AMA
AMERICAN MEDICAL ASSOCIATION

Jack Resneck, Jr., MD
PRESIDENT

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September 9, 2022

The Honorable Elizabeth Warren
United States Senate
309 Hart Office Building
Washington, DC 20510

Dear Senator Warren:

Thank you for your letter dated August 9, 2022, seeking the American Medical Association's (AMA) perspective on state-imposed abortion restrictions in the aftermath of the U.S. Supreme Court's June decision in *Dobbs v. Jackson Women's Health Organization,* which overturned *Roe v. Wade* and *Planned Parenthood v. Casey.* As the largest professional association for physicians and medical students, and the umbrella organization for state and national specialty medical societies, the AMA was deeply dismayed by the Supreme Court's decision to overturn nearly a half century of precedent protecting patients' right to critical reproductive health care. In this uncertain post-*Dobbs* environment, the AMA has been working with state medical associations and national medical specialty societies to hear their concerns about their patients' health and their confusion and questions about their patients' and their physician members' potential criminal exposure under the changing status of state laws restricting or banning abortion. In this fluid situation, with different state laws and conflicting state and federal laws, there are more questions than answers. In our responses below to your questions, we focus on how this uncertainty and lack of clarity is affecting our patients and our physicians.

1. How have state-imposed restrictions on abortion care affected patients?

In the post-*Dobbs* environment, the impact on patients depends on where one lives. As of August 25, most abortions are banned or soon will be banned in 15 states. Litigation is ongoing in many states, so there is much uncertainty about the status of state abortion laws. State-imposed restrictions on abortion care have certainly resulted in diminished access to pregnancy care, reproductive care, and other health care, as well as in delays in such care. However, while the AMA has heard about individual patient cases and seen the press reports of numerous cases, as you describe in your letter, it is difficult at this point to quantify the impact and we are not collecting comprehensive data about such incidents, nor are we aware of states and medical specialties that might be doing so.

What we can say, however, is that the Supreme Court's ruling has opened a deep political rift between states over access to reproductive health services that places sound medical practice and the health of patients at risk. State restrictions that intrude on the practice of medicine and interfere with the patient-physician relationship leave millions of patients with little or no access to abortion services while criminalizing medical care. While AMA policy recognizes that our members' *individual* views on abortion are determined by their own values and beliefs, we firmly and unequivocally support patients'

access to the full spectrum of reproductive health care options, including abortion, as a right. Our policies are the result of a democratic process in which physicians representing every state and national specialty medical society come together in our House of Delegates. In alignment with our long-held position that the termination of a pregnancy is a medical matter between the patient and physician, subject only to the physician's clinical judgment, the patient's informed consent, and access to appropriate facilities, the AMA opposes any government or any other third-party interference that compromises or criminalizes patient access to safe, evidence-based medical care. Unfortunately, patient care is being compromised now, patients are suffering from lack of access to necessary care, and some are at risk of dying due to delayed care in the context of termination of ectopic pregnancies or patients experiencing intrauterine infections, pre-eclampsia, malignancies, or hemorrhage during pregnancy.

One particular concern in terms of how state restrictions are impacting patients is access to medications such as methotrexate. Methotrexate is a commonly prescribed oncology and rheumatology drug that is widely used as an immune suppressant in the treatment of a variety of non-pregnancy, autoimmune conditions such as lupus, psoriasis, arthritis, and inflammatory bowel disease. Methotrexate is also commonly used as an alternative to surgery to treat ectopic pregnancies. Given its potential classification as an abortifacient, patients in several states, particularly those living where abortion is now illegal and in those where abortion laws are unclear or changing, are facing access challenges to methotrexate. The AMA is hearing that some pharmacies are refusing to stock the drug and some pharmacists are refusing to dispense it. In addition, it has been reported that some physicians are refusing to prescribe methotrexate to patients who may become pregnant given concerns about criminal prosecution despite these patients not being pregnant. Lack of access requires patients for which methotrexate is considered "gold standard" treatment to switch treatment regimens, resulting in delays in care and potential worse outcomes. There is no question that this is dangerous for our patients.

Complex health care decisions should be made between a physician and their patient without the federal, state, or local government intervening. Ectopic pregnancies are the leading cause of maternal mortality in the first trimester, and miscarriages with complications and ectopic pregnancies are not rare. Every day, physicians are making intense, time-sensitive decisions where delays threaten lives. New state laws restricting or banning abortion are making these situations dangerous for patients, and potentially deadly. States that ban or severely restrict abortion will not end abortion, they will end safe abortion—risking devastating consequences and even jeopardizing patient lives.

2. How have state-imposed restrictions on abortion care affected physicians?

The *Dobbs* decision leaves providers and health care institutions to navigate an ever-changing landscape of abortion care in their respective states. Physicians have been placed in an impossible situation—trying to meet their ethical duties to place patient health and well-being first, while attempting to comply with vague, restrictive, complex, and conflicting state laws that interfere in the practice of medicine and jeopardize the health of patients. State-imposed bans and restrictions on abortion care make this difficult, and in many cases, impossible to do.

The foundation of the patient-physician relationship relies upon honest, open communication and trust, which is undermined by substituting lawmakers' views for a physician's expert medical judgment. It is each physician's ethical responsibility to help his or her patients choose the optimal course of treatment through shared decision-making that is fully informed by evidence-based medical science and definitively shaped by patient autonomy. Anything less puts patients at risk and undermines both the practice of medicine and our nation's health. The AMA *Code of Medical Ethics* states that "The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical

judgment on patients' behalf, and to advocate for their patients' welfare." The AMA opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of a pregnancy and safety of the pregnant person, are determinations to be made only by health care professionals with their patients.

Physicians must be the ones determining at what point a patient presenting to the hospital faces an emergency situation that requires medical intervention. These determinations often must be made under intense, very time-sensitive conditions where a delay of even a few minutes can become a life-threatening situation. Conflicting, vague, and restrictive state laws, combined with second-guessing of physicians' clinical judgment leaves physicians fearful of prosecution for felonies for doing their job and caring for their patients, facing jail time and loss of their licenses. This is definitely happening now: physicians seeing ectopic pregnancies or patients with sepsis or hemorrhage during pregnancy may need to call hospital attorneys who, in some cases, tell them to wait until there is a higher chance of death before intervening. Patients with new, life-threatening cancers are being forced to travel to other states and wait to terminate pregnancies and begin their chemotherapy.

Another concern that we are hearing from physicians is ensuring continued access to mifepristone. When used in combination with the drug misoprostol, mifepristone can be used safely to terminate pregnancies and for medical management of miscarriages. While much of the debate around mifepristone access is centered on its use to voluntarily terminate pregnancy as part of appropriate reproductive health care, mifepristone is also a critical tool in the medical management of miscarriage. State restrictions on access to this essential drug mean physicians lose the preferred treatment to help patients who have lost a pregnancy involuntarily. Limiting access to mifepristone has serious consequences for treatment of these conditions and is impacting both patients and physicians' ability to practice evidence-based medicine. State restrictions are further complicated by federal policies: under risk evaluation and mitigation strategy (REMS) requirements imposed by the U.S. Food and Drug Administration (FDA). The current REMS still requires the drug to be prescribed by a "certified health care provider" and dispensed by a "certified pharmacy," which may result in continued limitations on access for physicians and patients. The AMA supports revision or removal of the REMS, as there is adequate evidence of safety and efficacy and a lack of evidence demonstrating continued need for the current REMS program.

3. What guidance have you provided to your members, if any, about how to perform their duties in light of state-imposed restrictions on abortion care? Do you plan to issue any future guidance to your members about how to perform their duties in light of state-imposed restrictions on abortion care?

Since the U.S. Supreme Court decision in *Dobbs*, the AMA has been pursuing multiple strategies, at the state and federal levels, to address the broad spectrum of issues and legislative challenges now facing physicians and patients. While the AMA does not provide legal advice to individual physicians or practices, the AMA has convened state medical associations and national medical specialty societies to understand different state dynamics and the challenges facing physicians and coordinate strategies to protect access to reproductive and other care. We have shared information on the federal guidance issued by the Biden Administration that reminded health care providers and hospitals of their obligations to comply with the provisions of the Emergency Medical Treatment and Labor Act (EMTALA) that preempt any state laws that restrict access to stabilizing medical treatment, including abortion procedures and other treatments that may result in the termination of a pregnancy, and reminded pharmacies of their obligations related to prescription medications for reproductive health under federal civil rights laws. We are also working with the legal community about emerging legal issues affecting physicians and how to address them and sharing resources on such legal issues and clinical issues. The AMA is also working with pharmacy groups, calling on policymakers to clarify legal obligations related to prescribing/

dispensing medications that are indicated for abortion but may be prescribed for other reasons (i.e., methotrexate).

The AMA is also involved in several court cases. We joined the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine in amicus briefs around the country seeking to protect access to reproductive care and challenge intrusion on the physician-patient relationship. We also joined amicus briefs challenging abortion restrictions in a number of states, including Arizona, Georgia, Idaho, Kentucky, Ohio, South Carolina, Utah, and West Virginia. Additional filings are expected in coming months. These briefs have supported challenges to a range of harmful laws, including bans from the 1800s, trigger laws intended to ban all abortion following the reversal of *Roe v. Wade*, and criminal penalties that potentially include felony charges for physicians. In addition, the AMA has worked to support federal guidance and litigation around access to care in the courts through its amicus efforts, including in two EMTALA cases in Texas and Idaho. The AMA will continue to work with the Federation and external stakeholders in the courts and at the state and federal levels to protect the physician-patient relationship and access to reproductive care.

4. How can the federal government help protect and expand access to pregnancy care, reproductive care, and other forms of health care in response to state-imposed restrictions on abortion care?

The AMA is very concerned that restrictions on access to abortion and related care will worsen existing gaps in health disparities and outcomes, compounding the harm that under-resourced communities already experience, and believes it is critical that adequate resources be provided, especially in historically marginalized and minoritized and other under-resourced communities. In those states that have already banned or severely restricted abortions and in other states that are expected to do so, access to legal reproductive care will be limited to those who have sufficient resources, circumstances, and financial means, thereby exacerbating health inequities by placing the heaviest burden on patients from Black, Hispanic, Indigenous, low-income, rural, and other historically disadvantaged communities that already face numerous structural and systemic barriers to accessing health care and experience increased rates of maternal mortality and morbidity. Accordingly, the AMA urges Congress and the Administration to continue to provide and expand adequate funding for maternal mortality and morbidity prevention, pregnancy education and prevention resources, for access to community health clinics, and continued funding for education and outreach to individuals who continue to be uninsured or underinsured.

The AMA understands the importance of decreasing maternal mortality and morbidity. The U.S. has the highest maternal mortality rate among developed countries, and according to the Centers for Disease Control and Prevention (CDC), 60 percent or more of these maternal deaths are preventable.[1]

Furthermore, CDC data shows that Black and Indigenous women are three to four times more likely to die from pregnancy-related causes than White women.[2] Approximately 700 women in the United States die annually as a result of pregnancy or related complications. As such, the AMA understands the importance of increasing access to maternal care.

More comprehensive health benefits and affordable health insurance are critical to obtaining access to maternal health care. Insurance coverage for births in the United States is essentially split between private

[1] https://www.cdcfoundation.org/sites/default/files/upload/pdf/MMRIAReport.pdf.
[2] https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6835a3-H.pdf.

insurance (49 percent of births in 2018) and Medicaid (43 percent of births in 2018).[3] However, maternity coverage under Medicaid ends at 60 days postpartum.[4] While some women successfully transition to other sources of coverage, many are left uninsured shortly after the major medical event of childbirth.[5] Though there has been movement to increase access to care for women for one year postpartum, it is not yet universal or guaranteed. As such, a clear policy improvement would be to extend Medicaid and Children's Health Insurance Program (CHIP) to cover new mothers for the full 12-month postpartum period.

In general, one in three women in the United States experiences discontinuous insurance coverage ("churn") before, during, or after pregnancy.[6] Reducing this churn in the postpartum period can help to decrease disparities in maternal health outcomes.[7] Additionally, more than half of pregnancy-related deaths occur after the birth of the infant.[8] Specifically, and critical to policy decisions regarding postpartum care, support, and insurance coverage, approximately 16 percent of pregnancy-related deaths occurred between 1-6 days postpartum, 19 percent occurred between 7-42 days postpartum, and 24 percent occurred between 43-365 days postpartum.[9] ACOG recommends that postpartum care be an ongoing process, rather than a single visit, with services and support tailored to each woman's needs.[10] Nevertheless, approximately 40 percent of women do not attend a postpartum visit.[11] Critical barriers to obtaining postpartum care include lack of child care, inability to obtain an appointment, mistrust of health care providers, and limited understanding of the value of the visit.[12] These barriers are even more challenging for patients with limited resources, decreasing attendance rates and contributing to disparities.[13] Notably, 23 percent of employed women return to work within 10 days of giving birth, and an additional 22 percent return to work between days 10 and 42 postpartum. Only 14 percent of American workers—and only five percent of low-wage workers—have access to paid leave.[14] The AMA agrees with ACOG in recommending that obstetric care physicians ensure that women, their families, and their employers understand the need for continued recovery and support for postpartum women.[15] Recognizing the burden of traveling to and attending an office visit, especially with the new responsibility of an infant,

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[3] MACPAC. Medicaid's Role in Financing Maternity Care: Fact Sheet. January 2020. Available at: https://www.macpac.gov/wpcontent/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf.
[4] Emily Eckert. Preserving the Momentum to Extend Postpartum Medicaid Coverage. Womens Health Issues. 2020 November December; 30(6): 401–404. Published online 2020 Sep 9. doi: 10.1016/j.whi.2020.07.006. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7480528/.
[5] *Id*.
[6] *Id*.
[7] *Id*.
[8] American College of Obstetricians and Gynecologists. Optimizing Postpartum Care. ACOG Committee Opinion Number 736. May 2018. Available at:https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizingpostpartum-care.
[9] Davis NL, et. al. Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2019. Available at: https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/MMR-Data-Brief_2019-h.pdf.
[10] American College of Obstetricians and Gynecologists. ACOG Postpartum Toolkit. Available at: https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/publications/2018-postpartum-toolkit.pdf.
[11] *Id*.
[12] *Id*.
[13] American College of Obstetricians and Gynecologists, supra note 13.
[14] American College of Obstetricians and Gynecologists, supra note 15.
[15] American College of Obstetricians and Gynecologists, supra note 13.

ACOG explains that in-person care may not always be required.[16] Telephone support during the postpartum period can reduce depression, improve breastfeeding outcomes, and increase patient satisfaction.[17] Moreover, holistic care that considers the circumstances of the individual and their ability to access care is needed. Additionally, beyond a full 12-month postpartum coverage period, a mechanism should be developed to allow for presumptive assessment of eligibility and retroactive coverage to the time at which a CHIP-eligible person seeks medical care, and pregnancy should be included as a qualifying life event for special enrollment in the health insurance marketplace.

Additionally, expanding access to physician-led teams that will provide all encompassing reproductive and pregnancy care is important to ensuring optimal patient care. In general, the Medicare residency cap should be raised so that additional physicians can train and join the workforce. It also would be beneficial to provide additional scholarship and loan repayment programs so that a greater number of underrepresented individuals feel that they are able to join the physician workforce. Reducing medical student indebtedness promotes diversity within medicine. Rising medical school debt disproportionately impacts students who are low-income. Due to the cost of medical school many low-income individuals are completely deterred from attending medical school in the first place. According to a national survey, the cost of attending medical school was the number one reason why qualified applicants chose not to apply.[18] Additional surveys by the Association of American Medical Colleges support this conclusion and found that underrepresented minorities cited cost of attendance as the top deterrent to applying to medical school.[19]

The AMA appreciates the opportunity to provide information on the impact on patients and physicians in this very uncertain, fluid post-*Dobbs* environment. The AMA remains committed to protecting our patients and physicians and will oppose laws or regulations that limit access to comprehensive, evidence-based reproductive health care, including abortion.

Sincerely,

Jack Resneck, Jr., MD

[16] *Id*.
[17] *Id*.
[18]https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.
[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760863/.
Grayson, M. S., Newton, D. A. and Thompson, L. F. (2012), Payback time: the associations of debt and income with medical student career choice. Medical Education, 46: 983–991.

