CHARLOTTE
LOZIER
INSTITUTE

Fact Sheet: Are Pro-Life State Laws Preventing Pregnant Women from Receiving Emergency Care?

Tessa Cox, Ingrid Skop, M.D., FACOG, Mary E. Harned, J.D.

September 2024

Executive Summary

- All pro-life state laws allow doctors to exercise their medical judgment to treat women with pregnancy emergencies. No law requires "imminence" or "certainty" before a doctor can act to save the patient's life.
- All but five of these laws include language permitting abortion when a woman's health is in serious jeopardy. Even in states without this language, doctors may use "reasonable" or "good faith" medical judgment to determine if a separation of the mother and baby is necessary, because clinically, the same serious conditions that pose severe risk to a major bodily function may also lead to a woman's death.
- Every state with a strong pro-life law permits doctors to treat women suffering from spontaneous miscarriages or ectopic pregnancies, and the treatment of these conditions is not considered an abortion under any law.
- Doctors and hospitals who fail to provide patients with necessary treatment in emergency circumstances may be committing malpractice.
- Pro-life states are stepping up to provide doctors with necessary guidance.

A flurry of news articles and reports from pro-abortion medical organizations highlighting poor quality medical care in pro-life states have raised concerns that state laws may be preventing pregnant women from obtaining necessary care in medical emergencies.[1, 2] Some articles report cases of women being turned away from hospitals despite suffering ectopic pregnancies, incomplete miscarriages, premature rupture of membranes, or other emergencies and pregnancy complications. In one case, a woman was turned away from a hospital multiple times before an ectopic pregnancy ruptured her fallopian tube, threatening her life.[3] While it is not always easy to determine from a news article whether medical malpractice occurred, pro-life state laws are clear: doctors can intervene in medical emergencies.[4]

Do pro-life state laws allow doctors to treat women in pregnancy emergencies?

Yes, all pro-life state laws allow doctors to exercise their medical judgment to treat women with pregnancy emergencies.[5] The laws include definitions of what constitutes an abortion as well as exceptions, and a plain reading of these laws' language shows that no pro-life state law prevents a doctor from providing needed medical care. According to the American Association of Pro-Life Obstetricians and Gynecologists, abortion "is the purposeful killing of the unborn in the termination of a pregnancy."[6] The American College of Obstetricians and Gynecologists (ACOG) defines induced abortion as an "intervention to end a pregnancy *so that it does not result in a live birth"* (emphasis added).[7] While in some medical emergencies it is necessary to prematurely separate a mother from her unborn child to protect the mother's life, the intent of the separation is not to "purposefully" kill her child or ensure that there is not a "live birth." A separation that is *intended to save the life of a mother* is legal in every state even when, tragically, the baby dies as a result.

Ectopic Pregnancy Treatment and Miscarriage Management

Every state with a strong pro-life law permits doctors to treat women suffering from spontaneous miscarriages or ectopic pregnancies, and the treatment of these conditions is not considered an abortion under any law.[8] While some state laws explicitly exclude miscarriage management and treatment for ectopic pregnancy from the definition of abortion (e.g., "An act is not an abortion if the act is done with the intent to … remove a dead, unborn child whose death was caused by spontaneous

---

[1] Amanda Seitz, "Dozens of Pregnant Women, Some Bleeding or in Labor, Are Turned Away from ERs despite Federal Law," *The Associated Press*, August 14, 2024, https://apnews.com/article/pregnant-women-emergency-room-ectopic-er-edd66276d2f6c412c988051b618fb8f9?taid=66ba0d15d1662d0001f201af#; Brian Dulle and Dave D'Marko, "Woman Sues KU Hospital for Denial of Emergency Abortion," *KSN-TV*, July 30, 2024, https://www.ksn.com/news/state-regional/woman-sues-ku-hospital-for-denial-of-emergency-abortion/.
[2] "Care Post-Roe: How Post-Roe Laws Are Obstructing Clinical Care," ANSIRH, September 9, 2024, https://www.ansirh.org/research/research/care-post-roe-how-post-roe-laws-are-obstructing-clinical-care.
[3] Seitz, "Dozens of Pregnant Women, Some Bleeding or in Labor, Are Turned Away from ERs despite Federal Law."
[4] Mary Harned and Ingrid Skop, "Pro-Life Laws Protect Mom and Baby: Pregnant Women's Lives Are Protected in All States," *Charlotte Lozier Institute*, September 11, 2023, https://lozierinstitute.org/pro-life-laws-protect-mom-and-baby-pregnant-womens-lives-are-protected-in-all-states/.
[5] Id.
[6] AAPLOG, "What Is AAPLOG's Position on 'Abortion to Save the Life of the Mother?'?," AAPLOG, June 10, 2009, https://aaplog.org/what-is-aaplogs-position-on-abortion-to-save-the-life-of-the-mother-2/.
[7] "Abortion Care," ACOG, accessed September 10, 2024, https://www.acog.org/womens-health/faqs/induced-abortion.
[8] Harned and Skop, "Pro-Life Laws Protect Mom and Baby."

