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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.

STATE OF IDAHO,
Petitioner,
v.
UNITED STATES OF AMERICA,
Respondent.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF *AMICUS CURIAE* PHYSICIANS FOR REPRODUCTIVE HEALTH IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICUS CURIAE*[1]

Physicians for Reproductive Health ("PRH") is a doctor-led nonprofit that seeks to ensure meaningful access to comprehensive reproductive health care services, including contraception and abortion. Since its founding in 1992, PRH has organized and amplified the voices of medical providers to advance reproductive health, rights, and justice. PRH's network is comprised of physicians in all 50 states, the District of Columbia, and Puerto Rico, and includes over 500 physicians. PRH has unique insight into the challenges providers and patients face when confronted by actions designed or applied to prevent pregnant people from accessing necessary medical care, which harms their ability to live freely with dignity, safety, and security.

In public discussions of reproductive health care, PRH seeks to share physicians' distinctive voices, expertise, and experiences. To that end, PRH has long gathered and shared stories of physicians who provide reproductive health services. State-level restrictions on the provision of abortion care can conflict with physicians' responsibilities under the federal Emergency Medical Treatment and Labor Act ("EMTALA," largely codified in Section 1867 of the Social Security Act, 42 U.S.C. § 1395dd), directly impacting PRH's network of physicians, many of whom work in emergency departments or treat patients referred by emergency departments. PRH

[1] No counsel for any party has authored this brief in whole or in part, and no person has made any monetary contribution intended to fund the preparation or submission of this brief.

fellows attest that laws, like Idaho Code § 18-622, which criminalize abortion care except in narrow, life-threatening circumstances—even when that care is necessary to stabilize patients—have deprived patients of necessary treatment and tied the hands of their health care providers.

SUMMARY OF ARGUMENT

The conflict between EMTALA, a decades-old federal law that requires most hospitals to provide stabilizing treatment in emergency circumstances, and laws such as Idaho Code § 18-622, commonly referred to as the Idaho "Total Abortion Ban," leaves medical providers unsure of when they can provide pregnant patients with urgently needed care. PRH physicians, many of whom specialize in obstetrics and gynecology ("OB/GYN"), complex family planning, maternal fetal medicine, pediatrics, and emergency medicine, have witnessed firsthand the effects of abortion bans like the Idaho Total Abortion Ban, and share their stories illustrating the dangers of these bans and the confusion they cause in emergency departments and hospital settings.[2]

[2] Physician accounts were compiled from interviews conducted by the undersigned counsel, and each physician personally reviewed and approved their statements herein. The medical opinions expressed are their own and not necessarily shared by the institutions with which they are affiliated, many of which are in states with restrictive abortion bans. To promote candid testimony and to protect the legal and privacy interests of these providers, the identities of the providers interviewed have been anonymized, except for the identify of Dr. Jamila Perritt, the President and CEO of PRH.

The Idaho Total Abortion Ban provides that "[e]very person who performs or attempts to perform an abortion . . . commits the crime of criminal abortion." Idaho Code § 18-622(1). It broadly defines "abortion" as "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child . . . ." Idaho Code § 18-604(1). The criminal consequences for health care professionals convicted of violating Idaho's Total Abortion Ban are severe, resulting in a felony punishable by two to five years of imprisonment, as well as the suspension of the provider's medical license for at least six months for a first offense (and permanently for any subsequent offense). Idaho Code § 18-622(1).

The Idaho Total Abortion Ban provides only two narrow exceptions to its strict abortion ban. First, abortion is permitted when "the abortion was necessary to prevent the death of the pregnant woman" *and* the physician provided the abortion in a manner that gave "the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman." Idaho Code § 18-622(2)(a)(i)–(ii). Second, physicians may provide abortion care in the first trimester for a pregnancy resulting from rape or incest. *Id.* § 18-622(2)(b). Notably, there is no exception to criminal prosecution for abortion care provided by a physician to protect the health of a pregnant patient in an emergency that

is not (yet) "necessary to prevent the death of the pregnant woman."[3] *Id.* § 18-622(2)(a)(i).

Unlike Idaho's Total Abortion Ban, which prohibits abortion care except in life-threatening situations, EMTALA requires hospitals to provide "necessary *stabilizing treatment*" to individuals with "emergency medical conditions."[4] 42 U.S.C. § 1395dd(b) (emphasis added). EMTALA defines "stabiliz[ing]" treatment as the provision of care

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[3] Unless otherwise noted, this brief uses the term "life-threatening" to reference any situation where medical care is "necessary to prevent the death of the pregnant woman," as that phrase is used in Idaho's Total Abortion Ban. The medical care provided in those situations is referenced as "life-saving."

[4] Hospitals with Medicare-funded emergency departments are required to comply with EMTALA. Consequently, nearly all emergency room physicians are bound by EMTALA's mandate to provide stabilizing care in emergency situations. *Compare* Ctrs. for Medicare & Medicaid Servs., *Hospital General Information*, https://data.cms.gov/ provider-data/dataset/xubh-q36u (last updated Jan. 17, 2024) (5,425 hospitals registered with Medicare), *with* Am. Hosp. Ass'n, *Fast Facts on U.S. Hospitals, 2024* (Jan. 2024), https://www.aha.org/statistics/fast-facts-us-hospitals (6,120 hospitals in the United States); *see also EMW Women's Surgical Ctr., P.S.C. v. Glisson*, No. 3:17-CV-00189-GNS, 2018 WL 6444391, at *14 n.17 (W.D. Ky. Sept. 28, 2018), *rev'd in part, vacated in part on other grounds sub nom. EMW Women's Surgical Ctr., P.S.C. v. Friedlander*, 978 F.3d 418 (6th Cir. 2020). The Idaho Department of Health & Welfare reports that 51 of the 53 hospitals in Idaho are Medicare/Medicaid-certified hospitals—thus, 96.2% of hospitals are affected by the conflict caused by the Idaho Total Abortion Ban. Idaho Dep't Health & Welfare, *Hospital Provider List* (Feb. 5, 2024), https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=25469&dbid=0&repo=PUBLIC-DOCUMENTS &cr=1.

"necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely[.]" *Id.* § 1395dd(e)(3)(A) (alterations added). This treatment is required when a hospital determines that a patient is suffering from an "emergency medical condition," defined as situations where:

> [T]he 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 . . . .

Id. § 1395dd(e)(1). Physicians understand EMTALA's language to be patient-protective in that it explicitly incorporates physician discretion, allowing physicians to act based on "*reasonable medical probability*," 42 U.S.C. § 1395dd(e)(3)(A) (emphasis added), which is especially important in a fast-paced emergency setting. Of course, that discretion is bounded and informed by prevailing clinical guidelines on standards of care.

Both courts and the medical community repeatedly have recognized that situations arise where "stabilizing treatment" under EMTALA requires termination of a pregnancy. *See, e.g., New York v. U.S. Dep't of Health & Human Servs.*, 414 F. Supp. 3d 475, 537–38 (S.D.N.Y. 2019); *California v. United States*, No. C 05-00328 JSW, 2008 WL

744840, at *4 (N.D. Cal. Mar. 18, 2008). Under EMTALA, hospitals "*must* provide medical care to stabilize *all* emergency patients," including patients requiring abortion care. *EMW Women's Surgical Ctr.*, 2018 WL 6444391, at *14.[5]

Yet emergency circumstances under EMTALA do not always meet the benchmark set by the Idaho Total Abortion Ban and similar laws, which allow abortion care *only* if, in that moment, it is "necessary to prevent the death" of the pregnant patient. As demonstrated by the accounts of PRH physicians, even when medical conditions and complications are not considered imminently life-threatening, they can have serious consequences to patients' wellbeing and can *become* life-threatening if stabilizing intervention is withheld. Indeed, waiting to meet the life-threatening threshold before providing abortion care can jeopardize a pregnant patient's health.

The conflict between state abortion restrictions like Idaho's Total Abortion Ban and EMTALA continues to cause rampant confusion and undue stress for practicing physicians both in Idaho and in states with similar statutes. Physicians have always understood EMTALA to require the provision of

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[5] *See also* Kimberly Chernoby, et al., *Pregnancy Complications After Dobbs: The Role of EMTALA*, 25 W.J. Emergency Med. 79, 79 (Jan. 2024), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10777191/pdf/wjem-25-79.pdf ("[E]ven in the face of state abortion restrictions, physicians need to be cognizant of their duties under EMTALA to render stabilizing medical care, which in some circumstances includes emergency abortion care.").

abortion care when it is necessary stabilizing treatment. The proliferation of state laws criminalizing abortion, however, has created uncertainty about a physician's ability to provide this essential stabilizing care when it is not "life-saving." Rather than exercise their medical judgment while treating patients in emergency situations, physicians are now forced to make a series of challenging—and potentially criminal or career-ending—decisions about how to treat pregnant patients within both the confines of increasingly restrictive statutory law and their moral and professional medical obligations.[6]

According to Dr. Jamila Perritt, the President and CEO of PRH, the question is "no longer 'how should we treat the patient's medical condition?' but rather 'is this person close enough to death to even qualify for treatment?'" Dr. Perritt describes "mass confusion among care providers. That's just really the

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[6] These decisions are particularly burdensome as "physicians [who] provide care that is technically an abortion [under these restrictive state bans but] . . . do not characterize the care as abortion care." Chernoby, *supra* note 5, at 80–81. And neither do many of their patients. *Id.*; Alicia J. VandeVusse et al., "*Technically an abortion": Understanding perceptions and definitions of abortion in the United States*, 335 Soc. Science & Med., no. 116216 (2023), https://www.sciencedirect.com/science/article/pii/S0277953623005737?via%3Dihub. The District Court also highlighted that the Idaho law, like other restrictive abortion bans, "controls the inquiry on [what is considered an abortion]—not the medical community. Indeed, [the Legislature's] argument crystallizes the conflict between Idaho law and EMTALA: Idaho law criminalizes as an 'abortion' what physicians in emergency medicine have long understood as both life- and health-preserving care." *United States v. Idaho*, 623 F. Supp. 3d 1096, 1110 (D. Idaho 2022) (alterations added).

bottom line. We are hearing from physicians over and over that before they act they are forced to ask the question 'Is this person sick enough?'" Such a position is untenable and unworkable in practice.

