Nos. 23-726, 23-727

In The
Supreme Court of the United States

Mike Moyle, Speaker of the Idaho House of Representatives, et al., *Petitioners*

v.

United States of America, *Respondent*

State of Idaho, *Petitioner*

v.

United States of America, *Respondent*

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

Brief of *Amicus Curiae* National Right to Life Committee In Support of Petitioners

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Interests of Amicus Curiae[1]

Founded in 1968, the National Right to Life Committee, Inc. (NRLC) is the nation's oldest and largest pro-life organization. NRLC is the federation of 50 state right-to-life affiliates and more than 3,000 local chapters. Through education and legislation, NRLC is working to restore legal protection to the most defenseless members of our society who are threatened by abortion, infanticide, assisted suicide, and euthanasia.

Summary of the Argument

The Emergency Medical Treatment and Labor Act (EMTALA) sets a minimum requirement for emergency medical treatment, instead of establishing a uniform, national standard of care. EMTALA, which is part of the Medicare regime, does not confer an inherent right to emergency medical care but instead imposes conditions for hospitals to provide such care. The Department of Health and Human Services (HHS) lacks the authority to interpret EMTALA as prescribing abortion as a national standard of care. The legislative history of EMTALA underscores its limited scope and deference to state regulation, and Congress has historically rejected efforts to expand EMTALA's reach beyond its original anti-dumping purpose.

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[1] Rule 37.6 Statement: No party's counsel authored this brief in whole or in part; no party's counsel or party made a monetary contribution intended to fund the preparation or submission of this brief; and no person or entity other than amicus or its counsel funded it.

Federal agencies historically plays a complementary role to state healthcare laws, not a preemptive one. States share regulatory powers with the federal government over health facilities and must retain the authority to surpass federal protections. The bifurcated system ensures a balanced approach that respects state autonomy while providing a foundational level of care, fostering innovation, and addressing local health challenges to ensure the highest standard of care for patients.

Idaho, like all states, has a vested interest in maintaining its sovereign power to establish and implement medical care standards within its borders. The regulation of state medical boards and the definition of requirements for abortion practitioners and practices are quintessential examples of state governance in action. These state-defined requirements play a critical role in regulating and standardizing abortion care, allowing states to specify essential qualifications for abortion physicians, mandate comprehensive training standards, and define the standard of care for emergency treatment procedures. Such autonomy is crucial for states to effectively address the unique healthcare needs of their populations, ensuring that care is tailored to the specific realities and values of each state.

For these reasons, the Ninth Circuit's decision should be reversed.

Argument

I.
EMTALA establishes a baseline for emergency treatment, not a national standard of care.

HHS issued guidance erroneously interpreting EMTALA as requiring physicians to provide specific stabilizing treatments regardless of medical judgment or standards of care. See Centers for Medicare & Medicaid Services (CMS), *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (July 11, 2022).[2] The government employed the aforementioned guidance as a foundational basis to assert that Idaho's Defense of Life Act, Idaho Code § 18-622, contravenes federal legislation by precluding the provision of abortions when deemed "necessary" for stabilizing treatment pursuant to EMTALA.

A state is under no constitutional duty to provide substantive services for those within its border. *Youngberg* v. *Romeo*, 457 U.S. 307, 317 (1982); *Harris* v. *McRae*, 448 U.S. 297, 318 (1980) (upholding the Hyde Amendment, which restricted the use of federal funds for abortions); *Maher* v. *Roe*, 432 U.S. 464, 469 (1977) (finding no constitutional requirement for states to fund non-therapeutic abortions)). Healthcare providers should not be subjected to a novel duty

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[2] The HHS guidance reads:
"If a physician believes that a pregnant woman presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician *must* provide that treatment."
Id.

departing from this precedent.

By suggesting EMTALA effectively conscripts Medicare-participating facilities to treat any and all emergency conditions, HHS ignores these limiting principles. Its guidance articulates a nebulous standard that could require providers to render unpaid treatment any time a patient has an urgent medical concern. This stretches EMTALA far beyond its statutory intent into unprecedented territory.

