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Federally Mandated Informed Consent: Has Government Gone Too Far

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Recommended Citation

Linda P. McKenzie, Federally Mandated Informed Consent: Has Government Gone Too Far, 20 J.L. & Health 267 (2006-2007)

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FEDERALLY MANDATED INFORMED CONSENT: HAS
GOVERNMENT GONE TOO FAR?*

LINDA P. MCKENZIE*

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I. INTRODUCTION

On April 17, 2007, the United States Supreme Court handed down a long awaited opinion concerning the constitutionality of a law banning a single, specific abortion procedure.¹ The Partial-Birth Abortion Ban Act (the Act) criminalized a surgical procedure known as “intact D & E” or “D & X” [hereafter D & X].² The method,

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¹Gonzales v. Carhart, 127 S. Ct. 1610 (2007).

²Carhart v. Ashcroft, 331 F. Supp 2d 805 (2004). D & E refers to dilation and extraction.

which is extremely rare and used only after the first trimester of pregnancy, is known outside of the medical community as “partial-birth abortion.”³

In the months of litigation leading up to the Supreme Court’s decision to review the Act, opponents had expressed two primary concerns. First, the Act lacked an exception for the health of the mother. The Supreme Court mandated such an exception in *Roe v. Wade* and reaffirmed its position numerous times, most recently in *Ayotte v. Planned Parenthood of Northern New England*.⁴ Second, while proponents claimed it applied only to D & X, it was actually broad enough to include all surgical techniques used after thirteen and one third weeks of gestation, thus, imposing an undue burden on women undergoing abortion after that point.

Three federal districts courts agreed with those challenging the Act. The decisions of these courts were upheld by the circuit courts which reviewed the Partial-Birth Abortion Ban Act of 2003.⁵ For guidance, all of the courts reviewing the Act relied on a 2000 Supreme Court opinion finding almost identical language in a Nebraska law to be unconstitutional.⁶ Surprisingly, the Supreme Court agreed to review two of the circuit court cases.

Before the Supreme Court accepted certiorari, in what appeared to be no more than an attempt to circumvent the judicial system, the 109th United States Congress considered a new abortion measure. If passed, the Unborn Child Pain Awareness Act would have forced abortion providers to deliver a scripted message to women requesting abortion services.⁷ Under this legislation, physicians violate the law unless they inform patients who have attained thirteen and one third weeks of pregnancy that “the process of being killed in an abortion will cause the unborn child pain.”⁸ Sponsors claimed that the bill merely required “informed consent” but opponents contended that the language was meant to dissuade women from undergoing second trimester abortions. Congress was also criticized for choosing physicians to deliver the government’s message about fetal pain, a topic on which the medical community has not reached a consensus.

³*Id.* In 2001, 1.4 percent of abortions were performed at twenty-one weeks or more. Lilo T. Strauss et al., *Abortion Surveillance --- United States, 2001*, 53 (SS09) MORBIDITY & MORTALITY WKLY. REP. SURVEILLANCE SUMMARIES 1, 1-32 (2004), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5309a1.htm> (last visited May 22, 2007).

⁴*Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320 (2006) (stating that “our precedents hold, that a State may not restrict access to abortions that are ‘necessary, in appropriate medical judgment, for preservation of the life or health of the mother’”). See also *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992) (plurality opinion) (quoting *Roe v. Wade*, 410 U.S. 113, 164–165 (1973), “[i]f the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother”).

⁵*Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005); *Planned Parenthood Fed’n of Am. v. Gonzales*, 453 F.3d 1163 (9th Cir. 2006); *Nat’l Abortion Fed’n v. Gonzales*, 437 F.3d 278 (2d Cir. 2006).

⁶*Stenberg v. Carhart*, 530 U.S. 914, 948 (2000).

⁷Unborn Child Pain Awareness Act of 2005, H.R. 356, 109th Cong. (2005); see also Unborn Child Pain Awareness Act of 2005, S. 51, 109th Cong. (2005).

⁸*Id.*

Laws mandating disclosure of particular information are known as informed consent laws. They exist primarily in the area of reproductive health and most often apply to women seeking abortion. This article discusses the legal and ethical issues that arise when lawmakers decide what patients must be told before they can access certain medical procedures.

Part II examines some of the ethical implications of informed consent laws. Physicians have a duty to obtain a patient's informed consent before acting.⁹ The duty to inform arises from the principle of individual autonomy.¹⁰ In the past, physicians were sometimes accused of withholding material information from patients. This paternalism was justified on the ground that the patient would not want to know all of the negative or unpleasant facts. As a result of litigation, legislation, and a change in public perception about the appropriate balance in the doctor-patient relationship, physician paternalism has given way to patient self-determination.¹¹

Part III discusses legal concerns raised by informed consent laws. These include the First Amendment free speech rights of physicians¹² and patients' right to obtain their physicians' advice and counsel without government interference.¹³ This article examines two United States Supreme Court cases that addressed these aspects of informed consent and the implications of the Court's holdings for fetal pain informed consent legislation.¹⁴

Part IV reviews two recent pieces of federal legislation with the potential to significantly affect abortion practice and the lives of women who seek abortion services. The first law, the Partial-Birth Abortion Ban Act, criminalized two common abortion procedures.¹⁵ Although signed into law in 2003,¹⁶ implementation of the Act was enjoined by three federal courts.¹⁷ Ultimately, the decisions of the Court of Appeals for the Eighth and Ninth Circuits were reversed by the United States Supreme Court.¹⁸

⁹*Cantebury v. Spence*, 464 F.2d 772, 782-83 (D.C. Cir. 1972). "The doctrine that a consent effective as authority to perform therapy can arise only from the patient's understanding of alternatives to and risks of the therapy is commonly denominated 'informed consent.'" *Id.* at 780 n.15 (citation omitted).

¹⁰*Id.* at 786.

¹¹*Id.*

¹²*Rust v. Sullivan*, 500 U.S. 173 (1991); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

¹³*Roe v. Wade*, 410 U.S. 113, 153 (1973).

¹⁴*Rust*, 500 U.S. at 173; *Casey*, 505 U.S. at 833.

¹⁵Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531 (2006).

¹⁶*Id.*

¹⁷*Nat'l Abortion Fed'n v. Ashcroft*, 330 F. Supp 2d 436 (S.D.N.Y. 2004), *aff'd*, 437 F.3d 278 (2d Cir. 2006); *Planned Parenthood Fed'n of Am. v. Ashcroft*, 320 F. Supp 2d 957 (N.D. Cal. 2004), *aff'd*, 435 F.3d 1163 (9th Cir. 2006); *Carhart v. Ashcroft*, 331 F. Supp 2d 805 (D. Neb. 2004), *aff'd sub nom. Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005).

¹⁸*Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005), *rev'd*, 127 S. Ct. 1610 (2007); *Planned Parenthood Fed'n of Am. v. Gonzales*, 435 F.3d 1163 (9th Cir. 2006), *rev'd*, 127 S.

Prior to the 2007 *Gonzales v. Carhart* decision, members of Congress introduced a second bill aimed at eliminating mid-trimester surgical abortions. The Unborn Child Pain Awareness Act would criminalize the performance of abortions after thirteen-and-one-third weeks of pregnancy without first informing the patient that the fetus would experience profound pain.¹⁹ Additionally, it required the abortion provider to offer the option of fetal anesthesia.²⁰ Judging from the title, it was not readily apparent that the Unborn Child Pain Awareness Act was aimed at curbing late-term abortion but the surrounding circumstances suggested just that. This article argues that Congress's use of this back door approach to achieving its objective actually undermined its credibility and its chance for success.

Part V briefly reviews the cases that identified and defined the constitutional right to an abortion.²¹ It then discusses cases where courts considered the constitutionality of informed consent laws and compares the reasoning of those courts to the arguments likely to be raised in any challenge to the federal Unborn Child Pain Awareness Act of 2005.

Part VI summarizes the findings of a team of physicians at the University of California at San Francisco, concluding that fetal perception of pain is unlikely prior to twenty-nine weeks gestation. Reaction to the article, which appeared in the August 2005 issue of the *Journal of the American Medical Association*, was positive for the most part.²² Some physicians as well as pro-life advocates, however, criticized the article as no more than an effort to discredit fetal pain legislation.

II. ETHICAL IMPLICATIONS OF INFORMED CONSENT

“[I]t is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.”²³

Informed consent encompasses the principle that an individual is entitled to decide what will happen to her body. Furthermore, based on this individual right physicians incur a duty to inform each patient about the potential risks and benefits of any recommended medical treatment.²⁴ The physician's duty arises from the concept, “fundamental in American jurisprudence, that ‘[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .’”²⁵

Ct. 1610 (2007). The Supreme Court heard oral argument in both cases on Nov. 8, 2006. It handed down an opinion in April 2007.

¹⁹Unborn Child Pain Awareness Act of 2005, S. 51, 109th Cong. (2005).

²⁰*Id.*

²¹*Roe v. Wade*, 410 U.S. 113, 153 (1973).

²²Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 JAMA 947, 947-54 (2005).

²³*Cantebury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972).

²⁴*Id.* at 780. “True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options and the risks attendant upon each.” *Id.*

²⁵*Id.* (quoting *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)).

In the seminal informed consent case, *Cantebury v. Spence*, the Court of Appeals for the D.C. Circuit held that a physician has a duty to communicate the specific information that a patient needs to make an informed decision.²⁶ Other courts judged the extent of the physician's duty by what prudent physicians disclosed in similar circumstances.²⁷ The *Cantebury* court rejected this reasoning, finding that neither the obligation to disclose nor the scope of disclosure originates from a community standard.²⁸ Instead, the physician's duty and the scope of his obligation to inform originate from the patient's right of self-determination.²⁹ That right cannot be exercised effectively unless the patient possesses "enough information to enable an intelligent choice."³⁰ Thus, the scope of the physician's duty requires disclosure of information that the patient would find material to making a treatment decision, to weighing the risks associated with having or not having the treatment, and to decide on any alternative treatment.³¹

The *Cantebury* court recognized that there are two instances where a physician holds the privilege not to disclose.³² The first arises in an emergency situation where a patient is incapable of consent.³³ The second situation is one where the disclosure may be so detrimental to the patient that it is medically contraindicated.³⁴ The second exception provides leeway for the physician to determine, within limits, what is in a patient's best interests to know and to tailor disclosure to a patient's unique circumstance.³⁵ This exception has been invoked in the context of informed consent for abortion. Some physicians feel that giving a detailed account of the effect of abortion on the fetus is harmful to the health interests of the patient.³⁶

²⁶*Id.* at 781.

