The Science, Law, and Politics of Fetal Pain Legislation

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THE SCIENCE, LAW, AND POLITICS OF FETAL PAIN LEGISLATION

Most people prefer not to inflict gratuitous pain on other sentient beings, especially other humans. What, then, should be the legal system’s reaction to the mounting evidence that in late-term abortions doctors are inflicting just such pain on fetuses who have the anatomical, physiological, and neurological capacity to experience it? The pain being inflicted is gratuitous because it can be easily avoided with no significant increases in cost or health risk by the administration of targeted fetal pain relief.

If informed that an abortion is likely to cause pain to the fetus and given a choice between a procedure that would inflict fetal pain and a slightly more expensive but safe procedure that would not do so, would not most women facing a late-term abortion choose the latter? Such is the premise of this Note, which argues that states should pass legislation to decrease the gratuitous infliction of pain in late-term abortions. Legislation is necessary for informed choice on this matter because most women are not given the choice to make for themselves. Legislation is appropriate because “[t]he State’s constitutional authority is a vital means for citizens to address [the] grave and serious issues [surrounding abortion], as [we] must if we are to progress in knowledge and understanding and in the attainment of some degree of consensus.”

Part I of this Note describes the scientific evidence supporting the claims that the human fetus may experience pain as early as the thirteenth week of development, probably experiences pain by the twentieth week, and almost definitely experiences pain by the twenty-eighth week. Part II argues that legislation to address fetal pain during late-term abortions is necessary because physicians performing such procedures usually do not treat fetal pain as a distinct problem and therefore typically do not provide women with the option of fetal pain relief. Part III discusses legal and prudential considerations relevant to the design of such legislation and concludes with proposed model legislation. Part IV explains why the proposed legislation passes constitutional muster. Part V explores the politics of fetal pain in light of the constitutive function of the law.

I. CAN A HUMAN FETUS FEEL PAIN?

Determining whether the human fetus can feel pain first requires a conception of what “feeling pain” means. Determining how any other

sentient being feels pain is problematic, given that pain is experienced "internally" and that each individual only has direct access to his or her own sensory experiences.

The problem of pain is a particular version of the general problem described by philosophers as the problem of other minds: without access to the internal, subjective consciousness of any other being, it is impossible to verify whether that being has conscious experience.\(^2\) This is not much of a problem for most people most of the time, at least with regard to other people's pain. The doctor deciding how to treat a patient, for example, is generally not troubled by lack of access to the phenomenal experience of her patient's pain. The patient can usually describe the pain (for example, as sharp, dull, or throbbing) and indicate where it is located. The doctor can also ask questions and use empathy and imagination to help her understand the patient's self-report. But verbal communication is not always necessary. Consider, for instance, the still-conscious accident victim wheeled into the emergency room. One look at the angle of the victim's leg or the blood streaming from his wounds signals to the doctor that the patient requires pain relief. The doctor does not stop to ponder whether the person is suffering or just looks like he is suffering but rather interprets what she sees in light of context and experience and acts accordingly.

The problem becomes more difficult when words cannot bridge the experiential gap — for instance, when the doctor's patient is an infant. The medical consensus on whether it is appropriate to administer anesthesia or analgesia to infants has changed in the past two decades.\(^3\) As of the late 1980s, it was within standard practice not to administer pain relief to infants either in the operating room or postoperatively.\(^4\) The prevailing view now, however, is that "humane considerations should apply as forcefully to the care of neonates and young, nonverbal infants as they do to children and adults in similar painful and stressful situations."\(^5\)

\(^2\) "The problem of other minds is the problem of whether one can know whether anybody else has a mind and, by extension, whether they have thoughts, perceptual experiences, and pains." David Benatar & Michael Benatar, *A Pain in the Fetus: Toward Ending Confusion About Fetal Pain*, 15 BIOETHICS 57, 61 (2001).


\(^4\) See id. at 181.

The experience of animals provides yet another twist on the problem of knowing whether a particular being experiences pain. Dogs cannot speak, nor do they have the same nervous system as humans, and yet most people are sure that dogs experience pain. Through a combination of empathy and reasoning, we come to believe not only that the dog that is kicked feels pain, but also that the dog knows the difference between being stumbled over and being kicked.6

If direct access to the subjective states of another being were necessary to establish that he, she, or it feels pain, it would be impossible to "know" or "prove" that any other human or animal feels pain. Instead of imposing such a standard of proof on ourselves, however, we make do with inference from context, experience, knowledge of anatomical capabilities, and behavioral observation. Such inference is easiest in the case of other human adults, more difficult in the case of newborns and infants, and perhaps more difficult still in the case of animals.

When trying to determine whether a particular being feels pain, the only alternative to a stubborn solipsism is the careful sifting of observation and empathy. In the case of a human fetus, this sifting must begin with consideration of the relevant anatomical and behavioral indicia.

Assuming that the fully developed, mature human nervous system equips people to feel pain, at what stage in physiological and neurological development is the "hardware" in place? It is unlikely that there is one particular moment at which pain awareness flips from off to on. Consciousness of pain, like consciousness itself, may operate more like a dimmer switch.7 Particular moments in fetal development may correspond to increases in fetal consciousness, including consciousness of pain.

The physical development of the fetal nervous system is well understood, though debate continues over the significance of particular stages. Nerve receptors to sense outside stimuli, neural pathways to carry the message from the receptors, and interpretive mechanisms to respond to the stimulus are all necessary for the human experience of pain. Sensory receptors begin to appear in the perioral area in the sev-

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6 Cf. Oliver Wendell Holmes, Jr., The Common Law 3 (1881).
7 Vivette Glover & Nicholas M. Fisk, Fetal Pain: Implications for Research and Practice, 106 Brit. J. Obstetrics & Gynaecology 881 (1999). This analogy implies a developmental continuum in the capacity to experience pain. The intensity of pain, however, is not best thought of as a dimmer switch, given that fetuses and newborns may actually experience more intense pain than adults exposed to the same painful stimulus. See Effects of Anesthesia During a Partial-Birth Abortion: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary, 104th Cong., 147-48 (1996) [hereinafter Effects of Anesthesia During a Partial-Birth Abortion] (statement of Dr. Jean A. Wright, Medical Dir., Egleston Children's Hospital, Emory University) (reviewing the scientific evidence indicating that "preterm neonates have greater pain sensitivity than term neonates or older infants").
enth week of gestation. They spread to the rest of the face, the palms of the hands, and the soles of the feet by the eleventh week, to the trunk and nearby parts of the arms and legs by the fifteenth week, and to all skin surfaces by the twentieth week. Neural pathways develop throughout gestation.