Exacerbating this problem, HHS also unlawfully presumes to dictate specific elements of emergency care. However, federalism does not empower federal agencies to establish national standards of medical practice. That would infringe on the states' sovereign powers over healthcare quality regulation. In effect, HHS has claimed for itself the ability not just to invent duties, but to define the particular clinical standards by which those obligations must be discharged. This usurpation finds no support in statute or precedent. EMTALA cannot override the fundamental notion that "the Constitution is not a medical code that mandates specific medical treatment." *Snipes* v. *DeTella*, 95 F.3d 586, 592 (7th Cir. 1996).

A. Executive agency overreach exceeds the anti-dumping statutory framework enacted by Congress.

The legislative history of EMTALA underscores its narrow focus on safeguarding indigent patients, explicitly deferring to state medical practice laws, and resisting congressional efforts to broaden its scope beyond preventing patient dumping. EMTALA is under the purview of HHS. Specifically, HHS delegates

regulatory and enforcement authority over EMTALA between two federal bodies: the CMS and the Office of Inspector General, U.S. Department of Health and Human Services (OIG). By expanding EMTALA's limited purpose through regulatory and enforcement actions beyond what Congress intended, these agencies have effectively usurped the legislature's constitutional authority to write this nation's laws.

1. EMTALA's legislative history reinforces its limited scope on state regulation.

EMTALA was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. See Pub. L. 99- 272, §9121(b), 100 Stat. 164-167 (codified as amended 42 U.S.C. 1395dd). EMTALA was introduced in response to growing concerns over the practice of "patient dumping," in which hospitals would transfer uninsured or indigent patients to other hospitals without first stabilizing their emergency medical conditions.[3] See *Marshall* v. *East Carroll Parish Hosp.*, 134 F.3d 319, 322 (5th Cir. 1998); *Summers* v. *Baptist Medical Center Arkadelphia*, 91 F.3d 1132, 1136-37 (8th Cir. 1996).

As the House Report explained, Congress was "'concerned about the increasing number of reports that hospital emergency rooms are refusing to accept

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[3] Lynn Healey Scaduto, *The Emergency Medical Treatment and Active Labor Act Gone Astray: A Proposal to Reclaim EMTALA for Its Intended Beneficiaries*, 46 UCLA L. Rev. 943, 948 (1999) ("The legislative history strongly supports the conclusion that the intent behind EMTALA was to deter what Congress perceived to be the burgeoning practice among hospital emergency rooms of dumping indigent and uninsured patients.").

or treat patients with emergency conditions if the patient does not have medical insurance." (H.R. Rep. No. 99-241, Pt. 1, at 27, 1985). Concurrently, the House Committee Report acknowledged the impetus of "growing concern about the provision of adequate emergency room services to individuals who seek care, particularly as to the indigent and uninsured." H.R. Rep. No. 241(III), 99th Cong., 1st Sess. 6-7. Hence EMTALA simultaneously clarified emergency care duties under Medicare while addressing access barriers for marginalized populations.[4]

EMTALA's original purpose of enactment, to prevent hospital emergency department refusal to low-income and indigent patients, poses no conflict to federalism. However, HHS's overbroad interpretation of EMTALA stabilization duties detaches mandates from legislative intent of serving vulnerable populations. Further, such open-ended regulatory discretion may diminish emergency care access for the low-income patients EMTALA sought to protect. Particularly in resource-constrained settings disproportionately serving Medicaid and uninsured populations, broad EMTALA interpretations regarding abortion services could limit staffing and capacity for true emergency care needs. Hence, HHS effectively undermines EMTALA's limited purpose by overextending stabilization duties beyond original

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[4] See 131 Cong. Rec. 28,568 (1985) (statement of Sen. Durenberger) ("[The] practice of rejecting indigent patients in life threatening situations for economic reasons alone is unconscionable… . Congress and the State legislatures are groping for areas to get quality health care to the uninsured Americans.").

intent.

2. HHS interpretation of "stabilizing treatment" contradicts plain language of EMTALA and previous agency guidance.

HHS's attempt to discover an abortion mandate within EMTALA's limited stabilization requirement for emergency medical conditions exceeds the bounds of regulatory authority granted by Congress. EMTALA contains no language expressly directing abortion services. Rather, HHS is reaching beyond EMTALA's text and structure to insert its own policy preferences favoring abortion access. This overreach contravenes foundational limits on agency power.

