantial, if undefined risk to the mother's life, SJH would now require "**certain death"** before doctors could offer definitive treatment. (Hewitt Decl. Ex. 1 at 3, emphasis original.) Humboldt County will have, in practice, a ban on abortion whose only exception is when a woman is at death's door. (Hedriana Decl. ¶¶ 40-44.) Unfortunately, the risks of such a policy are clearly illustrated by the experiences of women living in states with abortion bans. Since the *Dobbs v. Jackson Women's Health Organization* (2022) 597 U.S. 215 decision, a number of states have banned abortion with ill-defined exceptions for life-threatening situations.[10] Yet, as here, there are no bright line rules as

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

[10] Felix, et al., *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services* (Jun. 6, 2024) Propublica, https://www.kff.org/womens-health- (continued…)

to what constitutes a "life-threatening" situation, so doctors hesitate to rely on their professional medical judgment, even in situations where the standard of care dictates that an abortion should be performed to relieve an emergent condition.[11] Thus, these "life-only" exceptions have only been used in the most extreme circumstances.[12] The result: Patients experience life-threatening outcomes exacerbated by unnecessary delays or refusal of treatment, suffer intense trauma, and several have even died preventable deaths.[13] Absent injunctive relief, this would be the reality in Humboldt County as well. The balance of equities therefore tips overwhelmingly in favor of an injunction at this stage.

CONCLUSION

The Court should grant the People's motion for preliminary injunction to prevent SJH 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.

policy/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/#82f39306-adfc-4ce5-b96b-a9c5f58b68b6.

[11] Kavita Surana, *Their States Banned Abortion. Doctors Now Say They Can't Give Women Potentially Lifesaving Care*, ProPublica, (Feb. 26, 2024), https://www.propublica.org/article/abortion-doctor-decisions-hospital-committee (describing Tennessee doctors' uncertainty as to whether 50% chance of death is "necessary" to prevent death in doctor's "reasonable" medical judgment).

[12] *Ibid*; Klibanoff, *Texas Legislature Clarifies When Doctors Can Perform Life-saving Abortions*, The Texas Tribune (May 22, 2025), https://www.texastribune.org/2025/05/21/texas-abortion-exception-save-mothers/ (Texas abortion ban exception that allows doctors to terminate a pregnancy only to save a pregnant patient's life resulted in at least three women dying as a result).

[13] Daniel Grossman et al., *Care Post-Roe: Documenting Cases of Poor-Quality Care Since the Dobbs Decision*, Advancing Studies in Reproductive Health, p. 2, (May 2023), https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf.

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