No. 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 AMERICAN PUBLIC HEALTH ASSOCIATION, ROBERT WOOD JOHNSON FOUNDATION, NETWORK FOR PUBLIC HEALTH LAW, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AND 133 DEANS AND SCHOLARS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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INTERESTS OF *AMICI CURIAE* [1]

Amici public health organizations include the American Public Health Association, the Robert Wood Johnson Foundation, the Network for Public Health Law, and the American Medical Women's Association. Collectively, these organizations count as members tens of thousands of public health professionals. *Amici* also include the oldest multispecialty organization dedicated to advancing women in medicine and improving women's health. They advocate for the power of public health law and policy to make communities safer, and they are committed to improving health and health equity in the United States. The members of *Amici* public health organizations have both the lived experience of providing emergency healthcare services and a concrete interest in maintaining the critical nationwide standards imposed by the Emergency Medical Treatment and Labor Act ("EMTALA").

The individual *Amici* are a group of 133 distinguished deans and professors of disciplines spanning the health professions, public health, and health law and policy with deep expertise in policies that promote population health and alleviate barriers to care. They are identified in the Appendix.[2] Their expertise bears on the issues presented in this appeal, including the vital role played by federal policy in shaping the U.S. health care system, the history,

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[1] Pursuant to Supreme Court Rule 37.6, Amici certify that no party or counsel for a party authored this brief in whole or in part, and no party other than Amici or their counsel contributed money to fund the brief.

[2] All individual *Amici* write in their individual capacities and not as representatives of their institutions.

purpose, and text of EMTALA and its implementing regulations, and how Congress used its spending powers to ensure timely, appropriate emergency care for all people in the United States, including pregnant women.

Amici collectively file this brief to assist the Court in its consideration of these extremely important questions by explaining the basis for EMTALA's national guarantees and why those guarantees preempt Idaho's contradictory law.

SUMMARY OF THE ARGUMENT

A legal landmark, EMTALA guarantees emergency medical screening and stabilization nationwide. EMTALA's protections are narrow but powerful; they set a uniform nationwide foundation of emergency care for all individuals and are thus vital to public health. Assuring access to emergency care during pregnancy was one of EMTALA's central goals. Permitting states to undermine this federal guarantee by carving out disfavored emergency care during pregnancy would be catastrophic.

Congress enacted EMTALA as an express condition of hospital Medicare participation, like numerous other statutory and regulatory obligations that govern participating providers and the services they offer. Just two terms ago, this Court reaffirmed Congress's broad authority to enact public health measures through its regulation of federal health care programs in *Biden v. Missouri.*

EMTALA expressly preempts state laws that directly conflict with the emergency care obligations it imposes on Medicare-participating hospitals. Idaho

Code § 18-622 ("Section 18-622") criminalizes the provision of abortion care in nearly all circumstances. But abortion care may be the necessary stabilizing treatment for pregnant women experiencing an emergency medical condition in certain circumstances. Thus, where a treating emergency room physician determines that abortion is a medically reasonable treatment to stabilize the health of a patient, EMTALA commands that the patient have access to such care. Accordingly, to the extent Section 18-622 forecloses such stabilizing treatment, it must give way to the federal law.

Petitioners mischaracterize EMTALA's text and purpose. Furthermore, they ground their fearmongering portrayal of emergency departments as potential "abortion enclaves" in a fundamental misunderstanding of emergency care and the operation of emergency departments. These critical and resource-limited facilities are not equipped or prepared for non-emergency, elective care—and certainly not non-emergent abortion. Terminating pregnancies is an exceptionally rare event in emergency departments. Moreover, Section 18-622 threatens to impose a chilling effect on a vast range of emergency care for pregnant women, since the loss of a pregnancy may be the unavoidable result of emergency care for non-obstetric emergencies.

Finally, Petitioners' assertion that EMTALA allows states to carve out disfavored emergency treatments opens the door to state laws that excise from EMTALA a host of disfavored conditions, populations, and treatments, thereby eviscerating the very purpose of the law. The Court should reject this position and protect EMTALA's federal guarantees.

ARGUMENT

Amici public health organizations, deans and scholars believe this case presents a matter of great and urgent public health concern. A federal health policy landmark, EMTALA, codified at 42 U.S.C. § 1395dd, creates a federal duty for all Medicare participating hospitals with emergency departments to provide emergency care to all individuals. Although this Court's decision in *Dobbs v. Jackson Women's Health Organization,* 597 U.S. 215, 232 (2022), overruled *Roe v. Wade*, 410 U.S. 113 (1973) and "return[ed] the issue of abortion to the people's elected representatives," nothing in the Court's decision eclipsed EMTALA's narrow but powerful duty, which requires the provision of stabilizing emergency care to prevent severe and long-lasting health injury, in accordance with professional medical judgment. As the district court correctly found, under limited circumstances, such stabilizing care for pregnant women facing emergencies can require abortion. Section 18-622 criminalizes the provision of abortion unless doing so is "necessary" to prevent the pregnant woman's death, and thus prohibits abortion care short of care needed to save a patient's life. Section 18-622 thereby criminalizes abortions in situations in which EMTALA would mandate stabilizing care. This clear conflict requires preemption of Section 18-622.

I. EMTALA Guarantees All Individuals Access to Emergency Health Care.

Prior to EMTALA's enactment, hospitals regularly turned away indigent patients unable to pay for care, including women in labor; even when patients made it through the door, they were in some

cases left to languish untreated. *See, e.g.*, *Campbell v. Mincey*, 413 F. Supp. 16 (N.D. Miss. 1975) (infant delivered in refusing hospital's parking lot); *New Biloxi Hosp., Inc. v. Frazier*, 146 So. 2d 882 (Miss. 1962) (gunshot victim openly bled out in emergency department for two hours before transfer). This practice of "patient dumping" resulted in numerous reports of serious injuries and death resulting from lack of care. *See* T. M. Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 Annals of Health L. 145, 147-48 (2004).

