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 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 DR. CAITLIN BERNARD, DR. LAUREN MILLER, DR. LEILAH ZAHEDI-SPUNG, & DR. NIKKI ZITE AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICI CURIAE*

Amici[1] are obstetrician-gynecologists ("OB/GYNs"), including maternal-fetal medicine specialists ("MFMs"),[2] who have dedicated their lives to helping people through some of the most important moments of their own lives. This has included delivering babies, supporting patients through the miscarriage of a cherished pregnancy, counseling patients about the risks and benefits of continuing a wanted pregnancy that threatens their fertility, and providing an abortion that enables a patient to have a healthy child in the future.

Importantly, *amici* have done this vital work in states with high levels of maternal mortality, with a dearth of abortion providers, and where abortion providers are routinely targeted and harassed[3]—all

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[1] Pursuant to Rule 37.6, no counsel for any party authored this brief in whole or in part, and no person or entity other than *amici* or their counsel funded the brief's preparation or submission.

[2] MFM specialists care for pregnant individuals who have high-risk pregnancies, have chronic health conditions, or who unexpectedly develop serious medical conditions. *What do Maternal-Fetal Medicine Subspecialists do?*, SOCIETY FOR MATERNAL-FETAL MEDICINE, https://www.smfm.org/whatwedo (last visited Mar. 22, 2024).

[3] *See Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1333–34 (M.D. Ala.), *as corrected* (Oct. 24, 2014), *supplemented by* 33 F. Supp. 3d 1381 (M.D. Ala. 2014), *and amended*, No. 2:13CV405-MHT, 2014 WL 5426891 (M.D. Ala. Oct. 24, 2014) ("Although the vast majority of those who oppose abortion do so in nonviolent ways, this court cannot overlook the backdrop to this case: a history of severe violence against abortion providers in Alabama and the surrounding region. . . . Nationally, during the same period of time, other abortion doctors have been

because their conscientious or religious convictions compel them to use their training and talents to help people in need.

Dr. Caitlin Bernard is an OB/GYN who is fellowship-trained in Complex Family Planning. She provides clinical care at Indiana University Health Hospital and is an Assistant Professor of Clinical Obstetrics & Gynecology at the Indiana University School of Medicine. Dr. Bernard provides general OB/GYN, contraception, and miscarriage care. She also provides abortion care to the extent permitted by the narrow exceptions to Indiana's abortion ban.[4] Although Dr. Bernard is not a member of any organized religious sect, she fundamentally believes as a matter of conscience that all people are born with inherent value and dignity, and thus entitled to equal compassion and respect.

Dr. Lauren Miller is an MFM and has a Master of Public Health. She provides clinical care in Denver, Colorado. She also serves as an assistant professor at a university in Denver. For over five years, she practiced and taught at several hospitals in Boise, Idaho.

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murdered, other clinics have been bombed and burned, and abortion providers have endured other, less dangerous forms of extreme harassment that exceed the boundaries of peaceful protest.").

[4] *See* Ind. Code Ann. §§16-34-2-1(a), 16-18-2-327.9 (criminalizing the termination of a pregnancy unless the pregnancy poses a risk of death or a serious risk of "substantial and irreversible physical impairment of a major bodily function," the pregnant person has been diagnosed with a lethal fetal anomaly, or the pregnancy resulted from rape or incest).

In fact, she hoped to establish the first-ever OB/GYN residency in Boise when her children were older. Last year, however, Idaho's abortion ban forced her to move her home and practice to Colorado by criminally prohibiting her from providing the standard of care to vulnerable patients and limiting the medical care that Dr. Miller herself would be able to obtain if she became pregnant. Although Dr. Miller is not a member of any organized religious sect, she has a sincere conscientious belief that people's bodies belong to them and that they should be able to choose what to do with their own bodies. Dr. Miller also believes as a matter of conscience that human beings are interconnected and that they have a duty to support one another and their communities.

Dr. Leilah Zahedi-Spung is an MFM who also provides family planning and general OB/GYN services in Denver, Colorado. She also serves as an assistant professor at a university in Denver. Dr. Zahedi-Spung, who identifies as a Southerner and for whom it was important to remain in the South, practiced and taught in Chattanooga, Tennessee until last year. Tennessee's abortion ban forced her to relocate to Colorado by criminally prohibiting her from providing the standard of care to vulnerable patients.[5] Dr. Zahedi-Spung was the last abortion provider left in Chattanooga. Although

[5] *See* Tenn. Code Ann. §39-15-213(b), (c)(1), (c)(2) (criminalizing the termination of a pregnancy unless the pregnancy poses a risk of death or a serious risk of "substantial and irreversible impairment of a major bodily function," excluding mental health harm).

she does not identify with any organized religion, Dr. Zahedi-Spung deeply believes as a matter of conscience that people are born equal. This central belief, which she inherited as the daughter of a Persian immigrant, obligates her to help people without judgment and to combat inequality, including systemic racism.

Dr. Nikki Zite is an OB/GYN who practices at University of Tennessee Medical Center and is Professor, Vice Chair of Education and Advocacy at the University of Tennessee Graduate School of Medicine. She has lived and worked in Tennessee for over two decades. Dr. Zite is the only board-certified Complex Family Planning OB/GYN in east Tennessee. She provides abortions to the extent permitted by the narrow exceptions to Tennessee's abortion ban. Dr. Zite is Jewish. She believes as a matter of religious conviction that life is sacred and that each person has inestimable value.

