ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

NORTH DAKOTA

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.

Last updated July 2026

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.

Abortion is prohibited under North Dakota law unless (1) the “probable gestational age” is six weeks or less and the pregnancy is the result of rape or incest, or (2) the abortion is “deemed necessary based on reasonable medical judgment” and “intended to prevent” death or “a serious health risk.”

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State Constitutional Protection for Life- and Health-Saving 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]

In September 2024, a North Dakota trial court declared the ban unconstitutional because it violated this constitutional right and violated the due process rights of physicians by using vague and confusing language.[2] In November 2025, the North Dakota Supreme Court reversed that ruling, and put the ban back in place.[3] Although three out of five Supreme Court Justices agreed that the law was unconstitutionally vague, North Dakota law requires that at least four Justices find a law is unconstitutional.[4] As a result, the abortion ban is back in effect.

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]reat[ing] a woman for an ectopic pregnancy;" or (c) "[t]reat[ing] a woman for a molar pregnancy."[5] 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, and 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 was 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).

Abortion Ban: North Dakota's Abortion Ban criminalizes abortion, with three exceptions (discussed below).[6] Outside of the exceptions, it is a class C felony for anyone (other than the pregnant

person) to perform an abortion.[7] Class C felonies are punishable by up to five years' imprisonment and/or a $10,000 fine.[8]

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.[9] 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.[10] 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.[11] On November 21, 2025, the North Dakota Supreme Court reversed the state trial court ruling that the Ban was unconstitutional, and put the Ban back in place.[12] Although three out of five Supreme Court Justices agreed that the law was unconstitutional because of its use of vague language, a supermajority of four justices would have been required to declare the Ban unconstitutional.[13]

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).[14] Specifically, the law prohibits "intentionally caus[ing] the death of a living intact fetus while that living intact fetus is partially born."[15] "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."[16] 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."[17] 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."[18] Violation of the D&X ban is a class AA felony, punishable by a maximum penalty of life imprisonment without parole.[19]

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"),[20] 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."[21] 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."[22] 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)."[23] Violation of the requirement is a class C felony.[24]

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.[25] Violation of this requirement is a class A misdemeanor, punishable by up to 360 days' imprisonment and/or a $3,000 fine.[26] 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.[27] Violation of this prohibition is a class B misdemeanor, punishable by up to thirty days' imprisonment and/or a fine of $1,500.[28]

Physician-Only Restriction: Abortions may only be performed by North Dakota-licensed physicians.[29] 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.[30]

Physician Education Requirement: As of January 1, 2026, a physician may not perform an abortion unless they have reviewed an instructional course about North Dakota's Abortion Ban, the Abortion Control Act, and the D&X ban on the Board of Medicine's website in the past two years.[31] This does not apply in the case of a medical emergency.[32] As of October 2025, it is not clear what information will be included in this instructional course, and the attorney general has final approval of its contents.[33]

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.[34] The physician must also certify in writing the pregnant person's marital status and age based upon proof of age offered by her.[35] Physicians may not receive or obtain payment for the abortion until the mandated 24-hour delay has elapsed.[36]

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.[37] 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.[38] 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.[39]

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.[40]

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.[41] However, for unmarried, minors, the attending physician must obtain written consent from both parents.[42] If one parent is deceased or if the parents are separated/divorced, the surviving or custodial parent, respectively, must provide written consent.[43] If the minor is subject to guardianship, the legal guardian(s) must provide written consent.[44] A minor may seek judicial bypass of the parental consent requirements in juvenile court.[45] 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").[46]

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.[47] 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.[48] 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.[49]

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."[50] "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."[51] "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."[52] 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."[53] "Probable gestational age" is defined as "what, in reasonable medical judgment, will with reasonable probability be the gestational age of the unborn child."[54]

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.[55]

EMTALA

A federal law called the Emergency Medical Treatment & Labor Act ("EMTALA") requires the provision of abortion care when necessary to stabilize an emergency medical condition. Specifically, EMTALA requires hospitals with emergency departments that participate in Medicare (i.e., most hospitals) to perform a medical screening

exam for any individual who comes to the emergency department and requests evaluation or treatment, in order to determine whether the individual has an emergency medical condition.[56] 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."[57] Additionally, "with respect to a pregnant woman who is having contractions," an "emergency medical condition" is further defined to include when "there is inadequate time to effect a safe transfer to another hospital before delivery" or when "transfer may pose a threat to the health or safety of the woman or the unborn child."[58]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[59] including people in labor or with emergency pregnancy complications,[60] unless the individual refuses to consent to such treatment.[61] 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."[62] A person experiencing an emergency medical condition can be transferred to a different hospital only once they are stable or if certain other conditions are met, such as the medical benefits of transfer outweighing the increased risks to the person experiencing the emergency medical condition.[63] 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."[64]

