

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES HEADQUARTERS**

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF REGIONAL HEALTH OPERATIONS
REGION 5**

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ADMINISTRATIVE COMPLAINT

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PRELIMINARY STATEMENT

1. This complaint is filed by Harmonie Perrone, through her undersigned counsel, pursuant to the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (“EMTALA”). In October 2025, Advocate Good Shepherd Hospital in Barrington, Illinois violated EMTALA when it refused Ms. Perrone medical treatment necessary to stabilize her emergency medical condition and terminate her ectopic pregnancy. As a direct result of this denied and delayed care, Ms. Perrone has lost her natural fertility and will only be able to have children with in-vitro fertilization (IVF), treatment she cannot afford.

2. Ms. Perrone had an ectopic pregnancy in which a fertilized egg implanted in her fallopian tube. A tubal ectopic pregnancy is never viable and if not treated promptly, it can be deadly for the pregnant patient. Specifically, an ectopic pregnancy can rupture, as it did in Ms. Perrone’s case, causing major internal bleeding and emergency surgery requiring the removal of fallopian tube to save her life.

3. From the beginning of Ms. Perrone’s pregnancy in October 2025, the warning signs were clear. She presented with vaginal bleeding, along with cramping and pain radiating up her left side to her shoulder. These were exactly the symptoms she had experienced during both of her two prior ectopic pregnancies, one of which ruptured and resulted in the loss of her right fallopian tube. Additionally, an ultrasound showed a mass on her remaining left tube, consistent with ectopic pregnancy. Yet despite her medical history of two prior ectopic pregnancies, the visible mass, and her textbook symptoms of ectopic pregnancy, Ms. Perrone was denied care and turned away by Advocate Good Shepherd’s staff. The on-call OB/GYN did not treat or even examine her in person. Instead, Advocate Good Shepherd staff

discharged Ms. Perrone with nothing more than an appointment the following day at the on-call OB/GYN's outpatient clinic.

4. The following day, the on-call OB/GYN again denied Ms. Perrone care, telling her there was allegedly “a 1% chance that there is a baby in there,” “I cannot in good faith intervene at this time,” and “I will only intervene if your tube is rupturing.” By the time Ms. Perrone was finally able to access life-saving care, it was too late. Her tube ruptured, necessitating emergency surgery. At just 28, she now will need to undergo IVF to become pregnant. Had Advocate Good Shepherd promptly provided Ms. Perrone with stabilizing care as required by federal law, none of this would have happened.

5. Sadly, Ms. Perrone's experience is not unique. Across the country, pregnant people seeking care in “church-affiliated” hospitals such as Advocate Good Shepherd¹ are denied stabilizing treatment for emergency medical conditions associated with pregnancy, even in states like Illinois.² And after *Roe v. Wade* was overturned in 2022, reports of pregnant patients facing delays or outright denials of emergency care have only multiplied, including for treatment like termination of ectopic pregnancy, which remains legal even under the most restrictive of state

¹ Advocate Health—the health system within which Advocate Good Shepherd Hospital operates—has self-identified as a “church-affiliated” institution in public court filings, including a case it brought before the Supreme Court along with two Catholic co-plaintiffs, arguing that they qualify for the “church plan” ERISA exemption. See *Advocate Health Care Network v. Stapleton*, 137 S. Ct. 1652 (2017).

² See, e.g., Julia Kaye et al, *Health Care Denied: Patients And Physicians Speak Out About Catholic Hospitals And The Threat To Women's Health And Lives*, ACLU (May 2016), at 5, <https://www.aclu.org/publications/report-health-care-denied> (describing an Illinois patient who was denied abortions at two separate church-affiliated hospitals “even though she was bleeding so heavily that one of the hospitals gave her a blood transfusion before sending her home”); *Tamesha Means v. United States Conference of Catholic Bishops*, ACLU (June 30, 2015), <https://www.aclu.org/cases/tamesha-means-v-united-states-conference-catholic-bishops> (describing lawsuit involving a Michigan patient who was denied appropriate medical care for her miscarriage at a church-affiliated hospital); Kristen Hwang, *Her miscarriage showed the limits of California's abortion protections. Where you live matters*, CAL MATTERS (May 21, 2025), <https://calmatters.org/health/2025/05/abortion-law-catholic-hospitals/> (describing a California patient who was denied appropriate medical care for her miscarriage at a church-affiliated hospital).

abortion laws.³ As a result, patients have been forced to travel across state lines to obtain treatment for ectopic pregnancies after delays in their home states placed them at increased medical risk.⁴ In other cases, pregnant people with ectopic pregnancies bypass local hospitals altogether, traveling instead out-of-state due to fear that receiving treatment would be considered a crime.⁵ This new reality has raised the stakes for care in Illinois, which now sees the largest number of out-of-state abortion patients in the country.⁶ Recognizing the gravity of this development, Illinois Attorney General Kwame Raoul signed a letter to the president of the American Health Association reaffirming hospitals' responsibilities under EMTALA to provide patients like Ms. Perrone access to abortion care.⁷

6. EMTALA forbids hospitals like Advocate Good Shepherd from refusing stabilizing treatment to patients with presumed or suspected ectopic pregnancies, like Ms. Perrone, because their health is in immediate and serious jeopardy without prompt intervention. And in Illinois—now a presumed safe haven for pregnant people from neighboring states that criminalize certain pregnancy-related care—strict enforcement of EMTALA's mandates is especially critical to

³ Amanda Seitz, *Emergency Rooms Refused to Treat Pregnant Women, Leaving One to Miscarry in a Lobby Restroom*, THE ASSOCIATED PRESS (April 19, 2024), <https://apnews.com/article/pregnancy-emergency-care-abortion-supreme-court-roe-9ce6c87c8fc653c840654de1ae5f7a1c>.

