Abortion and Reproductive Rights

1. The recent proliferation of abortion bans across U.S. states has precipitated a crisis, infringing upon medical ethics, contravening international human rights obligations, and severely impacting patient care. PHR has documented these profound implications on both those seeking care and those providing it, including delays in emergency care, increased maternal mortality risks, and the chilling effect on medical professionals.

2. The concept of *dual loyalty* refers to the conflict that arises when health care professionals' obligations to their patients are at odds with directives from employers or governing bodies – often leading to violations of human rights. Restrictive abortion laws place clinicians in untenable positions, compelling them to choose between adhering to legal mandates and fulfilling their ethical duty to provide comprehensive medical care. This scenario not only undermines the sanctity of the patient-provider relationship but also erodes the foundational principles of medical ethics. For example, PHR documented how abortion bans in Idaho,[1] Louisiana,[2] and Oklahoma[3] violate medical ethics, forcing providers to choose between their patients and legal or professional consequences, while being harmful to pregnant people and directly leading to avoidable suffering and long-term health consequences. In Florida, clinicians told PHR that the abortion ban's narrow exceptions are endangering patients and preventing providers from meeting ethical and medical standards.[4] Restrictions to and the criminalization of abortion violates the rights to life, health, privacy, equality and non-discrimination, and freedom from torture and cruel, inhuman, or degrading treatment.[5]

3. The United States, through its participation in the Universal Periodic Review (UPR), has pledged to "continue efforts to ensure access to sexual and reproductive health."[6] However, the enforcement of abortion bans contradicts these commitments. The current bans are in direct opposition to this pledge, violating international norms and standards. The U.S. asserts that there is "no international right to an abortion."[7] However, in a 2022 statement responding to the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health*, UN experts highlighted that legal protections for abortion access are essential for enjoyment of rights such as life, health, equality, non-discrimination, privacy, and freedom from torture and cruel, inhuman, and degrading treatment.[8] UN treaty-monitoring bodies – including the UN Human Rights Committee, the UN Committee against Torture and the UN Committee on the Elimination of Racial Discrimination which monitor treaties the U.S. has signed and ratified – have recognized that abortion bans can lead to violations of numerous human rights, including the right to life, freedom from torture and ill treatment, and non-discrimination.[9, 10]

4. Abortion bans have engendered a pervasive climate of fear among health care providers. Clinicians are concerned about potential legal repercussions, including civil or criminal charges, fines, and the revocation of medical licenses, simply for delivering standard reproductive care. This atmosphere has led to delays and denials of critical medical services, as practitioners grapple with the risk of penalization for exercising their medical judgment. PHR's report *Criminalized Care* documents numerous cases in which physicians feared prosecution for providing medically necessary abortion care, resulting in patients suffering life-threatening complications. In June 2023, ten ob-gyns in the panhandle region of Idaho alone had

left or resigned, confused about how to practice under strict abortion bans.[11] By February 2024, this had increased to over 50 (almost one in four) clinicians who had left the state since August 2022.[12] This exacerbated preexisting health care staff shortages and impacts maternal health care access across the state. By March 2025, high-profile prosecutions and indictments of midwives and physicians for providing abortion care have intensified fears among health care providers, reinforcing concerns about criminalization and legal risk among providers.[13]

5. Abortion bans that permit exceptions, such as those for rape, incest, or threats to the mother's life, are not only impractical but not grounded in medical realities. States like Idaho and Louisiana have implemented such exception-based frameworks, which fail to account for the complexities and nuances inherent in medical decision-making, especially in emergency scenarios. In Idaho, the ban's narrow and ill-defined exceptions create confusion, uncertainty, and fear for both pregnant patients and clinicians alike.[14] Major medical associations have criticized these bans, emphasizing that they impede clinicians' ability to provide care that aligns with established medical standards and patient needs.[15]

