UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF KANSAS

MYLISSA FARMER,

Plaintiff,

vs.

THE UNIVERSITY OF KANSAS HOSPITAL AUTHORITY,

Defendant.

Case No. 2:24-CV-02335-HLT

PLAINTIFF'S OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

On August 2, 2022, Mylissa Farmer ("Plaintiff" or "Ms. Farmer") was just under 18 weeks into her pregnancy with her daughter when her water broke. After her local hospital in Missouri confirmed that her pregnancy was no longer viable and she was in the midst of a life-threatening miscarriage, she traveled three hours to the University of Kansas Hospital ("TUKH"), which is operated by Defendant University of Kansas Hospital Authority ("Defendant"). She arrived heartbroken, bleeding, in pain, and terrified for her life. TUKH staff confirmed she had suffered previable, preterm premature rupture of membranes (PPROM), she had lost all her amniotic fluid, her pregnancy—which she had dreamed of and longed for—was no longer viable, and unless she received immediate medical intervention to end the pregnancy in a medical setting—either via induction of labor or a dilation and evacuation (D&E)—she was at risk of severe blood loss, sepsis, loss of fertility, and death.

But, contrary to hospital guidelines, TUKH staff did not perform a pain assessment (to diagnose preterm labor) or a temperature check (to diagnose infection). Nor did they offer Ms. Farmer *any* treatment for her previable PPROM. While TUKH's own clinical guidelines *required*

the hospital to offer Ms. Farmer an emergency pregnancy termination[1] (or, if she declined the termination, monitoring and antibiotics), TUKH staff told Ms. Farmer that they could not treat her because of a "heated" political climate. By tragic coincidence, Ms. Farmer arrived at TUKH on the evening of the 2022 election determining the future of abortion rights in Kansas. Because of Defendant's politically motivated denial of care, Ms. Farmer endured hours of agonizing labor in her car as she and her husband raced to a clinic that would help her, and she developed an infection that prolonged her recovery from her miscarriage.

The Centers for Medicare and Medicaid Services ("CMS") concluded that Defendant's denial of care violated the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. 1395dd *et seq*. The denial of care also violated the Kansas Act Against Discrimination ("KAAD"), Kan. Stat. Ann. § 44-1001 *et seq*. Refusing critical emergency care to pregnant patients—and pregnant patients alone—is sex discrimination under Kansas law.

Defendant's motion to dismiss ("Mot.") misstates the facts alleged in the Complaint, fabricates inconsistencies between the Complaint and external evidence (which should not be considered on a motion to dismiss), and ignores the dire risks Ms. Farmer faced. At the same time, Defendant ignores Plaintiff's clear allegations that she had at least *two* emergency medical conditions—previable PPROM and preterm labor—and may also have been suffering from a third: infection. The Complaint explains that Defendant did not adequately screen for preterm labor or infection and refused to treat her previable PPROM. Finally, in seeking dismissal of Plaintiff's KAAD claim, Defendant cites old law. Subsequent, controlling law makes clear that discrimination based on pregnancy constitutes sex discrimination in Kansas. Defendant's motion to dismiss should be denied.

[1] While Ms. Farmer was in the midst of a dangerous miscarriage—with no chance her fetus could survive—the care she needed was an abortion because fetal cardiac activity was still detectible. Compl. ¶ 5.

STATEMENT OF FACTS

Defendant ignores many well-pled allegations in the Complaint and falsely claims that other allegations are inconsistent with extrinsic evidence. Even if reliance on that extrinsic evidence were appropriate at the pleading stage—and it is not[2]—the evidence only reaffirms how dangerous it was for Defendant to deny Ms. Farmer emergency treatment.

I. Ms. Farmer Suffers an Emergency Medical Condition.

In the early hours of August 2, 2022, just prior to 18 weeks into her much-wanted pregnancy, Ms. Farmer felt her water break, and she began to experience bleeding, abdominal pressure, pain, and cramping. Compl. ¶ 19; *accord* Ex. 2 (ECF No. 18-2), at 11 ¶ 17; Ex. 3, (ECF No. 18-3), at 6-7 ¶ 12; Ex. 5, (ECF No. 18-5), at 22, 27. Ms. Farmer rushed to her local emergency department at Freeman Hospital West, where her doctors determined that she had previable PPROM, her cervix was dilated, and she had lost *all* of her amniotic fluid. Compl. ¶¶ 20-21; *accord* Ex. 2 at 11-12 ¶¶ 17-19; Ex. 3 at 6-7 ¶¶ 12-13; Ex. 5 at 22. Because she was still so early in her pregnancy, the doctors at Freeman determined that it was impossible for her fetus to survive. Compl. ¶ 21; *accord* Ex. 2 at 12 ¶ 19; Ex. 3 at 7 ¶ 13. Further, given Ms. Farmer's age and pre-existing medical conditions, waiting for her to finish miscarrying without medical intervention would put her at risk for "maternal thrombosis," "infection/sepsis," "severe blood loss," loss of her uterus, and death. Compl. ¶ 21; *accord* Ex. 2 at 11, 13 ¶¶ 19, 21; Ex. 5 at 2, 7.

Despite these serious risks, doctors at Freeman refused to aid Ms. Farmer, claiming that

[2] *See Becher v. United Healthcare Servs., Inc.*, 374 F. Supp. 3d 1102, 1106 (D. Kan. 2019) ("When considering a motion to dismiss under Rule 12(b)(6), the court generally 'may not look beyond the four corners of the complaint.'" (quoting *Am. Power Chassis, Inc. v. Jones*, No. 13-4134-KHV, 2017 WL 3149291, at *3 (D. Kan. July 25, 2017)). The Tenth Circuit provides a limited exception for "documents *both* referred to in the complaint *and* central to the plaintiff's claims." *Waller v. City & Cnty. of Denver*, 932 F.3d 1277, 1283 (10th Cir. 2019) (emphasis added). "Otherwise, to consider a matter outside the pleadings, the court must convert the motion to dismiss into one for summary judgment." *Becher*, 347 F. Supp. 3d at 1106. Defendant does not show that the extrinsic documents it cites are "central" to Plaintiff's claims. *See* Mot. 2-3 (arguing only that the documents are referred to in the Complaint). While these documents only bolster Plaintiff's claims, they cannot be considered at the pleadings stage.

Missouri's ban on abortion care prevented them from terminating her pregnancy. Compl. ¶ 22; *accord* Ex. 2 at 12-13 ¶ 20; Ex. 3 at 7-8 ¶ 14. They advised her to seek immediate care at an out-of-state emergency department. Compl. ¶ 22; *accord* Ex. 2 at 13 ¶ 21; Ex. 3 at 9 ¶ 16.[3]

II. Ms. Farmer Seeks Emergency Medical Care at TUKH.

Ms. Farmer and her husband rushed to the emergency department at TUKH, a Level I Trauma Center. Compl. ¶¶ 23-24; *accord* Ex. 3 at 11 ¶ 21.[4] When she arrived, TUKH staff took Ms. Farmer by wheelchair to the labor and delivery unit. There, she was directed to disrobe in a bathroom. Blood had seeped through her clothes even though she was wearing a sanitary napkin, and it covered the toilet and the floor when she undressed; Ms. Farmer apologized to Dr. Dunmire about the mess. Compl. ¶ 26; *accord* Ex. 5 at 34.

