Fetal Pain Legislation: Is it Viable?

Teresa Stanton Collett[i]

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 1980s 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,"[ii] and the release of a controversial film entitled "The Silent Scream"[iii] 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 1990s reignited public debate over fetal pain.[iv] 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's tiny hand apparently grasping the finger of the perinatal surgeon who was repairing the spine of the twenty-one week old fetus.[v] 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.[vi]

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 the words "feels" and "pain" mean in this context.[vii] 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.

Conscious Appreciation

Some physicians restrictively define "feels" to mean only those responses that reflect some self-awareness or "conscious appreciation of pain."[viii] In the absence of consciousness, they argue that the most researchers can conclude is that the human fetus "reacts to physical stimulation."[ix] "Whether the fetus feels pain, however, hinges not on its biological development but on its conscious development. Unless it can be shown that the fetus has a conscious appreciation of pain after 26 weeks, then the response to noxious stimulation must still essentially be reflex, exactly as before 26 weeks."[x]

While representing a minority view among physicians, as evidenced by the use of pain medication for certain *in utero* procedures performed on the fetus,[xi] this reasoning was embraced by the federal district court in *Women's Medical Professional Corp. v. Voinovich*.[xii] 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" abortion, as preventing unnecessary cruelty to the fetus.[xiii] In essence, the court reasoned that absent "mindful awareness" of noxious stimuli by the fetus,[xiv] there can be no pain, and in the absence of pain, there can be no cruelty.[xv]

Behavioral and Physiological Responses

This requirement of consciousness, as a predicate to the experience of pain, has been rejected by other physicians. These doctors argue that

observed physiological[xvi] and behavioral responses[xvii] to stimuli are reliable indicators of pain, particularly for those individuals who are incapable of the self-reporting that is seemingly required for identification of self-awareness or consciousness.[xviii] 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 correspondence.[xix] 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."[xx] 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.[xxi]

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.[xxii] Within four weeks after conception, the primitive structures of the brain are recognizable (ibid). The internal structure of the brain will continue to develop throughout the pregnancy and during the first year of infancy, eventually resulting in a complex structure that regulates many distinct physical processes (ibid).

In addition to the brain and spinal cord, the human nervous system involves an intricate network of peripheral receptors and transmitters (ibid). The receptors specifically involved in discerning pain are called nociceptors (ibid.). Nociceptors are naked nerve endings that lie free in the skin and have their cell bodies in the dorsal root ganglia.[xxiii] 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 (ibid). 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.[xxiv] 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.[xxv] Impulses received by the dorsal horn are transmitted to the various parts of the brain via neural and chemical connections.[xxvi]

When received by the brain, the impulses enter the thalamus (ibid). 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.[xxvii] After interconnection, the thalamus may also forward the initial impulse to the cortex of the brain for more complex processing including psychological reaction and directed physical responses (ibid). 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.[xxviii] 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 (ibid). 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.[xxix]

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.[xxx] Where medical opinion divides is over 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 hydranencephalic

infants who have no or minimal cortex development, these 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.[xxxi] 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.[xxxii]

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.[xxxiii] This position seems to dominate the thinking of organized medicine as evidenced by the recent policy positions on administering anesthetic or performing feticide prior to abortions performed during or after twenty weeks of gestation.[xxxiv]

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

While advocates involved in the abortion debate had long argued over whether a human fetus feels pain,[xxxv] on July 9, 1994 *Lancet*, a highly respected British medical journal, published an article that seemingly changed the parameters of the debate. In *Fetal Plasma Cortisol and ß-endorphin Response to Intrauterine Needling*,[xxxvi] researchers reported the results of a study investigating fetal hormonal response to intrauterine needling. Summarizing the implications of their results, the authors stated that, "data suggest[s] that the fetus mounts hormonal stress response to invasive procedures…. [and] raise the possibility that the human fetus feels pain *in utero*, and may benefit from anesthesia or analgesia for invasive procedures."[xxxvii]

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 of 1995, the Department of Heath for the United Kingdom commissioned "an update on current scientific knowledge" by Professor Maria Fitzgerald.[xxxviii] 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 twenty-sixth week of gestation (ibid.).

