ABORTION DEFENSE NETWORK

Know Your State's Abortion Laws

A Guide for Medical Professionals

SOUTH 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 October 2025

Key Takeaways

Providing contraception, including emergency contraception, is legal.

Providing medical care for ectopic pregnancies and miscarriages is legal.

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

Abortion is prohibited under South Dakota law unless there is “appropriate and reasonable medical judgement” that an abortion is necessary to preserve the life of the pregnant person.

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Definition of Abortion & Contraception

ABORTION

The legal definition of abortion in South Dakota is "the intentional termination of the life of a human being in the uterus."[1] South Dakota law asserts that "all abortions, whether surgically or chemically induced, terminate the life of a whole, separate, unique, living human being."[2] The South Dakota Department of Health has stated[3] that "[i]ntent plays a crucial role" in defining abortion, and therefore the treatment for a miscarriage, ectopic pregnancy, or in a situation "where the fetus never forms" are not considered abortions, and physicians should treat these conditions as "they always have" with the most "clinically appropriate procedure."[4]

No law prevents treating a patient who has self-managed an abortion and required subsequent medical care after the abortion.

CONTRACEPTION

Contraception is not illegal in any state in the country. South Dakota does not explicitly define contraception in its statutory code. There are also no restrictions on what types of contraceptives are available, including for emergency contraception.

Abortion Bans

Total Ban: South Dakota bans abortion "unless there is appropriate and reasonable medical judgment that performance of an abortion is necessary to preserve the life of the pregnant [person]."[5] Violation of the law is a Class 6 felony, and violators are subject to two years imprisonment, a $4,000 fine, or both.[6]

Other Bans & Restrictions: South Dakota has other bans and restrictions on abortion, some of which have emergency exceptions. South Dakota prohibits dilation and extraction ("D&X") procedures, with civil penalties for violation of this provision.[7] Abortions sought due to a fetal Down syndrome diagnosis or suspicion of potential diagnosis are also prohibited, with possible civil penalties for violating this provision.[8]

South Dakota also has a pre-abortion disclosure requirement;[9] a mandatory ultrasound requirement;[10] and a mandatory waiting period of 72-hours between the initial consultation and the procedure or dispensing of medication abortion, all of which have emergency exceptions.[11] During the initial consultation, the physician must provide the patient with a list of registered crisis pregnancy centers and instruct the patient to have a consultation with one of the centers.[12] The physician must have a written statement from the patient that the patient obtained a consultation from a specified crisis pregnancy center prior to consenting to the abortion procedure.[13]

There is an affirmative duty on the physician to assess that the patient is not being coerced into seeking an abortion, though this is not required in certain medical emergencies.[14] As part of assessing that the patient is not being coerced into seeking an abortion, physicians "shall obtain from the pregnant mother the age or approximate age of the father of the unborn child, and the physician shall consider whether any disparity in age between the mother and father is a factor when determining whether the pregnant mother has been subjected to pressure, undue influence, or coercion."[15]

In South Dakota, parents or guardians must receive notice at least 48 hours before an abortion procedure takes place. A young patient may seek a judge's permission in lieu of this notice requirement.[16] Notice is not required in medical emergencies where there is not enough time to provide it; however, notice must be sent 24 hours after the emergency abortion has been performed unless the young patient seeks a judicial waiver.[17]

Performing an abortion sought for reasons based on the sex of the fetus is prohibited and a Class C felony with no emergency exceptions and potential life imprisonment, a harsher punishment than the state's total abortion ban.[18] South Dakota has a physician-only requirement—meaning a only a physician can perform an abortion—and there is no emergency exception for this requirement.[19]

Abortion Ban Exceptions

South Dakota's abortion ban has an exception to save the life of the pregnant person.[20] The South Dakota Department of Health stated that "South Dakota law does not require a woman be critically ill or actively dying for a needed medical intervention to end the pregnancy."[21] The Department provided a "non-exhaustive list of conditions that could necessitate ending a pregnancy pre-viability, including the following:

- The presence of active hemorrhage into the peritoneal cavity, pelvic cavity, pelvic organs, or through the cervical canal associated with a maternal hemoglobin of less than 9.0 grams per deciliter, hematocrit less than 27.0, or profuse bleeding;
- Intrauterine infection as defined by 2 or more signs including: maternal fever greater than 100.4 degrees, uterine tenderness, persistent maternal heart rate greater than 100, persistent fetal heart rate greater than 160, or foul-smelling discharge through the cervical ostium;
- Premature rupture of the membranes prior to 24 weeks gestational age;
- Severe hyperemesis gravidarum as evidenced by 3 or more hospital stays for dehydration and hypokalemia (that is, blood potassium levels of less than 3 milliequivalents per liter) that is unresolved by multiple medication therapy;
- Cardiovascular collapse associated with obstetric conditions (such as amniotic fluid embolus) or non-obstetric conditions;
- Preeclampsia with severe features, including Hemolysis, Elevated Liver enzyme levels, and Low Platlet levels (HELLP) syndrome or mirror syndrome, occurring prior to 24 weeks gestational age;
- Acute Fatty Liver of Pregnancy;
- Partial molar pregnancy;
- Hemolytic Uremic Syndrome or Thrombotic Thrombocytopenic Purpura;
- Chronic or acute kidney disease with serum creatinine level of 1.4 or greater;
- Prior or planned solid organ transplant;
- Current maternal malignancy;
- Poorly controlled autoimmune disease, such as catastrophic antiphospholipid syndrome, scleroderma renal crisis, or severe lupus nephritis; or
- Substantial cardiovascular disease as defined by WHO III and IV."[22]

However, the Department noted that physicians still must use their medical judgment, as an abortion is not always permitted in these circumstances if the life of the pregnant person is not endangered.[23] The Department stated that physicians should "thoroughly document" the clinical assessment that led to their conclusion that an abortion is necessary to save the life of the pregnant patient.[24]

Other Legal Requirements: The physician that conducted the initial consultation may obtain informed consent from the patient and perform the abortion procedure or dispense the medication abortion, "unless serious unforeseen circumstances prevent that physician from taking the consent and performing the abortion."[25] Physicians are required to use a specific informed consent form that details the necessary disclosures.[26] However, the informed consent requirements discussed above do not apply

in situations where "consent is impossible due to a medical emergency," or where delaying the procedure to obtain informed consent from the patient or their "next of kin" is "impossible."[27] The term "medical emergency" is defined as "any condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function."[28] Hospitals may refuse to admit patients "for the purpose of terminating a pregnancy."[29]

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.[30] 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."[31] 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."[32]

EMTALA requires stabilizing medical treatment be provided to any individual experiencing an emergency medical condition,[33] including people in labor or with emergency pregnancy complications,[34] unless the individual refuses to consent to such treatment.[35] 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."[36] 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.[37] 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."[38]

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.[39]

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."[40] 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."[41] 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." [42] 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.[43]

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.[44] 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]."[45] 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.[46] 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.[47] Following the change of presidential administrations, the United States dismissed that case entirely. [48]

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.[49] As a result, the Fifth Circuit's decision is final.[50] [51]

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.[52]
- **Protection Against Discrimination in Employment:** The federal law known as the Church Amendments prohibits hospitals that receive certain federal funds from discriminating against health care providers who participate or are willing to participate in abortion care or sterilization procedures.[53]
- **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.[54]
- **Resident Training:** The Accreditation Council for Graduate Medical Education (ACGME) requires that accredited programs provide access to training in the provision of abortion.[55] 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.[56]

Documentation and 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.[57] The South Dakota Department of Health recommends clearly documenting in the patient's medical records the medical reasoning behind providing an abortion under the state's exception to "preserve the life of the pregnant [person]."[58] Hospitals may have specific policies on how to approach documenting emergency abortion procedures. The only abortion-specific reporting requirements are:

Abortion Reporting: Abortion facilities and physicians are required to report specific data to the South Dakota Department of Health, including:

(1) The number of abortions performed;

(2) The method of abortion used in each abortion performed;

(3) Complete pathology reports including the period of gestation of fetuses, the presence of abnormality, and the measurements of fetuses, if the facility where the abortion is performed is equipped to complete the reports;

(4) The number of maternal deaths due directly or indirectly to abortions;

(5) Reports of all follow-up, including short-term and long-term complications due to abortion in the female who received an abortion;

(6) The number of infants who survived an attempted abortion;

(7) Medical action taken to preserve the life of an aborted child born alive;

(8) The outcome for an aborted child born alive, including the child's survival, death, and location of death, if known; and

(9) Any other information required by the department, as authorized by this section.[59]