AMA
AMERICAN MEDICAL ASSOCIATION

Jack Resneck, Jr., MD
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October 18, 2022

The Honorable Elizabeth Warren
United States Senate
309 Hart Office Building
Washington, DC 20510

Dear Senator Warren:

On behalf of the physician and medical students of the American Medical Association (AMA), I am responding to your letter dated September 22, 2022, seeking the AMA's perspective on the potential impact of a nationwide ban on abortion. As I indicated in my response to your earlier September letter, restrictions on access to abortion, reproductive health care, and other health care are placing sound medical practice and the health of patients at risk. Such restrictions intrude on the practice of medicine and interfere with the patient-physician relationship, leaving millions of patients with little or no access to abortion services while criminalizing medical care. Physicians have been put into situations where they are uncertain about what services they are legally allowed to provide, often forced to consult hospital lawyers on decisions they used to be able to make on their own and scared for their patients' lives and about being prosecuted for doing their jobs.

The AMA recognizes that health care, including reproductive health services like contraception and abortion, is a human right, opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion, and opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by health care professionals with their patients. Moreover, the AMA opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other health care workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services. Our policy on abortion does not differentiate between 15-week bans or earlier bans; however, the AMA does recommend that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. With respect to your specific questions on the impact of a national 15-week abortion ban, we believe that our responses to your letter dated August 9th are relevant, and refer you back to our previous letter dated September 9, 2022.

The AMA is continuing to advocate at the state and federal levels, and in the courts, to protect access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion, as well as access to other health care and medications that are being impacted by restrictions on abortion. We appreciate your leadership on these issues.

Sincerely,

Jack Resneck, Jr. MD

September 8, 2022

Senator Elizabeth Warren
309 Hart Senate Office Building
United States Senate
Washington, DC 20510

Dear Senator Warren:

As a board-certified OB/GYN and abortion provider here in Washington, DC as well as the President & CEO of Physicians for Reproductive Health (PRH), I appreciate your commitment to ensuring our communities have access to the comprehensive reproductive health care they need, including access to abortion care. As you know, PRH is a national network of physician advocates that includes doctors of all specialties from across the country. We work to mobilize the medical community, by educating and organizing providers, and using medicine and science to advance access to comprehensive reproductive and sexual health care for all people. We are grounded in the belief that we, as physicians, have an opportunity and an obligation to leverage the privilege that our white coats provide to center those we care for in our work and our advocacy. We believe this work is necessary to ensure all people are able to live freely with dignity, safety, and security.

For many providers and patients across the country this moment is truly frightening. In the aftermath of the Supreme Court's decision to overturn *Roe v. Wade*, we have watched an already devastating abortion access crisis become far worse. As of today's date, fifteen states have banned abortion care, and we anticipate that at least eleven more will soon follow. And in some states providers are ceasing to provide care out of an abundance of caution and fear due to conflicting and confusing laws. The Supreme Court's decision has created chaos and turmoil for both patients and providers. Make no mistake, what we have witnessed over the last two months is only the beginning.

The harm, caused by the Supreme Court's decision and state efforts to ban abortion entirely, is devastating. People in states where abortion is now illegal are facing tremendous obstacles. Those who are able to gather the necessary resources are being forced to travel to get care – sometimes hundreds of miles away from their communities and homes, often at great personal expense. Those without the means and resources to travel will not be able to get the essential care they need and will be forced to remain pregnant.

Our network of providers is reeling as we grapple with this new and constantly shifting legal landscape; however, at the forefront of our minds are the people we care for. We know that regardless of the Supreme Court's decision and regardless of the abortion bans states impose people will continue needing care. Our movement – providers, funds, advocates, practical support organizations – is collectively doing everything it can to make sure people have both the resources they need, as well as accurate information to make informed decisions about their options for accessing abortion, including self-managing their abortion care. People have been self-managing their abortions either in whole or in part outside of the formal medical system forever. With the development of medication abortion, research shows that people are able to

safely and effectively self-manage their abortions with pills with accurate information and quality medications. As a community of health care providers, we are committed to correcting misinformation and ensuring people have the support and resources they both want and need in a way that is best for them. We know that changes to the legality of abortion does not have to change the safety of abortion care. Medication abortion is extremely safe, whether the medication is obtained from providers or self-sourced. The real threat to people who self-manage their care is not a medical one. It is a legal one. People who self-manage their abortion care and those who support them have been targeted, surveilled, and criminalized for seeking care.

As you rightly named in your letter to PRH, the consequences of this moment are not limited to abortion care. Restrictions on abortion care impact access to the full range of pregnancy related care, including miscarriage management, treatment for medical conditions that arise later in pregnancy, fertility care, and so much more. In addition, abortion bans have a chilling effect on providers seeking to provide care that should not be implicated by an abortion ban because they fear liability and criminalization under the state's abortion restrictions. In some cases, this fear of criminalization has made it difficult for people to obtain care for conditions unrelated to pregnancy, such as treatment for autoimmune disorders or cancers out of concern that medications could impact pregnancy and ultimately result in pregnancy loss or the need to access abortion care.

This is not how health care should work, and it does not have to be this way. Everyone should be able to get care in their own community, in a manner that is best for them, with people they trust. Whether that's in clinic care, accessing medication abortion through telehealth services, or self-managing their abortion with pills on their own terms. I'm glad to be working with you towards this better world.

Please find responses to your questions below. We hope it is helpful to you as you continue championing the importance of access to comprehensive reproductive health care, including abortion care. Should you need additional information please do not hesitate to reach out.

Sincerely,

Dr. Jamila Perritt, MD, MPH, FACOG
President & CEO
Physicians for Reproductive Health

1. **How have state-imposed restrictions on abortion care affected patients?**

Restrictions on abortion care are devastating to the health and well-being of individuals and their families. They have far-reaching consequences that deepen existing inequities and worsen health outcomes for pregnant people and people giving birth. For example, women who have been denied an abortion are more likely to experience high blood pressure and other serious medical

conditions during the end of pregnancy; more likely to remain in relationships where interpersonal violence is present; and more likely to experience poverty. Research also shows that the states with higher numbers of abortion restrictions are the same states with the poorest maternal and infant health outcomes. This is because while most people will have healthy pregnancies, some will experience illnesses or conditions where pregnancy can cause serious problems. Efforts to ban abortion entirely will continue to exacerbate this country's maternal health crises. Data shows that efforts to ban abortion would lead to a 24 percent increase in maternal mortality overall. The consequences would be even more dire for Black women. It is projected that abortion bans are estimated to lead to a 39 percent increase in maternal mortality for Black women and birthing people.

It is undeniable that state-imposed restrictions on abortion impact everyone. Nevertheless, Black, Indigenous, people of color, immigrant communities, young people, LGBTQ+ people, people with disabilities, as well as those living in geographically isolated areas, will be impacted the most. It is critical to understand that restrictions and bans on abortion do not exist in a vacuum. They are shaped by systemic and structural conditions. Factors including entrenched institutional racism and discrimination, barriers to health care and coverage for that care, systemic and intentional income inequality, and inadequate workplace supports including lack of paid leave from work, all contribute to the disproportionate impact of abortion restrictions on people who experience oppression across numerous domains of their identities.

The Supreme Court's decision has compounded the harm of already diminished access to abortion that previously existed under the *Roe v. Wade* framework. Currently fifteen states have implemented abortion bans, and we expect twenty-six states in total to ban abortion almost entirely. This patchwork of states has created enormous barriers to care. People in restrictive states are being forced to travel hundreds of miles to obtain care they should be able to get in their own communities. Already, there have been at least 43 abortion clinics across 11 states that have stopped offering abortion care with more to follow. Seven of these states, containing only limited or no exceptions for abortion, no longer have a single clinic providing abortion care. For those who are not able to pull together the resources to travel, many will be forced to remain pregnant at the expense of their autonomy, well-being, and health.

a. Have state-imposed restrictions on abortion care resulted in diminished access to pregnancy care, reproductive care, or any other form of health care? If so, please explain.

Yes, restrictions on abortion care have far reaching consequences and limit access to the full scope of sexual and reproductive health care, including miscarriage care, ectopic pregnancy care, and more. As documented in the New England Journal of Medicine, abortion bans like TX S.B. 8 provide insight into the broad consequences of banning abortion and imposing criminal liability on health care providers. Consequences of such severe abortion restrictions range from: providers not believing they have the ability to provide abortion counseling or referrals for people in need of care; providers refusing to treat ectopic pregnancy; and providers being forced to wait to intervene until their patient's condition worsens because of uncertainty around what is "sick enough" to qualify for an exception under the state's abortion ban. These laws put

providers in the tenuous position of having to choose between providing nonjudgmental, comprehensive, evidence-based care and risking criminal or civil repercussions. The consequences we've seen stem from Texas's abortion ban is only the tip of the iceberg. As more states ban or severely restrict access to abortion, the ripple effects of numerous state abortion bans will continue to compound. Below I have outlined some additional consequences abortion bans have on other types of care.

Contraceptive Care. Abortion bans have the potential to be intentionally misconstrued and may impact access to contraceptive care, specifically emergency contraception and intrauterine devices (IUDs). Although abortion bans should not affect contraceptive care, there is confusing and misleading language in some states' abortion restrictions that may limit or prevent access to this care. Specifically, some research indicates that the copper IUD may have a post-fertilization effect, preventing implantation of a fertilized egg. This is not the same action as causing an abortion, but anti-abortion legislators are manipulating, and misconstruing abortion bans and restrictions to suggest that the copper IUD functions as an abortifacient. Similarly, additional misinformation and disinformation about the mechanisms of action for various other contraceptives has the potential to disrupt and prevent access to the full spectrum of contraceptive care.

Miscarriage Care. Abortion bans impact access to miscarriage care since treatments used to help manage a miscarriage are the same used to provide an induced abortion. Many miscarriages can be managed using the same medications that are used during a medication abortion, mifepristone and misoprostol. Miscarriages can also be treated using a procedure to remove the pregnancy tissue. This procedure uses the same tools and techniques used during an in-clinic or procedural abortion.

Ectopic Pregnancy Care. While ectopic pregnancy care should never be impacted by an abortion ban, the confusion and uncertainty created by abortion restrictions has ensured this is the case. Health care institutions and providers across the country are worried about being held criminally responsible just for providing the emergency care patients need. There are numerous accounts of providers refusing to provide ectopic pregnancy care due to the immense legal uncertainty and severe penalties the current patchwork of abortion bans has created.

Cancer Care. Cancer care during pregnancy is another area of health care that will continue to be impacted by state restrictions on abortion. While some patients who are pregnant and have cancer can receive the proper treatment while maintaining their pregnancies, that is not true for everyone. In some cases, abortion is necessary to enable further or timely treatment of the cancer. For example, pelvic radiation can be required for some cancers and such treatment is not done during pregnancy because of the risk to the fetus. Providers must be able to discuss with patients the full scope of options and associated risk, and ultimately allow the patient to decide the best course of treatment based on their diagnosis, preferences, and desires.

Auto-Immune Disorder(s). Patients have reported having trouble accessing essential medications that are considered "abortion inducing" in states that have banned abortion. A

primary example is methotrexate, which is used to treat rheumatoid arthritis, lupus, and some cancers.

b. Have state-imposed restrictions on abortion care resulted in delays in care for patients? If so, please explain.

Yes, abortion restrictions delay care for patients who are forced to travel out of state for abortion care, as well as for patients seeking other types of essential health care in restrictive states.

According to the Guttmacher Institute, even before *Roe v. Wade* was overturned, nearly one in ten people seeking abortion care were forced to travel across state lines. Now with the Supreme Court's decision and states continuing to ban abortion, patients are being pushed further and further away from their homes as they grapple with increased travel distances, cost, and other systemic barriers to care.

The uptick in the number of patients travelling to less restrictive states for abortion care is increasing wait times at clinics, straining the already thin resources available, and pushing people further and further away from their homes. For example, in New Mexico where seven clinics are still operating, the wait times for abortion at five of these clinics are a minimum of three weeks because of the influx of patients travelling from the South. Other clinics in New Mexico are so full they have had to periodically stop booking new appointments. These circumstances aren't unique to New Mexico. Across the country, clinics are trying to manage a large influx of people needing care, forcing patients to travel further into other neighboring states in order to get the care they need. The impact of abortion bans is not limited to the pregnant people in those states. As more people travel outside of their communities to access care in less restrictive states, pregnant people in those states are also feeling the impact of longer wait times for appointments. For those patients who are able to afford the costs of additional travel and extremely long wait times they may be pushed later into pregnancy before they are able to obtain an abortion, if they are able to do so at all. Likewise, patients in less restrictive states, who are experiencing increased appointment wait times may also be forced later into pregnancy and forced to travel outside of their community to receive care. This increases the cost of their care and forces people to travel further distances as they reach arbitrary state mandated gestational limits, even in places where the procedure is still legal. For many others who are unable to absorb the additional costs and surmount the logistical barriers, they will be forced to remain pregnant.

Patients seeking other types of pregnancy related care in restrictive states including miscarriage care, ectopic pregnancy care, care for complications arising during pregnancy, and more, may face significant delays as health care institutions and providers work to determine the legal implications of providing care. Doctors being forced to delay care in emergency situations, when they know the appropriate course of action, is unacceptable. This is an impossible situation to be in. We are allowing the laws of the state to directly violate the medical expertise we as providers have gained through years of experience and training and the oath we've taken to care for our communities and to do no harm. Again, this is not how health care should work.

2. How have state-imposed restrictions on abortion care affected physicians?

As a provider of abortion care, I can tell you this moment is not just frightening, it is devastating. As doctors, we take an oath to do no harm and provide our patients with the compassionate, non-judgmental, comprehensive care they need and deserve. Abortion restrictions put providers at odds with their oath, their training, and with their obligations to care for their communities.

Because of restrictions on abortion care, providers in our network are unable to do their jobs and continue providing the care they were trained to do in their own communities. Some are being forced to uproot their families, leave their support networks, and move to other states to provide the care they feel called to. Others are staying in their communities and providing what care they can, even under the severe restrictions imposed by the state. And many more are travelling around the country, at great personal cost, to provide care, something that was happening before the Supreme Court overturned *Roe v. Wade*. These are very difficult, personal decisions we are being forced to make and all of us are hurting. We're hurting for our communities and the people we've cared for, for those we want to care for but are unable to, and for our colleagues, all of whom face unprecedented legal risk in this moment.

I would be remiss not to mention that in this moment in states that are banning abortion care we are also being threatened with civil or criminal liability and other severe restrictions just for providing essential, life-saving care to our communities. Leading medical associations including the American Medical Association, American Public Health Association, American Academy of Pediatrics, American Society of Addiction Medicine, American College of Obstetricians and Gynecologists, the American Bar Association, and others, oppose the criminalization of health care provision. It keeps people from care. It makes our communities less safe.

a. Have state-imposed restrictions on abortion care affected physicians' ability to independently exercise their medical judgment? If so, please explain.

Yes, abortion restrictions directly interfere with the patient-provider relationship and limit a provider's ability to exercise their best medical judgment to care for the patient in front of them. Arbitrary bans on abortion interfere with a provider's ability to provide evidence-based, patient centered care, and improperly insert politics into the patient-provider relationship. Each patient is different and every pregnancy is unique, which is why patients should be able to get a full spectrum of individualized care responsive to their needs. There are many instances during pregnancy when abortion care is medically indicated and is in the best interests of the patient. Furthermore, the people we care for are all able to make complex, thoughtful decisions about their health and lives. As providers of comprehensive reproductive health care, we must be able to support our patients in the decisions they have determined is best for themselves and their families.

b. Have state-imposed restrictions on abortion care affected physicians' ability to provide the full range of care necessary for their patients? If so, please explain.

Yes, abortion bans implicate the full range of pregnancy related care and impact a provider's ability to provide comprehensive health care to their patients.

Abortion is necessary, compassionate, and essential health care. It is part of the full spectrum of care we should be able to provide our patients. The people I provide abortions for and the people I help give birth both deserve to be able to get the care they need, when they need it, from someone they trust. Abortion is extremely safe and none of the barriers or bans being imposed by states make it any safer.

Furthermore, as described above, abortion bans and restrictions can tie providers' hands and prevent them from providing the care they know their patients need. Take miscarriage care as an example; patients have reported not being able to receive the standard of care in places where abortion has been banned. This has included being denied a procedure to evacuate the uterus and sending patients home to undertake expectant management of their miscarriage, despite the patients wishes and in spite of the recommended course of treatment. This has also extended to pharmacists refusing to provide medications for miscarriage management, as these medications are the same as used in an abortion.

