Nos. 23-726 & 23-727

IN THE

Supreme Court of the United States

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

v.

UNITED STATES.

IDAHO,

v.

UNITED STATES.

On Writs Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION, THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AND AMERICA'S ESSENTIAL HOSPITALS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

Amanda K. Rice
JONES DAY
150 W. Jefferson Ave.
Suite 2100
Detroit, MI 48226

Charlotte H. Taylor
Counsel of Record
Amelia A. DeGory
JONES DAY
51 Louisiana Avenue, NW
Washington, DC 20001
(202) 879-3872
ctaylor@jonesday.com

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

OTHER AUTHORITIES

INTEREST OF *AMICI CURIAE*[1]

The American Hospital Association (AHA) represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations across the country. Its members are committed to improving the health of the communities that they serve and to helping ensure that care is available to and affordable for all Americans. AHA educates its members on healthcare issues and advocates on their behalf. AHA also frequently participates as *amicus curiae* in cases with important and wide-ranging consequences for AHA's members and the communities they serve. 37 of AHA's member-hospitals operate in the State of Idaho. Those hospitals range from one of the nation's most remote healthcare facilities in Salmon, Idaho, to tertiary facilities in Boise, Pocatello, and Idaho Falls.

The Association of American Medical Colleges (AAMC) is a nonprofit association dedicated to improving the health of people everywhere through medical education, healthcare, medical research, and community collaborations. Its members include all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; approximately 400 academic health systems and teaching hospitals; and more than 70 academic societies.

America's Essential Hospitals is dedicated to equitable, high-quality care for all people, including those who face social and financial barriers to care.

---

[1] Consistent with this Court's Rule 37.6, this brief was not authored in whole or in part by counsel for any party, and no person or entity other than *Amici* and their counsel made a monetary contribution to the preparation or submission of this brief.

Consistent with this safety-net mission, the association's more than 300 members provide a disproportionate share of the nation's uncompensated care, with three-quarters of their patients uninsured or covered by Medicare or Medicaid.

Virtually all of *Amici*'s member hospitals provide emergency services and, as a result, are subject to the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd. In *Amici*'s experience, EMTALA on rare occasions requires the termination of a pregnancy to stabilize a patient's emergency condition—including in circumstances that Idaho law criminalizes. *Amici*'s members thus have a direct and profound interest in the outcome of this case. Absent judicial relief, physicians and nurses at *Amici*'s member hospitals will face the intolerable threat of criminal liability for exercising their medical judgment and doing what federal law requires. *Amici* are uniquely positioned to speak to the interests of hospitals and healthcare providers and to offer this Court important information about the consequences of Idaho's law for emergency care.

INTRODUCTION AND SUMMARY OF ARGUMENT

Every day, pregnant patients arrive at hospital emergency rooms in the midst of grave health emergencies. When that happens, physicians, nurses, and other qualified medical personnel must make split-second decisions about what care to give to those patients, who are at risk not only of death or serious lifelong impairment but also of losing their pregnancies. In those tragic situations, healthcare professionals must rely on their experience, expertise, ethical training, and ultimately their best medical judgment to provide emergency care.

Federal law, as reflected in EMTALA, requires hospitals to do exactly that. Specifically, it requires that caregivers use their expert medical judgment to provide "stabilizing" services to patients experiencing an "emergency medical condition," including in situations where the health or safety of "a pregnant woman" or "her unborn child" is in "serious jeopardy." 42 U.S.C. § 1395dd(b)(1), (e). The statute turns on a healthcare provider's assessment of "reasonable medical probabilities." *Id.* at § 1395dd(e)(1)(A). Its plain text makes clear that EMTALA requires emergency "treatment based on diagnostic medical judgment." *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139, 144 (4th Cir. 1996).

Idaho Code § 18-622, however, allows criminal prosecutors not present in the emergency room to second-guess the medical judgments made by caregivers in their efforts to stabilize patients in extreme duress. If the law is allowed to take effect, the consequences of this prosecutorial second-

guessing will be severe for clinicians—and, more importantly, for patients. Section 18-622 makes it a crime for healthcare providers to terminate a pregnancy, but it does not include exceptions for stabilizing services necessary to prevent "material deterioration" of medical conditions that, in the absence of immediate medical attention, could result in serious jeopardy to the pregnant patient's health, serious impairment to her bodily functions, or serious dysfunction of her bodily organs, as EMTALA requires. 42 U.S.C. § 1395dd(b)(1), (e)(1). Providers who seek to comply with EMTALA but violate § 18-622's criminal prohibition are subject to felony charges, a mandatory minimum of two years' imprisonment, and revocation or suspension of their professional licenses.

Amici respectfully submit this brief to explain why Idaho's decision to criminalize medically necessary and federally mandated emergency care carries profound consequences. The mere threat of criminal sanctions interferes with the exercise of expert medical judgment, and it chills even the provision of care that would ultimately be adjudicated lawful. It intrudes upon the trustful relationship between a patient and her physician—precisely at the moment when she is most dependent on that physician to promote her and her unborn child's health. And it is particularly troubling in the emergency-department context, where healthcare providers must make decisions in the heat of the moment—and where hesitation can mean the difference between life and death.