²⁷*Id.* at 783-84.

²⁸*Id.* at 780-81, 786.

In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision.

Id. at 786.

²⁹*Id.* at 780-81.

³⁰*Id.* at 786.

³¹*Id.* at 782.

³²*Id.* at 788.

³³*Id.*

³⁴*Id.* at 789.

³⁵*Id.*

³⁶*Permits Human Stem Cell Research in New Jersey: Hearing on S.1909 Before the S. Comm. on Health, Human Serv., and Senior Citizens*, 2002-2003 Leg. Sess. (Nov. 4, 2002) (statement of Dr. Dianne Irving, Professor of Philosophy, Catholic University of America) [hereinafter Statement of Dr. Dianne Irving], available at http://www.njleg.state.nj.us/media/archive_audio2.asp?KEY=SHH&SESSION=2002.

There are three important public policy reasons behind designating to physicians responsibility for obtaining the informed consent of patients. First, physicians have knowledge and experience beyond that of the average patient, putting them in a position to provide information about disease processes, risks and benefits of potential treatments, and prognoses.³⁷ Second, the personal and intimate nature of the doctor-patient relationship invites the patient to rely on the advice and expertise of the physician.³⁸ Third, the idea that physicians owe patients a duty of care is already established in tort law, such that failure to obtain a patient's informed consent breaches that duty and gives rise to a claim of negligence.³⁹ The underlying public policy is to ensure that patients have sufficient facts for making health care decisions. Physicians are uniquely qualified and properly motivated to see that patients get the information they need.

The scope of informed consent in the context of a decision regarding abortion has been thoroughly examined through litigation. In 1992, the United States Supreme Court found that a Pennsylvania informed consent law did not intrude on a physician's prerogative to tailor information to the needs of individual patients.⁴⁰ The law at issue in *Planned Parenthood of Southeastern Pennsylvania v. Casey* contained an exception to the informed consent requirement where the physician determined that disclosing certain information would have "a severely adverse effect on the physical or mental health of the patient."⁴¹ If a statute mandated informed consent but failed to include an exception like the one found in *Casey*, the common law exception to the duty to disclose recognized in *Cantebury* would still permit physicians to withhold information that would adversely affect a patient's health.⁴²

The duty to inform suggests several questions of particular significance to abortion providers. First, in the rapidly evolving field of medicine, what should be the extent of a physician's duty to possess "state of the art" knowledge? At least one commentator has called for a standard that would require physicians providing abortion services to stay abreast of research on fetal development in order to inform patients of the "most internationally agreed upon, objective, current, and accurate scientific facts."⁴³ This could include advances in fetal neurology, fetal consciousness, and fetal pain. Dr. Dianne Irving, a professor of philosophy at the

³⁷*Cantebury*, 464 F.2d at 787. "Indeed, with knowledge of, or ability to learn, his patient's background and current condition, he is in a position superior to that of most others--attorneys, for example--who are called upon to make judgments on pain of liability in damages for unreasonable miscalculation (citation omitted)." *Id.*

³⁸*Id.* at 782. "The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with armslength transactions. His dependence upon the physician for information affecting his well-being ... is well-nigh abject." *Id.*

³⁹*Id.* at 781, 783.

⁴⁰*Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

⁴¹*Id.* at 883-84.

⁴²*Cantebury*, 464 F.2d at 788-89.

⁴³Statement of Dr. Dianne Irving, *supra* note 36. Dr. Irving is a former bench research biochemist and biologist with the National Institutes of Health—National Cancer Institute.

Catholic University of America in Washington, D.C., testified before a New Jersey Senate Committee about the ethical implications of informed consent and legislation regulating fetal stem cell research and human cloning.⁴⁴ She claimed that, “‘informed consent’ requires that full, accurate, and truthful information be disseminated to all concerned decision makers.” Dr. Irving maintained that in a discussion of informed consent requirements, the first inquiry must be into the state of existing scientific evidence.⁴⁵ Like abortion, this is a highly disruptive subject often open to emotional appeals from those on both sides of the debate. Both topics raise the question of when human life begins. Dr. Irving based her conclusions about the beginning of human life on the findings of the *Nomina Embryologica Committee*, an international body “consisting of over 20 of the best and brightest human embryologist’s from around the world.”⁴⁶ If policy makers fail to rely on internationally agreed upon scientific facts, she warned that “public policy will continue to be irresponsibly based on mere fantasies and wishful thinking.”⁴⁷

Physicians’ duty to inform suggests a second question. Where informed consent statutes essentially substitute the judgment of lawmakers for the judgment of physicians, should legislators be expected to be equally as informed as physicians must be? Politicians are increasingly involved in regulating the content of informed consent. As such, it follows that any standard governing physicians’ level of knowledge must apply equally to legislators. While this makes logical sense, there is presently no mechanism in place, other than the democratic process, to ensure that policy makers are adequately informed. By contrast, a well developed system exists for monitoring physician practice, including oversight by federal, state, and various private agencies. A physician must meet state licensure requirements, adhere to federal guidelines if participating in federally funded programs such as Medicare and Medicaid, comply with federal standards to qualify for a license to prescribe controlled substances, and practice in conformance with the regulations imposed by the hospital(s) where she has staff privileges.⁴⁸ A physician may be further regulated by professional organizations and specialty boards. Medical malpractice litigation is another means of enforcing adherence to recognized standards of care. If legislators are allowed to be the arbiters of what information should be communicated by doctors to their patients, then a similar regulatory scheme should apply to them. For practical purposes, it is difficult to imagine how our present system of government might accomplish this.

A congressional body cannot possess the qualities deemed necessary for determining what information patients need in order to make educated health care

⁴⁴*Id.*

⁴⁵*Id.*

⁴⁶*Id.* “After reviewing the latest research studies in human embryology, [the *Nomina Embryologica Committee*’s] deliberations are published in the *Nomina Embryologica*, part of the larger *Nomina Anatomica*, and are professionally required to be used, along with *The Carnegie Stages of Early Human Development*, by all human embryologists in their own work.” *Id.*

⁴⁷*Id.*

⁴⁸61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 9 (2006); 70 C.J.S. *Physicians and Surgeons* § 9 (2006).

decisions. Yet through the introduction of informed consent laws, Congress and state legislatures around the country are challenging physicians for the right to make these determinations. At their core, informed consent laws are no more than an attempt to substitute the judgment of elected politicians for that of physicians. This article argues that legislative bodies, for the reasons suggested above, are not well suited to decide what is in patients' best interests. Physicians are still far better equipped to inform and advise their patients.

Cantebury v. Spence held that physicians must disclose information material to a patient's decision.⁴⁹ Today, this means that physicians should be familiar enough with contemporary research to understand how it might apply to their patients. Whether it is in a particular patient's best interest to have specific information, however, is still a decision for physicians, not lawmakers.⁵⁰

III. LEGAL IMPLICATIONS OF INFORMED CONSENT LAWS

In the past, physicians resisted informed consent laws on the basis that a legislatively imposed mandate to disclose particular information violated their First Amendment free speech rights.⁵¹ There is established First Amendment precedent for this argument.⁵² Before it became a health care issue, the question of compelled speech was raised in other contexts.⁵³ In the 1940's, the United States Supreme Court twice considered whether public school students could be forced to participate in patriotic exercises that included a pledge of allegiance to the United States, where the school child or his parents objected to the content of the pledge.⁵⁴ Reversing its earlier precedent,⁵⁵ the Court in *West Virginia State Board of Education v. Barnette* held that compelling an individual to speak infringed his rights in the same way that restricting his speech did.⁵⁶ *Barnette* and later cases challenging compelled speech in schools differ in two important ways from current challenges to mandatory informed consent laws. First, the Court recognized that the students in *Barnette* were

⁴⁹*See generally* *Cantebury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

⁵⁰*Leigh v. Olson*, 497 F. Supp. 1340, 1345 (D.N.D. 1980). The court considered a bill requiring physicians to disclose:

the 'probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed....' The physician must be permitted to exercise medical judgment and determine to what extent, if any, disclosure in this area is in the patient's best interest. To require such disclosure to every patient impermissibly injects the state into the private physician-patient relationship.

Id.

⁵¹*See* *Rust v. Sullivan*, 500 U.S. 173 (1991); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

⁵²*W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943).

⁵³*Id. See also* *Minersville Sch. Dist. v. Gobitis*, 310 U.S. 586 (1940).

⁵⁴*Barnette*, 319 U.S. at 624; *Gobitis*, 310 U.S. at 586.

⁵⁵*Gobitis*, 310 U.S. at 586.

⁵⁶*Barnette*, 319 U.S. at 624.

essentially being forced to adopt an ideology.⁵⁷ Laws requiring physicians to make statements to patients about government's appraisal of the risks and benefits associated with a proposed treatment do not force physicians to accept the government's view as their own.⁵⁸ Second, the Court emphasized that children are particularly vulnerable to coercion.⁵⁹ Informed consent laws, on the other hand, apply to physicians, a group that is not so readily coerced.

In 1991, the Supreme Court directly addressed physicians' free speech rights in *Rust v. Sullivan*.⁶⁰ In *Rust*, family planning clinics that received Title X funds were ineligible for the funding if they offered abortion services, including counseling.⁶¹ Physicians were not permitted to discuss abortion as an option or even to refer a patient to another clinic that could present the full range of alternatives.⁶² Physicians working in these clinics brought suit, claiming that the regulation abridged their free speech rights and unduly interfered with the doctor-patient relationship.⁶³ The Court disagreed with the physicians.⁶⁴ Instead, the Court reframed the issue as whether Congress could impose restrictions as a condition of receiving a federal grant.⁶⁵ The grantee was free to reject Title X funds and continue to counsel patients about abortion services; thus, there was no government interference with speech.⁶⁶

The Court also rejected the physician's contention that the regulation imposed significantly on the doctor-patient relationship.⁶⁷ The clinics provided family planning services only. The doctor-patient relationship, therefore, was not "sufficiently all encompassing so as to justify an expectation on the part of the patient of comprehensive medical advice."⁶⁸ A patient would, therefore, not mistake the clinic physician's silence about abortion to mean that the physician did not consider abortion an alternative in her case.⁶⁹ The Court also noted that the regulations did not require any physician "to represent as his own any opinion that he does not in fact hold."⁷⁰

⁵⁷*Id.* at 633. The pledge and salute require an "affirmation of a belief and an attitude of mind." *Id.*

⁵⁸*Rust v. Sullivan*, 500 U.S. 173, 200 (1991).

