Adopted

2022-1

RESOLUTION

Subject: Bylaws Amendments

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, the KMA House of Delegates, based on recommendations of the KMA Long Range Planning Commission and Board of Trustees, have made a number of proposed changes to the KMA bylaws over the past several years that have helped to modernize and streamline the work of the Association; and

WHEREAS, in an attempt to continue the modernization process, the Long Range Planning Commission conducted an exhaustive review of the KMA bylaws earlier this year to further modernize the organization and presented their recommendations to the Board of Trustees, which is now recommending these changes, many of which involve modernizing the administrative functions of the organization to have them fit into modern business practices; and

WHEREAS, Chapter II, Section 4; Chapter III, Section 3; and Chapter IV, Section 2 require specific actions and credentials for the KMA Annual Meeting that can be modernized and provide greater flexibility to the organization and its members, especially in the event of virtual meetings of the House in the future; and

WHEREAS, Chapter V, Section 7 provides that the Secretary-Treasurer and all officers authorized to sign vouchers must post a bond, when modern liability insurance now covers organizations, and provides for a number of backups to signing vouchers when the Secretary-Treasurer may not be available, despite modern technology that would allow simply having one other backup; and

WHEREAS, Chapter VI, Section 1 requires a specific number of members of the KMA Executive Committee to be present for a quorum, despite the fact that the number of committee members might change, or committee members may drop off for a number of reasons, as well as the fact that state law provides the requirement that a majority of those serving on the committee be present; and

WHEREAS, Chapter VI, Section 3 requires Trustees to perform certain duties including being the censor of the District, which could impose personal liability on the Trustee to perform such duties when they are already performed by the KBML; and

WHEREAS, Chapter VI, Section 8 implies that the Association is to act as an insurance company, which requires a specific license and substantial financial reserves that the Association does not and cannot possess; and

WHEREAS, Chapter XI, Sections 5, 6, and 8 do not reflect the common situation in which many physicians may practice in one county but reside in another county, thus necessitating a change that allows for greater membership flexibility for individual physicians; and

WHEREAS, Chapter XI, Section 12 imposes on county societies – many of which either do not exist or have no administrative personnel – certain administrative functions that are now performed by the KBML and the KMA; now, therefore, be it

RESOLVED, that Chapter II, Section 4 of the bylaws be amended to read as follows: "Each member in attendance at any meeting shall register indicating the component society of which they are a member. When their right to membership has been verified by reference to the roster of the society, they shall receive ~~a badge~~ the appropriate credentials to participate which shall be evidence of their right to all privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until they have complied with the provisions of this section."; and be it further

RESOLVED, that Chapter III, Section 3 of the bylaws be amended to read as follows: "When a special session is called, the Secretary-Treasurer shall ~~mail a~~ provide the appropriate notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session."; and be it further

RESOLVED, that Chapter IV, Section 2 of the bylaws be amended to read as follows: "The Immediate Past President shall serve as the Nominating Review Authority to verify the eligibility and willingness to serve of each candidate nominated. Should the Immediate Past President be nominated for an elected office or is not available to serve as the Nominating Review Authority, the Speaker shall appoint another KMA officer who is not nominated for an elected office that year to serve as the Nominating Review Authority. The Nominating Review Authority shall accept and post for information all eligible and willing candidates proposed for offices elected from the state at large~~. On the second day of the Annual Meeting, the Nominating Review Authority shall post on a bulletin board near the entrance to the hall in which the Annual Meeting is being held, the nomination, or nominations, for each office to be filled,~~ on the day prior to the start of the House of Delegates and shall formally present said nomination, or nominations, to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussion or comment."; and be it further

RESOLVED, that Chapter V, Section 7 of the bylaws be amended to read as follows: "The Secretary-Treasurer shall advise the Executive Vice President in all administrative matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. They shall perform such duties as are placed upon them by the Constitution and Bylaws, and as may be prescribed by the Board of Trustees. The Secretary-Treasurer shall demand and receive all funds due the Association, including bequests and donations. They shall, if

so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Executive Vice President or their designee and shall be countersigned by the Secretary-Treasurer of the Association. If the Secretary-Treasurer is unavailable to sign vouchers, the President shall perform that function. ~~When one or more of the above-named officials are not readily available, four specifically designated representatives of the Executive Committee are authorized to countersign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a countersignature. The four members of the Executive Committee authorized to countersign vouchers shall be designated by the Board during their reorganizational meeting in September and, whenever possible should be easily accessible from the KMA Headquarters Office. All those authorized to countersign vouchers shall be required to give bond in an amount to be determined by the Board of Trustees.~~ The Secretary-Treasurer shall report the operations of their office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into their hands during the year. Their accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees. The Association's annual audit shall be made available to the membership."; and be it further

RESOLVED, that Chapter VI, Section 1 be amended to read as follows: "The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the Vice-President, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary-Treasurer, the Delegates and Alternate Delegates to the American Medical Association, the President of the KMA Resident and Fellows Section, and the President of the KMA Medical Student Section. The Executive Committee of the Board of Trustees shall consist of the President, the Vice-President, the President-Elect, the Secretary-Treasurer, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, and a majority of the full Executive Committee~~, to wit, 5,~~ shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all the powers belonging to the Board except those powers specifically reserved by the Board to itself."; and be it further

RESOLVED, that Chapter VI, Section 3 of the bylaws be amended to read as follows: "Each Trustee shall be the representative of their district. ~~organizer, peacemaker and censor for their district. They shall hold at least one district meeting each year for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by~~

~~a Trustee in the line of their duties herein imposed may be paid by the Secretary-Treasurer upon a proper itemized statement but this shall not be constituted to include their expenses in attending the Annual Meeting of the Association.~~"; and be it further

RESOLVED, that Chapter VI, Section 8 of the bylaws be deleted and the current Section 9 be renumbered as Section 8 as follows:

"~~**Section 8.** The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary-Treasurer acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.~~

Section ~~9~~ 8. The Board shall employ an Executive Vice President whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. Their compensation shall be fixed by the Board. The Executive Vice President shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. They shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

They shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. They shall, at all times, hold themself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the Association. They shall be allowed traveling expenses to the extent approved by the Board.

They shall be the custodian of the general papers and records of the Association (including those of the Secretary-Treasurer) and shall conduct the official correspondence of the Association. They shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

They shall account for and promptly turn over to the Secretary-Treasurer all funds of the Association which come into their hands. It shall be their duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Secretary-Treasurer for appropriate action. They shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to

the Secretary-Treasurer. They shall annually submit their financial books and records to a certified public accountant, approved by the Board, whose report shall be made available to the membership.

They shall keep a record of all physicians in the State by counties, noting on each their status in relation to their county society, and upon request shall transmit a copy of this list to the American Medical Association.

They shall act as Managing Editor, or otherwise supervise the publication of The Journal of the Kentucky Medical Association and such other publications as may be authorized by the House of Delegates, under the guidance and direction of the Board.

They shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. They shall serve at the pleasure of the Board, and in the event of their death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, they shall make written reports to the Board and House of Delegates concerning their activities and those of the Headquarters Office."; and be it further

RESOLVED, that Chapter XI, Sections 5 and 6 be amended, with Sections 8 and 12 being deleted and Sections 9, 10 and 11 being renumbered as follows:

"**Section 5**. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association and shall be classified in accordance with Chapter I, Section 2 of these Bylaws, provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which they practice or reside, for membership therein. Except as hereinafter provided in Section~~s~~ 6 ~~and/or 8~~ of this chapter, no physician shall be an active member of a component society in any county other than the county in which they practice or reside.

Section 6. Any physician who may feel aggrieved by the action of the component society of the county in which they practice or reside, in refusing them membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit them to apply for membership in a component society in a county which is adjacent to the county in which they practice or reside.

~~**Section 8**. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which they reside, may, with the consent of the component society within whose jurisdiction they reside, hold membership in said adjacent component society.~~

Section ~~9~~ 8. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral

and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of their county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until they comply with all lawful orders of their component society and the Board of Trustees.

Section ~~10~~ 9. Frequent meetings shall be encouraged and the most attractive programs arranged that are possible. Members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section ~~11~~ 10. At the time of the annual election of officers, each component society shall elect a delegate or Delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following their election, and shall end on the day before the first day of the next regular session, provided, however, that component societies may elect Delegates for more than one term at any election. Each component society may elect one delegate for each 25 voting members in good standing, plus one delegate for one or more voting members in excess of multiples of 25, provided, however that each component society shall be entitled to at least one delegate regardless of the number of voting members it may have and that each multi-county society shall be entitled to the same number of Delegates as its component societies would have had. The secretary of the society shall send a list of such Delegates to the Secretary-Treasurer of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects Delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its Delegates each year.

~~**Section 12**. The secretary of each component society shall keep a roster of its members and a list of nonaffiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. They shall furnish an official report containing such information upon blanks~~

~~supplied them for the purpose, to the Secretary-Treasurer of the Association, on the first day of January of each year or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making their annual report they shall be certain to account for every physician who has lived in the county during the year.~~"

Adopted

2022-2

RESOLUTION

Subject: Acceptance of HB 1 CME from Another State

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, HB 1 (passed in 2012) requires a minimum of 4.5 hours required for physicians who are authorized to prescribe or dispense controlled substances in Kentucky; and

WHEREAS, This CME is required every three year (3) CME cycle period; and

WHEREAS, a HB 1 CME course must be preapproved by the KBML; now, therefore, be it

RESOLVED, that KMA engage with the Kentucky Board of Medical Licensure to develop procedures to approve and recognize out-of-state accredited *AMA PRA Category 1*™ credit related to mandatory HB 1 CME.