The current scientific consensus is that no conscious awareness of stimuli is present in the human fetus at least until neural pathways link to the cortex or the subplate zone, and most likely not until such pathways link the thalamus and the subplate zone or cortex. In light of current knowledge, the "early limit on when it is likely that the fetus might be aware of anything" is at thirteen weeks, when the first neural pathways reach the subplate zone. Any legislation addressing fetal pain premised on present knowledge, therefore, would not apply to the eighty-six percent of abortions performed in the first twelve weeks of pregnancy.

Connections between the thalamus and the cortex — which most scientists believe are necessary for the human fetus to perceive pain — form between the twentieth and the twenty-fourth week. One scientist who has participated in many studies of fetal anatomy and neurology has concluded that "from mid-gestation [twenty weeks] onwards it seems that extrinsic influences (via thalamo-cortical pathways) can act

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8 Anand & Hickey, supra note 5, at 1322.
9 Id.
10 See generally WILLIAM J. LARSEN, HUMAN EMBRYOLOGY 107-17 (2d ed. 1997) (describing the development of the peripheral nervous system in the fetus).
11 The subplate zone is "a layer of neurones below the cortex that is specific to the fetus." Glover & Fisk, supra note 7, at 881.
12 See, e.g., Benatar & Benatar, supra note 2, at 64 ("It is certainly the case that the perception of pain as a result of external noxious stimuli would not be possible until a complete neuronal connection is established from peripheral nociceptors to cerebral cortex (via spinal cord, brain stem and thalamus)."). This view is not unanimously held. The Commission of Inquiry into Fetal Sentience, established by the charity CARE, issued a report in 1996 that challenged the assertion that the cortex is the sole region of awareness. See COMM'N OF INQUIRY INTO FETAL SENTIENCE, HUMAN SENTIENCE BEFORE BIRTH § 5.3, available at http://www.care.org.uk/resource/pub/fs/index.htm (last visited Apr. 7, 2002). The timing of the onset of sentience seems to be revealed to be earlier and earlier as more research is done in this area. See Teresa Stanton Collett, Fetal Pain Legislation: Is It Viable? 2-11 (2002) (unpublished draft, on file with the Harvard Law School Library) (describing developments in fetal pain research over the past decade).
13 Glover & Fisk, supra note 7, at 882. The first neural pathways reach the cortex at about sixteen weeks. Id.
14 According to the most recent statistics from the Centers for Disease Control, at least 54.2% of abortions in 1997 were performed on fetuses of eight weeks gestational age or younger, 21.5% on fetuses of nine to ten weeks gestational age, 10.5% on fetuses of eleven to twelve weeks, 6.1% on fetuses of thirteen to fifteen weeks, 4.2% on fetuses of sixteen to twenty weeks, and 1.4% on fetuses of twenty-one weeks of gestational age or older. Lisa M. Koonin, Lilo T. Strauss, Camaryn E. Chrisman & Wilda Y. Parker, Abortion Surveillance — United States, 1997, 49 MORBIDITY & MORTALITY WKLY. REP. 1, 27-28 tbl.6 (2000).
15 See Anand & Hickey, supra note 5, at 1322.
through demonstrable synapses, which, if physiologically active, may be involved in the modulation of the activity of the fetal neocortex."16 In other words, by twenty weeks, the fetus may be able to sense, interpret, and respond to pain signals that travel via complex neural pathways.

The development of anatomical structures sufficient to provide a neural substrate for the experience of pain by the human fetus can and should be interpreted in light of physiological and behavioral responses to noxious stimuli. Physiological evidence includes hormonal stress responses and electroencephalography readings (EEGs). Researchers investigating fetal stress response in reaction to a noxious stimulus compared cortisol and endorphin levels after performing two procedures — one affecting an area where the fetus had sensory receptors and another where it lacked them.17 These researchers found elevated levels of cortisol and endorphins following the procedure in the sensitive area, and no similar elevation following the procedure in the nonsensitive area.18 They concluded that "the fetus mounts a similar hormonal response to that which would be mounted by older children and adults to stimuli which they would find painful."19 EEG studies of preterm babies20 indicate evoked responses to visual and somatosensory stimuli as early as twenty-four weeks, and well-developed responses by twenty-seven weeks.21

Behavioral evidence includes observation of physical movements and facial expressions. Simple behavioral responses to external stimuli first appear around eight weeks and increase in complexity over the next few weeks.22 The fetus "can respond to sound from 20 weeks and discriminate between different tones from 28 weeks."23 Preterm babies older than twenty-eight weeks exhibit distinctive facial expressions characteristic of older infants and adults subject to painful stimuli in response to a heel prick.24

One must not jump directly from observing that the fetus reacts to an external stimulus to concluding that the fetus must have consciously "felt" the stimulus. "External" evidence, such as the anatomi-

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16 Glover & Fisk, supra note 7, at 881 (quoting personal communication with I. Kostovic).
18 Id. at 79.
19 Id. at 80.
20 This Note uses "fetus" to denote a human being in utero and "preterm baby" to denote a human being ex utero (delivered before the due date).
21 Glover & Fisk, supra note 7, at 882.
22 Id.
23 Id.
24 Benatar & Benatar, supra note 2, at 71.
cal, physiological, and behavioral evidence described in this Part, must be interpreted as a whole, and no one piece of external evidence can support a conclusive inference regarding the fetus’s “internal” experience.