⁵⁹*Lee v. Weisman*, 505 U.S. 577, 599 (1992).

⁶⁰*Rust*, 500 U.S. at 173.

⁶¹*Id.*

⁶²*Id.*

⁶³*Id.*

⁶⁴*Id.*

⁶⁵*Id.*

⁶⁶*Id.* at 199. "Title X subsidies are just that, subsidies . . . to avoid the force of the regulations, [the recipient] can simply decline the subsidy." *Id.*

⁶⁷*Id.* at 200.

⁶⁸*Id.*

⁶⁹*Id.*

⁷⁰*Id.*

In 1992, the Supreme Court considered an informed consent law imposing a duty on physicians to affirmatively provide specific information to patients undergoing abortion.⁷¹ Unlike the physicians in *Rust*, these doctors were not receiving government grants.⁷² The statute at issue in *Planned Parenthood of Pennsylvania v. Casey* specified that a physician performing an abortion must “inform the woman of the nature of the abortion procedure, the health risks of the abortion and of childbirth, and the ‘probable gestational age of the unborn child.’”⁷³ In addition, the physician or a “qualified nonphysician” was required to “inform the woman of the availability of printed materials published by the State describing the fetus. . . .”⁷⁴

The doctors argued that they had a First Amendment right “not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State.”⁷⁵ While agreeing that the Pennsylvania law implicated the physicians’ First Amendment rights not to speak, the Supreme Court found that the rights applied only to the physicians’ practice of medicine, which was already subject to regulation and licensure by the states.⁷⁶ Furthermore, the law itself contained an exception.⁷⁷ Physicians were not required to disclose information to a patient where disclosure would adversely affect the patient’s physical or mental health.⁷⁸

Under *Rust* and *Casey*, the federal government is free to restrict speech as a condition for the receipt of grant money. The case law allows states to go further and impose “informed consent” obligations on all doctors, at least to the extent that any such law contains an exception in cases where disclosure would adversely affect a patient.

IV. FEDERAL ABORTION LEGISLATION

A. *Partial-Birth Abortion Ban Act*

President Bush signed the federal Partial-Birth Abortion Ban Act [hereinafter PBABA] into law on November 5, 2003.⁷⁹ Congress passed the law partially out of

⁷¹*Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

⁷²*Id.*

⁷³*Id.* at 881.

⁷⁴*Id.* Additionally, the statute required the physician or qualified nonphysician to provide “information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion.” *Id.*

⁷⁵*Id.* at 884.

⁷⁶*Id.* at 885.

⁷⁷*Id.* at 883.

⁷⁸*Id.* at 883-84. In order to exercise this exception the physician must be able to “demonstrate by a preponderance of the evidence, that he or she reasonably believed that furnishing the information would have resulted in a severely adverse effect on the physical or mental health of the patient.” *Id.*

⁷⁹Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531 (2006).

concern that fetuses were subjected to pain during late-term abortion procedures.⁸⁰ Given its conclusion that a fetus is capable of experiencing pain, Congress deemed partial-birth abortion, also termed D&X, to be exceptionally barbaric and cruel.⁸¹ The PBABA was enacted to stop D&X abortions. D&X was only minimally different from another method common in the second trimester of pregnancy known as intact D&E.⁸² In a challenge to a Nebraska law with language similar to the federal ban,⁸³ the United States Supreme Court held that the wording used was broad enough to encompass both D&E and D&X.⁸⁴ Since the statute outlawed D&E and D&X, the two most common procedures used for late-term abortions, it placed an

⁸⁰§ 1531, Congressional Findings § 2(14)(M). “It is a medical fact, however, that unborn infants at this stage can feel pain when subjected to painful stimuli and that their perception of this pain is even more intense than that of newborn infants and older children when subjected to the same stimuli.” *Id.*

⁸¹*Carhart v. Gonzales*, 413 F.3d 791, 794 (8th Cir. 2005). Two procedures are currently referred to as partial-birth abortion: “intact D&E” and “D&X.” From the perspective of fetal pain, these procedures are arguably more humane than D&E. In an intact D&E abortion, the fetus is delivered intact into the vagina. “If the fetus presents head first the physician collapses the skull of the fetus and then removes the ‘intact’ fetus.” If the fetus presents feet first, the physician “pulls the fetal body through the cervix, collapses the skull, and extracts the fetus through the cervix.” The D&E involves grasping a fetus with clamps and pulling it through a partially dilated maternal cervix into the vagina. Cervical resistance causes dismemberment of the fetus while the brain and neurological system remain intact.

⁸²*Stenberg v. Carhart*, 530 U.S. 914, 948 (2000).

⁸³*Id.* at 921-22. The Supreme Court described the Nebraska Act as:

‘No partial-birth abortion shall be performed in this state, unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.’ The statute defines ‘partial birth abortion’ as: ‘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.’ It further defines ‘partially delivers vaginally a living unborn child before killing the unborn child’ to mean ‘deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.’

Id. (citations omitted). See also Stuart Derbyshire, *Late Abortion and the ‘Fetal Pain’ Fallacy: The USA’s Ban on ‘Partial-Birth Abortion’ Rests on Flawed Arguments About Fetal Development*, *Spiked Essays*, Mar. 15, 2005, <http://www.spiked-online.com/Articles/0000000CA93C.htm>. The Partial-Birth Abortion Ban Act of 2003 prohibits:

[A]n abortion in which the person performing the abortion (A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of a breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered fetus; and (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus.

18 U.S.C. § 1531 (2006).

⁸⁴*Stenberg*, 530 U.S. at 922.

undue burden on a woman seeking an abortion after twenty weeks gestation; therefore, the legislation was found unconstitutional.⁸⁵

Under the PBABA, a practitioner employing one of the banned methods could be fined up to two hundred fifty thousand dollars and sentenced to up to two years in prison.⁸⁶ Shortly after the bill was signed into law, Dr. Leroy Carhart, the National Abortion Federation, and Planned Parenthood each filed for an injunction to prevent its implementation.⁸⁷ The various plaintiffs alleged that the PBABA was unconstitutional because it did not contain an exception allowing the procedures when necessary to preserve a woman's health.⁸⁸ In addition, they asserted that the PBABA was unconstitutionally vague, imposed an undue burden on a woman's right to choose an abortion, served no legitimate state interest, violated women's right to equal protection under the law, and provided a constitutionally insufficient exception for allowing procedures to save a woman's life.⁸⁹

Concurrent trials were conducted in federal courts in New York, California, and Nebraska.⁹⁰ All three courts concluded that the law was unconstitutional.⁹¹ Each of the decisions was appealed and upheld by the appropriate Court of Appeals.⁹² In a lengthy and detailed opinion in one of the cases, *Carhart v. Ashcroft*, Federal District Court Judge Richard Kopf recounted the testimony of dozens of physicians who provided abortions.⁹³ Applying Supreme Court precedent, Judge Kopf found the ban unconstitutional on the ground that it lacked a health exception.⁹⁴ The Court of Appeals for the Eighth Circuit upheld the District Court's ruling.⁹⁵ While this

⁸⁵*Id.* at 914. The court does not define "late-term abortion" but seems to use "abortion after twenty weeks gestation" and "late-term abortion" interchangeably.

⁸⁶Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531 (2006).

⁸⁷*Nat'l Abortion Fed'n v. Ashcroft*, 330 F. Supp 2d 436 (S.D.N.Y. 2004); *Planned Parenthood Fed'n of Am. v. Ashcroft*, 320 F. Supp 2d 957 (N.D. Cal. 2004); *Carhart v. Ashcroft*, 331 F. Supp 2d 805 (D. Neb. 2004).

⁸⁸The United States Supreme Court held in *Roe v. Wade*, 410 U.S. 113, 163-64 (1973), that such an exception is a requisite component of any restrictive scheme. *See also* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992).

⁸⁹*Derbyshire*, *supra* note 83. Stuart Derbyshire is assistant professor of radiology and anesthesiology at the University of Pittsburgh Medical Center.

⁹⁰*Nat'l Abortion Fed'n*, 330 F. Supp 2d at 436; *Planned Parenthood Fed'n of Am.*, 320 F. Supp 2d at 957; *Carhart*, 331 F. Supp 2d at 805.

⁹¹*Nat'l Abortion Fed'n*, 330 F. Supp 2d at 436; *Planned Parenthood Fed'n of Am.*, 320 F. Supp 2d at 957; *Carhart*, 331 F. Supp 2d at 805.

⁹²*Nat'l Abortion Fed'n v. Gonzales*, 437 F.3d 278 (2d Cir. 2006); *Planned Parenthood Fed'n of Am. v. Gonzales*, 435 F.3d 1163 (9th Cir. 2006), *rev'd*, 127 S. Ct. 1610 (2007); *Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005), *rev'd*, 127 S. Ct. 1610 (2007).

⁹³*Carhart*, 331 F. Supp 2d at 805 (Kopf, J.).

⁹⁴*Id.*

⁹⁵The Supreme Court subsequently reversed the Court of Appeals for the Eight Circuit. *Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005), *rev'd*, 127 S. Ct. 1610 (2007).

litigation was in progress over the constitutionality of the PBABA, Congress introduced similar legislation under the guise of preventing fetal pain.⁹⁶

B. Unborn Child Pain Awareness Act of 2005

In January 2005, Senator Sam Brownback (R-KS) and various co-sponsors introduced a bill entitled the Unborn Child Pain Awareness Act of 2005 [hereinafter UCPA Act]; its stated purpose was “[t]o ensure that women seeking an abortion are fully informed regarding the pain experienced by their unborn child.”⁹⁷ The UCPA Act arose out of concern over the capacity of a fetus to experience pain.⁹⁸ Whether fetuses perceive pain has been debated for over two decades⁹⁹ but testimony presented during the Partial-Birth Abortion Ban Act trials regarding the severe pain experienced by the fetus renewed congressional concern.¹⁰⁰

The UCPA Act states in pertinent part:

An abortion provider or the provider’s agent . . . shall make the following oral statement to the pregnant woman . . . : You are considering having

⁹⁶Unborn Child Pain Awareness Act of 2005, S. 51, 109th Cong. (2005). The bill included language similar to that found in the Partial-Birth Abortion Ban Act of 2003, describing the abortion methods commonly used at twenty weeks after fertilization.

