EMTALA'S LATENT CAUSE OF ACTION: HOSPITALS' DUTY TO KEEP EMERGENCY CARE "AVAILABLE"

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ABSTRACT

After *Dobbs v. Jackson Women's Health Organization*, states have enacted criminal abortion bans with only narrow and ambiguous exceptions, resulting in dangerous treatment delays for pregnant patients experiencing emergency medical complications. Abortion-access advocates have turned to the Emergency Medical Treatment and Labor Act (EMTALA), a federal statute that imposes a duty on hospitals to stabilize emergency conditions, arguing that EMTALA preempts restrictive state laws. The ensuing preemption debate has paid little attention to a key aspect of the statute: a provision specifying that the treatment obligation applies only to care "within the staff and facilities available at the hospital," which reveals that EMTALA's reach turns on hospitals' own choices about which services to make available. This Note raises that even if EMTALA preempts state abortion bans, this statutory carve-out enables hospitals to adopt categorical anti-abortion policies to evade EMTALA's requirements, threatening abortion access even in life-threatening medical emergencies.

This Note argues that courts should recognize an affirmative obligation under EMTALA—which necessarily follows from the statute's text and structure—that requires hospitals to keep standard emergency treatments available and to provide

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specialized treatments whenever they have the medical capability to do so. By distinguishing standard from specialized care using objective medical criteria (not state restrictions, and not hospital policy) courts can prevent administrators from adopting "unavailability" policies to avoid federal obligations. This interpretation simultaneously vindicates EMTALA's core anti–patient-dumping purpose and avoids creating a *de facto* federal malpractice regime. Properly understood, EMTALA contains a previously unarticulated cause of action that prevents hospitals from eliminating emergency treatment options, and thereby ensures access to life-preserving abortion care in emergency medical situations.

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INTRODUCTION

Amber Nicole Thurman, a twenty-eight-year-old Georgia resident, took abortion pills that failed to expel the fetal tissue from her body.[1] Beginning to suffer from a severe infection, she went to Piedmont Henry Hospital in need of a routine procedure to clear the tissue from her uterus.[2] Georgia imposes criminal penalties, including up to ten years of prison time, upon doctors who provide an abortion after around six weeks of pregnancy, with a narrow exception for when an abortion is needed to save the pregnant person's life.[3] Awaiting an imminent threat to Thurman's life, doctors at the hospital delayed twenty hours while she suffered in her hospital bed—her infection spreading, her blood pressure falling, and her organs beginning to fail.[4] When the doctors finally intervened, it was too late to save her life.[5] Investigating members of the Georgia Maternal Mortality Review Committee reported that Thurman's death was "preventable."[6]

In the wake of *Dobbs v. Jackson Women's Health Organization*, fourteen states have enacted total abortion bans that prohibit doctors from performing an abortion at any stage in a pregnancy, no matter how early.[7] Four states, including Georgia,

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1. Kavitha Surana, *Abortion Bans Have Delayed Emergency Medical Care. In Georgia, Experts Say This Mother's Death Was Preventable*, PROPUBLICA (Sept. 16, 2024), https://www.propublica.org/article/georgia-abortion-ban-amber-thurman-death [https://perma.cc/FB5V-SH4V].

2. *Id.*

3. GA. CODE ANN. § 16-12-140–141 (2025) (prohibiting abortions once embryonic cardiac activity is detectable); *The Science Behind Embryonic Heartbeats – A Fact Sheet*, CHARLOTTE LOZIER INST. (Aug. 4, 2025), https://lozierinstitute.org/the-science-behind-embryonic-heartbeats-a-fact-sheet/ [https://perma.cc/2LQA-8VF4] (providing that a heartbeat is typically detectable at around six weeks).

4. Surana, *supra* note 1.

5. *Id.*

6. *Id.*; Georgia has since dismissed all members of that Committee for "inappropriately" sharing information with outside individuals. Amy Yurkanin, *Georgia Dismissed All Members of Maternal Mortality Committee After ProPublica Obtained Internal Details of Two Deaths*, CNN HEALTH (Nov. 21, 2024), https://www.cnn.com/2024/11/21/health/georgia-maternal-mortality-committee-propublica [https://perma.cc/J3F2-6JBH].

7. Allison McCann & Amy Schoenfeld Walker, *Tracking Abortion Laws Across the Country*, N.Y. TIMES (last updated July 7, 2025), https://www.nytimes.com/interactive/2024/us/abortion-laws-roe-v-wade.html [https://perma.cc/3HYW-MHJN] (providing that abortion is not sanctioned at any point in a pregnancy, save narrow exceptional circumstances that vary by state, in

have banned abortion after six weeks,[8] before many people learn that they are pregnant.[9] Three additional states ban the treatment well before fetal viability,[10] and three states ban it just before viability at twenty-two weeks.[11] All bans currently include at least one narrow exception for circumstances in which the life of the pregnant person is in imminent danger,[12] as may be constitutionally required.[13] However, due to the exceptions' vague language and narrow applicability,

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Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia); *see* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

8. *Abortion in the United States Dashboard*, KAISER FAM. FOUND., https://www.kff.org/womens-health-policy/dashboard/abortion-in-the-u-s-dashboard/ [https://perma.cc/7B9P-QA3C] (last updated Dec. 20, 2024) (indicating that Florida, Georgia, Iowa, and South Carolina have a gestational limit of 6 weeks on abortion access) [hereinafter Abortion Dashboard].

9. Katie Watson & Cara Angelotta, *The Frequency of Pregnancy Recognition Across the Gestational Spectrum and its Consequences in the United States*, 54 PERSP. ON SEXUAL & REPROD. HEALTH 32, 33 (2022) (reporting that twenty-eight percent of survey respondents became aware of their pregnancy later than six weeks' gestation).

10. *See* McCann & Walker, *supra* note 7 (indicating that Nebraska and North Carolina ban abortion at 12 weeks and Utah after 18 weeks); AM. COLL. OF OBSTET. & GYNECOL., *Facts Are Important: Understanding and Navigating Viability*, https://www.acog.org/advocacy/facts-are-important/understanding-and-navigating-viability [https://perma.cc/DHS8-6UY9] (placing fetal viability in the U.S. between twenty- and twenty-five-weeks' gestation).

11. *See* McCann & Walker, *supra* note 7 (indicating that Ohio, Kansas, and Wisconsin ban abortion after twenty-two weeks).

12. *See* Mabel Felix et al., *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KAISER FAM. FOUND. (June 6, 2024), https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/ [https://perma.cc/QZ3E-NE7X] (summarizing that all bans and restrictions have an exception to "prevent the death of the pregnant person"); *see also* ARK. CODE ANN. § 5-61-303 (2025) (allowing abortion to "save the life" of the pregnant person); IDAHO CODE § 18-622 (2025) (similar); MISS. CODE ANN. § 41-41-45(2) (2025) (similar); OKLA. STAT. ANN. tit. 21, § 861 (West 2025) (similar); S.D. CODIFIED LAWS § 22-17-5.1 (2025) (similar); TEX. HEALTH & SAFETY CODE ANN. §§ 170A.001–7 (West 2025) (similar).

13. *See* Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 339 n.2 (2022) (Kavanaugh, J., concurring) ("[A]n exception to a State's restriction on abortion would be constitutionally required when an abortion is necessary to save the life of the mother." (citation omitted)); State v. Zurawski, 690 S.W.3d 644, 673 (Tex. 2024) (Lehrmann, J., concurring) ("[I]t should go without saying that, although the U.S. Supreme Court has concluded that abortion is not a constitutional right, a pregnant patient retains a liberty interest in access to medical care, including abortion, to protect her life and health." (citation omitted)).

combined with criminal liability imposed on doctors for mistaken judgment, doctors are hesitant to provide even life-saving care.[14] The vagueness and ambiguity in these exceptions endanger the lives of pregnant patients like Thurman.[15]

Abortion access advocates turn to the Emergency Medical Treatment and Labor Act (EMTALA), a federal statute that requires hospitals to provide emergency care to all patients. They argue that the statute forbids states from outlawing abortion when the health of a pregnant person is in danger—long before death is imminent.[16] Because EMTALA compels care in broadly defined emergency circumstances,[17] including those in which state bans prohibit abortion,[18] EMTALA preempts state bans to the extent that they conflict with federal law.[19] On the other hand, states say that the federal law cannot dictate the types of treatments they offer to emergency patients.[20] The Supreme Court has thus far declined to

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14. *See infra* Part I.B (explaining that vague exceptions and liability risks deter doctors from providing care).

15. *See* Danielle Campoamor, *Mom Who Needed an Abortion Says She Was Told to 'Sit in the Parking Lot' Until Her Cancerous Pregnancy Got Worse*, TODAY (May 8, 2023), https://www.today.com/parents/pregnancy/mom-needed-abortion-says-was-told-wait-parking-lot-rcna82281 [https://perma.cc/Y6HD-LZS8] (describing the story of an Oklahoma mother who was told she could either travel to get an abortion or "sit in the parking lot and wait to get worse" when her pregnancy turned deadly).

16. *See* 42 U.S.C. § 1395dd; *see, e.g.*, Brief for Respondent at 12, Moyle v. United States, 603 U.S. 324 (2024) (Nos. 23-726, 23-727) (consolidated with Idaho v. United States, 144 S. Ct. 541 (2024)) [hereinafter Brief for the Federal Government] ("But EMTALA's plain text promises essential emergency care to all Americans. And when a pregnant woman experiences an emergency medical condition that makes continuing the pregnancy a grave threat to her life or health, pregnancy termination is essential medical care."); Brief of American Civil Liberties Union and ACLU of Idaho as Amici Curiae in Support of Respondent at 2, Moyle, 603 U.S. 324 (Nos. 23-726, 23-727) ("[I]n those narrow but critical situations where abortion is the necessary stabilizing treatment, EMTALA's plain text requires covered hospitals to provide it, just as it requires any other stabilizing treatment, and preempts any state law to the contrary.").

17. *See id.* § 1395dd(e) (defining "emergency medical condition").

18. *See* Brief for the Federal Government, *supra* note 16, at 12 ("[EMTALA] does not displace states' judgment on abortion policy in general, and it has no effect on Section 18-622 in the vast majority of its applications.").

19. *Id.*; *see also* 42 U.S.C. § 1395dd(f) (providing that EMTALA preempts state laws "to the extent that the requirement directly conflicts with a requirement" of the statute).

20. *See* Reply Brief for the Petitioner at 4–5, Idaho v. United States, 144 S. Ct. 541 (2024) (No. 23-727) [hereinafter Brief for Idaho] (arguing that federal law cannot dictate the types of treatments hospitals provide to emergency patients).

hear the issue of preemption on the merits.[21] The question turns on whether EMTALA compels hospitals to treat patients presenting with a medical emergency who require a type of treatment the hospital is unwilling to provide.

This Note proceeds in three parts. Part I describes how state abortion bans' exceptions fail to protect pregnant people's health and lives. It explains how litigants are attempting to apply EMTALA to compel broader health exceptions and end doctors' dangerous practice of delaying life-saving care. Part II describes potential adverse consequences of these litigants' successes. A judicial finding that EMTALA can require a hospital to provide abortions in broad, federally defined emergencies, would necessarily condition that requirement on the fact that any given hospital offers abortions in at least *some* circumstances due to an EMTALA provision limiting required treatment to that which is "within the staff and facilities available at the hospital[.]"[22] Therefore, while a ruling that EMTALA *does not* preempt narrow state abortion bans allows hospitals to adopt absolute anti-abortion policies, a ruling that EMTALA *does* preempt narrow abortion bans would create strong perverse incentives for hospitals to adopt absolute anti-abortion policies to duck out of EMTALA's reach.