abortion [miscarriage]; or remove an ectopic pregnancy"[9]), this exclusion is not necessary to safeguard care for a mother suffering from miscarriage (where her unborn child has already died), or ectopic pregnancy (where her unborn child has either died or has no chance for survival). Even Planned Parenthood has acknowledged that "[t]reating an ectopic pregnancy isn't the same thing as getting an abortion."[10]

Serious and Potentially Life-Threatening Pregnancy Complications Treatment

Every state with a strong pro-life law permits abortion in a medical emergency arising from periviable, premature rupture of membranes (PPROM) or other pregnancy complications when necessary to prevent a woman's death.[11] Further, all but five of these laws include language permitting abortion when a woman's health is in serious jeopardy (e.g., "to avert serious risk of substantial physical impairment of a major bodily function" (Ala. Code § 26-23H-3)).[12] Even in states without this or similar statutory language, a doctor who has determined that a pregnancy places his or her patient at serious risk of injury to the kidneys, liver, heart, or other organs, but is uncertain whether the pregnancy will ultimately lead to her death, may use "reasonable" or "good faith" medical judgment to determine if a separation of the mother and baby is necessary. Clinically, the same serious conditions that pose severe risk to a major bodily function may also lead to a woman's death. Doctors are often unable to predict which result will occur but may intervene as they deem necessary.

When a physician makes this determination, no law requires "imminence" or "certainty" before he or she can act to save the patient's life. The supreme courts in Texas and Idaho, states with two of the strongest pro-life laws in the nation, recently affirmed that imminence is not necessary. The court in Texas wrote that state law does *not* require "the doctor to wait until the mother is within an inch of death or her bodily impairment is fully manifest or practically irreversible." Instead, "the exception is predicated on a doctor's acting within the zone of reasonable medical judgment."[13] Similarly, Idaho's court wrote, "[T]he statute does not require *objective* certainty, or a particular level of immediacy, before the abortion can be 'necessary' to save the woman's life. Instead, the statute uses broad language to allow for the 'clinical judgment that physicians are routinely called upon to make for proper

[9] Tex. Health & Safety Code §§ 245.002. See: https://statutes.capitol.texas.gov/Docs/HS/htm/HS.245.htm.
[10] "Ectopic Pregnancy," Planned Parenthood, July 14, 2022, https://web.archive.org/web/20220714210739/https:/www.plannedparenthood.org/learn/pregnancy/ectopic-pregnancy. Planned Parenthood also here says, "The medical procedures for abortions are not the same as the medical procedures for an ectopic pregnancy."
[11] Harned and Skop, "Pro-Life Laws Protect Mom and Baby."
[12] Id.
[13] *In re State of Texas*, No. 23-0994, Per Curiam (Dec. 11, 2023), https://casetext.com/case/in-re-state-322203. *See also*, Mary Harned and Ingrid Skop, "Misleading Statements About 'Life of the Mother' Exceptions in Pro-Life Laws Require Correction," *Issues in Law & Medicine* 39, no. 1 (May 11, 2024), https://issuesinlawandmedicine.com/articles/misleading-statements-about-life-of-the-mother-exceptions-in-pro-life-laws-require-correction/.

treatment of their patients.'"[14] Again, the goal of separation in these rare cases is to protect the life of the mother and, when possible, to also save her child's life.[15]

Importantly, a recent review of court cases demonstrated that only two physicians in U.S. history were reported to have been prosecuted for performing abortions where there was "some credible evidence" the abortions had been performed to save the life of the mother. Critically, both convictions were reversed, and both were many decades ago – one in the 1960s and the other over 100 years ago. Post-*Dobbs* and as of publication, there has never been a reported case of a physician being prosecuted for performing an abortion to save the life of the mother.[16]

What is the standard of care for pregnancy emergencies?