In January 1996, a private British organization, the Christian Action, Research, and Education Trust ("CARE Trust") created the Commission of Inquiry into Fetal Sentience.[xxxix] After almost a year of collecting and evaluating evidence,[xl] 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 movement in the baby has been observed at 5.5 weeks after conception, and that it may be able to suffer from this stage.[xli]

Based upon this finding the Commission recommended that from the early stages of gestation the fetus should be protected from potentially painful procedures by the use of adequate anesthesia.[xlii] 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.'"[xliii]

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.[xliv] 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.[xlv]

In 1999, the British Department of Health requested that the Medical Research Council review the report of the Royal College and make recommendations as to areas where further scientific research was

needed.[xlvi] 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.[xlvii] This has prompted calls for the Royal College to change its recommendation concerning the use of fetal analgesia in fetal surgery or abortions back from twenty-four weeks to twenty weeks.[xlviii]

This would be consistent with the 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.[xlix]

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.[l] As early as the 1970s certain states have enacted laws seeking to minimize fetal suffering.[li] The constitutionality of these statutes has 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. 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,[lii] while statutes restricting or prohibiting particular methods of abortion in order to minimize or avoid fetal pain would not.[liii]

Statutes Restricting or Mandating Particular Methods of Abortion

In *Stenberg v. Carhart*, the 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" (ibid. at 922). In holding the statute unconstitutional, the majority found that the law effectively outlawed both dismemberment and partial birth abortions (ibid. at 938-39). Read broadly, the prohibition unduly burdened women's ability to obtain abortions in the second half of pregnancy, and therefore violated the Constitution (ibid. at 945-46). 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 mother (ibid. at 930-31). 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 (ibid. at 946-47, J. Stevens concurring).

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,[liv] and courts may view any claim that the information advances the emotional or psychological well being of women with some skepticism.[lv]

Even assuming the courts recognize the state's interest in limiting fetal suffering as substantial,[lvi] 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.[lvii] The constitutionality of 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,[lviii] 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 that women be informed of fetal pain. In *Charles v. Carey*,[lix] a federal court of appeals reversed a trial court's refusal to grant a preliminary injunction against the enforcement of Illinois statutes governing abortion (ibid. at 792). One of the provisions at issue required physicians to inform patients of any reasonable medical certainty of organic pain[lx] to the fetus that might result from the particular abortion method to be employed, and of available ways to control such pain.[lxi] The statute provided criminal penalties for physicians who recklessly, knowingly, or intentionally disregard its requirements (ibid). Relying upon the Supreme Court's opinion in *Planned Parenthood v. Danforth*,[lxii] the Court of Appeals found that the Illinois informed consent statutes unconstitutionally intruded into the physician/patient relationship.[lxiii] In addressing the provisions requiring that 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.[lxiv]

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.[lxv] Relying upon the Supreme Court's reasoning in *City of Akron v. Akron Ctr. For Reproductive Health, Inc.*,[lxvi] the district court held that the Illinois requirement was a direct burden on the abortion decision and therefore unconstitutional.[lxvii] The continuing viability of this decision, however, is suspect in light of advances in medical knowledge regarding fetal pain and the Supreme Court's repudiation of much of the reasoning

and the holding of *Akron I* in *Planned Parenthood v. Casey*.[lxviii]

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. 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 (ibid. at 876). 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" (ibid. at 877). Justice Stevens asserted that 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).[lxix] Neutral regulations on the health aspects of her decision would also be constitutional in Justice Stevens' opinion (ibid. at 917). Justice Blackmun would have evaluated "informed consent" laws under strict scrutiny, requiring the state to show that the limitation "is both necessary and narrowly tailored to serve a compelling governmental interest."[lxx] 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 standard for reviewing abortion legislation.[lxxi] This interpretation is consistent with the Supreme Court's instruction in prior cases regarding the treatment of plurality opinions.[lxxii]