Amici OB/GYNs and MFMs have a deep interest in this Court vindicating Congress's intent for the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. §1395dd, to accord with medical ethics and enable abortions necessary to stabilize emergency conditions that seriously threaten a patient's health. Accepting Petitioners' interpretation of EMTALA would have the absurd result of placing EMTALA at odds with fundamental medical ethics. As such, it would force OB/GYNs and MFMs in states that have criminalized abortions necessary to prevent serious health harms to violate their medical ethics. By the same token, accepting Petitioners' interpretation of EMTALA would force the *amici* remaining in these

states to violate their conscientious and religious convictions. While EMTALA has always required abortions necessary to stabilize emergencies that seriously threaten a patient's health, the confusion generated by *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), chilled that care in states that criminalized it, with alarming consequences.

INTRODUCTION AND SUMMARY OF ARGUMENT

Breathtakingly, Petitioners claim that EMTALA does not require any particular stabilizing treatments to be offered in specific emergencies–irrespective of the standard of care–unless state law authorizes those treatments. Idaho Br. 24–26; Leg. Br. 23–27. Petitioners further claim that, even if EMTALA requires particular stabilizing treatments to be offered in specific emergencies, those treatments can never be abortion care. As Petitioners tell it, Congress intended for EMTALA to subordinate the pregnant individual's interests to those of their embryo or fetus, regardless of the individual's wishes or circumstances, unless and until the pregnancy threatens the individual's life. *See* Idaho Br. 9, 34, 37. The natural and chilling consequence of Petitioners' position is that EMTALA allows a covered hospital to deny an emergency abortion to an individual suffering from a condition that seriously threatens their health or fertility even when the standard of care requires a physician to offer abortion as a treatment option, so long as the hospital subjects every

such individual to the same, subpar treatment. *See* Idaho Br. 9; Leg. Br. 36.

This position is untenable because Congress intended for EMTALA to serve the government's interest in promoting medical ethics. And *amici* have first-hand knowledge of how the inability to offer an abortion necessary to stabilize an emergency condition that seriously threatens an individual's health defies fundamental medical ethics. That is, it forces physicians to delay or withhold wanted care that would preserve their patients' health and future fertility for fear of losing their freedom and livelihood. *Amici* also have personal knowledge of how the inability to provide emergency abortion care to patients who want it and urgently need it forces many physicians to violate conscientious and religious beliefs that forbid them from abandoning individuals who need their help.

ARGUMENT

I. Congress Intended for EMTALA to Protect the Ethics and Integrity of Physicians Providing Emergency Care.

Protecting the "ethics and integrity of the medical profession" is decidedly in the public interest. *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997); *see Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Congress plainly intended to serve this interest in enacting EMTALA. Interpreting EMTALA in a manner at variance with medical ethics, as Petitioners do,

would ascribe an absurd intent to Congress. *See Compton Unified Sch. Dist. v. Addison*, 598 F.3d 1181, 1184 (9th Cir. 2010) ("We read statutes as a whole, and avoid statutory interpretations which would produce absurd results."); *Matter of Hunter*, 970 F.2d 299, 307 (7th Cir. 1992) (rejecting a statutory interpretation that would require the court to "attribute to the Indiana legislature . . . an implausible intent"); *Hines v. Blue Cross Blue Shield of Va.*, 788 F.2d 1016, 1021 (4th Cir. 1986) ("In upholding this . . . provision under Virginia law, we do not attribute to the Virginia legislature an implausible intent."); *Am. Fed'n of Gov't Employees v. Fed. Labor Rels. Auth.*, 798 F.2d 1525, 1529 (D.C. Cir. 1986) (rejecting a statutory interpretation that would "attribute [an] absurd intent to Congress").

The text of EMTALA, which does not prescribe any particular medical treatments, comports with an ethical approach to providing medical care. *See*, *e.g.*, 42 U.S.C. §1395dd(e)(3)(B) (providing that stabilizing treatment for a laboring woman is delivery without specifying the method of delivery). Medical ethics, including the core ethical principle of respect for patient autonomy, require physicians to engage in shared decision-making with patients to identify a course of action.[6] *See infra* 16. In shared decision-making, physicians provide evidence-based information and

[6] *See* AMA, Patient-Physician Relationships, *Code of Medical Ethics* Opinion §1.1.1, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/1.1.1.pdf (last visited Mar. 24, 2024); ACOG, Code of Professional Ethics, *Patient–Physician Relationship* §(I)(5) (Dec. 2018).

options to the patient, explore the patient's values and preferences, and help the patient choose options consistent with their values and preferences.[7] As Dr. Miller notes, "we are never treating the illness alone. Rather, we are caring for the whole patient, which requires us to consider her broader health, self-identity, major relationships, and personal beliefs."[8] To illustrate, Dr. Zite once treated an anemic patient who was a Jehovah's Witness and who had a molar pregnancy, in which abnormal cells and chromosomal abnormalities make the pregnancy non-viable and life-threatening for the pregnant person. After fully explaining the relevant risks, Dr. Zite honored the patient's wishes for more time to consider whether to continue the pregnancy and to not receive a blood transfusion if she suffered life-threatening bleeding. As Dr. Zite explains, "although the patient ultimately did decide to have a dilation and curettage ("D&C") procedure, it would be contrary to medical ethics to override my patients' deeply-held beliefs."

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[7] ACOG Committee Opinion No. 819*, Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (2021), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology.

[8] The accounts in this brief come from interviews conducted by *amici*'s counsel. All the *amici* have reviewed and approved their accounts. The opinions expressed in the accounts are the *amici's* alone and not necessarily shared by the institutions with which *amici* are affiliated.

