No. 23-726 and 23-727

In the Supreme Court of the United States

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, ET AL.,

Petitioners,

v.

UNITED STATES OF AMERICA

Respondent.

(For continuation of caption, see inside cover.)

On Writs of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AMERICAN MEDICAL ASSOCIATION, ET AL. AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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STATE OF IDAHO

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INTEREST OF *AMICI CURIAE*[1]

Amici are the leading professional medical organizations; ensuring access to evidence-based health care and promoting health care policy that improves patient health are central to their missions. *Amici* believe that all patients are entitled to prompt, complete, and unbiased emergency health care that is medically and scientifically sound and is provided in compliance with the federal Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"). *Amici* submit this brief to explain how EMTALA has been understood and applied in the practice of emergency medicine and the role that abortion care plays as stabilizing treatment required by EMTALA. A full list of the twenty-three participating medical organizations is provided as an appendix to the brief. Among them are:

American College of Obstetricians and Gynecologists (ACOG): Representing more than 90% of board-certified OB/GYNs in the United States, ACOG is the nation's premier professional membership organization for obstetrician-gynecologists dedicated to access to evidence-based, high-quality, safe, and equitable obstetric and gynecologic care. ACOG maintains the highest standards of clinical practice and continuing education of its members,

[1] No counsel for any party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae* or their counsel made a monetary contribution to the preparation or submission of this brief.

promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access for all people to the full spectrum of evidence-based quality reproductive health care, including abortion care, and is a leader in the effort to confront the maternal mortality crisis in the United States.

American College of Emergency Physicians (ACEP): ACEP is the nation's leading medical society representing emergency medicine. Through continuing education, research, public education, and advocacy, ACEP advances emergency care on behalf of its approximately 38,000 emergency physician members and the more than 150 million people they treat on an annual basis. Both by law and by oath, emergency physicians must care for all patients seeking emergency medical treatment. ACEP members represent a diverse array of personal and political beliefs, yet they are united in the belief that emergency physicians must be able to practice high-quality, objective, evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship.

American Medical Association (AMA): The AMA is the largest professional association of physicians, residents, and medical students in the United States. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty and in every state.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Idaho's abortion ban, Idaho Code § 18-622 (the "Idaho Law"), endangers patients by interfering with the patient-clinician relationship and medical ethics, and by preventing medically indicated care, in violation of federal law. As a result of the Idaho Law, clinicians are unable to provide necessary treatment to some pregnant patients experiencing medical emergencies. For nearly four decades, EMTALA has ensured that patients with emergency medical conditions, as defined by EMTALA, receive the care they require—but the Idaho Law conflicts with that long-established requirement and creates a dangerous situation for both clinicians and patients.

Amici's members have long provided abortion as a necessary stabilizing treatment under EMTALA for pregnant patients in some instances. But the Idaho Law prohibits that emergency care even when it is appropriately based on well-established clinical guidelines and dictated by medical ethics. As a result, healthcare providers are being forced to disregard their patients' clinical presentations, their own medical expertise and training, and their obligations under EMTALA—or else face criminal prosecution. This bind has compelled clinicians to leave Idaho for states where they will not face criminal liability for responsibly practicing medicine, depriving many in Idaho who seek reproductive healthcare, including people who are not pregnant and people needing routine pregnancy care, from easily accessing even routine OB/GYN care.

ARGUMENT

I. Pregnant Patients Can Require Stabilizing Treatment in Emergency Medical Situations.

A. Nature of Emergency Care for Pregnant Patients

"Emergency medicine" is a wide-ranging medical specialty that is "dedicated to the diagnosis and treatment of unforeseen illness or injury."[2] This practice encompasses the initial evaluation and diagnosis, as well as "treatment, coordination of care among multiple clinicians or community resources, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care."[3] Emergency care is not confined to treatment in an emergency department ("ED") and can be practiced across a hospital and other locations.[4]

Amici's members provide emergency medical care in all its forms, serving patients across the nation. In doing so, clinicians use their medical judgment—honed through years of education, training, and experience—to provide evidence-based care that is consistent with clinical guidance and responsive to

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[2] ACEP, *Definition of Emergency Medicine* 1 (Jan. 2021), https://www.acep.org/siteassets/new-pdfs/policy-statements/definition-of-emergency-medicine.pdf.

[3] *Id.*

[4] *Id.* ("Emergency medicine is not defined by location but may be practiced in a variety of settings including, but not limited to, hospital-based and freestanding emergency departments (EDs), urgent care clinics, observation medicine units, emergency medical response vehicles, at disaster sites, or via telehealth.").

their patients' individualized needs to ensure the health and safety of their patients.[5]

Emergency care providers regularly treat pregnant patients for emergent medical conditions, which can and do arise from the many risks associated with pregnancy,[6] as well as other trauma that may implicate the pregnancy's safety or viability, like car accidents.[7] Pregnant patients may receive emergency care in the ED or in labor and delivery

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[5] Idaho suggests that allowing EMTALA to preempt the Idaho Law means EMTALA would also preempt other state laws, potentially allowing for experimental medicine to be administered in emergency rooms. *See* Idaho Br. 4, 25-26. This misunderstands the nature of emergency medicine, where myriad checks exist to ensure that clinicians provide quality, evidence-based medical care. All care is subject to review under the direction of a hospital medical director, a compliance practice required for a hospital to retain accreditation. And of course, providers could face malpractice lawsuits or the loss of their medical license for inappropriate care.

[6] The U.S. mortality rate associated with live births was a staggering 32.9 per 100,000 live births in 2021, up from 23.8 in 2020. *See* Donna Hoyert, *Maternal Mortality Rates in the United States, 2021*, Ctrs. for Disease Control & Prevention 1 (Mar. 2023), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf. Pre-existing conditions and comorbidity with other illnesses further increase the likelihood of pregnancy complications. *See*, *e.g.*, *High-Risk Pregnancy*, Cleveland Clinic, https://my.clevelandclinic.org/health/diseases/22190-high-risk-pregnancy (last reviewed Dec. 14, 2021) (describing how preexisting conditions exacerbate the risks of the pregnancy). *See infra*, Section IV.