In an attempt to reduce patient dumping, several states passed emergency care laws. *See, e.g.,* W. King, *Texas Adopts Stringent Rules on Rights of Poor at Hospitals*, The New York Times (Dec. 15, 1985). However, these laws suffered from several weaknesses, including inconsistent and inadequate definitions of emergency care that left room for refusal of care under the guise of confusion, or that did not extend to situations where the health of the patient, but not their life, was in jeopardy. *See* Karen I. Trieger, *Note: Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U L. Rev. 1186, 1202 (1986); *see also* Thomas L. Stricker, Jr., *The Emergency Medical Treatment & Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 NOTRE DAME L. Rev. 1121, 1125 n. 16 (1992) (collecting state statutes); *see, e.g.*, *Thompson v. Sun City Comm. Hosp.*, 688 P.2d 605, 609-11 (Ariz. 1984) (hospital interpreted state emergency-care statute to permit economic cause for transfer); Ky. Rev. Stat. Ann. §§ 216B.400(1), 216B.990(3) (1982) (statute contained no definition of

emergency); R.I. Gen. Laws § 23-17-26(a) (1985) (mandating only "prompt *life saving* medical care treatment" in emergency (emphasis added)).

In response to continued reports of hospital emergency rooms refusing to treat poor and uninsured patients, including pregnant women, Congress enacted EMTALA in the Consolidated Omnibus Budget Reconciliation Act of 1985. EMTALA clarified for all hospitals "public and private alike, that all individuals, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress." 131 Cong. Rec. S13892 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger).

In order to accomplish Congress' goal of a universal nationwide guarantee of emergency hospital care for all people in a way that accounts for the realities of hospital emergency practice, EMTALA rests on three interrelated statutory pillars: A) a duty to screen and stabilize all individuals presenting to the emergency department with an emergency medical condition; B) deference to professional medical judgment of the treating physicians; and C) preemption of conflicting state laws that would undermine this nationwide guarantee. Together, these pillars create a minimum patient health and safety foundation while also permitting emergency medical personnel to make crucial decisions in the heat of the moment using reasonable medical judgment. State laws that purport to work to the contrary are to be set aside.

A. EMTALA Creates a Federal Duty for Medicare Participating Hospitals with Emergency Departments to Provide Emergency Care to All Individuals.

EMTALA creates a right to medical screening and stabilization care for *all* individuals who come to a hospital's emergency department. It provides that, as a condition of participation in the Medicare program for any hospital with an emergency department "if *any individual* (whether or not eligible for benefits under [Medicare]) comes to the emergency department … *the hospital must provide for an appropriate medical screening examination* … to determine whether or not an emergency medical condition … exists." 42 U.S.C. § 1395dd(a). (emphasis added).

If the individual has an emergency medical condition, "the hospital must provide [such treatment] within the staff and facilities available at the hospital … as *may be required to stabilize* the medical condition." *Id*. at § 1395dd(b)(1). (emphasis added). If the individual cannot be stabilized, the hospital may transfer the patient to another hospital with the necessary staff and facilities *only if* certain conditions are met, including if the "medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer." *Id*. at § 1395dd(c).

EMTALA includes a broad definition of "emergency medical condition" that triggers its right

to care. In a clear repudiation of inadequate state emergency-care laws, Congress adopted a definition of "emergency medical condition" that rejected a "life endangerment" standard, in favor of stronger protections for conditions that "plac[ed] the patient's *health* in serious jeopardy" but fall short of being life threatening. *See* 42 U.S.C. § 1395dd(e) (defining an "emergency medical condition" to include, in relevant part, acute symptoms that absent immediate care could result in placing the health of the individual in serious jeopardy); *see also* H.R. Rep. No. 99-453, at 477–78 (1985) (Conf. Rep.).

EMTALA's textual evolution further underscores Congress's decision to go beyond life endangerment in defining an emergency medical condition and the corresponding stabilization duty. An earlier Senate version of the bill would have adopted a definition of "to stabilize" that required only care necessary to avoid *"substantial risk of death or serious impairment* …", H.R. Rep. No. 99-453, at 477–78 (1985) (Conf. Rep.). The final measure broadened the standard to encompass "material deterioration of the condition" without reference to death. 42 U.S.C. § 1395dd(e)(3).

B. Congress Explicitly Deferred to the Professional Judgment of the Treating Physician to Determine the Care Needed to Stabilize a Patient.

To create a law that would encompass all professionally reasonable treatments for all medical emergencies, Congress defined the scope of the stabilization obligation by explicitly creating a duty coextensive with professionally reasonable medical

judgment on the part of treating personnel. EMTALA thus articulates the stabilization duty as providing "such medical treatment of the [emergency] condition as may be necessary to assure, *within reasonable medical probability*, that no material deterioration of the condition is likely to result…" 42 U.S.C. § 1395dd(e)(3)(A).

Notably, earlier versions of the legislative language did not include the phrase "within reasonable medical probability." Deficit Reduction Amendments of 1985, H.R. 3128, § 124, 99th Cong. (1985). As the bill was being negotiated, emergency physicians expressed reservations with the early drafts of the House version of the bill, which did not include language referring to the professional judgment of the treating physician.[3] The conference agreement between the House and Senate versions of the legislative language thus included a modification from the Senate amendment to clarify that the bill's definition of "to stabilize" is to be measured "*within reasonable medical probability*." H.R. Rep. No. 99-453, at 477–78 (1985) (Conf. Rep.).

Deference to professional judgment is EMTALA's touchstone. Since the universe of presenting emergency conditions and possible treatments is limitless, a statute that expressly lists conditions and treatments simply cannot be drafted. *See* T. M. Lee, *supra*, at 160 ("EMTALA's intentionally

[3] H.R. Rep. No. 99-241, pt. 3, at 745 (1985) (statement of Am. Coll. of Emergency Physicians) (recommending that emergency stabilization include "adequate evaluation and initiation of treatment to assure the transfer of a patient will not, within *reasonable medical probility* [sic], result in death, or loss or serious impairment of bodily parts or organs.").

vague language has eliminated potential loopholes that providers may have used to deny poor persons emergency care"); *see also* Barry R. Furrow, *An Overview and Analysis of the Impact of the Emergency Medical Treatment and Active Labor Act*, 16 J. Legal Med. 325, 329 (1995) (former CMS administrator noting that the EMTALA statute is purposefully broad since not all conduct can be anticipated by the statute and regulations.). Nor would such an approach be desirable. Emergency medicine rests on quick, decisive action by highly trained medical personnel, not the opinion of hospital legal counsel.