The following hypothetical illustrates why the criminalization of emergency medical services is so

dangerous for hospitals and the patients they serve. Late one evening, Linda, a 24-year-old married woman who is 16 weeks pregnant with her first child, arrives at the emergency department with preterm premature rupture of membranes. Her physician observes that Linda's cervix is dilated and amniotic fluid is leaking. Fetal parts are palpable through the cervix. Linda's white blood cell count is elevated, and she has a fever. The physician exercises his expert medical judgment to determine that the risk of chorioamnionitis—an infection of the amniotic fluid and membranes—is intolerably high.

Thus, consistent with the physician's medical judgment, Linda and her doctor both agree that they should induce labor and delivery because of serious threats to her health, even if it means that, tragically, her baby will not survive. That decision to induce labor would be required under EMTALA, as reinforced by the Affordable Care Act. *See infra* pp. 21–25 (discussing 42 U.S.C. § 18023(d)). But under § 18-622, Linda's physician could be subject to serious criminal penalties for providing that emergency care.

Allowing prosecutors, courts, and juries to armchair quarterback these kinds of medical judgments—and impose criminal liability—will make the provision of emergency healthcare more challenging for providers, with potentially disastrous consequences for patients. This Court should protect emergency providers who exercise their professional judgment as federal law requires and hold that § 18-622 is preempted because it forbids stabilizing emergency services that fall within the ambit of EMTALA.

ARGUMENT

I. Criminal Statutes Can Chill Lawful Conduct, Especially in Emergency Medical Contexts.

Laws that criminalize medical care can have a severe chilling effect—even outside of the prohibited contexts. That chilling effect is frostiest in the emergency room, where healthcare providers must make on-the-spot medical decisions.

1. Criminal prohibitions deter bad conduct. *Cf., e.g.*, 18 U.S.C. § 3553(a)(2)(B) (explaining that criminal sentences should provide "adequate deterrence to criminal conduct"). But criminal prohibitions can also overdeter by chilling lawful conduct, particularly where the criminalized conduct involves standards that can be difficult to predictably apply. *See, e.g.*, *Ruan v. United States*, 597 U.S. 450, 459 (2022) (explaining that "'overdeterrence" happens when a criminal statute deters people from engaging in "acceptable and beneficial conduct that lies close to, but on the permissible side of, the criminal line"); *United States v. Alvarez*, 567 U.S. 709, 733 (2012) (Breyer, J., concurring in the judgment) (noting that the "threat of criminal prosecution" carries a powerful "chilling" effect and can "inhibit" lawful conduct). That is because criminal convictions carry singular "opprobrium and stigma," along with potential prison time. *Reno v. ACLU*, 521 U.S. 844, 872 (1997) (recognizing that a "criminal statute" can have an "increased deterrent effect"); *see Virginia v. Hicks*, 539 U.S. 113, 119 (2003) (explaining that the risk that a law will "deter or 'chill'" conduct is heightened when the statute "imposes criminal sanctions").

In light of the potential consequences, only "those hardy enough to risk criminal prosecution" will proceed where there is some question about whether conduct might be considered criminal. *Dombrowski v. Pfister*, 380 U.S. 479, 487 (1965). Reasonable people will steer clear of activities that might *arguably* subject them to criminal charges—even where those activities are lawful.

2. This chilling effect is particularly likely—and particularly problematic—in the medical context. The threat of criminal sanctions is an especially potent deterrent for doctors, nurses, and other healthcare workers who need professional licenses to earn a living. Even if a provider is ultimately vindicated, the mere fact of a criminal prosecution "could be reported to the provider's licensing board, which typically has broad discretion in governing provider ethics and standards of conduct." David S. Cohen et al., *The New Abortion Battleground*, 123 COLUM. L. REV. 1, 45 (2023). And "[b]eing named as a defendant too many times or being subject to a disciplinary investigation, even if the provider ultimately prevails, could result in licensure suspension, high malpractice insurance costs, and reputational damage." *Id.* As a result, "[a] physician's career can be effectively destroyed merely by the fact that a governmental body has investigated his or her practice." *Conant v. Walters*, 309 F.3d 629, 640 n.2 (9th Cir. 2002) (Kozinski, J., concurring); *see also* Cohen, *supra*, at 45 ("These effects threaten providers' ability to practice medicine and support themselves and their families.").

For those reasons, many physicians are forced to practice "defensive medicine" by avoiding "procedures and patients that [a]re perceived to elevate the

probability of litigation." David M. Studdert, et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, JAMA (2005); *see also, e.g.*, Jill Fairchild, *The Defensive Medicine Debate: Driven by Special Interests*, 19 ANNALS HEALTH L. ADVANCE DIRECTIVE 297, 299 (2010) (recognizing that doctors sometimes seek "to avoid legal liability by refusing to see high-risk patients or by refusing to perform high-risk operations"). The threat of criminal sanctions ratchets that deterrent effect even higher. *See, e.g.*, *Conant*, 309 F.3d at 640 n.2 (Kozinski, J., concurring) (quoting expert report for proposition that "physicians are particularly easily deterred by the threat of governmental investigation and/or sanction from engaging in conduct that is entirely lawful and medically appropriate"). And chilling lawful medical care can have tragic consequences for patients who do not receive the treatment they need.

