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,
Respondent.

IDAHO,
Petitioner,

v.

UNITED STATES,
Respondent.

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

---

BRIEF OF *AMICI CURIAE* LOCAL PROSECUTORS AND LAW ENFORCEMENT LEADERS IN SUPPORT OF RESPONDENT

ELI SAVIT
VICTORIA BURTON-HARRIS
WASHTENAW COUNTY (MI) OFFICE OF THE PROSECUTING ATTORNEY

JONATHAN B. MILLER
AADIKA SINGH
PUBLIC RIGHTS PROJECT

COREY STOUGHTON
Counsel of Record
RAJAT RANA
ADAM GOULD
SEAN GOLDMAN-HUNT
SELENDY GAY PLLC
1290 Avenue of the Americas
New York, New York 10104
(212) 390-9000
cstoughton@selendygay.com

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

Cases

Statutes

Other Authorities

STATEMENT OF INTEREST

Amici are current and former local prosecutors and law enforcement leaders from across the country.[1] Collectively, they have initiated investigations, brought charges, and sought accountability for many hundreds of thousands of crimes covering the full range of the penal code. *Amici* file this brief in furtherance of their shared interest in supporting public safety, ensuring public confidence in law enforcement, and protecting the health and safety of their communities, including preserving access to essential emergency healthcare.

At issue in this case is the ability of trained medical doctors to make judgments about what care is necessary for people experiencing medical emergencies. In *amici*'s expert view, injecting the after-the-fact perspectives of prosecutors and law enforcement into precarious emergency healthcare decisions entangles them in choices they are ill-equipped to make and imposes an impossible task that misunderstands the role of law enforcement, undermines community trust, and threatens public safety.

SUMMARY OF ARGUMENT

For almost forty years, emergency room physicians have understood that criminal liability does not attach to the provision of care necessary to stabilize patients

---

[1] No counsel for a party authored this brief in whole or in part. No person other than *amici* or *amici*'s counsel made a monetary contribution to the preparation or submission of this brief. A list of all *amici* is available at Appendix A.

presenting with medical emergencies. That understanding derives in part from federal law, which requires hospitals receiving Medicare funding to provide stabilizing care to patients who present with an emergency medical condition which, without "immediate medical attention," puts the "health" of the patient in "serious jeopardy." Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd(b)(1), (e)(1)(A)(i).

EMTALA—which expressly preempts directly conflicting state and local laws, 42 U.S.C. § 1395dd(f)—places stabilizing emergency medical care beyond the scope of local prosecution. That is a function of the law's design, which provides a national baseline for hospitals covered by EMTALA. It is also consistent with bedrock prosecutorial standards. Prosecutors are not doctors and are ill-suited to second-guess medical professionals' emergency decisions. And doctors, in turn, should be focused on their patients in times of crisis, not forced to consider how local prosecutors, reviewing a cold record, might later view their on-the-ground medical judgments.

Now, in what can only be described as an inversion of the Supremacy Clause, Petitioners seek to have this Court rule that state criminal laws trump federal EMTALA standards. States like Idaho, Oklahoma, and South Dakota have enacted abortion laws that criminalize emergency stabilizing care. Under these laws, an emergency room doctor may avoid criminal liability only if an abortion is "necessary" to save the life of the pregnant patient. Such laws risk upending the

longstanding, stable understanding of when providing emergency abortions is consistent with the lawful practice of medicine.

These state laws not only conflict with EMTALA, but they also inject an amorphous distinction between threats to life and threats to health that is utterly detached from the practice of medicine. Doctors themselves have made clear that determining when a medical crisis reaches an artificial legal threshold of "life-or-death" is practically impossible. The inherent complexities of such determinations are amplified in the emergency context, where time is of the essence and the blurry lines separating risk to life from "mere" risk to health become indiscernible.

Nevertheless, these state laws ask prosecutors and law enforcement—like *amici*—to second-guess emergency room physicians' judgments about these indeterminate medical matters when initiating investigations, arrests, or prosecutions. Simply put, prosecutors and law enforcement leaders like *amici* are ill-equipped to do so. To the extent it is possible to draw these lines at all, it is particularly dangerous to ask medically untrained criminal justice professionals to substitute their judgment for that of medical professionals acting in emergency situations. What's more, vague state statutes, like the Idaho law at issue in this case and laws like it, do not provide law enforcement or prosecutors with any meaningful framework for exercising their discretion.