C. EMTALA Preempts Conflicting State Laws.

EMTALA was structured to create a nationwide right to emergency hospital care for health-endangering medical emergencies. As such, Congress sought to supersede narrower state laws. *See* 101 Cong. Rec. 28569 (statement of Sen. Kennedy) ("[E]ven in the 22 states which already have emergency medical care statutes on the books, enforcement of those laws has been poor. Many of the abuses have occurred in States which already have laws on the books"). EMTALA is limited to emergency care. But within its narrow space, EMTALA preempts state laws "to the extent that the [state or local] requirement directly conflicts with [EMTALA] requirements." 42 U.S.C. § 1395dd(f).

Given the text of the statute and its core purpose, it is essential that EMTALA preempt any state law that seeks to establish a narrower duty of care. *See Oneok, Inc. v. Learjet, Inc.*, 575 U.S. 373, 377 (2015) ("[F]ederal law must prevail," *inter alia,* where

"compliance with both state and federal law is impossible."). For this reason, since first being charged with enforcing EMTALA's requirements, the Department of Health and Human Services (HHS) has long taken the position that "regardless of State law or practice, a hospital must fulfill the requirements of the statute and cannot simply cite State law or practice as the basis for a transfer under the statute." Health Care Financing Administration and Office of the Inspector General, Medicare Program; Participation in CHAMPUS and CHAMPVA, Hospital Admissions for Veterans, Discharge Rights Notice, and Hospital Responsibility for Emergency Care, 59 Fed. Reg. 32,086, 32,104-05 (June 22, 1994).

II. EMTALA Emphasizes Labor and Delivery, but Nothing in the Law Subordinates the Health of Pregnant Women to Fetal Health.

EMTALA reflects Congress's particular concern for the health of pregnant women and their unborn children. One important context for this concern is labor and delivery. But nothing in the law limits EMTALA's protections for pregnant women to *only* labor and delivery. Pregnant patients who present to the emergency department with *any* type of medical emergency are fully entitled under EMTALA to receive emergency stabilization care "as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result…." 42 U.S.C. § 1395dd(e)(3).

As originally enacted, EMTALA contained explicit guarantees of emergency medical care for women in "active labor," which the law defined as a time in which "delivery is imminent" or "transfer may pose a threat of the health and safety of the patient or the unborn child." Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, 164 (1986). But post-enactment reports persisted of hospitals denying emergency care to pregnant patients whose symptoms did not rise to "active" labor status. *See e.g., Burditt v. U.S. Dep't of HHS*, 934 F.2d 1362, 1369 (5th Cir. 1991) (interpreting the original reference to "active labor" as limiting EMTALA protections for only "a subset of all women in labor"). To address this issue, in 1989, Congress amended the statute to strike the word "active," leaving the statute with references to "labor." *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6211(h)(2)(A)–(E), 103 Stat. 2106, 2249; H.R. Rep. No. 101-386, at 838 (1989) (Conf. Rep.); *see also* 59 Fed. Reg. 32,086, 32,105 (June 22, 1994) (HHS noting "that OBRA 89 removed the term "active labor" from [EMTALA] and included the full range of symptoms that term was intended to include within the scope of the term "emergency medical condition…").

Consistent with this expansion of "labor" care guarantees, Congress simultaneously amended EMTALA to expand the considerations a hospital must assess before transferring a pregnant woman in labor, to include potential harms to the "unborn child." 42 U.S.C. § 1395dd(c)(2)(A); *id.* § 1395dd(e)(1)(B)(ii); *id.* § 1395dd(c)(1)(A)(ii).

Nothing in the term "unborn child," or the legislative history, indicates Congressional intent to subordinate the health of the mother to that of the fetus. Petitioners argue that referencing an "unborn child" "demands equal treatment for the unborn child," and that EMTALA thus restricts the scope of emergency care to which pregnant women are entitled. Idaho Br. at 32. But in three of its four provisions referencing the "unborn child," EMTALA expressly cabins such language to the labor context. 42 U.S.C. § 1395dd(c)(1)(A)(ii) ("…risks to the individual and, *in the case of labor*, to the unborn child…"); *id.* § 1395dd(c)(2)(A) (same); *id.* § 1395dd(e)(1)(B)(ii) ("…with respect to *a pregnant woman who is having contractions*…the health or safety of the woman or the unborn child"). The fourth reference defines "emergency medical condition," to include symptoms that would "plac[e] the health of the individual (or, with respect to the woman, the health of the woman or her unborn child) in serious jeopardy." *Id.* § 1395dd (e)(1)(A)(i). This provision merely ensures that hospitals cannot turn away pregnant patients whose emergencies threaten their fetuses'—but not their own—health. EMTALA's substantive screening, stabilization, and transfer guarantees continue to extend only to the "individual"—i.e., the pregnant woman—without any "unborn child" addition. *Id.* § 1395dd(a), (b)(1), (c)(1). Each of the four references to the "unborn child" is thus consistent with the intent to *expand*—not restrict—emergency care access for pregnant women.

III. The Federal Government Has Well-Established Authority to Protect the Health and Safety of Patients Through the Regulation of Federal Healthcare Programs.

EMTALA's requirement to provide specific stabilizing care in limited circumstances fits comfortably within the Federal government's well-recognized power to regulate federal healthcare programs. Petitioners' contrary argument, that this mandate would require some extraordinary exercise of federal power at the expense of state police powers, Idaho Br. at 10, ignores EMTALA's context as a condition of participation in the Medicare program.

EMTALA creates a national duty of emergency care, and within that narrow sphere, the law is plenary. EMTALA's obligations are independent of state standards of care, which is why courts have recognized that EMTALA's stabilization requirement can require something greater than would a state's standard.

