

**S 1373: Educational Points and Suggested Amending Language**

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| **Bill Section #** | **Educational Points**  | **Suggested Amendment** |
| **44-41-830 (B)** | **Medical treatment provided resulting in accidental death or unintentional injury to the unborn child**Language is limited to pregnant woman, age 18+. Pregnant minors, defined in Section 44-41-820, also need to be included in this exception language.  | **Section 44-41-830 (B)** Medical treatment provided to a pregnant woman or a pregnant minor that results in the accidental death of or unintentional injury to or death of the unborn child does not constitute a violation of this section. |
| **NEW****44-41-830 (C)**  | **New section on exclusions**1. Minors who are raped, sexually assaulted, victims of sex trafficking, or victims of incest should be provided an exception as in the fetal heartbeat law.
2. The majority of these minors are victimized by someone known to them - i.e. a family member, a family acquaintance, or a dating partner if they are old enough to date.
3. Adolescent pregnancies can have a higher risk of cesarean delivery, premature delivery, and hypertensive disorders.
4. Research shows that teen pregnancies have a substantial adverse impact on the mother and her life trajectory. By age 22, only 50% of teen mothers have received a high school diploma as opposed to 90% of teens who did not give birth during adolescence. For more information on the adverse impacts of teen pregnancy: <https://youth.gov/youth-topics/pregnancy-prevention/adverse-effects-teen-pregnancy>
 | **New section: 44-41-830 ( C)** 1. A physician may perform, induce, or attempt to perform or induce an abortion on a pregnant minor if the pregnancy or potential pregnancy is a result of rape, sexual assault, incest, or human trafficking and the age of the fetus is fewer than 20 weeks. The physician must report in accordance with requirements established in 44-41-680 (C ).
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| 44-41-840 (A) (1) | **No prohibition to save life of mother:**1. Pregnant minors need to be added or “pregnant woman” needs to be changed to “pregnant female”. As written, the physician cannot perform a medical procedure to save the life of a pregnant minor – only for a pregnant woman presumably age 18+ years.
2. Physicians should not have to wait until the mother is near death or at risk for a substantial and irreversible physical impairment of a major bodily function due to a physical condition to provide the appropriate medical procedure or treatment. (i.e. medical conditions such as miscarriage, ectopic pregnancy, severe preeclampsia, abruptio placentae, and other serious conditions. )

