IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
CIVIL DIVISION

EMILY WALDORF; **THERESA VAN**; **CHELSEA STOVALL**; **ALLISON HOWLAND**; and **CHAD B. TAYLOR, M.D.**, on behalf of himself and his patients,

v. CASE NO. _____ PLAINTIFFS

THE STATE OF ARKANSAS; **SARAH HUCKABEE SANDERS**, in her official capacity as Governor of the State of Arkansas; **TIM GRIFFIN**, in his official capacity as Attorney General of Arkansas; **BRANDON CARTER**, in his official capacity as Prosecuting Attorney of Washington and Madison Counties; **DANIEL SHUE**, in his official capacity as Prosecuting Attorney of Sebastian County; **WILL JONES**, in his official capacity as Prosecuting Attorney of Pulaski County; **EDWARD "WARD" GARDNER, M.D.**, in his official capacity as Chairman of the Arkansas State Medical Board; and **DON R. PHILLIPS, M.D.**, **CHRISTOPHER D. DAVIS, P.A.**, **BRAD A. THOMAS, M.D.**, **ELIZABETH ANDERSON**, **MICHAEL J. BIRRER, M.D.**, **SARAH C. BONE, M.D.**, **MARK CAMP**, **RODNEY GRIFFIN, M.D.**, **KENNETH B. JONES, M.D.**, **C. WESLEY KLUCK JR., M.D.**, **BRIAN L. MCGEE, M.D.**, **TIMOTHY C. PADE, M.D.**, and **JOSHUA E. ROLLER, M.D.**, in their official capacities as officers and members of the Arkansas State Medical Board, DEFENDANTS.

COMPLAINT FOR INJUNCTIVE RELIEF
AND DECLARATORY JUDGMENT

The Arkansas Constitution promises its citizens extraordinary rights, not just to the equality and liberty rights all Americans enjoy, but to the "inherent and inalienable rights" of "enjoying and defending life and liberty" and "of pursuing their own happiness." Nothing can be more fundamental to those pursuits than the ability to build your family and protect your own well-being

and that of your children. Arkansas purports to be the "most pro-life state" in the country. Yet the reality of life for Arkansans and their families, particularly since the overturning of *Roe v. Wade*, is anything but. Both scientific evidence and the real, lived experiences of Arkansans show that Arkansas's abortion bans are destroying not only the healthcare infrastructure of the state, but countless lives and families.

Other states have put the legality of abortion to the voters. But not Arkansas. While more than 101,000 Arkansans signed a petition seeking to return legal abortion to Arkansas, state officials allowed a mere paperwork technicality to halt their efforts. In other states, elected officials have sought to clarify their bans or issue guidance to medical professionals. But not in Arkansas. Indeed, when one Arkansan, Emily Waldorf, was denied healthcare in the middle of an obstetrical crisis, lawyers justified their inaction under Arkansas's abortion bans by stating that they simply "cannot rule out the possibility of an overzealous prosecutor." When Ms. Waldorf then contacted Governor Huckabee Sanders' office begging for help, the only advice she received was to "get a lawyer."

So she did.

As Emily Waldorf's experience, as well as those of Theresa Van, Chelsea Stovall, Allison Howland, and Dr. Chad B. Taylor, demonstrate, Arkansas's abortion bans are vague, confusing, and worse, extremely dangerous. Plaintiffs have felt firsthand the perilous risks of relying on travel to other states for access to time-sensitive, fundamental healthcare. How are pregnant Arkansans supposed to access comprehensive obstetric care when leaving Arkansas means traveling through some of the most remote parts of the state, and when Arkansas is surrounded by other states with their own abortion bans? Why should they have to, when their own Constitution protects their fundamental rights to life, liberty, happiness, and equality?

The question is: Are those individual rights and freedoms still within reach for the nearly 600,000 women of child-bearing age in Arkansas? Or is pregnancy alone enough to strip Arkansans of their fundamental rights?

In support of their Complaint for Injunctive Relief and Declaratory Judgment, Plaintiffs allege and state the following:

INTRODUCTION

1. On the same day *Roe v. Wade* was overturned by the United States Supreme Court, June 24, 2022, Arkansas's Attorney General immediately put into effect a complete ban on abortions at all weeks of gestation. Since then, the Attorney General and the other Defendants in this action have enforced two separate abortion bans, Ark. Code §§ 5-61-304, 5-61-404 ("Arkansas's abortion bans"), each containing vague and confusing language regarding the sole exception to the abortion bans—a "medical emergency." The trouble is, in practice, no one knows what that means.

2. Arkansas was recently named the "most pro-life state" in the nation for the sixth year in a row by Americans United for Life, a group best known for drafting anti-abortion model legislation—including the abortion bans now in effect across the country—that has long been pushed by through state legislatures by lobbyists in Arkansas and elsewhere.[1] As she has done repeatedly as Governor, Sarah Huckabee Sanders celebrated this distinction with an official statement from her office.

[1] Neal Earley, *Arkansas Receives Top Ranking as "Most Pro-Life State" from Anti-Abortion Organization*, Ark. Democrat Gazette (Oct. 27, 2025), https://www.arkansasonline.com/news/2025/oct/27/arkansas-receives-top-ranking-as-most-pro-life; *2020 State Legislative Sessions Report: Annual Report on Government Affairs from America's Leader in Life-Affirming Law and Policy*, Ams. United for Life (2020), https://aul.org/wp-content/uploads/2020/10/2020-State-Legislative-Sessions-Report.pdf.

3. Not once has Governor Huckabee Sanders or anyone else in the state government responsible for enforcing Arkansas's abortion bans attempted to decipher, inform, or in any way aid the patients, families, and medical professionals desperate to understand the laws' meaning. Not even when directly asked.

4. Meanwhile, patients and their families have been left to deal with the laws' impact on their lives by themselves, attempting to navigate travel out of state that is often dangerous if not impossible. Ms. Waldorf was only able to get an ambulance transport to Kansas after securing a lawyer to fight for her rights. Ms. Van, meanwhile, was unable to secure travel out of state and was forced to continue her pregnancy for weeks until her daughter's death—at great physical and emotional cost to her and her family. And while Ms. Stovall and Ms. Howland ultimately found transportation out of state, their experiences of being forced to flee their state like criminals just to secure necessary healthcare has caused lasting and traumatic consequences to their lives, their health and well-being, and their relationships.

5. This is an action for injunctive and declaratory relief blocking enforcement of those abortion bans in their entirety. This action is brought by Arkansans whose "inherent and inalienable rights" under the Arkansas Constitution to "equality," to "enjoying and defending [their] life and liberty," and "of pursuing their own happiness" have been deeply infringed by Arkansas's abortion bans. Those bans are also unconstitutionally vague under the Arkansas Constitution, which protects against criminal laws that give insufficient guidance to the accused regarding what conduct is and is not criminal, particularly when "life" and "liberty" is at stake.

6. Arkansas's strong Constitutional protections for individual liberty protect Arkansans against precisely the harms that the state's abortion bans have inflicted on too many of

its citizens already. Arkansas's abortion bans cannot survive constitutional review and must be struck down in their entirety.

JURISDICTION AND VENUE

7. This Court has subject matter jurisdiction under Amendment 80 of the Arkansas Constitution, Ark. Code § 16-13-201, and the Arkansas Declaratory Judgments Act, Ark. Code § 16-111-101 *et seq*. "A person . . . whose rights, status or other legal relations are affected by a statute . . . may have determined any question of construction or validity arising under the . . . statute . . . and obtain a declaration of rights, status or other legal relations thereunder." Ark. Code § 16-111-102.

8. In an action for declaratory and/or injunctive relief, the Circuit Courts have subject matter jurisdiction under the Arkansas Declaratory Judgment Act to consider whether state actors have committed *ultra vires*, unconstitutional, or illegal acts under the Arkansas Constitution, and those state actors are not entitled to sovereign immunity. *See Martin v. Haas*, 2018 Ark. 283, at *7, 556 S.W.3d 509, 514-15 (2018); *City of Jacksonville v. Smith*, 2018 Ark. 87, at *7, 540 S.W.3d 661, 666 (2018).

9. Venue is proper in Pulaski County pursuant to Ark. Code § 16-60-104.

PLAINTIFFS

A. Emily Waldorf

10. Emily Waldorf is 40 years old and lives with her husband and their five-year-old daughter in Fayetteville. Ms. Waldorf was born and raised in South Arkansas, and after attending graduate school out of state, Ms. Waldorf returned to Arkansas to raise her family surrounded by her parents, her sister, and her nephews.

11. Ms. Waldorf was looking forward to continuing to grow her family, and after a miscarriage in 2023, she was thrilled to learn she was pregnant in July 2024. At the time, Ms. Waldorf, a physical therapist, worked at Washington Regional Medical Center.

12. At first, Ms. Waldorf's pregnancy progressed normally, although, due to her previous miscarriage, she remained anxious. Then, in the early hours of Monday, September 16, 2024, Ms. Waldorf, then 17 weeks pregnant,[2] began experiencing vaginal bleeding and thought she could feel something coming out of her cervix. She knew something was wrong.

13. Ms. Waldorf immediately went to Washington Regional Medical Center, the same hospital where she worked. Ms. Waldorf was told that patients who are less than 20 weeks pregnant must ordinarily go through triage in the emergency room. When she informed staff that she was experiencing an obstetrical emergency, they sent her to the hospital's labor and delivery department for triage.

14. In triage, Ms. Waldorf was examined by the obstetrician on call who performed an ultrasound and showed Ms. Waldorf, via the ultrasound, where her amniotic sac was ballooning out of her cervix, and with it, her baby's foot.[3] Ms. Waldorf was then evaluated by the on-call maternal fetal medicine (MFM) specialist and her primary obstetrician who diagnosed her with cervical insufficiency and told her she was already two centimeters dilated. The MFM briefly discussed the possibility of an emergency cerclage procedure to stitch her cervix closed until delivery but advised Ms. Waldorf that because of the advanced stage of her condition and the high risk of infection from the procedure, she was not a good candidate for the procedure.

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[2] Consistent with standard medical practice, gestational ages as used in this complaint are dated from the first day of the patient's last menstrual period ("LMP"), which is typically approximately two weeks before the estimated date of fertilization of a pregnancy.

[3] This complaint describes pregnancy using medical terminology, unless describing a particular patient's pregnancy, in which case, consistent with principles of medical ethics, it adopts the terminology preferred by the individual patient.

15. Ms. Waldorf was then admitted for observation. Hospital staff explained to Ms. Waldorf and her family that she was going to lose this pregnancy, and her risk of infection was already high, but because her baby still had a heartbeat, Arkansas's abortion ban prohibited them from inducing labor until her own physical condition deteriorated further. Ms. Waldorf was shocked: "I expected the OBs to take care of me, but their answer was, our hands are tied behind our backs. I knew then that I had to be brave enough to survive because nobody else was going to help me."

16. Ms. Waldorf was told that because she could go into labor at any moment, the hospital would observe her for 24 to 48 hours to see if her condition changed—and if it did not, then they would discharge her. Ms. Waldorf requested prophylactic antibiotics to protect her against infection, which hospital staff refused throughout her hospital stay at Washington Regional.

17. In the middle of the night, Ms. Waldorf got up to use the bathroom and saw blood everywhere, including one clot that was the size of a tennis ball. On Tuesday morning, she underwent another cervical exam and was told she was now four centimeters dilated. Despite the clear and early signs of labor, her condition was not progressing. Hospital staff were eager to discharge Ms. Waldorf and started explaining to her what she should do if she went into labor at home. Ms. Waldorf begged them to let her stay in the hospital where they could monitor her condition for signs of infection and repeatedly said she did not feel safe going home. Hospital staff eventually allowed her to stay for continued monitoring.

18. In the days that followed, Ms. Waldorf's condition did not materially change. Each day, a different doctor checked her temperature to see if she had an infection and looked for the baby's heartbeat with a doppler and ultrasound. During one ultrasound examination, the doctor

remarked, “look, she’s opening and closing her mouth!” To Ms. Waldorf, the remark felt cruel and dehumanizing given the circumstances.

19. Throughout this time, Ms. Waldorf continually requested labor induction, understanding the reality that this pregnancy was no longer viable, but failing to grasp why hospital staff refused. One staff member told her, “Make sure your friends vote differently” going forward, which made no sense to Ms. Waldorf at the time. “I felt like a prisoner. I felt like I was literally in my worst nightmare. My anticipatory grief was being prolonged because nobody would induce me.” As a medical professional herself, her situation was particularly baffling. “I think about the Hippocratic Oath and do no harm. I was going to have a baby that was not going to live, but I am also a living person who has a family.”

20. On Thursday morning at around 8 A.M., Ms. Waldorf’s water broke. She began passing small blood clots, another sign of labor. Ms. Waldorf again asked to be induced but was again told that Arkansas’s abortion ban prohibited any intervention from the hospital to speed labor. Ms. Waldorf was extremely worried about the risk of infection, which she was told increases the more time that passes after a patient’s water breaks. The on-call obstetrician informed Ms. Waldorf that she had consulted with the hospital’s legal team and that they would not authorize induction of labor, as induction at that stage of pregnancy is an abortion. According to the obstetrician, Ms. Waldorf only had two options: (1) she could stay in the hospital; or (2) drive herself to Kansas, where the laws are different. Ms. Waldorf asked if the hospital could medically transfer her to Kansas, given how quickly deadly infections can arise in her circumstance, but she was told the hospital could not provide a transfer either. Ms. Waldorf and her husband expressed concern that she would go into labor and/or start bleeding during the 240-mile drive through rural Arkansas and Missouri. These concerns were ignored.

21. Desperate, scared, and feeling like "a ticking time bomb," Ms. Waldorf and her family and friends began looking for other options. Ms. Waldorf's sister and her best friend separately contacted the office of Arkansas Governor Sarah Huckabee Sanders. Both women had conversations with officials from the Governor's office in which they asked her staff to either provide an interpretation of the law for the hospital's general counsel, grant Ms. Waldorf an exception from the law, or help her to get out of state to protect her own life.

22. Ms. Waldorf's sister, Elizabeth, talked to an official from the Governor's office on the phone, but he did not seem to grasp the gravity or urgency of Ms. Waldorf's situation. The official asked Ms. Waldorf's sister "What do you expect the Governor to do?" and recommended that Ms. Waldorf "find a lawyer." While the official asked for Ms. Waldorf's direct number and promised to call her back, no one from the Governor's office ever reached out to her.

23. Meanwhile, Ms. Waldorf's close friend, Jamieson, was similarly told by an official from the Governor's office, "I'm sorry, we cannot advise you on this, but we suggest you get your friend a lawyer." The official told her that Ms. Waldorf "should be really grateful that she has a friend like you."

24. For Ms. Waldorf, the Governor's indifference was shocking. "I thought that the governor would understand and grant me an exception. That we would get clarification. Don't they know the law more than anyone? And I just felt unseen, like their backs were all turned." As the days and hours passed, Ms. Waldorf continued to bleed and leak amniotic fluid, and hospital staff had to change her sheets repeatedly.

25. On Friday morning, day five in the hospital, Ms. Waldorf's best friend was connected through various family friends to the undersigned attorney, Molly Duane, who specializes in the legal exceptions to abortion bans. Shortly thereafter, Ms. Waldorf retained

Ms. Duane and an Arkansas-based attorney as counsel to represent Ms. Waldorf in requesting that the hospital provide her with a labor induction abortion to protect her life, her health, and her future fertility.

26. Ms. Waldorf's counsel provided the hospital's general counsel with both medical research underscoring the grave risks to Ms. Waldorf's health if she continued to be denied a labor induction abortion, and legal support showing that providing a labor induction abortion to Ms. Waldorf was both allowed under the medical emergency exception to Arkansas's abortion ban and required by the Emergency Medical Treatment & Labor Act (EMTALA). The evidence underscores that for a patient like Ms. Waldorf, the standard of care is to offer both termination of pregnancy (i.e., abortion) and expectant management (i.e., wait and see) and allow the patient to choose the option that is best for them. Hospital staff then deliberated for several hours.

27. Around 5 P.M., the CEO of Washington Regional Medical Center came into Ms. Waldorf's hospital room unannounced and told her: "We are going to take the very best care of you. I'm sorry this is happening." Ms. Waldorf had worked at Washington Regional for six years at that point, and this was the first time she met the CEO.

28. At around 6 P.M., the hospital informed Ms. Waldorf, through her counsel, that they would not authorize an induction abortion for her because, in the words of the hospital's general counsel, "we cannot rule out the possibility of an overzealous prosecutor."

29. Ms. Waldorf next requested, through her counsel, that the hospital transport Ms. Waldorf via ambulance to a facility in another state that could legally provide an abortion. The hospital's general counsel was resistant but grudgingly agreed that if Ms. Waldorf's counsel could identify the hospital and an on-call specialist at the receiving hospital who would accept the transfer, they would consider facilitating.

30. Ms. Waldorf's counsel identified a hospital in Kansas City as well as an on-call specialist who was prepared to accept Ms. Waldorf and could promptly provide an induction abortion. Meanwhile, Ms. Waldorf's physician insisted that she repeat, what seemed to her, the magic words the medical staff needed to hear: "I want to be transferred to a higher level of care." Only then did Washington Regional, the hospital where Ms. Waldorf was both a patient and an employee, agree to facilitate the transfer.

31. At approximately 10:30 P.M., an ambulance arrived to drive Ms. Waldorf to Kansas City. The next three hours were physically and emotionally difficult. Ms. Waldorf scrolled through her phone and saw news about Amber Thurman, a woman in Georgia, who had died because of her state's abortion ban.

32. When they stopped at a gas station so Ms. Waldorf could use the bathroom, the paramedic said she would need to accompany Ms. Waldorf to the bathroom in case she went into labor. The gas station clerk asked them what was going on and Ms. Waldorf recalled feeling "like a prisoner being chaperoned."

33. Ms. Waldorf was relieved to arrive safely in Kansas City, where the medical staff greeted her with these words: "We are so glad you made it; we have been waiting for you." Ms. Waldorf's husband and sister had driven right behind the ambulance the whole way. The ambulance's paramedic gave Ms. Waldorf a baby blanket she knitted during the drive. It was the first time in a week Ms. Waldorf had felt compassion from someone outside of her family.