Part III argues that this outcome is possible only because courts have never fully fleshed out the nature of hospitals' obligations under EMTALA to provide specific treatments. Courts should recognize that EMTALA prevents hospitals from adopting policies barring treatment that is within its medical capabilities—either because the treatment is so simple and common that all emergency facilities must provide it, or because the facility has chosen to offer the needed specialized care. First, by contemplating only that hospitals need not provide *specialized* emergency services that they never make available, EMTALA implicitly requires that hospitals keep *standard* emergency care available. In recognizing that this obligation is a logical consequence of the statute's language, courts would unveil a latent cause of action to compel standard emergency treatments. This part offers that to evaluate whether emergency abortions constitute standard care, courts should adopt objective medical criteria, rather than reflexive criteria that leave categorization to the regulated entities. Second, by conditioning hospitals' obligation to receive patients only on hospitals' medical

21. *Moyle*, 603 U.S. at 325 (dismissing certiorari as improvidently granted).
22. 42 U.S.C. § 1395dd(b)(1)(A).

capabilities, courts have made clear that EMTALA requires hospitals to take emergency patients whose needs are within their staff's expertise and facility's equipment. Hospitals may not, as a policy, refuse certain kinds of patients based on the emergency care they require. This section concludes by defending the cause of action to compel specific emergency treatments against two likely attacks, urging that it does not contravene EMTALA's purpose nor create a national standard of medical malpractice.

I. THE EMERGENCY MEDICAL TREATMENT ACT AND ABORTION BANS

A. Emergency Medical Treatment and Labor Act (EMTALA)

EMTALA is a 1986 federal statute that imposes a duty on Medicare-funded hospitals[23] to provide essential care to any individual with an emergency medical condition who seeks examination or treatment at their emergency departments.[24] EMTALA requires covered hospitals to provide stabilizing treatment before transferring or discharging an individual.[25] Signed into law by Ronald Reagan, the statute was widely understood as an attempt to eliminate the rampant problem of "patient dumping"—hospitals' practice of transferring low-income and uninsured patients to other

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23. Although EMTALA's obligations apply only to Medicare-funded hospitals, they apply with respect to *all persons* who present to a covered hospital, not just Medicare recipients. *See, e.g.*, Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145 (2004) (explaining EMTALA's duty to screen all emergency patients, not just Medicare recipients); Collins v. DePaul Hosp., 963 F.2d 303, 308 (10th Cir. 1992) ("The fact that Congress … viewed [EMTALA] as a so-called "anti-dumping" bill, i.e., a bill designed to prohibit hospitals from 'dumping' poor or uninsured patients in need of emergency care, does not subtract from its use of the broad term "any individual."); Cleland v. Bronson Health Care Grp., 917 F.2d 266, 269–70 (6th Cir. 1990) (emphasizing that "[t]he benefits and rights of the statutes extend 'to any individual' who arrives at the hospital.").

24. *See* Pub. L. No. 99-272, tit. IX, § 9121, 100 Stat. 92, 164–67 (1986) (codified as amended at 42 U.S.C. § 1395dd (2000 & Supp. IV 2004)); *see also* Lauren A. Dame, *The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care*, 8 HEALTH MATRIX 3, 9 n.21 (1998) (discussing the passage of EMTALA in 1985); *see also* 42 U.S.C. § 1395dd(a) (providing that EMTALA's duty to treat applies when any individual "comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition").

25. 42 U.S.C. § 1395dd(a).

hospitals without first stabilizing their condition.[26] Because of this function, EMTALA is thought to impose "a statutory duty to treat emergency patients" which is otherwise missing from the negligence law landscape.[27]

When a patient presents to a covered hospital's emergency department, EMTALA dictates that the hospital has three obligations.[28] First, it must *screen* the person to determine whether they have an emergency medical condition.[29] EMTALA defines an "emergency medical condition" as one of such severity that the absence of immediate medical attention could reasonably result in (1) jeopardization of the patient's health, (2) serious impairment to their bodily functions, or (3) serious dysfunction of any bodily organ or part.[30] Second, if the individual has an emergency medical condition, the hospital must *stabilize* the condition.[31] The statute defines stabilizing treatment as that which is "necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility[.]"[32] Alternatively, if the hospital cannot stabilize the patient because they require specialized treatment not

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26. Mayere Lee, *supra* note 23, at 146 (defining patient dumping as "when poor or uninsured patients in need of emergency treatment are transferred from hospital to hospital before they are medically stable, solely or primarily because of their inability to afford medical services"); *The Emergency Medical Treatment and Labor Act (EMTALA)*, DEP'T OF HEALTH AND HUM. SERVS. (Sept. 11, 2024), https://oig.hhs.gov/reports-and-publications/featured-topics/emtala/ [https://perma.cc/5MSL-3GAX] (noting that EMTALA is also referred to as "the patient dumping statute").

27. Mayere Lee, *supra* note 23, at 146; *see also* Dame, *supra* note 24, at 4 ("EMTALA establishes a right unique in the American health care system: a right to medical care without regard to ability to pay").

28. *See* Dame, *supra* note 24, at 9–10 ("These three requirements – provision of a screening exam, treatment to stabilize the medical condition, and appropriate transfer – form the core requirements of the statute.").

29. 42 U.S.C § 1395dd(a) ("In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.").

30. *Id.* § 1395dd(e)(1).

31. *Id.* § 1395dd(b)(1)(A).

32. *Id.* § 1395dd(e)(3)(A).

available at the hospital, it must *transfer* them to another medical facility.[33]

The consequences of a hospital's failure or unwillingness to comply with EMTALA's demands are severe. Hospitals that violate EMTALA are subject to civil penalties of up to about $130,000 per violation.[34] Importantly, those flagrantly violating the statute may become ineligible for participation in Medicare—a penalty commonly recognized as a "death sentence" for hospitals.[35] Several hospitals that have been found in violation of EMTALA have subsequently closed.[36]

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33. *Id.* § 1395cc(b)(1)(B) (providing that a hospital fulfills its duty to "provide necessary stabilizing treatment for emergency medical conditions" where it either provides stabilizing treatment itself or "provides...for transfer of the individual to another medical facility"); JENNIFER A. STAMAN, CONG. RSCH. SERV., IF12355.2, OVERVIEW OF THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) AND EMERGENCY ABORTION SERVICES (2023) [hereinafter "CRS Report"] (providing that, "if a hospital determines that an individual has an emergency medical condition, the hospital must either provide further medical examination and treatment to stabilize the patient using available staff or facilities, or transfer the patient to a different medical facility with more specialized capabilities.")

34. 42 U.S.C § 1395dd(d)(1)(A) (providing for a maximum civil fine of $25,000 for hospitals with fewer than 100 beds and a maximum fine of $50,000 for larger hospitals); 42 C.F.R. § 1003.510 (2024); 45 C.F.R. § 102.3 (2024) (providing the 2024 penalty adjustment).

35. 42 U.S.C. § 1395dd(d)(1)(B) (providing for the termination of hospitals' Medicare provider agreement in the event of "gross and flagrant" violations); Rachele Taylor Yohe, *Reexamining the Civil Money Penalties of EMTALA and their Effect on Inner-City Hospitals*, 108 KY. L. J. ONLINE 1, 7 (2022) (noting that loss of Medicare funding can constitute a "death sentence" for many facilities); Mark R. Whitmore & J. Scott Anderson, *Decisions of the Supreme Court and DHHS Continue to Expand Hospital Liability Under EMTALA*, 11 HEALTH L. 14, 14 (1999); *see also* Christopher J. Young, *Emergency! Says Who?: Analysis of the Legal Issues Concerning Managed Care and Emergency Medical Services*, 13 J. CONTEMP. HEALTH L. & POL'Y 553, 562–63 (1997) (recognizing that the threat of Medicare ineligibility is the "real economic weapon" of EMTALA).

36. *See* Sophie Terp et al., *Individual Physician Penalties Resulting From Violation of Emergency Medical Treatment and Labor Act: A Review of Office of the Inspector General Patient Dumping Settlements, 2002-2015*, 24 ACAD. EMERGENCY MED., 442, 444–45 (2017) (describing that between 2005 and 2014, twelve hospitals had CMS provider agreements terminated as a result of EMTALA citations, with "resulting hospital closure or downgrading of emergency services" at nine such facilities).

By design, EMTALA fundamentally changed emergency health care.[37] As the only federal statute that creates a universal right to a minimal level of health care, EMTALA has been regarded as a bedrock of the country's health law.[38]

B. Abortion Bans' Ineffectual "Life" Exceptions in the Post-*Dobbs* Era

Under the nearly fifty-year reign of *Roe v. Wade* and *Casey v. Planned Parenthood*, no state could infringe upon a woman's privacy right to abortion before fetal viability.[39] After fetal viability, no state could outlaw abortions "necessary to preserve the life or health of the mother."[40] But when the Supreme Court overturned *Roe* in *Dobbs v. Jackson Women's Health Organization*, it eliminated the constitutional bar on state regulation of pre-viability abortions.[41] States can now regulate the procedure as early in the pregnancy as they see fit.[42] They have not missed the opportunity.

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37. *See, e.g.*, Robert A. Bitterman, *EMTALA: The Law That Forever Changed the Practice of EM*, AM. COLL. OF EMERGENCY PHYSICIANS NOW (Sept. 25, 2018), https://www.acepnow.com/article/emtala-the-law-that-forever-changed-the-practice-of-em/ [https://perma.cc/PTA4-HR24] ("Essentially, the law created a federal right to emergency care for anyone in the United States.").

38. Sara Rosenbaum, *EMTALA Pregnancy Protections Versus State Abortion Bans: The Supreme Court Will Decide*, HEALTH AFFS. (Jan. 9, 2024), https://www.healthaffairs.org/content/forefront/emtala-pregnancy-protections-versus-state-abortion-bans-supreme-court-decide [https://perma.cc/H38W-HKRV].

39. Roe v. Wade, 410 U.S. 113, 114, 164–65 (1973) (recognizing a constitutional right to abortion during the first trimester without state interference), *overruled by*, Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 231 (2022); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 845–46 (1992) (reaffirming but reframing the right established in *Roe*), *overruled by, Dobbs*, 597 U.S. at 231.

40. *Roe*, 410 U.S. at 164–65 (providing that "[i]f the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother").

41. *Dobbs*, 597 U.S. at 221 ("Given that procuring an abortion is not a fundamental constitutional right, it follows that the States may regulate abortion for legitimate reasons . . . .").

42. *Id.*; Adrienne R. Ghorashi & DeAnna Baumle, *Legal and Health Risks of Abortion Criminalization: State Policy Responses in the Immediate Aftermath of Dobbs*, 37 J. L. HEALTH 1, 3 (2023) ("The *Dobbs* ruling uprooted nearly 50 years of federal and state abortion rights jurisprudence by holding that the Constitution did not confer a right to abortion and overturning the precedents set by *Roe* and *Casey*, allowing states to ban pre-viability abortions freely.").

