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 SANCTUARY FOR FAMILIES AND 16 OTHER ORGANIZATIONS SUPPORTING SURVIVORS OF GENDER-BASED VIOLENCE AS AMICI CURIAE IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI CURIAE[1]

Amici curiae are seventeen non-profit organizations and advocacy groups that support survivors of gender-based violence (together, "Amici"). Amici are gravely concerned that Idaho Code § 18-622 ("Section 18-622") will deprive the vulnerable populations that Amici serve of emergency stabilizing care in contravention of the 1986 Emergency Medical Treatment and Labor Act ("EMTALA"), and in so doing, cause severe yet preventable suffering and lasting harm. Amici include: Sanctuary for Families, Day One, End Domestic Abuse Wisconsin, Equality Now, Hope's Door, Jewish Women International, Lawyers Committee Against Domestic Violence, National Alliance to End Sexual Violence, National Center on Domestic Violence, Trauma, and Mental Health, National Network to End Domestic Violence, National Resource Center on Domestic Violence, Sakhi for South Asian Women, Sexual Violence Prevention Association, The National Domestic Violence Hotline, Urban Justice Center - Domestic Violence Project, Women's Equal Justice Project and YWCA USA.

Amici believe their understanding of gender-based violence and the law can assist this Court in considering the issues presented on appeal. Each organization has a strong interest in ensuring that pregnant patients, in particular those who are

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

members of marginalized communities and may have experienced intimate partner violence ("IPV"), have full access to emergency stabilizing care, including termination of pregnancy, where necessary to prevent death or serious injury, as required by EMTALA. These organizations are united in their opposition to Section 18-622, which prohibits medical providers from providing the very care EMTALA requires, because it will disproportionately, materially and detrimentally harm the communities and individuals they are committed to serving, who are among Idaho's most vulnerable citizens and the very patients EMTALA was designed to protect.

INTRODUCTION AND SUMMARY OF ARGUMENT

The stakes of this Court's decision could not be higher. EMTALA requires a hospital that participates in Medicare to offer stabilizing treatment to any patient with an emergency condition that seriously threatens her life or health, including an abortion where necessary to prevent grave harm or death to a pregnant patient. Section 18-622 conflicts with EMTALA's guarantee of emergency stabilizing care by prohibiting the provision of abortion care even when necessary to prevent grave and lasting harms to the mother. If this law is not struck down, it will result in higher maternal mortality and impose cruel and needless suffering upon some of the most vulnerable women in Idaho, many of whom may be facing emergency medical circumstances and need abortion care because of IPV—revictimizing them with yet another, equally pernicious form of gender-based violence.

The need for access to emergency stabilizing care permeates the lives of those experiencing IPV. This is especially so during pregnancy. Pregnant women are at an increased risk of experiencing IPV in general, and more violent forms of IPV in particular. It is estimated that 324,000 pregnant women experience IPV in the United States each year, a figure that Amici consider an underestimation. Injuries from IPV, such as kicking, punching and pushing, can and do lead pregnant patients to seek emergency stabilizing care guaranteed under EMTALA, which, in some cases, requires abortion care to protect the patient from serious harm. Women experiencing IPV, who are disproportionately low-income and from other marginalized communities, are also less likely to receive consistent, quality primary care throughout pregnancy—making them more likely to experience the types of obstetric complications that endanger pregnant patients' long-term health and lives and necessitate emergency treatment. EMTALA guarantees that these vulnerable patients will receive emergency stabilizing care, including emergency abortion services where necessary, to protect their lives and to prevent serious adverse health consequences.

Section 18-622 denies pregnant patients access to this necessary emergency stabilizing care, directly causing serious bodily harm and potentially death. On its face, the law requires a patient to be at death's door to receive an abortion, even when that is the only stabilizing care that may prevent grave harm to her health. If this Court concludes that EMTALA does not preempt state abortion bans like Section 18-622, emergency room doctors and hospitals will deny

necessary treatment out of fear of criminal prosecution or loss of license, and pregnant patients experiencing health emergencies will not receive the emergency stabilizing care they desperately need and are entitled to under EMTALA. Patients will suffer until their conditions worsen to such an extent that a doctor feels confident that performing an emergency abortion will not trigger the statute. Some patients will not survive, due to the serious and unpredictable nature of conditions like eclampsia and sepsis, and many will never fully recover. By preventing access to critical, emergency stabilizing care that pregnant patients require, Section 18-622 itself constitutes a form of gender-based violence, offending domestic and international norms of political and social equality. This grotesque abuse of pregnant patients, and particularly those experiencing IPV, undeniably sets Idaho and states with similar abortion bans on a backward path.