3. These tragic consequences are even more likely in emergency situations. A hospital's emergency department "is a unique environment of uncontrolled patient volume and brief clinical encounters of variable acuity." George Kovacs, MD, MHPE and Pat Croskerry, MD, PhD, *Clinical Decision Making: An Emergency Medicine Perspective*, ACADEMIC EMERGENCY MEDICINE 947 (Sep. 1999). As a result, "emergency physician[s] … must often make complicated clinical decisions with limited information while faced with a multitude of competing demands and distractions." *Id.* That task can be even more daunting in rural areas, where emergency departments often serve as the only source of acute, unscheduled medical care. *See, e.g.*, Kyle Urban,

Patient Visits Higher at Rural Emergency Departments, UNIV. OF MICH. MEDICINE (Apr. 19, 2019), https://www.michiganmedicine.org/health-lab/patient-visits-higher-rural-emergency-departments.

The stakes of emergency care are also very high. In the emergency department, even more than in other hospital settings, momentary hesitation to perform medically necessary procedures can mean the difference between life and death. Indeed, "[e]very hour of delayed care substantially increases a patient's risk of adverse outcomes or death." Andrea MacDonald, et al., *The Challenge of Emergency Abortion Care Following the* Dobbs *Ruling*, 328 JAMA 1691, 1691 (2022); *see id.* ("[E]ach hour of delayed care increases a patient's likelihood of dying by approximately 4%.").

4. In many respects, the challenges faced by emergency-room providers are similar to those faced by officers responding to law enforcement emergencies. In those fast-moving, touch-and-go situations, this Court has emphasized the need for "breathing room" and warned against imposing retrospective liability based on uncertain standards. *See Graham v. Connor*, 490 U.S. 386, 396–97 (1989) (reasoning that the law "must embody allowance for the fact that police officers are often forced to make split-second judgments," and do so "in circumstances that are tense, uncertain, and rapidly evolving"); *Atwater v. City of Lago Vista*, 532 U.S. 318, 347 (2001) (emphasizing that officers who must act "on the spur (and in the heat) of the moment" need "clear" rules). Courts, after all, are not well equipped to "second-guess[]," with the "benefit of hindsight and calm deliberation," an "on the scene" professional

assessment "of the danger presented by a … rapidly unfolding chain of events." *Ryburn v. Huff*, 565 U.S. 469, 477 (2012) (per curiam).

So too in the E.R. Doctors, nurses, and other hospital employees make in-the-moment, high-stakes professional judgments every day. As in the law enforcement context, criminal penalties are ill-suited to the medical-emergency setting. This is particularly true because emergency-room physicians and nurses have practiced under the EMTALA regime for decades, and so the threat of state law criminal penalties will only disrupt the sensitive medical decisions they have successfully balanced.

II. Idaho's Criminal Statute Chills Medically Necessary Emergency Services.

Section 18-622 criminalizes certain stabilizing emergency services that may be, in rare and tragic circumstances, medically necessary and required under EMTALA. But its effects will extend much further than that formal prohibition. By subjecting providers to criminal and professional sanctions, § 18-622 will chill the provision of lawful, medically necessary care.

1. The Idaho statute imposes harsh criminal sanctions. Providers who violate § 18-622 are subject to "a sentence of imprisonment of no less than two (2) years and no more than five (5) years in prison." § 18-622(1). They also face collateral consequences of § 18-622 prosecution. The statute *requires* that any healthcare professional who performs or attempts to perform a prohibited procedure "be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently

revoked upon a subsequent offense." § 18-622(1). And those collateral consequences may ensue even if the charges are ultimately dropped. *See supra* pp. 7–8; Idaho Code §§ 54-1805, 54-1806, 54-1806A, 54-1814, 54-1815 (establishing Board of Medicine and delegating broad oversight powers, including with respect to professional discipline).

2. The threat of those criminal and professional sanctions will chill the provision of care to pregnant women in emergency settings. "Pregnancy complications are the fifth most common reason women between ages 15–64 visit emergency departments," Kimberly Chernoby & Brian Acunto, *Pregnancy Complications After* Dobbs*: The Role of EMTALA*, 25 W. J. OF EMERGENCY MED. 1 (2024); *see* Ctrs. For Disease Control, *National Hospital Ambulatory Medical Care Survey: 2021 Emergency Department Summary Tables* at Table 9, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2021-nhamcs-ed-web-tables-508.pdf. And that statistic does not even capture the many *other* reasons why a pregnant woman might need emergency services—such as accidents or sudden cardiac arrest—that could impact her unborn child. Plainly, emergency-room providers are regularly called upon to manage medical emergencies in circumstances involving pregnant women and their unborn children.