Anticipating *Dobbs*, several states prepared abortion restrictions in two kinds of laws. Thirteen states utilized "trigger bans"—statutes designed to lay dormant in legal codes and become effective at the moment *Roe*'s protections fell or shortly thereafter.[43] Ten states maintained "pre-*Roe*" bans—laws left in state legal codes which had gone unenforced for decades due to their unconstitutionality.[44] While every state abortion ban currently includes an exception to prevent the death of the pregnant person ("life" exceptions),[45] five states' bans go absolutely no further than that, refusing to make any exception for the patient's mental or physical health.[46]

But these "life" exceptions plainly fail to protect lives. States draw these exceptions so narrowly, write them so ambiguously, and impose such radical criminal sanctions that doctors are reluctant to perform even life-saving care.[47] Instead, doctors feel no choice but to

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43. *Id.* at 11–12 (describing that Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, and Wyoming had enacted trigger bans prior to *Dobbs*, with Arkansas and Tennessee requiring the Attorney General or other official certification).

44. *Id.* at 11 (describing that Alabama, Arizona, Arkansas, Michigan, Mississippi, North Carolina, Oklahoma, Texas, West Virginia, and Wisconsin had pre-*Roe* abortion bans in state codes at the time of *Dobbs*, which "potentially became legally enforceable").

45. Elizabeth Sepper, *Free Exercise of Abortion*, 49 BYU L. REV. 177, 202 (2023) (summarizing that all bans and restrictions have an exception to "author[ize] rescue only where a pregnant person is 'on death's door"); *see* Felix, *supra* note 12 ("All state abortion bans currently in effect contain exceptions to 'prevent the death' or 'preserve the life' of the pregnant person.").

46. ARK. CODE ANN. § 5-61-303–304 (2025) (permitting abortion where necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself"); IDAHO CODE § 18-622 (permitting abortion when "[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"); MISS. CODE ANN. § 41-41-45(2) ("Abortion is permitted when "necessary for the preservation of the mother's life."); OKLA. STAT. ANN. tit. 21, § 861 (West 2025) (similar to Mississippi); S.D. CODIFIED LAWS § 22-17-5.1 (similar to Mississippi).

47. *See* Natasha Rappazzo, *Emergency Room to the Courtroom: Providing Abortion Care Under EMTALA and State Abortion Bans*, 128 DICK. L. REV. 325, 339 (2023) ("The compounding realities of criminalization and violence would make even the most overzealous patient advocate pause before providing an abortion under new abortion laws."); Amy Schoenfeld Walker, *Most Abortion Bans Include Exceptions. In Practice, Few Are Granted*., N.Y. TIMES (Jan. 21, 2023), https://www.nytimes.com/interactive/2023/01/21/us/abortion-ban-exceptions.html [https://perma.cc/QP6Y-7B2Z] (explaining that the exceptions within abortion

wait for the pregnant patient's condition to escalate into what is incontrovertibly a life-threatening emergency.[48] Pregnant people suffer while they wait for their condition to pose a sufficiently dire threat to their life such that doctors are willing to perform an abortion,[49] and patients die preventable deaths.[50]

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bans are complex and difficult for physicians to navigate in practice); Nadine El-Bawab, *Fear, confusion, anxiety, stress: Tennessee doctors describe care under abortion ban*, ABC NEWS (Sept. 16, 2022), https://abcnews.go.com/US/fear-confusion-anxiety-stress-tennessee-doctors-describe-care/story?id=89878848 [https://perma.cc/623G-K77K] (describing that physicians fear misinterpreting what constitutes a legal abortion); Ari Fife, *After Court Rulings, Oklahoma Doctors Are Still Confused About When Abortion is Legal to Save a Patient's Life*, THE FRONTIER (Jul. 7, 2023, 6:00 AM CDT), https://www.readfrontier.org/stories/after-court-rulings-oklahoma-doctors-are-still-confused-about-when-abortion-is-legal-to-save-a-patients-life [https://perma.cc/PL3R-QN8D] (describing experiences of Oklahoma physicians interpreting abortion ban exceptions).

48. *See* Campoamor, *supra* note 15, at 3 (describing the story of an Oklahoma mother who was told she could either travel to get an abortion or "sit in the parking lot and wait to get worse" when her pregnancy turned deadly); Frances Stead Sellers & Fenit Nirappil, *Confusion post-Roe spurs delays, denials for some lifesaving pregnancy care*, WASH. POST (July 16, 2022), https://www.washingtonpost.com/health/2022/07/16/abortion-miscarriage-ectopic-pregnancy-care/ [https://perma.cc/R6FT-F8YL] (describing a woman with a life-threatening ectopic pregnancy who was denied an abortion in her state because a doctor worried the state ban prohibited its provision due to the presence of a fetal heartbeat); Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 OBSTET. & GYNECOL. SURV. 194, 195 (2022) (describing a study of pregnant patients at two Texas hospitals with dangerous pregnancy complications, including preeclampsia, who could not receive an abortion due to the presence of a fetal heartbeat and therefore experienced serious complications during childbirth, including clinical chorioamnionitis and hemorrhage; some patients ultimately required intensive care unit admission and hysterectomy).

49. *See* Rachel Sharp, *Woman left to bleed for 10 days from incomplete miscarriage after being turned away by hospital post-Roe*, INDEPENDENT (July 17, 2022, 7:45 PM BST), https://www.independent.co.uk/news/world/americas/wisconsin-miscarriage-roe-v-wade-abortion-b2125168.html [https://perma.cc/2N5B-8C42] (describing that a Wisconsin woman experiencing a miscarriage went to a hospital to remove fetal tissue from her uterus, but was turned away by emergency room staff due to "[c]onfusion around whether doctors can treat patients without facing criminal prosecution[.]" Appearing at the hospital ten days later, she was still "bleeding severely and at serious risk of infection").

50. *See* Surana, *supra* note 1 (describing the death of Amber Nicole Thurman); Kavitha Surana et al., *Are Abortion Bans Across America Causing Deaths? The States That Passed Them Are Doing Little to Find Out.*, PROPUBLICA

C. Litigation around the Extent of EMTALA's Duty to Treat

The Supreme Court has not yet resolved whether EMTALA may be applied to compel a hospital to provide any particular kind of medical treatment in an emergency. The answer to this question will determine if EMTALA preempts state abortion bans with narrow exceptions

Litigants argue that EMTALA preempts state abortion bans because the federal statute's definition of "medical emergency" is broader than the life-threatening circumstances in which state abortion bans carve exceptions. Specifically, they argue that EMTALA requires hospitals to provide care as soon as failure to do so could reasonably be expected to result in "serious harm" to the pregnant person's health, [51] whereas some state bans require doctors to delay care until death is imminent, with severe criminal sanctions for intervention that comes too early.[52]

A preemption ruling would strike down states' highly restrictive "life" exceptions because federal law would require hospitals to provide abortion treatment in broader circumstances than some state laws permit. A preemption finding would also compel courts to find that state law "health" exceptions must be interpreted more expansively to apply in all EMTALA-defined medical emergencies. This expansion of state bans' narrow exceptions would eliminate the dangerous, state-mandated delays pregnant patients are facing, enabling—indeed, compelling—doctors to intervene early in severely health-threatening circumstances.

The question has moved through the federal courts in two primary cases. In the first, Texas challenged guidance promulgated by the Centers for Medicare & Medicaid Services (CMS) to the effect

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(Dec. 18, 2024, 5:00 AM ET), https://www.propublica.org/article/abortion-bans-deaths-state-maternal-mortality-committees [https://perma.cc/M5K3-VSVT] (describing the organization's private investigation of the deaths of pregnant people resulting from overly narrow "life" exceptions).

51. Brief for the Federal Government, *supra* note 16, at 20.

52. *See* Sepper, *supra* note 45, at 202 (noting that all bans allow exceptions to save the pregnant person's life, at least); cases cited *supra* note 46 (providing that state laws allow for abortion only to "save the life" or "prevent the death" of the pregnant person); Nambiar et al., *supra* note 48 (noting that Texas state law prohibits hospitals from providing care unless there is an "immediate threat to maternal life" and that any mistaken judgment "would potentially be considered a felony," and describing that hospitals are wondering "How imminent must death be?").

that EMTALA can preempt overly restrictive state abortion bans.[53] The Fifth Circuit found in the state's favor, declaring the guidance invalid,[54] and the Supreme Court denied certiorari.[55] In the second, the federal government sued for a declaratory judgment to the effect that EMTALA preempts Idaho's stringent abortion ban, which makes an exception only to save the life of the pregnant person.[56] The Supreme Court has thus far declined to hear the issue on the merits.[57] This section describes these two challenges, and notes that the Supreme Court's avoidance of the question has resulted in an unsettled relationship between EMTALA and state law in most circuits—which, as the following Part describes, the Court must thoroughly resolve.

1. *Texas v. Becerra*

After *Dobbs*, CMS released guidance advising state healthcare agency directors on their continuing obligations under federal law. The agency wrote:

> If a physician believes that a pregnant woman presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment.…When a state law prohibits abortion and does not include an exception for the life and health of the pregnant person—or draws the exception more narrowly than EMTALA's emergency medical condition definition—that state law is preempted.[58]

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53. *See* Texas v. Becerra, 89 F.4th 529, 536 (5th Cir. 2024), cert. denied, 145 S. Ct. 139 (2024).

54. *See id.* at 533.

55. *See* Becerra v. Texas, 145 S. Ct. 139 (2024) (denying writ of certiorari).

56. *See* Complaint at 1, United States v. Idaho, 623 F. Supp. 3d 1096 (D. Idaho 2022) (No. 1:22-cv-329).

57. *See* Moyle v. United States, 603 U.S. 324, 325 (2024) (Nos. 23-726, 23-727) (consolidated with Idaho v. United States, 144 S. Ct. 541 (2024) (dismissing certiorari as improvidently granted).

58. CMS, *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-21-22-Hospitals-UPDATED JULY 2022)* (July 11, 2022); *see* Texas v. Becerra, 89 F.4th 529, 536 (5th Cir. 2024), cert. denied, 145 S. Ct. 139 (2024).

Texas claimed that the CMS guidance asserted an invalid interpretation of EMTALA.[59] The state sought to protect its abortion ban—the Texas Human Life Protection Act, which prohibits abortions unless the pregnancy "places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function"—from preemption by the federal law.[60]

The Fifth Circuit agreed with Texas, finding that the guidance was invalidly promulgated without notice and comment because it changed a substantive legal standard.[61] In doing so, the Court noted that "EMTALA does not address any specific medical procedures or treatments besides the requirement 'to deliver . . . .'" the child.[62] It emphasized that "Congress specifically chose to define an emergency medical condition as one that places 'the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,'"[63] and found that "EMTALA leaves the balancing of stabilization [between the pregnant person and the unborn child] to doctors, who must comply with state law."[64] On this basis, the Fifth Circuit held that EMTALA created no duty to provide abortion as emergency medical treatment and that there is no "direct[] conflict" between EMTALA and state law.[65] The Supreme Court denied certiorari,[66] and in June 2025, the Trump Administration rescinded the CMS Guidance.[67]

2. *Idaho v. United States*

The second major challenge placing EMTALA's duty to treat before the federal courts has come out of Idaho. Idaho's Defense of Life Act criminalizes abortion as a felony punishable by two to five

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59. *Becerra*, 89 F.4th at 533.

60. *Id.*; TEX. HEALTH & SAFETY CODE ANN. § 170A.002(b)(2).