[7] Kimberly A. Kilfoyle et al., *Non-Urgent and Urgent Emergency Department Use During Pregnancy: An Observational Study*, Am. J. Obstetrics & Gynecology, Feb. 1, 2018, at 1, 2, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5290191/pdf/nihms824518.pdf.

units from obstetrician-gynecologists, from family physicians, or from any number of other medical specialists.[8] Hospital-based obstetric units collaborate with EDs because "labor and delivery units frequently serve as emergency units for pregnant women."[9] Hospitals structure these collaborative treatment efforts by establishing protocols for cooperation and triage between delivery units and EDs, as well as for the appropriate stabilization of pregnant patients in accordance with EMTALA.[10]

Speed is of the essence when providing emergency care. When patients first present with emergency conditions, providers must make the complex determination of what care is needed and what specialists should be involved in a time-sensitive situation. Rapid treatment improves patient outcomes, while delayed treatment increases the risk of complications, permanent injury, or death.[11] Accordingly, clinicians regularly provide rapid treatment in emergency scenarios: "Patients often arrive at the emergency department with acute illnesses or injuries that require immediate care * * * there is a presumption for quick action guided by predetermined

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[8] ACEP, *Definition of Emergency Medicine*, *supra* n.2, at 1; *see also* ACOG Committee Opinion No. 667, *Hospital-Based Triage of Obstetric Patients* (July 2016), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2016/07/hospital-based-triage-of-obstetric-patients.pdf.

[9] *See* ACOG Committee Opinion No. 667, *supra* n.8, at 1.

[10] *See id.* at 2.

[11] *See*, *e.g.*, Robert W. Neumar, *The Zerhouni Challenge: Defining the Fundamental Hypothesis of Emergency Care Research*, 49 Annals Emergency Med. 696 (2007).

treatment protocols."[12] This includes treatment of pregnancy-related emergencies where "[e]arly diagnosis and treatment are paramount to reducing maternal morbidity and mortality."[13]

B. Pregnant Patients Regularly Require Emergency Care, and that Care Sometimes Includes Abortion.

Pregnant patients are regular visitors to emergency departments, often as a result of complications that occur during pregnancy.[14] The majority of emergency providers see pregnant patients in virtually every shift, presenting with conditions like abdominal pain, vaginal bleeding, or other pregnancy-related issues.[15] While not all pregnancy complications require emergency intervention,

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[12] ACEP, *Code of Ethics for Emergency Physicians* 4 (Oct. 2023), https://www.acep.org/siteassets/new-pdfs/policy-statements/code-of-ethics-for-emergency-physicians.pdf; *see also* infra Section V.

[13] Katherine Tucker et al., *Delayed Diagnosis and Management of Second Trimester Abdominal Pregnancy*, BMJ Case Rep., Sept. 2017, at 1, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5589052/pdf/bcr-2017-221433.pdf.

[14] In 2019, over 3.5 million women visited EDs for reasons related to pregnancy (other than delivery), with an additional 216,981 pregnant women visiting for reasons not primarily related to their pregnancy. Healthcare Cost & Utilization Project, *Emergency Department and Inpatient Utilization and Cost for Pregnant Women: Variation by Expected Primary Payer and State of Residence, 2019*, Agency for Healthcare Rsch. & Quality 30 (Dec. 14, 2021), https://hcup-us.ahrq.gov/reports/ataglance/HCUPanalysisHospUtilPregnancy.pdf.

[15] *Id.*

emergencies involving pregnant patients are frequent and can be dangerous. Pregnant patients may present with a range of serious issues, including:

- **Preterm prelabor rupture of membranes** ("PPROM"), where the amniotic sac ruptures early, presenting a major maternal risk of infection, abruption, and sepsis;[16]

- **Miscarriage or early pregnancy loss** ("EPL"), which is extremely common, occurring in approximately 10% of clinically recognized pregnancies.[17] Pregnant patients seek care in the ED with miscarriage-related concerns hundreds of thousands of times each year.[18] A miscarriage

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[16] ACOG Practice Bulletin No. 217, *Prelabor Rupture of Membranes*, 135 Obstetrics & Gynecology, Mar. 2020, at e80. PPROM occurs in approximately 150,000 pregnancies yearly in the United States. *See* Allahyar Jazayeri, *Premature Rupture of Membranes*, Medscape, https://emedicine.medscape.com/article/261137-overview?form=fpf (last updated Feb. 24, 2023).

[17] ACOG Practice Bulletin No. 200, *Early Pregnancy Loss* (Nov. 2018).

[18] Carolyn A. Miller et al., *Patient Experiences with Miscarriage Management in the Emergency and Ambulatory Settings*, 134 Obstetrics & Gynecology 1285, 1285 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6882532/pdf/ong-134-1285.pdf (noting that "[p]atients with concerns about a potential miscarriage * * * present for care in [EDs] at a rate of approximately 500,000 each year in the United States"); Lyndsey S. Benson et al., *Early Pregnancy Loss in the Emergency Department, 2006–2016*, J. Am. Coll. Emergency Physicians, Aug. 2021, at 1–2,

may put a patient at risk of excessive blood loss and serious infection as long as the products of conception remain in the uterus, yet also may involve a pregnancy that will not continue but in which embryonic or fetal cardiac activity is observed;[19]

- **Gestational hypertension and preeclampsia** (high blood pressure), which complicate 2–8% of pregnancies globally and are among the leading causes of maternal mortality around the world;[20]

- **Excessive bleeding**, which can be caused by placenta accreta spectrum and other conditions;[21]

- **Placental abruption**, which is when the placenta separates from the inner wall of the uterus, causing serious and potentially uncontrollable bleeding. It is the cause of stillbirth in up to 10% of cases and can

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8571073/pdf/EMP2-2-e12549.pdf (finding that "EPL-related care accounts for over 900,000 ED visits in the United States each year").

[19] ACOG Practice Bulletin No. 200, *supra* n.17.

[20] ACOG Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (June 2020); *see also* J.A. 670 (discussing situations in which high blood pressure or preeclampsia might occur).

[21] *See FAQs: Bleeding During Pregnancy*, ACOG (Aug. 2022), https://www.acog.org/womens-health/faqs/bleeding-during-pregnancy; ACOG Obstetric Care Consensus No. 7, *Placenta Accreta Spectrum* (last updated 2021).