Comparison of two situations may illuminate the distinction between reasonable and unreasonable inferences of pain. The anti-abortion video The Silent Scream, a realtime ultrasound of a suction abortion at the twelfth week of development, provides an example of the latter. The title of the video comes from the way in which the fetus opens its mouth after the suction instrument locates its body though the fetus has moved away from the instrument. Given the present state of knowledge about fetal development, these fetal reactions are best interpreted as reflex responses rather than responses to pain. A fetus at twelve weeks of gestation does not have a developed cortex, which is a necessary condition, under the current consensus, for the sensation of pain. Because one cannot directly infer sensation from the presence of reflex actions, and because the fetus has not reached a stage of neural development at which it can interpret “pain messages,” the fetus probably did not “feel” the tip of the instrument.

An example of a reasonable inference of pain appears in the following excerpt from congressional testimony regarding a nurse’s observation of a partial-birth abortion performed on a fetus of twenty-six and a half weeks:

The baby’s little fingers were clasping and unclasping, and his feet were kicking. Then the doctor stuck the scissors through the back of his head, and the baby’s arms jerked out, a startle reaction, in a flinch like a baby does when you throw him up in the air and he thinks he is going to fall. The doctor opened up the scissors, stuck a high-powered suction tube into the opening, and sucked the baby’s brains out. Now the baby went completely limp.

Given the gestational age of this fetus and the anatomical, physiological, and behavioral evidence from studies of fetuses at similar stages of development, it would be reasonable to conclude that the fetus felt pain when the doctor inserted the scissors at the base of its skull during the abortion.

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26 The movie does not itself make that inference. Rather, the movie points to the fetus’s elevated heart rate and increasingly agitated movements away from the suction tip as evidence that the fetus senses danger. See THE SILENT SCREAM, http://www.silentscream.org/silent_e.htm (script) (last visited Apr. 7, 2002).
27 Effects of Anesthesia During a Partial-Birth Abortion, supra note 7, at 311 (statement of Brenda Pratt Shafer, Registered Nurse).
28 Compare id. at 293–94 (remarks of Rep. Henry J. Hyde) (concluding from the testimony of four medical specialists that “we’re talking about a lot of pain, I would think, . . . [and] it’s an ac-
II. THE NEED FOR FETAL PAIN LEGISLATION

This Note adopts a simple premise: given the choice between a procedure that would inflict fetal pain and a marginally more expensive procedure involving a longer exposure to pain relief that would prevent fetal pain, most women would prefer the latter. If this premise were true and if the market for late-term abortions functioned perfectly, one would expect that physicians would regularly administer pain relief to fetuses as part of late-term abortion procedures. There is no indication that physicians presently do so.

Outside of the abortion context, it is clear that fetal pain matters to women and to physicians who perform surgical procedures involving fetuses. Medical texts recommend that a doctor performing fetal surgery administer pain relief effective for the fetus as well as for the pregnant woman. Physicians performing in utero surgeries routinely provide targeted fetal pain relief. It would be surprising if the mothers of the fetuses being operated on (and the fathers, for that matter) were indifferent to the infliction of fetal pain.

People act differently when abortion is involved. In discussing abortion-related legislation, some doctors deny that any fetus can feel
pain\textsuperscript{32} despite substantial evidence to the contrary.\textsuperscript{33} Though some doctors perform abortion procedures that minimize fetal pain (as a side effect of a procedure performed in a pain-minimizing way for unrelated reasons),\textsuperscript{34} current medical practice does not include targeted fetal pain relief in late-term abortion procedures. The issue is primarily one of timing. Physicians performing late-term abortions generally administer pain relief to the pregnant woman in the form of opioid analgesics (alone or in combination with general anesthesia).\textsuperscript{35} Most analgesics and anesthetics administered to the pregnant woman cross the placental barrier, but their effect on the fetus is delayed because it takes time for such drugs to reach full equilibration in the fetus\textsuperscript{36} and because passage through the fetus’s liver and blood stream dilutes drug concentration in some circumstances.\textsuperscript{37} This time lag is significant because most physicians presently perform abortion procedures almost immediately after administering pain relief, without the delay necessary to allow for effective transmission to the fetus.\textsuperscript{38} Because of this delay, these drugs must be administered early enough before the procedure for full effectiveness in providing fetal pain relief.\textsuperscript{39} The only increased health risks posed are those associated with longer ma-

\textsuperscript{32} See \textit{Effects of Anesthesia During a Partial-Birth Abortion}, supra note 7, at 289 (letter from Dr. Mitchell Creinin, Ass't Prof. & Dir. of Family Planning & Family Planning Research, Magee-Womens Hosp.) [hereinafter Creinin letter] (“As a physician, I can assure you that there is no such thing as pain to a fetus; plain and simple, pain does not exist to a fetus. Any doctor who states otherwise is flat out lying and twisting medical data.”).

\textsuperscript{33} See \textsuperscript{supra} Part I; see also \textit{Effects of Anesthesia During a Partial-Birth Abortion}, supra note 7, at 288 (statement of Dr. Norig Ellison, President, Am. Soc’y of Anesthesiologists) (“I find it inconceivable that any physician . . . would attach his name to a letter like that.”) (commenting on Creinin letter, supra note 32).

\textsuperscript{34} For example, one doctor has indicated that he typically causes fetal death by injecting digoxin and lidocaine directly into the fetus’s heart when performing a partial-birth abortion on fetuses with a gestational age of twenty weeks or more. Carhart v. Stenberg, 11 F. Supp. 2d 1099, 1106 (D. Neb. 1998) (describing the testimony of Dr. Leroy Carhart).

\textsuperscript{35} See \textit{Effects of Anesthesia During a Partial-Birth Abortion}, supra note 7, at 356 (letter from Dr. Lewis H. Koplik) [hereinafter Koplik letter] (discussing Dr. Koplik’s and Dr. James McMahon’s practices of administering Versed and Fentanyl when performing abortions).


\textsuperscript{37} Id. at 21.

