

Fetal Pain Legislation: Is it Viable?

Teresa Stanton Collett*

"Patients may be frightened by antiabortion protesters or materials falsely alleging . . . that abortion causes fetal pain. Giving them facts and valid sources of information usually eliminates these fears."¹

Whether a human fetus experiences pain during an abortion has been the subject of heated debate within medical, legal, and political circles for over two decades. In the 1980's President Reagan's statement that "when the lives of the unborn are snuffed out [by abortion], they often feel pain, pain that is long and agonizing,"² and the release of a controversial film entitled "The Silent Scream"³ were merely two of the events that kept this issue in public view. Federal and state legislative efforts to enact "partial birth abortion bans" during the last half of the 1990's reignited public debate over fetal pain.⁴ Two and a half years ago, the argument intensified when the world caught a glimpse of life within the womb through the picture of Samuel Armas' tiny hand apparently grasping the finger of the perinatal surgeon who was repairing the spine of the twenty-one week old fetus.⁵ As the twenty-first century begins, there are some indications that advances in medical knowledge are resolving the debate in medical circles surrounding fetal pain, and the resolution favors its acknowledgment at some point prior to birth.⁶

* Professor of Law, South Texas College of Law, Houston, Texas. I am grateful for the thoughtful critiques of this article by Dr. Watson A. Bowes, Jr., Dr. Byron Calhoun, Jan Mort, and Elisa Ugarte, Esq.

¹ Anne Baker et al., *Informed Consent, Counseling, and Patient Preparation in* Maureen Paul et al., *A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION* (1999) at 27.

² President Ronald Reagan, Remarks at The National Religious Broadcasters Convention, Washington D.C., January 30, 1984.

³ THE SILENT SCREAM (American Portrait Films 1984) (script and visual images available at www.silentscream.org).

⁴ These efforts are described in James Bopp, Jr. & Curtis R. Cook, *Partial Birth Abortion: The Final Frontier of Abortion Jurisprudence*, 14 *ISSUES IN L & MED.* 3 (1998).

⁵ The photo can be viewed at <<http://www.fetal-surgery.com/fs-pics.htm>>. In utero fetal surgery made the news recently with reports of successful heart surgery on a 23-week-old fetus. Denise Grady, *Operation on Fetus's Heart Valve Called a "Science Fiction" Success*, THE N.Y. TIMES (Feb. 25, 2002) available at <http://www.nytimes.com/2002/02/25/health/25FETA.html>.

⁶ See Fran Lang Porter, et al., *Pain and Pain Management in Newborn Infants: A Survey of Physicians and Nurses*, 100 *Pediatrics* 626 (1997) ("ample data now indicate that the neurophysiologic basis for pain is

The purpose of this article is to explore the nature and extent of the medical community's emerging consensus on the issue of fetal pain, and consider whether this consensus should be reflected in American law. Part I discusses the current state of medical knowledge regarding fetal experiences of pain. Part II describes recent changes in medical standards to acknowledge the possibility of fetal pain. The federal constitutionality of laws directed at minimizing or protecting the human fetus from pain is discussed in Part III. Common objections to fetal pain legislation are identified and answered in Part IV. This article concludes with a call for legal requirements that women seeking abortions be informed of the possibility that the fetus may experience pain after twelve weeks gestation, and offered fetal anesthetic or modified abortion procedures to minimize any possibility of fetal pain.

I. The Science of Fetal Pain

Physicians, like lawyers, must carefully define their terms prior to seeking an answer to any particular question. Before attempting to answer the question of whether a human fetus "feels pain," it is necessary to establish what "feels" and "pain" mean in this context.⁷ Much of the divergence in medical opinion on the existence of fetal pain can be explained by noting the absence of a common definition of these key terms. The three competing definitions revolve around whether "feels" means to have a "conscious appreciation of" or merely experience, and how such appreciation or experience can be ascertained.

established by the end of the second trimester of pregnancy"); British Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Report of a Working Party* (Oct. 1997) (practitioners who undertake termination of pregnancy at 24 weeks or later should consider the requirements for fetal analgesia or sedation prior to fetocide); American Academy of Pediatrics & Canadian Paediatric Society, Committee on Fetus and Newborn, *Prevention and Management of Pain and Stress in the Neonate*, 105 *Pediatrics* 454 (Feb. 2000) ("By late gestation, the fetus has developed the anatomic, neurophysiologicla, and hormonal components necessary to perceive pain."); Commission of Inquiry into Fetal Sentience (the Rawlinson Report) (1996) ("the fetus may be able to experience suffering from around 11 weeks of development") available at www.care.org.uk; Royal College of Physicians and Surgeons of Alberta, *Policy on Termination of Pregnancy* (as amended June 2000) ("In some circumstances, in order to reduce suffering where intervention is necessary to terminate pregnancy after 20 weeks/0 days, patient and physician may consider fetocide prior to initiating the termination procedure"). Additional sources are collected at *Can a fetus feel pain?*, www.religioustolerance.org/abo_pain.htm.

Conscious Appreciation

Some physicians restrictively define "feels" to mean only those responses that reflect some self-awareness or "conscious appreciation of pain."⁸ In the absence of consciousness, they argue that the most researchers can conclude is that the human fetus "reacts to physical stimulation."⁹ "Whether or not the fetus feels what we understand as pain hinges not on its biological development, but on its conscious development. Unless it can be reasonably demonstrated that the fetus has a conscious appreciation of pain after 26 weeks' gestation, then its response to noxious stimulation are still essentially reflex responses, exactly as those prior to 26 weeks."¹⁰

While representing a minority view among physicians as evidenced by the use of pain medication for certain *in utero* procedures performed on the fetus,¹¹ this reasoning was embraced by the federal district court in *Women's Medical Professional Corp. v. Voinovich*.¹² In the absence of medical testimony that the fetus "experiences a conscious awareness of pain," the Court concluded that the state could not justify a ban on D&X (or "partial birth")

⁷ Adrian R. Lloyd-Thomas & Maria Fitzgerald, *Reflex Responses Do Not Necessarily Signify Pain*, 313 Brit. Med. J. 797 (1996).

⁸ Testimony of Dr. Stuart Derbyshire, Commission of Inquiry into Fetal Sentience (March 6, 1996) (available at www.care.org.uk/issues/fs/derbyshr.htm). See also Zbigniew Szawarski, *Commentary: Probably No Pain in the Absence of "Self"*, 313 British Med. J. 796 (1996) (available at www.bmj.com upon search of archives for "fetal pain").

⁹ Hugh Muir, *When does pain begin?*, THE DAILY TELEGRAPH (LONDON), Sept. 28, 1996 at 8. "Groups such as the Birth Control Trust, whose director Ann Furedi co-wrote one of the papers, admit that the foetus reacts to physical stimulation, such as procedures involving needles, from around 12 to 14 weeks. They agree that stress levels can rise in these circumstances. But they argue that the mere reaction to physical stimuli does not automatically indicate the feeling of pain." *Id.*

¹⁰ Stuart Derbyshire & Ann Furedi, "*Fetal Pain*" is a Misnomer, 313 BRIT. MED. J. 795 (1996). Also contained in Stuart Derbyshire, *There is no such thing as 'fetal pain'*, LIVING MARXISM (Sept. 1996) available at www.informinc.co.uk/LM/LM93/LM93-Taboos.html. See also Adrian R. Lloyd-Thoma & Maria Fitzgerald, *For Debate: Reflex Responses Do Not Necessarily Signify Pain*, 313 Brit. Med. J. 797 (1996) available at www.bmj.com from archives with search for "fetal pain."