61. *Becerra*, 89 F.4th at 545–46.

62. *Id.* at 535 (quoting 42 U.S.C. § 1395dd(e)(3)(A)).

63. *Id.* at 544 (emphasis omitted) (quoting 42 U.S.C. § 1395dd(e)(1)(A)).

64. *Id.* at 545 (citing 42 U.S.C. §§ 1395dd(e)(1)), (e)(3)(A)).

65. *See id.* at 544–45 ("The question before the court is whether the EMTALA, according to HHS's Guidance, mandates physicians to provide abortions when that is the necessary stabilizing treatment for an emergency medical condition. It does not.").

66. Becerra v. Texas, 145 S. Ct. 139 (2024).

67. Press Release, Dep't of Health & Hum. Servs. and Ctrs. for Medicare and Medicaid Servs., *CMS Statement on Emergency Medical Treatment and Labor ACT (EMTALA)* (June 3, 2025), https://www.cms.gov/newsroom/press-releases/cms-statement-emergency-medical-treatment-and-labor-act-emtala [https://perma.cc/7M8M-HXZG].

years in prison.[68] The statute includes an exception when an abortion is, in the physician's good faith medical judgment, "necessary to prevent the death of the pregnant woman."[69] In August 2022, before the law took effect, the Department of Justice sued the state of Idaho.[70] The United States claimed that Idaho's restrictive ban conflicted with EMTALA and is preempted because EMTALA requires abortions in circumstances other than when a pregnant person's life is in imminent danger.[71]

The plaintiffs asserted that EMTALA preempts the Defense of Life Act under two theories: impossibility preemption and obstacle preemption.[72] The Ninth Circuit held that EMTALA's savings clause, which limits the statute's preemptive effect to state laws that "directly conflict[]" with the federal obligations, permits both theories.[73] Impossibility preemption occurs "where it is impossible for a private party to comply with both state and federal law."[74] Obstacle preemption exists where state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."[75]

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68. Defense of Life Act, IDAHO CODE § 18-622 (2025); *see* WEN W. SHEN, CONG. RSCH. SERV., LSB11196, SUPREME COURT ALLOWS EMERGENCY ABORTIONS IN IDAHO BUT LEAVES LITIGATION UNRESOLVED 1 (2024) (interpreting the Defense of Life Act).

69. Defense of Life Act, IDAHO CODE § 18-622 (2025).

70. *See* United States v. Idaho, 623 F. Supp. 3d 1096 (D. Idaho 2022); United States v. Idaho, 342 F.R.D. 144 (D. Idaho 2022) (allowing legislators to intervene as defendants for the limited purpose of presenting argument and evidence).

71. *See* Complaint at 3, United States v. Idaho, 623 F. Supp. 3d 1096 (D. Idaho 2022) (No. 1:22-cv-329) ("To the extent Idaho's law prohibits doctors from providing medically necessary treatment, including abortions, that EMTALA requires as emergency care, Idaho's new abortion law directly conflicts with EMTALA.") (citing 42 U.S.C. § 1395dd(f)).

72. *See id.* ("To the extent Idaho's law renders compliance with EMTALA impossible or stands as an obstacle to the accomplishment of federal statutes and objectives, EMTALA preempts the Idaho law under the Supremacy Clause of the United States Constitution.").

73. 42 U.S.C. § 1395dd(f) ("The provisions of this section do not preempt any state or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section."); *see* Draper v. Chiapuzio, 9 F.3d 1391, 1393 (9th Cir. 1993) (explaining that impossibility and obstacles are the two cases in which a state statute can "directly conflict" with federal law).

74. Crosby v. Nat'l Foreign Trade Council, 530 U.S. 363, 372 (2000) (citing Fla. Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 142–243 (1963)).

75. *Id.* at 373 (quoting Hines v. Davidowitz, 312 U.S. 52, 67 (1941)).

The District Court of Idaho granted a preliminary injunction, and in January 2024, while the case was being adjudicated in the Ninth Circuit, the Supreme Court granted a writ of certiorari to an emergency application for relief submitted by the Idaho legislature.[76] The Court also issued a stay that lifted the District Court's preliminary injunction and allowed Idaho's abortion ban to go into effect for the first time.[77] This decision significantly increased the number of patients experiencing serious pregnancy complications who were airlifted out of their home state to receive an abortion.[78] Then, in a per curium decision on June 2024, the Supreme Court reversed the grant of certiorari as improvidently granted and vacated its stay.[79]

In her concurrence, Justice Kagan stated that "EMTALA unambiguously requires that a Medicare-funded hospital provide *whatever medical treatment* is necessary to stabilize a health emergency—and an abortion, in rare situations, is such a treatment."[80] There, Justice Kagan assumed, without deciding, that EMTALA compels a hospital to provide specific treatment types. This claim runs directly counter to the Fifth Circuit's finding in *Texas v. Becerra*, suggesting ample room for federal courts to break from that circuit's holding and find that EMTALA preempts the country's most stringent state abortion bans. As Part II describes, courts must not only settle whether EMTALA can preempt state bans; they must also carefully define the parameters of hospitals' duty to treat under EMTALA. If courts fail to do so, hospitals could easily circumvent their obligation.

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76. Moyle v. United States, 603 U.S. 324, 334 (2024) (consolidated with Idaho v. United States, 144 S. Ct. 541 (2024)); Emergency Application for a Stay Pending Appeal, Idaho v. United States, 144 S. Ct. 541 (2024) (No. 23-727).

77. *Moyle*, 603 U.S. at 325.

78. Sabrina Talukder, *Supreme Court Dismisses Idaho v. United States Without Making a Decision on Emergency Abortion Care*, CENTER FOR AM. PROGRESS (June 27, 2024), https://www.americanprogress.org/article/supreme-court-dismisses-idaho-v-united-states-without-making-a-decision-on-emergency-abortion-care/ [https://perma.cc/S7F3-TSVE] ("After the stay went into effect, St. Luke's hospital in Boise airlifted six patients experiencing pregnancy complications from January 2024 to April 2024. By comparison, for the entirety of 2023—when EMTALA's protections were in effect in Idaho and the provision of necessary care was still permitted—only one pregnant patient was airlifted.").

79. *Moyle*, 603 U.S. at 325 (dismissing certiorari as improvidently granted).

80. *Id.* at 329–30 (Kagan, J., concurring) (emphasis added).

II. POTENTIAL ADVERSE CONSEQUENCES OF EMTALA PREEMPTION

As discussed, federal courts have not conclusively stated that EMTALA requires hospitals to provide any particular treatment, let alone that it does so "unambiguously," as Justice Kagan has asserted.[81] While the statute requires hospitals to provide "[n]ecessary stabilizing treatment,"[82] a central but little-discussed caveat in the statute complicates the analysis. EMTALA limits required treatment to that which is "available" at the hospital, specifically providing:

> If any individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—(A) *within the staff and facilities available at the hospital*, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer . . .[83]

In ruling on EMTALA's preemptive effect, a court must decide the meaning of the phrase "within the staff and facilities available at the hospital."[84] Because this language determines when EMTALA's obligations attach, it is implicated by any holding with respect to the statute's preemptive effect.

This Part reviews the possible grounds on which a court could interpret this "available" carve-out. One interpretation lends itself to a finding that EMTALA does not preempt state abortion bans, leaving states free to enact exceptionless bans and hospitals free to adopt total anti-abortion policies.[85] On the other hand, a holding that EMTALA *does* preempt state laws may create perverse incentives for medical providers. A finding of preemption (i.e., that the "available" qualification does not obviate Idaho's obligation to provide abortion in health-threatening circumstances) necessarily conditions providers' EMTALA obligations on their independent choice to make abortion

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81. *Id.* (Kagan, J., concurring) ("EMTALA unambiguously requires that a Medicare-funded hospital provide whatever medical treatment is necessary to stabilize a health emergency—and an abortion, in rare situations, is such a treatment.").

82. 42 U.S.C. § 1395dd(b).

83. *Id.* § 1395dd(b)(1) (emphasis added).

84. *See id.*

85. *But see* cases cited in *supra* note 13 (indicating that in that scenario, states' discretion would nonetheless be at least minimally constrained according to thus-far poorly articulated constitutional principles).

available in *at least some circumstances*. This presents providers with a new choice: offer abortions in far broader circumstances than they might prefer or cease to offer abortions at all.

A. How Courts May Interpret "Available"

To interpret how the "available" language affects hospitals' obligations to provide medical *treatments*, courts are likely to look to analogous language modifying hospitals' obligations to provide medical *screenings*. Courts have thoroughly considered the extent of hospitals' obligation to perform screenings, including specific kinds of screenings.[86] In general, EMTALA requires hospitals to perform an "appropriate medical screening examination" upon receipt of a patient seeking emergency care to discern their medical condition.[87] By establishing the extent of hospitals' obligation to diagnose, this language determines the existence of subsequent obligations to treat or transfer.[88] An analogy to the "available" language would be appropriate, since the fact that hospitals need only provide "appropriate" screenings qualifies their diagnostic obligations[89] in the same way that the "available" language qualifies the nature and

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86. *See* Larry D. Weiss, *Current Status of the Patient Transfer Act (EMTALA) in the Fifth Circuit*, 43 LOY. L. REV. 263, 272 (1997) ("Perhaps the greatest EMTALA controversy and the most frequently litigated issue concerns the meaning of the term 'appropriate medical screening examination.'").

87. 42 U.S.C. § 1395dd(a); *see* Baker v. Adventist Health, Inc., 260 F.3d 987, 992 (9th Cir. 2001) (providing that EMTALA "imposes two duties on hospital emergency rooms: a duty to screen a patient for an emergency medical condition, and, once an emergency condition is found, a duty to stabilize the patient before transferring or discharging him").

88. *See, e.g.*, *Baker*, 260 F.3d at 993 ("The hospital's duty to stabilize arises only when it actually detects an emergency medical condition."); Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1041 (D.C. Cir. 1991) (stabilization and transfer provisions "are triggered only after a hospital determines that an individual has an emergency medical condition"); Cleland v. Bronson Health Care Group, 917 F.2d 266, 271–72 n.2 (6th Cir. 1990) (finding that a hospital did not violate its duty to stabilize a condition that it failed to detect through an appropriate screening) (citations omitted).

89. *See* Weiss, *supra* note 81, at 273–74 (describing cases in which courts found that hospitals did not violate EMTALA because they provided all medical screenings that were "appropriate"); *see also* Bryant v. Adventist Health Sys./W., 289 F.3d 1162, 1166 (9th Cir. 2002) (holding that a hospital does not violate EMTALA if it fails to detect or misdiagnoses an emergency condition where it provided appropriate medical screenings); *Baker*, 260 F.3d at 993–94.

extent of "[n]ecessary stabilizing treatment" hospitals are required to provide.[90]

Courts interpreting the "appropriate" qualifier have applied three approaches.[91] First, courts using a "comparability test" find that a medical screening was inappropriate if the patient did not receive an examination comparable to similarly-situated patients.[92] Second, under the "capability test," courts find that a screening was inappropriate where the hospital failed to provide an examination according to its medical capabilities.[93] Third, the Sixth Circuit's "bad motive test" dictates that a screening was inappropriate where a hospital or physician acted in bad faith in performing it—motivated by non-medical factors like race, sex, the patient's disease (like AIDS), or personal animosity.[94]

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90. *See* 42 U.S.C. § 1395dd(b).

