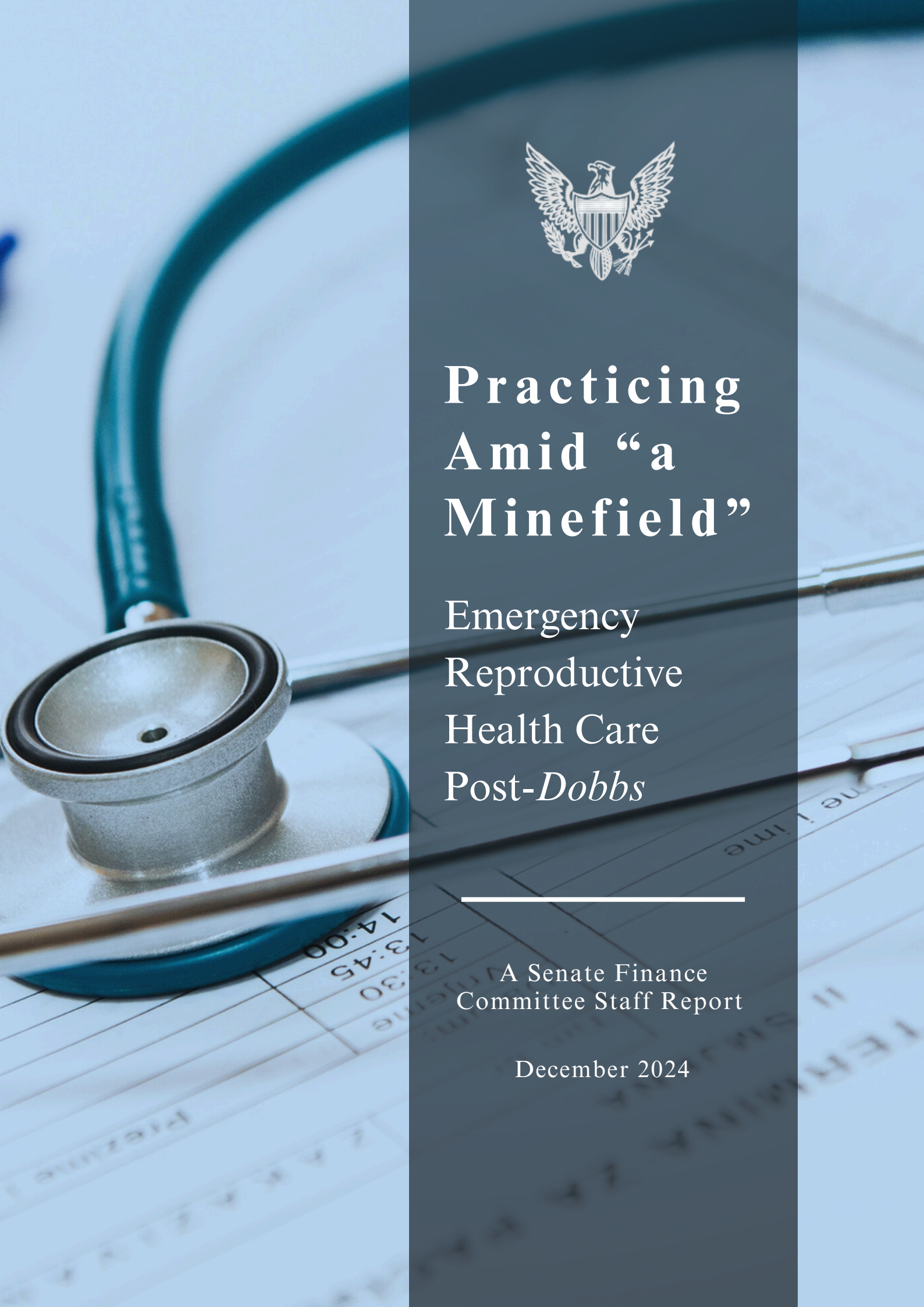

Practicing Amid "a Minefield"

Emergency Reproductive Health Care Post-*Dobbs*

A Senate Finance Committee Staff Report

December 2024

I. Introduction

1. Investigation Background and Overview

The Supreme Court's destruction of the constitutional right to abortion has led to deadly consequences around the country. The right to abortion is no longer enshrined at the federal level, giving way to a patchwork of state abortion bans and restrictions. State-level partial and total abortion bans in 23 states sow legal uncertainties, undermine the provision of the standard of reproductive health care, and conflict with the federal Emergency Medical Treatment and Active Labor Act (EMTALA). Recent investigative reporting identified numerous instances of pregnant women being denied emergency reproductive health care, including miscarriage management and rare post-abortion complications. EMTALA preempts state abortion restrictions and guarantees that all people receive the medical standard of care, including abortion care, when they present at a hospital with an emergency condition.

These ambiguities thrust patients and providers into legal uncertainty that may limit their willingness and ability to seek and provide care. In the case of an emergency reproductive health care situation, complexities that chill access are even more dire. Even in states with total abortion bans, providers are required under EMTALA to provide an abortion if it is stabilizing emergency care. EMTALA was enacted in 1986 to require Medicare-enrolled hospitals to provide screening and appropriate stabilizing care to patients who present with emergency medical conditions, regardless of insurance status. In 2022, the Department of Health and Human Services (HHS) issued guidance explicitly protecting the provision of abortion where appropriate under EMTALA and clarifying that EMTALA requirements under federal law preempt state law. However, the Committee's investigation has found that in practice, providers and patients find that this federal requirement conflicts with state abortion bans, even when they allow an exception for the life of the pregnant person.

When doctors are forced to navigate the complex legal interplay of state abortion bans and federal EMTALA protections, pregnant people experience care delays and may receive substandard care. For example, physicians may avoid surgical interventions or pregnancy terminations, even if they are medically necessary, leading to tragic and sometimes fatal events. It is clear that abortion bans cause confusion and lead women to die preventable deaths.

On September 23, 2024, the Senate Finance Committee (the Committee) Chairman Ron Wyden sent letters to eight hospitals in the wake of concerning reports of pregnant women being denied or experiencing delays in accessing emergency, stabilizing health care at their facilities. To better understand the experiences of people seeking emergency reproductive health care at these hospitals, the letters requested copies of patient-facing signage and written information on a patient's right to care, as well as hospital policies, processes, and procedures related to state abortion laws and emergency reproductive health care. The Committee also requested any legal or human resource support provided to staff navigating the conflict between a state abortion ban

and the medical standard of care when a patient presents in need of emergency medical care. The letters requested responses from hospitals by October 22, 2024.

Chairman Wyden sent letters to the following eight hospitals: Ascension Seton Edgar B. Davis (Texas), Baton Rouge General (Louisiana), Falls Community Hospital and Clinic (Texas), Freeman Health System (Missouri), Holmes Regional Medical Center (Florida), Person Memorial Hospital (North Carolina), Piedmont Henry Hospital (Georgia), and Woman's Hospital (Louisiana). This report's findings draw on all eight hospitals' responses and document productions.

In addition to these document requests, the Committee held roundtable discussions with emergency room physicians, family medicine physicians, and obstetrician and gynecologists (OBGYNs) from across the country. These doctors practice in a diverse sample of environments: rural and urban community hospitals, academic medical centers, states with abortion bans that interact with the provision of emergency reproductive health care, and states without restrictions on abortion care. These conversations produced anonymized observations on the state of health care under abortion bans, the conflicts between state abortion bans and EMTALA, and the impact of navigating the current emergency reproductive health care landscape on providers. Reflections and quotes from these sessions are incorporated into the report to support its findings.

This report also draws on public reporting of pregnant women who experienced pregnancy complications and experienced health care delays or denials, resulting in life-threatening and sometimes fatal outcomes, as a result of state abortion bans. Stories like those centered in ProPublica's extensive reporting demonstrate both the human toll of abortion bans and the erosion of comprehensive reproductive health care under a patchwork of state abortion restrictions. The human toll is evidenced not only in the tragic, avoidable losses of life of pregnant people, but also in the accounts of pregnant women being turned away from hospitals during emergencies. Reporting has revealed instances of pregnant women being turned away from emergency care while experiencing contractions, pregnant women being denied an ultrasound and delivering a child who did not survive while driving to a larger hospital, and pregnant women who were bleeding and in grave physical conditions being denied stabilizing care because a fetal heartbeat was still detectable.[1]

[1] Amanda Seitz, *Emergency rooms refused to treat pregnant women, leaving one to miscarry in a lobby restroom*, Associated Press News (Apr. 19, 2024) https://apnews.com/article/pregnancy-emergency-care-abortion-supreme-court-roe-9ce6c87c8fc653c840654de1ae5f7a1c; [permalink unavailable]; Amanda Seitz, *Federal investigation finds hospitals that denied emergency abortion broke the law*, PBS News (May 1, 2023) https://www.pbs.org/newshour/politics/federal-investigation-finds-hospitals-that-denied-emergency-abortion-broke-the-law; [permalink unavailable]; Rosemary Westwood, *Bleeding and in pain, she couldn't get 2 Louisiana ERs to answer: Is it a miscarriage?*, NPR (Dec. 29, 2022) https://www.npr.org/sections/health-shots/2022/12/29/1143823727/bleeding-and-in-pain-she-couldnt-get-2-louisiana-ers-to-answer-is-it-a-miscarria; [https://perma.cc/AZG4-QYU3].

