STATE OF IDAHO

Petitioner ,

v.

UNITED STATES OF AMERICA

Respondent.

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INTEREST OF AMICI CURIAE [1]

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

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

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

promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access for all people to the full spectrum of evidence - -

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INTRODUCTION AND SUMMARY OF THE ARGUMENT

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

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

ARGUMENT

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

A. Nature of Emergency Care for Pregnant Patients

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

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

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

[3] Id.

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

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

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

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

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

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[8] ACEP, Definition of Emergency Medicine, supra n. 2, at 1; see also ACOG Committee Opinion No. 667, Hospital-Based Triage of Obstetric Patients (July 2016), https://www.acog.org/-/me-

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

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

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

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

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[22] See United States v. Idaho, 623 F. Supp. 3d 1096, 1104 (D. Idaho 2022) (discussing placental abruption complications); ACOG Obstetric Care Consensus No. 10, Management of Stillbirth (Mar. 2020), https://www.act(ag)-/(1)-157 (p)-17.3 (s)4.ted8 (e).001 Tc 04.1 ( )0.Td [(

PPROM prior to viability, continuing the pregnancy risks serious health consequences including sepsis and death.[28] Pre-eclampsia prior to viability also presents a risk of serious health consequences in-

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

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

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

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

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

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

III. The Idaho Law Criminalizes Care EMTALA Requires.

The Idaho Law directly conflicts with a provider's ability to provide stabilizing care required by EMTALA. Abortion has long been understood as a necessary, standard, and evidence -.b a

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

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

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

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

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

In states with abortion bans —including Idaho — nearly 40 percent of OB /GYNs surveyed stated that 44

is and isn't legal. [46] For example, clinician interviews about a similar ban in Texas showed confu-

The devastating impact of delaying necessary care is not hypothetical, and neither are the consequences for pregnant patients. Indeed, a recent study in the American Journal of Obstetrics and Gynecology of the impacts of a Texas abortion ban concluded that "expectant management of obstetrical complications in the periviable period [i.e., at the border of viability] was associated with significant maternal morbidity." [50] "Expectant management resulted in 57% of patients having a serious maternal morbidity compared with 33% who elected immediate pregnancy interruption under similar clinical circumstances reported in states without such legislation." [51] "4n (t)-5 (a)2 (/T5 (t)-1 (h)11i (c)1.i)5 (..TJ 0.0h)11i (c)1.ite3 0.095 Tw 0.39

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

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

C. The Idaho Law Has and Will Continue to

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

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

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

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

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

Each of these categories of pregnant patients is therefore more likely to experience emergency medical conditions when pregnant and thus more likely to need the critical care that the Idaho L aw obstructs. The Idaho Law not only limits the ability of these populations to access the full spectrum of OB/GYN care

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

As EMTALA reflects, the core of medical practice is the patient-clinician relationship. ACEP's Code of Ethics for Emergency Physicians states that "[e]mergency physicians shall embrace patient welfare as their primary professional responsibility" and "shall respond promptly and expertly, without prejum4(3-1 (a)e Tc 00cn)-7 (s w)-6 (i)a25(3

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

Beneficence and non-maleficence, respectively the obligations to promote the well-being of others and to do no harm, are not only ensured by EMTALA, but have been cornerstone principles of the medical profession since the beginning of the Hippocratic tradition nearly 2500 years ago.[99] Patient autonomy, the

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

* * *

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

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted,

SHANNON ROSE SELDEN ´(Ks$g%ã'dvXQ)© cP ´(,$g%àÓ7Ê25d 3 246.72 5ter ECK

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APPENDIX A —LIST OF AMICI CURIAE

APPENDIX A—

- Society of Gynecologic Oncology