

The “Born-Alive Infants Protection Act” and Its Potential Impact on Medical Care and Practice

By Laura Hermer, J.D., L.L.M.
lhermer@central.uh.edu

What effect will the Born Alive Infants Protection Act of 2002 (BAIPA) have on the care and treatment of very premature infants? BAIPA made what at first glance appears to be an intuitive and probably unnecessary clarification of the definition of the words “person,” “human being,” “child,” and “individual” in United States law. The Act simply provides that the foregoing terms include all “born alive” infants, where a “born alive” infant is one who, after “complete expulsion or extraction from his or her mother . . . , at any stage of development, . . . breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.”¹ It further provides that it is irrelevant for the purpose of the definition “whether the umbilical cord has been cut, and . . . whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion.”²

One would presume that there should be no need at present for the federal government to make such a clarification in the law. The proposition that a viable infant who has been born alive should be treated as a person under the law (e.g., with respect to certain matters that occurred while in utero) has been accepted for many decades.³ It further comports generally with international standards; the World Health Organization, for example, uses a largely identical definition of “live birth” for its purposes.⁴

Certain specifics, such as whether the umbilical cord has been cut, also appear to do little to change present law.⁵ Even the provision including aborted but live-born infants would seem largely unnecessary. First, while there appear to be no solid statistics in the United States on the number of infants who survive attempted abortions, the number is likely miniscule.⁶ One British study examining a six-year period found only 31 cases, out of

¹ Born Alive Infants Protection Act of 2002 (BAIPA), Pub. L. No. 107-207, § 2, 116 Stat. 926 (codified at 1 U.S.C. § 8).

² 1 U.S.C. § 8(b).

³ See, e.g., *Pearson v. Carlton*, 18 S.C. 47, (1882); *Williams v. Marion Rapid Transit*, 152 Ohio St. 114, 128 – 29 (1949); *Woods v. Lancet*, 303 N.Y. 349 (1951); *Damasiewicz v. Gorsuch*, 197 Md. 417 (1951); *Amann v. Faidy*, 415 Ill. 422 (1953); *Steggal v. Morris*, 363 Mo. 1224 (1953). But see, e.g., *Harman v. Daniels*, 525 F.Supp. 798, 800 (W. D. Va. 1981) (finding no right for a child to recover for damages sustained in utero).

⁴ See, e.g., World Health Organization, *Health Status Statistics: Mortality*, <http://www.who.int/healthinfo/statistics/indunder5mortality/en/> (last viewed Sept. 12, 2006).

⁵ See, e.g., *Duncan v. Flynn*, 342 So.2d 123, 125 - 26 (1977) (discussing the state of the common law concerning whether the umbilical cord must have been cut while the infant was alive for the infant’s death to be actionable as murder).

⁶ It appears no testimony was proffered on this issue when the Act was being debated. Only five percent of the 1.29 million abortions in the United States in 2002 took place at or after 16 weeks gestation. See Alan Guttmacher Institute, *Facts on Induced Abortion in the United States* (2006), available at http://www.guttmacher.org/pubs/fb_induced_abortion.html. Particularly given its delicateness, it is

thousands, in which an infant was born alive following an attempted abortion.⁷ The infants all had attained a gestational age of at least 18 weeks.⁸ Second, and more saliently, it is difficult to imagine that any court would determine that the active killing of a fully delivered, living infant, even if the birth followed a termination attempt, was anything but murder.⁹

Yet BAIPA's supporters did believe the act was necessary. The legislative history indicates two primary areas of concern. First, they were concerned that it was necessary in light of *Stenberg v. Carhart*. *Carhart* struck down a Nebraska law that made a particular abortion procedure - intact dilation and extraction - illegal except to save the life of the mother.¹⁰ The Supreme Court held in relevant part that the law's failure to include an exception for the health of the mother and to sufficiently limit the law only to intact dilation and extractions rendered the statute unconstitutional.¹¹ The ruling deeply upset certain members of Congress, who found the abortion procedure unspeakably brutal and horrific and wished to ban it. As an outright ban would not pass constitutional muster under *Carhart*, it appears that they chose instead, at least preliminarily, to take an incremental approach by seeking to protect the lives of all infants born alive, even if the birth occurred in the process of an abortion. Presumably, the hope was to diminish the distinction between a later-term fetus that may be aborted and that same fetus who, if it emerges alive from its mother, must then be protected with the full force of the law.¹²

scarcely conceivable that any fetus could survive an abortion attempt before 16 weeks' gestation, if not later.