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.[lxxiii] 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.[lxxiv] "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" (ibid. at 882). 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 an abortion technique and impacts the probability of post-operative complications.[lxxv]

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:

> 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.[lxxvi]

This expansion of permissible considerations to matters beyond those which can be shown to directly impact 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 that 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."[lxxvii] 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" (ibid). 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.[lxxviii] As originally proposed, a fetal pain bill presented to the Texas House of Representatives suffered from the same defect.[lxxix]

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 in gestational age.[lxxx]

According to the reasoning of *Casey*, the New York provision, if enacted, would have been constitutional. The plurality opinion in *Casey* found that it is constitutionally permissible to require physicians to offer materials prepared by others or provide actual information and counseling on fetal development.[lxxxi] The capacity of the fetus to feel pain is an aspect of fetal development of special concern to women considering abortion.[lxxxii] 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*,[lxxxiii] 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."[lxxxiv] Plaintiffs challenged this provision as unconstitutionally vague because "physicians have no way of knowing whether their descriptions of the 'probable' characteristics of the fetus are adequate or accurate enough to avoid liability" (ibid. at 471). The court rejected this argument and interpreted *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 mother's health."[lxxxv] Only when it can be shown that the required information is false and misleading is such a requirement unconstitutional (ibid).

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 that providing such information is consistent with the individual physician's best medical judgment as to the patient's well being (ibid. at 472-73). For example, if "a physician 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" (ibid. at 472). 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 (ibid. at 473).

Perhaps even more encouraging than *Karlin's* affirmation of informed consent statutes is the dicta contained in *Women's Medical Professional Corp. v. Voinovich.*[lxxxvi] In reviewing a statute restricting D&X, also known as "partial birth" abortion, the court suggested that a fetal pain statute would be a reasonable manner of accommodating the state's interest in preventing cruelty to fetuses. "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" (ibid. at 1075).

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 pre-viability abortion.[lxxxvii]

If *Karlin* and *Voinovich* represent the approach federal courts would take in reviewing fetal pain statutes, it would be constitutional to require abortion providers to 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 to 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 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 that administering anesthesia to the fetus would pose a health risk to the mother.[lxxxviii] 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.[lxxxix] 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.[xc]

In the vast majority of cases, however, use of fetal anesthetic poses no medically significant risk to the mother.[xci] This was established in hearings before the United States Senate 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 Society of Anesthesiologists testified that the separate physical integrity of the mother and fetus minimized any collateral affect of maternal anesthesia on the fetus (ibid).

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 consent to use of the anesthetic.[xcii]

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 the physician-patient relationship.[xciii] This objection relies upon pre-*Casey* rhetoric suggesting that a state may not mandate any particular information be given to a woman considering abortion.[xciv] 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, non-misleading 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* acknowledgment of an important interest in potential life, and are overruled."[xcv]

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" (ibid. at 882.)

Various groups have also objected to offering women information about fetal pain and anesthesia on the basis that abortions after twelve weeks are rare.[xcvi] It is true that a substantial majority of abortions in the United States occur within the first twelve weeks of gestation.[xcvii] 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."[xcviii] 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 a "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 Times that the majority of D&X abortions involve "a healthy mother with a healthy fetus that is twenty weeks or more along."[xcix] Subsequently he estimated that four to five thousand D&X abortions occur annually.[c] 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.[ci] 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.[cii] By withholding information, abortion providers risk women subsequently learning of the emerging consensus

surrounding fetal pain and experiencing great regret.[ciii] Perhaps even more importantly, women are deprived of the opportunity to ensure the fetus feels no pain during the abortion through the use of modified procedures or fetal anesthetic.