\textsuperscript{38} A survey in England asked “[a]naesthetists working in all clinics approved to perform terminations at 20–24 weeks’ gestation . . . to provide information on whether premedication was used, what agents and doses were used for induction and maintenance of anaesthesia, and how soon after induction of anaesthesia the procedure was started.” \textit{Id.} at 13. This survey found that “no sedative premedication was given” and that “[t]he [abortion] procedure was started either immediately after induction of anaesthesia or within 2–3 minutes.” \textit{Id.} Practice in the United States may differ, particularly in more liberal administration of sedative premedication. \textit{See} Koplik letter, \textit{supra} note 35, at 356.

\textsuperscript{39} The lag time differs depending on the particular analgesic or anesthetic. Intramuscular injections of pethidine require three hours to be maximally effective, whereas injection of fentanyl, alfentanil, or benzodiazepines may work more rapidly. \textit{Id.}
ternal exposure to pain relief. People undergoing surgical procedures of all sorts routinely expose themselves to similar minor risks, and there is no reason to expect women seeking late-term abortions to act any differently.

Physicians do not provide for direct fetal pain relief as part of late-term abortions for two interconnected reasons. First, physicians performing abortions are unlikely to view the fetus as a patient and thus are unlikely to consider fetal pain a significant problem. Second, fetal pain relief involves extra cost, most of which comes from the increased time needed for physician involvement, and some extra health risk associated with longer sedation. Physicians therefore use the minimum amount of pain relief deemed “necessary,” and do not consider fetal pain when making this calculation.

There is no reason to believe that physicians presently provide women seeking late-term abortions with information about fetal pain or fetal pain relief. Physicians have little incentive to discuss the evidence that abortions inflict pain on the fetus, even though they could address fetal pain with little increased cost or health risk. Discussing fetal pain before an abortion might be uncomfortable even for a physician accustomed to having conversations about sensitive matters with patients. Because abortion has as its purpose the destruction of the fetus, and physicians naturally prefer to discuss matters that patients find reassuring, the default arrangement seems to be that physicians provide no information on fetal pain or fetal pain relief.

The present default arrangement is acceptable only if women seeking late-term abortions are indifferent to the infliction of fetal pain under circumstances in which the physician could minimize that pain with little increased cost or health risk. This assumption seems dubious in light of testimony from women who have obtained late-term abortions, who reported that they made a difficult and tragic decision to end a wanted pregnancy in which they cared deeply for the baby. Though it is unlikely that women who obtain late-term abortions are indifferent to fetal pain, it is also unlikely that such women will actively seek information about fetal pain given the welter of competing concerns vying for their attention. Legislation requiring physicians to offer information on fetal pain and seek informed consent to administr-
ter fetal pain relief would correct the failure of the present arrangement.

III. THE DESIGN OF FETAL PAIN LEGISLATION

Having discussed the scientific evidence regarding fetal pain and the failure of physicians to offer targeted fetal pain relief, this Note turns to the design of legislation to decrease the infliction of pain in late-term abortions. This section discusses three possible rules: a ban on all postviability abortions, a requirement that physicians always administer fetal pain relief when performing abortions after twenty weeks gestational age, and a requirement that physicians offer information on fetal pain and also provide the option of fetal pain relief when performing abortions after twenty weeks gestational age. After evaluating how each rule would function in conjunction with the Supreme Court’s health exception jurisprudence, this section concludes that an information requirement coupled with a mandate to offer the option of fetal pain relief would best accomplish the goals of state legislatures. The section ends by proposing model legislation.

If a state’s only interest with regard to late-term abortions were to minimize fetal pain, one straightforward way of serving this interest would be to ban all postviability abortions. The Court in Planned Parenthood of Southeastern Pennsylvania v. Casey reaffirmed the holding of Roe v. Wade that “subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.” Such a ban would not, however, fully address the state’s interest in minimizing fetal pain. If pain perception begins at twenty weeks and viability is placed at twenty-three to twenty-four weeks, there would be some pain-inducing abortions not covered by a postviability ban. More significantly, however, the health exception, as interpreted in Stenberg v. Carhart, would allow for circumvention of the legislative prohibition on postviability abortions. The scope of the health exception is coextensive with the limits imposed by legislation. Thus, when the state attempts to ban abortion categorically after a certain gestational age or to ban the use of a particular procedure, it provides more situations in which a health excep-

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43 410 U.S. 113 (1973).
44 Casey, 505 U.S. at 879 (plurality opinion) (quoting Roe, 410 U.S. at 164–65) (internal quotation marks omitted).
45 This is the time during which thalamo-cortical connections begin to form. See supra pp. 2013–14.
tion can plausibly be invoked. In each case, the categorical restriction meets a similarly categorical exception. A law that places fewer hard limits therefore provides fewer occasions in which a health exception can defeat legislative requirements.

The availability of fetal pain relief gives the state a way to address fetal pain directly without banning late-term abortions wholesale. The state would then face a choice between mandating the administration of targeted fetal pain relief in all abortions performed after a certain time and mandating only that the pregnant woman be given information about fetal pain and fetal pain relief along with a surgical option that would include targeted fetal pain relief.

Requiring the provision of information seems less intrusive than legislatively imposing a new element of a surgical procedure. The reverse may be true, however, if one measures the impact of the law from the perspective of a woman and her doctor. Mandating fetal pain relief permits the woman and her doctor to sidestep discussion of fetal pain while simultaneously ensuring that the fetus will not suffer pain as a consequence of the perceived difficulty of having such a discussion. Because administration of fetal pain relief would be part of the abortion and all surgical procedures require informed consent, some mention of fetal pain would be necessary, but the doctor could downplay the likelihood of fetal pain and chalk up the requirement to legislative overreaching, if so inclined.

