

2024 Council Resolution 37: Reinforcing EMTALA in Pregnancy Related Emergency Medical Care

Council Action: ADOPTED

Board Action: ADOPTED

Status: In Progress

SUBMITTED BY: Rachel Solnick, MD
California ACEP
Michael J Bresler, MD, FACEP
American Association of Women Emergency Physicians Section
Kelly E Quinley, MD
Emily Erickson Ager, MD
Sophia Spadafore, MD, MA
Monica Saxena, MD, JD
Joshua S da Silva, DO, FACEP
Katherine Wegman, MD

Purpose:

Develop a policy statement reinforcing that: EMTALA applies universally to all emergency medical conditions without exception; support that treatment decisions, including those involving abortion, should be made solely between the patient and emergency clinician without legal interference; and emphasize the importance of allowing emergency physicians to provide care based on medical best practices without restrictions on treatment options.

Fiscal Impact:

Budgeted committee and staff resources for development and distribution of policy statements.

WHEREAS, Physician advocacy groups including the American College of Emergency Physicians (ACEP), the American College of Obstetricians and Gynecologists and the American Medical Association have affirmed that emergency physicians must be able to practice high quality, objective, evidence-based medicine without legislative, regulatory or judicial interference in the physician-patient relationship; and

WHEREAS, The Emergency Medicine Treatment and Labor Act (EMTALA) mandates that any patient who presents to an emergency department with an emergency medical condition receive stabilizing and life-saving care, and where such emergency medical conditions are defined as a conditions where the absence of immediate medical treatment could reasonably be expected to result in placing the individual's health in serious jeopardy or jeopardize bodily organs or functions; and

WHEREAS, EMTALA was established to ensure all patients, and specifically pregnant persons, have access to care and, moreover, protect the ability of physicians and clinicians to provide evidence-based care for patients and use their clinical judgment and expertise to determine how and when to stabilize and treat patients with life-threatening emergencies; and

WHEREAS, More than 2.77 million pregnant persons visit U.S. emergency departments annually; and

WHEREAS, Certain pregnancy-related emergencies and complications require termination of pregnancy to prevent death or the endangerment of the health of the pregnant and lifelong impairment including loss of fertility and kidney failure; and

WHEREAS, Abortion bans have created maternity care deserts where pregnant patients have limited access to prenatal care, resulting in greater numbers of patients likely to present to emergency departments with undiagnosed life-threatening pregnancy complications; and

WHEREAS, Abortion bans in some states have also created ambiguity and/or legal threats to emergency clinicians and other physicians for providing pregnancy-terminating care that is medically required, therefore be it

RESOLVED, ACEP develop a policy statement that delineates:

- EMTALA applies to all emergency medical conditions and there should be no exceptions to EMTALA for any specific emergency medical condition or the evidence-based treatment that would be used to stabilize a patient.
- ACEP supports that the decision to provide any procedure in the course of patient care to satisfy EMTALA requirements, including, but not limited to, abortion care and/or pregnancy termination, be made between the patient and the emergency clinician, and that laws and regulations should not inhibit or obstruct the patient-physician relationship.
- ACEP reinforces the need for emergency physicians to be able to provide care at the standard required by medical best practices and that no procedure or treatment be removed from those treatment options in the care of emergency patients served under federal EMTALA protections.

Background:

The resolution directs the College to develop a policy statement that delineates that the Emergency Medical Treatment and Labor Act (EMTALA) applies to all emergency medical conditions and evidence-based treatments used to stabilize a patient, without any exceptions; that ACEP supports the autonomy of the patient-physician relationship without inhibition or obstruction by laws and regulations; and that ACEP reinforces the need for emergency physicians to have all procedures and treatment options available to them to provide care at the standard required by medical best practices in the care of emergency patients served under federal EMTALA protections.

The June 24, 2022, decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization* held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. Because emergency departments commonly see patients presenting with obstetrical emergencies, this decision immediately triggered significant uncertainty on whether, in light of the existing federal EMTALA law, restrictions or prohibitions could now be imposed on their treatment in states with abortion and related reproductive health restrictions.