¹¹ See generally Charles B. Caldwell et al., *Anesthesia and Monitoring for Fetal Intervention* at 149 in Michael R. Harrison et al., THE UNBORN PATIENT (3rd ed. 2001), Alan C. Santos & Mieczysla Finster, *Perinatal Pharmacology*, at 61 in Samuel C. Hughes et al., SHNIDER AND LEVINSON'S ANESTHESIA FOR OBSTETRICS (2002), and Mark A. Rosen, *Anesthesia for Fetal Procedures and Surgery* at 285 in Sol M. Shooder, et al., ANESTHESIA FOR OBSTETRICS 3d ed. (1993).

¹² 911 F.Supp. 1051 (S.D. Ohio 1995).

abortion as preventing unnecessary cruelty to the fetus.¹³ In essence, the court reasoned that absent "mindful awareness" by the fetus of noxious stimuli,¹⁴ there can be no pain, and in the absence of pain, there can be no cruelty.¹⁵

Behavioral and Physiological Responses

This requirement of consciousness as a predicate to the experience of pain is rejected by other physicians. These doctors argue that observed physiological¹⁶ and behavioral responses¹⁷ to stimuli are reliable indicators of pain--particularly for those individuals who are incapable of the self-reporting that seemingly is required for identification of self-awareness or consciousness.¹⁸ While conceding the lack of perfect correspondence between behavioral and physiological indicia and the actual experience of pain, these physicians note that self-reports of pain and the actual experience of pain also lack a perfect

¹³ Id. at 1074. In *Stenberg v. Carhart*, Justice Kennedy provided a layperson's description of the D&X procedure:

In the D&X, the abortionist initiates the woman's natural delivery process by causing the cervix of the woman to be dilated, sometimes over a sequence of days. The fetus' arms and legs are delivered outside the uterus while the fetus is alive; witnesses to the procedure report seeing the body of the fetus moving outside the woman's body. At this point, the abortion procedure has the appearance of a live birth. . . . With only the head of the fetus remaining in utero, the abortionist tears open the skull. According to Dr. Martin Haskell, a leading proponent of the procedure, the appropriate instrument to be used at this stage of the abortion is a pair of scissors. Witnesses report observing the portion of the fetus outside the woman react to the skull penetration. The abortionist then inserts a suction tube and vacuums out the developing brain and other matter found within the skull. The process of making the size of the fetus' head smaller is given the clinically neutral term "reduction procedure." Brain death does not occur until after the skull invasion, and, according to Dr. Carhart, the heart of the fetus may continue to beat for minutes after the contents of the skull are vacuumed out. The abortionist next completes the delivery of a dead fetus, intact except for the damage to the head and the missing contents of the skull.

530 U.S. 914 at 958-59 (Kennedy, J. dissenting)(internal citations omitted).

¹⁴ 911 F.Supp. at 1073.

¹⁵ Compare the arguments of Princeton Professor Peter Singer. "Killing a newborn baby -- whether able-bodied or not -- I think, is never equivalent to killing a being who wants to go on living. It's different. It's still -- almost always wrong, but it's different, anyway." PBS *Religion & Ethics NewsWeekly* interview, 1999 available at <http://www.pbs.org/wnet/religionandethics/transcripts/singer.html>.

¹⁶ Physiological changes include changes in heart rate or the increased production of stress hormones. Parliamentary Office of Science & Tech., *Advice to the Department of Health in Fetal Awareness*, Feb. 1997, available at www.parliament.uk/post/pn094.pdf.

¹⁷ Behavioral changes include withdrawal of affected body parts, crying, and facial expressions. Id.

¹⁸ See K.J.S. Anand and Kenneth D. Craig, *Editorial: New Perspectives on the Definition of Pain*, 67 PAIN 3 (1996) ("Because self-report may be absent or a faulty source of inference, nonverbal behavioral information is often needed and used for pain assessment.") See also American Academy of Pediatrics and the Canadian

correspondence.¹⁹ In the absence of the ability to self-report, physical evidence of pain-like responses should be viewed as "infantile forms of self-report and should not be discounted as 'surrogate measures' of pain."²⁰ In the face of physiological and behavioral responses to noxious stimuli, these physicians assert that the burden of proof shifts to those who challenge the existence of fetal pain rather than having to be borne by those who seek to alleviate it.²¹

Neurological Development

Physicians subscribing to the view that fetal pain should be presumed in cases involving physiological and behavioral responses often reinforce their argument by referring to the development of the fetal nervous system. The spinal cord and brain develop within the neural tube of the human embryo. This tube forms within the first two to three weeks of gestation.²² Within four weeks after conception, the primitive structures of the brain are recognizable.²³ The internal structure of the brain will continue to develop throughout the

Paediatric Society, *Prevention and Management of Pain and Stress in the Neonate*, 105 PEDIATRICS 454 (2000), available at www.aap.orgpolicy/re9945.html.

¹⁹ K.J.S. Anand and Kenneth D. Craig, *Editorial: New Perspectives on the Definition of Pain*, 67 PAIN 3 (1996).

²⁰ *Id.* at 5 (1996). See also Vivette Glover & Nicholas Fisk, *Do Fetuses Feel Pain?*, 313 BRIT. MED. J. 796 (1996) (fetal stress responses may be the best indices of pain currently available).

²¹ John Wyatt, *When Do We Begin to Feel the Pain?*, THE GUARDIAN (LONDON), Oct. 24, 1996 at 2. "While responsible scientists have a duty to emphasize what they don't know, doctors have a duty of care that should lead them to err on the side of caution. If there is a possibility of lasting harm, we must act in the best interest of our patients even when the evidence is ambiguous. We should, in the words of Glover [a clinical scientists in the psychobiology group at Queen Charlotte's and Chelsea Hospital in London] 'give the foetus the benefit of the doubt', and extend the use of effective pain relief to surgical procedures before birth." *Id.* See also S. Vanhatalo & O. Van Nieuwenhuizen, *Fetal Pain*, BRAIN AND DEVELOPMENT May 24, 2000 (proper response to evidence of fetal response to noxious stimuli is to avoid or treat any possibly noxious stimuli rather than speculate on the possible emotional experiences of pain by the fetus or neonate). See also, Mark Owens, *Pain in Infancy: Conceptual and Methodological Issues*, 20 PAIN 213 at 230 (Nov. 1984) ("If the assumption that infants experience pain is correct, then the benefits are measured by a decrease in needless human suffering. The cost of a mistaken assumption of infant pain would be to waste the effort. Costs and benefits come down squarely on the side of assuming that infants do experience pain. The burden of proof should be shifted to those who maintain that infants do not feel pain.").

²² Parliamentary Office of Science & Tech., *Key Stages in the Development of the Fetal Nervous System and Brain in Fetal Awareness*, Feb. 1997, available at www.parliament.uk/post/pn094.pdf.

²³ Parliamentary Office of Science & Tech., *Key Stages in the Development of the Fetal Nervous System and Brain in Fetal Awareness*, Feb. 1997, available at www.parliament.uk/post/pn094.pdf.

pregnancy and during the first year of infancy, eventually resulting in a complex structure that regulates many distinct physical processes.²⁴

In addition to the brain and spinal cord, the human nervous system involves an intricate network of peripheral receptors and transmitters. The receptors specifically involved in discerning pain are called nociceptors. Nociceptors are naked nerve endings that lie free in the skin and have their cell bodies in the dorsal root ganglia.²⁵ They respond to pressure, thermal and chemical stimuli, and transmit their sensory signals to the spinal cord (and ultimately to the brain) via cutaneous nerve fibres.²⁶ The network of nociceptors and fibres develop in the period from seven to twenty weeks gestation, beginning with the skin of the face, continuing to the soles of the hands and feet, and ultimately covering the entire body.²⁷ The fibres are connected to the central nervous system via a network of synapse-like connections to the cells of the fetal dorsal horn in the spinal cord.²⁸ Impulses received by the dorsal horn are transmitted to the various parts of the brain via neural and chemical connections.²⁹

When received by the brain, the impulses enter the thalamus. The thalamus registers the impulse and, if the impulse is identified as one of organic pain, physiologically signals the motor nerves to initiate the body's complex reflexive response to pain.³⁰ After interconnection, the thalamus may also forward the initial impulse to the cortex of the brain

²⁴ Id.

