Resuscitating Abortion Rights in Emergency Care

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On August 26, 2022, officials from the US Department of Health and Human Services warned state governors that the Biden administration would initiate legal action against states that bar physicians from providing abortion care in emergency situations. As reports mount of pregnant patients being denied potentially lifesaving care in emergency departments, the warning escalates a pitched battle over whether the administration can blunt the sharpest edges of Roe v Wade’s overturn.

At issue is a question with profound importance (given the rise of political polarization), which takes priority when state and federal health laws conflict? More pointedly, when state and federal laws require a physician to take divergent actions, “Which law should she violate?”

Because congressional Democrats lack the votes to pass legislation to restore abortion rights, the Biden administration has made several efforts to restore pieces of these rights through executive action. The administration's view is that regardless of the Supreme Court’s constitutional ruling, federal statutes protect certain avenues of access to abortion care. One key statute is the Emergency Medical Treatment and Labor Act (EMTALA), a Reagan-era law that requires hospitals with an emergency department that participate in Medicare to provide “stabilizing treatment” to patients presenting with an "emergency medical condition." EMTALA preempts state law only where the state law clearly conflicts with EMTALA’s requirements—ie, where one cannot comply with both laws.

On July 11, 2022, the Centers for Medicare & Medicaid Services (CMS) issued guidance stating that EMTALA requires emergency care facilities to provide abortion care when necessary to stabilize a patient’s emergency condition, even if state law prohibits it. Further, it is up to the care team to decide whether a patient has an emergency medical condition and what treatment is needed.

Texas immediately sued. Texas has a pre-Roe law criminalizing abortion except to save the pregnant person’s life and a “trigger law” prohibiting abortion unless patients have a life-threatening physical condition carrying a risk of death or serious risk of substantial impairment of a major bodily function.

On August 2, 2022, the Biden administration sued Idaho over its trigger law, which makes it a crime for any person to perform an abortion. That law’s only provision for emergency situations is an affirmative defense: a physician brought to trial can try to persuade the jury that she performed the abortion because she concluded it was necessary to prevent the pregnant person’s death.

On August 23 and 24, 2022, respectively, federal district court judges James Wesley Hendrix of Texas and B. Lynn Winmill of Idaho issued conflicting decisions. Hendrix held that EMTALA did not preempt Texas’s laws, whereas Winmill held that it did preempt Idaho’s law. Consequently, at this time, the EMTALA guidance cannot be enforced in Texas, but it precludes Idaho officials from enforcing that state’s abortion law in emergency situations. A bewildering patchwork of state abortion laws has thus become even more confusing.

What accounts for the disparate decisions? Both judges are highly qualified, were initially nominated by Democratic presidents, and wrote erudite opinions. The Idaho and Texas laws have differences—Texas allows abortions for ectopic pregnancies and to prevent very serious but nonfatal harm. But in many situations, both states’ laws would conflict with EMTALA because EMTALA’s definition of an emergency medical condition is broader than the states’ laws.

Three distinctions in the judges’ reasoning are discernible. First, Hendrix identified “gaps” in EMTALA. He wrote that Congress had not spoken to the precise issue—what EMTALA requires when
it comes to abortion. Yet, there was no reason for Congress to think it needed to issue specific instructions about abortion but not other kinds of emergency care because the legality of abortion was not in question at the time. Hendrix further opined that Congress created a gap when it made reference in EMTALA to providing care to both pregnant patients and unborn children but did not specify how to resolve conflicts between them. A natural explanation is that Congress assumed that when continuing a pregnancy involved serious risk, the pregnant patient and the physician would decide what to do. Congress did not need to dictate whether abortion should be chosen—only that it must be provided if medically necessary and consented to by the patient. Real or not, these purported gaps in EMTALA matter because they created the basis for Hendrix to conclude that, quite apart from the preemption question, the guidance was not legal because it overstepped the authority of the CMS.

Second, Winmill took a broader view of Congress’s objective in passing EMTALA than Hendrix, thereby finding state law to conflict with Congress’s purpose. Hendrix described EMTALA’s objective as preventing patient dumping (refusing to treat patients who cannot pay); Winmill characterized it as establishing “a bare minimum of emergency care that would be available to all.” Winmill found that Idaho’s law subverted this purpose by incentivizing physicians to delay care.7

Third, Winmill’s opinion alone is attuned to the realities of providing abortion care in the emergency setting. Hendrix is concerned that the guidance from the CMS “exclud[es] the health of the unborn child as a consideration” in care decisions. This conjures up a picture of emergency care greatly divorced from reality. Although some patients present with incomplete medical abortions, common scenarios include nonviable pregnancies (eg, incomplete spontaneous miscarriage, ectopic pregnancy) and difficult decisions to terminate wanted pregnancies after rejecting other options as insufficiently likely to address a severe health condition.8 To assert that the patient and the physician do not consider the fate of the fetus is not credible.

Winmill, for his part, acknowledged that physicians often cannot confidently predict which patients will die without abortion care—a prerequisite for invoking Idaho’s affirmative defense. Preeclampsia may or may not quickly progress to eclampsia; a ruptured amniotic sac could become septic and cause organ failure, but might not. Physicians may be unable to conclude that abortion is essential to prevent death in such situations, but feel confident it is needed to prevent serious harm. EMTALA accommodates such clinical uncertainty by requiring care whenever patients “could reasonably be expected” to suffer harm; state laws that do otherwise clearly conflict with EMTALA.

The uncertainty created by the divergent court decisions is unlikely to be resolved soon. The circuit courts that would hear appeals lean in different ideological directions and Supreme Court intervention may ultimately be needed. Meanwhile, Texas’s success may embolden other abortion-restricting states to press similar claims. Texas prosecutors could decide not to enforce the state’s laws in egregious emergency cases that would garner public sympathy, tempering the Texas ruling’s effect, but the Texas attorney general’s swift challenge to the EMTALA guidance instead signals an aggressive approach to enforcing these laws.

Also unresolved is how these statutes interact with malpractice liability. If the customary standard of care is to offer abortion in a particular medical crisis, physicians are arguably negligent if they do not. In theory, the legal standard of care should exclude treatment options that have become illegal. In reality, tort law can be slow to adapt. Where legal uncertainty exists, physicians can be counted on to fill the void with very cautious behavior.9 Until physicians feel secure practicing emergency care according to their clinical judgment, a new and pernicious form of defensive medicine is likely to predominate,10 and delays and denials of emergency care will exact a bitter human toll.
REFERENCES

2. 42 USC §1395dd.
4. HB 1280 §2 (to be codified at Tex Health and Safety Code 170A.002[b]).
5. Idaho Code §18-622.