EMTALA has been in place since 1987 and includes three main obligations:

1. The law requires hospitals to provide a **medical screening examination** to every individual who comes to the ED seeking examination or treatment. The purpose of the medical screening exam is to determine whether a patient has an emergency medical condition (EMC).
2. If an individual is determined to have an emergency medical condition, the individual must receive **stabilizing treatment** within the capability of the hospital. Hospitals cannot transfer patients to another hospital unless the individual is stabilized.
3. If the individual is not stabilized, **they may only be transferred** if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks (the Centers for Medicare & Medicaid Services, or CMS, states in the guidance that patients who request to be transferred can only be transferred after a physician certifies that the medical benefits of the transfer outweigh the risks.)

A little less than a year before *Dobbs*, in September 2021 HHS released [guidance](#) reaffirming physicians' legal obligations under EMTALA, specifically when treating patients who are pregnant or are experiencing pregnancy loss. In this guidance, CMS:

- Stated that "an appropriate medical screening exam can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures." Patients must continue to be monitored until a physician or qualified health professional determines if the individual has an

- emergency medical condition, and if they do, until they are stabilized or appropriately transferred.
- Included a non-comprehensive list of EMCs involving pregnant people: ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features. CMS states that the “course of treatment necessary to resolve such emergency medical conditions is also under the purview of the physician or other qualified medical personnel. Stabilizing treatment could include medical and/or surgical interventions (e.g., dilation and curettage (D&C), removal of one or both fallopian tubes, anti-hypertensive therapy, etc.)” In other words, none of these procedures that a physician or other qualified medical professional directly involved in the care of the patient deems necessary to treat and stabilize a patient under the EMTALA mandate can be restricted by state laws.
- Declared that hospitals can only transfer women in labor “if the benefits of the transfer to the woman and/or the unborn child outweigh its risks. For example, if the hospital does not have staff or resources to provide obstetrical services, the benefits of a transfer may outweigh the risks.” Hospitals cannot cite state laws or practices as the basis for transfer. In other words, regardless of where the hospital is located and what state laws are in effect, patients with emergency medical conditions must be treated and cannot be transferred—unless the limited transfer allowances under EMTALA apply.

ACEP issued [a statement](#) the day of the *Dobbs* ruling in response expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, and reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship.

Just weeks later, in July 2022 CMS issued [additional EMTALA guidance](#). In this updated guidance, CMS:

- Reiterates that EMTALA pre-empts any directly contradicting state laws around the medical screening examination, stabilizing treatment, and transfer requirements. It specifically clarifies that if a physician believes that an abortion needs to be performed to stabilize a patient with an emergency medical condition, the physician MUST provide the treatment regardless of any state law that may prohibit abortions.
- States that with respect to what constitutes an EMC, the determination of an EMC “is the responsibility of the examining physician or other qualified medical personnel. An emergency medical condition may include a condition that is likely or certain to become emergent without stabilizing treatment.”
- States that EMTALA pre-empts “any state actions against a physician who provides an abortion in order to stabilize an emergency medical condition in a pregnant individual presenting to the hospital.”

In addition to the guidance, HHS Secretary Xavier Becerra, in a [letter to providers](#), further made clear that this federal law preempts state law restricting access to abortion in emergency situations.

However, there is still some grey area after the additional guidance from CMS. While the guidance noted that EMTALA can be raised as a defense by a physician facing state action, EMTALA does not provide any *proactive* protection to prevent an emergency physician from facing criminal charges brought by the state for providing this federally-mandated care. Some state restrictions only have an exception to allow abortion if it’s to prevent the death of the pregnant patient, but as noted EMTALA requires stabilizing treatment to prevent “serious impairment of bodily functions,” “serious dysfunction of any bodily organ or part,” or to prevent placing the health of the patient “in serious jeopardy.” ACEP has noted this is a key area of concern, potentially forcing emergency physicians in such states to choose between following EMTALA to avoid potential civil monetary penalties or following the state law to avoid potential criminal charges.