3. **What guidance have you provided to your members, if any, about how to perform their duties in light of state-imposed restrictions on abortion care? Do you plan to issue any future guidance to your members about how to perform their duties in light of state imposed restrictions on abortion care?**

PRH is not a legal organization, nor do we set medical or clinical policy guidelines for abortion providers. However, we stand in strong support of the physicians in our network who are fighting to provide compassionate, lifesaving essential care to their communities.

4. **How can the federal government help protect and expand access to pregnancy care, reproductive care, and other forms of health care in response to state-imposed restrictions on abortion care?**

In this moment we need bold action from the federal government to ensure access to the full range of comprehensive reproductive health care, including abortion care. We need Congress to pass:

- **The Women's Health Protection Act**, which would create a statutory right for health care providers to provide abortion care and a corresponding right for their patients to receive that care, free from medically unnecessary restrictions that single out abortion and impede access;
- **The EACH Act**, which would reverse the discriminatory Hyde Amendment and expand insurance coverage for abortion care regardless of where someone gets their insurance;
- **The HEAL for Immigrant Families Act**, which would ensure people who are immigrants are able to get the care they need free from xenophobic restrictions that prevent them from obtaining health coverage;
- **The Pregnant Workers Fairness Act**, which would prevent employers from forcing pregnant people out of the workplace and ensure pregnant people are able to obtain reasonable accommodations – such as sitting instead of standing, or having a glass of

water at their workstation – that would enable them to continue working and supporting their families;

- **The Black Maternal Health Momnibus Act**, a package of bills, that would work to comprehensively address every dimension of the ongoing maternal health crises in the United States. Maternal health and access to abortion are deeply connected. We cannot expect improvements in one without acknowledging the impact of the other;
- **Investments in Title X**, to fulfill the promise of the Title X program and provide people the care they need, Congress must make critical investments in Title X. The nation's family planning program has been devastated due to past administrations efforts and chronic underfunding. Current funding levels are less than 40 percent of what is needed to meet the need for publicly funded family planning in this country, according to analyses published in the *American Journal of Public Health*, which found that Title X would need $737 million annually to meet the need for its services;
- **Legislation Affirming the right to travel**, Congress should pass legislation affirming the fundamental right to travel across state lines to obtain care and protect the providers who care for them;
- **Legislation Protecting providers ability to provide care**, Congress should pass legislation protecting providers who are providing abortion care in places where it is still legal from liability;
- **Appropriations legislation that includes an abortion fund**, Congress should provide funding so that people who are forced to travel to obtain care have the supports they need including coverage of childcare, travel expenses, and more.

These bold legislative efforts working in tandem would help ensure the people we care for are able to get the care they need to live full, healthy, and dignified lives.

September 30, 2022

Senator Elizabeth Warren
309 Hart Senate Office Building
United States Senate
Washington, DC 20510

Dear Senator Warren:

As a board-certified OB/GYN and abortion provider here in Washington, DC as well as the President & CEO of Physicians for Reproductive Health (PRH), I appreciate your commitment to ensuring our communities have access to the comprehensive reproductive health care they need, including access to abortion care. As you know, PRH is a national network of physician advocates that includes doctors of all specialties from across the country. We work to mobilize the medical community, by educating and organizing providers, and using medicine and science to advance access to comprehensive reproductive and sexual health care for all people. We are grounded in the belief that we, as physicians, have an opportunity and an obligation to leverage the privilege that our white coats provide to center those we care for in our work and our advocacy. We believe this work is necessary to ensure all people can live freely with dignity, safety, and security.

For many providers and patients across the country the radical proposal to ban abortion nationwide is not surprising, albeit frightening, as we have known this was the intention of anti-abortion politicians from the beginning. The devastating harm, caused by the Supreme Court's decision will be exacerbated further should this aggressive legislation to ban abortion nationwide become law. People in states where abortion is now illegal are already facing tremendous obstacles. Right now, those who are able to gather the necessary resources are being forced to travel to get care – sometimes hundreds of miles away from their communities and homes, often at great personal cost. Those without the means and resources to travel are not able to get the essential care they need and are being forced to remain pregnant. A nationwide ban will mean many more people will be forced to remain pregnant, and will be deprived of the right to make decisions about their bodies and lives.

History has shown us that regardless of any efforts to ban abortion, people will continue needing care. Our movement – providers, funds, advocates, practical support organizations – is collectively doing everything it can right now to make sure people have both the resources they need, as well as accurate information to make informed decisions about their options for accessing abortion, including self-managing their abortion care.

As you rightly named in your letter to PRH, the consequences of a nationwide abortion ban would not be limited to abortion care. Restrictions on abortion care impact access to the full range of pregnancy related care, including miscarriage management, treatment for medical conditions that arise later in pregnancy, fertility care, and so much more. In addition, abortion bans have a deleterious effect on access to care that should not be impacted by an abortion ban because providers fear liability and criminalization. In some cases, this fear of criminalization has made it difficult for people to obtain care for conditions unrelated to pregnancy, such as

treatment for autoimmune disorders or cancers out of concern that medications could impact pregnancy and ultimately result in pregnancy loss or the need to access abortion care.

This is not how health care should work, and it does not have to be this way. Everyone should be able to get care in their own community, in a manner that is best for them, with people they trust. I'm glad to be working with you towards this better world.

Please find responses to your questions below. We hope it is helpful to you as you continue championing the importance of access to comprehensive reproductive health care, including abortion care. Should you need additional information please do not hesitate to reach out.

Sincerely,

Dr. Jamila Perritt, MD, MPH, FACOG
President & CEO
Physicians for Reproductive Health

1. **How would the proposed national abortion ban affect patients?**

We know that a federal abortion ban would be devastating to the health and well-being of individuals and families across the country. Research has shown for example, that women who have been denied an abortion are more likely to experience high blood pressure and other serious medical conditions during the end of pregnancy; more likely to remain in relationships where interpersonal violence is present; and more likely to experience poverty. Research also shows that the states with higher numbers of abortion restrictions are the same states with the poorest maternal and infant health outcomes. This is because while most people will have healthy pregnancies, some will experience illnesses or conditions where pregnancy can cause serious problems. Efforts to ban abortion across the nation will continue to cause devastating harm to people and continue to exacerbate this country's maternal health crises. Data shows that current efforts to ban abortion would lead to a 24 percent increase in maternal mortality overall. The consequences would be even more dire for Black women. It is projected that abortion bans are estimated to lead to a 39 percent increase in maternal mortality for Black women and birthing people. Under a federal ban the outcomes for pregnant people and people giving birth would be far worse.

Although it is undeniable that a national ban on abortion would harm everyone, Black, Indigenous, people of color, immigrant communities, young people, LGBTQ+ people, people with disabilities, as well as those living in geographically isolated areas, would be impacted the most. It is critical to understand that restrictions and bans on abortion do not exist in a vacuum. They are shaped by systemic and structural conditions. Factors including entrenched institutional racism and discrimination, barriers to health care and coverage for that care, systemic and intentional income inequality, and inadequate workplace supports including lack of paid leave

from work, would all contribute to the disproportionate impact of a national abortion ban on people who experience oppression across numerous domains of their identities.

A proposed nationwide ban on abortion will compound the already existing harm of limited access to abortion that previously existed even before the Supreme Court's decision. Currently fifteen states have implemented abortion bans, and we expect twenty-six states in total to ban abortion almost entirely. This patchwork of states has created enormous barriers to care. People in restrictive states are being forced to travel hundreds of miles to obtain care they should be able to get in their own communities. Already, there have been at least 43 abortion clinics across 11 states that have stopped offering abortion care with more to follow. Seven of these states, containing only limited or no exceptions for abortion, no longer have a single clinic providing abortion care. Under a nationwide abortion ban this picture would look much bleaker – with longer distances to travel, fewer providers of this essential care, and many more people who are forced to remain pregnant at the expense of their autonomy, well-being, and health.

a. Would the ban result in diminished access to pregnancy care, reproductive care, or any other form of health care? If so, please explain.

Yes, restrictions on abortion care have far reaching consequences and limit access to the full scope of sexual and reproductive health care, including miscarriage care, ectopic pregnancy care, and more. And we already know a national abortion ban would compound these harms. As documented in the New England Journal of Medicine, abortion bans like TX S.B. 8 provide insight into the broad consequences of banning abortion and imposing criminal liability on health care providers. Consequences of such severe abortion restrictions range from: providers not believing they have the ability to provide abortion counseling or referrals for people in need of care; providers refusing to treat ectopic pregnancy; and providers being forced to wait to intervene until their patient's condition worsens because of uncertainty around what is "sick enough" to qualify for an exception under the state's abortion ban. These laws put providers in the tenuous position of having to choose between providing nonjudgmental, comprehensive, evidence-based care and risking criminal or civil repercussions. The consequences we've seen stem from Texas's abortion ban is only the tip of the iceberg. Should a nationwide abortion ban be passed into law the ripple effects would continue to compound. Below I have outlined some additional consequences abortion bans have on other types of care that would be exacerbated under a federal abortion ban.

Contraceptive Care. Abortion bans have the potential to be intentionally misconstrued and may impact access to contraceptive care, specifically emergency contraception and intrauterine devices (IUDs). Although abortion bans should not affect contraceptive care, there is confusing and misleading language in some states' abortion restrictions that may limit or prevent access to this care. Specifically, some research indicates that the copper IUD may have a post-fertilization effect, preventing implantation of a fertilized egg. This is not the same action as causing an abortion, but anti-abortion legislators are manipulating, and misconstruing abortion bans and restrictions to suggest that the copper IUD functions as an abortifacient. Similarly, additional misinformation and disinformation about the mechanisms of action for various other contraceptives has the potential to disrupt and prevent access to the full spectrum of

contraceptive care. We have already seen this begin to play out in Idaho in response to the State's abortion ban.

Miscarriage Care. Abortion bans also impact access to miscarriage care since treatments used to help manage a pregnancy loss (spontaneous abortion) are the same treatments used to provide an induced abortion. Many miscarriages can be managed using the same medications that are used during a medication abortion, mifepristone and misoprostol. Miscarriages can also be treated using a procedure to remove the pregnancy tissue. This procedure uses the same tools and techniques used during an in-clinic or procedural abortion.

Ectopic Pregnancy Care. While ectopic pregnancy care should never be impacted by an abortion ban, the confusion and uncertainty created by abortion restrictions has ensured this is the case. Health care institutions and providers across the country are worried about being held criminally responsible for providing the lifesaving emergency care patients need. There are numerous accounts of providers refusing to provide ectopic pregnancy care due to the immense legal uncertainty and severe penalties the current patchwork of abortion bans has created.

Cancer Care. Cancer care during pregnancy is another area of health care that will continue to be impacted by state restrictions on abortion. While some patients who are pregnant and have cancer can receive the proper treatment while maintaining their pregnancies, that is not true for everyone. In some cases, abortion is necessary to enable further or timely treatment of the cancer. For example, pelvic radiation can be required for some cancers and such treatment is not done during pregnancy because of the risk to the fetus. Providers must be able to discuss with patients the full scope of options and associated risk, and ultimately allow the patient to decide the best course of treatment based on their diagnosis, preferences, and desires.

Auto-Immune Disorder(s). Patients have reported having trouble accessing essential medications that are considered "abortion inducing" in states that have banned abortion. A primary example is methotrexate, which is used to treat rheumatoid arthritis, lupus, and some cancers.

Maternal Health Outcomes. Under a federal abortion ban more patients would be forced to continue with pregnancies they were not planning or are unable to continue, and will likely face long term physical, mental health, and financial challenges. Pregnancy is a challenging medical condition that is taxing on even the healthiest bodies. For people with underlying medical conditions that exacerbate the strain of pregnancy, they will be placed in life altering and life-threatening situations. This is particularly worrisome given the worsening maternal mortality crisis that disproportionately impacts Black, Brown, and Indigenous women and birthing people.

b. Would the ban result in delays in care for patients? If so, please explain.

Yes, right now abortion restrictions delay care for patients who are forced to travel out of state for abortion care, as well as for patients seeking other types of essential health care in restrictive states. Under a federal abortion ban, care would be delayed even more and pushed even further out of reach.

According to the Guttmacher Institute, even before *Roe v. Wade* was overturned, nearly one in ten people seeking abortion care were forced to travel across state lines. Now with the Supreme Court's decision and states continuing to ban abortion, patients are being pushed further and further away from their homes as they grapple with increased travel distances, cost, and other systemic barriers to care. These consequences would be made far worse should people be forced to travel outside the country for care under a national abortion ban.

Already the uptick in the number of patients travelling to less restrictive states for abortion care is increasing wait times at clinics, straining the already thin resources available, and pushing people further and further away from their homes. Right now, across the country, clinics are trying to manage a large influx of people needing care, forcing patients to travel further into other neighboring states in order to get the care they need. The impact of abortion bans is not limited to the pregnant people in those states. As more people travel outside of their communities to access care in less restrictive states, pregnant people in those states are also feeling the impact of longer wait times for appointments. Under a nationwide abortion ban people who are able to afford the costs of additional travel will be pushed later into pregnancy before they are able to obtain an abortion, if they are able to do so at all. For many others who are unable to absorb the additional costs and surmount the logistical barriers of traveling, they will be forced to remain pregnant.

Patients seeking other types of pregnancy related care including miscarriage care, ectopic pregnancy care, care for complications arising during pregnancy, and more, may face significant delays as health care institutions and providers work to determine the legal implications of providing care under a nationwide ban. Doctors being forced to delay care in emergency situations, when they know the appropriate course of action, is unacceptable. This is an impossible situation to be in. We are allowing the laws of the state to directly violate the medical expertise we as providers have gained through years of experience and training and the oath we've taken to care for our communities and to do no harm. Again, this is not how health care should work.

2. **How would the proposed national ban affect physicians?**

As a provider of abortion care, I can tell you a proposed national ban would be devastating. As doctors, we take an oath to do no harm and provide our patients with the compassionate, non-judgmental, comprehensive care they need and deserve. A national abortion ban would put providers at odds with their oath, their training, and with their obligations to care for their communities. We would be remiss not to mention that a national abortion ban imposing penalties on providers for providing essential, lifesaving care would be devastating. Attempts to criminalize abortion providers are harmful as it keeps people from care and makes our communities less safe. Leading medical associations including the American Medical Association, American Public Health Association, American Academy of Pediatrics, American Society of Addiction Medicine, American College of Obstetricians and Gynecologists, the American Bar Association, and others, oppose the criminalization of health care provision.

Many of the providers in our network have also voiced concern about the impact of the Supreme Court's decision on medical education and training, specifically as it relates to pregnancy loss and abortion care. These concerns would only be compounded by a national abortion ban as it would almost certainly make it difficult, if not impossible, for many providers to learn to perform abortions, provide miscarriage management, and other types of pregnancy related care. Without this training, reproductive health care providers will be providing care that is not based in science or medical evidence and goes against well-established protocols for standards of care. This is not how health care should work. We are doing a deep disservice to the future generations of providers who will not have the opportunities to receive training that they need, and their communities deserve. Our communities will be harmed by all but guaranteeing there will be some providers who do not have the skills necessary to provide the care they need.

a. Would the national ban affect physicians' ability to independently exercise their medical judgement? If so, please explain.

Yes, a national ban on abortion would directly interfere with the patient-provider relationship and limit a provider's ability to exercise their best medical judgment to care for the patient in front of them. Arbitrary bans such as the proposed federal abortion ban interfere with a provider's ability to provide evidence-based, patient centered care, and improperly insert politics into the patient-provider relationship. Each patient is different and every pregnancy is unique, which is why patients should be able to get a full spectrum of individualized care responsive to their needs. There are many instances during pregnancy when abortion care is medically indicated and is in the best interests of the patient. Furthermore, the people we care for are all able to make complex, thoughtful decisions about their health and lives. As providers of comprehensive reproductive health care, we must be able to support our patients in the decisions they have determined is best for themselves and their families.

b. Would the national ban affect physicians' ability to provide the full range of care necessary for their patients? If so, please explain.

Yes, a federal abortion ban would implicate the full range of pregnancy related care and impact a provider's ability to provide comprehensive health care to their patients.

Abortion is necessary, compassionate, and essential health care. It is part of the full spectrum of care we should be able to provide our patients. People deserve to be able to get the care they need, when they need it, from someone they trust. Abortion is extremely safe and bans on abortion care do not make it any safer.