In Labor & Delivery, TUKH staff documented Ms. Farmer's complex medical history—including deep vein thrombosis (blood clots), an irregular heartbeat, polycystic ovary syndrome, and history of miscarriage—and her advanced maternal age. Compl. ¶ 27; *accord* Ex. 5 at 21. Dr. Dunmire examined Ms. Farmer and independently confirmed that she had previable PPROM, which the hospital's internal guidelines identify as a significant and continuing risk to pregnant

[3] Defendant misleadingly states that in a prior administrative complaint, "Plaintiff acknowledged that the physicians at Freeman Hospital West concluded that she was *not* having a medical emergency at that time." Mot. 6 ¶ 17. Not so. While Ms. Farmer's administrative complaint accurately alleged that her "vital signs were currently stable" during her first visit to Freeman, Ex. 2 at 11 ¶ 19, it also alleged, as does the Complaint, that all treating physicians at Freeman had determined that her previable PPROM was an emergency medical condition requiring pregnancy termination. *See* Compl. ¶¶ 21–22, *accord* Ex. 2 at 12-14 ¶¶ 20, 22 (Ms. Farmer's OB-GYN at Freeman "urged that if Ms. Farmer was not able to travel immediately to an out of state hospital, she should stay at Freeman Hospital West because her life would be in jeopardy if she traveled more than 30 minutes away from an emergency department.").

[4] In another attempt to rewrite the Complaint to minimize the true emergent nature of Ms. Farmer's condition, Defendant points out that in an administrative complaint Ms. Farmer noted that she first returned home to sleep before traveling to TUKH. Mot. 6-7 ¶ 22 (citing Ex. 3 at 9 ¶ 17). Again, reliance on this extrinsic evidence at the pleading stage is not appropriate, but a review of that administrative complaint reveals the full context: Ms. Farmer was emotionally drained, physically exhausted, and unsure of what to do after being told that she had lost her daughter, she was facing serious risks to her life and health, and she could not obtain the care she needed at her local hospital. So Ms. Farmer and her husband hurriedly called multiple out of state hospitals, and Ms. Farmer's husband stayed awake to watch over her as she slept before they began the three-hour drive to TUKH. Ex. 3 at 9-11 ¶¶ 17-21.

patients that "increases the earlier and longer the membranes are ruptured." Compl. ¶¶ 28, 32; *accord* Ex. 2 at 15 ¶ 26; Ex. 3 at 12 ¶ 22; Ex. 4 (ECF No. 18-4); Ex. 5 at 7, 22-23. According to these guidelines, potential maternal complications of PPROM include infection, sepsis, placental abruption, hemorrhage, hypoxia, endometriosis, retained placenta, and death. Compl. ¶ 32; *accord* Ex. 5 at 7.

Via a bedside ultrasound, Dr. Dunmire confirmed that Ms. Farmer's pregnancy was anhydramnios—meaning that she had lost all amniotic fluid surrounding the fetus. Compl. ¶ 28; *accord* Ex. 2 at 15 ¶ 26. Upon visual examination, Dr. Dunmire concluded that Ms. Farmer's cervix was dilated. The ultrasound and visual cervical examination confirmed that Ms. Farmer's pregnancy was not viable, which meant that the only possible outcome from failing to provide the requisite treatment would be further deterioration of her health. Compl. ¶ 28; *accord* Ex. 2 at 15 ¶ 26, 28; Ex. 3 at 12 ¶ 24. Ms. Farmer felt her symptoms worsen while at TUKH. She felt acute pain and pressure in her lower abdomen consistent with contractions, her fatigue grew more intense, she experienced mental fog, and her bleeding was the heaviest it had been since her water broke. Compl. ¶ 29; *accord* Ex. 2 at 15 ¶ 27; Ex. 3 at 12 ¶ 23; Ex. 5 at 33-34.

III. Defendant Refuses to Treat Ms. Farmer.

According to TUKH's internal PPROM guidelines, when a patient experiences PPROM before viability (*i.e.*, 23 to 24 weeks gestation), "[t]he practitioner should explain the risks and benefits of outpatient expectant management and surveillance and *offer immediate delivery*," and if the patient declines immediate delivery, the hospital should offer the patient to "be admitted to an antenatal unit for monitoring for infection and fetal well-being" and receive "antibiotic prophylaxis." Compl. ¶ 33 (emphasis added); *accord* Ex. 5 at 7. Defendant's medical staff took none of these measures. Compl. ¶ 34; *accord* Ex. 5 at 9.

Consistent with TUKH's internal guidelines, given the risks to Ms. Farmer's health caused by previable PPROM, her existing medical conditions, and the nonviability of her fetus, Dr. Dunmire initially recommended medical intervention to quickly terminate Ms. Farmer's pregnancy. She told Ms. Farmer that she could either induce labor or perform a D&E, a surgical method for ending a pregnancy. Dr. Dunmire recommended inducing labor due to concerns that a D&E would "resemble[] an abortion." Dr. Dunmire also advised that inducing labor would give Ms. Farmer the opportunity to hold her daughter and say goodbye. Ms. Farmer desperately wanted that opportunity. Compl. ¶ 35; *accord* Ex. 2 at 15-16 ¶ 28; Ex. 3 at 12 ¶ 24; Ex. 5 at 30.[5]

However, Ms. Farmer had arrived at TUKH on the night of Primary Election Day 2022, when Kansas voters had been asked to decide whether the state's constitution should continue to protect abortion access. Compl. ¶ 25. Approximately 20 minutes after Dr. Dunmire recommended medical intervention to end Ms. Farmer's pregnancy, she returned to Ms. Farmer's bedside to explain that her (Dr. Dunmire's) medical judgment had been overridden. Dr. Dunmire stated that she could not induce labor because it would be too "risky" in the "heated" "political" environment. Compl. ¶ 37; *accord* Ex. 2 at 16 ¶ 29; Ex. 3 at 12 ¶ 25; Ex. 5 at 30.