The Committee has sole Senate subject matter jurisdiction over the Social Security Act. Title XVIII of the Social Security Act establishes the Medicare program. In 1986, Congress passed EMTALA, which requires any hospital that receives Medicare funding to provide necessary, stabilizing treatment to any person who presents with an emergency medical condition.[2]

2. Maternal Mortality in the United States

Pregnancy is at once miraculous and dangerous, requiring stable and accessible care for myriad foreseeable and unforeseeable circumstances. The risk of death faced by pregnant people in the United States is far greater than that of its peer nations.[3] In 2022, the most recent year for which there is data, the maternal mortality rate was 22.3 deaths per 100,000 live births.[4] The maternal mortality rate varies across race and ethnicity. Across all groups studied, the maternal mortality rate is highest for Black women: 49.5 deaths per 100,000 live births.[5] Eight hundred seventeen women died of maternal complications over the course of 2022. By comparison, the maternal mortality rate in Norway in 2022 was 0, meaning that there were no maternal deaths.[6]

In some tragic cases, a pregnancy complication may escalate and endanger the life of the pregnant person, necessitating emergency intervention to save the person's life or to avoid life-long health complications. In many such emergencies, a surgical intervention to remove the contents of the uterus, called dilation and curettage (D&C), is the standard of care, which removes the contents of the uterus.[7] This, or other surgical interventions, may be necessary when a pregnant person experiences a miscarriage, ectopic pregnancy, life-threatening pregnancy related condition, or a pregnancy-related complication such as sepsis, heart failure, or uterine damage. In these and other cases, pregnant people and their health care providers continue to be harmed by the uncertainty around their ability to access essential medical care in a timely manner due to state abortion bans.

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[2] Social Security Act, 42 U.S.C. § 1395dd(b).
[3] Munira Z. Gunja, Evan D. Gumas, Relebohile Masitha, Laurie C. Zephyrin Downloads, *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*, The Commonwealth Fund (June 4, 2024) https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison; [permalink unavailable].
[4] Centers for Disease Control and Prevention, *Maternal Mortality Rates in the United States, 2022* (May 2024) https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2022/maternal-mortality-rates-2022.pdf; [https://perma.cc/8D62-PR5R].
[5] *Id.*
[6] Munira Z. Gunja, Evan D. Gumas, Relebohile Masitha, Laurie C. Zephyrin Downloads, *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*, The Commonwealth Fund (June 4, 2024) https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison; [permalink unavailable].
[7] American College of Obstetricians and Gynecologists, *Practice Bulletin: Early Pregnancy Loss* (November 2018) https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss; [https://perma.cc/PHE4-PXHD].

II. The Legal Landscape of Reproductive Health Care in the United States

1. *"This is reality, whether you agree with it or not."*

On September 24, 2024, the Committee held a hearing on the state of reproductive health care titled "Chaos and Control: How Trump Criminalized Women's Health Care," where members heard moving testimony from a patient and a provider about the heartbreaking reality of reproductive health care today in light of restrictive abortion bans across the country.

Kaitlyn Joshua of Baton Rouge, Louisiana, a state that implemented a near-total abortion ban following *Dobbs*, testified to experiencing care delays during her second pregnancy. Joshua drove herself to the hospital when she experienced unexplained bleeding and cramping. The hospital turned her away without addressing her health needs. At home, Joshua's symptoms worsened. She experienced significant loss of blood, periodically fainted, and eventually presented to a second hospital in a wheelchair. The second hospital also sent her home without care. Over the next few weeks, Joshua would ultimately pass her miscarriage at home, terrified and unable to access comprehensive emergency medical care.

Dr. Amelia Huntsberger, a generalist OBGYN who was forced to move from Idaho to Oregon due to Idaho's strict abortion laws, testified at the hearing about her guiding belief that "it was essential for [her] to be able to provide the health care that [her] patients needed without government interference." When she practiced in Idaho, the state's abortion ban created "really challenging circumstances [for] both pregnant patients and doctors…[which] put everyone at risk." Due to the criminalization of healthcare in Idaho, Dr. Huntsberger and her family left and moved to Oregon.

Republican Members of the Committee, directly contradicting the moving testimonies of Joshua and Dr. Huntsberger, denied that abortion bans compromise emergency reproductive health care. To support this fiction, they relied on theoretical legal standards for prosecution, statutory exceptions to abortion bans, and academic arguments about how the law *should* function. Senator Lankford claimed that it was simply "rhetoric" that prevents pregnant people from accessing emergency reproductive health care. Representing the American Association of Pro-Life Obstetricians and Gynecologists, Dr. Christina Francis echoed the claim that it was "dangerous rhetoric" that "falsely tells women they could be prosecuted if they go to the hospital for complications after an abortion, where in fact pro-life laws hold women harmless." She likewise hand-waved concerns that abortion bans limit the use of D&C for miscarriage management or the removal of ectopic pregnancies.

At the prompting of Senator Lankford, Republican witness Heather Hacker denied outright that there are "any states in which women face prosecution for having an abortion" or that there "are

any states that criminalize miscarriage [...] or the care for a miscarriage."[8] The exchange continued:

"Are there any states that prohibit lifesaving care for the mother?"
"No."
"Are there any states where women have to be actively dying for a doctor to be able to act for her care?"
"No."[9]

The reality of abortion bans in practice tells a different story. As this report lays out, legal restrictions to women's reproductive health care have created an environment where doctors and pregnant women alike are uncertain of their legal exposure and are afraid to provide and access lifesaving health care. In the midst of this uncertainty, many hospitals discussed in this report have failed to meet the moment of supporting their providers with clear and updated guidance.

As Chairman Wyden reminded Committee Members following this exchange, the letter of the law often belies its cruel application. Amari Marsh was charged with murder/homicide by child abuse after she lost her pregnancy in 2023 in South Carolina, a state that bans abortion with limited exceptions any time after fetal cardiac activity can be detected. Though this law does not provide for criminal consequences to women who seek or obtain abortions, Marsh was nevertheless arrested, charged, and jailed. Marsh was placed on house arrest with an ankle monitor and was not cleared of her charges until August of 2024.[10] Marsh is not alone– at least 210 pregnant people were charged criminally for pregnancy, abortion, pregnancy loss, or birth-related conduct post-*Dobbs* as of June 2023.[11]

The facts speak for themselves. Abortion bans lead to pregnant people being denied emergency reproductive health care across the country, and as a result, they are losing their lives. As Senator Cortez Masto made clear at this hearing, "this is reality, whether you agree with it or not."

2. Juxtaposing Reproductive Health Care Access in Two States: Oregon v. Idaho

On June 24, 2022, the United States Supreme Court ruled in *Dobbs v. Jackson Women's Health* (*Dobbs*) that the Constitution does not guarantee the right to abortion. Its ruling dismantled the almost five decades of precedent created by *Roe v. Wade* (*Roe*), which found a fundamental right

[8] Senate Finance Committee, *Chaos and Control: How Trump Criminalized Women's Health Care* (Sep. 24, 2024) at 2:05:07-2:05:16, https://www.youtube.com/watch?v=n_tkZX_upAA [https://perma.cc/2UFC-746A]; Lauren Sausser, *She was accused of murder after losing her pregnancy. SC woman now tells her story*, CNN (Sep. 23, 2024) https://www.cnn.com/2024/09/23/health/south-carolina-abortion-kff-health-news-partner/index.html; [https://perma.cc/7EFC-MU45].
[9] Senate Finance Committee, *Chaos and Control: How Trump Criminalized Women's Health Care* (Sep 24, 2024) at 2:05:21-2:05:33.
[10] *Id.* at 2:10:10.
[11] Wendy A. Bach and Madalyn K. Wasilczuk, *Pregnancy as a Crime: A Preliminary Report on the First Year After Dobbs.*, Pregnancy Justice (Sep. 2024) https://www.pregnancyjusticeus.org/wp-content/uploads/2024/09/Pregnancy-as-a-Crime.pdf; [https://perma.cc/E7YM-86S6].

to abortion access enshrined in the due process clause of the 14th Amendment of the Constitution. This erosion of personal liberty is out of step with the views of the majority of Americans, who believe abortion should be legal in all or most cases (63%) and that abortion care is a personal choice, rather than something that should be restricted by law (74%).[12]

In today's post-*Roe* era, each state determines its own abortion policies. This creates a fractured American reproductive health care access landscape: some states have expanded reproductive health care access, whereas others have created environments that are hostile to people seeking or providing reproductive health care. States may do this by declining to expand their Medicaid programs, restricting Medicaid's ability to pay for reproductive health services and coverage for pre-pregnancy and postpartum care.[13] Despite the importance of Medicaid coverage for family planning services, access to these services continues to be a lottery of geography determined by the state in which an individual resides.

States may also do this by passing legal bans on abortion. Since *Dobbs*, 23 states have implemented abortion bans which restrict access to abortion to earlier cutoffs than the framework set out by *Roe*, including total bans and cutoffs as early as six weeks of pregnancy.[14] Most states have exceptions to these abortion bans in instances where a pregnancy threatens the health or life of the pregnant person, if the pregnancy is a result of a rape or incest, or if there is a fetal anomaly. These exceptions in law are often moot in practice and serve to undermine the provision of the standard of care.[15]

Juxtaposing reproductive health laws in two neighboring states, Oregon and Idaho, offers a window into the jarring variation in reproductive health access in the nation and the impact that these disparities have on the people living in those states.