The above information, along with additional data, is collected by the South Dakota Department of Health on an annual basis, due January 15th of each calendar year.[60]

Minors: Physicians must report the number of notices sent to the parents seeking an abortion, and the number of those young patients that then went on to obtain abortion care.[61] The report must also include the number of abortions performed on young people, and designate the number of patients whose parents received notice and those who fell into other exceptions to the notice requirement (such as the minor being emancipated, or the minor obtaining a judicial waiver).[62]

Informed Consent Reporting: Physicians must report to the South Dakota Department of Health the number of patients the physician provided the mandatory informed consent information to.[63] Physicians must also report the number of patients the physician provided information about medical assistance, child support, other potential programs, and the written state-provided disclosures.[64] Physicians must report the number of patients who requested a copy of written disclosures, and of those, how many then obtained abortion care.[65] The physician must report the number of patients who declined or opted to view the mandatory sonogram, as well as those that went onto receive abortion care after viewing the sonogram.[66] The physician must report abortions that were performed without the required disclosures due to a medical emergency that

necessitated abortion care to save the life of the patient.[67] In the initial consultation, the physician must also evaluate whether the patient has any alleged "risk factors" that coincide with "adverse psychological outcomes following an abortion," including: (a) coercion; (b) pressure from others to have an abortion; (c) the pregnant mother views an abortion to be in conflict with her personal or religious values; (d) he pregnant mother is ambivalent about her decision to have an abortion, or finds the decision of whether to have an abortion difficult and she has a high degree of decisional distress; (e) that the pregnant mother has a commitment to the pregnancy or prefers to carry the child to term; (f) the pregnant mother has a medical history that includes a pre-abortion mental health or psychiatric problem; and (g) the pregnant mother is twenty-two years old or younger[68] The physician must indicate in the patient's medical records which factors are or are not present, and note in the patient's medical record that the physician discussed any present alleged risk factors with the patient.[69]

Fetal Death Reporting: South Dakota law requires "[a] fetal death report for the death of each fetus which has attained a gestational age of not less than twenty completed weeks and is not an abortion."[70] The report must be filed by the "physician or other person in attendance at or after the delivery . . . to the Department of Health within seven days of delivery."[71] South Dakota defines the term "stillbirth" to be "any intrauterine fetal death occurring in this state after a gestational age of not less than twenty completed weeks."[72] In instances where a stillbirth occurs, according to the South Dakota definition, a physician must also "advise the parent or parents of a stillborn child" that they may request a birth certificate, and the means to contact the Department of Health to do so.[73] There are no fetal death reporting requirements prior to twenty weeks gestation.

Other Mandatory Reporting: All other general mandatory reporting also applies for abortion patients.[74] This includes reporting known or suspected child abuse or neglect.[75] Child abuse and neglect include sexual abuse, molestation, or exploitation "by the child's parent, guardian, custodian, or any other person responsible for the child's care."[76]

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.[77] 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.[78, 79]

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.[80] 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.[81]

Counseling and Referral

Speech about abortion is legal in South Dakota. Medical professionals, and those in other profession where "the abortion question may appear as part of their workday routine," can refer patients to medical

providers in states where abortion is legal, and assist in arranging for the patient's abortion care in another state.[82]

Medication Abortion

South Dakota limits the use of medication abortion to nine weeks gestation.[83] The physician that provided the informed consent materials and mandatory disclosures must administer the initial Mifepristone dose, "unless serious unforeseen circumstances prevent that physician from taking the consent and performing the abortion."[84] The patient must take the first dose of mifepristone at the medical facility, wait for a suitable observation period, and then may return home.[85] The patient then must return to the facility 24-72 hours for Misoprostol, which must be dispensed by the same physician.[86] The patient is required to schedule a follow-up appointment 14 days after taking the medication.[87] Pharmacists may refuse to dispense medication abortion and contraceptives in South Dakota.[88]

Disposition of Fetal Tissue Remains

Unless the abortion was to prevent the death of the pregnant person, "any tissue, organ, or body part . . . may not be used in animal or human research or for animal or human transplantation."[89]

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).

ACLU

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Justice for Her. Justice for All.

RAD RESOURCES FOR ABORTION DELIVERY

References

[1] S.D. CODIFIED LAWS § 34-23A-1.

[2] *Id.* § 34-23A-1.2.