Adopted as Amended

2022-3

RESOLUTION

Subject: Solidifying Adverse Childhood Experiences and Trauma-Informed Care Networks

Submitted by: Lisa Anakwenze, MPH, MS and Madison Smith (University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, trauma is a physical or psychological response to a stressful event such as abuse, witnessing of violence, familial instability and incarceration, displacement, familial substance use, over policing of neighborhoods, food insecurity, or racism/discrimination [1-3]; and

WHEREAS, trauma-Informed Care (TIC) is a clinical approach that asks patients' what happened to you' instead of asking 'what is wrong with you,' and recognizes the presence of trauma symptoms in an individual's life and health [1-3]; and

WHEREAS, TIC helps address the complex combination of social, behavioral, and physical factors affecting patients' well-being [4,5]; and

WHEREAS, Adverse Childhood Experiences (ACEs) are potentially traumatic events that can have negative lasting effects on future health outcomes; encompassing physical, sexual, and emotional maltreatment and abuse as well as living in an environment that is potentially harmful to an individual's overall development [6]; and

WHEREAS, in 2017 and 2019, it was estimated that 25.8% of Kentucky youth ages 0 to 17 experienced two or more ACEs, including witnessing domestic violence, witnessing community violence, living with someone with mental illness, and racial/ethnic discrimination[7,8]; and

WHEREAS, in 2019, KY had the highest percent of child victimization in the country with 20.1%, encompassing forms of neglect, sexual, physical or emotional abuse corresponding to a positive ACEs screen[9]; and

WHEREAS, research shows that trauma, especially incurred during childhood (ie ACEs), can positively predict adverse long term health outcomes such as but not limited to lethality of chronic health conditions (chronic liver and lung disease), poor mental health (higher likelihood of depression), and high risk behaviors (sexually transmitted diseases and substance use) [8,10]; and

WHEREAS, social and structural inequities disproportionately concentrate ACEs and their consequences in racially, socially, and economically marginalized communities [10,11]; and

WHEREAS, many marginalized and minority communities face higher rates of ACEs and trauma, while healthcare institutions that have gaps in ACE and TIC screening and treatment may lead to the re-traumatization of patients and a failure to provide appropriate referrals [5,7,8,10, 12-14]; and

WHEREAS, healthcare providers have limited opportunities to receive regular training in ACEs and TIC [15]; and

WHEREAS, there is limited community-based research on TIC in marginalized populations; therefore, evidence-based interventions have limited generalizability [16,17]; and

WHEREAS, comprehensive TIC for children is financed through sources such as Medicare, Medicaid, commercial insurance, out of pocket payment, state and federal grants, private philanthropy, and military funding[18]; and

WHEREAS, there are a range of billing codes that cover ACE and TIC screenings, group sessions, evidence-based treatments, and referrals for children [18]; now, therefore, be it

RESOLVED, that KMA supports physicians collaborating with, including but not limited to, Medicare, Medicaid, private payers, nonprofit and nongovernmental entities that support survivors of physical and psychological trauma, trauma-informed care (TIC) researchers and advocates, as well as TIC educators, to further enhance desired multi-dimensional implementation of TIC in independent and academic healthcare settings; and be it further

RESOLVED, that KMA encourages patient access to resources including but not limited to Medicare, Medicaid and non-profit institutions that further support the victims and survivors of physical and psychological trauma and to further enhance a multi-dimensional care approach; and be it further

RESOLVED, that KMA provide education to physicians on the recognition of adverse childhood experiences-associated health conditions and the subsequent use of evidence-based trauma-informed care to create a patient-centered care experience; and be it further

RESOLVED, that KMA supports research into the best practice of utilizing adverse childhood experiences-screening tools in healthcare settings.

References:

[1] Hecht, A. A., Biehl, E., Buzogany, S., & Neff, R. A. (2018). Using a trauma-informed policy approach to create a resilient urban food system. *Public health nutrition*, *21*(10), 1961–1970. https://doi.org/10.1017/S1368980018000198

[2] Dudley, R. (2015, July). *Childhood Trauma and Its Effects: Implications for Police*. US Department of Justice, https://nij.ojp.gov/library/publications/childhood-trauma-and-its-effects-implications-police

[3] *APA. (2021). Trauma*. American Psychological Association, https://www.apa.org/topics/trauma

[4] Center for Health Care Strategies, Menschner, C., & Maul, A. (2016, April). *Key Ingredients for Successful Trauma-Informed Care Implementation*. http://www.chcs.org/media/Brief-Key-Ingredients-for-TIC-Implementation-1.pdf

[5] Accounting, N. (2020, July 1). *Building Resilience Through Trauma-Informed Care*. National Alliance for Mental Illness Dane County. https://www.namidanecounty.org/blog/2020/6/15/building-resilience-through-trauma-informed-care

[6] Boullier, M., & Blair, M. (2018, February 13). *Adverse childhood experiences*. Paediatrics and Child Health. Retrieved July 25, 2022, from https://www.sciencedirect.com/science/article/pii/S1751722217302913?casa_token=JPNM-CQgjRAAAAAA%3A8U4jaoGpJGtHNd6fLzTeeoX224MNe0xPBFsY4M_eWUTaHdcAMtvwBC5845uc7UKMxtUpbeJV

[7] Raja, S., Rabinowitz, E. P., & Gray, M. J. (2021). Universal screening and trauma informed care: Current concerns and future directions. *Families, Systems, & Health,* doi:http://dx.doi.org.echo.louisville.edu/10.1037/fsh0000585

[8] United Health Foundation. (2021). *Adverse Childhood Experiences*. America's Health Rankings. https://www.americashealthrankings.org/explore/annual/measure/ACEs_8/state/KY

[9] *Preventing Adverse Childhood Experiences* (2021, April). Violence Prevention: Injury Center. CDC, https://www.cdc.gov/violenceprevention/aces/fastfact.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Ffastfact.html

[10] America's Health Rankings (2020). Adverse Childhood Experiences in Kentucky. https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/ACEs/state/KY

[11] Oral, R., Ramirez, M., Coohey, C., Nakada, S., Walz, A., Kuntz, A., Benoit, J., & Peek-Asa, C. (2016). Adverse childhood experiences and trauma informed care: the future of health care. *Pediatric Research*, *79*(1–2), 227–233. https://doi.org/10.1038/pr.2015.197

[12] Center for Health Equity. 2017 Health Equity Report: Uncovering the Root Causes of Health. Louisville Metro Department of Public Health and Wellness. 2017; Louisville, KY. Available from: https://louisvilleky.gov/government/center-health-equity/health-equity-report

[13] Schippert, A. C. S. P., Grov, E. K., & Bjørnnes, A. K. (2021). Uncovering re-traumatization experiences of torture survivors in somatic health care: A qualitative systematic review. *PLOS ONE*, *16*(2), e0246074. https://doi.org/10.1371/journal.pone.0246074

[14] Menschner, C., Maul, A. (2016). Brief: Key Ingredients for Successful Trauma-Informed Care Implementation. *Center for Health Care Strategies.* https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/

[15] Marsac, M. L., Kassam-Adams, N., Hildenbrand, A. K., Nicholls, E., Winston, F. K., Leff, S. S., & Fein, J. (2016). Implementing a Trauma-Informed Approach in Pediatric Health Care Networks. *JAMA Pediatrics*, *170*(1), 70. https://doi.org/10.1001/jamapediatrics.2015.2206

[16] Goddard, A. (2021). Adverse Childhood Experiences and Trauma-Informed Care. *Journal of Pediatric Health Care*, *35*(2), 145–155. https://doi.org/10.1016/j.pedhc.2020.09.001

[17] Scheer, J. R., & Poteat, V. P. (2018). Trauma-Informed Care and Health Among LGBTQ Intimate Partner Violence Survivors. *Journal of Interpersonal Violence*, *36*(13–14), 6670–6692. https://doi.org/10.1177/0886260518820688

[18] National Council for Behavioral Health. (2019). *FINANCING TRAUMA-INFORMED CARE*. https://www.thenationalcouncil.org/wp-content/uploads/2019/11/Financing-Trauma-Informed-Primary-Care.pdf?daf=375ateTbd56

Adopted as Amended

2022-4

RESOLUTION

Subject: Mental Health Mobile Response Teams

Submitted by: Alex Thebert, MD - Resident and Fellows Section

Referred to: Reference Committee

WHEREAS, according to the National Alliance on Mental Illness, a mental health crisis is an episode during which a "person's behavior puts themselves at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community"[1]; and

WHEREAS, a mental health crisis often leads to law enforcement involvement as a first contact, 2 million people with mental illnesses get booked into jail yearly and serious mental illness is present in 15% of men and 30% of women in jail[1]; and

WHEREAS, law enforcement officers do not have the same mental health training as mental health professionals, yet spend 21% of their time and 10% of their budget responding to mental health crises and transporting persons to hospitals[2]; and

WHEREAS, lack of training means escalation of crises and potential police shooting during a crisis, a police shooting database reports that 22% of victims of fatal police shootings had mental illness[3]; and

WHEREAS, in a survey in which 72% of respondents had a favorable view of police in their community, 4 in 5 respondents believed that mental health professionals should be the first response for mental health crises[4]; and

WHEREAS, federal law has created a 988 calling code for the National Suicide Prevention Hotline and mental health crisis counselors[5]; and

WHEREAS, the US Substance Abuse and Mental Health Services Administration (SAMHSA) provides guidelines with best practices on response to mental health crises, featuring crisis call centers, crisis mobile team response, and crisis receiving and stabilization facilities[6]; and

WHEREAS, SAMHSA guidelines recommend using law enforcement only as backup in situations where significant danger present, and it is often not needed as the CAHOOTS program in Oregon demonstrated that only 311 of 24,000 calls required police backup[6,7]; and

WHEREAS, there is a wide variety of implementation of 988 hotline and mental health crises response among states with many states failing to meet SAMHSA best practice recommendations[7-11]; and

WHEREAS, Kentucky has no legislation on mental health crisis response teams but has recently provided $500,000 for promotion of the 988 Mental Health Hotline in rural communities[11]; now, therefore, be it

RESOLVED, that KMA support state implementation of regional crisis call centers, mobile crisis team services, and crisis receiving and stabilizing services which follow best practice guidelines; and be it further

RESOLVED, that KMA supports law enforcement accompanying mobile crisis teams only if there is a significant risk of danger during the call response.