Furthermore, as described above, abortion bans, and restrictions can tie providers' hands and prevent them from providing the care they know their patients need. Take miscarriage care as an example; patients have reported not being able to receive the standard of care in places where abortion has been banned. This has included being denied a procedure to evacuate the uterus and sending patients home to undertake expectant management of their miscarriage, despite the patients wishes and in spite of the recommended course of treatment. This has also extended to pharmacists refusing to provide medications for miscarriage management, as these medications

are the same as used in an abortion. All of these consequences would be made far worse by a federal ban on abortion.

Finally, the ripple effects of a national abortion ban on the health and safety of people with the capacity for pregnancy are numerous. One of the most significant concerns many providers have voiced is that people will be forced to seek care outside of formal medical systems. However, importantly, with the development of medication abortion, research shows that people are able to self-manage their abortions with pills with accurate information and quality medications. Medication abortion is extremely safe and effective. The threat that people will face is not medical. It is legal. As we've seen, the real threat to people who self-manage their care is the targeting, surveillance, and criminalization by the state. This risk is even greater when people seek care during or after the process. New research from If/When/How shows that from 2000-2020, there have been sixty-one cases of people being criminally investigated or arrested for allegedly ending their own pregnancy or helping someone else to do so. The data also shows that these cases most often come to the attention of law enforcement via reporting by health care providers. A federal abortion ban that seeks to criminalize this essential care would be pitting providers against their patients, undermining the provider-patient relationship and trust in our medical systems. The fact that people can and do safely self-manage their own abortions does not mitigate the impact of restrictions on abortion care. These restrictions have far reaching consequences and limit access to the full scope of sexual and reproductive health care, including miscarriage care, ectopic pregnancy care, and more.

National Nurses United
The National Voice for Direct-Care RNs

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Senator Elizabeth Warren
309 Hart Senate Office Building
Washington D.C. 20510

September 9, 2022

Dear Senator Warren:

I write in response to your letter from August 9th, 2022, regarding state-imposed abortion restrictions and the impacts these restrictions have on the delivery of health care. We appreciate your outreach to better understand the experiences and perspectives of registered nurses as various states implement restrictions on reproductive health care services.

Abortion care is a basic health care service, and abortion restrictions place a burden on women and result in unequal access to comprehensive health services. As a union of majority-female health care providers dedicated to advocating for the best interests of our patients, National Nurses United opposes any efforts to restrict patients' control and choices over their own health care. We have vociferously condemned the Supreme Court's overturning of the 1973 Roe v. Wade ruling earlier this year and oppose state-imposed restrictions on abortion and reproductive health care. The basic tenets of ethical medical care dictate that patients should enjoy autonomy, self-determination, and dignity over their bodies and the health care they receive. By restricting the right to end a pregnancy, these laws violate the nursing ethics we have pledged to uphold in our profession, and they increase health risks for patients.

As you noted in your letter, abortion bans or restrictions will have an impact on tens of millions of people of reproductive age that live in the 26 states that are certain or likely to implement such laws. At the time of writing, there are 12 states that have enacted full abortion bans, with numerous other states having enacted new restrictions on abortions.

National Nurses United, the largest union of registered nurses in the United States, represents nurses working in multiple states that now have abortion bans or restrictions including Texas, Missouri, Georgia, Florida, North Carolina, Kentucky, and Ohio.

Please find answers to your questions below. They are informed by the experiences of NNU union nurses working in states that have imposed abortion bans or restrictions in recent months, and by our professional judgement as trained and licensed registered nurses.

1. How have state-imposed restrictions on abortion care affected patients?

a. Have state-imposed restrictions on abortion care resulted in diminished access to pregnancy care, reproductive care, or any other form of health care? If so, please explain.

Yes, state-imposed restrictions on abortion care are already diminishing access to pregnancy care, reproductive care, and at times, other forms of health care. Specific examples of trigger laws impacting nurses are still accumulating, but we already know that access to pregnancy care and reproductive health services has been affected in states with these laws.

As hospital employees, our nurses are not just providers of healthcare; they are also patients who are entitled to the healthcare benefits guaranteed in their contracts. The Dobbs decision throws into question many of the benefits of health insurance plans held by our nurses. We are currently in the process of collecting information from our hospital employers on support for workers and their dependents in states with abortion restrictions, including information on what care is covered under the plan, what travel expenses the policy may cover (for employees as well as their dependents who may live in other states) and how employee privacy will be ensured.

Questions related to how "reproductive healthcare" is defined by the insurance policy are paramount to understanding what rights will be covered in this new legal landscape. While the insurance plan may or may not cover abortion or abortion-related services (such as abortion counseling), employees also deserve to know if the plan provides for telehealth appointments where prescriptions to aid medication abortion are given, regardless of where the employee (and/or their dependents) reside. Does the plan cover those medications used for medication abortion for both employees and their dependents? Are there any restrictions on that eligibility?

Additionally, there are questions related to travel expenses required to access abortion services should an employee or their dependent need to travel to receive care. Employers must clarify if there are any dollar limitations on such travel expenses, whether there are eligibility requirements (including deductibles), and who judges whether "reproductive healthcare" is available within 100 miles (or whatever distance the plan specifies). Do employees and their covered dependents have to provide proof of their location to receive services? And finally, is PTO required to access these travel benefits?

Under the Dobbs decision, health plans and employers could disclose private information in response to a court order. We are actively seeking information from hospital employers on who is responsible for keeping these patient records, what the retention policy is, and how employers will ensure these records remain private.

b. Have state-imposed restrictions on abortion care resulted in delays in care for patients? If so, please explain.

Yes, state-imposed restrictions on abortion care are already resulting in delayed care for patients. These delays are occurring for multiple reasons.

First, state laws restricting abortion care are condemning patients to delays in abortion care, because they cannot receive an abortion in their state. As a result, patients must find ways to travel to other states in which they can receive the care they need. It's important to recognize that many women are financially unable to travel to other states and are then forced to continue their pregnancy against their will. Others will seek out illegal and unsafe abortions and could suffer serious medical consequences without access to qualified medical professionals.

Second, state laws restricting abortion care are leaving health care workers in the difficult position of trying to understand legal questions pertaining to the new laws, instead of immediately implementing the health care that patients need. Often, this care is not for abortion care, but for other critical reproductive health services. For example, in some states, health care workers have delayed giving much needed care to pregnant people experiencing miscarriages, because surgical procedures and medications for miscarriages are identical to those for abortion. Health care workers are being forced to prioritize legal questions and concerns, instead of prioritizing the quality patient care that we know our patients require. These restrictions impede an RN's ability to exercise her professional judgment on providing the necessary care she is trained to provide.

In some states, health care workers must postpone necessary care until a patient's symptoms are so bad that their life may be in danger in order for abortion care to qualify as "life-saving care". But even once a patient can clearly qualify for an abortion under an exemption for life-saving care, some health care workers are still hesitant to assist on these procedures because they fear legal repercussions for "aiding and abetting" an abortion.

Any and all delays in reproductive health care can have disastrous impacts on patients, that may result in severe symptoms, illness, and even death.

2. How have state-imposed restrictions on abortion care affected nurses?

a. Have state-imposed restrictions on abortion care affected nurses' ability to independently exercise their medical judgment? If so, please explain.

State-imposed restrictions on abortion care affect a registered nurse's ability to carry out her responsibility and obligation to advocate for her patient, and to provide competent and supportive nursing care. As outlined earlier in this letter, medical ethics dictate that patients have the right to autonomy and self-determination over their bodies and the health care they receive. As nurses, we have a responsibility to uphold these ethics in our nursing care. State-imposed restrictions on the right to end a pregnancy prevent us from upholding these ethics and prevent us from providing the quality supportive care that our patients need.

In states with abortion restrictions, nurses are being forced to deny care that patients want or need. They are also being forced to decide between upholding their responsibilities as a nurse and putting themselves at risk of criminalization for aiding or abetting in an abortion.

Nurses are also concerned about how these new and nebulous laws could impact medical training and education. Abortion care is a very common procedure and training in this care also prepares health care practitioners to address other reproductive health emergency situations. If health care providers are unable to access this vital training, they are at risk of not having the complete medical knowledge and competence that is necessary for addressing crisis situations.

b. Have state-imposed restrictions on abortion care affected nurses' ability to provide the full range of care necessary for their patients? If so, please explain.

Yes, across the country, nurses' ability to provide the full range of care necessary for their patients is being impacted.

In states with new state-imposed abortion restrictions, nurses are prevented from providing the full spectrum of reproductive health care services that their patients want and need. In states where abortion is legal and protected, nurses are beginning to see increased patient loads because of patients traveling to these states to receive the reproductive health care they need. This will put additional strain on nurses who are already chronically understaffed at hospitals across the country.

3. What guidance have you provided to your members, if any, about how to perform their duties in light of state-imposed restrictions on abortion care? Do you plan to issue any future guidance to your members about how to perform their duties in light of state-imposed restrictions on abortion care?

As mentioned in the first question, we are in the process of getting information from hospital employers about how these changes will impact our members as patients and enrollees in employer health plans.

We are continuing to monitor the situation in states where our members (and their dependents) will be most affected, both as nursing professionals and as patients themselves, and will continue to provide more guidance and information as the legal landscape becomes clearer.

4. How can the federal government help protect and expand access to pregnancy care, reproductive care, and other forms of health care in response to state-imposed restrictions on abortion care?

Congress and the President must quickly pass and sign into law the Women's Health Protection Act, which would codify the right to an abortion. Congress has a responsibility to permanently reverse the impact of the Dobbs v. Jackson decision, and the only way to do this comprehensively is to codify the right to an abortion and the protections of Roe v. Wade.

Further, Congress must end the Hyde Amendment and any bans on federal spending and insurance coverage for abortion care. Ensuring full funding and insurance coverage for abortion care is necessary to expand access not only to abortion care, but to all reproductive health care, pregnancy care, and women's health care across the country.

Congress must act to codify the right to contraception. Patients have already faced obstacles to contraception access caused by anti-abortion state laws. We cannot rely on courts to protect the Constitutional right to contraception. Codifying the right to contraception will protect an essential aspect of reproductive health and ensure access for the entire country.

Congress must also codify the right of any person to travel outside of their state to obtain an abortion. Legislation to codify the right to travel should include protections for persons seeking an abortion, health care providers who provide abortion care that is legal in their state, and anyone who assists someone traveling to another state for an abortion.

Additionally, Congress and federal agencies should consider options to protect the privacy and security of personal data that reveals details of individuals' reproductive health. Companies collect extensive information relating to individuals' reproductive health from search histories, health apps, location history, and private communications. Some of this data is aggregated and sold through data brokers, and all of it is accessible via subpoena to state actors seeking to prosecute people based on the ending of a pregnancy. Congress should enact legislation to limit the collection, retention, and dissemination of personal reproductive health data within the context of broader data privacy protections.

Finally, Congress should enact Medicare for All to ensure access to reproductive health care of all kinds for everyone in the country. Under Medicare for All, the cost of abortion care would be covered. Medicare for All legislation in the House and Senate would prohibit the Hyde Amendment from applying to Medicare for All funds. Passing Medicare for All would ensure equitable access to contraception and abortion as part of guaranteed, comprehensive health care for all.

The Dobbs decision has set in motion a landslide of legal questions that will continue to be borne out in hospitals and courtrooms across the country for years to come. Ultimately, this decision has put the health and wellbeing of our patients at risk. The right to basic reproductive health care is now a constantly changing landscape and we look forward to being in touch with Senator Warren on issues affecting working nurses and our patients as we continue into uncharted territory.

Thank you.

Sincerely,

Bonnie Castillo, RN
Executive Director, National Nurses United

National Nurses United
The National Voice for Direct-Care RNs

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October 14, 2022

Dear Senator Warren:

I write in response to your letter from September 22, 2022, regarding the effects of a proposed nationwide abortion ban. The legislation, introduced by Senator Graham, would be harmful for both nurses and the patients we serve, and encroaches on the right of people everywhere to receive the health care they need.

As a union of majority-female health care providers dedicated to advocating for the best interests of our patients, National Nurses United opposes any efforts to restrict patients' control and choices over their own health care. Abortion care is a basic health care service and should be accessible to everyone, regardless of where they live. We have vociferously condemned the Supreme Court's overturning of the 1973 Roe v. Wade ruling earlier this year and oppose any state-imposed restrictions on abortion and reproductive health care.

National Nurses United, the largest union of registered nurses in the United States, represents nurses working in multiple states that now have abortion bans or restrictions including Texas, Missouri, Georgia, Florida, North Carolina, Kentucky, and Ohio. Our answers to your questions about the legislation introduced by Senator Graham are informed by the experiences of nurses working in these states, and by our professional judgment as trained and licensed registered nurses.

Please find answers to your questions below.

1. How would the proposed national abortion ban affect patients?

a. Would the ban result in diminished access to pregnancy care, reproductive care, or any other form of health care? If so, please explain.

Yes, the proposed ban on abortions would end access to basic health care services for patients across the country. As nurses, we know that Senator Graham's proposed legislation would have devastating effects on our patients' basic access to health, safety, and well-being. This denial of health care will disproportionately harm low-income communities and communities who already struggle to access health care services. In doing so, it would deepen existing inequalities for these communities, including amongst Black, Latinx, and immigrant women specifically.

As health care providers, we know from experience that abortions will not stop because of this legislation. People who can become pregnant will continue to seek out abortion care, which will be pushed underground. As such, abortions will become more expensive, harder to access, and in many cases, unsafe. Patients with money and resources will continue to be able to get safe

abortions, and those without will not. Those who cannot find safe, clinical spaces to get abortion services will resort to do-it-yourself methods which may put them at risk of medical complications.

b. Would the ban result in delays in care for patients? If so, please explain.

Yes. A nationwide abortion ban would result in delays in care for patients.

A nationwide ban on abortion care would leave health care workers in the difficult position of trying to understand legal questions pertaining to the new law, instead of immediately implementing the health care that patients need. Often, this care is not for abortion care, but for other critical reproductive health services. We are already seeing these delays happen in states where abortion bans or restrictions have been implemented in recent months. For example, in some states, health care workers have delayed giving much needed care to pregnant people experiencing miscarriages, because surgical procedures and medications for miscarriages are identical to those for abortion. In addition, patients have been denied access to medications for numerous conditions, even when they are not pregnant, because of their potential to cause birth defects or miscarriage. These conditions include arthritis, autoimmune diseases, cancer, epilepsy, and stomach ulcers, to name just a few.

These issues would only grow more pronounced under a nationwide abortion ban. Any and all delays in reproductive health care can have disastrous impacts on patients, that may result in severe symptoms, illness, and even death.

2. How has the proposed national abortion ban affected nurses?

a. Would the national ban affect nurses' ability to independently exercise their medical judgment? If so, please explain.

Restrictions on abortion care – and especially a nationwide ban – would affect a registered nurse's ability to carry out her responsibility and obligation to advocate for her patient, and to provide competent and supportive nursing care. The basic tenets of ethical medical care dictate that patients should enjoy autonomy, self-determination, and dignity over their bodies and the health care they receive. As nurses, we have a responsibility to uphold these ethics in our nursing care. By restricting the right to end a pregnancy, a national abortion ban would force nurses to violate the nursing ethics we have pledged to uphold in our profession. Further, a national abortion ban could force us to knowingly put our patients at risk of medical complications, illness, and even death.

Nurses are also concerned about how a nationwide abortion ban could impact medical training and education. Abortion care is a very common procedure and training in this care also prepares health care practitioners to address other reproductive health emergency situations. If health care providers are unable to access this vital training, they are at risk of not having the complete medical knowledge and competence that is necessary for addressing crisis situations.

b. Would the national ban affect nurses' ability to provide the full range of care necessary for their patients? If so, please explain.

Yes, across the country, nurses' ability to provide the full range of care necessary for their patients would be impacted.

Already in states with new state-imposed abortion restrictions, nurses are prevented from providing the full spectrum of reproductive health care services that their patients want and need and under a nationwide abortion ban, nurses would be forced to deny care that patients want or need. They would be forced to decide between upholding their responsibilities as a nurse and putting themselves at risk of criminalization for aiding or abetting in an abortion.

Thank you once again for consulting National Nurses United about the impacts of abortion bans and restrictions on reproductive health services.