²⁵ J.A. Rushford, Pain Perception in Malcolm I. Levine & Richard J. Lilford, Sr., FETAL & NEONATAL NEUROLOGY AND NEUROSURGERY (1995) at 601.

²⁶ Id.

²⁷ Phil Anand & D.B. Carr, *The Neuroanatomy, Neuophysiology, and Neurochemistry of Pain, Stress and Analgesia in Newborns and Children*, 36 ACUTE PAIN IN CHILDREN 795 at 798 (Aug. 1989).

²⁸ J.A. Rushford, Pain Perception in Malcolm I. Levine & Richard J. Lilford, Sr., FETAL & NEONATAL NEUROLOGY AND NEUROSURGERY (1995) at 602.

²⁹ K.J.S. Anand, *The Applied Physiology of Pain* in K.J.S. Anand and P.J. McGrath, PAIN IN NEONATES (1993) at 40.

³⁰ Richard S. Snell, CLINICAL NEUROANATOMY: A REVIEW WITH QUESTIONS AND EXPLANATIONS 138 (3rd ed. 2001) (“A vast amount of sensory information (except smell) converges on the thalamus and is integrated through the interconnections between the nuclei. The resulting information pattern is distributed to other parts of the central nervous system.”)

for more complex processing including psychological reaction and directed physical responses.³¹ Both the thalamus and cortex are recognizable in the basic brain structure from about six weeks gestation. They continue to grow in size and internal structure throughout the pregnancy.³² The thalamus, however, develops and interconnects with the nervous system much earlier than the cortex. By twelve weeks of gestation the thalamus is sufficiently mature to respond to impulses received from the sensory network.³³ Only at twenty weeks or beyond is the interconnection between the thalamus and the cortex sufficiently developed for the cortex to receive the impulses transmitted from the network via the thalamus.³⁴

From the perspective of neurological development, the key to answering the question of whether fetuses experience pain depends primarily upon the development and function of the various regions of the brain. While simple reflex responses can be observed as early as seven weeks of gestation, there is no involvement of the brain. In the absence of any brain activity there can be no perception of pain, according to the current consensus of the medical community.³⁵ Where medical opinion divides is over the question of whether pain perception by the human fetus is controlled exclusively by the cortex or whether the thalamus and lower brain stem can generate perceptions of pain.

Some physicians argue that the earlier development of the thalamus and lower brain stem is sufficient for pain perception. Citing evidence obtained through observation of anencephalic and hydrocephalic infants who have no or minimal cortex development, these

³¹ Id.

³² Parliamentary Office of Science & Tech., *Key Stages in the Development of the Fetal Nervous System and Brain in Fetal Awareness*, Feb. 1997, available at www.parliament.uk/post/pn094.pdf.

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³⁴ Medical Research Council, *Report of the MRC Expert Group on Fetal Pain*, §3.3 (Aug. 28, 2001) available at http://www.mrc.ac.uk/b3/index/publications/research_reviews/fetal_pain_summary_report.htm.

“Connections from the thalamus to the cortex begin to form at about 20 weeks gestation (Glover and Fisk, 1999) and continue to mature along with other cortical connections well into childhood and adolescence.” Id.

³⁵ Commission on Inquiry into Fetal Sentience, *Human Sentience Before Birth* sec. 5.2.1.

experts argue that pain perception is not dependant upon established connections from the thalamus to the cortex, but can exist after the thalamus establishes its connection with the sensory network.³⁶ This connection can be established as early as twelve weeks of gestation. Thus some experts would date possible pain perception at twelve to thirteen weeks.³⁷

Other physicians assert that the cortex-thalamus connection is essential to the experience of pain. Since the earliest this connection is established is between twenty and twenty-four weeks of gestation, these experts assert that only those fetuses of twenty or more weeks of gestation are capable of experiencing pain.³⁸ This position seems to dominate current medical thinking as evidenced by the recent policy positions on administering anesthetic or performing feticide prior to abortions performed during or after twenty weeks of gestation.³⁹

II. *Recent Changes in Medical Standards to Acknowledge the Possibility of Fetal Pain*

While advocates involved in the abortion debate had long argued over the question of whether a human fetus feels pain,⁴⁰ on July 9, 1994 *Lancet*, a highly respected British

³⁶ Commission on Inquiry into Fetal Sentience, *Human Sentience Before Birth* sec. 5.3.1. See also Stephen G. Waxman, CORRELATIVE NEUROANATOMY 125 (24th ed. 2000) ("The thalamus (rather than the sensory cortex) is thought to be the crucial structure for the perception of some types of sensation, especially pain, and the sensory cortex may function to give finer detail to the sensation.") (emphasis added). This conclusion, although distinguishable, is consistent with the statement of the American Academy of Pediatrics that "[t]he decision [to administer anesthesia to neonates undergoing surgical procedures] should not be based solely on the infant's age or perceived degree of cortical maturity." Amer. Acad. Pediatrics, *Policy Statement: Neonatal Anesthesia*, 80 PEDIATRICS 446 (Sept. 1987) available at www.aap.org/policy/01730.html.

³⁷ Commission on Inquiry into Fetal Sentience, *Human Sentience Before Birth* sec. 8.1. See also *Growing Pains*, THE LONDON TELEGRAPH (June 26, 2001) (reporting that 80% of British neuroscientists responding to survey believed that the fetus should receive pain control after eleven weeks of gestation).

³⁸ E.g. Medical Research Council, *Report of the MRC Expert Group on Fetal Pain*, §3.3 (Aug. 28, 2001) available at http://www.mrc.ac.uk/b3/index/publications/research_reviews/fetal_pain_summary_report.htm.

³⁹ The British Royal College of Obstetricians and Gynaecologists recommend that prior to the termination of a pregnancy during or after 24 weeks of gestation, practitioners consider the need for fetal analgesia and sedation. Andrea O'Donnell, *And Before Birth?*, 349 *Lancet* 546 (1997) citing British Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Report of a Working Party* (Oct. 1997). "In order to reduce suffering" the College of Physicians and Surgeons of Alberta (Canada) recommend "feticide prior to initiating the termination procedure" during or after twenty weeks of gestation through intracardiac injection of KCl into the fetus in utero.

⁴⁰ See John T. Noonan, Jr., *The Experience of Pain by the Unborn*, in Thomas W. Hilgers et al., NEW PERSPECTIVES ON HUMAN ABORTION (1981); and Cristine Russell, *Physician Group Supports President on*

medical journal, published an article that seemingly changed the tenor of the debate. In *Fetal Plasma Cortisol and β -endorphin Response to Intrauterine Needling*,⁴¹ researchers reported the results of a study investigating fetal hormonal response to intrauterine needling. Summarizing the implications of their results, the authors wrote, "These data suggest that the fetus mounts hormonal stress response to invasive procedures. They raise the possibility that the human fetus feels pain in utero, and may benefit from anesthesia or analgesia for invasive procedures."⁴²

This sparked a lively debate within the British medical community, and resulted in numerous investigations into the question of whether human fetuses feel pain. In May, 1995 the Department of Health for the United Kingdom commissioned "an update on current scientific knowledge" by Professor Maria Fitzgerald.⁴³ Based on a review of all scientific literature then available, she concluded that a human fetus could only perceive pain after the neural connections are established to the cortex during or after the 26th week of gestation.⁴⁴

In January, 1996, a private British organization, the Christian Action, Research, and Education Trust ("CARE Trust") created the Commission of Inquiry into Fetal Sentience.⁴⁵

After almost a year of collecting and evaluating evidence,⁴⁶ the Commission found:

Almost everyone now agrees that unborn babies have the ability to feel pain by 24 weeks after conception and there is a considerable and growing body of evidence that the fetus may be able to experience suffering from around 11 weeks of development. Some commentators point out that the earliest

Fetal Pain; Human Nervous System Early Development in Life, Group of Abortion Opponents Says, The Washington Post A6 (Feb. 14, 1984).