References:

1 Navigating a Mental Health Crisis | NAMI: National Alliance on Mental Illness. https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis

2 Meier M. Road Runners. Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/road-runners

3 Fatal Force: Police shootings database. Washington Post. https://www.washingtonpost.com/graphics/investigations/police-shootings-database/

4 As Launch of 988 Mental Health Crisis Number Looms, NAMI Poll Finds Broad Support for the System and | NAMI: National Alliance on Mental Illness. https://www.nami.org/Press-Media/Press-Releases/2021/As-Launch-of-988-Mental-Health-Crisis-Number-Looms-NAMI-Poll-Finds-Broad-Support-for-the-System-and

5 Suicide Prevention Hotline. Federal Communications Commission. Published March 5, 2020. https://www.fcc.gov/suicide-prevention-hotline

6 SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit Executive Summary. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf

7 CASE STUDY: CAHOOTS. Vera Institute of Justice. https://www.vera.org/behavioral-health-crisis-alternatives/cahoots

8 State Legislation to Fund and Implement “988” for the National Suicide Prevention Lifeline. The National Academy for State Health Policy. Published January 18, 2022. https://www.nashp.org/state-legislation-to-fund-and-implement-988-for-the-national-suicide-prevention-lifeline/

9 Statewide Model for Mental Health Emergency Co-Responder Program Passes Georgia House. Office of the Lieutenant Governor Geoff Duncan. https://ltgov.georgia.gov/press-releases/2022-03-30/statewide-model-mental-health-emergency-co-responder-program-passes

10 Houghton K. In Mental Health Crises, a 911 Call Now Brings a Mixed Team of Helpers — And Maybe No Cops. Kaiser Health News. Published June 14, 2021. https://khn.org/news/article/in-mental-health-crises-a-911-call-now-brings-a-mixed-team-of-helpers-and-maybe-no-cops/

11 *KY HB 192 Chapter 169*. https://apps.legislature.ky.gov/law/acts/21RS/documents/0169.pdf

Adopted as Amended

2022-5

RESOLUTION

Subject: Opioid Overdose Prevention Centers

Submitted by: Alex Thebert, MD - Resident and Fellows Section

Referred to: Reference Committee

WHEREAS, since 2013, opioid and psychostimulant drug overdose rates throughout the country have been increasing, recently the US crossed 100,000 drug overdose deaths in 12 months[1,2]; and

WHEREAS, these increases are largely driven by the increased use of potent synthetic opioids, such as fentanyl and fentanyl analogs[2-5]; and

WHEREAS, the co-use of synthetic opioids with other opioids or psychostimulants could be deliberate or inadvertent, unbeknownst to the user[2]; and

WHEREAS, Kentucky has one of the highest death rates from opioid overdoses in the nation and since 2019 the rate of overdose deaths in Kentucky has increased over 70% from 1,316 to 2,250[4]; and

WHEREAS, in Kentucky, fentanyl was detected in over 70% of all overdose deaths[4]; and

WHEREAS, harm reduction programs are public health approaches to reduce the risks of high-risk sexual and drug-use behaviors; and

WHEREAS, Syringe Services Programs (SSPs) are harm reduction programs that exchange used needles for clean needles in order to prevent the spread of infectious disease and connect drug users to rehabilitation programs[6,7]; and

WHEREAS, SSPs do not encourage drug use or increase frequency among current users, they do not increase community crime in the area surrounding the program, they reduce the spread of HIV and viral hepatitis, they decrease amount of syringes in public areas, and they make program participants more likely to enter drug treatment programs[6,7]; and

WHEREAS, SSPs provide clean materials to reduce harm from injecting drugs, however they do not help with the rapidly increasing overdose deaths; and

WHEREAS, overdose prevention centers (formerly known as safe injection sites or supervised injection sites) are harm reduction programs where people who use drugs do so in controlled settings under clinical supervision in order to prevent overdose, receive counseling, and receive referrals to drug treatment[8]; and

WHEREAS, there are hundreds of overdose prevention centers internationally, with sites in Australia, Canada, and throughout Europe; and

WHEREAS, the federal legality of overdose prevention centers is unclear, previously US federal prosecutors closed a supervised injection site in Philadelphia, however there is now potential for them to be allowed[10,11]; and

WHEREAS, two overdose prevention centers have recently opened in New York without the backing of the federal government[12]; and

WHEREAS, much of the available data comes from the Vancouver and Sydney overdose prevention centers, in systematic reviews sites were associated with decreased overdose mortality, improvement in harm reduction behavior, improvement in access to treatment programs, and no increase in crime or public nuisance in the surrounding areas[13-15]; and

WHEREAS, in a preliminary cost-benefit analysis for a San Francisco site, it was estimated that every dollar spent on centers would lead to over two dollars in savings[16]; and

WHEREAS, the concerns about overdose prevention sites may be unfounded like many of the concerns surrounding the implementation of needle exchange programs; and

WHEREAS, KMA currently supports harm reduction programs, including syringe access and exchange; now, therefore, be it

RESOLVED, that KMA educate the public and legislators about the utility of overdose prevention centers in Kentucky and support the creation of these centers.

References:

[1] Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data. Published May 5, 2022. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[2] Mattson CL. Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019. *MMWR Morb Mortal Wkly Rep*. 2021;70. doi:10.15585/mmwr.mm7006a4

[3] HAN Archive - 00438 | Health Alert Network (HAN). Published September 21, 2021. https://emergency.cdc.gov/han/2020/han00438.asp?ACSTrackingID=USCDC_1026-DM45245&ACSTrackingLabel=December%202020%20Drug%20Overdose%20Updates&deliveryName=USCDC_1026-DM45245

[4] *KY Office of Drug Control Policy 2021 Overdose Fatality Report*. https://odcp.ky.gov/Reports/2021%20Overdose%20Fatality%20Report%20%28final%29.pdf

[5] O'Donnell JK. Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700 — 10 States, July–December 2016. *MMWR Morb Mortal Wkly Rep*. 2017;66. doi:10.15585/mmwr.mm6643e1.

[6] Syringe Exchange Programs - Cabinet for Health and Family Services. https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/kyseps.aspx

[7] Syringe Services Programs (SSPs) Fact Sheet | CDC. Published July 24, 2019. https://www.cdc.gov/ssp/syringe-services-programs-factsheet.html

[8] DPA Fact Sheet_Supervised Injection Facilities .pdf. https://drugpolicy.org/sites/default/files/DPA%20Fact%20Sheet_Supervised%20Injection%20Facilities%20(Feb.%202016).pdf

[9] IDPC Briefing Paper - Drug consumption rooms: Evidence and practice. https://idpc.net/publications/2012/06/idpc-briefing-paper-drug-consumption-rooms-evidence-and-practice

[10] Allyn B. U.S. Prosecutors Sue To Stop Nation's First Supervised Injection Site For Opioids. *NPR*. https://www.npr.org/sections/health-shots/2019/02/06/691746907/u-s-prosecutors-sue-to-stop-nation-s-first-supervised-injection-site. Published February 6, 2019.

[11] U.S. Justice Dept. Might Allow Safe Injection Sites to Curb Opioid Deaths - Drugs.com MedNews. Drugs.com. https://www.drugs.com/news/u-s-justice-dept-might-allow-safe-curb-opioid-deaths-103386.html

[12] Mann B, Lewis C. New York City allows the nation's 1st supervised consumption sites for illegal drugs. *NPR*. https://www.npr.org/2021/11/30/1054921116/illegal-drug-injection-sites-nyc. Published November 30, 2021.

[13] Kennedy MC, Karamouzian M, Kerr T. Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review. *Curr HIV/AIDS Rep*. 2017;14(5):161-183. doi:10.1007/s11904-017-0363-y

[14] Levengood TW, Yoon GH, Davoust MJ, et al. Supervised Injection Facilities as Harm Reduction: A Systematic Review. *Am J Prev Med*. 2021;61(5):738-749. doi:10.1016/j.amepre.2021.04.017

[15] Potier C, Laprévote V, Dubois-Arber F, Cottencin O, Rolland B. Supervised injection services: What has been demonstrated? A systematic literature review. *Drug and Alcohol Dependence*. 2014;145:48-68. doi:10.1016/j.drugalcdep.2014.10.012

[16] Irwin A, Jozaghi E, Bluthenthal RN, Kral AH. A Cost-Benefit Analysis of a Potential Supervised Injection Facility in San Francisco, California, USA. *Journal of Drug Issues*. 2017;47(2):164-184. doi:10.1177/0022042616679829

Adopted as Amended

2022-6

RESOLUTION

Subject: Fentanyl Testing Strips

Submitted by: Alex Thebert, MD - Resident and Fellows Section

Referred to: Reference Committee

WHEREAS, since 2013, opioid and psychostimulant drug overdose rates throughout the country have been increasing, recently the US crossed 100,000 drug overdose deaths in 12 months[1,2]; and

WHEREAS, these increases are largely driven by the increased use of potent synthetic opioids, such as fentanyl and fentanyl analogs[2,3,4,5]; and

WHEREAS, the co-use of synthetic opioids with other opioids or psychostimulants could be deliberate or inadvertent, unbeknownst to the user[2]; and

WHEREAS, Kentucky has one of the highest death rates from opioid overdoses in the nation and since 2019 the rate of overdose deaths in Kentucky has increased over 70% from 1,316 to 2,250[4]; and

WHEREAS, in Kentucky, fentanyl was detected in over 70% of all overdose deaths[4]; and

WHEREAS, harm reduction programs are public health approaches to reduce the risks of high-risk sexual and drug-use behaviors; and

WHEREAS, harm reduction programs have limitations in the services and materials they can provide due to laws classifying what constitutes “drug paraphernalia”; and

WHEREAS, current Kentucky law classifies drug paraphernalia as **“**all equipment, products and materials of any kind which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance”[6]; and

WHEREAS, the law makes exemptions for items exchanged at health departments, such as needles, but all other items which are distributed, not exchanged, are still considered drug paraphernalia, leaving health departments in a legal gray area[6]; and

WHEREAS, recent studies have shown fentanyl testing strips to decrease risky drug use behavior in ways that could reduce overdose deaths[7]; and

WHEREAS, studies show high sensitivity (96-100%) and specificity (90-98%) of fentanyl testing strips on street-acquired drug samples[8,9]; and

WHEREAS, other states, such as Wisconsin, have recently passed laws exempting products which test for fentanyl and fentanyl analogs from being classified as "drug paraphernalia"[10,11]; and

WHEREAS, by allowing health departments more latitude in distribution of select items previously deemed paraphernalia they can provide more comprehensive harm reduction services; now, therefore, be it

RESOLVED, that KMA support exempting materials distributed for the appropriate use in evidence-based harm reduction programs from being classified as "drug paraphernalia."

References:

1 Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data. Published May 5, 2022. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

2 Mattson CL. Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019. *MMWR Morb Mortal Wkly Rep*. 2021;70. doi:10.15585/mmwr.mm7006a4

3 HAN Archive - 00438 | Health Alert Network (HAN). Published September 21, 2021. https://emergency.cdc.gov/han/2020/han00438.asp?ACSTrackingID=USCDC_1026-DM45245&ACSTrackingLabel=December%202020%20Drug%20Overdose%20Updates&deliveryName=USCDC_1026-DM45245

4 *KY Office of Drug Control Policy 2021 Overdose Fatality Report*. https://odcp.ky.gov/Reports/2021%20Overdose%20Fatality%20Report%20%28final%29.pdf

5 O'Donnell JK. Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700 — 10 States, July–December 2016. *MMWR Morb Mortal Wkly Rep*. 2017;66. doi:10.15585/mmwr.mm6643e1.