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[12] Pew Research Center, *Public Opinion on Abortion* (May 13, 2024) https://www.pewresearch.org/religion/fact-sheet/public-opinion-on-abortion/; [https://perma.cc/2FVF-AZGF]; Audrey Kearney, Ashley Kirzinger, , Mellisha Stokes, Mollyann Brodie, Laurie Sobel, Michelle Long, Alina Salganicoff, and Usha Ranji, *KFF Health Tracking Poll: Views on and Knowledge about Abortion in Wake of Leaked Supreme Court Opinion*, KFF (June 9, 2022) https://www.kff.org/womens-health-policy/poll-finding/kff-health-tracking-poll-views-knowledge-abortion-2022/; [https://perma.cc/M7TG-V62S].

[13] Urban Institute, *2.3 Million People Would Gain Health Coverage in 2024 if 10 States Were to Expand Medicaid Eligibility* (Oct. 2023) https://www.urban.org/sites/default/files/2023-10/2.3%20Million%20People%20Would%20Gain%20Health%20Coverage%20in%202024%20if%2010%20States%20Were%20to%20Expand%20Medicaid%20Eligibility_1.pdf#page=29; [https://perma.cc/HJE9-AVYJ].

[14] Guttmacher Institute, *State Bans on Abortion Throughout Pregnancy* (Dec. 5, 2024) https://www.guttmacher.org/state-policy/explore/state-policies-abortion-bans; [https://perma.cc/8PDJ-W8RL].

[15] *See e.g.*, Mabel Felix, Laurie Sobel, and Alina Salganicoff, *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KFF (Jun. 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/TW63-J5NJ]; Naomi R. Cahn & Sonia Suter, *Most state abortion bans have limited exceptions − but it's hard to understand what they mean*, The Conversation (January 26, 2024) https://theconversation.com/most-state-abortion-bans-have-limited-exceptions-but-its-hard-to-understand-what-they-mean-221389; [https://perma.cc/9BPY-GAQL]; Selena Simmons-Duffin, *For Doctors, Abortion Restrictions Create an 'Impossible Choice' When Providing Care*, NPR (Jun. 24, 2022) https://www.npr.org/sections/health-shots/2022/06/24/1107316711/doctors-ethical-bind-abortion; [https://perma.cc/MAP2-YXDY].

In Oregon, abortion is a fundamental right, and the state has taken numerous actions to protect access to critical reproductive health care. In preparation for the *Dobbs* decision in 2022, the Oregon legislature established the Oregon Reproductive Health Equity Fund, which provided $15 million to invest in reproductive health care infrastructure, expand access to reproductive health care, and provide concrete support to people seeking abortion care, including funding for people from out of state. The following year, in 2023, Oregon passed a Shield Law which prohibits law enforcement actions, professional licensure consequences, and adverse insurance determinations related to the provision, receipt, or facilitation of access to legal and protected health services in the state, including abortion care. Finally, Oregon established legal protections for the right to contraception.

The laws in Idaho, just on the other side of Oregon's eastern border, paint a very different picture for access to reproductive health care. Idaho has one of the most draconian abortion bans in the nation: it bans abortions after six weeks of pregnancy.[16] The state abortion ban does not have an exception for when the pregnant person's health is at risk. An abortion may only be performed to stabilize a patient when it will directly "prevent the death of the pregnant woman" or if the pregnancy results from a rape or incest that has been reported to law enforcement. If a provider violates the abortion ban, they can face felony criminal charges, punishable with two to five years in prison, and may have their medical license suspended or revoked.[17] Further, Idaho is one of only five states where the state Supreme Court ruled that the state constitution does not protect the right to abortion, allowing the state's stringent abortion ban to stand.

While Idaho's physician shortage predated its abortion ban, this crisis is intensified by the state's anti-reproductive health care laws. The abortion ban is driving OBGYNs and emergency medicine physicians out of the state, fueling a health care access crisis. As the CEO of the Idaho Medical Association reportedly said in a presentation at the Idaho State Capitol Building, "Idaho is digging itself into a workforce hole…we have to stop digging. And we need more clarity in our laws to help with that."[18] In a social media post announcing the shuttering of its obstetric services, an Idaho hospital explained:

> Idaho's legal and political climate - Highly respected, talented physicians are leaving. Recruiting replacements will be extraordinarily difficult. In addition, the Idaho Legislature continues to introduce and pass bills that criminalize physicians for medical care nationally recognized as the standard of care. Consequences for Idaho Physicians

[16] Many people are not aware of their pregnancies at six weeks. As a result, six week abortion bans amount to acute attacks on people's ability to exercise their reproductive autonomy. Further, in maternity care deserts, pregnant people may not be able to secure appointments within the six week window, gutting their ability to exercise their state-limited reproductive health care rights.

[17] Kelcie Moseley-Morris, *Doctors in Idaho ERs no longer shielded from prosecution under abortion law*, Idaho Capital Sun (Sep. 29, 2023) https://idahocapitalsun.com/2023/09/29/doctors-in-idaho-ers-no-longer-shielded-from-prosecution-under-abortion-law/; [https://perma.cc/VV5D-ZTY8].

[18] Kyle Pfannenstiel, *Idaho is losing OB-GYNs after strict abortion ban. But health exceptions unlikely this year*, Idaho Capital Sun. (Apr. 5, 2024) https://idahocapitalsun.com/2024/04/05/idaho-is-losing-ob-gyns-after-strict-abortion-ban-but-health-exceptions-unlikely-this-year/; [https://perma.cc/8HGH-5DKT].

providing the standard of care may include civil litigation and criminal prosecution, leading to jail time or fines.[19]

3. ***Abortion Bans Sow Clinical Chaos and Legal Uncertainty***

Following *Dobbs*, newly enacted abortion bans and restrictions around the country are creating legal confusion for patients seeking reproductive health care and their providers. Even abortion bans which provide exceptions for rape, incest, life of the mother, and nonviable pregnancies serve to dissuade pregnant people from seeking reproductive health care and providers from offering such care. As a Texas OBGYN explained to Committee staff, "people are very confused" by the exceptions and they "just want to get these patients out of the hospital"[20] because they are afraid of the professional and personal risks of treating these patients. The prospect of prosecution under these ambiguous exceptions chills the practice of comprehensive reproductive health care.

Where state law allows rape or incest exceptions to an abortion ban, the exception usually requires a prior police report by the victim or requires the provider to report the crime. Requiring people to navigate the criminal justice system to justify their medical care is dehumanizing, as well as time-consuming, expensive, and likely to lead to public scrutiny.

State abortion bans create additional uncertainty because hospitals, providers, and patients are left to interpret what does and does not constitute an abortion, in conflict with evidence-based medicine. In guidance developed by some hospitals included in this investigation, hospitals rigorously interpret state law to understand the bounds of the state's definition of "abortion." For example, Freeman Hospital in Missouri advises doctors that "abortion," as defined under state law, could include the interruption of any potential life post-conception. For this reason, this hospital warns providers that the use of emergency contraceptives and intrauterine devices (IUDs) that may prevent a fertilized egg from implanting in the uterus could be considered to be an abortion.[21]

This conflict has real consequences for pregnant patients and their providers. Pregnant people experiencing medical emergencies have to wait for lifesaving care or receive less comprehensive care while their doctors seek legal counsel. Doctors are playing lawyer, and lawyers are playing doctor, while pregnant women experiencing anything short of what amounts to a dire emergency are sent away and told to return to the emergency room once a preventable situation becomes life-threatening. These horrific realities have resulted in irreversible physical and emotional harm to pregnant women and preventable deaths.

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[19] Bonner General Health, *Facebook Post: Bonner General Health*, Facebook (Mar. 17, 2023) https://www.facebook.com/BonnerGeneral/posts/pfbid02MhSttRjMj5VAgWocuP81WdPhetZzpxNfjZYBihu74CdHurbDW2sZrDHLJMh2QjZQl; [https://perma.cc/P2ZG-MJ9X].

[20] Notes from Physician Roundtable (Oct. 2024) (on file with Committee).

[21] Freeman Health Systems, *Freeman Documents to Senate FHS* at 30-31.

For this reason, the Biden Administration clarified in federal guidance that EMTALA requires Medicare-participating hospitals to render abortion care to pregnant women presenting with emergency conditions for which the medical standard of care is an abortion, including ectopic pregnancies or miscarriages, regardless of state law. In such emergency situations, a patient may be irrevocably harmed by the failure to provide necessary, stabilizing care or by the delay in care caused by a potential conflict between a state abortion ban and a hospital's obligations under EMTALA.

Legal challenges to this EMTALA guidance have focused on language in the statute that defines an emergency medical condition requiring stabilization as one in which "the absence of immediate medical attention could reasonably be expected to result in – (i) placing the health of the individual *(or, with respect to a pregnant woman, the health of the woman or her unborn child)* in serious jeopardy" (italics added), arguing a dual stabilization obligation to a mother and her "unborn child" that in fact prohibits abortion under any circumstances. While the Supreme Court has made no pronouncements as to this interpretation of the statute and declined to resolve a recent challenge to the Biden Administration's guidance, the theory appears in the Project 2025 Mandate, a roadmap to far-right governance written by former Trump Administration officials at the Heritage Foundation.[22]

III. The Conflict Between Abortion Bans and EMTALA Creates Confusion

1. Abortion Bans Are Deadly for Pregnant People

Abortion bans kill. Recent reports shine a light on cases of pregnant women who lost their lives or faced near-death experiences. In emergency rooms, providers are forced to determine whether they can provide an emergency abortion in high-pressure, time-sensitive situations, and whether the medical standard of care comports with the legal framework of a state abortion ban. This diverts time and resources from the emergency and creates care delays that translate to health impacts for pregnant patients. Beyond the danger posed to individual pregnant people, these bans promote increased avoidable costs to the health care system because they lead to repeated emergency room visits and higher acuity interventions.