In the absence of clarity regarding EMTALA's preemptive effect, physicians may let their patients' conditions worsen before providing care. Allowing a situation to become life-threatening can have dire consequences for a patient's health, including the development of chronic medical conditions, significant disability, or even death. Moreover, it threatens to worsen maternal morbidity and mortality rates, particularly for Black and Indigenous people, people of color, and people living with low incomes, who are already more likely to experience maternal mortality and morbidity, thereby exacerbating existing inequities in the United States.[7]

The true impact of this confusing legal landscape is best understood by those who navigate it daily, including the physicians charged with treating pregnant patients in emergency situations who are in urgent need of abortion care. In these situations, where legislative and judicial decisions directly impact the practice of medicine, courts routinely consider the opinions of the medical professionals on

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[7] *See* Anna Kheyfets et al., *The Impact of Hostile Abortion Legislation on the United States Maternal Mortality Crisis: A Call for Increased Abortion Education*, Frontiers in Pub. Health 4 (Dec. 2023), https://www.ncbi.nlm.nih.gov/pmc/ articles/PMC 10728320/pdf/fpubh-11-1291668.pdf.

the front lines.[8] The stories and experiences of physicians with specialties in emergency medicine, obstetrics and gynecology, maternal fetal medicine, and complex family planning, as well as the experiences of those in other specialties like family medicine and pediatrics, provide critical context for understanding the wide-ranging detrimental impacts of state laws that exempt pregnant patients from the full scope of EMTALA's protections.

ARGUMENT

Every day, physicians practicing in states with restrictive abortion bans like Idaho's attempt to balance their medical, legal, and moral obligations. Physicians continually emphasize that complying with requirements to provide abortion care only when

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[8] *See, e.g.*, *Stenberg v. Carhart*, 530 U.S. 914, 926–36, 945–46 (2000) (relying on testimony and briefing from physicians and medical associations in affirming determination that Nebraska abortion restriction was unconstitutional), *abrogated by Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 287 & n.64 (2022); *Peters v. Aetna Inc.*, 2 F.4th 199, 234 (4th Cir. 2021) (relying on briefing from medical association *amici* concerning the definition of medical "provider"), *cert. denied sub nom. OptumHealth Care Sols., LLC v. Peters*, 142 S. Ct. 1227 (2022); *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2122 (2020) ("We wrote that these inferences [regarding clinic closures] were bolstered by the submissions of *amici* in the medical profession . . . .") (alterations added), *abrogated by Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 281-82 (2022); *Charles v. Orange County*, 925 F.3d 73, 84 (2d Cir. 2019) (relying on briefing from medical association *amici* in analyzing the applicable standard of medical care for immigration detainees); *Chalk v. U.S. District Court Cent. Dist. of Cal.*, 840 F.2d 701, 706–07 (9th Cir. 1988) (relying on medical association briefing regarding the likelihood of HIV transmission).

"necessary to prevent the death" of a pregnant patient can be inconsistent with EMTALA's requirement to provide "stabilizing treatment," with physician training, and with the reality of practicing medicine. As the chair of the OB/GYN department of one hospital said: "in medicine, we don't study, 'well, is this life-threatening?'" Another physician with a background in OB/GYN and complex family planning explains:

> Things can turn on a dime . . . . there is no algorithm to make the decision for how close someone is to death or whether or not you need to intervene in order to prevent that death. It's a spectrum. It's a continuum. So if I intervene at one point for Patient A, that may be early enough, but for Patient B, it may be too late. So it depends on the individual. It depends on the situation.

Similarly, other physicians state:

> "You don't know its life threatening until [the patient is] about to die and at that point it is too late."
>
> – *An emergency medicine provider in a state with an abortion ban*

> "No one understands what life-threatening means or what the timeframe is around intervention . . . . It's bad medical practice to wait until [a situation] worsens to intervene. And there is no other area of

> medicine in which we wait for our patient to deteriorate [before intervening]."
>
> – *An OB/GYN in a state with an abortion ban*

> "What does the timeline need to be? Does the emergency need to be that the person is going to die? What's the risk? Eighty percent in the next hour? Sixty percent in the next four hours? There's so much uncertainty about level of risk and immediacy."
>
> – *An OB/GYN in a state with an abortion ban*

> "Many of these medical emergency cases are not life-threatening in the immediate sense, but are life-threatening and have threats in hours, days, week, months."
>
> – *An OB/GYN in a state with an abortion ban*

The experiences of these physicians illustrate that drawing a hard line between what is "life-saving" care and what is "stabilizing" care leaves physicians and patients in impossible positions that have heartbreaking, and often tragic, outcomes. Forcing physicians and patients to wait for patients' conditions to deteriorate flies in the face of physicians' medical training, instincts, and experience.

I. "She's Not Sick Enough Yet"

In states where restrictive abortion bans conflict with EMTALA, physicians often must

determine whether a condition is "life-threatening" before local laws and hospital compliance procedures allow them to proceed with necessary treatment. This requirement can put hospital compliance measures in direct conflict with the patient-physician relationship, often resulting in the denial of stabilizing care. A case seen by Dr. A, a board-certified OB/GYN and complex family planning specialist, who is the chair of her hospital system's OB/GYN department, illustrates the challenges faced by hospitals and physicians operating in states with restrictive abortion bans.

After her state enacted a restrictive abortion ban similar to the Idaho Total Abortion Ban, the hospital system in which Dr. A worked created an ethics committee to assist physicians in assessing the legality of providing abortion care. The ethics committee is comprised of physicians, legal counsel, and hospital administrators. When a physician, in consultation with their patient, deems abortion care to be the appropriate and necessary treatment, the physician must first petition the ethics committee for permission to provide the abortion. In practice, the physician explains the reasons for recommending an abortion, and the committee assesses whether an abortion is lawful in the context of the governing abortion laws. Ethical and legal review of a physician's medical decisions can force patients to wait to receive treatment until a hospital's ethics committee or legal team decides whether the condition is life-threatening.