Where abortion, including the premature delivery of a non-viable fetus, is the medical treatment necessary to, within a reasonable probability, ensure no material deterioration of an individual's condition, EMTALA requires a covered hospital provide such care or, if the aforementioned criteria are met, an appropriate transfer. The U.S. Department of Health and Human Services ("HHS") has reaffirmed these requirements numerous times.[65]

Most recently, on June 13, 2025, HHS Secretary Robert F. Kennedy distributed a letter to health care providers reiterating that, notwithstanding the recent rescission of earlier guidance on the subject, "EMTALA continues to ensure pregnant women facing medical emergencies have access to stabilizing care."[66] The letter specifically states that EMTALA "applies equally to expectant mothers facing obstetric emergencies, including ectopic pregnancies, miscarriages, premature ruptures of membranes, trophoblastic tumors, and other similar conditions."[67] And, during a June 24, 2025, subcommittee hearing in the U.S. House of Representatives, Secretary Kennedy was asked explicitly about whether he agreed that in some circumstances abortion is the necessary stabilizing care that EMTALA requires hospitals to provide, to which he responded, "Yes, and that is what President Trump believes."[68] Further, as recently as May 2025, HHS announced that it had cited at least one hospital in Texas for violating EMTALA by failing to properly screen a patient with an ectopic pregnancy, an emergency medical condition that threatened the patient's life and future fertility.[69]

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, but with only varying degrees of success.

In January 2025, Idaho's largest hospital system, St. Luke's Health System, filed a lawsuit seeking to

prevent the state of Idaho from enforcing its abortion ban, which creates criminal penalties for the provision of certain emergency abortions required under EMTALA.[70] St. Luke's was successful in obtaining a preliminary injunction that prevents the state of Idaho from enforcing its abortion ban "against St. Luke's or any of its medical providers as applied to medical care required by [EMTALA]."[71] Litigation in that case is ongoing. St. Luke's case is related to one brought in 2022 by the Biden Administration, *United States v. Idaho*, in which the federal government sued Idaho challenging its abortion ban to the extent that it conflicted with EMTALA.[72] That case made it all the way to the U.S. Supreme Court, where the appeal was ultimately dismissed as prematurely granted in June 2024.[73] Following the change of presidential administrations, the United States dismissed that case entirely. [74]

And, in October 2024, the U.S. Supreme Court refused to review a Fifth Circuit decision that affirmed a lower court decision blocking federal enforcement of EMTALA in certain circumstances in Texas and as to other organizational plaintiffs in that case.[75] As a result, the Fifth Circuit's decision is final.[76,77]

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.[78]

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.[79]

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.[80]

Resident Training: The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[81] 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.[82]

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.[83] The only abortion-specific documentation and reporting requirements are listed below. Any violation of North Dakota's documentation and reporting requirements is a class A misdemeanor, punishable by up to 360 days imprisonment and/or a $3,000 fine.[84]

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."[85] 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.[86] 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.[87] The records must be maintained for at least seven years.[88]

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.[89] 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.[90] These requirements do not apply to hospitals in which abortions are performed.[91]

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.[92]

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 D&X ban, and nondiscrimination protections for choosing not to participate in an abortion.[93] 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.[94] 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.[95] Abortion compliance reports received by NDHHS are public records.[96] A copy must be made part of the patient's medical record.[97]

The abortion data report must be confidential and cannot contain the name of the pregnant person.[98] 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.[99] All abortion data reports must be signed by the attending physician and submitted to NDHHS within 30 days from the date of the abortion.[100] A copy must also be made part of the patient's medical record.[101]

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.[102] The form must be used by the hospital or facility in which the abortion was performed.[103]

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.[104] A copy of the report must be made a part of the patient's medical record.[105] 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.[106]

"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."[107] 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.[108] A copy of the report must be made a part of the patient's medical record.[109]