HHS has issued guidance purporting to discover a federal abortion mandate in EMTALA's requirement to provide stabilizing treatment. See Centers for Medicare & Medicaid Services (CMS), *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (July 11, 2022). But this mandate exists only from HHS's erroneous interpretation, not EMTALA's text. The guidance represents a stark example of agency overreach— HHS conjuring new regulatory powers on a political whim. Moreover, this guidance is contradictory to the final rule that HHS published in September 2003 clarifying "EMTALA does not purport to establish a medical malpractice cause of action nor establish a national standard of care." See Medicare Program; *Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions*, 68 Fed. Reg. 53,222, 53,222 (Sept. 9, 2003)

(codified at 42 C.F.R. 489.24).[5]

HHS's broad preemption interpretation also directly conflicts with EMTALA's plain statutory language that "the provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement *directly conflicts* with a requirement of this section." 42 U.S.C. 1395dd(f) (emphasis added). This unambiguous text signals Congress's intent to allow state laws to reinforce and supplement EMTALA's federal emergency care requirements.

Moreover, EMTALA must be interpreted in light of both the surrounding statutory framework and the Medicare Act's overarching purpose. As this Court has held, the meaning of an express preemption provision turns on "the statutory framework surrounding it" and "the structure and purpose of the statute as a whole." *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470 (1996). Here, the Medicare Act expressly disclaims federal control over medical practice, stating "Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." 42 U.S.C. 1395. This provision supports the conclusion that EMTALA allows complementary state regulation of emergency medical care.

EMTALA explicitly preserves state regulation of medical practice and standards of care. The Medicare Prohibition applies as "[n]othing in this subchapter

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[5] *Id.* ("These reiterations and clarifying changes are needed to ensure uniform and consistent application of policy and to avoid any misunderstanding of EMTALA requirements by individuals, physicians, or hospital employees.").

shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." 42 U.S.C. 1395. This provision bars any interpretation of EMTALA as imposing federal control over medical decision-making, an area long governed by state law.

EMTALA also contains an express preemption clause limiting its effect on state laws: "The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. 1395dd(f). This clause indicates EMTALA will displace state law only where compliance with both statutes is impossible, not based on generalized supposed obstacles to statutory purpose and objectives. See *PLIVA, Inc. v. Mensing*, 564 U.S. 604, 617 (2011) (describing types of preemption).

Together, these provisions signal Congress's intent for EMTALA to leave intact state laws on medical practice and standards of care. As this Court has emphasized, "[t]he case for federal preemption is particularly weak where Congress has indicated its awareness of the operation of state law in a field of federal interest, and has nonetheless decided to stand by both concepts and to tolerate whatever tension there is between them." *Wyeth v. Levine*, 555 U.S. 555, 575 (2009) (quoting *Bonito Boats, Inc. v. Thunder Craft Boats, Inc.*, 489 U.S. 141, 166-167 (1989). That principle squarely applies to EMTALA and state regulation of medicine.

This statutory language and interpretive guidance indicate EMTALA does not impose federal standards of care overriding state medical practice laws. Congress

explicitly preserved state authority in this traditional area of state police powers. Any interpretation of EMTALA as an abortion mandate or other federalization of emergency medicine would contravene this deference to state sovereignty.

B. States retain authority to establish heightened emergency care protections that exceed federal regulatory floor.

A national standard of emergency care could actually undermine states that have worked diligently to implement robust systems to optimize emergency services. Regional differences in risk factors, capacity, and resources mean that emergency care needs vary across states. Allowing state policymakers who best understand their jurisdiction's unique needs to tailor heightened protections gives them better tools to ensure their medical infrastructure and workforce are equipped to save lives when seconds count. Eliminating this flexibility in favor of a single national standard risks deteriorating emergency care capabilities in states that have prioritized developing stringent emergency medicine safeguards for their citizens.

1. The federal government has a history of complementary, not preemptive, function with state healthcare laws.

Two seminal cases reinforce states' primacy in regulating medical practice. In *Linder* v. *United States*, this Court invalidated direct federal control over physicians' prescriptions, deferring instead to state

medical regulations. 268 U.S. 5, 18 (1925). More recently, in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, this Court upheld a state law affecting insurance payments for hospital services against a federal preemption challenge. 514 U.S. 645, 654 (1995). Through these rulings, the court established that states retain oversight over healthcare regulations when a federal agency oversteps its authority.