As advocates for the vulnerable populations that will disproportionately bear the unconscionable impacts of Section 18-622, Amici respectfully submit this brief in support of Respondent the United States.

ARGUMENT

A. By prohibiting care that EMTALA requires, Section 18-622 exacerbates the suffering and risk of serious life-long injury or death of pregnant patients experiencing intimate partner violence.

This case concerns whether EMTALA preempts Idaho law in the narrow but critically important circumstance where terminating a pregnancy is required in order to stabilize an emergency medical condition posing grave risks to a patient's health, but Section 18-622 prohibits an emergency-room physician from providing that care. For any pregnant patient, experiencing this type of serious medical emergency is painful and terrifying—and all the more so for pregnant patients experiencing IPV. Amici urge this Court to consider the compounding effect of the harms caused by Section 18-622 for pregnant patients who arrive at an emergency department with emergency medical conditions resulting from physical abuse. This Court should not permit Idaho to further endanger these women's lives and empower their abusers by denying them emergency stabilizing care. This Court should affirm the judgment of the district court.

1. Physical violence often sends pregnant patients to the emergency department with dangerous injuries that qualify as "emergency medical conditions" under EMTALA.

EMTALA's protections are especially important for pregnant patients experiencing IPV because this

group is more likely than other groups to need emergency stabilizing care. When "any individual . . . comes to a [Medicare participating] hospital" with an "emergency medical condition," EMTALA requires emergency departments to offer treatments "as may be required to stabilize the medical condition."[2] Abuse can be, and often is, the direct cause of pregnant women's emergency medical conditions by causing physical injuries to their pregnancies.[3] These injuries can include "preterm premature rupture of the membranes," which can result in infection, sepsis or organ failure; "placental abruption," which can result in "uncontrollable bleeding" or "organ failure"; and "uncontrollable uterine hemorrhage," which can "requir[e] hysterectomy" or result in "kidney failure requiring lifelong dialysis."[4] In fact, IPV against pregnant women is so common that *homicide is the number one cause of death for pregnant women in the United States*.[5] Without EMTALA, many pregnant women would not get the care they need for the near-fatal injuries abusers inflict upon them. Unless this

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[2] 42 U.S.C. § 1395dd(b)(1). *See also* § 1395dd(e)(1)(A) (defining "emergency medical condition"); § 1395dd(e)(4) (defining "to stabilize").

[3] *See* Sristy Agarwal et al., *A Comprehensive Review of Intimate Partner Violence During Pregnancy and Its Adverse Effects on Maternal and Fetal Health*, 15 Cureus e39262 at 2 (May 20, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10278872/.

[4] *United States v. Idaho*, 623 F.Supp.3d 1096, 1101, 1105 (D. Idaho 2022).

[5] *See Homicide Leading Cause of Death for Pregnant Women in U.S.*, Harv. T.H. Chan Sch. Pub. Health (Oct. 21, 2022), https://www.hsph.harvard.edu/news/hsph-in-the-news/homicide-leading-cause-of-death-for-pregnant-women-in-u-s/.

Court concludes that EMTALA preempts state abortion bans like Section 18-622, pregnant patients experiencing IPV will be at increased risk of substantial suffering, life-long injury or death.

