Nos. 23-726, 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

IDAHO, *Petitioner,*

*v.*

UNITED STATES

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

**BRIEF FOR CHARLOTTE LOZIER INSTITUTE AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS**

GENE C. SCHAERR
*Counsel of Record*
CRISTINA MARTINEZ SQUIERS
JUSTIN A. MILLER
MIRANDA CHERKAS SHERRILL
SCHAERR | JAFFE LLP
1717 K Street NW, Suite 900
Washington, DC 20006
(202) 787-1060
gschaerr@schaerr-jaffe.com

*Counsel for Amicus Curiae*

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## INTRODUCTION AND INTEREST OF *AMICUS CURIAE*[1]

This case and the proper interpretation of the Emergency Medical Treatment and Labor Act (EMTALA) are of enormous importance to *Amicus Curiae* Charlotte Lozier Institute (CLI), a nonprofit research and education organization committed to bringing modern science to bear in life-related policy and legal decision-making. CLI believes that laws governing abortion should be informed by the most current medical and scientific knowledge on human development and not by attempts to promote a political or ideological agenda.

CLI agrees with the many points persuasively made by the Petitioners in their briefs and writes separately to expand on two of them.

*First*, as Idaho explains, EMTALA requires physicians to do everything in their power to preserve the life of both the mother and her unborn child. Idaho Br. 7-9. Thus, no conflict exists between EMTALA and Idaho's Defense of Life Act. Yet the United States drastically departs from a faithful reading of EMTALA by ignoring the unborn child and elevating the provision of abortion above all else.

*Second*, Idaho is also correct that the United States' reading of EMTALA will, in some instances, require or coerce physicians to participate in abortions even in cases where the life of the mother is not

[1] This brief was not authored in whole or in part by counsel for any party and no person or entity other than *amicus curiae* or its counsel has made a monetary contribution toward the brief's preparation or submission.

endangered or there are treatment options available to protect both the mother and her unborn baby. This interpretation therefore undermines the intent of both EMTALA and Idaho's Defense of Life Act to protect both women and their unborn children. Idaho Br. 4, 35. The United States ignores this risk by citing rare examples where pregnancy complications *may* require abortion. But, as a matter of statutory interpretation and sound policy, those rare examples cannot trump the general rule under EMTALA of protecting unborn children as well as their mothers.

Thus, the Ninth Circuit panel was correct to stay the district court's order because "EMTALA does not require abortions, and even if it did in some circumstances, that requirement would not directly conflict with section 622." *United States* v. *Idaho*, 83 F.4th 1130, 1134 (9th Cir.), *vacated and reh'g en banc granted*, 82 F.4th 1296 (9th Cir. 2023) (mem.). The *en banc* Ninth Circuit erroneously vacated that order pending rehearing. This Court should reverse the district court's erroneous preliminary injunction.

## SUMMARY OF ARGUMENT

Almost two years ago, this Court "return[ed] the issue of abortion to the people's elected representatives." *Dobbs* v. *Jackson Women's Health Org.*, 597 U.S. 215, 232 (2022). Now the United States seeks to thwart the democratic process, twisting EMTALA, a statute designed to *preserve* life, into a federal override of Idaho's Defense of Life Act (the "Act"), Idaho Code § 18-622, which is also designed to preserve life.

EMTALA's plain text requires hospitals to treat individuals seeking emergency care, including *both* women and unborn children. But the effect of the United States' twisted interpretation is that physicians will be coerced to provide abortion when there are treatment options that can protect both the mother and her unborn child. This Court should therefore reject the United States' flawed statutory interpretation and reverse the district court's preliminary injunction. As the Ninth Circuit panel held, "the two laws would not conflict" because, "even if the federal government were right that EMTALA requires abortions in certain limited circumstances, EMTALA would not require abortions *that are punishable by* [Idaho's law]." *United States* v. *Idaho*, 83 F.4th 1130, 1138 (9th Cir.), *vacated and reh'g en banc granted*, 82 F.4th 1296 (9th Cir. 2023) (mem.). Nor was EMTALA designed "to force hospitals to treat medical conditions using certain procedures." *Ibid.* Simply put, no conflict exists between EMTALA and the Act.

The United States' preemption argument, rooted in a misinterpretation of EMTALA, is wrong for two reasons.