The regulation of healthcare facilities involves layers of overlapping state and federal laws. While states retain broad authority to license facilities, Congress enacted Medicare Conditions of Participation which facilities must meet to qualify for federal healthcare program reimbursement. 42 C.F.R. 482.13(b) (CMS "Condition of participation: Patient's rights"); 42 C.F.R. 482.24(c)(4)(v) (CMS "Condition of participation: medical record services"). Thus, Medicare and Medicaid certification requires compliance with both state and federal requirements. This provides a check and balance between the two sovereigns.[6] States retain power to address local

[6] See 42 U.S.C. 299b-21(7)(B)(iii)(II) (providing that network reporting entities may disclose patient identifiable health information as a "report[ ] of information . . . to a Federal, State, or local governmental agency for the purpose of preventing or controlling disease"); *id.* 299b-21(7)(B)(iii)(III) (allowing network reporting entities to use or disclose patient identifiable health information that they are otherwise prohibited from using or disclosing "to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law" including "any record keeping obligation . . . under Federal, State, or local law").

concerns and needs, while the CMS ensures baseline standards for quality and safety.

Similar federal regulations, such as Section 353 of the Public Health Service Act (PHSA) and the Health Insurance Portability and Accountability Act (HIPAA), reinforce that federal requirements are meant to complement, not eliminate, state regulation of medical practice and liability.

It is an explicit requirement for participation in Medicare that a hospital operate a laboratory that complies with the Clinical Laboratory Improvement Amendments of 1988 (CLIA). See 42 C.F.R. 482.27(a); see also 42 U.S.C 263a(b). CLIA-certified laboratories must adhere to particular standards and requirements pertaining to each test they conduct. See 42 C.F.R. 493.2. Section 353 of the Public Health Service Act (PHSA) provides an exemption for laboratories from CLIA requirements in states that have legal requirements equal to or more stringent than CLIA. 42 C.F.R. 493. This framework allows balancing national consistency with state flexibility to enhance protections.

HIPAA established national standards for the protection of health information. 42 U.S.C. 1320d. HIPAA sets a baseline federal standard for health privacy and security protections. *Id.* The HIPAA statute explicitly permits state laws that provide greater privacy protections or afford patients enhanced rights. 45 C.F.R. 160.203(b). For example, California mandates breach notification rules, confidentiality safeguards, and patient consent requirements that expand upon federal regulation. Cal. Ins. Code §10273.4-6. This framework balances consistency across jurisdictions with flexibility to address local

privacy priorities. States can build upon the HIPAA foundation to further regulate health entities within their borders.

2. State responsiveness to local realities enables adaptive protections.

Under 42 CFR 489.24(b), hospitals can go on drive-by status if they lack "qualified personnel or transportation" required for treatment. This regulation demonstrates that while hospitals have treatment duties, these are limited by capacity constraints. State tailoring allows policy alignment with local capacity and expertise limitations unforeseen federally. 42 CFR 489.24(b)(4) affirms hospital authority to redirect incoming ambulances when reaching drive-by status due to capacity saturation or capability constraints. While access has public value, so does preserving institutional competence. Reasonable drive-by policies represent careful state calibration to reconcile these competing imperatives.

States have crafted emergency department regulations to address local needs, creating a spectrum of standards across jurisdictions. Texas imposes minimal constraints on free-standing emergency departments (FSEDs), allowing flexible independent and hospital-affiliated models meeting EMTALA minimums.[7] This promotes healthcare industry growth. Meanwhile, California prohibits FSEDs under

[7] Gutierrez, Catherine et al. *State Regulation Of Freestanding Emergency Departments Varies Widely, Affecting Location, Growth, And Services Provided*, Health affairs (Project Hope) vol. 35,10, Oct., 2016.

its hospital laws to control costs.[8] Most states fall between these poles, like Indiana which requires FSEDs to be hospital-affiliated but exempts rural locales.[9] Varied state regulation lets policies keep pace with local healthcare priorities whether economic development, cost-control, or rural access. While EMTALA ensures a common baseline, state tailoring then optimizes consumer protections for regional contexts. Complete state inflexibility could erode specialized, quality care contrary to patient interests.

Though patient dumping risks call for narrow construction, state leeway to authorize drive-by procedures is federally sanctioned when departments would otherwise deliver substandard, unsafe care. Thus judicious state regulation enables context-appropriate protections compared to rigid universal mandates.