⁷ Shantala Vadeyar et al., *Neonatal Death Following Termination of Pregnancy*, 112 BRIT. J. OBSTETRICS & GYNAECOLOGY 1159, 1160 (2005). The study does not provide the total number of abortions that occurred in the relevant geographical area during that time. To allow a rough comparison with the U.S. statistics given above, approximately seven percent of all abortions in the United Kingdom (excluding Scotland) occurred at or after 15 weeks gestation. Department of Health, *Statistical Bulletin, Abortion Statistics: England and Wales* 1, 13 (2005), <http://www.dh.gov.uk/assetRoot/04/11/75/74/04117574.pdf>.

⁸ *Id.*

⁹ At least one physician has been successfully prosecuted for smothering to death a fetus that was born alive in the course of an attempted abortion. See *Showery v. State*, 690 S.W.2d 689 (Tex. App. – El Paso 1985). In this context, a case that was cited by a speaker who provided testimony in support of BAIPA did not quite stand for the proposition he implied it did. In *Floyd v. Anders*, 440 F.Supp. 535 (D.S.C., 1977), vacated, 440 U.S. 445, 99 S.Ct. 1200, 59 L.Ed.2d 442 (1979), the physician in question was being prosecuted for performing an abortion after 24 weeks gestation, in violation of South Carolina law then in effect. *Floyd*, 440 F.Supp. at 538. He was not being prosecuted for attempting to murder the live-born infant, which in fact survived for 20 days. *Id.* Yet Hadley Arkes claimed in his testimony before the House Judiciary Committee that the case posed the question “whether there’s an obligation to preserve the life of that child (that was born alive), and the answer tended by Judge Clement Haynsworth was no. That was not a termination. In other words, the right to an abortion entailed the right to an effective abortion for a dead child.” *Born Alive Infants Protection Act of 2000: Hearing on H.R. 4292 Before the H. Comm. on the Judiciary*, 106th Cong. 6 (2000) (testimony of Hadley Arkes, Professor, Amherst College).

¹⁰ An intact dilation and extraction is a late-term abortion procedure in which a physician dilates the cervix and then brings the fetus out feet-first up to the neck, at which point the physician crushes the fetus's skull in utero and evacuates the contents in order to remove the remainder of the body. See *Stenberg v. Carhart*, 530 U.S. 914, 938 - 39, 120 S.Ct. 2597, 147 L.Ed.2d 743, 68 USLW 4702 (2000).

¹¹ *Id.* at 938 - 39.

¹² In this context see, e.g., Nat'l Right to Life Council, “*I Am Not Answering These Questions!*” – A Senate Exchange on Birth and Partial-Birth, available at <http://www.nrlc.org/abortion/pba/notansweringboxersantorum.html> (last viewed Sept. 13, 2006). There also existed a largely theoretical worry about outright infanticide, as evidenced by the remarks of Robert

Second, certain members of Congress worried that physicians were not doing everything they could to resuscitate and otherwise preserve the lives of infants who survived abortion attempts, but instead were merely letting them die.¹³ Thus, for example, during a hearing concerning the Act, Representative Spencer Bachus questioned Jill Stanek, a nurse who testified that she had seen three infants born alive after attempted abortions, what differences in care a “wanted” versus “living, aborted” infant would receive.¹⁴ Elsewhere, Representative Sam Graves stated that “a child exhibiting these signs of a living, breathing little boy or girl should receive the full protection of law, rather than being left to die a horrible death.”¹⁵ Representative Stearns referenced the earlier testimony of Ms. Stanek, opining that the law would prohibit the practices Ms. Stanek allegedly encountered at her hospital.¹⁶

A memorandum issued last year by the Department of Health and Human Services addresses this concern. It instructs that all references to “child” in the federal Child Abuse Prevention and Treatment Act (CAPTA) “are to be read to include infants who are ‘born-alive’ . . .,” and that states’ laws and procedures regarding abuse and neglect must take account of this change.¹⁷ To help ensure there is no misunderstanding, the memorandum specifies that cases of “medical neglect,” “including withholding of medically indicated treatment from disabled infants with life-threatening conditions,” be reported to the proper authorities.¹⁸ Furthermore, each state must give its Child Protective Services the authority to take legal steps to ensure that medical care or treatment “necessary to prevent or remedy serious harm to the child” is provided, and to prevent such treatment from being withheld.¹⁹