> result in serious complications for the patient, like cardiac arrest or kidney failure.[22]

These are just a few examples of the myriad emergencies that can arise during pregnancy. The American Board of Emergency Medicine's Model of Clinical Practice of Emergency Medicine, the definitive source and guide to the core content found on emergency physicians' board examinations, contains an entire section devoted to "Complications of Pregnancy."[23] Nearly all listed conditions are graded as "critical" or "emergent," meaning that they "may progress in severity or result in complications with a high probability for morbidity if treatment is not begun quickly."[24]

Clinicians who provide emergency care have always understood that stabilizing treatment for pregnant patients experiencing one of these complications can include abortion. Abortion may be the necessary stabilizing care when continuing a pregnancy risks severe health consequences to the patient, like loss of uterus (and future fertility),

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[22] See *United States* v. *Idaho*, 623 F. Supp. 3d 1096, 1104 (D. Idaho 2022) (discussing placental abruption complications); ACOG Obstetric Care Consensus No. 10, *Management of Stillbirth* (Mar. 2020), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/obstetric-care-consensus/articles/2020/03/management-of-stillbirth.pdf.

[23] Michael S. Beeson et al., *2022 Model of the Clinical Practice of Emergency Medicine*, 64 J. Emergency Med. 659, 679 (2022), https://www.jem-journal.com/action/showPdf?pii=S0736-4679%2823%2900063-X.

[24] *Id.* at 661–662.

seizures, stroke, vital organ damage and failure, and death.

Petitioners' *amici* suggest that abortion is never medically indicated in an emergency.[25] But they do so by creating a new, non-medical definition of "abortion." According to *amici*, to know whether something is an "abortion," you must look to the intent behind the procedure.[26] If a provider terminates the pregnancy of a patient with PPROM in her 17th week of pregnancy—but did so to save the patient's life—the procedure is transformed from an abortion to a "separation."[27] But if another provider terminates a pregnancy of a second patient experiencing the same complications at the same gestational age—but did so to prevent organ loss—that *is* an abortion. This new theory invents a distinction and non-existent classification that are contrary to established medical standards of care and unworkable in practice. By trying to rename certain medically necessary abortions, Petitioners' *amici* attempt to remove the conflict between Idaho's criminal abortion ban, which prohibits abortion care unless necessary to prevent the death of the pregnant person, and EMTALA, which requires stabilizing care for the broad range of emergent conditions that can result in serious threats to life and health.

In many of the emergency medical conditions requiring abortion care, the loss of the pregnancy is inevitable. When a pregnant patient experiences

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[25] *See* Amicus Br. of the Am. Ass'n of Pro-Life Obstetricians & Gynecologists 10.

[26] *See id.* at 6.

[27] *See id.*

PPROM prior to viability, continuing the pregnancy risks serious health consequences including sepsis and death.[28] Pre-eclampsia prior to viability also presents a risk of serious health consequences including seizure, stroke, multiple organ failure, and even death.[29] An inevitable or incomplete abortion—commonly called a miscarriage—can cause excessive bleeding and risk of hemorrhage or infection and fetal or embryonic cardiac activity may remain. Other emergency situations occur precisely because a pregnancy is not viable and will not result in a live birth, like a molar or ectopic pregnancy.[30] In these and other cases, abortion may be required to stabilize the patient.[31]

II. EMTALA Has Always Required Clinicians to Provide Stabilizing Treatment to Pregnant Patients—Including Termination of Pregnancy in Some Situations.

EMTALA has required hospitals to provide stabilizing care since its passage over 35 years ago. And since that time, that care has included abortion care when it is the medically indicated treatment to

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[28] ACOG Practice Bulletin No. 217, *supra* n.16, at 81.

[29] ACOG Practice Bulletin No. 222, *supra* n.20, at 245.

[30] ACOG Practice Bulletin No. 193, *Tubal Ectopic Pregnancy* (Mar. 2018); Neil Horowitz et al., *Epidemiology, Diagnosis, and Treatment of Gestational Trophoblastic Disease: A Society of Gynecologic Oncology Evidenced-Based Review and Recommendation*, 163 Gynecologic Oncology 605 (2021), https://www.gynecologiconcology-online.net/action/showPdf?pii=S0090-8258%2821%2901421-9.

[31] *See, e.g.*, ACOG Practice Bulletin No. 217, *supra* n.16, at 88.

stabilize a pregnant patient. EMTALA defines an emergency medical condition as:

> A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.[32]

EMTALA requires that treatment be provided to any patient that presents with an emergency condition "until the emergency medical condition is resolved or stabilized."[33]

EMTALA does not specify the particular treatment that should be provided in a given situation. Instead, when a clinician determines that an individual has an emergency medical condition, the clinician must provide "*such treatment as may be required* to stabilize the medical condition."[34] EMTALA properly defers to the medical judgment of the

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[32] 42 U.S.C. § 1395dd(e)(1)(A).

[33] ACEP, *Understanding EMTALA*, https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/ (last visited Mar. 26, 2024).

[34] 42 U.S.C. § 1395dd(b)(1)(A) (emphasis added). Of course, EMTALA also recognizes that patients may refuse to consent to the recommended medical treatment. *Id.* § 1395dd(b)(2).

clinician(s) responsible for treating the patient to determine how best to achieve the required objective of stabilization. That decision-making, in turn, is informed by established clinical guidelines that are painstakingly developed and regularly updated according to the latest expert reviews of the medical evidence.[35]

The reverse is also true. EMTALA does not allow physicians to withhold specific treatments for non-medical reasons. Rather, if a treatment is "required to stabilize the medical condition," it must be made available to the patient—full stop.[36]

III. The Idaho Law Criminalizes Care EMTALA Requires.

The Idaho Law directly conflicts with a provider's ability to provide stabilizing care required by EMTALA. Abortion has long been understood as a necessary, standard, and evidence-based medical treatment in emergency situations. Yet the Idaho Law has taken a long-standing, essential medical practice and defined it as criminal, even in emergency

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[35] ACOG, *Clinical Practice Guideline Methodology*, 138 Obstetrics & Gynecology 518 (2021).

[36] *Id.* Principles of informed consent allow patients to make an intentional and voluntary choice regarding their medical care, which may include refusal of care or treatment. While EMTALA requires clinicians to make available appropriate medical care, patients retain the ultimate authority to accept or decline care. 42 U.S.C. § 1395dd(b)(2); *see also* ACOG Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology.

situations that endanger the lives, health, and well-being of patients and their families.[37]

Providers are unable to comply with both the Idaho Law and EMTALA during obstetrical emergencies for two related reasons. The Idaho Law allows for abortion only in the most narrow and limited situations: when "necessary to prevent the death" of the pregnant patient.[38] EMTALA, in contrast, requires stabilizing medical treatment be provided to patients presenting for emergency care in a broader set of circumstances to ensure the patient's health is not placed in jeopardy.[39] There are many situations where providers will be unable to comply with both EMTALA and the Idaho Law, given the level of severity and the delayed timing of intervention that is required by the Idaho Law.