At Dr. A's hospital, the ethics committee system was developed to provide physicians with

guidance on interpreting complicated, conflicting, and constantly changing abortion laws, and for this reason, the physicians there generally appreciate the committee's guidance. But, in Dr. A's experience, the committee does not always get it right. This is in part because an unspoken function of the ethics committee is to shield the hospital from liability. As a result, the ethics committee often takes a conservative approach to allowing abortion care to proceed, such that physicians are, at times, prevented from providing the care that is, in their medical expertise, necessary to stabilize a patient. Critically, this can place patients at risk of suffering potentially devastating consequences.

Dr. A describes a situation in which Dr. A attempted to treat a patient suffering from peripartum cardiomyopathy, or PPCM. PPCM is a form of heart failure often caused by a previous pregnancy.[9] PPCM is "one of the leading causes of pregnancy-related morbidity and mortality worldwide," and once a patient has experienced PPCM in connection with one pregnancy, the risk of heart failure continues for subsequent pregnancies, in which "maternal complication rates [] are high."[10] Almost half (46%) of PPCM patients experience major adverse cardiac events during hospitalization for

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[9] Kathleen Stergiopoulos & Fabio V. Lima, *Peripartum cardiomyopathy-diagnosis, management, and long term implications*, 29 Trends in Cardiovascular Med. 164, 164 (2019), https://www.sciencedirect.com/science/article/abs/pii/S1050173818301452?via%3Dihub.

[10] *Id.* at 164–65, 170.

labor and delivery, and the relapse of PPCM in a subsequent pregnancy is associated with deterioration of heart function, congestive heart failure, and arrhythmias.[11] Patients with PPCM require daily heart medications, but these medications cannot be taken while pregnant—and that is one of the reasons why patients with pregnancy-induced heart failure are advised against future pregnancies.[12] In Dr. A's experience, "we pretty much across the board advise against pregnancy if you have peripartum cardiomyopathy like this."

Dr. A's soon-to-be patient arrived at the hospital in her second trimester experiencing serious distress. She had difficulty breathing and was unable to walk, requiring a wheelchair. Dr. A was advised that the patient had been diagnosed with PPCM during an earlier pregnancy, but was unable to take her daily heart medication while pregnant. It quickly became apparent that her current symptoms were caused, at least in part, by decreased lung function from PPCM. Pregnancy increases the level of fluid in a pregnant person's body, and in this patient's case, an echo-cardiogram revealed that her heart was extremely weak and unable to effectively beat the increased volume of blood throughout her body. The excess fluid therefore seeped into the patient's lungs,

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[11] *Id.* at 167–68; Uri Elkayam, *Risk of Subsequent Pregnancy in Women with a History of Peripartum Cardiomyopathy*, 64 J. Am. Coll. Cardiology 1629, 1632, 1635 (2014).

[12] Elkayam, *supra* note 11, at 1634.

preventing her from breathing properly. Dr. A was concerned because the patient's "heart function was just not there."

Dr. A determined that unless the pregnancy was terminated, the patient's heart would continue to deteriorate until she went into a fatal arrhythmia and suffered a cardiac arrest. Dr. A explains that in such a severe case of heart failure, the patient "needed to not be pregnant to live. This [would have been] an abortion to save her life." The patient was scared, and desperately wanted medical intervention to terminate her pregnancy, particularly because she had children at home who needed her. To provide an abortion, however, Dr. A needed permission from the hospital's ethics committee. Dr. A urged the committee to permit the abortion immediately, explaining that the patient's condition was life-threatening.

Nonetheless, the hospital ethics committee denied Dr. A's request. Dr. A's understanding of the committee's decision was that the patient was "not sick enough ***yet***." Dr. A understood the committee's message to be that "when [the patient] is sicker, or if she gets close enough to death, then we can act." Dr. A disagreed with the decision and believes that it was contrary to standard medical advice given the patient's condition and the likelihood that she would imminently suffer from a catastrophic cardiac event. Yet, Dr. A was left to relay the committee's decision to the patient, even though Dr. A knew her patient was in desperate need of an abortion to live and continue to be present for her children at home. Dr. A also knew that if, as the ethics committee required, Dr. A waited until the patient's condition deteriorated further or

until she entered cardiac arrest, it would likely be too late to save her. Unable to provide the patient with the necessary stabilizing treatment, Dr. A instead gave the patient names of clinics in a neighboring state that could provide the care the patient needed. But without access to a car, unable to walk, and with children at home, the patient said that she could not make such a trip.[13] Dr. A was left with no other option but to send the patient home without treatment, instructing her to return to the hospital if her condition worsened.

Dr. A never saw the patient again and does not know what happened to her. Dr. A has frequently wondered and worried about the patient. In Dr. A's medical opinion, the most likely scenario is that the patient went into cardiac arrest, and likely neither she nor the fetus survived.

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[13] In Dr. A's experience, patients with severe PPCM often cannot drive or get on a plane, and therefore are unlikely to be able to leave the state to obtain abortion care. *See also infra* note 20. They are therefore likely to stay pregnant until they have experienced a cardiac arrest. In the unlikely event that a patient does not have a cardiac arrest prior to delivery, the patient's decreased heart function would render her unable to deliver vaginally: she would not have enough oxygen available to push. The patient would likely only be able to deliver via caesarian section, but "[h]aving a surgery and trying to recover from a surgery like that with heart failure is catastrophic." Even if the patient makes it to delivery, "[t]here is a high likelihood of death for her." If the patient survives delivery, "there are these huge, massive fluid shifts that will occur as her body stabilizes back to normal," which "will just put more pressure on her heart."