Examples of abortion methods used twenty weeks after fertilization include, but are not limited to the following:

(A) The Dilation and Evacuation (D&E) method of abortion is commonly performed in the second trimester of pregnancy. In a dilation and evacuation abortion, the unborn child’s body parts are grasped at random with a long-toothed clamp. The fetal body parts are then torn off of the body and pulled out of the vaginal canal. The remaining body parts are grasped and pulled out until only the head remains. The head is then grasped and crushed in order to remove it from the vaginal canal.

(B) Partial-Birth Abortion is an abortion in which the abortion practitioner delivers an unborn child’s body until only the head remains inside the womb, punctures the back of the child’s skull with a sharp instrument, and sucks the child’s brains out before completing the delivery of the dead infant.

Id.

⁹⁷*Id.* Similar legislation was introduced by Rep. Christopher Smith [R-NJ] in 2004. See Unborn Child Pain Awareness Act of 2004, H.R. 4420, 108th Cong. (2004), available at <http://www.govtrack.us/congress/bill.xpd?bill=h108-4420>. Three states enacted legislation in 2005 requiring physicians who provide abortions or abortion counseling to instruct patients that a fetus feels pain. See Act of May 10, 2005, Woman’s Right to Know Act, H.B. 197 (to be codified at GA. CODE ANN. §31-9A-4); see also Unborn Child Pain Awareness and Prevention Act of 2005, No. 1696 (to be codified at ARK. CODE ANN. §§20-16-1101-1111); see also H.F. 235, 2005 Leg. 84th Sess. (Mo. 2005).

⁹⁸Press Release, United States Senator Sam Brownback, Brownback Reintroduces Unborn Child Pain Bill (Jan. 26, 2005), available at <http://brownback.senate.gov/pressapp/record.cfm?id=230920>.

⁹⁹Teresa S. Collett, *Fetal Pain Legislation: Is It Viable?*, 30 PEPP. L. REV. 161, 161 (2003).

¹⁰⁰*Partial-Birth Abortion Ban Act of 2003: Hearing on H.R. 760 Before the H. Subcomm. on the Constitution of the H. Comm. on the Judiciary*, 108th Cong. (2003) (statement of Dr. Mark G. Neerhof, Associate Professor of Obstetrics and Gynecology, Northwestern University Medical School).

an abortion of an unborn child who will have developed, at the time of the abortion, approximately XX weeks after fertilization. The Congress of the United States has determined that at this stage of development, an unborn child has the physical structures necessary to experience pain . . . Congress finds that there is substantial evidence that the process of being killed in an abortion will cause the unborn child pain, even though you receive a pain-reducing drug or drugs . . . [Y]ou have the option of choosing to have anesthesia . . . administered directly to the pain-capable unborn child if you so desire. The purpose of administering such drug or drugs would be to reduce or eliminate the capacity of the unborn child to experience pain during the abortion procedure. In some cases, there may be some additional risk to you associated with administering such a drug.¹⁰¹

Congress' rationale for enacting federal legislation was government's "interest in reducing the number of events in which great pain is inflicted on sentient creatures."¹⁰² Congress analogized the UCPA Act to federal legislation protecting animals during transportation and slaughter and laws protecting animals used in research.¹⁰³ The scientific community has criticized the UCPA Act and the underlying medical science used to justify it.¹⁰⁴ The legislation has three obvious flaws, which undermine the credibility of Congress as fact finder. First, the legislation is inconsistent with its stated goals. The bill was intended to reduce the suffering of sentient creatures, yet it fails to consider fetal pain in all situations where it may arise.¹⁰⁵ Second, the scientific support for the bill is not accepted by the majority of experts in science and medicine.¹⁰⁶ Third, Congress invited testimony from scientists who agree with its findings about fetal pain to the exclusions of those who do not.¹⁰⁷

The ostensible purpose of the bill is to eliminate fetal pain, yet the bill does not address fetal pain in any context other than abortion. If Congress truly meant to reduce fetal suffering it would have imposed similar informed consent standards in all situations where a fetus might feel pain. For example, if, as Congress found, a fetus is capable of experiencing pain at twenty weeks after fertilization, then

¹⁰¹Unborn Child Pain Awareness Act of 2005, S. 51, 109th Cong. § 2902 (2005) (emphasis added).

¹⁰²*Id.* at § 2(7).

¹⁰³*Id.* at § 2(7)(A)-(C).

¹⁰⁴Derbyshire, *supra* note 83.

¹⁰⁵Unborn Child Pain Awareness Act of 2005, § 2(7). "There is a valid Federal Government interest in reducing the number of events in which great pain is inflicted on sentient creatures." *Id.*

¹⁰⁶*See, e.g.,* W. Huang et al., *Management of Fetal Pain During Invasive Fetal Procedures: A Review*, 55 ACTA ANAESTHESIOLOGICA BELGICA 119 (2004); Lee, *supra* note 22.

¹⁰⁷For example, Congress heard testimony from Dr. K.S. Anand, who testified for the federal government in the Partial-Birth Abortion Ban Act trials, but did not invite the University of California at San Francisco investigators to present evidence.

certainly a full-term fetus experiences significant pain during labor and the process of birth.¹⁰⁸ Modern diagnostic techniques enable physicians to diagnose painful fetal conditions weeks or even months before birth.¹⁰⁹ These fetuses would benefit from pain management until the condition can be corrected. Until recently, it was uncommon for the parents of male newborns to be consulted about whether they wanted their infant to receive anesthesia or analgesia for a circumcision surgery. A child recently born should be eligible for the same protection as the unborn child. Yet the UCPA Act does not require a physician to offer anesthesia for the fetus during labor and birth, does not require ongoing pain management for fetuses with painful conditions, and does not require parents to acknowledge the likelihood of significant pain before authorizing circumcision surgery for their newly born child.¹¹⁰

Congress has been criticized for relying on unproven “facts” and forcing physicians to deliver its message to women contemplating abortion. The bill contains the following factual findings: (i) at twenty weeks after fertilization a fetus has the “physical structures necessary to experience pain;” (ii) “substantial evidence” shows that fetus at this gestational age “draw away from certain stimuli” in a manner that suggests that they are responding to a painful stimulus; (iii) fetus who undergo prenatal surgery at twenty or more weeks post-fertilization routinely receive anesthesia; and (iv) “substantial evidence” shows that abortion procedures are painful to the fetus.¹¹¹

In November 2005, Congress held oversight hearings on the UCPA Act and invited two physicians, an attorney, and a medical ethicist to testify.¹¹² Dr. Kanwaljeet Anand, a pediatrician and professor at the University of Arkansas for Medical Sciences, testified in support of the proposed law.¹¹³ He was previously the government’s expert witness in the three District Court challenges to the Partial-Birth Abortion Ban Act.¹¹⁴ Dr. Anand contended that a fetus is capable of

¹⁰⁸Some authors have suggested providing analgesia for painful fetal conditions, such as instrumental vaginal delivery. Huang, *supra* note 106, at 122 (citing V. Glover & N.M. Fisk, *Fetal Pain: Implications for Research and Practice*, 106 BRIT. J. OBSTETRICS & GYNAECOLOGY 881, 881-886 (1999); J.S. Deprest et al., *Operative Fetoscopy: New Perspective in Fetal Therapy?*, 17 PRENATAL DIAGNOSIS 1247, 1247-60 (1997).

¹⁰⁹Huang, *supra* note 106, at 121, 122.

¹¹⁰Unborn Child Pain Awareness Act of 2005, S. 51, 109th Cong. (2005).

¹¹¹*Id.* at § 2.

¹¹²Erin K. McCormick, *House Holds Unborn Child Pain Hearing*, THE WILBERFORCE FORUM, Nov. 8, 2005, <http://www.wilberforce.org/article.asp?ID=1041>.

¹¹³*Id.* Dr. Anand has published several studies on neonatal hormonal stress responses. See K.S. Anand, *Relationships Between Stress Responses and Clinical Outcome in Newborns, Infants, and Children*, 21 CRITICAL CARE MED. 358, 358-59 (1993); Sinno H.P. Simmons et al., *Do We Still Hurt Newborn Babies? A Prospective Study of Procedural Pain and Analgesia in Neonates*, 157 ARCHIVES PEDIATRICS & ADOLESCENT MED. 1058, 1058-64 (2003).

¹¹⁴For a critique of Dr. Anand’s testimony, see Derbyshire, *supra* note 83. “His testimony in California, Nebraska, and New York, for which he was paid \$450 an hour plus expenses by the current U.S. government, was based on an evidently dubious and shaky claim of ‘medical certainty.’” *Id.*

experiencing pain after twenty weeks gestation.¹¹⁵ He attacked a meta-analysis of fetal pain research recently published in the *Journal of the American Medical Association* [hereinafter JAMA].¹¹⁶

Dr. Jean Wright, Professor and Chair of Pediatrics at the Mercer School of Medicine, has worked with premature infants for several decades.¹¹⁷ Based on her clinical experience, Dr. Wright testified that infants born at twenty-three weeks and beyond are capable of feeling pain.¹¹⁸ Law professor Teresa Collett testified that requiring physicians to inform patients about fetal pain would be consistent with the Court's informed consent jurisprudence.¹¹⁹

Only one expert witness opposed the UCPA Act. Dr. Arthur Caplan, Director of the Center for Bioethics and Department of Medical Ethics at the University of Pennsylvania, opposed the legislation, primarily because there is no medical consensus on fetal pain and the risks associated with anesthesia outweigh the possible benefits.¹²⁰ He also testified that it would be poor public policy for Congress to decide that a physician must "represent something as a fact which is not known to be true or agreed upon by the majority of medical and scientific experts as valid."¹²¹

The hearings were also notable for the physicians and scientists who were not asked to present evidence. The committee did not hear from Dr. Stuart Derbyshire, assistant professor of radiology and anesthesiology at the University of Pittsburgh Medical Center, and a critic of Dr. Anand.¹²² It did not solicit testimony from any of the investigators responsible for the JAMA article entitled *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*.¹²³ None of the leading fetal surgery

¹¹⁵While testifying for the government in the PBABA trials, Dr. Anand acknowledged that investigators at Britain's Royal College of Obstetricians and Gynecologists placed the age at no earlier than twenty-six weeks. Cynthia L. Cooper, 'Fetal Pain' Bill New Item on Anti-Choice Agenda, WOMEN'S ENEWS, Aug. 16, 2004, <http://www.womensenews.org/article.cfm/dyn/aid/1951>.

¹¹⁶McCormick, *supra* note 112.

