NORTH DAKOTA

# Know Your State's Abortion Laws

## A Guide for Medical Professionals

Since *Roe v. Wade* was overturned in June 2022, medical providers across the country have struggled to understand their state's abortion laws, which contain undefined terms and non-medical language.

Fear and confusion throughout the medical community has led some hospitals to adopt policies that are overly strict or burdensome, causing patients to be denied care in emergencies. While the law remains in flux and some questions have no clear answers, this document aims to provide clarification, where possible, of what conduct is still permitted in your state. Know what your state's law does and does not require, so you can advocate for yourself and your patients.

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# Key Takeaways

Providing contraception, including emergency contraception, is legal.

Providing medical care for ectopic and for molar pregnancies is legal, as is providing medical care for miscarriages when there is no fetal cardiac activity or there is “serious health risk” to the pregnant person.

Providing information about how to obtain a legal abortion in another state is legal.

The North Dakota Constitution protects the right to an abortion to preserve the pregnant person’s life or health.

A trial court declared North Dakota’s abortion ban unconstitutional (meaning abortion is currently legal), but litigation in the North Dakota Supreme Court is ongoing

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## State Constitutional Protection for Abortion

The North Dakota Supreme Court has held that the inalienable rights clause in article 1, section 1 of the state constitution— which protects the rights to "enjoying and defending life" and "pursuing and obtaining safety," among others—"necessarily includes a pregnant [person's] . . . fundamental right to obtain an abortion to preserve her life or her health."[1] Litigation in the North Dakota Supreme Court regarding the scope of the right to health-preserving abortions under the state constitution is ongoing.[2]

## Definition of Abortion & Contraception

### ABORTION

North Dakota defines abortion as "the act of using, selling, or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman, including the elimination of one or more unborn children in a multifetal pregnancy, with knowledge the termination by those means will with reasonable likelihood cause the death of the unborn child. The following are explicitly excluded from North Dakota law's definition of abortion:: (a) removing a "dead unborn child caused by spontaneous abortion"; (b) "[t]reating a woman for an ectopic pregnancy;" or (c) "[t]reating a woman for a molar pregnancy."[3] While undefined, it is generally understood that in the context of North Dakota's definition of abortion, "dead" means that there is no cardiac activity present in the embryo or fetus. This means that treatment for miscarriage where there is no cardiac activity (including medications, D&C, D&E, labor induction), treatment for ectopic pregnancy (including use of methotrexate and surgical removal), and treatment for molar pregnancy (including D&C) are not abortions under North Dakota law and thus are not prohibited by its abortion ban.

Miscarriage care is legal, so long as there is no fetal cardiac activity or when there is "serious health risk" to the pregnant person. With respect to self-managed abortion, it is legal for providers to give medical care during or after a self-managed abortion if the abortion is "deemed necessary based on reasonable medical judgment which w[as] intended to prevent the death or a serious health risk" to the pregnant person or if the pregnancy resulted from certain sex offenses (see below). There is not an explicit crime of self-managed abortion in North Dakota law, and no civil law explicitly prohibiting a person from self-managing an abortion.

### CONTRACEPTION

Contraception is not illegal in any state in the country, including North Dakota.

## Abortion Bans

North Dakota has several abortion bans or restrictions that carry criminal penalties (prison time and/or fine). One of the bans has been declared unconstitutional by a trial court but litigation before the North Dakota Supreme Court is ongoing and there is a risk of retroactive enforcement.

**Abortion Ban:** North Dakota's Abortion Ban criminalizes abortion, with three exceptions (discussed below).[4] Outside of the exceptions, it is a class C felony for anyone (other than the pregnant person) to perform an abortion.[5] Class C felonies are punishable by up to five years' imprisonment and/or a $10,000 fine.[6]

On September 12, 2024, a state trial court ruled that the Ban is unconstitutional, and the trial court later rejected the State's request to stay (pause) the ruling while the case is being appealed.[7] On January 24, 2025, the North Dakota Supreme Court also rejected

the State's request to stay (pause) the ruling during the appeal, with three justices joining the decision.[8] However, two justices dissented from the decision, with one justice suggesting that if the North Dakota Supreme Court ultimately finds the Ban constitutional, retroactive enforcement of the criminal penalties would be permissible for abortions performed while the appeal was pending.[9] The North Dakota Supreme Court has yet to rule on the constitutionality of the Ban, and a supermajority of four justices is required to declare the Ban unconstitutional.[10]