Ectopic Pregnancy

In approximately 1-2% of pregnancies, the embryo implants outside of the normal location in the uterus, most frequently in the fallopian tube.[17] Often, by the time a tubal ectopic pregnancy is diagnosed, the unborn baby has already died, but the other pregnancy tissue may continue to grow.[18] Ectopic pregnancy can be life-threatening, because as the pregnancy grows, the fallopian tube will be stretched and may rupture, causing catastrophic internal bleeding. In fact, this condition is responsible for around 4-10% of pregnancy-related deaths.[19]

Ectopic pregnancy can be difficult to diagnose because the gestational sac is not always visible on an ultrasound early in pregnancy and it can be difficult for doctors to determine whether the baby has implanted inside or outside of the uterus.[20] If a woman arrives in the emergency room with pain and bleeding, standard care would include ultrasound and quantitative beta human chorionic gonadotropin (β-hCG) testing (a blood test to determine whether pregnancy hormone levels are high enough that doctors should expect to see the intrauterine unborn child via ultrasound).[21] If the doctor definitively

---

[14] *Planned Parenthood Great Nw. v. Idaho*, 522 P.3d 1132, 1203 (Idaho 2023) (internal citation omitted), https://cases.justia.com/idaho/supreme-court-civil/2023-49615.pdf?ts=1672956271.

[15] Harned and Skop, "Pro-Life Laws Protect Mom and Baby." The laws in Idaho, Texas, and Tennessee require physicians to attempt to separate mother and child in a manner that provides the best opportunity for the unborn child to survive unless doing so would pose a greater risk of death to the pregnant woman, in which case abortion is permitted.

[16] Maura Quinlan and Paul Benjamin Linton, "Medically Necessary Abortions After Dobbs: What, If Anything, Has Changed?," *Notre Dame Journal of Law, Ethics & Public Policy* 39 (forthcoming 2025), https://papers.ssrn.com/abstract=4909792.

[17] Danielle M. Panelli, Catherine H. Phillips, and Paula C. Brady, "Incidence, Diagnosis and Management of Tubal and Nontubal Ectopic Pregnancies: A Review," *Fertility Research and Practice* 1 (October 15, 2015): 15, https://doi.org/10.1186/s40738-015-0008-z.

[18] Mary C. Frates et al., "Adnexal Sonographic Findings in Ectopic Pregnancy and Their Correlation With Tubal Rupture and Human Chorionic Gonadotropin Levels," *Journal of Ultrasound in Medicine* 33, no. 4 (2014): 697–703, https://doi.org/10.7863/ultra.33.4.697; Ammar Al Naimi et al., "Ectopic Pregnancy: A Single-Center Experience over Ten Years," *Reproductive Biology and Endocrinology* 19, no. 1 (June 1, 2021): 79, https://doi.org/10.1186/s12958-021-00761-w.

[19] Laura L. Marion and George Rodney Meeks, "Ectopic Pregnancy: History, Incidence, Epidemiology, and Risk Factors," *Clinical Obstetrics and Gynecology* 55, no. 2 (June 2012): 376–86, https://doi.org/10.1097/GRF.0b013e3182516d7b.

[20] Mark Baker and Jonathan dela Cruz, "Ectopic Pregnancy, Ultrasound," in *StatPearls* (Treasure Island (FL): StatPearls Publishing, 2024), http://www.ncbi.nlm.nih.gov/books/NBK482192/.

[21] Kellie Mullany et al., "Overview of Ectopic Pregnancy Diagnosis, Management, and Innovation," *Women's Health* 19 (March 31, 2023): 17455057231160349, https://doi.org/10.1177/17455057231160349.

diagnoses ectopic pregnancy at that time, the woman should be offered treatment to resolve the ectopic pregnancy and prevent internal hemorrhage which may threaten her life. Treatment options include methotrexate or surgery. In some cases, if it appears the pregnancy is ending on its own, the patient may be offered expectant management (close monitoring without treatment until the pregnancy resolves completely).[22] If the doctor is unable to determine where the pregnancy has implanted, ACOG stresses the doctor should not intervene "to avoid ... possible interruption of an intrauterine pregnancy that a woman hopes to continue," but should instead provide the woman with short-term follow-up in the ER or with her own gynecologist.[23] Rarely, the unborn child implants in an abnormal location inside the uterus, such as in a cesarean scar, the cervix, or cornua (junction between the uterine cavity and the tube). These are also ectopic pregnancies and are considered dangerous because growth of the pregnancy in these locations can also cause life-threatening internal bleeding. Treatment should also be offered upon diagnosis in these situations.

No pro-life law prohibits treatment of an ectopic pregnancy because it may cause a pregnant woman's death.