Fetal pain relief mandated, discussion averted, problem solved? No. Once again, legislators must account for the Court's health exception jurisprudence as articulated in Stenberg. Any post-Stenberg legislation that did not include a health exception would be begging for invalidation on that basis alone.47

How would a health exception work? A doctor might invoke the exception for at least two reasons. First, the doctor may face a truly exceptional situation in which administration of fetal anesthesia would impose abnormally high health risks on the pregnant woman. Second, he or she may believe as a general matter that administration of "extra" pain relief is risky and therefore unwarranted unless the patient specifically requests it. Allowing an exception for the first reason would let the legislature set a generally applicable rule that implements the legislature's determination of the relevant costs and benefits. Allowing an exception for the second reason would permit each doctor to set his or her own general rule based on an independent determina-

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47 In evaluating Nebraska's ban on partial-birth abortions, Justice Breyer's majority opinion stated that a statutory health exception is necessary when "a significant body of medical opinion believes a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view." *Id.*
tion of the relevant costs and benefits. Because there is nothing under current law to prevent doctors from relying on either reason when invoking a statutory health exception, doctors could rely on general objections to decide unilaterally not to administer targeted fetal pain relief. Such a state of affairs would be no improvement over the status quo.

The problem in designing abortion-related legislation lies in allowing an exception for exceptional circumstances without letting the exception swallow the rule. As Justice Kennedy pointed out in his Stenberg dissent, application of a health exception is physician-centered: any legislative restriction on abortion must give way if the doctor performing the abortion determines that the restriction poses an increased health risk to the woman. Unless abortion legislation provides for its own circumvention by the physician on a case-by-case basis, it will run afoul of Stenberg.

Because doctors can invoke the health exception in situations other than truly exceptional ones, the best way for a legislature to minimize fetal pain may be to avoid designing its rule as a restriction. Instead of imposing a restriction, the legislature could require the doctor to provide information sufficient to let the woman herself make the choice whether to include fetal pain relief in the procedure. Every use of additional pain relief will have some risks as well as some countervailing benefits. By requiring the doctor to provide information and empowering the pregnant woman herself to weigh the costs and benefits of targeted fetal pain relief, state legislation can ensure that the woman,

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48 One might argue that legislatures are not well-positioned to weigh the costs and benefits of medical procedures at all. Such an argument would have to explain why it is permissible for the legislature to require immunizations, regulate medical devices, limit access to prescription drugs, require insurers to provide coverage for at least forty-eight hours of hospital time following delivery, and act in myriad ways to determine the relevant costs and benefits of medical treatment, but not to determine as a general matter that pain inflicted on the fetus in the absence of fetal pain relief outweighs any marginal risks that such pain relief poses to the woman.

49 Stenberg, 530 U.S. at 964 (Kennedy, J., dissenting) ("[T]he Court awards each physician a veto power over the State's judgment that the procedures should not be performed."). Justice Breyer's majority opinion and Justice O'Connor's concurrence each disclaimed such a rule. Stenberg, 530 U.S. at 938; id. at 948 (O'Connor, J., concurring). Justices Breyer and O'Connor note that a single physician's idiosyncratic judgment about the general safety benefits of a particular procedure is insufficient to support a health exception. The real disagreement between them and Justice Kennedy centers on the physician's invocation of a health exception in particular circumstances. Under Stenberg, a physician's determination that the use of a prohibited procedure for a particular patient would provide some increased safety, however marginal, allows for circumvention of the legislative prohibition. The legislature can address this problem by setting the acceptable level of risk, but the physician always retains a great amount of functionally unreviewable discretion in applying this risk standard to particular facts, thus exercising a veto power over the legislative determination.
rather than the doctor alone, has the final say in intelligently weighing the relevant costs and benefits.\textsuperscript{50}

Legislation that requires doctors to provide information on fetal pain and to offer fetal pain relief should include an exception that relaxes the requirements in exceptional circumstances. The legislature could model an appropriate medical emergency exception on the statutory provisions upheld by the Supreme Court in \textit{Casey}.\textsuperscript{51} Because the law’s requirements would simply add another component to the informed consent that must be provided for any surgical procedure, there would likely be few situations in which a physician could credibly invoke a medical emergency exception.

The Fetal Pain Prevention Act (FPPA)\textsuperscript{52} introduced in the New York Assembly in March 2001 provides model legislation for addressing the issue of fetal pain in a manner consistent with the latest scientific findings and the regnant interpretation of the requirements of the Constitution. The FPPA would apply “[i]f a physician who is to perform an abortion has reason to believe that the pregnant female is carrying a fetus of twenty or more weeks gestational age.”\textsuperscript{53} In such circumstances, the FPPA would require the physician, personally, to provide the pregnant woman with oral information on fetal pain as well as written information prepared by the State Commissioner of Health.\textsuperscript{54}

After providing the required information, the physician must “personally request [the pregnant woman’s] voluntary and knowing consent for the administration of an anesthesia or analgesic to eliminate or

\begin{footnotesize}
\textsuperscript{50} Of course, the physician, as the patient’s main source of information and expertise, would remain the primary influence over the patient’s choice.

\textsuperscript{51} See Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 879–80 (1992) (plurality opinion) (concluding that a statutory exception, triggered by a doctor’s determination that following the general rule would “create serious risk of substantial and irreversible impairment of a major bodily function,” did not impose an undue burden on a woman’s abortion right).

\textsuperscript{52} A. 7940, 2001–02 Reg. Sess. (N.Y. 2001). This bill was introduced on March 27, 2001, and was referred to the Committee on Health, where it has remained ever since. A substantively identical bill was introduced in the State Senate and referred to the Committee on Health. S.B. 3385, 2001–02 Reg. Sess. (N.Y. 2001). As of May 2002, there was no indication that either bill had a realistic chance even of getting out of committee. Similar bills have been introduced in Texas and California, but both have remained in committee. See H.B. 1244, 77th Reg. Sess. (Tex. 2001); A. 1758, 1997–98 Reg. Sess. (Cal. 1998). These bills are discussed in Collett, supra note 12, at 17–18.

\textsuperscript{53} A. 7940, § 2514(1).

