2022 Council Resolution 26: Promoting Safe Reproductive Health Care for Patients

Council Action: **AMENDED AND ADOPTED**

Board Action: **ADOPTED**

Status: **In Progress**

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Purpose:

That ACEP promote the equitable and knowledgeable treatment of patients seeking peri-abortion and post-abortion care in the ED irrespective of the state in which the patient is seeking care; that ACEP promote legal protections for doctors practicing within best practices; that ACEP encourage hospitals and EM residency programs to provide education and more on miscarriage and post-abortion care; that ACEP broaden its clinical policy to include considerations for miscarriage management; that ACEP continue to develop practices and policies to protect the physician-patient relationship, including legal resources; and that ACEP promote adherence to laws that provide the strongest possible protections for high quality patient care.

Fiscal Impact:

Budgeted committee and staff resources for policy development and advocacy initiatives.

Background:

WHEREAS, Reproductive health services including abortion are healthcare; and

WHEREAS, According to the Centers for Disease Control more than 600,000 American women have abortions each year with almost half of these women living at or below the poverty line; and

WHEREAS, Unplanned pregnancies are associated with higher maternal and child prenatal and perinatal morbidity, poverty and decreased education attainment for mothers and children, and as such hold health equity implications; and

WHEREAS, A federal constitutional right to abortion is no longer guaranteed and more than 26 states have passed laws regulating or prohibiting the provision of abortion care; and

WHEREAS, In December 2021 the Federal Drug Administration approved abortion pills by mail and 19 states prohibit telehealth abortion; and

WHEREAS, In light of these barriers to accessing safe health care, people will seek self-managed abortions or initiate abortions without medical management, and as these cases will clinically appear similar to miscarriages, emergency departments may see a rise in miscarriage cases; and

WHEREAS, Patients with ectopic pregnancies who present to emergency departments in abortion-restricted states may encounter physicians or hospitals who refuse to treat their ectopic pregnancy; and

WHEREAS, In June 2022, ACEP that states the doctor-patient relationship should remain free of legislative, regulatory, or judicial interference in the physician-patient relationship; therefore be it

RESOLVED, That ACEP promote the equitable and knowledgeable treatment of patients seeking peri-abortion and post-abortion care in the emergency department irrespective of the state in which the patient is seeking reproductive health care; and be it further

RESOLVED, That ACEP promote legal protections for doctors practicing within the best practices and laws of their own states, irrespective of the state of origin of their patients; and be it further

RESOLVED, That ACEP encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining best clinical practices on miscarriage and post-abortion care, including for patients who have self-managed abortions; and be it further

RESOLVED, That ACEP broaden its clinical policy on Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy to include considerations for miscarriage management; and be it further

RESOLVED, That ACEP continue to develop practices and policies that protect the integrity of the physician-patient relationship including developing legal resources for physicians caring for peri-abortion and post-abortion patients in states where abortion access is limited; and be it further

RESOLVED, That ACEP promote adherence to laws that provide the strongest possible protections for high quality patient care including its continued support of adhering to the federal Emergency Medical Treatment and Labor Act (EMTALA) over state abortion laws when failure to treat or securely transfer a patient with a potentially life-threatening pregnancy-related complication, including but not limited to ectopic pregnancy, severe hemorrhage or uterine infection from either abortion or miscarriage contradicts EMTALA.

The resolution directs the College to promote the equitable and knowledgeable treatment of patients seeking peri-abortion and post-abortion care in the emergency department irrespective of the state in which the patient is seeking reproductive health care; promote legal protections for doctors practicing within the best practices and laws of their own states, irrespective of the state or origin of their patients; encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining best clinical practices on miscarriage and post-abortion care, including for patients who have self-managed abortions; broaden its clinical policy on Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy to include considerations for miscarriage management; continue to develop practices and policies that protect the integrity of the physician-patient relationship including developing legal resources for physicians caring for peri-abortion and post-abortion patients in states where abortion access is limited; and, promote adherence to laws that provide the strongest possible protections for high quality patient care including its continued support for adhering to the federal Emergency Medical Treatment and Labor Act (EMTALA) over state abortion laws when failure to treat or securely transfer a patient with a potentially life-threatening pregnancy-related complication, including but not limited to ectopic pregnancy, severe hemorrhage or uterine infection from either abortion or miscarriage contradicts EMTALA.