Amicus non-profit organization The National Domestic Violence Hotline ("The Hotline") has received numerous reports demonstrating how IPV can directly cause a need for emergency stabilizing care, including emergency pregnancy care:[6]

- **Caller, Age 19-24**: "Contact's partner ran her over with his car last night, and she says that her whole body is hurt, she has a big knot on the back of her head, and she's pregnant & started bleeding."[7]

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[6] Nat'l Domestic Violence Hotline, Hospitalization Due to Abuse–EMTALA Stories (March 21, 2024) (unpublished report) (on file with author). This brief contains stories from August 2020 to March 2024 that were collected by The National Domestic Violence Hotline's highly-trained advocates, who interact via phone, text and chat with survivors experiencing domestic violence or questioning unhealthy aspects of their relationships. During those interactions, The Hotline systematically collects data that reflects the demographic and situational details of those who seek assistance; however, The Hotline does not collect any personally identifiable information. The information, referrals and resources provided to individuals who contact The Hotline are anonymous and confidential. Data is managed at the highest level of sensitivity, then aggregated and summarized to better inform key decisions on how best to respond to those seeking help. Data may also derive from The Hotline's youth-focused healthy relationship and dating abuse prevention helpline, "love is respect."

[7] *See id*.

- **Caller, Age 25-33**: "In hospital right now due to [domestic violence] last night. [She] and kid's father were arguing. He was drunk. He's an alcoholic. He's been to rehab but it didn't work. He's been drinking heavier since she got pregnant. He came in [with] two screwdrivers in his hands. He was angry, acting crazy. Was telling her to "Get the f out" (sic), wants nothing to do [with] her or their child. Thinks he's trying to go get [with] his other child's mother. He ended up hitting her on the left side of her stomach. She ran away. Came to the hospital to check on baby and get help."[8]
- **Caller, Age 19-24**: "[P]regnant, calling from hospital. Back broken from [abusive partner's] physical abuse, strangled to the point to where she needed a neck brace."[9]
- **Caller, Age 19-24**: "Caller said her boyfriend, baby's dad (she's pregnant and due in Dec) hit her, strangled her today and threatened to kill her . . . I urged her to go to ER to seek medical care and she will have friend drive her."[10]
- **Caller, Age 25-33**: "Victim is 6 months pregnant and was just physically abused by her partner (punched, kicked in stomach). I talked with her a bit and she decided to

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[8] *See id.* (proper capitalization added).

[9] *See id.*

[10] *See id.*

> disconnect to go to get checked out at the hospital. I encouraged her to contact us again after she gets checked out."[11]

As is clear from these examples, women experiencing IPV are likely to suffer more, and more intense, violence during pregnancy.[12] Physical abuse during pregnancy, such as kicking, punching and pushing, can lead to emergency pregnancy complications, including placental abruption, hemorrhage, premature rupture of membranes and preterm labor.[13] If these emergency complications develop prior to fetal viability, the necessary stabilizing treatment may be abortion care.[14]

Without guidance on how to reconcile their EMTALA obligations with new state abortion restrictions, hospitals in states with bans similar to Idaho's are turning away bleeding women or telling them to wait in the parking lot until they are actively

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[11] *See id.*

[12] *See* Kamran Abbasi, *Obstetricians Must Ask About Domestic Violence*, 316 BMJ 9 (Jan. 1998), https://pubmed.ncbi.nlm.nih.gov/9451256/; Am. Coll. Obstet. & Gynecol., *Committee Opinion No. 518: Intimate Partner Violence*, 119 Obstet. & Gynecol. 412, 2 (2012, reaffirmed 2022), https://pubmed.ncbi.nlm.nih.gov/22270317/.

[13] *See* Agarwal et al., *supra* note 3, at 2.

[14] *See* J.A. 36-37; J.A. 357-59; J.A. 374; Ariel Sklar et al., *Maternal Morbidity After Preterm Premature Rupture of Membranes at <24 Weeks' Gestation*, 226 Am J. Obstet. & Gynecol. 558.e1, 558.e7 (Apr. 2022), https://pubmed.ncbi.nlm.nih.gov/34736914/.

crashing or in cardiac arrest,[15] and women are traveling thousands of miles and spending their entire life savings in order to receive necessary emergency stabilizing care.[16] Sadly, stories of pregnant patients enduring serious medical conditions while searching for emergency stabilizing care are becoming increasingly commonplace:

- A Wisconsin woman with placenta previa, a condition where the placenta attaches to the wrong part of the uterus, and which can cause bleeding during pregnancy or during or after delivery,[17] was told by local doctors that her pregnancy was life-threatening, but nevertheless, she had to travel 100 miles

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[15] For many pregnant patients experiencing IPV, contact with medical professionals, who in most states are mandatory reporters, is the first step to accessing resources and help (including The Hotline). Such interventions are potentially life-saving. Turning pregnant patients experiencing IPV away from the emergency department, or otherwise limiting opportunities for their contact with medical professionals, raises the risk that those patients will be subject to further violence, or killed.