34. On Saturday morning, the hospital in Kansas City began the induction abortion. Soon after, Ms. Waldorf's blood pressure plummeted. Medical staff informed Ms. Waldorf that she had a high risk of sepsis and hemorrhage from the delay in care, as it had been more than 48 hours

since her water broke. After several hours of labor, Ms. Waldorf gave birth to her second daughter, who died shortly after. She named her daughter Bee.

35. After delivering Bee, Ms. Waldorf lost a liter of blood, her blood pressure dropped, and she began to feel light-headed and dizzy. Ms. Waldorf's placenta had not delivered naturally. One obstetrician began pushing on Ms. Waldorf's abdomen while another obstetrician reached into her vagina to remove her placenta by hand. They were within minutes of taking Ms. Waldorf to the operating room when the obstetrician finally delivered her placenta. Even after delivery, Ms. Waldorf continued to have complications throughout the night, including low blood pressure, and medical staff performed heart tests to rule out underlying health concerns. Ms. Waldorf was told by medical staff in Kansas that these complications likely would not have arisen had she not been forced to wait so long after her water broke to receive care.

36. On Sunday, Ms. Waldorf returned home to grieve the loss of her daughter and the denial of essential medical care. She immediately went on leave from her position at Washington Regional. She used up her vacation days first, then went on unpaid medical leave under the Family and Medical Leave Act (FMLA). In moments when she felt up to it, she would look at job postings, but she did not see anything that felt right.

37. Meanwhile, Ms. Waldorf's counsel reported Washington Regional to the Department of Health and Human Services (HHS) and the Center for Medicare and Medicaid Services (CMS) for a potential violation of EMTALA.

38. On September 26, Ms. Waldorf was interviewed by investigators from HHS, CMS, and the Arkansas Health Department via telephone regarding the EMTALA complaint.

39. In October, Ms. Waldorf began receiving bills from Washington Regional and the Washington County Regional Ambulance Authority, both for the "care" she received at

Washington Regional and the ambulance transfer to Kansas City. These bills totaled nearly $6,000. In addition, Ms. Waldorf's insurance did not fully cover the care she received in Kansas City, so she owed the Kansas hospital another $3,000. Ms. Waldorf and her family did not have sufficient funds to pay any of the bills.

40. At the beginning of December, having exhausted three months of FMLA leave, Ms. Waldorf returned to work at Washington Regional. In the weeks that followed, Ms. Waldorf found it very difficult to keep returning to the site of the most traumatic experience of her life.

41. On December 24, Ms. Waldorf's counsel sent a demand letter to Washington Regional's general counsel asking it to excuse the $6,000 in medical bills she currently owed, including $5,000 for the ambulance ride (attached hereto as Exhibit 1). The letter characterized the bills as "exorbitant and unreasonable" and noted that "Washington Regional's failure to protect Ms. Waldorf's health and life—while billing her for that deficient care—is particularly galling, as Ms. Waldorf is an employee of Washington Regional, and she and her family receive their health insurance coverage through Washington Regional's health plan."

42. On January 7, 2025, Washington Regional's general counsel responded to Ms. Waldorf, via her counsel, refusing to excuse Ms. Waldorf's medical debt (attached hereto as Exhibit 2). The hospital's response included the following statements:

- "WRMC does not agree with the narrative you have put forward" and "is of the opinion that the care provided Ms. Waldorf was appropriate and that the charges for that care provided by WRMC are reasonable."
- "The [ambulance] transfer was not effected because the attending physician at WRMC believed that Ms. Waldorf's condition required a higher level of care. . . . and it is simply not reasonable for you to make demand [sic] that WRMC assume responsibility for the cost of a patient-directed transfer."
- "WRMC was advised by CMS on December 17, 2024 that CMS has determined that WRMC is and was in compliance with EMTALA regulatory requirements . . . ."

43. Upon receipt of the hospital's response, Ms. Waldorf's counsel made inquiries with CMS and received the results of their survey and investigation (attached hereto as Exhibit 3). Because Ms. Waldorf was not treated in the emergency room and instead was admitted into labor and delivery at the time she was denied care, CMS concluded that Washington Regional's failure to offer an abortion to Ms. Waldorf was not a violation of EMTALA. The survey results did conclude, however, that Washington Regional was in violation of several unrelated conditions of participation in the Medicare program, but that it had since come back into compliance.

44. In mid-January 2025, Ms. Waldorf decided that working at Washington Regional was too traumatic and she formally submitted her resignation letter. Ms. Waldorf has since started her own physical therapy practice, which she named in honor of the baby she lost.

45. Ms. Waldorf is anxious to have more children, but fears that if she gets pregnant again, she will suffer similar harms. The medical condition that doomed her prior pregnancy—cervical insufficiency—is known to recur in subsequent pregnancies.

46. Ms. Waldorf's claims are capable of repetition but evading review. Ms. Waldorf sues on her own behalf.

A. Theresa Van

47. Theresa Van is 30 years old and lives in Fort Smith, Arkansas with her four-year-old daughter, Camille. Ms. Van grew up in Fort Smith and knows so many people that her family often refers to her as the "mayor" of Fort Smith.

48. Ms. Van has had multiple pregnancy losses in her life. She had an abortion in 2019 before she was ready to be a mom. A year later, she got pregnant again, and by then, her life had changed dramatically—she was in a long-term, committed relationship and thrilled to be pregnant.

But at 14 weeks pregnant, Ms. Van was in a car accident and lost the baby—a son she named Tristan. In 2021, Ms. Van finally gave birth to her first child, Camille, and was instantly in love.

49. Ms. Van got pregnant again in early 2023. She was enjoying being a stay-at-home mom and was excited to give her daughter a sibling—she loved the idea of having a family of four. Throughout the early weeks of pregnancy, Ms. Van's excitement grew. She looked forward to her 20-week anatomy scan when she would learn if she was having a boy or a girl.

50. At Ms. Van's anatomy scan, however, everything changed. At first, all seemed on track; the baby's heartbeat was strong, and Ms. Van learned that she was having another girl. But the ultrasound also showed signs of concern: the baby was not moving very much, was measuring small, and Ms. Van's amniotic fluid was low. Ms. Van's doctor recommended that she see a specialist. Ms. Van made the appointment and during the next two weeks, she completely changed her diet to be as healthy as possible and started drinking lots of water, hoping it would increase her amniotic fluid. While she waited for her appointment with the specialist, she began having weekly appointments with her OB/GYN to check the baby's heartrate. She tried to remain optimistic.

51. At Ms. Van's appointment with the specialist, she learned that the specialist was not physically present at the facility and that she would be communicating with him through an iPad. Still, she spent hours at the office. First, a technician performed the ultrasound and initially, Ms. Van was hopeful. The baby's heartbeat was once again strong, and she was moving. When Ms. Van sat down to communicate with the specialist through the iPad, however, she learned that she no longer had any amniotic fluid—a condition called oligohydramnios—and that without it, her daughter's organs would not fully develop, and if she made it full term, the baby would not survive delivery.

52. The specialist then explained that because of Arkansas's abortion bans, he would go to prison if he intervened to induce labor. The specialist did not mention traveling out of state. "I wish I had been told what my options were. Providers might have a fear of dancing around what they can and can't say. But he did tell me the consequences of what would happen if he were to intervene—a hundred thousand dollars fine and a ten-year prison sentence." Ms. Van worried that if she nonetheless tried to leave the state, someone would come after her, that it would make her a criminal, too. In addition, the financial strain of traveling for abortion care was too intense. She felt she had no choice but to continue her pregnancy until her daughter passed.

53. That was when the real agony began. On Tuesday of every week, Ms. Van would travel to her small local hospital for two appointments: the first, with her OB/GYN to check to see if her daughter's heart was still beating; the second, with a psychiatrist who tried to help her process the trauma. "Week after week that I went in, she was alive every time and had a strong heartbeat. So I had a false sense of hope. I thought, I'm really going to have to carry her to full term."

54. For seven long weeks, Ms. Van also struggled to grieve a baby that was not going to make it, while still trying to be a good wife and mother. Every day, she would try to wait until Camille went down for her nap and then cry for at least an hour. Ms. Van tried to hide her pain, but it was impossible. "I wanted to shield Camille from the hurt I was going through. But she was still breastfeeding, so it wasn't like I could process that at nighttime either." There were even times she thought about suicide, feelings she suffered in isolation. But she kept returning to the fact that she still had a family to take care of. She tried to continue showing up as a wife and mother, even hosting a birthday party for her husband where she cooked for family and friends. Meanwhile, young Camille struggled to understand. Because the hospital visits were so upsetting for Ms. Van, to Camille, it seemed that everyone at the hospital that was supposed to take away pain was instead

hurting her mother. Ms. Van was prescribed anti-depressants, anti-anxiety medication, and strong sleep-aids.

55. During one appointment, Ms. Van learned that her placenta had moved and was now covering part of her cervix (a condition known as placenta previa), putting her at risk of hemorrhage, classical cesarean delivery, and even hysterectomy. Ms. Van was terrified. She wanted more children. That was when Ms. Van and her husband first started talking about her own wishes for her funeral if she did not survive the pregnancy. Yet still, her medical providers were unsure if she was sick enough to qualify for an exception to the abortion bans. Ms. Van's sister-in-law, sister, and best friend started taking turns accompanying her to the Tuesday appointments because Ms. Van was told that if and when the baby's heartbeat stopped, she would need to go to Little Rock for delivery, likely via helicopter, as her local hospital was not equipped to handle a birth with such a high risk of hemorrhage.

56. At one appointment, on July 18, Ms. Van's sister-in-law was running late. Ms. Van had no choice but to bring Camille into the room for her ultrasound. Camille was in extreme distress, and a nurse worked to calm her down. It was during that ultrasound, with the doppler equipment unusually quiet, that Ms. Van asked, "she's gone, isn't she?" and the technician replied, "yes, sweetheart, I'm sorry." Ms. Van lost it—she went into shock and started hyperventilating—all with Camille in the room.

57. Once she was able to calm down and her sister-in-law arrived, Ms. Van, her family, and her medical team discussed what to do next. They contemplated an ambulance transfer or air-lifting her to Little Rock. Ultimately, Ms. Van decided instead to have her husband drive her to Little Rock so that they could be alone in their grief. For three hours, the couple listened to gospel music and prayed that Ms. Van would survive the delivery. Ms. Van again reviewed with her

husband her wishes for her own funeral and for Camille as she grew older, in case Ms. Van did not survive the delivery.

58. Once in Little Rock, at 27 weeks pregnant, Ms. Van finally received the medications to induce labor. She labored for hours to push out increasingly large blood clots. Her daughter, whom she named Cielle, was stillborn.

59. Ms. Van and her family had already made arrangements with a funeral home back in Fort Smith but learned that transporting Cielle back home would drastically increase the price. They called around to other funeral homes, and one agreed to a much lower price provided that the family transported Cielle home themselves.

60. Two days later, Ms. Van's husband drove them home from Little Rock with a small casket containing Cielle's body on Ms. Van's lap. For three hours, Ms. Van sang to Cielle and told her stories, trying to make sense of her grief and loss.

61. Once home, Ms. Van and her family struggled to get back to normal. Before the trip, the couple had been training Camille to sleep in her own bed. But while Ms. Van was away—the first time Camille had ever been away from Ms. Van—Camille struggled to sleep. Now, Camille has regressed to sleeping in Ms. Van's bed—where she still sleeps to this day.

62. At the same time, Ms. Van and her husband began to drift apart. The family briefly moved to Oklahoma, seeking a new start. A couple months ago, however, Ms. Van and her husband separated.

63. Ms. Van and Camille then moved back to Fort Smith. Ms. Van is currently living with her sister and trying to adjust to life as a single mother.

64. Ms. Van reflects on her experience as follows: "What happened to me isn't rare. It's not political, it's personal and it does affect real people and real families. And it has deeply

traumatized and affected mine. And I am just a normal woman in the state of Arkansas who wanted her baby."

65. Ms. Van wants more children but fears that if she gets pregnant again in the future, she will suffer similar harms. Her claims are capable of repetition but evading review. Ms. Van sues on her own behalf.

B. Chelsea Stovall

66. Chelsea Stovall is 35 years old and lives in Fayetteville, Arkansas. She has two children, ages five and seven, and loves being a mother.

67. Ms. Stovall learned she was pregnant with what she hoped would be her third child in April 2022. She and her husband were thrilled at the idea of having a third child. Ms. Stovall's doctor has delivered both of her children and Ms. Stovall looked forward to continuing to receive her pregnancy care from the OB/GYN she knew and trusted.

68. The months passed, and in June 2022, *Roe v. Wade* was overturned and abortion became illegal in Arkansas. Ms. Stovall did not think much of it, as she never thought she would need an abortion. She had saved her older children's baby things, hoping for a third. Now, as her excitement mounted, Ms. Stovall began to prepare. She took her bassinet out of storage. She set up her high chair in the kitchen.

69. Leading up to her anatomy scan, Ms. Stovall began telling friends and family about the pregnancy. She planned to have a party after the scan, when she would learn the baby's gender.

70. In July 2022, when Ms. Stovall was almost 19 weeks, she finally had her anatomy scan appointment. Yet as the ultrasound technician started the scan, the room fell quiet. Ms. Stovall's husband asked the technician if everything was alright, and the technician said she needed to get the doctor to share the results. The couple waited, uneasy.

71. When Ms. Stovall's doctor entered the room, she explained that Ms. Stovall's baby had a congenital diaphragmatic hernia (CDH), meaning that many of the baby's organs, including the stomach and bowels, had moved into the chest cavity, compressing the lungs and heart. Ms. Stovall's doctor went on to explain that she—for the baby was a girl—would not survive. She was not going to make it to term.

72. Ms. Stovall was in denial and could not understand what was happening. She kept looking from the doctor to her husband, saying "what do you mean?" again and again. Ms. Stovall began crying uncontrollably, wailing, screaming, clutching at her husband's shirt and arms. Now, Ms. Stovall and her husband had a choice to make. Would they continue the pregnancy, or would they terminate?

73. Ms. Stovall's doctor offered to make an appointment with a specialist—who traveled once a week up from Little Rock—to confirm the results. Ms. Stovall waited five days to see the specialist. At the appointment, the specialist confirmed the diagnosis of CDH. Looking at the ultrasound, Ms. Stovall finally understood the diagnosis: "She had a hole where her diaphragm should have been, and her intestines were wrapped so tightly around her lungs and her heart that they were not growing. It was not a matter of if I would have to say goodbye to her, it was a matter of when."

74. The specialist explained that there was less than a 1% chance for her baby to make it to term and that while there were operations they could attempt, there was also less than a 1% chance of the baby surviving each successive surgery. The specialist explained that if she had been diagnosed just four weeks earlier, before Arkansas's abortion bans took effect, the specialist would have been able to help Ms. Stovall and offer her immediate abortion care. Now, they only had two

options: continue the pregnancy in Arkansas, and with it, the associated risks to Ms. Stovall's health, or attempt to travel out of state for the compassionate abortion care they sought.

75. Ms. Stovall decided that she wanted an abortion. She did not want her baby to suffer, nor did she want to put herself and her family through the trauma of a long and painful death. "It was not the way that I wanted to say goodbye." Ms. Stovall worried that because she was already 20 weeks pregnant, the options in nearby states were limited. She could not get an appointment in Kansas before she would be past their gestational limit. Ms. Stovall wanted to be able to deliver her baby in a hospital but could not find one that could provide the care quickly and affordably out of state.

76. Finally, Ms. Stovall got an appointment at an abortion clinic in Illinois. To pay for the appointment and the associated travel, the Stovalls emptied their bank account and all their savings.

77. Ms. Stovall and her husband traveled to Illinois and rented a hotel room. Ms. Stovall's parents agreed to watch their kids.

78. It took two days and multiple trips to the clinic for Ms. Stovall's cervix to dilate. She could do nothing but sit in her hotel room for days, holding onto her husband, crying, and taking baths to try to ease the pain. Ms. Stovall was in a strange place, without her extended support network and her own obstetrician. She felt like she was losing everything. In her darkest moment, she worried she would not survive.

79. On the third day, Ms. Stovall received her abortion procedure.

80. With each trip to and from the clinic, Ms. Stovall had to pass through a sea of protesters with signs, screaming at Ms. Stovall that she was killing her baby. The clinic staff had advised her to wear a hat and headphones, and Mr. Stovall walked her to the door each time. But

she could not drown out the sights and sounds of the protesters. When Ms. Stovall left the clinic on the third day, a protester threw a bloody pad at her car.

81. Mr. Stovall, meanwhile, was not allowed to enter the building. He was unable to bear the thought of leaving his wife in this moment, so Mr. Stovall remained in the clinic parking lot for hours. All the while, the protesters yelled at him and attempted to provoke a response.

82. When Ms. Stovall returned home to Arkansas, she continued to bleed. She returned to her doctor who performed an additional aspiration procedure. The high chair she had taken out of storage remained in her kitchen, a reminder of her loss.

83. The experience changed Ms. Stovall and her family forever. Ms. Stovall and her husband drifted apart in their grief, and in 2024, they got divorced. They continue to co-parent their children and grapple with a loss made so much worse by their state's cruel laws and the traumatic travel they required.

84. Ms. Stovall reflects on her experience as follows: "I had no little understanding of what an abortion actually was—that it's healthcare. I planned on having a baby. But she was very sick, and her body was strangling her. That's not something I would wish on anyone."

85. Ms. Stovall wants more children but fears that if she gets pregnant again in the future, she will suffer similar harms. Her claims are capable of repetition but evading review. Ms. Stovall sues on her own behalf.

C. Allison Howland

86. Allison Howland is 38 years old and lives with her husband and their six-year-old son in Little Rock. She loves puzzles and trivia challenges and first met her husband when they were both captains of their respective co-ed adult kickball teams.