Not only did Defendant refuse to provide Ms. Farmer with the medical treatment that its own guidelines and treating physician deemed appropriate—it did not provide Ms. Farmer with

[5] Defendant misleadingly claims that "the assessing physician explained two different procedures that could be undertaken *if they became medically necessary*: induced labor, or surgical dilation and curettage ("D&C.") [*sic*]." Mot. 8 ¶ 36 (emphasis added). But Plaintiff's well-pled allegation, which the Court must accept as true, is that Dr. Dunmire offered to provide either induction of labor or dilation and evacuation (D&E) immediately, consistent with "TUKH's internal medical guidelines requiring its practitioners to offer to the patient *immediate delivery*"—not delivery at a future date if her condition worsened. Compl. ¶¶ 35-36 (emphasis added). The clinical notes Defendant cites in Exhibit 4 confirm that Ms. Farmer was *only* denied treatment due to detectable fetal heart tones—not because Defendant had changed its determination that she faced a medical emergency. *See* Ex. 4 ("Due to +FHT, cannot offer IOL or D&E . . . Counseled that if at any point there is no FHT and they desire IOL or D&E, we could perform at KU"). Moreover, Defendant is wrong to suggest that Plaintiff has been inconsistent in asserting that termination of pregnancy was the necessary stabilizing treatment in her case. Mot. 8-9 ¶¶ 36-39. Defendant overlooks the fact that *both* induction of labor and D&E would have terminated the pregnancy. Providing either would have discharged Defendant's EMTALA obligation to provide stabilizing treatment.

the treatment that it had provided to a patient with nearly identical symptoms at the same gestational age approximately three weeks earlier (on July 13, 2022). CMS investigators referred to the prior patient as "Patient 4." Ms. Farmer's and Patient 4's situations were remarkably similar:

> Both patients were of advanced maternal age and had prior pregnancies. Ultrasounds confirmed that both patients' fetuses had detectable cardiac activity, despite the rupture of their amniotic membranes. Both patients' fetuses were incapable of surviving outside the womb. And both patients received counseling on the serious risks of PPROM. As with Ms. Farmer, Patient 4 was warned that she would "likely" develop "either chorio (chorioamnionitis) or PTL (preterm labor) with demise due to young gestational age."

Compl. ¶ 54; *accord* Ex. 5 at 31-34. However, while Defendant provided emergency abortion care to Patient 4, it provided no care to Ms. Farmer.

According to Ms. Farmer's records, and in defiance of hospital policy, TUKH staff not only failed to provide the pregnancy termination necessary to stabilize her previable PPROM, it never took Ms. Farmer's temperature to determine whether she had developed a fever (a sign of infection); it never performed a pain assessment to evaluate Ms. Farmer's considerable and increasing abdominal pain and pressure (consistent with contractions), despite Ms. Farmer's statement that she was experiencing cramping; it never offered to admit Ms. Farmer to an antenatal unit for monitoring for an infection, further dilation of her cervix, further bleeding, or other deterioration of her health; and it never administered prophylactic antibiotics or pain medication. Compl. ¶¶ 39-42, 63-65; *accord* Ex. 2 at 16 ¶ 30; Ex. 3 at 13 ¶ 26; Ex. 5 at 23, 26, 33. Rather, according to TUKH medical records, Dr. Dunmire discharged Ms. Farmer in the early hours of August 3, approximately two hours after her arrival at TUKH, counseling her about "how quickly she could become ill from chorioamnionitis" (*i.e.*, intra-amniotic infection), but providing no

treatment whatsoever. Compl. ¶ 38, 44; *accord* Ex. 3 at 12-13 ¶ 25; Ex. 4; Ex. 5 at 23.[6]

Without better options, Ms. Farmer went back to Freeman Hospital for monitoring as her health further deteriorated. Compl. ¶ 45. Ms. Farmer ultimately received the emergency care she needed from an Illinois clinic. *Id*. ¶ 46; *accord* Ex. 2 at 18 ¶ 37; Ex. 3 at 15 ¶ 34. With only a few hours of sleep, Ms. Farmer and her husband left their home at 3:00 AM on August 5 for the lengthy drive. *Id.* ¶ 46 On the way, Ms. Farmer continued to experience "severe cramping, contractions, and excruciating pain." *Id.* By the time Ms. Farmer arrived, around 10:00 A.M., "she was several days into her miscarriage, in active labor, and nearly fully dilated. Doctors at the Illinois clinic immediately performed a D&E" to terminate the pregnancy. *Id.* In the following days, "Ms. Farmer continued to experience pain and vaginal discharge. She contacted her local obstetrician, who said that Ms. Farmer had likely developed an infection by the time she reached the clinic in Illinois." *Id.* ¶ 47. Although she received antibiotics, the infection prolonged her recovery. *Id.*

Ms. Farmer continues to suffer physically, psychologically, and financially as a result of Defendant's denial of care. Compl. ¶ 50. Her doctor believes the physical and mental "trauma from the denial of care exacerbated a chronic illness, for which she has been hospitalized several times" since she miscarried. *Id.* Ms. Farmer was unable to work for many months and, without the ability to earn wages, she lost the home she owned. *Id.*

LEGAL STANDARD

When evaluating motions to dismiss, courts ask whether plaintiffs have pled sufficient factual allegations "to state a claim to relief that is plausible on its face." *Reznik v. inContact, Inc.*,

[6] Defendant not only mischaracterizes the Complaint but also the medical record that it appends to its motion by suggesting that record "states that Ms. Farmer was specifically counseled on what signs or symptoms could change the medical analysis *as to whether she was having a medical emergency*, and she was instructed to return if any of those signs or symptoms developed." Mot. 10 ¶ 46. The attached record does not discuss a medical emergency calculus—it simply and clearly states that Ms. Farmer was "counseled on chorioamnionitis signs/symptoms" and "how quickly" an infection could set in, and that she was told to return to her local hospital if she had those symptoms.

18 F.4th 1257, 1260 (10th Cir. 2021) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). To apply that standard, courts "take as true all well-pleaded facts, as distinguished from conclusory allegations, view all reasonable inferences in favor of the nonmoving party, and liberally construe the pleadings." *Id*. (internal quotations omitted). The plausibility standard does not impose a probability requirement at the pleading stage; rather, plaintiffs must allege enough facts to "nudge[ ] their claims across the line from conceivable to plausible." *Brown v. Montoya*, 662 F.3d 1152, 1163 (10th Cir. 2011) (quoting *Twombly*, 550 U.S. at 570).

ARGUMENT

I. Plaintiff Has Stated a Plausible Claim that Defendant Violated EMTALA.

Under EMTALA, Medicare-funded hospitals operating an emergency department must: (1) provide an "appropriate medical screening examination" to any "individual" who "comes to the emergency department" (the Screening Requirement), 42 U.S.C. § 1395dd(a); and (2) provide "necessary stabilizing treatment" to any "individual" who is determined to have an "emergency medical condition" (the Stabilization Requirement), *id.* § 1395dd(b). The Complaint plausibly alleges that Defendant failed to meet EMTALA's requirements in two ways. First, Defendant violated the Stabilization Requirement by failing to offer *any* treatment for Ms. Farmer's medically complicated previable PPROM, which was an emergency medical condition ("EMC"). Second, Defendant violated the Screening Requirement by failing to perform a routine pain assessment or temperature check. Had Defendant followed its own screening procedures, it could have discovered that Ms. Farmer had other EMCs: infection or preterm labor.[7]

[7] At the outset, the Court should disregard Defendant's baseless argument that EMTALA should apply only to patients without insurance, as this is squarely foreclosed by controlling law and EMTALA's plain text (which Defendant does not dispute). Mot. 18. EMTALA does not limit its application to uninsured individuals; to the contrary, the statute applies to "any individual" who comes to the emergency department. 42 U.S.C. §§ 1395dd(a), (b)(1); *see also Collins v. DePaul Hosp.*, 963 F.2d 303, 308 (10th Cir. 1992) (explaining the fact that EMTALA was "designed to

A. Defendant Violated EMTALA's Stabilization Requirement by Failing to Treat Ms. Farmer's Medically Complicated Previable PPROM.