[3] Under South Dakota Codified Laws § 34-23A-94, the Department of Health was required to create an informational video that describes "acts that do and do not constitute an abortion," and "common medical conditions that threaten the life or health of a pregnant woman." South Dakota requires this video to list "the generally accepted standards of care

applicable to the treatment of a pregnant woman experiencing life-threatening or health-threatening medical conditions" as well as "criteria" a physician "might use in determining the best course of treatment for a pregnant woman experiencing life-threatening conditions." *Id.*

[4] South Dakota Department of Health, *Medical Education & Guidance | South Dakota's Law & Medical Conditions*, YouTube (Sept. 4, 2024), at 0:56, https://www.youtube.com/watch?v=vrYxPkSzTTw&t=96s.

[5] S.D. CODIFIED LAWS § 22-17-5.1.

[6] *Id.* § 22-17-5.1; § 22-6-1.

[7] *Id.* §§ 34-23A-27; 34-23A-29; 34-23A-30; 34-23A-31; 34-23A-32; 34-23A-33 (there is an exception to prohibition on the D&X procedure where the procedure is "necessary to save the life of the mother because her life is endangered by a physical disorder, illness, or injury, including a life-endangering condition caused by or arising from the pregnancy itself, if no other medical procedure would suffice." *Id.* § 34-23A-28).

[8] *Id.* §§ 34-23A-89; 34-23A-90; 34-23A-91; 34-23A-93. There is an exception to this rule for "any abortion that is necessary to save the life of the pregnant woman because her life is endangered by a physical disorder, illness, or injury, including a life-endangering condition caused by or arising from the pregnancy itself, if no other medical procedure would suffice for that purpose." *Id.* § 34-23A-92.

[9] *Id.* §§ 34-23A-10.1; 34-23A-22 (there is an exception if making the disclosures to obtain informed consent from either the patient or a next of kin would be "impossible due to a medical emergency." The determination that the medical emergency made it impossible to make these disclosures must be "documented in the medical records of the patient.").

[10] *Id.* §§ 34-23A-52; 34-23A-52.1 (the ultrasound is not required in the case of a medical emergency, and the physician must "certify the specific medical conditions that constitute the emergency" in the patients medical records).

[11] *Id.* §§ 34-23A-10.1; 34-23A-56; 34-23A-1(5) (the waiting period is not required when there is a "medical emergency," defined as "any condition which, on the basis of the physician's good faith clinic judgment, so complicated the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.).

[12] *Id.* §§ 34-23A-56(3)(b); 34-23A-10.1(the requirements that the patient consult a crisis pregnancy center is not required in the case of a "medical emergency," as defined above in 34-23A-1(5)).

[13] § 34-23A-56(3)(b) (note that the portions of § 35-23A-56 requiring a consultation from a crisis pregnancy center were enjoined temporarily, until the injunction was lifted in 2022. *Planned Parenthood Minnesota, N. Dakota, S. Dakota v. Noem*, No. 21-2913, 2022 WL 18861791, at *1 (8th Cir. Oct. 6, 2022)).

[14] *Id.* § 34-23A-56.

[15] *Id.* (note that there is an exception to this requirement for "medical emergencies," defined in § 34-23A-1(5) as "any condition which, on the basis of the physician's good faith clinic judgment, so complicated the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function").

[16] *Id.* § 34-23A-7.

[17] *Id.* § 34-23A-7(1).

[18] *Id.* §§ 34-23A-63; 34-23A-64.

[19] *Id.* § 36-9A-17.2.

[20] S.D. CODIFIED LAWS § 22-17-5.1.

[21] South Dakota Department of Health, *Medical Education & Guidance | South Dakota's Law & Medical Conditions*, YouTube (Sept. 4, 2024), at 1:37, https://www.youtube.com/watch?v=vrYxPkSzTTw&t=96s (South Dakota law 34-23A-94 required the Department of Health to create this video to "describe . . . [t]he state's abortion law and acts that do and do not constitute an abortion." The video is not official guidance that can be unequivocally relied upon).

[22] *Id.* at 2:20.

[23] *Id.* at 4:21.

[24] *Id.* at 4:36.

[25] *Id.* § 34-23A-57.

[26] S.D. ADMIN. R. 44:67:04.

[27] S.D. CODIFIED LAWS § 34-23A-10.1.

[28] *Id.* § 34-23A-1(5).