¹¹⁷*Id.*

¹¹⁸*Id.*

¹¹⁹*Id.*

¹²⁰*Id.*

¹²¹*Id.*

¹²²*See generally* Derbyshire, *supra* note 83.

¹²³Lee, *supra* note 22. The article was authored by an attorney and four physicians at the University of California at San Francisco (UCSF) who concluded that fetal pain is unlikely before the third trimester of pregnancy. *Id.* UCSF is one of only three U.S. medical centers selected to participate in a five year study of fetal surgery for spina bifida, the most common fetal anomaly amenable to surgery, funded by the National Institute of Child Health and Human Development. *Id.* See MOMS: Management of Myelomeningocele Study, <http://www.spinabifidamoms.com/english/faq.html> (last visited May 4, 2007). The study will compare the outcome of fetal surgery for spina bifida against the traditional treatment of surgery after birth. *Id.*

centers were represented before the committee.¹²⁴ The committee did not take testimony from investigators at Britain's Royal College of Obstetricians and Gynecologists, although Dr. Anand had earlier acknowledged that their research placed the age at which a fetus could possibly experience pain at no earlier than twenty-six weeks.¹²⁵ The UCPA Act is positioned to make a huge impact on reproductive health. Congress, therefore, has an obligation to consider all of the available research before imposing this legislation on the American people. Inviting testimony primarily from those who support the law in question is unfair to constituents and undermines congressional credibility.

C. Potential Impact of the Unborn Child Pain Awareness Act

If enacted, such a law would have a significant effect on abortion providers. Unlike the law at issue in *Rust*, the UCPA Act applies to all physicians that practice abortion, not merely those receiving federal funds.¹²⁶ In contrast to the challenged state law in *Casey*, the UCPA Act does not create an exception where disclosure would adversely affect the patient's physical or mental health.¹²⁷ Further, the UCPA Act criminalizes violations and imposes penalties ranging from one hundred to two hundred fifty thousand dollars and suspension or revocation of the violator's medical license.¹²⁸

The impact on women seeking abortion services will be substantial and multifaceted. After being subjected to the mandatory disclosure, some women will undoubtedly elect to have fetal anesthesia. According to medical literature, there are two options for delivering anesthesia or analgesic drugs to the fetus.¹²⁹ The first method involves administering anesthesia to the pregnant woman in order for it to

¹²⁴*Cf.* MOMS: Management of Myelomeningocele Study, <http://www.spinabifidamoms.com/english/faq.html> (last visited May 4, 2007). For an overview of fetal surgery, see Michael R. Harrison, *Fetal Surgery: Trials, Tribulations, and Turf*, 38 J. PEDIATRIC SURGERY 275, 275-82 (2003).

¹²⁵Cooper, *supra* note 115; *see also* McCormick, *supra* note 112.

¹²⁶Unborn Child Pain Awareness Act of 2005, S. 51, 109th Cong. (2005).

¹²⁷*Id.*

¹²⁸Unborn Child Pain Awareness Act of 2005, §2904(d)-(e):

(d) First Offense- Upon a finding by a court that a respondent in an action commenced under this section has knowingly violated a provision of this title, the court shall notify the appropriate State medical licensing authority in order to effect the suspension of the respondent's medical license in accordance with the regulations and procedures promulgated under section 2905, or shall assess a civil penalty against the respondent in an amount not to exceed \$100,000, or both. (e) Second Offense- Upon a finding by a court that the respondent in an action commenced under this section has knowingly violated a provision of this title and the respondent has been found to have knowingly violated a provision of this title on a prior occasion, the court shall notify the appropriate State medical licensing authority in order to effect the revocation of the respondent's medical license in accordance with the regulations and procedures promulgated under section 2905, or shall assess a civil penalty against the respondent in an amount not to exceed \$250,000, or both.

Id.

¹²⁹Huang, *supra* note 106, at 122.

cross the placenta and affect the fetus indirectly.¹³⁰ Congressional findings, however, discounted the value of indirect anesthesia to the fetus.¹³¹ “Expert testimony confirms that by twenty weeks after fertilization an unborn child may experience substantial pain even if the woman herself has received local analgesic or general anesthesia. Medical science is capable of reducing such pain through the administration of anesthesia or other pain-reducing drugs directly to the unborn child.”¹³²

The second option, the one chosen by Congress, is the direct administration of anesthesia or other pain-reducing drugs.¹³³ Yet there are currently “no established protocols [] for administering anesthesia or analgesia directly to the fetus. . . .”¹³⁴ Experimental techniques have been employed in laboratory settings but have not “been shown to decrease fetal pain and are of unknown safety in humans.”¹³⁵

Another important consideration is that anesthesia, especially general anesthesia, has emerged as one of the leading causes of abortion related death.¹³⁶ Consequently, a woman desiring fetal anesthesia would need an anesthesiologist with sufficient expertise to achieve optimal fetal anesthesia while ensuring that the woman’s own health and safety were protected to the fullest extent.¹³⁷

¹³⁰*Id.* This method is “considered to provide adequate fetal anesthesia” during surgical procedures on the fetus, such as repair of myelomeningocele. *Id.* This approach would present numerous problems. Although inhaled anesthetics cross the placenta, the amount of anesthetic required to anesthetize the fetus is unknown. Nicola M. Miller et al., *The Fetal Patient, in ANESTHESIA FOR FETAL INTERVENTION AND SURGERY* 1, 6 (2005).

¹³¹Unborn Child Pain Awareness Act of 2005, § 2(5)-(6).

¹³²*Id.*

¹³³*Id.* See Huang, *supra* note 106, at 121-22. This article suggested that when a fetus undergoes surgery and where the mother has not received general anesthesia, injection of opioids and muscle relaxants into the umbilical cord or directly into fetal muscle tissue would decrease the fetal stress response. The article distinguishes between fetal pain and the fetal stress response.

According to the definitions of pain and feeling, a fetus definitely cannot feel pain. Fetuses do have hormonal and hemodynamic responses to invasive stimuli, however, indicating that invasive procedures cause fetal stress responses. The concern of the authors was that noxious stimuli, even where the fetus is not conscious of it, “most likely induce[s] long-term neurodevelopmental changes” in the fetus. Fetal stress responses can be blocked by analgesia, but it is not clear whether effective analgesia can impact long-term effects. The authors concluded that further study is needed to ascertain whether analgesia and anesthesia are capable of preventing the long-term neurodevelopmental effects.

Id. Long-term fetal neurodevelopment is obviously not a consideration when weighing the benefits of anesthesia or analgesia for abortion.

¹³⁴Lee, *supra* note 22, at 952; see also Huang, *supra* note 106.

¹³⁵Lee, *supra* note 22, at 952.

¹³⁶H.W. Lawson et al., *Abortion Mortality: United States, 1972 through 1987*, 171 AM. J. OBSTETRICS & GYNAECOLOGY 1365, 1368-69, 1371 (1994).

¹³⁷For a thorough discussion of necessary considerations for fetal anesthesia, see Miller et al., *supra* note 130, at 1-12.

Finding a qualified practitioner could be difficult because fetal anesthesia is just emerging as a specialty.¹³⁸ The increased cost associated with specialized anesthesia might prevent some women from choosing abortion. Issues of access and affordability would likely delay the abortion procedure, which in turn would create an increased risk of morbidity and mortality.¹³⁹ In an analysis of abortion related deaths occurring in the United States between 1972 and 1987, investigators found that women having abortions at twenty weeks gestation or later were about eight times more likely to die as their counterparts undergoing abortion at eleven to twelve weeks.¹⁴⁰ Studies have clearly demonstrated that mandated waiting periods of twenty-four to forty-eight hours result in women having later abortions later in pregnancy and there is no evidence that arranging for fetal anesthesia would be different.¹⁴¹ The probable effect of the UCPA Act on abortion timing and, consequently, abortion morbidity and mortality are important factors that Congress should weigh against any perceived fetal benefit prior to voting on this legislation.

One final adverse effect of the UCPA Act is that it subjects a woman's choice to the influence of congressional "findings" unsupported by medical consensus. Given the status often afforded high ranking politicians, these findings may carry more weight than they merit. Congress does not have the education and training necessary to make medical recommendations, nor does it have the relationship with or responsibility to individual patients that doctors have. Where the law has already established the duty that physicians owe patients and where patients have a remedy for injuries resulting from breach of this duty, public policy weighs in favor of

¹³⁸Laura B. Myers, *Fetal Surgery: The Anesthesia Perspective* (2003) (unpublished comment, on file with author). In the preface to this text, physician-authors Laura Myers and Linda Bulich warn:

With fetal intervention, the anesthesiologist is placed in a unique position, required to provide anesthesia for two, or possibly three, patients simultaneously. These patients may each have different and, at times, conflicting anesthetic requirements. . . . As a result, an anesthesiologist, facing a proposed fetal intervention, may not possess the necessary information needed to ensure maternal and fetal safety and a successful intervention without first doing an extensive literature search. Even with the literature at hand, vast gaps in knowledge exist in regard to the anesthetic care of these patients.

LAURA B. MYERS & LINDA A. BULICH, *ANESTHESIA FOR FETAL INTERVENTION AND SURGERY* 1 (2005).

¹³⁹Lawson, *supra* note 136.

¹⁴⁰*Id.* See also Slava V. Gaufberg, *Abortion Complications*, EMEDICINE, <http://www.emedicine.com/emerg/topic4.htm> (last visited May 4, 2007). Press Release, American College of Obstetricians and Gynecologists, *Most Maternal Deaths from Abortion Could be Avoided if Procedure Performed Earlier* (Mar. 29, 2004) (on file with author). "There is a 38% increase in death risk for induced abortion with each additional week of pregnancy." *Id.*

¹⁴¹American Civil Liberties Union, *Government-Mandated Delays Before Abortion* (Jan. 15, 2003), <http://www.aclu.org/ReproductiveRights/ReproductiveRights.cfm?ID=9045&c=143>. For example, after Mississippi enacted a mandatory waiting period law, "the proportion of abortions performed after the first trimester increased by 40 percent." *Id.* "As the American Medical Association in its report on abortion states, 'Mandatory waiting periods [and other barriers] have the potential to threaten the safety of induced abortion. [They] increase[] the gestational age at which the induced pregnancy termination occurs, thereby also increasing the risk associated with the procedure.'" *Id.*

physicians, not Congress, providing the information patients need to consent in a truly informed way.