⁴¹ Xenophon Giannakouloupoulos, et al., *Fetal Plasma Cortisol and β -endorphin Response to Intrauterine Needling*, 344 LANCET 77 (July 9, 1994).

⁴² Xenophon Giannakouloupoulos, et al., *Fetal Plasma Cortisol and β -endorphin Response to Intrauterine Needling*, 344 LANCET 77 (July 9, 1994).

⁴³ Parliamentary Office of Science & Tech., *Key Stages in the Development of the Fetal Nervous System and Brain in Fetal Awareness*, Feb. 1997, available at www.parliament.uk/post/pn094.pdf.

⁴⁴ Id.

⁴⁵ Id. The Commission is also referred to by some commentators as the "Rawlinson Commission" in reference to the fact that it was chaired by the Right Honorable Lord Rawlinson of Ewall, PC QC. Stuart Derbyshire, *There is no such thing as 'fetal pain'*, LIVING MARXISM (Sept. 1996) available via the Internet at www.informinc.co.uk/LM/LM93/LM93-Taboos.html.

⁴⁶ John Wyatt, *When Do We Begin to Feel the Pain?*, THE GUARDIAN (LONDON), Oct. 24, 1996 at 2.

movement in the baby has been observed at 5.5 weeks after conception, and that it may be able to suffer from this stage.⁴⁷

Based upon this finding the Commission recommended that from the early stages of gestation the fetus be protected from potentially painful procedures by the use of adequate anesthesia.⁴⁸

In July, 1996, the All-Party Parliamentary Pro-Life Group also produced a paper on fetal pain, which concluded that "the anatomical structures in the fetal nervous system necessary for the appreciation of pain are 'present and functional before the tenth week of intrauterine life.'"⁴⁹

Responding to these and other reports that the human fetus exhibited pain-like responses in utero, the Royal College of Obstetricians and Gynaecologists of Great Britain established a working party to determine whether a fetus might be aware of pain, and if so, what the implications of that determination might be on diagnostic and therapeutic procedures carried out on the fetus, as well as termination of pregnancy when the fetus is not expected to live.⁵⁰ In October, 1997 the Royal College issued its Working Party Report on Fetal Awareness. Based upon the physiological and behavioral evidence, the Working Party recommended that practitioners who undertake procedures directly on the fetus or who undertake termination of a pregnancy at 24 weeks or later should consider the requirements of fetal analgesia or sedation prior to the procedure.⁵¹

⁴⁷ Commission of Inquiry into Fetal Sentience, *Human Sentience Before Birth*, sec. 2 (summary) at www.care.org.uk/resouce/pub/fs.fs02.htm.

⁴⁸ Id. at sec. 8 (recommendations).

⁴⁹ Parliamentary Office of Science & Tech., *Key Stages in the Development of the Fetal Nervous System and Brain in Fetal Awareness*, Feb. 1997, available at www.parliament.uk/post/pn094.pdf. See also Hugh Muir, *When does pain begin?*, THE DAILY TELEGRAPH (LONDON), Sept. 28, 1996 at 8. "The society's [Society for the Protection of the Unborn Child] current line on foetal pain is based on research by Dr. Peter McCullagh, of the Australian National University in Canberra, and published in July by the All Party Parliamentary Pro-life Group. . . . Dr. McCullagh argues that it is also possible to make a judgment [about the existence of fetal pain] by establishing the presence of nerve and brain faculties that register pain in developed humans. He concludes that these faculties are likely to be developed by the tenth week of life." Id.

⁵⁰ Royal College of Obstetricians and Gynaecologists, Description of Working Party Report on Fetal Awareness at www.rcog.org.uk/bookshop/bookshelf.htm.

⁵¹ Id. See also David James, *Recent Advances: Fetal Medicine*, 316 Brit. Med. J. 1580 (May 23, 1998).

In 1999, the British Department of Health requested the Medical Research Council review the report of the Royal College and make recommendations as to areas where further scientific research was needed.⁵² As a result of their study, members of the Council's expert panel found that the sensory pathways and connections to the cortex necessary for pain perception are present or begin to form at twenty weeks gestation.⁵³ This has prompted calls for the Royal College to move its recommendation concerning use of fetal analgesia in fetal surgery or abortions back from twenty-four weeks to twenty weeks.⁵⁴

This would be consistent with policy of the College of Physicians and Surgeons of Alberta, Canada. In the summer of 2000, the Alberta College modified its policy on termination of pregnancy to "reduce suffering where intervention is necessary to terminate pregnancy after 20 weeks/0 days" by recommending that the fetus be killed via intracardiac injection of potassium chloride prior to initiating the termination procedure.⁵⁵

III. *Constitutionality of American Laws that Seek to Protect the Fetus from Pain*

In the United States, questions regarding fetal pain are entangled in the debate over abortion. Typically those who identify themselves as "prolife" have maintained that the fetus feels pain, while those who embrace the label "prochoice" have argued that fetal pain is a myth.⁵⁶ As early as the 1970's some states enacted laws seeking to minimize fetal suffering.⁵⁷ The constitutionality of these statutes have been reviewed by the courts in two contexts; statutes requiring women be informed of the possibility of fetal pain, and statutes restricting or prohibiting particular methods of abortion in an attempt to minimize fetal pain.

⁵² Medical Research Council, *Summary of Report on Fetal Pain*, Background (Aug. 28, 2001) available at <http://www.mrc.ac.uk/index/publications-publications/publications-research_reviews/publications-fetal_pain_summary_report.htm>.

⁵³ Id at §3.3.

⁵⁴ See Roger Highfield, *Unborn child can feel pain at 20 weeks, say researchers*, THE DAILY TELEGRAPH 2 (Aug. 28, 2001).

⁵⁵ College of Physicians and Surgeons of Alberta, *Termination of Pregnancy*, amended June, 2000.

⁵⁶ *What About Abortion Victims?*, THE NEW AMERICAN (Oct. 8, 2001). See Gregg Easterbrook, *What Neither Side Wants You to Know. Abortion and Brian Waves*, THE NEW REPUBLIC 21 (Jan. 31, 2000).

Under the current abortion jurisprudence of the United States Supreme Court, it appears that statutes informing women of the possibility of fetal pain would be constitutionally permissible,⁵⁸ while statutes restricting or prohibiting particular methods of abortion in order to minimize or avoid fetal pain would not.⁵⁹

Statutes Restricting or Mandating Particular Methods of Abortion

In *Stenberg v. Carhart*, the United States Supreme Court examined a Nebraska law prohibiting the use of "an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery."⁶⁰ In holding the statute unconstitutional, the majority found that the law effectively outlawed both dismemberment and partial birth abortions.⁶¹ Read broadly, the prohibition unduly burdened women's ability to obtain abortions in the second half of pregnancy, and therefore violated the Constitution.⁶² Justice Breyer, writing for the majority, explained that the statute also failed constitutional review because it contained no exception for performing the procedure when necessary to sustain the health of the woman.⁶³ In their concurrence Justices Stevens and Ginsburg argued that the statute was irrational, and that the state could not justify a ban on any particular abortion procedure as advancing its interest in potential human life, since no lives were saved.⁶⁴

Similarly mandating fetal anesthetic or feticide prior to mid or late-term abortions may be attacked as irrational. A statute mandating modification of abortion procedures or administration of fetal anesthetic to preclude the possibility of fetal pain saves no lives. The state's interest in the protection of women's physical health is not advanced,⁶⁵ and courts may

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⁵⁸ See *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 882 (1992)(Pennsylvania statute requiring physician provide truthful information to women is not an undue burden on the right to obtain an abortion).