⁴ See First Amended Verified Complaint for Preliminary and Permanent Injunctive Relief and Declaratory Judgment, *Waldorf v. Arkansas*, No. 60-CV-26-1539 (Ark. Cir. Ct. Pulaski County Apr. 9, 2026), at 29-36 (describing an Arkansas patient who had to travel to Kansas to receive treatment for an ectopic pregnancy after being denied care by three hospitals in two states).

⁵ Daniel Grossman et al., *Care Post-Roe: Documenting Cases of Poor-Quality Care Since the Dobbs Decision*, Advancing New Standards in Reproductive Health (Sept. 2024), at 10, <https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf>.

⁶ Alia Cornell et al, *Seeking Abortion Care Across State Lines After the Dobbs Decision*, 9 JAMA Network Open (March 9, 2026), at 3.

⁷ Letter from Rob Bonta, Cal. Att'y Gen., et al., to Richard J. Pollack, President & CEO, Am. Hosp. Ass'n (June 24, 2025), <https://illinoisattorneygeneral.gov/News-Room/Current-News/2025.06.24-Multistate-Letter-to-AHA-re-EMTALA.pdf>.

protect the lives, health, and fertility of the tens of thousands of pregnant patients per year seeking reproductive care in the state.⁸

7. Ms. Perrone respectfully requests that the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (“CMS”) and Region 5 Office investigate the refusal by Advocate Good Shepherd Hospital to provide her with emergency medical treatment in October 2025 and issue a finding that Advocate Good Shepherd Hospital violated EMTALA by failing to provide her with stabilizing care. This investigation and finding are necessary to safeguard access to emergency medical treatment for all pregnant people who reside or seek care in Illinois, and who remain vulnerable so long as Illinois hospitals can deny them emergency care during pregnancy.

JURISDICTION

8. CMS is responsible for ensuring compliance with EMTALA. The CMS Region 5 Office, based in Chicago, Illinois, serves the region where the Recipient Advocate Good Shepherd Hospital is located.⁹

9. CMS Regional Offices evaluate EMTALA complaints and, for those requiring further investigation, may refer the case to state survey agencies to investigate on CMS’s behalf.¹⁰

⁸ Isaac Maddow-Zimet and Kimya Forouzan, *Full-Year Estimates Show Overall Stability in Abortion Incidence, Decreased Travel and Increased Telehealth Provision*, GUTTMACHER INSTITUTE (March 2026), <https://www.guttmacher.org/report/full-year-estimates-show-overall-stability-abortion-incidence-decreased-travel-increased-telehealth-provision> (noting that in 2025, 32,000 abortions in Illinois were provided to out-of-state residents); *see also* Isabela Nieto, *Illinois remains abortion ‘safe haven’ for out-of-state patients in 2025, report shows*, CHICAGO SUN TIMES (Apr. 3, 2026), <https://chicago.suntimes.com/abortion/2026/04/03/illinois-abortion-safe-haven-out-of-state-patients-2025-report>.

⁹ Ctrs. for Medicare & Medicaid Servs., *CMS Regional Offices*, <https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices> (last visited April 8, 2026).

¹⁰ Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Chapter 5 – Complaint Procedures § 5430.1* (Feb. 10, 2023), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c05pdf.pdf> (hereinafter “SOM Ch. 5”).

FACTUAL ALLEGATIONS

A. Ectopic Pregnancy is an Emergency Medical Condition that Requires Stabilizing Treatment

10. Ectopic pregnancy—where the fertilized egg implants and grows in a location other than inside of the uterine cavity—is the leading cause of maternal mortality in the first trimester, accounting for 5-10% of all pregnancy-related deaths.¹¹ Ectopic pregnancies often implant in one of the fallopian tubes (a “tubal ectopic”), but may also implant in the scar from a previous cesarean delivery or other locations including the abdominal cavity, the cervix, or an ovary. Tubal ectopic pregnancies cannot result in live births and are life-threatening to the pregnant person; left untreated, the pregnancy will grow and rupture, causing massive internal bleeding. Ectopic pregnancies therefore must be terminated as soon as they are diagnosed.¹²

11. Treatment of a tubal ectopic pregnancy involves either medication or surgery. If an ectopic pregnancy is detected early enough and the patient’s vital signs are stable, it is most commonly treated with injection of a medication called methotrexate, which prevents the pregnancy from continuing to grow.¹³ The pregnancy is then absorbed by the body over a period of weeks and the affected fallopian tube returns to normal functioning.