Accordingly, the Centers for Medicare and Medicaid Services (CMS) issued guidance the same day about the interaction of BAIPA and the Emergency Medical Treatment and Active Labor Act (EMTALA).²⁰ The memorandum provides in relevant part that if an

George, Professor of Politics at Princeton University, who supported passage of BAIPA in an effort to prevent the implementation of suggestions such as that of Peter Singer, a Princeton bioethicist who once proposed that infanticide within a certain period after birth should be permitted. *Born Alive Infants Protection Act of 2000: Hearing on H.R. 4292 Before the H. Comm. on the Judiciary*, *supra* note 9.

¹³ See, e.g., *Born Alive Infants Protection Act of 2000: Hearing on H.R. 4292 Before the H. Comm. on the Judiciary*, *supra* note 9.

¹⁴ *Id.* She testified that aborted, live-born infants would be wrapped in a blanket and left to die, whereas premature “wanted” infants would receive intensive medical care to preserve their lives. *Id.*

¹⁵ 148 Cong. Rec. E526-02 (2002) (statement of Rep. Graves).

¹⁶ 148 Cong. Rec. H787-04 (statement of Rep. Stearns).

¹⁷ Dep’ of Health & Human Services, Admin. for Children and Families, *Program Instruction* (Apr. 22, 2005), www.acf.hhs.gov/programs/cb/laws_policies/policy/pi/pi0501.pdf. All 50 states participate in CAPTA.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ EMTALA provides that anyone who presents to the emergency department of a hospital must be given a medical screening examination, without regard to his or her ability to pay. See 42 U.S.C. § 1395dd(a) & (h) (West 2006). If the examination reveals an emergency medical condition – generally, one that immediately jeopardizes life, limb or organ – then the hospital must stabilize the condition, again without regard to the patient’s ability to pay. 42 U.S.C. 1395dd(b)(1)(A) & (e)(3)(A). The hospital may not transfer a patient with an emergency medical condition unless the patient requests it, or the medical benefits

infant is born alive in either a hospital's emergency department or elsewhere on its campus, and if either someone requests treatment on the infant's behalf or if a prudent layperson would conclude from the infant's appearance that it may be having a medical emergency, then

the hospital and physician could be liable for violating EMTALA for failure to provide ... a screening examination. ... If the hospital or its medical staff determined [from the screening examination] that the born-alive infant were suffering from an emergency medical condition, there would then arise an obligation to admit the infant, or to comply with either the stabilization requirement or the transfer requirement, or risk a finding of an EMTALA violation. This follows because the born-alive infant is a "person" and an "individual," ... and the stabilization and transfer requirements of EMTALA apply to "any individual" who comes to the hospital.²¹

These memoranda have significant implications for medical practice regarding not only live-born, aborted infants, but also arguably all infants born prematurely or with any disability, no matter how incompatible with life. Because of the clear connection the CAPTA memorandum makes between the failure to provide medical treatment and state child abuse and neglect laws, it appears that physicians and hospitals may be subject to a criminal charge of abuse and neglect should they withhold medical care from premature and/or disabled infants. Additionally, the EMTALA memorandum indicates they may also be subject to penalties under EMTALA for failure to provide stabilizing treatment.

The salient question is how the new rules will interact with present medical practice. While the CAPTA memorandum at times refers to providing "medically indicated" care, in one key instance that qualifier is left out.²² It provides that Child Protective Services must be able to take legal steps to ensure that medical care or treatment "necessary to prevent or remedy serious harm to the child."²³ This language significantly deviates from the language used elsewhere in the CAPTA regulations, which usually refer to "medically indicated" treatment, and provide a list of exceptions to what it means to withhold "medically indicated" care.²⁴ The failure of the memorandum to use the qualifier in that key location could arguably encourage a broad interpretation of the requisite medical care under the circumstances and the steps that may be taken to ensure it is provided.²⁵

of the transfer outweigh its risks. 42 U.S.C. § 1395dd(c)(1)(A). If a hospital violates EMTALA, it may be subject to significant monetary penalties and termination as a Medicare provider. 42 U.S.C. § 1395dd(d)(1).