A. Compliance with EMTALA is a Condition of Participation in Medicare.

In order for a hospital to participate in the Medicare program and be eligible for payments for providing care to Medicare patients, it must comply with certain conditions. *See, e.g.*, 42 U.S.C. § 1395cc. These conditions manifest "perhaps the most basic" function of HHS: "to ensure that the healthcare providers who care for Medicare and Medicaid patients protect their patients' health and safety." *Biden v. Missouri*, 142 S. Ct. 647, 650 (2022). Among

these conditions, every hospital that has an emergency department and elects to participate in Medicare must abide by EMTALA's screening, stabilization, and transfer requirements. 42 U.S.C. § 1395cc(a)(1)(I)(i). This narrowly drawn power to regulate emergency practice is not, as Petitioners propose, an island of federal interference in a sea of state police powers. *See* Idaho Br. at 10. It is, instead, a manifestation of what the Court has recognized as longstanding federal power to oversee federal healthcare programs.

This Court has long recognized the federal government's authority to regulate the manner in which Medicare-participating hospitals furnish medical care, through Medicare's conditions of participation. Just two terms ago, the Supreme Court reiterated this longstanding principle in *Biden v. Missouri*, 142 S. Ct. 647 (2022). There, the Court upheld a federal regulatory condition of participation that required covered facilities to ensure that their covered staff were vaccinated against COVID-19. *Biden*, 142 S. Ct. at 651. Several states challenged the regulation, arguing that the Secretary was authorized only to propound "bureaucratic rules regarding the technical administration" of Medicare and Medicaid. *Id.* at 652. The Court rejected this argument, concluding that HHS is empowered by statute to promulgate obligations on participating facilities to "address the safe and effective provision of healthcare, not simply sound accounting." *Id.* (collecting examples of myriad conditions of participation from the Code of Federal Regulation).

EMTALA, like the vaccination requirements in *Biden,* is a federal condition of participation that

regulates medical care provided by Medicare participating hospitals under a narrowly drawn circumstance—namely, hospital conduct in connection with medical emergencies.

B. EMTALA's Conditions on Participating Facilities—Like Innumerable Other Conditions of Participation in Federal Healthcare Programs—Do Not Offend the Prohibition on Federal Interference In 42 U.S.C. § 1395.

Petitioners repeatedly invoke 42 U.S.C. § 1395, a "Prohibition against any Federal interference" which bars federal "supervision or control over" "the practice of medicine," as a purported shield against federal regulation of healthcare. *See* Idaho Br. at 11, 20, 25; Moyle Br. at 21, 44. Their reliance is misplaced. Indeed, Petitioners' argument regarding the reach of § 1395 conflicts with this Court's prior interpretation of that section and undermines innumerable federal Medicare conditions of participation.

This Court recognized the shortcomings of such an expansive reading of § 1395 to limit the federal government's regulation of the Medicare program in *Biden v. Missouri*, swiftly dismissing in two sentences Missouri's non-interference argument against the vaccination condition there, because "[t]hat reading of section 1395 would mean that nearly every condition of participation the Secretary has long insisted upon is unlawful." 142 S. Ct. 647, 654 (2022). EMTALA no more violates § 1395's prohibitions than do countless other conditions of Medicare and Medicaid

participation, recognized in *Biden*, "that govern in detail, for instance, the amount of time after admission or surgery within which a hospital patient must be examined and by whom," or, indeed, vaccine requirements for hospital staff. *Biden*, 142 S. Ct. at 652. (internal citations omitted).

Beyond EMTALA, many other provisions of the Medicare Act impose statutory conditions of participation that appear to regulate the provision of medical services. *See, e.g.*, 42 U.S.C. § 1395x(e)(1) (requiring hospital care by "physicians"); *id.* § 1395x(r) (setting "physician" qualifications); *id.* § 1395x(e)(5) (imposing nursing staffing requirements). Other regulatory conditions of participation govern such wide-ranging topics as: the use of restraints and seclusion; infection control measures; and the qualifications for lab directors. 42 C.F.R. §§ 482.13(e), 482.42, & 493.1405(b)(1)(i).

And the Court's recent articulation of § 1395's limits is consistent with a long track record in lower courts. *See, e.g.*, *Szekely v. Fla. Med. Ass'n*, 517 F.2d 345, 350 (5th Cir. 1975) (upholding the government's right to recoup funds from providers who render unnecessary services); *Rasulis v. Weinberger*, 502 F.2d 1006, 1010 (7th Cir. 1974) (reimbursement conditions setting professional standards for physical therapists did not constitute interference). One case cited by Petitioners, Idaho Br. at 25, presents an apt example of a court *rejecting* the very challenge Petitioners now bring. In *Goodman v. Sullivan*, the plaintiff challenged Medicare criteria that denied coverage for services "not reasonable and necessary," arguing such criteria breached the section 1395 non-interference principle. 891 F.2d 449, 450-51 (2d Cir.

1989). The Second Circuit rejected this argument, holding that the regulation did not "direct or prohibit any kind of treatment," but only "refuse[d] subsequent Medicare reimbursement for certain kinds of services." *Id.* at 451. The court recognized—as the Supreme Court would decades later in *Biden*—that "if tangential influence [on medical decisions] alone violates § 1395, then the Secretary would scarcely be able to regulate the Medicare program at all." *Id.*

C. EMTALA Does Not Permit States to Limit a Hospital's Screening and Stabilization Obligations.

Petitioners assert that EMTALA lacks any substantive care standards. To this end, Petitioners spill considerable ink arguing first that EMTALA merely bars hospitals from denying indigent patients whatever level of emergency care a state permits hospitals to offer, second, that EMTALA is not a malpractice law and thus creates no duty of care, and finally, that EMTALA's limitation to care "available" at the hospital is Congress's way of giving states the power to carve out disfavored conditions and treatments. Petitioners are wrong on all counts.

First, by its terms, and as long recognized by courts, EMTALA's protections are not limited to indigent people in need of emergency hospital care. EMTALA's guarantees, by its text, extend to "any individual"—not "any *indigent* individual." Accordingly, Petitioners' insistence that the law be construed as no broader than necessary to effectuate its anti-dumping origins should meet the same wholesale rejection that litigants contending as much have long faced. *See Collins v. DePaul Hosp.*, 963 F.2d

303, 308 (10th Cir. 1992) ("The fact that Congress, or some of its members, viewed [EMTALA] as a so-called "anti-dumping" bill . . . does not subtract from its use of the broad term "any individual."); *Blake v. Richardson*, No. 98-2576, 1999 U.S. Dist. LEXIS 7391, at *8 (D. Kan. Apr. 1, 1999) (rejecting argument that inadequate screening claim under EMTALA requires showing of "economic" discrimination).