91. *See id.* at 273–74; Larry D. Weiss & Jorge A. Martinez, *Fixing EMTALA: What's Wrong with the Patient Transfer Act*, 20 J. PUB. HEALTH POL'Y 335, 339 (1999) ("In some ways, this issue controls many other EMTALA issues. The performance of an appropriate medical screening examination and the diagnosis of an emergency medical condition create the duty to stabilize or transfer.").

92. *See* Weiss, *supra* note 81, at 273 (defining how courts use the comparability test); Correa v. Hosp. S.F., 69 F.3d 1184, 1192 (1st Cir. 1995), *cert. denied sub nom*., Hosp. S. F. v. Gonzalez, 116 S. Ct. 1423 (1996) (describing that courts have achieved a consensus on appropriateness in the EMTALA context); Summers v. Baptist Medical Ctr. Arkadelphia, 91 F.3d 1132, 1138 (8th Cir. 1996) (en banc) (defining an inappropriate screening exam as "one that has a disparate impact on the plaintiff"); Vickers v. Nash Gen. Hosp., Inc., 78 F.3d 139, 145 (4th Cir. 1996) (holding that the hospital provided an appropriate screening exam as the plaintiff did not allege different treatment than other patients perceived to have the same medical condition); Baber v. Hosp. Corp. of America, 977 F.2d 872, 878 (4th Cir. 1992) ("We conclude instead that EMTALA only requires hospitals to apply their standard screening procedure for identification of an emergency medical condition uniformly to all patients…."); Repp v. Anadarko Mun. Hosp., 43 F.3d 519, 522 (10th Cir. 1994) ("[A] hospital satisfies the requirements of 1395dd(a) if its standard screening procedure is applied uniformly to all patients in similar medical circumstances.").

93. *See* Power v. Arlington Hosp., 800 F. Supp. 1384, 1387 n.6 (E.D. Va. 1992), *aff'd in part, rev'd in part*, 42 F.3d 851, 857 (4th Cir. 1994) (defining the capability test).

94. *See* Weiss, *supra* note 81, at 274 (noting that the Sixth Circuit is the only federal appellate court to have adopted the bad motive test); Cleland v. Bronson Health Care Group, 917 F.2d 266, 272 (6th Cir. 1990) (finding that the screening was appropriate because plaintiffs failed to show any bad or inappropriate motive on the part of the hospital).

1. "Available" may mean offered at the hospital in the relevant medical circumstances

Courts could find that EMTALA's "available" carve-out means that hospitals need only treat emergent medical conditions with the care that the hospital typically offers to similarly situated patients. In doing so, courts could rely on precedent interpreting the "appropriate" carve-out to the screening obligation under a comparability test, taking note that almost all federal appellate courts have adopted the comparability test and required plaintiffs to prove that they received a disparate screening examination as compared to patients presenting with similar symptoms.[95]

In *Idaho*, the state essentially advocated for an analogous approach to the treatment obligation. It asserted that abortions are necessarily unavailable at in-state hospitals in all circumstances outside the ban's exceptions because, in accordance with state law, hospitals do not offer abortions in those circumstances.[96] Therefore, the state argued, Idaho's law does not conflict with EMTALA's treatment obligation, which only requires hospitals to deny abortions equally.

If EMTALA's treatment provision is interpreted as compelling only equal treatment at hospitals, EMTALA cannot preempt the most stringent state abortion bans. Further, because it would provide no federal backstop against even exceptionless bans, it would leave state regulators and individual providers unfettered discretion as to whether abortion care will be available in a geographic region at all.[97]

2. "Available" may mean offered at the hospital under any circumstances

However, it is possible that courts will take a different route. Following in line with a seminal Fourth Circuit case, some federal

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95. *See* Weiss, *supra* note 81, at 273 (noting that federal courts have adopted the comparability test and that the burden of proof for disparate treatment is on the patient).

96. *See* Brief for Idaho, *supra* note 20 at 5–6 (noting the Idaho state law and its exceptions).

97. *See* Amanda Nguyen et al., *Mapping Healthcare Deserts*, GOODRX, at 4 (Sept. 2021), https://www.goodrx.com/healthcare-access/research/healthcare-deserts-80-percent-of-country-lacks-adequate-healthcare-access [https://perma.cc/72XZ-TFAR] (providing that over twenty percent of counties in the U.S. are considered "hospital deserts," where most people have to drive more than thirty minutes to reach the closest hospital).

courts have acknowledged that the nature of EMTALA's screening obligations may be substantively different than that of their treatment obligations, opening the possibility that courts will apply a more zealous approach to the latter.[98] A court could find that "available" care is that which the hospital has *the medical expertise and equipment to perform*.[99] This interpretation is analogous to the capability test for the "appropriate medical screening" language, which requires examination in accordance with the hospital's *medical capabilities*.[100]

While the comparability-based interpretation of "available" described in the previous subsection takes into consideration state law and hospital policies,[101] this capability-based interpretation mandates care that the hospital is demonstrably able to provide. Indeed, the fact that a hospital actually provides abortions in some circumstances—for example, life-saving circumstances—demonstrates that it has the expertise and equipment to perform them. Therefore, under this interpretation, a hospital that performs abortions in *at least some* circumstances must perform abortions in

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98. *See In re* Baby K, 16 F.3d 590, 595 (4th Cir. 1994) ("[W]e conclude that the duty of the Hospital to provide stabilizing treatment for an emergency medical condition is not coextensive with the duty of the Hospital to provide an "appropriate medical screening…."); Eberhardt v. City of L.A., 62 F.3d 1253, 1259 n.3 (9th Cir. 1995) (finding that "the stabilization requirement is not met by simply dispensing uniform stabilizing treatment, but rather, by providing the treatment necessary 'to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result....'") (quoting 42 U.S.C. § 1395dd(e)(3)(A)); Brown v. St. Mary's Hosp., No. 3:14CV228 DJS, 2015 WL 144673, at *7 (D. Conn. Jan. 12, 2015) (finding that "EMTALA screening and stabilization requirements are two distinct obligations").

99. *See* Brief for the Federal Government, *supra* note 16, at 36 ("But by its plain terms, the reference to 'available' facilities and staff refers to physical and personnel constraints") (citing CMS, Interpretive Guidelines §489.24(d)(1)(i) (suggesting that "available" means within the "physical space, equipment, supplies, and specialized services," as well as "personnel")) [hereinafter CMS State Operations Manual].

100. *See In re Baby K*, 16 F.3d at 595 ("[W]e conclude that the duty of the Hospital to provide stabilizing treatment for an emergency medical condition is not coextensive with the duty of the Hospital to provide an "appropriate medical screening") (finding that a screening was deficient even where it was comparable to that provided to similarly-situated patients) (emphasis added); Eberhardt, 62 F.3d at 1259 n.3 (finding that "the stabilization requirement is not met by simply dispensing uniform stabilizing treatment, but rather, by providing the treatment necessary 'to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result . . . .'") (quoting 42 U.S.C. § 1395dd(e)(3)(A)).

101. *See* Brief for Idaho, *supra* note 20, at 5–6.

all emergency circumstances (with EMTALA defining what those emergency circumstances are), making it "impossible to comply" with the mandates of EMTALA and state abortion bans that limit the emergency circumstances in which hospitals may offer abortions.[102]

While this interpretation enables a finding of preemption—an apparently desirable result for abortion advocates—it potentially would be devastating to pregnant people's health. Under this interpretation, EMTALA would require a hospital to provide an emergency abortion only when the hospital is medically capable of providing one (and no other treatment could stabilize the condition). This would mean that hospitals could circumvent their EMTALA treatment obligations by offering abortions in no medical circumstances—even when the pregnant person's life is at stake—thereby making abortions unavailable at the facility.

If a court adopted this interpretation, hospitals' incentive to circumvent their EMTALA obligations would be strong because EMTALA defines emergencies broadly, meaning that their potential liability is significant. Specifically, EMTALA defines emergency conditions as those "of such severity that the absence of immediate medical attention could reasonably result in (1) jeopardization of the patient's health, (2) serious impairment to their bodily functions, or (3) serious dysfunction of any bodily organ or part."[103] Under this definition, stabilizing care is required when the person's health is threatened, even if that condition is not currently and may never become life-threatening.[104] If EMTALA can preempt state bans, it imposes a broad positive obligation to provide emergency abortions,

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102. United States v. Idaho, 623 F. Supp. 3d 1096, 1109 (D. Idaho 2022) ("Here, it is impossible to comply with both statutes."); *see also* Brief for the Federal Government, *supra* note 16, at 6 (summarizing its argument, vindicated in district court, that it is impossible for Idaho hospitals to comply with the state abortion ban, which "allows pregnancy termination only when '*necessary* to prevent the patient's death,' and EMTALA's "'broader'" requirements, which require "'care . . . to prevent injuries that are more wide-ranging than death'").

103. 42 U.S.C. § 1395dd(e)(1).

104. *See* CRS Report, *supra* note 33, at 1–2 ("Pursuant to the Act and accompanying regulations, elements of an emergency medical condition may include severe pain, psychiatric disturbances, or substance abuse symptoms. With respect to pregnant women, an emergency medical condition includes one that *endangers the health of the woman* or her unborn child.") (emphasis added); Baber v. Hosp. Corp. of Am., 977 F.2d 872, 879 (4th Cir. 1992) (providing that EMTALA's treatment obligations kick in even when the condition is not "life-threatening," as long as it is "serious").

displacing state laws that impose no such obligation and instead allow them only narrow circumstances.[105]

EMTALA's broad conception of emergencies also means that, if courts find that EMTALA preempts state bans, some hospitals would be required to provide abortion care in a broader set of circumstances than hospital administrations would prefer to allow. Administrators that find abortion morally intolerable might prefer that the hospital adopt a no-abortion policy to avoid a federal obligation to provide innumerable abortions in medical circumstances that are not imminently life-threatening to the pregnant person. The consequences of a single hospital's decision not to provide abortions would be highly consequential in geographic regions that rely on single hospital networks, or even single hospitals, for emergency care.[106] Indeed, some have recognized that the "biggest" threat to pregnant people "comes from hospitals refusing to provide care."[107]

III. EMTALA PREEMPTS HOSPITAL POLICIES AGAINST PROVISION OF SPECIFIC CARE TYPES

This Part urges federal courts to recognize that EMTALA prevents emergency care providers from adopting policies barring its staff from providing abortions to save the lives of pregnant people. Part II has described that courts may find that EMTALA preempts state abortion bans because hospitals that offer life-saving abortions must provide abortions in a wider range of emergency medical

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105. By stark contrast to EMTALA's broad definition of emergency, state legislatures that have enacted total abortion bans with only narrow life exceptions permit abortions only when a condition is strictly life-threatening. *See* Ghorashi & Baumle, *supra* note 44 (listing the five most restrictive state bans). Only Texas has slightly expanded the circumstances in which its ban applies, with its Supreme Court has found that the patient's life need not be in imminent danger, but their condition must be at least potentially life-threatening if it were to deteriorate. *See, e.g.*, State v. Zurawski, 690 S.W.3d 644 (Tex. 2024).

106. *See* Solomon et al., *Bigger and Bigger: The Growth of Catholic Health Systems*, CMTY. CATALYST (2020), https://www.communitycatalyst.org/wp-content/uploads/2022/11/2020-Cath-Hosp-Report-2020-31.pdf [https://perma.cc/7XK3-MEG6] (reporting that, as of 2020, fifty-two Catholic hospitals were the "sole community hospital" for their region, representing a significant increase from prior years. "Increasingly, where patients live determines what kind of care they can receive, especially if the only choice is a Catholic hospital.").