87. In August of 2024, Ms. Howland realized her period was late. She usually has a regular menstrual cycle, so she was confused. She knew she couldn't be pregnant based on the last time she'd had sex with her husband. Then she thought maybe the stress of her job had disrupted her cycle. But she had an uneasy feeling, so just to be sure, she bought a drugstore pregnancy test.

88. It was positive. Weeks earlier, she had been traveling for work and woke up in her hotel room with no memory of how she had gotten from the hotel restaurant—where she had been eating dinner, doing crossword puzzles, and watching the U.S. Olympic track trials on TV—to her hotel room. She remembers chatting with others who were sitting at the bar about the athletes on TV, but after that, her memory goes blank. Since then, she had had an unsettling feeling that *something* had happened to her in that hotel that night.

89. Staring at the positive pregnancy test, Ms. Howland knew she had been sexually assaulted in that hotel. "I was in the stall of my office bathroom. I can still remember the feeling to this day. I immediately grabbed my phone, ran to the stair-well and leaned against the concrete wall. My heart was racing, I felt myself leave a sweat stain on the wall. I can still feel how it felt. And I called my husband, and started screaming and sobbing, saying 'I'm pregnant, I'm pregnant! I knew it, I knew it, I knew something happened!' It was like once I got that confirmation, the memories started coming back."

90. Ms. Howland called her parents next, and her mother met her at the hospital where she was examined and tested for sexually transmitted infections. Together with her family, Ms. Howland decided to file a police report with the county police department where the hotel was located, and an investigation was launched.

91. Ms. Howland immediately knew she wanted to terminate the pregnancy. "I do not want to keep the product of this assault. It is not fair to me, and it's my life. It is not fair to the

potential child that could come out of it—to be born into a world where I feel the way I do is not fair. Call that selfish but I stand by it. I was violated and put into extreme danger and living in a state like Arkansas—I was royally fucked."

92. Yet Ms. Howland delayed making plans for an abortion—for weeks—while the investigation was underway, as she wanted her assailant to be caught and was unsure if the police needed her to remain pregnant for purposes of collecting DNA evidence. In the meantime, Ms. Howland felt gaslit by the police, and nothing appeared to be happening in the investigation.

93. At the time, Ms. Howland reflected: "Part of me hopes we can't find him so I never have to know what he looks like and this doesn't have to get bigger than myself and I can just take care of it and be done with it. But part of me is like I need to do this for literally everyone else who's ever been assaulted."

94. The police eventually identified Ms. Howland's assailant, but the detective informed Ms. Howland that the assailant maintained that the sexual encounter was consensual. The detective elaborated that the assailant "seemed like a really nice guy," and because it was essentially a he-said/she-said situation, there was little the police could do.

95. By the time Ms. Howland received this news, she was approximately eight weeks pregnant. She informed the detective that she intended to terminate the pregnancy and, because Arkansas' abortion ban has no rape exception, she had identified an abortion clinic in Illinois and was planning to travel there for an abortion procedure. She asked the detective if she should request any special handling of the products of conception. The detective said they would not be able to get an officer to Illinois to maintain its chain of custody, so she should not bother.

96. The clinic in Illinois told Ms. Howland she had to be accompanied to her appointment by a friend or family member who could drive her to and from the clinic—she could

not use Uber or take a cab. Ms. Howland and her husband started talking with family about the logistics of the trip, childcare for their son, and gathering the funds necessary to travel as none of her abortion or travel expenses would be covered by their in-state health insurance.

97. Because her husband was diagnosed with epilepsy in his 20s, and was unable to drive at that point, they found another family member willing to travel with her to Illinois. Ms. Howland's parents helped to pay for much of the trip, which included two airplane tickets, a two-night stay in a hotel, and the cost of a rental car. The abortion and associated travel cost them over $4,000. Ms. Howland and her husband are still paying off the medical bills, which included an STD panel, routine after a rape, that cost $1,700.

98. Ms. Howland is grateful for the family support and resources that allowed her to leave the state and receive the abortion care she needed.

99. On her way home from Illinois, Ms. Howland was stopped by airport security, who forced her to remove and to discard the portable heating pad the clinic staff gave her for the flight home, which she was wearing inside her underpants.

100. After the incident, Ms. Howland began seeing a therapist for the first time in her life, and she shared her experience with close friends and family. Upon hearing her story, a friend of Ms. Howland's confessed to her that the same thing had happened to them: they had been drugged at a hotel bar and woke up naked in their hotel room, knowing they had been violated.

101. Ms. Howland and her husband want more children. But since the assault, Ms. Howland has struggled with intimacy. The added trauma of being forced to flee her state for an abortion and the economic burden and the emotional costs have made her recovery even more difficult.

102. Ms. Howland's claims are capable of repetition but evading review. Ms. Howland sues on her own behalf.

D. Dr. Chad B. Taylor

103. Plaintiff Chad B. Taylor, M.D. is a practicing physician in Little Rock and is licensed to practice medicine in Arkansas. Dr. Taylor is board-certified in OB/GYN and clinical informatics.

104. Dr. Taylor has practiced obstetrics and gynecology in Little Rock since 2016. As part of his practice, Dr. Taylor provides comprehensive OB/GYN care to patients from menarche to menopause and beyond, including: gynecological care, prenatal care, labor and delivery, and other obstetric care. Dr. Taylor has patients he sees regularly in-clinic, as well as patients he treats when on call or when working at the hospital where he has admitting privileges.

105. Dr. Taylor's job responsibilities are as follows. Approximately 50% of Dr. Taylor's time is spent in typical OB/GYN practice: seeing patients in clinic, performing gynecological surgeries in the operating room (e.g., hysterectomy, hysteroscopy, uterine aspiration), and delivering babies in the labor and delivery unit of his hospital. The other 50% of Dr. Taylor's time is spent in clinical informatics at his hospital: governing and developing the hospital medical interface, improving workflow and safety in the hospital, and performing other hospital management duties.

106. Dr. Taylor is also an Associate Professor of OB/GYN, providing lectures to residents, medical students, and physician assistant students on various topics in OB/GYN, including: miscarriage management, ectopic pregnancy, and pelvic pain.

107. Dr. Taylor received his medical training at Dell Medical School at The University of Texas at Austin, the University of Illinois College of Medicine at Peoria, and the University of

Texas Medical School at Houston (now McGovern Medical School). Dr. Taylor received his undergraduate degree in Biology from the University of Texas at Austin.

108. Dr. Taylor is trained to provide a variety of care to terminate pregnancy, including: induction of labor, uterine aspiration (a.k.a. D&C), dilation and evacuation ("D&E"), medical and surgical termination of ectopic pregnancies, and management of various pregnancy complications requiring termination of pregnancy. Over his career, Dr. Taylor has participated in the delivery of thousands of babies and terminated approximately one hundred pregnancies that lacked cardiac activity (a.k.a. medical intervention for miscarriage or ectopic pregnancy). Dr. Taylor has also terminated pregnancies with or without cardiac activity where the patient was experiencing an obstetrical or other health complication that developed during pregnancy, including but not limited to: cervical insufficiency, pre-term pre-labor rupture of membranes ("PPROM"), placenta previa and other bleeding conditions, preeclampsia, sepsis and other severe infections, molar pregnancies, complicated twin pregnancies, and maternal comorbidities such as hypertension, diabetes, heart disease, kidney disease, and cancer.

109. Since Arkansas's abortion bans went into effect, Dr. Taylor has been constrained in the kinds of pregnancies he can terminate by the presence of embryonic or fetal cardiac activity. In the absence of Arkansas's abortion bans, Dr. Taylor would provide other terminations of pregnancy required by his patients in cases with cardiac activity.

110. Since Arkansas's abortion bans went into effect in 2022, Dr. Taylor has observed first-hand the devastating effect Arkansas's vague abortion bans have on the medical care of pregnant patients in Little Rock and around the state. In addition to attempting to legally and ethically treat his own patients and those of his colleagues while on call, Dr. Taylor has treated

patients with complex pregnancies from around the state that are transferred to Little Rock for a higher standard of care.

111. For over three years, Dr. Taylor has been forced to practice OB/GYN medicine under the constant imminent threat of enforcement of an Arkansas's unconstitutional abortion bans. Dr. Taylor regularly encounters patients with obstetrical complications where it is unclear to him and his colleagues if the standard of care for that patient—offering termination—is still legal.

112. For example, Dr. Taylor has treated approximately four to six patients with previable PPROM since Arkansas's abortion bans went into effect. Dr. Taylor understands the standard of care for previable PPROM patients to be to offer both expectant management (i.e., wait and see) and abortion regardless of the presence of cardiac activity. Because it is not clear under the abortion bans how sick a patient with previable PPROM needs to be to qualify as a "medical emergency," however, Dr. Taylor does not offer abortion (via induction of labor or D&E) unless the patient shows signs of infection. Instead, Dr. Taylor had admitted the previable PPROM patient for a few days to see if they develop signs of infection and if they do not, he discharges them with instructions to return when they go into labor or show signs of infection. When a patient has desired termination of the pregnancy, Dr. Taylor has directed the patient to Kansas or Illinois where abortion is still legal.

113. In one of these cases, the patient was 16 weeks and had both previable PPROM and placenta previa, putting her at risk of both infection and hemorrhage. The patient was concerned about the ability to get pregnant in the future, saying she could not become a mother in the future if she was dead. Due to the vagueness of Arkansas's abortion bans, however, Dr. Taylor was forced to tell the patient that it was unclear if he could intervene under Arkansas law because there is

disagreement over whether her case qualified as a medical emergency. Instead, Dr. Taylor offered expectant management or suggested travel to another state.

114. In another case, Dr. Taylor treated a patient at 20 weeks with a twin pregnancy. One of the twins was deceased and had already descended into the patient's vagina, but the other twin was in the patient's uterus and still had cardiac activity. Delivery of both twins was consistent with both the standard of care and the patient's wishes. Yet Dr. Taylor was unsure of whether this qualified as a medical emergency under the law.

115. In another case, Dr. Taylor observed the hospital's cardiac team discussing a pregnant patient with severe cardiac disease trying to discern how high the risk of death would need to be to meet the medical emergency exception: was 30% sufficient? Ten percent? Dr. Taylor remembers reflecting that many hospitals do not allow patients to deliver VBAC (vaginal birth after cesarean) because the risk of uterine rupture (not even necessarily maternal death) is less than 1%, yet Arkansas's abortion bans were forcing patients to regularly accept much higher risks to their lives.

116. In another case, Dr. Taylor treated a patient who had been diagnosed with breast cancer who, when she went to have a port placed for chemotherapy, learned she was unexpectedly pregnant. The drugs she was to receive are contraindicated in pregnancy, so her medical team paused treatment while they tried to determine if it was legal to either treat the cancer while she was pregnant, which would likely cause a miscarriage, or provide an abortion. The patient died before she ever received treatment.

117. In Dr. Taylor's experience, Arkansas's abortion bans have also gravely impacted necessary OB/GYN training. For example, OB/GYN training for D&E is severely limited in Arkansas, and this lack of sufficient training has contributed to worse care for patients.

118. For example, Dr. Taylor treated a patient who presented to the hospital at 28 weeks with fetal loss (no cardiac activity) and placental abruption (detachment of the placenta from the uterus) causing significant bleeding. The patient also had a history of high blood pressure and eclampsia. Because of the various comorbidities, the patient became sick very quickly and was transferred to the ICU. The best course of treatment to save the patient's life was an immediate abortion via D&E, as performing a C-section immediately would have caused the patient to bleed to death and induction of labor to deliver vaginally would have taken a day or more. Because no one at Dr. Taylor's hospital was trained to perform a D&E at 28 weeks, however, they had no choice but to start an induction and hope that the patient's vital signs and labs would stabilize enough for them to perform a C-section. It took 24 hours to stabilize the patient, at which point they were able to perform a C-section, a much more invasive surgery than a D&E. Thankfully, the patient survived.

119. Under Arkansas law, Dr. Taylor has standing to represent the constitutional rights of his patients and other pregnant Arkansans both because Arkansas's abortion bans directly regulate his activity as a physician treating pregnant patients and because he has third-party standing to represent their interests. *See Ross v. State*, 347 Ark. 334, 335 (2002) (stating that an "entrapped innocent" has standing in a vagueness challenge); *Cox v. Stayton*, 273 Ark. 298, 302 (1981) (citing cases where physician challenging ban on contraception as example of third-party standing).

120. Dr. Taylor sues on his own behalf and on behalf of his patients.

DEFENDANTS

121. Defendant the State of Arkansas enacted and maintains Arkansas's abortion bans. Under Arkansas law, sovereign immunity does not preclude lawsuits seeking prospective

declaratory or injunctive relief against the State for unconstitutional, illegal, or *ultra vires* acts. *Ark. Dep't of Educ. v. Jackson*, 2023 Ark. 140, at *7 (2023); *see also* Ark. Code § 16-111-101.

122. Defendant Sarah Huckabee Sanders is the Governor of Arkansas and as such, is the top executive of the State responsible for approving all Arkansas legislation and managing the executive branch of the State government. *See* Ark. Const. Amend. VI, §§ 2, 15.

123. As Governor, Defendant Huckabee Sanders has created and advanced a staunch anti-abortion policy for the State of Arkansas and disclaimed any exceptions. Defendant Huckabee Sanders has espoused this policy many times, including via the following:

- On the day *Roe v. Wade* was overturned, Defendant Huckabee Sanders issued an official statement as a candidate running to become Governor of Arkansas, in which she celebrated the ruling and stated: "as governor, I will fight to keep Arkansas one of the most pro-life states in the nation."[4]

- On the subsequent anniversary of the *Roe* decision shortly after becoming Governor, Defendant Huckabee Sanders issued an official proclamation on behalf of the Governor's Office declaring "a day of tears in Arkansas."[5]

- When directly asked about exceptions to save the pregnant person's life or in cases of rape or incest, Defendant Huckabee Sanders stated that she would not support "exceptions" and that even in difficult cases, she is "always going to go on the side of life and protecting the unborn." She elaborated: "I'm never going to apologize for being pro-life" and "When we start picking and choosing when we [protect life] I think that really takes away from who we are as a society."[6]

[4] *Sanders Releases Statement After Supreme Court Overturns* Roe v. Wade, Sarah for Governor (June 24, 2022), https://www.sarahforgovernor.com/2022/06/24/sanders-releases-statement-after-supreme-court-overturns-roe-v-wade/?utm_source=chatgpt.com.

[5] *Proclamation on A Day of Tears in Arkansas*, Governor Sarah Huckabee Sanders (Jan. 23, 2023), https://governor.arkansas.gov/news_post/proclamation-on-a-day-of-tears-in-arkansas.

[6] Roby Brock, *Governor Sarah Sanders on Abortion, National Politics, and Education*, KASU.org (June 24, 2024), https://www.kasu.org/show/talk-business-politics/2024-06-24/governor-sarah-sanders-on-abortion-national-politics-and-education; *Sarah Huckabee Sanders Talks Abortion Laws & COVID-19*, THV11 (Sept. 7, 2021), https://www.youtube.com/watch?v=lIsZK5PvcLg.

- Defendant Huckabee Sanders declared that Arkansas, with its abortion bans in effect, should be the "standard" on abortion for the rest of the country and "an example of how to do it right."[7]

- Defendant Huckabee Sanders has authorized the building of a "monument to the unborn" on the grounds of the Arkansas State Capitol and the use of taxpayer funds to maintain it.[8]

- Throughout the candidacy and term of former President Joe Biden, Defendant Huckabee Sanders repeatedly accused the administration of supporting "federally funded abortions" and denounced policies that allowed funding even in limited cases for service members who needed to travel out-of-state.[9]

- When directly asked about Arkansas's proposed ballot initiative on abortion in 2024 and its protections for life- and health-saving abortions, Defendant Huckabee Sanders stated: "I haven't seen anything that I would be supportive of."[10]

- The same day she was interviewed about the ballot initiative, Defendant Huckabee Sanders "proud[ly]" joined Arkansas's March for Life in Little Rock and later posted online: "Arkansas has been ranked the most pro-life state in the country four years in a row. Under my administration, we'll make sure we keep it that way."[11] This is a statement she has made repeatedly over the years, including after attending anti-abortion fundraisers and on each anniversary of the day *Roe* was overturned.[12]

- When Arkansas's Secretary of State refused to certify the ballot initiative, Defendant Huckabee Sanders called the initiative's supporters "immoral and incompetent."[13] And

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[7] Ark. March for Life (statement of Gov. Sanders at 0:58-1:01) (Jan. 22, 2023), https://www.youtube.com/watch?v=vmEBEPwEybs .

[8] Libby Cathey, *Sarah Huckabee Sanders Signs Bill to Create 'Monument to the Unborn' on Arkansas Capitol Grounds*, ABC News (Mar. 18, 2023), https://abcnews.go.com/Politics/sarah-sanders-signs-bill-create-monument-unborn-arkansas/story?id=97892231.

[9] *See, e.g.*, Sarah Huckabee Sanders (@SarahHuckabee), Twitter (Jan 2, 2024), https://x.com/SarahHuckabee/status/1742288182530429392; Sarah Huckabee Sanders (@SarahHuckabee), Twitter (June 4, 2021), https://x.com/SarahHuckabee/status/1400623724320202753; Sarah Huckabee Sanders (@SarahHuckabee), Twitter (Aug 17, 2020), https://x.com/SarahHuckabee/status/1295555459697594373.

[10] *Transcript: Arkansas Gov. Sarah Huckabee Sanders on "Face the Nation,"* CBS News (Jan. 21, 2024) https://www.cbsnews.com/news/sarah-huckabee-sanders-arkansas-governor-face-the-nation-transcript-01-21-2024.

[11] Sarah Huckabee Sanders (@SarahHuckabee), Twitter (Jan 22, 2024), https://x.com/SarahHuckabee/status/1749435527625896176.

[12] Sarah Huckabee Sanders (@SarahHuckabee), Twitter (Jan 26, 2024), https://x.com/SarahHuckabee/status/1751012449937961087?lang=ar; Sarah Huckabee Sanders (@SarahHuckabee), Twitter (June 24, 2023), https://x.com/SarahHuckabee/status/1672681505838055429.