12. Studies indicate that the success rate of methotrexate to terminate an ectopic pregnancy is 98.52% when hCG is less than 1,000 mIU/mL but becomes much less effective as

¹¹ Kellie Mullany et al., *Overview of Ectopic Pregnancy Diagnosis, Management, and Innovation*, 19 *Women’s Health*, 1 (2023).

¹² See The American College of Obstetricians and Gynecologists (“ACOG”), *Practice Bulletin 193: Tubal Ectopic Pregnancy*, 131 *Obstetrics Gyn.* e91 (2018) (hereinafter “ACOG Practice Bulletin 193”); Soc’y for Maternal Fetal Med. (“SMFM”) et al., *SMFM Consult Series #63: Cesarean Scar Ectopic Pregnancy*, 227 *Am. J. Obstetrics Gyn.* B9 (2022); ACOG, *Facts Are Important: Understanding Ectopic Pregnancy*, <https://www.acog.org/advocacy/facts-are-important/understanding-ectopic-pregnancy>.

¹³ ACOG, *FAQs: Ectopic Pregnancy* (April 2020), <https://www.acog.org/womens-health/faqs/ectopic-pregnancy>.

hCG climbs. In fact, some studies suggest that methotrexate should not be used for hCG above 1,500 mIU/mL because the failure rate is higher.¹⁴

13. If the ectopic pregnancy is not detected early and has grown too large to be treated with methotrexate, the pregnancy must be surgically removed from the fallopian tube. Surgical intervention entails removal of part or all of the affected fallopian tube (salpingectomy) or removal of the ectopic pregnancy while leaving the affected fallopian tube in site (salpingostomy), both of which can result in loss of fertility.¹⁵ For this reason, the leading medical association for OB/GYNs, the American College of Obstetricians and Gynecologists (“ACOG”), advises that choice of treatment options for ectopic pregnancy “should be guided by the patient’s clinical status, her desire for future fertility, and the extent of fallopian tube damage.”¹⁶

14. Ectopic pregnancy is diagnosed by a combination of factors: the patient’s medical history; ultrasound findings; symptoms, including localized abdominal pain and cramping, abnormal vaginal bleeding, shoulder pain, and dizziness; and serum hCG values.¹⁷ ACOG emphasizes that “[s]erum hCG values alone should not be used to diagnose an ectopic pregnancy and should be correlated with the patient’s history, symptoms, and ultrasound findings.”¹⁸

15. Ectopic pregnancies occur in about 2% of pregnancies, yet the recurrence risk after a prior ectopic pregnancy can soar to 27%.¹⁹ The risk more than triples for those with two or more

¹⁴ Menon S, Colins J, Barnhart KT. Establishing a human chorionic gonadotropin cutoff to guide methotrexate treatment of ectopic pregnancy: a systematic review. *Fertil Steril*. 2007;87(3):481-484 (for example, the success rate of methotrexate is 94.44% when hCG is 1,000-1,999); Corsan GH, Karacan M, Qasim S, Bohrer MK, Ranson MX, Kemmann E. Identification of hormonal parameters for successful systemic singledose methotrexate therapy in ectopic pregnancy. *Hum Reprod* 1995; 10:2719 –22.

¹⁵ ACOG Practice Bulletin 193 at e98.

¹⁶ ACOG Practice Bulletin 193 at e99.

¹⁷ ACOG, *FAQs: Ectopic Pregnancy* (April 2020), <https://www.acog.org/womens-health/faqs/ectopic-pregnancy>.

¹⁸ ACOG Practice Bulletin 193 at e99.

¹⁹ See Allison Petrini & Steven Spandorfer, *Recurrent Ectopic Pregnancy: Current Perspectives*, 12 *Int J Womens Health* 597 (2020).

prior tubal ectopic pregnancies, and climbs even higher when the interval between pregnancies is longer than six months.²⁰

16. Expectant management—the “wait and see” approach—is almost never recommended. Per ACOG: “Candidates for successful expectant management of ectopic pregnancy should be asymptomatic; should have objective evidence of resolution (generally, manifested by a plateau or decrease in hCG levels); and must be counseled and willing to accept the potential risks, which include tubal rupture, hemorrhage, and emergency surgery.”²¹

B. Ms. Perrone has an Extensive History of Pregnancy Loss, Including Two Prior Ectopic Pregnancies, Putting Her at an Elevated Risk of Recurrence

17. Ms. Perrone has been pregnant eight times.

18. Ms. Perrone got pregnant for the first time when she was a teenager. Before the age of twenty, Ms. Perrone had two children.

19. Over the last ten years, Ms. Perrone has suffered repeated early pregnancy losses. She has had three miscarriages; with each, Ms. Perrone did not receive medication or surgical intervention, but rather bled at home until the pregnancies passed. Ms. Perrone sometimes refers to one of those miscarriages as a “chemical pregnancy,” another word for a very early miscarriage—meaning she experienced a period shortly after a positive pregnancy test.

20. Ms. Perrone also has a significant history of ectopic pregnancy. In 2021, Ms. Perrone had her first ectopic pregnancy and had to have a salpingectomy (i.e., surgical removal) of her right fallopian tube, leaving her with only one remaining fallopian tube on her left side. A

²⁰ See William Dooley et al, Interpregnancy interval and risk of recurrence following tubal ectopic pregnancy: retrospective cohort study from UK tertiary center, 66 *Ultrasound Obstet Gynol* 89 (2025).