Sincerely,

Bonnie Castillo, RN
Executive Director, National Nurses United

APhA
American Pharmacists Association

September 9, 2022

The Honorable Elizabeth Warren
309 Hart Senate Office Building
U.S. Senate
Washington, DC 20510-2105

Dear Senator Warren:

On behalf of the American Pharmacists Association (APhA), we would like to thank you for your correspondence on August 9, 2022 and focus on ensuring continuity of care for patients across the country following the U.S. Supreme Court decision in *Dobbs v Jackson Women's Health Organization*. Optimizing patient access to FDA-approved medications and pharmacist provided patient care services are key strategic goals of our organization's vision and mission. We appreciate the opportunity to provide our perspective on press reports of restrictions to patients' access to their medications.

Founded in 1852, APhA is the largest association of pharmacists in the United States representing the entire pharmacy profession. APhA members practice in community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

As noted in your letter, APhA shares your concerns with the troubling reports of delays in care or lost access to medications following the *Dobbs* decision. The impetus of these reports has been: 1) Lack of clarity in state laws and rules, 2) Lack of clarity in federal laws, rules, and guidances, and 3) conflicts between state and federal law. These obscurities and conflicts have resulted in an environment, post-Dobbs, in which many health care professionals, including, but not limited to pharmacists, are unsure of their professional, financial, and legal liability when providing necessary care to their patients. APhA has spoken publicly of these concerns and requested action from policymakers to ensure patients' continuity of care is not interrupted,[1,2,3,4,5] and most recently in a joint-statement with the American Medical Association (AMA), Society of Health-System Pharmacists (ASHP), and National Community Pharmacists Association

[1] Breaking: APhA issues statement in response to Supreme Court's Dobbs v Jackson decision. July 25, 20222. Available at https://www.pharmacist.com/APhA-Press-Releases/breaking-apha-issues-statement-in-response-to-supreme-courts-dobbs-v-jackson-decision
[2] New Federal Guidance confuses an already complicated landscape for pharmacists. July 13, 2022. Available at https://www.pharmacist.com/APhA-Press-Releases/new-federal-guidance-confuses-an-already-complicated-landscape-for-pharmacists
[3] Abortion Restrictions May Be Making It Harder for Patients to Get a Cancer and Arthritis Drug. *Time Magazine*. Available at https://time.com/6194179/abortion-restrictions-methotrexate-cancer-arthritis/
[4] Women with chronic conditions struggle to find medications after abortion laws limit access. *CNN*. July 22, 2022. Available at https://www.cnn.com/2022/07/22/health/abortion-law-medications-methotrexate/index.html
[5] Post-Roe drug delays weigh on patients, providers. *Axios*. July 26, 2022. Available at https://www.axios.com/2022/07/26/post-roe-drug-delays-weigh-on-patients-providers

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(NCPA).[6] In the joint statement, the organizations call on state policymakers to ensure through guidance, law, or regulation that patient care is not disrupted and that physicians and pharmacists shall be free to continue to practice medicine and pharmacy without fear of professional sanction or liability. Through the joint statement, we strongly urge state medical and pharmacy boards, agencies, and policymakers to act to help ensure that our patients retain continuity of care and that our members clearly understand their legal and licensing obligations.

In response to your questions, please see the below answers:

1. **How have state-imposed restrictions on abortion care affected patients?**
    a. **Have state-imposed restrictions on abortion care resulted in diminished access to pregnancy care, reproductive care, or any other form of health care? If so, please explain.**
    b. **Have state-imposed restrictions on abortion care resulted in delays in care for patients? If so, please explain.**

    State-imposed restrictions on abortion care have affected patients in multiple ways. Most directly, patient access to elective abortion care services has become illegal or has been severely restricted in many states. Although this impacts the entire population capable of becoming pregnant in the state, these policies disproportionally impact individuals who face issues related to social determinants of health and do not have the ability, or access to travel to a state where they could receive elective abortion care and related health care services.

    Indirectly, state-imposed restrictions on abortion care have impacted pregnancy care, reproductive care, and other forms of health care. Many of these issues have been the result of vaguely worded state policies that could be interpreted as being more broadly applied to patients even if they are not receiving care related to an abortion. For example, see the below definitions of "abortion-inducing drug," medical abortion, or other comparable terms:

        Wisconsin: "Abortion-inducing drug" means a drug, medicine, oral hormonal compound, mixture, or preparation, when it is prescribed to terminate the pregnancy of a woman known to be pregnant."[7]

        Idaho: "Abortifacient" means mifepristone, misoprostol and/or other chemical or drug dispensed with the intent of causing an abortion as defined in section 18-604(1), Idaho Code. Nothing in the definition shall apply when used to treat ectopic pregnancy;"[8]

        Texas: "Medical abortion--The use of a medication or combination of medications to induce an abortion, with the purpose of terminating the pregnancy of a woman known to be pregnant. Medical abortion does not include forms of birth control."[9]

[6] AMA, APhA, ASHP, NCPA Statement on State Laws Impacting Patient Access to Medically Necessary Medications. September 8, 2022. Available at: https://www.pharmacist.com/APhA-Press-Releases/ama-apha-ashp-ncpa-statement-on-state-laws-impacting-patient-access-to-medically-necessary-medications
[7] Wis. Stat. § 253.10
[8] Idaho Code § 18-617
[9] 25 TAC § 139.2

The definitions from these three states exemplify the variability in defining these terms which is seen in many more state laws and regulations. This variability adds further confusion to an already complicated situation for health care professionals to navigate.

Without clear guidance from federal and state policymakers, pharmacists in many states are uncertain of the professional, financial, and legal liability they may face when providing care to their patients regardless if the care is related to abortion care services. One example is a lack of clarity of the federal and state liability for a pharmacist in a state where abortion is legal and may face penalties if they provide care or dispense a medication, regardless if the care or medication is related to abortion care services, to a patient that has traveled from a state where abortion is illegal or severely restricted.

These restrictions have resulted in limited access, delays in care, and confusion for numerous health care professionals and organizations as they attempt to follow obscure and conflicting federal and state laws and regulations.

2. **How have state-imposed restrictions on abortion care affected pharmacists?**
    a. **Have state-imposed restrictions on abortion care affected pharmacists' ability to independently exercise their medical judgment? If so, please explain.**
    b. **Have state-imposed restrictions on abortion care affected pharmacists' ability to provide the full range of care necessary for their patients? If so, please explain.**

State-imposed restrictions on abortion care have significantly impacted pharmacists and their ability to care for their patients in multiple ways, including, an inability to practice evidence-based health care, an increase in administrative burden, and uncertainty about their liability. First and foremost, the issue most concerning to pharmacists is that state-imposed restrictions are limiting or delaying their ability to provide evidence-based therapies to their patients. Restricting or limiting access to FDA-approved therapies that the pharmacist has identified as medically necessary based on their extensive education and training conflicts with the Oath of a Pharmacist[10] and the Code of Ethics for Pharmacists.[11] These professional standards hold pharmacists to ensuring optimal care and outcomes for their patients, which is jeopardized when state-imposed restrictions limit their ability to provide needed care to their patients.

For example, take a patient that has been taking methotrexate, referenced in your letter, for an extended period of time for their rheumatoid arthritis (RA). Although methotrexate is commonly used for RA, it is also used off-label for the termination of intrauterine pregnancy. In many states,

[10] Oath Of A Pharmacist. Available at https://www.pharmacist.com/About/Oath-of-a-Pharmacist
[11] Code of Ethics for Pharmacists. Available at https://aphanet.pharmacist.com/code-ethics

such as Alabama[12,13,14], Arkansas[15,16,17,18,19], Kansas[20], Kentucky[21], Louisiana[22,23], Montana[24], Oklahoma[25,26], South Carolina[27,28], Tennessee[29], Texas[30], and Virginia[31], methotrexate is specifically mentioned in state laws and regulations related to abortion care services. Due to the lack of guidance in interpreting laws in many states, pharmacists are unsure of the liability they would face in dispensing methotrexate, despite it being used for RA. This limits or delays patients from receiving their needed care and affects pharmacists' ability to independently exercise their professional judgement.

Complicating the current environment following the *Dobbs* decision has been President Biden's Executive Order (EO) on Securing Access to Reproductive and Other Healthcare Services[32] and the guidance[33] from the U.S. Department of Health and Human Services' Office for Civil Rights (OCR) that interprets pharmacists' obligations under federal civil rights laws, conflicting with some state laws, and raising concerns for our nation's pharmacies and pharmacists. The EO perpetuates existing confusion in an already complicated landscape for our patients and profession. While we understand the intent, without consultation with our nation's pharmacists the OCR's guidance, as written, has language in conflict with a pharmacists' professional judgment to make "determinations regarding the suitability of a prescribed medication for a patient; or advising patients about medications and how to take them."

The OCR's guidance lists potential examples when a pharmacist's refusal to dispense a drug to a patient "may be" a violation of federal law. As you know, the practice of pharmacy is regulated by the states and State Boards of Pharmacy, which provide and oversee pharmacy and pharmacist licenses. In addition, OCR's guidance does not address all federal conscience protections for health

[12] Ala. Admin. Code r. 420-5-1-.01
[13] Code of Ala. § 22-9A-13
[14] Code of Ala. § 26-23E-3
[15] 060 00 CARR 001
[16] 007 05 CARR 004
[17] A.C.A. § 20-16-1503
[18] A.C.A. § 20-16-1702
[19] A.C.A. § 20-16-2502
[20] K.A.R. § 28-56-2
[21] KRS § 311.7731
[22] La. R.S. § 14:87.1
[23] La. R.S. § 14:87.1
[24] 50-20-703, MCA
[25] 63 Okl. St. § 1-756.2
[26] 63 Okl. St. § 1-757.2
[27] S.C. Code Ann. § 40-47-37
[28] S.C. Code Ann. § 44-41-460
[29] Tenn. Code Ann. § 63-6-1102
[30] Tex. Health & Safety Code § 171.061
[31] 18 VAC 110-30-20
[32] Executive Order on Securing Access to Reproductive and Other Healthcare Services. Available at https://www.whitehouse.gov/briefing-room/presidential-actions/2022/08/03/executive-order-on-securing-access-to-reproductive-and-other-healthcare-services/
[33] U.S. Department of Health and Human Services. Office for Civil Rights. Guidance to Nation's Retail Pharmacies: Obligations under Federal Civil Rights Laws to Ensure Access to Comprehensive Reproductive Health Care Services. Available at https://www.hhs.gov/sites/default/files/pharmacies-guidance.pdf

care professionals.[34] More than just the Church Amendments applies because the scope and impact of this federal guidance goes beyond health care services only related to abortion. Pharmacists cannot ignore state law if a pharmacy and pharmacist licenses would be in jeopardy, even with OCR's interpretation of a limited number of existing federal statutes. The implications of OCR's federal guidance also has the potential to cause widespread unintended consequences beyond reproductive health care services which could force pharmacists to dispense any medication that could impact the safety of our patients. For example, if there is a drug-drug interaction, drug allergy, drug-condition interaction, or other clinical concern that may impact patient safety.

Additionally, state-imposed restrictions have increased administrative burden on pharmacists and other health care professionals. Due to the obscurities and conflicts in state and federal law, pharmacists must take additional steps to ensure they are not violating any laws when providing care to their patients. This increase in administrative burden has the potential to delay care for multiple patients as it interrupts the workflow of the pharmacist.

State-imposed restrictions on abortion care and the response from the federal government are both contributing to legal confusion and impacting health care professionals, including pharmacists, ability to independently exercise their professional judgement.

3. **What guidance have you provided to your members, if any, about how to perform their duties in light of state-imposed restrictions on abortion care? Do you plan to issue any future guidance to your members about how to perform their duties in light of state-imposed restrictions on abortion care?**

We have provided information[35] to our members on relevant terminology differences related to reproductive health care services, guidance to assist on navigating conflicting interpretations of federal and state laws, state and federal[36] conscience protections for health care professionals along with APhA policy on the topic[37], and resources to guide their practice following the *Dobbs* decision. Additionally, APhA is gathering members' feedback through a series of listening sessions as existing APhA policy does not explicitly contemplate the complexities and sensitivities that the *Dobbs* decision brings to light. This input will feed into APhA's deliberation on these issues at the next seating of the APhA House of Delegates.

Unfortunately, due to the 1) Lack of clarity in state laws and rules, 2) Lack of clarity in federal laws, rules, and guidances, and 3) conflicts between state and federal law, additional guidance to our members has been limited to educating pharmacists to follow state and federal laws - while urging action from policymakers to ensure patients' continuity of care is not interrupted. As more laws, rules, and guidances are published in the future we plan to interpret and update our members.

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[34] HHS. Conscience Protections for Health Care Providers. Content last reviewed September 14, 2021. Available at: https://www.hhs.gov/conscience/conscience-protections/index.html#:~:text=Federal%20statutes%20protect%20health%20care,moral%20objections%20or%20religious%20beliefs

[35] Reproductive Health Care: Navigating The Dobbs Decision. Available at https://www.pharmacist.com/Advocacy/Issues/Reproductive-Health

[36] Conscience Protections for Health Care Providers. Content last reviewed September 14, 2021. Available at https://www.hhs.gov/conscience/conscience-protections/index.html

[37] Pharmacist Conscience Clause. Available at https://aphanet.pharmacist.com/policy-manual?key=Pharmacist+Conscience+Clause&op=Search

4. **How can the federal government help protect and expand access to pregnancy care, reproductive care, and other forms of health care in response to state-imposed restrictions on abortion care?**

   APhA respectfully requests federal policymakers ensure through guidance, law or regulation recognition of a pharmacist's professional judgement and that patient care is not disrupted. Pharmacists and other health care professionals should be free to continue to meet the health care needs of our patients without fear of professional sanction or liability. We strongly urge federal policymakers to work with state policymakers to prevent further confusion and act to help ensure our patients retain continuity of care and that pharmacists clearly understand their legal and licensing obligations under both state and federal laws, as well as FDA, state and State Board of Pharmacy regulations.

We deeply appreciate your focus on these important and urgent issues. We hope that this correspondence can foster a positive collaboration with your office, APhA, and the pharmacy community to address the many issues impacting patients' continuity of care and provide helpful guidance from state and federal policymakers to assist our nation's pharmacists. We welcome and encourage Senator Warren to meet with us to discuss these many issues facing our nation's pharmacists and our patients in advance of any future correspondence. Please contact Michael Baxter, Senior Director, Regulatory Policy at mbaxter@aphanet.org with any additional questions and/or to arrange a meeting with us.

Sincerely,

Ilisa BG Bernstein, PharmD, JD, FAPhA
Interim Executive Vice President and CEO

cc: Theresa Tolle, BPharm, FAPhA, APhA President

APhA
American Pharmacists Association

September 30, 2022

The Honorable Elizabeth Warren
309 Hart Senate Office Building
U.S. Senate
Washington, DC 20510-2105

Dear Senator Warren:

On behalf of the American Pharmacists Association (APhA), we would like to thank you for your correspondence on September 22, 2022, and the opportunity to provide comments related to abortion care services in addition to our letter to your office on September 9, 2022.[1]

Founded in 1852, APhA is the largest association of pharmacists in the United States representing the entire pharmacy profession. APhA members practice in community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

APhA continues to call on state and federal policymakers to ensure that patient care is not disrupted as a result of passage and interpretation of these laws and that pharmacists shall be free to continue to practice pharmacy without fear of professional sanctions or liability. In response to your questions specific to pharmacists, please see the answers below:

In your letter, you ask about the impact of S.4840 on pharmacists' ability to provide care. APhA is unable to predict the comprehensive effects S.4840 would have on pharmacists nationally, as state laws vary and the implementation, interpretation, and application of those laws, in light of federal requirements, remains unclear in many states.

We would like to reiterate our concerns highlighted in our September 9, 2022, letter of current and the growing reports of delays in care and lost access to medications following the *Dobbs* decision and state-imposed restrictions on abortion care. APhA respectfully requests federal policymakers provide clearer guidance or pass additional laws or regulations allowing pharmacists to exercise their professional judgement to ensure that patient care is not disrupted. Pharmacists and other health care professionals should be free to continue to meet the health care needs of our patients without fear of professional sanction or liability. We strongly urge federal policymakers to work with state policymakers to prevent further confusion and act to help ensure patients retain continuity of care and that pharmacists clearly understand their legal and licensing obligations under both state and federal laws, as well as FDA, State, and State Board of Pharmacy regulations.