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."[110] 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."[111]

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."[112] When the fetal death occurs in an "institution," which includes abortion clinics and hospitals,[113] 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.[114] 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.[115]

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.[116] These records must be made available to the state registrar for inspection upon demand.[117]

Other Mandatory Reporting: All other general mandatory reporting to North Dakota Child Protection Services, local law enforcement, etc., also applies for abortion patients.[118] 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. Hospital and other healthcare systems often use their EMR's default settings that widely share patient records.[119] Though these settings are often helpful for continuity of care, they 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.[120, 121]

EMRs have settings that can limit sharing of certain records and/or allow patients to choose how and when their records are shared, but because these are not the default settings, healthcare systems often must take steps to implement them.[122] For example, one EMR, Epic, has a filter that each Epic healthcare system can choose to turn on that exclusively blocks abortion care information from patients' externally-shared medical records, while allowing each patient's other medical records to be transmitted in full, in line

with their authorization. We encourage you to discuss with your institution's general counsel and/or compliance or technology officers counsel

alternative settings such as this that can protect abortion patient information while also complying with any other legal requirements.[123]

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.[124] State funds also cannot be used to pay for the performance or to promote the performance of abortion unless the abortion is necessary to save the life of the pregnant person.[125]

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."[126] It is unclear whether the definition of "abortion-inducing drug" only applies to mifepristone or whether it also includes misoprostol.[127]

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."[128] The physician must provide the pregnant patient with a copy of the drug's label.[129] 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.[130] The patient must be provided with the name and telephone number of the second physician and hospital.[131] The prescribing physician must produce the signed contract on demand by the patient, state health department, or a criminal justice agency.[132]

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.[133] North Dakota regulations define "humane disposal of a nonviable fetus" as consisting of "incineration, burial, or cremation."[134] 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.[135] Any failure to dispose of fetal remains in accordance with these requirements is a class A misdemeanor, punishable by up to 360 days imprisonment and/or a $3,000 fine.[136]

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), National Women's Law Center (NWLC), and Resources for Abortion Delivery (RAD).

References

[1] *Wrigley v. Romanick*, 2023 N.D. 50, ¶ 27.
[2] *Access Indep. Health Servs., Inc., v. Wrigley*, No. 20240291 (N.D. S. Cent. Dist. Ct. Sept. 12, 2024).
[3] *Access Indep. Health Servs., Inc., v. Wrigley*, 2025 ND 199.
[4] N.D. Const. art. VI, § 4.
[5] 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.").
[6] N.D. Cent. Code ch. 12.1-19.1.
[7] *Id.* § 12.1-19.1-02.
[8] N.D. Cent. Code § 12.1-32-01(4).
[9] 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.
[10] *See generally Access Indep. Health Servs., Inc., v. Wrigley*, 2025 N.D. 26.
[11] *Id.* ¶ 51 n.1 (Tufte, J., dissenting).
[12] *Access Indep. Health Servs., Inc., v. Wrigley*, 2025 ND 199.
[13] N.D. Const. art. VI, § 4.
[14] N.D. Cent. Code § 14-02.6-02(1).
[15] *Id.*
[16] *Id.* § 14-02.6-01(1).
[17] *Id.* §§ 14-02.6-02(2), -01(2).
[18] *Id.* § 14-02.6-03.
[19] *Id.* § 14-02.6-02(1); N.D. Cent. Code § 12.1-32-01(1).
[20] N.D. Cent. Code § 14-02.1-02(16).