V. INFORMED CONSENT LAWS

In *Roe v. Wade*, the United States Supreme Court identified a fundamental right of privacy in the Due Process Clause of the Fourteenth Amendment.¹⁴² The Court held that this right of privacy is broad enough to encompass a woman's decision to terminate her pregnancy.¹⁴³ On the other hand, the Court recognized a state's right to regulate abortion based on its interests in maternal health and in potential life.¹⁴⁴ In *Roe*, the Court applied a trimester framework and required states to demonstrate a compelling interest served by laws regulating abortion.¹⁴⁵ During the first trimester, a state's interests, although important and legitimate, are not compelling.¹⁴⁶ Thus any law that unduly burdens abortion in the first trimester is invalid.¹⁴⁷ The states' interests become greater as pregnancy progresses.¹⁴⁸ Shortly after *Roe v. Wade*, states began enacting informed consent laws mandating the disclosure of specified information. The Supreme Court considered challenges to three such statutes in the immediate aftermath of *Roe*.

A. Planned Parenthood of Central Missouri v. Danforth

In 1976, the Supreme Court considered the constitutionality of Mississippi's abortion statute, which included an informed consent provision.¹⁴⁹ The contested language provided that "[n]o abortion shall be performed prior to the end of the first twelve weeks of pregnancy except: . . . (2) After the woman, prior to submitting to the abortion, certifies in writing her consent to the abortion and that her consent is informed and freely given and is not the result of coercion."¹⁵⁰ The Supreme Court

¹⁴²*Roe v. Wade*, 410 U.S. 113, 153 (1973).

¹⁴³*Id.*

¹⁴⁴*Id.* at 162-63.

¹⁴⁵*Id.* at 163-64; *Leigh v. Olsen*, 497 F. Supp. 1340, 1343 (D.N.D. 1980).

¹⁴⁶*Roe*, 410 U.S. at 163.

With respect to the State's important and legitimate interest in the health of the mother, the 'compelling' point, in the light of present medical knowledge, is at approximately the end of the first trimester. This is so because of the now-established medical fact (internal citation omitted) that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. . . . With respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability.

Id.

¹⁴⁷*Leigh*, 497 F. Supp. at 1343 (citing *Maher v. Roe*, 432 U.S. 464, 473 (1977); *Bellotti v. Baird*, 428 U.S. 132, 147 (1976)).

¹⁴⁸*Roe*, 410 U.S. at 162-63.

¹⁴⁹*Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976).

¹⁵⁰*Id.* at 85.

upheld the lower court's finding that the informed consent requirement was a constitutional exercise of the state's authority.¹⁵¹

The Court pointed out that Mississippi's statute merely required written documentation of a patient's informed and freely given consent.¹⁵² The Court defined consent as "the giving of information to the patient as to just what would be done and as to its consequences."¹⁵³ The Court cautioned in dictum that reading informed consent to mean more than that "might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession."¹⁵⁴ The point at which an informed consent law unconstitutionally circumscribed the exchange of information between a patient and her doctor would be squarely presented in future cases.

B. Franklin v. Fitzpatrick

At issue in *Franklin*, was a Pennsylvania statute making it a first degree misdemeanor for a physician to perform an abortion without first obtaining informed consent.¹⁵⁵ To meet the statutory "informed consent" requirement the woman seeking the abortion had to affirmatively state in writing that she had been told that abortion may cause "detrimental physical and psychological effects which are not foreseeable . . . [that there are] alternatives to abortion, including childbirth and adoption, and [given an explanation of] the medical procedures to be used."¹⁵⁶ A federal district court upheld the constitutionality of the law.¹⁵⁷ The United States Supreme Court affirmed without rendering a written opinion.¹⁵⁸

C. Freiman v. Ashcroft

In *Freiman*, physicians brought suit to prevent enforcement of a Missouri law requiring them to inform a woman considering an abortion that if the abortion resulted in a live infant, her parental rights would be terminated.¹⁵⁹ The law also required that prior to the abortion the physician certify that the fetus was not viable.¹⁶⁰ Since an abortion could not be performed unless the fetus was certified as nonviable, the court held that the language was "for all practical purposes meaningless."¹⁶¹

¹⁵¹*Id.* at 66-67.

¹⁵²*Id.* at 85.

¹⁵³*Id.* at 67 n.8.

¹⁵⁴*Id.*

¹⁵⁵*Planned Parenthood Ass'n v. Fitzpatrick*, 401 F. Supp. 554 (E.D. Pa. 1975), *aff'd sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).

¹⁵⁶*Id.* at 583-84 (Green, J., dissenting).

¹⁵⁷*Id.*

¹⁵⁸*Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).

¹⁵⁹*Freiman v. Ashcroft*, 584 F.2d 247, 248-49 (8th Cir. 1978), *aff'd*, 440 U.S. 941 (1979).

¹⁶⁰*Id.* at 251.

¹⁶¹*Id.*

The Court of Appeals for the Eighth Circuit upheld the District Court, concluding that the provision violated both the Equal Protection Clause and the Due Process Clause of the Fourteenth Amendment.¹⁶² The Eighth Circuit went further, conveying in dictum that the state may not require physicians “to provide to each patient any and all information required by the state, regardless of its legality, truth, constitutionality or medical advisability.”¹⁶³ Again, the United States Supreme Court summarily affirmed.¹⁶⁴

Following the Supreme Court’s instruction in *Danforth*, *Franklin*, and *Freiman*, states continued to enact legislation dictating the content of informed consent for abortion procedures.

D. Leigh v. Olson

In this 1980 District Court case, a physician and an abortion counselor challenged a North Dakota informed consent statute.¹⁶⁵ They asserted that providing the information unduly burdened a woman’s right to decide, in consultation with her physician, whether to have an abortion.¹⁶⁶ The abortion providers in *Leigh* specifically disputed the validity of telling patients that abortion was associated with “psychological trauma . . . sterility and increases in the incidence of premature births, tubal pregnancies and stillbirths in subsequent pregnancies . . .” where there was broad disagreement in the medical community over the accuracy of these “facts.”¹⁶⁷

The court turned to the standards set by the United States Supreme Court in *Danforth*.¹⁶⁸ Based on those standards, the court found that the North Dakota statute went beyond both the definition of informed consent articulated in *Danforth* and the medical community’s understanding of the term.¹⁶⁹ In addition, the statute prescribed the giving of information that was of “questionable truth and validity”¹⁷⁰ The court found such information to be a direct burden on the abortion decision.¹⁷¹ As to the statutory requirement that physicians disclose the “probable anatomical and physiological characteristics of the unborn child,” the court found that it imposed an

¹⁶²*Id.* at 252. “It is a violation of the due process clause because of the invasion into the delicate and private physician-patient relationship. Requiring the physician to relate section 188.040 interferes with the woman’s right to consult with her physician concerning her decision of abortion without undue restriction by the state.” *Id.* It is a violation of the equal protection clause “inasmuch as it singles out the abortion operation for this ‘straitjacket’ requirement.” *Id.*

¹⁶³*Id.* at 251.

¹⁶⁴*Freiman v. Ashcroft*, 440 U.S. 941 (1979).

¹⁶⁵*Leigh v. Olson*, 497 F. Supp. 1340 (D.N.D. 1980).

¹⁶⁶*Id.* at 1344.

¹⁶⁷*Id.* at 1345.

¹⁶⁸*Id.* at 1344 (citing *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976)).

¹⁶⁹*Id.* at 1345.

¹⁷⁰*Id.*

¹⁷¹*Id.*

undue burden and additionally found no legitimate medical reason for giving the information.¹⁷²

E. Charles v. Carey

In *Charles v. Carey*, the Court of Appeals for the Seventh Circuit consolidated several appeals from a lower court that were based on the court's decision not to enjoin sections of the Illinois Abortion Law of 1975.¹⁷³ The Seventh Circuit addressed the constitutionality of three separate sections, which defined the elements necessary to obtain informed consent.¹⁷⁴ Among other things, the statute required a physician to provide the following information at least twenty-four hours prior to the procedure: (i) the name of the physician who would be performing the abortion (although the act mandated that the physician performing the abortion also be the person providing the informed consent information); (ii) medical risks associated with the abortion procedure; (iii) probable gestational age of the fetus; (iv) the availability of state sanctioned materials detailing the anatomical characteristics of a fetus at various stages of gestation, including information on the possibility of fetal survival; and (v) a true copy of the patient's pregnancy test.¹⁷⁵ Failure to do so was a Class B misdemeanor.¹⁷⁶ Another section provided criminal penalties for a physician who failed to "inform the patient of any reasonable medical certainty of organic pain to the fetus" and methods for controlling fetal pain.¹⁷⁷ The law required a patient be given all of the informed consent information regardless of gestational age.¹⁷⁸

The State of Illinois argued that the law did not infringe a woman's constitutionally protected right to abortion, and was, therefore, not subject to strict scrutiny because it applied only to physicians.¹⁷⁹ The Seventh Circuit, applying *Danforth*, found that a law regulating only physician practice might still impose a substantial obstacle to the exercise of a woman's fundamental right if it interfered with her ability to rely on her physician's advice.¹⁸⁰ The Seventh Circuit held that the Illinois statute imposed such an obstacle and was, therefore, unconstitutional.¹⁸¹ Further, the court found that, on the basis of the expert testimony in the record, the required information about fetal pain was "medically meaningless, confusing, medically unjustified, and contraindicated, causing cruel and harmful stress to . . . patients."¹⁸²

¹⁷²*Id.*

¹⁷³*Charles v. Carey*, 627 F.2d 772, 775 (7th Cir. 1980).

¹⁷⁴*Id.* at 775-76.

¹⁷⁵*Id.* at 781.

¹⁷⁶*Id.* at 781 n.11.

¹⁷⁷*Id.* at 782.

¹⁷⁸*Id.*

¹⁷⁹*Id.*

¹⁸⁰*Id.*

¹⁸¹*Id.* at 782-83.

¹⁸²*Id.* at 784; *see also* Collett, *supra* note 99, at 173.