Miscarriage Management

In the case of miscarriage, the unborn baby has already died. Doctors must ensure that the woman passes the baby and pregnancy tissue to prevent complications like hemorrhage and infection. Treatment options recommended by ACOG include expectant management (monitoring and waiting to see if the unborn child and pregnancy tissue will be expelled naturally), treatment with medication to facilitate expelling the unborn child and tissue, or surgical removal of the deceased unborn baby and other contents of the uterus.[24]

If a woman has an uncomplicated miscarriage in the first trimester, she and her doctors may choose expectant management to see if the miscarriage resolves on its own. In the case of a later miscarriage after the first trimester, doctors will generally offer active medical or surgical intervention rather than expectant management, due to the larger size of the deceased unborn child and amount of tissue. Women who are hemorrhaging, hemodynamically unstable, or who show signs of infection should be immediately treated with surgery to protect their lives.

No pro-life law prohibits treatment of a pregnancy in which the life of the unborn child has already tragically ended.

"Threatened" Miscarriage Management

Sometimes a pregnant woman will present with bleeding or pain that indicates a possible miscarriage, but the heartbeat of the unborn child can still be detected. If there is no sign of infection and the patient

---

[22] Joshua H. Barash, Edward M. Buchanan, and Christina Hillson, "Diagnosis and Management of Ectopic Pregnancy," *American Family Physician* 90, no. 1 (July 1, 2014): 34–40, https://www.aafp.org/pubs/afp/issues/2014/0701/p34.html.

[23] American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Gynecology. ACOG Practice Bulletin No. 193: Tubal Ectopic Pregnancy. *Obstet Gynecol*. 2018;131(3):e91-e103, https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/03/tubal-ectopic-pregnancy.

[24] ACOG Committee on Practice Bulletins—Gynecology, "Early Pregnancy Loss," *Practice Bulletin*, no. 200 (November 2018): 197–207, https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss.

is hemodynamically stable, the situation is typically addressed with expectant management with close monitoring.[25] A physician should not intervene if he or she is not certain that a miscarriage is occurring because the symptoms may resolve, and the pregnancy may continue to a healthy birth. ACOG emphasizes the importance of diagnostic certainty because "[t]reatment of an early pregnancy loss before confirmed diagnosis can have detrimental consequences, including interruption of a normal pregnancy, pregnancy complications, or birth defects."[26] There are some signs, however, that indicate that a miscarriage is in process and the pregnancy will not continue (inevitable or incomplete miscarriage). For example, heavy bleeding may occur in the presence of placental separation (abruption) or the cervix may have begun to dilate (cervical incompetence) and fetal parts such as the umbilical cord or limbs may have begun to deliver into the vaginal canal (sometimes associated with ruptured membranes).[27] In those situations, a doctor may use his or her clinical judgment to intervene to complete the removal of the baby and pregnancy tissue to protect a woman from life-threatening bleeding or infection.

No pro-life law prevents treatment of an inevitable or incomplete miscarriage if a doctor believes it is necessary to prevent a woman's death.

Periviable Premature Rupture of Membranes (PPROM)

A small fraction of pregnancies are complicated by periviable premature rupture of membranes (PPROM). In this case, the amniotic sac ruptures before the unborn baby has matured enough to survive outside the womb (sometimes as early as 21-23 weeks of gestation).[28] Sometimes the woman will go into labor or demonstrate evidence of infection requiring immediate delivery, but if not, the doctor and mother face a difficult decision. In this tragic situation, the unborn baby may not survive,[29] and the risk of serious infection for the mother is high.[30] If an infection occurs, the presence of the unborn baby and pregnancy tissue in the uterus may prevent intravenous antibiotics from adequately

