REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-A-24

Subject: Criminalization of Providing Medical Care (Res. 015-A-23)

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At the 2023 Annual Meeting of the House of Delegates (HOD), the HOD adopted Resolution 015-A-23 entitled, "Report Regarding the Criminalization of Providing Medical Care," which instructed the American Medical Association (AMA) to:

> [S]tudy the changing environment in which some medical practices have been criminalized including the degree to which such criminalization is based or not based upon valid scientific findings, the degree to which this is altering the actual practice of medicine due to physician concerns and personal risk assessment, and the degree to which hospitals and health care systems are responding to this rapidly changing environment, with report back to the HOD no later than the November 2023 Interim meeting.

This report is submitted for the information of the HOD.

BACKGROUND

Abortion

On June 24, 2022, the U.S. Supreme Court issued its landmark decision in *Dobbs v. Jackson Women's Health Organization*, holding that the U.S. Constitution does not confer a constitutional right to abortion and returned the authority to regulate abortion to the states. As of the writing of this report in March 2024, 14 states (Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia) prohibit the provision of nearly all abortions, two states (Georgia and South Carolina) prohibit abortion after fetal cardiac activity is detected around six weeks of pregnancy, and nine states (Arizona, Florida, Iowa, Kansas, Nebraska, North Carolina, Ohio, Utah, and Wisconsin) prohibit abortion later in pregnancy, but before the point at which a fetus is generally considered viable. Many of those latter nine states have passed laws prohibiting abortion earlier in pregnancy that have been blocked in court. Importantly, the status of state abortion laws is fluid. Legal challenges are ongoing in nearly two dozen states and the legality of abortion in those states is subject to change.

At the time the *Dobbs* decision was published, 13 states had abortion prohibitions that predated the *Roe v. Wade* decision or so-called "trigger laws" that became effective upon the overruling of *Roe*, including several that were enacted in 2022 just prior to the *Dobbs* decision. In August 2022, the Indiana legislature became the first in the country to pass a post-*Dobbs* abortion ban. West Virginia followed in September 2022, and in 2023, seven states enacted new abortion bans. North Dakota and Wyoming enacted near-total bans; Florida, Iowa, and South Carolina enacted six-week bans;

and Nebraska and North Carolina enacted 12-week bans. Not all the newly enacted laws are in effect.

Some, but not all, state abortion bans are punishable with criminal penalties. In other states, violations are subject to professional discipline up to mandatory revocation of the health care professional's license. Some also authorize civil enforcement of abortion bans by private citizens, though courts have declined to authorize those suits.

Each state abortion ban contains an exception or affirmative defense, under specified conditions, when abortion is necessary to preserve the life of pregnant women and other pregnant patients. Most, but not all of the states' laws, also contain exceptions or affirmative defenses when abortion is necessary to prevent serious health consequences (e.g., "serious and irreversible impairment of a major bodily function"). Some laws also contain exceptions or affirmative defenses in cases where the pregnancy was due to rape or incest or when the fetus is diagnosed with a serious condition incompatible with life.

These exceptions, however, are not crafted in a way that aligns with the complexity of medical practice and have led to significant confusion about how to practice medicine when pregnancy complications arise. As a result, physicians report significant uncertainty in navigating the new restrictions and describe a chilling effect on the practice of medicine that extends beyond obstetrics and gynecology into a range of specialties including emergency medicine, oncology, rheumatology, cardiology, psychiatry, and others. The AMA is not aware of data that can reliably quantify the degree to which medical practice has been altered in response to abortion restrictions but understands the impact on physicians, their practice, and their patients to be immense. Media reports have profiled numerous patients who describe harrowing experiences in which they suffered preventable medical complications because legal restrictions prevented medical professionals from providing recommended treatment. Similarly, in a lawsuit seeking to clarify the scope of Texas' medical emergency exception, 22 women describe being denied medically necessary and potentially lifesaving treatment when they were experiencing medical emergencies during their pregnancies.[1] To better track these cases, researchers at the University of California in San Francisco have undertaken a study, *"The Care Post-Roe Study,"* to collect stories from clinicians about how abortion laws have altered the usual standard of care. In May 2023, preliminary findings described 50 cases in which abortion laws resulted in delays, worsened health outcomes, and increased the cost and logistic complexity of care.[2] Additionally, qualitative research published in January 2024 reported on obstetrician-gynecologists' perceived impacts of abortion bans.[3] The 54 research participants described delays in medical care, institutional restrictions on referrals and patient counseling, and inability to provide appropriate medical care. The research also reported high rates of moral distress and other personal impacts among the participants.