F. Planned Parenthood of Southeastern Pennsylvania v. Casey

The United States Supreme Court again considered the limits of informed consent in 1992.¹⁸³ The statute at issue in *Planned Parenthood of Southeastern Pennsylvania v. Casey* directed a physician or “qualified nonphysician” to inform the patient about materials published by the state that describe the fetus, provide information about medical assistance for childbirth and about child support obligations, and list agencies that provide adoption.¹⁸⁴ Under the law, a woman could not have an abortion without first certifying in writing that she had been offered the state published materials.¹⁸⁵

The Supreme Court expressly renounced its decision in *Thornburgh* where it held that a similar statute was “an outright attempt to wedge the Commonwealth’s message discouraging abortion into the privacy of the informed-consent dialogue between the woman and her physician.”¹⁸⁶ The *Casey* plurality said that requiring a woman be informed about the availability of state published materials, even where those materials contained information about the “consequences to the fetus” with no direct relation to the woman’s health, was not a substantial obstacle to obtaining an abortion.¹⁸⁷ The test articulated by the Supreme Court in *Casey* is whether the information is “truthful and not misleading.”¹⁸⁸ A state’s requirement that physicians disclose information that meets this standard “may be permissible.”¹⁸⁹

Two recently published law review articles maintain that the UCPA Act is consistent with the plurality opinion in *Casey*.¹⁹⁰ An article by Professor Teresa Collett discounted claims that the UCPA Act impermissibly intrudes into the doctor-patient relationship.¹⁹¹ The article pointed out that the *Casey* plurality “specifically approve[d] 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.’”¹⁹² Fetal pain undoubtedly fits into the category of information approved by the Supreme Court in *Casey*. What the argument fails to consider, however, is that the informed consent statute in *Casey* required physicians to disclose information

¹⁸³*Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

¹⁸⁴*Id.* at 881.

¹⁸⁵*Id.*

¹⁸⁶*Id.* at 883. *See Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747 (1986).

¹⁸⁷*Id.* at 882-83. “[I]nformed choice need not be defined in such narrow terms that all considerations of the effect on the fetus are made irrelevant.” *Id.* at 883.

¹⁸⁸*Id.* at 882.

¹⁸⁹*Id.* *Casey* concluded that “[i]f the information the state requires to be made available to the woman is truthful and not misleading, the requirement may be permissible.” *Id.* *See also Summit Med. Ctr. of Ala., Inc. v. Siegelman*, 227 F. Supp 2d 1194 (M.D. Ala. 2002).

¹⁹⁰Collett, *supra* note 99; *see also* Note, *The Science, Law, and Politics of Fetal Pain Legislation*, 115 HARV. L. REV. 2010, 2025 (2002).

¹⁹¹Collett, *supra* note 99, at 180.

¹⁹²*Id.* at 181 (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992)).

that the Supreme Court determined to be “truthful and not misleading.”¹⁹³ If the UCPA Act passes, the information physicians will be required to give cannot be fairly described as “truthful and not misleading.” There is currently no consensus as to when or even if fetuses experience pain.

In the other law review article about fetal pain, the author described the mandatory fetal pain language in the UCPA Act as, “just a specific form of information on fetal development that describes a consequence of the fetus’s anatomical, physiological, and neurological development.”¹⁹⁴ Fetal neurological development is indeed one of the issues involved in the debate about fetal pain. Experts in the field of fetal development, however, do not agree about the ability of fetuses to experience pain. Neither do they concur as to the validity of the fetal pain information contained in the UCPA Act. Although the UCPA Act information relates to fetal development and is permissible, it fails *Casey’s* “truthful and not misleading” test.¹⁹⁵

G. Summit Medical Center of Alabama, Inc. v. Siegelman

In 2002, a group of health care facilities and physicians challenged the constitutionality of Alabama’s Woman’s Right to Know Act.¹⁹⁶ The Act forced physicians to give “certain information and a designated set of printed informational materials . . .” to women seeking abortion.¹⁹⁷ The plaintiffs objected to a section of the statute mandating that abortion providers inform patients that “an unborn child with the gestational age of nineteen weeks can survive outside the womb.”¹⁹⁸ They argued that the information was medically untrue and, thus, unconstitutional under *Casey*.¹⁹⁹

The District Court heard the testimony of several experts, who were able to agree only that the meaning of “survive” varies between health care providers and in different situations.²⁰⁰ The court concluded that the language was misleading.²⁰¹ Although technically truthful, the information was misleading because it was incomplete. In order to meet *Casey’s* “truthful and not misleading” standard the court held that abortion providers must go beyond the language of the statute and inform patients “about the meaning of the term survival as well as the nature and extent of any possible survival. . . . [J]ust as a woman has a right to know that there

¹⁹³Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 882 (1992).

¹⁹⁴Note, *supra* note 190, at 2025 (citation omitted).

¹⁹⁵*Casey*, 505 U.S. at 882.

¹⁹⁶Summit Med. Ctr. of Ala., Inc. v. Siegelman, 227 F. Supp 2d 1194 (M.D. Ala. 2002).

¹⁹⁷*Id.* at 1197.

¹⁹⁸*Id.* at 1203. “[I]f the unborn child is viable or has reached a gestational age of more than 19 weeks,” the physician or qualified person must inform the patient that “the unborn child may be able to survive outside the womb.” *Id.* (quoting Alabama’s Woman’s Right to Know Act, ALA. CODE § 26-23A-4(b)(3)(a) (2007)).

¹⁹⁹*Id.*

²⁰⁰*Id.*

²⁰¹*Id.* at 1203-04.

may be even momentary 'survival,' she has a right to be fully informed of the nature of such survival."²⁰²

The standard articulated by the court in *Siegelman* adopts the definition of informed consent proposed by research biochemist and philosopher Dr. Irving,²⁰³ and should be considered in any challenge to the fetal pain act. Patients are entitled to scientifically proven information. Fetal pain, like fetal survival, contains qualitative components that should be part of the informed consent discussion.

Fetal pain, nonetheless, presents a slightly different problem than fetal survival. *Siegelman* considered a statute requiring disclosure of truthful information about survival that was misleading because it was incomplete.²⁰⁴ The court was able to remedy the defect by mandating disclosure of additional truthful information, thus, aligning the statutorily mandated informed consent with *Casey's* "truthful and not misleading" standard.²⁰⁵ In contrast, the obligation that Congress seeks to impose on physicians via the UCPA Act is to disclose information that is arguably untrue.²⁰⁶ The question of truthfulness is further complicated because there is presently no scientifically sound way to determine whether fetuses perceive pain.²⁰⁷ Generally, doctors rely on patients to express and explain their pain and on observable indicia of pain. A fetus cannot communicate experiences so pain must be measured in some other way.

There are measurable physiologic signs associated with pain, but their presence alone cannot confirm the existence of pain.²⁰⁸ Based on what science currently knows about fetal neurological development, some investigators conclude that fetuses do not feel pain.²⁰⁹ Even among experts who think that fetuses can feel pain, there is wide disagreement as to the gestational age where this becomes possible.²¹⁰

Fetal pain is different from survival in that far less is known about it. Where experts do not agree on the nature of fetal pain or a fetus's ability to experience pain

²⁰²*Id.* at 1204.

[T]he court holds that physicians and qualified persons must go beyond a simple mechanical reading of this provision and provide the woman with the following information: 1) a full and complete definition of the term 'survive' in accordance with the physician's good faith clinical judgment; 2) the nature of any survival; 3) survival is merely a possibility; 4) survival will or may be of extremely limited duration. (citation omitted) The evidence in the record suggests multiple definitions of the word 'survival,' ranging from living to 120 days after birth to simply surviving for a few minutes.

Id. at 1203.

²⁰³Statement of Dr. Dianne Irving, *supra* note 36.

²⁰⁴*Siegelman*, 227 F. Supp 2d at 1203-04.

²⁰⁵*Id.*

²⁰⁶Unborn Child Pain Awareness Act of 2005, S. 51, 109th Congress (2005).

²⁰⁷Lee, *supra* note 22.

²⁰⁸*Id.*

²⁰⁹"According to the definitions of pain and feeling, a fetus definitely cannot feel pain." Huang, *supra* note 106, at 121.

²¹⁰*Id.*

at all, physicians cannot simply “go beyond the language of the statute” and supplement statutorily mandated information.²¹¹ To meet their legal duty to present truthful information, physicians must refrain from presenting information not proven to be truthful.

Charles v. Carey is the only lower court opinion considering the constitutionality of informed consent language about fetal pain.²¹² The *Charles* court issued its opinion prior to *Casey*.²¹³ Nonetheless, the Court of Appeals for the Seventh Circuit arrived at the result that *Casey* would have compelled. The court rejected the fetal pain language on the ground that the experts did not agree that the information was accurate.²¹⁴ Absent consensus in the scientific community, the court was unwilling to impose on physicians an obligation to convey the state mandated information.²¹⁵ As *Siegelman* made clear, the scientific and medical communities are no closer to consensus today than in 1980 when the Seventh Circuit decided *Carey*.²¹⁶

VI. THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION ARTICLE

A team of physicians at the University of California at San Francisco reviewed existing literature related to pain in fetuses less than thirty weeks gestational age.²¹⁷ The pending UCPA Act was the catalyst for their meta-analysis; the stated purpose was to determine whether a fetus feels pain and, if so, whether safe and effective techniques exist for administering direct fetal anesthesia.²¹⁸

The study first addressed the nature of pain, describing it as a “subjective sensory and emotional experience that requires the presence of consciousness to permit recognition of a stimulus as unpleasant.”²¹⁹ Pain is distinguishable from nociception, which involves activation of nociceptive pathways but no subjective experience of pain.²²⁰ By way of example, a person with a spinal cord injury will have nociception

²¹¹Summit Med. Ctr. of Ala., Inc. v. Siegelman, 227 F. Supp 2d 1194, 1203-04 (M.D. Ala. 2002).

²¹²Charles v. Carey, 627 F.2d 772, 781-82 (7th Cir. 1980); Collett, *supra* note 99, at 172-73.

²¹³*Carey*, 627 F.2d at 772.

²¹⁴*Id.* at 784.

²¹⁵*Id.*

²¹⁶*Id.*

²¹⁷Lee, *supra* note 22.

²¹⁸*Id.* at 947.

²¹⁹*Id.* at 948 (citing D. Benatar & M. Benatar, *A pain in the Fetus: Toward Ending Confusion About Fetal Pain*, 15 *BIOETHICS* 57, 57-76 (2001) and V. Glover & N.M. Fisk, *Fetal Pain: Implications for Research and Practice*, 106 *BRIT. J. OBSTETRICS & GYNAECOLOGY* 881, 881-86 (1999) and International Association for the Study of Pain, *IASP Pain Terminology* (2004), available at <http://www.iasp-pain.org/terms-p.html> (last visited May 4, 2007)).