107. Elizabeth Sepper, *The Ever-Expanding Right to Refuse to Provide Healthcare*, THE PETRIE-FLOM CTR. AT HARV.L. SCH., https://petrieflom.law.harvard.edu/2024/09/23/the-ever-expanding-right-to-refuse-to-provide-healthcare/ [https://perma.cc/9MJC-L2C9].

circumstances than state bans allow. This would create a perverse incentive for hospitals to make abortion unavailable at their facilities by declining to offer the procedure even in the direst emergency circumstances. While courts have repeatedly affirmed that hospitals violate EMTALA by failing to provide any stabilizing treatment to an emergency patient,[108] no court has yet ruled on whether EMTALA requires a hospital to offer a specific type of treatment.

First, this Part argues that EMTALA requires hospitals to provide standard emergency care. By distinguishing between standard and specialized care and contemplating that hospitals may refuse to accept transferred patients only when they lack the specialized services a patient requires, the statute obligates hospitals to provide simple, common emergency care—giving teeth to its anti-patient-dumping purpose. This Part then urges that courts adopt medical criteria to distinguish between standard and specialized care. Second, this Part argues that EMTALA obligates hospitals to provide emergency patients with any necessary specialized treatment that is within its medical capabilities. Thus, even if courts treat abortions as specialized care, EMTALA prevents hospitals from adopting policies that prohibit its staff from performing emergency abortions if a hospital is medically capable of providing one. Finally, this Part defends this EMTALA-based cause of action to compel treatment types against two potential criticisms, highlighting that it neither creates a comprehensive national standard of medical care nor contravenes the intent of the statute.

A. Courts Should Recognize that EMTALA Compels Hospitals to Offer Standard Care

First, EMTALA requires hospitals to keep standard emergency medical care available. EMTALA's plain language

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108. *See e.g.*, Bryant v. Adventist Health Sys./W., 289 F.3d 1162, 1165 (9th Cir. 2002) (noting that EMTALA bars hospitals from "refusing to provide emergency medical treatment or transferring patients before their conditions were stabilized"); Burditt v. U.S. Dep't of Health & Hum. Servs., 934 F.2d 1362, 1370, 1376 (5th Cir. 1991) (affirming administrative finding that a hospital violated EMTALA by "transfer[ing] someone who ha[d] an emergency medical condition which has not been stabilized); *Baber*, 977 F.2d at 879 ("EMTALA requires that a hospital which has determined that a patient has an 'emergency medical condition' must stabilize the patient before transferring her to another facility."); *In re* Baby K, 16 F.3d 590, 598 (4th Cir. 1994) (finding that a hospital violated EMTALA by failing to provide necessary stabilizing care, even though the hospital typically did not offer that care in the patient's circumstances).

contemplates only that hospitals might not have the ability to offer *specialized* emergency treatments, in which case they have no obligation to provide the treatment to an emergency patient.[109] In one sense, the "specialized service" language broadens EMTALA's treatment obligation for hospitals that have specialized departments capable of treating the emergent condition—requiring that hospitals accept the patient and provide necessary stabilizing care. However, in another sense, the language is a carve-out to EMTALA's treatment obligation—exempting hospitals from treating a patient with an emergent condition if they require a specialized service that the hospital never offers.[110] By exempting hospitals *only* from providing specialized emergency services (i.e. leaving hospitals the option whether to offer these services), the statute creates a positive obligation to provide *standard* emergency services.[111]

That the statute only exempts specialized services is clear from the text and corroborated by CMS guidance.[112] Together, EMTALA and the guidance instruct that necessary stabilizing care is required unless is it *unavailable*[113] and care is *only* unavailable in two circumstances: (1) when the required treatment is not within the physical capacity of the hospital (i.e., there are not enough beds or qualified staff able to treat the condition at that time) and (2) when the required treatment is a "specialized service" the hospital elects not to provide.[114] Only the latter pertains to hospitals' obligation to provide certain treatment types. The logical consequence of this limited carve-out to the treatment types hospitals must provide is a

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109. 42 U.S.C. § 1395dd(b).

110. *See, e.g.*, *Baber*, 977 F.2d at 879–80 (holding that EMTALA does not require a hospital to provide specialized services it does not offer); St. Anthony Hosp. v. U.S. Dep't of Health & Hum. Servs., 309 F.3d 680, 689, 712 (10th Cir. 2002) (finding that the hospital to whom the patient originally presented appropriately transferred the patient where they "did not have the capacity to provide further stabilizing treatment in the form of vascular surgery.").

111. *See supra* Part III.A.

112. *See* CMS State Operations Manual, *supra* note 99, §489.24(d)(1)(i) ("After the medical screening has been implemented and the hospital has determined that an emergency medical condition exists, the hospital *must provide stabilizing treatment* within its capability and capacity.") (emphasis added).

113. 42 U.S.C. § 1395dd(b).

114. *See* CMS State Operations Manual, *supra* note 99, § 489.24(d)(1)(i) (providing that the hospital *must provide stabilizing treatment* within its capability and capacity, and that the "capabilities of a medical facility mean that there is physical space, equipment, supplies, and specialized services that the hospital provides (e.g., surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma care).").

positive obligation to provide all treatment that falls into the non-exempt categories.[115] Because procedures that are not specialized services are necessarily available (as long as there is space in the hospital), hospitals must provide *all non-specialized* care (i.e., standard care) in emergency circumstances.

Although EMTALA implies some obligations with respect to the provision of standard care, it is not immediately clear how far these obligations extend. One possibility is that the statute creates an affirmative obligation to actually provide standard care for specific patients, but it is unlikely that the statute goes so far.[116] Rather, courts should adopt a stricter interpretation of the statute and find that EMTALA's affirmative obligations to keep care "available" are rather limited. Hospitals cannot adopt policies against the provision of standard care, meaning that they cannot render themselves incapable, in medical terms, of providing standard care by declining to keep standard equipment on hand. This gives rise to a corollary obligation to treat emergency patients with standard care only in the limited circumstances where the treatment is the only one that can treat the patient's condition.[117]

To summarize, this obligation arises because EMTALA compels hospitals to provide all available and necessary stabilizing care.[118] Because the statute only exempts hospitals from that obligation when they do not make available the necessary specialized care,[119] it necessarily requires that hospitals cannot make standard care unavailable. Instead, they must keep the equipment on hand, remaining able to provide an emergency abortion if that intervention is the only one that can stabilize a patient. This obligation's primary consequence is to prohibit hospital administrators from categorically barring staff from providing necessary stabilizing care to emergency

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115. *See* United States v. Johnson, 529 U.S. 53, 58 (2000) (applying a principle of statutory construction to find that because at-issue conduct was not included in a list of exceptions, it was necessarily included in the statute's coverage, writing that "[w]hen Congress provides exceptions in a statute, it does not follow that courts have authority to create others").

116. *See infra* note 147 and accompanying text (describing that EMTALA does not create a federal standard for medical negligence).

117. *See* 42 U.S.C. § 1395dd(b) (requiring that hospitals provide some "necessary stabilizing treatment").

118. *Id.*

119. *See* CMS State Operations Manual, *supra* note 99, § 489.24(d)(1)(i) ("Capabilities of a medical facility mean that there is physical space, equipment, supplies, and specialized services that the hospital provides (e.g., surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma care).").

patients. If courts find that certain abortion procedures constitute standard medical care and EMTALA preempts stringent state abortion bans, then hospitals cannot easily evade their EMTALA obligations simply by keeping the necessary supplies out of the hospital.

B. Courts Should Distinguish Specialized from Standard Care Using Objective Medical Criteria

In medicine generally, "[t]he point at which special care becomes distinct from routine care is vigorously debated"[120] and clear administrative guidance does not exist.[121] This Section briefly overviews the divergent and contradictory interpretations at play in the medical field, which may raise interpretive challenges for courts, before urging that courts adopt objective medical criteria for the distinction when applying EMTALA.

Medicine has become increasingly specialized over time. At EMTALA's passage in 1986, clearer lines existed between specialized and standard medical care than do today.[122] Treatments which were formerly considered routine are now more often physically separated from routine care spaces and provided by specially certified practitioners.[123] This presents a danger that was less immediate at the time of EMTALA's passage: that hospitals easily evade their statutory obligations by simply designating care as *specialized*. Providers themselves have always played a central role in designating specialized care. For example, physicians have long had discretion to legally classify themselves as specialists.[124] Similarly, medical administrators exercise boundless discretion in designating

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120. Lois P. Myers et al., *What's So Special About Specialty Care?*, 21 INQUIRY 113, 114 (1984).

121. CMS, *Specialty Care* (May 13, 2024), https://www.cms.gov/priorities/innovation/key-concepts/specialty-care [perma.cc/VVV9-QGZE] (defining "specialty care" broadly as "an area of health care focused on a specific area of medicine or specific types of symptoms and conditions.").

122. *See* George Weisz, *The Emergence of Medical Specialization in the Nineteenth Century*, 77 BULL. HIST. MED. 536, 574 (2003) (describing that in the twentieth century, "the proper training of specialist practitioners and demarcation of the boundaries of various specialist activities would emerge as major issues").

123. *See* Myers, *supra* note 115, at 114–15 ("[I]ntermediate- to low-level special care also is expanding into former routine care areas.").

124. Rosemary Stevens, *Trends in Medical Specialization in the United States*, 8 INQUIRY 9, 11–12 (1971) (describing the "self-classification" system for physicians with respect to their specialized status).

care units as intensive.[125] Providers that train and certify medical staff also determine how widely available abortion training and provision is in their covered region.[126] While Idaho did not, states could assert that abortion is specialized care because it is not a procedure that is commonly taught and routinely performed within the state.[127]

If courts looked to providers' training choices for the purpose of designating standard care under EMTALA, they would enable private actors to shirk their federal obligations. If courts were to defer to state law, they would run into the same issue. While state law often designates hospitals as "specialized" or "general," these laws tend to defer to hospitals' self-identification.[128]

Courts interpreting EMTALA should be wary that the medical field largely leaves designations of specialized care up to providers themselves. To effectuate EMTALA's function as a backstop against non-provision of essential standard care, courts should avoid deference to the medical field's classification of specialized services. Courts should instead rely on stable medical criteria, which may be informed by the medical field, to classify services independently. Specifically, courts should find that emergency care is standard when it involves (1) simple and affordable equipment and (2) no or minimal training beyond that which all generalists receive.[129] Neither of these

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125. *See* Myers, *supra* note 115, at 113–16 (To designate specialty care, an administrator may direct that the care be performed in a "unit" that is physically separated from where routine care is provided. A unit's designation as "specialty" does not require that it be of the highest intensiveness; intermediate and low-intensive units may still be specialized).

126. AM. COLL. OF OBSTET. & GYNECOL., *Abortion Training and Education* (Nov. 2014), Committee Opinion 612, at 2, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/11/abortion-training-and-education [https://perma.cc/P775-4YCD] [hereinafter ACOG Opinion].