Defendant violated EMTALA's Stabilization Requirement when it discharged Ms. Farmer without providing any medical treatment at all for the EMC that its own physicians diagnosed—medically complicated PPROM with complete loss of amniotic fluid at less than 18 weeks' gestation. EMTALA defines an EMC as a 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 woman or her unborn child) in serious jeopardy", (ii) "serious impairment to bodily functions," or (iii) "serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e)(1)(A).[8] Ms. Farmer's medically complicated previable PPROM met this standard, yet, contrary to its own guidelines, Defendant refused to provide the "further medical examination" and "treatment" "required to stabilize" this condition. *Id.* § 1395dd(b)(1)(A).

i. Defendant Had Actual Knowledge that Ms. Farmer's Complex Previable PPROM Was an EMC Requiring Termination of Her Pregnancy.

Defendant had actual knowledge that Ms. Farmer's PPROM, with complete loss of amniotic fluid at less than 18 weeks' gestation, complicated by bleeding, reports of abdominal cramping, and her complex medical history, was an EMC. Compl. ¶¶ 5, 26-28, 55; *accord* Ex. 5 at 21; *see Urban v. King*, 43 F.3d 523, 526 (10th Cir. 1994) (Stabilization Requirement applies when "the hospital determines the individual has an emergency medical condition."). Ms. Farmer's

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prohibit hospitals from 'dumping' poor or uninsured patients in need of emergency care, does not subtract from its use of the broad term 'any individual.'"). Accordingly, with respect to the Stabilization Requirement, the U.S. Supreme Court held in *Roberts v. Galen of Virginia, Inc.*, that a plaintiff need not prove that the hospital acted with an improper motive—whether involving the patient's indigency, race, sex, or otherwise—to state a claim. 525 U.S. 249, 253 (1999). Defendant likewise recognizes that, under Tenth Circuit precedent, EMTALA's Screening Requirement applies to all patients, regardless of ability to pay. *See* Mot. 17; *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 797 (10th Cir. 2001)); *see also Genova v. Banner Health*, 734 F.3d 1095, 1097 n.1 (10th Cir. 2013) ("[U]nder this court's precedent[,] . . . [a]ll that's required is a failure, for whatever reason, to examine and stabilize").

[8] As discussed below, labor is also an EMC under certain circumstances. *See* 42 U.S.C. § 1395dd(e)(1)(B).

condition was an EMC for two independent reasons: (1) it involved "serious dysfunction" of a "bodily organ or part"—Ms. Farmer's amniotic membrane, 42 U.S.C. § 1395dd(e)(1)(A)(iii); and (2) it placed her health in "serious jeopardy," *id.* § 1395dd(e)(1)(A)(i).

First, Defendant knew that Ms. Farmer's previable PPROM was an EMC because it involved "serious dysfunction" of her amniotic membrane—a "bodily organ or part." 42 U.S.C. § 1395dd(e)(1)(A)(iii). Tests performed at TUKH confirmed that Ms. Farmer's amniotic membrane had ruptured, causing complete loss of her amniotic fluid. Compl. ¶¶ 5, 28. This ongoing "serious dysfunction"—which could reasonably be expected to continue absent medical intervention—constituted an EMC. *See, e.g.*, *Jeude v. Ste. Genevieve Mem'l Hosp.*, No. 1:22-CV-151-SNLJ, 2023 WL 3275505, at *6 (E.D. Mo. May 5, 2023) (plaintiff adequately alleged that he had an EMC where he alleged that he arrived at the hospital with existing "'serious dysfunction' of a body part"—his fractured shoulder and vertebrae).

Second, Defendant knew that denying Ms. Farmer treatment to end her pregnancy placed her health in "serious jeopardy." 42 U.S.C. § 1395dd(e)(1)(A)(i). As TUKH's own obstetric guidelines recognize, without medical intervention, patients with PPROM can expect their health to deteriorate, and the potential maternal complications of PPROM include infection, sepsis, placental abruption, hemorrhage, hypoxia, endometriosis, retained placenta, and death. Compl. ¶¶ 32, 76; *see also id.* ¶ 1 n.1 (citing Brief for Am. Coll. of Obstetricians & Gynecologists et al. as *Amici Curiae* in Support of Respondent, *Moyle v. United States*, Nos. 23-726 & 23-727 (Mar. 28, 2024) ("ACOG Br."), at 11-12 ("When a pregnant patient experiences PPROM prior to viability, continuing the pregnancy risks serious health consequences including sepsis and death.")). These same TUKH guidelines recognize that "[t]he risk of complications generally increases the earlier and longer the membranes are ruptured." Compl. ¶ 32. Accordingly, TUKH's guidelines state that

when a patient experiences PPROM before viability (i.e., 23 to 24 weeks gestation), TUKH practitioners must "offer *immediate* delivery." *Id.* ¶ 33 (emphasis added).

Dr. Dunmire recognized the "risks to Ms. Farmer's health caused by PPROM and the nonviability of her fetus," Compl. ¶ 35, made all the more urgent by Ms. Farmer's bleeding (which Dr. Dunmire saw had seeped through a sanitary napkin and covered the toilet and the floor when Ms. Farmer undressed in the TUKH bathroom), *id.* ¶¶ 19, 26, 29, 55; her reports of abdominal cramping, *id.* ¶¶ 29, 55; *accord* Ex. 5 at 26, 33; and her complicated medical history, including deep vein thrombosis (blood clots), an irregular heartbeat, polycystic ovary syndrome, prior miscarriage, and advanced maternal age, *id.* ¶ 27.[9] And because Ms. Farmer was so early in her pregnancy and had lost *all* amniotic fluid necessary for fetal development, Dr. Dunmire determined that there was no chance for the fetus to survive; thus, there was substantial risk—and zero benefit—to withholding immediate treatment. *Id.* ¶¶ 6, 21, 28, 32. Accordingly, consistent with hospital guidelines, Dr. Dunmire recommended terminating the pregnancy. Compl. ¶¶ 35-36.[10]

Defendant's contention that Ms. Farmer did not have an EMC because "[she] does not even allege that [she] was 'unstable'" misunderstands the legal standard.[11] Mot. 15. EMTALA defines an EMC and what it means to be "stabilized" *as a matter of law*—not as a matter of medical

[9] *Cf. McClure v. Parvis*, 294 F. Supp. 3d 318, 326 (E.D. Pa. 2018) (symptoms "coupled with additional information like medical history" might suggest an EMC) (internal quotation marks and citations omitted).