**D&X Ban:** North Dakota law prohibits D&X (dilation and extraction or intact dilation and evacuation) abortions (referred to in the law as "partial-birth" abortions).[11] Specifically, the law prohibits "intentionally caus[ing] the death of a living intact fetus while that living intact fetus is partially born."[12] "Partially born" is defined as when the "living intact fetus's body, with the entire head attached, is delivered so that any of the following has occurred: a. [t]he living intact fetus's entire head, in the case of a cephalic presentation, or any portion of the living intact fetus's torso above the navel, in the case of a breech presentation, is delivered past the mother's vaginal opening; or b. [t]he living intact fetus's entire head, in the case of a cephalic presentation, or any portion of the living intact fetus's torso above the navel, in the case of a breech presentation, is delivered outside the mother's abdominal wall."[13] The ban does not apply to "sharp curettage or suction curettage abortion," defined as "an abortion in which the developing child and products of conception are evacuated from the uterus with a sharp curettage or through a suction cannula with an attached vacuum apparatus."[14] However, the D&X ban does not "prohibit a physician from taking measures that in the physician's medical judgment are necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury," if "[e]very reasonable precaution is also taken, in this case, to save the child's life" and the physician "first certifies in writing, setting forth in detail the facts upon which the physician relies in making this judgment. This certification is not required in the case of an emergency and the procedure is necessary to preserve the life of the mother."[15] Violation of the D&X ban is a class AA felony, punishable by a maximum penalty of life imprisonment without parole.[16]

**Post-Viability Two Physician Restriction:** If a fetus is viable (defined as the "ability of an unborn child to live outside the mother's womb, albeit with artificial aid"), an abortion may only be performed by a physician when there is a second physician in attendance who "shall take control and provide immediate medical care for the viable child born as a result of the abortion."[17] Both physicians must "take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the unborn child."[18] Life-supporting equipment to preserve a viable fetus must, at minimum, include an oxygen source and a "[h]eat source (overhead warmer, incubator, warmed blankets)."[19] Violation of the requirement is a class C felony.[20]

## Other Abortion Restrictions

The North Dakota Abortion Control Act contains additional restrictions on performing abortions.

**Hospital Restrictions:** "After the first twelve weeks of pregnancy but before the time at which the unborn child may reasonably be expected to have reached viability," an abortion must be performed in a licensed hospital.[21] Violation of this requirement is a class A misdemeanor, punishable by up to 360 days' imprisonment and/or a $3,000 fine.[22] North Dakota law also prohibits authorizing or performing an abortion in a hospital that is owned, maintained, or operated by the State of North Dakota unless the

abortion is "necessary to prevent the death" of the pregnant person.[23] Violation of this prohibition is a class B misdemeanor, punishable by up to thirty days' imprisonment and/or a fine of $1,500.[24]

**Physician-Only Restriction:** Abortions may only be performed by North Dakota-licensed physicians.[25] If an abortion is performed outside of a hospital at an abortion facility, the physician must have admitting privileges at a hospital located within thirty miles of the abortion facility and staff privileges to replace hospital on-staff physicians at that hospital.[26]

**Biased Counseling, 24-Hour Delay, and Parental Notification for Minors:** Patients must be provided state-mandated verbal disclosures and state-created print materials at least 24 hours before an abortion, and the patient must certify in writing before the performance of the abortion that this mandated information has been provided to her.[27] The physician must also certify in writing the pregnant person's marital status and age based upon proof of age offered by her.[28] Physicians may not receive or obtain payment for the abortion until the mandated 24-hour delay has elapsed.[29]

In the case of pre-viability abortions for minors under 18 years old, the attending physician must also certify in writing that they have provided the state-mandated verbal disclosures and state-created print materials to each of the minor's parents at least 24 hours before the minor's consent to the abortion or that they have mailed these materials by certified mail to each of the minor's parents' last known addresses at least 48 hours before the minor's consent to the abortion.[30] If a parent has died or had their parental rights terminated, these materials must be provided to the surviving/remaining parent, and if both parents have died or had their parental rights terminated, these materials must be provided to the minor's guardian or another person standing in loco parentis.[31] This parental notification is not required when a juvenile court has authorized the abortion (discussed below) and the minor elects to not allow notification of the minor's parents.[32]

These biased counseling requirements and 24-hour delay do not apply in a "medical emergency" (defined as a "condition that, in reasonable medical judgment, so complicates the medical condition of the pregnant woman that it necessitates an immediate abortion to prevent her death or a serious health risk") but the physician must inform the patient, before the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is "necessary to prevent her death or prevent a serious health risk" and certify those indications in writing.[33]

**Parental/Judicial Consent for Minors:** For minors under 18 years old, if the minor is married, the attending physician only needs to obtain the minor's consent.[34] However, for unmarried, minors, the attending physician must obtain written consent from both parents. If one parent is deceased or if the parents are separated/divorced, the surviving or custodial parent, respectively, must provide written consent. If the minor is subject to guardianship, the legal guardian(s) must provide written consent.[35] A minor may seek judicial bypass of the parental consent requirements in juvenile court.[36] These additional minor consent requirements do not apply in "medical emergency" (defined as a "condition that, in reasonable medical judgment, so complicates the medical condition of the pregnant woman that it necessitates an immediate abortion to prevent her death or a serious health risk").[37]

