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Perspective

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# Supporting, Not Reporting — Emergency Department Ethics in a Post-*Roe* Era

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A woman in Texas went to an emergency department (ED) for help. Seeking reassurance about symptoms she was having, she shared intimate details about her life with health care workers she had never met and had a pelvic exam. In response, hospital staff reportedly called the authorities. A grand jury indicted the patient for murder for allegedly self-managing an abortion, and on April 7, 2022, she was arrested and jailed.[1]

The ethical and legal obligations related to confidentiality, privacy, and duty of care that ED staff embrace apply to patients who have had, or attempted to have, an abortion — which we believe is especially urgent to affirm, now that the right to abortion is no longer protected by *Roe v. Wade*. Between 2000 and 2020, there were at least 61 instances of people being arrested or criminally investigated for allegedly self-managing an abortion or helping someone else do so, according to a report from the organization If/When/How. One third of these cases were brought to law enforcement's attention by health care providers.

How can we prevent EDs, which are the health care safety net for underserved and marginalized people in the United States, from becoming a dragnet? And in the rare situations in which ethical duties conflict with the law, what should ED clinicians do?

Abortion bans have never actually ended abortion, and many pregnant people will circumvent this era's bans by using medication abortion (misoprostol and mifepristone) and information obtained from the Internet. Although abortion pills are very safe, a subgroup of people using them will come to the ED.[2] Some will need reassurance that their pain, bleeding, or vomiting is to be expected, whereas others may need treatment for a complication such as heavy bleeding.[3] People who try to end their pregnancies using dangerous methods such as blunt trauma, inserting sharp objects into the uterus, or ingesting or inserting caustic agents may also seek ED care. In addition, the reversal of *Roe* will exacerbate long-standing disparities in the need for abortion: 75% of patients who have an abortion in the United States are poor or have low-income status, and 62% are members of marginalized racial or ethnic groups, yet in restrictive states, only pregnant people who can afford to travel will be able to obtain mainstream care. The principle of justice requires staff to treat people who rely on ED care after self-managed abortion with compassion and respect.

ED staff are well prepared to provide exemplary care to the influx of patients that will result from the criminalization of abortion. The ED ethos of caring for "anyone, with anything, at any time"[4] is woven from threads of egalitarianism, social justice, and compassion — and was codified in U.S. law in 1986 with the Emergency Medical Treatment and Labor Act. This act established a federal right to emergency care and obligates clinicians to evaluate and stabilize as necessary the condition of every person who arrives at the ED.

ED staff also have extensive experience providing care for patients who may feel embarrassed or afraid because they present with problems stemming from stigmatized or illegal actions. To ensure that vulnerable patients will be honest and forthcoming with clinicians, especially those they are meeting for the first time, the ethical and legal obligation to respect patient confidentiality and privacy is foundational.

Trust can be further established by constructing a firewall between medical care and the criminal–legal system, as ED staff regularly do when providing care to undocumented patients or people who use illicit drugs. Patients who fear that their health status will be shared with law-enforcement officers are less likely to disclose critical information or to seek care at all, and reluctance to seek help after heavy bleeding or other injuries occurring during a self-managed abortion may result in serious adverse outcomes.

Despite ED staff's experience and skills in navigating complex situations, the rapid emergence of restrictive state abortion laws is bound to create confusion among some clinicians about the ways in which such laws affect their ethical and legal obligations. On June 29, 2022, the Department of Health and Human Services (HHS) issued guidance on how the Health Information Portability and Accountability Act (HIPAA) privacy regulations apply to abortion cases. If state law doesn't expressly require reporting a patient to law enforcement for having an abortion, doing so would be an impermissible breach of HIPAA.

The abortion bans passed to date target abortion providers and sometimes third parties who help a person obtain an abortion, but none explicitly criminalize actions of the person seeking care, and many shield that person from prosecution. (For example, 3 days after the woman in the Texas case was arrested, charges were dropped because she hadn't committed a crime.[1]) But even if states pass laws criminalizing patients' actions, such laws should have no effect on confidentiality requirements. Determining whether a pregnant person who discloses use of abortion pills has violated a law is never an ED staff member's job.