²¹ ACOG Practice Bulletin 193 at e99.

year later, Ms. Perrone had her second ectopic pregnancy. This time she self-identified the symptoms early, received methotrexate, and recovered with her left tube intact.

21. Accordingly, Ms. Perrone is very familiar with the symptoms of ectopic pregnancy and how they compare to the symptoms of both miscarriage and ongoing pregnancy.

C. Ms. Perrone’s Interactions with Dr. Coll and Advocate Good Shepherd²²

22. In early October 2025, Ms. Perrone discovered she was pregnant again. She and her husband were thrilled, yet because of Ms. Perrone’s traumatic medical history with pregnancy, she remained wary. She began taking drug store pregnancy tests every day to track the darkness of the line, as she had a sinking suspicion that something was wrong.

23. Sure enough, on October 8, Ms. Perrone noticed some light vaginal bleeding. The next morning, October 9, the bleeding continued, and a few hours later, Ms. Perrone began to feel cramping and pain in her shoulder. She panicked. These were exactly the symptoms Ms. Perrone had experienced during her two prior ectopic pregnancies. She immediately called her husband at work, and he was so concerned that he left his company truck unattended and rushed home to take Ms. Perrone to the emergency room. Ms. Perrone was approximately six weeks pregnant.²³

24. Ms. Perrone and her husband arrived at the emergency room of Advocate Good Shepherd Hospital around 11 A.M. on October 9. Ms. Perrone was terrified, in tears, and told the nurses she thought she had an ectopic pregnancy. Ms. Perrone described her pregnancy history to Advocate Good Shepherd’s ER staff, which they recorded as follows:

²² The allegations contained herein are to the best of Ms. Perrone’s knowledge and recollection.

²³ 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.

G8P2

T 2 vaginal deliveries

P0

A 2 ectopics 1 resulted in right salpingectomy 1 chemical pregnancy, 2 miscarriages

L 2

25. Ms. Perrone promptly received bloodwork and was moved to an imaging room where she received a transvaginal and abdominal ultrasound. Ms. Perrone and her husband then waited anxiously for the results.

26. After waiting for several hours, Ms. Perrone received her test results from the emergency room staff. Her hCG was 1,011 mIU/mL and her ultrasound indicated that there was a mass inside her left fallopian tube. Given her medical history, it was likely an ectopic pregnancy. According to her medical records:

Left Adnexa: The left ovary is normal in size and morphology. 1.2 cm left ovarian corpus luteum. 1.4 x 1.4 x 1.3 cm round peripherally echogenic centrally anechoic lesion inferior to the left ovary.

27. Crying, Ms. Perrone told the staff that this wasn't her first time—she had two prior ectopic pregnancies and she was terrified of rupturing. Ms. Perrone told the staff she wanted methotrexate and to avoid surgery. The ER staff told Ms. Perrone they need to consult with the on-call OB/GYN and would return with more information.

28. An hour later—and four hours into her ER visit at Advocate Good Shepherd—ER staff returned and told Ms. Perrone they had consulted with the on-call OB/GYN who was a “specialist.” They assured Ms. Perrone she would be fine, she did not need surgery, and they had made an appointment for her to visit the specialist the next day. Ms. Perrone again asked for methotrexate but was told that the emergency room could not prescribe methotrexate, and she would need to talk to the specialist OB/GYN the next day. Though confused, Ms. Perrone left the

hospital with the understanding that she was under the care of a specialist and would be receiving the emergency health care she needed in the morning.

29. Dr. Dympna Coll was the on-call OB/GYN and alleged “specialist,” but she never visited Ms. Perrone while she was in the hospital that day.

30. The next morning, October 10, at 11:30 A.M, as scheduled, Ms. Perrone and her husband arrived at Dohr, Coll & Gadson OBGYN Associates and Medical Spa for her appointment with Dr. Coll. At check in, Ms. Perrone told the nurse she was there to receive methotrexate to treat an ectopic pregnancy.

31. Ms. Perrone and her husband were ushered into a room where a nurse took her vitals and a urine sample. Ms. Perrone repeated that she was experiencing bleeding, cramps, and shoulder pain, and had received a likely diagnosis of an ectopic pregnancy at the hospital the day before. The nurse told Ms. Perrone and her husband that the doctor would be with them shortly. As they waited, Ms. Perrone noticed there were advertisements for Botox on the walls. Ms. Perrone began to feel uneasy, as it did not look like an obstetrical specialist’s office.

32. When Dr. Coll entered the exam room, Ms. Perrone again catalogued her medical history of two prior ectopic pregnancies, her symptoms, and the test results from the day prior—all of which all pointed to a likely third ectopic pregnancy. Ms. Perrone repeated that she wanted methotrexate and did not want surgery. However, Dr. Coll refused to provide methotrexate and the conversation quickly became heated. Ms. Perrone began to cry. As Ms. Perrone talked, Dr. Coll repeatedly made eye contact not with Ms. Perrone, but with her husband.

