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Understanding the harmful nature of "born-alive" abortion bills

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Summary

The "Born-Alive Infants Protection Act" of 2002 granted any infant born alive at any stage of development and by any method (natural or induced labor, cesarean section, or induced abortion) the rights of a person.[1] In the years since, Republican senators have proposed several "Born-Alive" bills at the federal and state levels that attempt to expand on the 2002 law by mandating that physicians perform lifesaving medical interventions on those infants born alive after an abortion attempt and institute felony charges, incarceration, and/or steep fines for providers who do not comply and witnesses who fail to report them.[2–10] The "Born-Alive" bills are based on false claims that create and perpetuate myths about people getting abortions and the providers who care for them; they are a transparent attempt by anti-abortion advocates to further reduce abortion access. In mandating medical interventions for infants born alive after an abortion attempt, some of whom may have a condition that would result in neonatal death, "Born-Alive" bills require clinicians to perform unnecessary medical procedures that often prevent families from spending what little time they may have with their infants bonding and providing comfort measures.

The history of the "born-alive" bills

The original "Born-Alive Infants Protection Act" passed Congress via a unanimous Senate vote in 2002 and defined "born alive" as: "the complete expulsion or extraction from his or her mother of that member, at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion".[1]

Republican Senator Marsha Blackburn introduced the "Born-Alive Abortion Survivors Protection Act" in 2017. This bill used the 2002 definition of "born alive," but referred specifically to infants born alive after an abortion attempt and expanded the responsibilities of healthcare providers to: "exercise the same degree of care as reasonably provided to any other child born alive at the same gestational age, and ensure that such child is immediately admitted to a hospital". The bill also established mandated reporting of healthcare providers who fail to comply with the standards detailed in the bill.[11] It was never passed by the Senate, and in 2019, Republican senator Ben Sasse introduced another, very similar "Born-Alive" bill that was meant to address "passive" situations in which providers are "backing away" from medical interventions after an abortion attempt.[12] The bill was defeated by the Senate.

In September 2020, President Trump signed an executive order on "Protecting Vulnerable Newborn and Infant Children". The order makes no direct mention of abortion but instead triangulates three existing laws (the Emergency Medical Treatment and Labor Act, the Rehabilitation Act, and Born-Alive Infants Protection act of 2002) to assert that infants born alive at any gestational age and by any method are entitled to "meaningful and non-discriminatory access to medical examination and services, with the consent of a parent or guardian, when they present at hospitals receiving Federal funds".[5]

Extra-uterine viability and later abortion

The gestational age (GA) at which a fetus is considered viable depends on numerous factors and is different for every pregnancy; the likelihood of a fetus surviving outside the uterus can only be determined by assessing the individual pregnant person and fetus (see our factsheet, "The Science of 'Viability'" for more information).

About 93% of abortions at or after 21 weeks' GA in the United States (US) are performed surgically.[13] When an abortion is performed at 20 weeks of gestation or later, the World Health Organization recommends the use of a pre-procedure feticidal agent such as potassium chloride or digoxin to stop the fetal heartbeat;[14] fetal demise is typically confirmed before proceeding with the abortion procedure, making a live birth highly unlikely. Some abortion clients, especially those with maternal indications and/or who are pregnant with a fetus that has been diagnosed with a fatal condition, may choose to forego the medication that causes fetal demise prior to the abortion in order to spend time with the infant after its birth.

Understanding the statistics and reports?

Both national and state-level data underscore that live births following abortion are extremely rare. The Centers for Disease Control and Prevention conducted a systematic review of infant deaths using National Vital Statistics System Mortality Data from 2003 to 2014 and found that 143 (0.05%) infant deaths were clearly classified as involving an induced abortion and two thirds of these (ie. 97 cases) involved a maternal complication or multiple congenital indications.[15] Almost 90% of the 143 infants (n=128) died within four hours of birth, while nine lived between five and 23 hours and the remaining six lived for one day or more.[15]

Six US states require reporting on live births following an abortion attempt; review of the most recent reports available from these states corroborates the rarity of such events. Arizona, Florida, and Minnesota each reported ten or fewer live births following abortion

during the report year, while Michigan, Oklahoma, and Texas reported none.

The most comprehensive and current abortion surveillance data indicate that infants are born alive following induced abortion only in a very small number of cases, and that the majority of these cases involve fetal and/or or maternal indications; in these instances, the time families are able to spend with their infants after birth is precious.

