Proponent testimony HB 2313

House Health and Human Services Committee

March 8, 2023

Chairwoman Landwehr and Members of the Committee,

My name is Doctor Kelly Byrd and I am grateful for the opportunity to speak with you all today in support of House Bill 2313. I was born and raised in Wichita and am currently living in Leawood. I am a board-certified general pediatrician practicing emergency medicine in Overland Park.

I have experience taking care of infants born healthy and full term, as well as infants born prematurely & infants born with complex medical conditions that are not compatible with a long life outside the womb. I have training in treating critically ill newborns and firsthand experience in caring for these infants.

A common factor for all these infants that I have had the privilege of caring for is that they are, in fact, alive, and therefore warrant compassionate and complete care to the best scope of my abilities. Each one of these patients is a unique life and therefore deserving of my complete and compassionate care. However, what that care entails can vary based on the gestational age, medical conditions, and physical presentation of the infant.

The physician or other provider performing the elective abortion procedure may be frustrated with the outcomes of the procedure – that being a living infant now outside the womb – however the scientific fact remains. While this was not the provider's intended outcome, the provider should still be required to respond appropriately. He or she has been trained to care for infants – training that is required by all in perinatology – and they should be expected to extend this level of care to the infant regardless of opinion or bias.

The order of this bill appropriately aligns with how physicians are trained to approach a patient. Before discussing the treatment plan, or "care", one must understand the history and exam of the patient, or in this instance the newly born infant.

The abortionist should be aware of the infant's gestation age, any known anomalies, and pertinent maternal history. These are important elements of the infant's history and care. The abortionist would also be aware of what was just inflicted on the infant, as in what trauma it endured during the preceding procedure. These are important elements of the infant's history and care.

But as I read through the bill it is the definition of "born alive" that resonates with me and correlates to an important piece – the physical exam. Starting on line 18 it lists 4 mutually exclusive physical exam findings that could be used to identify the infant as alive: breathes, has a beating heart, pulsation of the umbilical cord, OR definite movement of voluntary muscles. It struck me that infants do all 4 of these things in utero as well. No, the lungs do not exchange oxygen, however diaphragmatic movement occurs, and pulmonary tissue expands and contracts allowing for the development of pulmonary vasculature.

With a knowledge of the infant's history and exam, there are 3 concepts of neonatal care that are important to discuss here.

First, let's walk through the standard of care for a term newborn infant born by uncomplicated delivery. Healthy infant care, in general, is a high touch, low tech process. Warm the baby. Dry the baby. Stimulate the baby. Suction the baby. Many of these actions are nothing more than innate human interaction. These are behaviors that do not require expensive equipment or complicated training.

Infants born premature or with other maternal-fetal complications clearly have higher care needs. There is generally a highly structured, algorithmic approach to the care of these infants that utilizes the basic tenants of a neonatal resuscitation protocol. This is a similar structure to a CPR algorithm but takes into account the unique physiology of a newborn. That vast majority of medical providers in newborn care are required to be certified in this protocol. The advances in medicine now allow many of these sick infants to be saved. These life-saving measures can include supplemental oxygen, assisting respirations, use of incubator or warming device, and administration of intravenous fluids and medications.

It is important to address another type of care that may be indicated and appropriate in some of these deliveries - palliative or hospice care. Approximately 13% of elective abortions are due to an in-utero diagnosis of chromosomal abnormality or fetal anomaly. Clinicians are trained to appropriate care in the setting of such conditions based on anatomy at presentation. This bill provides this same treatment paradigm for infants born alive after an attempted abortion. This bill **does not** exclude comfort care measures if it is a reasonable and medically sound treatment decision given the infant's presentation.

The next piece, as required in this bill, in a medical emergency – be it the newly born or the elderly – is to call 911. We teach this to our toddlers and enforce it throughout life. Why? Because you are increasing the level of care based on the acuity at presentation. Most elective terminations take place outside the safety net of a hospital setting therefore transfer will be necessary to provide further supportive measures.

Expecting that the standard of care practiced but most providers be extended to those infants that have survived an attempted abortion procedure is a clear and educated extension of the Hippocratic oath. I am not here to debate life inside a womb, but instead to focus on life outside the womb. Each and every living patient deserves thoughtful, expert care. Failure to provide appropriate care, based on the presenting patient, is a direct violation of our moral and professional obligation as medical professionals.

Thank you and I ask the committee to pass HB 2313 out favorably.

Kell Byrd

kmb.peds@gmail.com