Second, EMTALA establishes a duty of screening and stabilization in medical emergencies, independent of state law malpractice duties. To be sure, EMTALA does not supplant the remedies available under state malpractice law if they do not impose inconsistent obligations. *See Bryan v. Rectors & Visitors*, 95 F.3d 349, 352 (4th Cir. 1996) (EMTALA does not "preempt state tort law except where absolutely necessary"). But contrary to Petitioners' conclusions, this observation does not obviate any substantive federal obligations. Rather, as the Fourth Circuit explained, EMTALA sets a baseline stabilization duty, but "[o]nce EMTALA has met that purpose" and "ensure[d] that a hospital undertakes stabilizing treatment," "the legal adequacy of care is *then* governed not by EMTALA but by the state malpractice law." *Id.* at 351 (emphasis added). Courts have also reached the corollary conclusions that EMTALA imposes duties that may exceed state malpractice law, *see, e.g.*, *Romar ex rel. Romar v. Fresno Cmty. Hosp. & Med. Ctr.*, 583 F. Supp. 2d 1179, 1187 (E.D. Cal. 2008) (holding a hospital could simultaneously comply with state malpractice law and violate EMTALA); and that the same conduct can implicate both regimes, *Bloomer v. Norman Reg'l Hosp.*, 221 F.3d 1351, 2000 U.S. App. LEXIS 24621, at *7 (10th Cir. July 12, 2000) (unpublished)

("EMTALA was drafted broadly, and [its screening and stabilization] issues necessarily overlap with malpractice issues.").

Third, contrary to Petitioners' assertions, Idaho Br. at 25, EMTALA's caveat that a hospital need only provide the stabilizing care "within the staff and facilities available at the hospital," 42 U.S.C. § 1395dd(b)(1)(A), is not a license for states to suppress EMTALA's duty of care. Rather, this provision simply recognizes the obvious, namely, that there are vast differences in hospitals' operational capabilities and capacity in terms of medical personnel, medical equipment and medications. *See* 42 USC § 1395dd (c)(2)(A) (an appropriate transfer is one "in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health"). As a result, for example, the practical effect of imposing the EMTALA duty of care on a Level One trauma center differs from the level of emergency care that will be available in a small rural hospital. The Centers for Medicare & Medicaid Services (CMS) has also consistently interpreted this language as referring to care "within the capabilities of the staff and facilities available at the hospital." *See* 42 C.F.R. § 489.24(d)(1)(i); *see also* SOM Appendix V ("[T]he hospital must provide stabilizing treatment within its capability and capacity. Capabilities of a medical facility mean that there is physical space, equipment, supplies, and specialized services that the hospital provides."). The phrase "available at the hospital" would present an unassuming vehicle indeed for wholesale subordination of landmark federal guarantees. *See Sackett v. EPA*, 143 S. Ct. 1322 (2023)

(“Congress does not hide elephants in mouseholes,” nor “fundamental details” in “ancillary provisions”).

Finally, if Congress intended for EMTALA’s stabilization obligation to defer to state law, it knew how to say so. Congress deferred to state law in setting the quantum of recovery for EMTALA’s civil actions, which provides for “those damages available for personal injury under the law of the State in which the hospital is located.” 42 U.S.C. § 1395dd(d)(2)(A)-(B). Such deferential language is conspicuous in its absence from EMTALA provisions imposing substantive obligations.

D. EMTALA Preempts State Laws That Would Limit Stabilizing Care.

In the context of EMTALA preemption, at least one federal court of appeals has recognized that where the “necessary stabilizing treatment” in light of the patient’s diagnosis is limited to a single treatment, then EMTALA unquestionably mandates the hospital provide that treatment—even where this treatment surpasses the state standard of care, and potentially even conflicts with state law. *See In re Baby “K”*, 16 F.3d 590, 594-95 (4th Cir. 1994).

In the seminal EMTALA preemption case, *In re Baby “K”*, a hospital sought a declaratory judgment that it would not be required under EMTALA to provide treatment other than “warmth, nutrition, and hydration” to a baby born with anencephaly, lacking a cerebrum and all cognitive and sensory function, and presenting at the emergency department with respiratory distress. *Id.* at 592. The hospital recognized that, in light of diagnosed breathing difficulties, respiratory support with a ventilator

would be the necessary "stabilizing care" as defined by EMTALA. *Id.* at 594-95. Nonetheless, among other points, the hospital argued that requiring such care would expand prevailing state standards of care, would aggrandize EMTALA beyond the requirement of uniform treatment for all similarly-diagnosed patients, and would conflict with a state law permitting ethical refusals of care. *Id.* at 595.

The Fourth Circuit rejected each of these arguments in holding that EMTALA's stabilization requirement must mandate something *greater* than mere uniform treatment or application of a prevailing standard of care, where such uniform treatment or prevailing standards would permit the patient's condition to materially deteriorate in direct contravention of EMTALA. *Id.* at 595-96. Moreover, the court properly held that the state ethical-refusal law must be preempted to the extent it permitted physicians to refuse to provide stabilizing treatment to anencephalic infants. *Id.* at 597.

Petitioners attempt to distinguish *In re Baby "K"* by characterizing the dispute as "whether the hospital could withhold treatment," and then conceding, "[n]o one disputes that Medicare-participating hospitals must treat emergency medical conditions." Moyle Br. at 27; *see also* Idaho Br. at 33. But this mischaracterizes the dispute in *In re Baby "K"*: The hospital did not refuse to treat Baby K altogether; it proposed the (non-stabilizing) alternative treatment of warmth, nutrition, and hydration—treatment which satisfied the state law standard of care. Ultimately, however, EMTALA's duty to provide stabilizing care took precedence over the state's prevailing standard.