⁵⁹ See *Stenberg v. Carhart*, 530 U.S. 914 (2000)(Nebraska law prohibiting D&X procedure found unconstitutional).

view any claim that the information advances the emotional or psychological well-being of women with some skepticism.⁶⁶

Even assuming the courts recognize the state's interest in limiting fetal suffering as substantial,⁶⁷ in order to survive constitutional review any law mandating fetal anesthetic or modified procedures would have to contain an exception for the health of the mother, and the effect of such an exception is a subject of substantial debate.⁶⁸ The constitutionality of law mandating fetal anesthetic would be enhanced by limiting the law to abortions occurring after viability, yet viability and inception of the capacity to feel pain are not simultaneous,⁶⁹ leaving some cases where fetal suffering would occur. These objections suggest that the better legislative approach is a statute informing women of the possibility of fetal pain and offering them the opportunity to direct the use of fetal anesthetic.

Informed Consent Type Statutes

Research revealed only one case involving constitutional review of a statute requiring women be informed of fetal pain. In *Charles v. Carey*,⁷⁰ a federal court of appeals reversed a trial court's refusal to grant a preliminary injunction against the enforcement of Illinois statutes governing abortion. One of the provisions at issue required physicians inform

⁶⁰ 530 U.S. at

⁶¹ 530 U.S. at

⁶² Id. at

⁶³ Id. at

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⁶⁵ See *Planned Parenthood of Wisc. v. Doyle*, 162 F.3d 463 (7th Cir. 1998)

⁶⁶ Compare the summary of research and bibliographies related to post-abortion regret prepared by the Elliot Institute, found at <<http://www.afterabortion.org>>, with the information provided by the National Abortion Federation at <<http://www.prochoice.org/>>.

⁶⁷ See *Women's Medical Corp. v. Ohio*, 162 F.Supp.2d 929, 936 n. 7 (S.D. Ohio 2001)(assuming validity of state's interest in minimizing fetal pain).

⁶⁸ See Kevin Walsh, Note, *Harv. L. Rev.* (forthcoming).

⁶⁹ Viability is now considered to be achieved generally in the 24th week of gestation, while research dates the ability to experience fetal pain as arising earlier in the pregnancy.

⁷⁰ 627 F.2d 772 (7th Cir. 1980).

patients of any reasonable medical certainty of organic pain⁷¹ to the fetus that might result from the particular abortion method to be employed, and of available ways to control such pain. The statute provided criminal penalties for physicians who recklessly, knowingly, or intentionally disregard its requirements. Relying upon the United States Supreme Court's opinion in *Planned Parenthood of Missouri v. Danforth*,⁷² the Court of Appeals found that the Illinois informed consent statutes unconstitutionally intruded into the physician/patient relationship. In addressing the provisions requiring a woman be informed of the possibility of fetal pain the court stated:

The uncontroverted medical testimony in the record at this stage describes this information as "medically meaningless, confusing, medically unjustified, and contraindicated, causing cruel and harmful stress to ... patients." The defendants have submitted no evidence to rebut the plaintiffs' characterization of this information as false and unwarranted. Even assuming, therefore, that the State may further at all stages of pregnancy its asserted interest in "humane disposition of the fetus," a question we do not decide, the record now before us indicates that this particular informational requirement furthers no such purpose.⁷³

At the conclusion of subsequent proceedings, the federal district court, following the lead of the appellate court, struck down the portion of the Illinois statute that required physicians inform women of the possibility that a fetus would experience pain when certain abortion techniques were utilized.⁷⁴ Relying upon the United States Supreme Court's reasoning in *Akron I*,⁷⁵ the district court held that the Illinois requirement was a direct burden on the abortion decision and therefore unconstitutional.⁷⁶ The continuing viability of this decision, however, is suspect in light of advances in medical knowledge regarding fetal pain

⁷¹ "Organic pain is a physiological or neurological response to noxious (harmful or damaging) stimuli." William F. Colliton & John Cavanaugh-O'Keefe, *Fetal Pain: An Agonizing Reality* 1 (1996).

⁷² 428 U.S. 52 (1976).

⁷³ 627 F.2d at

⁷⁴ 579 F.Supp. 464, at 470 (N.D. Ill. 1983).

⁷⁵ 462 U.S. 416 (19).

⁷⁶ 579 F.Supp. at 470.

and the U.S. Supreme Court's repudiation of much of the reasoning and holding of *Akron I* in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.⁷⁷

In *Casey*, the Court addressed the constitutionality of informed consent legislation at length. However, no single standard of review for abortion legislation commanded the support of a majority of the justices. According to Justices Rehnquist, White, Scalia, and Thomas, the proper test is whether the state law at issue is rationally related to a legitimate state interest in regulating the exercise of the liberty interest of the woman in obtaining an abortion.⁷⁸ Justices O'Connor, Kennedy, and Souter opined that the proper test is whether the law imposes an undue burden on the woman's liberty interest in obtaining an abortion. A law imposes an undue burden when it "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."⁷⁹ Justice Stevens asserted the proper standard was whether the law sought to influence a woman's choice (therefore unconstitutional), or merely enhances the deliberative quality of the woman's choice (constitutional). Neutral regulations on the health aspects of her decision would also be constitutional in Stevens' opinion.⁸⁰ Justice Blackmun would have evaluated "informed consent" laws under strict scrutiny requiring that the state show that the limitation "is both necessary and narrowly tailored to serve a compelling governmental interest."⁸¹ Because seven justices concurred in upholding the informed consent aspects of the Pennsylvania statutes, and because the "undue burden" standard was the most protective of the woman's asserted liberty interest, lower courts have utilized the "undue burden" analysis as the proper

⁷⁷ 505 U.S. 833 (1992) at 882.

⁷⁸ *Casey* at 966.

⁷⁹ *Casey* at 877.

⁸⁰ *Casey* at 917.

⁸¹ *Casey* at 934.

standard for reviewing abortion legislation.⁸² This interpretation is consistent with the Supreme Court's instruction in prior cases regarding the treatment of plurality opinions.⁸³

Two types of information requirements were at issue in *Casey*: 1) requirements that a physician give particular information to the woman (i.e. risks of abortion and childbirth, and the probable gestational age of the child), and 2) requirements that the woman be informed of the availability of information regarding fetal development and resources for adoption and abortion alternatives. These requirements were addressed separately by the plurality opinion.

The Pennsylvania requirement that a woman be informed of the probable gestational age of the child was upheld in *Casey* because of the state's "important" interest in potential life, and because of the state's interest in protecting the psychological well-being of women seeking abortions. "Nor can it be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision."⁸⁴ However, the gestational age requirement could also be defended as protecting the woman's physical health, since the gestational age of the child is a relevant consideration in the selection of abortion technique and impacts the probability of post-operative complications.⁸⁵

The *Casey* court also upheld Pennsylvania's requirement that a woman be informed of the availability of state prepared materials describing fetal development and alternatives to abortion.

⁸² E.g. *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 at 166-67 (4th Cir. 2000)(regulations to address medical and safety aspects of abortion do not constitute an undue burden); and *Women's Medical Center of NW Houston v. Bell*, 248 F.3d 411 (5th Cir. 2001)(undue burden test is proper standard for review of abortion clinic regulations).

⁸³ "When a fragmented court decides a case and no single rationale explaining the result enjoys the assent of five Justices, 'the holding of the Court may be viewed as that position taken by those Members who concurred in the judgments on the narrowest grounds. . . ." *Marks v. U.S.*, 430 U.S. 188, 193 (1977).

⁸⁴ *Casey* at 882.