If these state laws are not preempted by EMTALA, doctors will be forced not only to contend with impossible questions and vague state laws, but to anticipate how their local prosecutor will grapple with them as well. That, in turn, will invariably chill the provision of emergency medical care and undermine relationships between law enforcement and the communities they serve—undercutting the "public interest" that prosecutors are duty-bound to pursue.[2]

ARGUMENT

I. STATE LAWS CRIMINALIZING ABORTION PLACE IMPOSSIBLE DEMANDS UPON PROSECUTORS AND LAW ENFORCEMENT TO SECOND-GUESS DIFFICULT EMERGENCY MEDICAL JUDGMENTS

Multiple states—including Idaho, Oklahoma, and South Dakota—have outlawed the provision of an abortion unless necessary to save the life of a pregnant patient. *See* Idaho Code § 18-622 (2023) (criminalizing abortion unless "necessary to prevent the death of the pregnant woman"); Okla. Stat. Ann. 21 § 861 (1999) (effective June 24, 2022) (criminalizing abortion unless "necessary to preserve [a woman's] life"); S.D. Codified Laws § 22-17-5.1 (2005) (effective June 24, 2022) (criminalizing abortion unless "necessary to preserve

---

[2] *See* American Bar Association, *Functions and Duties of the Prosecutor,* https://www.americanbar.org/groups/criminal_justice/standards/ProsecutionFunctionFourthEdition/ (last visited Mar. 28, 2024).

the life of the pregnant female"). These state laws demand that prosecutors enforce an artificial line between lawful and unlawful abortions in an emergency-room context that doctors themselves cannot meaningfully draw. The laws' vague terms compound the difficulty of navigating such ambiguity. As a result, law enforcement officials like *amici* are left to second-guess medical judgments in a manner irreconcilable with their obligations to the rule of law and public safety.

A. Determining Whether An Abortion Is Necessary To Prevent Death Is Medically Ambiguous

Emergency room physicians "frequent[ly]" encounter pregnancy-related crises.[3] Contrary to the simplistic statutory standards in states like Idaho, Oklahoma, and South Dakota, however, there is no bright-line clinical consensus delineating when a medical crisis crosses into the realm of life-or-death.[4] As Dr. Lisa Harris, a professor of obstetrics and gynecology at the University of Michigan explained, "[i]t sounds like it's [a] straightforward criteria, but it's not in practice."[5]

---

[3] *See* Br. of Am. Coll. of Emergency Physicians of Idaho, *et al.*, as Amici Curiae Supporting Plaintiffs at 12, *United States v. Idaho*, No. 1:22-cv-00329-BLW (D. Idaho Aug. 16, 2022) (hereinafter "Br. of ACEP").

[4] *Id.* at 15–16.

[5] Mary Kekatos, *Why Doctors Say The 'Save The Mother's Life' Exception of Abortion Bans Is Medically Risky*, ABC NEWS (June 13, 2022), https://abcnews.go.com/Health/doctors-save-mothers-life-exception-abortion-bans-medically/story?id=84668658.

Dr. Harris elaborated in the *New England Journal of Medicine*:

> What does the risk of death have to be, and how imminent must it be? Might abortion be permissible in a patient with pulmonary hypertension, for whom we cite a 30-50% chance of dying with ongoing pregnancy? Or must it be 100%? When we diagnose a new cancer during pregnancy, some patients will decide to end their pregnancy to permit immediate surgery, radiation, or chemotherapy, treatments that can cause significant fetal injury. Will abortion be permissible in these cases, or will patients have to delay treatment until after delivery? These patients' increased risk of death may not manifest for years, when they have a recurrence that would have been averted by immediate cancer treatment. We've identified countless similar questions.[6]

In the emergency medical context, in particular, "life or death exist on a fragile and shifting continuum."[7] Patients' conditions can resolve or deteriorate

---

[6] Lisa Harris, *Navigating Loss of Abortion Services — A Large Academic Medical Center Prepares for the Overturn of Roe v. Wade*, New Eng. J. Med. (May 11, 2022), https://www.nejm.org/doi/full/10.1056/NEJMp2206246.

[7] Br. of ACEP, *supra* note 3, at 21; *see also* Br. of Am. Coll. of Obstetricians and Gynecologists, et al. as Amici Curiae Supporting Plaintiff-Appellee at 23, *United States v. Idaho*, No. 23-35440 (9th Cir. Sept. 9, 2023) ("In the emergency medical context, 'life-threatening' situations are those where death is reasonably

at variable rates, or manifest in different ways, and some ostensibly non-life-threatening conditions can rapidly escalate into a life-or-death situation when they intersect with other underlying conditions that may or may not be immediately discernible.[8] "Each patient brings unique medical considerations to the field," and there can be no "one-size-fits-all" approach to assessing whether or to what extent death is likely.[9] "The practice of medicine is complex and requires individualization—it cannot be distilled down to a one-page document or list that is generalizable in every situation."[10] For one pregnant patient, a certain emergent medical condition may allow for multiple treatments. But that same condition may, for another patient, only be safely treated with an abortion.[11] Thus, "a finite list of high-risk conditions for which an abortion is allowed . . . couldn't account for the nuances

---

possible if the patient does not receive medical treatment, even if there is a chance that the patient could fortuitously survive.").

[8] Am. Coll. of Obstetricians and Gynecologists, *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions* (Aug. 15, 2022), https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions (hereinafter "ACOG Website").