A related objection is that for those abortions involving fetal abnormalities, there is little reason to fear that the fetus suffers pain because the brain and/or nervous system of those fetuses may have already been severely compromised.[civ] In the rare case where this is so, a physician should inform the woman of these facts. There is no doubt this additional information will influence her decision regarding the use of fetal anesthetic. 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 is customary practice in third trimester abortions to induce death prior to removal of the fetus, making anesthesia unnecessary.[cv] Representatives of a California district of the American College of Obstetricians and Gynecologists argued that informing women of the possibility of fetal pain is unnecessary because third trimester abortions most often occur in hospitals and the doctors performing them must obtain approval from hospital ethics committees.[cvi] In fact, neither of these statements addresses 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.[cvii] During that year, only seventeen percent of abortions performed after twenty weeks of gestation occurred in a hospital.[cviii] 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,[cix] a number of providers consider it unnecessary, and even dangerous in some cases.[cx]

CONCLUSION

In the end, legislators must confront 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 pregnancy. It is not a 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.[cxi] It is the worst sort of paternalism that suggests that because women may be discomforted by this information, and may even make different choices about continuing their pregnancy, that they should not be informed that they can prevent unnecessary pain to the fetus. Legislation requiring that women be informed of their ability to foreclose the possibility of fetal pain facilitates informed choices by women, and may reduce to some small degree the suffering associated with abortion.

NOTES

---

i. 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.

ii. President Ronald Reagan, "Remarks at The National Religious Broadcasters Convention" (Jan. 30, 1984) (transcript available at http://wwwreagan.utexas.edu/ resource/speeches/1984/13084b.htm).

iii. *The Silent Scream* (American Portrait Films 1984), script and visual images *available at* http://www.silentscream.org.

iv. James Bopp, Jr. & Curtis R. Cook, "Partial Birth Abortion: The Final Frontier of Abortion Jurisprudence," *Issues in Life & Medicine* 3 (1998) 14.

v. Samuel Armas photo (2002), available 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," *New York Times*, Feb.

25, 2002, at A1, available at http://www.nytimes.com/2002/02/25/health/25FETA.html.

vi. See Fran Lang Porter et al., "Pain and Pain Management in Newborn Infants: A Survey of Physicians and Nurses," 100 *Pediatrics* 626 (1997), stating that "ample data now indicate that the neurophysiologic basis for pain is established by the end of the second trimester of pregnancy"; Royal College of Obstetricians and Gynaecologists, "Fetal Awareness: Report of a Working Party" (1997), providing that 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 (2000), stating that "[b]y late gestation, the fetus has developed the anatomic, neurophysiological, 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" (2000), stating that "[i]n some circumstances, in order to reduce suffering where intervention is necessary to terminate pregnancy after 20 weeks/0 days, patient and physician may consider feticide prior to initiating the termination procedure". See also B.A. Robinson, "Can a Fetus Feel Pain?" (2001), available at http://www.religioustolerance.org/abo_pain.htm.

vii.Adrian R. Lloyd-Thomas & Maria Fitzgerald, "Reflex Responses Do Not Necessarily Signify Pain," 313 *Brit. Med. J.* 797 (1996), available at http://www.bmj.com/cgi/content/full/313/7060/797.

viii. Testimony of Dr. Stuart Derbyshire, Commission of Inquiry into Fetal Sentience (Mar. 6, 1996), available at http://www.care.org.uk/issues/fs/derbyshr.htm. See also Zbigniew Szawarski, "Commentary: Probably No Pain in the Absence of 'Self'," 313 *Brit. Med. J.* 796 (1996), available at http://www.bmj.com/cgi/content/full/313/7060/796.

ix. Hugh Muir, "When does pain begin?" in *The Daily Telegraph*, 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."

x. Stuart Derbyshire & Ann Furedi, "'Fetal Pain' is a Misnomer," 313 *Brit. Med. J.* 795 (1996), available at http:wwwbmj.com/cgi/content/full/313/7060/795/a. See also Stuart Derbyshire, "There Is No Such Thing as 'Fetal Pain'," *Living Marxism*, Sept. 1996, at 8; Lloyd-Thomas & Fitzgerald, supra n7, at 797.

