**RESOLUTION #23-09**
**ENTITLED:** Regulating Crisis Pregnancy Centers
**SUBMITTED BY:** Alison Case, MD; Cynthia Heckman-Davis, MD; Mary Mahern, MD

WHEREAS, Crisis Pregnancy Centers (CPCs), sometimes known as “pregnancy resource centers,” “pregnancy care centers,” “pregnancy support centers,” or simply “pregnancy centers,” are defined by the American Medical Association (AMA) as organizations that seek to intercept patients with unintended or “crisis” pregnancies who might be considering abortion[1]; and

WHEREAS, CPCs were established in the 1960s by women advocates of the anti-abortion movement to discourage and limit access to abortion[2]; and

WHEREAS, CPCs have over 90 centers located in the state of Indiana[3]; and

WHEREAS, as of February 5, 2022, Indiana has allocated $18,250,000 of state funds to CPCs, with a further $45 million appropriated to the Hoosier Families First Fund during the 2022 special session, for which CPCs would qualify[4,5]; and

WHEREAS, greater than 80% of CPC staff and volunteers are not licensed medical professionals, allowing for unlicensed, untrained individuals to provide “non-diagnostic” ultrasounds that may misidentify a positive pregnancy, incorrectly estimate gestational age, and fail to recognize any medical anomalies in the location of implantation, placenta, amniotic fluid, and fetus[6,7]; and

WHEREAS, despite giving the impression of medical expertise, the majority of CPCs are not licensed medical clinics and therefore cannot legally be held to the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), and research has found that only 14% of CPCs disclose their non-medical status, and only 42% disclose after direct questioning[1,8]; and

WHEREAS, CPCs provide misinformation on the failure rates of condoms, their permeability to sexually transmitted infections (STIs), and effects of hormonal birth control, and fail to provide comprehensive sex education or referrals for contraceptives, STIs, and pregnancy termination options despite advertisement suggesting otherwise[1,6,9]; and

WHEREAS, CPCs assert false risks of abortion such as links between abortion and breast cancer, infertility, mental illness, preterm birth, and high rates of post-procedure complications[10,11]; and

WHEREAS, CPCs concentrate their advertising efforts on groups that they feel to be the most “abortion-minded,” including women of color and those of lower socioeconomic classes, by strategically placing billboards near high schools and colleges and advertising on public transportation and bus shelters[12]; and

WHEREAS, CPC misinformation and deception often intentionally create delays that can leave people unable to access abortion care in their communities due to gestational age cutoffs, forcing them to continue their pregnancies and/or increasing health risks for the individuals using their services[6,11]; and

WHEREAS, by impeding access to abortion through delays, expense, or other tactics, CPCs may propagate racial, ethnic, and socioeconomic inequities[1,13]; and

WHEREAS, the Indiana State Medical Association (ISMA), the American Academy of Family Physicians (AAFP), the AMA, and the American College of Obstetrics and Gynecology (ACOG) assert

that the patient-physician relationship is sacred and that healthcare decisions should be made by patients in consultation with their healthcare providers without interference from outside parties[14]; and

WHEREAS, the AMA Code of Medical Ethics indicates patient safety, privacy, autonomy, and informed decision making are core values of healthcare and that physicians as a collective should strive to advocate for their patients in these areas; and

WHEREAS, according to the AMA Code of Medical Ethics, patients should expect that their physician will coordinate medically indicated care with other health care professionals and when physicians seek or provide consultation about a patient's care or refer a patient for health care services they should refer the patient only to health care professionals who have appropriate knowledge and skills and are licensed to provide the services needed; and

WHEREAS, the AAFP emphasizes the importance of physician oversight of non-physicians who are providing medical services; and

WHEREAS, the IAFP supports and the ISMA has extensive policy emphasizing the importance of transparency in credentials of non-physicians who are providing medical services; and

WHEREAS, the Resolution 22-80 draft study report states that "after extensive research, ISMA staff did not find any evidence that the State of Indiana has a broad licensure framework in place for CPCs"; therefore be it

RESOLVED, that the Indiana Academy of Family Physicians (i) oppose the expansion of taxpayer funding of crisis pregnancy centers which offer medical and clinical services until these centers demonstrate that they meet ethical standards of licensed medical facilities and (ii) support legislation that prohibits the use of taxpayer money to fund Crisis Pregnancy Centers that violate the ethical standards of licensed medical facilities; and be it further

RESOLVED, that the Indiana State Medical Association and Indiana Academy of Family Physicians work with the medical board and Indiana state government to design and implement a framework for defining and licensing crisis pregnancy centers which market medical or clinical services; and be it further

RESOLVED, that the Indiana Academy of Family Physicians seek and support policies and legislation that require crisis pregnancy centers to disclose whether or not they have been licensed by the state of Indiana (i) on their advertising and (ii) at their physical location prior to services being offered or provided; and be it further