The situation is even more delicate in rural areas, where labor and delivery units are closing their doors at an alarming rate. As a result, "emergency physicians are [frequently] responsible for managing pregnancy complications … without the support of an in-house OB." Chernoby & Acunto, *supra*, at 1. Laws like § 18-622 are only making that problem worse. A

recent announcement from an Idaho hospital demonstrates how criminalizing medical care can adversely impact access to services:

> "Bonner General Health[ ] … has made the … difficult decision to discontinue providing Obstetrical services … for the following reasons: … [T]he Idaho Legislature continues to introduce and pass bills that *criminalize physicians for medical care* nationally recognized as the standard of care. Consequences for Idaho Physicians providing the standard of care may include civil litigation and *criminal prosecution, leading to jail time or fines*."

Press Release, Bonner General Health, March 17, 2023, https://bonnergeneral.org/wp-content/uploads/2023/03/Bonner-General-Health-Press-Release-Closure-of-LD-3.17.2023.pdf (emphases added).

Hospitals can respond to criminal laws that interfere with the exercise of medical judgment by closing their obstetric departments, but they *cannot* shutter their emergency departments. And as hospitals continue to provide 24/7 emergency care to pregnant women, there is strong evidence that the threat of criminal sanctions causes providers to hesitate to provide medically necessary treatment. *See, e.g.*, Brandice Canes-Wrone & Michael C. Dorf, *Measuring the Chilling Effect*, 90 N.Y.U. L. REV. 1095, 1114 (2015) (concluding that laws governing pregnancy termination "affect not only the unprotected conduct they (perhaps permissibly) target, but also discourage protected conduct outside of their direct ambit"); *see also* Caroline Kitchener &

Dan Diamond, *Faced with abortion bans, doctors beg hospitals for help with key decisions*, WASH. POST (Oct. 28, 2023); Pam Belluck, *They Had Miscarriages, and New Abortion Laws Obstructed Treatment*, NEW YORK TIMES (July 17, 2022); Ariana Eunjung Cha, *Physicians face confusion and fear in post-*Roe *world*, WASH. POST (June 28, 2023); *cf.* Brittni Frederiksen, Usha Ranji, Ivette Gomez, and Alina Salganicoff, *A National Survey of OBGYNs' Experiences After* Dobbs, KAISER FAMILY FOUNDATION, https://www.kff.org/womens-health-policy/report/a-national-survey-of-obgyns- experiences-after-dobbs/ (68% of OBGYNs reported that their ability to manage pregnancy-related emergencies has worsened since 2022).

"The chilling effect," in other words, "is real." Canes-Wrone & Dorf, *supra*, at 1114.

3. The consequences for patients are staggering. Imagine an emergency-room physician or nurse attempting to provide care to a pregnant woman named Julia, who was just in a car accident on I-84 in rural Idaho. Julia is losing blood, and she begins to go into hypovolemic shock. A stabilizing surgery to stop the bleeding is medically necessary, but there is a chance it will result in termination of Julia's pregnancy. Instead of balancing the risks to Julia and her unborn child and exercising his best medical judgment about how to proceed, the Idaho physician or nurse must now consider—even subconsciously—whether proceeding with the surgery could result in a criminal prosecution or the revocation of a professional license.

This chilling effect is not cured by the Idaho statute's reference to a physician's "good faith medical

judgment… that the abortion was necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(2)(a). This language is not co-extensive with EMTALA, which mandates care necessary to prevent further serious jeopardy to a patient's health, serious impairment to her bodily functions, or serious dysfunction of her bodily organs. *See infra* pp. 26–27. Nor does it provide the clarity that hospitals and caregivers need in emergency circumstances. *See* JA 640–41 ("[T]he Legislature submits declarations from two physicians who offer up opinions as to what Idaho Code § 18-622 means.… [I]t should go without saying that *Idaho law controls the inquiry on this point*—not the medical community." (emphasis added)).[2] This is especially true because, from a medical perspective, the clinical line between preventing death and

---

[2] *See also* Sarah Varney, *After Idaho's Strict Abortion Ban, OB-GYNs Stage a Quick Exodus*, KFF HEALTH NEWS (May 2, 2023), https://kffhealthnews.org/news/article/after-idahos-strict-abortion-ban-ob-gyns-stage-a-quick-exodus/ ("The Idaho Supreme Court has since ruled that the law does not apply to ectopic or molar pregnancies.… But physicians say that limited change does not account for many common pregnancy complications that can escalate rapidly. That has led to deep frustration and turmoil in hospital emergency rooms. 'When is it OK for me to act? [Dr.] Huntsberger said.… When is it that I can intervene? How close to death does she need to be before I take care of her?'"); Kavitha Surana, *Inside the Internal Debates of a Hospital Abortion Committee*, PROPUBLICA (Feb. 26, 2024), https://www.propublica.org/article/abortion-doctor-decisions-hospital-committee ("[T]here is a wide spectrum of health risks patients can face during pregnancy.… Without clarification from legislators and prosecutors on how to handle the real-life nuances that have emerged in hospitals across America, doctors in abortion ban states say they are unable to provide care to high-risk pregnant patients that meets medical standards.").

preventing further serious jeopardy to a patient's health, serious impairment to her bodily functions, or serious dysfunction of her bodily organs is vanishingly small—especially during a fast-moving emergency.