IV. Petitioners' Assertion that Pregnant Patients will Use Emergency Departments As "Abortion Enclaves" to Circumvent State Abortion Bans Misunderstands the Role and Capacity of Hospital Emergency Departments and Will Disrupt Access to Emergency Pregnancy Care.

Petitioners mischaracterize the services and conditions of emergency departments as well as the emergency conditions facing pregnant patients in contending that emergency departments will become "abortion enclaves" if they are permitted to perform abortion as necessary stabilizing treatment under EMTALA. Emergency departments, which operate under tremendous constraints, are not organized and operated to furnish non-emergent care. Nonetheless, Section 18-622 threatens *genuine* emergency care both by directly prohibiting such care and by chilling myriad forms of necessary emergency care for non-obstetrical emergencies that could, in fact, carry implications for the continuation of a pregnancy. Further, in limited circumstances, Section 18-622 would directly bar care necessary to stabilize pregnant patients, and in so doing, it directly conflicts with EMTALA's federal obligations.

A. Petitioners Display a Complete Lack of Understanding of The Conditions Under Which Emergency Medicine Currently Operates as Well as the Scope of Services Provided in Emergency Departments.

Petitioners assert that the Administration's position would "turn emergency rooms into federal

abortion enclaves," Idaho Br. at 23. Its oddly envisioned position evidences a misunderstanding of how emergency departments operate and the conditions under which they provide care.

Emergency departments are not available for non-emergent, elective care. An emergency department is "an organized, hospital-based facility for providing unscheduled or episodic services to patients who present for immediate medical attention." *See* HHS OIG, *Audit of Medicare Emergency Department Evaluation and Management Services* (2004); *see also* ACEP, *Definition of an Emergency Service* (Jan. 2021) ("An emergency service is any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health, believes that immediate unscheduled medical care is required."). Emergency departments thus serve a vital, but specific, public safety function to screen for and stabilize unplanned and emergent medical conditions.

Today's emergency departments operate under enormous stress and capacity restraints that make it impossible for them to provide services, such as elective or non-emergent abortions, that are outside of their core functions. Notably, the number of emergency department visits is increasing even as the number of emergency departments is decreasing, worsening access. *See* American Hospital Association, *Trendwatch Chartbook* 32 (2018) (finding that, between 1995 and 2016, the number of ED visits significantly increased, while the number of ED departments has steadily decreased). Further, hospitals are experiencing worsening emergency

department overcrowding, *see* S. M. Peterson et al., *Trends and Characterization of Academic Emergency Department Patient Visits: A Five-Year Review*, 26(4) Acad. Emerg. Med. 410-419 (Sept. 24, 2018) (finding increasing overcrowding between 2012 and 2016), and issues relating to boarding, *see* G. D. Kelen, *Emergency Department Crowding: The Canary in The Health Care System*, NEJM Catalyst (Sept. 28, 2021) (finding that ED patient boarding of at least 8 hours rose almost 130% between 2012 and 2019, and instances of boarding of at least 24 hours doubled from 2018 to 2019).

Operational stress coupled with other stresses of emergency practice have led to a staffing crisis, including fewer emergency department residencies being filled. *See* C. Preiksaitis et al., *Characteristics of Emergency Medicine Residency Programs With Unfilled Positions in the 2023 Match*, 82(5) Annals of Emergency Med. 598 (2023); *see also* G. R. Schmitz &, Z. J. Jarou, *The Emergency Medicine Match: Is the Sky Falling or Is This Just Growing Pains?*, 82(5) Annals of Emergency Med. 608 (2023). Emergency department physicians are also more likely to experience burnout. *See* T.D. Shanafelt, *Changes in Burnout and Satisfaction with Work-Life Integration in Physicians and the General US Working Population Between 2011 and 2017*, 94(9) Mayo Clin Proc. 1681 (Sept. 2019).

Furthermore, the very structure of emergency medicine guarantees that the termination of a pregnancy will be a rare event, undertaken in only the most exigent circumstances. Emergency departments are not equipped for, and their personnel are not prepared for, the provision of non-urgent care.

Ultimately, abortion rarely falls to emergency department personnel, and does so only in those rare cases in which abortion is in fact the professional standard of emergency care to medically stabilize the mother. *See* R. K. Jones & K. Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43(1) Perspectives on Sexual and Reproductive Health 41, 41-50 (March 2011) ("Many hospitals provide abortions only in cases of fetal anomaly or serious risk to the woman's health, and a majority (65%) performed fewer than 30 abortions in 2008").

Thus, the reality is that emergency departments simply do not have the capacity or operational structure to function as the walk-in "abortion enclaves" that Petitioners suggest.

B. Section 18-622 Will Disrupt Access to Vital Emergency Care for Pregnant Patients.

EMTALA recognizes that unfettered access to emergency care is crucial for all individuals. However, Petitioners' position falls with particular severity on pregnant women seeking emergency care, regardless of whether care is sought for an obstetrical or non-obstetrical emergency. Indeed, Idaho's attempt to restrict emergency treatment choices for pregnant patients effectively makes treating pregnant women a precarious proposition for emergency departments.

The broad scope of pregnancy emergencies provides critical context for realizing the full implications of Section 18-622. "Problems of pregnancy" make up 1.3% of all emergency department visits for women, which comes out to an estimated 1.2 million emergency department visits

each year. C. Cairns & K. Kang, *National Hospital Ambulatory Medical Care Survey: 2019 Emergency Department Summary Tables*, Centers for Disease Control and Prevention, National Center for Health Statistics (2022). But *non-obstetric* emergencies are common as well, and their successful treatment can imperil a pregnancy and thus be implicated by Section 18-622. *See* M. T. Coleman, *Nonobstetric Emergencies in Pregnancy: Trauma and Surgical Conditions*, Am. J. Obstet. Gynecol. (Sept. 1997).