127. *Id.*; *see also* Carrie Feibel, *Can Doctors Learn To Perform Abortions Without Doing One?*, NPR (Jun. 21, 2016), https://www.npr.org/sections/health-shots/2016/06/21/481774579/can-doctors-learn-to-perform-abortions-without-doing-one [https://perma.cc/TAT7-RN7K] (describing that clinics' closures within state borders has made it difficult for residents training to be OB/GYNs to receive abortion training).

128. *See, e.g.*, MD CODE ANN., Health–General, § 19-307 (West 2025) (providing that Maryland hospitals are "special" if they themselves "define[] a program of specialized services").

129. *See* Myers, *supra* note 115, at 114 (providing that a factor for determining the intensiveness of care should be nurse staffing (including their certification and training) and physician roles (including specialty board certifications), as well as the sophistication of necessary technologies).

criteria should be evaluated with reference to what equipment a particular hospital actually has or training that entities within a particular geography actually make accessible. Instead, the standard should turn on how burdensome it is for hospitals to equip itself to offer the standard care.[130]

Courts should apply these objective criteria to consider whether abortion—particularly medical (i.e., pharmaceutical-induced) abortions—are standard care. Life-saving medical abortions are likely to fit within this classification of standard care, given that the necessary pharmaceuticals are low-cost to providers, and all physicians are qualified to administer these drugs without specialized certifications beyond standard medical training and qualifications.[131] But the next Section describes that regardless of whether emergency abortions are classified as standard or specialized care, EMTALA's obligation to provide life-saving abortions still turns on objective criteria rather than a hospital administration's policies.

C. EMTALA's Obligation to Provide Specialized Services within Hospitals' Capabilities

First, courts should recognize that EMTALA creates a duty to treat in emergencies using care that a hospital is medically capable of providing. It is widely agreed that EMTALA does not compel hospitals to provide "specialized services" it doesn't otherwise offer.[132] In *Idaho*, both parties have adopted this interpretation,[133] and the parties' reading is well-founded in the statutory text. EMTALA does not mention "specialized services" with respect to hospitals' duty to

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130. *See supra* Part III.A (describing that the obligation to make standard care only gives rise to an obligation to provide that care in extremely limited circumstances).

131. The Availability and Use of Medication Abortion, KAISER FAM. FOUND. (Mar. 20, 2024), https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/ [https://perma.cc/PW3F-89DD].

132. *See e.g.*, St. Anthony Hosp. v. U.S. Dep't of Health & Hum. Servs., 309 F.3d 680, 690 (10th Cir. 2002) (finding that a hospital has an obligation to accept a patient for transfer unless it can affirmatively prove that it does not have the specialized capability to treat the patient).

133. *See* Brief for Idaho, *supra* note 20, at 6 ("CMS has reiterated that required treatments are limited not only by physical or staffing constraints but by the 'specialized services that the hospital provides.'"); *see also* Brief for the Federal Government, *supra* note 16, at 36 (agreeing that EMTALA does not compel provision of "specialized services" because "by [ETMALA's] plain terms, the reference to 'available' facilities and staff refers to physical and personnel constraints") (citing CMS Guidance).

accept patients in the first instance (i.e., at the first hospital to which the patient presents), but it makes a recipient hospital's obligation to accept a *transferred* patient contingent on its ability to provide the specialized services that the patient needs.[134] And as the *Idaho* parties suggest, the best reading of the statute is that hospitals must treat transferred patients under the same conditions and in the same manner in which they would accept patients arriving at a hospital in the first instance.[135]

This interpretation—that EMTALA does not obligate hospitals to provide specialized services they don't otherwise offer—makes intuitive sense because specialized services often require significant capital investment, and the choice to make that investment depends on a hospital's resources, the needs of the community, state policy, and local demographic conditions.[136] Potentially recognizing the myriad of economic factors at play, the drafters of EMTALA decided that providers should retain discretion as to whether to make these significant investments.

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134. 42 U.S.C. § 1395dd(g) ("A participating hospital *that has specialized capabilities* or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) *shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities* if the hospital has the capacity to treat the individual.") (emphasis added).

135. Arrington v. Wong, 237 F.3d 1066, 1072 (9th Cir. 2001) (emphasizing that hospitals receiving a transferred patient must continue to provide appropriate emergency care and stabilization); Smith v. Botsford Gen. Hosp., 419 F.3d 513, 515 (6th Cir. 2005) (suggesting that if a hospital receives a patient under EMTALA's transfer provisions, it is subject to the screening and treatment obligations of the statute).

136. *See* Younis et al., *Estimating the Unit Costs of Public Hospitals and Primary Healthcare Centers*, 28 INTL. J. HEALTH PLAN. & MGMT. 320, 320 (2012) (reporting the high daily cost of providing specialized services); *see also* Hospital for Special Surgery, *Community Needs Health Assessment*, https://www.hss.edu/community-health-needs-assessment.asp [https://perma.cc/W3JS-2K5E] (describing that the hospital network assesses the community's health care needs every three years to determine which services it should provide); *Community Health Needs Assessment & Community Service Plan*, NYU LANGONE HEALTH, https://nyulangone.org/our-story/community-health-needs-assessment-service-plan [https://perma.cc/6QSN-YMB6] (stating the hospital's Community Service Plan promotes evidence-based health initiatives specific to the target communities); U.S. GOV'T ACCOUNTABILITY OFF., GAO-04-167 SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, SERVICES PROVIDED, AND FINANCIAL PERFORMANCE, *11 (2003) (describing that specialty hospitals are more common "where state policy and local demographic conditions favor growth").

CMS guidance affirms this understanding that the obligation to accept patients turns on a hospital's medical capabilities, providing:

> [A]ny participating Medicare hospital is *required to accept appropriate transfers* of individuals with emergency medical conditions *if the hospital has the specialized capabilities* not available at the transferring hospital, and has the capacity to treat those individuals.[137]

Like in the statutory provision, notably absent from this interpretation is any reference to whether the recipient hospital would prefer to provide the necessary medical care or not, given how its administration values the patient's life.

Accordingly, courts have found that a hospital is obligated to provide specialized services to a patient when the hospital has made itself capable of doing so by acquiring qualified staff, procuring advanced equipment, and profiting from the provision of the care at issue. Courts have done so without inquiring into hospitals' policies governing whether they tend to provide this kind of care to this kind of patient (as they do under their comparability approach to the "appropriate screening" language).[138] The Tenth Circuit held in *St. Anthony Hospital v. U.S. Department of Health & Human Services* that "any hospital within reasonable transporting distance that employs specialists and utilizes advanced equipment may be liable to accept transfers from various smaller hospitals *unless it can affirmatively prove that it does not have the specialized capability to treat the patient*."[139] The Court found that the hospital did have the specialized services the patient needed, and thus was obligated to accept the transfer, because "[i]t had on hand or available to it the qualified staff, including [a named doctor], necessary to provide vascular surgery to [the patient]."[140] In so ruling, the Court illuminated that the qualifications of staff on hand determined

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137. U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., State Operations Manual Interpretive Guidelines § 489.20(l) (2009).

138. *See supra* Part II.A.1 (introduces the comparability approach used in other circumstances).

139. St. Anthony Hosp. v. U.S. Dep't of Health & Hum. Servs., 309 F.3d 680 (10th Cir. 2002); Ercan E. Iscan, *EMTALA's Oft-Overlooked "Reverse Dumping" Provision and the Implications for Transferee Hospital Liability Following* St. Anthony Hospital, 82 WASH. U. L. Q. 1201, 1218 (2004) (emphasis added).

140. *St. Anthony*, 309 F.3d at 690 (quotation omitted) (noting that space and resources were not issues).

whether the hospital had the specialized capacity to treat a patient's condition. It did not consider whether the hospital typically provides specialized treatment to patients with this condition.

This obligation to accept patients needing specialized care necessarily entails a corollary obligation to provide the care. Hospitals must *accept* emergency patients when they have the medical capabilities to provide the care they require, regardless of hospital policy barring staff from *providing* the specialized care to the patient. It follows that hospitals must treat the patients they accept. Any other result—under which EMTALA obligates hospitals to accept patients needing specialized life or health preserving care, before permitting them to deny patients that care—would be incoherent, leading to dangerous patient transfers that waste precious time as their health deteriorates. This is the very patient-dumping the statute was enacted to prevent.

In other words, when a patient presents to a covered hospital that can provide the necessary specialized treatment, EMTALA creates a duty to treat. It becomes impossible for the hospital to comply with its own policy and obligations under EMTALA; therefore, EMTALA preempts the hospitals' right to adopt policies barring its personnel from providing emergency care that the hospital has the resources to provide (when that care is needed to save the person's life or prevent significant health harm).

In this way, EMTALA serves as an important backstop against hospitals' refusal to offer specialized medical services. Courts may find that certain abortions are properly classified as specialized services. If they did, hospitals looking to shed their obligations could not simply adopt policies against the provision of these essential services; they would have to adopt a total bar on hiring all personnel qualified to perform abortions, and strong market forces—including that OB/GYN services generate significant revenue—disincentivize them from doing so.[141] Therefore, if courts classify emergency abortions as specialized care, EMTALA puts a significant but imperfect obstacle in the way of hospitals seeking not to offer them. But if courts classify emergency abortions as standard care, EMTALA's protections are more robust.

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141. *See Struggling OB/GYN Practice Gains Control of Profits and its Future*, https://www.doctorsmanagement.com/case-studies/ob-gyn/ [https://perma.cc/Y3K4-SK65] (highlighting the profitability of OB/GYN services); *see also* ACOG Opinion, *supra* note 121 (describing that standard OB/GYN training often involves surgical abortion training).

D. Two Potential Criticisms of This Interpretation Fail

1. A cause of action for standard emergency care vindicates EMTALA's purpose

Opponents may argue that EMTALA only prevents hospitals from denying patients based on their ability to pay, not based on their need for an emergency abortion. But courts' recognition of EMTALA's obligations to provide specific treatments under certain conditions would vindicate Congress's anti-patient-dumping purpose. "Patient-dumping"—the practice of turning away patients who present to an emergency department but whom the hospital is reluctant to treat—may occur for reasons which include patients' uninsured status or inability to pay, but which are not limited to these factors. Any refusal to provide life-saving care for non-medical reasons—including administrators' personal opinions or religious convictions—falls within that definition.[142]

This understanding is compatible with EMTALA's legislative history. During House Committee on Ways and Means hearings, members indicated that they were particularly concerned that economic factors were playing a significant role in the patient-dumping crisis unfolding during enactment.[143] However, the Committee indicated a broader overarching aim, stating that it was "most concerned that medically unstable patients are not being treated appropriately."[144] This more fundamental purpose of ensuring access to emergency medical care suggests that EMTALA applies to patient-dumping on bases other than ability to pay.

Indeed, federal courts have emphatically declined to limit EMTALA's applicability to only the uninsured or unable to pay, instead finding that *all* people who presented to an emergency department seeking screening or care have a cause of action under

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142. *See supra* Part I.A (defining the "patient dumping" concept).

143. *See* H.R. REP. NO. 99-241, pt. 1, at 27 (1985) (pointing to the "increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance"); *see also* Abercrombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676, 680 (10th Cir. 1991) (acknowledging the adverse practice of "dumping" patients in the context of EMTALA).

144. H.R. REP. NO. 99-241, pt. 1, at 27; *see* Summers, 91 F.3d at 1136–37 (acknowledging Congress's concern that "medically unstable patients are not being treated appropriately").