EMTALA respects the shared decision-making model and the medical ethics underlying it by allowing shared decision-making to flourish rather than imposing particular treatments in specific emergencies regardless of the standard of care and the unique needs of the patient. By the same token, shared decision-making requires physicians to be able to offer an abortion that, in their reasonable medical judgment, is necessary to stabilize an emergency health condition that seriously threatens their patient's health. *See*, *e.g.*, infra 17–18.

Petitioners are flatly wrong that EMTALA creates duties towards the embryo or fetus independent of the duties towards the pregnant individual. *See* Idaho Br. 4; Leg. Br. 21. Although the statute distinguishes between "the individual" and "her unborn child," 42 U.S.C. §1395dd(e)(1)(A)(i), it makes clear that EMTALA's duties to screen, stabilize, or transfer run to the "individual" seeking care. *Id*. §1395dd(a), (b)(1), and (c)(1). That is, the "individual" must be informed of risks and benefits and can "refuse" particular examination or treatment. *Id*. §1395dd(b)(2). Thus, EMTALA creates duties, including the obtaining of informed consent, towards the pregnant individual and not their embryo or fetus.

This is consistent with medical ethics, which require healthcare providers to approach the treatment of an embryo or fetus through the lens of the pregnant

individual.[9] Dr. Miller, for example, echoes the language her individual patients use to refer to their pregnancies: "If a patient describes her pregnancy as a fetus, I refer to the pregnancy as a fetus. If a patient describes her pregnancy as a baby, I refer to the pregnancy as a baby." Dr. Zahedi-Spung illustrates how physicians approach the treatment of a fetus through the lens of the pregnant individual using accounts of pregnancy complications before *Dobbs*:

> A person's pregnancy means to me what it means to them. I have had patients for whom their pregnancy was the best thing that ever happened to them until they discovered that the fetus had a severe anomaly. Many of these patients decided to end their pregnancy because they wanted to shield the fetus from suffering. I honored that decision. In cases where patients were dismayed to learn there was no heartbeat, some assumed the risks of labor and delivery rather than having a dilation and evacuation ("D&E") so they could hold their baby and take footprints. I honored that decision. In each one of these incredibly difficult situations, my care reflected my individual patient's solicitude and preferences for their fetus.

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[9] *See*, *e.g.*, Anjali Kaimal & Mary E. Norton, *SMFM Consult Series #55: Counseling Women at Increased Risk of Maternal Morbidity and Mortality* 4 *Am J Obstet Gynecol* B16, B17 (2021) ("Discussing the benefits and harms of treatment interventions and understanding patient preferences and priorities are central to good clinical practice and the provision of high-quality, patient-centered care.").

That EMTALA creates obligations to a pregnant individual—who are not themselves experiencing a health emergency—in connection with an emergency that seriously threatens the health of their "unborn child" comports with the ethical practice of accounting for the pregnant individual's wishes in determining how to treat their fetus. *See*, *e.g.*, H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess., at 838 (1989); *see* 42 U.S.C. §1395dd(b)(2) (noting that the "individual" can "refuse" particular examination or treatment). So too EMTALA's requirement that in determining whether to transfer a laboring woman experiencing no other emergency, hospitals consider any risks to her "unborn child." 42 U.S.C. §1395dd(c)(1)(A)(ii), (c)(2)(A), and (e)(1)(B)(ii). Certainly, nothing in EMTALA requires physicians to subordinate the interests of the pregnant individual to the interests of their embryo or fetus. To the contrary, the language and structure of the statute make clear that the pregnant individual's wishes are paramount. *See id*. §1395dd(b)(2).

II. The Inability to Provide an Abortion Necessary to Stabilize an Emergency Condition that Seriously Threatens an Individual's Health Forces Physicians to Violate Their Medical Ethics.

> As a medical resident, I quickly realized that high-risk OB/GYNs can do great things. But a lot of pregnancy complications would go away if a patient was not pregnant, and many pregnant patients do not want to be pregnant anymore. It is not fair to force them to wait until

> they are at death's door before we can treat them, and ethically, they should not have to.

Dr. Nikki Zite.

The inability to provide an abortion necessary to stabilize an emergency that seriously threatens a patient's health forces physicians to violate the cornerstones of medical ethics, including: (1) respect for patient autonomy, (2) beneficence, and (3) non-maleficence.[10] These principles are taught in medical school,[11] reinforced during a physician's hands-on residency training,[12] and continuously practiced throughout a physician's career.[13] They are reflected in medical ethics codes, which recognize that "[t]he practice of medicine . . . is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering."[14]

Having to delay or withhold abortion care until an emergency condition is clearly life-threatening forces

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[10] Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* (8th ed. 2019).

[11] *See*, *e.g.*, Steven J. Girdler et al., *Non-maleficence in Medical Training: Balancing Patient Care and Efficient Education*, 4 Indian J. Med. Ethics. 129, 129–133 (2019).

[12] *Id.*

[13] *See*, *e.g*, AMA Code of Medical Ethics, *Principles of Medical Ethics* (adopted June 1957; revised June 1980; revised June 2001), https://code-medical-ethics.ama-assn.org/principles (last visited Mar. 24, 2024) (describing ongoing "standards of conduct that define the essentials of honorable behavior for the physician").