So even with § 18-622(2)(a)'s "good faith" language, a clinician who must make medical decisions in rapidly-unfolding emergencies still faces the prospect of having his judgment second-guessed by an Idaho law enforcement officer, criminal prosecutor, and jury if the emergency ends, tragically, in the loss of a pregnancy. *Cf. Dombrowski*, 380 U.S. at 494 ("Even the prospect of ultimate failure of … prosecutions [under an overbroad statute] by no means dispels their chilling effect…."). And again, even an investigation or criminal charge, without an ultimate conviction, can result in the loss of a physician's license.

As the record in this case makes clear, even the hardiest, most devoted emergency-department caregiver cannot help but hesitate to proceed with an emergency service that "lies close to, but on the permissible side of, the criminal line." *Ruan*, 597 U.S. at 459. One declarant captured it well when she stated: "In the future, though I know what the appropriate medical treatment is for my patients, I would be hesitant to provide the necessary care due to the significant risk to my professional license, my livelihood, my personal security, and the well-being of my family." JA 370, Cooper Decl. ¶ 12; *see* JA 375, Seyb Decl. ¶ 13 (describing call from a physician who was forced to balance his "medical judgment or best practices for handling pregnancy complications" with the "ramifications of his actions if he proceeded with termination"); *id.* ¶ 14 ("In emergency situations,

physicians may delay the medically necessary care because they fear a financially ruinous investigation or criminal liability.").

III. EMTALA Preempts Idaho's Criminal Statute in the Narrow Domain of Emergency Care Because EMTALA Expressly Turns on a Provider's Medical Judgment.

For decades, EMTALA has been a workable legal regime in the narrow context of emergency medical care. It does not govern—and never mandates—"elective" abortions. Instead, it provides rules for hospitals confronted with medical emergencies. Crucially, EMTALA's limited legal regime *expressly* turns on the exercise of medical judgment. Idaho's criminal statute conflicts with that regime—and, most importantly, with the judgment of medical professionals providing emergency care. It is therefore preempted in the narrow domain of emergency stabilizing care.

1. EMTALA contains two features that are critical to the preemption analysis in this case.

a. *First*, EMTALA applies *only* in emergency situations. The Act's stabilization requirement is triggered when "an individual at a hospital has an emergency medical condition." 42 U.S.C. § 1395dd(c)(1). Significantly, EMTALA does not set a national standard of care for all medical services. It was "not intended to be a federal malpractice statute, but instead was meant to supplement state law solely with regard to the provision of limited medical services to patients in emergency situations." *Harry v. Marchant*, 291 F.3d 767, 773 (11th Cir. 2002) (en banc) (emphasis added); *see also Bryan v. Rectors &*

Visitors of Univ. of Va., 95 F.3d 349, 352 (4th Cir. 1996) ("It seems manifest to us that the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment."); 131 Cong. Rec. S28567 (daily ed. Oct. 23, 1985) (statement of Sen. Dole) ("Under the provision of this amendment, a hospital is charged only with the responsibility of providing an adequate first response to a medical crisis. That means the patient must be evaluated and, at a minimum, provided with whatever medical support services and/or transfer arrangements that are consistent with the capability of the institution and the well-being of the patient. We should expect nothing less.").

"Once EMTALA has met [its] purpose of ensuring that a hospital undertakes stabilizing treatment for a patient who arrives with an emergency condition, … the legal adequacy of that care is then governed not by EMTALA but by the state malpractice law that everyone agrees EMTALA was not intended to preempt." *Bryan* 95 F.3d at 351; *see also Harry*, 291 F.3d at 774 ("In prescribing minimal standards for screening and transferring patients, but not for patient care outside these two narrowly defined contexts, Congress confined EMTALA solely to address its concerns and, at the same time, avoided supplanting available state malpractice and tort remedies."). EMTALA "cannot plausibly be interpreted to regulate medical and ethical decisions outside that narrow context." *Bryan*, 95 F.3d at 352. Put another way, EMTALA's preemptive force ends as soon as a patient receives stabilizing treatment. Here, the conflict between EMTALA and Idaho criminal law

exists only in this circumscribed domain of emergency medical care.[3]

b. *Second*, EMTALA is focused on "stabilizing" care. *See, e.g.*, *Genova v. Banner Health*, 734 F.3d 1095, 1097 n.1 (10th Cir. 2013) (Gorsuch, J.) ("All that's required [to violate EMTALA] is a failure, for whatever reason, to … stabilize."). And crucially, EMTALA's stabilization requirement expressly turns on the exercise of expert medical judgment. EMTALA's definition of "to stabilize" requires emergency caregivers "to provide such medical treatment of the condition as may be necessary to

---

[3] Idaho's assertion that preemption would make "doctors a law unto themselves" and override state laws governing euthanasia, electroconvulsive therapy, or experimental drugs misses the mark. *See* Br. for Idaho Petr. 29–30. Even within the narrow domain of emergency treatment, all EMTALA governs (as relevant here) is *whether* stabilizing treatment is provided. It does not address *the quality* of that stabilizing treatment, which is instead left to state malpractice law. Unlike emergency termination in exceedingly rare circumstances, *see* Br. for St. Luke's Health System as *Amicus Curiae* 2, 6, none of those hypothetical treatments would satisfy a generally accepted medical standard of care. Thus, a doctor who, per Idaho's hypotheticals, euthanized a mental-health patient or lobotomized a child would still be subject to state malpractice laws. *See Vickers*, 78 F.3d at 142 ("In general, [q]uestions regarding whether a physician or other hospital personnel failed properly to … treat a patient's condition are best resolved under existing and developing state negligence and medical malpractice theories of recovery…. EMTALA is not intended to duplicate preexisting legal protections, but rather to create a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat." (internal citation and quotation marks omitted)); *del Carmen Guadalupe v. Agosto*, 299 F.3d 15, 21 (1st Cir. 2002) (similar).