[9] *See id.*

[10] *See id.*

[11] *See* Br. of ACEP, *supra* note 3, at 12 ("Because pregnancy termination is part of the medically indicated treatment to stabilize patients in certain emergency scenarios, physicians—to comply with EMTALA and the principles of medical ethics—must, and do, consider abortion a necessary treatment option.").

that inevitably arise in individual cases."[12] After all, doctors "regularly practice and make medical decisions in gray areas," rather than in absolutes.[13]

The record before the Court—which served as the basis for the preliminary injunction— illustrates these uncertainties clearly. One patient presented with "persistent stroke range blood pressures" that risked inducing seizures. J.A. 367 (Decl. of Kylie Cooper, M.D.). That patient subsequently was diagnosed with preeclampsia, a potentially fatal complication from pregnancy. That patient's fetus had been diagnosed with triploidy, a chromosomal abnormality "not compatible with life." *Id.* With additional risk factors and "severe features" present in the case, an abortion was the "only medically acceptable action." *Id.* at 367–68. But while the treatment was clear medically, it was

---

[12] Emily Baumgaertner, *Doctors in Abortion-Ban States Fear Prosecution for Treating Patients with Life-Threatening Pregnancies*, L.A. Times (July 29, 2022) (citing Dr. Lorie Harper, a maternal-fetal medicine specialist in Austin, Texas).

[13] ACOG Website, *supra* note 8; *see also* Br. of St. Luke's Health Sys. as Amicus Curiae in Support of Respondent at 13–14, *Moyle v. United States*, No. 23-726 (Mar. 14, 2024). (hereinafter "Br. of St. Luke's"); Br. of Am. Hosp. Ass'n, et al. as Amici Curiae in Support of Respondent at 14–15, *Moyle v. United States*, No. 23-726 (Mar. 14, 2024) (hereinafter "Br. of AHA") ("[F]rom a medical perspective, the clinical line between preventing death and 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.").

unclear whether it was legally "necessary" under Idaho law.

In another case involving a "lethal fetal condition," a patient presented with "rapidly rising liver enzymes" that "were indicative of liver injury, and her platelets were declining rapidly." *Id.* 369. Left untreated, the patient was at risk of "liver hemorrhage and failure, kidney failure, stroke, seizure, [and] pulmonary edema." *Id.* Again, given the patient's rapidly deteriorating condition, an abortion was the "only medically acceptable action." *Id.* Yet it was unclear whether (and the precise point at which) an abortion would become "necessary" to prevent death under Idaho law.

And in yet another case, a patient arrived with an elevated heart rate and an intrauterine infection. J.A. 373 (Decl. of Stacy T. Seyb, M.D.). Further tests revealed that there was no fluid around the fetus. *Id.* Antibiotics were administered, and the risk of sepsis was "very high." *Id.* In this case, the outcome was apparent—the fetus could not survive for much longer, and an immediate abortion was medically indicated. *Id.* at 373–74. Yet the moment at which legal "necessity" emerged remained debatable, given that the infection had not crossed the line to sepsis or caused organ failure *yet*.

As these cases and others offered by various *amici* demonstrate, there is "no viable way to apply a 'life-threatening' test in emergency medicine."[14]

B. State Laws That Turn On The Line Between Threats To Life And Threats To Health Compound This Inherent Medical Ambiguity

State laws criminalizing the provision of an abortion except when necessary to save the life of the pregnant person do nothing to address these inherent ambiguities. Rather, they often accentuate them. Under Idaho law, it is a crime to perform an abortion unless the doctor determines, based on the facts known at the time and the doctor's "good faith medical judgment," that an abortion is "necessary to prevent the death of the pregnant woman." Idaho Code § 18-622. The law does not clarify the probability of death required for the procedure to be considered legal. Nor does it give guidance as to how doctors could make such determinations in rapidly evolving emergency situations where probabilities may swing erratically from one moment to the next. The "good faith" standard does nothing to solve this problem, as it addresses

---

[14] Br. of ACEP, *supra* n. 3, at 16. Nor is this a medically acceptable threshold. Getting close to death almost always come with harms from which the human body may never recover, and those circumstances makes the provision of treatment higher risk: procedures, anesthesia, and medications all pose greater risk of harms when utilized for a near-death patient compared to a more stable patient. By waiting to extreme thresholds, the likelihood of success of standard treatments decreases dramatically.

subjective motivations without providing any objective rubric by which good-faith emergency medical decisions should be judged.