[16] *See, e.g.,* Selena Simmons-Duffin, *'I'll Lose My Family.' A Husband's Dread During an Abortion Ordeal in Oklahoma*, NPR (May 1, 2023), https://www.npr.org/sections/health-shots/2023/05/01/1172973274/oklahoma-abortion-ban-exception-life-of-mother-molar-pregnancy; Nadine El-Bawab et al., *Delayed and Denied: Women Pushed to Death's Door for Abortion Care in Post-Roe America*, ABC News (Dec. 14, 2023), https://abcnews.go.com/US/delayed-denied-women-pushed-deaths-door-abortion-care/story?id=105563255.

[17] *See Placenta Previa*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/placenta-previa/symptoms-causes/syc-20352768 (last visited Mar. 27, 2024).

across state lines in order to find a doctor who would terminate it.[18]

- A Texas woman developed placenta accreta (a condition where the placenta grows further than normal into the uterine wall and which can cause severe bleeding after delivery [19]) due to delays in receiving abortion care caused by having to travel to Colorado to receive it, and almost had to have a hysterectomy as a result.[20]
- An Idaho-based health system already reports having to transfer patients who presented with preterm premature rupture of membranes (PPROM) out of state as a result of Section 18-622.[21]

Unlike these women, pregnant patients experiencing IPV typically cannot travel long distances or out of state to receive necessary emergency stabilizing care. This is because within relationships characterized by IPV, coercion and control can involve not only physical and sexual violence, but also emotional abuse, threats and

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[18] *See* El-Bawab et al., *supra* note 16.

[19] *See Placenta Accreta*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/placenta-accreta/symptoms-causes/syc-20376431 (last visited Mar. 27, 2024).

[20] *See* El-Bawab et al., *supra* note 16.

[21] *See* Brief for St. Luke's Health System as Amici Curiae Supporting Respondents, *Mike Moyle, Speaker of Idaho House of Representatives, et al. v. United States*, at 14 (Nos. 23-726, 23-727).

intimidation, economic abuse, surveillance and social isolation.[22] Abusers can control "how much [the IPV victim] is allowed to work, and [have] access to all of her digital passwords for [her] accounts."[23] As one caller shared with The Hotline, "they have each other's location, [and] he goes through [her] phone."[24] Women experiencing IPV often do not have the autonomy to carry out day-to-day activities, let alone to travel hundreds or thousands of miles while under physical duress. Moreover, they frequently cannot afford to travel, particularly when they do not control their own finances. Women living in poverty are nearly twice as likely to experience IPV.[25] IPV affects 70% of those receiving public assistance, 50% of those who are homeless and 38% of those on Medicaid.[26] Women who report high levels of household food insecurity, and who have borrowed money in the past four weeks due to hunger, are also more likely to have

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[22] *See Power and Control*, Nat'l Domestic Violence Hotline, https://www.thehotline.org/identify-abuse/power-and-control/ (last visited Mar. 27, 2024).

[23] *See* Nat'l Domestic Violence Hotline, *supra* note 6.

[24] *See id.*

[25] *See* Erika A. Sussman & Sara Wee, *Accounting for Survivors' Economic Security: An Atlas for Direct Service Providers,* Ctr. for Survivor Agency & Just., at 1 (2016), https://csaj.org/wp-content/uploads/2021/10/Accounting-for-Survivors-Economic-Security-Atlas-Mapping-the-Terrain-.pdf; *see generally* Natalie J. Sokoloff & Ida Dupont, *Domestic Violence at the Intersections of Race, Class, and Gender: Challenges and Contributions to Understanding Violence Against Marginalized Women in Diverse Communities*, 11 Violence Against Women 38 (2005), https://pubmed.ncbi.nlm.nih.gov/16043540/.