*First*, the United States disregards EMTALA's plain text requiring physicians to protect the lives of unborn children. EMTALA mandates that subject hospitals treat individuals seeking emergency care. When a potential emergency medical condition involves a "pregnant woman," EMTALA considers whether the condition places the mother's health "*or* [the health of] *her unborn child* in serious jeopardy." 42 U.S.C. § 1395dd(e)(1)(A)(1). This language,

employed here and elsewhere in EMTALA, reflects Congress's commitment to the centuries-old two-patient paradigm: that ethically minded physicians must act in the interest of both the mother and her unborn child.

Yet the United States argues that the addition of "unborn child" to the statute should be ignored. But that reading disregards the plain text and rejects the purpose of the EMTALA amendments, which expanded the scope of protection for mothers *and* unborn children. Opp'n Stay Appl. 31-32.

*Second*, the United States' erroneous interpretation of EMTALA would effectively require physicians to perform abortions that are not necessary. Abortion is rarely medically necessary to stabilize a pregnant woman, and an abortion will (obviously) never stabilize an unborn child. Most life-threatening complications in pregnancy occur after fetal viability, when the unborn child can be successfully separated from her mother in a manner that protects both of their lives. Under such circumstances, EMTALA cannot be read to *require* an abortion, but instead requires that the unborn child be stabilized, just as any other patient would be. And in early pregnancy, many complications can be treated with medication, expectant management, and close monitoring—not with abortion. Early pregnancy complications such as ectopic pregnancy and molar pregnancy should be treated immediately, but intervention in these circumstances is allowed by every state law's emergency exception for life-threatening conditions.

Like EMTALA, the Idaho Defense of Life Act reflects a two-patient paradigm. Under the Act, medically indicated maternal-fetal separation cannot be performed unless done with "good faith medical judgment" in the manner that provides the best opportunity for the unborn child's survival, while also preserving the life of the mother. Idaho Code § 18-622(2)(a). Thus, nothing in the Act contradicts a proper reading of EMTALA.

## ARGUMENT

### I. The United States Disregards EMTALA's Plain Text Requiring Physicians to Protect the Life of Unborn Children.

As this Court has recognized "time and again," "courts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Connecticut Nat'l Bank* v. *Germain*, 503 U.S. 249, 253-254 (1992); accord *Rotkiske* v. *Klemm*, 140 S. Ct. 355, 360 (2019). And thus, "the best evidence of Congress's intent is the statutory text." *National Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, 544 (2012). "So any evidence of pre-emptive purpose, whether express or implied, must therefore be sought in the text and structure of the statute at issue." *West Virginia Uranium, Inc.* v. *Warren*, 139 S. Ct. 1894, 1907 (2019).

The United States' reading of EMTALA violates these basic principles by disregarding the plain text that expressly protects the lives of unborn children. Properly understood, therefore, EMTALA simply does not preempt the Act. The two laws instead complement each other.

### A. EMTALA's repeated references to the "unborn child" reflect a statutory command to recognize both the pregnant woman and her unborn child as patients protected by the statute.

Starting with the statute's text, EMTALA requires hospitals to determine whether someone presenting at the hospital has an "emergency medical condition." 42 U.S.C. § 1395dd(a). Congress amended EMTALA in 1989 to explicitly extend its protections to unborn children. Accordingly, for 35 years EMTALA has defined "emergency medical condition" to apply to both a pregnant woman and her unborn child: The definition includes, among other things, medical conditions from which "the absence of immediate medical attention" could reasonably be expected to place "the health of the individual" or, "with respect to a pregnant woman, the health of the woman *or her unborn child*" in "serious jeopardy," *id.* § 1395dd(e)(1)(A) (emphasis added), and where transferring a pregnant woman experiencing contractions would threaten her "or the unborn child," *id.* § 1395dd(e)(1)(B)(ii).[2]

If a patient has such a condition, hospitals must either (a) provide "further medical examination" of the woman and her unborn child, (b) provide "such treatment as may be required to stabilize the medical condition," or (c) "transfer" them "to another medical

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[2] Indeed, before a transfer to another facility may occur, a physician must certify that the transfer would benefit both the woman and her unborn child. 42 U.S.C. § 1395dd(c)(1)(A)(ii), (c)(2)(A).

facility" that can provide the care that the woman and her unborn child need. 42 U.S.C. § 1395dd(b)(1), (c)(1).