First, the level of severity. The Idaho Law sets the threshold far higher before a physician can provide medical treatment: the patient must be facing death before an abortion can be provided. EMTALA, on the other hand, requires stabilizing medical care when "the absence of immediate medical attention" would place the patient's health in "serious jeopardy" or cause serious bodily impairment or dysfunction.[40] This is appropriate given the course of many pregnancy complications. Delaying care can and does result in severe maternal morbidity and

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[37] St. Luke's Health Sys. Amicus Br. 12–16.

[38] Idaho Code § 18-622(2)(a)(i); *see also Idaho*, 623 F. Supp. 3d at 1109–1112.

[39] 42 U.S.C. § 1395dd(e)(1)(A).

[40] *Id.*

mortality for many patients.[41] In contrast, even if the pregnant patient is at risk of severe health consequences or even death, the Idaho Law's requirement that the procedure be "necessary" to prevent death requires a level of certainty that is not consistent with actual medical practice and will delay stabilizing treatment past the point when EMTALA and medical ethics require intervention.

This presents the second issue, timing. No clinical bright line defines when a patient's condition crosses the lines of this continuum. At what point does the condition of a pregnant woman with a uterine hemorrhage deteriorate from health-threatening to the point that an abortion is "necessary" to prevent death? When is it certain she will die but for medical intervention? How many blood units does she have to lose? One? Two? Five? How fast does she have to be bleeding? Soaking through two

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[41] One *amicus* has relied on a selective interpretation of statistics to suggest to this Court that reduced access to abortion care following this Court's decision in *Dobbs* v. *Jackson Women's Health Organization*, 597 U.S. 215 (2022), has counterintuitively led to a decrease in maternal mortality. Am. Ass'n of Pro-Life Obstetricians & Gynecologists Amicus Br. 21. This conclusion is premised on a misunderstanding of underlying data: the source on which that *amicus* relies provides a rolling 12-month mortality count, and the decline in rolling 12-month mortality which began in the summer of 2022 reflects decreasing maternal mortality over the course of 2021—nearly a full year before the decision. Amanda Jean Stevenson & Leslie Root, *Do Abortion Bans Somehow Save Pregnant People's Lives? A Cautionary Research Note on Trends in Maternal Death Post-Dobbs* (2024), https://osf.io/preprints/socarxiv/jtkqe. Indeed, "data with which to examine the relationship between post-Dobbs abortion bans and trends in maternal death will take years to become available." *Id*.

pads an hour? Three? How low does her blood pressure need to be? 90 over 60? 80 over 50? And at what point in time does the condition of a pregnant patient with sepsis from a uterine infection deteriorate from health threatening, to life-threatening, to necessarily about to die? If the standard treatment of IV fluids does not stop her blood pressure from dropping, is her condition now life-threatening? Even if life-threatening, is the care "necessary" to prevent her death? Is it when she is unconscious, and any further treatment has become more complex and fraught with risk and further complications? And clinicians are expected to make these judgments under threat of severe criminal penalties.

The decision by the Idaho Supreme Court, issued after the preliminary injunction before the Court, that finds the Idaho Law to have a "subjective" standard does not change this result.[42] Even under the subjective standard, a provider in an emergency situation in Idaho must believe that an abortion is "necessary" to save the life of the pregnant patient before delivering medical care—a standard inconsistent with actual medical practice and the complex and nuanced situations that clinicians face every day.

There is simply no practicable way to apply this test in emergency medical care—as the District Court recognized, "medicine rarely works in absolutes."[43] Life and health exist on a fragile and

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[42] *Planned Parenthood Great Nw.* v. *State*, 522 P.3d 1132, 1203–1204 (Idaho 2023).

[43] *Idaho*, 623 F. Supp. 3d at 1112.

shifting continuum, and in emergent situations, providers must and do act quickly to preserve it. They cannot be expected, and should not be compelled, to delay stabilizing treatment until a legislatively imagined but medically nonexistent line has been crossed.

IV. The Idaho Law Has Devastating Consequences for Pregnant People and People Who May Become Pregnant.

The narrow exceptions in the Idaho Law prevent clinicians from performing abortions in emergencies. Any provider considering terminating a pregnancy—even where the life of the pregnant patient is clearly threatened—will have the possibility of prosecution looming. Providers have to consider that they may still face criminal investigation and indictment; that they may bear the cost of retaining counsel and defending their decisions to a lay jury; and that they would risk loss of their medical license, livelihood, reputation, or even conviction if a jury decides that they were not correct in their medical judgment. These considerations inevitably lead both to the delay of necessary care, and to clinicians making the personal choice to leave Idaho and practice in states where they do not face these threats simply for practicing medicine.

A. Pregnant People Are Already Experiencing and Will Continue to Experience Negative Consequences as a Result of the Idaho Law.

Patients already suffer and will continue to suffer direct harms from the Idaho Law. Maternal mortality remains a crisis in America. Most maternal deaths are preventable. Indeed, a recent study concluded that approximately four in five pregnancy-related deaths nationwide are preventable.[44] Deterring and delaying care to Idaho patients facing obstetrical emergencies will inevitably worsen those outcomes.

In states with abortion bans—including Idaho—nearly 40 percent of OB/GYNs surveyed stated that they've been constrained in providing care for pregnancy-related emergencies.[45] Abortion bans like Idaho's fail to capture the nuances of emergency medicine, creating substantial confusion about what

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[44] *Four in 5 Pregnancy-Related Deaths in the U.S. Are Preventable*, Ctrs. for Disease Control & Prevention (Sept. 19, 2022), https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html; *see also* Susanna Trost et al., *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019*, Ctrs. for Disease Control and Prevention (2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/docs/pdf/Pregnancy-Related-Deaths-Data-MMRCs-2017-2019-H.pdf.