[26] *See* Sussman & Wee, *supra* note 25, at 1.

experienced IPV.[27] An abuser can "[have a woman] put her paycheck into his account" or "financially ruin[] her and [cause enough] emotional distress that [she has] to take short term disability from her job for [post-traumatic stress disorder]."[28] The costs of the travel, lodging and medical bills required to seek an emergency stabilizing abortion out of state can amount to thousands or even tens of thousands of dollars,[29] expenses that are simply out of reach for many patients suffering from IPV.

In sum, traveling out of state for needed emergency stabilizing care is impossible for women like The Hotline caller whose "partner has taken all her money [and] also refuses to leave her home," where she remains unsafe as her partner is "biting her stomach" during her pregnancy.[30]

IPV during pregnancy is not a hypothetical or niche issue: an estimated 324,000 pregnant women experience IPV in the United States each year,[31] a figure that Amici consider an underestimation. Pregnant women are at an increased risk of IPV; when

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[27] Andrew Gibbs et al., *Associations Between Poverty, Mental Health and Substance Use, Gender Power, and Intimate Partner Violence Amongst Young (18-30) Women and Men in Urban Informal Settlements in South Africa: A Cross-Sectional Study and Structural Equation Model*. 13 PLOS ONE e0204956 at 7-9 (2018), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0204956.

[28] *See* Nat'l Domestic Violence Hotline, *supra* note 6.

[29] *See* El-Bawab et al., *supra* note 16.

[30] *See* Nat'l Domestic Violence Hotline, *supra* note 6.

[31] *See* Am. Coll. Obstet. & Gynecol., *supra* note 12, at 413.

reported and detected, the prevalence of IPV during pregnancy can range as high as 35%.[32] Low-income pregnant women and pregnant women of color, who are further burdened by transgenerational racism and poverty, suffer even higher rates of IPV.[33] Pregnant IPV victims are incredibly vulnerable to physical abuse, as demonstrated by The Hotline callers who recount how abusers target their pregnancies, directing punches, kicks and other attacks at their stomachs.[34] Such injuries require medical attention and, if the patient is experiencing an emergency medical condition, the emergency stabilizing care that EMTALA guarantees, including, in some cases, emergency abortion care. Section 18-622 prevents doctors from providing this care when it would fall outside of Section 18-622's exceedingly narrow and amorphous "life" exception, effectively doubling-down on the harm the abuser has caused.

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[32] *See* Agarwal et al., *supra* note 3, at 1.

[33] One study found that the rate for pregnant mothers on Medicaid was 49.5 versus 16.3 for those with private health insurance. The same study found that 157 Black women were admitted to the hospital for an assault while pregnant per 100,000 births, as compared to 19 for White women and 20 for Hispanic women. Anna Aizer, *Poverty, Violence and Health: The Impact of Domestic Violence During Pregnancy on Newborn Health*, 46 J. Hum, Resour. 518, 522 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4019993/.

[34] *See* Nat'l Domestic Violence Hotline, *supra* note 6.

2. Section 18-622, to the extent that it conflicts with EMTALA, does not account for the complex dynamics of intimate partner violence and the importance of emergency stabilizing care in the lives of pregnant patients experiencing it.

Beyond direct physical injury to pregnant women, the experience of IPV heightens barriers to accessing timely and preventative prenatal care, thus increasing the risk and severity of potential pregnancy complications and the likelihood that a pregnant woman will develop an emergency medical condition.[35] Abusers—who have a heightened interest in limiting access to healthcare to hide their abuse—often track, control and restrict their victims' access to medical care, and closely monitor their phone and Internet usage. [36] Many abusers also use "reproductive coercion," defined as threats or acts of violence against a partner's reproductive health or

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[35] *See* Susan Cha & Saba W. Masho, *Intimate Partner Violence and Utilization of Prenatal Care in the United States*, 29 J. Interpersonal Violence 911, 918 (Nov. 6, 2013), https://journals.sagepub.com/doi/abs/10.1177/0886260513505711; Brittany Jamieson, *Exposure to Interpersonal Violence During Pregnancy and Its Association with Women's Prenatal Care Utilization: A Meta-Analytic Review*, 21 Trauma, Violence & Abuse 904, 909-16 (2020), https://pubmed.ncbi.nlm.nih.gov/30322355/.