Risk-averse hospitals and institutional policies are also likely to contribute to changes in medical practice. In May 2023, the Centers for Medicare & Medicaid Services announced investigations into two Missouri hospitals that allegedly withheld necessary stabilizing care to a pregnant patient experiencing preterm premature rupture of membranes in violation of the Emergency Medical Treatment and Labor Act.[4] The government's announcement stated that, in one situation, although the patient's doctors advised her that her pregnancy was no longer viable and her condition could rapidly deteriorate, they could not provide her with the care that would prevent infection, hemorrhage, and potentially death due to hospital policies. Physicians have described other similar hospital policies in which non-clinicians determine whether and at what point abortion care may be provided.

Though abortion bans may be altering the treatment of pregnancy complications, available data indicate that abortion bans have not reduced the total number of abortions provided but have shifted the geographic distribution of abortion care. The #WeCount initiative led by the Society for Family Planning reported that from July 2022 to June 2023 the number of clinician-provided abortions increased modestly, with a monthly average of 82,115 abortions before the *Dobbs* decision and a monthly average of 82,298 in the 12 months after the *Dobbs* decision.[5] As anticipated, states with abortion bans reported significant declines in the number of abortions provided after *Dobbs*, with 14 states experiencing a 100 percent decrease. Accordingly, the number of live births has risen in places that ban abortion. Research published in November 2024 estimated that, in the first six months of 2023, births rose by an average of 2.3 percent in ban states compared to states where abortion remained legal.[6] The authors estimated that roughly one-fifth to one-fourth of people seeking abortions did not receive them due to bans. Another study from the Johns Hopkins Bloomberg School of Public Health estimated that nearly 9,800 additional live births occurred in Texas in the year after the state's abortion ban took effect.[7]

Conversely, health care professionals in states that do not severely restrict access to abortion have reported an increase in demand for abortion care from out-of-state patients, as well as greater complexity of cases and abortion care, sought later in pregnancy. The #WeCount initiative reported in October 2023 that the increase in abortions provided in these states was greater than the decrease of abortion provided in restrictive states and notes that much of the increase has been in states that border restrictive states.

Abortion bans are also likely to impact the physician workforce. Though data is not available, there have been anecdotal reports of individual physicians opting to leave states with restrictive laws. Similarly, two hospitals in Idaho closed their labor and delivery units, citing difficulties in recruiting staff and the hostile legal environment.[8] The American Association of Medical Colleges (AAMC) also reported that obstetrics and gynecology residency applications declined significantly in states that have banned abortion.[9] AAMC posits that restrictive abortion laws may deter applicants from applying to programs in those jurisdictions.

The AMA is not aware of any investigation, criminal prosecution, or medical board disciplinary action taken against a physician for the illegal provision of abortion in a state with a strict prohibition. The lack of enforcement action coupled with the data described above from restrictive states suggests that physicians are complying with the laws and have ceased providing prohibited abortion care except when a legally recognized exception applies.

Gender-affirming Care for Minor Patients

As of the writing of this report in March 2024, 23 states have enacted bans on gender-affirming care for minor patients. Twenty-one states (Alabama, Arkansas, Florida, Georgia, Iowa, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Montana, Missouri, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Texas, Utah, and West Virginia) broadly prohibit the provision of gender-affirming care to minor patients, including medications to delay puberty, hormonal therapy, and surgeries. Two states (Arizona and Nebraska) prohibit surgical interventions on patients younger than 18 years of age but do not ban non-surgical interventions. Legislative prohibitions on gender-affirming care have been relatively recent developments. The Arkansas legislature enacted the first such law in 2021, followed in 2022 with legislation in Alabama and Arizona and administrative action in Florida and Texas. Twenty-two states then enacted bans in 2023 and 2024.

Among the 23 states that prohibit providing gender-affirming care to minors, some, but not all, impose criminal penalties for violations. In other states, violations are subject to professional discipline, including, in some places, mandatory revocation of the health care professional's license. Several state laws also authorize patients and their families to bring civil suits against health care professionals for decades after the care was provided.

Some laws have been successfully challenged in court. Arkansas's law has been permanently enjoined, and laws in Florida, Idaho, and Montana have been temporarily enjoined in whole or part. Like abortion laws, the status of laws regulating the provision of gender-affirming care is subject to change as legal challenges progress.

At the start of 2023, no law was in effect that broadly prohibited gender-affirming care for minors, though some clinicians and institutions, including in Texas and Tennessee, paused care for minors in response to political pressure.[10] Many laws have since gone into effect, but the full impact is not yet known. It is reasonable to expect that physicians will cease to provide gender-affirming care to their minor patients in compliance with state law. It is also expected that the impact may extend to services provided to transgender adults, as well. For instance, the University of Mississippi Medical Center, which also treated adults, recently closed its gender clinic in response to legislative activity.[11] Conversely, health care professionals in states that protect gender-affirming care may experience increased demand for services. In contrast to abortion services, however, gender-affirming care generally requires ongoing treatment and monitoring, which could complicate patients' ability to travel to distant locations for care. Additionally, while the impact of state laws on patients and the LGBTQ+ community is immense, those patient outcomes are beyond the scope of this report.

Treatment of Patients with Pain and those with a Substance Use Disorder

The nation's overdose and death epidemic was—and continues to be—driven by a complex set of factors, including the current dominance of illicitly manufactured fentanyl; illicit use of drugs such as heroin, cocaine, and methamphetamine; new toxic adulterants such as xylazine and nitazines; and a lack of access to evidence-based care for pain or a substance use disorder. The history of the epidemic also includes actions of physicians and other health care professionals essentially engaging in drug dealing through what is colloquially termed, "pill mills."[12] As part of its enforcement efforts, several years ago, the U.S. Department of Justice Criminal Division launched a "Prescription Strike Force," which targets "Medicare Part-D fraud and other schemes involving false or fraudulent representations related to prescription medications, in addition to the illegal prescribing, distribution, and diversion of pharmaceutical-grade controlled substances."[13] The U.S. Drug Enforcement Administration (DEA) regularly issues news releases highlighting convictions and other actions against physicians, nurse practitioners and pharmacists for crimes related to "illegally prescribing opioids."[14]

The AMA continues to be concerned about how the actions of the DEA and others in law enforcement have led to what has been referred to as a "chilling effect" in treating patients with pain. In a qualitative review of interviews with 20 West Virginia physicians, the review authors found that physicians' feared discipline even as opioid prescribing was decreasing. Specifically, physicians "felt that taking on patients who legitimately required opioids could jeopardize their career."[15] Stories of patient harm and physician fear are abundant and disturbing to read.[16] But it is important to note that government intrusion into the practice of treating patients with pain or with a substance use disorder has existed for more than 100 years.[17] The Board of Trustees feels strongly that the AMA must continue its decades-long tradition of strongly advocating against third-party

intrusion, which includes but is not limited to government intrusion, into the patient-physician relationship.

Notably, ensuring access to evidence-based care for patients with pain or with a substance use disorder remains top priorities for the work of the AMA and the AMA Substance Use and Pain Care Task Force (SUPCTF). AMA advocacy was vital to securing revisions to the 2016 Centers for Disease Control and Prevention (CDC) opioid prescribing guideline. AMA advocacy remains critical in advocating against misapplication of the 2016 CDC opioid prescribing guideline by payers, states, pharmacy chains, pharmacy benefit managers, and others. AMA advocacy also continues to work to remove all barriers to treatment for substance use disorders. This includes helping to lead the national discussion that unequivocally advocates for the understanding that substance use disorders are medical diseases and not moral failings. The Board of Trustees is grateful to the organizations in the SUPCTF for their partnership in furthering these efforts.

Ultimately, it is difficult to specifically quantify the degree to which fear of law enforcement in treating pain or substance use disorders has altered the actual practice of medicine. There is ample anecdotal evidence, but limited research about physician concerns and personal risk assessment. The fear is real, and our colleagues and patients have suffered as a result. In response, AMA will continue to advance its policy opposing third-party/government intrusion into individualized patient care decisions.

DISCUSSION

Opposing third-party intrusion into the practice of medicine (including but not limited to governmental intrusion) has long been a core priority for the AMA. The AMA continues to execute a multifaceted strategy, including engagement with policymakers at the state and federal levels, judicial advocacy, and more, to counter the deleterious impact of legislative efforts to criminalize the practice of medicine. The AMA Advocacy Resource Center continues to work extensively with state medical associations and national medical specialty societies, both publicly and behind-the-scenes, to oppose state laws and regulations targeting the practice of medicine.

Additionally, development of the AMA Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted (Task Force), established by the HOD during the 2022 Annual Meeting, is in progress and the Task Force will update the HOD on its activities, as instructed in Policy D-5.998, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era." The Task Force is well-suited to address the issues raised in this report and will help guide organized medicine's response to the criminalization of medical practice, as well as identify and create implementation-focused practice and advocacy resources on the issues identified in Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," including but not limited to:

1. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;

2. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;

3. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;

4. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;

5. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

6. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need;

7. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications; and

8. Making recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.

CONCLUSION

The Board of Trustees reiterates its support and gratitude for physicians and all health care professionals who confront the reality of law enforcement or other government intrusion into the practice of medicine. These intrusions have sometimes caused irreparable harms to physicians and patients across the United States. The AMA recognizes that law enforcement plays an important role in our society, but it should not in the exam room, operating suite, or any other patient-physician encounter. Whether it is through the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted to protect access to reproductive rights and gender-affirming care, the Substance Use and Pain Care Task Force to enhance evidence-based care for patients with pain or a substance use disorder; or other areas that must confront the criminalization of health care, the AMA will continue to fight to protect and preserve the sacred nature of the patient-physician relationship.

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