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Hearing of the House Judiciary Committee Regarding H.R. 962,

"Born-Alive Abortion Survivors Protection Act"

September 10, 2019, 1:00 p.m.
HVC-215

September 10, 2019

Hon. Steve Scalise, Republican Whip
Hon. Ann Wagner, Sponsor of H.R. 962
Hon. Chris Smith, Pro-Life Caucus Chairman
Honorable Members
United States House of Representatives
Minority Hearing on H.R. 962, Born-Alive Abortion Survivors Protection Act
House Visitor Center, 215
Washington, DC 20515

Republican Whip Scalise, Congresswoman Wagner, Congressman Smith, and Members of Congress:

As a neonatologist with a background in medical ethics, I wish to present the medical standard of care every baby who is born alive is supposed to receive. This standard of care is as equally applicable to prematurely born babies as it is to those born at term. The medical standard of care is sufficiently wise to include an intrinsic understanding that not every baby can be rescued, yet that never negates our obligation to care for these most vulnerable of little ones. It is a fallacy to equate the degree of "wantedness" with the baby's degree of humanness. The baby, at every stage of development, is never anything other than a human being complete with his or her own unique DNA blueprint—the guide to an entire lifetime of maturation. Whether planned or not, whether desired or not, whether perfectly formed or not, the first diagnosis of every single person ever born is, "It's a baby!", and no additional diagnoses or problems can ever change this. Which is exactly why, every baby who is born alive at any gestational age, should ethically receive the same medical standard care.

As a way to further explain why, regardless of a baby's birth circumstances, they should all receive the same standard of care, the following is a series of responses to relevant questions.

1. **What is the medical standard of care for tending to all newborn babies?**
   At birth, all babies are to be evaluated and receive the necessary degree of intervention that is outlined by the Neonatal Resuscitation Program (NRP).[1] This guideline is based on the evidence compiled by the American Academy of Pediatrics (AAP) and the American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care of the Neonate. This program was devised to help the medical personnel "learn the cognitive, technical, and teamwork skills…to resuscitate

[1]Weiner, Gary M., Jeanette Zaichkin, and John Kattwinkel. *Textbook of Neonatal Resuscitation*. Elk Grove Village, IL: American Academy of Pediatrics, 2016.

and stabilize newborns"[2]. This is the medical standard of care all newborn infants are to receive. This is the standard of care medical staff are expected to provide.

2. **Is NRP applicable to premature babies?**
   Absolutely. In fact, because premature babies will encounter greater/more frequent challenges than term babies in transitioning from intra-uterine to extra-uterine life, the NRP program specifically addresses how to resuscitate our sickest, most immature babies.

3. **How immature can a baby be, and the staff attempt to resuscitate?**
   The current edge of viability is approximately 22 to 23 weeks gestation[3,4,5,6,7]; however, (while there is not guarantee of our success), overall our ability to resuscitate these young lives, continues to improve. There is now published evidence of resuscitation and survival of very premature infants as young as 21 weeks 4 days gestation.[8,9] Let me be clear, I personally have cared for babies at 22 weeks, but not at 21 weeks. At the edge of viability, it is with the utmost humility that we must evaluate the specific nuances of each

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[2] Ibid, pg 3

[3] Rysavy MA *et al.*, Between-Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants, *N Engl J Med* 372, 1801, May 7, 2015
Groundbreaking *New England Journal of Medicine* study demonstrated that babies delivered as young as 22 weeks can survive, and active intervention for treatment greatly improves their survival.

[4] "Survival Rate May Be Improving for Extremely Preterm Infants," National Institutes of Health, last modified February 15, 2017
NIH press release for paper describing increased survival, with lower neurological concerns, for preterm babies delivered at 22-24 weeks who received active care.

[5] Younge N *et al.*, Survival and Neurodevelopmental Outcomes among Periviable Infants. *N Engl J Med* 376, 617, 2017
Paper describing survival without neurological impairment for extremely pre-term babies delivered at 22-24 weeks.

[6] Shah PS, Neonatal Intensive Care—The Only Constant is Change, *N Engl J Med* 376, 694, 2017
Editorial in *New England Journal of Medicine* describing the survival of ever younger pre-term babies, when given active treatment.

[7] Mehler K *et al.*, Survival Among Infants Born at 22 or 23 Weeks' Gestation Following Active Prenatal and Postnatal Care. *JAMA Pediatr.* 170, 671, 2016
Paper studies increasing survival rates of pre-term infants, and finds that 60% of infants born at 22 weeks who receive active hospital treatment will survive.

[8] A. Pawlowski, 'Miracle baby': Born at 21 weeks, she may be the most premature surviving infant, *Today*, updated Nov 21, 2018
Lyla Stensrud was born at 21 weeks 4 days, has grown into a healthy little girl.

[9] Ahmad KA *et al.*, Two-Year Neurodevelopmental Outcome of an Infant Born at 21 Weeks' 4 Days' Gestation, *Pediatrics* 2017;140(6):e20170103
Published case study of Lyla's birth

individual case—ethical medical decision making is complex, and given the risks involved, just because we can does not automatically mean that we should.