6 Kentucky Legislature: KRS 218A.500. https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=51015

7 Fentanyl Test Strips • LAPPA. LAPPA. Published June 1, 2021. https://legislativeanalysis.org/fentanyl-test-strips-2/

8 Green TC, Park JN, Gilbert M, et al. An assessment of the limits of detection, sensitivity and specificity of three devices for public health-based drug checking of fentanyl in street-acquired samples. *International Journal of Drug Policy*. 2020;77:102661. doi:10.1016/j.drugpo.2020.102661

9 Fentanyl overdose reduction checking analysis study. https://idpc.net/publications/2018/02/fentanyl-overdose-reduction-checking-analysis-study

10 Wisconsin Legislature: 961.571. https://docs.legis.wisconsin.gov/statutes/statutes/961/vi/571

11 Wisconsin Legislature: SB600: Bill Text. https://docs.legis.wisconsin.gov/2021/related/proposals/sb600

Adopted as Amended

2022-7

RESOLUTION

Subject: Implementing Strategies to Expand Use of Harm Reduction Programs

Submitted by: Juliana Cobb, MS, Danielle Graves, Katarina Jones, MPH, and Nicole McGrath, MS (University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, there has been an increase in the number of overdose deaths by 14.5% from 2020 to 2021, of which 90% of overdose deaths involved opioids, and in 2021, "2,250 Kentucky residents died from a drug overdose" where, and "fentanyl was identified in 1,639 of those deaths"[1]; and

WHEREAS, Kentucky statute 218A.133 provides exemption from prosecution for drug paraphernalia if a user or witness is seeking assistance with a confirmed drug overdose[2]; and

WHEREAS, Kentucky statute 217.186 dictates that the Kentucky Department of Public Health "shall develop clinical protocols to address supplies of an opioid antagonist" and its administration in schools and that the board of any private, parochial, or public school district may permit opioid antagonists to be kept for use in the reversal of an opioid overdose on premises[3]; and

WHEREAS, fentanyl test strips are considered "drug paraphernalia" under Kentucky statute 218.A500, and therefore, it is declared unlawful to use or possess fentanyl test strips[4]; and

WHEREAS, KRS 218.A500 allows items exchanged at local substance use outreach programs "not be deemed drug paraphernalia while located at the program" but does not protect individuals possessing fentanyl test strips in other circumstances[4]; and

WHEREAS, research on harm reduction programs distributing fentanyl test strips demonstrated a statistically significant change in consumer behavior, while needle exchange programs reduce transmission of HCV and HIV up to 50%[5,6]; now, therefore, be it

RESOLVED, that KMA support policies that expand access to evidence-based harm reduction programs.

References:

[1] Kerry Harvey and Van Ingram. 2021 Overdose Fatality Report. Kentucky Office of Drug Control Policy. Commonwealth of Kentucky Justice and Public Safety Cabinet. 2022.

[2] Exemption from prosecution for possession of controlled substance or drug paraphernalia if seeking assistance with drug overdose. 218A.133. Effective 2015.

[3] Definition -- Provider prescribing or dispensing opioid antagonist -- Administration by third party -- Use of opioid antagonist by person or agency authorized to administer medication -- Immunity from liability -- Administrative regulations -- Use of opioid antagonist by schools -- Use of opioid antagonist by licensed health care provider. 217.186. Effective 2022.

[4] Definitions for KRS 218A.500 and 218A.510 -- Unlawful practices -- Substance abuse treatment outreach program -- Informing peace officer about presence of needles or other sharp objects before search -- Retail pharmacy exception -- Penalties. 218A.500 Effective 2015.

[5] Centers for Disease Control and Prevention. Syringe Services Program Fact Sheet. National Center for HIV, Viral Hepatitis, STD, and TB Prevention. 2019.

[6] Goldman, JE. et al. Perspectives on rapid fentanyl test strips as a harm reduction practice among young adults who use drugs: a qualitative study. Journal of Harm Reduction. 2019;16(3). https://doi.org/10.1186/s12954-018-0276-0

RELEVANT AMA AND AMA-MSS POLICY

Prevention of Drug-Related Overdose D-95.987

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs;
(b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

Adopted as Amended

2022-8

RESOLUTION

Subject: Limitations of Kentucky Health Insurance Marketplace

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, in Kentucky, it is not possible to purchase individual insurance outside of the KYNECT marketplace; and

WHEREAS, the KYNECT marketplace only offers HMO plans with no out-of-network benefits; and

WHEREAS, the HMO networks are not defined, but are generally understood to be at best within a limited geographic area in proximity to the subscriber's home; and

WHEREAS, Kentuckians may have life or health circumstances which may necessitate the need for medical services beyond this limited geographic and provider network; now, therefore, be it

RESOLVED, that KMA support and collaborate with relevant parties to make PPO plans available through the KYNECT marketplace; and be it further

RESOLVED, that KMA support requiring geographic scope and a list of in-network providers be available on the health insurance exchange.

References:

[1] Leonhardt M. Nearly 1 in 4 Americans are skipping medical care because of the cost. CNBC. Published March 12, 2020. Accessed April 29, 2022. https://www.cnbc.com/2020/03/11/nearly-1-in-4-americans-are-skipping-medical-care-because-of-the-cost.html

[2] Lagasse J. More than half of Americans have avoided medical care due to cost. Healthcare Finance News. Published November 25, 2019. Accessed April 29, 2022. https://www.healthcarefinancenews.com/news/more-half-americans-have-avoided-medical-care-due-cost

[3] Peterson JA, Albright BB, Moss HA, Bianco A. Catastrophic Health Expenditures With Pregnancy and Delivery in the United States. *Obstetrics & Gynecology*. 2022;139(4):509-520. doi:10.1097/AOG.0000000000004704

[4] Esselen KM, Gompers A, Hacker MR, et al. Evaluating meaningful levels of financial toxicity in gynecologic cancers. *International Journal of Gynecologic Cancer*. 2021;31(6). doi:10.1136/ijgc-2021-002475

Adopted as Amended

2022-9

RESOLUTION

Subject: Aligning Health Insurance Policy Terms with Benefits

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Kentucky Department of Insurance does not require commercial insurance companies to align benefit programs with premium contract cycles; and

WHEREAS, this can result in an insured having to meet their deductible and out-of-pocket maximums twice in one calendar year; now, therefore, be it

RESOLVED, that KMA support a requirement that commercial carriers in Kentucky offer plans that synchronize the benefit terms and the premium contract durations.

Referred to the Board of Trustees for Action

2022-10

RESOLUTION

Subject: Achieving Equitable, Affordable, Efficient Healthcare

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, 22[1]-51[2]% of patients forgo medical care secondary to cost; and

WHEREAS, absence of care adversely affects healthcare outcomes; and

WHEREAS, the privatization of the U.S. CDS results in deleterious consequences with regards to cost and access to care. A recent study showed that out-of-pocket delivery costs were higher for privately insured patients than those with Medicaid or even the uninsured, and costs including insurance premiums exceeded 10% of income for 21% of all birth parents[3]. In a study of gynecologic oncology patients, by a wide margin the largest cohort in each category of financial hardship (severe, moderate, no/mild) were those with private insurance (46, 41 and 54%, respectively)[4]; and

WHEREAS, these problems do not exist in countries which provide universal coverage to their inhabitants; and

WHEREAS, a progressive tax-based system of health insurance financing is more equitable than the current system, would be easier to navigate for patients, and less cumbersome for providers, would ensure that everyone has healthcare coverage, and would improve outcomes; now, therefore, be it

RESOLVED, that KMA support a tax-based system of healthcare financing in the U.S., which would be available to all Americans; and be it further

RESOLVED, that this must not preclude the availability of private payment or private insurance purchase for non-covered services, or for those who can afford and wish to purchase them.

References:

1 Leonhardt M. Nearly 1 in 4 Americans are skipping medical care because of the cost. CNBC. Published March 12, 2020. Accessed April 29, 2022. https://www.cnbc.com/2020/03/11/nearly-1-in-4-americans-are-skipping-medical-care-because-of-the-cost.html

2 Lagasse J. More than half of Americans have avoided medical care due to cost. Healthcare Finance News. Published November 25, 2019. Accessed April 29, 2022. https://www.healthcarefinancenews.com/news/more-half-americans-have-avoided-medical-care-due-cost

3 Peterson JA, Albright BB, Moss HA, Bianco A. Catastrophic Health Expenditures With Pregnancy and Delivery in the United States. *Obstetrics & Gynecology*. 2022;139(4):509-520. doi:10.1097/AOG.0000000000004704

4 Esselen KM, Gompers A, Hacker MR, et al. Evaluating meaningful levels of financial toxicity in gynecologic cancers. *International Journal of Gynecologic Cancer*. 2021;31(6). doi:10.1136/ijgc-2021-002475

Adopted as Amended

2022-11

RESOLUTION

Subject: National Tort Reform

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, the shortage of physicians in the United States can be related to the expenses of medical education and medical practice; and

WHEREAS, Kentucky and most other states have physicians with major expenses related to medical liability; and

WHEREAS, Kentucky continues to lose physicians to states which have malpractice damage caps; and

WHEREAS, 30 states have some form of malpractice damage caps, such as caps on pain and suffering, noneconomic damages, and absolute caps; and

WHEREAS, some states, such as Indiana, have a provider liability cap of $250,000; and

WHEREAS, major changes in tort reform in Kentucky will require a change in the state constitution and a referendum by the people; and

WHEREAS, a national approach to limiting medical liability expenses would be fairer and more consistent to physicians in all states; and

WHEREAS, the state and national political climate would likely support a more consistent approach to medical liability expenses; now, therefore, be it

RESOLVED, that KMA continue to collaborate with relevant stakeholders to advocate for a national cap on provider liability and solicit congressional support for such improvement in the medical practice environment.