Data from the six states that mandate reporting

State	Year(s)	Total abortions	Live births	Proportion
Arizona[16–18]	2017–2019	38,068	37	0.097%
Florida[19–21]	2018–2020	214,385	16	0.007%
Minnesota[22–26]	2015–2019	49,824	19	0.038%
Michigan[27–29]	2017–2019	80,649	0	0.0%
Oklahoma[30]	2013–2019	31,749	0	0.0%
Texas[31]	2013–2019	281,214	3	0.001%

Why born alive bills are superfluous and cause harm

Born-Alive bills are invoked as a pretext for protecting the lives of infants; in reality, existing laws and healthcare providers' obligation to provide appropriate medical care to their clients already accomplish this. These bills serve instead to position politicians between healthcare providers and families as a transparent attempt to further criminalize abortion. They rely on inflammatory rhetoric that belittles the lived experiences of families and healthcare providers and has no basis in medical or scientific fact. Pregnant people deserve access to a full spectrum of reproductive health services, including abortion care, throughout their pregnancies; every pregnant person's circumstances differ, and their decisions around whether to continue a pregnancy are complex and deeply personal. These decisions should always be guided by client choice and the best possible scientific evidence, and not by political rhetoric.

Though President Trump's 2020 executive order makes no direct mention of abortion, he uses similarly false and inflammatory rhetoric, claiming that some hospitals, "refuse the required medical screening examination and stabilizing treatment or otherwise do not provide potentially lifesaving medical treatment to extremely premature or disabled infants, even when parents plead for such treatment".[5] This is not only an insult to healthcare providers—who are legally and contractually obligated to provide adequate and appropriate medical care to all clients—it has no basis in medical fact. Ethical considerations regarding neonatal resuscitation are complex and vary greatly case by case. According to guidelines set forth by the American Heart Association (AHA) and the American Academy of Pediatrics (AAP) in 2015, "initiation of resuscitation is not an ethical treatment option and should not be offered" when physicians believe there is no chance for survival, including when infants are born at less than 22 weeks GA or born with certain malformations and indications.[32] Further, the AHA and AAP guidelines recommend that caregivers allow parents to participate in decision-making about whether resuscitation is the best course of action when there is a high risk of mortality or significant burden of morbidity for the baby, including birth at 22–24 weeks GA and in the presence of some serious congenital malformations and indications.[32]

FAQ

Why might people have later abortions around or past the time of viability?

Abortions later in pregnancy occur most often when legal and logistical obstacles hamper more timely access to abortion for the pregnant person; a smaller percent of later abortion are due to conditions that may result in neonatal death or health problems in the pregnant person that are not detected or diagnosed until later in pregnancy.[33] Read the LAI fact sheet on Who needs abortion later in pregnancy in the United States, and why? to learn more.

What happens when an infant with severe indications or with a fatal diagnosis is born alive after an abortion?

In cases where infants are born with severe indications or cannot survive outside the uterus, parents may choose to provide comfort or palliative care rather than undertaking futile measures;[34] this decision is made by the parent(s) in conjunction with the doctor after considering all possible medically-appropriate and compassionate treatment options. Comfort or palliative care ensures that the infant is not in pain and can include respiratory support (oxygen), nutrition, warmth, pain medication, and skin-to-skin contact.[35,36]

Why might parents decide with their doctors not to intervene with medical care?

Parent(s) together with their doctors may decide to forego medical interventions when a baby is born with a condition with a fatal diagnosis if such interventions are determined to be futile and could prolong the infant's suffering or pain and discomfort without improving their chance of survival. The parent(s) in these cases may want to spend their infant's short life providing comfort care, bonding, and grieving rather than initiating unnecessary medical interventions. "Born-Alive" bills would force clinicians to attempt extraordinary measures to prolong these infants' short lives, sometimes against the wishes of their parents, ultimately taking up precious time that families could use to bond with their infant, grieve, and find closure.

What are the implications for the doctor-client relationship if these proposed bills were to become law?

While these bills do not criminalize the person giving birth, they affect pregnant people and their families by positioning politicians between them and their doctors, intimidating providers with the threat of criminal penalties, and interfering with sound medical decisions and the delivery of ethical and high-quality care. These bills also generate and perpetuate misconceptions that providers who perform later abortions are carrying out unethical practices rather than providing safe, legal, and high-quality care, ultimately disincentivizing evidence-based and compassionate medicine.

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