[13] Sarah Huckabee Sanders (@SarahHuckabee), Twitter (July 10, 2024), https://x.com/SarahHuckabee/status/1811119504971420000.

after the Arkansas Supreme Court shut down the ballot initiative based on a paperwork error, Defendant Huckabee Sanders took credit for the decision and celebrated how the decision "upheld…the right to life."[14]

- Most recently, Defendant Huckabee Sanders stated she was "proud" that Americans United for Life "named Arkansas the most pro-life state in the nation for the 6th year in a row," posting online: "As a mom of three, I know the miracle of life firsthand. That's why I'll always stand for the pro-life cause, from conception to natural conclusion."[15] She also issued an official statement celebrating the distinction: "Pro-life is whole life, and I'm proud that for the past six years, Arkansas has ranked number one in the nation—not just in protecting the unborn, but in preserving life from conception to natural conclusion. I'm thankful to the activists who have fought for this day for decades and promise that as governor, I will continue to fight every day to protect the most vulnerable among us."[16]

124. Defendant Huckabee Sanders and her agents and successors are sued in their official capacities.

125. The Office of the Attorney General of Arkansas is the top law enforcement agency of the State. *See* Ark. Code §§ 25-16-702, 25-16-713; *see also Jackson*, 2023 Ark. 140, at *7. The Arkansas Attorney General must maintain and defend the interests of the State before the Arkansas Supreme Court. Ark. Code § 25-16-704. The Attorney General is also empowered to assist the Arkansas State Medical Board in investigating and revoking physicians' licenses based on "unprofessional conduct." *See* Ark. Code § 17-95-409.

126. Defendant Tim Griffin took office in 2023 as the Attorney General of the State of Arkansas. Defendant Griffin's predecessor, Attorney General Leslie Rutledge, issued an opinion on the day *Roe v. Wade* was overturned certifying that Arkansas's ban on abortion would take effect

[14] Sarah Huckabee Sanders (@SarahHuckabee), X (Aug. 22, 2024), https://x.com/SarahHuckabee/status/1826675980246949938.

[15] Sarah Huckabee Sanders (@SarahHuckabee), X (Oct 27, 2025), https://x.com/SarahHuckabee/status/1982897549544661234.

[16] Neal Earley, *Arkansas Receives Top Ranking as "Most Pro-Life State" From Anti-Abortion Organization*, Ark. Democrat Gazette (Oct. 27, 2025), https://www.arkansasonline.com/news/2025/oct/27/arkansas-receives-top-ranking-as-most-pro-life/.

immediately, and stating that "[m]y office will vigorously defend any challenge to [the abortion ban] and stands by to assist those charged with enforcing [the abortion ban]." The opinion also noted that the overturning of *Roe* "vindicates years of work by my office to defend Arkansas's prolife legislation." [17]

127. Since taking office, Defendant Griffin has reinforced these statements. Defendant Griffin has sent cease and desist letters to at least six out-of-state organizations that provide abortion and/or information about abortion, stating that the Office of the Attorney General "is the state's chief . . . law enforcement officer," "[a]bortions are prohibited in Arkansas except under very limited circumstances," and "[a]s Attorney General, I will continue fighting to enforce the laws of our state."[18] Defendant Griffin also celebrated—with a press release and a tweet—the Arkansas Supreme Court's decision to prevent the question of legalization of abortion from appearing on the ballot in 2024.[19] Defendant Griffin has even asked the United States Congress to take additional actions to restrict abortion nationwide.[20] He and his agents and successors are sued in their official capacities.

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[17] Ark. Att'y Gen. Op. No. 2022-26: Act 180 of 2019 Certification (June 24, 2022), https://content.govdelivery.com/attachments/ARAG/2022/06/24/file_attachments/2193849/Color%20Scan%20Act%20180%20of%202019%20Certification.pdf.

[18] Ark. Att'y Gen. Tim Griffin, *Attorney General Griffin Calls on Congress to Prevent Abortion Pills from Being Shipped to Arkansas, Sends Four Cease-and-Desist Letters* (July 29, 2025), https://arkansasag.gov/news-release/attorney-general-griffin-calls-on-congress-to-prevent-abortion-pills-from-being-shipped-to-arkansas-sends-four-cease-and-desist-letters; Ark. Att'y Gen. Tim Griffin, *Attorney General Griffin Issues Cease and Desist Letters to Abortion Pill Companies Advertising in Arkansas*, (May 21, 2024), https://arkansasag.gov/news-release/attorney-general-griffin-issues-cease-and-desist-letters-to-abortion-pill-companies-advertising-in-arkansas.

[19] Ark. Att'y Gen. Tim Griffin, *Attorney General Griffin Successfully Defends Secretary of State in Abortion Advocates' Lawsuit* (Aug. 22, 2024), https://arkansasag.gov/news-release/attorney-general-griffin-successfully-defends-secretary-of-state-in-abortion-advocates-lawsuit; Tim Griffin (@AGTimGriffin), Twitter (Aug. 22, 2024), https://x.com/AGTimGriffin/status/1826658723961463090.

[20] Letter from Tim Griffin to Leader of the U.S. Congress (July 29, 2025), https://media.ark.org/ag/2025-07-29-Letter-to-Congress-Shield-Laws.pdf.

128. Defendant Brandon Carter is the Prosecuting Attorney of Washington and Madison Counties, located at 280 N. College Ave., Suite 301, Fayetteville, AR 72701. Under Arkansas law, prosecuting attorneys "shall commence and prosecute all criminal actions in which the state or any county in his district may be concerned." Ark. Code § 16-21-103. Defendant Carter is responsible for criminal enforcement of Arkansas's abortion bans. He and his agents and successors are sued in their official capacities.

129. Defendant Daniel Shue is the Prosecuting Attorney of Sebastian County, located at 901 S. B Street, Fort Smith, AR 72901. Under Arkansas law, prosecuting attorneys "shall commence and prosecute all criminal actions in which the state or any county in his district may be concerned." Ark. Code § 16-21-103. Defendant Carter is responsible for criminal enforcement of Arkansas's abortion bans. He and his agents and successors are sued in their official capacities.

130. Defendant Will Jones is the Prosecuting Attorney of Pulaski County, located at 224 S. Spring St., Little Rock, AR 72201. Under Arkansas law, prosecuting attorneys "shall commence and prosecute all criminal actions in which the state or any county in his district may be concerned." Ark. Code § 16-21-103. Defendant Carter is responsible for criminal enforcement of Arkansas's abortion bans. He and his agents and successors are sued in their official capacities.

131. Defendant Edward "Ward" Gardner, M.D., is the Chairman of the Arkansas State Medical Board. Defendants Don R. Phillips, M.D., Christopher D. Davis, P.A., Brad A. Thomas, M.D., Elizabeth Anderson, Michael J. Birrer, M.D., Sarah C. Bone, M.D., Mark Camp, Rodney Griffin, M.D., Kenneth B. Jones, M.D., C. Wesley Kluck Jr., M.D., Brian L. McGee, M.D., Timothy C. Pade, M.D., and Joshua E. Roller, M.D., are members of the Arkansas State Medical Board. The State Medical Board is responsible for licensing medical professionals under Arkansas law. Ark. Code §§ 17- 95-403, 409, 410. The Medical Board and its members are responsible for

imposing licensing penalties under Arkansas's abortion bans and imposing licensing penalties for "unprofessional conduct," which includes performing abortions. Ark. Code §§ 17-95-409, 17-95-303. Defendants and their agents and successors in office are sued in their official capacity.

ARKANSAS'S ABORTION BANS

132. Arkansas has two identical abortion bans. The first was passed in 2021 before *Roe v. Wade* was overturned and was blocked by a federal court until *Roe* was overturned. Ark. Code § 5-61-404; *Little Rock Fam. Plan. Servs. v. Jegley*, 549 F. Supp. 3d 922, 935 (E.D. Ark. 2021), *dismissed without prejudice* (July 26, 2022). The second abortion ban is a so-called "trigger ban," set to go into effect if and when *Roe* was overturned upon certification by the Arkansas Attorney General. Arkansas's Attorney General provided that certification on the day *Roe* was overturned, and it went into effect immediately. Ark. Code § 5-61-304.

133. Under both bans, "Abortion" is defined as "the act of using, prescribing, administering, procuring, or selling of any instrument, medicine, drug, or any other substance, device, or means with the purpose to terminate the pregnancy of a woman, with knowledge that the termination by any of those means will with reasonable likelihood cause the death of the unborn child." Ark. Code §§ 5-61-303(1)(A), 5-61-403(1)(A).

134. Excluded from the definition of "abortion" under Arkansas law are acts performed with the purposes to: "(i) Save the life or preserve the health of the unborn child; (ii) Remove a dead unborn child caused by spontaneous abortion; or (iii) Remove an ectopic pregnancy." Ark. Code §§ 5-61-303(1)(B), 5-61-403(1)(B).

135. Both abortion bans prohibit all abortions with only a single narrow "life" exception. Specifically, the bans state: "A person shall not purposely perform or attempt to perform an

abortion except to save the life of a pregnant woman in a medical emergency." Ark. Code §§ 5-61-304(a), 5-61-404(a).

136. The penalty for violating the bans is "an unclassified felony with a fine not to exceed one hundred thousand dollars ($100,000) or imprisonment not to exceed ten (10) years, or both." Ark. Code §§ 5-61-304(b), 5-61-404(a).

137. In addition, medical providers licensed by the Arkansas State Medical Board are subject to professional discipline, including loss of their medical license, for any "unprofessional conduct" which is defined to include "[c]onviction of a felony" and "[p]rocuring or aiding or abetting in procuring a wrongful and criminal abortion." Ark. Code §§ 17-95-409(a)(2)(A), (D), 17-95-303.

138. For the first three years following the overturning of *Roe v. Wade*, the abortion bans contained the following definition for "medical emergency," the lone exception to the abortion bans: "a condition in which an abortion is necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." Ark. Code §§ 5-61-303(3), 5-61-403(3).

139. Neither the abortion bans nor the definitions of "medical emergency" included any legal standard regarding how a physician's intent in performing an abortion in a medical emergency would be judged—e.g., whether the use of reasonable medical judgment or good-faith medical judgment would guide enforcement of the abortion bans. As such, Arkansas's abortion bans are among the most restrictive, if not the most restrictive, abortion bans in the country.

140. In fact, in both 2023 and 2024—the latest years for which data is available—the Arkansas Department of Health reported that zero abortions were performed in the state. *Zero*.[21]

141. An amendment to the definition of "medical emergency"—passed by the Arkansas legislature and signed into law by Defendant Huckabee Sanders—went into effect in July of 2025. Under that amendment, "medical emergency" is now defined as "a condition" "which, in reasonable medical judgment, complicates the medical condition of a pregnant woman to such an extent that termination of a pregnancy is necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." Ark. Code §§ 5-61-303(3)(A), 5-61-403(3)(A), as amended by H.B. 1610, 95th Leg., Reg. Sess. (Ark. 2025).

142. "Reasonable medical judgment" is now defined as "a medical judgment that would be made or medical action that would be undertaken by a reasonably prudent, qualified physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." Ark. Code §§ 5-61-303(4), 5-61-403(4), as amended by H.B. 1610.

143. Thus, Arkansas's abortion bans now have a "reasonable medical judgment" standard similar to the abortion bans in states like Texas and Tennessee. Tex. Health & Safety Code §§ 170A.001(4), 170A.002(b)(2), 171.205(a); Tenn. Code § 39-15-213.

144. Arkansas physicians have affirmed that the 2025 amendment to Arkansas's abortion bans does not clarify the scope of the medical emergency exception.[22] This is because in practice, the consequences for any given physician relying on the exception turn on an

[21] Ark. Dep't of Health, Induced Abortion Report 2024, https://healthy.arkansas.gov/wp-content/uploads/Induced-Abortion-2024-June3.pdf#:~:text=Effective%20June%2024%2C%202022%2C%20the%20State%20of,to%20save%20the%20life%20of%20the%20mo; Ark. Dep't of Health, Induced Abortion Report 2023, https://healthy.arkansas.gov/wp-content/uploads/Induced_Abortion_2023_vital_stat.pdf.

[22] Caroline McCoy, *Why Doctors Are Opting Out of Arkansas*, Oxford Am. (Apr. 18, 2025), https://oxfordamerican.org/oa-now/why-doctors-are-opting-out-of-arkansas.

after-the-fact assessment of whether the physician's determination was a "reasonable medical judgment." Determinations of medical necessity, however, are often complex, highly fact-specific, and inherently subject to disagreement. Physicians seeking to rely on the exception are put to an impossible choice: either (1) provide the care that they believe in their best medical judgment to be necessary to preserve their patients' lives and risk arbitrary enforcement of the law by politically appointed regulators, elected prosecutors, and the whims of juries; or (2) refrain from providing the care and avoid the risk of prosecution while watching their patients sicken.

145. Even with this change to its language, Arkansas's abortion bans remain among the most restrictive in the country, allowing abortion only to "preserve the life" of the patient.

146. All the amendment does is bring the legal standard under Arkansas's abortion bans into line with other states where similar laws have themselves been found vague. *See* Mem. & Order on Pls.' Mot. for Temp. Inj., *Blackmon v. Tennessee*, No. 23-1196-IV(I) (Tenn. Ch. Ct., 12th Jud. Dist. Oct. 17, 2024).

FACTUAL ALLEGATIONS

A. Abortion Is Essential Health Care

147. Every major mainstream medical organization, including the American Medical Association ("AMA"), the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Emergency Physicians ("ACEP"), and the Society for Maternal-Fetal Medicine ("SMFM"), recognizes that abortion is necessary health care. These organizations are all opposed to governmental interference into patient-physician relationships. Such interference is contrary to the appropriate exercise of professional judgment that medical professionals need to exercise to protect patients' well-being.

148. The AMA's Principles of Medical Ethics state that in the context of abortion, "physicians must have latitude to act in accord with their best professional judgment" and be

"expressly permitt[ed] . . . to perform abortions in keeping with good medical practice."[23] The AMA also states that "[l]ike all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient's unique values and needs and the physician's best professional judgment."[24]

149. ACOG, the nation's leading organization of physicians who provide health services unique to people seeking obstetric or gynecologic care, has long maintained the following policy on abortion: "All people should have access to the full spectrum of comprehensive, evidence-based health care. Abortion is an essential component of comprehensive, evidence-based health care."[25]

150. While state laws each adopt slightly different legal definitions for abortion, and the word is sometimes erroneously imbued with political significance, the medical definition of abortion is simple and well understood: An abortion is any termination of pregnancy, other than birth and delivery of a baby, by removal or expulsion from the uterus of an embryo or fetus and the products of conception.[26]

151. While the medical treatment is generally the same, medical professionals may draw a distinction from the patient's perspective between a "spontaneous abortion" or "miscarriage"—where the embryo or fetus has no discernable cardiac activity—and an "induced abortion"—where

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[23] *AMA Announces New Adopted Policies Related to Reproductive Health Care*, Am. Med. Ass'n (Nov. 16, 2022), https://www.ama-assn.org/press-center/ama-press-releases/ama-announces-new-adopted-policies-related-reproductive-health-care.

[24] *Am. to Op. 4.2.7, Abortion H-140.823*, Am. Med. Ass'n (2022) https://policysearch.ama-assn.org/policyfinder/detail/%224.2.7%20Abortion%22?uri=%2FAMADoc%2FHOD.xml-H-140.823.xml.

[25] *Abortion Policy*, ACOG (May 2022) https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy.

[26] *See, e.g.*, *ACOG Guide to Language and Abortion*, ACOG (Oct. 2024), https://www.acog.org/contact/media-center/abortion-language-guide.

the embryo or fetus has cardiac activity. The pregnant person's desire to have a baby or not, however, has no bearing on whether or not an abortion is considered spontaneous or induced.[27]

152. The majority of abortions in the United States are accomplished either through use of medications (medication abortion) or via an outpatient procedure (procedural abortion). Medication abortions are typically indicated up to approximately 11 weeks of pregnancy and involve the ingestion of medication(s) to terminate the pregnancy, expelling the pregnancy via vaginal bleeding. Procedural abortions are possible throughout pregnancy and involve a two-step process where the medical provider first partially dilates the patient's cervix (using medications and/or mechanical or osmotic dilators), then evacuates the uterus using suction aspiration, instruments, or some combination, all using appropriate pain management for the patient's comfort. Dilation is done the same day and/or in the preceding day(s), and the evacuation phase of a procedural abortion typically takes around 5 minutes in the first trimester of pregnancy and 10-20 minutes in the second trimester, depending on the patient's response to the procedure and the complexity of the case.[28]

153. Another medically proven abortion method occasionally used in the United States is induction abortion, where a physician uses medication to induce labor and delivery of a non-viable fetus. Induction of labor accounts for only about 2% of second-trimester abortions nationally. Inductions are usually performed in a hospital or similar facility that has the capacity to monitor a patient overnight and provide pain management (e.g., epidural). Induction abortions can last anywhere from five hours to three days; are extremely expensive; and entail more pain,

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[27] *See Practice Bulletin 200: Early Pregnancy Loss*, ACOG (Nov. 2018) https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss; Andrew Moscrop, *Miscarriage or Abortion? Understanding the Medical Language of Pregnancy Loss in Britain; A Historical Perspective*, 39 Med. Humanities 98 (2013), https://mh.bmj.com/content/39/2/98.

[28] *See The Safety and Quality of Abortion Care in the United States* at 51-65, Nat'l Acads. of Sci., Eng'g, & Med. (2018).

discomfort, and recovery time for the patient.[29] In other words, induction abortions are similar to giving birth. Indeed, it may be difficult or even meaningless to distinguish an induction abortion from an early delivery, as the only difference is the physician's intent in inducing the patient's labor.

154. While some people attempt to stigmatize abortion care by misusing or conflating pregnancy terminology—e.g., villainizing particular methods of abortion or attempting to distinguish "elective abortion" from "miscarriage" and/or "termination for medical reasons"—mainstream medical professionals understand that patients in any number of circumstances need abortions and that pregnant people, in consultation with their medical providers as desired, should be able to choose the method of abortion appropriate for their circumstances.