6. Pregnant people bear the brunt of these restrictive laws, facing numerous obstacles in accessing essential reproductive health services. In Oklahoma, PHR revealed that many hospitals were unable to provide information about procedures, policies or support available to doctors regarding when it is clinically necessary to terminate a pregnancy, raising significant concerns about the ability of pregnant patients to receive clear, accurate information and necessary medical care during emergencies.[16] In Louisiana, the erosion of patient-doctor confidentiality and privacy protections not only undermines Emergency Medical Treatment and Labor Act (EMTALA) but impairs the vulnerability of those seeking care.[17] The creation of "health care deserts," stemming from a "brain drain" as providers relocate to less restrictive environments as in Idaho, coupled with barriers such as the necessity to travel out of state, disproportionately affects communities that are marginalized. This amplifies existing health disparities.[18]

7. The landscape of abortion restrictions in the United States as of April 2025 not only undermines the ethical foundations of medical practice but also violates international human rights obligations and detrimentally impacts patient welfare. Addressing this crisis necessitates a concerted effort to realign domestic policies with ethical medical practices and international legal standards, ensuring the protection and promotion of reproductive rights for all individuals.

8. Recommendations

    - Enact legislation that establishes a federal right to the highest attainable standard of medical care, including all forms of reproductive health care.
    - Ensure legal protection for health care providers to act in compliance with their professional ethical duties.
    - Repeal current state and federal laws that impede individuals' access to reproductive health care.
    - Require clear and accessible information to all patients and providers on their right to health.

Asylum and Immigration

9. In its previous UPR cycles, the United States accepted recommendations to uphold its obligations under international human rights law by ensuring access to asylum,

eliminating family separation practices, and improving conditions of immigration detention. These commitments included protecting migrants and asylum seekers from cruel and degrading treatment, ensuring access to medical care, and strengthening accountability mechanisms. However, the United States has since implemented or maintained policies and practices that violate these commitments. This submission outlines concerns related to health conditions in immigration detention, lack of accountability for harm, treatment of asylum seekers at the border, and how the evolving policy landscape is harming not only individual health of immigrants within the United States, but U.S. citizens both directly and indirectly.

10. Immigration detention facilities in the United States continue to be sites of serious health-related human rights abuses. A 2024 joint report by PHR, the American Civil Liberties Union (ACLU), and American Oversight analyzed deaths occurring in immigration detention and concluded that Immigration and Customs Enforcement (ICE) failed to respond to clear warning signs, delayed or denied emergency care, and routinely ignored repeated pleas for medical attention.[19] In many cases, basic medical protocols were not followed, contributing directly to the deaths of individuals who should never have died in custody, according to medical expert reviewers. Research by PHR and partners also confirms that there is widespread and prolonged use of solitary confinement in immigration detention, in violation of ICE's own policies.[20] Many individuals are held in isolation for weeks or even months, causing severe psychological distress. The use of solitary confinement in U.S. immigration detention constitutes cruel, inhuman, and degrading treatment, and in some cases, rises to the level of torture.[21]

11. "Title 42", first implemented by the Trump administration in March 2020 and continued by the Biden administration well into 2022, invoked an obscure provision of the 1944 Public Health Service Act to expel people seeking asylum without access to legal proceedings, under the pretext of controlling the spread of COVID-19. PHR, along with public health experts, consistently denounced the policy as scientifically unfounded and discriminatory, emphasizing that it excluded only people seeking asylum while allowing most other categories of travelers to cross the border freely.[22]

12. Despite mounting scientific and documentary evidence of human rights violations by PHR, the government's own oversight bodies, and other experts, the U.S. government is poised to expand, rather than dismantle, the immigration detention system. Plans to repurpose facilities such as Guantánamo Bay and the re-opening of family detention facilities signals a return to, and potential expansion of, practices that have already been widely discredited for their cruelty and ineffectiveness.[23] Instead of implementing reforms recommended by internal watchdogs, the administration has instead shuttered or sidelined these entities, including the Department of Homeland Security's Office for Civil Rights and Civil Liberties (CRCL), severely limiting avenues for accountability.[24]

13. President Trump has introduced a series of executive actions that further erode access to asylum and expand the infrastructure of expedited removal, among other things.[25] In total, these policies aim to dismantle asylum protections by disqualifying individuals based on transit through third countries and accelerating fast-track deportation procedures that lack basic due process safeguards. At the same time, the administration is moving to rescind previous guidance that restricted immigration enforcement in sensitive locations such as hospitals, schools, and places of worship. Together, these shifts are dismantling long-standing protections and have created a pervasive climate of fear among immigrants, documented and undocumented alike, including lawful permanent residents, and U.S. citizens in mixed-status families.