33. Both Ms. Perrone and her husband recall Dr. Coll making all of the following statements, in sum and substance, during their conversation:

- “We have to weigh the pros and cons of the life of the baby and the life of the mother.”

- “There is a 1% chance that there is a baby in there.”
- “I cannot in good faith intervene at this time.”
- “I will only intervene if your tube is rupturing.”
- “You are not going to bully me into giving you methotrexate.”
- “We do not do abortions here. You will have to go somewhere else.”

34. During their conversation, Dr. Coll also referenced an unspecified Illinois law, saying the law was an additional reason why Dr. Coll would not intervene. To the extent Dr. Coll may have been referring to the Illinois Healthcare Right of Conscience Act, 745 ILCS, 70/1, et seq., she later denied that her refusal to treat Ms. Perrone was based on a religious or conscience objection to abortion, rendering that point moot. In any event, she failed to refer, transfer, or provide Ms. Perrone with written information about other providers who she reasonably believed may offer the service Ms. Perrone was seeking, as required under that law. 745 ILCS 70/6.1(3).

35. Ms. Perrone asked Dr. Coll if Dr. Coll could do labs and an ultrasound. Dr. Coll said she could, but then repeated that she still would not be able to intervene until Ms. Perrone’s tube ruptured. Ms. Perrone then declined further testing at Dr. Coll’s office, realizing it would be futile given that Dr. Coll refused to provide her the care she sought and needed. For Ms. Perrone, “it felt as though they wanted me to die.”

36. During the conversation, Ms. Perrone’s husband was holding a canned energy drink in his hand. He got so frustrated while Dr. Coll was talking that he crushed the can with his hand.

37. As they realized she would clearly not receive any medical assistance from Dr. Coll, Ms. Perrone and her husband asked where they could go for urgent treatment. Dr. Coll told them they should not go back to Advocate Good Shepherd because it was out of network for their

insurance. Dr. Coll instead wrote the name and address of a different facility on a piece of paper: Mercy Health, a Catholic provider in McHenry.

38. Ms. Perrone's medical records from Dr. Coll's office catalogue Ms. Perrone's obstetrical history, including her two prior ectopic pregnancies. Strangely, however, Dr. Coll's notes incorrectly recount Ms. Perrone's miscarriages, stating she had two "spontaneous" abortions and one "induced" abortion. It is possible that Dr. Coll misread "chemical pregnancy" from Ms. Perrone's records from Advocate Good Shepherd as "chemical abortion," a phrase anti-abortion individuals often use to describe an induced abortion with the medications mifepristone and misoprostol.

39. Dr. Coll's records are otherwise sparse and reflect none of the details of their extensive conversation. Dr. Coll's notes from the visit read as follows:

Chief Complaints:

1. GSH ER fu per DAC. History of 2 ectopic pregnancies. G8 P2052, H/O right salpingectomy. Presents to GSH 10/9/25 with spotting. RH pos. Quant bhcg was only 1011. 2. HGb was 14. No free fluid on gyn u/s. 1.4 cm left adnexal cyst next to left ovary. Cannot exclude left side ectopic pregnancy. Pt told to f/u 10/10/25 for gyn u/s and repeat quant. Instructed by PA at GSH ER to present to ER if signs of ruptured ectopic such as severe abdominal and pelvic pain.. 3. Pt states she is still having vaginal bleeding. , Pt is declining laparoscopic surgery for possible ectopic.. 4. Pt is requesting Methotrexate today. Pt counseled not ACOG standard of care to give methotrexate when quant less than 1500 to avoid the error of administering methotrexate when a potential intrauterine pregnancy could be present.. 5. Was trying for pregnancy. Accompanied by spouse..

Assessment:

1. Threatened miscarriage - O20.0 (Primary)
2. Amenorrhea - N91.2

early pregnancy 5 6/7 . Possible left ectopic vs threatened AB vs IUP. Recommend repeat quant today as quant from yesterday was only 1011. Pt requesting methotrexate today. I advised not standard of care to administer methotrexate unless certainty of diagnosis of ectopic. Declined exam or u/s or lab today. Recommend pt go to in local in network ER for u/s and quant and consult with a gynecoloist for ongoing care. Aware of sign and symptoms of ruptured ectopic and to present to ER if severe pain. Pt refusing diagnostic laparoscopy today. Aware cystic lesion 1.4 cm left adnexa may be an ectopic pregnancy. Patient left without ultasound or lab draw and states she will go directly to Mercy Health ER for repeat quant today and ultrasound.

40. Dr. Coll's first note states "Pt is declining laparoscopic surgery for possible ectopic" and her second note states "Pt refusing diagnostic laparoscopy today." Dr. Coll's records do not otherwise detail what kind of "laparoscopic surgery" she allegedly offered, nor on what timeline.