155. All pregnancy care, including abortion, is time sensitive. Medically unnecessary delays in access to abortion care always harm pregnant people.

B. Arkansans' Support for Legal Abortion Has Been Subverted by the State Government

156. Roughly half of the states in the country, including Arkansas, allow for citizen-led ballot initiatives or referenda to amend their state constitutions. In the last several decades, however, the Arkansas Legislature has added numerous byzantine rules and restrictions to the process that make it extremely difficult and expensive for an initiative to qualify for the ballot.

157. Arkansans have twice considered issues related to the right to abortion as it relates to their State's constitutional rights and have never sought to strip pregnant Arkansans from the fundamental rights they already enjoy under the Arkansas Constitution—nor could they.

[29] *See id.* at 5-8, 66-68.

158. In 1988, by a vote of 398,107 to 368,117, Arkansans voted in favor of a ballot initiative to restrict state funding of (but not access to) abortion through Medicaid coverage.[30] Litigation by abortion providers challenging the potential inconsistency between federal funding requirements for abortion and the Amendment's funding restrictions was unsuccessful. *Little Rock Fam. Plan. Servs., P.A. v. Dalton*, 860 F. Supp. 609, 617 (E.D. Ark. 1994), *aff'd*, 60 F.3d 497 (8th Cir. 1995), *cert. granted in part, judgment rev'd in part*, 516 U.S. 474 (1996).

159. After *Roe* was overturned and abortion became illegal in Arkansas, Arkansans revisited the question of abortion under their State Constitution. Between January 2023 and July 2024, more than 101,000 Arkansans submitted signatures in support of a proposed constitutional amendment to explicitly protect abortion in the following ways: the proposed amendment would have prohibited the State from banning or restricting abortion during the first 18 weeks of pregnancy, and after 18 weeks, would have prohibited the State from banning or restricting abortion in cases of rape, incest, in the event of fatal fetal diagnoses, or when, in a physician's good-faith medical judgment, abortion was necessary to protect the patient from physical disorder, illness, or injury. Under Arkansas law, a ballot initiative petition must contain the signatures of at least 10% of the total votes cast for Governor in the state's last gubernatorial election, which translated to 90,704 registered voters. *See* Ark. Const. art. 5, § 1.[31] The proposed abortion amendment thus garnered more than enough signatures to place the initiative directly on the ballot for voters to either approve or disapprove in November 2024.

[30] The amendment also added the following policy statement to the Arkansas Constitution, which has never been interpreted to apply outside the context of government-funding: "The policy of Arkansas is to protect the life of every unborn child from conception until birth, to the extent permitted by the Federal Constitution." Ark. Const., Am. 68, § 2.

[31] *See also* Ark. Sec'y of State John Thurston, 2024 Initiatives & Referenda Handbook: Facts & Information for the 2024 General Election at 3 (rev. Oct. 2023), https://www.sos.arkansas.gov/uploads/elections/2023-2024_I__R_Handbook_-_October_2023.pdf.

160. The proposed abortion rights amendment, however, never made it onto the 2024 ballot.[32] Like all proposed ballot initiatives, sponsors of the abortion amendment in 2024 had to submit extensive paperwork to the Arkansas Secretary of State and Attorney General to qualify for the ballot. Ark. Const. art. 5, § 1; Ark. Code § 7-9-107. Unlike other proposed ballot initiatives, however, the abortion amendment's sponsor, Arkansans for Limited Government ("AFLG"), was subjected to uniquely heightened scrutiny by the State government.

161. *First*, Defendant Griffin repeatedly withheld his approval of the abortion amendment's language, requiring AFLG to submit three separate rewrites. Defendant Griffin rejected the first version, claiming it contained various "ambiguities" including: a prohibition on restricting "access to abortion" when an abortion is "needed to protect the pregnant female's life or health," where it was allegedly unclear if "health" included both mental and physical health and, if only the latter, whether health was "restricted to emergent medical conditions" or "extend[ed] to pregnancies that increase the risk of certain medical complications." Defendant Griffin also took issue with the proposed name of the measure—the Arkansas Reproductive Healthcare Amendment—alleging that it was "tinged with partisan coloring and misleading because [the] proposal is solely related to abortion, not 'reproductive healthcare' generally."[33]

162. In response, AFLG submitted a second version of the abortion amendment with multiple revisions, including: changing the popular name to "the Arkansas Abortion Amendment"; defining the health exception to cover only "physical health," defined as "a physical disorder,

[32] *See generally* David Ramsey, *"We Had to be Perfect" What Went Right and What Went Wrong in the Campaign to Restore Abortion Rights in Arkansas*, Ark. Times (Jan. 29, Feb. 4, Feb. 17, Mar. 12, April 5, 2025), https://arktimes.com/arkansas-blog/2025/04/05/we-had-to-be-perfect.

[33] Ark. Att'y Gen. Tim Griffin, Op. No. 2023-107 at 4-5, (Nov. 28, 2023); *see also* Tess Vrbin, *Arkansas AG Rejects Proposed Ballot Measure to Make Abortion Access a Constitutional Right*, Ark. Advocate (Nov. 28, 2023), https://arkansasadvocate.com/2023/11/28/arkansas-ag-rejects-proposed-ballot-measure-to-make-abortion-access-a-constitutional-right.

physical illness, or physical injury . . . caused by or arising from the pregnancy itself"; and prohibiting the state from denying "abortion services," rather than "access to abortion."[34] Defendant Griffin again rejected the proposal, stating that the definition of "physical health" was "misleading."[35]

163. AFLG then submitted a third version of the abortion amendment that omitted the term "physical health" and instead provided that the State could not prohibit "abortion services" when needed to protect the pregnant person from "a physical disorder, physical illness, or physical injury."[36] Defendant Griffin finally approved this version.

164. *Second*, canvassers for the abortion amendment faced unique harassment and intimidation from anti-abortion advocates, including those with direct ties to Defendant Huckabee Sanders.[37] Hundreds of volunteers from across the state as well as paid canvassers from a company called Verified Arkansas LLC ("Verified") worked to collect signatures to put the amendment on the ballot. The canvassers faced verbal assaults and were often followed by protesters from organized groups, including Family Council Action Committee, Arkansas Right to Life, and Catholic Diocese of Little Rock. Another group, the Arkansas Family Council posted on its website the names and home cities of 79 paid canvassers hired by Verified.[38] Another group called

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[34] Arkansas Abortion Amendment (Dec. 18, 2023), https://arkansasadvocate.com/wp-content/uploads/2023/12/Arkansas-Abortion-Act-ballot-title.pdf.

[35] Ark. Att'y Gen. Tim Griffin, Op. No. 2023-121 (Jan. 4, 2024); *see also* Tess Vrbin, *Arkansas AG Rejects Second Proposed Amendment to Make Abortion a Constitutional Right*, Ark. Advocate (Jan. 4, 2025), https://www.newsfromthestates.com/article/arkansas-ag-rejects-second-proposed-amendment-make-abortion-constitutional-right.

[36] Arkansas Abortion Amendment (Jan. 8, 2024), https://arkansasadvocate.com/wp-content/uploads/2024/01/Arkansas-Abortion-Amendment-1.8.24-submission.pdf.

[37] Barbara Rodriguez & Grace Panetta, *"They Want Us To Be Scared": Protesters Target Organizers for Abortion Ballot Measure in Arkansas*, The 19th, (June 14, 2024), https://19thnews.org/2024/06/arkansas-abortion-ballot-measure-harassment.

[38] Tess Vrbin, *Publication of Abortion Amendment Canvasser List Is Intimidation, Ballot Question Committee Says*, Ark. Advocate (June 7, 2024), http://arkansasadvocate.com/2024/06/07/publication-of-abortion-amendment-canvasser-list-is-intimidation-ballot-question-committee-says.

"Stronger Arkansas," led by Defendant Huckabee Sanders's former campaign manager, former finance director for her campaign, and the mother of her deputy Chief of Staff, was formed specifically to oppose the amendment. [39] Yet by the deadline, the canvassers had surpassed the number of necessary signatures.

165. *Third*, the Arkansas's Secretary of State sought a pretext for refusing to certify the signatures. On July 5, officials from the Secretary of State's office reviewed the paperwork with AFLG leadership and accepted the filing. A week later, however, the Secretary of State unilaterally claimed, using a series of shifting justifications, that AFLG had failed to comply with all of the statutory paperwork requirements for paid canvassers. Specifically, he alleged that AFLG had not submitted a statement to the Secretary of State on July 5 affirming that they had "Explained the requirements under Arkansas law for obtaining signatures on an initiative or referendum petition to each paid canvasser before the paid canvasser solicited signatures." Ark. Code § 7-9-111(f)(2). While the paid canvassers themselves had turned in signed affidavits affirming that they reviewed and followed Arkansas law, AFLG had not submitted an affidavit affirming the same. The paid canvassers had collected 14,143 total signatures and without those signatures, the abortion amendment fell just shy of the required signatures. The Secretary of State thus disqualified the entire petition and gave no opportunity to correct the alleged paperwork error or collect more signatures.[40]

[39] Antoinette Grajeda, *Arkansas Governor's Campaign Manager Leads Abortion Amendment Opposition Group*, Ark. Advocate (Mar. 20, 2024), https://arkansasadvocate.com/2024/03/20/arkansas-governors-campaign-manager-leads-abortion-amendment-opposition-group; Stephanie Kirchgaessner, *How a Rightwing Machine Stopped Arkansas's Ballot Initiative to Roll Back One of the Strictest Abortion Bans*, The Guardian (Oct. 29, 2024), https://www.theguardian.com/us-news/2024/oct/29/arkansas-abortion-ban-ballot.

[40] Letter from John Thurston to Lauren Cowles Re: Proposed Constitutional Amendment, Popular Name: Arkansas Abortion Amendment of 2024 (July 10, 2024), https://npr.brightspotcdn.com/eb/be/78789955401dacd31dc9fc0f43c7/abortion-amendment-letter-7-10-2024.pdf.

166. Defendant Huckabee Sanders mocked the amendment's supporters, stating that, "Today the far left pro-abortion crowd in Arkansas showed they are both immoral and incompetent." Defendant Griffin similarly gloated, "Failure to follow such a basic requirement is inexcusable. The abortion advocates have no one to blame but themselves."[41]

167. In the days that followed, AFLG both contested the Secretary of State's allegations and made several attempts to cure any perceived errors, as allowed by Arkansas law.[42] Among other objections, AFLG noted that it had, in fact, submitted an affidavit to the Attorney General on June 27 that covered each paid canvasser who had been hired up until that date. Yet, Arkansas's position remained unchanged.[43] AFLG thus filed a lawsuit to adjudicate the dispute.

168. *Ultimately*, on August 22, 2024, the deadline by which initiative petitions had to be certified for the ballot, the Arkansas Supreme Court upheld by a 4-3 vote the Secretary of State's refusal to certify the abortion-rights amendment. *Cowles v. Thurston*, 2024 Ark. 121, 695 S.W.3d 60 (2024). The decision had the effect of preventing the proposed amendment from going before voters in November.

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[41] Tess Vrbin, *Updated*: *Arkansas Secretary of State Rejects Proposed Abortion Amendment*, Ark. Advocate (July 10, 2024), https://arkansasadvocate.com/2024/07/10/arkansas-secretary-of-state-rejects-proposed-abortion-amendment.

[42] Letter from Lauren Cowles to John Thurston Re: Response to Your Letter of July 10, 2024, https://arkansasadvocate.com/wp-content/uploads/2024/07/2024-07-11-Response-to-Secretary-Thurston-with-Enclosure-1-1.pdf.

[43] Letter from John Thurston to Lauren Cowles Re: Response to Your Letter of July 11, 2024, https://arkansasadvocate.com/wp-content/uploads/2024/07/Abortion-Amendment-Responsive-Letter-7-15-2024.pdf.

C. It Is Impossible to Apply Arkansas's Definition of "Medical Emergency" to Real Pregnancies

169. Pregnancy can lead to any number of urgent situations where especially prompt termination of pregnancy is necessary to preserve the life of the pregnant person.

170. It is not now, nor has it ever been clear under Arkansas law: 1) *which* health conditions potentially pose sufficient risks to fall within the exception; and 2) *when* in the process of deteriorating health during pregnancy the patient becomes sick enough to be eligible for an abortion under Arkansas's exception.

171. Arkansas's abortion bans put medical providers in an impossible situation: whenever a physician seeks to offer abortion as a treatment option, the physician must always be concerned that a prosecutor, jury, or disciplinary board second guessing their medical judgment will send them to prison and/or revoke their medical license.

172. The following examples illustrate the impossibility of applying Arkansas's definition of "medical emergency" to real complications during pregnancy:

173. An ectopic pregnancy is a pregnancy where a fertilized egg implants and grows outside the typical locations in the uterine cavity, usually in the fallopian tube, but sometimes in the cervix or in the scar of a previous cesarean delivery.[44] Ectopic pregnancies are life-threatening to the pregnant person because the pregnancy can rupture and cause massive internal bleeding. Ectopic pregnancies should be terminated with medication or surgery as soon as possible after diagnosis to preserve the life of the pregnant person.[45]

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[44] *SMFM Consult Series #63: Cesarean Scar Ectopic Pregnancy*, Soc'y for Maternal Fetal Med. (Sept. 2022), https://www.smfm.org/publications/448-smfm-consult-series-63-cesarean-scar-ectopic-pregnancy#:~:text=Cesarean%20scar%20ectopic%20pregnancy%20is,in%20securing%20a%20prompt%20diagnosis.

[45] *See Practice Bulletin 193: Tubal Ectopic Pregnancy*, ACOG (Mar. 2018), https://www.fertilehealthexpert.com/wp-content/uploads/2021/11/Ectopic-Pregnancy-ACOG.pdf.

174. While Arkansas's abortion bans like other state bans exclude "remov[al of] an ectopic pregnancy" from the definition of abortion, abortion bans are nonetheless causing delays in *diagnosis* of ectopic pregnancies. This is because medical providers, fearful of incorrectly labeling a pregnancy ectopic and later facing prosecution, are performing additional steps to diagnose, including additional blood test monitoring over days or weeks. The result is that patients are experiencing the rupture of their ectopic pregnancies during the delay, leading to loss of fertility or even death.[46] A hospital in Texas was cited for violation of federal law when it sent a patient with clear symptoms of ectopic pregnancy home with a pamphlet on miscarriage and instructions to return in a few days for repeat blood testing. The patient, Kyleigh Thurman, lost her fallopian tube when the pregnancy ruptured.[47] A similar complaint on behalf of a different patient, Kelsie Norris-De La Cruz, remains pending.[48]

175. Excessive bleeding, or hemorrhage, can occur during pregnancy for a number of reasons and can lead to organ damage, organ failure, or even death. A variety of preexisting chronic health conditions and health conditions that develop during pregnancy can lead to hemorrhage, including, but not limited to: placenta previa (when the placenta covers the cervix—as was the case for Ms. Van); placental abruption (when the placenta prematurely detaches from the uterine lining); placenta accreta (when the placenta grows into the uterine wall); uterine fibroids (that

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[46] Daniel Grossman et al., *Care Post*-Roe*: Documenting Cases of Poor-Quality Care since the* Dobbs *Decision*, ANSIRH (Sept. 2024) at 11-13, https://www.ansirh.org/sites/default/files/2024-09/ANSIRH%20Care%20Post-Roe%20Report%209.04.24_FINAL%20EMBARGOED_0.pdf.

[47] Admin. Compl., *Thurman v. Ascension Seton Williamson Hosp.*, U.S. Dep't of Health & Human Servs. (Aug. 6, 2024), https://reproductiverights.org/wp-content/uploads/2024/08/Thurman-EMTALA-complaint_2024.pdf; Amanda Seitz, *Texas Hospital that Discharged Woman with Doomed Pregnancy Violated the Law, a Federal Inquiry Finds*, Associated Press (June 4, 2025), https://apnews.com/article/abortion-texas-hospital-doomed-pregnancy-discharge-308ea695a17f72500cbf31622fdb521a.

[48] Admin. Compl., *De La Cruz v. Tex. Health Arlington Mem. Hosp.*, U.S. Dep't of Health & Human Servs. (Aug. 6, 2024), https://reproductiverights.org/wp-content/uploads/2024/08/Norris-De-La-Cruz-EMTALA-complaint-2024.pdf.

inhibit the uterus from contracting effectively and stopping bleeding from the placental implantation site); and other forms of first or second trimester bleeding.[49]

176. Yet because some forms of bleeding during pregnancy are relatively innocuous, it is unclear how much bleeding must occur before an abortion is considered necessary to save the life of the patient. And particularly in early pregnancy, it may be unclear if bleeding is a "miscarriage" or not, leading patients to hemorrhage while awaiting definitive diagnosis that their pregnancy is not viable.[50]

177. Severe forms of hypertension in pregnancy can also lead to life-threatening conditions. For example, preeclampsia is a complication of pregnancy which, when severe, can cause seizures, injury to the pregnant person's liver and kidneys, stroke, and death. HELLP (Hemolysis, Elevated Liver Enzymes, and Low Platelets) syndrome is a particularly dangerous variant of preeclampsia. For some patients, other forms of hypertension (sometimes in conjunction with other chronic conditions like obesity and diabetes) can increase in severity and cause the same complications seen with severe preeclampsia.

178. It is unclear whether medical providers must wait for a patient to develop life-threatening hypertension before offering abortion. If a patient had preeclampsia in a prior pregnancy that led to an emergency delivery and is showing elevated blood pressure in a current pregnancy, is that sufficient for the exception to apply?

179. Infection of the reproductive organs, which can lead to chorioamnionitis (infection of the placenta or amniotic fluid) or sepsis (where the body's response to infection damages its

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[49] *See Practice Bulletin 222: Gestational Hypertension and Preeclampsia*, ACOG (June 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/06/gestational-hypertension-and-preeclampsia; *Practice Bulletin 203: Chronic Hypertension in Pregnancy*, ACOG (Jan. 2019), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2019/01/chronic-hypertension-in-pregnancy.