Judicial guidance has also been of little help. Indeed, the Idaho Supreme Court explicitly rejected the idea that "more guidelines" were required for the statute to survive a constitutional vagueness challenge. *Planned Parenthood Great Northwest v. State*, 522 P.3d 1132, 1204 (Idaho 2023). Discussing the parameters of Idaho's "necessary to prevent the death of the pregnant woman" exception, § 18-622, the court referenced "a 'core of circumstances' that a person of ordinary intelligence could unquestionably understand." 552 P. 3d at 1204. The court failed, however, to identify what that "core of circumstances" entails. Instead, it tautologically returned to the terms of the statute: this "core of circumstances includes every situation where, in the physician's good faith medical judgment, an abortion was 'necessary' to prevent the death of the pregnant woman." *Id.* (cleaned up).

The problems identified in the Idaho law are not unique. Oklahoma, for example, also criminalizes providing an abortion to a pregnant patient unless "necessary to preserve her life." Okla. Stat. Ann. 21 § 861. In explaining this exception, the Oklahoma Supreme Court held that abortion is legal if there is a "reasonable degree of medical certainty or probability" that a woman's life would be "endanger[ed]" if an abortion was not performed. *Okla. Call for Reprod. Just. v. Drummond*, 526 P.3d 1123, 1131 (Okla. 2023). It is illegal for a doctor to provide an abortion, however, if

the doctor's medical judgment is based on "mere possibility or speculation." *Id.* But what does any of that mean? Is a specific numeric "probability" required to reach the threshold of "reasonable" and move beyond "mere possibility or speculation?" If so, what "probability" is sufficient? Does a 15% chance of dying from pulmonary hypertension qualify as "a reasonable degree of medical certainty or probability" that a woman's life will be "endanger[ed]?" Or is some greater threshold (33%, 50.1%, 67%) required? What if there is only a probability that an emergency medical condition could develop into a complication that itself would create some probability of death?[15] Would a doctor's decision to terminate a pregnancy in that circumstance qualify as a "reasonable degree of medical . . . probability?" Or would that decision be deemed to have been based on unacceptable "speculation," or "mere possibility?"[16]

---

[15] Another clinical example from the testimony of Dr. Emily Corrigan in the record below underscores this point: she testified about providing an abortion to a patient who presented with signs of an infection from a serious complication known as preterm premature rupture of membranes; while the infection was not sepsis, it risked developing into life-threatening sepsis. J.A. 357–359. Was the patients' risk of sepsis, which itself risked death, high enough at the time to make the abortion "necessary" under laws like Idaho's?

[16] Presumably recognizing these challenges, the Oklahoma Attorney General offered non-binding guidance to prosecutors attempting to significantly limit the scope of prosecutions under the law. *See* Memorandum from the Oklahoma Attorney General to All Oklahoma Law Enforcement Agencies (Nov. 21, 2023) at 2 (opining that "there is no requirement that the woman be septic,

Finally, South Dakota has criminalized the performance of an abortion "unless there is appropriate and reasonable medical judgment that performance of an abortion is necessary to preserve the life of the pregnant female." S.D. Codified Laws § 22-17-5.1 (2022). As with its sister-states' laws, there is no definition of terms like "appropriate and reasonable" and no indication of whether "necessary" requires a specific quantum of risk to life—and, if so, what that quantum might be and how it can be determined in the fluid context of a medical emergency. While the South Dakota legislature has resolved to create an "informational video" to better "describe" the law for medical professionals, *see* South Dakota H.B. 1224 (2024), the very fact that such a video might be required reinforces the absurdity—and the danger—of state laws that impose legislative and prosecutorial judgment on complex emergency medical decision-making.

The inability of any state entity to provide meaningful, binding guidance concerning vague "necessary-to-prevent-death" standards underscores the wide gap between the realities of emergency medicine and the legal standards imposed by these state laws. Doctors have explained the challenge of determining when an abortion is legally "necessary" in these contexts. Yet

---

bleeding profusely, or otherwise close to death"). Such non-binding recommendations, however, provide no safe harbor for doctors who have no reasonable way of knowing whether local prosecutors under whose jurisdiction they practice will choose to follow the guidance or instead operate pursuant to their own plausible interpretations of the statute's vague standard.

state laws like Idaho's continue to demand such impossible judgments.

C. Prosecutors And Law Enforcement Are Not Equipped To Resolve These Ambiguities

The uncertainty inherent in states' criminal abortion laws is only exacerbated by the fact that *prosecutors* must review whether an abortion was "necessary" to prevent death. Prosecutors are JDs, not MDs. They have taken the Bar, not the Boards. Lacking medical training and experience, prosecutors and law enforcement are simply not equipped to look over the shoulders of doctors practicing emergency medicine and discern when an emergency abortion was necessary to save the life of the pregnant person.

There are more than 2,400 elected prosecutors in the United States.[17] Each of these prosecutors brings to the table unique perspectives, experience, and values. Yet vanishingly few (if any) of them can claim training in emergency medicine—much less obstetric-gynecological expertise. Nonetheless, state laws charge these individuals with determining whether an abortion was "necessary" to save a person's life.