The issue of access to and provision of abortion, including peri-abortion and post-abortion care in the emergency department, is in a state of significant uncertainty as a result of the recent decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization*, which held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. As noted in the majority opinion by Justice Samuel Alito, the *Dobbs* decision is limited to the question of a "…constitutional right to abortion and no other right," and that "…[n]othing in this opinion should be understood to cast doubt on precedents that do not concern abortion," such as *Griswold v. Connecticut* that established the right for married couples to purchase and use contraception. More simply, the *Dobbs* ruling is limited solely to the issue of abortion (termination of an established pregnancy) and not contraception or other reproductive health options.

As it does for other important emerging issues impacting emergency physicians and the care of emergency medicine patients, ACEP issued a statement in response to the *Dobbs* ruling expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative,

regulatory, or judicial interference in the physician-patient relationship (as codified in the policy statement, "Interference in the Physician-Patient Relationship," approved by the Board of Directors in June 2022).

Given wide variation in state regulation of abortion and reproductive health procedures, including new prohibitions on abortions in some states even in cases of rape, incest, or where the life or physical health of the pregnant patient is in danger, and some potential efforts to restrict access to or the provision of emergency contraception or other contraceptives, the legal landscape is still in flux and there remain many unanswered questions regarding legislative, regulatory, and judicial implications for the practice of emergency medicine and the provision of reproductive health care. Some advocates have expressed concerns that this uncertainty may also discourage physicians or hospitals from providing emergency contraception or other reproductive health care out of an abundance of caution to avoid potential legal exposure. Additionally, there are worries that there may be additional civil and criminal penalties at the state level against health care providers for assisting individuals in accessing abortions, or aggressive enforcement of mandatory reporting laws that may put physicians in legal peril.

In years prior to the *Dobbs* decision, there were numerous efforts at the state level to significantly limit abortions and penalize physicians and health care providers who perform the procedure. On July 26, 2022, when the Supreme Court took the procedural step to enter its judgment overturning *Roe v Wade,* the process began for some states to implement existing statutes. In Alabama, a law passed in 2019 makes it a felony for physicians to perform any abortion unless the pregnant patient's life is in jeopardy, punishable by up to 99 years in prison. In Oklahoma, a 2021 law enacted a statewide ban on abortion with exceptions for the life or physical health of the pregnant patient, along with criminal penalties and up to five years in prison for any individual who advises or provides any means of accessing an abortion. After the Dobbs decision, Texas law banned abortions from fertilization with the exception of life or physical health of the pregnant patient increasing criminal and civil penalties for providing, advising, or abetting an abortion. Twenty-six states have enacted what are known as born-alive laws, that require physicians to provide medical care and treatment to a fetus or infant born at any stage of development. Under the Texas law, passed in June 2019, physicians who fail to provide that level of treatment face fines of at least $100,000 and third-degree felony charges that could lead to a prison term of two to ten years.

The Clinical Policies Committee defines a clinical policy as an evidence-based recommendation informed by a systematic review of critically appraised literature developed in accordance with accepted guideline development standards. The ACEP Clinical Policies Subcommittee on Early Pregnancy published "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy" in February 2016. It was the most accessed clinical policy in 2021, with 1776 downloads. Clinical policies are comprised of one or more critical questions. Critical questions addressed are drafted as PICO questions. The critical questions addressed in the clinical policy were:

1. Should the emergency physician obtain a pelvic ultrasound in a clinically stable pregnant patient who presents to the ED with abdominal pain and/or vaginal bleeding and a β-hCG level below a discriminatory threshold?
2. In patients who have an indeterminate transvaginal ultrasound result, what is the diagnostic utility of β-hCG for predicting possible ectopic pregnancy?

With respect to the issue of full1 spectrum reproductive care, existing ACEP policy is succinct and limited to the issue of emergency contraception. The ACEP policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy," states in its entirety, "ACEP supports the availability of non-prescription emergency contraception." Prophylaxis and contraception are also discussed as a consideration in the guidelines established under the "Management of the Patient with the Complaint of Sexual Assault" policy, which states:

"A victim of sexual assault should be offered prophylaxis for pregnancy and for sexually transmitted diseases, subject to informed consent and consistent with current treatment guidelines. Physicians and allied health practitioners who find this practice morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide these services in a timely fashion."