⁸⁵ "Although medical acceptability, and logistical factors are important, the most fundamental determinant of the set of abortion options open to a woman and her provider is the duration of the pregnancy to be terminated." David A. Grimes, *Sequelae of Abortion in Modern Methods of Inducing Abortion* 95-111 at 105 (David T. Baird et al. eds., 1995).

We also see no reason why the State may not require doctors to inform a woman seeking an abortion of the availability of materials relating to the consequences to the fetus, even when those consequences have no direct relation to her health. An example illustrates the point. We would think it constitutional for the State to require that in order for there to be informed consent to a kidney transplant operation the recipient must be supplied with information about risks to the donor as well as risks to himself or herself.⁸⁶

This expansion of permissible considerations to matters beyond those which can be shown to directly impact upon the woman's health strongly suggests that it may be constitutional to enact legislation requiring a woman be provided truthful information regarding the possibility that a fetus may experience pain during the abortion.

However, even if it is permissible for the state to require women be informed of fetal pain, the wording of any such legislation must be carefully drafted to avoid challenges due to vagueness. California legislation on fetal pain proposed in 1998 may have suffered from such infirmity. Section (c) of California Bill AB 1758 as amended in Assembly required the physician "offer information and counseling on fetal pain."⁸⁷ This requirement, however, seemed to be modified by the language of section (f), "the pregnant woman shall sign a document that information and counseling on fetal pain was provided and that the physician offered anesthesia for the fetus." It could be argued that subsection (c) merely requires information be offered, while subsection (f) requires the woman actually receive information and counseling. This ambiguity concerning what is required of physicians could have provided the basis for a constitutional challenge had the legislation been enacted.⁸⁸ As originally proposed, a fetal pain bill presented to the Texas House of Representatives suffered from the same defect.⁸⁹

⁸⁶ *Casey* at 882-83.

⁸⁷ A. 1758, 1997-98 Reg. Sess. (Cal. 1998) (as amended in Assembly, Apr. 23, 1998) available at www.leginfo.ca.gov/pub/97-98/bill_asm/ab_1758_status.html.

⁸⁸ The legislation died in committee by a vote of 8 in favor to 11 opposed to passage of the bill. See Complete Bill History at www.leginfo.ca.gov/pub/97-98/bill_asm/ab_1758_bill_history.html.

⁸⁹ HB 1244, 77th Reg. Sess. (Tex. 2001) available at <http://www.capitol.state.tx.us/tlo/billnbr.htm> and search for HB 1244. Like the California proposal, the bill died in committee.

A more carefully crafted bill has been introduced this legislative session in New York. Assembly Bill 7940, and its companion Senate Bill 3385, requires a physician to “(a) orally and in person provide her [the pregnant woman] with information on fetal pain; and (b) personally give her the written material with information on fetal pain that has been prepared by the commissioner [of the New York State Health Department]” prior to performing an abortion in cases involving a fetus of twenty weeks or more weeks in gestational age.⁹⁰

According to the reasoning of *Casey* the New York provision, if enacted, would be constitutional. The plurality opinion in *Casey* finds that it is constitutionally permissible to require physicians offer materials prepared by others or provide actual information and counseling on fetal development.⁹¹ The capacity of the fetus to feel pain is an aspect of fetal development of concern to women considering abortion.⁹² Therefore a law requiring physicians provide medically accurate information about fetal pain to women should be constitutional. This optimism is supported by post-*Casey* treatment of informed consent legislation by the lower federal courts.

In *Karlin v. Foust*,⁹³ the Court of Appeals for the Seventh Circuit reviewed a constitutional challenge to a statute similar to a fetal pain statute. The Wisconsin statute at issue required, among other things, that a woman be informed of "the probable anatomical and physiological characteristics of the woman's unborn child at the time the information is given." Plaintiffs challenged this provision as unconstitutionally vague since "physicians have no way of knowing whether their descriptions of the 'probable" characteristics of the

⁹⁰ A 7950, 2001-2002 Reg. Sess. (N.Y. 2001) available at <http://assembly.state.ny.us/leg> and enter search A 7940. This bill is examined in Kevin Walsh, Note, Harv. L. Rev. (2002).

⁹¹ *Casey* at 882-83.

⁹² Anne Baker et al., *Informed Consent, Counseling, and Patient Preparation in* Maureen Paul et al., A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION (1999) at 27.

⁹³ 188 F.3d 446 (7th Cir. 1999).

fetus are adequate or accurate enough to avoid liability."⁹⁴ The court rejected this argument interpreting *Casey* as permitting state requirements that doctors "inform a woman seeking an abortion of information relating to the fetus, and the consequences of the abortion on the fetus, even when that information has no direct relation to the woman's health."⁹⁵ Only when it can be shown that the required information is false and misleading is such a requirement unconstitutional.⁹⁶

The *Karlin* court buttressed its conclusion by affirming the trial court's interpretation of the statute that a physician is to inform the patient to the extent providing such information is consistent with the individual physician's best medical judgment as to the patient's well being. For example, "a physician who believes that no psychological trauma is associated with the abortion procedure to be used, that is what the statute requires him or her to tell the patient."⁹⁷ Recognizing the risk that this individual discretion might be read as an invitation to circumvent the requirements of the statute, the Court cautioned that protection from liability was dependent upon the exercise of the physician's best medical judgment based on the physician's training and experience.

Perhaps even more encouraging than *Karlin's* affirmation of informed consent statutes is the dicta contained in *Women's Medical Professional Corp. v. Voinovich*.⁹⁸ In reviewing a statute restricting D&X (also known as "partial birth") abortion, the Court of Appeals for the Sixth Circuit suggested that a fetal pain statute would be a reasonable manner of accommodating the state's interest in preventing cruelty to fetuses.

⁹⁴ Id. at 471.

⁹⁵ Id. at 472.

⁹⁶ Id.

⁹⁷ Id. at 472.

⁹⁸ 911 F.Supp. 1051 (S.D. Ohio 1995). affirmed on other ground, 130 F.3d 187 (6th Cir. 1997). The court addressed the state's argument that the Ohio ban of D&X abortion was in furtherance of the state's interest in avoiding unnecessary cruelty to the fetus during the abortion process. The court agreed that the state has an interest in preventing unnecessary cruelty to fetuses. Id. at 1072. However, the evidence on the existence of fetal pain was contradictory and the ban at issue was not sufficiently narrow in pursuit of the state's interest.

Assuming, however, that the fetus is conscious of the pain involved in the D & X procedure, it appears to this Court that the state could still seek to vindicate its asserted interest in preventing arguably unnecessary cruelty to the fetus, by regulating the procedure without banning it outright.

Although the testimony on this issue was not conclusive, one such possible regulation may require the physician to cut the umbilical cord prior to making an incision in the base of the skull, and to wait until the fetus dies as a result. Another possible regulation might require the use of local or general anesthetic, on the fetus or the mother. By use of such regulations, states could prevent arguably unnecessary cruelty in the abortion procedure, without taking away the right to seek a previability abortion.⁹⁹

If *Karlin* and *Voinovich* represent the approach federal courts would take in reviewing fetal pain statutes, it would be constitutional to require abortion providers inform women of the possibility that the fetus would experience fetal pain during the abortion process, and offer to administer fetal anesthesia to minimize the pain. Even if other courts interpret *Casey* more restrictively, under the narrowest construction of *Casey* it is constitutional to require that providers inform women of the availability of state-prepared materials regarding fetal pain and provide those materials upon request.