[1] APhA response to Senator Warrant Regarding States' Access to Reproductive Services (September 2022). Available at https://pharmacist.com/DNNGlobalStorageRedirector.ashx?egsfid=IuAXtHhcy_Y%3d

We appreciate your focus on these important and urgent issues. We welcome and encourage you and your staff to meet with us to discuss these and many other issues facing our nation's pharmacists and their patients. Please contact Michael Baxter, Senior Director, Regulatory Policy at mbaxter@aphanet.org with any additional questions and/or to arrange a meeting with us.

Sincerely,

Ilisa BG Bernstein, PharmD, JD, FAPhA
Interim Executive Vice President and CEO

cc: Theresa Tolle, BPharm, FAPhA, APhA President

American Hospital Association™
Advancing Health in America

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August 29, 2022

The Honorable Elizabeth Warren
United States Senate
309 Hart Senate Office Building
Washington, DC 20510

Dear Senator Warren:

Thank you for your recent letter asking for the American Hospital Association's (AHA) perspective on the issues precipitated by United States Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization.* Specifically, you asked for information on the impact of the decision on physicians and patients.

On that topic, I am attaching the recent *amicus* brief the AHA and the Association of American Medical Colleges filed in the United States Department of Justice's challenge to the Idaho Code § 18-622, which makes it a crime for health care providers to choose to terminate a pregnancy regardless of the circumstances. The central question in this action was the intersection of the Idaho law with the Emergency Medical Treatment & Active Labor Act (EMTALA).

In the brief, we emphasized the hospital field's longstanding commitment to EMTALA because of the important role it plays in allowing physicians to exercise their best medical judgment in caring for patients in emergency situations. EMTALA requires that physicians be allowed to exercise medical judgment in providing stabilizing care to those experiencing an emergency medical condition, including where the health or safety of a pregnant woman or her unborn child is in serious jeopardy. Because the Idaho law appeared to conflict with EMTALA's requirements by criminalizing a physician's judgment in certain circumstances, we supported the Justice Department in urging the district court to enjoin its enforcement. In particular, we stated in our brief that the Idaho law "generate(s) exactly the kind of uncertainty that is antithetical to the practice of sound emergency medicine."

More detailed information on the impact of the Idaho law on physician judgment and patients was described in detail in the affidavits supplied by several physicians affiliated with St. Luke's Medical Center, an AHA member hospital system. We have attached those as well.

We have and will continue to share with our members guidance issued by the Department of Health and Human Services and other federal agencies on issues like EMTALA, the Health Insurance Portability and Accountability Act, and delivering medications in compliance with applicable laws. We will continue to work with our members, our allied state, regional and local hospital associations, the Administration and Congress on the issues raised by the *Dobbs* decision. If you would like further information, please contact Priscilla A. Ross, executive director of executive branch relations and senior director of federal relations, at pross@aha.org or 202-626-2677.

Sincerely,

Richard J. Pollack
President and Chief Executive Officer

Attachments: Amicus brief of AHA and AAMC in *United States v. Idaho*
Affidavits in *United States v. Idaho*

EXHIBIT A

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The Association of American Medical Colleges

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

THE UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-00329-BLW Hon. B. Lynn Winmill

BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION AND THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES AS AMICI CURIAE IN SUPPORT OF THE UNITED STATES' MOTION FOR PRELIMINARY INJUNCTION

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OTHER AUTHORITIES

INTEREST OF AMICI CURIAE[1]

The American Hospital Association (AHA) represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations. Its members are committed to improving the health of the communities that they serve, and to helping ensure that care is available to and affordable for all Americans. The AHA educates its members on healthcare issues and advocates on their behalf, so that their perspectives are considered in formulating health policy. One way in which the AHA promotes its members' interests is by participating as *amicus curiae* in cases with important and far-ranging consequences. Virtually all of AHA's member-hospitals provide emergency room services. Therefore, virtually all of AHA's member-hospitals are covered by the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd. This includes 37 member-hospitals in the State of Idaho, from one of the nation's most remote hospitals in Salmon, Idaho, to tertiary facilities in Idaho Falls, Pocatello, and Boise.

The Association of American Medical Colleges (AAMC) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 156 accredited U.S. medical schools; 14 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and nearly 80 academic societies. Accredited medical schools prepare students to provide care to patients for the full range of services needed. The University of Washington School of Medicine runs WWAMI, a multistate medical education program through which students engage in clinical

[1] No party or counsel for a party authored any portion of this brief or made any monetary contribution intended to fund its preparation or submission. The United States has consented to the filing of this brief. The State of Idaho takes no position.

training in Washington, Wyoming, Alaska, Montana and Idaho. There are currently 40 Idaho WWAMI medical students in each class. Students complete 84 credits in the Patient Care Phase Curriculum, including 12 credits in a required obstetrics and gynecology clerkship.

In *Amici*'s experience, EMTALA-mandated stabilizing care for pregnant patients sometimes requires the termination of a pregnancy. *Amici* and their members thus have a direct and profound interest in the outcome of this case. Absent judicial relief, physicians, nurses, and other qualified medical personnel at Idaho hospitals will face the intolerable threat of criminal liability for doing what federal law requires. As the nation's largest association of hospitals, and as the leading voice representing American medical schools and teaching hospitals, *Amici* are uniquely positioned to provide this Court with important information about consequences of such liability for the provision of emergency healthcare in the State of Idaho.

INTRODUCTION

Every day, pregnant patients arrive at hospital emergency rooms in the midst of grave health emergencies. Physicians, nurses, and other qualified medical personnel must make split-second decisions about what care to provide to those patients, who are at risk not only of death or serious lifelong impairment, but also of tragically losing their pregnancies. In some cases, there is no available treatment that will both save the life of the pregnant woman and allow her pregnancy to continue. In these situations, physicians and nurses must rely on their experience, expertise, and medical judgment to deliver emergency care. And federal law, as reflected in EMTALA, requires hospitals to do exactly that: exercise their medical judgment to provide "stabilizing" care to those experiencing an "emergency medical condition," including in situations where the health or safety of "a pregnant woman" or "her unborn child" is in "serious jeopardy." 42 U.S.C. § 1395dd(b)(1), (e); *see Vickers v. Nash Gen. Hosp., Inc*., 78 F.3d 139, 144 (4th Cir. 1996) ("[T]reatment based on diagnostic medical judgment … is precisely what EMTALA hoped to achieve—handling of patients according to an assessment of their medical needs.").

Idaho Code § 18-622, however, makes it a crime for healthcare providers to choose to terminate a pregnancy—no matter the circumstances. To be sure, the statute provides a narrow affirmative defense if a provider can prove both that termination was "necessary to prevent the death of the pregnant woman" and that the provider's medical judgments "provided the best opportunity for the unborn child to survive." Idaho Code § 18-622(3)(a)(ii)–(iii). But the statute provides no such defense for treatment necessary to prevent serious and irreversible harm to the woman's organs or bodily functions, as EMTALA requires. And even where the defense applies, the physician—not the prosecutor—must prove the validity of her medical judgment to avoid

felony punishment. As the United States argues in its Motion for Preliminary Injunction, those provisions of § 18-622 conflict with, and pose an obstacle to, federal law.

AHA and AAMC respectfully submit this *amicus* brief to explain, from an on-the-ground perspective, why this conflict between federal and state law carries profound consequences for Idaho hospitals, Idaho health systems, and the thousands of Idaho patients they serve. Notwithstanding the Idaho law's affirmative defense, its threat of criminal sanctions will interfere with the exercise of healthcare providers' expert judgment in the provision of medically necessary care. And this sort of chilling effect is particularly troubling in the emergency room context, where providers must make life-or-death decisions in the heat of the moment—and where delay or restraint can make all the difference.

Hospitals and emergency room physicians need clarity about the legal regimes that govern the provision of care. They need to know what treatments they may—and, in the context of EMTALA, *must*—provide. The conflicting federal and Idaho frameworks, however, generate exactly the kind of uncertainty that is antithetical to the practice of sound emergency medicine. Accordingly, this Court should enjoin the enforcement of Idaho Code § 18-622 as applied to EMTALA-mandated care.

ARGUMENT

I. BY CRIMINALIZING MEDICAL JUDGMENTS, THE IDAHO STATUTE WILL CHILL THE PROVISION OF EMERGENCY MEDICAL CARE.

The determinative issue in this case is whether the Idaho statute can coexist with EMTALA, without contradicting its directives or standing in the way of its purposes. It cannot. There is a clear conflict between federal and state law.

On the one hand, EMTALA directs covered hospitals to provide whatever "treatment" is "required to stabilize the medical condition" of any patient who arrives with an "emergency medical condition." 42 U.S.C. § 1395dd(b)(1). An "emergency medical condition" is defined to include any condition that, in the absence of immediate medical attention, places the patient's health in "serious jeopardy" or threatens "serious impairment to bodily functions" or "serious dysfunction of any bodily organ or part." *Id.* § 1395dd(e)(1). Where a patient is pregnant, EMTALA directs providers to consider both "the health of the woman" and the health of "her unborn child." *Id.* § 1395dd(e)(1)(A)(i).

On the other hand, Idaho Code § 18-622 provides that every intentional termination of a pregnancy is "a felony," subject to "a sentence of imprisonment of no less than two (2) years and no more than five (5) years in prison." Idaho Code § 18-622(2). The operative criminal prohibition itself provides no exceptions for instances where termination is medically necessary to preserve the mother's life or stabilize her health.

The statute does authorize an affirmative defense, whereby the healthcare provider can seek to prove that termination "was necessary to prevent the death of the pregnant woman" and that the provider acted in the manner that "provided the best opportunity for the unborn child to survive." *Id.* § 18-622(3)(a)(ii)–(iii). But that defense does *not* apply where termination is necessary to prevent "serious" and potentially irreversible "impairment to bodily functions" or "dysfunction of a[] bodily organ or part," which qualify as emergency conditions under EMTALA. 42 U.S.C. § 1395dd(e)(1)(A)(ii)–(iii). And even where a provider correctly determines that termination is necessary to prevent death, that fact is not a bar to arrest and prosecution, nor does the prosecution bear any burden of showing otherwise. Rather, to avoid conviction, *the physician*

must prove to a jury that termination "was necessary to prevent the death of the pregnant woman" and that the physician "provided the best opportunity for the unborn child to survive." Idaho Code § 18-622(3)(a)(ii)–(iii).

Providers also face collateral consequences of § 18-622 prosecution. The statute provides that any health care professional who performs or attempts to perform a prohibited abortion "shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently revoked upon a subsequent offense." Idaho Code § 18-622(2). Worse, those collateral consequences may ensue even if the professional *succeeds* in proving the affirmative defense. The prosecution itself "could be reported to the provider's licensing board, which typically has broad discretion in governing provider ethics and standards of conduct." David S. Cohen, et al., *The New Abortion Battleground*, 123 COLUMBIA L. REV. (forthcoming 2023), Draft at 35, *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4032931; *see, e.g.*, Idaho Code §§ 54-1805, 54-1806, 54-1805A, 54-1814, 54-1815 (establishing Board of Medicine and delegating broad oversight powers, including with respect to professional discipline). And "being named as a defendant too many times or being subject to a disciplinary investigation, even if the provider ultimately prevails, could result in licensure suspension, high malpractice insurance costs, and reputational damage." Cohen, *supra* at 35. As a result, "[a] physician's career can be effectively destroyed merely by the fact that a governmental body has investigated his or her practice." *Conant v. Walters*, 309 F.3d 629, 640 n.2 (9th Cir. 2002) (Kozinski, J., concurring).

A. Criminal Statutes Impose Chilling Effects That Can Overdeter Lawful and Beneficial Conduct, Especially in Emergency Contexts.

Although the difference between what Idaho law criminalizes and what EMTALA requires may seem technical or academic, it is incredibly consequential for hospitals and their emergency physicians. By erecting a criminal prohibition for potentially life-saving stabilizing care, and then limiting the physician in that scenario to a mere affirmative defense, the Idaho statute imposes a severe chilling effect on the provision of medicine. And that chilling effect is frostiest in the emergency room, where healthcare providers must make immediate medical decisions without the benefit of legal counsel.

Criminal prohibitions deter bad conduct. But criminal statutes can also *overdeter* by chilling lawful conduct. In some cases, that sort of chilling effect poses constitutional problems, such as by burdening the exercise of First Amendment rights. In other cases, like this one, the chilling effect is problematic because it discourages conduct that federal law actively requires: the provision of stabilizing care consistent with the provider's medical judgment.

The Supreme Court has repeatedly recognized that a "criminal statute," because of its "opprobrium and stigma," as well as the penalty of "prison," causes an "increased deterrent effect," above and beyond the impact of ordinary "civil regulation." *Reno v. ACLU*, 521 U.S. 844, 872 (1997); *see also, e.g.*, *Virginia v. Hicks*, 539 U.S. 113, 119 (2003) (repeating that the risk that a law will "deter or 'chill'" conduct is heightened when the statute "imposes criminal sanctions"); *United States v. Alvarez*, 567 U.S. 709, 733 (2012) (Breyer, J., concurring in the judgment) (noting that the "threat of criminal prosecution" carries a powerful "chilling" effect and can "inhibit" lawful conduct). The reason is simple: In the case of any doubt or uncertainty, only "those hardy

enough to risk criminal prosecution" will plow ahead, whereas the rest will steer clear of the "protracted litigation" that may otherwise ensue. *Dombrowski v. Pfister*, 380 U.S. 479, 487 (1965).

This deterrent effect is heightened if the burden on the key disputed issue is shifted in the form of an affirmative defense. Affirmative defenses are "matters for the defendant to prove" and therefore need not be established by the prosecution beyond a reasonable doubt. *Martin v. Ohio*, 480 U.S. 228, 235 (1987). That makes a major practical difference. As the Supreme Court has explained, "where the defendant is required to prove the critical fact in dispute," that "increase[s] further the likelihood of an erroneous … conviction." *Mullaney v. Wilbur*, 421 U.S. 684, 701 (1975). That heightened risk of false conviction, in turn, means the individual will be *even more cautious* about acting in a way that might be misunderstood by a jury as violating the law. Put simply, shifting the burden from the prosecutor to the defendant, particularly on a matter of medical judgment, dramatically increases the risk of "'overdeterrence,' *i.e.*, punishing acceptable and beneficial conduct that lies close to, but on the permissible side of, the criminal line." *Ruan v. United States*, 142 S. Ct. 2370, 2377–78 (2022); *cf. id.* at 2377 (observing that the requirement that prosecutors prove *mens rea* "plays a 'crucial' role in separating innocent conduct—and, in the case of doctors, socially beneficial conduct—from wrongful conduct").

These considerations are at their apex in emergency contexts. In fast-moving, touch-and-go situations, the Supreme Court has emphasized the need for "breathing room" and warned against imposing retrospective liability based on uncertain standards. *Cf. Graham v. Connor*, 490 U.S. 386, 396–97 (1989) (reasoning that the law "must embody allowance for the fact that police officers are often forced to make split-second judgments," and do so "in circumstances that are tense, uncertain, and rapidly evolving"); *Atwater v. City of Lago Vista*, 532 U.S. 318, 347 (2001)

(emphasizing that officers who must act "on the spur (and in the heat) of the moment" need "clear" rules). Courts are not well equipped to "second-guess[]," with the "benefit of hindsight and calm deliberation," an "on the scene" professional assessment "of the danger presented by a particular situation." *Ryburn v. Huff*, 565 U.S. 469, 477 (2012) (per curiam).

B. The Idaho Statute Threatens To Overdeter Medically-Necessary Emergency Care That Federal Law Actively Requires.

The factors described above converge to give Idaho Code § 18-622 a potent chilling effect in the context of emergency care. Because that statute imposes criminal penalties and severe licensing consequences, and because the statute relegates questions surrounding an emergency caregiver's expert medical judgment into a mere affirmative defense, healthcare providers in Idaho will be forced to balance their own liberty and livelihood against the health and safety of their patients.