[29] *Id.* § 34-23A-14 (note that Medicare-participating hospitals must follow EMTALA, as it is a federal law that takes

precedence over state law in this instance).
[30] EMTALA, 42 U.S.C. § 1395dd(a).
[31] EMTALA, 42 U.S.C. § 1395dd(e)(1)(A).
[32] EMTALA, 42 U.S.C. § 1395dd(e)(1)(B).
[33] EMTALA, 42 U.S.C. § 1395dd(b)(1)(A).
[34] EMTALA, 42 U.S.C. § 1395dd(e)(1).
[35] EMTALA, 42 U.S.C. § 1395dd(b)(2).
[36] EMTALA, 42 U.S.C. § 1395dd(e)(3)(A).
[37] 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).
[38] EMTALA, 42 U.S.C. § 1395dd(c)(1)(B)–(c)(2)(A).
[39] 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.
[40] Kennedy Letter.
[41] Kennedy Letter.
[42] *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.).
[43] Center for Reproductive Rights, *Complaints Against Texas Hospitals for Denying Emergency Care for Ectopic Pregnancies*, (updated May 8, 2025).
[44] *St. Luke's Health System, LTD. v. Labrador*, No. 1:25-cv-00015, ECF No. 1 (D. Idaho Jan 14, 2025).
[45] *St. Luke's Health System, LTD v. Labrador*, No. 1:25-cv-00015, ECF No. 49 at 59 (D. Idaho Mar. 20, 2025).
[46] *United States v. Idaho*, 623 F. Supp. 3d 1096, 1117 (D. Idaho 2022).
[47] *Moyle v. United States*, 144 S. Ct. 2015 (June 27, 2024) (per curiam).
[48] *Idaho v. United States*, No. 1:22-cv-00329, ECF No. 182 (D. Idaho Mar. 5, 2025).
[49] *Becerra v. Texas*, No. 23-1076 (U.S. Oct. 7, 2024) (denying certiorari).
[50] *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).
[51] 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.
[52] 42 C.F.R. §§ 482.13(a)(1), (b)(1), (b)(2).
[53] Know Your Rights: Existing Laws May Protect Health Care Professional Who Provide or Support Abortion from Discrimination in Employment, Nat'l Women's Law Ctr. (Feb. 9, 2023).
[54] S.D. Codified Laws § 21-3-11.
[55] Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* (Sept. 3, 2025).
[56] 42 U.S.C. § 238n.
[57] 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.
[58] S.D. CODIFIED LAWS § 22-17-5.1.
[59] *Id.* § 34-23A-19.
[60] *Id.* §§ 34-23A-34; 34-23A-35.
[61] *Id.* § 34-23A-39; *see also* § 34-23A-7 (requiring notice to parents or guardians 48 hours prior to a minor obtaining abortion care, with specific exceptions for emergencies and for minors who receive a judicial bypass).
[62] *Id.* § 34-23A-39.
[63] *Id.* § 34-23A-37(1).
[64] *Id.* § 34-23A-37(2).
[65] *Id.* § 34-23A-37(3).
[66] *Id.* § 34-23A-37(4).
[67] *Id.* § 34-23A-37(5).
[68] *Id.* §34-23A-56(4).
[69] *Id.* § 34-23A-56.
[70] *Id.* § 34-25-32.1.
[71] *Id.* § 34-25-32.2.
[72] *Id.* § 34-25.32.8.
[73] *Id.* § 34-25-32.9.
[74] 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.
[75] S.D. CODIFIED LAWS § 26-8A-3.
[76] *Id.* § 26-8A-2.
[77] 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).
[78] 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.
[79] 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 go 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.
[80] 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.
[81] 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.

[82] S.D. CODIFIED LAWS § 34-23A-11.

[83] *Id.* § 36-4-47. This restriction on medication abortion was preliminarily enjoined, but the injunction was vacated on July 22, 2022, re-instating enforcement of the restriction. *Planned Parenthood Minnesota, N. Dakota, S. Dakota v. Noem*, No. 22-1362, 2022 WL 3449758, at *1 (8th Cir. July 22, 2022).

[84] S.D. CODIFIED LAWS §§ 36-4-47; 34-23A-57.

[85] *Id.* § 36-4-47.

[86] *Id.*

[87] *Id.*

[88] *Id.* § 36-11-70.

[89] *Id.* § 34-23A-17.