EMTALA for a provider's failure to treat.[145] The Fourth Circuit has found that Congress sought "to provide an adequate first response to a medical crisis for *all* patients."[146] The Tenth Circuit agreed, articulating that the statute's "core purpose is to get patients into the system who might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat."[147] Similarly rejecting the notion that EMTALA applies only to patient dumping of indigent patients, the Sixth Circuit has explained:

> We can think of many reasons other than indigency that might lead a hospital to give less than standard attention to a person who arrives at the emergency room. These might include: prejudice against the race, sex, or ethnic group of the patient; *distaste for the patient's condition* (e.g., AIDS patients); . . . or political or cultural opposition. If a hospital refused treatment to persons for any of these reasons, or gave cursory treatment, the evil inflicted would be quite akin to that discussed by Congress in the legislative history, and the patient would fall squarely within the statutory language.[148]

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145. *See, e.g.*, 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, i.e., a bill designed to prohibit hospitals from "dumping" poor or uninsured patients in need of emergency care, does not subtract from its use of the broad term "any individual."); Brooker v. Desert Hosp. Corp., 947 F.2d 412, 414 (9th Cir. 1991) (clarifying that nothing in the language of EMTALA indicates any economic criteria to receive medical care); Gatewood v. Wash. Healthcare Corp., 933 F.2d 1037, 1040 (D.C. Cir. 1991) ("Though the Emergency Act's legislative history reflects an unmistakable concern with the treatment of uninsured patients … the Act's plain language unambiguously extends its protections to "*any* individual" who seeks emergency room assistance."); Cleland v. Bronson Health Care Group, 917 F.2d 266, 269–70 (6th Cir. 1990) ("[T]here is no principle of construction that Congress may not … write a statute that is far broader than any area of concern that it has conceived of or has had brought to its attention…The benefits and rights of the statutes extend 'to any individual' who arrives at the hospital.); Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302, 1306 (N.D. 111. 1990) (noting that while legislative history indicates that enacting legislators were concerned with inability to pay, "the language of the statute quite plainly goes further" and coverage is not limited to those who are unable to pay).

146. Baber v. Hosp. Corp. of America, 977 F.2d 872, 880 (4th Cir. 1992) (emphasis added) (internal quotations omitted).

147. St. Anthony Hosp. v. U.S. Dep't of Health & Hum. Servs., 309 F.3d 680, 694 (10th Cir. 2002) (quoting Bryan v. Rectors Visitors, 95 F.3d 349, 351 (4th Cir. 1996)).

148. *Cleland*, 917 F.2d at 272 (emphasis added).

Other courts have similarly held that EMTALA's reach is not limited to indigent patients, and, therefore, the statute's doctrinal history strongly indicates that EMTALA targets patient dumping for reasons other than ability to pay.[149] Scholars have acknowledged that even if this understanding is beyond drafters' original intention, it is the reality of EMTALA jurisprudence today.[150] A modern definition of patient-dumping, therefore, is the practice of turning away emergency medical patients for reasons besides their medical needs, the hospital's medical capabilities, or the hospital's physical capacity to treat the patients.[151] Hospitals' practice of turning away pregnant patients because they desire not to provide the life-saving care these patients require—a consideration utterly disconnected from the patients' medical needs and hospitals' medical capabilities—is thus a form of patient-dumping under current doctrine.

2. This interpretation of EMTALA does not establish a national standard of care

Courts and scholars have widely rejected the notion that EMTALA creates a national standard of care for emergency medical treatment—or, in other words, a federal medical malpractice cause of action that is available even when providers met state negligence standards.[152] Indeed, a federal standard of medical malpractice which

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149. *See Baber*, 977 F.2d at 880 n.8 (stating that the Sixth and D.C. Circuits impose hospital liability for motives outside of patient's payment or insurance status); CRS Report, *supra* note 33 (providing that "agency guidelines and several lower court decisions indicate that hospitals must [meet EMTALA obligations with respect to] all individuals . . . regardless of an individual's payment status *or other factors*") (emphasis added).

150. D.W., *Baby K and the Courts' Reading of EMTALA*, 22 J.L. MED. & ETHICS 358, 359 (1994) ("In interpreting EMTALA, however, the courts have looked at its broad language and have afforded its protections to all patients, not just to those who are uninsured or indigent. Indeed, the courts have consistently rejected requests to limit EMTALA's scope to the uninsured and indigent populations or to transfers that are improperly economically motivated. In the absence of any congressional signals to the contrary, the courts in effect have expanded the scope of the act beyond its original designs.").

151. *See* Beverly Cohen, *Disentangling EMTALA from Medical Malpractice: Revising EMTALA's Screening Standard to Differentiate between Ordinary Negligence and Discriminatory Denials of Care*, 82 TUL. L. REV. 645, 648 (2007) (describing the purpose of EMTALA as "prohibiting hospital emergency rooms from refusing treatment for nonmedical reasons").

152. *See, e.g.*, Bryan v. Rectors Visitors, 95 F.3d 349, 351 (4th Cir. 1996); Repp v. Anadarko Mun. Hosp., 43 F.3d 519, 522 (10th Cir. 1994); Elaina Michele Maragakis, *EMTALA Rears Its Ugly Head: The Case of Baby K*, UTAH L. REV.

dictates that patients are entitled to one type of treatment over another in given medical circumstances would unduly interfere with physician discretion.[153]

Standing alone, the Fourth Circuit held in *Matter of Baby K* that while EMTALA does not create a national standard of care with respect to the medical *screenings* hospitals must perform, it does with respect to the *treatments* it must provide. The Court acknowledged that hospitals' obligation to provide an "appropriate medical screening" compels only equal screenings for similarly situated patients.[154] It held, however, that EMTALA obligates hospitals to provide all care that is necessary to stabilize the emergent medical condition—more than merely equal treatment.[155] Accordingly, it determined that a hospital violated EMTALA in declining to keep a dying newborn (suffering from anencephaly) on respiratory support even though this was a permissible exercise of physician discretion under state law. In doing so, the Fourth Circuit suggested that EMTALA creates a federal cause of action for damages according to a federal negligence standard of emergency medical care even when doctors complied with state malpractice standards. The Court wrote, "We recognize the dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate, but we cannot ignore the plain language of the statute because 'to do so would "transcend our judicial function."'"[156]

1099, 1119 (1996) ("EMTALA was not a mechanism to enforce a standard of care. It was only meant to ensure that patients receive treatment. To illustrate, EMTALA contains no language that a physician's judgment must yield to EMTALA's mandates. The absence of any language specifying a uniform standard by which physicians must abide might indicate a legislative unwillingness to do so. Instead, Congress required only that a hospital provide an appropriate screening and appeared to leave the task of defining the screening's scope to individual physicians.").

153. Maragakis, *supra* note 147, at 1119 ("To pretend that a single statute can address the infinite combinations of conditions among patients is an unrealistic expectation of EMTALA's scope.").

154. *In re* Baby K, 16 F.3d 590, 597 (4th Cir. 1994) ("First, those hospitals with an emergency medical department must provide an appropriate medical screening to determine whether an emergency medical condition exists for any individual who comes to the emergency medical department requesting treatment.") (citing 42 U.S.C.A § 1395dd(a)).

155. *Id.* at 595 ("[W]e conclude that the duty of the Hospital to provide stabilizing treatment for an emergency medical condition is not coextensive with the duty of the Hospital to provide an 'appropriate medical screening.'").

156. *Id.* at 596 (quoting Baber v. Hosp. Corp. of America, 977 F.2d 872, 884 (4th Cir. 1992)).

Critics have raised federalism objections to the Fourth Circuit's holding, arguing that it interferes with states' authority to establish medical negligence standards and preserve hospitals' clinical autonomy.[157] However, courts should recognize that EMTALA imposes positive obligations to keep care types available without unduly coercing providers or creating a federal standard of care. Instead, EMTALA prevents hospitals from *adopting policies* that make standard emergency treatments unavailable or that bar qualified staff from performing life-saving specialized services. Then, EMTALA requires that the hospital provide emergency patients with necessary, available care. In the vast majority of circumstances, hospitals may choose between available care types for a particular patient, with their discretion confined only by state medical malpractice standards.

In the narrow circumstances in which there is only one type of care able to stabilize the patient and it is available at the hospital, EMTALA requires hospitals to provide it.[158] In these circumstances, EMTALA does eliminate some physician discretion. However, the choice that the federal law removes is between the only possible medical intervention and no medical intervention—not between possible treatments, the relative efficacy of which doctors may dispute. EMTALA's power to compel hospitals to provide *some* treatment as opposed to *no* treatment is already well-established.[159]

In another respect, hospitals' obligation to make its specialized services available in emergency circumstances increases

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157. Scott B. Smith, *The Critical Condition of the Emergency Medical Treatment and Active Labor Act: A Proposed Amendment to the Act After "In the Matter of Baby K",* 48 VAND. L. REV. 1491, 1527 ("The Fourth Circuit's interpretation of the Act now allows plaintiffs to overcome a hospital's clinical autonomy with federal law."); Kevin T. Brown, *The Fourth Circuit Stretches EMTALA Even Further*, 47 MERCER L. REV. 1773, 1779 (1996) ("The Fourth Circuit … held that state laws allowing physicians to make life-and-death decisions based on medical and ethical concerns were pre-empted by EMTALA. This finding of pre-emption in the area of ethical and moral decision-making limits will substantially affect the states' ability to regulate the dispensing of medical care within their borders."); Vickers v. Nash Gen. Hosp., Inc., 78 F.3d 139, 142 (4th Cir. 1996) ("EMTALA is a limited one in a very critical sense: EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence.") (internal quotations omitted).

158. *See supra* Part III.A–C (describing hospitals' obligation to provide stabilizing care available at the facility).

159. *See, e.g.*, Bitterman, *supra* note 37 (describing how EMTALA *guarantees* universal emergency access).

physician discretion. In the absence of hospital policies against care provision when hospitals have equipment available, physicians retain more autonomy to choose the treatment they will offer to a specific patient, not less.[160] Further, hospitals remain free under federal law to refuse to equip themselves with the capabilities for whatever specialized services they choose—for example, by declining to invest in equipment or specially trained staff.

CONCLUSION

Courts have not squarely addressed EMTALA's positive obligations to provide specific types of medical care hospitals may find undesirable. In pending litigation, federal courts will have to determine whether EMTALA compels hospitals to provide specific types of care in emergency circumstances. The most obvious way for courts to do so is to adapt the way they have interpreted EMTALA's requirement that hospitals *screen* patients to EMTALA's obligation to provide necessary stabilizing care. However, if they simply adapt the existing framework, any holding on EMTALA's preemptive effect either leaves open the possibility that hospitals refuse to provide life-saving abortions or encourages hospitals to adopt policies against the provision of life-saving abortions—a stance more radical than many hospitals' current policies. This is because a little-acknowledged carve-out in EMTALA's language makes its ability to compel treatment contingent on the fact that hospitals currently make the care "available" at their facility. To avoid this adverse outcome, which runs counter to EMTALA's purpose, courts should recognize that the statute provides a backstop against hospital policies barring the provision of standard care and other life-saving treatments that it is medically capable of providing. Only by recognizing the full breadth of EMTALA's positive obligations can courts avoid devastating circumstances in which hospitals can shed those obligations altogether.

160. *See* Maragakis, *supra* note 147, at 1119 (asserting that a federal standard of care would unduly interfere with physicians' discretion to provide adequate medical treatment in individual circumstances).