## Exceptions to Abortion Ban

North Dakota's Abortion Ban contains three exceptions. First, it permits abortions "deemed necessary based on reasonable medical judgment which w[ere] intended to prevent the death or a serious health risk" to the pregnant person.[38] Second, it permits abortions to terminate

pregnancies that resulted from certain sex offenses if the probable gestational age of the fetus is six weeks or less.[39] Third, it exempts from liability individuals "assisting" in performing an abortion who did not know the physician was performing an abortion which violated the Ban.[40]

**Death or "Serious Health Risk" Exception:** North Dakota law permits an "abortion deemed necessary based on reasonable medical judgment which was intended to prevent the death or a serious health risk to the pregnant female."[41] "Reasonable medical judgment" is defined as "a medical judgment that would be made by a reasonably prudent physician who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved."[42] "Serious health risk" is defined as "a condition that, in reasonable medical judgment, complicates the medical condition of the pregnant woman so that it necessitates an abortion to prevent substantial physical impairment of a major bodily function, not including any psychological or emotional condition. The term may not be based on a claim or diagnosis that the woman will engage in conduct that will result in her death or in substantial physical impairment of a major bodily function."[43] The Ban does not define the terms "necessary"/"necessitates," "substantial physical impairment," or "major bodily function," and the State has not issued guidance on the meaning of those terms.

**Sex Offenses Exception:** North Dakota law permits an "abortion to terminate a pregnancy that based on reasonable medical judgment resulted from gross sexual imposition, sexual imposition, sexual abuse of a ward, or incest . . . if the probable gestational age of the unborn child is six weeks or less."[44] "Probable gestational age" is defined as "what, in reasonable medical judgment, will with reasonable probability be the gestational age of the unborn child."[45]

**Individuals Assisting in Performing an Abortion:** North Dakota law exempts from criminal liability "an individual assisting in performing an abortion if the individual was acting within the scope of that individual's regulated profession, was under the direction of or at the direction of a physician, and did not know the physician was performing an abortion in violation" of the ban.[46]

# EMTALA

A federal law called the Emergency Medical Treatment & Labor Act ("EMTALA") requires emergency abortion care in some cases. EMTALA requires Medicare-participating hospitals with emergency departments (which includes most hospitals), to perform a medical screening to determine whether an emergency medical condition exists for any individual who comes to the emergency department and requests an examination or treatment.[47] Stabilizing medical treatment must be provided to individuals experiencing an emergency medical condition,[48] including people in labor or with emergency pregnancy complications.[49] Under the EMTALA statute, "to stabilize" means to provide medical treatment "as may be necessary" to ensure, "within reasonable medical probability, that no material deterioration of the condition is likely."[50] A person experiencing an emergency medical condition can only be transferred to a different hospital once they are stable or if certain conditions are met, such as the medical benefits of transfer outweighing the increased risks to the person experiencing the emergency medical condition.[51] Even where a hospital is permitted to transfer such a person without first stabilizing them, the hospital still must provide "the medical treatment within its capacity which minimizes the risks to the individual's health."[52] EMTALA defines "emergency medical condition" to include "acute symptoms of sufficient

severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."[53] The stabilizing treatment required by EMTALA can include abortion care in certain circumstances.

The U.S. Department of Health and Human Services ("HHS") reaffirmed these requirements in guidance issued after *Roe v. Wade* was overturned. That guidance emphasizes that stabilizing treatment required by EMTALA could include abortion care if the examining physician or other qualified medical personnel determines that such treatment is required to stabilize a patient experiencing an emergency medical condition, including a condition that is "likely or certain to become emergent without stabilizing treatment."[54] The guidance made clear those conditions might include, but are not limited to: "ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features."[55] The guidance reiterates that if EMTALA requires the provision of abortion care, then EMTALA expressly preempts any state law prohibiting or restricting access to abortion.[56] Indeed, since *Dobbs*, HHS has cited hospitals in Kansas, Missouri, and Florida for violating EMTALA by failing to provide abortion care to a patient with PPROM or other life-threatening pregnancy condition.[57]

Notwithstanding EMTALA's clear requirements with respect to emergency abortion, state officials in Idaho and Texas have attempted to restrict hospitals from complying with their federal legal obligations, resulting in litigation.