Non-obstetrical emergency conditions affect 1 in 500 pregnancies, and can include appendicitis, cholecystitis, pancreatitis, and bowel obstruction, all of which affect the abdominal area but can be masked by the physiologic changes that occur in pregnancy, including abdominal girth, elevated serum enzyme levels and problems of adrenal insufficiency. *Id*. Moreover, trauma is the leading non-obstetrical cause of fetal death and occurs in 7% of all pregnancies – caused by motor vehicle accidents, falls, and direct assaults – all of which can require emergency stabilizing care but can increase the risk of fetal loss and rupture of the placenta. *Id*. Pregnant women also face a risk of non-obstetrical surgery during pregnancy, with surgery related to appendicitis and biliary disease being the most common types of abdominal surgery. *See* E. R. Norwitz & J. S. Park, *Nonobstetric Surgery In Pregnant Patients: Patient Counseling, Surgical Considerations, and Obstetric Management*, UpToDate (Jan. 2024).

Given the myriad conditions that can necessitate emergency stabilizing care for a pregnant woman, the potential harm caused by Section 18-622 cannot be overstated. To be sure, Section 18-622 does

not prohibit abortion where "necessary" to prevent the mother's death, and it excludes certain limited circumstances—i.e., "ectopic and nonviable pregnancies"—from Section 18-622's prohibition. *See Planned Parenthood Great Nw. v. State*, 522 P.3d 1132, 1202-03 (Idaho 2023); Idaho Code § 18-604(1)(b)-(c) (2023). But these limited circumstances do not encompass the universe of emergency conditions that could require abortion for stabilizing treatment and which present emergent—but not life-threatening—conditions.

Moreover, providers treating women whose emergencies are advanced and require the most aggressive interventions to avert severe and long-lasting physical health impact will inevitably be confronted with the increased risk of fetal loss as an unintended consequence of treatment. Facing these pressures, Idaho's criminal prohibition and penalty create a tension that will naturally lead to an overdeterrence for physicians that will disrupt medical judgments regarding stabilizing care for pregnant patients. *See, e.g.*, David M. Studdert, et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, JAMA (2005) (explaining that many physicians practice "defensive medicine" by, among other things, avoiding "procedures and patients that [a]re perceived to elevate the probability of litigation"); *see also* G. Kovacs, MD, MHPE and P. Croskerry, MD, PhD, *Clinical Decision Making: An Emergency Medicine Perspective*, Academic Emergency Medicine 947 (Sep. 1999) ("The emergency physician … must often make complicated clinical decisions with limited information while faced with a multitude of competing demands and distractions.").

The harms caused to pregnant women by Section 18-622 create precisely the type of danger that EMTALA was designed to avert. Emergency department use for obstetrical emergencies is common during pregnancy. *See* S. Malik et al., *Emergency Department Use in the Perinatal Period: An Opportunity for Early Intervention*, 70(6) Annals of Emergency Medicine 835 (Dec. 2017) (finding that at least a third of pregnant women visit the emergency department during their pregnancy). Complications during pregnancy occur frequently, and rates of pregnancy-related complications are rising. *See* G. Goodwin, et al., *A National Analysis of ED Presentations for Early Pregnancy and Complications: Implications for Post-Roe America*, Am. J. of Emergency Med., 70, 90–95, (Aug. 2023) (finding that 87% of pregnancy-related emergency department visits include bleeding, including threatened miscarriage, maternal hemorrhage, and spontaneous miscarriage); N. A. Cameron et al., *Association of Birth Year of Pregnant Individuals With Trends in Hypertensive Disorders of Pregnancy in the United States*, *1995-2019*, JAMA Network Open (Aug. 24, 2022) (finding significant increases in hypertension disorders during pregnancy, which is associated with pre-eclampsia). Furthermore, individuals who visit the emergency department during pregnancy are more likely to be vulnerable populations, including adolescents and women of color, as well as more likely to have experienced domestic abuse, and to have had delayed access to prenatal care. *See* S. Malik et al., *supra*. The importance of emergency care for obstetrical emergencies is underscored by The American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Control and

Prevention (CDC), which, in guidance materials for emergency practice, explains the range of obstetrical emergency conditions that can confront emergency personnel. *See Identifying and Managing Obstetric Emergencies in Nonobstetric Settings*, The American College of Obstetricians and Gynecologists (2023).

By criminalizing one form of treatment for pregnant patients with emergencies, Idaho implicates emergency care for pregnant women that extends well beyond obstetrical emergencies alone, effectively rendering pregnant patients problematic to treat out of fear of what could happen if medically reasonable stabilizing treatment is rendered.

C. Section 18-622 Prohibits Necessary Care and Creates Obligations that Directly Contravene EMTALA.

Beyond the practical chilling effects of Section 18-622 on providers and patients, the law also creates obligations that contravene federal law by forcing hospitals to withhold abortion care that may be the required stabilizing care under EMTALA.

As the district court correctly found after an extensive factfinding hearing, "it is impossible to comply with both laws." *United States v. Idaho*, No. 22-cv-00329, 2023 U.S. Dist. LEXIS 79235, at *11 (D. Idaho May 4, 2023). The district court identified several circumstances under which the appropriate stabilizing care could include abortion, including: infection of the amniotic sac resulting in sepsis, elevated blood pressure or blood clots and placental abruption. *Id.* at *13-14. These circumstances were not cured by the Idaho Supreme Court's limiting judicial construction of Section 18-622, and the

legislature's revisions to its definition of abortion, which only excluded the limited categories of "ectopic and nonviable pregnancies" from the scope of its prohibition. *See id.* at *14; *Planned Parenthood*, 522 P.3d at 1202-03; Idaho Code § 18-604(1)(b)-(c) (2023). And where presented with such circumstances, where EMTALA mandates the provision of stabilizing abortion care but Section 18-622 would clearly prohibit such care, physicians would be presented with the Hobson's choice of complying with only one competing law. Such a choice is anathema to the Supremacy Clause and thus the subject of fundamental preemption concerns. *See Murphy v. NCAA*, 138 S. Ct. 1461, 1479-80 (2018).

Moreover, nothing in *Dobbs v. Jackson Women's Health Organization* disturbs this framework of impossible compliance. While *Dobbs* overruled *Roe* and "return[ed] the issue of abortion to the people's elected representatives," 597 U.S. at 232, it did not change the fact that there is an existing, long-standing federal statute—enacted by the people's elected, *federal* representatives—guaranteeing a narrow but powerful right to emergency care that tolerates no limits on the ability of physicians to make medically reasonable determinations regarding what treatment may be required in any particular emergency situation. EMTALA's unique federal protection preempts state abortion regulations when they impinge on emergency care.