xi. See generally Charles B. Caldwell et al., "Anesthesia and Monitoring for Fetal Intervention" in *The Unborn Patient* 149 (Michael R. Harrison et al., 3d ed. 2001); Alan C. Santos & Mieczyslaw Finster, "Perinatal Pharmacology" in *Shnider and Levinson's Anesthesia for Obstetrics* 61 (Samuel C. Hughes et al. eds., 2002); Mark A. Rosen, "Anesthesia for Fetal Procedures and Surgery" in *Anesthesia for Obstetrics* 285 (Sol M. Shooder et al. 3d ed. 1993).

xii. 911 F. Supp. 1051 (S.D. Ohio 1995).

xiii. Ibid. 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, 958-59 (2000) (Kennedy, J. dissenting), internal citations omitted.

xiv. 911 F. Supp. at 1073.

xv. Ibid. at 1074. See also Interview by Bob Abernethy with Peter Singer, Professor, Princeton University in *PBA Religion & Ethics Newsweekly* (1999), stating that "[k]illing 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," available at http://www.pbs.org/wnet/religionandethics/transcripts/singer.html.

xvi. 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* 3 (Feb. 1997), available at http://www.parliament.uk/post/pn094.pdf.

xvii. Ibid. "Behavioral changes include withdrawal of affected body parts, crying, and facial expressions."

xviii. See K.J.S. Anand & Kenneth D. Craig, "Editorial: New Perspectives on the Definition of Pain," 67 PAIN 3 (1996), stating that "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 & Canadian Paediatric Society, "Prevention and Management of Pain and Stress in the Neonate," 105 *Pediatrics* 454 (2000), available at http://www.aap.orgpolicy/re9945.html.

xix. Anand & Craig, supra n18, at 3.

xx. Ibid. at 5. See also Vivette Glover & Nicholas Fisk, "Do Fetuses Feel Pain?" 313 *Brit. Med. J.* 796 (1996), arguing that fetal stress responses may be the best indices of pain currently available.

xxi. John Wyatt, "When Do We Begin to Feel the Pain?"*The Guardian*, 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 interests of our patients even when the evidence is ambiguous. We should, in the words of Glover [a clinical scientist 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." See also S. Vanhatalo & O. Van Nieuwenhuizen, "Fetal Pain," *Brain and Development*, May 24, 2000, stating that the 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, 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."

xxii. Parliamentary Office of Science & Tech., supra n16, at 2.

xxiii. J.A. Rushford, "Pain Perception" in *Fetal & Neonatal Neurology and Neurosurgery* 601 (Malcolm I. Levine & Richard J. Lilford, Sr. eds., 1995).

xxiv. 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, 798 (Aug. 1989).

xxv. Rushford, supra n27, at 602.

xxvi. K.J.S. Anand & P.J. McGrath, "The Applied Physiology of Pain" in *Pain in Neonates* 40 (1993).

xxvii. Richard S. Snell, *Clinical Neuroanatomy: a review with Questions and Explanations* 138 (3d ed. 2001), stating that "[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.".

xxviii. Parliamentary Office of Science & Tech., supra n16, at 2.

xxix. Medical Research Council, "Report of the MRC Expert Group on Fetal Pain," §3.3 (2001), available at http://www.mrc.ac.uk/index/publications/publications-research_reviews.htm : "Connections from the thalamus to the cortex begin to form at about 20 weeks gestation…and continue to mature along with other cortical connections well into childhood and adolescence."

xxx. Care Commission on Inquiry into Fetal Sentience, "Human Sentience Before Birth" § 5.2.1 (1996), available at http://www.care.org.uk/resource/pub/

fs/fs05.htm#521.

xxxi. Care Commission on Inquiry into Fetal Sentience, supra n38, § 5.3.1. See also Stephen G. Waxman in *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." 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." American Academy of Pediatrics, "Policy Statement: Neonatal Anesthesia," 80 *Pediatrics* 446 (1987), available at http://www.aap.org/policy/01730.html.