Ultimately, it is difficult to predict the range of hypothetical scenarios and individual considerations that may arise within EM, and further clarity may be needed from various authorities to address these potential circumstances. ACEP is also continuing to work its way through other associated issues, such as medical liability, privacy and security of medical records and personal health data, and the ability to treat patients across state lines. For emergency medicine specifically, much of the consideration is related to how these new federal and state laws

and regulations interact with the Emergency Medical Treatment and Labor Act (EMTALA) – an essential law that has been in place since 1987. The law includes three main obligations: the screening requirement, the stabilization requirement, and the transfer requirement. First, the law requires hospitals to provide a medical screening examination to every individual who comes to the ED seeking examination or treatment. The purpose of the medical screening exam is to determine whether a patient has an emergency medical condition. If an individual is determined to have an emergency medical condition, the individual must receive stabilizing treatment within the capability of the hospital. Hospitals cannot transfer patients to another hospital unless the individual is stabilized. If the individual is not stabilized, they may only be transferred if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks.

On July 11, the Centers for Medicare & Medicaid Services (CMS) issued additional EMTALA guidance, following up on its previous guidance from September 2021. In this updated guidance, CMS reiterates that EMTALA pre-empts any directly contradicting state laws around the medical screening examination, stabilizing treatment, and transfer requirements. It specifically clarifies that if a physician believes that an abortion needs to be performed to stabilize a patient with an emergency medical condition, the physician MUST provide the treatment regardless of any state law that may prohibit abortions. Further, with respect to what constitutes an “emergency medical condition” (EMC), the guidance states that the determination of an EMC “is the responsibility of the examining physician or other qualified medical personnel. An emergency medical condition may include a condition that is likely or certain to become emergent without stabilizing treatment." Finally, the guidance states that EMTALA pre-empts “any state actions against a physician who provides an abortion in order to stabilize an emergency medical condition in a pregnant individual presenting to the hospital.”

In addition to the guidance, HHS Secretary Xavier Becerra, in a letter to providers, further made clear that this federal law pre-empts state law restricting access to abortion in emergency situations. Even with this new guidance there is still significant grey area. While the guidance notes that EMTALA can be raised as a defense by a physician facing state action, EMTALA does not provide any *proactive* protection to prevent an emergency physician from facing criminal charges brought by the state for providing this federally-mandated care. Some state restrictions only have an exception allowing abortion if it’s to prevent the death of the pregnant patient. But EMTALA requires stabilizing treatment to prevent “serious impairment of bodily functions,” “serious dysfunction of any bodily organ or part," or to place the health of the patient "in serious jeopardy." This is a significant area of concern, potentially forcing emergency physicians in such states to choose between following EMTALA in order to avoid potential civil monetary penalties, or following the state law in order to avoid potential criminal charges.

ACEP is working to identify other such gaps in existing regulation or statute that could create clinical and legal barriers to how emergency physicians practice medicine. In order to do so, ACEP President Gillian Schmitz has formed a cross-disciplinary task force of experts from across EM to help identify clinical and legal barriers to how emergency physicians practice medicine, and develop recommendations to address them.

As well, ACEP recently joined amicus briefs addressing these issues. On August 15, 2022, ACEP along with the Idaho College of Emergency Physicians, submitted a brief in the U.S. District Court for the District of Idaho in support of in support of the U.S. Department of Justice’s challenge to an Idaho law in *United States v. State of Idaho*. If applied to emergency medical care, the brief argued that Idaho Law would force physicians to disregard their patients’ clinical presentations, their own medical expertise and training, aMnd their obligations under EMTALA—or risk criminal prosecution. The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus brief, this time in in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services’ guidance on the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). The brief explained that the Federal guidance merely restates physicians’ obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

In both cases, the amici have determined the law (ID) or state action (TX) will have damaging professional and legal implications for physicians and adversely impact patient safety. As such, ACEP and other amici, filed the briefs to educate the Courts regarding our physicians' EMTALA obligations as well as the legal and ethical dilemma created by the Idaho legislature's and Texas Attorney General's actions.

Stragegic Plan Reference:

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

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and

administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Prior Council Action:

Substitute resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted. Directed the College to support the availability of non-prescription emergency contraception.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted. Called for the College to take the position that a victim of sexual assault should be offered prophylaxis for sexually transmitted diseases, subject to informed consent consistent with current treatment guidelines and revise the policy statement "Management of the Patient with the Complaint of Sexual Assault" accordingly; and that victims of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent consistent with the current treatment guidelines, and that physicians or others who find this morally objectionable or practice at facilities that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide those services in a timely fashion; and revise the aforementioned policy statement accordingly.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted. Called for the College to assume a leadership role in organizing formal collaboration with key stakeholders including clinical, legal, forensic, judicial, advocacy, and law enforcement organizations to establish areas of cooperation, mutual training, standardization, and continuous quality improvement for the benefit of the sexually assaulted patient.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted. Called for ACEP to take the lead in the development of a national multidisciplinary model protocol that would include training programs and standards for the collection of evidence, examination, and treatment of sexually assaulted patients and that funding sources for the project be sought.