[36] *See A Glimpse From the Field: How Abusers are Misusing Technology*, Nat'l Network to End Domestic Violence (2014) at 2, https://static1.squarespace.com/static/51dc541ce4b03ebab8c5c88c/t/54e3d1b6e4b08500fcb455a0/1424216502058/NNEDV_Glimpse+From+the+Field+-+2014.pdf. Approximately 71% of domestic abusers monitor victims' computer activities and 54% of abusers track victims' cellphones with stalking apps. *Id.*

reproductive decision-making.[37] In fact, calls to The Hotline concerning reproductive coercion nearly doubled in the year after the *Dobbs* decision as compared to the prior year.[38] Women experiencing IPV are especially likely to delay prenatal care for fear of pelvic exams, which can be retraumatizing to survivors of sexual violence,[39] or as a result of increased anxiety around discovery by their

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[37] *See Reproductive Coercion*, Nat'l Domestic Violence Hotline, https://www.thehotline.org/resources/reproductive-coercion/ (last visited Mar. 27, 2024). Furthermore, human traffickers, who often engage in physical abuse, will impregnate their victims as a tool to manipulate them into compliance. *See The Intersections of Domestic Violence and Human Trafficking*, Nat'l Network to End Domestic Violence, Ctrs. for Disease Control & Prevention, https://nnedv.org/latest_update/intersections-domestic-violence-human-trafficking/ (last visited Mar. 27, 2024).

[38] *See* Jennifer Gerson, *Domestic Violence Calls About "Reproductive Coercion" Doubled After the Overturn of Roe*, The 19th (Oct. 18, 2023), https://19thnews.org/2023/10/domestic-violence-calls-reproductive-coercion-dobbs-decision/.

[39] Compounding the trauma, pregnancies in relationships characterized by IPV are often the result of reproductive coercion or rape. Almost three million women in the United States have experienced rape-related pregnancy in their lifetime, and 30% of those raped by an intimate partner having experienced a form of reproductive coercion, such as refusing to wear a condom. *See Understanding Pregnancy Resulting from Rape in the United States*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/violenceprevention/sexualviolence/understanding-RRP-inUS.html (last visited Mar. 27, 2024).

partners.[40] Research has indicated that women experiencing IPV during pregnancy are twice as likely to miss prenatal care appointments, and are also twice as likely not to initiate prenatal care until the third trimester.[41] As a result, an already vulnerable population is made even more so. Pregnant women who do not receive routine prenatal care are more likely to develop the types of emergency pregnancy complications for which EMTALA ensures stabilizing treatment.[42]

At bottom, Section 18-622 demonstrates a troubling disregard for the experiences of pregnant patients, ensuring that those already experiencing violence in their homes and intimate relationships will again be victimized in the hospitals they turn to for protection and necessary emergency care. Should this Court hold that EMTALA does not preempt state

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[40] *See* Hunter K. Holt et al., *Delayed Visits for Contraception Due to Concerns Regarding Pelvic Examination Among Women with History of Intimate Partner Violence*, 36 J. Gen. Intern. Med. 1883, 1887 (July 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8298732/; Jessica Leight & Nicholas Wilson, *Intimate Partner Violence and Maternal Health Services Utilization: Evidence From 36 National Household Surveys*, 21 BMC Pub. Health at 13 (Feb. 25, 2021), https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10447-y.

[41] *See* Jeanne L. Alhusen et al., *Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes*, 24 J. Women's Health 100, 101 (Jan. 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4361157.

[42] *See* Cristina Novoa, *Ensuring Healthy Births Through Prenatal Support*, Am. Prog. (Jan. 31, 2020), https://www.americanprogress.org/article/ensuring-healthy-births-prenatal-support/.

abortion bans similar to Section 18-622, pregnant patients will experience severe and potentially fatal consequences. EMTALA does not permit this outcome, which will be borne disproportionately by already vulnerable populations, including pregnant patients experiencing IPV.

B. By requiring pregnant patients to incur serious but preventable harms or to suffer until their medical conditions become life-threatening, Section 18-622 amounts to gender-based violence.