As with most medical crises, the earlier the intervention, the better. For example, when a patient presents at an emergency department having an asthma attack, the physician will immediately intervene, rather than waiting until the patient's condition worsens and they are in respiratory distress. The same should be true in cases of emergency reproductive health care where delays can mean the difference between a treatable condition and one that results in life-altering conditions, including infertility, organ failure, or even death. However, in situations where the threat of one of these grave outcomes is present, doctors may be barred from intervening by an

[22] The Heritage Foundation, Project 2025 Presidential Transition Project, Mandate for Leadership: The Conservative Promise (2023) at 473-4, https://static.project2025.org/2025_MandateForLeadership_FULL.pdf [https://perma.cc/5G8N-2BZM].

abortion ban until a pregnant person's condition worsens substantially. Abortion bans are putting proactive, stabilizing reproductive health care interventions on shaky legal ground. As one Oklahoma OBGYN described to Committee staff:

> Now you have to think about, "Do I just stabilize and wait until there's no heartbeat? Or do I do what needs to be done?" The law is very vague. There's always that gray area. Things that we know, that we never would have hesitated before, now it is very different. Everything is just muddied.[23]

When an emergency is precipitously approaching and a pregnant person's life is at risk, physicians may feel as though they must withhold care they would otherwise provide so that the pregnant patient's condition clearly qualifies as a legally recognizable emergency. As a Texas emergency physician explained, "EMTALA only protects where the patient is unstable.… If [providers] know that a patient is going to suffer the consequences of no care, but it's not an emergency, they [may feel that they] can't act on that concern."[24] This means that providers "aren't able to prevent emergencies, only to act in the case of an emergency."[25] As an Idaho family physician plainly told the Committee, in cases like that "when you have an actual bleeding patient considered non-emergent, it's pretty ironic."[26]

Physicians shared numerous patient accounts that fall into the devastating fact pattern of watching a pregnant patient deteriorate until being legally permitted to deliver stabilizing reproductive health care. According to an Idaho family medicine doctor, a pregnant patient's placenta sheared off the side of their uterus, leading to a massive hemorrhage.[27] The patient presented to the emergency room "four or five times, bleeding"[28] and was sent home each time. The final time, the patient "was going to bleed out"[29] from the miscarriage, so the hospital finally believed they were legally allowed to stabilize the patient. Another family medicine provider in Idaho described a similar patient encounter: a person who was 19 weeks pregnant presented with cramping and slight spotting, but the hospital's maternal-fetal medicine specialists directed the other providers "to send her home so she [could] be brought into an emergency situation."[30] In a third case, a 21-week pregnant person carrying a nonviable fetus went to the emergency room after her water broke. The doctors sent her home, and she returned to delivery but without contractions. The providers refused to remove the nonviable fetus until the heartbeat stopped, requiring the patient to wait over six hours before physicians agreed to induce labor.

Doctors may be forced to resort to substandard care in order to conform to state abortion bans, placing pregnant people's lives in jeopardy. For example, when a pregnant person is

[23] Notes from Physician Roundtable (Oct. 2024) (on file with Committee).
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Id.*

experiencing a miscarriage, providers may administer a medication abortion or other forms of health care to avoid a D&C. However, there are instances where the uterus does not clear naturally, and a D&C or induction is the standard of care for a miscarriage. This protocol speeds up the miscarriage to reduce a person's suffering, limit exposure to bacteria, and remove the fetal tissue from the body. Failure to remove tissue through a D&C in these circumstances can have deadly results. In this way, abortion bans position doctors to deprive pregnant people of first-line medical care during reproductive health care emergencies, like miscarriages.

Reporting by ProPublica revealed four instances in which pregnant people in states with abortion bans died after being denied D&C procedures during miscarriages. In Georgia, doctors waited 20 hours to perform a D&C on Amber Thurman, who presented at an emergency room with a septic miscarriage which had caused extreme bleeding and dangerously low blood pressure.[31] The standard of care was to immediately remove the infected tissue with a D&C. Instead, Thurman's doctors waited nearly 20 hours before performing the procedure, during which time Thurman went into "acute severe sepsis." Thurman died during surgery. The Georgia Maternal Mortality Review Committee concluded that her death was preventable.[32]

Thurman's story echoes the experiences of pregnant women in other states with restrictive abortion bans who died as a consequence of care delays. ProPublica uncovered the stories of three additional pregnant women in Texas who died after experiencing significant care delays: Porsha Ngumezi, Nevaeh Crain, and Josseli Barnica.

In the case of Porsha Ngumezi, doctors attempted to circumvent a D&C by treating her miscarriage with a medication abortion.[33] When Ngumezi, a mother of two young boys, presented at the emergency department, she was bleeding so profusely that she required two blood transfusions. Despite the severity of Ngumezi's bleeding and her known history of a blood-clotting disorder, doctors gave her misoprostol. Given this patient's presentation and medical history, avoiding a D&C is substandard treatment. The medication worked too slowly and caused additional bleeding. Three hours after beginning her course of misoprostol, Ngumezi died from hemorrhaging. Medical experts interviewed by ProPublica agreed: a timely D&C likely would have saved Ngumezi's life.

Nevaeh Crain, 18 years old, presented at the emergency room three times before a hospital evaluated her pregnancy as the potential cause of the serious infection she had. During the first hospital visit, Crain was diagnosed with strep. At the second hospital visit, Crain was diagnosed

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[31] Kavitha Surana, *Abortion Bans Have Delayed Emergency Medical Care. In Georgia, Experts Say This Mother's Death was Preventable*, ProPublica (Sep. 16, 2024) https://www.propublica.org/article/georgia-abortion-ban-amber-thurman-death; [https://perma.cc/327M-XRAS].

[32] *Id.*

[33] Lizzie Presser and Kavitha Surana, *A Third Woman Died Under Texas' Abortion Ban. Doctors Are Avoiding D&Cs and Reaching for Riskier Miscarriage Treatments*, ProPublica (Nov. 25, 2024) https://www.propublica.org/article/porsha-ngumezi-miscarriage-death-texas-abortion-ban/; [https://perma.cc/9FA6-2YR8].

with a urinary tract infection and was discharged with a fever of over 102, unable to walk. At the third hospital visit, Crain was subjected to two ultrasounds before being admitted to intensive care. The hospital conducted the ultrasounds to prove that there had been fetal demise, in compliance with Texas's abortion ban, prior to initiating any further interventions. At one point, while waiting for care, "[o]ld, black blood gushed from her nostrils and mouth."[34] Medical experts interviewed by ProPublica agreed: timely treatment of sepsis through a D&C, or other invention, may have saved Crain's life.

Josseli Barnica, a mother to a one year old girl, miscarried at 17 weeks, but a Texas hospital refused to intervene in her care while there was a detectable fetal heartbeat.[35] Barnica waited 40 hours in the hospital before receiving care. Three days later, she died of an infection. Medical experts interviewed by ProPublica agreed: proper miscarriage management likely would have saved Barnica's life.

2. Abortion Bans Make it Difficult for Doctors to Practice Evidence-Based Medicine

The Committee spoke with emergency medicine providers, OBGYNs, and family medicine doctors to better understand the reality of practicing emergency reproductive health care in a post-*Dobbs* environment. Restrictive abortion bans are ultimately the problem. In states where they stand, doctors reported limited communication and guidance from hospital leadership regarding how to navigate conflicts between state abortion bans and best practices in emergency reproductive health care. Physicians detailed how the conflict between abortion bans and EMTALA hinders timely access to medical services, undermines providers' ability to offer high-quality health care, and creates operational challenges across the hospital. At a personal level, providers spoke about the emotional toll that navigating abortion bans is causing each of them. They noted that this personal impact is likely to intensify OBGYN access issues in any state with an abortion ban and further diminish access to health care in rural areas as OBGYNs are more likely to leave states with restrictive abortion laws or to stop practicing altogether.

Doctors generally reported receiving minimal written information from hospital leadership on protocols, standards of care, or changes in procedures related to state abortion laws. According to a Tennessee OBGYN, "when all of this became very confusing, they just disbanded the [hospital] committee"[36] that was tasked with parsing through the state abortion ban and its impact on reproductive health care, completely abdicating the responsibility to provide guidance and leaving it up to individual doctors to fend for themselves. One full-scope family physician who provides obstetrics services in Texas described the hospital as being "conspicuously and

[34] Lizzie Presser and Kavitha Surana, *A Pregnant Teenager Died After Trying to Get Care in Three Visits To Texas Emergency Rooms*, ProPublica (Nov. 1, 2024) https://www.propublica.org/article/nevaeh-crain-death-texas-abortion-ban-emtala; [https://perma.cc/Z8DV-CT8T].
[35] Cassandra Jaramillo and Kavitha Surana, *A Woman Died After Being Told It Would Be a "Crime" to Intervene in Her Miscarriage at a Texas Hospital*, ProPublica (Oct. 30, 2024) https://www.propublica.org/article/josseli-barnica-death-miscarriage-texas-abortion-ban; [https://perma.cc/N394-8SGT].
[36] Notes from Physician Roundtable (Oct. 2024) (on file with Committee).

deliberately silent"[37] on the matter. Another provider in Texas, an emergency medicine doctor, said that "[t]here was only directed education about EMTALA when the hospital…was cited for an EMTALA violation."[38] An Indiana OGBYN said that the hospital where they work does not "put out protocols at all [and] they don't discuss [how to navigate the standard of care] with their physicians."[39] One full-spectrum family medicine provider in Idaho disagreed with this and, instead, expressed gratitude that the hospital where they worked had "communications come as emails regularly, which update physicians on where the line exists with the law."[40] According to a former Texas emergency medicine physician, though, even in instances where hospitals are communicative, "some physicians may disagree with the hospital's guidance because they feel their duty to the patient is different from the way the hospital views its relationship to the patient."[41] This reflection hits home how abortion bans anywhere drive harm to pregnant people seeking reproductive health care and that in any state with restrictive abortion laws, comprehensive care is compromised.