41. Neither Ms. Perrone nor her husband have any memory of Dr. Coll offering her “laparoscopic surgery.”

42. Dr. Coll’s claim in the records that it is “not ACOG standard of care to give methotrexate when quant [hCG] less than 1500 to avoid the error of administering methotrexate when a potential intrauterine pregnancy could be present,” is patently false. To the contrary, ACOG recommends counseling the patient about the options of salpingostomy and methotrexate, along with the risks of administering methotrexate if the pregnancy turns out to be intrauterine, and allowing *the patient to decide* the best option for them. If anything, studies suggest the opposite of Dr. Coll’s claim—that methotrexate is not as effective to treat ectopic pregnancy when hCG is 1,500 mIU/mL or *higher*.

43. In addition, as discussed above, ACOG cautions against relying exclusively on hCG values and recommends diagnosing ectopic pregnancy with a combination of the following: history of ectopic pregnancy; ultrasound findings; symptoms, including localized abdominal pain and cramping, abnormal vaginal bleeding, shoulder pain, and dizziness; and serum hCG. Further, ACOG states that expectant management—the very approach Dr. Coll exclusively employed—is not recommended for suspected ectopic pregnancy.

44. It is far outside the standard of care to wait to intervene until an ectopic pregnancy ruptures, as rupture often leads to loss of fertility, hemorrhage, or death.

D. Ms. Perrone’s Search for Medical Care and Ultimate Loss of Fertility

45. Ms. Perrone and her husband rushed to the address Dr. Coll had given them for Mercy Health in McHenry, about 30 minutes away, to what they were told was a hospital that could treat her. Through tears, Ms. Perrone again explained to the front desk staff that she needed methotrexate to treat an ectopic pregnancy. But the staff explained that the facility where they were located was a clinic, not Mercy’s hospital location, which was in Crystal Lake. Accordingly, Ms. Perrone and

her husband then drove 15 minutes back the way they came to Crystal Lake, but were told that Mercy’s hospital location had neither an OB/GYN nor access to methotrexate. If Ms. Perrone stayed, they would need to admit her and then transfer her to a different facility, which could take hours. Instead, one staff member suggested Ms. Perrone leave immediately and drive to Northwestern Medicine – Huntley (“Northwestern Huntley”), another 30 minutes away by car.

46. As they left Mercy, one thought kept going through Ms. Perrone’s mind: “This is it, I am going to die.”

47. It was nearly 4 P.M. by the time Ms. Perrone and her husband finally arrived at Northwestern Huntley—after Dr. Coll had denied Ms. Perrone care and then given her the wrong address to a different facility that did not even have the capacity to treat her in the first place. There, Ms. Perrone went through triage and had to explain the story all over again. A note in her medical records from Northwestern Huntley’s triage states that Ms. Perrone had an ectopic pregnancy but then incorrectly characterizes the treatment Ms. Perrone requested as an “elective abortion”:

- Abdominal Pain (Abdominal pain and vaginal bleeding with hx of ectopic pregnancy. Was seen at advocate yesterday with positive ectopic pregnancy. Pt has already had hx of right tube removed from previous ectopic. Attempted to f/u with advocate OB to have elective abortion and save her remaining fallopian tube, but doctor was unable to do so and sent pt to ER.)

48. As Ms. Perrone was explaining her interactions with Dr. Coll to Northwestern Huntley’s ER staff, an emergency medicine physician came over and expressed confusion regarding Advocate Good Shepherd’s and Dr. Coll’s refusal to administer methotrexate when Ms. Perrone has such an extensive history of ectopic pregnancy. Emergency room staff also took labs. Ms. Perrone’s hCG had risen and was now 1,308 mIU/mL.

49. The emergency room physician said he would call an OB/GYN to come down to the emergency room, and within twenty minutes, one arrived to speak with Ms. Perrone. The OB/GYN had reviewed Ms. Perrone’s ultrasound and labs and expressed shock that a hospital would let Ms.

Perrone leave in her condition, saying that it was crazy and made no sense. The OB/GYN's notes in Ms. Perrone's medical records reflect that Ms. Perrone provided the OB/GYN with the same description of her experience with Dr. Coll as detailed in this complaint:

History of Present Illness: Patient is a 28 y.o. G8P2062 female who presents due to being told she likely has a left ectopic pregnancy. Pt states she was seen at Advocate Good Sheperd Hospital yesterday and US showed possible left ectopic pregnancy, no IUP with BHCG 1000. Pt saw an OB through there and was told by that provider that she could not treat her because she "does not do terminations" Pt was frustrated with this therefore presented to ED at Huntley hoping to get treatment. Pt's hx is significant for prior ectopic pregnancy x2, one treated with Right salpingectomy due to rupture. The second one was treated with methotrexate. Pt has mild pain at this time. Having some mild vaginal bleeding. No n/v. No lightheaded or dizziness. Pt would like to receive methotrexate

50. The OB/GYN then appropriately counseled Ms. Perrone regarding her options, including the small possibility of an intrauterine pregnancy, and administered an injection of methotrexate at Ms. Perrone's request. Through tears, Ms. Perrone thanked the OB/GYN for saving her life.

51. While Ms. Perrone received methotrexate late in the day on October 10, it is clear from the medical records that Dr. Coll's and Advocate Good Shepherd's actions had delayed and denied that urgent care by a day and a half. For the successful treatment of ectopic pregnancy, every hour counts.