Adopted as Amended

2022-12

RESOLUTION

Subject: Protecting Kentucky's Youth with Gender Dysphoria, Their Parent's Autonomy, and the Doctor-Patient Relationship in Providing Evidence-Based Care

Submitted by: Northern Kentucky Medical Society

Referred to: Reference Committee

WHEREAS, youth are experiencing high rates of mental health conditions such as depression, suicidal ideation, and anxiety; and

WHEREAS, youth with gender dysphoria exhibit even higher rates of mental health conditions such as depression, suicidal ideation, and anxiety than peers; and

WHEREAS, there are evidence-based approaches to medically treat gender dysphoria and associated mental health conditions that are supported by major medical associations; and

WHEREAS, parent or guardian consent is required for medical treatment of gender dysphoria in children under 18 years of age; and

WHEREAS, surgeries to treat gender dysphoria are not recommended for individuals under 18 years of age; and

WHEREAS, parents' authority in making medical decisions in consultation with their minor children's healthcare providers should be protected; and

WHEREAS, several states have enacted bills banning the provision of medical or behavioral health treatment to youth with gender dysphoria and such bills have been introduced in the Kentucky legislature; now, therefore, be it

RESOLVED, that KMA advocate against any prohibition of physicians or other healthcare providers socially affirming gender identity or discussing evidence-based therapies for the management of gender dysphoria with their patients and their parents; and be it further

RESOLVED, that KMA support evidence-based standards of care for the treatment of gender dysphoria including behavioral health or medical non-surgical treatment provided to youth by appropriately trained and experienced healthcare providers.

Adopted

2022-13

RESOLUTION

Subject: Menstrual Poverty

Submitted by: Alex Thebert, MD and Jessica Adkins-Murphy, MD - Resident and Fellows Section

Referred to: Reference Committee

WHEREAS, menstrual poverty refers to the inability to purchase hygiene products (tampons, pads, reusable menstrual cups) regularly and lack of access to private areas with water and soap and places to dispose of menstrual products[1]; and

WHEREAS, the poverty rate in Kentucky is 16% overall and 21% for children under 18, which is 48th and 47th worst in the nation respectively[2,3,4]; and

WHEREAS, a study of low-income women in a large urban center showed that menstrual poverty may be more common than previously thought, with 64% of respondents being unable to afford menstrual products at one point in the past year[5]; and

WHEREAS, girls in school also struggle with period poverty, one study of teenage girls showed that 23% had difficulty obtaining menstrual products and 51% have worn menstrual products longer than recommended[6]; and

WHEREAS, low-income benefits such as SNAP and WIC do not cover menstrual hygiene products[7]; and

WHEREAS, the lifetime cost for menstrual products are estimated to be $1800 and state taxes can add as much as 10% to the cost of menstrual products[8]; and

WHEREAS, Kentucky has a 6% sales tax applied to menstrual products[9]; and

WHEREAS, insecurity in menstruation hygiene can lead to anxiety, school absences, and decisions between menstrual hygiene and food[1,5] ; and

WHEREAS, when unable to afford menstrual product, women had to use alternatives such as rags, toilet paper, and children's diapers[5,6]; and

WHEREAS, use of standard menstrual products for longer durations than recommended and these alternatives could produce negative side effects such as UTI, vulvar contact dermatitis, yeast infections, bacterial vaginosis, and even toxic shock syndrome; and

WHEREAS, Kentucky currently provides free menstrual products at state prisons[10]; now, therefore, be it

RESOLVED, that KMA support legislation exempting menstrual products from the state sales tax; and be it further

RESOLVED, that KMA support providing menstrual hygiene products free of charge in public facilities such as state prisons and public schools.

References:

[1] Cardoso LF, Scolese AM, Hamidaddin A, Gupta J. Period poverty and mental health implications among college-aged women in the United States. *BMC Women's Health*. 2021;21(1):14. doi:10.1186/s12905-020-01149-5

[2] Kentucky Report - 2020. Talk Poverty. Accessed May 5, 2022. https://talkpoverty.org/state-year-report/kentucky-2020-report/

[3] Kentucky Poverty Rate. WelfareInfo.org. Accessed May 5, 2022. https://www.welfareinfo.org/poverty-rate/kentucky/

[4] Advocates KY. 2021 Kentucky KIDS COUNT County Data Book: A Look at Data Trends and Solutions to Advance Racial Equity in the Commonwealth. Kentucky Youth Advocates. Accessed May 5, 2022. https://kyyouth.org/2021-kentucky-kids-count-county-data-book-a-look-at-data-trends-and-solutions-to-advance-racial-equity-in-the-commonwealth/

[5] Sebert Kuhlmann A, Peters Bergquist E, Danjoint D, Wall LL. Unmet Menstrual Hygiene Needs Among Low-Income Women. *Obstetrics & Gynecology*. 2019;133(2):238-244. doi:10.1097/AOG.0000000000003060

[6] Period.org State of the Period 2021. Period.org. Accessed May 5, 2022. https://period.org/uploads/State-of-the-Period-2021.pdf

[7] Kilpatrick AR and S. Changing the Cycle: Period Poverty as a Public Health Crisis. Accessed May 5, 2022. https://sph.umich.edu/pursuit/2020posts/period-poverty.html

[8] The Unequal Price of Periods. American Civil Liberties Union. Accessed May 5, 2022. https://www.aclu.org/report/unequal-price-periods

[9] Kentucky 2021 - Streamlined Sales Tax. Accessed May 5, 2022. https://sst.streamlinedsalestax.org/TM/Form/4684

[10] *Regulation of Jails - Adoption and Revision of Standards - Classification of Jails.* https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=51312

Adopted as Amended

2022-14

RESOLUTION

Subject: Repeal the Kentucky Provider Tax on Cosmetic Procedures

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the 2022 Kentucky Legislature passed a budget bill imposing a 6% provider tax on all cosmetic procedures, with subsequent override of the Governors' veto, to become law as of July 1, 2022; and

WHEREAS, a similar tax in New Jersey (2004-2014) brought disappointing revenue[1], and caused a net state revenue loss (3 times revenue lost over taxes collected), due to driving patients and practices to adjacent states[2], which led to repeal; and

WHEREAS, KMA policy opposes physician provider taxes of any kind; now, therefore, be it

RESOLVED, that KMA support legislation repealing the tax on cosmetic procedures, in order to prevent patient exodus to adjacent states for these services.

References:

[1] https://taxfoundation.org/new-jersey-reverses-cosmetics-tax/ accessed 6/10/2022
[2] https://www.jjrothmd.com/blog/new-jersey-repeals-tax-on-cosmetic-surgery/ accessed 6/10/2022

KMA House of Delegates
August 2022

Adopted as Amended in Lieu of Resolutions 22, 24, and 25

2022-15

RESOLUTION

Subject: Encourage the Use of Peer-Reviewed Research and Evidence-Based Practices as the Foundation of Health Care Policy

Submitted by: Juliana Cobb, MS, Danielle Graves, Katelyn Rice, and Shruti Wadhwa (University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, prior KMA resolutions called for a reduction in "the burden of government and third-party regulation on medical practice and health insurance" to minimize intrusion into the physician-patient relationship, decrease costs and delays in the treatment of patients, and that "only physicians may determine medical necessity"[1]; and

WHEREAS, where legislation regarding medical practice is not based on peer-reviewed evidence, it hinders the ability of physicians to "uphold professional autonomy and clinical independence and advocate for the freedom to exercise professional judgment in the care and treatment of patients without undue influence by individuals, governments or third parties" as outlined by the AMA Medical Code of Ethics[2]; and

WHEREAS, legislation has been passed in many states including Florida, Colorado, Pennsylvania, and New York that hinder physician ability to provide high quality care to patients[3]; and

WHEREAS, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, and the American College of Surgeons have agreed that legislative interference in medicine weakens the patient-physician relationship and undermines patient autonomy[4]; now, therefore, be it

RESOLVED, that KMA affirms that the doctor-patient relationship is the bedrock on which safe and ethical medical care is provided, with decision-making between a physician and a patient private and specific to the patient's conditions; and be it further

RESOLVED, that KMA encourages the passage and implementation of laws, regulations, health codes, medical practice standards and institutional/corporate rules that are evidence-based with significant efficacy and value, as demonstrated by best available evidence, including peer-reviewed scientific literature; and be it further

RESOLVED, that KMA oppose criminal sanctions against physicians and other medical providers who deliver, and patients who receive, care that is evidence-based, and has significant efficacy and value, as demonstrated by the best available evidence, including peer-reviewed scientific literature; and be it further

RESOLVED, that KMA policy initially passed more than 10 years from the date of each KMA House of Delegates meeting will be automatically sunset each year, unless action is taken by the House of Delegates to reestablish the sunsetting policies.

References:

[1] Kentucky Medical Association House of Delegates. *KMA* Policy Manual. 2019; 31-32.

[2] American Medical Association. *AMA Code of Ethics*; 2016. 6.

[3] Cairney P, Oliver K. Evidence-based policymaking is not like evidence-based medicine, so how far should you go to bridge the divide between evidence and policy? *Health Research Policy and Systems*. 2017;15(1). doi:10.1186/s12961-017-0192-x

[4] Weinberger SE, Lawrence HC, Henley DE, Alden ER, Hoyt DB. Legislative interference with the patient–physician relationship. *New England Journal of Medicine*. 2012;367(16):1557-1559. doi:10.1056/nejmsb1209858

[5] Crowley DM, Scott JT, Long EC, et al. Lawmakers' use of scientific evidence can be improved. *Proceedings of the National Academy of Sciences*. 2021;118(9). doi:10.1073/pnas.2012955118

RELEVANT AMA AND AMA-MSS POLICY

Regulatory Standards Should be Evidence-Based H-220.930

Our AMA will work through its representatives on the Joint Commission and with other deeming authorities and the Centers for Medicare & Medicaid Services to: (1) ensure that clinical standards imposed on health care institutions and providers be evidence-based with significant efficacy and value, as demonstrated by best available evidence; and (2) require that appropriate citations(s) from the peer reviewed scientific literature be appended to the documentation for every clinical standard imposed on health care institutions and providers.