According to providers, fragmented hospital communication related to reproductive health care can create dysfunction within the medical team, diminishing a patient's quality of care. A Louisiana OBGYN explained how information at their hospital is only shared on a "need to know basis, so there are only a handful of us [providers] who get information"[42] rather than clearly articulating protocols hospital-wide. An Idaho family medicine provider echoed a similar sentiment noting that "nurses are not receiving the same systematic email as the physicians, so, nurses have been anxious to work with physicians when physicians tell them it is okay to treat a patient. This disrupts care."[43] This provider went on to explain how "a team might not back you up" about what care to provide, which means that doctors then must "figure out the second or third best option,"[44] rather than deliver the best care possible. Similarly, a family physician in Texas explained that "member[s] of the team may disagree with care being recommended or may be frightened to provision certain care [and] when the team doesn't function well, it does not serve the patient."[45] An emergency medicine provider who used to practice in Texas shed light on some of the specific challenges saying that, "sometimes they [OBGYN providers] refuse to assist in the situation because they aren't willing on the basis of the law to offer definitive care."[46]

In states where abortion bans stand – in conflict with evidence-based reproductive health care – this dearth of hospital guidance can breed confusion, which is almost certainly part of the

[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] *Id.*

purpose of abortion bans. In cases when there is limited communication from hospitals, providers sometimes come up with inaccurate interpretations of abortion bans.[47] An OBGYN in Idaho shared an example of a resident who told a patient that, under the law, pregnant people cannot choose their own course of treatment.[48] In Texas, an OBGYN revealed that "there is a lack of education around the laws [which is leading to] doctors telling patients they can't treat an ectopic pregnancy, which is not true."[49] While the challenge presented by abortion bans is one that is designed to create chaos, hospitals must do more to support providers in these environments.

Physicians who spoke with the Committee described the difficulty of making decisions during a reproductive health emergency when there is a lack of clarity on what is permissible in that state. An OBGYN who practices in Idaho described how "this idea that hospital lawyers are smarter than doctors is infuriating and ridiculous in practice"[50] but that is how the process is currently working. Lawyers lack clinical expertise, so deferring to them in a medical emergency is problematic. One family physician practicing in Missouri likened navigating the bounds of the state's abortion ban to working amid "a minefield" where each doctor has to "think about how much risk [they] are really willing to take on."[51]

To protect themselves, some physicians feel they need to consult resources in the hospital, including other types of providers or legal counsel, which may create care delays. An Idaho family physician said that "doctors are trying to protect themselves from going to jail or getting sued. For this reason, they try to contact legal [counsel] whenever they have a question"[52] which takes time. A Texas emergency medicine provider shared that ethics and legal counsel "aren't typically available on call 24/7. In a life or death situation, it's pretty much impossible that the physicians could reach ethics and legal [in a] timely [manner] in many instances."[53] Care delays can also stem from needing to consult with other specialties. As a former Texas emergency medicine doctor explained, "[i]t's not always the case that the OB [obstetrics] is on hand 24/7,"[54] making it impossible to coordinate emergency reproductive health care.

In instances when doctors reached out for ethics or legal counsel related to reproductive health care, they described being stonewalled or receiving minimal support. An Idaho OBGYN lamented how "the advice to talk to your hospital lawyer is infuriating" because providers "have talked to all the lawyers and they refused to meet with us for over two months. [Then, when legal counsel finally met with us,] they would just regurgitate what the law said back to me." In Texas, a full-scope family physician echoed this experience by reflecting that they have "often met with

[47] *Id.*
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.*

counsel and risk managers who do not want to be involved"[55] in helping them navigate the reproductive health care landscape.

The inability to receive ethics or legal counsel support appears to be unique to reproductive health care issues. According to a Missouri family medicine doctor, "resources are generally available [at the hospital], but anything directly related to abortion goes without help."[56] A Texas emergency medicine provider shared a similar account of having "made use of these resources [like ethics and legal counsel] in the past, [but] felt that they did not want to talk about [reproductive health care and] EMTALA."[57] Based on these reflections, it seems that reproductive health care providers, who are perhaps most in need of institutional support and guidance as they navigate a complicated legal landscape, are the least likely to receive legal and ethics counsel.

Providing emergency reproductive health care amid a compromised reproductive health care landscape has a grave impact on providers. As a former Texas emergency medicine provider made clear, providers "go into emergency medicine because of an 'anything, anyone, anywhere' mentality. When [there are] state laws that are putting that at risk, …[this is a] moral injury."[58] A Texas family medicine provider shared that "trying to deal with the daily emotionality of devastating patient outcomes"[59] is draining, and a full-spectrum physician in Missouri described it as "extraordinarily stressful."[60] A Texas emergency medicine physician said that the "mental and emotional"[61] burden is significant, and the abortion ban in the state "absolutely" contributes to feelings of burnout. Compounded with the personal sadness providers feel is the reality that it is dangerous to provide reproductive health care. One Louisiana OBGYN expressed that, "I feel my safety is at risk because of the medically necessary care I am providing,"[62] while an OBGYN from South Carolina told the Committee that the hospital where they work now has a "criminal defense attorney on retainer"[63] because providers are in danger. Seventy-five percent of the family medicine providers who spoke to the Committee said they had personally experienced physical threats to their safety or verbal threats connected to their employment and the abortion ban in their states.[64] Put simply, an Indiana OBGYN said that "physician practice is becoming untenable."[65]

Given this reality, it is unsurprising that abortion bans are accelerating acute reproductive health care access issues nationwide. From 2011 to 2021, 267 rural hospitals stopped providing

[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *Id.*

obstetrics services.[66] Across the country, one in three counties – which are home to over 2.3 million people of reproductive age – are already maternity care deserts.[67] Further, in the last two years, one in every 25 obstetric units closed.[68] An Idaho family medicine doctor noted the precipitous reduction in trainees in the state of "greater than 20% [this year as compared to previous years] based on restrictive bans in the state."[69] The same Idaho provider observed that many peers are "retiring early because of this."[70] One Texas emergency medicine provider explained that the hospital in which they practice offers "good OBGYN coverage. If there was a place that didn't have that coverage, [this doctor] wouldn't work there."[71] This drastically reduces the types of facilities in which this physician would practice and almost certainly eliminates any rural or underserved setting. Numerous doctors from Idaho, Missouri, Texas, and South Carolina affirmed to Committee staff that the abortion bans in their respective states would impact their long-term employment decisions, and two providers had already moved to practice in states without abortion bans.[72]

3. Some Hospitals Fail to Meet Challenge of Supporting Doctors in Navigating Extraordinary Legal Environment Created by Abortion Bans.

To better understand the state of chaos produced by state abortion bans and the hospital environment physicians now practice in, the Committee requested documentation from hospitals where there have been reports of pregnant women being turned away, denied, or experiencing delays in accessing emergency, stabilizing reproductive health care at their facilities. The Committee sought examples of formal communication between hospitals and their staff regarding state abortion bans, procedures governing how to determine the standard of care, and the legal and human resources available to doctors who may need to perform reproductive health care procedures. The Committee also asked hospitals to describe their processes for receiving and evaluating pregnant patients seeking emergency health care for scenarios in which an abortion would be the appropriate course of treatment, such as pre-viability preterm rupture of membranes, an ectopic pregnancy, a molar pregnancy, or an incomplete medication abortion. Some hospitals produced general emergency department information and/or labor and delivery processes, while other hospitals produced documents specifically related to pregnancy termination.

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[66] Chartis, *Rural America's OB Deserts Widen in Fallout From Pandemic*, (Dec. 2013) https://www.chartis.com/sites/default/files/documents/rural_americas_ob_deserts_widen_in_fallout_from_pandemic_12-19-23.pdf; [https://perma.cc/YDH5-FUQJ].
[67] March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the US* (Sep. 10, 2024) https://www.marchofdimes.org/sites/default/files/2024-09/2024_MoD_MCD_Report.pdf; [https://perma.cc/VP55-49HY].
[68] *Id.*
[69] Notes from Physician Roundtable (Oct. 2024) (on file with Committee).
[70] *Id.*
[71] *Id.*
[72] *Id.*

a. Hospitals' Legal Guidance to Providers

Documents reviewed by the Committee showed that many hospitals have not created guidance to physicians to support them through this shifting legal landscape and continue to rely on guidance developed pre-*Dobbs*. A few hospitals included in the investigation issued proactive guidance to help their providers navigate this changed landscape that specifically addresses conflicts between EMTALA and abortion bans and describes providers' obligations under both laws.[73]

In response to the Committee's inquiry, hospitals returned information that supported the physicians' observations of inadequate communication regarding the changing legal landscape and lack of meaningful support from hospital leadership. In many cases, procedures and communication to hospital staff and doctors have not been updated since state abortion bans took effect. Similarly, most hospitals included in the investigation have not offered supplemental training or legal guidance to preemptively address the legal tension between the medical standard of care, EMTALA, and state abortion bans. Instead, physicians at these facilities are directed to largely unchanged EMTALA policies and given the option to contact ethics or legal counsel. As noted by the physicians interviewed for this investigation, legal counsel may not be available 24/7 to help support physicians in navigating potential conflicts between EMTALA and abortion bans in emergency situations.