By requiring medical professionals to withhold abortions even where necessary to avoid serious harm, Section 18-622 will result in severe bodily injury and death to pregnant persons—a form of gender-based violence that cannot be reconciled with international consensus around the need for emergency stabilizing care.

Put bluntly, Section 18-622 will cause the deaths of pregnant patients. In Idaho, pregnant patients and their doctors are prevented from making decisions about how to treat terrifying and grave medical concerns, some of which may truly be life-or-death decisions that must be made quickly. Conditions that may not yet necessarily or definitively pose an immediate risk to a pregnant patient's life, including serious infections, preeclampsia or premature preterm rupture of membranes, may require pregnancy termination as emergency stabilizing care.[43] Leaving these conditions untreated,

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[43] *See Idaho*, 623 F.Supp.3d at 1104-05 (*citing* Fleisher Decl. ¶¶ 15-22, ECF 17-3).

or delaying treatment until the patient is on the verge of death, can cause grave harms, such as strokes, sepsis and kidney failure, which can ultimately kill the patient or cause debilitating long-term conditions.[44]

Section 18-622 will also brutalize pregnant patients by forcing them to wait to receive necessary medical treatment until their condition is so severe that their medical provider determines that they are at risk of imminent death. By preventing medical professionals from administering emergency stabilizing care, Section 18-622 may cause pregnant patients to lose their ovaries, uteruses and the ability to have children in the future.[45] Apart from threatening a patient's fertility, Section 18-622 creates grave risks that patients will suffer any number of other seriously debilitating consequences. Upon evaluating the record, the district court recognized the range of medical dangers posed by the statute:

> [I]f the physician does not perform the abortion, the pregnant patient faces grave risks to her health—such as severe sepsis requiring limb amputation, uncontrollable uterine hemorrhage requiring hysterectomy, kidney failure requiring lifelong dialysis, hypoxic brain

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[44] *Id.*

[45] *See, e.g.*, J.A. 373-74, J.A.37-38; Jennifer W. Tsai & Hazar Khidir, *Emergency Medical Treatment and Labor Act is No End-Run Around Abortion Bans*, STAT, (Jan. 4, 2023), https://www.statnews.com/2023/01/04/emergency-medical-treatment-labor-act-no-end-run-around-abortion-bans/.

> injury, or even death. And this woman, if she lives, potentially may have to live the remainder of her life with significant disabilities and chronic medical conditions as a result of her pregnancy complication. All because Idaho law prohibited the physician from performing the abortion.[46]

Moreover, while women wait for critical emergency stabilizing care, they will be in pain. For example, severe sepsis, which can result from denial of abortion as emergency stabilizing care for preeclampsia, is a "life-threatening emergency that happens when your body's response to infection damages vital organs and, often, causes death."[47] Sepsis patients "are usually the sickest patients in the hospital and time is of the utmost importance."[48] Section 18-622 does not allow for an abortion as emergency stabilizing care even when the denial of such treatment places a patient at serious risk of harm, requiring an artificial, frightening and dangerous wait for stabilizing treatment until the patient's medical condition becomes grave enough to threaten her life. Far from inevitable, these risks are preventable through a medically indicated abortion, as required by EMTALA.

Data emerging from states with abortion bans that conflict with EMTALA paint a grim picture. For

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[46] *Idaho*, 623 F.Supp.3d at 1101.

[47] *Severe Sepsis*, Sepsis All., https://www.sepsis.org/sepsis-basics/what-is-sepsis/severe-sepsis/ (last visited Mar. 27, 2024).

[48] *Id.*

example, a recent study analyzed maternal morbidity and medical consequences in Texas as compared to other states without such bans,[49] after Texas, like Idaho, banned abortions except to save the life of the pregnant patient.[50] In Texas, so-called "expectant management" (monitoring a patient's condition until symptoms worsen) resulted in 57% of patients experiencing a serious maternal morbidity, including conditions such as clinical chorioamnionitis, hemorrhage and placental abruption.[51] By comparison, in states without similar abortion restrictions, only 33% of patients who elected immediate pregnancy termination experienced such conditions.[52] EMTALA provides critical protections for these types of emergency conditions that seriously threaten a pregnant patient's health.