---

[25] Michelle Mouri, Heather Hall, and Timothy J. Rupp, "Threatened Miscarriage," in *StatPearls* (Treasure Island (FL): StatPearls Publishing, 2024), http://www.ncbi.nlm.nih.gov/books/NBK430747/.
[26] American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Gynecology. ACOG Practice Bulletin No. 200: Early Pregnancy Loss. *Obstet Gynecol*. 2018;132(5):e197-e207, https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss.
[27] Ashley Redinger and Hao Nguyen, "Incomplete Miscarriage," in *StatPearls* (Treasure Island (FL): StatPearls Publishing, 2024), http://www.ncbi.nlm.nih.gov/books/NBK559071/.
[28] "Saving Extremely Premature Babies." Voyage of Life. Available at https://lozierinstitute.org/dive-deeper/saving-extremely-premature-babies/; For reports of babies being saved by medical teams at 21 and 22 weeks of gestation, see also "Stories of Premature Births, Anomalies Involving Fetal Surgery and Perinatal Hospice." Available at https://lozierinstitute.org/stories-of-premature-births-anomalies-with-fetal-surgery-and-perinatal-hospice/.
[29] Winnie Huiyan Sim, Hamon Ng, and Penelope Sheehan, "Maternal and Neonatal Outcomes Following Expectant Management of Preterm Prelabor Rupture of Membranes before Viability," *The Journal of Maternal-Fetal & Neonatal Medicine* 33, no. 4 (August 13, 2018): 533–41, https://doi.org/10.1080/14767058.2018.1495706.
[30] Allahyar Jazayeri, "Premature Rupture of Membranes," Medscape, May 3, 2023, https://emedicine.medscape.com/article/261137-overview#a5?form=fpf.

reaching the infected tissue.[31] If the pregnancy is not ended, the mother is at high risk of developing a more serious uterine infection (chorioamnionitis), blood infection (sepsis), and possibly death.[32]

The options at the time of diagnosis of PPROM are expectant management (if not infected), immediate induced delivery, or dilation and evacuation abortion (although women generally prefer induction to D&E abortion, which dismembers the child).[33] Regardless of the management chosen, the patient should be observed in the hospital to rule out labor or infection and will often be given intravenous antibiotics. If a woman chooses expectant management and remains stable under observation, she may be able to go home, while her doctors continue to stay in close communication and closely monitor her condition.[34] However, no patient should be sent home after diagnosis without initial observation in the hospital to ensure that her condition is stable, as was described in one of the recent articles documenting substandard care.[35]

No pro-life law prevents immediate treatment of periviable premature rupture of membranes if a doctor believes it is necessary to prevent a woman's death.

What are doctors and hospitals obligated to do to help pregnant women experiencing a medical emergency?

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal law that applies to hospitals with emergency departments.[36] Under this law, hospitals must evaluate every person who presents for care, provide stabilizing treatment for emergency conditions and women in labor, and transfer patients to another hospital if the services they need cannot be provided at that hospital. Hospitals cannot transfer patients without stabilizing them, unless the benefits of the transfer to the patient outweigh the risks. In the case of a woman in labor, the unborn child is also considered a patient under EMTALA.

Some of the cases described in recent news articles may represent violations of EMTALA, if hospitals failed to stabilize women's emergency conditions. However, most articles do not provide enough detailed medical information to allow readers to determine this with certainty.

Why do medical providers not always provide appropriate care, and what can be done?

Although some articles attempt to blame pro-life laws for bad outcomes and poor patient experiences, no state law prevents immediate treatment of a miscarriage, ectopic pregnancy, or life-threatening pregnancy complication. Physicians who decline to provide appropriate interventions in emergency circumstances, because they are confused about the extent to which pro-life laws impact their ability to

---

[31] Alexander Saucedo et al., "Periviable Premature Rupture of Membranes—Maternal and Neonatal Risks: A Meta-Analysis," *Obstetrics & Gynecology* 141, no. 5S (May 2023): 29S, https://doi.org/10.1097/01.AOG.0000930080.27015.56.
[32] Laura Goodfellow et al., "Preterm Prelabour Rupture of Membranes before 23 Weeks' Gestation: Prospective Observational Study," *BMJ Medicine* 3, no. 1 (March 19, 2024): e000729, https://doi.org/10.1136/bmjmed-2023-000729.
[33] Ariel Sklar et al., "Maternal Morbidity after Preterm Premature Rupture of Membranes at <24 Weeks' Gestation," *American Journal of Obstetrics & Gynecology* 226, no. 4 (April 1, 2022): 558.e1-558.e11, https://doi.org/10.1016/j.ajog.2021.10.036.
[34] Jazayeri, "Premature Rupture of Membranes."
[35] Seitz, "Dozens of Pregnant Women, Some Bleeding or in Labor, Are Turned Away from ERs despite Federal Law."
[36] Emergency Medical Treatment and Active Labor Act (EMTALA).

care for their patients,[37] may be committing medical malpractice. However, physician confusion is exacerbated by the failure of some hospitals and medical organizations that support physicians to explain the laws to them.[38]

Healthcare providers in states *without* pro-life laws have also failed to provide appropriate care to pregnant women experiencing emergencies, with one article documenting multiple instances of California hospitals failing to treat pregnancy emergencies.[39] As this article acknowledges, many hospitals are experiencing staffing shortages of nurses, ultrasound technicians, and other necessary medical professionals, as well as financial shortfalls, which can impact patient care.[40] This is a long-term problem that is projected to worsen[41] in coming years and should not be blamed on pro-life laws.