[50] Grossman, *supra* n.46 at 17-18.

own tissue), is another risk that can cause a pregnant person's medical condition to become an emergency. Premature dilation of the cervix, for example, dramatically increases a pregnant person's risk of infection and can be caused by conditions like an incompetent cervix (weak cervical tissue) and/or PPROM before the onset of labor. PPROM has a relatively high incidence, occurring in approximately 2% to 3% of pregnancies in the United States.[51]

180. Yet as Ms. Waldorf's and Dr. Taylor's experiences show, medical providers in Arkansas do not know if an incompetent cervix diagnosis on its own and/or PPROM on its own is a "medical emergency" under Arkansas's abortion bans. While the standard of care is to offer abortion upon diagnosis of either condition, medical providers in Arkansas now routinely send patients home to get worse or watch patients deteriorate in front of them—a practice unheard of in medicine—because they worry that without signs of potentially septic infection, abortion is not yet necessary to save the patient's life. In the words of Ms. Waldorf's providers, they have no other choice because they "cannot rule out the possibility of an overzealous prosecutor."

181. Other medical conditions can become life threatening during pregnancy, either because being pregnant causes or exacerbates a chronic condition or increases other health risks, or because treatment for the chronic condition is unsafe while pregnant. For example: certain cancers requiring radiation, chemotherapy, or major surgery; certain cardiac, autoimmune, respiratory, or endocrine diseases; certain cases of hyperemesis gravidarum; and certain psychiatric conditions like bipolar disorder, major depressive disorder, anxiety disorders, and psychotic disorders can all be life-threatening, depending on the circumstances. Intentional acts of violence or accidents, e.g., motor vehicle crashes, firearm violence, intimate partner violence, etc.,

[51] *See Practice Bulletin 217: Prelabor Rupture of Membranes*, ACOG (Mar. 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/03/prelabor-rupture-of-membranes.

and substance use disorder can also lead to medical emergencies. Because each patient's circumstances are unique, it is within the purview of the patient's medical provider to determine whether the patient's comorbidities and/or other circumstances make abortion part of the patient's recommended course of treatment.[52]

182. Again, the impossible task for any physician in Arkansas is to determine when in the progression of any of these diseases a patient is sick enough that abortion is necessary to save the patient's life.

183. In addition, certain fetal conditions or diagnoses can increase the risks to a pregnant person's health such that, when combined with the patient's other comorbidities, her medical provider may determine that an abortion is necessary or recommended to prevent serious jeopardy to the pregnant person's health.

184. For example, neural tube defects (like anencephaly); certain trisomies like trisomy 13 and 18 (the presence of an extra chromosome); triploidy (the presence of an extra set of chromosomes); certain gastric and cardiac defects in the fetus; and Potter syndrome (where the fetus does not properly develop kidneys), are examples of conditions where the fetus either will not survive delivery or likely will not survive more than a few hours or days after birth. The standard of care is to offer abortion to patients with such pregnancies, as abortion is typically medically safer, both physically and mentally, for the pregnant person than carrying the pregnancy to term and delivering a baby with no meaningful chance of survival.

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[52] *See High-Risk Pregnancy*, Cleveland Clinic, https://my.clevelandclinic.org/health/diseases/22190-high-risk-pregnancy (last updated Dec. 14, 2021) (describing how certain preexisting conditions exacerbate the risks of the pregnancy); *Practice Bulletin 189: Nausea and Vomiting of Pregnancy*, ACOG (Jan. 2018), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/01/nausea-and-vomiting-of-pregnancy; Nicole T. Christian & Virginia F. Borges, *What* Dobbs *Means for Patients with Breast Cancer*, 387 N. Engl. J. Med. 765-67 (Sept. 1, 2022).

185. Some fetal conditions present particularly acute risks to the pregnant person. For example, partial molar pregnancy is a condition where the placenta transforms into an invasive pre-cancerous tumor, thus creating an emergency for the pregnant person. Mirror syndrome is a condition where the pregnant person and fetus both experience severe fluid retention that can lead to both fetal and maternal demise.

186. In the case of multiple pregnancies (twins, triplets, etc.), a fetal condition in one or more of the fetuses, combined with the pregnant person's other comorbidities, may be a medical indication for selective abortion (sometimes called selective "fetal reduction" or "fetal termination") of one (or more) fetus where necessary to give the pregnant person and the remaining fetus(es) the best chance of survival.[53]

187. It is for the pregnant person to weigh the risks and benefits of the pregnancy for them and their family and decide the best course. The standard of care is thus to thoroughly counsel the patient about the medical diagnosis(es) and offer both expectant management and abortion and allow the patient to choose the best course.

188. The complexity of pregnancy and its health impacts are not limited to medical indications. Many other factors in a pregnant person's life—including their relationship with their sexual partner or lack thereof, economic status, educational and professional plans, existence of other children, and other familiar factors—all influence whether a pregnancy is well-timed for the person and their family. Research has shown that denial of abortion for unwanted pregnancy has significant mental, physical, and socioeconomic consequences on a person's life and family.[54]

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[53] *Practice Bulletin 231: Multifetal Gestations Twin Triplet and Higher-Order Multifetal Pregnancies*, ACOG (June 2021), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2021/06/multifetal-gestations-twin-triplet-and-higher-order-multifetal-pregnancies.

[54] *See generally* ANSIRH, The Turnaway Study, https://www.ansirh.org/research/ongoing/turnaway-study.

189. The discussion above highlights some of the reasons patients seek abortion care, but the list is by no means exhaustive, nor could it be. Mainstream medical associations emphasize that physician discretion to diagnose and treat pregnancy, and patient autonomy over their pregnancy, is paramount to patient health.

D. Pregnancy in Arkansas Is Dangerous, and Travel Out-of-State Is Often Treacherous, If Not Impossible

190. Arkansas's abortion bans are contributing to an already alarming healthcare crisis in Arkansas for women, children, and families.

191. Arkansas ranks #1 in the country for maternal mortality,[55] #1 in the country for teen birth rate (twice the national average),[56] and #3 in the country for infant mortality.[57]

192. According to the most recent data available from Arkansas's Maternal Mortality Review Committee, a staggering 94% of maternal deaths were preventable.[58]

193. Over 50% of Arkansas counties are maternity care deserts, and Arkansas ranks sixth in terms of states with the highest percentage of maternity care deserts.[59] Since *Roe* was overturned, even more Arkansas hospitals are closing their maternity wards.[60]

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[55] Kaiser Family Found., *Maternal Deaths and Mortality Rates per 100,000 Live Births (2018-2022)*, https://www.kff.org/state-health-policy-data/state-indicator/maternal-deaths-and-mortality-rates-per-100000-live-births/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; Sonny Albarado, *If Arkansas Claims to Protect Life, it Needs to Do More for Mothers and Infants*, Ark. Advocate (Jan 30, 2024), https://arkansasadvocate.com/2024/01/30/if-arkansas-claims-to-protect-life-it-needs-to-do-more-for-mothers-and-infants/.

[56] Nastassja Campell, *The Challenge of Arkansas Teen Births Facing Reality to Lower the Nation's Highest Rate*, Ark. Advocates for Children & Fams. (Oct. 2022), https://www.aradvocates.org/wp-content/uploads/AACF.teen_.birth_.webfinal.9.30.2022.pdf.

[57] Ark. Dep't of Health, Primary Care Needs Assessment of Arkansas (2020), https://healthy.arkansas.gov/wp-content/uploads/Office_of_Rural_Health_and_Primary_Care_Primary_Care_Needs_Assessment.pdf.

[58] Ark. Dep't of Health, Arkansas Maternal Mortality, 2018-2022 Deaths, https://healthy.arkansas.gov/wp-content/uploads/Factsheet-MMRC-2025-for-web.pdf.

[59] March of Dimes, Maternity Care Desert: Arkansas, https://www.marchofdimes.org/peristats/data?reg=99&top=23&stop=641&lev=1&slev=4&obj=9&sreg=05.

[60] Annie Gowen, *This State Calls Itself the 'Most Pro-Life.' But Moms There Keep Dying*, Wash. Post (Aug. 27, 2024), https://www.washingtonpost.com/nation/2024/08/27/arkansas-maternal-mortality-rate-abortion-ban.

194. Twenty-eight percent of Arkansas counties do not have a hospital at all.[61]

195. Since *Roe* was overturned, research has consistently demonstrated the increased health harms—both physical and emotional—to people living in states with abortion bans, including Arkansas.[62] This includes peer reviewed research that has found: abortion bans cause fear and confusion among the medical profession and administrative delays that endanger patient

[61] Ark. Dep't of Health, Primary Care Needs Assessment of Arkansas (2020), https://healthy.arkansas.gov/wp-content/uploads/Office_of_Rural_Health_and_Primary_Care_Primary_Care_Needs_Assessment.pdf.

[62] *See, e.g.*, Resound Research, *How Texas Abortion Bans Affect Mental and Emotional Well-Being*(Sept. 16, 2025), https://resoundrh.org/how-texas-abortion-bans-affect-mental-and-emotional-well-being; Physicians for Human Rights, *Cascading Harms: How Abortion Bans Lead to Discriminatory Care Across Medical Specialties* (Sept. 30, 2025), https://phr.org/our-work/resources/cascading-harms-how-abortion-bans-lead-to-discriminatory-care-across-medical-specialties; Daniel Grossman et al., *Care Post*-Roe*: Documenting Cases of Poor-Quality Care since the* Dobbs *Decision*, ANSIRH (Sept. 2024) at 11-13, https://www.ansirh.org/sites/default/files/2024-09/ANSIRH%20Care%20Post-Roe%20Report%209.04.24_FINAL%20EMBARGOED_0.pdf; Physicians for Human Rights, *Criminalized Care: How Louisiana's Abortion Bans Endanger Patients and Clinicians* (Mar. 19, 2024), https://phr.org/our-work/resources/louisiana-abortion-bans; Physicians for Human Rights, *No One Could Say: Accessing Emergency Obstetrics Information as a Prospective Prenatal Patient in Post*-Roe *Oklahoma* (Apr. 2023), https://phr.org/wp-content/uploads/2023/04/Oklahoma-Abortion-Ban-Report-2023.pdf; Drew Amorosi, *Treat the Mother or Save the Baby? Unraveling* Dobbs *Decision's Impact on Cancer Care*, 23 HemOnc Today 13 (Oct. 10, 2022).

health;[63] abortion bans cause an increase in blood transfusions for pregnancy loss;[64] delayed care for PPROM patients under abortion bans leads to infection, hemorrhage, ICU admission, blood transfusion, and hysterectomy;[65] and states with abortion bans, including Arkansas, have seen increased infant mortality since the bans went into effect.[66]

196. Meanwhile, traveling out-of-state for pregnancy care, including abortion, is complex and costly, if not outright dangerous. This is particularly true in Arkansas.

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[63] *See, e.g.*, Nisha Verma et al., *A Qualitative Exploration of the Impact of Abortion Restrictions on People with High Risk Pregnancies in Georgia*, 151 Contraception (2025), https://www.contraceptionjournal.org/article/S0010-7824(25)00233-1/fulltext; Lauren Thaxton et al., *Texas' Abortion Ban Conflicts With Person-Centered Health Care: Experiences of Texans With Medically Complex Pregnancies*, Women's Health Issues (2025), https://www.whijournal.com/article/S1049-3867(25)00136-7/fulltext; Abigail Cutler et al., *Experiences of Obstetrician-Gynecologists Providing Pregnancy Care After* Dobbs, 8(3) JAMA Network Open (2025), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2831948; Samantha M. McKetchnie et al., *"I Feel Like there's a Politician in the Room": Provider Perceptions of the Impacts of State Abortion Bans on Physician-Patient Relationships*, 11 Soc. Work & Public Health 1 (2025), https://doi.org/10.1080/19371918.2025.2557349; Rachel Jensen et al., *Semantics Matter: Maternal-Fetal Medicine Physician Perspectives on Defining Abortion Care in the Post*-Dobbs *Southeast*, 34(6) J. Women's Health 760 (2025), https://doi.org/10.1089/jwh.2024.0639; Erika L. Sabbath et al., *Are State Abortion Bans an Occupational Health Hazard for Obstetrician-Gynaecologists? Findings from a Multistate Qualitative Study*, 81 (10) Occupational & Envtl. Med. 493 (2024), https://oem.bmj.com/content/81/10/493; Erika L. Sabbath et al., US Obstetrician-Gynecologists' Perceived Impacts of Post–Dobbs v Jackson State Abortion Bans, 7(1) JAMA Network Open (2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2814017; Katherine Rivlin et al., *State Abortion Policy and Moral Distress Among Clinicians Providing Abortion After the* Dobbs *Decision*, 7 JAMA Network Open 8 (2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2821810; Abby Schultz et al., *Impact of Post*-Dobbs *Abortion Restrictions on Maternal-Fetal Medicine Physicians in the Southeast: A Qualitative Study*, Am. J. of Obstetrics & Gynecology (2024), https://pubmed.ncbi.nlm.nih.gov/38772442/; Danielle Czarnecki et al., *State of Confusion: Ohio's Restrictive Abortion Landscape and the Production of Uncertainty in Reproductive Health Care*, 64(4) J. Health & Soc. Behavior 470 (2023), https://doi.org/10.1177/00221465231172l7; Whitney Arey et al., *Abortion Access and Medically Complex Pregnancies Before and After Texas Senate Bill 8*, 141 Obstetrics & Gynecology 5 (May 2023); Whitney Arey et al., *A Preview of the Dangerous Future of Abortion Bans – Texas Senate Bill 8*, 387 N. Engl. J. Med. 388 (Aug. 4, 2022).

[64] Amanda Nagle et al., *Blood Transfusions for Pregnancy Loss in Texas Before and After Abortion Bans, 2017–2023*, Am. J. of Pub. Health (Nov. 2025).

[65] *See* Mara Buchbinder et al., *Medical Uncertainty in the Shadow of* Dobbs: *Treating Obstetric Complications in a New Reproductive Frontier*, Soc. Sci. & Med. (2025), https://doi.org/10.1016/j.socscimed.2025.117856; Anjali Nambiar, et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in Two Texas Hospitals After Legislation on Abortion*, 227 Am. J. Obstetrics & Gynecology 648 (2022), https://doi.org/10.1016/j.ajog.2022.06.060.

[66] Alison Gemmill, et al., *US Abortion Bans and Infant Mortality*, 15 JAMA (Apr. 2025), https://pubmed.ncbi.nlm.nih.gov/39946113.

197. The Society of Family Planning estimates that since *Roe* was overturned, approximately 1,300 Arkansans travel out of state for abortion per year.[67]

198. Arkansas is approximately 270 miles wide and 240 miles long, and aside from a handful of urban centers, the state is predominately rural. Forty-one percent of Arkansans live in rural communities.[68]

199. Arkansas ranks fifth highest in the nation for percentage of people living in poverty.[69] One third of pregnant rural Arkansans are on Medicaid,[70] and Arkansas is one of only two states in the country that has not expanded Medicaid postpartum coverage to one year.[71]

200. Many Arkansans in rural areas and/or in poverty have never been on an airplane before and lack access to reliable transportation.

201. Arkansas is surrounded on nearly all sides by other states with complete abortion bans: Tennessee, Mississippi, Louisiana, Texas, and Oklahoma. The only bordering state where abortion is technically legal is Missouri, yet ongoing legal battles have limited the availability of abortion in Missouri to locations in St. Louis that are variably open then closed again, due to constantly changing legal orders.

202. Kansas is the closest state to Arkansas without an abortion ban, but it is a three-and-a-half hour drive to medical providers in Kansas who can perform abortions from

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[67] Soc'y of Fam. Plan., #WeCount Report, April 2022 to June 2024 (Oct. 22, 2024), https://societyfp.org/wp-content/uploads/2024/10/WeCount-Report-8-June-2024-data.pdf.

[68] Ark. Dep't of Health, Primary Care Needs Assessment of Arkansas (2020), https://healthy.arkansas.gov/wp-content/uploads/Office_of_Rural_Health_and_Primary_Care_Primary_Care_Needs_Assessment.pdf.

[69] Ark. Dep't of Health, Primary Care Needs Assessment of Arkansas (2020), https://healthy.arkansas.gov/wp-content/uploads/Office_of_Rural_Health_and_Primary_Care_Primary_Care_Needs_Assessment.pdf.

[70] Antoinette Grajeda, *Nearly a Third of Pregnant Rural Arkansans Rely On Medicaid, Study Shows*, Ark. Advocate (May 15, 2025), https://arkansasadvocate.com/2025/05/15/nearly-a-third-of-pregnant-rural-arkansans-rely-on-medicaid-study-shows/.

[71] Annie Gowen, *This State Calls Itself the 'Most Pro-Life.' But Moms There Keep Dying*, Wash. Post (Aug. 27, 2024), https://www.washingtonpost.com/nation/2024/08/27/arkansas-maternal-mortality-rate-abortion-ban.

Fayetteville, the closest urban center in Arkansas. In addition, abortion is highly regulated in Kansas. For example, while it is currently blocked by a temporary injunction, Kansas has a 24-hour waiting period between state-mandated biased counseling and receiving an abortion, and abortion is generally prohibited in Kansas after 22 weeks.

203. Illinois has less restricted abortion access, but travel to abortion providers in Illinois is even more onerous for Arkansans. The southernmost abortion providers in Illinois are a five-hour drive from Little Rock and more than seven hours from Fayetteville and Fort Smith.

204. Traveling for abortion care is expensive, and none of it is covered by insurance. The cost of the procedure, plus the costs of travel—gas, flights, hotels, incidentals, etc.—and childcare during the patient's travel, can easily add up to thousands of dollars even under the best circumstances, even more if there are complications or delays.

205. Traveling for abortion care also carries physical and emotional risks, not only for the pregnant person but for their family.

206. Due to the risks of and barriers to travel for out-of-state abortion care, many Arkansans, like Ms. Van, are unable to travel and are instead forced to give birth against their will.