II. "It Shouldn't Have To Be This Way"

Several states have enacted statutes that, like the Idaho Total Abortion Ban, prohibit abortion care if there is fetal cardiac activity, except in the case of life-threatening emergencies.[14] Patients in these states are forced to wait until their condition worsens or until fetal cardiac activity stops before they are eligible for abortion care. Physicians are confronted with the dilemma of drawing the line between providing the care required to stabilize a patient and waiting to provide such care until the patient's condition becomes life-threatening or fetal cardiac activity ceases. This problem could be avoided if the Court holds that EMTALA preempts the Idaho Total Abortion Ban and similar state laws.

A common situation in which a physician may be forced to wait for fetal cardiac activity to cease before providing an abortion is when a pregnant patient presents with preterm premature rupture of the membrane, also known as PPROM. In PPROM, the gestational membrane ruptures before 37 weeks of pregnancy (*i.e.*, the patient's water breaks too

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[14] For example, Arkansas, Georgia, Idaho, Iowa, Kentucky, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, and Texas have enacted statutes barring the provision of abortion care (with limited exceptions in some cases) where fetal cardiac activity is present. *See* Ark. Code Ann. § 20-16-1304; Ga. Code Ann. § 16-12-141(b); Idaho Code § 18-8804; Iowa Code § 146C.2; Ky. Rev. Stat. Ann. § 311.7706; La. Rev. Stat. Ann. § 40:1061.1.5; Miss. Code Ann. § 41-41-34.1; Okla. Stat. tit. 63, § 1-731.3; S.C. Code Ann. § 44-41-630; Tenn. Code Ann. § 39-15-216(c)(1); Tex. Health & Safety Code Ann. § 171.204.

early).[15] PPROM places the pregnant person at serious risk of infection, and the risk increases for PPROM occurring at earlier, pre-viable gestational ages.[16] Patients experiencing PPROM prior to 24 weeks of gestation are at a higher risk of sepsis, transfusion, hemorrhage, infection, or acute renal injury.[17] Multiple physicians interviewed emphasize that in cases where the membrane ruptures prior to 24 weeks of pregnancy, the fetus is no longer viable, even if fetal cardiac activity persists, because the lungs cannot develop outside of the womb.

Dr. A reports that in many cases of PPROM, a ruptured membrane can be "life-threatening for someone who is pregnant." Intervention is critical, and physicians interviewed about PPROM treatment agreed that treatment options for a pre-viable PPROM patient must include termination. Indeed, best practices require that physicians offer immediate termination of the pregnancy as a treatment option for patients suffering from PPROM prior to 24 weeks gestational age.[18] This is particularly true because the patient has a heightened infection risk at an early gestational age. Dr. C, a board-certified OB/GYN, complex family planning specialist, and clinical

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[15] Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin No. 217, *Prelabor Rupture of Membranes*, 135 Obstetrics & Gynecology e80, e80 (Mar. 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles2020/03/prelabor-rupture-of-membranes.

[16] *Id.* at e81.

[17] *Id.*

[18] *Id.*

assistant professor at a major academic institution in a Northeastern city, cautions that, in these cases, "[i]f we do nothing, there is a major risk of infection and sepsis." Dr. A further explains just how perilous waiting to provide this treatment can be:

> Even before a fever presents, we know [the patient suffering from PPROM] need[s] to deliver immediately.
>
> The longer we wait, the sicker the patient will become. The water has broken because of an infection. If they have a fever, then we are already going down the path of a serious, systemic infection. And the longer you wait to treat the infection, the closer you get to serious infection and death. Pregnant people have a lowered immune system, so once they're down the path of serious infection, it can become really hard to save their life. If you wait until the moment before death, you will not be able to save someone.

Dr. B, a maternal fetal medicine specialist and an assistant professor at a major academic institution in a state with a cessation of fetal cardiac activity requirement, has seen the impact of waiting to terminate the pregnancy of a patient with PPROM firsthand. Dr. B describes examining a patient whose water had broken at 18 weeks—well before viability, a situation in which Dr. B would advise all patients to seek emergency termination. Because the fetus had detectable cardiac activity, Dr. B could not terminate the pregnancy. Dr. B believes (and believes that his

colleagues would agree) that providing abortion care to patients actively experiencing PPROM qualifies as stabilizing care that all hospital systems should provide. In Dr. B's medical opinion, at this gestational age, "the fetal benefit is zero, so all the risks are taken on by mom," and the patient is "at a higher risk of infection and bleeding with zero benefit for the fetus."

Nonetheless, Dr. B knew that, due a lack of clarity over the relationship between EMTALA and his state's abortion ban, if Dr. B sent the patient to the emergency room, the hospital would be unable to provide her with the stabilizing abortion care she required. So instead, the only care Dr. B could offer was to advise the patient to travel back and forth to his hospital's outpatient clinic each day, until the patient's condition became sufficiently life-threatening to allow the required care. During each visit, the patient received an ultrasound of her non-viable fetus to confirm that there was still detectable fetal cardiac activity. The patient explained to clinic staff that this was a desired second pregnancy, and that repeatedly being forced to sit in a waiting room full of pregnant patients while knowing that she would not give birth to a living baby was deeply painful. Finally, two weeks after her water had broken and while she was at home, the patient's umbilical cord prolapsed through her cervix and outside of her vagina, compounding her PPROM with yet another obstetric medical emergency. The patient attempted to reinsert the umbilical cord as she rushed to the hospital, essentially trying to "shove it back in" until she could obtain medical care. Because the umbilical cord was completely exposed, she was

finally admitted to the hospital. But rather than immediately providing the abortion needed to stabilize the patient, the hospital physicians continued to wait for all fetal cardiac activity to cease. The next day, fetal cardiac activity stopped and hospital staff were finally able to induce labor and end the pregnancy.