[14] *Id.*, *Patient-Physician Relationships* §1.1.1.

physicians to undermine the physician-patient relationship by requiring them to consider the personal costs of inadvertently violating an abortion ban. It also forces physicians to violate the principle of respect for patient autonomy by requiring them to ignore a patient's informed and considered wish to obtain an abortion for an emergency seriously threatening their health. The inability to provide an abortion in this circumstance forces physicians to breach the time-honored principles of beneficence and non-maleficence by needlessly allowing their patients' health to deteriorate. When a physician is unable to provide stabilizing abortion treatment to a patient experiencing a pregnancy-related medical emergency, they are forced to violate their ethical dictates, threatening patient health and safety and jeopardizing the physician's status as caregiver and healer.

A. The Inability to Provide an Abortion Necessary to Stabilize an Emergency Condition that Seriously Threatens an Individual's Health Undermines the Physician-Patient Relationship.

A central tenet of medical ethics is the sanctity of the physician-patient relationship. An ethical physician-patient relationship requires that patients trust their physicians enough to express themselves honestly so that their physician can form a medical judgment about what information is material to the patient, provide the patient that information, and support them in choosing a treatment plan consistent with

their values, preferences, and healthcare goals.[15] Further, "[t]he physician's primary commitment must always be to the patient's welfare and best interests."[16] In fact, the American Medical Association *Code of Medical Ethics* places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligation to others."[17]

The specter of criminal penalties and professional discipline for providing an abortion necessary to stabilize an emergency condition that seriously threatens a patient's health, but is not yet life-threatening, complicates a physician's allegiance to their patient in a way that undermines the all-important physician-patient relationship. As *amici* demonstrate, the inability to rely on EMTALA to provide such abortion care compels physicians to consider the risks to their personal freedom, livelihood, and family of promoting their patients' welfare and best interests. Dr. Miller, for example, notes how Idaho's abortion ban caused physicians to think twice about providing essential care to patients suffering emergent pregnancy complications because of the personal costs of transgressing the ban:

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[15] *See*, *e.g.*, Ann. S. O'Mailey et al., *The Role of Trust in Use of Preventive Services Among Low-Income African American Women*, 38 Prev. Med. 777, 777–78 (2004).

[16] Lois Snyder Sulmasy & Thomas A. Bledsoe, *American College of Physicians Ethics Manual: Seventh Edition*, 170 *Annals of Internal Medicine* s1, s1-s32 (Jan. 2019), https://www.acpjournals.org/doi/10.7326/M18-2160.

[17] AMA, Code of Medical Ethics, *Patient-Physician Relationships* §1.1.1.

> When I was practicing in Boise, I consulted on a case involving a patient carrying two fetuses. The patient went into preterm labor and delivered one of the fetuses. She was bleeding heavily, signaling that she had sustained a placental abruption, an alarming complication in which the placenta detaches from the uterus. The standard of care in that circumstance is to hasten labor and deliver the second fetus. But the physician feared that doing so and potentially causing the fetus's death could trigger criminal prosecution and revocation of his medical license. He even considered providing a blood transfusion to the patient instead. The physician ultimately hastened the patient's labor and delivered the second fetus once staff agreed that it did not constitute an abortion, but only after several hours of deliberation—and unnecessary delay.

As Dr. Zite explains, "a physician should never have to decide between providing wanted medical care that will relieve their patient's suffering or avoiding prison and maintaining the medical license that is supposed to allow them to take care of their patients." Dr. Bernard puts it plainly: "The inability to provide abortions pursuant to EMTALA makes it so I am torn between my ethical duties to my patients and my own life and family, which is the inverse of how we were taught to practice medicine."

Amici and other physicians work hard to establish and maintain ethical physician-patient relationships.

The inability to provide abortions necessary to stabilize emergency conditions jeopardizes them.

B. The Inability to Provide an Abortion Necessary to Stabilize an Emergency Condition that Seriously Threatens an Individual's Health Violates the Ethical Principle of Respect for Patient Autonomy.

The ethical principle of respect for patient autonomy requires physicians to support patients in making and carrying out informed choices. In this process, a physician works with patients to clarify their values, preferences, and treatment goals. The physician provides evidence-based information about the risks, benefits, and alternatives of a given course of treatment in light of the patient's values, preferences, and goals. Dr. Zite, who practices in Knoxville, Tennessee, distills how comprehensive, material information helps protect the autonomy of a pregnant individual suffering a health emergency by enabling them to choose among all possible options for them:

> I should not be the most terrified person in the room, or the only person that truly understands how dangerous the situation is. I understand that at times people make their medical decisions based mostly on their religious or moral beliefs. But I also know that people do not know what decision they are going to make until they are faced with a particular situation. For instance, I have had

> several patients who consider themselves "pro-life," but opted for an abortion when faced with a medical emergency. One such patient was about 17 weeks pregnant when she was diagnosed with a molar pregnancy that would have killed her if she remained pregnant. She and her husband told me to do whatever I needed to do to save her life. This meant terminating her pregnancy despite it being a very desired pregnancy prior to the grim diagnosis. We are obligated to give our patients the full picture and then heed their choices. In an emergency that seriously threatens a patient's health, that choice is often an abortion.

Dr. Miller illustrates how the inability to heed a patient's choice to promptly obtain an abortion for an emergency that seriously threatens their health tramples on their autonomy in violation of medical ethics:

> In Idaho, I had been treating a patient with kidney disease ever since she came to me for preconception counseling, a process intended to reduce the chances of poor obstetric, maternal, and fetal outcomes. She had a multiple pregnancy, meaning she was carrying two fetuses, and became extremely sick with preeclampsia before the pregnancy was viable. At that point, only one of the fetuses still had a heartbeat. The physician treating her when she presented with preeclampsia immediately explained that the pregnancy posed extraordinary risks to her health and fertility, and she wanted to terminate it. But Idaho's abortion ban left me in the callous position of

> communicating the substantial hazards of remaining pregnant any longer only to refuse my patient the abortion she needed and wanted. Instead, my MFM partner had to arrange for a helicopter to fly her out of state in her precarious condition. This isn't medicine.