[21] *Id.* § 14-02.1-05.
[22] *Id.*
[23] N.D. Admin. Code. § 33-03-02-02.
[24] N.D. Cent. Code § 14-02.1-05.
[25] N.D. Cent. Code § 14-02.1-04(2).
[26] *Id.* § 14-02.1-04(4); N.D. Cent. Code § 12.1-32-01(5).
[27] N.D. Cent. Code § 14-02.3-04.
[28] *Id.* § 14-02.3-05; N.D. Cent. Code § 12.1-32-01(6).
[29] N.D. Cent. Code § 14-02.1-04(1).
[30] *Id.*
[31] H.B. 1511, 69th Leg. Assemb., Reg. Sess. (N.D. 2025).
[32] *Id.*
[33] *Id.*
[34] 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).
[35] N.D. Cent. Code § 14-02.1-03(1).
[36] *Id.* § 14-02.1-02(9)(e).
[37] *Id.* § 14-02.1-03(1).
[38] *Id.*
[39] *Id.*
[40] *Id.* § 14-02.1-03(1), -02(10).
[41] N.D. Cent. Code § 14-02.1-03.1(1)(b).
[42] *Id.* § 14-02.1-03.1(1)(a).
[43] *Id.*
[44] *Id.*
[45] *See, e.g.*, N.D. Cent. Code §§ 14-02.3-02.1, -03, -03.1, -03.4.
[46] *Id.* § 14-02.1-03.1(12), -02(10).
[47] N.D. Cent. Code § 12.1-19.1-03(1).
[48] *Id.* § 12.1-19.1-03(2).
[49] *Id.* § 12.1-19.1-03(3).
[50] *Id.* § 12.1-19.1-03(1).
[51] *Id.* § 12.1-19.1-01(4).
[52] *Id.* § 12.1-19.1-01(5).
[53] *Id.* § 12.1-19.1-03(2).
[54] *Id.* § 12.1-19.1-01(3).
[55] *Id.* § 12.1-19.1-03(3).
[56] EMTALA, 42 U.S.C. § 1395dd(a).
[57] EMTALA, 42 U.S.C. § 1395dd(e)(1)(A).
[58] EMTALA, 42 U.S.C. § 1395dd(e)(1)(B).
[59] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[60] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[61] EMTALA, 42 U.S.C. § 1395dd(b)(2).
[62] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[63] 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).
[64] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[65] For example, in 2022, the Biden Administration issued guidance reiterating past administrative statements that the treatment required by EMTALA includes abortion care when such care is necessary to stabilize a pregnant person's emergency medical condition. Ctrs. for Medicare & Medicaid Servs., *Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (updated July 2022) ("2022 EMTALA Guidance"). While this guidance has

since been rescinded, the requirements of EMTALA as outlined in it and other prior HHS statements have not changed. Indeed, in the Trump Administration's June 3, 2025 statement rescinding the 2022 guidance, the Administration stated that "CMS will continue to enforce EMTALA . . . including for identified emergency medical conditions that place the health of a pregnant woman or unborn child in serious jeopardy." Ctrs. for Medicare & Medicaid Servs., *CMS Statement on Emergency Medical Treatment and Labor Act (EMTALA)* (June 3, 2025); *see also* Letter from Robert F. Kennedy Jr., Sec'y, U.S. Dep't of Health & Hum. Servs., to Healthcare Providers (June 13, 2025) ("Kennedy Letter"), available at https://essentialhospitals.org/wp-content/uploads/2025/06/6.13.25-EMTALA-letter-final.pdf.pdf.

[66] Kennedy Letter.

[67] Kennedy Letter.

[68] *Hearing on the Fiscal Year 2026 Dep't of Health and Hum. Servs. Budget Before the H. Comm. on Energy & Com., Subcomm. on Health,* 119th Cong. (2025) (statement of Robert F. Kennedy Jr., Sec'y of Health & Hum. Serv.).

[69] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated May 8, 2025).

[70] *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).

[71] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).

[72] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).

[73] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).

[74] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).

[75] *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).

[76] *Texas v. Becerra*, 89 F.4th 529, 546 (5th Cir. 2024) (affirming permanent injunction barring HHS from enforcing the 2022 EMTALA Guidance's "interpretation that Texas abortion laws are preempted by EMTALA" and "it's interpretation of EMTALA—both as to when an abortion is required and EMTALA's effect on state laws governing abortion—within the State of Texas or against [plaintiff organizations'] members."); *see also* 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).

[77] 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 plaintiff voluntarily dismissed that action on June 3, 2025.

[78] 42 C.F.R. § 482.13(a)(1), (b)(1)–(2).

[79] 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).

[80] N.D. Cent. Code § 28-01-46.

[81] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 3, 2025).

[82] 42 U.S.C. § 238n.

[83] 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.

[84] N.D. Cent. Code §§ 14-02.1-11, 12.1-32-01(5).

[85] N.D. Cent. Code § 14-02.1-07(1)(a).

[86] *Id.*

[87] *Id.* § 14-02.1-07(1)(b).

[88] *Id.* § 14-02.1-07(1)(c).