xxxii. Care Commission on Inquiry into Fetal Sentience, supra n38, § 8.1. See also Mary Sheridan & Roger Highfield, "Growing Pains," *London Telegraph* (Oct. 12, 2001), reporting that 80% of British neuroscientists responding to survey believed that the fetus should receive pain control after eleven weeks of gestation.

xxxiii. E.g., Medical Research Council, supra n37, § 3.3.

xxxiv. 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" (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*.

xxxv. See John T. Noonan, Jr., "The Experience of Pain by the Unborn," in *New Perspectives on Human Abortion* 205 (Thomas W. Hilgers et al. eds., 1981); see also Cristine Russell, "Physician Group Supports President on Fetus Pain," *Washington Post*, Feb. 14, 1984, at A6.

xxxvi. Xenophon Giannakoulopoulos et al., "Fetal Plasma Cortisol and ß-endorphin Response to Intrauterine Needling," 344 *Lancet* 77 (1994).

xxxvii. Giannakoulopoulos et al., supra n44, at 77.

xxxviii. Parliamentary Office of Science & Tech., supra n16, at 2.

xxxix. Ibid. 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. See also Derbyshire, supra n10.

xl. Wyatt, supra n21, at 2.

xli. Commission of Inquiry into Fetal Sentience, Human Sentience Before Birth § 2, available at http://www.care.org.uk/resource/pub/fs.fs02.htm.

xlii. Ibid. § 8.

xliii. Parliamentary Office of Science & Tech., supra n16, at 2. See also Muir, supra n9, 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."

xliv. Royal College of Obstetricians and Gynaecologists, Description of Working Party Report on Fetal Awareness (1997).

xlv. Ibid. See also David James, "Recent Advances: Fetal Medicine," 316 *Brit. Med. J.* 1580 (1998).

xlvi. Medical Research Council, "Summary of Report on Fetal Pain" (2001), available at http://www.mrc.ac.uk/index/publications-publications/publications-research_reviews/publications-fetal_pain_summary_report.htm.

xlvii. Ibid. §3.3.

xlviii. See Roger Highfield, "Unborn Child Can Feel Pain at 20 Weeks, Say Researchers," *The Daily Telegraph*, Aug. 28, 2001, at 2.

xlix. College of Physicians and Surgeons of Alberta, "Termination of

Pregnancy" (2000).

l. "What About Abortion Victims?" in *The New American*, Oct. 8, 2001, available at http://thenewamerican.com/tna/2001/10-08-2001/insider/vo17no21_abortion.htm. See also Gregg Easterbrook, "What Neither Side Wants You to Know. Abortion and Brain Waves," *The New Republic*, Jan. 31, 2000, at 21.

li. See 720 Ill. St. Ch. 720 §51016, formerly Ill. Rev. Stat. 1991 ch. 38 ¶81-26.

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

liii. See *Stenberg v. Carhart*, 530 U.S. 914, 921 (2000), holding that a Nebraska law prohibiting the D&X procedure is unconstitutional.

liv. See *Planned Parenthood v. Doyle*, 162 F.3d 463, 471 (7th Cir. 1998).

lv. Compare the summary of research and bibliographies related to post-abortion regret prepared by the Elliot Institute, available at http://www.afterabortion.org (last visited Nov. 1, 2002), with the information provided by the National Abortion Federation at http://www.prochoice.org/ (last visited Nov. 1, 2002).

lvi. See *Women's Medical Prof'l 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.

lvii. See Kevin Walsh, Note, "The Science, Law and Politics of Fetal Pain Legislation," 115 *Harv. L. Rev*. 2010, 2023-31 (2002).

lviii. Ibid. Viability is now considered to be achieved generally in the twenty-forth week of gestation, while research dates the ability to experience fetal pain as arising earlier in the pregnancy. Ibid. at 2012-15.

lix. *Charles v. Carey*, 627 F.2d 772 (7th Cir. 1980).