\textsuperscript{54} Id. The written information prepared by the Commissioner must be “objective, nonjudgmental and designed to convey accurate scientific information,” and must include information regarding “[t]he development of the nervous system of the fetus; [f]etal responsiveness to adverse stimuli; [a]nd a description of the actual steps in the abortion procedure to be administered.” Id. § 2514(2).
\end{footnotesize}
alleviate fetal pain during the course of the abortion." If the pregnant woman consents:

[The physician] shall administer an anesthesia or analgesic which in [the] physician's reasonable medical judgment is necessary to eliminate or alleviate fetal pain during the course of the abortion[, but] the physician shall not administer any medication that would to a medically significant degree decrease the possibility of sustained survival of the fetus apart from the body of the mother, with or without artificial life support, or that would cause the death of the fetus.56

The FPPA includes two exceptions. The first exception would apply if immediate abortion were necessary to avert the death of the pregnant woman or if "a delay would create a serious risk of a substantial and irreversible impairment of a major bodily function."57 The second exception would apply if "[t]he administration of an anesthetic or analgesic would cause the pregnant woman's death or would create a serious risk of a substantial and irreversible impairment of a major bodily function."58 If either exception applies "in the reasonable medical judgment of the physician who performs the abortion,"59 the physician need not comply with the specific informed consent procedures otherwise required by the FPPA. In such a case, the physician must certify in the pregnant woman's medical records "the specific medical grounds for [the] physician's judgment."60

IV. CONSTITUTIONAL ANALYSIS

The FPPA is a species of informed consent law similar to the informed consent provisions upheld by the Supreme Court in Planned Parenthood of Southeastern Pennsylvania v. Casey. In Casey, the Court discarded the trimester framework of Roe v. Wade while reaf-

55 Id. § 2515(1). The physician must certify, on a state-provided form, that he or she personally provided the required information to the patient, id. § 2514(3), and personally requested the patient's consent, id. § 2515(2). Similarly, the patient must certify her grant or refusal of consent. Id. § 2515(3). The physician must include these certification forms in the patient's medical records. Id. § 2514(3), 2515(2)-(3).
56 Id. § 2515(4). The FPPA defines as professional misconduct a physician's failure to provide the required information or request the required consent. Id. § 2517(1). An additional provision states that "[a]ny person who knowingly makes a false entry in a medical record as required by this section shall be guilty of a class A misdemeanor." Id. § 2517(3). The law provides the pregnant woman on whom an abortion is performed without the required information or consent a personal civil action against the physician for actual and punitive damages. Id. § 2517(2). The law also awards "reasonable attorneys' fees to a prevailing plaintiff." Id. Finally, the FPPA states that "[t]he female upon whom an abortion has been performed shall not be liable for any offense under this title." Id. § 2517(3).
57 Id. § 2516(1)(a).
58 Id. § 2516(1)(b).
59 Id. § 2516(1).
60 Id. § 2516(2).
firming what it termed the “essential holding” of Roe.61 The Court stated:

States are free to enact laws to provide a reasonable framework for a woman to make a decision that has such profound and lasting meaning. This, too, we find consistent with Roe’s central premises, and indeed the inevitable consequence of our holding that the State has an interest in protecting the life of the unborn.62

In applying its principles to the statutory provisions at issue, the Casey plurality upheld the constitutionality of Pennsylvania’s informed consent and waiting period provisions, which required that “at least 24 hours before performing an abortion a physician inform the woman of the nature of the procedure, the health risks of the abortion and of childbirth, and the ‘probable gestational age of the unborn child.’”63 The statute also required the physician or another qualified person to “inform the woman of the availability of printed materials published by the State describing the fetus and providing 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.”64 The informed consent and waiting period provisions did not apply in the case of a medical emergency, defined as a circumstance in which delay would lead to the pregnant woman’s death or the serious impairment of a major bodily function.65

In light of Casey, analysis of the constitutionality of the FPPA is straightforward. Neither banning any procedure nor restricting the power of women to choose whether to abort, the Act lets women choose whether to obtain fetal pain relief. If the FPPA is enacted pursuant to a legitimate state interest, it is valid if it imposes no undue burden on the right to privacy.66 Because the undue burden inquiry is

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61 As articulated by the plurality opinion, this “essential holding” had three elements: First is a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State. . . . Second is a confirmation of the State’s power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman’s life or health. And third is the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child. Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 846 (1992).
62 Id. at 873; see also id. at 872 (“Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed.”).
63 Id. at 881 (describing the Pennsylvania statute, 18 PA. CONS. STAT. ANN. § 3205 (West 2000)).
64 Id.
65 Id. at 879–80; see also 18 PA. CONS. STAT. ANN. § 3203 (West 2000).
66 As the Court said in Casey: The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure...
often determinative, analysis of abortion-related legislation typically addresses this issue first even though the state interest inquiry is prior as a matter of law and logic.

After *Casey*, there is no credible argument that the FPPA unduly burdens the constitutional right to privacy. Fetal pain information is just a specific form of information on fetal development that describes a consequence of the fetus’s anatomical, physiological, and neurological development. An opponent of the legislation might argue that providing information on fetal pain unduly burdens the woman’s right to privacy by providing “upsetting” information. Apart from the paternalism inherent in this objection, this attempted distinction of *Casey* also overlooks that the FPPA requires the doctor to provide the pregnant woman with the option of mitigating fetal pain. To the extent that a woman would rather the doctor not inflict fetal pain, the FPPA empowers her with the ability to choose a procedure involving fetal pain relief. Indeed, the fact that some women seeking late-term abortions might find the prospect of fetal pain “upsetting” lends support to the legislative premise that fetal pain matters to such women.

Unlike Nebraska’s ban on partial-birth abortions that was found unconstitutional in *Stenberg v. Carhart*, the FPPA has a medical emergency exception that satisfies the constitutional requirement articulated in *Casey* and reiterated in *Stenberg*. The two exceptions built into the FPPA are structurally the same as the medical emergency exception in *Casey*.

Given that the FPPA does not unduly burden the right to privacy, the appropriate level of scrutiny for a court to apply is deferential rational basis scrutiny, under which the FPPA is valid if passed pursuant to a legitimate state interest. The remainder of this section discusses a number of state interests that support the FPPA. This discussion begins with consideration of the state’s interest in the potential human life of the fetus because this interest was found to support the in-

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an abortion cannot be enough to invalidate it. Only where state regulation imposes an *undue burden* on a woman’s ability to make this decision does the power of the state reach into the heart of the liberty protected by the Due Process Clause. *Casey*, 505 U.S. at 874 (emphasis added).