*Ref. House Ad Hoc committee draft language* | **Section 44-41-840 (A) (1**) Nothing in this article shall be construed to prohibit a licensed physician from performing a medical procedure or providing medical treatment or intended to prevent the death, to prevent a substantial risk of death because of a physical condition, or to prevent the substantial and irreversible physical impairment of a major bodily function of a pregnant woman or pregnant minor. However, a physician shall make reasonable medical efforts under the circumstances to preserve both the life of the mother and the life of the unborn child in a manner consistent with accepted medical standards. Under such circumstances, the accidental or unintentional injury to or death of the unborn child is not a violation of this article. A physician’s understanding of a risk of death for the pregnant woman or pregnant minor must not be based on a diagnosis or claim that the pregnant woman or pregnant minor will purposefully engage in conduct that she intends to result in her death. The provisions of this section must not be construed to authorize the intentional killing of an unborn child. |
| **44-41-840 (A) (2)****44-41-840 (A)(2) (a)** | “**Non-emergency premature deliveries after 19 weeks”**“Premature delivery” is generally considered to be any delivery before 37 weeks of gestation. Women with serious maternal complications may have a planned “premature” delivery at or around 36 weeks to minimize the risk associated with those complications. These late preterm babies have a higher risk of respiratory distress, and they may or may not need additional medical care upon delivery. Unplanned premature deliveries, on the other hand, are generally considered to be medical emergencies. **Delivery after 19 weeks must be performed in hospital providing neonatal services for premature infants**.1. South Carolina has an established system of perinatal care known as perinatal regionalization. Regulations and requirements for hospitals providing maternal and neonatal (perinatal) services can be found in the SC Code of Regulations, Chapter 61-16, Sections 1305-1313. These regulations are designed to route mothers and infants to the appropriate level of care per currently accepted medical practice standards.
2. Per the perinatal regionalization regulations outlined in 61-16, all Level I hospitals providing maternity services must have the ability to stabilize an infant. If needed, these hospitals shall make arrangements, in consultation with the regional perinatal center, to transfer the infant to a hospital with the appropriate level of care.
3. Women in premature labor may present at a hospital or facility without neonatal services. Depending upon the condition of the pregnant woman and the urgency of delivery, it may not be safe to transfer the laboring woman.
4. **EMS and standard ambulances generally do not have the equipment and training to provide care for premature infants especially those with very low birthweight. These infants should only be transferred in specialized ambulances with trained neonatal providers.** [Note: The children’s hospitals are regional perinatal centers with specialized transport ambulances and care teams for premature infants. Any needed transfers to a higher level of care for the mother or infant is done in consultation with the regional perinatal center. ]
 | *See suggested language on page 3.* **Section 44-41-840 (A)(2)** In the case of a ~~non-emergency~~ premature delivery: ~~after nineteen weeks of pregnancy:~~(a)~~the delivery must be performed in a hospital or other health care facility that has appropriate neonatal services for premature infants;~~ in accordance with current medical standards and state perinatal regionalization regulations established by the South Carolina Department of Health and Environmental Control in the South Carolina Code of Regulations, Chapter 61-16, the physician performing the delivery shall determine the level of perinatal care needed for both the mother and unborn child, making arrangements in consultation with the regional perinatal center for transfer to a higher level of perinatal care if needed and if the mother can be transferred safely. (b) ~~the physician performing the delivery must arrange for the attendance, in the same room in which the delivery is performed, another physician who it to take control of, provide immediate medical care for and take all steps reasonably necessary to preserve the life and health of the unborn child immediately upon the child’s delivery~~. Per the state perinatal regionalization regulations established in the Code of Regulations, Chapter 61-16 and current medical practice standards, appropriate medical care will be provided to the child immediately upon delivery. For infants needing a higher level of care, the physician attending the delivery or the physician or advanced practice provider attending the child upon delivery will, in consultation with the regional perinatal center, make any arrangements to transfer the infant to the appropriate level of care.  |
| **44-41-840 (A) (2) (b)** | **Physician attending delivery must arrange for other physician to be in delivery room for infant and “take all steps reasonably necessary to preserve the life and health of the unborn child immediately upon the child’s delivery”.** 1. Depending on the urgency and the location of the delivery, it may not be possible to pre-arrange for the presence of another physician.
2. All hospitals providing maternity services are already required to provide stabilization services to infants and to transfer to a higher level of care in consultation with their regional perinatal center if needed.
3. The attending provider for the infant may be an advanced practice provider. Hospitals providing comprehensive neonatal services generally have neonatal nurse practitioners or other neonatal advanced practice providers.
4. **The language “take all steps reasonably necessary” is ambiguous from the medical perspective and subject to political or legal interpretation in a manner inconsistent with current practice standards**. Neonatologists and pediatricians, as with other physicians, practice according to the current standard of care for their specialty. All medically appropriate medical care will be provided to the infant. To practice otherwise would violate their Hippocratic oath, threaten their medical license, and potentially subject them to malpractice.
 | *See suggested language on page 3 for 44-41-840 (A) (2)* |
| **44-41-840 (A)(3)** | **Consent for medical treatment or procedure, consent for minors**1. Hospitals already comply with healthcare consent requirements established in Title 44, Chapter 66 – the SC Adult Healthcare Consent Act.
2. Obtaining consent **in-person** from a parent or legal guardian of a minor can be problematic if the parent is out of town, deployed, or otherwise unavailable. Written consent can be obtained through other methods.
3. Emancipated and married minors are currently treated as adults in terms of consent for healthcare.
 | **Section 44-41-840 (3)** Prior to performing a medical procedure or medical treatment pursuant to this subsection, the physician must obtain in-person, non-coerced consent from the pregnant woman, married minor, or emancipated minor, of if the pregnant woman is a minor, the ~~in-person~~ informed written consent of the pregnant woman’s parent or legal guardian.  |
| **44-41-850 (4)** | **Medical treatment that results in the unintentional death of the unborn child**See notes above in reference to current statutory authority for healthcare consent.  | 44-41-850 (4) a certification that the physician obtained the in-person, non-coerced consent from the pregnant woman, married or emancipated minor for the physician to perform the medical procedure or medical treatment or if the pregnant woman is a minor, the ~~in-person~~, non-coerced informed consent of one of the minor’s parents or the minor’s legal guardian;  |
| **44-41-850 (B)** | **DHEC reporting requirements if accidental/unintentional death of unborn child due to medical treatment**1. A 30-day reporting period is way too short for the large amount of information being requested on this report. Obtaining medical records from other providers and waiting on pathology results can take weeks. Ninety days at a minimum is a significantly more reasonable timeframe.
2. As noted above, it is not possible to gather all the information being requested for this reporting requirement in 30 days, let alone 3 days if the pregnant female was a minor.
3. **The requirement to report to DSS protected health information in the absence of an ongoing child abuse investigation is a violation of HIPAA and a violation of requirements for the release of medical records established in SC 63-7-380.** This section does not involve any allegations of abuse. It references the exception for an abortion that is an accidental outcome of medical treatment or a medical procedure.
 | 44-41-850 (B) The physician shall complete the form prescribed in subsection (A) and transmit the completed form within ~~thirty~~ ninety days of performing the medical procedure or medical treatment. ~~However, if the pregnant woman was a minor, then the physician must complete and transmit the form to the Department of Health and Environmental Control and the Department of Social Services within three days.~~  |
|  | For questions or additional information, please contact: | Ms. Maggie Cash, Executive DirectorSC Children’s Hospital CollaborativeEmail: maggie@scchildrenshospitals.orgCell: (843) 270-0533 |