Dr. B saw the patient two weeks later at a post-partum follow-up visit. The patient revealed how devastating this ordeal had been for her—she described feeling guilt-ridden carrying a pregnancy that could not survive and helpless because she could not afford to leave the state and her young child to terminate the pregnancy. She was deeply upset by the delay in her care: she had been in the midst of a medical emergency for weeks, yet the hospital physicians acted as if they were unable to stabilize her. She had found it overwhelming to return to the outpatient clinic and be surrounded by other pregnant patients. She was traumatized from having to deal with an avoidable prolapsed umbilical cord, an experience which never would have occurred had her pregnancy been timely terminated.

During the two-week period between her water breaking and the prolapse of her umbilical cord, Dr. B says that the patient faced a heightened risk of a placental abruption, which can cause severe, life-threatening blood loss and hemorrhage. She also faced a heightened risk of potentially life-threatening infection or sepsis. Dr. B has seen patients in similar circumstances contract infections while there is still fetal cardiac activity. Dr. B believes it is dangerous to deny an abortion to a pre-viable PPROM patient,

yet without clarity that EMTALA preempts a more restrictive abortion ban, his state law and his institution forbade the provision of an abortion in this situation.

Dr. D, a complex family planning specialist who practices at a major academic institution in a state with strict abortion prohibitions like those in Idaho, explains that the experience of Dr. B's patient is not uncommon. "From a practical standpoint, in states with [so-called] fetal heartbeat laws, people who break their water in the pre-24-week period [are] not able to get care until they developed an infection or heavy bleeding."[19] Dr. D recounts the story of one such patient that Dr. D met when providing a family planning call to a major hospital. The patient had undergone in vitro fertilization to become pregnant, and the pregnancy was the result of the final embryo transfer. The expectant parents had even picked out a name for the baby. The family was devastated when the patient's water broke at 17 weeks. At that gestational age, there was no chance that the fetus could develop lungs that would allow it to live; the only possible treatment was termination.

After determining that there was still fetal cardiac activity, the hospital called Dr. D for a consult. The treating physicians were distressed, and hoped that another hospital could provide the patient with care to terminate the pregnancy. Given the fetal cardiac activity, Dr. D was forced to repeat a line physicians have been "say[ing] a lot": "it shouldn't

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[19] Even then, after infection has set in, some physicians have still been unable to provide abortion care.

have to be this way." Again, despite confusion and fear regarding potential violations of EMTALA, the physician deferred to the state's abortion ban, given the ban's potential criminal penalties, and the hospital concluded there was "nothing any of us could do" to help the patient. Dr. D explains that the fetal cardiac activity had to cease or the patient had to "hang out waiting to get sick"—she needed to start bleeding heavily or to develop a serious infection before she could obtain treatment.

Eventually, the patient drove to a hospital in another state to receive care. She began bleeding while driving. Thankfully, the patient was able to access the care she needed at the out-of-state hospital, but at a cost: "there was so much more risk and trauma that she had to go through" to receive care than there would have been had her home-state hospital had clarity that EMTALA applied notwithstanding the state's abortion ban. Dr. D notes that being unable to provide care to patients is hard on physicians as well: "I have the skills to provide the care they want and need, but I can't because of the laws of the state. It creates moral injury for providers."

Stories like these, where patients living in states with restrictive abortion bans elect to travel to out-of-state hospitals that will not deny them care are not uncommon. These stories illustrate the risks taken by patients to obtain abortion care (for wanted pregnancies that threaten their health) and provide insight into the reality patients across the country will face if state laws exclude pregnant patients in need of emergency abortion care from

EMTALA's longstanding protections. Dr. C, whose practice is not limited by a restrictive abortion ban, recalls seeing a patient who traveled from a state that requires cessation of fetal cardiac activity before allowing abortion care. The patient was 19 weeks pregnant when her water broke, but because there was fetal cardiac activity, her doctors had been unable to offer a termination. Like Dr. D's patient, Dr. C's patient had remained in the hospital in her home state under observation, waiting to get sicker or for the fetal cardiac activity to stop before she could receive care. After three days without the care she needed, the patient signed herself out of the hospital against medical advice, boarded a plane to Dr. C's city, flew several hours, and went straight to the hospital upon landing. She arrived very scared, having worried throughout the flight that she would pass the pregnancy in the air. Dr. C explains that had the patient passed the pregnancy during the flight, she could have experienced significant and rapid bleeding without a blood transfusion or pain medication available.

An examination of the patient revealed that the fetal cardiac activity had stopped and the patient had also developed a fever during travel. Dr. C provided an abortion, during which Dr. C noticed a foul odor, further indicating that the patient had contracted an infection. After the procedure, the patient, while devastated by the loss of this wanted pregnancy, was extremely grateful and relieved to have received the care she had been denied in her home state.