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)(1)(A) (emphasis added). Critically, the plain text of this statutory definition relies on the medical judgments of emergency providers.

EMTALA therefore neither requires nor prohibits any *specific* form of care in a given case. But it does call for medical professionals to assess probabilities and determine the best course of stabilizing care consistent with their medical judgments. *See Cherukuri v. Shalala*, 175 F.3d 446, 454 (6th Cir. 1999) ("The statutory definition of 'stabilize' requires a flexible standard of reasonableness that depends on the circumstances."). As the Fifth Circuit has correctly recognized, the "reasonable medical probability" standard calls for "'[t]reatment that *medical experts* agree would prevent the threatening and severe consequence of' the patient's emergency medical condition while in transit." *Battle ex rel. Battle v. Mem'l Hosp. at Gulfport*, 228 F.3d 544, 559 (5th Cir. 2000) (emphasis added) (alteration in original) (citation omitted); *see Smith v. Botsford Gen. Hosp.*, 419 F.3d 513, 519 (6th Cir. 2005) ("[C]ompliance with EMTALA's stabilization requirements entails medical judgment[.]"); *accord* 42 C.F.R. § 489.24(g)(2)(v) (a peer review organization must provide CMS with an "expert medical opinion" to establish an EMTALA violation under the process set forth in 42 U.S.C. § 1395dd(d)(3)).

EMTALA's definition of "to stabilize" is both flexible and deferential, but for good reason. Congress recognized that untrained legislators never could

have specified *every* form of care that might be needed for *every* type of medical emergency a hospital might confront. Instead, Congress accounted for the endless variability of care that may be needed in emergency situations while expressly respecting providers' expertise about the particular form of care that any emergency situation may require. In so doing, EMTALA strikes a careful balance by mandating a goal—stabilization—but deferring to reasonable medical judgment for how to achieve that goal.

2. If there were any doubt that termination may qualify as a form of emergency service that falls within EMTALA's broad stabilization requirement, the Affordable Care Act put it to rest. *See Great N. Ry. Co. v. United States*, 315 U.S. 262, 277 (1942) ("It is settled that 'subsequent legislation may be considered to assist in the interpretation of prior legislation upon the same subject.'" (quoting *Tiger v. Western Investment Co.*, 221 U.S. 286, 309 (1911)). "Abortion had proved a contentious issue throughout the health care debate," John Cannan, *A Legislative History of the Affordable Care Act*, 105 L. LIB. J. 131, 167 (2013), and the ACA contains several express provisions related to the subject. In fact, unlike other provisions of the ACA that may "not reflect the type of care and deliberation that one might expect of such significant legislation," *King v. Burwell*, 576 U.S. 473, 492 (2015), these provisions were meticulously negotiated and given the closest attention, *see* The Staff of the Washington Post, LANDMARK: THE INSIDE STORY OF AMERICA'S NEW HEALTH-CARE LAW AND WHAT IT MEANS FOR US ALL 31–33 (2010); David M. Herszenhorn & Jackie Calmes, *Abortion Was at Heart of Wrangling*, N.Y. TIMES (Nov. 7, 2009).

In a section entitled "Special rules," the ACA uses the word "abortion" *nineteen times*. It addresses topics like "State opt-out of abortion coverage," "Special rules relating to coverage of abortion services," and "Application of State and Federal laws regarding abortion." 42 U.S.C. § 18023. Among other things, the section preserves federal conscience protections and prohibitions on the use of federal funds for abortion services. 42 U.S.C. § 18023(c)(2).[4]

Importantly, this section also contains a provision entitled "Application of emergency services laws." It states: "Nothing in th[e] Act shall be construed to relieve any health care provider from providing *emergency services* as required by State or Federal law, *including section 1867 of the Social Security Act (popularly known as 'EMTALA')*." 42 U.S.C. § 18023(d) (emphases added). Thus, in a section of the

---

[4] The United States has correctly "disclaimed the suggestion that 'EMTALA would compel individuals to perform abortions contrary to their sincerely held religious or moral beliefs.'" Br. for Fed. Pet'rs 23 n.3, *U.S. Food & Drug Administration v. Alliance for Hippocratic Medicine*, Nos. 23-235 and 23-236. *Amici* welcome the United States' acknowledgement of an individual caregiver's conscience rights. But the government's apparent reasoning for this disclaimer—that "EMTALA imposes obligations on covered hospital[s], not individual doctors," *id*. (quotation marks omitted)—raises additional questions that this Court need not decide in this case. For example, the government does not address the rights of hospitals under the Weldon Amendment (which defines a covered "health care entity" to include a "hospital"), *see* Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, 118 Stat. 2809, or the Religious Freedom Restoration Act, 42 U.S.C. § 2000bb *et seq*. If necessary, this Court can address the intersection between such authorities and EMTALA in a future case involving hospitals or health systems.