That is not what prosecutors do. It is not what prosecutors are trained to do. And it is not what prosecutors should be asked to do. To be sure, prosecutors

---

[17] Brennan Center Live, *The Revolution in Prosecutors' Offices*, Brennan Center for Justice (Apr. 9, 2019).

must make judgments about the necessity of action in other circumstances—for example, in self-defense or defense-of-others cases. But those circumstances are easily distinguishable. None require prosecutors to act as quasi-medical review boards and second-guess doctors' emergency-room judgments based on what lawyers believe was medically "necessary." Prosecutors can put themselves in the shoes of a reasonable person who may fear for his or her life, but that is a far cry from putting themselves in the lab coat of a trained doctor managing a complex medical crisis.

Indeed, prosecutors like *amici* would not know the first place to start when assessing one of the myriad serious medical emergencies pregnant patients may face. Take, for example, one of the many real-world medical emergencies that are a part of the record in this case. Is an abortion "necessary" to prevent death under Idaho Code § 18-622 if a patient diagnosed with preeclampsia presents with "rapidly rising liver enzymes" that are "indicative of liver injury?" J.A. 369. How should a prosecutor weigh the risk not just of "liver hemorrhage and failure," but also the potential for "kidney failure, stroke, seizure, [and] pulmonary edema?" *Id.* And how should a prosecutor weigh any pre-existing conditions and co-morbidities in determining whether an abortion was "necessary" to prevent death?

Lawyers (and law enforcement personnel) are ill-equipped to answer these questions. Nobody faced with a medical emergency would seek the advice of their local district attorney or police chief as to what

type of care is medically indicated. But these are precisely the questions that state laws like Idaho's, Oklahoma's, and South Dakota's require prosecutors to answer.

Strikingly, at least one state high court has recognized that prosecutors are ill-suited to second-guess the nuanced medical decisions that emergency doctors must make. In *Planned Parenthood Great Northwest*, the Idaho Supreme Court suggested that prosecutors, to prove their case, may need to consult with "other medical experts on whether the abortion was, in their expert opinion, medically necessary." 522 P.3d at 1204. Invariably, therefore, prosecutors—who are ethically bound to consider whether they can prove their case beyond a reasonable doubt before bringing charges[18]—would be required to consult a quasi-medical review board at the charging stage. But the core of the prosecutorial function is the exercise of "sound discretion and *independent* judgment."[19] Idaho's suggestion amounts to an unacceptable recommendation to outsource prosecutorial discretion.

Medically untrained prosecutors have no foundation for evaluating a doctor's emergency-room decisions without consulting such a medical board. And yet, exercising that discretion without the guidance of medical experts is equally unthinkable. Prosecutors charged with enforcing state laws like Idaho's thus face an impossible choice: Either effectively outsource

---

[18] American Bar Association, *supra* note 2.

[19] *Id.*

criminal charging decisions to medical professionals, or make uninformed decisions about a doctor's medical judgment without anything resembling the necessary expertise.

And the downstream effects of prosecutorial second-guessing will be pronounced. Doctors, during a moment of medical emergency, will be forced to consider not just whether an abortion is medically indicated, but whether their local district attorney would agree. Such guesswork requires weighing the district attorney's reputation, her background, and her handling of previous cases involving medical abortion care (if any). If a local election is forthcoming, doctors may also have to consider whether a challenger is more or less likely than the incumbent district attorney to believe that a medically indicated abortion was lawful.

As the record below confirms, this dynamic will invariably chill the provision of potentially lifesaving care. *See, e.g.*, J.A. 362 ("[T]he threat of criminal prosecution has already deterred doctors from providing medically necessary, life-saving care"). An analysis of abortion bans in Texas published in the *New England Journal of Medicine* similarly describes a pervasive "climate of fear" among the medical community.[20] Such chilling may result in refusals to perform necessary abortions but, critically, may also involve simply delaying such abortions until the patient's life is more

[20] Whitney Arey, et al., *A Preview of the Dangerous Future of Abortion Bans—Texas Senate Bill 8*, 387 N. ENGL. J. MED. 388, 389 (2022).

clearly in jeopardy, creating greater harm to patients and risking unnecessary death.[21]

II. EMTALA PROVIDES A *DE FACTO* SAFE HARBOR FOR THE EXERCISE OF SOUND MEDICAL JUDGMENT AND RELIEVES PROSECUTORS AND LAW ENFORCEMENT FROM UNDERTAKING A TASK FOR WHICH THEY ARE UNSUITED

A. EMTALA Clearly Preempts Abortion Bans With Narrow Exceptions, Like Idaho's

In enacting EMTALA, Congress recognized the danger inherent in having emergency medical decisions governed by 50 different state laws. The "'overarching purpose'" of EMTALA is to ensure that *all* patients "'receive adequate emergency medical care.'" *Arrington v. Wong*, 237 F.3d 1066, 1073–74 (9th Cir. 2001) (quoting *Vargas v. Del Puerto Hosp.*, 98 F.3d 1202, 1205 (9th Cir. 1996)). That is why EMTALA contains an express preemption provision, providing that its requirements supersede "any State or local law requirement . . . to the extent that the requirement directly conflicts with a requirement of [EMTALA]." 42

---

[21] *See supra* Section I.A. St. Luke's Health System confirms this point. Br. of St. Luke's, *supra* note 13, at 21 (The limited necessity exception "encourages providers to delay medically-necessary treatment until the patient is close to death, even though the provider understands that the condition will inevitably worsen and even though the patient suffers in the meantime.").