IV. Objections to Legal Protection of the Fetus from Pain and Possible Responses

The constitutionality of any proposed statute requiring that women seeking abortions be informed of fetal pain and offered fetal anesthesia, however, is largely irrelevant if the appropriate legislative or policy making body is unpersuaded as to the need or prudence of such a requirement. Establishing that the fetus is physiologically capable of experiencing pain is just the first step in making the case for the legislation. Beyond disputing the existence of the fetal capacity to experience pain, opponents of proposed legislation in the various states

⁹⁹ *Id.* at 1075. Compare *Planned Parenthood of Wisc. v. Doyle*, 162 F.3d 463 (7th Cir. 1998) ("No argument is made, and we are not aware of any basis for such an argument, that if a fetus feels pain, the pain is worse when the fetus is killed in the birth canal than when death occurs a moment earlier in the womb. And therefore Wisconsin's statute cannot be analogized to states that prohibit cruelty to animals.") See also *Eubanks v. Stengal*, 28 F.Supp. 2d 1024 (W.D. Ky. 1998) ("After all, it is hard to imagine that even the gruesome partial birth abortion procedure would be more painful to a fetus than being torn limb from limb as in an ordinary D & E procedure.")

have raised several objections that must be addressed in order to obtain public support for fetal pain legislation.

By far, the most serious objection, if true, is the objection that administering anesthesia to the fetus would pose a health risk to the woman.¹⁰⁰ Opponents of fetal pain legislation have argued that the health of women would be adversely affected by the use of fetal anesthesia. This simply is not relevant where the statutory requirement is merely informational. A physician has a fiduciary duty to inform the woman of any known adverse affects from any aspect of a proposed treatment.¹⁰¹ In the rare case of a woman whose physical health or life would be adversely affected to a medically significant degree by the use of fetal anesthetic, the physician would have a duty to so advise her.¹⁰²

In the vast majority of cases, however, use of fetal anesthetic poses no medically significant risk to the mother.¹⁰³ This was established in hearings before the United States House of Representatives committee evaluating legislation banning partial birth abortion. Responding to pregnant patients' alarm caused by abortion rights activists' claims that maternal anesthetic caused the death of the fetus prior to performance of the D&X procedure, the American Academy of Anesthesiologists testified that the separate physical integrity of the mother and fetus minimized any collateral affect of maternal anesthesia on the fetus.¹⁰⁴

¹⁰⁰ Cal. Chapter of Amer. Assoc. Univ. Women, Memo to Martin Gallegos, Chair of the Assembly Health Committee, dated April 27, 1998 and District IX, Amer. College of Obstetricians and Gynecologists, ltr. To Martin Gallegos, Chair of the Assembly Health Committee, dated April 23, 1998 and Planned Parenthood Affiliates of California, reflected in legislative analysis prepared by Sara S. Nichols.

¹⁰¹ See generally W. Page Keeton et al., PROSSER AND KEETON ON THE LAW OF TORTS §§ 9, 32 (5th ed. 1984).

¹⁰² Id.

¹⁰³ See The Partial-Birth Abortion Ban Act of 1995: Hearing Before the Senate Comm. on the Judiciary, 104th Cong. 248 (1995) [hereinafter Senate Hearing] at 107-08 (statement of Dr. Norig Ellison).

¹⁰⁴ Id.

Should exceptional circumstances exist where use of fetal anesthetic poses a threat to the mother's life or physical health, the physician would have an obligation to inform the woman of these risks and, doubtless, she would decline to consent to use of the anesthetic.¹⁰⁵

A much weaker, but related objection was raised by California physicians' groups, who protested that any legally required discussion of fetal pain was an unwarranted intrusion into physician-patient relationships.¹⁰⁶ This objection relies upon pre-*Casey* rhetoric suggesting that a state may not mandate any particular information be given to a woman considering abortion.¹⁰⁷ Yet any support earlier cases may lend to this complaint is directly repudiated in *Casey*. Justices O'Connor, Kennedy, and Souter recognized, "To the extent Akron I and Thornburgh find a constitutional violation when the government requires, as it does here, the giving of truthful, nonmisleading information about the nature of the procedure, the attendant health risks and those of childbirth, and the 'probable gestational age' of the fetus, those cases go too far, are inconsistent with Roe's acknowledgement of an important interest in potential life, and are overruled."¹⁰⁸ The plurality opinion goes on to specifically approve the providing of information "relating to the consequences to the fetus, even when those consequences have no direct relation to her [the woman's] health."¹⁰⁹

¹⁰⁵ The California bill required the physician to inform the woman of "the effects [of fetal anesthesia] on both the fetus and the pregnant woman when anesthesia is administered to the fetus." AB 1758 §1(d)(2). The Texas bill excused use of fetal anesthesia in cases where the physician reasonably believed its use would "increase the risk to the woman's life or physical health" or if the woman refused to consent to its use. HB 1244 §170.054 (b). Similarly the New York legislation excludes use of fetal anesthetic in cases where the physician reasonably believes "the administration or an anesthetic or analgesic would cause the pregnant woman's death or would create a serious risk of a substantial and irreversible impairment of a major bodily function." AB 7940 §2516 (1)(B).

¹⁰⁶ Cal. Medical Association, ltr. to Martin Gallegos, Chair of the Assembly Health Committee, dated April 30, 1998 and District IX, Amer. College of Obstetricians and Gynecologists, ltr. To Martin Gallegos, Chair of the Assembly Health Committee, dated April 23, 1998, and Cal. Dist. American Academy of Pediatrics, ltr. to Assembly Member George Runner, no date reflected on file copy.

¹⁰⁷ Compare *Planned Parenthood League of Massachusetts v. Bellotti*, 641 F.2d 1006 at 1021.

¹⁰⁸ *Casey*, 505 U.S. at 884. "Whatever constitutional status the doctor-patient relation may have as a general matter, in the present context it is derivative of the woman's position. . . . Thus, a requirement that a doctor give a woman certain information as part of obtaining her consent to an abortion is, for constitutional purposes, no different from a requirement that a doctor give specific information about any medical procedure." *Id.*

¹⁰⁹ *Id.* at 882.

Various groups also have objected to offering women information about fetal pain and anesthesia on the basis that abortions after twelve weeks are rare.¹¹⁰ It is true that a substantial majority of abortions in the United States occur within the first twelve weeks of gestation.¹¹¹ Nonetheless, this objection seems unrelated to the issue of whether women obtaining abortions after a pregnancy has progressed beyond twelve weeks should be informed of their opportunity to request fetal anesthesia or analgesic, foreclosing the possibility that the fetus would experience pain during the termination of the pregnancy.

Opponents of fetal pain legislation have also objected to informing women of the ability of the fetus to experience pain, arguing that such information unreasonably increases the emotional burden for families "already facing a devastating personal situation."¹¹² Implicit in this objection are two assumptions: first, that the overwhelming majority of women seeking abortions after twelve weeks are doing so because of the discovery of fetal abnormalities or the development of a pregnancy-related condition threatening the mother's health or life, and second, that being informed of the ability to foreclose fetal pain through the use of fetal anesthetic will be an additional burden to an already emotionally fragile woman. The first assumption is highly contested, and the second is irrational.

During the 1997 congressional debates surrounding a national ban on the procedure known as "D&X abortion" or "partial birth abortion," Ron Fitzsimmons, a spokesman for the National Abortion Federation created a political firestorm when he revealed to the New York

¹¹⁰ For examples of opponents arguing that third trimester abortions are rare, see Jenifer Warren, *California and the West: For Aborted Fetuses, A Question of Pain*, L.A. Times 3A (Jan. 4, 1998), Cal. Chapter of Amer. Assoc. Univ. Women, Memo to Martin Gallegos, Chair of the Assembly Health Committee, dated April 27, 1998, and District IX, Amer. College of Obstetricians and Gynecologists, ltr. To Martin Gallegos, Chair of the Assembly Health Committee, dated April 23, 1998.

¹¹¹ According to the most recent figures from the Centers for Disease Control, 88% of all abortions obtained in 1997 occurred before the thirteenth week of pregnancy. Lisa M. Koonin et al., *Abortion Surveillance: United States, 1997*, 49 MMRW 1 (Dec. 8, 2000) available at <<http://www.cdc.gov/mmwr/preview/mmwrhtml/ss4911a1.htm>>.