Adopted as Amended

2022-16

RESOLUTION

Subject: Identifying Factors of Physician Stress and Utilization of Telehealth to Reduce Strain

Submitted by: Avery Henderson, Connor Colby, Emma Buechlein, Emily Hollingsworth, Fawad Alam-Siddiqui, Joshua Nowicki, Leah Thomas, Omar Jafry, Tara Von Mach, and Joseph Bott (University of Pikeville - Kentucky College of Osteopathic Medicine)

Referred to: Reference Committee

WHEREAS, a stressed-out physician is "angry, irritable, impatient, has increased absenteeism, decreased productivity and decreased quality of care"[5]; and

WHEREAS, increased physician stress will result in an increase in costs, lower quality of care, errors in diagnosis, and ultimately worse outcomes[5]; and

WHEREAS, factors such as working long hours to complete non-clinical tasks, absence of respect amongst colleagues, inadequate compensation, and decreased clinical autonomy can all lead to increased physician stress[10]; and

WHEREAS, with the lack of physicians practicing within sub-specialties (such as psychiatry, pediatrics, neurology, etc.) in rural Kentucky, there is a broader scope, and therefore, more strain put on rural physicians[11]; and

WHEREAS, by 2025, Kentucky will have a shortage of 960 primary care physicians practicing, the third most significant decrease in the United States[11]; and

WHEREAS, 61% of the physician shortage is located in rural areas of Kentucky[11]; and

WHEREAS, in rural Kentucky, there are multiple barriers to accessing healthcare, including education, distance, accessibility, and socioeconomic factors[1]; and

WHEREAS, the rise of COVID-19 and the issue of a mandatory stay-at-home order in March 2020 led to the increased use of telehealth for cardiology consultations in Kentucky[7]; and

WHEREAS, in a survey conducted of Kentucky patients who had a visit scheduled during the COVID-19 telehealth-only time frame, reduced travel time, lower visit wait time, and cost savings were seen as significant advantages for the use of telehealth visits[7]; and

WHEREAS, in the same survey of Kentucky patients, both in-person and telehealth visits were viewed favorably, but in-person visits were rated higher across all domains of patient satisfaction[7]; and

WHEREAS, poor internet connectivity was rated as at least somewhat of a factor by 33.0% (35/106) of respondents[7]; and

WHEREAS, the COVID-19 pandemic and suspension of elective neurosurgeries lead to increased use of telehealth visits for the University of Kentucky, Brain Restoration Center[2]; and

WHEREAS, in a survey conducted to determine if telehealth visits could be sustained as an alternative to in-person visits, it was determined that telehealth visits were challenging due to the need for in-person physical examinations for neurosurgery[2]; and

WHEREAS, in the same survey, it was determined that video telehealth visits worked well for non-urgent issues, such as minor visual examinations[2]; and

WHEREAS, in a study conducted by the Department of Psychological & Brain Sciences at the University of Louisville on the use of telehealth visits for those with eating disorders, it was determined that a multi-disciplinary telehealth eating disorder intensive outpatient program (IOP) is feasible and has comparable outcomes to in-person IOP treatment[5]; and

WHEREAS, in the same survey, a recommendation was made to expand telehealth IOPs to reach underserved populations, especially in rural areas where treatment is often difficult to access[5]; and

WHEREAS, in a study conducted in rural Germany, the use of video consultations in nursing homes was determined to reduce the burden and additional workload for health care workers and increase the efficiency of care provision for nursing home residents[6]; and

WHEREAS, telehealth consultations can be utilized to address the shortage of medical specialists in rural areas[6]; and

WHEREAS, increasing the availability of telehealth throughout Kentucky would allow more physicians the ability to seek mental health treatment, reduce the workload on physicians, and decrease physician stress levels; now, therefore, be it

RESOLVED, that KMA conduct a survey to investigate what factors cause stress in the physician population; and be it further

RESOLVED, that KMA advocate to Congress for the loosening of federal telehealth regulations; and be it further

RESOLVED, that KMA continue to advocate for expanding telehealth infrastructure at both state and federal levels; and be it further

RESOLVED, that KMA work with the Kentucky Foundation for Medical Care and other appropriate health-related organizations to help Kentucky residents living in rural areas learn about telehealth and its benefits.

References:

[1] Bush, M. L., Hardin, B., Rayle, C., Lester, C., Studts, C. R., Shinn, J. B. (2015). Rural barriers to early diagnosis and treatment of infant hearing loss in Appalachia. *Otol Neurotol*, *36*(1), 93-8. https://doi: 10.1097/MAO.0000000000000636

[2] Chau, M. J., Quintero, J. E., Guiliani, A., Hines, T., Samaan, C., Seybold, K., Stowe, M., Hanlon, D., Gerhardth, G. A., van Horne, C. G. (2021). Telehealth Sustainability in a Neurosurgery Department During the COVID-19 Pandemic. *World Neurosurg*, *152*, e617-e624. https://doi: 10.1016/j.wneu.2021.06.018

[3] Doraiswamy, S., Abraham, A., Mamtani, R., Cheema, S. (2020). Use of Telehealth During the COVID-19 Pandemic: Scoping Review. *J Med Internet Res*, *22*(12), e24087. https://doi: 10.2196/24087

[4] Fred, H. L., & Scheid, M. S. (2018). Physician Burnout: Causes, Consequences, and (?) Cures. Texas Heart Institute journal, 45(4), 198–202. https://doi.org/10.14503/THIJ-18-6842

[5] Levinson, C. A., Spoor, S. P., Keshishian, A. C., Pruitt, A. (2021). Pilot outcomes from a multidisciplinary telehealth versus in-person intensive outpatient program for eating disorders during versus before the Covid-19 pandemic. *Int J Eat Disord*, *54*(9), 1672-1679. doi: 10.1002/eat.23579

[6] May, S., Jonas, K., Fehler, G. V., Zahn, T., Heinze, M., Muehlensiepen, F. (2021). Challenges in current nursing home care in rural Germany and how they can be reduced by telehealth - an exploratory qualitative pre-post study. *BMC Health Serv Res*, *21*(1), 925. https://doi: 10.1186/s12913-021-06950-y

[7] Singh, A., Mountjoy, N., McElroy, D., Mittal, S., Hemyari, B. A., Coffey, N., Miller, K., Gaines, K. (2021). Patient Perspectives With Telehealth Visits in Cardiology During COVID-19: Online Patient Survey Study. *JMIR Cardio*, *22;5*(1), e25074. https://doi: 10.2196/25074

[8] Werner, E. A., Aloisio, C. E., Butler, A. D., D'Antonio, K. M., Kenny, J. M., Mitchell, A., Ona, S., Monka, C. (2020). Addressing mental health in patients and providers during the COVID-19 pandemic. *Semin Perinatol*, *44*(7), 151279. https://doi: 10.1016/j.semperi.2020.151279

[9] Woolhandler, S., & Himmelstein, D. U. (2014). Administrative work consumes one-sixth of U.S. physicians' working hours and lowers their career satisfaction. *International journal of health services : planning, administration, evaluation*, *44*(4), 635–642. https://doi.org/10.2190/HS.44.4.a

[10] Woolhandler, S., & Himmelstein, D. U. (2014). Administrative work consumes one-sixth of U.S. physicians' working hours and lowers their career satisfaction. *International journal of health services : planning, administration, evaluation*, *44*(4), 635–642. https://doi.org/10.2190/HS.44.4.a

[11] Griffith, Charles H. III MD, MSPH; de Beer, Fred MD; Edwards, Robert L. DrPH; Smith, Connie; Colvin, Garren; Karpf, Michael MD Addressing Kentucky's Physician Shortage While Securing a Network for a Research-Intensive, Referral Academic Medical Center: Where Public Policy Meets Effective Clinical Strategic Planning, Academic Medicine: March 2021 - Volume 96 - Issue 3 - p 375-380 doi: 10.1097/ACM.0000000000003582

[12] Robinson, B. (n.d.). *The surprising difference between stress and Burnout*. Psychology Today. Retrieved July 24, 2022, from https://www.psychologytoday.com/us/blog/the-right-mindset/202011/the-surprising-difference-between-stress-and-burnout

[13] Kentucky Medical Association. (2021). *2021 Annual Report to the Membership*. Retrieved from https://kyma.org/shared/content/uploads/2021/07/2021-Annual-Report-to-the-Membership-final.pdf

Adopted

2022-17

RESOLUTION

Subject: Hemorrhage Control Training for Schools & Colleges

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the escalating U.S. gun violence epidemic[1] (currently over 100 deaths/day and now the leading cause of death in children[2]) includes mass shootings in schools and colleges, which has more than doubled over the past 9 ½ years, compared to the previous 10 years; and

WHEREAS, Kentucky ranks in the 8 most lethal states for gun deaths of children[2]; and

WHEREAS, exsanguinating hemorrhage before transport to a medical facility precipitates a majority of these (and all trauma) deaths (CDC data); and

WHEREAS, the American College of Surgeons (ACS) has created an effective, 1-2 hour hemorrhage control course for laypersons (Stop the Bleed course) to prevent exsanguination deaths[3]; and

WHEREAS, the UofL Surgery Trauma Center has deployed this course to local schools, with exceptionally positive receptions; and

WHEREAS, an ACS supported, bipartisan US Senate and House Bill (Prevent BLEEDing Act of 2022) has been introduced to fund such courses; now, therefore, be it

RESOLVED, that KMA address gun violence epidemic harm by supporting 2023 Kentucky legislation to establish and require American College of Surgeons Stop the Bleed training annually for all Kentucky school and college teachers and employees (every other year for educators who have completed 3 consecutive annual courses), and for students (voluntary for elementary school students); and be it further

RESOLVED, that funding for such hemorrhage control courses and supplies come from the Kentucky General Fund, with partial or full replacement by federal funds, if the Prevent BLEEDing Act of 2022 or other funding is enacted.

References:

[1] https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/acs-brief/june-7-2022-issue/acs-calls-for-urgent-action-to-address-us-firearm-vio accessed 6/10/2022

[2] https://www.axios.com/2022/05/26/gun-deaths-children-america accessed 6/27/2022

[3] https://www.stopthebleed.org/ accessed 6/10/2022

Adopted as Amended

2022-18

RESOLUTION

Subject: Research Into a Multifaceted Approach to Gun Control

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, there are more gun suicides than gun homicides in the United States; and

WHEREAS, gun laws focus on the user with very few laws focusing on the design, manufacture, distribution, advertising, sale of firearms, and ammunition; and

WHEREAS, changing the design of new guns to “smart guns” that can only be fired by an authorized user, currently being sold in Western European nations; and

WHEREAS, banning assault weapons or guns with large-capacity ammunition feeding devices as these account for majority of mass shootings; and

WHEREAS, if guns with large-capacity ammunition feeding devices are bought, to require their owners to purchase insurance in case that weapon is ultimately used to kill another human being, protecting tax payers’ dollars; and

WHEREAS, studying from which gun companies the majority of guns used in crimes are bought; and

WHEREAS, there has been significant increase in marketing in gun magazines and online, playing on people’s fears of crime as well as attracting young men enamored with military fantasies, that has significantly increased gun sales; and

WHEREAS, individuals are allowed to purchase any number of guns, even hundreds; and

WHEREAS, mental illness may not often be reported to the FBI background check system; now, therefore, be it

RESOLVED, that resolutions 18-21 be combined for review by a task force to be appointed by the Board. The task force will review the medical literature and report evidence-based recommendations for public policy actions to reduce injury and death due to firearms. The recommendations of the task force will be reported to the House of Delegates no later than the 2023 annual meeting.