U.S.C. § 1395dd(f). By its terms, EMTALA thus precludes states from enacting laws that would require covered hospitals not to provide care otherwise mandated by EMTALA.

EMTALA requires covered hospitals to provide "[n]ecessary stabilizing treatment" to "any individual" who presents with an "emergency medical condition." 42 U.S.C. 1395dd(b)(1). An "emergency medical condition" is defined to mean a medical condition, manifested by "acute symptoms," which could "reasonably be expected" to result in (1) "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"; (2) "serious impairment to bodily functions"; or (3) "serious dysfunction of any bodily organ or part." *Id.* § 1395dd(e)(1). When a covered hospital is presented with a patient experiencing an "emergency medical condition," EMTALA requires the provision of "such treatment as may be required to stabilize" the condition. *Id.* § 1395dd(b). Stabilizing a patient means "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur" once the hospital takes steps to transfer or discharge the patient.[22] *Id.* § 1395dd(e)(3)(A). These requirements expressly

[22] The Department of Health and Human Services has long required hospitals to ensure that the treating physician has "determined, within reasonable clinical confidence, that the emergency medical condition has been resolved." CMS, *State Operations Manual*, App. V, at 50 (Rev. 191, July 19, 2019), https://perma.cc/23A7-KYGQ.

apply to pregnant women. *Id.* §§ 1395dd(e)(1)(A)(i) & (e)(1)(B).

Under EMTALA, then, emergency room physicians are empowered to exercise their sound medical judgment about how to best stabilize the patient. In some instances, following best medical practices, such stabilizing care may not just allow for, but, in fact, require an abortion. The Department of Health and Human Services has repeatedly taken this position in rulemaking and compliance actions.[23] Though the number of judicial cases involving abortion in the EMTALA context is limited, federal courts have agreed that EMTALA can mandate an abortion to stabilize a patient. *See, e.g.*, *Ritten v. Lapeer Reg'l Med. Ctr.*, 611 F. Supp. 2d 696 (E.D. Mich. 2009); *New York v. United States Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 537-539 (S.D.N.Y. 2019); *California v. United States*, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008). And as other *amici* demonstrate, it is well-understood within the medical community that an abortion may qualify as EMTALA-mandated stabilizing care.[24]

In this context, EMTALA therefore preempts state laws, like Idaho's, to the extent they would criminalize the provision of an abortion that is necessary to stabilize a patient in a medical emergency. *See, e.g.*, *PLIVA, Inc. v. Mensing*, 564 U.S. 604, 618 (2011) ("We have

---

[23] *See* Br. for the Respondent at 16–17, *Moyle v. United States*, No. 23-726 (Mar. 21, 2014).

[24] *See* Br. of St. Luke's, *supra* note 13, at 8–10; Br. of AHA, *supra* note 13, at 20–23.

held that state and federal law conflict where it is 'impossible for a private party to comply with both state and federal requirements.") (citation and internal quotation omitted). Under the Idaho statute and other similar laws, abortions are lawful only when "necessary" to "prevent death." EMTALA, however, requires stabilizing care—including abortion, in some circumstances—when a pregnant patient is suffering from an emergency medical condition which (1) threatens serious harm to her health, but (2) does not immediately threaten her life. In other words, Idaho criminalizes emergency care that EMTALA requires. For that reason, EMTALA preempts Idaho state law.

B. EMTALA's Preemption Of Conflicting State Laws Removes The Threat Of Prosecutors Undermining Essential Emergency Care

EMTALA's preemptive effect is essential to the delivery of critical care in emergency situations. Under the EMTALA standard, a doctor need not determine whether or at what precise point an abortion becomes necessary to save a patient's life. Nor will the doctor need to consult with in-house counsel before making an emergency-room decision, or consider whether her local district attorney will ultimately agree with her medical judgment. Instead, EMTALA allows—and requires—physicians to provide emergency-room patients with necessary stabilizing treatment including, where appropriate, an abortion.

