RESOLUTION

Subject: Protecting Access to Abortion and Reproductive Healthcare

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the current Kentucky Medical Association (KMA) policy regarding the termination of pregnancy was written in 1973 and is no longer consistent with current evidence-based medicine; and

WHEREAS, Kentucky providers who do not wish to participate directly or indirectly in an abortion procedure are not required to do so; and

WHEREAS, KMA policy endorses the position that the physician should be in the focal position of directing medical care to produce an outcome in the best interest of the patient, appropriate to the patient's situation, in the most timely and cost-effective manner possible, adhering to established principles of ethics, and for fair and reasonable compensation; and

WHEREAS, abortion is one of the most common medical procedures globally, as 29% of all pregnancies worldwide end in induced abortion and 24% of women in the United States aged 15 to 44 will have an abortion by age 45[1,2]; and

WHEREAS, the United Nations' (UN) Humans Rights Committee (HRC) and American Public Health Association (APHA) have expressed that abortion is necessary to ensuring the right to life for women and girls due to its role in prevention of maternal morbidity and mortality[3,4]; and

WHEREAS, the World Health Organization (WHO) and the Center for Reproductive Rights recognize that restrictive abortion laws do not decrease abortion; rather, they lead to a higher number of unsafe or illegal abortions, endangering women's health and leading to significant maternal morbidity and mortality[6]; and

WHEREAS, medication abortion with mifepristone, one of just two U.S. Food and Drug Administration (FDA) approved drugs to manage abortion and early miscarriage, comprises 54% of all abortions in the United States as of 2020, and has a 20-year record of safety and efficacy[7,9]; and

WHEREAS, when patients face barriers to abortion health care such as long travel distances to clinics and high costs, 10-28% attempt to self-manage their abortions, with 38-52% using herbs, supplements or vitamins, 18-20% using misoprostol and/or mifepristone, 19-29% using other medications, and 18-19% inflicting abdominal or other physical trauma[10,12]; and

WHEREAS, criminalizing abortion care and counseling is an interference of patient-provider shared decision-making as denounced by the American College of Obstetricians and Gynecologists (ACOG)[13]; and

WHEREAS, significant racial and ethnic disparities exist surrounding abortion access, and these disparities are exacerbated by restrictive state abortion laws[14-16]; and

WHEREAS, KMA policy recognizes the burdens of government and third-party regulation on medical practice, its intrusion into the physician-patient relationship and vigorously opposes uncompensated regulatory requirements; and

WHEREAS, current American Medical Association (AMA) policy supports reproductive rights and the ability for physicians to practice and be appropriately reimbursed in this field without state interference; now, therefore, be it

RESOLVED, that KMA immediately deletes the policies found under both sections of the heading “Pregnancy, Termination of”; and be it further

RESOLVED, that KMA recognizes that the term “abortion” is medical terminology for the premature exit of the products of conception which includes a range of situations including miscarriages as well as procedures following fetal demise or ectopic pregnancy; and be it further

RESOLVED, that KMA opposes limitations on access to evidence-based health services including fertility treatments, contraception and abortion; and be it further

RESOLVED, that KMA opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other health care workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; and be it further

RESOLVED, that KMA respects an individual doctor’s choice whether to perform or participate in an abortion; and be it further

RESOLVED, that KMA support providers safely providing medication for abortion, like mifepristone, without in-person physical examination and instead through patient interviews via telehealth, laboratory testing and ultrasonography; and be it further

RESOLVED, that KMA opposes restrictive abortion laws and policies, such as Medicaid funding restrictions, mandatory parental involvement, mandatory counseling, mandatory waiting period, and two-visit mandate; and be it further

RESOLVED, that KMA opposes the criminalization of self-managed abortions; and be it further

RESOLVED, that KMA opposes an abortion reporting process; and be it further

RESOLVED, that KMA will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications

for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and be it further

RESOLVED, that KMA supports shared decision-making between patients and their physicians regarding reproductive healthcare; and be it further

RESOLVED, that KMA opposes any effort to undermine the basic medical principle that clinical assessments, such as the viability and safety of a pregnant person, are determinations to be made only between a patient and their physicians; and be it further

RESOLVED, that KMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine; and be it further

RESOLVED, that KMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:

A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and

preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?

G. Is there a process for appeal to accommodate individual patients' circumstances?

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Relevant KMA policies

MEDICAL PRACTICE

5) Quality of Patient Care: AMA defines quality of care as "the degree to which care services influence the probability of optimal patient outcomes." Physicians are uniquely qualified and positioned to provide quality measurement.