References:

http://www.apa.org/pubs/info/reports/gun-violence-prevention.aspx
https://www.nytimes.com/2022/06/18/us/firearm-gun-sales.html?smid=url-share
https://www.ncsl.org/research/civil-and-criminal-justice/possession-of-a-firearm-by-the-mentally-ill.aspx

Not Adopted

2022-19

RESOLUTION

Subject: Gun Violence Prevention – Banning Large Capacity Weapons and Ammunitions Magazines

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, assault weapons and high-capacity magazines are commonplace in mass shootings making shootings more lethal; and

WHEREAS, 155% more people are shot where assault weapons and high capacity magazines are used; and

WHEREAS, Kentucky is 15th highest state for deaths from firearms; and

WHEREAS, Kentucky is 3rd out of 51 U.S. jurisdictions that are found to be the source of weapons for interstate gun trafficking; and

WHEREAS, in Kentucky, civilians are allowed to possess assault weapons, 0.50 caliber rifles and large capacity ammunition and magazines; and

WHEREAS, in Kentucky, private possession of semi-automatic assault weapons and handguns (pistols and revolvers) is permitted without a license; now, therefore, be it

RESOLVED, that KMA supports legislation that Kentucky ban large capacity weapons and large capacity ammunitions magazines; and be it further

RESOLVED, that KMA supports legislation that requires a license for possession of semi-automatic assault-type weapons (for example, AK-47 and AR-15 rifles).

References:

https://www.healthline.com/health-news/midterm-candidates-vie-for-votes-on-gun-control-110314#Experts-Say-Guns-Are-a-Major-Public-Health-Issue

https://www.bradyunited.org

CDC.gov: Firearm Mortality by State

KMA House of Delegates
August 2022

Not Adopted

2022-20

RESOLUTION

Subject: Gun Violence Prevention – Universal Background Checks for Firearms Purchases

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the rate of gun deaths has escalated year after year, 46 percent from 2011 to 2022; and

WHEREAS, firearms-related deaths comprise 67.5% of all homicides in the Land of the Free; and

WHEREAS, in Kentucky, 80% of all homicides and 63% of all suicide deaths involve firearms; and

WHEREAS, in Kentucky, guns are the second-leading cause of death for children ages 1–17; and

WHEREAS, Kentucky's state law is amongst states with more lenient gun violence prevention policy; and

WHEREAS, gun-related suicide attempts and homicides (including mass-shootings) are more common in states with relaxed gun laws; and

WHEREAS, Kentucky ranks 15th in the nation with gun related mortality; and

WHEREAS, gun deaths and injuries cost Kentucky $5 billion per year, with $181 million paid by taxpayers; and

WHEREAS, the recent pandemic of gun violence is a nationwide public health crisis calling for physician leadership to prevent death and injury, and protect vulnerable children unable to vote against use of firearms; and

WHEREAS, universal background checks are related to lower rates of firearm injury morbidity and mortality with the majority of Americans supporting universal background checks; now, therefore, be it

RESOLVED, that KMA support legislation that requires universal (not just from age 18-21) and comprehensive background checks for firearms ammunition purchases.

References:

Kalesan B, Mobily ME, Keiser O, Fagan JA, & Galea S. (April 30, 2016) Firearm legislation and firearm mortality in the USA: a cross-sectional, state-level study. The Lancet 387(10030): 1847-1858. DOI: https://doi.org/10.1016/S0140-6736(15)01026-0

giffords.org

https://everystat.org/wp-content/uploads/2019/10/Gun-Violence-in-Kentucky.pdf

https://www.gunpolicy.org/firearms/region/kentucky

Alpers, Philip, Michael Picard and Irene Pavesi. 2021. *Kentucky — Gun Facts, Figures and the Law.* Sydney School of Public Health, The University of Sydney. GunPolicy.org, 22 February. Accessed 26 June 2022. at: https://www.gunpolicy.org/firearms/region/kentucky

https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies?f%5B0%5D=health-factor%3ACommunity%20Safety

cdc.gov

Not Adopted

2022-21

RESOLUTION

Subject: Modification of the Kentucky Concealed Carry Law without a Permit

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, former Governor Matt Bevin signed into law June 2019 Senate Bill 150 repealing Kentucky's concealed carry law requiring a firearms course and a permit, set forth in KRS § 237.110[1], and the Louisville Metro Police and the Kentucky State Fraternal Order of Police both opposed this new legislation[2]; and

WHEREAS, now anyone over the age of 21 may carry any concealed deadly weapon without a permit[2] and the previously required firearms course is now optional; and

WHEREAS, this decreases safety to both citizens and the police force; and

WHEREAS, visitors to the Kentucky Capitol building are banned from entering with umbrellas or sticks that are used for protest signs because they can be “used as weapons,” but guns and rifles are permitted[2]; now, therefore, be it

RESOLVED, that KMA support legislation requiring the previously required 8 hours firearms safety course and require a permit to carry a concealed deadly weapon; and be it further

RESOLVED, that KMA not permit any deadly weapon into the Kentucky Capitol building and other sensitive areas, such as churches, schools, health care facilities (including physician offices and clinics) or courthouses by non-approved law personal civilians.

References:

[1] https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=47039

https://www.courier-journal.com/story/news/politics/ky-governor/2019/03/12/kentucky-gov-matt-bevin-signs-permitless-concealed-carry-bill/3137955002/

[2] *Wade, Peter (February 1, 2020). "Fully Armed Rally-Goers Enter Kentucky's Capitol Building With Zero Resistance". Rolling Stone. Retrieved April 21, 2020.*

Amended Resolution 15 Adopted in Lieu of Resolution 22

2022-22

RESOLUTION

Subject: Protecting Appropriate Care for Patients

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, the great medical educator Sir William Osler declared that “Caring for patients means …CARING… for patients”; and

WHEREAS, Kentucky physicians and other health care providers strongly endorse this adage by CARING for their patients; and

WHEREAS, the Kentucky state legislature has violated this adage by severely limiting reproductive care for women in Kentucky; and

WHEREAS, the potential is there for the Kentucky state legislature to deprive Kentucky women of other appropriate reproductive health care related to contraception and assisted reproductive techniques such as in vitro fertilization; and

WHEREAS, Kentucky was included in the 2021 case of State of Louisiana, et. al. vs. Xavier Bacerra, et.al. which attempted to block a CMS mandate for COVId-19 vaccination of all health care workers of programs funded by CMS, thereby attempting to protect the caregivers and patients of those facilities; now, therefore, be it

RESOLVED, that KMA oppose any actions to restrict reproductive rights for women; and be it further

RESOLVED, that KMA oppose actions by the Kentucky state legislature which imped appropriate healthcare for patients, and provision of such by health care providers; and be it further

RESOLVED, that KMA be the reference source for the Kentucky legislature on issues that affect healthcare for patients.

Adopted as Amended

2022-23

RESOLUTION

Subject: Improving Maternal Health

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, maternal death is a public health crisis in the United States with a 134% increase in maternal death from 1987-2018 and an increase of 7.2 to 17.3 maternal deaths/100,000 live births[1]. Conversely, maternal death has globally decreased 38% from 2000 to 2017[2]; and

WHEREAS, the United States has the highest maternal death rate in the world of any developed country, making it the most unsafe place in the developed world for a woman to give birth[3]; and

WHEREAS, in Kentucky, 79% of maternal deaths were found to be preventable. Heart disease and stroke are the leading 2 non-accidental causes, at a combined rate of 34%[4]. Mental health illness is one of the top 7 underlying causes of pregnancy-related deaths at a rate of 7%[5]. Over 50% of accidental maternal death was related to substance use[6]; and

WHEREAS, black women are more than twice as likely to die from a pregnancy-related cause as white women; and

WHEREAS, pregnancy is inherently dangerous as maternal death from abortion is 0.7/100,000[7], while maternal death related to pregnancy is 18/100,000[8] or 25-fold higher; and

WHEREAS, an abortion ban is estimated to lead to a 7% increase in maternal death in year one and 21% in subsequent years of the ban[8]; and

WHEREAS, non-Hispanic Black women are projected to have the greatest increase in maternal death with a 12% increase in year one of the ban and 33% in subsequent years. Hispanic women have the next greatest increase with 6% and 18%, respectively. This data does not include how the rate of unsafe abortions will increase maternal death[9]; and

WHEREAS, physicians have an obligation to protect and save lives (mentally and physically) and respect all people's privacy. Preventing the right to abortion defies this oath by increasing maternal mortality and dehumanizing women; now, therefore, be it

RESOLVED, that KMA recognize that maternal death and mental health illness are public health issues; and be it further

RESOLVED, that KMA advocate for improved reproductive healthcare and resources for women in Kentucky including preconception, prenatal and post-partum care.