[10] Defendant is wrong to contend that it was the "judgment of the medical professionals … that Ms. Farmer did not have an unstable emergency medical condition." Mot. 17. Plaintiff's well-pled allegation, which this Court must accept as true, is that Dr. Dunmire determined that Ms. Farmer's complex previable PPROM required emergency care: immediate pregnancy termination. Compl. ¶¶ 35-36. That medical opinion did not change; it was "overridden" for political reasons due to a detectable fetal heart tone. *Id.* at ¶ 37.

[11] And in any event, Ms. Farmer *does* allege several facts underscoring the acuity of her condition. As noted, Defendant knew she was experiencing vaginal bleeding and cramping, symptoms made all the more dangerous by her complex medical history. Compl. ¶¶ 19, 26-27, 29, 55. And as discussed *infra*, Defendant could not know if she was already suffering from an infection or the severity of her pain because Defendant never properly assessed for it. *Id.* ¶¶ 6, 40, 63-64. Thus, this case is unlike *Urban v. King*, in which the parties agreed that the hospital did not have actual knowledge of the EMC, where the patient had not presented to the emergency room, "[s]he was not in pain, and she had not displayed acute symptoms of severity at the time she was sent home." 43 F.3d at 524, 525-26. *Tank v. Chronister* is also inapposite as the court there dismissed plaintiff's EMTALA action because there was "no allegation that the hospital or [the doctor]" had actual knowledge of the EMC. 941 F. Supp. 969, 973 (D. Kan. 1996).

charting. 42 U.S.C. §§ 1395dd(e)(1), (3)(B); *see St. Anthony Hosp. v. U.S. Dep't of Health & Hum. Servs.*, 309 F.3d 680, 694 (10th Cir 2002) ("EMTALA's definition of 'stability' does not share the same meaning as the medical term "stable condition""). The plain text of the statute protects not only people who have *already* experienced material deterioration of their health, but also patients who need immediate treatment to limit the risk of material deterioration *in the future*. As explained above, an individual has an EMC under EMTALA if the absence of immediate treatment "*could reasonably be expected* to result in" placing the individual's health in "serious *jeopardy*." *Id.* § 1395dd(e)(1)(A)(i) (emphases added). Similarly, EMTALA considers a patient unstable if "material deterioration of the condition is *likely, within reasonable medical probability*" to occur absent treatment. 42 U.S.C. § 1395dd(e)(3)(B) (emphasis added). Both these definitions speak to risks of future harm. Thus, a patient need not have abnormal vital signs or *already* be close to death to have an EMC requiring stabilization.[12]

Ms. Farmer has more than plausibly alleged that her complex, previable PPROM placed her "health . . . in serious jeopardy" and that absent immediate treatment, "material deterioration of [her] condition [was] likely." 42 U.S.C. §§ 1395dd(e)(1)(A)(i), (3)(B). According to the Complaint, Ms. Farmer's doctors at Freeman Hospital West determined that, "given her medical history, waiting to end her pregnancy would put her at risk of 'maternal thrombosis,' 'infection/sepsis,' 'severe blood loss,' the loss of her uterus, and even death." Compl. ¶ 21. Likewise, Ms. Farmer's doctor at TUKH counseled Ms. Farmer about "how quickly she could become ill from chorioamnionitis" (*i.e.*, intra-amniotic infection) *Id.* ¶ 38. These detailed, well-

[12] Although Defendant's reliance on extrinsic evidence is improper, its own exhibit undermines its position: TUKH's own EMTALA policy states that individuals with EMCs are "not limited to patients with traditional evaluations of 'emergent' or 'urgent' and may include individuals with traditional evaluations of 'non-urgent' and possibly 'chronic' conditions. The phrase 'immediate medical attention' has been applied to situations in which the need for medical assessment and care was in a time frame of days rather than hours." Ex. 5 at 4.

pled allegations must be taken as true. *See Reznik v. inContact, Inc.*, 18 F.4th at 1260; *cf. McClure v. Parvis*, 294 F. Supp. 3d 318, 326 (E.D. Pa. 2018) (defendant's attempt to dispute plaintiff's EMC allegations raised a fact question that could not be resolved at the pleading stage).

Underscoring the immediacy and severity of the risks Ms. Farmer faced, TUKH's guidelines suggest that, even for patients without Ms. Farmer's symptoms and complex medical history, the risks of previable PPROM are significant enough that patients who decline "immediate delivery" should be admitted for "monitoring for infection" and "antibiotic prophylaxis" (although TUKH staff failed to offer Ms. Farmer even this). Compl. ¶¶ 33, 77. Indeed, when treating Patient 4, TUKH clinicians documented that, without an immediate pregnancy termination, complications from Patient 4's previable PPROM were "*likely*." *Id.* ¶¶ 53-55 (emphasis added); *accord* Ex. 5 at 33. Ms. Farmer's case was even more dire than Patient 4's, given that Ms. Farmer reported vaginal bleeding and Patient 4 did not, that Ms. Farmer had lost *all* amniotic fluid and Patient 4 had not, and given Ms. Farmer's reports of abdominal cramping and underlying conditions (including a history of blood clots). Compl. ¶¶ 29, 53-55; *accord* Ex. 5 at 26, 33-34.

Construing these facts in the light most favorable to Ms. Farmer, Defendant knew that, in the absence of an immediate pregnancy termination, Ms. Farmer's previable PPROM could "reasonably be expected to" place her health in "serious jeopardy," and thus that it constituted an EMC triggering the Stabilization Requirement. 42 U.S.C. § 1395dd(e)(1)(A)(i); *see also Vazquez-Rivera v. Hosp. Episcopal San Lucas, Inc.,* 620 F. Supp. 2d 264, 270 (D.P.R. 2009) (plaintiff's allegations of "pregnancy, vaginal bleeding, and severe abdominal pain …satisf[ied] the emergency medical condition element of EMTALA's stabilization requirement" at the pleading stage). Indeed, reviewing these same facts, CMS investigators concluded that Defendant's failure to treat Ms. Farmer violated EMTALA. Compl. ¶ 56; *accord* Ex. 5 at 21.

ii. Defendant Did Not Stabilize Ms. Farmer's EMC.

EMTALA's Stabilization Requirement provides that, when a hospital emergency department determines that a patient has an EMC, the hospital "*must* provide either—(A) within the staff and facilities available at the hospital, for such *further medical examination and such treatment* as may be required *to stabilize* the medical condition, or (B) for transfer of the individual to another medical facility" under narrow circumstances. 42 U.S.C. § 1395dd(b)(1) (emphases added). If the EMC "has not been stabilized…the hospital may not transfer the individual" (which includes discharge) unless certain conditions are met. *Id.* § 1395dd(c)(1); 42 C.F.R. § 489.24. EMTALA defines "to stabilize" 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 transferring or discharging the patient. 42 U.S.C. § 1395dd(e)(3)(A). Because the stabilization inquiry is fact-dependent, and because expert testimony is often necessary to ascertain whether "within reasonable medical probability, . . . no material deterioration [was] likely," it should not be resolved on a motion to dismiss. *See, e.g.*, *Lozoya v. Anderson*, No. 3:07-CV-02148, 2008 WL 2476187, at *3 (S.D. Cal. June 17, 2008); *see also, e.g.*, *Smith v. Botsford Gen. Hosp.*, 419 F.3d 513, 519 (6th Cir. 2005). ("[C]ompliance with EMTALA's stabilization requirements entails medical judgment . . . understood . . . only through expert testimony."). A hospital that fails to stabilize a known EMC is subject to strict liability. *Abercrombie v. Osteopathic Hosp. Founders Ass'n*, 950 F.2d 676, 681 (10th Cir. 1991).