3. States mandate operational, staffing, and capability standards that surpass EMTALA's stringent requirements.

While EMTALA mandates baseline emergency treatment standards, many states have created additional licensure and oversight systems to improve services. For example, 24 states require newly established FSEDs to obtain certificates of need certifying community healthcare need.[10] 21 other states compel FSEDs to acquire state licenses demonstrating

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[8] *Id.*

[9] *Id.*

[10] *Id.*

compliance with operational, staffing, and capability standards exceeding EMTALA's requirements.[11] Some states like New York and Washington regulate FSEDs tightly through individualized approvals.[12] These examples show state legislators leveraging their discretion to prioritize healthcare availability through Certificates of Need (CON) and licensure laws supplementing EMTALA's protections.[13]

States also increasingly regulate a new care model called rural emergency hospitals (REHs).[14] REHs continue emergency and outpatient services in rural areas where sustaining full-service hospitals has become challenging. State oversight ensures quality standards are maintained even as rural healthcare systems adapt. In all cases, additional state licensing and CON requirements on top of EMTALA mandate further institutional accountability towards patients beyond federal law.

II.
Idaho has a vested interest in maintaining its sovereign power to establish and implement medical care standards within its own borders.

The Tenth Amendment reserves powers not expressly delegated to the federal government under the Constitution to the state governments. U.S. Const.

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[11] *Id.*

[12] *Id.*

[13] *Id.*

[14] Isaac "Zack" D. Buck, *Financing Rural Health Care*, 124 W. VA. L. REV. 801 (2022).

amend. X. Regulating health, safety, and welfare through professional licensure is a longstanding component of states' police powers under this framework of federalism. See *Douglas* v. *Noble*, 261 U.S. 165 (1923) (upholding state's power to license dentists); *Graves* v. *Minnesota*, 272 U.S. 425 (1926) (upholding state's regulation of licensed dentists and physicians); *Williamson* v. *Lee Optical Co.*, 348 U.S. 483 (1955) (upholding state law regulating opticians as legitimate use of state's police power); *Florida* v. *Thomas*, 532 U.S. 774 (2001) (upholding state's police power to regulate health professions through licensure)

Extrapolating from the Court's signals, federal legislation displacing state governance of medical professional licensure would likely cross the line into unconstitutional overreach. Professional integrity, competency examinations, disciplinary procedures, and scopes of practice have remained squarely within state medical boards' authority throughout case law.

State-based medical licensure has served as the longstanding, legal mechanism granting authority to practice medicine in America.[15] Through localized legislation and administrative controls, states enact statutory schemes stipulating training prerequisites, scope of practice limitations and consequences for infractions among physicians seeking to legally treat patients within well-delineated boundaries.

In a line of precedent spanning over 130 years, the Supreme Court has consistently upheld medical

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[15] See Nadia Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. Health Care L. & Pol'y 285, 289-94 (2010) (tracing state authority to establish medical licensing boards through its history and practice).

licensure as within states' prerogative. In *Dent v. West Virginia*, 129 U.S. 114 (1889), this Court upheld West Virginia's physician licensing system as a valid use of state police power. The power vested to states to provide for the general welfare authorizes state regulation of the medical profession to safeguard citizens from "ignorance and incapacity as well as of deception and fraud." *Id.* at 122. In *Hawker v. New York*, 170 U.S. 189, 194 (1898), this Court reaffirmed this reasoning in determining that character is as important a qualification as knowledge, and if a state may properly require a defined course of study, or a certain examination as to learning, then a state may equally prescribe what evidence of good character is required for licensing. In *Gonzales v. Oregon*, 546 U.S. 243, 270, (2006), this Court prevented federal interference with Oregon's standards governing prescription of certain controlled substances, rooting its opinion in "the structure and limitations of federalism."

Modern constitutional interpretation provides greater latitude for federal legislation regulating economic conduct with substantial interstate effects. *Gonzales v. Raich*, 545 U.S. 1, 16-17 (2005) and *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 577-78 (2012) opened the door to Congress exercising its Commerce Clause powers to mandate or restrict certain activities despite their intrastate nature. In theory, then, some federal healthcare laws could potentially align with this expansive Commerce Clause precedent, if structured appropriately.