[45] Brittni Frederiksen et al., *A National Survey of OBGYNs' Experiences After Dobbs*, Kaiser Fam. Found. (June 21, 2023), https://www.kff.org/report-section/a-national-survey-of-obgyns-experiences-after-dobbs-report/.

is and isn't legal.[46] For example, clinician interviews about a similar ban in Texas showed confusion about whether patients with a rupture of membranes before viability could receive an abortion: "[s]ome clinicians believe that patients with rupture of membranes before fetal viability are eligible for a medical exemption under [Texas law], while others believe these patients cannot receive an abortion so long as there is fetal cardiac activity."[47] To avoid potential criminal liability, physicians often must ignore their judgment, their training, and clinical guidance, and engage in "expectant management," also known as the "wait and see approach," withholding treatment necessary to protect their patient's health and waiting to perform a clinically indicated abortion until it becomes "necessary to prevent the death of the"[48] patient. Providers describe delaying care until "labor start[s] or when they experience[] signs of infection."[49]

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[46] Whitney Arey et al., *A Preview of the Dangerous Future of Abortion Bans—Texas Senate Bill* 8, 387 New Engl. J. Med. 388, 389 (2022), https://www.nejm.org/doi/pdf/10.1056/NEJMp2207423?articleTools=true; *see also* Maria Mendez, *Texas Laws Say Treatments for Miscarriages, Ectopic Pregnancies Remain Legal But Leave Lots of Space for Confusion,* Tex. Tribune (July 20, 2022), https://www.texastribune.org/2022/07/20/texas-abortion-law-miscarriages-ectopic-pregnancies/.

[47] Whitney Arey et al., *supra* n.46, at 389.

[48] Idaho Code § 18-622(2)(a)(i).

[49] Daniel Grossman et al., *Care Post-Roe: Documenting Cases of Poor-Quality Care Since the Dobbs Decision*, Advancing New Standards in Reproductive Health 7 (May 2023) https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf.

The devastating impact of delaying necessary care is not hypothetical, and neither are the consequences for pregnant patients. Indeed, a recent study in the *American Journal of Obstetrics and Gynecology* of the impacts of a Texas abortion ban concluded that "expectant management of obstetrical complications in the periviable period [i.e., at the border of viability] was associated with significant maternal morbidity."[50] "Expectant management resulted in 57% of patients having a serious maternal morbidity compared with 33% who elected immediate pregnancy interruption under similar clinical circumstances reported in states without such legislation."[51]

Reflected in these statistics are devastating consequences for individual people. Jennifer Adkins,

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[50] Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 Am. J. Obstetrics & Gynecology 648, 649 (2022), https://www.ajog.org/action/showPdf?pii=S0002-9378%2822%2900536-1.

[51] *Id.* The study also documented a significant increase in maternal morbidity among patients with preterm labor who would have been promptly offered medication abortions before the Idaho Law but now cannot be offered such treatment until their physicians determined that an emergent condition poses "an immediate threat to maternal life." *Id.* at 648–49. The study followed patients with preterm premature rupture of the membranes and pregnancy tissue prolapsed into the vagina. Among these patients, 43% experienced maternal morbidity such as infection or hemorrhage; 32% required intensive care admission, dilation and curettage, or readmission; and one patient required a hysterectomy. *Id.* at 649. The study concluded that "state-mandated expectant management" is associated with "significant maternal morbidity." *Id.*

an Idaho mother, was "very excited" to be pregnant, until learning that her pregnancy was likely not viable, and that it posed a high risk to Jennifer of mirror syndrome, a condition for which "[t]imely intervention is needed to prevent fetal and maternal morbidity."[52] If she remained in Idaho, her only option would have been to continue to carry a non-viable fetus until her mirror syndrome or other conditions reached the point that terminating the pregnancy was deemed "necessary" to prevent her death. Fearful for her well-being, Jennifer felt that she "needed to stay alive for her two-year-old son," but her ability to do so reliably depended on her ability to get appropriate medical care—an abortion—in another state.[53] Only with the assistance of two abortion funds were she and her husband able to travel to Oregon and receive the care she needed without falling behind on their mortgage.[54] Other Idahoans will continue either to be forced out of state or to suffer the devastating consequences of pregnancy complications for as long as physicians and patients face the impossible bind created by the Idaho Law.

Tragic outcomes are inescapable under restrictive abortion bans. In Texas, where state law facially permits abortion necessary to prevent either death or "substantial impairment of a major bodily

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[52] Pl.'s Compl. for Declaratory J. and Inj. Rel. at 8, *Adkins* v. *Idaho*, CV01-23-14744 (Idaho Fourth Jud. Dist. Sep. 11, 2023); Caroline Mathias & Carmela Rizvi, *The Diagnostic Conundrum of Maternal Mirror Syndrome Progressing to Pre-Eclampsia – A Case Report*, 23 Case Reps. Women's Health 2 (2019).

[53] Pl.'s Compl. for Declaratory J. and Inj. Rel. at 10, *Adkins*, *supra* n.52.

[54] *Id*.

function,"[55] the chilling effect of threats of prosecution have inevitably led to expectant management and its attendant horrors. When a Texas woman named Amanda Zurawski suffered PPROM at just 18 weeks, her clinicians knew that her fetus could not survive, and that Amanda was at serious risk of developing a dangerous infection.[56] They nevertheless believed that Texas law prohibited them from terminating the doomed pregnancy until she was "sick enough that [her] life was at risk."[57] Three days later, "she went downhill very, very fast[,]" her fever spiking "in a matter of maybe five minutes."[58] By this time, her bacterial infection was severe enough that antibiotics and a blood transfusion were unable to stop it—she went into sepsis, requiring invasive treatment and leaving it unclear whether she would survive.[59] Emergency physicians were ultimately able to save her life, but only just.[60] Among other consequences, the infection caused uterine scarring that may leave Amanda unable to have another child,[61] a particularly cruel consequence. For many patients who face an emergency medical condition for which abortion is the

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[55] Tex. Health & Safety Code § 170A.002(b)(2).

[56] Elizabeth Cohen & John Bonifield, *Texas Woman Almost Dies Because She Couldn't Get an Abortion*, CNN, https://www.cnn.com/2022/11/16/health/abortion-texas-sepsis/index.html (last updated June 20, 2023).

[57] *Id.*

[58] *Id.*

[59] *Id.*

[60] *Id.*

[61] *Id.*

appropriate treatment, abortion represents a pregnant person's best chance at maintaining the ability to have additional children, while expectant management risks leaving patients unable to do so.[62] Protecting reproductive ability is particularly important for many patients in these circumstances because they are facing the inevitable loss of the pregnancy as a result of obstetric complications in those circumstances where EMTALA requires abortion.[63]

If their doctors had been able to follow what their training and judgment tells them and provide timely and medically indicated emergency treatment, Jennifer, Amanda, and countless others would not have suffered these consequences. Instead, abortion bans like Idaho's continue to lead to similar delays in medically necessary care around the country—many of them resulting in near-death misses and life-long impairments for pregnant patients.[64]

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[62] *See e.g.*, Cohen & Bonnifield, *supra* n.56.

