Ban on standard D&E abortion procedure is unsafe, unwarranted

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A successful appeal by Kentucky to reinstate its struck-down abortion statute would put patients at serious and unnecessary risk, argues an amicus brief file by the AMA and others.

The law, H.B. 454, is designed to block the standard dilation and evacuation (D&E) abortion method except in extremely limited circumstances. It adds the requirement that clinicians cause fetal demise, by one of three methods, before performing D&E. Lawmakers cited prevention of fetal pain in enacting the statute, which carries potential clinician penalties of jail time, significant fines, or licensure loss or suspension.

The fetal demise provisions require interventions that are "fallible, present additional risks to patient health without any offsetting medical benefits, and often are experimental," states the friend-of-the-court brief from the AMA and the American College of Obstetricians and Gynecologists (ACOG), joined by four organizations representing physicians, nurse-midwives and nurse practitioners.

The brief, in the case of *EMW Women's Surgical Center PSC et al. v. Meier et al.*, was filed in response to Kentucky's appeal to the 6th U.S. Circuit Court of Appeals. In May, the U.S. District Court for the Western District of Kentucky found the law unconstitutional. The AMA and ACOG have challenged virtually identical D&E laws before other courts.

Why H.B. 454 is a bad law

The brief declares flatly that "there is no medical justification for H.B. 454," and lays out four clinical and medical ethics-based arguments against it.

It criminalizes the state's primary second-trimester abortion method without "safe, available, and reliable alternatives." More than 99% of second-trimester abortions in Kentucky—and 95%

nationwide—are performed by D&E, with the brief noting it “is generally considered the safest abortion procedure beginning in the early second trimester.”

The three methods mandated by H.B. 454 are digoxin injection, potassium chloride injection and umbilical cord transection. The brief devotes nearly eight pages to detailed discussions of their shortcomings and risks.

Each method, in its own way, raises risks such as complication, infection and hospital admission. Both of the injectable methods require the delicate use of long hypodermic needles. The brief chillingly notes that in the case of potassium chloride, a miss into the patient’s bloodstream could cause cardiac arrest. Digoxin does not induce demise up to about 20% of the time. As for umbilical cord transection, the brief describes it as “blindly fishing around the woman’s uterus” to locate and transect a cord about as wide as a piece of yarn.

The law’s premise of fetal pain in the gestational period at issue is not supported by medical consensus. Every major medical organization that has examined the issue of fetal pain, and several peer-reviewed studies, agree that “fetal pain perception is not possible before at least 24 weeks” from last menstrual period,” says the brief. The plaintiff, EMW, stops performing abortions at 21.6 weeks. The “circuitry required to experience pain is simply not developed in earlier gestations,” the brief says.

Further, “medical literature shows that a fetus likely cannot experience pain at any gestational age, because it is kept in a sleep-like state by environmental factors in the uterus, including certain hormones and low oxygen levels.”

It intrudes on the patient-clinician relationship. The brief cites both AMA and ACOG ethics statements that underscore the fundamental understanding that the physician’s judgment will be guided by what is best for the patient.

The law “wrongfully intrudes on that relationship by substituting the clinician’s medical judgment with that of the Kentucky legislature,” which mandated a one-size-fits all, potentially harmful procedure. “Criminalizing the clinician’s ability to consider and prescribe the optimal form of treatment, in consultation with her patient, obstructs sound medical care and endangers a woman’s health.”

Patients suffer when clinicians are placed in ethically compromised positions. To comply with the law, clinicians have to ignore what they know is the best treatment for the patient. Additionally, H.B. 454 “pits the welfare of the patient against a clinician’s desire to avoid severe retribution—a burdensome ethical dilemma.

Meanwhile, patients can’t exercise their autonomy. “Even where a patient does not want to be subjected to additional, risk-enhancing, experimental procedures, because of the legal limitations imposed by H.B. 454, a physician must reject the patient’s choice.”