KMA House of Delegates
August 2022

References:

[1] https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm
[2] https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
[3] https://www.ajmc.com/view/us-ranks-worst-in-maternal-care-mortality-compared-with-10-other-developed-nations
[4] https://chfs.ky.gov/agencies/dms/mac/Documents/MACMaternalHealthUpdate.pdf
[5] https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf
[6] https://chfs.ky.gov/agencies/dph/dmch/Documents/MMRAnnualReport.pdf
[7] Zane S, Creanga AA, Berg CJ, et al. Abortion-Related Mortality in the United States:1998–2010. Obstetrics & Gynecology. 2015;126(2):258-265. doi:10.1097/AOG.0000000000000945
[8] Center for Disease Control. Pregnancy Mortality Surveillance System | Maternal and Infant Health | CDC. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm. Published August 7, 2018. Accessed February 12, 2019
[9] https://read.dukeupress.edu/demography/article/58/6/2019/265968/The-Pregnancy-Related-Mortality-Impact-of-a-Total

Amended Resolution 15 Adopted in Lieu of Resolution 24

2022-24

RESOLUTION

Subject: The Fallout of Banning Abortion in Kentucky

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the American Medical Association (AMA), the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) all have policy statements supporting the evidence-based right to abortion. According to ACOG, "abortion is an essential component of comprehensive medical care, and people need unimpeded access to the full spectrum of reproductive health care options" that is based on evidence-based medicine[1]; and

WHEREAS, the Kentucky Medical Association's current policy is not supportive of the right to an abortion and places many restrictions on who, where and when an abortion may be performed[2]; and

WHEREAS, regardless of personal belief, a "clinician must be able to provide unbiased, factual information to patients regarding their reproductive health care options"[1] without interference from the government in this sacred doctor-patient relationship; and

WHEREAS, half of U.S. counties do not have a single OB-GYN[3]. The U.S. Health Resources & Services Administration revealed that more than half of Kentucky's 120 counties had no dedicated OB-GYN in 2020 and 2021; and

WHEREAS, the physician shortage in Kentucky will continue to worsen. Until now, 55.5% of physician residents practiced medicine in the state where they trained[2]. Kentucky now not only faces the challenge of training residents in how to provide and manage induced abortions, spontaneous abortions, miscarriages, and the wide array of pregnancy losses from other reasons[4], it also faces the challenge of retaining these doctors with the knowledge that they cannot practice the full scope of their field without the threat of penalties or incarceration; and

WHEREAS, Kentucky's abortion ban will ultimately lead to an overall increase of 21% in maternal mortality[5]. According to CDC reports between 2018 and 2020, Kentucky's rate of maternal mortality was already double the nationwide rate at 30 deaths per 100,000 live births; and

WHEREAS, with the threat to reproductive medicine, there will be an overall decrease in reproductive services, specifically to in vitro fertilization[6] and genetic testing; and

WHEREAS, pregnancies with significant congenital anomalies that must now come to term will lead to significant financial strain and require many resources; and

WHEREAS, there will be an increased financial burden to the Department of Medicaid Services with increased recipients, increased foster children, decreased work force, increased mental health disease, increased violence, and increased taxes; now, therefore, be it

RESOLVED, that KMA immediately sunset its current policy on abortion; and be it further

RESOLVED, that KMA adopt as its policy to stand united in opposition to the banning of abortion in Kentucky; and be it further

RESOLVED, that KMA change its current policy on abortion, basing it on current evidence-based medicine, recognizing the FDA-approved medications used for spontaneous and voluntary abortions and the impact these policies have on in vitro fertilization; and be it further

RESOLVED, that KMA advocate for maintaining the privacy and confidentiality between a patient and their physician and that the intrusion of non-medical organizations on the privacy of reproductive health decisions between a patient and her physician be opposed by the KMA in its policy statements.

References:

[1] www.acog.org/news/news-articles/2022/05/understanding-acog-policy-on-abortion
[2] https://kyma.org/wp-content/uploads/2022/07/2021-2022-KMA-POLICY-MANUAL.pdf
[3] https://www.aamc.org/news-insights/labor-pains-ob-gyn-shortage
[4] Alicia Ault. Roe v. Wade Overturned, Ending 50 Years of Abortion Protections - *Medscape* - Jun 24, 2022.
[5] https://read.dukeupress.edu/demography/article/58/6/2019/265968/The-Pregnancy-Related-Mortality-Impact-of-a-Total
[6] Cohen, I.G., Daar, J., Adashi, EY. What Overturning Roe v Wade May Mean for Assisted Reproductive Technologies in the US. JAMA. 5 July 2022:328;1

KMA House of Delegates
August 2022

Amended Resolution 15 Adopted in Lieu of Resolution 25

2022-25

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?

References:

[1] Jones RK, Jerman J. Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014. *Am J Public Health*. 2017;107(12):1904-1909. doi:10.2105/AJPH.2017.304042

[2] Bearak J, Popinchalk A, Ganatra B, et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. *The Lancet Global Health*. 2020;8(9):e1152-e1161. doi:10.1016/S2214-109X(20)30315-6

[3] United Nations Human Rights Committee (HRC). General comment no. 36, Article 6 (Right to Life). Published online September 3, 2019. Accessed April 14, 2022. https://www.refworld.org/docid/5e5e75e04.html

[4] American Public Health Association. *Restricted Access to Abortion Violates Human Rights, Precludes Reproductive Justice, and Demands Public Health Intervention*.; 2015. Accessed April 14, 2022. https://www.apha.org/policies-andadvocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violateshuman-rights

[5] *What If Roe Fell 2019*. Center for Reproductive Rights; 2019:92. Accessed April 14, 2022. https://reproductiverights.org/wp-content/uploads/2021/12/USP-2019-WIRF-Report-Web_updated.pdf

[6] *Safe Abortion: Technical and Policy Guidance for Health Systems*. 2nd ed. World Health Organization; 2012. Accessed April 14, 2022. http://www.ncbi.nlm.nih.gov/books/NBK138196/

[7] Donovan MK. Improving Access to Abortion via Telehealth. Guttmacher Institute. Published May 7, 2019. Accessed April 14, 2022. https://www.guttmacher.org/gpr/2019/05/improving-access-abortion-telehealth

[8] Raymond EG, Chong E, Hyland P. Increasing Access to Abortion With Telemedicine. *JAMA Internal Medicine*. 2016;176(5):585-586. doi:10.1001/jamainternmed.2016.0573

[9] Jones RK, Nash E, Philbin J, Kirstein M. Medication Abortion Now Accounts for More Than Half of All US Abortions. Guttmacher Institute. Published February 2, 2022. Accessed April 14, 2022. https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions

[10] Grossman D, Ralph L, Raifman S, et al. Lifetime prevalence of self-induced abortion among a nationally representative sample of U.S. women. *Contraception*. 2018;97(5):460. doi:10.1016/j.contraception.2018.03.017

[11] Upadhyay UD, Cartwright AF, Grossman D. Barriers to abortion care and incidence of attempted self-managed abortion among individuals searching Google for abortion care: A national prospective study. *Contraception*. 2022;106:49-56. doi:10.1016/j.contraception.2021.09.009

[12] Moseson H, Herold S, Filippa S, Barr-Walker J, Baum SE, Gerdts C. Self-managed abortion: A systematic scoping review. *Best Practice & Research Clinical Obstetrics & Gynaecology*. 2020;63:87-110. doi:10.1016/j.bpobgyn.2019.08.002

[13] The American College of Obstetricians and Gynecologists. *Abortion Policy*.; 2020. Accessed April 15, 2022. https://www.acog.org/en/clinical-information/policy-and-position-statements/statements-of-policy/2020/abortion-policy

[14] Paltrow LM, Flavin J. Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health. *Journal of Health Politics, Policy and Law*. 2013;38(2):299-343.

[15] Goyal V, McLoughlin Brooks IH, Powers DA. Differences in abortion rates by race-ethnicity after implementation of a restrictive Texas law. *Contraception*. 2020;102(2):109-114. doi:10.1016/j.contraception.2020.04.008

[16] Wolfe T, van der Meulen Rodgers Y. Abortion During the COVID-19 Pandemic: Racial Disparities and Barriers to Care in the USA. *Sex Res Soc Policy*. 2022;19(2):541-548. doi:10.1007/s13178-021-00569-8

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*).

Adopted

2022-26

RESOLUTION

Subject: Memorial to William B. Monnig, MD

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, William B. Monnig, M.D. was committed to the Kentucky Medical Association for the last 46 years believing that it represents the essential element - the lynch pin, the keystone to quality patient care – the practicing physicians of the Commonwealth of Kentucky; and

WHEREAS, Dr. Monnig served the Kentucky Medical Association as a Board of Trustee member for the last 36 years, starting in 1984 as 8th District Trustee. He went on to serve the Board as Chair of the Board of Trustees from 1987-1990, President 1992-1993, and the AMA House of Delegates Alternate Delegate since 1995; and

WHEREAS, William B. Monnig, M.D., whom we all know as “Bill” is remembered as one of the nicest persons whose enthusiasm was contagious to all with a big heart and that quick smile; and

WHEREAS, Dr. Monnig lived up to his personal goal that he articulated in 1992 when he said “It would be nice to be remembered as a person who not only tolerated controversy but invited physicians to express their differing viewpoints. That through my efforts we were able to come together to accomplish an objective – even when everyone came to the table with a different viewpoint – by working together realizing that our goal was to deliver good health care – a leader who was also a facilitator”; and

WHEREAS, Bill certainly was a facilitative leader who will be missed by the Kentucky Medical Association; and

WHEREAS, Bill’s life is woven in the lives of Kathy Robinson; his long-time girlfriend, his sons Aaron and Tom, his siblings Carol, Mike, and Dan, and his grandchildren Lucy, William, Liesl, and Sydney; now, therefore, be it

RESOLVED, that the KMA House of Delegates recognize the outstanding contributions made by William B. Monnig, M.D. to patient care and all physicians of the Commonwealth of Kentucky; and be it further

RESOLVED, that the KMA House of Delegates, individually and collectively, hereby extend their most profound sympathy upon the passing of William B. Monnig, M.D March 27, 2022 and extend heartfelt condolences to his family and his esteemed colleagues; and be it further

RESOLVED, that a copy of this resolution be recorded in the proceedings of this House and

be forwarded to Dr. Monnig's family.

Adopted

2022-27

RESOLUTION

Subject: Memorial to SaraBeth Hartlage, MD

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, Dr. SarahBeth Hartlage was a dedicated public servant, committed to improving the health of Kentuckians and the practice of medicine; and

WHEREAS, Dr. Hartlage served as Vice Speaker of the Kentucky Medical Association House of Delegates; and

WHEREAS, Dr. Hartlage led the COVID-19 vaccination efforts for the Louisville Department for Public Health and coordinated the mass vaccination of hundreds of thousands of Kentuckians, leading thousands of volunteers and bringing the life-saving vaccines to every corner of the community; and

WHEREAS, Dr. Hartlage dedicated herself to public health and was an outspoken leader throughout the COVID-19 pandemic who will be missed by the Kentucky Medical Association and the medical community; now, therefore, be it

RESOLVED, that KMA honor the outstanding contributions made by Dr. Hartlage to the patients of the Commonwealth and the practice of medicine; and be it further

RESOLVED, that the KMA House of Delegates, individually and collectively, hereby extend their most profound sympathy upon the passing of SarahBeth Hartlage, M.D., March 16, 2022, and extend heartfelt condolences to her family and colleagues; and be it further

RESOLVED, that a copy of this resolution be recorded in the proceedings of this House and be forwarded to Dr. Hartlage's family.