Doctors, being human, may also make errors. Sometimes these mistakes are egregious, possibly constituting medical malpractice. However, sometimes medical conditions can be difficult to diagnose. Some of the clinical scenarios portrayed in these articles may not represent physician refusal to treat an ectopic pregnancy, for instance, but instead may indicate that the physician did not feel confident in the diagnosis that the pregnancy was located in an ectopic location. It would demonstrate poor care if a physician interrupted a normal pregnancy by rushing to treatment before he or she could verify the pregnancy's location with certainty.

Additionally, while hospitals must evaluate and stabilize patients, this may not always involve immediate intervention. An ER physician who diagnoses a miscarriage may not immediately perform surgery if the woman's condition is stable. There are several reasons this might be the case. ER doctors are often not trained to perform surgical suction aspiration, the procedure used to remove the pregnancy tissue, so an obstetrician/gynecologist would need to be consulted to perform this intervention.[42] Some hospitals do not have a labor and delivery unit or obstetricians on staff, so a physician with the necessary skills may be unavailable. Most do not have surgical teams located in the hospital 24 hours a day. In the event of a true emergency of hemorrhage, infection, or hemodynamic instability, surgical intervention is required, so a hospital would call in its surgery team.

If the hospital cannot perform the necessary surgery in an emergency, the hospital would stabilize the patient and transfer her to another hospital that can, as required by EMTALA. However, if the woman is not experiencing complications from her miscarriage, immediate surgical intervention is not required, and the doctor can counsel the patient to follow up with her ob/gyn for further treatment. These news articles do not provide enough information to determine whether the diagnosed miscarriages were true medical emergencies or to know whether the hospitals had the ability to offer surgical intervention.

---

[37] Eleanor Klibanoff, "At Five Hour Hearing, No One Is Happy with Texas Medical Board's Proposed Abortion Guidance," *The Texas Tribune*, May 20, 2024, https://www.texastribune.org/2024/05/20/texas-medical-board-abortion-guidance/.
[38] Ingrid Skop, "Abortion Policy Allows Physicians to Intervene to Protect a Mother's Life," *Charlotte Lozier Institute*, May 16, 2023, https://lozierinstitute.org/abortion-policy-allows-physicians-to-intervene-to-protect-a-mothers-life/.
[39] Seitz, "Dozens of Pregnant Women, Some Bleeding or in Labor, Are Turned Away from ERs despite Federal Law."
[40] Id.
[41] "Physician Workforce: Projections, 2020-2035" (HRSA Health Workforce, November 2022), https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Physicians-Projections-Factsheet.pdf.
[42] Kelly E. Quinley et al., "Manual Uterine Aspiration: Adding to the Emergency Physician Stabilization Toolkit," *Annals of Emergency Medicine* 72, no. 1 (July 1, 2018): 86–92, https://doi.org/10.1016/j.annemergmed.2017.10.019.

Pro-life states can serve doctors and protect women by offering clarifying guidance and medical education on their laws. Already, states including Texas,[43] Florida,[44] and South Dakota[45] have worked to provide this clarity to doctors. By offering needed guidance through state medical boards or creating medical education programs to help doctors understand the law, pro-life states can ensure that women receive the care they need and that no one is turned away during a pregnancy emergency.

[43] "Rule Changes Effective July 17, 2024" (Texas Medical Board, n.d.), https://www.tmb.state.tx.us/idl/81E2D29C-4DB3-F8B0-5F79-DB6EFA8E1799.

[44] "AHCA Rule Provides 'Med Ed' Clarity on FL Heartbeat Law's 'Life of the Mother' Provision," *SBA Pro-Life America Press Releases*, May 2, 2024, https://sbaprolife.org/newsroom/press-releases/ahca-rule-provides-med-ed-clarity-on-fl-heartbeat-laws-life-of-the-mother-provision.

[45] "Medical Education & Guidance | South Dakota's Abortion Law," South Dakota Department of Health, accessed September 12, 2024, https://doh.sd.gov/healthcare-professionals/medical-education-guidance/; "Gov. Noem Signs Nation's First Med Ed Bill," *SBA Pro-Life America Press Releases*, March 25, 2024, https://sbaprolife.org/newsroom/press-releases/gov-noem-signs-nations-first-med-ed-bill.