In 2022, in *United States v. Idaho*, the federal government sued Idaho and obtained a preliminary injunction ensuring that Idaho's abortion ban could not be enforced to prohibit health-saving emergency abortions required under EMTALA.[58] After temporarily staying that injunction,[59] the U.S. Supreme Court lifted the stay and restored the preliminary injunction in June 2024.[60]

Following the change of presidential administrations, the United States dismissed its case, effectively eliminating the injunction entered in that case.[61] By that time, however, a hospital system had filed a separate lawsuit and obtained a temporary restraining order effectively maintaining the status quo, meaning that Idaho still cannot enforce its abortion ban in circumstances where EMTALA would require abortion care.[62]

Meanwhile in Texas, the U.S. Supreme Court refused to review a Fifth Circuit decision that affirmed a lower court decision blocking federal enforcement of HHS' 2022 EMTALA guidance in Texas and as to other plaintiffs in that case. As a result, the Fifth Circuit's decision affirming the permanent injunction against the 2022 EMTALA guidance is final. This means HHS may not enforce the 2022 guidance in Texas or against any member of the American Association of Pro-Life OBGYNs (AAPLOG) or Christian Medical & Dental Associations (CMDA).[63, 64]

## Other Federal Laws & Professional Guidelines

In addition to EMTALA, hospitals and/or medical providers are required to abide by the following:

**Conditions of Participation in Medicare and Medicaid (COP):** The federal COP regulations require hospitals that participate in Medicare and Medicaid to inform patients of their rights in advance of furnishing or discontinuing care which include: the right to be informed of their health status, be involved in care planning and treatment,

and participate in the development of their plan of care.[65]

**Protection Against Discrimination in Employment:** The federal law known as the Church Amendments prohibits hospitals that receive certain federal funds from discriminating against healthcare providers who participate or are willing to participate in abortion care or sterilization procedures.[66]

**Medical Malpractice:** While this document does not detail state-specific medical malpractice law, medical providers should be aware that they risk liability under state medical malpractice law for failing to provide pregnant patients with the standard of care.[67]

**Resident Training:** The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[68] The federal law known as the Coats-Snowe Amendment both protects medical professionals in learning to provide abortion and limits the government's ability to penalize programs or institutions that fail to comply with ACGME requirements.[69]

## Documentation & Reporting

Generally, state law does not require documentation of irrelevant or non-medical information in patient charts. Nor does it explicitly require reporting to law enforcement patients who receive abortions out of state or self-manage their own abortion.[70] The only abortion-specific documentation and reporting requirements are listed below.

**Documentation:** North Dakota law requires all abortion facilities and hospitals where abortions are performed to keep records, "including admission and discharge notes, histories, results of tests and examinations, nurses' worksheets, social service records, and progress notes."[71] Additionally, abortion facilities and hospitals where abortions are performed must keep a copy of all required written certifications as well as a copy of the constructive notice forms, consent forms, court orders, abortion data reports, adverse event reports, abortion compliance reports, and complication reports.[72] These records must remain confidential and may be used by NDHHS only for gathering statistical data and ensuring compliance with other abortion restrictions and regulations.[73] The records must be maintained for at least seven years.[74]

Additionally, abortion facilities must keep records on the number of patients who chose to receive and view an ultrasound image of the fetus, the number who did not, and of each of those, the number who, to the best of the facility's information and belief, went on to obtain the abortion; and a record of the probable gestational age of the fetus at the time of the abortion.[75] If the probable gestational age was not made because of a medical emergency, the record must include the basis for the determination that a medical emergency existed.[76] These requirements do not apply to hospitals in which abortions are performed.[77]

**Abortion Reporting:** For each abortion, North Dakota law requires the attending physician to complete an individual abortion compliance report and an individual abortion data report.[78]

The abortion compliance report must include a checklist that confirms compliance with all provisions of the Abortion Control Act, North Dakota's restrictions on using public funds and other health insurance for abortion, the state's ban on "partial birth abortion," and nondiscrimination protections for choosing not to participate in an abortion.[79] If a determination of the fetus's probable gestational age was not made, the abortion compliance report must state the basis for the determination that a medical emergency existed.[80] All abortion compliance reports must be signed by the attending physician within 24 hours and submitted to NDHHS within 10 business days from

the date of the abortion.[81] Abortion compliance reports received by NDHHS are public records.[82]

The abortion data report must be confidential and cannot contain the name of the pregnant person.[83] Additionally, it must include the data called for in the U.S. standard Induced Termination of Pregnancy (ITOP) report as recommended by the National Center for Health Statistics and whether the abortion was (1) necessary in the physician's reasonable medical judgment and was intended to prevent the death of the pregnant person; (2) to terminate a pregnancy that resulted from gross sexual imposition, sexual imposition, sexual abuse of a ward, or incest, as those offenses are defined in N.D. Century Code chapter 12.1-20; or (3) necessary to prevent a serious health risk.[84] All abortion data reports must be signed by the attending physician and submitted to NDHHS within 30 days from the date of the abortion.[85] A copy must also be made part of the patient's medical record.[86]

In accordance with these statutory requirements, NDHHS requires a Report of Induced Abortion Form to be executed, including information about the patient's prior pregnancies, termination procedures, any complications or adverse events, and the reason for the procedure.[87] The form must be used by the hospital or facility in which the abortion was performed.[88]