4. **Does following the NRP guidelines always help?**
   Even in the hands of the best prepared and equipped NICU team, there are babies who are beyond our capacity to heal. The NRP guidelines acknowledges these situations:

   > "The birth of extremely premature babies and those with significant chromosomal abnormalities or congenital malformations frequently raises difficult questions about the initiation of resuscitation. Although general recommendations can guide practice, each situation is unique, and decision making should be individualized"[10]

   Because of our limitations, it is with a blend of humility, respect, and loving concern that the neonatologist should approach each individual patient with the recognition that the same diagnosis can present very differently in different babies and have different ramifications in different situations. We do not have the ability to save or heal every baby, thus the NRP appropriately, does not recommend that every baby must be resuscitated.

5. **Which babies are not automatically resuscitated?**
   The babies with the issues stated by the NRP guidelines whose diagnoses have been confirmed beyond a reasonable doubt, and the family as well as the members of the health care team agree that initiating resuscitation will cause greater harm than good. If this is not the case, then consistent with the standard of care for all other human beings, we always attempt to resuscitate the baby, and then sort out any underlying pathology.

   In cases where our technology is insufficient to help the baby, it is appropriate to provide "comfort" or palliative care. The goal of this kind of care is to help the baby and their family live well with what we do not have the ability to "fix". In such cases we not only try to avoid uncomfortable tests and procedures that will either solve nothing or prolong suffering, we also strive to minimize IV tubing and monitors that may interfere with a family's ability to simply hold their little one. It is paramount to remember: the baby's first and primary diagnosis is, it's a baby. All the other diagnoses are secondary and do not ever negate the first one. Because of diagnosis number one, (it is a baby), we are always obligated to care, whether or not we have the ability to heal.

6. **Have I ever intentionally ended the life of a baby?**
   No. I do not ever intentionally end anyone's life.

7. **What about the babies whose parents don't want them?**

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[10] Weiner, Gary M., Jeanette Zaichkin, and John Kattwinkel. *Textbook of Neonatal Resuscitation*. Elk Grove Village, IL: American Academy of Pediatrics, 2016, pg 269.

In ethics there is something called the Principle of Double Effect.[11] This principle explains that reaching a good goal (helping a woman who is also pregnant), can never be ethically accomplished by a bad means (intentionally killing someone—the woman who has a problem, someone who may have harmed her, or the baby). None of these deaths are ethical ways to solve the mother's problems. Likewise, the "wantedness" of the baby also does not determine if it is ethically permissible to *intentionally* kill him or her, either before or after birth.

Yes, there are instances of fetal demise which occur as a consequence of keeping the mother safe. This is ethically and medically very different from the intentional destruction of another person's life.

Whether or not the mother herself wants to live, whether or not she wants the baby to live, murder is always intrinsically wrong.

8. **Why should we treat a newborn baby—particularly a prematurely born baby with these kinds of "rights".**
   My embryology textbook[12] teaches that from the moment the sperm and egg combine (fertilization), the new arrangement of the DNA is neither that of the mother or the father—it is a new and unique road map that not only directs how the new person will develop, their DNA guides their physiologic function and development for the rest of their earthly life. Our lives are a continuous spectrum: baby, toddler, child, adolescent, adult, elderly. No one argues that this continuum ever pauses while we briefly transform into something else (a tree, a rock). This continuous spectrum of life begins months before birth; I've never seen a woman give birth to a brick, every single time it is a human being. What stage of development the baby arrives in, in this sense, does not matter, it is a human being and as a physician I promised to tend to these newborns—sometimes I get to help heal, always, there is an opportunity to care.

9. **Have I always held this view?**
   No. My view was informed and changed by the medical, scientific reality of caring for premature babies for over 20 years. The medical truth has been a huge part of what changed my mind from being pro-abortion to being against it.

Neither I nor the NICU team can always "fix" or heal the newborn little ones who come to us; but there is no such thing as a human being who is literally worth less than another. Even if there is a decision to not resuscitate due to severe prematurity or congenital abnormality, this is never equivalent to do not care or an excuse to abandon either the baby or the mother. Care is the minimum I owe to both of them. Whether the birth is premature or term, the people I meet are always worthy of this, without exception.

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[11] McIntyre, Alison. "Doctrine of Double Effect." Stanford Encyclopedia of Philosophy. Stanford University, December 24, 2018. https://plato.stanford.edu/entries/double-effect/.
[12] Moore, Keith L., T. V. N. Persaud, and Mark G. Torchia. *Before We Are Born: Essentials of Embryology and Birth Defects*. Philadelphia: Saunders, 2016.

In summary: being born alive qualifies all human babies to receive the same standard of medical care. I offer this testimony not as way to degrade those whose hearts and minds have not yet learned what I have had the privilege of to witness. I do offer this testimony in the hope that by consistently saving babies, we will simultaneously better care for their mothers, which will extend to an entire family tree of affected loved ones. I have learned that babies save us, if we will have the courage to consistently save them.

Sincerely,

Robin Pierucci, M.D., M.A.