RESOLVED, that our Indiana Academy of Family Physicians support policies and legislation that require crisis pregnancy centers to disclose and display the credentials of the individuals who are on staff or conducting services on site; and be it further

RESOLVED, that our Indiana Academy of Family Physicians support policies and legislation that require crisis pregnancy centers to disclose what medical and non-medical service options, including, but not limited to contraception, pregnancy termination, adoption, and referral for any such services on its advertising and at their physical location prior to services being offered or provided; and be it further

RESOLVED, that our Indiana Academy of Family Physicians educate/encourage physicians NOT to recommend crisis pregnancy centers to patients without ensuring the qualifications of individuals on staff, the transparency of the crisis pregnancy center regarding services provided, and credentials of those conducting these services on site, and be it further

RESOLVED, that this resolution, reframed as a national American Academy of Family Physicians (AAFP) policy resolution, be advanced by Indiana Academy of Family Physicians delegates to the AAFP Congress of Delegates.

**References**


1. Bryant A, Swartz J. Why Crisis Pregnancy Centers Are Legal but Unethical. *AMA Journal of Ethics*. 2018;20(3):269-277. doi:10.1001/journalofethics.2018.20.3.pfor1-1803
2. Haugeberg K. *The Emergence of Crisis Pregnancy Centers*. Vol 1. University of Illinois Press; 2017. doi:10.5406/illinois/9780252040962.003.0002
3. Crisis Pregnancy Center Map & Finder. CPC Map. Accessed May 15, 2023. https://crisispregnancycentermap.com/
4. *Indiana Code 2022 - Indiana General Assembly, 2023 Session*. Vol IC 4-12-1-17.2. Accessed May 15, 2023. https://iga.in.gov/legislative/laws/2022/ic/titles/004/#4-12-1-17.2
5. Millions in tax dollars flow to anti-abortion centers in US. AP NEWS. Published February 5, 2022. Accessed May 15, 2023. https://apnews.com/article/abortion-business-health-nashville-personal-taxes-fffa6f6f86e6eaa448b8ea89087a1c46
6. Montoya MN, Judge-Golden C, Swartz JJ. The Problems with Crisis Pregnancy Centers: Reviewing the Literature and Identifying New Directions for Future Research. *IJWH*. 2022;Volume 14:757-763. doi:10.2147/IJWH.S288861
7. McKenna J, Murtha T. *Designed to Deceive: A Study of the Crisis Pregnancy Center Industry in Nine States*. The Alliance; 2022. Accessed May 14, 2023. https://alliancestateadvocates.org/crisis-pregnancy-centers/
8. Frasik C, Jordan C, McLeod C, Flink-Bochacki R. A mystery client study of crisis pregnancy center practices in New York State. *Contraception*. 2023;117:36-38. doi:10.1016/j.contraception.2022.08.004
9. Rosen JD. The Public Health Risks of Crisis Pregnancy Centers. *Perspectives on Sexual and Reproductive Health*. 2012;44(3):201-205. Accessed May 15, 2023. http://www.jstor.org/stable/42004128
10. Bryant AG, Narasimhan S, Bryant-Comstock K, Levi EE. Crisis pregnancy center websites: Information, misinformation and disinformation. *Contraception*. 2014;90(6):601-605. doi:10.1016/j.contraception.2014.07.003
11. Issue Brief: Crisis Pregnancy Centers. Published online October 2022. Accessed May 15, 2023. https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/cpc-issue-brief.pdf?la=en&hash=0E118FA8C462E25F8BE5DF9506941BBA
12. *CRISIS PREGNANCY CENTERS LIE: THE INSIDIOUS THREAT TO REPRODUCTIVE FREEDOM*. NARAL ProChoice America Accessed May 29, 2023. https://www.prochoiceamerica.org/wp-content/uploads/2017/04/cpc-report-2015.pdf
13. National Women's Law Center. *Crisis pregnancy centers are targeting women of color, endangering their health*. Published March 6, 2013.
14. Abortion Policy. Abortion Policy: Statement of Policy. Accessed May 15, 2023. https://www.acog.org/en/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy


**RELEVANT AMA AND AAFP POLICY:**

**AMA POLICY:**

**Truth and Transparency in Pregnancy Counseling Centers H-420.954**

| | |
|---|---|
| **Topic:** Pregnancy and Childbirth | **Policy Subtopic:** NA |
| **Meeting Type:** Annual | **Year Last Modified:** 2022 |
| **Action:** Modified | **Type:** Health Policies |
| **Council & Committees:** Board of Trustees | |

1. It is AMA's position that any entity that represents itself as offering health-related services should uphold the standards of truthfulness, transparency, and confidentiality that govern health care professionals.
2. Our AMA urges the development of effective oversight for entities offering **pregnancy**-related health services and counseling.
3. Our AMA advocates that any entity offering **crisis pregnancy** services
a. truthfully describe the services they offer or for which they refer—including prenatal care, family planning, termination, or adoption services—in communications on site and in their advertising, and before any services are provided to an individual patient; and
b. be transparent with respect to their funding and sponsorship relationships.
4. Our AMA advocates that any entity licensed to provide medical or health services to pregnant women
a. ensure that care is provided by appropriately qualified, licensed personnel; and
b. abide by federal health information privacy laws.
5. Our AMA urges that public funding only support programs that provide complete, non-directive, medically accurate health information to support patients' informed, voluntary decisions.