Falls Community Hospital and Clinic (Texas) affirmed its commitment to "providing its patients with medically appropriate screening and stabilizing emergency care, including emergency reproductive healthcare."[74] Yet, none of the facility's documents inform providers of how to effectively navigate the state's fraught emergency reproductive health care landscape. When asked to provide a copy of any written information or oral communication distributed to staff regarding hospital protocols, standards of care, or changes in procedures related to the state abortion ban, Falls Community Hospital and Clinic (Texas) said it had "None."[75] Instead, the facility provided a series of three policies, none of which mention emergency reproductive health care situations: Emergency Treatment and Labor Act (EMTALA) Responding to the 250 Yard Rule, EMTALA and Medical Screening Exam, and Emergency Department Precipitous Delivery Protocol.[76] The third document states that "Falls Community Hospital and Clinic [(Texas)] provides obstetrical services on an emergency basis when delivery is imminent or when active labor has progressed to a stage where staff transfer is not possible. Exception: The medical risk of delivery at FCHC outweighs the risk of transfer."[77]

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[73] *Note*: While some hospitals issued proactive, detailed guidance to their physicians and staff, there is public reporting of people being denied comprehensive reproductive health care at each hospital included in this investigation that such hospital guidance and protocol is meant to prevent. This fact draws into sharper focus the reality that abortion bans will continue to negatively impact care, even where hospitals and providers do their best to keep patients safe.
[74] Falls Community Hospital & Clinic *2024-11-14 Supplemental Response to Senate Finance Committee Inquiry*.
[75] *Id.*
[76] *Id*. at FCHC_000002; FCHC_000003; FCHC_000004-FCHC_000011.
[77] *Id*. at FCHC_000004-FCHC_000011; FCHC_000008.

Holmes Regional Medical Center (Florida), part of HealthFirst, produced the system's policy for pregnancy termination outside of D&C procedures for the purposes of removal of stillbirth or for when termination of the pregnancy is deemed to be inevitable.[78] While the policy states that the traditional abortion approval process is not required during an emergency, it does not internally reference EMTALA.[79] When asked to produce hospital procedures for evaluating whether a pregnant patient is experiencing an emergency as defined by EMTALA, the hospital provided its procedure governing obstetrics outpatient medical screening exam, testing, and disposition, its policy governing nursing consultation for obstetric patients, its emergency department patient care policy, its continuum of care policy, its interfacility transfer policy, and its HealthFirst hospitals patient acceptance and transfer procedure.[80] These policies and procedures do not articulate the hospital's procedure in the event that a medical emergency requires an abortion to stabilize.

Baton Rouge General (Louisiana) likewise provided procedures and policies that cover emergency evaluation under EMTALA and specific policies related to the provision of patient care.[81] The hospital's EMTALA process explicitly identifies that "the primary course of care and preservation of life is prioritized with the mother."[82] Its policies dictate the procedure for when a pregnant patient presents in an emergency condition in need of an evaluation, but does not address abortion specifically.[83]

Ascension Seton (Texas) is a member of the Ascension health care system, the largest private Catholic health care system in the United States. While some Ascension hospitals offer obstetric services, this facility does not. Instead, pregnant patients presenting in an emergency condition to the hospital are screened, and stabilizing treatment is provided. Then, if necessary, patients are transferred. The hospital does not itself offer obstetric care, unless the patient cannot be safely transferred and an emergency necessitates such care. However, it specified that it retains proper equipment and trained staff to provide the medical standard of care should a pregnant woman present in an emergency condition.[84]

Person Memorial Hospital (North Carolina) also does not regularly provide obstetric care. In response to the Committee's inquiry, it provided its general EMTALA screening and treatment policy, which lays out guidance for providing emergency screenings under EMTALA. Its EMTALA policies do not address emergency reproductive health care or abortion specifically, despite the fact it is required by law to provide stabilizing care to such patients in emergencies. Instead, the procedure references EMTALA's definition of emergency as a medical condition "placing the health of the individual (or, with respect to a pregnant woman, the health of the

[78] Holmes Regional Medical Center *2024-11-05 Response Letter - Holmes*, Ex. 4(a) at 1.
[79] *Id.* at 4.
[80] Holmes Regional Medical Center *2024-11-05 Response Letter - Holmes*, Ex. 5(a)-(f).
[81] Baton Rouge General Medical Center, *SFC_Response_10.16.24* at 2-3.
[82] *Id.*
[83] *Id.* Ex. 2(c) at 22.
[84] Ascension Seton, *Ascension Seton Edgar B. Davis Response to Chairman Wyden* at 3.

woman or her unborn child) in serious jeopardy.[85] Unlike Ascension Seton, the hospital did not identify any specific precautions or policies it has in place in the event that a pregnant woman presents in emergency condition requiring abortion as the medical standard of care.

Woman's Hospital (Louisiana) detailed its process for receiving pregnant patients at the emergency room, which begins with an emergency assessment. If this assessment reveals that the medical condition threatens the life of the mother or the "life-sustaining organ of the pregnant woman," the presence of an ectopic pregnancy, a molar pregnancy that presents an emergency condition, the determination that the pregnancy has already terminated or will terminate, or any other medical emergency, the physician will consult with the patient regarding the "benefits and alternatives" of a course of care. Following this consultation, "as soon as possible," the physician will render the appropriate standard of care.[86] Neither the hospital's emergency procedures nor its maternal fetal triage index, used to assess the severity of an emergency, reference abortion care.[87]

Piedmont Henry (Georgia) has lengthy policies related to managing care for pregnant patients. One document is called "Guidelines for Management of Obstetric and Gynecologic Patients that Present to the Main ED."[88] It also identified a "decision tree for interruption of pregnancy procedures," which offers a series of questions to help physicians understand whether or not an abortion is legal under state law. This guidance instructs physicians that if they identify a medical emergency, as defined by EMTALA, requiring an abortion, they may proceed with care.[89]

Freeman Health System (Missouri) provided a flowchart of its intake protocol for pregnant patients experiencing potential emergencies, which identifies protocol for emergencies related and unrelated to the pregnancy.[90] It additionally identified procedures that govern the provision of abortion in the case of a ruptured membrane, in light of EMTALA and state law.[91] The hospital also provided protocols related to when a pregnant patient's condition requires treatment at the Birthing Center.[92]

b. Hospitals Surveyed Largely Rely on Decision-Making Resources Developed Pre-*Dobbs.*

The Committee also asked hospitals for the written or oral information given to staff to inform them of changes in law and procedures in accordance with state abortion bans. Additionally, the Committee asked hospitals to identify what resources, such as legal and human resources, are

[85] Person Memorial Hospital, PMH-RLW-00000008 at 00000010.
[86] Woman's Hospital, *Letter to Sen Wyden_10.18.2024* at 3.
[87] Woman's Hospital Ex. D, E.
[88] Piedmont, *Exhibits_Part 2 with dividers* at 11, Policy ID 14256833.
[89] Piedmont, *Exhibits_Part 1 with dividers* at 22.
[90] Freeman Health System, *Documents to Senate FHS - Full Packet* at 53.
[91] *Id*. at 54.
[92] Freeman Health System, *Documents to Senate FHS - Full Packet* at 57.

available to staff when navigating the conflict between the medical standard of care protected by EMTALA and state abortion bans. Doctors responding to emergency medical situations are making a series of difficult, technical decisions, all of which may have permanent outcomes. In order to do this work in an environment that also carries civil and criminal legal risks, physicians require rigorous and proactive legal and ethical support from their institutions. In the face of unique legal straits presented by state abortion bans, the hospitals surveyed have not met physicians' needs for clear and comprehensive guidance to navigate the delivery of emergency reproductive health care.

In response to the Committee's inquiry, some hospitals provided little evidence of proactive counseling for staff on changes in the law and potential impacts on their practice. Many hospitals surveyed in this investigation asserted that staff may contact human resources (HR) and legal counsel with live questions about EMTALA and state abortion bans. However, as noted above, physicians interviewed by the Committee explained that HR and legal support are very rarely accessible 24/7 in practice, and that those consultations can sometimes result in physicians being stonewalled or simply reminded of the letter of the law with no as-applied analysis.