**Complication Reporting:** All abortion complication reports must be signed by the attending physician and submitted to NDHHS within 30 days from the date of the abortion.[89] A copy of the report must be made a part of the patient's medical record.[90] In cases where a post-abortion complication is discovered, diagnosed, or treated by a physician not associated with the facility or hospital where the abortion was performed, NDHHS shall forward a copy of the report to that facility or hospital to be made part of the patient's permanent record.[91]

**"Adverse Event" Reporting:** In this context, "adverse event" is defined "based upon the federal [F]ood and [D]rug [A]dministration criteria given in the medwatch reporting system."[92] If a physician provides an "abortion-inducing drug" for the purpose of inducing an abortion and the physician knows that the individual experiences an adverse event either during or after the use, the physician must provide a written report of the adverse event within 30 days of the event to NDHHS and the federal Food and Drug Administration through the medwatch reporting system.[93] A copy of the report must be made a part of the patient's medical record.[94]

**Fetal Death Reporting:** North Dakota law defines "fetal death" as "death occurring before the complete expulsion from its mother of a product of human conception."[95] The death is indicated "by the fact that after such expulsion or extraction the fetus does not breathe or show any evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles."[96]

A fetal death record must be filed with the state registrar for "each fetal death that occurs in the state after a gestation period of twenty completed weeks."[97] When the fetal death occurs in an "institution," which includes abortion clinics and hospitals,[98] the person in charge or a designated representative must use NDHHS's electronic fetal death registration system to report the fetal death, including "all personal and medical facts," to the state registrar within 10 days after the delivery.[99] On or before the fifth day of each month, each hospital or abortion clinic must report to the state registrar, using the provided forms, information required by the state registrar regarding each fetal death handled during the preceding calendar month.[100]

When a fetus is released or disposed of by an institution, the person in charge must keep a record that includes the name of the deceased, date of

death, name and address of the person to whom the remains were released, date of removal from the institution, or if finally disposed of by the institution, the date, place, and manner of disposition.[101] These records must be made available to the state registrar for inspection upon demand.[102]

**Other Mandatory Reporting:** All other general mandatory reporting to North Dakota Child Protection Services, local law enforcement, etc., also applies for abortion patients.[103] This includes reporting of sexual abuse of young people, child abuse, and vulnerable adult abuse.

**Electronic Medical Records:** Many electronic medical record systems (EMRs) allow healthcare providers to securely share patient records across healthcare institutions.[104] While EMRs have settings that allow patients to choose how and when their records are shared, hospital systems often instead use their EMR's default settings that widely share patient records. Though often done for continuity of care purposes, these settings may put abortion providers and patients (or patients obtaining other sensitive care) at risk, and many patients do not know their records are shared in this way.[105]

The federal government has taken steps to address this concern by issuing a HIPAA rule that became effective on June 25, 2024.[106] The rule prohibits the use or disclosure of protected health information (PHI) if sought to conduct an investigation into or impose liability on any person solely for seeking, obtaining, providing, or facilitating lawful reproductive healthcare, or identifying any person for these purposes.[107] A provider who receives a request to disclose PHI potentially related to reproductive care must obtain an attestation from the requestor that the request is not for a prohibited purpose.[108] The attestation is required when the request is for: law enforcement purposes, disclosures to coroners and medical examiners, judicial and administrative proceedings, and health oversight activities.[109] If the abortion care – self-managed or otherwise – was provided by someone else, the rule allows a provider to assume it was provided lawfully unless 1) the patient tells them otherwise or 2) the attestation provides evidence of unlawfully provided care.[110] The rule only applies to healthcare providers who are subject to HIPAA.[111] Though several states are challenging this rule in litigation, it currently remains in place as these cases move forward.[112]

Separate from HIPAA, interoperability rules that penalize certain information blocking may apply when a healthcare provider uses EMRs.[113] Because of this, we encourage you to discuss alternative EMR settings and information blocking exceptions that may be available with your institution's compliance officers, counsel, and/or technology officers.[114]

## Counseling & Referral

Speech about abortion is legal in North Dakota. Medical professionals in North Dakota can thus (1) provide accurate options counseling, including about abortion; and (2) refer patients to medical providers in states where abortion is legal. There is, however, a prohibition on employees of school districts from referring a student to resources for abortion.[115] State funds also cannot be used to promote the performance of abortion unless the abortion is necessary to save the life of the pregnant person.[116]

## Medication Abortion

North Dakota has additional rules that apply specifically to abortions accomplished by the use of an "abortion-inducing drug," which is defined as "a medicine, drug, or any other substance prescribed or dispensed with the intent of causing an abortion."[117] It is unclear whether the definition of "abortion-inducing drug" only applies to mifepristone or whether it also includes misoprostol.[118]

