

## Joint Policy Committee

### SB 2402

### January 21, 2026

Chair Lee, Chair Ruby, and members of the Joint Policy Committee, I am Dr. Erica Hofland, an Obstetrician and Gynecologist in Dickinson. Thank you for the opportunity to provide testimony regarding Senate Bill 2402. I am asking this committee to accept and implement the amendments set forth by the North Dakota Board of Medicine to Senate Bill 2402.

For the last 11 years, I have been a practicing Obstetrician and Gynecologist in Dickinson and have provided care to women throughout southwest North Dakota. While I appreciate that the goal of SB 2402 is to expand access to care, this bill in its current form could have unintended and harmful consequences for subsections of the population. I especially have this concern regarding pregnant persons.

When treating urinary tract infections, pregnant patients are managed differently. Several commonly used antibiotics are avoided in pregnancy due to concerns for fetal harm. Some antibiotics may be used at certain gestational ages but not at others. The medications are selected for the stage of fetal development, proximity to delivery, etc. Further, a clear urine culture and sensitivity history is needed for pregnant women, given the lower threshold to start a pregnant woman on daily prophylaxis if concerns for recurrent infection. Daily prophylaxis is sometimes needed to prevent concerns for more serious pyelonephritis, possible sepsis, and associated risks of preterm delivery. The ability to start this therapy is hindered by a lack of culture data.

When it comes to using statins during pregnancy, fetal harm can occur. I have received many seemingly automated insurance and pharmacy letters recommending starting a patient with Type 2 diabetes on a statin. What is not understood by these generated reports is that my patients are at varying stages of

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pregnancy. Statin use is discouraged, except for a select few patients. Those patients who are kept on their medication or started on a statin are typically only done so after extensive counseling and with a multidisciplinary team panel. Therefore, I feel strongly that the prescriptive authority noted in this bill should be removed.

It is also my stance that therapeutic substitution be limited to drug classes as listed by the Board of Medicine. Not all drugs in the same class have the same amount of safety data and history when it comes to pregnancy. While attempts are made by providers to use the “best” medication possible for a fetus, there are also times, paradoxically, that a patient may be continued on a medication that is considered more dangerous than others. An example of this would be a patient with a history of seizure disorder that is only well controlled on a medication that is considered teratogenic. While the medication may increase the risk of fetal harm, this may be outweighed by a patient having uncontrolled seizures and the effect this would have on a developing pregnancy. Nuances in prescribing occur daily and medications should not be substituted without provider input.

The above scenarios are just a few examples of oversights with SB 2402. The amendments provided by the Board of Medicine help limit potential patient safety issues while still allowing the state to pursue funding programs with the Federal Government. I strongly encourage this Committee to adopt the amendments proposed by the Board of Medicine. I would be happy to answer any additional questions.

Sincerely,

Dr. Erica Hofland