Ascension Seton (Texas), a member of the nation's largest private Catholic hospital system, identified that it had made no changes to "protocols, standards of care, or procedures related to state abortion laws…since June 24, 2022."[93] Instead, members of the hospital's legal and ethics team met with obstetrics and maternal-fetal leadership teams to discuss the Texas abortion law, but no written communication materials were promulgated.[94] These conversations encompassed compliance with the Texas abortion ban, which the hospital understands to allow for the removal of a deceased fetus and ectopic pregnancies. Further, the hospital identified in these conversations that abortion is permitted under Texas law if the pregnant patient is at risk of death or is at "serious risk of substantial impairment."[95] The hospital did identify that hospital staff have 24/7 access to in-house legal counsel, the ethics department, and the risk management department to support its compliance with EMTALA and all state and federal laws.[96]

Baton Rouge General Medical Center (Louisiana) explained that it "did not change or communicate any changes in protocols, standards or procedures related to state abortion laws." The hospital did identify that staff have access to human resources, ethics, and legal teams, a

[93] Ascension Seton, *Ascension Seton Edgar B. Davis response to Chairman Wyden* at 2.
[94] *Note*: As described in the section prior, Ascension Seton, a hospital in the wider Ascension health care system, does not typically provide obstetric services. The hospital's response does not clarify this point, but the obstetrics and maternal-fetal leadership teams referenced here would seem to be system-wide leadership teams; *Id*. at 2.
[95] *Id*. at 2-3; *Note*: this exception to the total ban is premised in Texas state law, not in EMTALA. Accordingly, the standards of "risk of death" and "serious risk of substantial impairment" may diverge from EMTALA's standard of emergency condition: "The team specifically discussed that Texas law allows for the performance of an abortion if the pregnant patient has a condition which places the pregnant patient at risk of death or poses a serious risk of substantial impairment." The hospital asserts this is consistent with the care it had been providing prior to the *Dobbs* decision.
[96] *Id*. at 5 and 7.

corporate compliance program, and a "problem solving policy" that allows staff to "voice concerns."[97]

In response to the Committee's request that they "provide a copy of any…communication distributed to staff regarding hospital protocols, standards of care, or changes in procedures related to state abortion laws," Falls Community Hospital and Clinic (Texas) responded, "None."[98] The hospital retains legal counsel and employs a human resources department to support staff decision-making, but maintains that "[a]ny and all medical care, treatment and services provided to patients at the Hospital is delivered based solely on the independent medical judgement of the attending medical provider, consistent with the applicable standard of care."[99]

Likewise, Woman's Hospital (Louisiana) did not update its policies or procedures following *Dobbs* or to reflect changes under Louisiana's abortion ban.[100] Physicians may contact the Chief Medical Officer, Emergency Department Medical Director, and in-house legal counsel in the event of a suspected conflict between EMTALA and the state abortion ban.[101] Person Memorial Hospital (North Carolina) provided only a copy of its general EMTALA policy in response to the Committee's request. As noted above, the hospital does not provide ordinary reproductive health care services and its EMTALA policies do not address emergency reproductive health care or abortion specifically, despite the fact it is required by law to provide stabilizing care to such patients in emergencies. The hospital provided no indication that this policy had been updated in light of the state's abortion law or that it had communicated proactively with staff regarding changes in the law and resources they might access in the event of a conflict between EMTALA and the state law.[102]

c. Hospitals' Updates to Guidance in Response to *Dobbs* and State Laws.

Some hospitals responded to the *Dobbs* decision and changes to state law by proactively updating their policies and procedures, educating their staff about changes, and developing resources to support staff in the event of legal or ethical conflicts. These hospitals responded quickly to potential legal uncertainty, recognizing the difficult position providers would likely be placed in. While two of the three hospitals that provided this proactive response apprised their staff of the explicit conflict between abortion bans and EMTALA, one hospital advised their providers through this guidance on prohibitions under state law, rather than making mention of the federal requirements under EMTALA.

[97] Baton Rouge General, *SFC_Response_10.16.24* at 2.
[98] Falls Community Hospital & Clinic, *2024-11-14 Supplemental Response to Senate Finance Committee Inquiry* at 1.
[99] *Id.* at 2.
[100] Woman's Hospital, *Letter to Sen. Wyden_10.18.2024* at 2.
[101] *Id.* at 4.
[102] Person Memorial Hospital, *11.22.2024 PMH Letter* at 1; Person Memorial Hospital PMH-RLW-00000008.

Documents reviewed by the Committee showed that only three hospitals issued updated guidance to staff following *Dobbs*. One of these three hospitals issued guidance updated post-*Dobbs* that addressed staff obligations under the state abortion ban without reference to EMTALA obligations.

In June of 2022, Piedmont Clinic (Georgia) assembled a task force in response to Georgia's abortion ban being signed into law.[103] This task force produced materials for staff education, including a "decision tree" for the provision of abortion under Georgia law, compliance guidance for the law's documentation requirements, a statement by The American College of Obstetricians and Gynecologists (ACOG) regarding navigating emergency exceptions to abortion bans, and information about legal challenges to the Georgia ban.[104] Additionally, the hospital updated its consent to treatment policy to reflect the Georgia ban's informed consent requirements, which mandate that a pregnant patient be informed of the fetus's gestational age and presence of a heartbeat prior to consenting to an abortion. The hospital's guidance on the Georgia abortion ban, which was circulated to hospital staff, includes information about the law's potential conflict with EMTALA and providers' obligations under both laws. The hospital communicated that its task force offers legal and human resources support to physicians struggling with a conflict between EMTALA and state law, though this body does not participate in physicians' decision-making.[105]

Freeman Health Systems (Missouri) provided its maternal and fetal medicine staff with a detailed legal memo interpreting the interplay of the Missouri abortion ban and their obligations under EMTALA on July 30, 2022.[106] This memo identifies the definition of abortion under Missouri law and the definition of medical emergency under that law. Additionally, it delineates the legal status of emergency contraceptives and intrauterine devices (IUDs) and guidance as to when these interventions are likely legally protected.[107] The memo also includes an assurance that the hospital will provide full civil and criminal defense of providers who are sued or prosecuted under state law after rendering care in compliance with the medical standard of care, hospital policies, and in a good faith effort to comply with state law.[108] This document also includes a detailed explanation of EMTALA and a comparison between the definition of "emergency" as an exception to the abortion ban under EMTALA and under the state law.[109] The

[103] Piedmont Clinic, *Letter to Sen Wyden_signed_10.21.2024* at 2-3, *see also* Ex. 3, 4.
[104] Piedmont Clinic, Ex. 5, 7, 8, 9.
[105] Piedmont Hospital, *Letter to Sen Wyden_signed_10.21.2024* at 3, Ex. 10.
[106] Freeman Health Systems, *Documents to Senate FHS - Full Packet* at 30-35; Missouri's abortion ban only included exceptions for life of the pregnant person. This was overturned by a state constitutional amendment that passed on November 5, 2024. *See* Missouri Independent, *Missouri voters approve Amendment 3, overturn state's abortion ban* (Nov. 5, 2024) https://missouriindependent.com/2024/11/05/missouri-voters-overturn-states-near-total-abortion-ban/; [https://perma.cc/U58G-53YB].
[107] Freeman Health Systems, *Documents to Senate FHS - Full Packet* at 31.
[108] *Id.* at 31.
[109] *Id.* at 34.

hospital further offered step-by-step guidance to its staff should a pregnant patient present in an emergency condition at the hospital.[110]

Holmes Regional Medical Center (Florida) communicated an updated termination of pregnancy procedure to staff which lays out legal cutoffs for care under state law.[111] The hospital addressed changes to the law and internal procedure following *Dobbs* in an email to all staff and addressed the changes in maternal health quality improvement meetings.[112] This updated procedure and guidance do not name staff members' obligations under EMTALA, and instead these documents only reference legal standards relevant to the state abortion ban.[113] The process created by the hospital for the provision of non-emergency abortion services under Florida state law is cumbersome and time-consuming, requiring a complete review of a request for abortion supported by a patient's medical record, proof reviewed by at least two physicians of fatal fetal abnormality, and ultrasounds. When an abortion is provided due to an emergency or inevitable situation, the hospital does not require the same request and approval process, but it does require retrospective review of the procedure within five-to-seven days, requiring a physician to document a rationale for the abortion.[114] This new guidance was underscored by an email to staff from the hospital's Chief Legal Officer. This email likewise updates staff on changes in federal and state law to restrict the provision of abortion, but does not name EMTALA obligations.[115]

In response to the Committee's question about HR and legal resources available to staff, the hospital responded with procedures governing its patient safety event reporting system, where staff may report adverse events for the purposes of quality improvement.[116] Staff only have access to legal and human resources Monday through Friday during business hours, but may contact the hospital's risk managers 24/7.[117] Per hospital policy, risk managers are responsible for reporting terminations of pregnancies and adverse events to the Florida Agency of HealthCare Administration.[118] In the hospital's Quality Improvement Committee meeting minutes from February 21, 2024, attendees discussed that Emergency Department physicians had questions regarding obstetric care and emergency management that the Clinical RN Educator was "not comfortable answering."[119] The recommended action was for the Quality Improvement Committee to request education on this topic by the hospital's obstetricians to the Emergency Department physicians.[120]

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[110] *Id*. at 35.
[111] Holmes Regional, *2024-11-05 Response Letter - Holmes* at 2, Ex. 3(b).
[112] Holmes Regional, Ex. 3(c).
[113] Holmes Regional, Ex. 3(b) at 9 *citing* Florida Statutes Title XXIX Chapter 382.002, Florida Statutes Title XXIX Chapter 390, Florida House Bill 5 (2022).
[114] Holmes Regional, Ex. 3(b). at 2-4.
[115] Holmes Regional, Ex. 3(e).
[116] Holmes Regional, *2024-11-05 Response Letter* at 5-6; Ex. 7(a).
[117] *Id*. at 5-6.
[118] Holmes Regional, Ex. 4(a), Ex.7(a).
[119] Holmes Regional, Ex. 3(h).
[120] *Id*.

III. EMTALA Rights Unrealized: Pregnant People Die at Home Because of Abortion Bans

EMTALA guarantees that emergency medical services are available to all people, regardless of their health insurance status or other circumstances. Abortion bans sow confusion and chaos that are diminishing this right when people present to an emergency department. There is another erosion of EMTALA caused by abortion bans: people who require emergency reproductive health care are too afraid to seek out the care they need. While this impact is less visible, it is equally as harmful. Women are dying at home, unwilling to risk the legal consequences of presenting at the emergency room with pregnancy complications. Before people interact with the medical system for reproductive health care, the chilling effect of state abortion bans is making pregnancy incredibly dangerous by threatening deadly refusals of care.