67 As a political matter, it is likely that fetal pain legislation will first be enacted as an amendment to informed consent provisions in a state that already has an informed consent provision on the books.

68 Cf. *Stenberg*, 530 U.S. at 938 ("Where substantial medical authority supports the proposition that banning a particular abortion procedure could endanger women’s health, *Casey* requires the state to include a health exception when the procedure is ‘necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.’" (quoting *Casey*, 505 U.S. at 879)).

69 See *Casey*, 505 U.S. at 880 (discussing the application of the health exception requirement to Pennsylvania’s informed consent requirements).
formed consent provisions in *Casey*. The discussion proceeds to consider additional interests more closely related to the issue of fetal pain.

The third element of the "essential holding" of *Roe*, as described by the *Casey* plurality, is the recognition that the state has a legitimate interest in the potential human life of the fetus. One might object that this interest cannot support the FPPA because the law does not save any fetus from destruction but only minimizes fetal pain during the procedure. Justice Breyer's majority opinion\(^70\) and Justice Ginsburg's concurring opinion\(^71\) in *Stenberg* included an argument of this sort against Nebraska's partial-birth abortion ban, and Judge Posner made the same argument in dissenting from the Seventh Circuit's pre-*Stenberg* decision not to enjoin entirely Wisconsin's partial-birth abortion ban.\(^72\)

Applying this objection to the FPPA would not only rest on an unduly narrow interpretation of the state's interest, but would also misconstrue the law's potential effects. First, the legitimate state interest in potential human life recognized in *Casey* supports laws other than those that categorically limit abortions, such as laws promoting informed choice.\(^73\) Second, the FPPA advances this interest even if that interest is construed narrowly to require an actual decrease in the number of abortions. Though the information that the FPPA requires is unlikely to result in many decisions not to go through with the abortion (given the ready availability of fetal pain relief), the information may have that effect in at least some cases. By resulting in the birth of children who might not have otherwise been born, the legislation advances, in at least some cases, the state's legitimate interest in protecting potential human life. That this interest is advanced through the *choice* of the pregnant woman rather than the *command* of the state is a virtue, not a vice, of the state's approach.

Apart from the interest in protecting potential human life, the FPPA serves a number of other state interests. It is helpful in analyzing these state interests to distinguish between "derivative" and "de-
tached” interests, a distinction most forcefully advanced in the abortion context by Ronald Dworkin.\textsuperscript{74} A derivative interest is one derived from particular interests of individuals, whereas a detached interest is a general societal value that does not depend on or presuppose any particular individual interests.\textsuperscript{75} Applying this distinction provides a useful classification of the interests that the state can advance through the FPPA. These interests include promoting the woman’s right to privacy (derivative), protecting the fetus’s interest in being free from unnecessary pain (derivative), maintaining the role of doctors as caregivers (detached), and promoting a more compassionate approach to human life by minimizing the needless infliction of pain on human fetuses (detached).

Proponents of the FPPA can argue that the legislation enhances the pregnant woman’s exercise of her privacy right to choose abortion by ensuring that the doctor fully informs her of all consequences that she would find important. If the premise of this Note is correct, most women seeking late-term abortions would prefer to be informed whether the procedure will inflict pain on the fetus, so that the physician could minimize that pain, rather than to be kept in the dark due to paternalistic notions of emotional vulnerability. One might object that the FPPA interferes with, rather than promotes, a pregnant woman’s interest in exercising her privacy right by forcing on her state-approved information regarding fetal pain. This objection derives from an individualistic conception of autonomous choice that finds its origin in political theory rather than the Constitution. Though some statements in the Casey plurality opinion seem at first to constitutionalize such an individualism,\textsuperscript{76} the portions of the decision upholding Pennsylvania’s informed consent and waiting period requirements recognize that state-required information may in fact enhance the pregnant woman’s exercise of her privacy right.\textsuperscript{77} In a pas-

\textsuperscript{74} See RONALD DWORKIN, LIFE’S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM 11 (1993).

\textsuperscript{75} Id.

\textsuperscript{76} Particularly notable in this regard is the vaunted “mystery passage” of the plurality opinion: “At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.” Casey, 505 U.S. at 851.

\textsuperscript{77} Indeed, any critic of the “mystery passage” would be well advised to read on. The text immediately following the “mystery passage” recognizes that abortion is not an abstract exercise of disembodied autonomy, but a real-world choice with practical consequences. The vision of Casey is not the vision of the “mystery passage” alone, but the “mystery passage” followed immediately by the statement:

These considerations begin our analysis of the woman’s interest in terminating her pregnancy but cannot end it, for this reason: though the abortion decision may originate within the zone of conscience and belief, it is more than a philosophic exercise. Abortion is a unique act. It is an act fraught with consequences for others: for the woman who must live with the implications of her decision; for the persons who perform and
sage with obvious applicability to analysis of the FPPA, the plurality stated:

[M]ost women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision. In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.78

Thus, the FPPA does, in some way, force a “difficult conversation,” but it is necessary precisely for this reason. Absent such legislation, physician discomfort in broaching a sensitive topic may block the provision of information that a pregnant woman would find important but would not otherwise receive.79

The FPPA clearly serves the interest of the fetus in avoiding the pain that substantial scientific evidence indicates is inflicted on fetuses in late-term abortions. The primary argument against recognizing the fetus’s interest in avoiding pain as a legitimate state interest is that acknowledgment of such an interest is contrary to the Court’s determination in Roe that the fetus is not a person for purposes of constitutional law.80 This objection relies on the premise that the state may only protect the derivative interests of constitutional persons (a category that excludes fetuses). This premise is clearly wrong. In explaining why “complex philosophical issues about the nature of moral (as opposed to legal) rights and the identity of proper rights bearers . . . need not get in the way of progress on the issue of legal rights as such,”81 Cass Sunstein writes:

Speaking pragmatically, the foundation for a legal right is an enforceable claim of one kind or another. If rights are understood in this mundane and pragmatic way, there is nothing novel or unfamiliar about the notion of animal rights. Indeed, no one seriously urges that animals should lack legally enforceable claims against egregious cruelty, and animals have long had a wide range of rights against cruelty and mistreatment under state law, rights that have recently been growing in both state and national leg-

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Id. at 852.