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

lxi. *Charles,* 627 F.2d at 782.

lxii. *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976).

lxiii. *Charles*, 627 F.2d at 784.

lxiv. Ibid.

lxv. *Charles v. Carey*, 579 F. Supp. 464, 470 (N.D. Ill. 1983).

lxvi. *City of Akron v. Akron Ctr. For Reproductive Health, Inc*., 462 U.S. 416 (1983). This case is often referred to as *Akron I*.

lxvii. *Charles,* 579 F. Supp. at 470-71.

lxviii. *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992).

lxix. Ibid. at 916. (Stevens, J., concurring in part, dissenting in part).

lxx. Ibid. at 934. (Blackmun, J., concurring in part, concurring in the judgment, and dissenting in part).

lxxi. See *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 166-67 (4th Cir. 2000), holding that regulations addressing medical and safety aspects of abortion do not constitute undue burdens; see also *Women's Med. Ctr. v. Bell*, 248 F.3d 411 (5th Cir. 2001), holding that undue burden test is proper standard for review of abortion clinic regulations.

lxxii. "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), quoting *Gregg v. Georgia*, 428 U.S. 153, 169 n.15 (1976).

lxxiii. *Casey*, 505 U.S. at 882.

lxxiv. Ibid. at 880.

lxxv. "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, 105 (David T. Baird et al., eds., 1995).

---

lxxvi. *Casey,* 505 U.S. at 882-83.

lxxvii. AB § 1758 §1(d)(2), 1997-98 Reg. See. (Cal. 1998), available at http://www.leginfo.ca.gov/pub/97-98/bill/asm/ab_1751-1800/ab_1758_bill_19980423_amended_asm.html.

lxxviii. 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 http://www.leginfo.ca.gov/pub/97-98/bill/asm/ab_1751-1800/ab_1758_vote_19980505_000001_asm_comm.html (last visited Nov. 1, 2002).

lxxix. HB 1244 §170.054(b)(1)(B), 77thl Leg. (Tex. 2001), available at http://www.capitol.state.tx.us/tlo/billnbr.htm. As was the case with the California proposal, the Texas bill died in committee.

lxxx. AB § 7940 § 2516 (1)(B), 2001-02 Reg. Sess. (NY 2001), available at http://assembly.state.ny.us/leg. See Walsh, supra, n72.

lxxxi. *Planned Parenthood v. Casey,* 505 U.S. 833, 882-83 (1992).

lxxxii. "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." Anne Baker et al., "Informed Consent, Counseling, and Patient Preparation" in *A Clinician's Guide to Medical and Surgical Abortion* 27, 27 (Maureen Paul et al. eds., 1999).

lxxxiii. *Karlin v. Foust*, 188 F.3d 446, 453 (7th Cir. 1999).

lxxxiv. Ibid. at 454, discussing WIS. STAT. § 253.10(3)(c)1 (2002).

lxxxv. Ibid. at 472, n.12.

lxxxvi. *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051 (S.D. Ohio 1995), aff'd on other grounds, 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. Ibid. The court agreed that the state has an interest in preventing unnecessary cruelty to fetuses. Ibid. 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. Ibid. at 1078.

lxxxvii. Ibid. See also *Planned Parenthood v. Doyle*, 162 F.3d 463, 470 (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." The court in *Doyle* concluded by stating that "therefore Wisconsin's statute cannot be analogized to statutes that prohibit cruelty to animals." See also *Eubanks v. Stengel*, 28 F. Supp. 2d 1024, 1042 (W.D. Ky. 1998), stating that "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."

lxxxviii. Memorandum from the California Chapter of the American Association of University Women, to Martin Gallegos, Chair of the Assembly Health Committee (April 27, 1998) (on file with author); Letter from the American College of Obstetricians and Gynecologists, District IX, to Martin Gallegos, Chair of the Assembly Health Committee (April 23, 1998) (on file with author).

lxxxix. See generally W. Page Keeton et al., *Prosser and Keeton on the Law of Torts* §§ 9, 32 (5th ed. 1984).

xc. Ibid. § 32, at 189-90.