Wholesale preemption of those state licensing functions would contravene both judicial precedent and federalism principles. It raises anti-commandeering

concerns by imposing affirmative implementation burdens onto states. *See Printz v. United States*, 521 U.S. 898, 935 (1997) ("The Federal Government may neither issue directives requiring the States to address particular problems, nor command the States' officers, or those of their political subdivisions, to administer or enforce a federal regulatory program."). Such measures would warrant skeptical scrutiny from courts under existing standards for preserving states' constitutional role as arbiters of qualifications and ethical conduct of medical professionals.

State-based variability in licensing enables localized priorities and customization based on unique needs among constituents. As technology facilitates telemedicine across borders, lively debate continues regarding preserving state primacy in licensing physicians versus ceding determination of professional qualifications to federal agencies.[16] State flexibility remains vital as states must retain latitude to impose standards above any hypothetical federal regulatory floor to sustain quality and safety assurances.

A. Medical negligence claims in emergency departments fall under state malpractice law, not EMTALA.

Pursuant to EMTALA, all Medicare-participating

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[16] See Lindsey T. Goehring, *H.R. 2068: Expansion of Quality or Quantity in Telemedicine in the Rural Trenches of America?*, 11 N.C. J.L. & TECH. ONLINE 99, 103 (2009) (arguing that the interpretation of the Tenth Amendment precludes the federal government from regulating aspects of telemedicine that are within state borders).

hospitals offering emergency services must adhere to exacting federal requirements. First, the hospital must provide any individual who arrives at the emergency department requesting examination or treatment an appropriate medical screening to identify whether an emergency medical condition exists. 42 U.S.C. 1395dd(a). The statute specifically defines emergency medical condition as one manifesting itself through acute symptoms of sufficient severity that absence of immediate medical attention could reasonably result in serious medical risk. Secondly, if the medical screening reveals an emergency medical condition, the hospital must further offer stabilizing treatment within its capacities. 42 U.S.C. 1395dd(e)(3)(A). Should the hospital lack adequate capability to fully stabilize the patient, it maintains the duty to implement an appropriate transfer to another facility equipped to offer essential curative care. 42 U.S.C. 1395dd(c)(1)(B) (requiring the transfer to be "appropriate"). EMTALA confers these protections universally to all patients presenting at emergency departments, not merely Medicare beneficiaries.

Hospitals face civil monetary penalties of up to $50,000 per violation. 42 U.S.C. 1395dd(d)(1)(A)-(B). Each responsible physician can face a penalty of not more than $50,000 for each individual violation. 42 U.S.C. 1395dd(d)(1)(B). In addition to monetary penalties, severe violations can lead to termination of the hospital or provider's Medicare Provider Agreement. See Office of Inspector Gen., *The Emergency Medical Treatment and Labor Act: The Enforcement Process*, 6 (2001).

EMTALA was enacted to ensure public access to emergency care, not to establish federal medical

malpractice law. EMTALA does not provide a cause of action for negligent emergency screening, diagnosis or treatment. These constitute state law claims.

The Ninth Circuit has established that inadequate screening does not constitute an EMTALA violation provided the screening is applied uniformly, as this statute does not impose a national standard of care; rather, negligent screening gives rise to a state law claim. *Jackson v. E. Bay Hosp.*, 246 F.3d 1248, 1254 (9th Cir. 2001); see also *Bryant v. Adventist Health System/West*, 289 F.3d
1162, 1168 (9th Cir. 2002) (holding that a hospital's duty to stabilize terminates upon a patient's good faith inpatient admission, with negligent treatment post-admission falling under medical malpractice law, not EMTALA violations)).

Furthermore, the Eighth Circuit has emphasized that even non-uniform screening is governed by state malpractice law rather than EMTALA, as nearly any instance of negligent emergency department screening or diagnosis could be characterized as non-uniform treatment, such that findings of negligence pertain to state medical malpractice law and not EMTALA. *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1136–38 (8th Cir. 1996).

As evidenced in these cases and EMTALA's plain language, the statute sets a floor for non-discriminatory emergency access, not a federal malpractice standard. Negligent emergency care claims have always resided under state jurisdiction.

B. State-defined requirements for abortion regulation play a critical role in regulating and standardizing care.

States have historically regulated the provision of abortion services by establishing legal requirements for facilities and practitioners. These laws seek to ensure patient safety and standardized quality of care when accessing this medically and ethically complex procedure. While the federal government may establish overarching legislation and legal precedent on abortion rights, the implementation and oversight of clinical standards has traditionally fallen under states' jurisdiction. State policies often mandate provider qualifications, facility protocols, informed consent processes, and reporting procedures specifically for abortion services.