Reflecting on the experience, Dr. C wonders how the patient decided to leave her home state hospital against medical advice and seek treatment elsewhere. Dr. C has tried to step into the shoes of the treating physicians in the patient's home state and determine whether, in that position, Dr. C would have advised the patient to seek abortion care in another state rather than wait for her condition to worsen in her home state. Dr. C believes that many providers in states with abortion bans are afraid for their patients, and feel obligated to tell them about options available in other states, even though travel also places the patient at further medical risk. Although Dr. C's patient was able to travel to obtain care, traveling to seek necessary abortion care is not a feasible solution for most patients, even if they are able and willing to assume the associated medical risks. Aside from the emergency medical condition itself, several factors may hinder patients' ability to travel for care, including financial hardship, lack of access to paid leave, disability, childcare availability, and a lack of transportation options.[20]

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[20] *See* Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23 Women's Health Issues e173, e174 (2013), https://www.whijournal.com/article/S1049-3867(13)00022-4/fulltext; Amy N. Addante et al., *Differences in Financial and Social Burdens Experienced by Patients Traveling for Abortion Care*, 31 Women's Health Issues 426, 426–27, 431 (2021), https://www.whijournal.com/article/S1049-3867(21)00057-8/abstract ("Addante"). Traveling to seek care is also associated with increased psychological burdens and higher reported stress among patients, and studies have shown that it is associated with an increased likelihood of seeking subsequent care at an emergency department. *See* Addante, *supra* at 427, 431; Katrina Kimport & Maryani Palupy Rasidjan, *Exploring*

III. "We Were Just A Little Bit Too Late"

Severe obstetric hemorrhage, or excessive bleeding in connection with a pregnancy, is another leading cause of maternal morbidity in the United States. Uterine or placental complications, such as placental abruption or placenta previa, are the most common causes of severe obstetric hemorrhage during pregnancy.[21] Unexpected hemorrhaging "may become life-threatening in as little as 15 min[utes]."[22] As Dr. B explained, because pregnancy increases blood volume, bleeding caused by placental abruption can be sudden and life-threatening: "[i]t's a lot and it's fast." Dr. Perritt said that when a patient is bleeding, it can be "like a waterfall. It is not something you can really describe if you have not experienced it. It isn't like this slow buildup. It's often like a drop off a cliff." According to Dr. B, "stabilization is termination, because you need to stop the bleeding." For

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the emotional costs of abortion travel in the United States due to legal restriction, 120 Contraception, no. 109956, at 1–2, 4 (Apr. 2023), https://www.sciencedirect.com/science/article/pii/S0010782423000094; Ushma D. Upadhyay, Nicole E. Johns, Karen R. Mechstroth & Jennifer L. Kerns, *Distance Traveled for an Abortion and Source of Care After Abortion*, 130 Obstetrics & Gynecology 616, 616–17 (2017), https://journals.lww.com/greenjournal/abstract/2017/09000/distance_traveled_for_anabortion_and_source_of.17.aspx.

[21] Joy L. Hawkins, *Obstetric Hemorrhage*, 38 Anesthesiology Clinics 839, 847–48 (2020), https://pubmed.ncbi.nlm.nih.gov/33127031/.

[22] L.G. Johnson, B.A. Mueller, & J.R. Daling, *The Relationship of Placenta Previa and History of Induced Abortion*, 81 Int'l J. Gynecology & Obstetrics 191, 191 (2003), https://pubmed.ncbi.nlm.nih.gov/12706277/.

physicians practicing in states with restrictive abortion laws like Idaho, without clarity that EMTALA preempts the more restrictive law, allowing physicians to offer stabilizing care in medical emergencies, it can be challenging to determine at what point bleeding has become sufficiently severe to permit physicians to provide an abortion. As one physician explains, determining when to provide an abortion in these situations involves a series of split-second assessments:

> How much blood loss is a lot of blood? How sick does she have to be to terminate the pregnancy? Does she have to be pale? Does she require blood transfusions? There's no cutoff on how much blood is too much blood to lose before performing an abortion. You have about 5 liters of blood—do you have to lose half? Pass out? Is the mom losing blood faster than they can transfuse? It's so difficult to distinguish life-saving and stabilizing care.

Dr. E, an emergency physician, explained that "there is a lot of vaginal bleeding in the emergency department, and most don't end in death, but you don't know when it's going to be."

Dr. B describes seeing a patient in one of these high-risk, rapidly evolving situations. The patient had presented to Dr. B's hospital with bleeding caused by placenta previa, a dangerous condition in which the placenta blocks the cervix. That is, instead of attaching to the upper part of the uterus, the placenta attaches at the bottom of the uterus, partially

or completely obstructing the cervix.[23] One of the hallmark complications of placenta previa is severe bleeding that may result in hemorrhage.[24] Dr. B's patient presented at 20 weeks gestational age with a "very desired pregnancy" and bleeding caused by placenta previa. When the patient arrived at the hospital, she was "just hosing blood."

Although there was still fetal cardiac activity when the patient arrived at the hospital, at 20 weeks gestational age, the pregnancy was not viable, and the bleeding was endangering the pregnant patient. Once Dr. B determined that the pregnancy needed to be terminated, Dr. B nevertheless had to "jump through a series of hoops" before the proper care could be provided. At his hospital, even in an emergency,

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[23] *See* James P. Neilson, *Interventions for suspected placenta praevia (Review)*, 2 Cochrane Database of Systematic Revs., No. CD001998, at 1–3 (2003), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8411396/ pdf/CD001998.pdf; Yinka Oyelese & John C. Smulian, *Placenta Previa, Placenta Accreta, and Vasa Previa*, 107 Obstetrics & Gynecology 927, 928 (2006), https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi= 564b75e6c97266c13ab12bfa98faae2094d0380f.