Substitute Resolution 10(91) Sexual Assault adopted. Called for ACEP to develop a recommended list of equipment/supplies for evidence collection kits for victims of sexual assault and address the special needs of pediatric sexual assault patients in its guidelines for management of sexual assault patients.

Substitute Resolution 34(89) "Sexual Assault" adopted. Called for ACEP to develop a position paper on the appropriate management of sexual assault victims of all ages and act as a clearinghouse of resource materials concerning issues on the management of sexual assault victims.

Prior Board Action:

June 2022, approved the policy statement "Interference in the Physician-Patient Relationship."

January 2021, reaffirmed the policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy;" reaffirmed October 2015 and June 2010; originally approved October 2004.

February 2020, reaffirmed the policy statement "Management of the Patient with the Complaint of Sexual Assault;" reaffirmed April 2014 and October 2008; revised and approved October 2002; reaffirmed 1999; revised and approved December 1994; originally approved January 1992.

October 2016, approved the revised "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy" and rescinded the 2012 clinical policy.

Substitute Resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted.

October 2002, revised and approved policy statement "Management of the Patient with the Complaint of Sexual Assault."

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted.

June 1999, reviewed “Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient” handbook prepared by the Sexual Assault Grant Task Force.

June 1999, reaffirmed policy statement "Management of the Patient with the Complaint of Sexual Assault;” originally approved in January 1992.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted.

Substitute Resolution 10(91) Sexual Assault adopted.

Substitute Resolution 34(89) Sexual Assault adopted.

Council Action:

Reference Committee B recommended that Amended Resolution be adopted.

RESOLVED, That ACEP promote the equitable and knowledgeable treatment of patients seeking peri-abortion and post-abortion care in the emergency department irrespective of the state in which the patient is seeking reproductive health care; and be it further

RESOLVED, That ACEP promote legal protections for doctors practicing within the best practices and laws of their own states, irrespective of the state of origin of their patients; and be it further

RESOLVED, That ACEP encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining best **evidence-based** clinical practices on **acute presentations of pregnancy-related complications, including** miscarriage**,** and post-abortion care, **and** including for patients who have self-managed abortions; and be it further

RESOLVED, That ACEP broaden its clinical policy on Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy to include considerations for miscarriage management; and be it further

RESOLVED, That ACEP continue to develop **clinical** practices and policies that protect the integrity of the physician-patient relationship**, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions),** including developing legal resources for physicians caring for peri-abortion and post-abortion patients in states where abortion access is limited; and be it further

RESOLVED, That ACEP **support clear legal** promote adherence to laws that provide the strongest possible **p**rotections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws high quality patient care including its continued support of adhering to the federal Emergency Medical Treatment and Labor Act (EMTALA) over state abortion laws when failure to treat or securely transfer a patient with a potentially life-threatening pregnancy-related complication, including but not limited to ectopic pregnancy, severe hemorrhage or uterine infection from either abortion or miscarriage contradicts EMTALA**.**

The Council adopted Amended Resolution 26(22) on September 30, 2022.

Testimony:

Testimony was largely in support of the resolution. During asynchronous testimony, several comments recommended that the resolution should be focused on the protection of emergency department-related care and of emergency physicians providing this care. Comments noted that ACEP should ensure that physicians caring for these patients are protected and not subject to prosecution for providing life-saving care. During live testimony, comments largely supported the amended language though some preferred the original language. Several members suggested reinstating the final resolved to reiterate the importance of recognizing the supremacy of EMTALA over state law in this circumstance. The Reference Committee recommends the amended language to streamline the resolved while maintaining its intent as well as to ensure the resolution continues regardless of potential legal actions related to EMTALA.

Board Action:

The Board adopted Amended Resolution 26(22) on October 3, 2022.

RESOLVED, That ACEP encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; and be it further

RESOLVED, That ACEP continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions).

RESOLVED, That ACEP support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

References:

BACKGROUND REFERENCE

1ACEP recognizes that references to "reproductive health services" may be interpreted differently by the reader; however, in order to retain consistency with language used by the authors of the resolution, this verbiage is incorporated into the Background section of the document.

Implementation Action:

Assigned to the Emergency Medicine Reproductive Health & Patient Safety Task Force to develop a comprehensive policy statement on access to reproductive health care and include the tenets of Resolutions 24, 25, 26, and 27. Review ACEP's policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy" and determine if revisions are needed for a stand-alone policy statement or if it can be included in the comprehensive policy statement on access to reproductive health care.

Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

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