EMTALA then defines "stabilize" as "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." 42 U.S.C. § 1395dd(e)(3)(A). This definition is made "with respect to an emergency medical condition described in paragraph (1)(A)," which are those conditions that "plac[e] the health of *** the woman *or her unborn child* *** in serious jeopardy." *Id.* § 1395dd(e)(1)(A)(i), (3)(A) (emphasis added). Once again, the provision applies to both the pregnant woman and her unborn child.

The text of the statute thus demonstrates Congress's commitment to what bioethicists and physicians call a "two-patient paradigm." Under that view, "a physician's ethical duty toward the pregnant woman clearly requires the physician to act in the interest of the fetus as well as the woman."[3] And by defining "emergency medical conditions" to include conditions threatening the health of the unborn child, EMTALA ensures that it never departs from that paradigm. Thus, at all relevant points, physicians and hospitals subject to EMTALA's requirements are required to follow the two-patient paradigm to protect both the mother and her unborn child.

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[3] Helene M. Cole, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 J. Am. Med. Ass'n 2663, 2664 (1990).

### B. The United States' contrary interpretation is not only novel, but atextual and incoherent.

Despite EMTALA's clear text, the United States argues for a one-patient paradigm where the unborn child's health is only a consideration as in relation to the mother's health. For example, the United States has argued that EMTALA's repeated mentions of the unborn child in the statute's 1989 amendments "did not alter EMTALA's basic operation" that "what must be stabilized is the 'medical condition' of the 'individual'"—meaning only mothers and infants born alive. Opp'n Stay Appl. 30-32. But three of these mentions require considering the unborn child's health when transferring a laboring mother. 42 U.S.C. § 1395dd(c)(1)(A)(ii), (c)(2)(A), (e)(1)(B)(ii). And the fourth mention expands the definition of "emergency medical condition" to include medical conditions that "plac[e] the health of *** the woman *or her unborn child* *** in serious jeopardy." *Id.* § 1395dd(e)(1)(A)(i). Thus, the 1989 amendments *did* alter EMTALA's basic operation by protecting unborn children, and this Court should reject the United States' sophistry, which contradicts the statutory text in at least three ways.

*First*, the United States' argument ignores the statute's obvious treatment of an "unborn child" as requiring independent protection. The EMTALA amendments expanded "emergency medical condition" to include medical conditions that "plac[e] the health of *** the woman *or her unborn child* *** in serious jeopardy." 42 U.S.C. § 1395dd(e)(1)(A)(i). But the United States has argued that Congress meant only to

require hospitals to provide "her," *i.e.*, the mother, "stabilizing treatment" when "the health of her fetus," but not her own health, was in jeopardy. Opp'n Stay Appl. 32. No explanation was offered as to how stabilizing the mother would benefit her or the fetus under those circumstances. And the reason is obvious: in this case, the unborn child, not the mother, is the one who requires and is entitled to stabilizing treatment.

The United States concedes that EMTALA "sensibly requires hospitals to consider risks to the health" of unborn children when determining whether to transfer a laboring mother. *Id.* at 31. But according to the United States, those protections and health-providers' consideration of the health of the unborn child end as soon as the mother's health is also in peril. *Id.* at 33. The United States' attempt to diminish the "unborn child's" life as secondary—one that must be protected only if her mother's health is not threatened but loses all value if her mother's health *is* in jeopardy—is atextual. Congress expected hospitals and physicians to preserve *both* lives wherever possible.

*Second*, as noted above, the United States ignores that EMTALA recognizes that both the mother and unborn child are patients in need of stabilization, treatment, and potential transfer. When a pregnant woman presents at an EMTALA-regulated entity, EMTALA requires the entity to check for an "emergency medical condition," by expressly evaluating both the "woman" and "her unborn child." 42 U.S.C. § 1395dd(a), (e)(1). Because the United States disregards the requirement to consider the

welfare of an unborn child when determining how to stabilize a woman, its interpretation of EMTALA cannot be squared with the Act's text.