V. Petitioners' Position Would Allow States to Carve Out Any Form of Stabilizing Emergency Care and Would Directly Contravene the Federal Guarantee of Emergency Hospital Care Established by Congress.

An animating purpose of preemption doctrine is to ensure that state statutes do not frustrate the purposes of federal legislation. Under black-letter principles of conflict preemption, "federal law must prevail," either "where 'compliance with both state and federal law is impossible,' or where 'the state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" *Oneok*, 575 U.S. at 377 (citation and internal quotation marks omitted).

As discussed above, in enacting EMTALA, Congress's "overarching purpose" was to ensure that all individuals "receive adequate emergency medical care." *Arrington v. Wong*, 237 F.3d 1066, 1074 (9th Cir. 2001) (internal quotation omitted). Through EMTALA, Congress sought "to provide an 'adequate first response to a medical crisis' for all patients." *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 880 (4th Cir. 1992) (quoting 131 Cong. Rec. S13904 (daily ed. Oct. 23, 1985) (statement of Sen. Dole). EMTALA thus guarantees a uniform national right to medical stabilization in emergency situations by ensuring emergency care for "any individual" who presents at a Medicare-participating hospital's emergency department, regardless of the state in which that hospital is located.

Petitioners argue that Section 18-622 falls outside the scope of EMTALA because Idaho's law merely defines the scope of its standard of care, meaning that state law controls the scope of EMTALA stabilization. Idaho Br. at 17, 25, 29. But to permit states to carve out certain emergency treatments for pregnant patients would by definition permit a state to excise other disfavored conditions, treatments and populations that otherwise fall within the scope of hospitals' EMTALA duties as medically reasonable care to stabilize a patient. By Petitioners' logic, a state's absolute power to dictate the terms of emergency care would empower officials to select only the populations and treatments it favors, subjecting EMTALA to state whim and exposing the health of emergency patients to the arbitrary, harmful limits of state law.

For example, under this reasoning, a state legislature could enact a law that criminalizes the administration of emergency naloxone in opioid overdose situations because allowing such treatment encourages addiction. Or a state could, under the guise of regulating medical care, bar emergency care for auto accident victims in all but life-endangerment situations on the ground that a health-endangerment standards encourages reckless driving.

Under Petitioners' reading, EMTALA would not apply because neither naloxone nor emergency treatment of injuries arising from auto accidents is specifically named in the EMTALA statute. This is an absurd result, enabling states to define the scope of permissible emergency care according to their preferences, in contravention of the very purpose of EMTALA. *Cf. Yellen v. Confederated Tribes of the*

Chahlis Reservation, 141 S. Ct. 2434, 2448 (2021) (statutes should be read to avoid "contextually implausible outcome").

Ultimately, under Petitioners' interpretation, EMTALA's nationally uniform guarantee—unique in American health law—would effectively subject patients to the full force of any particular state's views about what constitutes appropriate emergency care, in direct contravention of Congressional intent to establish a national right to emergency department screening and stabilizing treatment for emergency medical conditions. A uniform national right to medically reasonable emergency care lies at EMTALA's heart and in its words.

To prevent this outcome, and to uphold the underlying intent of the EMTALA statute, Section 18-622 must be preempted insofar as it directly conflicts with EMTALA's commands and frustrates Congressional purpose.

CONCLUSION

Amici respectfully urge the Court to reinstate the district court's preliminary injunction.

March 28, 2024

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APPENDIX

LIST OF *AMICI CURIAE*

A. Public Health Organizations

1. American Public Health Association
2. Robert Wood Johnson Foundation
3. Network For Public Health Law
4. American Medical Women's Association

B. Public Health Deans

1. Burroughs, Thomas E., PhD, MS, MA, Dean and Professor, SLU College for Public Health and Social Justice, Saint Louis University
2. Deardorff, Julianna, PhD, Executive Associate Dean of Faculty and Academic Affairs and Associate Professor, University of California Berkeley School of Public Health
3. Drenkard, Karen, PhD, RN, NEA-BC, FAAN, Associate Dean of Clinical Practice and Community Engagement, School of Nursing Center for Health Policy and Medical Engagement, The George Washington University
4. El-Mohandes, Ayman, MBBCh, MD, MPH, Dean, CUNY Graduate School of Public Health & Health Policy

5. Fallin, Daniele, PhD, James W. Curran Dean of Public Health, Rollins School of Public Health, Emory University

6. Fried, Linda P., MD, MPH, Dean and DeLamar Professor of Public Health, Mailman School of Public Health, Professor of Epidemiology and Medicine, Columbia University

7. Galea, Sandro, MD, DrPH, Dean, Robert A. Knox Professor, Boston University

8. Godwin, Hilary, PhD, Dean, University of Washington School of Public Health

9. Goldman, Lynn R., MD, MPH, MS, Michael and Lori Milken Dean of Public Health, Milken Institute School of Public Health, The George Washington University

10. Grogan, Colleen M., PhD, Deputy Dean for Curriculum Policy, Deborah R. and Edgar D. Jannotta Professor, Crown Family School of Social Work, Policy, and Practice, The University of Chicago

11. Gusmano, Michael K., PhD, Professor and Associate Dean of Academic Programs, College of Health, Director, Center for Ethics, Lehigh University

12. Hoffman, Allison K., JD, Deputy Dean and Professor of Law, University of Pennsylvania Carey Law School

13. Jeffries, Pamela R., PhD, RN, FAAN, ANEF, FSSH, Dean, Vanderbilt School of Nursing, Valere Potter Distinguished Professor of Nursing, RWJF Nurse Executive Fellow Alumna, Vanderbilt School of Nursing

14. Lu, Michael C., MD, MS, MPH, Dean, UC Berkeley School of Public Health

15. Lushniak, Boris, MD, MPH, Professor and Dean, University of Maryland School of Public Health

16. McGovern, Terry, JD, Professor and Senior Associate Dean for Academic and Student Affairs, CUNY School of Public Health

17. Parker, Edith A., MPH, DrPH, Dean, Professor, Community and Behavioral Health, The University of Iowa College of Public Health

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