As discussed *supra*, Defendant's complete failure to treat Ms. Farmer meets this standard. Defendant not only refused to induce labor despite its own internal guidelines and Dr. Dunmire's medical judgment, Compl. ¶ 37, it refused to provide Ms. Farmer *any care whatsoever*—not even Tylenol or antibiotics, which at minimum should have been offered to a patient who was counseled

that she could "quickly" develop a life-threatening infection, *id.* ¶¶ 6, 38-39, 77, 89. Indeed, Defendant failed to provide Ms. Farmer the routine temperature checks necessary to assess whether she had already developed an infection, violating both internal protocols and its duty under EMTALA to provide "such further medical examination" as necessary to stabilize her EMC. Compl. ¶ 30-31.[13] As a result, Ms. Farmer's condition predictably did continue to deteriorate, culminating in an excruciating hours-long drive to an Illinois clinic while in active labor, nearly fully dilated, and suffering an infection. *Id.* ¶¶ 46-47. Defendant's refusal to treat Ms. Farmer violated the Stabilization Requirement. *Cf. Heimlicher v. Steele*, 615 F. Supp. 2d 884, 903-04 (N.D. Iowa 2009) (upholding jury's finding that hospital did not stabilize pregnant patient's EMC where the hospital "did not address the possible causes of her pain or vaginal bleeding" and did not have "assurances that her condition would not deteriorate during [an] ambulance ride").[14]

B. Defendant Violated EMTALA's Screening Requirement by Failing to Offer Temperature Checks and a Standard Pain Assessment.

Defendant violated EMTALA's Screening Requirement when it failed to perform a pain assessment or temperature checks for Ms. Farmer, which could have revealed that Ms. Farmer was suffering from the *additional* emergency medical conditions of preterm labor or infection in an already emergent situation. Compl. at ¶¶ 5, 21, 32.

i. Screening and Stabilization Claims Are Compatible.

[13] Defendant suggests that a temperature check can be inferred from one nurse reporting to CMS that Ms. Farmer had "no fever." Mot. 16 n.7. But this is contrary to CMS's finding that "[t]he medical record failed to show that staff checked [Ms. Farmer's] temperature to determine if she had a fever." Ex. 5 at 23.

[14] Defendant proffers a "parade of horribles" argument that if this case is allowed to proceed, "medical judgment of physicians might be written out of the process altogether" or "clinical treatments [will be] pre-determined by judicial fiat." Mot. 18, 22. Not so. EMTALA's decades-old statutory scheme does not usurp medical decision-making from physicians; to the contrary, because the definitions of "to stabilize" and "stabilized" require treatment that prevents material deterioration of the patient's condition "within reasonable medical probability," 42 U.S.C. §§ 1395dd(e)(3)(A), (B), EMTALA ensures hospitals provide the stabilizing treatment its physicians reasonably deem necessary, based on prevailing standards of care. *See Smith*, 419 F.3d at 519. Here, Dr. Dunmire determined that terminating Ms. Farmer's pregnancy was necessary, a determination that aligned with TUKH's own guidelines. Compl. ¶¶ 33, 35-36. Thus, far from asking this Court to commandeer medical decision-making, Plaintiff's claim is that Defendant acted in *contravention* of physician judgment and in so doing violated the law.

Defendant is wrong to suggest that Ms. Farmer's claims for failure to screen and failure to stabilize "are implicitly contradictory." Mot. 14-15. Defendant ignores that the screening and stabilizing violations pertain to distinct EMCs: while Defendant failed to stabilize the EMC it did diagnose—PPROM, Compl. ¶¶ 72-77,—it did not properly screen for infection and wholly failed to screen for preterm labor. Compl. ¶ 65. Under EMTALA, labor is itself an EMC if transferring or discharging the laboring patient "may pose a threat to the health or safety of the woman or the unborn child." 42 U.S.C. § 1395dd(e)(1)(B)(ii). Defendant's knowledge of Ms. Farmer's PPROM cannot cure its failure to follow its own standard protocols to screen for labor and infection.

In any event, an EMTALA plaintiff may simultaneously pursue screening and stabilization claims arising from the same EMC. For example, in *Griffith v. Mt. Carmel Medical Center*, after concluding that there were genuine issues of material fact as to whether the defendants provided the patient the same emergency room screening that would have been provided to any other patient with symptoms of cardiac arrest, 831 F. Supp. 1532, 1538-44 (D. Kan. 1993), the court also concluded that there was sufficient evidence from which a jury could legitimately infer that the defendants had determined the patient had an EMC and did not stabilize him before discharge, *id*. at 1544-45.[15] Screening and stabilization claims are not mutually exclusive.

ii. Defendant Failed to Follow Its Standard Procedure by Omitting Temperature Checks and a Pain Assessment.

Plaintiff adequately alleges that Ms. Farmer was not provided an "appropriate" medical screening examination because Defendant failed to follow its own internal procedures by not taking her temperature or assessing her pain level. The Tenth Circuit has held that EMTALA's Screening Requirement "is violated when [a hospital] does not follow its own standard procedures"

[15] *See also Isaac-Burgos v. Rodriguez*, 485 F. Supp. 2d 14, 19-20 (D.P.R. 2007) (denying defendants' motion for summary judgment on plaintiffs' claims of failure to screen and stabilize for the same EMC: chest pain).

for assessing emergency patients. *Phillips*, 244 F.3d at 797 (internal quotation marks omitted); *see also Repp v. Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994); *accord Cruz-Queipo v. Hosp. Espanol Auxilio Mutuo de P.R.*, 417 F.3d 67, 70 n.4 (1st Cir. 2005) (listing other circuits with similar standards). "[H]ospitals, and not reviewing courts, are in the best position to assess their own capabilities. Thus, a hospital violates section 1395dd(a) when it does not follow its own standard procedures." *Repp*, 43 F.3d at 522.

As noted above, Defendant's guidelines require temperature checks for PPROM patients, but Defendant did not provide one to Ms. Farmer. Had appropriate temperature checks been performed, Defendant may have discovered that her PPROM was complicated by an infection.