As numerous medical experts, judges, and scholars have recognized, subjecting doctors' clinical judgments to criminal liability will invariably chill the provision of lawful care. *See, e.g.,* David M. Studdert, et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, JAMA (2005) (explaining that many physicians practice "defensive medicine" by, among other things, avoiding "procedures and patients that [a]re perceived to elevate the probability of litigation"); *Conant*, 309 F.3d at 640 n.2 (Kozinski, J., concurring) (quoting expert report for proposition that "physicians are particularly easily deterred by the threat of governmental investigation and/or sanction from engaging in conduct that is entirely lawful and medically appropriate"). And in the specific context of emergency termination, there is evidence that the threat of criminal sanctions may cause providers to hesitate to provide *other* necessary care to pregnant women. *See, e.g.,* Brandice Canes-Wrone & Michael C. Dorf, *Measuring the*

Chilling Effect, 90 N.Y.U. L. REV. 1095, 1114 (2015) (analyzing whether laws governing the pregnancy termination chill lawful behavior, and concluding that these laws "affect not only the unprotected conduct they (perhaps permissibly) target, but also discourage protected conduct outside of their direct ambit. The chilling effect is real."); Lisa H. Harris, *Navigating Loss of Abortion Services—A Large Academic Medical Center Prepares for the Overturn of* Roe v. Wade, 386 NEW ENGLAND J. MED. 2061, 2063 (2022) ("Absent clear policies permitting it, doctors may hesitate to treat patients with ectopic pregnancy, inevitable miscarriage, or previability rupture of membranes when fetal cardiac activity remains."); Pam Belluck, *They Had Miscarriages, and New Abortion Laws Obstructed Treatment*, NEW YORK TIMES (July 17, 2022) (detailing stories of patients who received no care, less comprehensive care, or delayed intervention from providers while experiencing miscarriages after abortion bans took effect in certain states); Katie Shepherd & Frances Stead Sellers, *Abortion bans complicate access to drugs for cancer, arthritis, even ulcers*, WASH. POST (Aug. 8, 2022) ("Medicines that treat conditions from cancer to autoimmune diseases to ulcers can also end a pregnancy or cause birth defects. As a result, doctors and pharmacists in … states with strict abortion restrictions must suddenly navigate whether and when to order such drugs because they could be held criminally liable and lose their licenses for prescribing some of them to pregnant women."). These considerations are most significant in the emergency room, where professionals must make on-the-spot, heat-of-the-moment judgment calls that carry grave consequences. *See, e.g.*, George Kovacs, MD, MHPE and Pat Croskerry, MD, PhD, *Clinical Decision Making: An Emergency Medicine Perspective*, ACADEMIC EMERGENCY MEDICINE 947 (Sep. 1999) ("The [emergency department] is a unique environment of uncontrolled patient volume and brief clinical encounters of variable acuity. The emergency physician … must

often make complicated clinical decisions with limited information while faced with a multitude of competing demands and distractions.").

The consequences of this chilling effect for patients are staggering. Imagine a physician or nurse who is confronted in the emergency room by a pregnant woman who was just in a car crash. A stabilizing surgery would be medically necessary, but is likely to result in termination of the pregnancy. Instead of exercising medical judgment and relying on experience in deciding how to proceed, an Idaho physician or nurse must now consider—even subconsciously—whether proceeding with the surgery could result in a criminal prosecution or loss of license. And in any criminal case, the physician or nurse would have to convince an untrained jury that the surgery was necessary to save the woman's life and presented the least risks to her pregnancy. In such circumstances, as the declarations submitted by the United States make clear, even the hardiest, most devoted emergency-room caregiver cannot help but be "overdeterred" from proceeding with a life-saving surgery that "lies close to, but on the permissible side of, the criminal line." *Ruan*, 142 S. Ct. at 2378; *see, e.g.*, Seyb Decl. ¶ 13 (describing call from a physician who was forced to balance his "medical judgment or best practices for handling pregnancy complications" with the "ramifications of his actions if he proceeded with termination"); *id*. ¶ 14 ("In emergency situations, physicians may delay the medically necessary care because they fear a financially ruinous investigation or criminal liability."); Cooper Decl. ¶ 12 ("In the future, though I know what the appropriate medical treatment is for my patients, I would be hesitant to provide the necessary care due to the significant risk to my professional license, my livelihood, my personal security, and the well-being of my family.").

II. EMTALA PROVIDES HOSPITALS THE CLARITY THEY NEED TO PROVIDE EMERGENCY CARE.

A decision holding that EMTALA preempts § 18-622 will ensure that emergency room providers have the clarity they need to provide necessary care in keeping with federal law. As the United States explains in its Motion, EMTALA expressly provides that "any State or local law requirement" is preempted "to the extent that the requirement directly conflicts with the requirement of this section." 42 U.S.C. § 1395dd(f). Courts have consistently applied that preemption clause to find state laws preempted when they prohibit medical treatment EMTALA would otherwise require, thereby providing clear, uniform rules for hospitals to follow when confronted with medical emergencies. *See* U.S. Mot. 14–15 (citing cases).

But hospitals, physicians, nurses, and patients need clarity and protection from criminal prosecution *right now*. Allowing § 18-622 to take effect before its interaction with EMTALA has been definitively adjudicated will disrupt Idaho's emergency rooms—drastically increasingly the likelihood that emergency caregivers will hesitate to provide medically-necessary treatment to their patients. *See, e.g.,* Seyb Decl. ¶ 13 (recounting incident in which a physician wanted to transfer pregnant patient in need of termination because he "was afraid of the potential ramifications"). That is exactly the result EMTALA was enacted to prevent. *See, e.g.,* 131 CONG. REC. E5520 (daily ed. Dec. 10, 1985) (statement of Rep. Stark) (citing multiple media reports of hospitals refusing to treat pregnant and other patients experiencing medical emergencies). A preliminary injunction will preserve the status quo, appropriately respect the expert medical judgment of Idaho emergency caregivers like those who submitted declarations in this case, and ultimately protect patients who arrive at Idaho's hospitals at the most vulnerable moments of their lives, when they are in desperate need of emergency care.

CONCLUSION

For the foregoing reasons, as well as those given by the United States, the Court should grant the United States' motion and enter a preliminary injunction prohibiting the enforcement of Idaho Code § 18-622 as applied to EMTALA-mandated emergency care.

Dated: August ___, 2022

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the ___ day of August, 2022, I filed the foregoing **BRIEF OF AMERICAN HOSPITAL ASSOCIATION AND THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES AS AMICI CURIAE IN SUPPORT OF THE UNITED STATES' MOTION FOR PRELIMINARY INJUNCTION** electronically through the CM/ECF system, which caused the following to be served by electronic means on all parties.

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Exhibit B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **DECLARATION OF DR. EMILY CORRIGAN**

DECLARATION OF DR. EMILY CORRIGAN IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Emily Corrigan, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a board-certified Obstetrician-Gynecologist ("Ob-Gyn") physician at Saint Alphonsus Regional Medical Center in Boise, Idaho. In that capacity, I specialize in, among other aspects of care, inpatient management of complicated pregnancies and emergency assessment and management of pregnant women. Saint Alphonsus Regional Medical Center is a tertiary care medical center with a trauma designation and a Level 3 Neonatal Intensive Care Unit. Thus, it is a regional referral center for complicated pregnancies and frequently cares for patients with traumatic injuries during pregnancy. I submit this declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

2. I graduated from the University of California, San Francisco ("UCSF") School of Medicine in 2006 and subsequently completed my residency in Obstetrics and Gynecology at the University of Maryland Medical Center in 2011. I am Board Certified in General Obstetrics and Gynecology by the American Board of Obstetrics and Gynecology.

3. In 2019, I moved to Idaho after accepting my current employment position as an Obstetric Hospitalist at Saint Alphonsus Regional Medical Center in Boise, Idaho. I have subsequently been elected to the position of Vice Chair of the Department of Obstetrics and Gynecology.

4. My family and I were drawn to Idaho for its natural beauty—including vast mountains and beautiful forests and all the recreation opportunities incumbent therein—along with its desirable pace of life and friendly communities. I also came to Idaho, in part, to fill a serious need for physicians generally, and especially Ob-Gyns, in the state.

5. There are zero residency programs in Obstetrics and Gynecology in the State of Idaho, meaning that all Ob-Gyns must be recruited from out of state. Idaho also has one of the fastest growing populations in the country. This dynamic has created a significant shortage of Ob-Gyns in our state.

6. Over the course of my nearly 15-year career as a practicing Ob-Gyn, I have treated thousands of pregnant women and delivered thousands of healthy babies.

7. Although as physicians we work to help our patients to experience normal pregnancies, culminating in the delivery of a healthy baby, not all pregnancies are as simple and complication-free as physicians and patients would like.

8. At Saint Alphonsus Regional Medical Center, we do not perform purely elective abortions, which are abortions performed in pregnancies that do not seriously threaten the health

or life of the mother. However, there are situations where pregnancy termination in the form of an abortion is the only medical intervention that can preserve a patient's health or save their life. I will describe several recent examples of patients my colleagues and I have treated, which illustrate the dire circumstances that can make it medically necessary to terminate a pregnancy. Currently, our institution cares for patients in circumstances like these once every several months. However, I expect that this number will increase once Idaho Code § 18-622 goes into effect.

Jane Doe 1

9. Jane Doe 1 is a woman in her mid-20s who lives in a rural part of the state hundreds of miles away from Boise. I treated her and the facts I describe here were either personal observations I made or facts relayed to me for the purpose of treating Jane Doe 1.

10. Jane Doe 1 has two children of her own. Like many other women in our state, she decided to become a surrogate (also called gestational carrier) to provide additional income for her family and to help others who are unable to produce their own children. The intended parent and biological father of Jane Doe 1's pregnancy lives overseas.

11. When Jane Doe 1 was at 19-weeks' gestation, she was diagnosed with a pregnancy complication called preterm premature rupture of membranes ("PPROM"). PPROM is a premature breaking open of the amniotic sac. It increases the risk of life-threatening intra-amniotic infection (chorioamnionitis) and also increases the risk that the fetus will not develop normally due to a decrease in the amount of amniotic fluid.

12. Jane Doe 1 consulted with her personal obstetrician after the diagnosis of PPROM but was not advised that evacuation of the uterus was appropriate or necessary. Instead, she was incorrectly advised that terminating the pregnancy was illegal in Idaho following the Supreme

Court's decision in *Dobbs* (which had occurred one week prior) due to Idaho's trigger law (even though Idaho Code § 18-622 was not yet in effect).

13. As her condition worsened, Jane Doe 1 spent several days in consultation with her surrogacy agency to determine her options. Eventually, she drove to Boise and presented to the emergency department at another hospital in the area. At this point, Jane Doe 1 had been experiencing cramps and chills for three days—signs of infection. The treating physician gave her oral antibiotics and told her to return to her regular physician in a week.

14. Administration of oral antibiotics and discharge home is not the medically accepted standard of care for suspected chorioamnionitis. At this point, Jane Doe 1 was experiencing an increased risk of sepsis (a life-threatening condition) and a deepening infection of the uterus that, in addition to the deficient amniotic fluid, would have a direct negative impact on the fetus. In such cases, evacuation of the uterus and intravenous ("IV") antibiotics is the only medically acceptable form of treatment.

15. Eventually, Jane Doe 1 presented to the Labor and Delivery Unit at Saint Alphonsus Regional Medical Center, where I first met her. She had been diagnosed with PPROM almost two weeks prior to presentation and had been experiencing worsening uterine cramping and chills for the past three days. I informed Jane Doe 1 that although fetal cardiac activity was still present, termination of pregnancy was the necessary course of action to preserve her life. The overseas intended parent for whom Jane Doe 1 was carrying the baby agreed with Jane Doe 1 that terminating the pregnancy was the best course of action due to the serious risks to both Jane Doe 1's life and the health of his future child. I discussed with her medical and surgical options for uterine evacuation, and she chose a medical termination.

16. Shortly after she was given medication to induce labor, Jane Doe 1 spiked a high fever. She delivered the fetus after several hours; however, the placenta would not detach from the uterus, causing her to start hemorrhaging. I transferred Jane Doe 1 to the operating room for a uterine curettage to remove the retained placenta. She was also given multiple medications to decrease the bleeding from her uterus. Still, she lost almost two liters of blood and required a blood transfusion. She was continued on IV antibiotics for another 24 hours and was discharged home in stable condition on hospital day number three.

17. Had Jane Doe 1 not received medical care to terminate her pregnancy, her intraamniotic infection would likely have led to sepsis thereby significantly increasing her chance of death.

18. If Idaho Code §18-622 was in effect when Jane Doe 1's case presented, I would have felt the need to consult with a lawyer in addition to the ethics and medical professionals I had already consulted in her case. This additional consultation would have further delayed Jane Doe 1's treatment in addition to taking me away from treating other patients in need.

19. Jane Doe's case illustrates an additional reason why Idaho Code § 18-622 is especially dangerous: Idaho's status as a destination for surrogacy. In my experience, Idaho has a very significant number of women who carry babies as surrogates. The prevalence of surrogacy in Idaho means that many pregnancies in the state are initiated through in vitro fertilization ("IVF") and are likely to be high-risk pregnancies that carry an increased risk of serious health complications for both the mother and the fetus.

Jane Doe 2

20. One year and 8 months ago, Jane Doe 2 presented to an outlying hospital emergency department at 19-weeks' gestation experiencing significant bleeding. I eventually treated her and

the facts I describe here were either personal observations I made or facts relayed to me for the purpose of treating Jane Doe 2.

21. Jane Doe 2 was diagnosed with a placental abruption. This condition occurs when the placenta begins separating from the wall of the uterus before birth. Placental abruption decreases the blood and oxygen supply to the fetus and usually results in vaginal bleeding in the mother.

22. During the time she was under observation at the outside hospital, Jane Doe 2's condition worsened, and she developed disseminated intravascular coagulation ("DIC"). This is a dangerous condition that creates a high risk of death for the mother due to the rapid loss of large volumes of blood. Given that the outside hospital has minimal amounts of blood products in their blood bank, they requested to transfer Jane Doe 2 to Saint Alphonsus Regional Medical Center.

23. I first met Jane Doe 2 in the intensive care unit ("ICU") at Saint Alphonsus Regional Medical Center. The risk of her death at that point was imminent and the fetus still had a detectable heart rate by ultrasound. Although Jane Doe 2 was receiving multiple blood products at this point, her coagulation factors and anemia continued to worsen. The only medically acceptable action to preserve her life was immediate termination of the pregnancy.

24. An emergent dilation and evacuation procedure ("D&E") was advised, and Jane Doe 2 was taken to the operating room. The D&E procedure was uncomplicated. She remained intubated in the ICU overnight and continued to receive multiple blood products. By the next morning, the DIC had resolved and her anemia improved. Jane Doe 2 was transferred out of the ICU at that point and discharged from the hospital two days later.

25. Jane Doe 2's case illustrates the fact that some cases are so critical that there is simply no time to consult with a lawyer and debate, under the law, whether the proper medical standard of care should be used.

Jane Doe 3

26. Ten months ago, Jane Doe 3 presented to the Emergency Department at an outside hospital at 17-weeks' gestation. She was suffering from shortness of breath and high blood pressure. Like Jane Doe 1, Jane Doe 3's pregnancy was the result of IVF. I did not personally treat Jane Doe 3, but I have studied her case in the normal course of my work as part of educational conferences in the Department of Obstetrics and Gynecology at Saint Alphonsus Regional Medical Center.

27. After ruling out other conditions including COVID-19, pneumonia, and a blood clot in her lungs, Jane Doe 3 was diagnosed with pleural effusions, sometimes called "water on the lungs," a condition that causes fluid to accumulate between the tissues that line the lungs and chest. Further examination revealed that Jane Doe 3's pleural effusions were being caused by a case of preeclampsia with severe features. Her fetus had detectable cardiac activity.

28. Preeclampsia is a dangerous pregnancy complication that can result in serious and potentially fatal complications to both the mother and the fetus. It rarely occurs before 20-weeks' gestation. When it occurs before 20-week's gestation, as it did for Jane Doe 3, it is typically severe and carries a high risk of maternal and fetal death.

29. The only medically acceptable standard of care for preeclampsia with severe features in Jane Doe 3's case was to terminate the pregnancy through evacuation of the uterus. She underwent an urgent D&E procedure. The pleural effusions and high blood pressure immediately

began to improve after the pregnancy termination, and she was discharged home in stable condition several days later.

30. Had Idaho Code § 18-622 been in effect, my colleague, Jane Doe 3's treating physician, would have been in the position of assessing her own legal liability instead of simply assessing the patient's best interest.

Idaho Code § 18-622 and the Impact on Providers and Patients

31. Idaho Code § 18-622 is already harming women in Idaho. Specifically, in my experience as I describe above, the threat of criminal prosecution has already deterred doctors from providing medically necessary, life-saving care.