For their part, under EMTALA, local prosecutors need not—indeed, cannot—wade into the murky medical thicket to determine whether an abortion was necessary to prevent death. The real-life examples that are part of the record are again instructive. As noted, it would be nearly impossible for a prosecutor to determine when an abortion was necessary to prevent the death of a patient with symptoms "indicative of liver injury," including "rapidly rising liver enzymes" and rapidly declining "platelets." J.A. 368, *see supra* Section I.C. But, under the EMTALA standard, a prosecutor need not make that judgment because, although assessing the risk of death is unclear, an abortion would plainly prevent "placing the health of the individual . . . in serious jeopardy," "serious impairment to bodily functions" or "serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e)(1)(A)(i)-(iii). Doctors, therefore, are sheltered from prosecutorial second-guessing by EMTALA's *de facto* safe harbor.

As a result, EMTALA's preemptive effect protects doctors acting to provide stabilizing care and relieves prosecutors of the functionally impossible task of second-guessing, on a cold record, decisions made in an emergency context.

III. UPHOLDING EMTALA'S SAFE HARBOR FOR EMERGENCY ABORTIONS ENSURES THAT LAW ENFORCEMENT LEADERS ARE ABLE TO DRAW ON COMMUNITY TRUST AND FOCUS ON PRESSING THREATS TO PUBLIC SAFETY

A final point, of particular importance to *amici,* bears emphasis. If EMTALA's safe-harbor provision does not preempt conflicting state laws—and if law enforcement is required to enforce vague and amorphous state laws criminalizing abortion—it will undermine the investigation and prosecution of serious criminal offenses.

Emergency medical professionals, including physicians and nurses, are often the first point of contact for survivors of violent crime.[25] These professionals are in a critical position to detect, report, and assist in investigating serious crime. Local prosecutors and law enforcement must develop and maintain a relationship of trust with medical professionals in their communities, especially given that mandatory reporting laws do not cover all crimes reported to medical professionals.[26]

---

[25] J.P. Shephard, *Emergency medicine and police collaboration to prevent community violence*, 38 Annals Emergency Med. 430–37 (2001).

[26] *See, e.g.*, Joel M. Geiderman & Catherine A. Marco, *Mandatory and permissive reporting laws: obligations, challenges, moral*

If, however, medical professionals are exposed to prosecutorial second-guessing of their reasoned medical judgment on the basis of ill-defined state criminal laws, those relationships will be strained. Doctors, nurses, and medical professionals are far less likely to cooperate with law enforcement if they know that the next day, a prosecutor could charge them for providing care they believed was necessary to stabilize a patient. Signs that doctors are increasingly distrustful of law-enforcement are already apparent in the states that have purported to supersede EMTALA's requirements. In recent months, Idaho has witnessed a mass exodus of obstetrician-gynecologists spurred, in part, by doctors' fears that they could face prosecution if, by providing care they believe is required, they run afoul of state law criminalizing abortion.[27]

That is a dangerous state of affairs. Friction between law enforcement and the medical community could lead to serious crimes going unreported, undetected, and unpunished. It also risks directly interfering with the investigation and prosecution of the most serious crimes.

Imagine, for example, that a minor child is raped and becomes pregnant as a result. If that child is rushed to the hospital and needs emergency abortion

---

dilemmas, and opportunities, J. Am. Coll. Emergency Physicians 38–45 (2020).

[27] Angela Palermo, Idaho Statesman, *Idaho has lost 22% of its practicing obstetricians in the last 15 months, report says*, THE SEATTLE TIMES (Feb. 21, 2024).

care—a probable occurrence given the disproportionate rate of complications amongst children who become pregnant[28]—prosecutors and law enforcement must be able to build a relationship of trust with both the family and the treating medical professionals to investigate how that child became pregnant and secure their cooperation in any prosecution. But in states like Idaho (which contains no rape exception for abortion), the provision of an abortion in that context could subject doctors to criminal liability if a prosecutor determined it was not really "necessary" to save the child's life. The child's parents, too, could potentially face charges for aiding and abetting the abortion.[29] If medical professionals and families fear that an encounter with law enforcement may expose them to an investigation into the legitimacy of an emergency abortion, law enforcement's ability to investigate the crime that led to that abortion will be impaired. The uncertainties and ambiguities of state laws like Idaho's make such fears plausible.

Such a scenario creates an untenable situation for victims, prosecutors, and the community alike. The

---

[28] UT Southwestern Med. Ctr., *Pregnancy before 16 increases long-term health complications for girls and babies* (Apr. 11, 2023), https://utswmed.org/medblog/early-teen-pregnancy-health-risks/.

[29] The Oklahoma Attorney General, for example, has stated that Oklahoma's law "do[es] not contain independent exceptions for when the unborn child is conceived by rape," and that "Oklahoma law prohibits aiding and abetting the commission of an unlawful abortion." *See* Memorandum from the Oklahoma Attorney General, *supra* note 16, at 3.

investigation and prosecution of the rape of a child should be of the highest priority to law enforcement—and certainly is of the highest priority to *amici*. But state laws like Idaho's, unencumbered by EMTALA's preemptive provisions, will interfere with the investigation and prosecution of such serious offenses.