Therefore, ACEP joined amicus briefs addressing these issues. ACEP and the Idaho Chapter submitted a [brief](#) in the U.S. District Court for the District of Idaho on August 15, 2022, in support of the U.S. Department of Justice’s challenge to an Idaho law in *United States v. State of Idaho*. Because the Idaho law only allows for abortion if the life of the mother is in danger, the brief argued that if applied to emergency medical care, Idaho Law would force physicians to disregard their patients’ clinical presentations, their own medical expertise and training, and their obligations under EMTALA – or risk criminal prosecution. The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus [brief](#), this time in in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services’ guidance on the EMTALA. The State of Texas had filed suit (*State of Texas v. Becerra*) arguing the federal government did not have the authority to provide medical guidance. The amicus brief emphasized the proper interpretation of EMTALA and the possibility that what under Texas law would constitute pregnancy termination may be appropriate in the emergency department when deemed necessary to provide stabilizing treatment of the patient. The brief explained that the Federal guidance merely restates physicians’ obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

Since that time, there has been significant activity at the state level, in the courts, and at the federal level.

State level activities have been too numerous to summarize fully in this resolution background, but of note several states have undertaken their own EMTALA-like policy-setting:

- The Massachusetts governor, in June, released an executive order reaffirming that Massachusetts law provides a right to prompt treatment in an emergency – including emergency abortion care – without discrimination on account of economic status or source of payment.
- New York saw a bill introduced (A.5297A) under which a healthcare practitioner must not be prohibited from providing healthcare services related to complications with pregnancy in cases in which a failure to act would violate the accepted standard of care. The bill also prohibits a healthcare entity from taking adverse action against a practitioner for providing services consistent with this bill.
- In Washington, the Governor issued a directive calling on the Department of Health to issue a policy statement reaffirming and clarifying the requirements under state law for hospitals to provide emergency abortion services. Issued on June 17, the policy statement says, “If a pregnant person presents to a hospital’s emergency department with an emergency medical condition for which termination of the pregnancy is the standard of care, the hospital is required to provide that abortion care in accordance with and as promptly as dictated by the standard of care or, if authorized under RCW 70.170.060(2), WAC 246-320-281(1), and other applicable state and federal law, transfer the patient to another hospital capable of providing the care.”

In the courts:

- A preliminary injunction was issued by the U.S. District Court of Idaho (Southern Division) on August 24, 2022 that found that the exception for the life of the mother under Idaho’s abortion ban was narrower than federal law which “protects patients not only from imminent death but also from emergencies that seriously threaten their health,” and blocked the state law. The injunction provided a degree of legal certainty for EMTALA-certified hospitals, medical providers, and pregnant patients that care for obstetrical emergencies was still permissible under EMTALA.
 - The state legislature then filed an appeal before the 9th Circuit. After continued legal wrangling in the Circuit Court, the US Supreme Court intervened in January of 2024, allowing Idaho’s criminal abortion ban to take effect and agreeing to hear the case in April.
 - ACEP joined together with ACOG and the AMA as lead amici [on an amicus brief](#) joined by 23 other medical societies to educate the Supreme Court on the importance of protecting the physician-patient relationship and ensuring that all patients receive health care that is medically and scientifically sound and in compliance with EMTALA. ACEP also joined these groups in a statement calling for the Court not to weaken EMTALA, noting:

“...In many of these emergency situations, the only way to treat or stabilize a patient is to end the pregnancy that is complicating or threatening their health...As organizations representing health care professionals, we understand that not every patient who presents to the emergency room while pregnant will need abortion care. But EMTALA should guarantee that patients experiencing pregnancy complications in the emergency setting are able to get evidence-based care, which includes being counseled fairly and honestly and receiving an abortion if that is the intervention that they need for their health emergency. Without comprehensive EMTALA protections, the lives of pregnant patients will most certainly be at risk. EMTALA must continue to protect pregnant people just as it protects those who aren’t pregnant.”