E. Arkansas's Abortion Bans Are Hopelessly Vague

207. The Arkansas Constitution protects against criminal laws that give insufficient guidance to the accused regarding what conduct is and is not criminal. Particularly when "life" and "liberty" is at stake, a criminal statute is unconstitutionally vague when it lacks clarity. *See* Ark. Const., Art. 2, § 8.

208. The Arkansas Courts have long emphasized the importance of clarity in criminal laws and concluded that statutes which are too vague to be effective are void in their entirety. *Snow v. Riggs*, 172 Ark. 835 (1927); *see also A. B. Small Co. v. Am. Sugar Refining Co.*, 267 U.S. 233, 239 (1925). This is because "[c]riminality depends, under [a vague law], upon the moral

idiosyncrasies of the individuals who compose the court and jury. The standard of crime would be ever varying, and the courts would constantly be appealed to as the instruments of moral reform, changing with all fluctuations of moral sentiment. The law is simply null." *Ex parte Jackson*, 45 Ark. 158, 164 (1885).

209. The Arkansas Supreme Court has, in fact, struck down various laws—both criminal and civil—that were so poorly drafted as to be unconstitutionally vague. In such cases, the Court has found that facial invalidation is the proper remedy. *See, e.g.*, *Alc. Bev. Control Div. v. R.C. Edwards Distrib. Co.*, 284 Ark. 336, 339 (1984), *Davis v. Smith*, 266 Ark. 112, 118 (1979); *State v. Bryant*, 219 Ark. 313, 315 (1951).

210. In assessing a law's vagueness, Arkansas Courts look to various factors, including: whether the law is a criminal statute with a vague exception; the importance of the right at stake; and use of terminology with no accepted meaning in the relevant profession.

211. Arkansas's abortion bans embody all of these factors: the bans subject physicians to criminal liability subject to a vague exception; the liberty of the physician and the life of the patient are both at stake; and physicians in Arkansas like Dr. Taylor have affirmed that the language of the "medical emergency" exception has no meaning in the medical profession.

212. Under long-standing Arkansas law, Arkansas's abortion bans are the quintessential example of unconstitutional vagueness.

213. Indeed, Courts in other states examining similar laws have already concluded that such abortion bans are unconstitutionally vague. *See Blackmon v. Tennessee*, No. 23-1196-IV(I) (Davidson Cty. Ch. Ct., Oct. 17, 2024); *Phillips v. Tennessee*, No. 23-1196-IV(I) (Davidson Cty. Ch. Ct., Oct. 16, 2025).

F. The Arkansas Constitution Protects Arkansans' Inherent Rights to Equality, Life, Liberty, and Happiness

214. The Arkansas Constitution is more protective of individual rights than either the federal Constitution or many other state constitutions. Arkansas—like Kansas, Oklahoma, Indiana, and North Dakota among others—affirmatively protects "certain inherent and inalienable rights" as fundamental to its citizens. In Arkansas, these include the rights to "enjoying and defending life and liberty" and "of pursuing their own happiness." Ark. Cont. art. 2, § 2. The provision of the Arkansas Constitution containing this language, entitled "Individual liberty," goes on to state that "[t]o secure these rights governments are instituted among men, deriving their just powers from the consent of the governed."

215. Arkansas's abortion bans deny Arkansans the reproductive autonomy to build their families in the ways and at the times that are right for them and denies pregnant Arkansans the ability to protect their lives, their fertility, and their overall physical, mental, social, and economic health. As such, Arkansas's abortion bans deny Arkansans their fundamental rights under Article 2, section 2 of the Arkansas Constitution and are facially unconstitutional.

216. The Arkansas Constitution also protects the equality of all Arkansans under multiple provisions of the Arkansas Constitution. Ark. Const. art. 2, §§ 2, 3, 18. The Arkansas Supreme Court has interpreted this guarantee of equality to apply to all Arkansans, regardless of gender or sex. *See Howton v. State*, 2021 Ark. App. 86, at *7 (2021).

217. Arkansas's abortion bans deny pregnant Arkansans equality under the law by stripping Arkansans of their ability to protect their own health and families as soon as they become pregnant. As such, Arkansas's abortion bans thus deny Arkansans of legal equality under Article 2, section 3 of the Arkansas Constitution and are facially unconstitutional.

CLAIMS FOR RELIEF

COUNT I: UNCONSTITUTIONAL VAGUENESS

218. The allegations in paragraphs 1 through 217 above are incorporated as if fully set forth herein.

219. By failing to give physicians fair notice of how to ensure their conduct falls within the constrained limits of the medical emergency exception to Arkansas's abortion bans and permitting arbitrary enforcement of the abortion bans, the abortion bans are unconstitutionally vague and violate physicians' right to due process as guaranteed by Article 2, section 8 of the Arkansas Constitution.

220. Defendants' ongoing enforcement of Arkansas's abortion bans is thus *ultra vires*, unconstitutional, and illegal.

221. Because Arkansas's abortion bans are unconstitutionally vague, they are invalid and must be struck down in their entirety.

COUNT II: FUNDAMENTAL RIGHT TO LIFE, LIBERTY, AND HAPPINESS

222. The allegations in paragraphs 1 through 221 above are incorporated as if fully set forth herein.

223. Article 2, section 2 of the Arkansas Constitution affirmatively protects "certain inherent and inalienable rights" as fundamental "individual libert[ies]," including the rights to "enjoying and defending life and liberty" and "of pursuing their own happiness."

224. Because Arkansas's abortion bans prohibit pregnant Arkansans from exercising their inherent and inalienable rights to life, liberty, and the pursuit of their own happiness whenever exercising those rights involves accessing medical care during pregnancy that would terminate the pregnancy under Arkansas's definition of "abortion," Arkansas's abortion bans are unconstitutional.

225. Arkansas's abortion bans do not serve a compelling or important state interest and are not sufficiently tailored to serve any compelling interest.

226. Arkansas's abortion bans also lack any rational relationship to protecting life, health, or any other legitimate state interest.

227. Defendants' ongoing enforcement of Arkansas's abortion bans is thus *ultra vires*, unconstitutional, and illegal.

228. Because Arkansas's abortion bans are unconstitutional under Article 2, section 2 of the Arkansas Constitution, they are invalid and must be struck down in their entirety.

CLAIM III: RIGHT TO EQUALITY

229. The allegations in paragraphs 1 through 228 above are incorporated as if fully set forth herein.

230. Article 2, sections 2, 3, and 18 of the Arkansas Constitution protects the equality of all Arkansans and guarantees equal protection under the law. Section 2 guarantees that "[a]ll men are created equally free and independent." Section 3 assures that "[t]he equality of all persons before the law is recognized and shall ever remain inviolate; nor shall any citizen ever be deprived of any right, privilege or immunity; nor exempted from any burden or duty, on account of race, color or previous condition." And section 18 provides that "[t]he General Assembly shall not grant to any citizen, or class of citizens, privileges or immunities which, upon the same terms, shall not equally belong to all citizens." These protections must include pregnant Arkansans.

231. Because Arkansas's abortion bans discriminate against pregnant Arkansans in the exercise of their fundamental rights under the Arkansas Constitution, Arkansas's abortion bans violate pregnant Arkansans' constitutional rights to equality.

232. Arkansas's abortion bans do not serve a compelling or important state interest and are not sufficiently tailored to serve any compelling interest.

233. Arkansas's abortion bans also lack any rational relationship to protecting life, health, or any other legitimate state interest.

234. Defendants' ongoing enforcement of Arkansas's abortion bans is thus *ultra vires*, unconstitutional, and illegal.

235. Because Arkansas's abortion bans are unconstitutional under Article 2, section 3 of the Arkansas Constitution, they are invalid and must be struck down in their entirety.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs ask this Court to enter judgment:

A. Declaring that Arkansas's abortion bans are invalid and unenforceable because they violate the Arkansas Constitution;

B. Enjoining Defendants, their respective agents, officers, employees, and successors, and all persons acting in concert with each or any of them, from enforcing Arkansas's abortion bans;

C. Granting any such other and further relief as this Court deems just and proper.

Dated: January 28, 2026

Respectfully submitted,

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* Application for admission Pro hac vice forthcoming

VERIFICATION

STATE OF ~~ARKANSAS~~ Texas **)**
)ss.
COUNTY OF PULASKI Harris **)**

On the date set form below came before me, a Notary Public in and for the State and County aforesaid, Emily Waldorf, who after being identified as such by government-issued identification, and after being sworn to tell the truth, stated that she is the same person of that name who is a Plaintiff in the above and foregoing Complaint; that she has read the Complaint; and that the facts and allegations contained therein are true and correct to the bets of her knowledge, information, and belief.

Emily Waldorf 01/27/2026
Emily Waldorf

SUBSCRIBED AND SWORN TO before me, a Notary Public, on this 27th day of January, 20 26.

NOTARY PUBLIC STATE OF TEXAS
Odette Wilson
ID NUMBER
134220252
COMMISSION EXPIRES
February 24, 2027

Odette Wilson
Notary Public

Electronically signed and notarized online using the Proof platform.

Exhibit 1

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December 24, 2024

Tom Olmstead, General Counsel
Washington Regional Medical System
3215 N. Northhills Blvd.
Fayetteville, AR 72703

Re: Unreasonable and Excessive Billing for Emily Waldorf Hospital Visit

To Mr. Olmstead:

I am writing on behalf of my client Emily Waldorf, who visited your facility, Washington Regional Medical System, for a serious obstetrical complication on September 16-21, 2024. Ms. Waldorf was denied time-sensitive and potentially life-saving healthcare at your facility, which she later received at a Kansas hospital. Nonetheless, Ms. Waldorf has since received exorbitant and unreasonable medical bills from Washington Regional and its affiliates—totaling nearly $6,000. Under the circumstances, these bills are unconscionable, and I write to request that you forgive this debt immediately.

As you know, early in the morning on September 16, 2024, at 17 weeks pregnant, Ms. Waldorf began experiencing vaginal bleeding and symptoms of premature cervical dilation. She arrived at Washington Regional and was instructed by the hospital emergency department to report to labor and delivery for triage. Ms. Waldorf was then evaluated, diagnosed with cervical insufficiency, and told that her amniotic sac was bulging through her cervix. Ms. Wadorf was admitted for observation but was not provided with antibiotics or any other medications to aid labor, despite her repeated requests for both. On the morning of September 19, Ms. Waldorf's water broke. Still, she was not provided with medications to aid labor or any other treatments.

After her water broke, Washington Regional staff gave Ms. Waldorf only two options: (1) stay in the hospital for observation to wait until she became dangerously ill and thus sick enough to be eligible for induction of labor under Arkansas' abortion ban; or (2) check herself out and find a way to get to Kansas on her own. Ms. Waldorf was terrified she would rapidly deteriorate on the drive, and both she and her medical team knew that the appropriate treatment to protect her life and fertility was induction of labor. Yet she was denied this treatment because Washington Regional's staff feared that it violated Arkansas's abortion ban. When Ms. Waldorf requested a medical transfer to a facility who could treat her, Washington Regional refused.

CENTER *for* REPRODUCTIVE RIGHTS

It was not until Ms. Waldorf retained me as her attorney on September 20 that hospital staff reluctantly agreed to facilitate an ambulance transfer to Kansas. Even then, the transfer was conditioned on my ability, as her attorney, to identify a facility and physician to accept her and provide all necessary logistical support. Thankfully, I was able to do so, and Ms. Waldorf arrived safely in Kansas on September 21 where she received a labor induction abortion. While she experienced medical complications due to her delay in care, she survived with her life and fertility intact.

As you also know, Ms. Waldorf believes that the deficient medical care she received at Washington Regional constituted a violation of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd ("EMTALA"). Ms. Waldorf, through me as her attorney, has submitted a complaint to the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services as well as the Office of Civil Rights alleging violations of EMTALA, which is currently under investigation. You are no doubt aware that EMTALA also provides a private right of action for civil penalties. *See* 42 U.S.C. 1395dd. Ms. Waldorf is currently considering all of her legal options.

This alarming sequence of events notwithstanding, Ms. Waldorf has received the following medical bills (see attached) from Washington Regional and its affiliates:

	Date	*Amount*
Washington County Regional Ambulance Authority	Oct. 21, 2024	$5,108.28
Washington Regional	Nov. 8, 2024	$848.78
		$5,957.06 total

Ms. Waldorf has also received bills totaling $3,120.91 for the care she received in Kansas. When all of these bills are combined, Ms. Waldorf is over $9,000 in debt for the most traumatic experience of her life. This total does not even include the therapy and mental health treatments Ms. Waldorf has sought to address the trauma of losing her child while simultaneously almost losing her own life. Washington Regional's failure to protect Ms. Waldorf's health and life—while billing her for that deficient care—is particularly galling, as Ms. Waldorf is an employee of Washington Regional, and she and her family receive their health insurance coverage through Washington Regional's health plan.

Ms. Waldorf and her family want to move on from this horrifying experience without the added burden of cripplingly high bills. On behalf of my client, I request that Washington Regional forgive the bills above. **I request a response to this letter by January 7, 2025.**

Sincerely,

/s/ Molly Duane
Molly Duane
Senior Staff Attorney
Center for Reproductive Rights

Washington County Regional Ambulance Authority

CENTRAL EMS

PO Box 1162
Searcy AR 72145

Statement Date: October 21, 2024
Account Number: 1714524
Responsible Party: WALDORF,EMILY

If we do not have your insurance on file, please fill out & sign the tear off portion & mail to the address on the Statement.

Account Summary

Total Charges	$6,225.50
Insurance Payments/Adjustments	$1,117.22
Your Payments/Adjustments	$0.00
Your Current Balance	**$5,108.28**

Amount due by November 20, 2024

$5,108.28

Pay by Phone
Call 479-521-5801 to make payment arrangements.
Monday - Friday, 8am to 5pm.

Pay by Mail
Complete the form below and return in the enclosed envelope with your payment.

Pay Online
https://payground.com/centralems

Detach the bottom portion to return with your payment.

Washington County Regional Ambulance Authority

CENTRAL EMS

PO Box 1162
Searcy AR 72145

AUTOMIXED AADC 750 4 MAAD 148957AA22-A-1
657 1 MB 0.617

WALDORF EMILY
[redacted]

Statement Date: October 21, 2024
Account Number: 1714524

You owe $5,108.28
Due by November 20, 2024

Amount enclosed:

$

Mail payment to:

WASHINGTON COUNTY REGIONAL AMBULANCE AUT
PO BOX 1162
SEARCY AR 72145

Washington County Regional Ambulance Authority

CENTRAL EMS

PO Box 1162
Searcy AR 72145

Statement Date: October 21, 2024
Account Number: 1714524
Responsible Party: WALDORF,EMILY

Transport for BLS

September 20, 2024

Acct#: 17145240101

Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Balance
2024-09-20	BLS Non-Emergency	$750.00			
2024-09-20	Mileage	$5,475.50			
2024-10-18	Payment - BCBS - (010009666738)		-$1,000.00		
2024-10-18	Adjustment - BCBS - (010009666738)		-$117.22		
	Your Responsibility				**$5,108.28**

1. Primary Insurance:

Patient Name _____

Insurance Co. Name _____ Effective Date

Insurance Co. Address _____

City/St _____ Zip _____ Phone _____

Policy # _____ Group # _____

Policy Holder's Name _____ Relationship _____

2. Secondary Insurance:

Patient Name _____

Insurance Co. Name _____ Effective Date

Insurance Co. Address _____

City/St _____ Zip _____ Phone _____

Policy # _____ Group # _____

Policy Holder's Name _____ Relationship

I authorize the submission of a claim to Medicare, Medicaid or any other payer for any services provided to me by Washington County Regional Ambulance Aut whether in the past, now or in the future. I acknowledge that I am financially responsible for the services and supplies provided to me by Washington County Regional Ambulance Aut, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which will or has been paid by my insurance. I agree to immediately remit to Washington County Regional Ambulance Aut any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Washington County Regional Ambulance Aut. I authorize Washington County Regional Ambulance Aut to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to Washington County Regional Ambulance Aut and or billing agents, the Centers for Medicare and Medicaid Services, and its agents and contractors and/or any other payers or insurers and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Washington County Regional Ambulance Aut, in the past, now or in the future. I also authorize Washington County Regional Ambulance Aut to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

Signature: _____ Date: _____ Relationship of signer: _____

MID-1000

Washington Regional

Amount Due: $848.78

Summary of Charges

Portal Reference Number:	10177736
Statement Date:	11/8/2024
Due Date:	11/28/2024
Guarantor Name:	EMILY WALDORF

Amount Due: $848.78

Important Messages

Thank you for choosing Washington Regional for your healthcare needs. Your account is now due. Please pay in full now. If you are unable to pay in full and would like to establish a payment plan, please call one of our Customer Service Representatives at (888) 379-0053. For Financial Assistance, please call (479) 463-6000.

ESPAÑOL:
Si usted tiene alguna pregunta acerca de esta cuenta, por favor, llame a nuestra oficina al (888) 379-0053.

MARSHALLESE:
Elane elon jabrewot am kajitok ikijen elmokit in jouj im kir lok opiij eo am ilo (888) 379-0053.

Online Bill Pay

A fast, convenient way to manage your bill

www.evokepay.com/washingtonregionalmedical

Manage Your Account

Access Your Bill And Pay Online
Use your Reference Number: 10177736 to pay your balance online.

For Questions or to Pay By Phone
Call us Monday-Friday 8:00AM-7:00PM Friday 8:00AM - 7:00PM at (888) 379-0053.

Set up a Payment Plan
You can now set up and manage payment plans online.

V0248222771 - 007571 - 001/002

Washington Regional
P.O. Box 1128
Fayetteville AR 72702

1 of 2

Patient Statement

For help with billing questions,
please call: (479) 265-9185
Hours: Mon-Fri 8:00AM-7:00PM

ADDRESSEE:

EMILY WALDORF

[redacted]

0024 007571

Guarantor Name	EMILY WALDORF
Reference Number	10177736
Amount Due	$848.78
Due Date	11/28/2024

See reverse side for credit card options.