Defendant's own standard emergency procedures also require a pain assessment for all incoming emergency OB patients. Compl. ¶ 30. Ms. Farmer was in considerable and increasing pain in her lower abdomen, and she reported cramping to a TUKH nurse, but TUKH staff did not ask her to rate her pain or otherwise perform a pain assessment. *Id.* at ¶¶ 40, 55; *accord* Ex. 5 at 23, 26, 33–34. If TUKH staff had conducted the pain assessment required by their own procedures, they would have learned that Ms. Farmer was experiencing very painful abdominal cramping and pressure consistent with contractions, in addition to her broken water, cervical dilation, and vaginal bleeding. *Id*. ¶ 55. Taken together, it is more than plausible that Ms. Farmer was in the early stages of preterm labor. *Id.* ¶ 65. Ms. Farmer's PPROM and complex medical history (including her history of blood clots) meant that discharging her to labor outside of a hospital "may" have "pose[d] a threat" to her health. 42 U.S.C. § 1395dd(e)(1)(B)(ii). In other words, her preterm labor was an EMC. *Cf. Morin v. E. Me. Med. Ctr.*, 780 F. Supp. 2d 84, 86, 93-94 (D. Me. 2010) (pregnant woman had an EMC under 42 U.S.C. § 1395dd(e)(1)(B) when her fetus died at sixteen weeks, causing cramping consistent with contractions and blood in her urine).

Plaintiff's Complaint further alleges that Ms. Farmer received a different screening evaluation than Defendant provided to other patients in similar medical circumstances. EMTALA obligates hospitals to administer its screening procedure "uniformly to all those who present substantially similar complaints." *Correa v. Hosp. S.F.*, 69 F.3d 1184, 1192 (1st Cir. 1995); *see also Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 881 (4th Cir. 1992); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991). Just weeks prior, Defendant did perform a pain assessment for Patient 4. Compl. ¶ 55; *accord* Ex. 5 at 33. Had Defendant performed this assessment and discovered that Ms. Farmer was in preterm labor, hospital staff could have augmented it with medication, allowing her to deliver quickly and safely in a hospital.

iii. Defendant's Deviation Far Surpassed the* De Minimis *Standard.

Furthermore, Defendant's kitchen sink argument that its deviations from its normal screening procedures were *de minimis*, Mot. 14, falls flat because the consequence of those deviations was a complete failure to identify Ms. Farmer's labor or possible infection, further endangering her health.

Repp is the seminal case regarding what constitutes a *de minimis* deviation from a hospital's normal standards. In *Repp,* the patient alleged an EMTALA claim based on two departures from the hospital's normal standard: that the hospital did not obtain the patient's full medical history and nurses did not ask for a complete list of medications the patient was taking. 43 F.3d at 523. The court determined these deviations were *de minimis* because even though the nurses "did not ask specific questions about these items," they nevertheless "received information on each subject"; the patient's wife provided it without the nurses needing to ask for it. *Id.* The court held that such "purely formalistic deviations" from the hospital's standard policy were *de minimis* and not actionable. *Id.* In other words, where the repercussion of the deviation in policy

would have no effect on the care the individual received, the effect of deviation is *de minimis.*

As discussed above, this could not be further from the case for Ms. Farmer. Defendant did *not* get the material information it needed to see if Ms. Farmer had an infection or if her abdominal pain was indicative of preterm labor, leaving those EMCs unstabilized.

II. Plaintiff Has Plausibly Alleged Defendant Violated the KAAD.

Defendant's decision to single out pregnant women alone to be denied critical emergency care constituted facial sex discrimination in violation of the KAAD. Defendant's sole response is to insist that pregnancy discrimination is not sex discrimination. *See* Mot. 24. Defendant is wrong.

A. Defendant misrepresents *Harder*.

Defendant argues that *Harder v. Kansas Commission on Civil Rights*,[16] 225 Kan. 556 (1979), is dispositive of Plaintiff's KAAD claim, asserting that the case stands for the proposition that pregnant individuals are not a protected class for purposes of the KAAD. *See* Mot. 23. But Defendant incorrectly characterizes the trial court's decision as that of the Kansas Supreme Court and overlooks the key portions of the Supreme Court's analysis.

In *Harder*, the plaintiff challenged her employer's policy prohibiting use of sick leave for pregnancy-related absences. *Harder*, 225 Kan. at 557. A Kansas trial judge concluded that the exclusion of pregnancy from the sick leave policy did not constitute sex discrimination under the KAAD. *Id.* at 557-58. On appeal, the Kansas Supreme Court quoted the trial judge's opinion at length, but ultimately decided the case on other grounds. The Court noted that Kansas regulations in effect in 1972, when the alleged discrimination took place, "specifically excluded pregnancy related illnesses from sick leave benefits," and such regulations had the "force and effect of a

[16] The Kansas Commission on Civil Rights was the state commission established by the KAAD and given the "power to eliminate and prevent segregation and discrimination" covered by the KAAD. Kan. Stat. Ann. § 44-1001. It was renamed the Kansas Human Rights Commission in 1991. Kan. Stat. Ann. § 44-1003.

statute." *Id.* at 559. While those regulations were changed in 1975 to include pregnancy-related disabilities in "temporary disability insurance or sick leave plan[s]," the Court held that the plaintiffs' employer could not "be found to have violated a [1975] regulation that was not even in existence at the time the alleged discriminatory acts took place." *Id.* at 559-60. The Court's holding drew no conclusions as to whether pregnancy constituted sex discrimination under the KAAD in other contexts or in the future. Rather, the analysis focused on the law in effect in 1972, with the understanding that the law had changed.[17]

In arguing to the contrary, Defendant cites language excerpted from the *trial court's decision* and attributes it to the "unanimous Kansas Supreme Court."[18] *See* Mot. 23. In fact, *all* quotes cited by Defendant in support of dismissal are from the reprinted *trial court* decision, not from the Kansas Supreme Court's own analysis. *See id.* (citing 225 Kan. at 558); *see also* 225 Kan. at 557 ("The learned trial judge set forth his findings and conclusions as follows:"). The trial court language quoted, and the inferences drawn from it by Defendant, are not reflective of the Kansas Supreme Court's actual holding or reasoning in *Harder*.

B. Subsequent precedent demonstrates pregnancy discrimination is sex discrimination under the KAAD.

Crucially, *Harder* was not the last word on pregnancy and the KAAD. Nearly ten years later, in *Kansas Gas & Electric Co. v. Kansas Commission on Civil Rights*, the Kansas Supreme Court held that granting pregnancy leave for women did not discriminate against men under the KAAD. 242 Kan. 763, 765-67 (1988). The Court recognized that pregnancy discrimination undermines sex equality and cited favorably the trial court's determination that providing pregnant employees' leave was permissible because it "was not intended to give pregnant women an

[17] Indeed, *Harder* has never been cited by another Kansas court to support the proposition that pregnancy discrimination falls outside the scope of the KAAD.