North Dakota requires in-person dispensing by a physician for medication abortion, and the provision

or prescription must "satisf[y] the protocol tested and authorized by the federal food and drug administration and as outlined in the label for the abortion-inducing drug."[119] The physician must provide the pregnant patient with a copy of the drug's label.[120] Additionally, the physician must enter a signed contract with another physician who agrees to handle emergencies associated with the "use or ingestion of the abortion-inducing drug" and who has active admitting privileges at the hospital designated to handle any associated emergencies.[121] The patient must be provided with the name and telephone number of the second physician and hospital.[122] The prescribing physician must produce the signed contract on demand by the patient, state health department, or a criminal justice agency.[123]

## Disposition of Fetal Tissue Remains

North Dakota law requires that the physician performing the abortion for abortions performed outside of a hospital or the hospital where the abortion is performed see to it that fetal remains are disposed of in a "humane fashion" pursuant to regulations established by NDHHS.[124] North Dakota regulations define "humane disposal of a nonviable fetus" as consisting of "incineration, burial, or cremation."[125] The physician performing the abortion or the hospital in which the abortion is performed may contract with out-of-state incineration, burial, or cremation of nonviable fetuses.[126] Any failure to dispose of fetal remains in accordance with these requirements is a class A misdemeanor.[127]

## Need legal advice?

This document should not be construed as legal advice. If you need individualized legal advice, please contact the Abortion Defense Network, where you will be matched with a pro bono attorney.

The Abortion Defense Network is managed by the Lawyering Project in partnership with the American Civil Liberties Union, Center for Reproductive Rights (CRR), If/When/How: Lawyering for Reproductive Justice, National Women's Law Center (NWLC), and Resources for Abortion Delivery (RAD).

CENTER for REPRODUCTIVE RIGHTS

THE LAWYERING PROJECT

RAD RESOURCES FOR ABORTION DELIVERY

# References

[1] *Wrigley v. Romanick*, 2023 N.D. 50, ¶ 27.
[2] *Access Indep. Health Servs., Inc., v. Wrigley*, No. 20240291 (N.D. Sup. Ct. appeal filed Oct. 17. 2024).
[3] N.D. Cent. Code § 12.1-19.1-01(1); *see also* N.D. Cent. Code § 14-02.1-02(1) (defining abortion as "the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman, including the elimination of one or more unborn children in a multifetal pregnancy, with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to: a. Remove a dead unborn child caused by spontaneous abortion; b. Treat a woman for an ectopic pregnancy; or c. Treat a woman for a molar pregnancy").
[4] N.D. Cent. Code ch. 12.1-19.1.
[5] *Id.* § 12.1-19.1-02.
[6] N.D. Cent. Code § 12.1-32-01(4).
[7] Order on Defs.' Mot. Summ. J., *Access Indep. Health Servs., Inc., v. Wrigley*, No. 08-2022-CV-01608 (N.D. Burleigh County Dist. Ct. Sept. 12, 2024), Dkt. 603; Order Denying Defs.' Mot. Stay Pending Appeal, *Access Indep.*, *Wrigley*, No. 08-2022-CV-01608 (N.D. Burleigh County Dist. Ct. Oct. 10, 2024), Dkt. 629.
[8] *See generally Access Indep. Health Servs., Inc., v. Wrigley*, 2025 ND 26.
[9] *Id.* ¶ 51 n.1 (Tufte, J., dissenting).
[10] N.D. Const. art. VI, § 4.
[11] N.D. Cent. Code § 14-02.6-02.
[12] *Id.*
[13] N.D. Cent. Code § 14-02.6-01(1).
[14] *Id.* § 14-02.6-02(2), 01(2).
[15] *Id.* § 14-02.6-03.
[16] *Id.* § 14-02.6-02(1); N.D. Cent. Code § 12.1-32-01(1).
[17] N.D. Cent. Code § 14-02.1-05.
[18] *Id.*
[19] N.D. Admin. Code. § 33-03-02-02.
[20] N.D. Cent. Code § 14-02.1-05.
[21] N.D. Cent. Code § 14-02.1-04(2).
[22] N.D. Cent. Code § 14-02.1-04(4) ; N.D. Cent. Code § 12.1-32-01(1).
[23] N.D. Cent. Code § 14-02.3-04.
[24] *Id.*; N.D. Cent. Code § 12.1-32-01(6).
[25] N.D. Cent. Code § 14-02.1-04(1).
[26] *Id.*
[27] N.D. Cent. Code § 14-02.1-02(9), -03(1). The certification may occur "immediately before the medical procedure." *Fargo Women's Health Org. v. Schafer*, 18 F.3d 526, 531 (8th Cir. 1994).
[28] N.D. Cent. Code § 14-02.1-03(1).
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.* § 14-02.1-03(1), -02(10).
[34] N.D. Cent. Code § 14-02.1-03.1(1).
[35] *Id.*
[36] *See, e.g.*, N.D. Cent. Code § 14-02.3-02.1, -03, -03.1, -03.4.
[37] *Id.* § 14-02.1-03.1(12), -02(10).
[38] N.D. Cent. Code § 12.1-19.1-03(1).
[39] *Id.* § 12.1-19.1-03(2).