**AAFP Policy: Provider, Use of Term (Position Paper)**
The term "provider" levels distinctions and implies a uniformity of expertise and knowledge among health care professionals. The term diminishes those distinctions worthy of differentiation such as education, scope and range of ability. Generic terminology implies an interchangeability of skills that is inappropriate and erroneous, as well as conferring legitimacy on the provision of health services by non-physician providers that are best performed by, or under the supervision of, physicians. Academy policy clearly delineates different organizational roles for physicians and non-physician providers. Academy policy states that non-physician providers, "…should always function under the direction and responsible supervision of a practicing, licensed physician."1 Accordingly, any attempt to imply an interchangeability of expertise is derogatory to the profession, misleading to the consumer, and usurps the legitimate role and responsibility of the physician to oversee the activities of non-physician providers.

Academy policy also states that nurse practitioners and physician assistants, "…should only function in a collaborative practice environment under the direction and responsible supervision of a practicing, licensed physician."2,3 AAFP policy also states that payment for the services of non-physician professionals should be limited to those environments "…where services are provided in a collaborative practice arrangement."2

**References**


1. 2000-2001 AAFP Policies on Health Issues. "NON-PHYSICIAN PROVIDERS (NPPs) Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants."
2. 2000-2001 AAFP Policies on Health Issues. "NURSE PRACTITIONERS"
3. 2000-2001 AAFP Policies on Health Issues. "PHYSICIAN ASSISTANTS"

(2002) (2018 COD)

**AAFP Policy: Obstetric ultrasound Examination (Position Paper)**

Those who perform obstetric ultrasound examination must guard against potential drawbacks, including the following:

- Potential for misuse of the technology, particularly nonmedical uses 5,6
- Risk that easy availability will lead to overutilization
- Patients' unrealistic expectations related to outcomes or the power of the technology
- Possibility that increasing technological complexity will require additional training
- Ongoing interspecialty conflicts regarding the utilization of this technology

Under the Choosing Wisely campaign—a national effort to reduce waste in the health care system and avoid unnecessary or harmful tests and treatment—ACOG recommends that physicians should not perform prenatal ultrasounds for non-medical purposes (e.g., solely to create keepsake videos or photographs).5 ACOG's recommendation states: "While obstetric ultrasound has an excellent safety record, the U.S. Food and Drug Administration [FDA] considers keepsake imaging as an unapproved use of a medical device. The American Institute of Ultrasound in Medicine also discourages the non-medical use of ultrasound for entertainment purposes.

Keepsake ultrasounds are not medical tests and should not replace a clinically performed sonogram."5 In a standard first-trimester obstetric ultrasound examination, the uterus, cervix, adnexa, and cul de sac region should be examined.13,14 The presence, size, location, and number of gestational sac(s) should be evaluated, and gestational sac(s) should be examined for the presence of a yolk sac and embryo/fetus. When an embryo/fetus is present, crown-rump length and cardiac activity should be documented.

The ACOG practice guideline on ultrasound in pregnancy states the following qualifications for competence in obstetric ultrasound examination: "Physicians who perform, evaluate, and interpret diagnostic obstetric ultrasound examinations should be licensed medical practitioners with an understanding of the indications for such imaging studies, the expected content of a complete obstetric ultrasound examination, and a familiarity with the limitations of ultrasound imaging. They should be familiar with ultrasound safety and the anatomy, physiology, and pathophysiology of the pelvis, pregnant uterus, and fetus. All physicians who perform or supervise the performance of obstetric ultrasonography should have received specific training in obstetric ultrasonography."14
References:

5. Choosing Wisely®. Don't perform prenatal ultrasounds for non-medical purposes, for example, solely to create keepsake videos or photographs. Accessed April 6, 2018.

6. U.S. Food and Drug Administration. Avoid fetal "keepsake" images, heartbeat monitors. Accessed April 6, 2018.

13. American Institute of Ultrasound in Medicine. AIUM practice guideline for the performance of obstetric ultrasound examinations. J Ultrasound Med. 2013;32(6):1083-1101.

14. American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Obstetrics and American Institute of Ultrasound in Medicine. Practice bulletin no. 175: ultrasound in pregnancy. Obstet Gynecol. 2016;128(6):e241-e256.

Striving for Birth Equity: Family Medicine's Role in Overcoming Disparities in Maternal Morbidity and Mortality

Executive Summary