*Third*, the United States' argument ignores the purpose of the 1989 amendments. Far from merely clarifying the scope of medical conditions that can trigger the statute's obligations towards only pregnant women, Opp'n Stay Appl. 32, the EMTALA amendments *expanded* the scope of protection to include the mother and unborn child alike. Despite this expansion, the United States ignores EMTALA's protections for unborn children through an insistence that abortion is likely to be necessary to protect a mother in various circumstances. This view flatly denies the two-person paradigm present in the statutory text and instead adopts the pro-abortion, one-patient paradigm.

These three errors lie at the heart of the United States' argument that EMTALA and the Act conflict. But under a proper reading, they complement rather than conflict with each other: Like EMTALA, Idaho law ensures that any maternal-fetal separations are performed with "good faith medical judgment" in the manner that "provide[s] the best opportunity for the unborn child to survive"—while also preserving the life of the mother. Idaho Code § 18-622(2)(a)(ii). Thus, the goal under Idaho law, like the goal under EMTALA, is always the same—all reasonable attempts to preserve the life of *both* patients are required.

## II. The United States' Interpretation of EMTALA Effectively Mandates Abortions That Are Not Necessary Emergency Care.

The United States further errs as a matter of medical science by concluding that abortion is a necessary stabilizing treatment even when abortion is not actually necessary. And the threat of fines and loss of federal funding for contravening this misinterpretation of EMTALA's requirements will inevitably lead some physicians to perform abortions even when presented with other options.

1. Abortion is rarely medically necessary to stabilize a pregnant woman, and—critical in any EMTALA analysis—an abortion will *never* stabilize an unborn child.[4] To be sure, there may be situations where EMTALA's dual obligations to the mother and her unborn child cannot maintain both lives and preservation of the mother's life will result in the death of her child. But such tragic situations are rare.

In early pregnancy, complications are often treated with expectant management, where the woman and her unborn child are treated medically, stabilized, and closely monitored to allow the pregnancy to advance to a gestational age where the child can survive.[5]

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[4] Situations like the removal of an ectopic, molar, or non-viable pregnancy, while medically necessary, are not abortions. Idaho Code § 18-604(1); *Planned Parenthood Great Nw.* v. *Idaho*, 522 P.3d 1132, 1203 (Idaho 2023).

[5] ACOG, *Comm. Op. No. 831, Medically Indicated Late-Preterm and Early-Term Deliveries*, 138 Obstetrics & Gyn. e35 (2021); ACOG, *Practice Bulletin No. 217, Prelabor Rupture of Membranes*, 135 Obstetrics & Gyn. e80 (2020); ACOG, *Practice*

Consistent with EMTALA's two-patient paradigm, a doctor, in her own reasonable medical judgment, makes decisions along with the pregnant woman—even if a potential outcome is that an emergency medical condition as defined by EMTALA that requires delivery will develop.[6]

Further, many life-threatening complications in pregnancy occur *after* fetal viability (around 22 weeks' gestation), when an unborn child can survive separate from her mother.[7] At that stage of pregnancy, if a medically indicated maternal-fetal separation is required, it can often be done in such a way that the neonate can continue to live.[8] In such circumstances, far from *requiring* an abortion, EMTALA's text

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*Bulletin No. 222, Gestational Hypertension and Preeclampsia*, 135 Obstetrics & Gyn. e237 (2020); ACOG, *Practice Bulletin No. 212, Pregnancy and Heart Disease*, 133 Obstetrics & Gyn. e320 (2019); ACOG, *Practice Bulletin No. 203, Chronic Hypertension in Pregnancy*, 133 Obstetrics & Gyn. e26 (2019).

[6] Indeed, the majority of OB-GYNs follow a two-patient paradigm irrespective of EMTALA. The reality is that only 7-14% of obstetricians will perform an elective abortion when requested by a patient. Sheila Desai et al., *Estimating Abortion Provision and Abortion Referrals Among United States Obstetricians-Gynecologists in Private Practice*, 97 Contraception 297, 301 (2018); Debra B. Stulberg et al., *Abortion Provision Among Practicing Obstetrician-Gynecologists*, 118 Obstetrics & Gyn. 609, 611 (2011).