ACA that deals entirely with the topic of "abortion," the Act expressly references "EMTALA" and ensures that its "emergency services" requirements for "providers" remain undisturbed. *See* Sara Rosenbaum, *The Enduring Role Of The Emergency Medical Treatment And Active Labor Act*, 12 HEALTH AFFAIRS 2075, 2075 (2013) ("The Affordable Care Act reaffirmed EMTALA's preeminent position in American health law through provisions that clarify hospitals' emergency care duties in abortion cases.").

This section's text therefore makes clear that Congress understood that pregnancy terminations would sometimes occur during the provision of "emergency service[s]" under "EMTALA." *See Biden v. Nebraska*, 143 S. Ct. 2355, 2378 (2023) (Barrett, J., concurring) ("[T]he meaning of a word depends on the circumstances in which it is used. To strip a word from its context is to strip that word of its meaning."). Strikingly, Petitioners and their *Amici* do not address this provision *at all*, even though: (1) the United States raised it in its responses to Petitioners' stay applications, *see* United States' Response in Opposition to the Applications for a Stay 15; Consolidated Br. for United States 20, *United States v. Idaho*, Nos. 23-35440, 23-35450 (9th Cir.); and (2) it negates Petitioners' principal argument about EMTALA's text, which is that the presence of the term "unborn child" in the statute necessarily precludes "abortion" as an "emergency service," *see* Br. for Idaho Petr. 32; Br. for Idaho House of Representatives Petrs. 21.

Petitioners' and their *Amici*'s conspicuous silence about this subsection is devastating to their position. The ACA was enacted "formally through the

legislative process." *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 118, n. 13, (1980). Petitioners and their *Amici* cannot just pretend that § 18023(d) does not exist.[5] Their failure to address it is further proof that the only way to read this subsection's text and context is that EMTALA contemplates "abortion" as a stabilizing "emergency service." Or, to use the exact words of § 18023(d): hospitals are not "relieve[d]" of that legal duty under "EMTALA." At the very least, this "subsequent *legislation*," which "'declar[es] the intent of an earlier statute[,] is entitled to great weight in statutory construction.'" *GTE Sylvania, Inc.*, 447 U.S. at 118, n. 13, (quoting *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 380–81 (1969) (emphasis in original)); *see also United States v. Stewart*, 311 U.S. 60, 64–65 (1940) ("That these two acts are in pari materia is plain. Both deal with precisely the same subject matter…. The later act can therefore be regarded as a legislative interpretation of the earlier act … in the sense that it aids in ascertaining the meaning of the words as used in their contemporary setting. It is therefore entitled to great weight in resolving any ambiguities and doubts."); Antonin Scalia & Bryan A. Garner, READING LAW: THE INTERPRETATION OF LEGAL TEXTS 254–55 (2012) ("The meaning of an

---

[5] To be fair, Petitioner Idaho House of Representatives does not completely ignore the ACA. It and certain *Amici* do address other subsections of this ACA provision. *E.g.*, Br. for Idaho House of Representatives Petrs. 31–32, 55; Br. of *Amici* 121 Members of Congress 24; Br. *Amicus Curiae* of The Christian Medical & Dental Associations 22. But that only makes their failure to address § 18023(d) even more remarkable—and telling.

ambiguous provision may change in light of a subsequent enactment.").

Petitioners nonetheless attempt to use Congress' decision to create a broadly worded, medical-judgment-based standard in EMTALA as a reason why states may criminalize specific forms of care. *See* Br. for Idaho Petr. 25–26; Br. for Idaho House of Representatives Petrs. 23–26. Because EMTALA does not catalogue specific methods of "stabilizing treatment," Petitioners insist, states like Idaho may substitute their own policies for a provider's medical and ethical judgment.

Those arguments miss the point of EMTALA. Even leaving § 18023(d) to one side, the statute does not specify particular treatments *precisely because* it turns on the exercise of professional medical judgment. *See supra* pp. 18–20. It lets trained medical experts—not state legislators or criminal prosecutors—determine what treatment is needed to prevent further deterioration when a patient arrives on a hospital's doorstep with an emergency. The fact that EMTALA preserves on-the-ground flexibility by setting a general stabilization goal for clinicians does not mean there is room for states to prohibit specific forms of stabilizing emergency services that medical professionals otherwise deem necessary. *See Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 878, 881 (2000) (finding conflict preemption where federal "standard deliberately sought variety … and allowing manufacturers to choose among" ways of attaining safety goals); *Barnett Bank v. Nelson*, 517 U.S. 25, 32–33 (1996) (holding that when federal law affords regulated entities a choice of options, state law that would forbid particular options is conflict-preempted);