[63] *See, e.g.*, Cohen & Bonnifield, *supra* n.56 ("[T]he doctor told her the baby would not survive.").

[64] *See*, *e.g.*, Alicia Naspretto, *'My Heart Broke Into a Million Pieces': The Stories Behind the Texas Abortion Ban Lawsuit*, KXXV 25 ABC (Mar. 8, 2023), https://www.kxxv.com/news/in-depth/my-heart-broke-into-a-million-pieces-the-stories-behind-the-texas-abortion-ban-lawsuit; Laura Ungar & Heather Hollingsworth, *Despite Dangerous Pregnancy Complications, Abortions Denied*, AP News (Nov. 20, 2022), https://apnews.com/article/abortion-science-health-business-ap-top-news-890e813d855b57cf8e92ff799580e7e8; Stephanie Emma Pfeffer, *Texas Woman Nearly Loses Her Life After Doctors Can't Legally Perform an Abortion: 'Their Hands Were Tied'*, People Mag. (Oct. 18, 2022), https://people.com/health/texas-woman-nearly-loses-her-life-after-doctors-cannot-legally-perform-abortion/;

B. The Idaho Law Has Directly Caused an Exodus of Critical Healthcare Clinicians from Idaho, Further Worsening Its Impact on Pregnant People and People Who May Become Pregnant.

Women have endured horrific consequences as a result of abortion bans—despite having access to clinicians and potential obstetrical care. But bans like Idaho's are resulting in decisions by clinicians to move out of state in order to continue providing medically and ethically required care. As a result, pregnant people in Idaho may face similar health threats without the benefit of providers with obstetrical training—even ones whose hands are tied by the Idaho Law. Indeed, Idaho healthcare leaders note that the law has "had a profound chilling effect on recruitment and retention" of such providers and "smaller hospitals in Idaho have been unable to withstand the strain.[65]

Elizabeth Cohen et al., *'Heartbreaking' Stories Go Untold, Doctors Say, As Employers 'Muzzle' Them in Wake of Abortion Ruling*, CNN, https://www.cnn.com/2022/10/12/health/abortion-doctors-talking/index.html (last updated Oct. 12, 2022); Courtney Carpenter, *League City Family in 'Nightmare' Situation Under Texas Abortion Law*, ABC 13 (Sept. 29, 2022), https://abc13.com/texas-abortion-laws-heartbeat-act-senate-bill-8-pregnant-woman/12277047/; Emily Baumgaertner, *Doctors in Abortion Ban States Fear Prosecution for Treating Patients With Life-Threatening Pregnancies*, LA Times (July 29, 2022), https://www.latimes.com/world-nation/story/2022-07-29/fearful-of-prosecution-doctors-debate-how-to-treat-pregnant-patients.

[65] Sheryl Stolberg, *As Abortion Laws Drive Obstetricians from Red States, Maternity Care Suffers*, N.Y. Times (Sept. 7, 2023), https://www.nytimes.com/2023/09/06/us/politics/abortion-obstetricians-maternity-care.html.

Two hospitals closed their labor and delivery units [last] year; one of them, Bonner General Health, a 25-bed hospital in Sandpoint, in northern Idaho, cited the state's 'legal and political climate' and the departure of 'highly respected, talented physicians' as factors that contributed to its decision."[66]

These closures are unsurprising amidst the current exodus of obstetrical providers from Idaho. In the fifteen months following the Idaho Law taking effect, the state lost a net total of 58 of 268 obstetricians (21.6 percent).[67] During the same period, five of the state's nine maternal-fetal medicine experts—obstetricians with additional training specific to high-risk pregnancies—have either retired or left the state.[68] And these doctors are not being replaced: in that same fifteen-month period, only two new obstetricians moved to Idaho.[69] Obstetricians and maternal-fetal medicine experts have powerful professional reasons to leave Idaho, just as clinicians outside the state have powerful professional reasons not to move there. As one maternal-fetal medicine specialist explained her decision to leave Idaho, "the risk was too big for me and my family"[70] and they needed to be "where we felt that

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[66] *Id.*

[67] Idaho Physician Well-Being Action Collaborative, *A Post Roe Idaho Data Report* 3 (Feb. 2024), https://www.adamedicalsociety.org/assets/docs/FINAL%20Post%20Roe%20Idaho%20Data%20Report%20Feb.%202024.pdf.

[68] *Id.* at 5; Stolberg, *supra* n.65.

[69] Idaho Physician Well-Being Action Collaborative, *supra* n.67, at 4.

[70] Stolberg, *supra* n.65.

reproductive health care was protected and safe."[71] Another maternal-fetal health specialist who left the state noted that she was "very anxious being on the labor unit, just not knowing if somebody else was going to second-guess my decision. That's not how you want to go to work every day."[72]

Obstetricians' and maternal-fetal specialists' mass exodus from Idaho has left pregnant people across the state in a dangerous situation. One half of Idaho counties (22 out of 44) do not have a practicing obstetrician.[73] There are an estimated 2.22 obstetricians per 10,000 women in Idaho, compared to a national average of 5.5 obstetricians per 10,000 women *of reproductive age* in 2016.[74] Simply put, Idaho does not have enough obstetricians, let alone maternal-fetal specialists, to meet the needs of its population. The rapid departures of clinicians from Idaho in the wake of its abortion ban have worsened maternity care deserts in the state, where primary care physicians are left to provide care that should, ideally, be administered by obstetricians or maternal-fetal health specialists. As a result, many pregnant patients are unable to see specialists for healthy pregnancies, many patients with high-risk pregnancies are forced to rely

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[71] Laura Ungar, *Why Some Doctors Stay in US States with Restrictive Abortion Laws and Others Leave*, Assoc. Press (June 22, 2023), https://apnews.com/article/dobbs-anniversary-roe-v-wade-abortion-obgyn-699263284cced4bd421bc83207678816.

[72] Stolberg, *supra* n.65.

[73] Idaho Physician Well-Being Action Collab., *supra* n.67, at 4.