Times that the majority of D&X abortions involve “a healthy mother with a healthy fetus that is twenty weeks or more along.”¹¹³ Subsequently he estimated that four to five thousand D&X abortions occur annually.¹¹⁴ Planned Parenthood Federation of America lists a variety of reasons women obtain abortions after the twelfth week of pregnancy including having to travel long distances to obtain an abortion, having to accumulate financial resources from which to pay for the abortion, and having to comply with state laws regarding parental involvement in minors’ decisions to obtain abortions.¹¹⁵ None of these reasons suggest that a woman would be particularly fragile emotionally.

As for the claim that women will be “devastated” if told of the possibility that the fetus feels pain, this reflects a false and out-dated paternalism toward women seeking abortions. When contemplating their response to problem pregnancies, women often ask about the ability of the fetus to feel pain.¹¹⁶ By withholding information, abortion providers risk women subsequently learning of the emerging consensus surrounding fetal pain and experiencing great regret.¹¹⁷ Perhaps even more importantly, women are deprived of the opportunity to insure the fetus feels no pain during the abortion through the use of modified procedures or fetal anaesthetic.

¹¹² Cal. Medical Association, ltr. To Martin Gallegos, Chair of the Assembly Health Committee, dated April 30, 1998. Jenifer Warren, *California and the West: For Aborted Fetuses, A Question of Pain*, L.A. Times 3A (Jan. 4, 1998)(quoting Patricia Robertson, M.D.).

¹¹³ David Stout, *An Abortion Rights Advocate Says He Lied About Procedure*, NY Time A12 (Feb. 26, 1997).

¹¹⁴ Douglas Johnson, *Comforting Myths About Abortion*, Wall Street Journal (May 14, 2001).

¹¹⁵ Planned Parenthood Federation of America, *Fact Sheet: Abortion After the First Trimester*, available at <http://www.plannedparenthood.org/library/facts/abotaft1st_010600.html>.

¹¹⁶ See Anne Baker et al., *Informed Consent, Counseling, and Patient Preparation in* Maureen Paul et al., *A CLINICIAN’S GUIDE TO MEDICAL AND SURGICAL ABORTION* (1999) at 27.

¹¹⁷ Post-abortion regret is a common experience.

In the USA, it is estimated that 20% of women suffer from severe feelings of loss, grief and regret. These feelings may progress to anger (at herself and at her partner), or to depression and even obsession. These feelings are more likely to arise in women who: lack social support; whose decision to terminate the pregnancy is in conflict with their family or their religious beliefs; who feel they were pressurized into having an abortion; who have abortion because of fetal anomaly; and who are very young or have a very late abortion.

Anna Glasier, *Counseling for Abortion*, in *MODERN METHODS OF INDUCING ABORTION* 112, 117 (David T. Baird et al. eds., 1995

A related objection raised by some is that for those abortions involving fetal abnormalities, there is little reason to fear that the fetus suffers pain since the brain and/or nervous system of those fetuses may have already severely compromised.¹¹⁸ In the rare case where this is so, a physician should inform the woman of these facts. No doubt this additional information will influence her decision regarding the use of fetal anaesthetic. But the existence of these rare cases should not excuse the physician from a duty to inform women of the possibility of fetal pain.

Additional objections have been raised based on misinformation regarding the procedures involved in late term abortions. The American Association of University Women advised California legislators that it was customary practice in third trimester abortions to induce death prior to removal of the fetus, therefore anesthesia is unnecessary.¹¹⁹ Representatives of a California district of the American College of Obstetricians and Gynecologists have argued that informing women of the possibility of fetal pain was unnecessary because third trimester abortions most often occur in hospitals, and doctors must obtain approval from hospital ethics committees.¹²⁰ In fact, neither of these statements address abortions occurring during the mid-trimester of pregnancy and neither is true in the majority of cases involving abortions after twelve weeks of pregnancy. According to the most recently published medical text on abortion, only seven percent of all abortions were performed in a hospital in 1992.¹²¹ During that year only seventeen percent of abortions

¹¹⁸ Victoria Tepe, *Fetal Pain: What We (Don't) Know, and Why We Need to Know It*, THE BODY POLITIC, vol. 7, no. 3 (Mar. 1997) p. 8.

¹¹⁹ Cal. Chapter of Amer. Assoc. Univ. Women, Memo to Martin Gallegos, Chair of the Assembly Health Committee, dated April 27, 1998. See also Jenifer Warren, *California and the West: For Aborted Fetuses, A Question of Pain*, L.A. Times 3A (Jan. 4, 1998)(quoting Mark I. Evans, M.D.).

¹²⁰ Jenifer Warren, *California and the West: For Aborted Fetuses, A Question of Pain*, L.A. Times 3A (Jan. 4, 1998)(quoting Charlotte Newhart, chief administrative office of the American College of Obstetricians and Gynecologists in California); District IX, Amer. College of Obstetricians and Gynecologists, ltr. To Martin Gallegos, Chair of the Assembly Health Committee, dated April 23, 1998, and Planned Parenthood Affiliates of California, reflected in legislative analysis prepared by Sara S. Nichols.

¹²¹ Stanley K. Henshaw, *Unintended Pregnancy and Abortion: A Public Health Perspective*, in A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTIONS 19 (Maureen Paul et al., eds. 1999). See also National Abortion

performed after twenty weeks of gestation occurred in a hospital.¹²² Similarly, while a few abortion providers insure the death of the fetus through lethal injection prior to beginning removal in a mid or third-trimester abortion,¹²³ a number of providers consider it unnecessary, and even dangerous in some cases.¹²⁴

Conclusion

In the end, legislators must confront the question of whether women are entitled to know of the growing body of medical literature establishing that the human fetus is capable of experiencing pain after the first trimester of the pregnancy. It is not sufficient answer to “assume” that women know, nor should legislators assume that abortion providers will voluntarily inform women of this research. Women have a right to know the probable consequences of their choices. Many want to know the effect of the abortion on the fetus.¹²⁵ It is the worst sort of paternalism that suggests because women may be discomforted by this information, and may even make different choices about continuing their pregnancy, they should not be informed that they can prevent unnecessary pain to the fetus. Legislation requiring women be informed of their ability to foreclose the possibility of fetal pain facilitates informed choices by women.

Federation, What is Surgical Abortion? available at <<http://www.prochoice.org>> (majority of abortions occurring after thirteenth week are done on an outpatient basis).

¹²² Stanley K. Henshaw, *Unintended Pregnancy and Abortion: A Public Health Perspective*, in A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTIONS 20 (Maureen Paul et al., eds. 1999) (“A tabulation of data on approximately 300,000 abortions in 14 states in 1992 indicates that even after 20 weeks 83% were performed outside of hospitals.”).

¹²³ Dr. Hern, the author of a major medical text on abortion, told the Senate Judiciary Committee:

[An] approach, which I favor and which is followed by some other physicians, is to induce fetal death on the first or second day of treatment of the cervix. This requires an injection of a medication into the fetus under (usually) ultrasound guidance. This is the procedure which I and one or two other physicians follow. It is accompanied by other forms of treatment, but these vary according to the physician. In the case of a breech presentation of a dead fetus, the procedure described by sponsors of [the 1995 bill] is routinely followed.

See The Partial-Birth Abortion Ban Act of 1995: Hearing Before the Senate Comm. on the Judiciary, 104th Cong. 248 (1995) at 246 (statement of Warren M. Hern, M.D.).

¹²⁴ See *Evans v. Kelley*, 977 F. Supp. 1283, 1301 (E.D. Mich. 1997) (discussing risks attendant to lethal injection to fetus).

¹²⁵ See Anne Baker et al., *Informed Consent, Counseling, and Patient Preparation* in Maureen Paul et al., A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION (1999) at 27.