

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004  
(A-24)

Introduced by: Thomas W. Eppes, MD, Mark D. Townsend, MD MHCM, and Billie L. Jackson, MD.

Subject: The Rights of Newborns that Survive Abortion

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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- 1 Whereas, our American Medical Association recognizes healthcare as a human right; and  
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3 Whereas, the AMA has policy 2.2.4(d) Treatment Decisions for the Seriously Ill Newborn, which  
4 states, "Initiate life sustaining and life enhancing treatment when the child's prognosis is largely  
5 uncertain"; and  
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7 Whereas, AMA Code 2.2.1(I) calls on the physician to seek consultation when there is a  
8 reversible life-threatening condition and the patient (If capable) or parents or guardian refuses  
9 treatment the physician believes is clearly the patient's best interest (ii) there is disagreement  
10 about what the patient's best interest is; and  
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12 Whereas, CDC data shows from 2003-14 at least 143 babies died after being born alive after an  
13 abortion procedure, but did not count newborns that survived attempted abortions; and  
14  
15 Whereas, the number of children that live after an abortion procedure is only reported now by  
16 anecdotal reports; and  
17  
18 Whereas, cited in the Annotations section of the Code of Ethics, "Children Not Meant to Be:  
19 Protecting the Interests of the Child When Abortion Results in Live Birth", 6 Quinnipiac Health  
20 states in conclusion that "in these situations, abortive parents and physicians should not solely  
21 decide the child's best interests."; therefore be it  
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23 RESOLVED, that our American Medical Association amend the current policy right for an  
24 abortion to "a woman's right to abortion as only the right to terminate the pregnancy" (Modify  
25 Current HOD Policy); and be it further  
26  
27 RESOLVED, a newborn that survives an abortion procedure has a right to reasonable medical  
28 care. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

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## Relevant AMA Policy:

### AMA Policy 2.2.4 Treatment Decisions for Seriously Ill Newborns

Making treatment decisions for seriously ill newborns is emotionally and ethically challenging for both parents and health care professionals. Decisions must take into account the newborn's medical needs; the interests, needs, and resources of the family; and available treatment options. Decision makers must also assess whether the choice made for the newborn will abrogate a choice the future individual would want to make for him- or herself, i.e., whether the choice will undermine the child's right to an "open future." Providing information and other resources to support parents or guardians when they must make decisions about their child's care and future is a key responsibility for physicians and other health care professionals.

Decisions not to initiate care or to discontinue an intervention can be emotionally wrenching in any circumstance, but may be particularly so for a seriously ill newborn. Physicians are in a position to help parents, families, and fellow professionals understand that there is no ethical difference between withholding and withdrawing treatment—when an intervention no longer helps to achieve the goals of care or promote the quality of life desired for the patient, it is ethically appropriate to withdraw it.

To help parents formulate goals for their newborn's care and make decisions about life-sustaining treatment on their child's behalf, physicians should:

- a. Inform the parents about available therapeutic options, the nature of available interventions, and their child's expected prognosis with and without treatment.
- b. Help the parents formulate goals for care that will promote their child's best interests in light of:
  - i. the chance that the intervention will achieve the intended clinical benefit;
  - ii. the risks involved with treatment and nontreatment;
  - iii. the degree to which treatment can be expected to extend life;
  - iv. the pain and discomfort associated with the intervention; and
  - v. the quality of life the child can be expected to have with and without treatment.
- c. Discuss the option of initiating an intervention with the intention of evaluating its clinical effectiveness after a given amount of time to determine whether the intervention has led to improvement. Confirm that if the intervention has not achieved agreed-on goals, it may be withdrawn. Physicians should recognize, and help parents appreciate, that it is not necessary to have prognostic certainty to withdraw life-sustaining treatment, since prognostic certainty is often unattainable and may unnecessarily prolong the infant's suffering.
- d. Initiate life-sustaining and life-enhancing treatment when the child's prognosis is largely uncertain.
- e. Adhere to good clinical practice for palliative care when life-sustaining treatment is withheld or withdrawn.
- f. Provide access to counseling services or other resources to facilitate decision making and to enable parents opportunity to talk with others who have had to make similar decisions.
- g. Seek consultation through an ethics committee or other institutional resource when disagreement about the appropriate course of action persists.

### AMA Policy 2.2.1 Pediatric Decision Making

As the persons best positioned to understand their child's unique needs and interests, parents (or guardians) are asked to fill the dual responsibility of protecting their children and, at the same time, empowering them and promoting development of children's capacity to become independent decision makers. In giving or withholding permission for medical treatment for their children, parents/guardians are expected to safeguard their children's physical health and well-being and to nurture their children's developing personhood and autonomy.

But parents' authority as decision makers does not mean children should have no role in the decision-making process. Respect and shared decision making remain important in the context of decisions for minors. Thus, physicians should evaluate minor patients to determine if they can understand the risks and benefits of proposed treatment and tailor disclosure accordingly. The more mature a minor patient is, the better able to understand what a decision will mean, and the more clearly the child can communicate preferences, the stronger the ethical obligation to seek minor patients' assent to treatment. Except when immediate intervention is essential to preserve life or avert serious, irreversible harm, physicians and

parents/guardians should respect a child's refusal to assent, and when circumstances permit should explore the child's reason for dissent.

For health care decisions involving minor patients, physicians should:

- a. Provide compassionate, humane care to all pediatric patients.
- b. Negotiate with parents/guardians a shared understanding of the patient's medical and psychosocial needs and interests in the context of family relationships and resources.
- c. Develop an individualized plan of care that will best serve the patient, basing treatment recommendations on the best available evidence and in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify value to patients of different approaches to care.
- d. Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents/guardians in ways to avoid behaviors that will put the child or others at risk.
- e. Provide a supportive environment and encourage parents/guardians to discuss the child's health status with the patient, offering to facilitate the parent-child conversation for reluctant parents. Physicians should offer education and support to minimize the psychosocial impact of socially or culturally sensitive care, including putting the patient and parents/guardians in contact with others who have dealt with similar decisions and have volunteered their support as peers.
- f. When decisions involve life-sustaining treatment for a terminally ill child, ensure that patients have an opportunity to be involved in decision making in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardians understand the prognosis (with and without treatment). They should discuss the option of initiating therapy with the intention of evaluating its clinical effectiveness for the patient after a specified time to determine whether it has led to improvement and confirm that if the intervention has not achieved agreed-on goals it may be discontinued.
- g. When it is not clear whether a specific intervention promotes the patient's interests, respect the decision of the patient (if the patient has capacity and is able to express a preference) and parents/guardians.
- h. When there is ongoing disagreement about patient's best interest or treatment recommendations, seek consultation with an ethics committee or other institutional resource. (IV, VIII)