MAKE CHECKS PAYABLE AND REMIT TO:

WASHINGTON REGIONAL
PO BOX 1128
FAYETTEVILLE AR 72702

Washington Regional

Pay Online: www.evokepay.com/washingtonregionalmedical
(888) 379-0053

Date	Service Description	Charges	Payments/ Adjustments	Patient Balance
	Patient: WALDORF,EMILY Visit Number: H2105020446			
	Total Charges:	**$14,756.35**		
	Insurance Payments:		-$4,191.92	
	Insurance Adjustments:		$0.00	
	Other Payments:		$0.00	
	Other Adjustments:		-$9,779.09	
	Insurance Balance:		$0.00	
	Patient Balance for Visit Number: H2105020446			$785.34
	Patient: WALDORF,EMILY Visit Number: P2105020446			
	Total Charges:	**$1,069.00**		
	Insurance Payments:		-$758.55	
	Insurance Adjustments:		$0.00	
	Other Payments:		$0.00	
	Other Adjustments:		-$247.01	
	Insurance Balance:		$0.00	
	Patient Balance for Visit Number: P2105020446			$63.44
	Total Amount Due			**$848.78**

Exhibit 2

WashingtonRegional
Medical Center

3215 N. North Hills Blvd.
Fayetteville, AR 72703
Phone: (479) 463-5000
Facsimile: (479) 463-5977

January 7, 2025

Ms. Molly Duane
Center for Reproductive Rights
199 Water Street, Floor 22
New York, NY 20038

Re: Center for Reproductive Rights Demand Letter of December 24, 2024

Dear Ms. Duane:

Washington Regional Medical Center ("WRMC") does not agree with the narrative you have put forward in your letter of December 24, 2024, and WRMC does not agree that a $848.78 patient balance is unreasonable for a hospitalization that extended over several days. Please note that the Washington County Regional Ambulance Authority is not an "affiliate" of WRMC. WRMC is of the opinion that the care provided Ms. Waldorf was appropriate and that the charges for that care provided by WRMC are reasonable.

The transfer of Ms. Waldorf to the University of Kansas Medical Center was conducted at the specific request of Ms. Waldorf. The transfer was not effected because the attending physician at WRMC believed that Ms. Waldorf's clinical condition required a higher level of care. The transfer was requested by Ms. Waldorf because she and her legal advisor were of the view that in the hours immediately preceding the requested transfer Ms. Waldorf required an abortion and there were providers in Kansas willing to provide that care. WRMC facilitated a transfer at the patient's request to another provider of the patient's choice and selection. WRMC effected that transfer through appropriate means, e.g., by ground ambulance, and it is simply not reasonable for you to make demand that WRMC assume responsibility for the cost of a patient-directed transfer.

WRMC further rejects your suggestion that it violated the Emergency Medical Treatment and Active Labor Act ("EMTALA") in connection with the care provided Ms. Waldorf. The Centers for Medicare and Medicaid Services ("CMS") and Arkansas Department of Health ("ADH") conducted a three-day on-site EMTALA complaint survey from September 22 through September 24, 2024. In connection with that complaint, CMS and ADH reviewed numerous medical records including those of Ms. Waldorf. WRMC was advised by CMS on December 17, 2024 that CMS has determined that WRMC is and was in compliance with EMTALA regulatory requirements based on its review of facility documents, medical records and interviews with relevant facility staff.

While we extend our sympathies for Ms. Waldorf's medical complications, WRMC was not the cause of those complications. WRMC rendered appropriate clinical care that was consistent with applicable legal requirements.

Yours very truly,

Thomas J. Olmstead
General Counsel
Washington Regional Medical Center

Exhibit 3

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Survey & Operations Group
Division of Dallas Survey & Enforcement
1301 Young Street, Room 106-900
Dallas, Texas 75202

December 17, 2024

Our Reference: CCN 040004, Complaint Intake #AR00035304

Larry Shackelford, CEO
Washington Regional Medical Center
3215 N North Hills Boulevard
Fayetteville, AR 72703

Dear Mr. Shackelford:

We have reviewed the reports of the September 26, 2024, complaint survey conducted by the Arkansas Department of Health. The complaint alleged noncompliance with the requirements of 42 CFR 489.24, *Responsibilities of Medicare Participating Hospitals in Emergency Cases* and the related requirements of 42 CFR 489.20. We have determined that your hospital meets the requirements of the foregoing regulations based on the review of facility documents, medical records and interviews with facility staff.

During review of the September 26, 2024, survey reports, CMS has determined that your hospital was not in compliance with the Medicare Conditions of Participation.

Section 1865 of the Social Security Act (the Act) and Centers for Medicare & Medicaid Services (CMS) regulations provide that a provider entity accredited by a CMS-approved Medicare accreditation organization will be "deemed" to meet all of the applicable Medicare conditions and requirements.

Section 1864 of the Act requires the State Agency to conduct a survey of a deemed hospital on a selective sampling basis, in response to a substantial allegation of noncompliance, or when CMS determines that a full survey is required after a substantial allegation survey identifies substantial noncompliance.

We have reviewed the reports of the September 26, 2024, survey conducted by the Arkansas Department of Health (ARDH) and found that your hospital was not in compliance with the following Medicare Conditions of Participation:

42 CFR 482.12 Governing Body

We have determined that the deficiencies substantially limit your hospital's capacity to render adequate care and prevent it from being in compliance with all the applicable Medicare Conditions of Participation for hospitals. Hospitals must meet all provisions of Section 1861(c) of the Social Security Act, be in compliance with all of the applicable Medicare Conditions of Participation, and be free of hazard to patient health and safety in order to participate as providers of services in the Medicare program.

The deemed status of your hospital was removed on December 17, 2024, as a result of the findings of substantial noncompliance.

The date on which the Medicare agreement of Washington Regional Medical Center terminates is **March 17, 2025.**

Termination can only be averted by correction of the deficiencies, through submission of acceptable plans of correction (PoC) and subsequent verification of compliance by ARDH. A listing of deficiencies for the September 26, 2024, survey is enclosed for your response.

The Form CMS-2567 with your PoC, dated and signed by your hospital's authorized representative, must be submitted to **David Mitchum, ARDH, via email at David.Mitchum@arkansas.gov by December 27, 2024**. This will ensure that the ARDH will be able to schedule a timely survey of your hospital to evaluate your compliance with the applicable Medicare Conditions of Participation.

The criteria for acceptable plans of correction are as follows:

1. The plan for correcting the specific deficiency cited;
2. The plan for improving the processes that lead to the deficiency cited, including how the hospital is addressing improvements in its systems in order to prevent the likelihood of recurrence of the deficient practice;
3. The procedures for implementing the acceptable plans of correction for each deficiency cited;
4. A completion date for the implementation of the plans of correction for each deficiency cited;
5. The monitoring and tracking procedures that will be implemented to ensure that the plan of correction is effective and the specific deficiency cited remain corrected and in compliance with regulatory requirements; and
6. The title of the person responsible for implementing the acceptable plan of correction.

Copies of the Form CMS-2567, including copies containing the hospital's PoC, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 CFR 401.133(a). As such, the PoC should not contain personal identifiers, such as patient and staff names. However, it must be specific as to what corrective action the hospital will take to achieve compliance.

A follow-up survey will be conducted at your hospital to verify compliance. If CMS determines that the reasons for termination remain, you will be informed in writing of the continuation of the termination process. You will again be asked to submit acceptable plans of correction and an unannounced revisit may be conducted before the termination date. A provider is not entitled to a hearing before termination, but only after termination actually takes place under Medicare regulations.

The deemed status of Washington Regional Medical Center will be restored when it is determined to be in substantial compliance with the applicable Medicare Conditions of Participation and the ARDH will discontinue its survey jurisdiction.

You may contact Tiffany Curtis Baird at 214-767-4404 or by email at tiffany.curtis@cms.hhs.gov, if you have questions regarding this matter.

Sincerely,

Marcus Foster
Manager, Acute & Continuing Care Branch

Enclosure: CMS-2567

cc: Accrediting Organization, ARDH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	040004	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON REGIONAL MEDICAL CENTER	**3215 N NORTH HILLS BOULEVARD FAYETTEVILLE, AR 72703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS Intake ID #: AR00035304 On 09/24/2024 at 10:45 AM, an entrance conference was conducted with Facility Representatives. The Representatives were informed the purpose of the visit was to conduct a Medicare Emergency Medical Treatment and Labor Act complaint survey. On 09/26/2024 at 12:30 PM, an exit conference was conducted with the Facility Representatives. The Representatives were informed the final decision for compliance would be made by the Centers for Medicare and Medicaid Services.	A 000		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on review of the obstetric (OB) and emergency department (ED) employee education files, obstetric registered Nurse (RN) job description, Medical Staff by-laws rules and regulations, and interviews, the hospital 1. Failed to ensure that six of six OB RNs (RN 1, 2, 3, 4, 5, and 6) in a total universe of 44 Labor, Delivery, Recovery, Postpartum (LDRP) RNs had a job description that include the additional job skills of ED triage and Qualified Medical Professional (QMP),	A 043		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	040004	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON REGIONAL MEDICAL CENTER	3215 N NORTH HILLS BOULEVARD FAYETTEVILLE, AR 72703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 043	Continued From page 1 2. Failed to ensure that the medical staff included LDRP RNs as QMPs in their by-laws rules and regulations, had obtained the governing body (GB) review and approval for LDRP RNs as QMPs and/or defined the qualification, training and competency for the LDRP RN's for 44 of 44 LDRP RNs (RN1, 2, 3, 4, 5, 6, and RNs 19 - 56). The failed practice did not ensure the LDRP RNs were qualified to conduct MSE. See A-0048 for details.	A 043		
A 048	MEDICAL STAFF - BYLAWS AND RULES CFR(s): 482.12(a)(4) [The governing body must] approve medical staff bylaws and other medical staff rules and regulations. This STANDARD is not met as evidenced by: Based on review of the obstetric (OB) and emergency department (ED) employee education files, obstetric registered Nurse (RN) job description, Medical Staff by-laws rules and regulations, and interviews, the hospital 1. Failed to ensure that six of six OB RNs (RN 1, 2, 3, 4, 5, and 6) in a total universe of 44 Labor, Delivery, Recovery, Postpartum (LDRP) RNs had a job description that include the additional job skills of ED triage and Qualified Medical Professional (QMP), 2. Failed to ensure that the medical staff included LDRP RNs as QMPs in their by-laws rules and regulations, had obtained the governing body (GB) review and approval for LDRP RNs as QMPs and/or defined the qualification, training and competency for the LDRP RN's for 44 of 44 LDRP RNs (RN1, 2, 3, 4, 5, 6, and RNs 19 - 56). The failed practice did not ensure the LDRP RNs were qualified to conduct MSE.	A 048		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	040004	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON REGIONAL MEDICAL CENTER	3215 N NORTH HILLS BOULEVARD FAYETTEVILLE, AR 72703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 048	Continued From page 2 Findings include: A. Review of the Medical Staff by-laws rules and regulation approved by the GB on 12/19/23 defined the "Clinical Specialist" as "The Clinical Specialist category shall include those AHPs (Allied Health Professionals) who are employed by a Member and who have been authorized by Washington Regional to provide care, treatment, and services only under the supervision of their Sponsoring Member. ...6. Registered Nurse (RN) ARTICLE IV . . . I. Emergency Care The responsibility for providing emergency care within Washington Regional rests with the Medical Staff. Because this responsibility cannot be delegated, every active and provisional active Member shall serve according to the published call schedule and be available for emergency room and for inpatient emergencies. ... Any individual who comes to the Emergency Department and requests treatment or examination for a medical condition or has such a request made on their behalf, shall receive an appropriate medical screening examination performed by a "Qualified Medical Person." The term "Qualified Medical Person" shall be defined as physicians, advanced registered nurse practitioners, physician assistants, Sexual Abuse Nurse Examiners, and obstetric registered nurses. ... Where a pregnant woman presents to the Emergency Department and requests examination, or treatment of symptoms related to labor or has such a request made on their behalf| an Obstetric Registered Nurse or physician shall perform the medical screening examination." The medical staff rules and regulations did not include a list of LDRP RNs that have been approved by	A 048		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	040004	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 048	Continued From page 3 the Governing Board and did not include the EMTALA law requirements, defined training, qualifications, or competencies to ensure that the LDRP RNs remained competent in the specialty skills required to conduct emergency Medical Screening Exams as a QMP. B. Review of the hospital's job description for the RNs working in LDRP titled "Registered Nurse - Women and Infants," dated 07/22, showed that under the header "Position Summary" the definition for the specialty role of the QMP was not included. Review under the header "Essential Position Responsibilities," did not include the responsibilities of the specialty role of the QMP. Under the header "Qualifications," the QMP qualifications were not included. C. Review of the employee training, qualifications, and competency file for LDRP RN (Staff ID #1) showed the "Triage of the OB Patient and Medical Screening Exam (MSE) Competency and Evaluation" was completed as an initial competency on 02/21/14. There was no evidence provided of other training, qualifications, or competencies for this QMP. D. Review of the employee training, qualifications, and competency file for LDRP RN (Staff ID #2) showed the "Triage of the OB Patient and Medical Screening Exam (MSE) Competency and Evaluation" was completed as an initial competency on 05/19/18. There was no evidence provided of other training, qualifications, or competencies for this QMP. E. Review of the employee training, qualifications, and competency file for LDRP RN	A 048		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	040004	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON REGIONAL MEDICAL CENTER	3215 N NORTH HILLS BOULEVARD FAYETTEVILLE, AR 72703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 048	Continued From page 4 (Staff ID #3) showed the "Triage of the OB Patient and Medical Screening Exam (MSE) Competency and Evaluation" was completed as an initial competency on 06/06/24. There was no evidence provided of other training, qualifications, or competencies for this QMP. F. Review of the employee training, qualifications, and competency file for LDRP RN (Staff ID #4) showed the "Triage of the OB Patient and Medical Screening Exam (MSE) Competency and Evaluation" was completed as an initial competency on 12/27/23. There was no evidence provided of other training, qualifications, or competencies for this QMP. G. Review of the employee training, qualifications, and competency file for LDRP RN (Staff ID # 5) showed the "Triage of the OB Patient and Medical Screening Exam (MSE) Competency and Evaluation" was completed as an initial competency on 12/23/21. There was no evidence provided of other training, qualifications, or competencies for this QMP. H. Review of the employee training, qualifications, and competency file for LDRP RN (Staff ID #6) showed the "Triage of the OB Patient and Medical Screening Exam (MSE) Competency and Evaluation" was completed as an initial competency on 10/20/21. There was no evidence provided of other training, qualifications, or competencies for this QMP. I. During an interview on 09/25/24 at 2:34 PM, the Woman and Infant Director (Staff ID #7) and the RN Educator (Staff ID #8) stated that although not defined in the Medical staff by-laws,	A 048		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	040004	A. BUILDING _____ B. WING _____	C 09/26/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 048	Continued From page 5	A 048		

rules, and regulations, the LDRP RNs must have at minimum one year of LDRP experience to train and test to become a QMP. The Woman and Infant Director 7 and RN Educator 8 confirmed that the LDRP RN job description did not include the additional skills, training, or competencies for the EMTALA [Emergency Medical Treatment and Labor ACT] QMP designation. Woman and Infant Director (Staff ID #7) and the RN Educator (Staff ID # 8) confirmed that the competency form allows for "initial," "annual," or "other" and aside from the "initial" the LDRP RNs did not have annual training, qualifications, or competencies to perform an EMTALA MSE.

J. During an interview on 09/26/24 at 9:02 AM, the Director of Medical Staff and Continuing Medical Education (Staff ID #57) stated that the Medical Executive Committee had oversight of the Advanced Practice Registered Nurse and Medical Staff defined as QMPs for training, qualifications, and competencies, but the LDRP RNs were not privileged or approved by the Medical Executive Committee or the Governing Body as QMPs, stating that oversight was the responsibility of HR(Human Resources) and LDRP.

K. During an interview on 09/26/24 at 10:38 AM while reviewing the Medical staff by-laws rules and regulations related to the QMP qualifications, Vice President of Human Resources (VPHR) (Staff ID #18) and Chief Nursing Officer (CNO) (Staff ID #17) confirmed that even though the LDRP RN's were listed in the Medical staff by-laws rules and regulations as being QMPs, the Medical Staff services had no oversight of the LDRP RNs, that the LDRP Director and HR had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	040004	A. BUILDING _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON REGIONAL MEDICAL CENTER	3215 N NORTH HILLS BOULEVARD FAYETTEVILLE, AR 72703

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A 048	Continued From page 6 that oversight, and there were no defined training, qualifications or competencies for the specialized role of the QMP.. L. On 09/26/24 at 11:20 AM, the Woman and Infant Director (Staff ID #7) provided a full list of all LDRP RNs currently working in LDRP. A total of 44 RNs were documented as having been designated as a QMP. Woman and Infant Director (Staff ID #7) confirmed that the remaining 38 LDRP RNs LDRP RN (Staff ID #19 through 56) did not have defined qualifications, training, or competencies beyond the "initial" competency. M. During an interview on 09/26/24 at 11:06 AM, the Chief of Staff (Staff ID #15) confirmed that the Medical staff by-laws, rules, and regulations defined the LDRP RNs as QMPs to conduct EMTALA MSEs for patients coming to the LDRP department seeking care for a potential medical emergency. When asked how the Medical Executive Committee determined which LDRP RNs were qualified to conduct EMTALA MSEs, the Chief of Staff (Staff ID #15) stated the RNs were usually paired with an OB Hospitalist and checked off by the Hospitalist as qualified, usually after a year of OB experience. The Chief of Staff (Staff ID #15) confirmed that the Medical Staff Executive Committee had not defined the qualification training and competencies for consistency among the QMPs. When asked who set the qualification training and competencies for the Physician and APRN QMPs, the Chief of Staff (Staff ID #15) confirmed that it was the Medical Executive Committee. The Chief of Staff (Staff ID #15) stated he/she was not aware of a Governing Body approved list of LDRP RNs	A 048		

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A 048	Continued From page 7 based on qualifications, training, and competencies.	A 048		