[7] Y. Motojima et al., *Management and Outcomes of Periviable Neonates Born at 22 Weeks of Gestation: A Single-Center Experience in Japan*, J. Perinatology 43 (2023) (24 of 29 infants born at 22 weeks gestation at one clinic survived), https://doi.org/10.1038/s41372-023-01706-4.

[8] See generally AAPLOG, *Practice Guideline No. 10, Concluding Pregnancy Ethically* (2022), https://tinyurl.com/4eccu22c.

requires the unborn child to be stabilized—whether by birth through standard obstetric interventions of labor induction or by cesarean section.[9]

2. Although many of the specific conditions cited by the United States could be resolved by abortion, alternative stabilizing and life-affirming treatments are also available. Most mothers will opt for a treatment that optimizes her child's chance for life, rather than one that necessarily results in a child's death by dismemberment dilation and evacuation abortion procedure.

For instance, when the child survives an attempted medication abortion, EMTALA's textual requirement is to care for both the woman and the unborn child and does not require a physician to end the life of the living child. However, the United States' interpretation of EMTALA will likely pressure a physician to perform an abortion in that circumstance.

Approximately 1-3% of women who consume mifepristone and misoprostol to induce an abortion will continue to have a still living fetus.[10] They may present to an emergency room for care or reassurance.[11] The United States' argument implies

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[9] Colloquium, *Medical Intervention in Cases of Maternal-Fetal Vital Conflicts, A Statement of Consensus*, 14 Nat'l Cath. Bioethics Q. 477, 485 (2014), doi: 10.5840/ncbq20141439.

[10] Food & Drug Admin., Ref. ID: 3909592, Mifeprex Medication Guide at 13 (rev. 2016), https://tinyurl.com/3r72h3wf.

[11] While many of these women do not require emergency care, the tragic reality is that they do not have anywhere else to turn other than the emergency room. These women may have been given abortion pills out of state, through the mail from the internet or telemedicine providers, or by abortion doctors who are

that the emergency provider would need to complete the abortion in that circumstance, but that action would not be required if the woman is clinically stable. If mifepristone and misoprostol fail to kill the child, it is likely that the pregnancy will continue to a live birth. In that case, progesterone support and continued expectant management would be a preferable option for stabilizing the unborn child.[12]

Likewise, for women presenting with preterm, premature rupture of membranes (PPROM), abortion is not the only option. The American College of Obstetricians and Gynecologists advises that "[w]omen presenting with [P]PROM before neonatal viability should be counseled regarding the risks and benefits of expectant management versus immediate delivery" and provided with "a realistic appraisal of neonatal outcomes."[13] Thus even ACOG recognizes that, in the appropriate case, watchful waiting—not abortion—may be the best course.

Additionally, if the physician and patient desire intervention at the time of diagnosis, ACOG

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unwilling or unable to manage their complications. In fact, the FDA's complication data records that less than 40% of surgeries required for failed chemical abortions were performed by abortion providers. Kathi Aultman et al., *Deaths and Severe Adverse Events After the Use of Mifepristone as an Abortifacient from September 2000 to February 2019*, 36 Issues L. Med. 3, 4 (2021); Margaret M. Gary & Donna J. Harrison, *Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient*, 40 Annals Pharmacotherapy 191 (2006).

[12] George Delgado et al., *A Case Series Detailing the Successful Reversal of the Effects of Mifepristone Using Progesterone*, 33 Issues L. & Med. 21, 22-23 (2018).

[13] ACOG, *Practice Bulletin No. 217*, *supra* note 5, at e88.

recommends—and all state laws allow—immediate delivery by induced labor or cesarean section. And that means delivery without intentional destruction of the unborn child, which would obviously occur with a dilation and evacuation abortion.

The same is true with preeclampsia. In the event of a life-threatening hypertensive emergency, ACOG explains that "delivery is recommended *** at or beyond 34 0/7 weeks of gestation" and recognizes that, "before 34 0/7 weeks of gestation," expectant management may be appropriate "based on strict selection criteria of those appropriate candidates and is best accomplished in a setting with resources appropriate for maternal and neonatal care."[14] As dangerous as preeclampsia is, even ACOG makes clear that expectant management or delivery—both options that allow the unborn child to be born alive rather than aborted—are accepted treatments.

