Congress of the United States

Washington, DC 20515

July 8, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Secretary Becerra:

We write out of grave concern about the impact overturning *Roe v. Wade* and *Planned Parenthood v. Casey* will have on the health and safety of our nation's childbearing women. The Supreme Court decision *Dobbs v. Jackson Women's Health Organization* stripped away the constitutional right to abortion, and in so doing is jeopardizing access to lifesaving medical care. We are concerned about the legal and ethical issues health care providers now face as they try to navigate their medical obligation to provide evidence-based treatment amidst fear of civil or criminal penalties. As the consequences of this flagrant assault on reproductive rights come into sharper focus, we call on the Administration to take unequivocal steps to protect the clinical judgment of health care professionals, the doctor-patient relationship, and the financial stability of professionals who perform abortions so that this lifesaving care is preserved for childbearing people.

As a result of the overturning of *Roe v. Wade*, six states now have total bans on abortions, a number that is expected to grow as states implement "trigger-ban" laws.[1] In these six states, there are over 690 hospitals and over 280,000 physicians and nurses, the vast majority of which are bound by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd, which requires them to screen and provide stabilizing treatment to every person who seeks emergency medical care, including life-threatening reproductive health care. However, the overturning of *Roe v. Wade* and subsequent total bans on abortion have led to widespread concern among the medical community that those in abortion-ban states may face legal consequences for fulfilling their EMTALA obligation.[2] This is not a hypothetical issue - days after *Dobbs v. Jackson Women's Health Organization*, reports suggested that patients were unable to receive critical care as physicians tried to interpret the new laws in their states.

Several life-threatening medical conditions can emerge during pregnancy. Uncontrollable bleeding during the first or early second trimester, placental abruption, and septic abortions are just a few examples of medical conditions that, without treatment, can lead to severe illness and death in the mother. The treatment for these conditions is evacuation of the uterus and without

[1] Witherspoon, A., & Chang, A. (2022, June 28). *Tracking Where Abortion Laws Stand in Every State.* The Guardian. Retrieved July 7, 2022, from https://www.theguardian.com/us-news/ng-interactive/2022/jun/28/tracking-where-abortion-laws-stand-in-every-state

[2] Chernoby, K., & Donley, G. (2022, June 13). *How to Save Women's Lives After Roe*. The Atlantic. Retrieved July 7, 2022, from https://www.theatlantic.com/ideas/archive/2022/06/roe-v-wade-overturn-medically-necessary-abortion/661255/

this treatment, a woman can die even if she initially appears stable. Ectopic pregnancies and miscarriages can also be life-threatening without treatment. The medical community does not consider treatment for ectopic pregnancy to be abortion, given that neither ectopic pregnancies nor miscarriage can continue to a live birth. However, restrictions on abortion care in many states have confused and complicated the ability to provide life-saving care for people experiencing ectopic pregnancies and miscarriages. Physicians and other health care professionals need assurance that they will not be prosecuted, lose their license, or be fined when they treat these conditions appropriately.

A few relevant clinical scenarios which represent the quandary faced by clinicians are as follows:

- A pregnant patient presents with vaginal bleeding and retained pregnancy tissue. It is unclear whether this was a spontaneous abortion or self-managed abortion. Medical professionals may have concerns or questions about proceeding with standard treatment, fearing that they could be held liable for providing "abortion services" if it is later determined the abortion was self-managed.

- A pregnant patient presents to the emergency department and is diagnosed with an ectopic pregnancy that has fetal cardiac activity. Ectopic pregnancies are not viable. Without treatment, the ectopic pregnancy will eventually rupture causing hemorrhage that threatens the life of the pregnant person, even if they are stable at the time of presentation. Medical providers may fear providing the necessary, life-saving treatment in states where termination of pregnancy is outlawed.

- A pregnant patient presents with loss of amniotic fluid at 18 weeks gestation (preterm premature rupture of membranes or PPROM). The fetus still has cardiac activity, but the rupture of the amniotic sac places the pregnant person at risk of infection and sepsis. Ultimately, the patient is expected to go into labor and the fetus will not be viable because of the early gestational age. Providers may be hesitant to provide care in this scenario, for fear of being accused of unlawfully effectuating termination.