[40] *Id.* § 12.1-19.1-03(3).
[41] *Id.* § 12.1-19.1-03(1).
[42] *Id.* § 12.1-19.1-01(4).
[43] *Id.* § 12.1-19.1-01(5).
[44] N.D. Cent. Code § 12.1-19.1-03(2).
[45] N.D. Cent. Code § 12.1-19.1-01(3).
[46] N.D. Cent. Code § 12.1-19.1-03(3).
[47] EMTALA, 42 U.S.C. § 1395dd(a).
[48] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[49] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[50] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[51] EMTALA, 42 U.S.C. § 1395dd(c)(2) (requiring hospital to use "qualified personnel and transportation equipment" when making a permitted transfer under EMTALA, among other requirements).
[52] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–-(c)(2)(A).
[53] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[54] Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (updated July 2022).
[55] *Id.*
[56] *Id.*; *see also* EMTALA, 42 U.S.C. § 1395dd(f) ("The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.").
[57] Ctrs. for Medicare & Medicaid Servs., *Freeman Health System—Freeman West, Statement of Deficiencies and Plan of Correction* (April 10, 2023); Ctrs. for Medicare & Medicaid Servs., *University of Kansas Hospital, Statement of Deficiencies and Plan of Correction* (April 10, 2023); Caroline Kitchener & Dan Diamond, *She filed a complaint after being denied an abortion. The government shut her down*, Washington Post (Jan. 19, 2024), https://www.washingtonpost.com/politics/2024/01/19/oklahoma-abortion-emtala/ ("Biden officials also confirmed one additional case that the administration had determined violated EMTALA involving a woman who presented at two hospitals in Florida with a life-threatening pregnancy condition in December 2022."); Press Release, U.S. Dep't of Health and Human Servs., *HHS Secretary Xavier Becerra Statement on EMTALA Enforcement* (May 1, 2023).
[58] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[59] *Idaho v. United States*, 144 S. Ct. 541 (Mem) (2022).
[60] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[61] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
[62] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 33 (D. Idaho Mar. 4, 2025).
[63] Ctrs. for Medicare & Medicaid Servs., *Emergency Medical Treatment & Labor Act (EMTALA)*, https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act (last modified Dec. 6, 2024).
[64] A separate challenge to the guidance was filed by the Catholic Medical Association in Tennessee, Compl., *Catholic Med. Ass'n v. Dep't of Health & Hum. Servs.*, No 3:25-cv-00048, ECF No. 1 (M.D. Tenn. Jan. 10, 2025), but the federal government has not yet responded.
[65] 42 C.F.R. § 482.13(a)(1), (b)(1)–(2).
[66] Nat'l Women's Law Ctr., *Know Your Rights: Existing Laws May Protect Health Care Professional Who Provide or Support Abortion from Discrimination in Employment* (Feb. 9, 2023).
[67] Fla. Stat. § 766.101 *et seq.*
[68] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 17, 2022).
[69] 42 U.S.C. § 238n.
[70] There is no reason to report a self-managed abortion to the police. Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here. If/When/How adds state-specific fact sheets to their website as they are finalized.
[71] N.D.C.C. § 14-02.1-07(1)(a).