[24] Pregnant patients who develop placenta previa are almost ten times as likely to develop bleeding, and five times as likely to develop sepsis or abnormal clotting (thrombophlebitis) than patients whose placenta attaches higher up in the uterus. Oyelese & Smulian, *supra* note 23, at 928. Compared to patients without placenta previa, patients with the condition are ten times more likely to require blood transfusions, and thirty times more likely to require a hysterectomy. *Id.* at 928, 932, 933. Placenta previa is also associated with an approximately three times higher perinatal mortality rate and a five times greater risk of preterm birth. J.M. Crane et al., *Neonatal outcomes with placenta previa*, 93 Obstetrics & Gynecology 541, 541–43 (1999), https://pubmed.ncbi.nlm.nih.gov/10214830/.

two physicians must agree on the decision to terminate before that care can be provided. The physicians then call the director of labor and delivery, who notifies the hospital's chief of staff. It is only after obtaining these multiple rounds of approval that the treating physician can proceed. This process, like the complicated approval regimes implemented at many hospitals, is to protect the hospital (and its staff) from violating conflicting state laws and federal statutes. If the Court holds that EMTALA preempts the more restrictive state laws and requires care in these situations, physicians believe that their hospitals would streamline the approval process and rely on the treating physicians' discretion in these emergencies. Fortunately, in this case, Dr. B was able to obtain the necessary approvals quickly, and the patient was able to receive stabilizing care, safely proceeding to surgery for a dilation and evacuation. However, not all outcomes are positive.

Not all patients with bleeding present this clearly, which is one of the challenges posed by laws that require physicians, sometimes in busy emergency departments, to assess whether bleeding is "life-threatening" and then obtain multiple levels of approval before proceeding. Dr. E, an emergency physician in a major academic hospital system in a state with restrictive abortion laws, saw an 18 weeks pregnant patient who had been bleeding for an hour with an incomplete miscarriage. Yet, there was still fetal cardiac activity when the patient was first examined, and thus the physicians believed there was no leeway to move forward with stabilizing abortion care. Treating physicians in the emergency department therefore prioritized the care of other patients who were

more clearly permitted to receive the care they required. By the time Dr. E performed a pelvic exam however, "there was tons of blood" and the patient's blood pressure was dropping rapidly and uncontrollably. That patient was rushed to surgery, but "she didn't make it. We were just a little bit too late. You just don't know." Had EMTALA preempted the state law, allowing the hospital to act earlier, this patient might have received treatment sooner and still be alive today.

Reflecting on this case, Dr. E explains that it was a heartbreaking illustration of two challenging issues facing emergency physicians in states with restrictive abortion laws. First, while there was no active debate about immediate termination when the patient first arrived in the emergency department, Dr. E believes that restrictions on providing abortion care cause providers "to question what they are going to do. Instead of just acting to save the women's life, they wait" to let the situation play out before making medical decisions. And as Dr. E's experience illustrates, when providers wait to intervene, care can come too late. Second, in some emergency situations, even trained emergency physicians can find it hard to determine what is life-threatening. Drawing a line between "stabilizing" care and "life-saving" care is not always possible, and making the wrong call can have devastating consequences. "Hesitating in these situations," Dr. E emphasizes, "puts lives at risk." Holding that EMTALA preempts state restrictions in these situations will resolve these critical conflicts and provide physicians with the discretion to act immediately and in accordance with their medical judgment.

Dr. E speaks frequently with reproductive health care providers in connection with her research, which examines differences in care and equity for patients with vaginal bleeding in the context of restrictive abortion laws.[25] Dr. E explains that restrictions on abortion and the fear of criminalization or loss of license have taken "a huge toll" on providers offering reproductive health care. Dr. E says that it's "just so heartbreaking, the moral injury at stake every day, trying to figure out what you can and can't do. I can't practice medicine the way that I feel is right, and according to my values." With clarity that EMTALA preempts restrictive abortion bans, like the Idaho Total Abortion Ban, physicians will be able to provide stabilizing treatment in medical emergencies, and be relieved of the burden of navigating the landscape of conflicting state and federal statutes.

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[25] Research shows that abortion restrictions both deepen existing inequities and worsen health outcomes for pregnant people. "For example, women who [were] denied [abortion care] are more likely to experience high blood pressure and other seri[ous] medical conditions during the end of pregnancy[;] more likely to remain in relationships where interpersonal violence is present; and more like[ly] to experience poverty." *The Impact of the Supreme Court's Dobbs Decision on Abortion Rights and Access Across the United States: Hearing Before the House Oversight and Reform Comm.*, 117th Cong. 1–2 (2022), https://www.congress.gov/117/meeting /house/114986/documents/HHRG-117-GO00-20220713-SD005.pdf (statement of Physicians for Reproductive Health) (alterations added). Research also shows that states with abortion restrictions also have poorer maternal health outcomes. Terri-Ann Thompson et al., Ibis Reprod. Health & Ctr. for Reprod. Rts., *Evaluating Priorities: Measuring Women's and Children's Health and Well-being Against Abortion Restrictions in the States* 16–17, 23–24 (2017), https://www.ibisreproductivehealth.org/sites/default/ files/ files/pub lications/Evaluating%20Priorities%20August%202017.pdf.

CONCLUSION

For all the reasons set forth herein, PRH respectfully asks that the Court affirm the judgment of the District Court.

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Respectfully submitted,

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