[18] *Harder* was not unanimous. *See* 225 Kan. at 560 ("HERD, J., not participating").

advantage over males and nonpregnant female employees, but to give them an opportunity to remain equal with their male and female counterparts in the company." *Id*. at 767. In this way, the Kansas Supreme Court rejected the reasoning underlying *Geduldig v. Aiello*, 417 U.S. 484 (1974), and *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976)—the two U.S. Supreme Court cases on which the *Harder* trial court relied, *see* 225 Kan. at 558, and which determined that excluding pregnancy disability insurance was merely a choice not to cover "one physical condition" among many, albeit a condition that "only women" can experience, *id.* (quoting the trial court's quotation of *Geduldig*, 417 U.S. at 496 n.20). The *Kansas Gas* Court further distinguished *Geduldig* and *Gilbert* by recognizing the inescapable connection between pregnancy and sex discrimination: "It is easy to mouth platitudes to the effect that employers should consider all employees as 'its' and determine all employment policies on that basis... [] Such a position ignores the real world… [] The role of bearing children falls on the female sex." 242 Kan. at 766.

The *Kansas Gas* Court further departed from the trial court's decision in *Harder* by drawing upon precedent under Title VII of the Civil Rights Act of 1964, *as amended by the Pregnancy Discrimination Act (PDA) of 1978*, 42 U.S.C. § 2000e(k), to interpret the KAAD. 242 Kan. at 767 ("Some attention should be given to federal legislation in this area, although this action is predicated upon [the KAAD]"). Following *Gilbert*, the U.S. Congress swiftly enacted the PDA to repudiate the Court's decision and ensure that protections against sex discrimination would be properly interpreted as prohibiting pregnancy discrimination. *See id.* at 768; *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 677-78 (1983) (explaining that Congress amended Title VII to "unambiguously express[ ] disapproval of both the holding and the reasoning of the Court in [*Gilbert*]"). Courts have followed suit in relying on Title VII and the PDA when interpreting the KAAD. *See, e.g.*, *Best v. State Farm Mut. Auto. Ins. Co.*, 953 F.2d 1477, 1480 n.2

(10th Cir. 1991) ("[T]he Kansas Supreme Court is entitled to refer to Title VII when it interprets the KAAD, and we then are obliged to follow that interpretative tool as adopted by the Kansas Supreme Court."); *Bolton v. Dep't of Corr.*, No. 71,819, 1995 WL 18253660, at *2 (Kan. Ct. App. Apr. 14, 1995) (relying on the PDA to hold different treatment of an individual based on her status as parent of an illegitimate child stated a prima facie case of sex discrimination under the KAAD).

C. Binding regulations further establish that pregnancy discrimination is a form of sex discrimination prohibited by the KAAD.

As discussed in *Harder*, binding regulations clarify that pregnancy discrimination is prohibited by the KAAD. The KAAD, which by its terms must be "construed liberally," prohibits "unlawful discriminatory practices," including "[a]ny discrimination against persons by reason of their … sex" in a public accommodation or institution of the state of Kansas, as well as "unlawful employment practice[s]," such as refusing to hire or discharging an employee "because of the … sex" of the person. Kan. Stat. Ann. §§ 44-1006(a), 44-1009(a), (c); *see also* Kan. Stat. Ann. § 44-1002(i)(1). While the KAAD does not include a definition of sex, in 1975, shortly after "sex" was added to the list of characteristics protected against employment and public accommodations discrimination,[19] the Kansas Commission on Civil Rights permanently adopted "Guidelines on Discrimination Because of Sex," which state that discrimination based on "pregnancy is prima facie discrimination" under the KAAD. Kan. Admin. Regs. 21-32-6.[20] The section further requires that "[d]isabilities caused or contributed to by pregnancy, miscarriage, abortion, childbirth and recovery therefrom" must be treated with the same terms as all other temporary disabilities. Kan.

[19] *See Kan. Comm'n on C.R. v. Sears, Roebuck & Co.*, 216 Kan. 306, 316 (1975).

[20] Although these regulations refer to the employment context, and the Commission has not adopted regulations regarding public accommodations specifically, the meaning of "sex discrimination" under the KAAD should be uniform absent any textual basis for a contrary interpretation. *See In re Woods*, 743 F.3d 689, 697 (10th Cir. 2014) ("'[T]he normal rule of statutory construction assumes that identical words used in different parts of the same act are intended to have the same meaning.'" (quoting *Sorenson v. Sec'y of Treasury of U.S.,* 475 U.S. 851, 860 (1986)).

Admin. Regs. 21-32-6(d). This regulation has the full effect of law. *See Kansas Gas*, 242 Kan. At 765 ("Kansas Administrative Regulations, when adopted, have the force and effect of law."); *Harder*, 225 Kan. 556, 559 (similar); Kan. Stat. Ann. § 77-425.

Kansas law thus provides a straightforward mandate that is contrary to Defendant's position—when analyzing discrimination on the basis of sex for purposes of the KAAD, pregnancy discrimination must be considered prima facie discrimination.

D. Plaintiff Plausibly Alleges that Defendant Discriminated Based on Sex.

Under the KAAD, as properly interpreted pursuant to *Kansas Gas* and binding regulations, Ms. Farmer has stated a plausible claim of sex discrimination: On the night of August 2, 2022, Defendant provided all other emergency department patients with an appropriate medical screening and any necessary stabilizing treatment within its capacity as a Level I Trauma Center, but it determined that pregnant women experiencing medical emergencies that evening would be denied equally comprehensive care—or indeed any treatment whatsoever. Compl. ¶¶ 88-89. This decision, on its face, discriminated based on sex, both by singling out pregnant women for substandard treatment and by treating "disabilities caused or contributed to by pregnancy" and "miscarriage" differently from other temporary disabilities in violation of the KAAD. *Id.* ¶¶ 88, 90; Kan. Admin. Regs. 21-32-6(d).

If this Court determines that the issue of whether the KAAD prohibits pregnancy discrimination "has not been squarely addressed [and] guidance from the state court through certification is appropriate," Plaintiff requests that the Court certify questions to the Kansas Supreme Court on its own motion pursuant to Kan. Stat. Ann. § 60-3201. *See Beam v. Concord Hosp., Inc.*, No. 93-4188-SAC, 1995 WL 408436, at *2 (D. Kan. May 3, 1995). If the Court intends to certify issues regarding Plaintiff's KAAD claim, Plaintiff respectfully requests the opportunity

to submit proposed questions to the Court. *See U.S. Cable Television Grp., L.P. v. City of Osage City, Kan.*, No. 91-4195-R, 1991 WL 230704, at *5 (D. Kan. Oct. 31, 1991).

CONCLUSION

Defendant's motion to dismiss should be denied. However, if the motion is granted in any part, Plaintiff requests that any dismissal be without prejudice and with leave to amend.[21]

Respectfully submitted,

Dated: October 9, 2024

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CERTIFICATE OF SERVICE

The undersigned certifies that this motion was filed using the Court's electronic filing system, providing notice to all counsel of record.

/s/ Mark V. Dugan
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[21] *Chilcoat v. San Juan Cnty.*, 41 F.4th 1196, 1217 (10th Cir. 2022) ("Under Federal Rule of Civil Procedure 15(a)(2), the court should freely give leave to amend when justice so requires.") (cleaned up).