52. Six days after receiving the methotrexate injection, on October 16, Ms. Perrone was in a morning meeting when she was suddenly in so much pain she could not stand up straight. Ms. Perrone immediately called her husband, and they rushed back to Northwestern Huntley.

53. Back at Northwestern Huntley, Ms. Perrone went through testing in the emergency room. Her hCG was now 2,478 mIU/mL and staff attempted to do a transvaginal ultrasound, but it was excruciatingly painful for Ms. Perrone.

54. The same OB/GYN who had administered methotrexate reviewed Ms. Perrone's results and proceeded to counsel her on her options. As the OB/GYN explained, there was not yet evidence of ectopic rupture but based on her symptoms, the success of repeated methotrexate was low. At this point, surgery was her best chance for fertility preservation. The OB/GYN would

attempt to remove the ectopic pregnancy and leave her fallopian tube intact, but it was possible that to save her life, the OB/GYN would need to remove the tube as well. Ms. Perrone weighed the risks and benefits and elected to proceed with surgery.

55. During surgery, the physician discovered an ectopic pregnancy in her left tube. Blood was already pooling in her pelvis—a sign of rupture—and the physician was forced to remove her entire tube to save Ms. Perrone’s life. As a result, Ms. Perrone is now infertile.

LEGAL ALLEGATIONS

56. Congress enacted EMTALA in 1986 to “provide an ‘adequate first response to a medical crisis’ for all patients.” *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 880 (4th Cir. 1992) (quoting 131 Cong. Rec. S13904 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger)). Any hospital that has an emergency department and receives Medicare funds is subject to EMTALA’s requirements. 42 U.S.C. § 1395cc(a)(1). Because Advocate Good Shepherd operates an emergency department and participates in Medicare, it is subject to EMTALA.²⁴

57. Under EMTALA, when an individual “comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide “such treatment as may be required to stabilize the medical condition” or transfer the individual to another medical facility. 42 U.S.C. § 1395dd(b)(1). EMTALA defines “emergency medical condition” as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the

²⁴ Advocate Good Shepherd operates an emergency room. See Advocate Good Shepherd Hospital, *Emergency Services*, <https://www.advocatehealth.com/gshp/health-services/emergency-services> (last visited April 8, 2026). It also participates in Medicare. See CMS, *Advocate Good Shepherd Hospital*, <https://www.cms.gov/medicare/medicare-general-information/medicareapprovedfacilitie/carotid-artery-stenting-facilities-items/advocate-good-shepherd-hospital> (last visited April 8, 2026).

woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.” *Id.* § 1395dd(e)(1).

58. Patients who have an “emergency medical condition” must receive stabilizing care within the hospital’s capabilities. “[T]o stabilize” is defined as “to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during” the patient’s discharge or transfer. 42 U.S.C. § 1395dd(e)(3)(A). Although hospitals may admit a patient “as an inpatient in good faith in order to stabilize the emergency medical condition,” 42 C.F.R. § 489.24(d)(2)(i), EMTALA “requires more than the admission and further testing of a patient; it requires that actual care, or treatment, be provided as well,” *Moses v. Providence Hosp. and Med. Ctrs., Inc.*, 561 F.3d 573, 582 (6th Cir. 2009).

59. An ectopic pregnancy is an emergency medical condition requiring stabilization under EMTALA. *See United States v. Idaho*, 623 F. Supp. 3d 1096, 1103–04 (D. Idaho 2022) (“[S]ome patients will experience serious, pregnancy-related complications that qualify as an ‘emergency medical condition’ under EMTALA. One relatively straightforward example is a patient who presents at an emergency department with an ectopic pregnancy.” (internal citations omitted)). As discussed above, tubal ectopic pregnancies are never viable and, without treatment, can rupture or burst. Rupturing or bursting can lead to major internal bleeding, removal of the fallopian tube(s), and death. The absence of medical treatment for an ectopic pregnancy can “reasonably be expected to result” in (1) the health of the pregnant patient being placed “in serious jeopardy,” (2) “serious impairment to bodily functions,” and (3) “serious dysfunction of any bodily organ or part.” *See* 42 U.S.C. § 1395dd(e)(1).

60. Advocate Good Shepherd violated EMTALA for three independent reasons when it discharged Ms. Perrone without providing her the stabilizing care necessary to treat her ectopic pregnancy. First, hospital staff knew that failing to treat Ms. Perrone could reasonably be expected to result in serious jeopardy to her health—specifically, in a ruptured ectopic pregnancy. Second, hospital staff knew that failing to treat Ms. Perrone for ectopic pregnancy could result in serious impairment to bodily functions related to future pregnancy. Third, hospital staff knew that failing to treat Ms. Perrone could result in a dysfunction of her reproductive system and fallopian tubes. Indeed, hospital staff were well aware of her medical history of two prior ectopic pregnancies, her clear symptoms of ectopic pregnancy including bleeding and localized pain, and the visible mass on her ultrasound. Nonetheless, they discharged her without offering stabilizing care, even as Ms. Perrone begged for that care. This absence of immediate medical attention ultimately resulted in a ruptured ectopic pregnancy that required removing Ms. Perrone’s remaining fallopian tube to protect her life, directly causing infertility. The discharge by Advocate Good Shepherd thus recklessly endangered Ms. Perrone’s health, as well as her bodily functions and organs involved in future fertility, in violation of EMTALA.

