AMERICAN MEDICAL ASSOCIATION WOMEN PHYSICIANS SECTION

Resolution: (Assigned by HOD)
(A-25)

Introduced by: Taylor Lavalle

Subject: Protections for Pregnant Women

Referred to: Reference Committee (Assigned by HOD)

Whereas, intimate partner violence, IPV, is a public health issue that is most prevalent among women of reproductive age and can negatively affect a women's physical, mental, sexual, and reproductive health[1]; and

Whereas, violence against women and pregnant individuals is preventable and health care is often an entry point into receiving and referring women to additional support services[2]; and

Whereas, the societal and economic costs of IPV are due to isolation, inability to work, loss of wages, increased health care costs, and limited ability to care for themselves and their children2; and

Whereas, pregnant women experiencing IPV are twice as likely to miss prenatal appointments or initiate care later and more likely to engage in active alcohol and substance use during pregnancy[3]; and

Whereas, intimate partner violence in pregnancy increases the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight babies[3]; and

Whereas, there is an 8-fold increased risk of fetal death and 6-fold increased risk of neonatal death due to assault during pregnancy and increased risk of maternal death[4]; and

Whereas, IPV is associated with higher rates of depression and post-traumatic stress disorder in the postpartum period[5]; and

Whereas, the risk of IPV rises among pregnant individuals to as high as 20 percent[1]; and

Whereas, in the Missouri State law 425.310 requires a petition for dissolution of marriage that must include whether a wife is pregnant6; and

Whereas, similar statues are in Texas[7]; and

Whereas, there is a proposed bill in Missouri that would allow for divorce during pregnancy HB2402[8]; and

Whereas, a proposed United States Congress Bill 9196 aims to prohibit consideration of pregnancy status during divorce[9]; and

Whereas, another proposed United States Bill in both the house and senate, HR459 and SR323, prohibits providers and insurance plans from disclosing in a legal proceeding an

individual's personal health information related to an abortion or pregnancy without the individual's valid authorization[10]; and

Whereas, each state has individual waiting periods before signing divorce papers[11]; and

Whereas, additional barriers to divorce arise as waiting periods, longer than the ones legally required by each state, occur due to judges that choose to wait until after the baby is born to sign divorce papers, even if all requirements are met, such as custody, paternity or child support[12]; and

Whereas, inability to file divorce is related to higher rates of pregnancy- associated intimate partner homicide[12]; therefore be it

RESOLVED, that our American Medical Association supports policies that prohibit mandatory wait periods due solely to pregnancy; and be it further

RESOLVED, that our AMA supports policies that prohibit health care providers or insurance plans from disclosure in legal proceeding an individual's personal health information related to an abortion or pregnancy without the individual's valid authorization; and be it further

RESOLVED, that our AMA supports policies that prohibit judges from waiting longer than 30 days after all state requirements have been met, including mandatory waiting periods, custody, paternity and child support decisions.

Fiscal Note: (Assigned by HOD)

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REFERENCES

1. Violence against women Prevalence Estimates, 2018. Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. WHO: Geneva, 2021
2. Pastor-Moreno G, Ruiz-Perez,Henares-Montiel J, Petrova D. Intimate partner violence during pregnancy and risk of fetal and neonatal death: a meta-analysis with socioeconomic context indicators. Am J Obstet Gynecol. 2020; 222 (e5): 123-133
3. Drexler KA, Quist-Nelson J, Weil AB. Intimate partner violence and trauma-informed care in pregnancy. Am J Obstet Gynecol MFM. 2022 Mar;4(2):100542. doi: 10.1016/j.ajogmf.2021.100542. Epub 2021 Dec 3. PMID: 34864269.
4. Centers for Disease Control and Prevention. (n.d.). *About intimate partner violence*. Centers for Disease Control and Prevention. https://www.cdc.gov/intimate-partner-violence/about/?CDC_AAref_Val=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fintimatepartnerviolence%2Ffastfact.html
5. Campbell J, Matoff-Stepp S, Velez ML, Cox HH, Laughon K. Pregnancy-associated deaths from homicide, suicide, and drug overdose: review of research and the intersection with intimate partner violence. J Womens Health (Larchmt). 2021; 30: 236-244
6. *452.310*. Missouri Revisor of Statutes - Revised Statutes of Missouri, RSMo, Missouri Law, MO Law, Joint Committee on Legislative Research. (n.d.). https://revisor.mo.gov/main/OneSection.aspx?section=452.310&bid=33222&hl=divorce%25u2044pregnant
7. Family code chapter 6. suit for dissolution of Marriage. (n.d.). https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=FA%2FFA.6&Phrases=divorce%7Cpregnancy&HighlightType=1&ExactPhrase=False&QueryText=divorce%2Bpregnancy
8. Aune, A. (n.d.). HB 2402 - Missouri House of Representatives - Mo.gov. https://house.mo.gov/bill.aspx?bill=HB2402&year=2024&code=R
9. Text - H.R.9196 - 118th Congress (2023-2024): Pregnancy ... (n.d.). https://www.congress.gov/bill/118th-congress/house-bill/9196/text
10. H.R.4189 - 118th Congress (2023-2024): Connect for Health Act of 2023 | congress.gov | library of Congress. (n.d.-a). https://www.congress.gov/bill/118th-congress/house-bill/4189
11. Connor, M. (2022, May 5). The divorce waiting period in every State. Part As Friends®. https://partasfriends.com/the-divorce-waiting-period-in-every-state/?srsltid=AfmBOopvin0wr7DMILUCNptTOr8eewR-oJuhrXapL7HGVwZBs2toKdjw

12. Boyle KM, Regoeczi W, Meyer CB. State Divorce Laws, Reproductive Care Policies, and Pregnancy-Associated Homicide Rates, 2018-2021. *JAMA Netw Open.* 2024;7(11):e2444199. doi:10.1001/jamanetworkopen.2024.44199

RELEVANT AMA POLICY

Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse D-515.982

Our American Medical Association will work with members **of the** Federation **of** Medicine **and** other appropriate organizations to educate physicians on
(1) **the** relationship **between domestic violence and child abuse and** (2) **the** appropriate role **of the physician** in treating patients when **domestic violence and**/or **child abuse** are suspected. [Res. 415, A-09 Reaffirmed: CSAPH Rep. 01, A-19]

Legal Interventions During Pregnancy H-420.969

Court Ordered Medical Treatments And **Legal** Penalties For Potentially Harmful Behavior By Pregnant Persons:

1. Judicial intervention is inappropriate when a pregnant patient has made an informed refusal of a medical treatment designed to benefit their fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the pregnant patient, entails a minimal invasion of their bodily integrity, and would clearly prevent substantial and irreversible harm to their fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.
2. The physician's duty is to provide appropriate information, such that the pregnant patient may make an informed and thoughtful decision, not to dictate the woman's decision.
3. A physician should not be liable for honoring a pregnant patient's informed refusal of medical treatment designed to benefit the fetus.
4. Criminal sanctions or civil liability for harmful behavior by the pregnant patient toward their fetus are inappropriate.
5. Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
6. To minimize the risk of **legal** action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation.

[BOT Rep. OO, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CEJA Rep. 6, A-10 Reaffirmed: Res. 507, A-16 Reaffirmed: Res. 209, A-18 Reaffirmed: CSAPH Rep. 12, A-24 Modified: Speakers Rep. 02, I-24]

Family and Intimate Partner Violence H-515.965

1. Our American Medical Association believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.
2. Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist

survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

3. The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to:
    a. Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care.
    b. Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before they leave the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course.
    c. After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible.
    d. Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid.
    e. Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence.
    f. Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV.
    g. (Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves.
    h. Give due validation to the experience of IPV and of observed symptomatology as possible sequelae.
    i. Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made.
    j. Become involved in appropriate local programs designed to prevent violence and its effects at the community level.
4. Within the larger community, our AMA:
    a. Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
    b. Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
    c. Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
5. With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, our AMA believes the laws must incorporate provisions that:
    a. do not require the inclusion of survivors' identities;
    b. allow competent adult survivors to opt out of the reporting system if identifiers are required;
    c. provide that reports be made to public health agencies for surveillance purposes only;
    d. contain a sunset mechanism; and
    e. evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

6. Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
    a. Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
    b. Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
    c. Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
    d. Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
    e. The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

[CSA Rep. 7, I-00 Reaffirmed: CSAPH Rep. 2, I-09 Modified: CSAPH Rep. 01, A-19 Modified: Speakers Rep. 02, I-24]

Insurance Discrimination Against Victims of Domestic Violence H-185.976
Our AMA: (1) opposes the denial **of insurance** coverage to **victims of domestic violence** and abuse and seeks federal legislation to prohibit such **discrimination**; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner **violence**.
[Res. 814, I-94 Appended: Res. 419, I-00 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19]