Furthermore, the federalist structure of American government delineates state and federal authority. Thus, while the federal government may issue rulings relating to privacy rights and abortion access on a national level, it cannot simply override or fail to enforce longstanding state laws governing abortion providers and clinics. Overturning such state-defined requirements would undermine established governmental boundaries. Therefore, state policies constitute essential, constitutional oversight measures for standardizing abortion care provision.

1. States must be granted rights to specify the essential qualifications required of physicians.

States have enacted widely divergent laws regarding which medical providers may perform abortion services. A majority of states mandate that surgical abortions be performed by licensed physicians.

However, these physician requirements may overburden the healthcare system and reduce access to care, especially in rural areas with few providers. States with less restrictive laws allowing non-physician practitioners to provide medication or procedural abortions can meet patient demand without depleting resources. The interests of public health are best served by avoiding overly burdensome physician requirements that could diminish the quality and availability of care.

The majority of states only permit licensed physicians to perform surgical abortions.[17] For example, Idaho law mandates that surgical abortions must be performed by a licensed physician in a hospital or licensed abortion facility. Idaho Code §18-608a. Most other states have similar laws.[18] The practical effect of restricting surgical abortions to physicians only is that it overburdens the physician workforce and reduces access to care. Rural areas often have few physicians to begin with, let alone those willing and able to perform abortions. Requiring that all surgical abortions be performed by this single doctor would make access nearly impossible for most patients. The

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[17] Nat'l Conference of State Legislatures, State Abortion Laws: Protections and Restrictions January 29, 2024 https://www.ncsl.org/health/state-abortion-laws-protections-and-restrictions

[18] *Id.* Alabama, Alaska, American Samoa, Arizona, Arkansas, Florida, Georgia, Guam, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota*, Missouri, Mississippi, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, U.S. Virgin Islands, Utah, Wisconsin, and Wyoming.

quality of care may also suffer if the lone physician is overwhelmed with procedural and follow-up visits.

A growing minority of states require two physicians be present to perform abortions after 22 weeks gestation.[19] However, for many healthcare facilities, having two specialized physicians concurrently available to provide a time-sensitive abortion procedure past 22 weeks represents an insurmountable obstacle. Expecting both physicians to be physically present any time a 22-week abortion proves medically necessary is entirely impractical and would significantly restrict patient access.

EMTALA threatens this state authority by effectively preempting certain laws on abortion provider qualifications designed to balance access and clinical competency. South Carolina codified additional training and board certification requirements for physicians performing abortions after 14 weeks gestation.[20] This law embodies the state's judgment that later abortions necessitate heightened provider qualifications to minimize patient risk. Still, EMTALA may compel South Carolina hospitals to perform emergency abortions in violation of the state mandate if no physician on call meets the heightened qualifications.

Effectively, EMTALA denies states flexibility to regulate provider competency standards even when aimed at patient safety. A rural hospital with few

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[19] See An Overview of Abortion Laws, GUTTMACHER INST. (Nov. 23, 2022), https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions

[20] S.C. Code Regs. 61-12, Part III

abortion specialists on call may face impossible choices pitting federal obligations against state public health laws. Moreover, EMTALA rejects state judgments about the clinical capabilities required for later-term abortion procedures. Federal law should not discount reasoned determinations by state medical boards that advanced training and certification is necessary for physicians performing risky second-trimester abortions. Yet EMTALA forces hospitals to disregard such expert safety mandates whenever emergency care is sought.

2. States require the ability to mandate comprehensive training standards.

States have a recognized duty grounded in police powers to safeguard public health within their borders. This encompasses regulating the medical profession to ensure clinical competency, including through advanced certification and training rules for complex procedures like abortion. However, EMTALA actively hinders state efforts to guarantee abortion provider proficiency.