61. Moreover, Advocate Good Shepherd had the capacity to provide stabilizing care to Ms. Perrone and its staff never suggested otherwise. The on-call OB/GYN, Dr. Coll, did not even bother to come to the ER to examine or speak to Ms. Perrone on October 9, a plain violation of EMTALA’s medical screening requirement. *See* 42 U.S.C.A. § 1395dd(a). Indeed, CMS recently found a hospital in violation of EMTALA when its similar decision to send a patient home without treating her ectopic pregnancy caused her to lose part of her reproductive system.²⁵ In that case, as here,

²⁵ Ascension Seton Williamson, Statement of Deficiencies and Plan of Correction (Form CMS-2567), Survey Date: September 25, 2024 (CMS), available at https://reproductiverights.org/wp-content/uploads/2025/06/Kyleigh-Thurman-Deficiency-Letter_CONFIDENTIAL.pdf.

the on-call OB/GYN did not evaluate the patient when she first presented to the ER.²⁶ CMS concluded that the hospital’s “failure to provide an appropriate medical screening examination, within the capability of the hospital's emergency department (*including but not limited to the ancillary services of the on-call obstetrical physician*) ... placed the patient at risk for deterioration of her health and wellbeing as a result of an untreated medical condition.” (emphasis added).²⁷

62. Further, the decision of Advocate Good Shepherd’s ER staff to schedule a follow-up appointment the next day at Dr. Coll’s outpatient clinic falls far short of EMTALA’s “transfer” requirements. *See Duffus v. MaineHealth*, 791 F. Supp. 3d 61, 86 (D. Me. 2025) (“A hospital cannot transfer a patient until it actually stabilizes a patient's emergency medical condition. That means the risk of material deterioration of the condition must be low—'[un]likely'—before a hospital can transfer the patient.”). Advocate Good Shepherd did not even offer to admit Ms. Perrone to the hospital for observation or provide any indication that she could or would ever receive services to terminate her ectopic pregnancy in their emergency room. *See Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131, 1135 (6th Cir. 1990) (“Hospitals may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then immediately discharging that patient. Emergency care must be given until the patient's emergency medical condition is stabilized.”); *Moses v. Providence Hosp. and Med. Cent., Inc.*, 561 F.3d 573, 583 (6th Cir. 2009) (re-affirming holding).

63. Advocate Good Shepherd’s refusal to treat Ms. Perrone was also inconsistent with ACOG guidelines for the treatment and diagnosis of suspected ectopic pregnancy. First, ACOG cautions against relying exclusively on hCG values and recommends diagnosing ectopic pregnancy with a

²⁶ *Id.* at 2.

²⁷ *Id.* at 3.

combination of the following: history of ectopic pregnancy; ultrasound findings; symptoms, including localized abdominal pain and cramping, abnormal vaginal bleeding, shoulder pain, and dizziness; and serum hCG. Second, ACOG states that expectant management—the “wait and see” approach employed by Advocate Good Shepherd—is not recommended for suspected ectopic pregnancy. Instead, ACOG recommends counseling the patient about the options of salpingostomy and methotrexate, along with the risks of administering methotrexate if the pregnancy turns out to be intrauterine, and allowing *the patient to decide* the best option for them. Not only did Advocate Good Shepherd fail to follow these guidelines, it ignored Ms. Perrone’s own stated request to receive methotrexate.

64. To prevent further danger to pregnant patients’ health, lives, bodily functions and organs, it is critical that EMTALA be enforced against hospitals like Advocate Good Shepherd that refuse to provide stabilizing treatment for the emergency medical condition of ectopic pregnancy. Enforcing EMTALA is especially critical in Illinois, where hospitals care for tens of thousands of pregnant patients each year—many arriving because of delays, denials, and fear of prosecution in their home states.²⁸ The increased stakes warrant swift investigation and a determination that Advocate Good Shepherd’s failure to provide emergency treatment for Ms. Perrone’s ectopic pregnancy violated EMTALA.

RELIEF REQUESTED

65. Ms. Perrone respectfully requests that CMS and/or HHS OIG:

²⁸ Isaac Maddow-Zimet and Kimya Forouzan, *Full-Year Estimates Show Overall Stability in Abortion Incidence, Decreased Travel and Increased Telehealth Provision*, GUTTMACHER INSTITUTE (March 2026), <https://www.guttmacher.org/report/full-year-estimates-show-overall-stability-abortion-incidence-decreased-travel-increased-telehealth-provision>.

- a. Conduct an independent investigation of Advocate Good Shepherd for EMTALA violations arising from its repeated refusal to provide her with necessary stabilizing treatment to preserve her life, health, bodily functions, and bodily organs;
- b. Take all necessary steps to remedy all unlawful conduct identified in its investigation, including by imposing all appropriate penalties;
- c. Monitor any resulting agreements between CMS and Advocate Good Shepherd to ensure compliance with EMTALA; and
- d. Provide other appropriate equitable relief.

Respectfully submitted,

/s/Molly Duane

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Date: June 1, 2026