6) Reduction of Regulations: The burden of government and third-party regulation on medical practice and health insurance should be reduced. Its intrusion and "hassle factor" into the physician-patient relationship and doctor-patient time is costly and delays treatment of patients. The Association vigorously opposes uncompensated regulatory requirements for physicians and

supports economic impact statement requirements for all legislation and regulation affecting the delivery of medical care and increased cost. (*COSLA HOD 1999; Reaffirmed 2009, 2019)*

PATIENT/PHYSICIAN RELATIONSHIP

1) KMA endorses the position that the physician should be in the focal position of directing medical care to produce an outcome in the best interest of the patient, appropriate to the patient's situation, in the most timely and cost-effective manner possible, adhering to established principles of ethics, and for fair and reasonable compensation. (*Res 98-108, 1998 HOD, p 559; Reaffirmed 2008, 2018)*

PREGNANCY, TERMINATION OF

1) After the stage of viability, termination of pregnancy must be limited to those situations in which the life of the mother is jeopardized or a proven fetal anomaly exists;

Abortion on demand be discouraged at any time;

Any live infant must be accorded the same rights and the same care that would be given to an infant delivered by more traditional means;

The practice of using fetuses as experimental material is condemned;

No hospital, clinic, institution, or any other facility in this state should be required to admit any patient for the purpose of performing an abortion, nor required to allow the performance of an abortion;

No person should be required to perform or participate directly or indirectly in an abortion procedure. No hospital, governing board, or any other person, firm, association, or group should terminate the employment or alter the position of, prevent or impair the practice or occupation of, or impose any other sanction or otherwise discriminate against any person who refuses to participate in an abortion procedure; and

We recommend that the Bureau of Vital Statistics, Department of Health, establish an abortion reporting form, which shall be used for the reporting of every abortion performed or prescribed in this state. Such forms shall include the following items in addition to such other information as may be necessary to complete the form:

1. The age of the pregnant woman;
2. The marital status of the pregnant woman;
3. The location of the facility where the abortion was performed or prescribed;
4. The type of procedure performed or prescribed;
5. Complication, if any;
6. The pregnant woman's obstetrical history regarding previous pregnancies, abortion, and live births;
7. The stated reason or reasons for which the abortion was requested;
8. The state and county of the pregnant woman's legal residence. (*Ref Comm Sub Res, 1973 HOD, p 882; Reaffirmed 2000, 2010, 2021*)

2) KMA Recommendations on Guidelines for Facilities: Criteria laid down by the Board of Certificate of Need and Licensure, or any other agency determining where abortions may be performed on an out-patient basis, must meet the following standards:

1. A permanent record must be kept for each patient.
2. It should include a preoperative history and physical examination which is particularly directed to the identification of preexisting or concurrent illnesses or drug sensitivities that may have a bearing on operative procedures or anesthesia.
3. A hematocrit and/or hemoglobin and Rh typing should be done on all patients and any other further laboratory work that would be indicated by the patient's medical history.
4. In the case of an unmarried pregnant minor seeking an abortion, the same rules should be applied in requiring the consent to the abortion of the person legally responsible for the minor as are followed in obtaining such consent for any medical operation.

5. Analgesia and anesthesia should accompany the procedure in accordance with generally established good medical practice.
6. There should be means to resuscitate and treat the unconscious patient and the patient with cardiovascular collapse.
7. It shall be the responsibility of the licensed physician performing an abortion to provide pre- and post-operative care in a traditional and continuing manner. This physician should operate under a transfer agreement ensuring that any patient in whom complications develop will be accepted by a licensed hospital on an around-the-clock basis for emergency care.
8. Abortions should be done by standard and approved methods and recorded in the patient's record. Histologic examination of the tissues is necessary.
9. The presence of pregnancy should be confirmed by an appropriate and recognized test for gonadotropin by either immuno-assay methods. The pregnancy must also be confirmed by examination by a licensed physician.
10. Pre- and post-abortion counseling should be a part of the services offered. Counseling should include alternatives to abortion, possible psychological evaluation, and contraceptive and sterilization information.
11. Each facility must offer (but not require) tests for cervical carcinoma and venereal disease to each patient.
12. All Rh-negative patients should be given Rh immune globulin following the surgical procedure in order to prevent Rh sensitization.
13. No hospital, physician, or employee should be compelled to participate in abortion.
14. For the sake of clarity, the following definitions were agreed upon by the committee: a. Abortion – Termination of pregnancy prior to the 20th week, or before viability
    b. Viability is the ability of the fetus to sustain life outside the uterus with usual measures after the 20th week of pregnancy.
    c. First trimester begins with the first day of the last menstrual period and ends 12 weeks later.
    d. Second trimester begins at the 13th week after the onset of the last menstrual period and goes through the 24th week.
    e. Third trimester is from the 25th week until delivery. (*Report of the Ad Hoc Comm on Abortion Guidelines, Addendum to the Report of the Chairman, Board of Trustees, 1973 HOD, p 879; Reaffirmed 2000, 2010, 2021*).