[74] *Id.* at 5; *Graduate Medical Education*, ACOG, https://acog.org/advocacy/policy-priorities/graduate-medical-education (last visited Mar. 22, 2024).

on "consult services from more urban areas where coverage is already stretched thin,"[75] and OB/GYNs are often unavailable for labor and delivery. The exodus of OB/GYN clinicians necessarily also limits access to gynecological care for Idaho patients who are not pregnant. In short, "[t]his isn't an issue about abortion. This is an issue about access to comprehensive obstetric and gynecologic care."[76] This physician exodus deprives patients of OB/GYN care, leaves patients without access to care that could prevent a medical emergency in the first place and leaves them unable to access stabilizing care when it is needed.

C. The Idaho Law Has and Will Continue to Have a Disproportionately Negative Impact on Rural and Poor Pregnant People and Pregnant People of Color in Idaho.

The consequences of the Idaho Law if the district court's injunction is reversed will be especially devastating for underserved populations, including patients living in rural areas and pregnant patients with low incomes. As one obstetrician explained before leaving Idaho as a result of the law, "[f]or rural patients in particular, delaying medical care until we can say an abortion is necessary to prevent death is dangerous. Patients will suffer pain, complications, and could die if physicians comply with Idaho law as written when it conflicts with EMTALA."[77] As a result of structural

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[75] Idaho Physician Well-Being Action Collab., *supra* n.67, at 4.

[76] Stolberg, *supra* n.65.

[77] J.A. 612.

inequities and social determinants of health, these populations are "more likely to face barriers in accessing routine health care services," including prenatal care.[78] Emergency department use has been "consistently increasing" in the United States due to lack of access to medical care; however, use by low-income populations and people of color continues to rise at the highest rates.[79] This is especially true in Idaho, where 29.5% of counties are "maternity care deserts," and the number of birthing hospitals in the state decreased 12.5% from 2019 to 2020, even before the exodus and further closures caused by the Idaho Law.[80] In light of the socioeconomic constraints these populations already face in accessing health care services, EDs and "emergency physicians have been given a unique social role and responsibility to act as health care providers of last resort for many patients who have no other ready access to care," a role that EMTALA explicitly contemplated.[81]

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[78] Benson, *supra* n.18, at 2.

[79] *Id.* Increasing ED use is indicative of a lack of access to other medical care, delay of preventive care, and presentation for care only when symptoms have gotten severe.

[80] Jazmin Fontenot et al., *Where You Live Matters: Maternity Care Access in Idaho*, March of Dimes 1 (May 2023), https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Idaho.pdf.

[81] ACEP, *Code of Ethics for Emergency Physicians*, *supra* n.12; *see also Idaho*, 623 F. Supp. 3d at 1111–1112 (noting that Congress expressed particular concern for rural hospitals when designing EMTALA); Benson, *supra* n.18, at 7 (EDs play a "vital role" in "caring for those who are socioeconomically vulnerable").

The over half a million (or 30.8% of) Idaho residents living in rural areas are particularly endangered.[82] "[R]ural Americans are more likely to be living in poverty, unhealthy, older, uninsured or underinsured, and medically underserved."[83] Rural hospitals and EDs are "the safety net" for rural Americans, including rural pregnant patients.[84] Rural women are "more likely to be poor, lack health insurance, or rely substantially on Medicaid and Medicare" and "must travel longer distances to receive care."[85] Pregnant rural patients accordingly are less likely to seek prenatal care,[86] and the initiation of prenatal care in the first trimester is lower for rural pregnant patients compared with those in suburban areas.[87] It is therefore not surprising that "rural women experience poorer maternal outcomes compared to their non-

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[82] *Urban and Rural,* U.S. Census Bureau (June 28, 2023), https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html.

[83] Ctrs. for Medicare & Medicaid Servs., *CMS Rural Health Strategy* 2 (2018), https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf (choose "State-level Urban and Rural Information for the 2020 Census and 2010 Census").

[84] Anthony Mazzeo et al., *Delivery of Emergency Care in Rural Settings*, ACEP, at 1 (July 2017), https://www.acep.org/siteassets/sites/acep/blocks/section-blocks/rural/delivery-of-emergency-care-in-rural--settings.pdf.

[85] ACOG Committee Opinion No. 586, *Health Disparities in Rural Women* 2 (Feb. 2014), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2014/02/health-disparities-in-rural-women.pdf.

[86] *Id.* at 1.

[87] *Id.*

rural counterparts, including higher pregnancy-related mortality."[88]

Pregnant patients of color similarly will be disproportionately harmed by the Idaho Law. People of color and people with low incomes often have worse access to care and higher rates of ED visits.[89] Pregnant women of color are also less likely to receive prenatal care, resulting in an increased risk for complex health issues occurring in pregnancy.[90] As a result, women of color experience higher rates of severe maternal morbidity and are more likely to die from pregnancy-related complications.[91] Women of color are also more likely to experience miscarriage, the standard treatment for which can include abortion, and to visit an ED for their miscarriage-related care.[92]

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[88] Ctrs. for Medicare & Medicaid Servs., *Advancing Rural Maternal Health Equity* 1 (2022), https://www.cms.gov/files/document/maternal-health-may-2022.pdf.

[89] *See generally* Agency for Healthcare Rsch. & Quality, *2022 National Healthcare Quality and Disparities Report* (Oct. 2022), https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html; Off. of the Assistant Sec'y for Plan. & Evaluation, U.S. Dep't of Health & Hum. Servs., *Trends in the Utilization of Emergency Department Services, 2009-2018*, at 22 (Mar. 2021), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//199046/ED-report-to-Congress.pdf.

[90] Benson, *supra* n.18, at 2; *see also* Juanita J. Chinn et al., *Health Equity Among Black Women in the United States*, 30 J. Women's Health 212, 215 (2021) (explaining that "Black women are at a disadvantage regarding the protective factor of the early initiation of prenatal care").

[91] *See* Agency for Healthcare Rsch. & Quality, *supra* n.89, at 4; *see also* Chinn, *supra* n.90, at 215 (Black and Latina women "are at greater risk of poor pregnancy outcomes").

[92] Benson, *supra* n.18, at 5–7.