Although not an exhaustive list of the possible complications that a woman may experience during pregnancy, the complications discussed above and the life-affirming treatments that can protect both the mother and her unborn child illustrate that the United States' insistence that abortion is medically required when women suffer serious pregnancy complications is often incorrect.[15]

3. Though the United States asserts that EMTALA requires abortion only when it "is the

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[14] ACOG, *Practice Bulletin No. 222*, *supra* note 5, at e245; ACOG, *Practice Bulletin No. 203*, *supra* note 5, at e42.

[15] And in fact, many physicians would recognize that determining whether abortion is, in fact, medically necessary during emergency treatment varies greatly from case to case.

requisite stabilizing treatment for a specific emergency medical condition," Opp'n Stay Appl. 15, its position will encourage or pressure physicians to perform abortions as a primary intervention even when other options are available, undermining efforts to protect both the mother and the unborn child despite the statutory protections for unborn children in EMTALA. Tragically, the mothers facing these crises generally want their babies and with proper counseling and care will likely choose a treatment that may preserve both their lives.

Nonetheless, the United States' position in the related U.S. Department of Health and Human Services (HHS) guidance recently stayed in the Fifth Circuit was that a medical emergency is merely a situation that "*could place* the health of a person (including pregnant patients) in serious jeopardy." *Texas* v. *Becerra*, 623 F. Supp. 3d 696, 731 (N.D. Tex. 2022), *aff'd,* 89 F.4th 529 (5th Cir. 2024) (emphasis added). But this departs from EMTALA's text, which more narrowly defines medical emergency as a situation that "*could reasonably be expected* to" place the health of a mother or her unborn child in serious jeopardy. 42 U.S.C. § 1395dd(b)(1) (emphasis added). Thus, the United States intends to broaden the scope of what constitutes emergency care in favor of greater abortion access.

Further highlighting the incoherence of the United States' broad interpretation of EMTALA which, tragically, is shared by ACOG, is ACOG's argument to the Ninth Circuit that, when a physician decides an abortion is "medically necessary," the Act compels them "to deny necessary emergency care in violation

of the age-old principles of beneficence and non-maleficence." Brief of ACOG et al. as *Amici Curiae* Supporting Plaintiff-Appellee and Affirmance at 48, *United States* v. *Idaho*, 83 F.4th 1130 (9th Cir. 2023) (Nos. 23-35440, 23-35450), Dkt. No. 46-2.[16] But that argument, as stated earlier, ignores that the principles of beneficence and nonmaleficence also apply to the unborn child, as required by EMTALA's text.[17]

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[16] This statement is rooted in the Hippocratic Oath but fails to mention that the original Hippocratic Oath specifically pledged not to provide herbs to induce an abortion. Fritz Baumgartner & Gabriel Flores, *Contemporary Medical Students' Perceptions of the Hippocratic Oath*, 85 Linacre Q. 63, 70 (2018) ("I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion." (quoting Hippocrates, The Oath (Francis Adams trans. 1849) (400 B.C.E.)).

[17] While ACOG provides clinical practice guidelines for members that are developed through a peer-review process that generally ensures that the recommendations are based on science, ACOG has not abided by that scientific standard in its guidance about abortion. ACOG's publications on abortion are crafted by prominent abortion advocates, such as Mitchell Creinin (consultant for Danco, the manufacturer of the abortion drug, mifepristone) and Daniel Grossman (Director of ANSIRH, a vocal abortion advocacy organization), who collaborated on *Practice Bulletin No. 225, Medical Management Up to 70 Days Gestation*, and (in Grossman's case) who cowrote *Practice Bulletin No. 135, Second-Trimester Abortion*. Shelly Kaller et al., *Pharmacists' Knowledge, Perspectives, and Experiences with Mifepristone Dispensing for Medication Abortion*, 61 J. Am. Pharmacists Ass'n 785 (2021); ACOG, *Practice Bulletin No. 225, Medical Management Up to 70 Days Gestation,* 136 Obstetrics & Gyn. e31, e31 (2020); ACOG, *Practice Bulletin No. 135, Second-Trimester Abortion*, 121 Obstetrics & Gyn. 1394, 1394 (2013). Dr. Grossman is also the Principal Investigator of the clinical trials to test pharmacy dispensation of mifepristone for abortion. U.S.