Federal law only requires basic abortion education in OB/GYN residencies, allowing other programs to omit such training entirely.[21] The Accreditation Council for Graduate Medical Education (ACGME) merely requires OB/GYN programs provide "access" to abortion education, with no mandate that residents

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[21] Congressional Research Service, Abortion Training for Medical Students and Residents, September 7, 2022, https://crsreports.congress.gov/product/pdf/IN/IN12002

gain actual clinical experience.[22] Further, federal religious/moral exemption policies enable entire medical school classes to opt-out of abortion instruction.[23]

This lax federal oversight prompts states like South Carolina to demand advanced credentials - board certification in OB/GYN, surgery or family medicine - to perform later-term abortions. Yet EMTALA enforcement negates South Carolina's expert judgment that heightened qualifications are essential to patient safety for second-trimester procedures.

The inevitable result is physicians nationwide called upon to perform risky emergency abortions with inadequate, and sometimes nonexistent, training in the procedure. The potential for harm to women's reproductive health is obvious and unacceptable. Yet EMTALA denies states power to mitigate safety risks through stricter provider competency measures.

By overriding state abortion training laws in the name of emergency access, EMTALA severely erodes patient safety guardrails. Allowing barely-trained physicians to perform complex second-trimester abortions poses grave risks of irreparable harm.[24] Until federal requirements for thorough abortion education

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[22] *Id.*

[23] *Id.*

[24] Code of Ethics for Emergency Physicians, 70 Annals of Emergency Medicine 1, E7-E15 (July 1, 2017) ("In order to protect patients from avoidable harm, physicians who lack appropriate training and experience in emergency medicine should not misrepresent themselves as emergency physicians and should not practice without supervision in the emergency department or prehospital setting.").

are strengthened, EMTALA must yield to state laws ensuring provider qualifications through advanced certification. Protecting women's health demands nothing less.

Many states have enacted laws that specifically restrict the provision of abortion services, including the prohibition of such services in public institutions.[25] This directly impacts medical education and training programs, as a significant portion of clinical training occurs in public hospitals and health centers. When these institutions are barred from providing abortion services, medical students and residents lose critical opportunities to gain experience in performing these procedures under the supervision of experienced professionals. This gap in training is not merely a theoretical concern but a practical barrier to ensuring that all medical professionals are adequately prepared to provide comprehensive care in accordance with EMTALA requirements.

The suggestion that medical students should seek training opportunities across state lines to circumvent local restrictions is impractical and ignores the realities of medical education. Medical students and residents are often constrained by the demands of their educational programs, including coursework, clinical rotations, and exams. The expectation that they would have the time, resources, and flexibility to travel significant distances for abortion procedure training is unrealistic.

Furthermore, such an expectation places an undue burden on students, potentially exacerbating existing inequalities in medical education. Students from lower

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[25] *Id.*

socioeconomic backgrounds may find it particularly challenging to afford travel and accommodation expenses associated with out-of-state training. This could lead to a situation where only those with sufficient financial resources can access comprehensive training, further entrenching disparities within the medical profession.

3. States define the standard of care for emergency treatment procedures, not EMTALA

States have long had authority to regulate medical practice to protect public welfare. This includes disciplining physicians who fail to meet accepted standards of care, even without proof of patient harm. As state agencies, medical boards are authorized to determine if a physician's conduct meets community standards. If not, discipline may follow to deter future violations. This furthers states' interest in maintaining quality healthcare.

Circumstances vary between states, so a uniform nationwide standard of care is often impractical. States are best positioned to evaluate factors unique to their jurisdictions and adopt responsive medical standards.[26]

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[26] Idaho Code §54-1814(7) provides that a licensed physician is subject to discipline by the Board if the physician provides health care "which fails to meet the standard of health care provided by other qualified physicians in the same community or similar communities, taking into account his training, experience and the degree of expertise to which he holds himself out to the public." See *Woodfield v. Bd. of Prof'l Discipline of the Idaho State Bd. of Med.*, 127 Idaho 738, 742, 905 P.2d 1047, 1051 (Ct. App. 1995)

Imposing a rigid federal standard could force states to allow procedures they deem harmful or inappropriate. This infringes on state police powers over healthcare.

While EMTALA prohibits hospitals from turning away emergency patients based on inability to pay, it was not intended to nationalize standards of care. Doing so for abortion could force physicians to perform procedures against state law and medical board rules. It would also override state determinations that abortion is not necessary emergency care. Federal law should not dictate appropriate emergency medical responses reserved to the states.

Conclusion

For the foregoing reasons, this Court should reverse the decisions of the Ninth Circuit.

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