²¹ Centers for Medicare and Medicaid Services, *Interaction of the Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002* 5 – 6 (2005), www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter05-26.pdf.

²² *Program Instruction*, *supra* note 17.

²³ *Id.*

²⁴ 42 C.F.R. § 1340.15(b)(2) (West 2006).

²⁵ For example, the memorandum provides that a state must provide "the authority for State child protective services to pursue any legal remedies as may be necessary to provide medical care or treatment for a child when such care or treatment is necessary to prevent or remedy serious harm to the child..." *Program*

The interpretation of the EMTALA memorandum, on the other hand, may be somewhat more certain. It provides that, if an infant presents to essentially any portion of the hospital campus and a prudent layperson believes it would need emergency medical care, it must be screened for an emergency medical condition.²⁶ If such a condition is found, then it must be stabilized. The duty is not optional. Thus, even an infant whose life was intended to be terminated must be screened and, if necessary, stabilized, if born alive. Here, the issue of futility may come into play. It appears likely that hospitals must provide emergency medical treatment under EMTALA even in the event that extraordinary treatment is futile.²⁷ However, once the hospital admits the patient, the hospital's EMTALA obligation ends.²⁸ At this point, providers acting in good faith may be able to discontinue aggressive stabilization efforts, should the infant's providers determine that further efforts are futile and should be abandoned.²⁹ The strong language in the memoranda, however, may result in resuscitation and stabilization efforts even where they are undesired by the parents and even perhaps against the providers' best medical and ethical judgments.³⁰

Because of these new instructions from the Department of Health and Human Services, BAIPA may alter medical practice with respect to the most fragile of newborn infants. It remains to be seen what effect it will have in actual practice.

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Instruction, supra note 19 (emphasis in original). In this context see, e.g., *Born Alive Infants Protection Act of 2000: Hearing on H.R. 4292 Before the H. Comm. on the Judiciary, supra* note 9 (testimony of Francis Sessions Cole, Professor of Pediatrics and Cell Biology, Washington University School of Medicine).

²⁶ *Interaction of the Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002, supra* note 21, at 5 – 6; see also 42 C.F.R. § 489.24(b)(1) & (2) (West 2006).

²⁷ See, e.g., *In the Matter of Baby "K,"* 16 F.3d 590, 596 - 97 (4th Cir. 1994).

²⁸ It appears likely that hospitals must provide emergency medical treatment even where such care is likely futile, but that once the hospital admits the patient, the hospital's EMTALA obligation ends. See 42 C.F.R. 489.24(d)(2); *Morgan v. N. Miss. Med. Center, Inc.* 403 F.Supp.2d 1115, 1130 (S. D. Ala. 2005); *Bryant v. Adventist Health Systems/West*, 289 F.3d 1162, 1168 (9th Cir.2002); *Bryan v. Rectors and Visitors of Univ. of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996).

²⁹ If it is decided that the hospital's decision to admit an infant (or any other emergency patient) was merely a pretext to avoid the hospital's EMTALA obligations, then the hospital may be found to have violated EMTALA. See 42 C.F.R. 489.24(d)(2); 68 Fed. Reg. 53222, 53245 (2003); *Interaction of the Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002, supra* note 21, at 5.

³⁰ Here, one can imagine more cases occurring along the lines of *Miller v. H.C.A., Inc.*, in which the Texas Supreme Court held that a health care provider may provide medical care to a child, even over a parent's express refusal to consent to such treatment, where the care is necessary to prevent the immediate death of the child. *Miller v. H.C.A., Inc.*, 118 S.W.3d 758, 767 - 68 (Tex. 2003). In this case, the defendant hospital provided intensive life-sustaining care and treatment to an infant born emergently at 23 week's gestation. The infant ultimately survived but, according to the court, was "legally blind, suffered from severe mental retardation, cerebral palsy, seizures, and spastic quadriplegia in her limbs. She could not be toilet-trained and required a shunt in her brain to drain fluids that accumulate there and needed care twenty-four hours a day. The evidence further demonstrated that her circumstances will not change." *Id.* at 768. She still survives to this day.