Amici have all practiced medicine in states, including Idaho, that criminalize or chill abortions necessary to address emergent conditions that seriously threaten a patient's health. To their horror, the lack of clarity that EMTALA requires emergency abortion care to be offered even in states that have criminalized it after *Dobbs*, has forced them to deny this care to patients minutes after asking the patients to trust them and explaining why an abortion is medically indicated in that situation. In other words, the seeming inability to provide emergency abortions has forced *amici* to disregard their patients' well-informed and considered choices in violation of their medical ethical duty to respect patient autonomy.

C. The Inability to Provide an Abortion Necessary to Stabilize an Emergency Condition that Seriously Threatens an Individual's Health Violates the Ethical Principles of Beneficence and Non-Maleficence.

Beneficence is the notion that medical interventions should aim to maximally benefit the patient and, accordingly, physicians should act with the intent of maximally benefiting patients. Relatedly

non-maleficence is the obligation to "do no harm."[18] These bedrock ethical principles are essential for maintaining public trust in the medical profession and preserving the physician-patient relationship.[19] Dr. Zahedi-Spung puts it simply: "Like everyone else who goes into medicine, I went into it to help people."

Beneficence and non-maleficence mean more than simply avoiding causing harm. Instead, they require that the welfare of the patient form the basis of all medical decision-making.[20] Physicians have an ethical duty to actively prevent patients from experiencing future harm when safe and effective treatments are available.[21] Indeed, medical ethics scholars recognize that beneficence and non-maleficence collectively impose affirmative obligations on physicians, requiring that they act to avert harm—not simply that they *refrain* from acting in a manner that would violate these ethical values.[22] EMTALA embodies these principles

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[18] Beauchamp & Childress, *supra* note 10. These values are also expressed in the Hippocratic oath that is taken by all new physicians: "I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them."

[19] *Id.*; *see also* Eileen E. Morrison, *Ethics in Health Administration* 47–48 (4th ed. 2018) ([Non-maleficence and beneficence] are central to a trust-based healthcare system because they are assumed by society and individuals to be its pillars of practice.").

[20] AMA, Code of Medical Ethics Opinion, *Patient-Physician Relationships* §1.1.1.

[21] *See*, *e.g.*, Morrison, *supra* note 19 at 55.

[22] *See*, *e.g.*, *id.*; Lois Snyder Sulmasy & Thomas A. Bledsoe, *American College of Physicians Ethics Manual: Seventh Edition*,

by defining the "emergency medical condition" triggering obligations for healthcare providers to include conditions that "could reasonably be expected to" cause serious dysfunction to a bodily organ or part, result in serious impairment to a bodily function, or place a patient's health in serious jeopardy.[23]

The ethical principles of beneficence and non-maleficence require an abortion to be offered to a patient if it would protect the patient from grievous harm. For physicians like *amici*, who provide care in emergency settings, there is a special obligation to intervene quickly to prevent major harm because patients are likely to rapidly decline otherwise.[24] This is particularly true for pregnant patients experiencing medical emergencies, who can devolve from a stable condition to a life-threatening one in a matter of hours if they are not treated quickly.[25] As physicians across the country have reflected, the inability to provide abortions necessary to stabilize serious conditions forces them to make impossible choices between upholding

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170 *Annals of Internal Medicine* s1, s1-s32 (Jan. 2019), https://www.acpjournals.org/doi/10.7326/M18-2160.

[23] 42 U.S.C. 1395dd(e)(1)(A) (defining "emergency medical condition").

[24] This mandate is reinforced by the Code of Ethics for Emergency Physicians, which explains that emergency physicians must "respond promptly to acute illnesses and injuries in order to prevent or minimize pain and suffering, loss of function, and loss of life." Am. College of Emergency Physicians, *Code of Ethics for Emergency Physicians* 6, https://www.acep.org/siteassets/new-pdfs/policy-statements/code-of-ethics-for-emergency-physicians.pdf.

[25] *See*, *e.g.*, *id.*

the beneficence and non-maleficence principles and breaking the law.[26] Dr. Bernard, who practices in Indiana, provides an example:

> I often treat patients who are referred by physicians in other parts of the state who are concerned about the legal ramifications of terminating pregnancies in medical emergencies. Recently, I provided an abortion to one such patient who had suffered preterm premature rupture of membranes ("PPROM"). This means that her water had broken prematurely, at 17 weeks' gestational age. Although the patient's condition was stable when her previous physician discharged her, she arrived at my emergency room with a serious infection, fever, and in sepsis. It was very dangerous, so much so that she needed to be placed on an IV for several days after the abortion to return to a point of stability. If she had been provided with an abortion earlier, her condition would not have deteriorated to a grave degree. She would have been spared severe harm and suffering. Instead, she was left with a heightened risk of infertility and ectopic pregnancy.