Candi Miller's tragic passing sheds light on this invisible reality. According to a ProPublica profile, Miller was 41 years old and had multiple underlying conditions. When she became pregnant, she was told by her doctors that "her body may not be able to withstand"[121] carrying another child, so she sought a medication abortion. This process pairs mifepristone and misoprostol to safely terminate an early pregnancy, as approved by the Food and Drug Administration (FDA).[122] Patients who choose to pursue a medication abortion often cite its high degree of efficacy at ending an early stage pregnancy, strong safety profile, or its promise of privacy as rationales for seeking out this type of reproductive health care.[123] Medication abortions are a critical access cornerstone, especially for low-income women (like Miller), women of color (like Miller), and people living in states that are hostile towards all types of reproductive health care (like Georgia, where Miller lived and there is an abortion ban).

While medication abortions are safe and effective, according to medical records reviewed by ProPublica, Miller experienced rare complications from the termination.[124] The medicines did not completely expel the fetal tissue from her uterus and, in this case, the standard of care is a D&C. However, according to her family, "due to the current [Georgia] legislation on pregnancies and abortions,"[125] Miller stayed home. She suffered for days and later died in bed next to her three-year-old daughter.[126] As with Thurman's case, the Georgia maternal mortality review

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[121] Kavitha Surana, *Afraid to Seek Care Amid Georgia's Abortion Ban, She Stayed at Home and Died*, ProPublica (Sep. 18, 20224) https://www.propublica.org/article/candi-miller-abortion-ban-death-georgia; [https://perma.cc/4M28-PQMS].
[122] Guttmacher Institute, *Medication Abortion Accounted for 63% of All US Abortions in 2023 – An Increase from 53% in 2020* (Mar. 19, 2024) https://www.guttmacher.org/2024/03/medication-abortion-accounted-63-all-us-abortions-2023-increase-53-2020; [https://perma.cc/WW8W-X2FR].
[123] University of California San Francisco Health, *Patient Education: Aspiration Versus Medication Abortion* (2024) https://www.ucsfhealth.org/education/aspiration-versus-medication-abortion; [https://perma.cc/BK79-X5BB].
[124] Kavitha Surana, *Afraid to Seek Care Amid Georgia's Abortion Ban, She Stayed at Home and Died*, ProPublica (Sep. 18, 20224) https://www.propublica.org/article/candi-miller-abortion-ban-death-georgia; [https://perma.cc/4M28-PQMS].
[125] *Id*.
[126] *Id*.

committee concluded that Miller's death was preventable.[127] One member told ProPublica, "[t]he fact that she felt that she had to make these decisions, that she didn't have adequate choices here in Georgia, we felt that definitely influenced her care. She's absolutely responding to [the abortion ban] legislation."[128]

Today, medication abortions account for sixty-three percent of all abortions within the formal American health care system.[129] Since some people seek abortion care elsewhere or from entities that operate outside the bounds of the system, this statistic likely underrepresents the percentage of all abortions that occur through medication abortions. In the extremely rare and unusual circumstances where people experience complications from medication abortions or other forms of reproductive health care,[130] just as can happen with any other type of medical treatment, they must feel that they can safely seek out medical care and exercise their rights under EMTALA, just as they can for any other type of medical emergency.

IV. Conclusion and Recommendations

The Committee's investigation has further clarified that abortion bans create devastating patient and provider realities. The uncertainty and lack of clarity created by abortion bans and their conflict with EMTALA lead to substandard and deadly care during emergency reproductive health care episodes for pregnant people.

Republican assaults on reproductive health care, culminating in the destruction of the constitutional right to abortion through the overturning of *Roe*, have resulted in an untenable professional and medical environment for providers. Under a patchwork of state abortion restrictions, physicians are left to navigate this landscape on their own when hospitals fail to provide clear and comprehensive guidance. These providers sustain moral injury when the law seems to require that they must allow pregnant people's health to deteriorate to a state of emergency prior to providing lifesaving care. Abortion bans also exacerbate health care inequities and disparities as providers relocate to areas without abortion bans where they can practice the standard of care – and comprehensive emergency reproductive health care – without scrutiny and fear.

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[127] *Id*.
[128] *Id*.
[129] Guttmacher Institute, *Medication Abortion Accounted for 63% of All US Abortions in 2023 – An Increase from 53% in 2020* (Mar. 19, 2024) https://www.guttmacher.org/2024/03/medication-abortion-accounted-63-all-us-abortions-2023-increase-53-2020; [https://perma.cc/WW8W-X2FR].
[130] Advancing New Standards in Reproductive Health, *Safety and effectiveness of first-trimester medication abortion in the United States* (Aug. 2016) https://www.ansirh.org/sites/default/files/publications/files/medication-abortion-safety.pdf; [https://perma.cc/2GXV-HMAK]; Guttmacher Institute, *Medication Abortion Accounted for 63% of All US Abortions in 2023 – An Increase from 53% in 2020* (Mar. 19, 2024) https://www.guttmacher.org/2024/03/medication-abortion-accounted-63-all-us-abortions-2023-increase-53-2020; [https://perma.cc/WW8W-X2FR].

The same Republican officials who clawed back reproductive freedom now hold majorities in the U.S. House of Representatives and the U.S. Senate and have regained control of the White House. Based on the findings from this investigation, the Committee makes the following recommendations to federal, state, and local governments, industry stakeholders, and hospital facility leadership.

Priority actions that should be taken to restore comprehensive emergency reproductive health are as follows:

- **The protections guaranteed by *Roe v. Wade* should be established in all states.** State abortion bans kill pregnant people, erode individual liberties, and conflict with federal law (EMTALA). Without a national standard, the current confusion and chaos surrounding emergency reproductive health care will continue, and pregnant people will continue to die preventable deaths. States should enact laws that use the protections enshrined in *Roe* as the standard to protect access to abortion and comprehensive reproductive health care. Democrats will continue to champion the urgent need to restore *Roe* and codify a federal right to abortion.

- **EMTALA should be enforced to the fullest extent of the law.** When there is an EMTALA complaint, a federal and/or state surveyor generally conducts an onsite review and the Centers for Medicare & Medicaid Services (CMS) then takes enforcement action as appropriate. CMS should continue to take seriously its oversight responsibilities and role in making sure hospitals that participate in Medicare comply with EMTALA's requirements, including in cases related to emergency reproductive health care. Democrats and the Committee will demand strong enforcement by CMS as a leading watchdog and closely monitor the agency's enforcement efforts.

- **CMS and the independent HHS Office of the Inspector General (HHS-OIG) should receive the full resources needed to carry out comprehensive EMTALA enforcement activities.** As noted above, under longstanding procedures, CMS enforces EMTALA's requirements for hospitals participating in Medicare. In addition, HHS OIG may impose civil monetary penalties on Medicare-participating hospitals that violate EMTALA. Given the substantial public reports of hospitals violating EMTALA when pregnant people present with emergency reproductive health care needs, CMS and HHS OIG should be given additional resources in order to fulfill their duties, and HHS OIG should carry out those duties to the full extent possible. Democrats will continue to advocate for this essential funding and closely monitor enforcement efforts.

In recognition that incoming President Trump and Congressional Republicans are positioned to further erode comprehensive emergency reproductive health, there are priority actions that hospitals, provider groups, hospital associations, and other organizations should take to mitigate the devastating harms for pregnant people and their providers. They are as follows:

- **Hospital associations, provider groups, and hospitals should work together to provide training, guidance, and resources to doctors on the interplay between EMTALA and abortion bans.** Content should include state-specific information, a "decision tree" adapted to the requirements of state laws, protocol for assessing a pregnant patient, and information on how to navigate exceptions to abortion bans. These materials are similar to those produced by Piedmont Henry Hospital. Beyond written materials, hospitals should make legal support, human resources support, and behavioral health support available to providers in order to alleviate the burnout, stress, and trauma they feel from navigating abortion bans.

- **Professional medical organizations should issue guidance and publish standards that clearly define appropriate clinical care in obstetric emergencies.** There are a range of instances in which abortion is the medically-appropriate, stabilizing treatment for an emergency medical condition. In these cases, clinicians should continue to provide the standard of care for which they were trained to ensure pregnant people receive timely, essential medical care. Professional medical organizations should ensure that all clinicians receive appropriate education and training on these standards as well as comprehensive education on reproductive health care, including medication abortions. Education should not be biased by any state laws. In states with abortion restrictions, there should be additional education on how to stabilize pregnant patients, including when to pursue a surgical intervention.

- **Hospitals should support the full-spectrum of providers – OBGYNs, primary care physicians, and family medicine physicians – in becoming certified to prescribe mifepristone.** The consensus of the medical community is that medication abortions are safe and effective at terminating early pregnancy. Unfortunately, in too many cases, politicians are seeking to make access to these medications harder. In Louisiana, mifepristone and misoprostol were recently reclassified as controlled substances, making it more difficult to access these medications during an emergency. In Texas, Attorney General Ken Paxton has brought suit against a New York telehealth physician who legally prescribed and mailed a Texas resident mifepristone and misoprostol, asserting that the physician was not licensed to practice in the State of Texas. As reproductive health care access continues to be eroded across the country, providers must step up to be an access point for mifepristone and safeguard their patients' reproductive autonomy.

- **OBGYNs, primary care physicians, and family medicine physicians should proactively counsel pregnant patients on their EMTALA rights and how to report potential violations to CMS.** Anyone who witnesses a pregnant patient experiencing an emergency having a delay in care, being denied care, failing to have appropriate medical

stabilization offered, or failing to have a transfer to appropriate services should file an EMTALA complaint. These monitoring actions help to make sure the health care system is safe for everyone. To support this effort, provider groups should develop patient-facing information and training for their members on how to discuss patients’ rights under EMTALA.