14. Clinicians across the country report to PHR that their immigrant patients are increasingly avoiding medical care due to fear of arrest or deportation. A physician in private practice in California described the intense anxiety experienced by a 12-year-old U.S. citizen whose father is undocumented as "palpable." A physician in Florida shared: "People are more fearful of coming to the hospital for care, so they're waiting until it's an emergency or they are brought in by family or EMS [Emergency Medical Services]." An OB-GYN working in a public hospital in New York City observed: "We're seeing fewer walk-in patients, patients coming later to prenatal care, and more immigrant patients arriving on labor and delivery with no prenatal care at all." These chilling effects not only undermine individual health outcomes but also pose serious risks to public health and violate the ethical obligations of the medical profession. Coupled with the already documented health harms and human rights abuses that routinely occur in detention, as well as expansion plans already underway, it is critical that the UPR recognize this as a crisis and affirm that the United States is not immune to oversight and accountability.

15. Recommendations

    - Reduce or eliminate overall levels of immigration detention and implement non-custodial alternatives to detention for immigration case management.
    - Ensure that immigration detention sites are adequately staffed with trained medical personnel, and that detention site medical personnel have the authority to release individuals with complex medical or mental health conditions that are unable to be safely or effectively treated in detention.
    - Take steps to eliminate solitary confinement from immigration detention, beginning with particularly vulnerable populations such as those with medical and mental health conditions.
    - Reinstate the "Sensitive Locations" policy to restrict immigration enforcement actions in health care settings, schools and places of worship, and pass legislation to codify this policy into statute.
    - Refrain from utilizing public health authorities such as Title 42 as a tool of immigration policy rather than for legitimate public health emergencies.
    - Reconstitute and strengthen the independent oversight and accountability offices within the Department of Homeland Security, in particular the Civil Rights and Civil Liberties Office, and the various independent ombudsperson offices that were closed in March 2025.

"Excited Delirium"

16. "Excited Delirium" is a pseudoscientific term with racist roots that is often used to deny accountability for deaths during interactions with law enforcement. The term "excited delirium" cannot be disentangled from its racist and unscientific origins. The diagnosis of "excited delirium" has come to rest on racist tropes of Black men and other people of color as having "superhuman strength" and being "impervious to pain," while pathologizing resistance to law enforcement, which may be an expected or unsurprising reaction of a scared or ill individual (or anyone who is being restrained in a position that inhibits breathing). Presently, there is no rigorous scientific research that examines prevalence of death for people with "excited delirium" who are not physically restrained.[26]

17. “Excited delirium” is not a valid, independent medical diagnosis. There is no clear or consistent definition, established etiology, or agreed upon underlying pathophysiology. As a result, there are no diagnostic standards for “excited delirium.” [27] In general, there is a lack of scientific data, and even the body of literature that mentions “excited delirium” is small and largely written by individuals with rarely disclosed conflicts of interest. Because “excited delirium” is not a valid diagnosis, it should not be used as a cause of death.

18. PHR is concerned that the unscientific diagnosis of “excited delirium” has been used repeatedly over decades to mask deaths caused by inappropriate and often violent law enforcement responses to medical or mental health crises, and to exonerate perpetrators or cover up homicides.

19. Since 2023, states like California, Colorado, and Minnesota have passed legislation to ban “excited delirium” in police reports or official death reports.[28] Several other states like New York and Hawaii have their own “excited delirium” legislation pending or are considering similar bans.[29] These developments should be supported and encouraged in other states and localities across the country.

20. Recommendations

- Adopt legislation at the state, local and national level banning the concept of “excited delirium” in law enforcement training, official documents and reports, and in death certificates.
- Take all steps to remove the concept of “excited delirium” from judicial practice, including by reviewing previous cases that have relied in part on the concept of “excited delirium.”
- Ban the use of neck restraint and weighted or prolonged prone restraint by law enforcement.
- State and local governments should take steps to ensure that medically trained professionals are the primary responders and decision-makers in the management of acute medical emergencies, including mental health and substance use disorder crises.

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