Contrary to the time-honored principles of beneficence and non-maleficence, the inability to rely on EMTALA to provide emergency abortion care to patients with high-risk pregnancies has forced the *amici* to

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[26] *See*, *e.g.*, Kavitha Surana, *Their States Banned Abortion. Doctors Now Say They Can't Give Women Potential Lifesaving Care*, PRO PUBLICA (Feb. 26, 2024), https://www.propublica.org/article/abortion-doctor-decisions-hospital-committee.

delay or withhold needed treatment, with "horrific" and "truly awful" consequences.[27] As, Dr. Zahedi-Spung notes, this turns beneficence and non-maleficence on its head:

> When I practiced in Tennessee, I had situations where a patient developed a severe complication that would cease once the pregnancy ended. But state law prevented me from providing her an abortion for that condition alone because her life was not in danger yet. This left us both in limbo, waiting for something worse to happen to the patient so that I could provide her an abortion under an exception to Tennessee's abortion ban. Until then, there was nothing I could do for her, and I was essentially waiting around for something awful to happen instead of trying to protect my patient from something awful.

Dr. Zite shows how the "truly awful" consequences of delaying or withholding emergency abortion care, even in cases of inevitable fetal death, can include infertility:

> I had a patient who suffered PPROM at 14 weeks, making the much-wanted pregnancy nonviable. But for Tennessee's abortion ban, she could have had a simple D&E procedure, started healing, and gotten pregnant again. Instead, she was in and out of the hospital up to 27 weeks and delivered the baby. We watched for 45 minutes while the NICU team tried to ventilate the baby, but the oxygen

[27] Dr. Nikki Zite.

> never got above 50% (normal oxygen saturation is between 95 and 100%). The baby's lungs could not inflate because the lack of amniotic fluid caused by the PPROM had prevented them from developing appropriately. Because the woman was not able to terminate her pregnancy earlier, she had many health complications that could make getting pregnant again more difficult, and that could have prevented her from getting pregnant at all. The experience was extremely painful for both of us and the entire care team for mom and baby.

In fact, Dr. Bernard illustrates how the inability to provide emergency abortion care even in cases of virtually inevitable fetal death makes physicians feel as if they are *actively harming* the patients they are obligated to center:

> I also have situations where the patient previously had severe pregnancy complications, such as peripartum cardiomyopathy (a weakness of the heart muscle), that recur and now has a pregnancy with severe fetal anomalies and a heightened risk of stillbirth. The patient then asks for an abortion, and I have to explain that the state criminalizes it even when a pregnancy has a severe (but not 100% lethal) condition. I offer them emotional support while having to refer them to a healthcare provider with whom they have not yet built a relationship, and a state to which it may cost thousands of dollars and a substantial amount of time to travel. I say this over and

> over to patients. The absurdity and cruelty of this sequence makes no sense to me and is counter to my oath to do no harm.

Dr. Bernard elucidates that the perceived cruelty among physicians of having to refer a patient out of state whom they could otherwise treat extends to patients who have attempted suicide:

> It is extremely distressing to have to send a patient out of state for an abortion because their severe health emergency does not fit within the narrow health exception to Indiana's abortion ban. I have had to do this to patients who became pregnant as a result of sexual abuse, attempted suicide, and continued to experience suicidal ideations. Suicides have high rates of completion in such cases and it defies my ethical duty to protect, not to mention human compassion, to cease treating such patients after beginning to build trust with them.

As *amici* are well aware, the only reason that the inability to rely on EMTALA to provide emergency abortion care has not led to the death of one of their patients yet is pure luck. Devastatingly, other patients and physicians have not been so "lucky."[28]

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[28] *See*, *e.g.*, Stephanie Taladrid, *Did an Abortion Ban Cost a Young Texas Woman Her Life?*, THE NEW YORKER (Jan. 8, 2024), https://www.newyorker.com/magazine/2024/01/15/abortion-high-risk-pregnancy-yeni-glick; Brittni Frederiksen et al., *A National Survey of OBGYNs' Experiences After* Dobbs, KAISER FAMILY FOUNDATION (June 21, 2023), https://www.kff.org/report-section/a-national-survey-of-obgyns-experiences-after-dobbs-report/

Whether they are waiting for the earliest opportunity to intervene, or referring patients out of state, the inability to provide emergency abortion care forces physicians to allow their patients to get sicker and sicker despite the physicians' readiness to treat them. In this way, the inability to provide emergency abortion care forces physicians to compromise the time-honored principles of beneficence and non-maleficence. But the purpose of EMTALA is to ensure that physicians can provide stabilizing care to their patients without delay, consistent with their ethical obligations.

III. The Inability to Provide an Abortion Necessary to Stabilize an Emergency Condition that Seriously Threatens an Individual's Health Forces Many Physicians to Violate Conscientious and Religious Beliefs that Forbid Them from Abandoning an Individual in Need.

"Effectively turning away a patient in need chips away at your soul every time you do it." Dr. Caitlin Bernard.

As the *amici* demonstrate, having to delay or withhold emergency abortion care forces many physicians to compromise deeply held conscientious and religious beliefs. Thus, interpreting EMTALA as a source of

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(finding that "[s]even in ten OBGYNs say that since the *Dobbs* decision . . . management of pregnancy-related medical emergencies (68%) ha[s] gotten worse" and that "[m]ost [OBGYNs] are also concerned that pregnancy-related mortality . . . ha[s] gotten worse as a result of the ruling").

conscience protections incompatible with an obligation for hospitals to offer that care, as Petitioners do, would have EMTALA disfavor conscientious and religious beliefs that align with medical ethics, while favoring other conscientious and religious beliefs.[29] *See* Leg Br. 34; Idaho Br. 35. This too impermissibly ascribes an implausible intent to Congress. *See supra* 7.