"[J]ustice," this Court has emphasized, "must satisfy the appearance of justice." *Offutt v. United States*, 348 U.S. 11, 14 (1954). Our legal system "depends in large measure on the public's willingness to respect and follow its decisions." *Williams-Yulee v. Fla. Bar*, 575 U.S. 433, 445–46 (2015). These admonitions are as true for prosecutors as they are for the courts. Where trust is lacking, public safety is compromised.[30] EMTALA's express preemption of state law should be enough for this Court to decide this case. But from a prosecutorial perspective, this Court's recognition of a narrow, preemptive baseline will eliminate the need for medically untrained prosecutors to make criminal charging decisions on the basis of amorphous state laws. That will help preserve community relationships. It will "satisfy the appearance of justice." *Offut*, 348 U.S. at 14. And it will bolster public trust and public safety.

---

[30] *See* Giffords Law Center to Prevent Gun Violence, *In Pursuit of Peace* (Sept. 9, 2021), https://giffords.org/report/in-pursuit-of-peace-building-police-community-trust-to-break-the-cycle-of-violence/ (violent crime rates increase in areas with a lack of public trust in law enforcement).

CONCLUSION

Finding that EMTALA preempts conflicting state law would ensure that doctors remain free to administer necessary stabilizing care—consistent with their decades-long understanding of the minimum obligations they owe patients, and free from fear of misguided police action or prosecutorial intervention. Doing so will save lives and ensure that criminal justice leaders can continue to serve their respective communities effectively.

For the foregoing reasons, the Court should find that EMTALA preempts conflicting state laws like Idaho Code § 18-622 and reinstate the district court injunction.

Respectfully submitted,

COREY STOUGHTON
Counsel of Record
RAJAT RANA
ADAM GOULD
SEAN GOLDMAN-HUNT
SELENDY GAY PLLC
1290 Avenue of the Americas
New York, New York 10104
(212) 390-9000
cstoughton@selendygay.com
Counsel for Amici Curiae

JONATHAN B. MILLER
AADIKA SINGH
PUBLIC RIGHTS PROJECT
490 43rd Street, Unit #115
Oakland, California 94609
(510) 738-6788
jon@publicrightsproject.org
Counsel for Amici Curiae

ELI SAVIT
VICTORIA BURTON-HARRIS
WASHTENAW COUNTY (MI) OFFICE
OF THE PROSECUTING ATTORNEY
200 N. Main Street
P.O. Box 8645
Ann Arbor, Michigan 48107
(734) 222-6620
savite@washtenaw.org

Dated: March 28, 2024

APPENDIX

TABLE OF APPENDICES

APPENDIX
LIST OF *AMICI CURIAE*

Eli Savit
Prosecuting Attorney
Washtenaw County, Michigan

Wesley Bell
Prosecuting Attorney
St. Louis County, Missouri

Joseph Brann
Former Chief of Police
Hayward County, California

Chris Burbank
Former Chief of Police
Salt Lake City, Utah

John Choi
County Attorney
Ramsey County, Minnesota

Laura Conover
County Attorney
Pima County, Arizona

Brendan Cox
Former Police Chief
City of Albany, New York

Kara Davis
District Attorney
Gilliam County, Oregon

Steve Descano
Commonwealth's Attorney
Fairfax County, Virginia

Matthew Ellis
District Attorney
Wasco County, Oregon

Ramin Fatehi
Commonwealth's Attorney
City of Norfolk, Virginia

Gil Garcetti
Former District Attorney
Los Angeles County, California

George Gascón
District Attorney
Los Angeles County, California

Deborah Gonzalez
District Attorney
City of Athens, Georgia

Kimberly Graham
County Attorney
Polk County, Iowa

Andrea Harrington
Former District Attorney
Berkshire County, Massachusetts

Natasha Irving
District Attorney
Bath, Maine

Justin Kollar
Former Prosecuting Attorney
Kauai County, Hawaii

Beth McCann
District Attorney
City of Denver, Colorado

Mary Moriarty
County Attorney
Hennepin County, Minnesota

Jenna Nelson
Prosecuting Attorney
Marquette County, Michigan

Abdul Pridgen
Former Chief of Police
City of San Leandro, California

Dalia Racine
District Attorney
Douglas County, Georgia

Ira Reiner
Former District Attorney
Los Angeles County, California
Former City Attorney
City of Los Angeles, California

Marian Ryan
District Attorney
Middlesex County, Massachusetts

Daniel Satterberg
Former Prosecuting Attorney
King County, Washington

Mike Schmidt
District Attorney
Multnomah County, Oregon

Carol Siemon
Former Prosecuting Attorney
Ingham County, Michigan

Eric Sparr
District Attorney
Winnebago County, Wisconsin

Shannon Taylor
Commonwealth's Attorney
Henrico County, Virginia

Matthew Van Houten
District Attorney
Tompkins County, New York

Kym Worthy
Prosecuting Attorney
Wayne County, Michigan