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

xcii. 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), 1997-98 Reg. Sess. (Cal. 1998). 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)(1)(B), 77th Leg. (Tex. 2001). Similarly the New York legislation excludes use of fetal anesthetic in cases where the physician reasonably believes "the administration of 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), 2001-02 Reg. Sess. (NY 2001).

xciii. See Letter from the California Medical Association, to Martin Gallegos, Chair of the Assembly Health Committee (April 30, 1998) (on file with author);

Letter from The American College of Obstetricians and Gynecologists, District IX, to Martin Gallegos, Chair of the Assembly Health Committee (April 23, 1998) (on file with author); Letter from The California District American Academy of Pediatrics, to Assembly Member George Runner (no date on file) (on file with author).

xciv. Compare *Planned Parenthood League v. Bellotti*, 641 F.2d 1006, 1021 (1st Cir. 1981).

xcv. *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992). "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." Ibid. at 884.

xcvi. 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*, Jan 4, 1998, at 3A; Memorandum from the California Chapter of the American Association of University Women, to Martin Gallegos, Chair of the Assembly Health Committee (April 27, 1998) (on file with author); Letter from the American College of Obstetricians and Gynecologists, District IX, to Martin Gallegos, Chair of the Assembly Health Committee (April 23, 1998) (on file with author).

xcvii. According to the most recent figures from the Centers for Disease Control issued in the Morbidity and Mortality Weekly Report, 88% of all abortions obtained in 1999 occurred before the thirteenth week of pregnancy. Julie L. Gerberding et al., "Abortion Surveillance: United States, 1999," 51 MMWR 1 (2002), available at http://www.cdc.gov/mmwr/PDF/ss/ss5109.pdf.

xcviii. Letter from the California Medical Association, to Martin Gallegos, Chair of the Assembly Health Committee (April 30, 1998) (on file with author). See also Warren, supra n126, at 3A.

xcix. David Stout, "An Abortion Rights Advocate Says He Lied About Procedure," *N.Y. Times*, Feb. 26, 1997, at A12.

c. Douglas Johnson, "Comforting Myths About Abortion," *Wall St. J.*, May 14, 2001. Compare Lawrence B. Finer & Stanley K. Henshaw, "Incidence and

services in the United States in 2000," 35 *Perspec. on Sexual & Reprod. Health* 6 (Jan./Feb. 2003) available at http://www.agi-usa.org/pubs/journals/35006303.pdf (last visited Feb. 22, 2003).

ci. "Planned Parenthood Federation of America, Fact Sheet: Abortion After the First Trimester" (1997), available at http://www.plannedparenthood.org/library/facts/abotaft1st_010600.html (last visited Nov. 1, 2002).

cii. Baker et al., supra n103, at 27.

ciii. 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).

civ. Victoria Tepe, "Fetal Pain: What We (Don't) Know, and Why We Need to Know It," *The Body Politic*, Mar. 1997, at 8.

cv. Memorandum from the California Chapter of the American Association of University Women, to Martin Gallegos, Chair of the Assembly Health Committee (April 27, 1998) (on file with author). See also Warren, supra n126, at 3A (quoting Mark I. Evans, M.D.).

cvi. Warren, supra n126, at 3A (quoting Charlotte Newhart, chief administrative officer of the American College of Obstetricians and Gynecologists in California); Letter from the American College of Obstetricians and Gynecologists, District IX, to Martin Gallegos, Chair of the Assembly Health Committee, District IX (April 23, 1998) (on file with author).

cvii. 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 Susan Dudley, *What is Surgical Abortion?* (National Abortion Federation, 1996), majority of abortions occurring after thirteenth week are done on an outpatient basis, at http://www.prochoice.org.

cviii. See Henshaw, supra n137, at 20, providing that "[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."

cix. 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 Senate Hearings, supra n119 (statement of Warren M. Hern, M.D.).

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

cxi. See Baker et al., supra n103, at 27.