Moreover, courts have a "duty to guard and respect that sphere of inviolable conscience and belief which is the mark of a free people." *Lee v. Weisman*, 505 U.S. 577, 592 (1992). The inability to rely on EMTALA to offer an abortion necessary to stabilize an emergency condition that seriously threatens an individual's health forces many physicians to violate their conscientious and religious beliefs.

Dr. Zite, who is Jewish, firmly believes that life is sacred and that each person has inestimable value. By extension, she believes that it is a tragedy for anyone to lose their life or suffer substantial harm to their health due to complications of pregnancy. Indeed, her Jewish upbringing "always emphasized that the pregnant person's life is prioritized until the baby is born." Forcing someone to remain pregnant for any material period when the pregnancy seriously threatens their health is therefore inimical to her faith. Dr. Zite's faith propels her to provide abortions in this circumstance, particularly where virtually no one else will and where subsequent generations of medical professionals risk lacking the skills to care for pregnant patients in these situations.

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[29] Conscience protections for individual physicians arise from other statutes. *See* Respondent Br. 17.

Dr. Zite describes how the inability to rely on EMTALA to provide abortions in emergencies that seriously threaten her patients' health has forced her to violate these religious convictions:

> Recently, I treated a woman who had suffered PPROM and went into labor. The pregnancy was no longer viable, and my patient was grief-stricken. She asked for an abortion to avoid suffering through the delivery of a nonviable baby. An abortion is the standard of care in her circumstance because she was at major risk of infection and her condition could decline rapidly. But there was still a heartbeat and she could not be said to be deathly ill yet. Consequently, Tennessee's abortion ban, which has an exceedingly narrow health exception, and carries criminal and professional penalties, chilled our staff from terminating her pregnancy in a timely fashion. At the same time, my patient was not stable enough to transfer somewhere where she could legally obtain an abortion. As a result, my patient delivered a dead fetus in the holding area of the hospital and lost four pints of blood. I cried with her over the needless physical and emotional trauma she had to endure and my own anger at being forced to effectively abandon someone I was eminently capable of helping.

While Dr. Zite feels that the inability to provide emergency abortion care repeatedly forces her to compromise her religious ideals, she is terrified that things will get worse. Namely, she fears that one of her patients will die from a preventable cause: "What is more,

I live in perpetual fear that I will have to watch a woman die, grow so sick that she sustains life-long brain, heart, or lung deficits, or lose her fertility. The mere thought is devastating." Dr. Zite's powerlessness to avert such disasters despite her extensive training and her institution's resources forces her, on a regular basis, to violate her religious duty to uphold the dignity of people, and pregnant women in particular.

Having to withhold or delay abortion care for patients suffering severe health emergencies also undercuts Dr. Zite's faith-based commitment to help train the next generation of OB/GYNs:

> Our inability to offer abortions necessary to stabilize major health emergencies has made it substantially more likely that our medical residents will not feel comfortable treating a pregnant woman experiencing major bleeding at 17 weeks, for example, or a pregnant woman whose water breaks at 19 weeks and is at risk for sepsis, for instance.

Leaving her trainees ignorant of such fundamental aspects of pregnancy care again strikes at Dr. Zite's religious obligation to uphold the dignity of pregnant women.

Similarly, Dr. Zahedi-Spung deeply believes as a matter of conscience that people are born equal. This fundamental belief about humanity gives rise to a duty to help vulnerable people without judgment and to combat inequality, including systemic racism. Before she left Tennessee, having to refer seriously ill

pregnant patients out of state and thus delay their care forced her to forsake these principles and caused her severe moral distress:

> A patient who had been happy and excited about her pregnancy came in at 16 weeks for a regular visit. We discovered that the fetus had hydrops fetalis, in which a large amount of fluid builds up in the fetus's organs and tissues. My patient was shattered. To make matters worse, the fetal anomaly triggered preeclampsia. The standard of care in this situation is to end the pregnancy. But at that point, my patient's lab results were normal. Put differently, because the condition was not yet life-threatening, Tennessee's abortion ban forbade me from continuing to care for her.
>
> As with most of my patients, she was shocked that I could not end a pregnancy that was seriously jeopardizing her health and had no chance of coming to term. She kept asking if she was going to die. I kept saying, "I'm trying, I'm trying, we're going to make it happen. We just need to get you to the right place where you can be taken care of." And in fact, I pushed my rage and grief to the side to call a trusted abortion provider in North Carolina, the closest place my patient could legally obtain care. It is a testament to the dedication and compassion of abortion providers that I knew this physician would take my call and reshuffle her own life to help my patient. My patient lacked the resources to make the trip to North Carolina, so I arranged for an ambulance to take her. During the six-hour ride, her blood

> pressure skyrocketed to 200/120 mmHg and her kidneys began failing. I was terrified that she would die. Fortunately, she survived, but her ordeal turned me inside out.[30]

The practice of shuttling patients with destabilizing conditions between hospitals—at great risk to their health—is precisely what EMTALA was intended to end. Moreover, this was far from the only time that the inability to provide an abortion needed to stabilize a severe health emergency forced Dr. Zahedi-Spung to contradict her deeply-held conscientious belief in empowering the vulnerable. She shares an account of when she had no choice but to simply withhold care:

> I had another patient in Chattanooga who suffered PPROM at 16 weeks, which meant that her pregnancy was no longer viable. She went into labor, but was not yet facing a life-threatening emergency. So, Tennessee's abortion ban prohibited me from offering her an abortion, the standard of care in that circumstance. At the same time, my patient was not stable enough to transfer out-of-state. Thus, there was nothing I could do but offer her an

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[30] As the *amicus* brief for 121 Members of Congress in support of Petitioners shows, the physical and emotional repercussions of pregnant women being unable to obtain timely treatment were at the forefront of Congress's mind in enacting EMTALA. *See* Congress *Amicus* Br. 7 ("'Once at the hospital, the woman was told by a nurse that because she did not have a private doctor, nothing could be done for her.' The woman traveled two hours to a university hospital, where she delivered a premature baby. The baby died minutes after birth.") (citing statement of Judith G. Waxman, Managing Att'y, Nat'l Health L. Program).