As discussed by the district court, it is often difficult to definitively determine whether abortion is "necessary to prevent the death" of the mother—until it is too late.[53] Idaho has provided little comfort to

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[49] *See* Anjali Nambiar & Shivani Patel, *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in Two Texas Hospitals After Legislation on Abortion*, 227 Am. J. Obstet. & Gynecol. 648 (Oct. 2022), https://www.ajog.org/action/showPdf?pii=S0002-9378%2822%2900536-1.

[50] In *Texas v. Becerra*, the Fifth Circuit enjoined Department of Health and Human Services guidance that reminded healthcare providers that EMTALA requires emergency abortion care. *Texas v. Becerra*, 89 F.4th 529, 546 (5th Cir. 2024).

[51] *See* Nambiar & Patel, *supra* note 49, at 649.

[52] *See id.*

[53] *Idaho*, 623 F.Supp.3d at 1112-13.

doctors seeking guidance: the state has offered only that doctors should rely on their good faith judgment in this high-stakes determination.[54] As long as threats of jail or loss of their license loom should their good-faith judgment be questioned in court, doctors will be deterred from performing life-saving or stabilizing emergency procedures, even if they consider abortion necessary to prevent long-term serious health consequences or ultimately death.

By preventing access to critical, emergency stabilizing care that pregnant patients need, Section 18-622 itself constitutes a form of gender-based violence. A lack of access to emergency abortion care is far out of step with the international consensus that pregnant patients are entitled to at least a minimal level of emergency stabilizing care. The international community has agreed that women have the right to the highest attainable standards of health.[55] Even

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[54] *See* Idaho Code § 18-622(2)(a)(i) (permitting abortion only where "[t]he physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman.").

[55] *See* Declaration on the Elimination of Violence Against Women, Dec. 20, 1993, U.N.G.A. 48/104, art. 3 ("Women are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms," including "[t]he right to the highest standard attainable of physical and mental health."). Under international law, States should take legislative and other measures to ensure equality and non-discrimination and provide equal access to health care services for women. 189 UN Member States are party to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The United States is not one of them; the United States is only a signatory.

countries that do not recognize a right to abortion in all circumstances recognize exceptions beyond those permitted by Idaho.[56] The trend in peer countries is towards liberalization, rather than further restriction, of abortion.[57] For example, Ireland, which previously had a near-total abortion ban, in 2018 "legalized the termination of pregnancy before twelve weeks, as well as in cases in which the health of the mother is at stake."[58] On the other hand, in the United States, between 2018 and 2020, in states with abortion restrictions, the maternal mortality rate has increased

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The only other full Member States that are not party are: Iran, Palau, Somalia, Sudan, and Tonga. Convention on the Elimination of All Forms of Discrimination Against Women, Sept. 3, 1981, 1249 U.N.T.S. 13, arts. 1, 2, 3, 12(1).

[56] *See Abortion Law: Global Comparisons*, Council on Foreign Rels., https://www.cfr.org/article/abortion-law-global-comparisons (last visited Mar. 27, 2024); *see also* Johanna Fine et al., *The Role of International Human Rights Norms in the Liberalization of Abortions Laws Globally,* Health & Hum. Rts. J. (June 2, 2017), https://www.hhrjournal.org/2017/06/the-role-of-international-human-rights-norms-in-the-liberalization-of-abortion-laws-globally/.

[57] *See Accelerating Progress: Liberalization of Abortion Laws Since ICPD*, Ctr. Reprod. Rts., https://reproductiverights.org/sites/default/files/documents/World-Abortion-Map-AcceleratingProgress.pdf (last visited Mar. 27, 2024).

[58] *Id.*

almost twice as fast as in states without them.[59] Simply put, if allowed to override EMTALA's protections, Section 18-622 and similar laws will place the regard for the health of pregnant patients below that of virtually every other developed country.

CONCLUSION

Amici respectfully ask this Court to affirm the judgment of the district court and thereby protect the health and lives of pregnant patients in Idaho, as EMTALA requires.

Respectfully submitted,

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[59] *See* Eugene Declercq et al., *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions*, Commonwealth Fund (Dec. 14, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes#:~:text=We%20found%20that%20maternal%20death,17.8%20per%20100%2C000%20births).