[89] *Id.* § 14-02.1-07(1)(a).

[90] *Id.*

[91] *See id.* ("All abortion facilities shall keep the following records").

[92] N.D. Cent. Code § 14-02.1-07(2)(a).

[93] *Id.* § 14-02.1-02.2.

[94] *Id.* § 14-02.1-07(2)(b).

[95] *Id.*

[96] *Id.* § 14-02.1-07(2)(d).
[97] *Id.* § 14-02.1-07(2)(c).
[98] *Id.* § 14-02.1-07(2)(a).
[99] *Id.* § 14-02.1-02.2.
[100] *Id.* § 14-02.1-07(2)(b).
[101] *Id.* § 14-02.1-07(2)(c).
[102] N.D. Admin. Code 33-03-02-03.
[103] *Id.*
[104] N.D. Cent. Code § 14-02.1-07(2)(b).
[105] *Id.* § 14-02.1-07(2)(c).
[106] *Id.*
[107] N.D. Cent Code § 14-02.1-07(2)(b).
[108] *Id.*
[109] *Id.* § 14-02.1-07(2)(c).
[110] N.D. Cent. Code § 23-02.1-01(8).
[111] *Id.*
[112] *Id.* § 23-02.1-20(1).
[113] *See id.* § 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 . . .").
[114] *Id.* § 23-02.1-20(2).
[115] *Id.* § 23-02.1-30(5).
[116] *Id.* § 23-01.1-30(2).
[117] *Id.* § 23-02.1-30(4).
[118] 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.
[119] For example, an EMR may employ a tool that securely shares information among healthcare institutions that use the same EMR (e.g., from one hospital system to another) and allows robust sharing among affiliated healthcare institutions (e.g., a Texas hospital treating a patient may be able to see the patient's records from an Illinois hospital within the same health system).
[120] 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.
[121] Some states have taken steps to address vulnerabilities in information sharing, specifically for abortion and gender-affirming care. For example, Maryland and California, among other states, have enacted laws that restrict disclosure of abortion-related records and require EMRs to develop tools to limit or prohibit such disclosure. *See, e.g.,* H.B. 812, 445th Leg., Reg. Sess. (Md. 2023), A.B. 352, 2023 Leg., Reg. Sess. (Cal. 2023).
While the federal government under the Biden administration created additional HIPAA protections related to the disclosure of reproductive health care records by issuing a HIPAA Reproductive Health Rule, in 2025, a federal district court vacated the rule nationwide and the requirements of the rule are no longer in effect (except for the notice of privacy practices provisions related to substance use disorder treatment records, which went into effect on February 16, 2026). HIPAA Privacy Rule to Support Reproductive Health Care Privacy, 89 Fed. Reg. 32976 (2024) (modifying 45 C.F.R. §§ 160, 164), *Purl v. U.S. Dep't of Health & Hum. Servs.*, No. 2:24-cv-228-Z (N.D. Tex. Jun 18, 2025) (vacating the majority of the rule). All HIPAA protections that were in place prior to this rule remain in place.
[122] Many of these setting options are quite broad, blocking not only a subsequent provider's access to more "sensitive" information, but also to less sensitive information that is critical to continuity of care. For this reason, many patients may not want to limit access to their records.
[123] E.g., healthcare institutions must comply with interoperability rules that penalize certain information blocking (though exceptions are available). *See* 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). *See also* Health Data, Technology, and Interoperability: Protecting Care Access, 89 Fed. Reg. 102512 (Dec. 17, 2024) (adding 45 C.F.R. § 171.206 to except information blocking practices intended to reduce potential exposure to legal action based on lawful reproductive health care provision, subject to certain conditions). 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.

[124] 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.").

[125] *Id.* § 14-02.3-01.

[126] N.D. Cent. Code § 14-02.1-02(3).

[127] 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.

[128] N.D. Cent. Code § 14-02.1-03.5(1)-(2), (5).

[129] *Id.* § 14-02.1-03.5(3).

[130] *Id.* § 14-02.1-03.5(4).

[131] *Id.*

[132] *Id.*

[133] N.D. Cent. Code § 14-02.1-09.

[134] N.D. Admin. Code 33-03-02-05.

[135] *Id.*

[136] N.D. Cent. Code §§ 14-02.1-11, 23.1-32-01(5).