State laws requiring health care providers to report patients who may have had an illegal abortion would pose ethical dilemmas. No state has mandated such reporting. If disclosure of personal health information (PHI) is required by law, HIPAA "permits but does not require" health care providers and hospitals to disclose the information, according to the HHS guidance. If state legislatures pass abortion-specific reporting requirements, we believe ED staff should be guided by the American College of Emergency Physicians' code of ethics, which states, "Personal information may only be disclosed when such disclosure is necessary to carry out a stronger conflicting duty, such as a duty to protect an identifiable third party from serious harm or to comply with a just law."[5] This guidance is in keeping with the preamble to the American Medical Association's code of ethics, which states, "In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties."

Clinicians' obligations as mandatory reporters of child abuse aren't triggered by knowledge of an illegal abortion, even if an abortion statute refers to an embryo or fetus as a "child." The justification for breaching confidentiality to report child abuse is not punishment but prevention of harm, which doesn't apply in abortion cases. Policies mandating reporting when a child may have been killed by a parent are also inapplicable because abortion bans currently don't criminalize the patient's act, and having an abortion isn't an indicator of a threat to a person's existing children. The HHS guidance states that permission included in HIPAA's Privacy Rule to disclose PHI in cases of child abuse or neglect "would not apply to disclosures of PHI relating to reproductive health care."

Taking a harm-reduction approach would help clinicians provide ethical care in a punitive legal environment. Initially applied in the area of substance use, harm-reduction strategies minimize the negative health consequences of stigmatized or illegal behavior. For example, clinicians in states with abortion bans could begin interactions with pa-

tients who may have used abortion medications by saying, "You are safe here, and my only concern is your health. The medical care you need is the same whether you're having a spontaneous miscarriage or you took pills to end your pregnancy. I only need information like your current physical symptoms and your medical history to take care of you, and this information remains confidential."

Similarly, ED staff should consider carefully what information they need to include in a patient's medical record to support high-quality continuing care. There's no medical reason to document use of abortion pills or who accompanied the patient to the ED. Recent Society of Family Planning interim guidelines suggest noting that the "patient believes she was pregnant and is now bleeding," for example, without further details. Clinicians can also inform patients about helplines, such as the one operated by If/When/How, which provide legal information and support related to self-managed abortion.

ED staff have long navigated challenging ethical and legal situations to deliver compassionate, confidential care to vulnerable people. We believe these clinicians have the skills and moral compass to extend this care to patients who need their support in a post-*Roe* era. In the midst of the burnout and moral distress wrought by caring for patients with Covid-19, perhaps this opportunity for ED staff to provide the ethical, expert care that abortion patients will need could be a source of rejuvenation and empowerment for clinicians and their patients.

Disclosure forms provided by the authors are available at NEJM.org.

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# Will EMTALA Be There for People with Pregnancy-Related Emergencies?

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The Emergency Medical Treatment and Labor Act (EMTALA) is foundational to U.S. health care. In the wake of the Supreme Court's June 24, 2022, decision in *Dobbs v. Jackson Women's Health Organization*, which eliminated the constitutional right to abortion and returned the regulation of abortion to state control, a key question is whether EMTALA will survive to serve as a bulwark against state laws that bar emergency hospital care in pregnancy cases in all but life-threatening situations.[1]

EMTALA placed curbs on a long-standing tenet of U.S. law that absolved health care providers of any legal duty to furnish emergency medical care.[2] Enacted in 1986 with broad bipartisan support, the statute established a uniform federal duty of emergency care for Medicare-participating hospitals with emergency departments (EDs). Support for EMTALA was driven in large part by news reports of hospitals refusing to treat pregnancy-related emergencies; indeed, pregnant women are the only population explicitly named in the statute.

EMTALA isn't a malpractice statute; rather than focusing primarily on quality of care, the law aims to ensure access to medically appropriate, nondiscriminatory hospital emergency care for anyone who needs it. As an enforcement mechanism, the statute ties its obligations for hospitals to participation in the Medicare program.

Under the statute, Medicare-participating hospitals with EDs