[72] *Id.*
[73] N.D.C.C. § 14-02.1-07(1)(b).
[74] N.D.C.C. § 14-02.1-07(1)(c).
[75] N.D.C.C. § 14-02.1-07(1)(a).
[76] *Id.*
[77] *See id.*
[78] N.D.C.C. § 14-02.1-07(2)(a).
[79] N.D.C.C. § 14-02.1-02.2.
[80] N.D.C.C. § 14-02.1-07(2)(b).
[81] N.D.C.C. § 14-02.1-07(2)(b).
[82] N.D.C.C. § 14-02.1-07(2)(d).
[83] N.D.C.C. § 14-02.1-07(2)(a).
[84] N.D.C.C. § 14-02.1-02.2.
[85] N.D.C.C. § 14-02.1-07(2)(b).
[86] N.D.C.C. § 14-02.1-07(2)(c).
[87] N.D. Admin. Code 33-03-02-03.
[88] *Id*.
[89] N.D.C.C. § 14-02.1-07(2)(b).
[90] N.D.C.C. § 14-02.1-07(2)(c).
[91] *Id.*
[92] N.D.C.C. § 14-02.1-07(2)(b).
[93] *Id.*
[94] N.D.C.C. § 14-02.1-07(2)(c).
[95] N.D.C.C. § 23-02.1-01(8).
[96] *Id.*
[97] N.D.C.C. § 23-02.1-20(1).
[98] *See* N.D.C.C. § 23-02.1-01(14) (defining "institution" as "any establishment, public or private, which provides inpatient medical, surgical, or diagnostic care or treatment . . . to two or more individuals unrelated by blood . . .").
[99] N.D.C.C. § 23-02.1-20(2).
[100] N.D.C.C. § 23-02.1-30(5).
[101] N.D.C.C. § 23-01.1-30(2).
[102] N.D.C.C. § 23-02.1-30(4).
[103] Fact sheets from If/When/How with additional detail, including some state-specific fact sheets, are available here. If/When/How adds state-specific fact sheets to their website as they are finalized.
[104] For example, one EMR, Epic, uses a tool called Care Everywhere to securely share information between healthcare institutions (e.g., from one hospital system to another) and allows robust sharing within a single institution (e.g., a Texas hospital treating a patient may be able to see the patient's records from an Illinois hospital that within the same system).
[105] For example, if a patient travels from a ban state to an access state for abortion care or obtains an abortion in the ban state under an exception, then later obtains any type of healthcare at a different provider that uses the same EMR, the patient's records may be automatically shared with the second provider. If the second provider believes that the care violated the state's abortion ban, they may report it to authorities.
[106] Although effective on June 25, 2024, compliance with this rule was required on December 23, 2024, except for the applicable requirements for revising Notice of Policy Practices (as required by 45 CFR 164.520), which must be complied with by February 16, 2026.
[107] 42 U.S.C. § 164.502(a)(5)(iii). *See also HIPAA Privacy Rule Final Rule to Support Reproductive Health Care Privacy: Fact Sheet*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/final-rule-fact-sheet/index.html (content last reviewed April 22, 2024).
[108] 42 U.S.C. § 164.509. The U.S. Department of Health & Human Services (HHS) recently released a model attestation, available here: https://www.hhs.gov/sites/default/files/model-attestation.pdf.
[109] 42 U.S.C. §§ 164.509(a), 512(d)-(g)(1).

[110] 42 U.S.C. § 164.502(a)(5)(iii).
[111] American Medical Association, *HIPAA Privacy Rule to Support Reproductive Health Care Privacy AMA Drafted Summary of Regulatory Changes in Final Rule* (April 26, 2024), https://www.ama-assn.org/system/files/summary-regulatory-changes-final-rule-reproductive-health-information.pdf (last visited June 27, 2024).
[112] Tennessee et al. v. U.S. Dept. of Health & Human Servs., et al, Case No. 3:25-cv-00025 (E.D. Tenn. Jan. 17, 2025); Texas v. U.S. Dept. of Health & Human Servs., et al, Case. No. 5:24-cv-00204-H (N.D. Tex. Sept. 4, 2024); Purl v. U.S. Dept. of Health & Human Servs., et al., Case No. 2:24-cv-00228-Z (N.D. Tex. Dec. 22, 2024) (enjoining the 2024 HIPAA Rule as to Dr. Purl only).
[113] 21st Century Cures Act: Interoperability, Information Blocking and the ONC Health IT Certification Program, 85 Fed. Reg. 25642 (May 1, 2020) (amending 45 C.F.R. §§ 170, 171), 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking, 89 Fed. Reg. 54662 (July 1, 2024) (amending 42 C.F.R. §§ 171 414, 425, 495). Not all healthcare providers are currently subject to the disincentives included in the 2024 rule. However, the Centers for Medicare & Medicaid Services (CMS) may apply disincentives to certain hospitals and merit-based incentive payment system (MIPS) eligible clinicians. HHS intends to expand disincentives to other groups of health care providers in future rulemaking.
[114] In addition to the federal government, some states have taken steps to address vulnerabilities in this information sharing, specifically for abortion and gender-affirming care. For example, in 2023, Maryland and California passed bills that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure.
[115] N.D. Cent. Code § 15.1-19-06 ("No person while acting in an official capacity as an employee or agent of a school district may refer a student to another person, agency, or entity for the purpose of obtaining an abortion. This provision does not extend to private communications between the employee or agent and a child of the employee or agent. . . . A person acting in an official capacity as an employee or agent of a school district, between normal childbirth and abortion, shall give preference, encouragement, and support to normal childbirth.").
[116] N.D.C.C. § 14-02.3-01.
[117] N.D.C.C. § 14-02.1-02(3).
[118] In prior litigation regarding the medication abortion restrictions, the State took the position that misoprostol is not included in the definition because it merely "expels the contents of the uterus and does not cause or induce the death of an unborn child" and, thus, is not "prescribed or dispensed with the intent of causing an abortion." *MKB Mgmt. Corp.*, 2014 ND 197 ¶ 50, 855 N.W.2d 31.
[119] N.D.C.C. § 14-02.1-03.5(1)-(2), (5).
[120] N.D.C.C. § 14-02.1-03.5(3).
[121] N.D.C.C. § 14-02.1-03.5(4).
[122] *Id.*
[123] *Id.*
[124] N.D.C.C. § 14-02.1-09.
[125] N.D. Admin. Code 33-03-02-05.
[126] *Id.*
[127] N.D.C.C. § 14-02.1-11.