Each of these categories of pregnant patients is therefore more likely to experience emergency medical conditions when pregnant and thus more likely to need the critical care that the Idaho Law obstructs. The Idaho Law not only limits the ability of these populations to access the full spectrum of OB/GYN care by exacerbating the problem of maternity care deserts, but will, as described above and explicitly stated in the District Court's opinion, "undoubtedly deter physicians from providing abortions in some emergency situations."[93] This deterrence will serve only to exacerbate those poor outcomes, thereby "obviously frustrat[ing] Congress's intent to ensure adequate emergency care for all patients."[94]

V. The Idaho Law Undermines Principles of Medical Ethics that Have Long Been Protected by EMTALA.

In its specific conflict with EMTALA, the Idaho Law defeats core principles of medical ethics and practice that have been implicitly ensured by EMTALA for nearly 40 years. EMTALA's requirement that a clinician must provide "stabilizing treatment [to] prevent material deterioration" of all patients who present to a hospital's emergency department and must "act prior to the patient's condition declining"[95] served to

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[93] *Idaho*, 623 F. Supp. 3d at 1112.

[94] *Id.*

[95] Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations Specific to Patients Who Are Pregnant or Are Experiencing Pregnancy Loss* 4, https://www.cms.gov/files/document/qso-22-22-hospitals.pdf (last updated Aug. 25, 2022).

codify, among other things, the medical ethics principles of beneficence, non-maleficence, and respect for patient autonomy, which were already paramount in providers' professional obligations. In direct contrast, the Idaho Law's prohibition of medically indicated emergency care without regard to circumstance violates these long-established and widely accepted principles of medical ethics, by: (1) blocking appropriate medical care as determined by a health care provider and informed by clinical standards of care; (2) forcing providers to contend with their own legal exposure when treating emergent conditions; and (3) compelling health care professionals to deny necessary emergency care.

As EMTALA reflects, the core of medical practice is the patient-clinician relationship. ACEP's Code of Ethics for Emergency Physicians states that "[e]mergency physicians shall embrace patient welfare as their primary professional responsibility" and "shall respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care,"[96] two principles that are directly furthered by EMTALA's requirements. ACOG's Code of Professional Ethics similarly states that "the welfare of the patient must form the basis of all medical judgments" and that obstetrician-gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[97] The AMA Code of

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[96] ACEP, *Code of Ethics for Emergency Physicians*, *supra* n.12, at 3.

[97] ACOG, *Code of Professional Ethics* 2 (Dec. 2018), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-

Medical Ethics likewise places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[98]

Beneficence and non-maleficence, respectively the obligations to promote the well-being of others and to do no harm, are not only ensured by EMTALA, but have been cornerstone principles of the medical profession since the beginning of the Hippocratic tradition nearly 2500 years ago.[99] Patient autonomy, the respect for patients' right to control their bodies and make meaningful choices when making medical decisions, is another cornerstone.[100] Clinicians ensure patient autonomy by ensuring patients' rights to self-determination through robust reliance on informed

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ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf.

[98] AMA Council on Ethical & Jud. Affs. Opinion 1.1.1, *Patient-Physician Relationships* 1, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/1.1.1%20Patient-physician%20relationships--background%20reports_0.pdf (last updated 2017).

[99] Am. Med. Ass'n, *AMA Principles of Medical Ethics*, https://code-medicalethics.ama-assn.org/principles (last updated June 2001); ACOG Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, at 1, 3 (Dec. 2007), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2007/12/ethical-decision-making-in-obstetrics-and-gynecology.pdf.

[100] *See* ACOG, *Code of Professional Ethics*, *supra* n.97, at 1 ("[R]espect for the right of individual patients to make their own choices about their health care (*autonomy*) is fundamental."). Consistent with both the principle of patient autonomy and EMTALA, 42 U.S.C. § 1395dd(b)(2), a patient may decline necessary care, including a necessary abortion.

consent.[101] These principles are the natural result of the foundation of medical ethics: the welfare of the patient forms the basis of all medical decision-making.[102] Taken together, they provide a clear approach that physicians—including those whose hands are tied by the Idaho Law—must follow: provide patient-centered, evidence-based care, equipping patients with information about options, risks, and benefits, and ultimately empowering those patients to make an autonomous decision and obtain care informed by medical science.

Requiring EMTALA to yield to the Idaho Law obliterates these principles. Where an Idaho clinician providing emergency care concludes that an abortion would be the appropriate stabilizing care to prevent severe harm to a patient's health, beneficence, non-maleficence, and respect for patient autonomy require the clinician to recommend the abortion and provide information about risk, benefits, and options. If a patient decides that an abortion is the best course of action after receiving that recommendation, those same principles require that the patient be offered the care. Under the Idaho Law, a clinician who concludes that an abortion is the appropriate stabilizing care instead faces a dilemma: they can (1) provide the best and most appropriate medical care, consistent with

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[101] ACOG Committee Opinion No. 819, *supra* n.36; AMA Council on Ethical & Jud. Affs. Opinion 2.1.1, *Informed Consent*, https://code-medical-ethics.ama-assn.org/sites/amaco-edb/files/2022-08/2.1.1.pdf (last updated 2017).

[102] ACOG, *Code of Professional Ethics, supra* n.97; AMA Code of Medical Ethics Opinion 1.1.1, *supra* n.98, and accompanying text.

principles of medical ethics, and in so doing, risk substantial penalties, including the loss of their liberty and livelihood; or (2) they can follow the Idaho Law, violating basic principles of medical ethics and unnecessarily endangering their patient. In short, the Idaho Law prevents physicians from heeding the central tenet of the Hippocratic Oath: do no harm.

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In its plain inconsistency with federal law, the Idaho Law endangers the lives and well-being of vulnerable Idaho patients, and further limits all Idahoans' access even to routine OB/GYN care. These devastating effects are directly contrary to the purpose of EMTALA.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted,

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APPENDIX

TABLE OF APPENDICES

APPENDIX A—LIST OF *AMICI CURIAE*

***Amici Curiae* are:**

- American College of Obstetricians and Gynecologists
- American College of Emergency Physicians
- American Medical Association
- Society of Family Planning
- Society for Maternal-Fetal Medicine
- American Academy of Family Physicians
- American Academy of Nursing
- American Academy of Pediatrics
- American College of Chest Physicians
- American College of Medical Genetics and Genomics
- American College of Physicians
- American Gynecological and Obstetrical Society
- American Thoracic Society
- Association of Black Cardiologists
- Doctors for America
- National Association of Nurse Practitioners in Women's Health
- National Hispanic Health Foundation
- National Hispanic Medical Association
- National Medical Association
- Society for Academic Specialists in General Obstetrics and Gynecology
- Society for Adolescent Health and Medicine
- Society of General Internal Medicine

- Society of Gynecologic Oncology