> epidural and emotionally support her through needless, excruciating pain. *I felt I was torturing her and that tortured me.*

The inability to provide abortions to women suffering severe health emergencies despite EMTALA's protections for patients who need emergency treatment made Dr. Zahedi-Spung's commitment to racial justice feel hollow:

> After Tennessee's abortion ban took effect, I had to refer at least eight patients who needed an abortion to stabilize an emergency condition. Their faces are burned into my mind. In my experience, when this care is unavailable, Black people, Indigenous people, people of color, and immigrants suffer most. In 2018–2020, Tennessee had the fourth-highest maternal mortality rate in the country. And Black women are 2.5 times more likely to die than white women in the state. How much more preeclampsia, how much more preterm labor are we going to delay treating there when we are fully capable of doing so and our patients already bear the brunt of a healthcare crisis? In Tennessee, as in every state where I have practiced medicine, I tried to assist without judgment and help create a country where someone's race or ethnicity does not determine their welfare. But my values meant nothing where the law effectively prohibited me from upholding them.[31]

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[31] *See* Our Tennessee, *Grand Challenges: Changing Outcomes*, UNIV. OF TENN. (Jan. 5, 2023), https://our.tennessee.edu/

What is more, the inability to rely on EMTALA to offer abortions necessary to stabilize emergency conditions has forced physicians to violate their conscientious beliefs by driving them out of Idaho and other states that already have a shortage of high-risk obstetrical care providers. For Dr. Lauren Miller, leaving Boise, Idaho for Colorado resolved her medical ethical dilemma, in which she was serving as an MFM, but prohibited from offering essential care to patients upon penalty of losing her freedom and livelihood.[32] *See supra* 17–18. But leaving Idaho hardly resolved Dr. Miller's *conscientious* dilemma.

When considering in what area of medicine to specialize, Dr. Miller gravitated towards the quick problem-solving required of emergency room doctors. But she decided to become an MFM because it would allow her to address complex problems while building

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2023/changing-outcomes/. Maternal mortality review committees (MMRCs) are multidisciplinary committees that examine maternal deaths. Andy Schneider et al., *Medicaid Managed Care, Maternal Mortality Review Committees, and Maternal Health: A 12-State Scan*, Center for Children and Families, Georgetown University McCourt School of Public Policy, 6 (Oct. 16, 2023), https://ccf.georgetown.edu/wp-content/uploads/2023/10/MCOs-and-Maternal-Health-Final.pdf. Idaho disbanded its MMRC during its 2023 legislative session. *Maternal Mortality Review Committee*, IDAHO DEP'T. OF HEALTH & WELFARE, https://healthandwelfare.idaho.gov/about-dhw/boards-councils-committees/maternal-mortality-review-committee (last visited Mar. 24, 2024). It is the only state without such a committee.

[32] As Dr. Zahedi-Spung found upon arriving in Colorado, "I am now in a place where when I enter the room, no one walks in with me. No lawyers, no legislators, no policymakers, no one. I get to have very honest and open conversations with my patients."

long-term relationships with her patients. Likewise, Dr. Miller chose to raise her family in Boise, Idaho, because she valued the small-town feel of the city and putting down roots in her community. These major decisions—what work to do and where her children would grow up—reflect her deeply held conscientious belief that human beings are interconnected, and the duty she perceives from that fundamental belief to support others and enrich her community.

When Dr. Miller was no longer able to offer abortion care to patients suffering from major health emergencies because of Idaho's abortion ban, and she herself no longer felt safe or respected as a woman who may one day have another baby, she left Idaho. But this deepened a fear that timely, high-quality healthcare would be increasingly unavailable to pregnant Idahoans and made Dr. Miller feel complicit in the crisis:

> There are only a handful of abortion providers left in Idaho, And OB/GYNs are leaving in staggering numbers for the same reasons I did. As a consequence, the medical students and residents no longer have adequate instruction. I fear they will lack critical skills like how to manage a miscarriage. By leaving Idaho, I feel I deserted my community and contributed to the dearth of physicians capable of caring for pregnant women, however unpredictable or challenging their complications, for generations to come.

Dr. Miller's sense of abandonment is at utter odds with her fundamental conscientious belief that she has a

duty to use her education and talents to enrich her community.

Dr. Zahedi-Spung echoes this sentiment of yet again feeling torn, this time between her medical ethical obligations to pregnant women suffering from health emergencies, and her conscientious obligations to combat inequality, including systemic racism:

> Ultimately, I made the devastating decision to leave my home in Tennessee and make a new one in Colorado because what I was doing in Chattanooga was not medicine as I was taught it. That is, I knew when I made that decision that I was leaving a community lacking access to pregnancy care and with one of the highest maternal mortality rates in the nation with one less MFM. I still struggle with the grief and guilt of that decision.

CONCLUSION

The Court should affirm the district court's judgment.

Respectfully submitted,

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