- A pregnant patient presents to the emergency department with palpitations. She is found to be in atrial fibrillation. After a proper risk-to-fetus vs. risk-to-mother discussion with the patient, the shared decision is made to proceed with cardioversion under sedation to restore a normal heart rhythm. After the procedure she suffers a miscarriage. Providers may be concerned about and/or unwilling to provide this appropriate, necessary care if, by doing so, they could be charged with providing unintentional "abortion services."

We appreciate the steps the Administration is taking to examine its authority under EMTALA to ensure that the clinical judgment of doctors is supported and expedient care for potentially fatal conditions is provided to pregnant patients. We recognize that guidance was issued in September 2021, but we feel that further clarification is needed as there continues to be widespread confusion among health care professionals about patient care rights as they relate to pregnancy and abortion care under EMTALA. We respectfully ask that as you craft the next guidance, the Center for Medicare and Medicaid Services explicitly clarifies the following:

- When an individual comes to an emergency department, EMTALA protects a patient's right to receive emergency reproductive health care, including abortion;
- Waiting for a stable patient to decompensate before intervening, when that is the expected clinical course, constitutes a violation of EMTALA;
- Physicians and other health care professionals will not be prosecuted, lose their license, or be fined for providing critical healthcare, including abortion care; and
- EMTALA preempts any directly conflicting state requirement that might otherwise prohibit or restrict such treatment.

Finally, we ask that you detail your plans on how you will widely distribute this guidance once published so that hospitals, health care providers, and patients know their rights.

In a country where maternal mortality rates are the highest among all developed nations and disproportionally affect women of color and rural mothers, decreasing access to this lifesaving care puts vulnerable Americans at increased risk.[3,4] In critical medical scenarios where every second counts, we cannot and should not have to wait for our health care professionals to receive permission from their lawyers before moving ahead with lifesaving medical treatment.

Sincerely,

Lisa Blunt Rochester
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Alma S. Adams, Ph.D.
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Nanette Diaz Barragán
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[3] Tikkanen, R., Gunja, M., FitzGerald, M., & Zephyrin, L. (2020, November 18). *Maternal mortality and maternity care in the United States compared to 10 other developed countries*. Improving Health Care Quality. Retrieved July 7, 2022, from https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries

[4] Hoyert, D. (2021, March 23). *Maternal Mortality Rates in the United States*, 2019. National Center for Health Statistics. Retrieved July 7, 2022, from https://www.cdc.gov/nchs/data/hestat/maternal-mortality-2021/maternal-mortality-2021.htm

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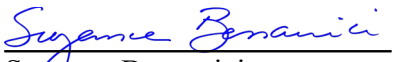

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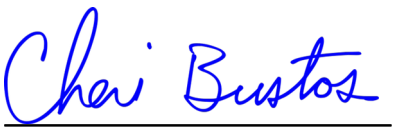

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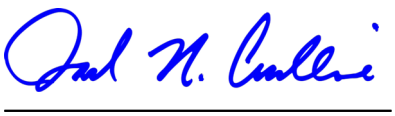

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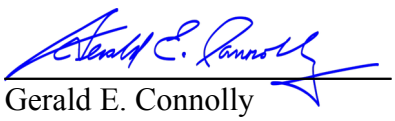

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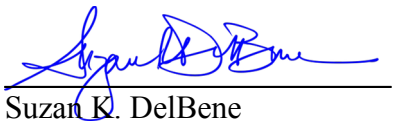

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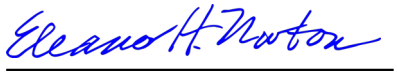

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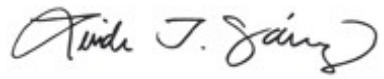

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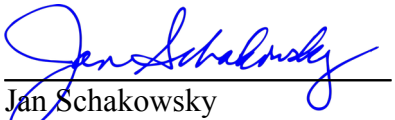

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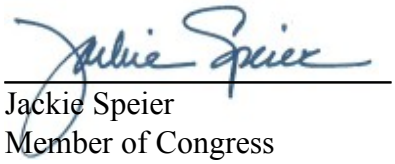

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