Fidelity Fed. Sav. & Loan Ass'n v. de la Cuesta, 458 U.S. 141, 155–56 (1982) (same); *see also POM Wonderful LLC v. Coca Cola Co.*, 573 U.S. 102, 120 (2014) ("In *Geier*, the agency enacted a regulation deliberately allowing manufacturers to choose between different options because the agency wanted to encourage diversity in the industry.… The Court concluded that the [state law] action was barred because it directly conflicted with the agency's policy choice to encourage flexibility.").[6]

---

[6] Citing no caselaw in support, Petitioners argue that if a state law bars a particular emergency service, that service is not "within the staff and facilities available at the hospital," 42 U.S.C. § 1395dd(b)(1), and thus not required under EMTALA, *see* Br. for Idaho Petr. 25; Br. for Moyle Petr. 26–27. But they overread this provision, which was designed to respect the inherent limitations of certain hospitals—particularly those in rural or other underserved areas that may lack a full suite of capabilities. *See* H.R. Rep. No. 241, 99th Cong., 1st Sess., pt. 1, at 27 (hospitals must provide treatment "within their competence"); 131 Cong. Rec. S28567 (daily ed. Oct. 23, 1985) (statement of Sen. Dole) ("[T]he patient must be evaluated and, at a minimum, provided with whatever medical support services and/or transfer arrangements that are consistent with the capability of the institution and the well-being of the patient."). Petitioners' attempt to transform this language into a sweeping anti-preemption provision proves far too much. On their view, states could regulate emergency care out of existence, and EMTALA would not be offended. That cannot be right. Moreover, Petitioners' anti-preemption interpretation of a provision that nowhere mentions preemption would render EMTALA's *actual*, more limited preemption provision superfluous and should be rejected. *See Ysleta Del Sur Pueblo v. Texas*, 596 U.S. 685, 699 (2022) (rejecting interpretation that would "render…*another* portion of the statute…a nullity"); *Pulsifer v. United States*, No. 22-340, slip op. at 16–19 (Mar. 15,

3. Idaho's criminal statute impermissibly conflicts with these core features of EMTALA by prohibiting a particular emergency service option that federal law contemplates. *See Geier*, 529 U.S. at 878, 881; *Barnett Bank*, 517 U.S. at 33 (citing *de la Cuesta*, 458 U.S. at 154–59). Specifically, § 18-622 criminalizes medically necessary and EMTALA-mandated stabilizing treatment in the rare case when termination is necessary to prevent "material deterioration" of a medical condition that *already* can be expected to result in "serious jeopardy" to a patient's health, "serious impairment to bodily functions," or "serious dysfunction of any bodily organ or part," 42 U.S.C. § 1395dd. Where withholding treatment will mean material deterioration of an already-severe emergency medical condition, and a physician accordingly determines that termination is unfortunately medically necessary, EMTALA's provisions are clear: Clinicians must stabilize the pregnant patient even if that requires the tragic performance of an emergency termination. Idaho law, however, is equally clear: Emergency termination in that circumstance is a crime.

Medical professionals therefore face an impossible choice. On the one hand, they can choose to provide services that are medically necessary, ethically permissible, and federally mandated but that entail the risk of § 18-622's criminal and professional sanctions. On the other hand, they can choose to steer clear of Idaho's criminal and professional sanctions,

---

2024). Petitioners' reading would "make a mockery of [EMTALA's] preemption provision." *Nat'l Meat Ass'n v. Harris*, 565 U.S. 452, 464 (2012).

but only by withholding medically necessary, ethically permissible, and federally mandated emergency services that would prevent *further* serious jeopardy to a pregnant patient's health, serious impairment of her bodily functions, or serious dysfunction of her organs.

This conflict is crystal clear in situations like those in the hypotheticals described above involving Linda and Julia. *See supra* pp. 4–5, 13. A pregnant woman suffering chorioamnionitis is at risk of sepsis, and her fetus can suffer brain damage or death. A pregnant woman who is losing enough blood to experience hypovolemic shock can suffer organ failure if her injuries are not treated immediately. In both cases, termination can be clinically necessary to prevent an already serious medical situation from worsening. EMTALA requires that their doctors use their judgment to assess the "reasonable medical probabilit[ies]" and determine what "medical treatment of the condition [is] necessary" to prevent an emergency medical condition from materially deteriorating. 42 U.S.C. § 1395dd(e)(1)(A). Section 18-622, however, tells doctors that they will be criminally liable for doing just that. In other words, Idaho law takes away from physicians the emergency service option that affords, in a doctor's and his patient's judgment, the best possible outcome in a tragic situation. That is an irreconcilable conflict, and § 18-622 is therefore preempted as applied to emergency medical services.

CONCLUSION

For the foregoing reasons, this Court should vacate the stay entered on January 5, 2024 and affirm the district court's order granting the United States' motion for a preliminary injunction.

March 18, 2024

Respectfully submitted,

Charlotte H. Taylor
Counsel of Record
Amelia A. DeGory
JONES DAY
51 Louisiana Avenue, NW
Washington, DC 20001
(202) 879-3872
ctaylor@jonesday.com

Amanda K. Rice
JONES DAY
150 W. Jefferson Ave.
Suite 2100
Detroit, MI 48226

Counsel for Amici Curiae