So, while the United States' position asserts that the "professional judgment" of the relevant medical personnel should determine what stabilizing treatment to provide—even "supersed[ing] those standards in the emergency room, making doctors a law unto themselves," Idaho Br. 30—the United States simultaneously diminishes the ability of many physicians to exercise their professional judgments *against* abortion.

Even if a physician decides with her patient that another stabilizing treatment besides abortion would be the best course, the physician does so at great personal risk, as the United States might ultimately disagree. Faced with the possibility of six-figure fines and the loss of federal funding, Opp'n Stay Appl. 4-5, many physicians may choose to provide abortions even if their consciences forbid it.

This fear of federal enforcement is not theoretical. The Department of Justice here sued Idaho, asserting that EMTALA requires the state's hospitals to provide abortion whenever the mother's health—but not her life—is at risk. Idaho Br. 14. And the federal government investigated and cited a hospital for allegedly denying an emergency abortion even though "[t]he care provided to the patient was reviewed by the hospital and found to be in accordance with hospital policy," "met the standard of care based upon the facts known at the time, and complied with all applicable

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Nat'l Libr. of Med., *NCT03320057, Medication Abortion Via Pharmacy Dispensing*, ClinicalTrials.gov, https://classic.clinicaltrials.gov/ct2/show/NCT03320057 (accessed Feb. 26, 2024).

law."[18] The woman ultimately received an abortion four days later at a different facility.[19] This lawsuit and investigation demonstrate that the United States intends to use its broad interpretation of EMTALA to ensure the expansion of abortion in emergency rooms nationwide.

Finally, the confusion that the United States' interpretation has now created—because its position conflicts with EMTALA and curtails medical judgment regarding abortion—exacerbates the difficulties physicians already faced regarding compliance with abortion laws. Leading medical organizations, such as ACOG and the American Medical Association (AMA), blatantly support abortion as essential healthcare. And they view any restrictions on abortion as "reckless government interference in the practice of medicine that is dangerous to the health of our patients."[20] The AMA president has further stated: "Under extraordinary circumstances, the ethical guidelines of the profession support physician conduct that sides with their patient's safety and health, acknowledging that this may conflict with legal constraints that limit access to abortion or reproductive care."[21] This

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[18] Heidi Schmidt & Malik Jackson, *University of Kansas Health Investigated for not Providing Emergency Abortion*, Fox4KC News (May 1, 2023), http://tinyurl.com/ywps943j.

[19] Harris Meyer, *Hospital Investigated for Allegedly Denying an Emergency Abortion After Patient's Water Broke*, KFF Health News (Nov. 1, 2022), http://tinyurl.com/mtt975kh.

[20] Press Release, Am. Med. Ass'n, *AMA Announces New Adopted Policies Related to Reproductive Health Care* (Nov. 16, 2022), https://tinyurl.com/4w7cbzzp.

[21] *Ibid.*

statement fails to acknowledge that physicians who treat pregnant women have two patients.

By interpreting EMTALA in a way that blatantly contradicts the Act's protections for both mothers and their unborn children and that mandates, or, at a minimum, strongly suggests that abortion care is needed in non-emergency situations, the federal government has now reiterated the message that the provision of abortion-related care must come before all else, including the plain text of laws, physicians' ethical obligations under the two-patient paradigm, physicians' individual medical judgments, and states' ability to regulate abortion after *Dobbs*. Applying EMTALA's plain text, the Ninth Circuit panel was correct to reject that message, and the *en banc* court erred in vacating the panel order.

## CONCLUSION

EMTALA, like the Idaho law at issue, protects both mothers and their unborn children. Yet the United States now promotes, and even requires, the destruction of the unborn child even when it is *unnecessary* to preserve the life of the mother. Because the United States' interpretation of EMTALA is deeply flawed and will—in many instances—require physicians to participate in non-emergency abortions, the district court's preliminary injunction should be vacated.

Respectfully submitted,

GENE C. SCHAERR
*Counsel of Record*
CRISTINA MARTINEZ SQUIERS
JUSTIN A. MILLER
MIRANDA CHERKAS SHERRILL
SCHAERR | JAFFE LLP
1717 K Street NW, Suite 900
Washington, DC 20006
(202) 787-1060
gschaerr@schaerr-jaffe.com
*Counsel for Amicus Curiae*

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