²²⁰Huang, *supra* note 106, at 119. Nociception requires only an intact sensory system. The experience of pain, on the other hand, requires “nociception and a subjective, emotional reaction.” In order for an emotional reaction to occur, there must be consciousness. *Id.* See also Lee, *supra* note 22, at 949.

without pain below the level of the injury.²²¹ Conversely, a person may experience pain without stimulation of nociceptive pathways, like phantom pain in an amputated limb.²²²

Whether a fetus has the capacity to experience pain depends on several factors. First, the pathways between the thalamus and the cortex, the thalamocortical pathways, must be present and functional.²²³ There are no studies that establish the point in gestational development at which thalamic pain fibers reach the cortex. The authors of the JAMA article examined several very small studies from which they were able to draw inferences about the development of thalamocortical pathways.²²⁴ The presence of the pathways, while necessary, is not sufficient to establish the capacity for pain.²²⁵ The structures must also be functional.²²⁶

Cortical function is measured using electroencephalography (EEG).²²⁷ An EEG alone, however, is not adequate to demonstrate functionality.²²⁸ This is known because infants born with no functional neural tissue above the brainstem may still have EEG activity.²²⁹ Another drawback to relying on an EEG study is that there is no known EEG "pain pattern."²³⁰ Some investigators posit that EEG patterns denoting wakefulness correspond with consciousness.²³¹ Since consciousness is a requisite of pain perception, this would pinpoint the earliest possible age at which a fetus might experience pain.²³² In pre-term infants, EEG indicators of consciousness do not appear until approximately thirty weeks.²³³ EEG alone does not prove consciousness, however, because patients in a persistent vegetative state sometimes have EEGs demonstrating wakefulness.²³⁴

²²¹Lee, *supra* note 22, at 949.

²²²*Id.*

²²³*Id.*

²²⁴*Id.* A histological study of the visual pathway involved eight fetuses; a similar study had seven fetuses; a third study of mediodorsal thalamic afferents included eight fetuses; a study of afferents from unspecified thalamic regions examined twelve fetuses. *Id.*

²²⁵*Id.* at 950.

²²⁶*Id.*

²²⁷*Id.*

²²⁸*Id.*

²²⁹*Id.* The term for this condition is anencephaly. *Id.*

²³⁰*Id.*

²³¹*Id.*

²³²*Id.*

²³³*Id.*

²³⁴*Id.* (citing D. Benatar & M. Benatar, *A Pain in the Fetus: Toward Ending Confusion About Fetal Pain*, 15 *BIOETHICS* 57, 57-76 (2001) and J.A. Burgess & S.A. Tawia, *When Did You First Begin to Feel it? - Locating the Beginning of Human Consciousness*, 10 *BIOETHICS* 1, 1-26 (1996)).

Researchers have relied on behavioral indications to prove the conscious awareness of pain, including withdrawal from a painful stimulus and facial grimacing.²³⁵ The authors of the JAMA article evaluated behavioral studies where researchers identified a distinct set of facial movements that were present in the newborn infant during invasive procedures but absent during noninvasive procedures.²³⁶ The earliest age at which these facial movements were identified was at twenty-eight to thirty weeks.²³⁷ One study, however, found no difference in facial movements in newborns “with and without significant cortical injury,” meaning that facial movements may not represent conscious perception of pain.²³⁸

Other known stress responses, such as vital signs, neuroendocrine changes, and altered fetal blood flow have been used to imply conscious fetal pain.²³⁹ Researchers have measured stress responses in fetuses undergoing invasive procedures and noted changes in fetuses as early as sixteen weeks gestational age.²⁴⁰ Still, not all investigators agree with using neuroendocrine stress response “as a surrogate indicator of fetal pain. . . . [t]his has limitations: stress responses do not necessarily signify pain . . . and stress responses do not involve the cortex.”²⁴¹ The JAMA article concluded, on the basis of the studies reviewed, that neuroendocrine measurements are not valid indicators of fetal pain.²⁴²

Based on the analysis of the existing studies, which was limited and undertaken with very small study groups, the JAMA article authors concluded that a fetus cannot perceive pain until the thalamocortical pathways become functional at around twenty-nine to thirty weeks gestational age.²⁴³ Prior to that time, fetal anesthesia would be of no benefit to the fetus but would impose added risks to the pregnant woman.²⁴⁴ Whether fetal anesthesia should be undertaken requires an analysis of its potential benefit to the fetus and the potential risks to the pregnant woman.²⁴⁵

²³⁵Lee, *supra* note 22, at 950; Huang, *supra* note 106, at 119. “Since the fetus cannot tell us whether he feels pain and since pain cannot be addressed using objective measures, only indirect methods are useful to determine whether or not the fetus feels pain.” *Id.*

²³⁶Lee, *supra* note 22, at 950.

²³⁷*Id.*

²³⁸*Id.*

²³⁹*Id.*

²⁴⁰*Id.* See also Huang, *supra* note 106, at 121. Dr. Anand’s own research measured hormonal stress responses in newborn infants following invasive interventions. *Id.* at 120.

²⁴¹*Id.*

²⁴²Lee, *supra* note 22, at 950-51 (citing G.A. Carrasco & L.D. Van de Kar, *Neuroendocrine Pharmacology of Stress*, 463 *EUROPEAN J. PHARMACOLOGY* 235, 235-272 (2003)). The body mediates neuroendocrine responses without conscious cortical processing. *Id.*

²⁴³*Id.* at 952. Abortion is extremely rare in the third trimester and is only performed to save the health or life of the pregnant woman. *Id.*

²⁴⁴Lawson, *supra* note 136; see also, Miller, *supra* note 130.

²⁴⁵Lawson, *supra* note 136; Lee, *supra* note 22, at 952. General anesthesia increases abortion morbidity and mortality as well as cost. *Id.* at 952.

Critics of the JAMA article have attacked it largely on two grounds: two of the researchers failed to disclose conflicts of interest, and the article is a meta-analysis of existing research and presents no new research.²⁴⁶ Dr. Eleanor A. Drey is medical director of the abortion clinic at San Francisco General Hospital. Her affiliation was not disclosed in the study and neither was that of another author, reported to have worked for an abortion rights organization.²⁴⁷ Critics point out that the authors' failure to consider that these affiliations might be perceived as conflicts of interest "illustrate the very bias they deny."²⁴⁸

While not disclosing potentially conflicting affiliations does detract from the credibility of the entire article, it does not mean that the article completely lacks merit. Rather, physicians who perform abortions should keep these conflicts in mind when considering this JAMA article. Prudence would require physicians to review the underlying research as well as other research in the area of fetal pain. Under the standard set forth in *Siegelman*, abortion providers have a legal duty to educate themselves about the findings of medical studies on the topic of fetal pain.²⁴⁹ Even in the absence of a legal duty, physicians are ethically obligated to offer patients the benefit of the latest, scientifically sound information available.

VII. CONCLUSION

The Supreme Court's reversal of the lower courts has taken pressure off of the law makers who felt compelled to put a stop to mid-trimester surgical abortion. Consequently, it is far less likely that these individuals will continue in their efforts to pass the Unborn Child Pain Awareness Act of 2005. It is foreseeable that in the future, however, some members of Congress will determine that other abortion methods should be outlawed. An outright prohibition on those abortion methods that remain legal would face tremendous social and legal challenges. Legislation targeted at "informing" a woman about the characteristics of the fetus, however, could be viewed as merely educational. Any law that mandates what physicians must say to their patients is potentially problematic. In the case of the Unborn Child Pain Awareness Act of 2005, one problem was that experts in the area of fetal development disagreed about whether the information subject to mandatory disclosure met the "truthful and not misleading" standard.

Society at large believes and government supports the notion that the decision whether to abort a pregnancy is one that should be made on the basis of all of the information that is available. *Roe v. Wade* held that a woman has a constitutionally protected right to make this decision, and *Casey* held that a state may not create an

²⁴⁶Press Release, National Right to Life Committee, Gullible Treatment of Trumped up "Study" on Fetal Pain Issue Should Embarrass J.A.M.A. and Some Journalists (Aug. 25, 2005), available at http://www.nrlc.org/abortion/fetal_pain/NRLC rebuttal JAMA.html. See also McCormick, *supra* note 112 (quoting Dr. K.S. Anand's critique of the JAMA article).

²⁴⁷Randy Dotinga, *Researcher Stands by Fetal Pain Findings*, HEALTH DAY NEWS, Aug. 24, 2005, <http://www.forbes.com/lifestyle/health/feeds/hscout/2005/08/24/hscout527596.html>. The *Philadelphia Inquirer* reported the authors' affiliations. *Id.*

²⁴⁸William Saletan, *I Feel Your Fetus's Pain: Compassionate Conservatism Enters the Womb*, SLATE, Aug. 31, 2005, <http://slate.msn.com/id/2125299/#ContinueArticle>.

²⁴⁹*Summit Med. Ctr. of Ala., Inc. v. Siegelman*, 227 F. Supp 2d 1194, 1203-04 (M.D. Ala. 2002).

undue burden on a woman in the exercise of this right.²⁵⁰ *Casey* itself, and subsequent lower court opinions, have interpreted the phrase “undue burden” to allow states to impose informed consent requirements on physicians who perform abortions.²⁵¹ Under *Casey*, a state may require a physician to disclose information that is “truthful and not misleading.”²⁵² According to the Court of Appeals for the Seventh Circuit, requiring physicians to tell patients that a fetus experiences pain fails *Casey*’s “truthful and not misleading” standard because it is “medically meaningless, confusing, medically unjustified, and contraindicated, causing cruel and harmful stress to . . . patients.”²⁵³ Although there has been investigation into fetal pain during the twenty-five years since *Charles v. Carey*, medical science seems to be no closer to reaching an agreement about if and when a fetus feels pain.

Women are entitled to make fully informed decisions about abortion. Until questions concerning fetal consciousness and fetal pain are more clearly answered, physicians or other qualified caregivers should provide current, scientifically credible information. Each woman, acting with the advice of her physician, is then free to weigh all of the factors involved and make the decision best suited to her individual needs. To the extent that legislation, such as the Unborn Child Pain Awareness Act of 2003, prevents a complete discussion of the factors influencing the abortion decision, it should not be enforced.

²⁵⁰*Roe v. Wade*, 410 U.S. 113, 153 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 883-84 (1992).

²⁵¹*Fargo Women’s Health Org. v. Schafer*, 18 F.3d 526 (8th Cir. 1994).

²⁵²*Casey*, 505 U.S. at 882.

²⁵³*Charles v. Carey*, 627 F.2d 772, 784 (7th Cir. 1980); *see also Collett, supra* note 99, at 173.