- The Supreme Court ultimately ruled on June 27, 2024, dismissing the case as improvidently granted, and restored the 2022 lower court order to, for now, allow emergency abortions to proceed in Idaho under EMTALA. This decision does not provide any clarity or determination on whether EMTALA supersedes state laws such as Idaho’s, and it is expected the case will return back to the Supreme Court in the coming year.
- In Texas, a federal district judge in August 2022 agreed with the state in *State of Texas v. Becerra*, saying the guidance amounted to a new interpretation of EMTALA and granted a temporary injunction upholding the implementation of the state’s law.
 - The case eventually made its way to the 5th Circuit which affirmed the lower court’s decision. Judge Leslie Southwick at the hearing described HHS’s guidance as an effort to expand abortion access beyond life-saving care to “broader categories of things, mental health or whatever HHS would say an abortion is required for.” HHS has since asked the Supreme Court to take up the case. In the meantime, the Biden administration’s guidance that EMTALA preempts state abortion bans is suspended in Texas only. It is possible that this case and the Idaho case could be

consolidated and considered by the Supreme Court as one.

Federally:

- In May of 2024, CMS [launched a new portal](#) for both patients and providers to submit anonymous complaints of potential EMTALA violations in hospital EDs for investigation. ACEP has added a link to the complaint portal on its own [resource page on reproductive health care](#). It should be noted the portal specifically exempts providers in the state of TX due to the injunction resulting from the Texas 5th Circuit decision.
- Following the Supreme Court decision in Idaho, HHS sent [another letter](#) to hospital and provider associations across the country reminding them that it is a hospital's legal duty to offer necessary stabilizing medical treatment (or transfer, if appropriate) to all patients in Medicare-participating hospitals who are found to have an emergency medical condition. CMS also announced that the investigation of EMTALA complaints would proceed in Idaho while litigation continues in the lower courts.

ACEP's policy statement "[Interference in the Physician-Patient Relationship](#)" states: "The American College of Emergency Physicians (ACEP) believes that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship."

Strategic Plan Reference:

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state and professional.

Prior Council Action:

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted. Directed ACEP to work with other relevant stakeholders to determine the best approaches for preparing emergency medicine trainees in the management of early pregnancy loss; recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

Amended Resolution 44(23) Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss referred to the Board of Directors.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP to affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals. Directed ACEP to support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care:

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine. Directed that ACEP oppose any and all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

Prior Board Action:

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted.

June 2023, approved the policy statement "[Access to Reproductive Healthcare in the Emergency Department.](#)"

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care

adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

June 2022, approved the policy statement "[Interference in the Physician-Patient Relationship](#)"

Amended Resolution 32(19) Legal and Civil Penalties for the Routine Practice of Medicine adopted.

October 2016, approved the revised "[Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy](#)."

Council Action:

Reference Committee B recommended that Resolution 37(24) be adopted.

The Council adopted Resolution 37(24) on September 28, 2024.

Testimony:

Asynchronous testimony was mostly supportive. Comments in support of the resolution noted the resolution would support the College's commitment to defending physician autonomy and providing necessary stabilizing care and that physicians understand there is a risk of being sued for patient outcomes but do not expect to be held criminally liable for medically appropriate care for pregnancy-related conditions. Some noted that the fear of prosecution has a chilling effect on physicians' ability to provide appropriate medical care, and that this resolution represents an important step to protect emergency physicians from criminal prosecution and gives them appropriate legal protections when administering appropriate medical treatment for pregnancy-related emergencies. The comment in opposition noted disagreement of the Idaho statute in question and that the statute is not written to be punitive for a physician acting in "good faith" to preserve the life of the mother, and that the end goal of the resolution seems to be to provide abortion services through the emergency department. Live testimony was largely in support of the resolution. Testimony in opposition was limited to concerns about generalized applicability to other states, as well as potential for the resolution to be duplicative to existing College policy statements.

Board Action:

The Board adopted Resolution 37(24) on October 2, 2024.

References:

Implementation Action:

Assigned to the Medical-Legal Committee.

Background Information Prepared by: Laura Wooster, MPH

Reviewed by: Sandy Schneider, MD, FACEP

Melissa Wysong Costello, MD, FACEP

Michael McCrea, MD, FACEP