Christina Sambor, American College of Obstetricians and Gynecologists, Lobbyist no. 312
Testimony in Opposition to HB 1511
Senate Appropriations Committee – E&E Division
March 25, 2025

Chairman Sorvaag and members of the Senate Judiciary Committee,

My name is Christina Sambor. I am offering testimony in opposition to HB 1511 on behalf of the American College of Obstetricians and Gynecologist, otherwise known as ACOG. I cannot appear in person at the appointed hearing time today due to this hearing being set at the same time as oral argument before the North Dakota Supreme Court in the lawsuit on SB 2150. I will, however, make an effort to reach out to the members of this subcommittee prior to or just after the hearing on this legislation.

Before addressing AGOG's opposition to the substance of HB 1511, I would like to offer our perspective on the appropriation attached to this bill. Spending $50,000 of taxpayer's dollars on an education course that if mandated, should be no longer than 5-10 minutes, is wasteful and unnecessary. South Dakota produced a similar video to that being proposed by HB 1511 and it is 6 minutes in length. Furthermore, the terms of the contract to produce the video should not direct any appropriated funds only to physicians with 25 or more years' experience. Many doctors who submitted testimony in opposition to HB 1511 have addressed in their testimony their strong feeling that the requirement that the contract go to a doctor with more than 25 years' experience is arbitrary as most practicing OBGYNs in the state have fewer years' experience, but are just as, if not more qualified, to practice their specialty than someone with 25 years' experience. Including the 25+ year requirement in the bill creates the appearance that the intent is to direct the contract toward a particular physician.

Moving on to AGOG's substantive objection to HB 1511, there are many pieces of testimony that were offered in opposition to HB 1511 from OBGYNs from across North Dakota. They recount the difficulties doctors have faced since SB2150 was passed. It is not only OBGYNs who are struggling with the meaning of the law and fear of being charged with a crime for providing the standard of care to their patients. It is other medical specialities and hospital legal teams. There is no amount of education from the medical board that is going to remedy the concern.

The issue this legislation purports to address is one that can only be remedied, at this time, by the North Dakota Supreme Court. This is because the law itself was found unconstitutional in District Court due to vagueness in the law, and due to the District Court's finding that the North Dakota Constitution protects the right to abortion. Therefore, this bill requires education on a law that was struck down as unconstitutional and which the ND Supreme Court declined to put back into effect with the appeal is pending. In essence, the Court's concern with the law is that the terminology used in various places does not adequately instruct physicians on whether or when a pregnancy health complication poses a serious health risk so that they clearly know what medical care falls within exceptions to the abortion ban and what care does not. SB 2150 enacted **felony charges** for a physician who violates the law by performing an abortion that does not meet the exceptions outlined

by ND century code. I would like to share several examples that have occurred since SB 2150 was passed that illustrate the very complicated situations physicians in North Dakota have faced.

A patient presented to a hospital in the state with heavy bleeding prior to the time the pregnancy was viable. The ob/gyn evaluating the patient contacted a colleague in the state—a colleague with over 20 years' experience for that matter—who advised her that the patient was "not sick enough" to meet with serious health risk exception. This patient was hemorrhaging and becoming unstable. Thinking that this could not be accurate, this ob/gyn then called a maternal fetal medicine specialist for advice. The specialist's advice to her was that they felt this should meet the health exception. However, the specialist noted they not a lawyer and could not guarantee that someone wouldn't question the decision as running afoul of the law. Despite that, the specialist recommended she provide the standard of care to her patient and if anyone questioned it, the specialist indicated they would be willing to testify on her behalf as to the necessity of the abortion care provided.

A patient presented to a hospital in the state with membrane rupture before viability and had signs of an intra-amniotic infection. The only cure for an intra-amniotic infection is to terminate the pregnancy irrespective of gestational age. The ob/gyn caring for this patient knew that that was the right thing to do and felt it met the serious health risk exception. Unfortunately, her hospital legal team was uncertain, and required her to provide guidelines indicating that this is the standard of care prior to allowing her to proceed with caring for the patient.

A patient presented to a hospital in the state with heavy bleeding to an emergency room and was not evaluated by an ob/gyn. The pregnancy was pre-viable. She was evaluated in the emergency room and according to the patient was discharged and instructed not to return to the hospital again if she has more concerns because they can't care for her due to the ND abortion law.

A colleague with over 25 years of experience called a maternal fetal medicine specialist to give "permission" to terminate a pregnancy at 22 weeks due to fetal anencephaly. Anencephaly is a lethal condition in which the skull is not covering the brain. Most infants who survive to delivery with this condition will die within hours or days of birth. The specialist informed this colleague who had been practicing in the state since the specialist was in elementary school that abortions for fetal anomalies have been illegal since at least 2017. He was unaware of this and planned to send the patient out of state.

These are a few examples to highlight the fact that years of experience does not equate to understanding ND abortion law. There are many more. Additionally, from doctors' experiences, OBGYNs are not the ones questioning the proper course of care. It is colleagues, other specialties, and hospital legal teams. And the reality is that anyone can after the fact question a physician's "reasonable medical judgement" and second guess whether the patient's situation presented a substantial enough danger to meet the serious health risk exception. The fear comes from the thought of someone questioning a doctor's effort to save their patient's life or health by providing an abortion with the benefit of hindsight, and without being there in the moment, and then being charged with a crime.

This requirement from the board will not improve health care providers' understanding of abortion law in ND, nor does it guarantee that they won't face criminal charges for following the advice given in the education. An amendment was added in the House to ensure that doctors have no right of action against the board for relying on the content of the material. So, what is the purpose then if doctors cannot rely on the information?

This requirement will only lead to more confusion and delays in providing patients the appropriate care. As mentioned previously, the law in question is not currently in effect. The lower Court's decision to strike down the law could be upheld by the ND Supreme Court.

In conclusion, obstetricians/gynecologists, family practice physicians, ER physicians, and all physicians and health care providers in this state are doing their best to care for their patients under very difficult circumstances. North Dakota is both a maternity care desert, and a health care desert and already has a shortage of physicians. Adding to their administrative burden to practice here, on top of threats of criminal charges, will only continue to drive physicians away.

Please recommend a DO NOT PASS on 1511.

Christina Sambor