32. Idaho Code § 18-622 is also making it even more difficult to recruit Ob-Gyns to the State of Idaho. As I said, we already have a shortage of Ob-Gyns in Idaho. Idaho Code § 18-622 places physicians in a very difficult position because of a conflict between the State law and our ethical obligations to patients and our obligations under Federal law. If an Ob-Gyn can practice in a state without these conflicts and risks, it is only natural that they would be deterred from practicing here. In fact, at least one of my colleagues has already decided to stop her part-time work at our hospital due to the stress of complying with this law.

33. In addition, in emergency situations, many of which present in the middle of the night, physicians often do not have time to consult with lawyers about whether a decision they believe is warranted by the standard of care and therefore in the best interest of their patient will result in a financially ruinous investigation into their practice or in criminal liability. Also, time spent by physicians in court defending their medical decisions will keep them from their clinical duties for significant periods of time. This will add to the shortages in hospital and clinic coverage, increasing the workload of their practice partners as well as increasing wait times for patients.

34. The fact that a doctor can defend herself in a criminal prosecution does not give me any comfort about the way the law will negatively affect patient care. Having to defend against such a case alone would be incredibly burdensome, stressful, costly, and accordingly, means that the availability of a defense really does not solve the problems presented by the law.

35. Idaho Code § 18-622's threatens to criminalize abortion, even in many medically necessary circumstances, in a state where there is both a shortage of qualified physicians and a disproportionate number of high-risk pregnancies. This puts the health of Idaho women at significant risk.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 8th day of August 2022, in Boise, Idaho.

8/8/22
Date

Emily Corrigan, MD.
Emily Corrigan, M.D.

Exhibit C

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **DECLARATION OF KYLIE COOPER, M.D.**

DECLARATION OF KYLIE COOPER, M.D. IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Kylie Cooper, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a double board-certified Obstetrician-Gynecologist ("Ob-Gyn") and Maternal-Fetal Medicine ("MFM") physician at St. Luke's Regional Medical Center in Boise, Idaho. In that capacity, I specialize in high-risk obstetrics. I submit this declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

2. I graduated from the University of Iowa Carver College of Medicine and subsequently completed my residency in Obstetrics and Gynecology at the University of Vermont. Following residency, I completed my Maternal-Fetal Medicine Fellowship at the University of Vermont. I am the current vice chair of the Idaho section of the American College of Obstetricians and Gynecologists (ACOG). I am teaching faculty for the Primary Care Obstetrics Fellowship with

Full Circle Health Family Medicine Residency which is a program to train family medicine physicians in obstetrical care to be used in their rural practice settings. This is particularly important given that there are no residency programs in OB/Gyn in Idaho. I also serve as an advisory board member for the Idaho Perinatal Project. My professional memberships include ACOG, the Society of Maternal-Fetal Medicine, and the Idaho Medical Association.

3. I came to Idaho specifically for my job as a maternal-fetal medicine physician at St. Luke's Regional Medical Center. As I was interviewing for MFM positions around the country it was clear that Idaho had a great need for high-risk obstetricians given the growing population and multitude of health conditions and pregnancy complications, such as obesity which impacts pregnancy in a multitude of ways. Additionally, there were very few female MFM physicians in Idaho, and I wanted to provide high quality and compassionate care to Idahoan families.

Idaho Code § 18-622 and the Impact on Providers and Patients

4. Over the course of my seven-year career as a practicing Ob-Gyn, I have treated thousands of pregnant women and delivered innumerable babies.

5. Pregnancy is not always straight forward and complication free. As an MFM physician my goal is to achieve the healthiest outcomes possible for my patients; however, there are many situations where pregnancy termination is the medically indicated treatment and is in the best interest of the patient's health and life. I will describe several recent examples of patients whom I have treated, which illustrate some circumstances that make it medically necessary to terminate a pregnancy. These cases occurred between September 2021 and June 2022.

Jane Doe 1

6. Jane Doe 1 presented to the emergency department at 15 weeks gestation feeling unwell and was found to have severe range blood pressures. Her fetus had recently been diagnosed

with triploidy, a chromosomal abnormality with an entire extra set of chromosomes leading to multiple severe birth defects and though there was a fetal heartbeat, this condition was not compatible with life. Fetal triploidy carries an increased risk of development of preeclampsia in the mother. She was admitted to the hospital with persistent stroke range blood pressures requiring high dose antihypertensive therapy and magnesium to reduce her risk for seizures. A diagnosis of preeclampsia with severe features was made. The only cure for preeclampsia is to end a pregnancy either by delivery of the neonate if after viability or by termination of pregnancy if pre-viable. The medical treatment for preeclampsia with severe features in patients who are at a previable gestational age is termination of pregnancy. Given her severe illness placing her at risk for stroke, seizure, pulmonary edema, development of HELLP syndrome (hemolysis, elevated liver enzymes, and low platelets), urgent termination of pregnancy was the recommended treatment to stop her disease progression to preserve her health and life.

7. The only medically acceptable action to preserve her health and life was termination of the pregnancy.

Jane Doe 2

8. Jane Doe 2 presented to the emergency room at 20 weeks gestation with acute and progressive right upper abdominal pain requiring intravenous narcotics. Her pregnancy was complicated by a recent diagnosis of severe intrauterine growth restriction and though there was a fetal heartbeat, there was abnormal amniotic fluid level and abnormal umbilical cord blood flow portending a poor prognosis. She was found to have elevated blood pressures and lab abnormalities consistent with a diagnosis of HELLP syndrome. Her labs quickly deteriorated as would be expected with HELLP syndrome. Her platelets were dropping so quickly she required a platelet transfusion; she had evidence of hemolysis and concern for liver injury based on rising liver

enzymes and upper abdominal pain. HELLP syndrome placed her at risk for Disseminated Intravascular Coagulation (DIC) which is a life-threatening emergency related to the body's inappropriate consumption of blood-clotting factors leading to systemic bleeding, liver hemorrhage and failure, kidney failure, stroke, seizure, pulmonary edema. The only cure is to end a pregnancy either by delivery of the neonate if after viability or by termination of pregnancy if pre-viable. In the setting of pre-viable HELLP syndrome, urgent termination of pregnancy is the necessary treatment to stop her disease progression to preserve her health and life.

9. The only medically acceptable action to preserve her health and life was termination of the pregnancy.

Jane Doe 3

10. Jane Doe 3 presented to the emergency room at 15 weeks gestation with acute onset severe abdominal pain. She was noted to be hypertensive and lab abnormalities were consistent with a diagnosis of HELLP syndrome. Additionally, fetal and placental ultrasound was concerning for anomalies most consistent with fetal triploidy, a lethal fetal condition. Her abdominal pain and rapidly rising liver enzymes were indicative of liver injury, and her platelets were declining rapidly. In the setting of pre-viable HELLP syndrome she was at risk for DIC, liver hemorrhage and failure, kidney failure, stroke, seizure, pulmonary edema. The medically necessary treatment to stop her disease progression and protect her health and life was termination of pregnancy.

11. The only medically acceptable action to preserve her health and life was to terminate the pregnancy.

12. Prior to Idaho's trigger law, my medical training and judgment allowed me to promptly identify what the appropriate standard of care treatment was for these patients. I was

able to expeditiously care for them in the appropriate manner to prevent long-term harm. The trigger law threatens to criminalize medically indicated termination of pregnancy. In the future, though I know what the appropriate medical treatment is for my patients, I would be hesitant to provide the necessary care due to the significant risk to my professional license, my livelihood, my personal security, and the well-being of my family.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 8th day of August 2022, in Boise, Idaho.

8/8/2022
Date

Kylie Cooper MD
Kylie Cooper MD

Exhibit D

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **DECLARATION OF STACY T. SEYB, M.D.**

DECLARATION OF STACY T. SEYB, M.D., IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Stacy T. Seyb, M.D., being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a board-certified Obstetrician-Gynecologist ("Ob-Gyn") physician at St. Luke's Regional Medical Center in Boise, Idaho. In that capacity, I specialize in Maternal-Fetal Medicine. I submit this declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

2. I graduated from University of Kansas and subsequently completed my residency in Obstetrics and Gynecology at the University of Colorado and fellowship in Maternal Fetal Medicine at Northwestern University Feinberg School of Medicine. I practiced as a general Ob-Gyn and served as teaching faculty before completing my fellowship specializing in high risk and abnormal pregnancy management.

3. I have practiced as a Maternal-Fetal Medicine provider in Idaho for 22 years working not only on the front lines treating complicated pregnancies but also as a consultant to general OB-Gyn providers and Family Medicine providers providing obstetric care primarily in Southwest Idaho as well as across the state. I worked over a decade with the Idaho March of Dimes improving programming support and updating providers on evolving practices to improve the health of women and children in our state. Currently I serve as a state liaison to Idaho for the Society for Maternal Fetal Medicine.

Idaho Code § 18-622 and the Impact on Providers and Patients

4. Over the course of my nearly 35-year career as a practicing Ob-Gyn, I have treated thousands of pregnant women, delivered thousands of healthy babies, and managed a variety of life-threatening conditions in pregnancy.

5. Although as physicians we work to help our patients to experience normal pregnancies, culminating in the delivery of a healthy baby, not all pregnancies are as simple and complication-free as physicians and patients would like.

6. In the practice of Ob-Gyn, there are situations where pregnancy termination is the only medical intervention that can preserve a patient's health or save their life. Abortion is a very important tool that has contributed to the reduction of the maternal mortality rate from nearly 800 to 25 deaths per 100,000 live births across the United States in the last century. Obstetrics & Gynecology: November 2019 - Volume 134 - Issue 5 - p 1105-1108. I will describe examples of patients my colleagues and I have treated, which illustrate the dire circumstances that can make it medically necessary to terminate a pregnancy. My colleagues and I encounter these pregnancy-related emergencies approximately a dozen times per year.

Jane Doe 1

7. A 22-year old woman at 18 weeks of her pregnancy presented to the Emergency Department and a Medical Screening Exam was remarkable for fever, tender uterus, elevated heart rate and evidence of an intrauterine infection without other obvious sources of infection. Her history was also suspicious, she may have ruptured her bag of water 10 days prior, and ultrasound confirmed both a fetal heartbeat as well as no fluid around the baby confirming that she has a condition termed Septic Abortion. While antibiotics are important for treating severe infections, a general tenet of medicine is that without drainage or removal of infected tissue the infection is unlikely to improve.

8. Had Jane Doe 1 not received both antibiotics and termination of the fetus to allow removal of the infected tissue, the chance of her progressing to severe sepsis and dying was very high. If she survived, other risks of not removing the infection include infertility or hysterectomy, as well as other sequala of sepsis including renal failure and clotting disorder, also known as Disseminated Intervascular Coagulation (DIC). The national standard for treating this condition is both antibiotics and emptying the contents of the uterus.

Jane Doe 2

9. A 35-year old woman presented to the Emergency Department with headache, vision changes, and feeling poorly for a few days. A Medical Screening Examination revealed severe range blood pressures, and laboratory values that were consistent with a pregnancy condition known as pre-eclampsia with severe features. Ultrasound revealed a fetal heartbeat but the fetus was small for dates and the placenta was large, consistent with what is termed a partial molar pregnancy.

10. The only medically acceptable action to preserve her life was termination of the pregnancy. Not only was the pregnancy ultimately not viable due to the nature of the molar pregnancy but removal of the placenta, i.e., delivery was the only cure to reverse the severe pre-eclampsia.

Jane Doe 3

11. A 25-year old woman in her 19th week of pregnancy presented to the Emergency Department after she started bleeding very heavily per vagina. The Medical Screening Examination indicated hypovolemic shock due to her blood loss. Initial resuscitation improved her condition but she continued to bleed in an uncontrolled manner. Although there was a fetal heartbeat present, without further treatment the bleeding was likely to continue. A Dilation and Evacuation (D and E) was performed, terminating the pregnancy.

12. The only medically available tool to stop the bleeding was termination of the pregnancy. If left untreated the risks of life-threatening shock, even with blood replacement were very high.

13. Idaho Code § 18-622 threatens to criminalize abortion, without clear definition of medically necessary circumstances. The assertion that "prevent the death of the pregnant woman" is clear to the medical community is not useful to medical providers because this is not a dichotomous variable.

In the three cases above, the medical standard was clear and if the trigger law goes into effect, providers will likely delay care for fear of criminal prosecution and loss of licensure. For example, as a high-risk pregnancy consultant, I recently received a call from an outside institution where the provider encountered a woman at 20-weeks of gestation, with severe bleeding similar to the one described above, and wanted to transfer her. He was qualified but was afraid of the potential

ramifications of his actions if he proceeded with termination. It was clear that the mother was in danger and that treatment could not be delayed. This situation was clear that termination was the only option, and I reassured this provider and recommended that management. This is one example that providers do not have a clear guide as to what situations will place their livelihood in danger. Providers from all over the state are voicing that they cannot rely upon their medical judgment or best practices for handling pregnancy complications.

14. Idaho Code § 18-622 threatens to make it difficult to recruit Ob-Gyns to the State of Idaho, where we have no in-state training for this specialty. In emergency situations, physicians may delay the medically necessary care because they fear a financially ruinous investigation or criminal liability. If an Ob-Gyn can practice in a state without these conflicts and risks, it is only natural that they would be deterred from practicing here.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 8th day of August 2022, in Boise, Idaho.

8/8/2022

Date

Stacy T. Seyb, M.D.

American Hospital Association™
Advancing Health in America

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September 30, 2022

The Honorable Elizabeth Warren
United States Senate
309 Hart Senate Office Building
Washington, DC 20510

Dear Senator Warren:

Thank you for your recent letter asking for the American Hospital Association's (AHA) view on the impact of various restrictive legislation that has been proposed or enacted in the wake of the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*.

Our responses to your questions follow:

1a and 1b. Although AHA is not in a position to provide a definitive answer to the national implications of a national abortion ban on patients' access to or delays in the delivery of care, we recognize that criminal prohibitions have the potential to result in limits on access and delays in needed care.

In the *amicus* brief that AHA and the American Association of Medical Colleges recently submitted in United States v State of Idaho, we attempted to explain how that's state's law could impact hospitals' delivery of care:

> [The two organizations] explain, from an on-the-ground perspective, why this conflict between federal [EMTALA] and state law carries profound consequences for Idaho hospitals, Idaho health systems, and the *thousands of Idaho patients they serve*. Notwithstanding the Idaho law's affirmative defense, its threat of criminal sanctions will interfere with the exercise of healthcare providers' expert judgment in the provision of medically necessary care. And this sort of chilling effect is particularly troubling in the emergency room context, where providers must make life-or-death decisions in the heat of the moment—and where delay or restraint can make all the difference.
>
> ....
>
> Criminal prohibitions deter bad conduct. But criminal statutes can also *overdeter* by chilling lawful conduct. In some cases, that sort of chilling effect poses constitutional problems, such as by burdening the exercise of First Amendment rights. In other cases, like this one, the chilling effect is problematic because it discourages conduct that federal

> law actively requires: the provision of stabilizing care consistent with the provider's medical judgment.
> ....
>
> As numerous medical experts, judges, and scholars have recognized, subjecting doctors' clinical judgments to criminal liability will invariably chill the provision of lawful care. *See, e.g.*, David M. Studdert, et al., Defensive Medicine Among High-Risk Specialist Physicians in a Volatile
> Malpractice Environment, JAMA (2005) (explaining that many physicians practice "defensive medicine" by, among other things, avoiding "procedures and patients that [a]re perceived to elevate the probability of litigation").

2a and 2b. Regarding the impact of a national abortion ban on physicians' ability to independently exercise their best medical judgment and provide the full range of necessary care, we would point you to the declarations submitted in connection with United States v State of Idaho In particular, we would point to the following statement from an Idaho physician:

> "Prior to Idaho's trigger law, my medical training and judgment allowed me to promptly identify what the appropriate standard of care treatment was for these patients....In the future though I know what the appropriate medical treatment is for my patients I would be hesitant to provide the necessary care due to the significant risk to my professional license, my livelihood, my personal security, and the well-being of my family."

Although AHA is not in a position to provide a definitive answer to the national implications of a ban, we do recognize that imposing criminal penalties on physicians' medical judgments has the potential to result in the sort of consequences about which you have inquired.

If you would like further information, please contact Priscilla A. Ross, executive director of executive branch relations and senior director of federal relations, at pross@aha.org or 202-626-2677.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer