



MAINE MEDICAL ASSOCIATION

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TESTIMONY OF THE MAINE MEDICAL ASSOCIATION

AND

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS - MAINE SECTION IN OPPOSITION TO

L.D. 116, An Act to Require a 24-hour Waiting Period Prior to an Abortion,

L.D. 924, An Act to Educate Women on the Medical Risks Associated with Abortion, and

*L.D. 1457, An Act to Strengthen the Consent Laws for Abortions Performed on Minors and
Incapacitated Persons*

Joint Standing Committee on Judiciary
Room 438, State House
Tuesday, May 3, 2011, 1 p.m.

Good afternoon Senator Hastings, Representative Nass, and Members of the Joint

Standing Committee on Judiciary. My name is Andrew MacLean and I speak today in

opposition to all of the abortion bills before you on behalf of the Maine Medical Association

(MMA) and the American College of Obstetricians and Gynecologists - Maine Section (Maine
ACOG).

The MMA is a professional association of more than 3400 Maine physicians, residents,
and medical students whose mission is “to support Maine physicians, advance the quality of
medicine in Maine, and promote the health of all Maine citizens.”

The Maine Section of the American College of Obstetricians and Gynecologists represents approximately 150 Maine physicians specializing in women's health care issues.

The moral and ethical issue of abortion is a difficult one for all segments of our society and physicians are no different from other Americans on this issue. The decision to support or oppose abortion, therefore, is a matter for physicians to decide individually, based upon personal values or beliefs. No medical society or hospital administration will compel a physician to perform abortions against firmly held moral principles. **However, abortion currently is a legal medical procedure in our country and we believe strongly that the decision about the medical necessity of and propriety of a particular medical procedure must be left to the patient and her physician acting in conformity with standards of good medical care.**

The abortion debate in this country is marked by different but important values and the diversity of beliefs should be respected. The MMA opposes abortion legislation that does not respect this diversity of beliefs. We oppose legislation intended to intimidate physicians and other health care providers and their families, and to obstruct patients' access to safe abortions. We oppose the harassment of abortion providers and patients as well as legislation that seeks to differentiate them from the medical community as a whole. It is on these principles that we oppose the bills before you today.

We all share a common goal of preventing unintended pregnancy and reducing the need for abortion in Maine. In hearings on similar bills in years past, the Maine CDC has provided this Committee with evidence that Maine has been successful in pursuing this goal because of two major factors:

- Free or low cost access to preventive reproductive health care through Maine's system of family planning clinics; and

- A standard of comprehensive family life education that begins with abstinence and provides full information to our youth.

Maine's current laws on minors' rights to confidential health care treatment have furthered our pursuit of this goal.

I have attached to my testimony a thoughtful statement from George R. Kunhardt, M.D., an obstetrician-gynecologist practicing with Mayo Women's Health in Dover-Foxcroft.

I will comment briefly on each of the bills before you today.

L.D. 116. *An Act to Require a 24-hour Waiting Period Prior to an Abortion*

First, enacting a law requiring a 24-hour waiting period is unnecessary because it is rare that a major surgical procedure like an abortion would be performed in an initial visit. But, enactment of such a waiting period in Maine law could threaten a woman's health if a health care provider must debate whether the patient's circumstances meet the definition of "medical emergency" in the bill. While abortion is one of the safest surgical procedures performed (childbirth has a mortality rate 11 times higher), mandated delays can increase the risk of complications.

L.D. 924. *An Act to Educate Women on the Medical Risks Associated with Abortion*

L.D. 924 represents an unwarranted intrusion in the physician-patient relationship.

The MMA generally opposes legislative or regulatory interference in the process of obtaining informed consent to treatment between a physician and patient - - a very personal discussion that is at the heart of the physician-patient relationship. According to Opinion 8.08, *Informed Consent of the AMA Code of Medical Ethics*, the physician must enable the patient's right to make his or her own determination on treatment by ensuring that the patient has enough information to make an intelligent choice. Consequently, a physician already has an ethical

obligation to help the patient make choices from among the full range of therapeutic alternatives consistent with good medical practice. The practitioner must tailor the information presented during an informed consent conversation to the patient's particular circumstances, not according to a mandated script as required by L.D. 924. I have attached an excerpt from a continuing legal education document that provides you with background on the practitioner's legal and ethical obligations to obtain a patient's informed consent to medical treatment or procedures.

L.D. 1457. *An Act to Strengthen the Consent Laws for Abortions Performed on Minors and Incapacitated Persons*

I have attached for your consideration in your deliberations on this bill, AMA Ethics Opinion 2.015, *Mandatory Parental Consent to Abortion*. As you will see, the opinion encourages minor patients to discuss their pregnancy with their parents, but recognizes that such a sensitive decision must be made by the patient with the medical advice of her physician and the counseling of adult advisors with whom she is comfortable. Maine's current abortion laws ensure appropriate adult involvement in this decision-making process, but recognize that, for a variety of reasons, a minor may not be comfortable involving a parent in that process. Maine's current law on a minor's right to an abortion is a national model that has been in place for more than 20 years. It is pragmatic and flexible enough to meet the needs of the broad range of minor patients and physicians as they face one of life's most difficult challenges. The process for approval of an abortion outlined in L.D. 1457 is so complex and unwieldy that we fear it would effectively obstruct a minor from obtaining an abortion. As examples of this complexity, I would point out the requirement for the patient's consent to be notarized (pages 1 and 2 of the bill); the intrusive and burdensome reporting requirements of the proposed §1597-B(6) (page 3 of the bill); and the requirement that a court considering a patient's petition to apply the higher

standard of proof, “clear and convincing” evidence and to “issue written and specific factual findings and conclusions of law supporting its decision” (page 4 of the bill).

Conclusion

The MMA and Maine Section - ACOG urge the Judiciary Committee to reject these 3 abortion bills. The Maine Legislature and the People of Maine should allow the patient and her physician to determine the most appropriate course of treatment based upon accepted standards of medical care and upon the patient's individual circumstances.

Thank you for considering the views of the MMA and Maine ACOG on these bills.

George Randy Kunhardt, MD
Mayo Women's Health
891 West Main St. Suite 600
Dover-Foxcroft, ME 04426
E-mail rkunhardt@mayohospital.com
(207) 564-4470
Fax (207) 564 4472
2/16/2011

DO NOT Modify the current Abortion Laws.

I have practiced OBGYN for 33 years and that includes large numbers of teenagers.

I am very dependent on the privacy that teens currently have. Privacy allows them to tell me the entire truth. I can get an accurate sexual history as they know I can not tell their parents or anyone else. I can get an accurate record of their symptoms. This privacy is critical to good care.

This privacy is critical to be able to make an assessment of their risks of disease and to diagnose and treat any current disease. Privacy guides me in what tests I choose. It gives these young patients the confidence to request a complete gynecology exam.

Privacy allows me to find out if there is abuse of any type, including by a parent, relative or partner.

I then am able to appropriately counsel teens. Counseling goes beyond the birth control methods, to include the decision to become sexual or to abstain. I probably see 200 pregnant teens before I see one who decides to proceed with questions about abortion. Of those who do ask about abortion only 1 in 10 will go thru with abortion and none on the same day. I do refer out for abortions and I have NEVER encountered an abortion clinic that does the procedure at the first visit. I personally do show pictures of a fetus at that gestation and show them the Ultrasound 'live'.

I have delivered over 7,000 babies and have performed about 15 abortions. Most are for severe lethal fetal anomalies or are indicated for maternal health.

I support a woman's (teens) choice to protect herself.

During the Bush years the states, such as Texas, who accepted "abstinence money" found an increase in teen pregnancies. Education, privacy and access are critical to keep the teen pregnancy rates down as well as the rates of Sexually Transmitted Diseases' and HIV.

Thank You,



George R Kunhardt, M.D.

Excerpt from *Health Law in Maine: the Legal Implications of Health Care Delivery
Systems and Managed Care*

National Business Institute, Inc.

September 28, 2004

Prepared by Andrew B. MacLean, J.D.

Vice President & General Counsel

Maine Medical Association

2. CONSENT TO TREATMENT

A. General

As suggested in the discussion of the physician-patient relationship, the patient's consent to medical treatment is a fundamental element of the relationship. Consent to treatment is more than simply having the patient sign a written consent form. It should be a process of communication between the physician and patient resulting in an agreement to pursue a specific medical or surgical course of treatment. In 1914, Judge (later Supreme Court Justice) Benjamin Cardozo described the principle of consent to treatment in writing, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914).

The first judicial opinion to use the term "informed consent" came many years after Schloendorff in Salgo v. Leland Stanford Jr. University Board of Trustees, 317 P.2d 170 (1957). The Salgo Court stated that a patient's documented consent is insufficient if the patient did not understand the physician's description of the treatment. The Court decided that "a physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment." Salgo, 317 P.2d at 181. The AMA Code of Medical Ethics addresses informed consent in Opinion 8.08, *Informed Consent*:

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient

should make his or her own determination on treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a basic social policy for which exceptions are permitted: (1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or (2) when risk disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated. Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment. (I, II, III, IV, V) Issued March 1981.

In short, "consent" means "permission" and "informed consent" means "permission given after a proper explanation." The physician's process of obtaining the patient's informed consent should include these disclosures:

- the nature and purpose of the treatment;
- the risks and consequences involved in the treatment;
- alternative courses of treatment, including the consequences of no treatment; and
- an opportunity for the patient to ask questions.

Consent forms should be drafted as specifically as possible and should provide evidence of the process of obtaining informed consent. A sample consent form is included in the Appendix.



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Physicians should ascertain the law in their state on parental involvement to ensure that their procedures are consistent with their legal obligations.

Physicians should strongly encourage minors to discuss their pregnancy with their parents. Physicians should explain how parental involvement can be helpful and that parents are generally very understanding and supportive. If a minor expresses concerns about parental involvement, the physician should ensure that the minor's reluctance is not based on any misperceptions about the likely consequences of parental involvement.

Physicians should not feel or be compelled to require minors to involve their parents before deciding whether to undergo an abortion. The patient, even an adolescent, generally must decide whether, on balance, parental involvement is advisable. Accordingly, minors should ultimately be allowed to decide whether parental involvement is appropriate. Physicians should explain under what circumstances (eg, life-threatening emergency) the minor's confidentiality will need to be abrogated.

Physicians should try to ensure that minor patients have made an informed decision after giving careful consideration to the issues involved. They should encourage their minor patients to consult alternative sources if parents are not going to be involved in the abortion decision. Minors should be urged to seek the advice and counsel of those adults in whom they have confidence, including professional counselors, relatives, friends, teachers, or the clergy. (III, IV) Issued June 1994 based on the report "Mandatory Parental Consent to Abortion," adopted June 1992. (JAMA. 1993; 269: 82-86)