78 Id. at 882.

79 The Court in Casey rejected the argument that requiring doctors to provide information violates the First Amendment by compelling physician speech. Id. at 884.

80 Roe v. Wade, 410 U.S. 113, 158 (1973) ("[T]he word ‘person,’ as used in the Fourteenth Amendment, does not include the unborn.").

islatures. The capacity to suffer is, in this sense, a sufficient basis for legal rights for animals.82

Our legal system has manipulated the concept of personhood in a number of ways,83 but one constant seems to be that personhood is not a prerequisite to recognition of legally enforceable interests. For example, even though pre-Civil War judges in Virginia and North Carolina "held that owners who severely and unjustifiably beat their slaves could not be indicted under the common law,"84 most judges "read laws proscribing the killing of persons to prohibit the killing of slaves."85 Though not full "persons" under the law and compared by some judges to animals and chattel, slaves nonetheless had a legally enforceable interest in not being murdered.86 The comparison to slavery also indicates that it is possible to recognize a legally enforceable interest while simultaneously providing that the interest may only be asserted by a third party. Ultimately, it is perhaps too obvious to merit extended consideration that preventing persons from inflicting gratuitous pain on other sentient beings is a legitimate state purpose.87

The state has detached interests in protecting the role of doctors and promoting a more compassionate approach to human life. States have a legitimate interest in regulating the practice of medicine to protect the role of the physician as a caregiver. In sustaining Washington's ban on assisted suicide against a substantive due process challenge, the Court stated that "[t]he State . . . has an interest in protecting the integrity and ethics of the medical profession."88 The physician performing a late-term abortion is unlikely to be the woman's regular physician because the relative rarity of such procedures makes it impractical for most physicians who specialize in women's health to develop expertise in performing late-term abortions.89 Given that the fe-

82 Id. at 1363.
83 See generally Note, What We Talk About When We Talk About Persons: The Language of a Legal Fiction, 114 HARV. L. REV. 1745 (2001) (describing the general incoherence of American approaches to the notion of legal personhood, including categories of human nonpersons (such as slaves), nonhuman persons (such as corporations), and borderline humans (such as fetuses)).
84 Id. at 1749.
85 Id. at 1748.
86 Whether this interest was enforceable as a practical matter is a separate question.
   We should be able to agree without help from philosophers and constitutional theorists that gratuitous cruelty is bad. Condemnation is built into the word "gratuitous," and few of us are either so sadistic, or so indifferent to animal suffering, that we are unwilling to incur at least modest costs to prevent gratuitous cruelty to animals. . . .
   Id. at 539-40.
89 Many doctors may also object to performing such procedures on moral grounds.
tus is not the doctor's patient in any conventional sense — at least during an abortion — the doctor is unlikely to view himself or herself as having a duty to inform the pregnant woman about consequences of the procedure for the fetus (other than the obvious consequence of fetal death). The FPPA promotes the role of the doctor as caregiver by ensuring that the doctor provides the woman with information that she would deem relevant but that the doctor might not otherwise provide.90

Finally, and most importantly, the FPPA may serve the state's interest in promoting a more compassionate approach to human life by minimizing the needless infliction of pain on human fetuses. Despite the Court's invalidation of Nebraska's ban on partial-birth abortions in _Stenberg_, the state may still protect human dignity by minimizing brutal procedures that may coarsen sensibilities and cheapen human life. A law that minimizes fetal pain promotes the state's interest in human life in a way that "is symbolic and aspirational as well as practical."91 This state interest is not derivative of, and does not depend on recognizing, a fetus's right to life or humane treatment. Rather, appeal to this interest reflects the idea expressed by Oxford ethics professor Jonathan Glover:

The effects of certain kinds of acts, not on those they are done to, but on those who do them, can be of overriding importance.

... [T]he moral claims of late fetuses and of babies are not exhausted by any rights depending on their qualifying as persons. Perhaps they are not persons, and have less of the required self-consciousness than some nonhuman animals. But we have reasons, to do with ourselves rather than them, for not treating them as merely disposable.92

Offering the option of administering targeted pain relief to the fetus promotes an understanding of the late-term fetus that appropriately demands more humane treatment under the present regime of abortion jurisprudence. The ultimate effect of such legislation may be to produce a more compassionate body politic, though as a practical matter, this is far from certain. As the next section explains, the constitutive

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90 _Cf._ Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 884 (1992) ("Whatever constitutional status the doctor-patient relation may have as a general matter, in the present context it is derivative of the woman's position."); _Stenberg v. Carhart_, 530 U.S. 914, 962 (2000) (Kennedy, J., dissenting) ("A State may take measures to ensure the medical profession and its members are viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others.").

91 _Glucksberg_, 521 U.S. at 729.

effects of fetal pain legislation are difficult to predict because such legislation rests on a deeply ambiguous conception of the appropriate legal status of the human fetus.

V. FETAL PAIN AND THE POLITICS OF COMPASSION

Perhaps many people would prefer not to confront the evidence that a late-term abortion inflicts pain on the fetus. Once presented with this evidence, however, people may respond in a number of ways. Some may reject it; some may manipulate it for political gain; yet others may mourn it but ultimately accept it passively. This Note contends that this evidence provides the basis for legislative action.

Many pro-lifers are likely to view the FPPA or similar legislation as a potentially dangerous compromise with an unjustified abortion jurisprudence, premised on "the sense that the pain inflicted by the abortion is of secondary importance to the intolerable taking of life." Many pro-choicers are likely to view such legislation as designed to chip away at the robust abortion right recognized in Roe and modified in Casey. Both "sides" are right to fear, because addressing fetal pain does not exhaust social concerns about abortion, even though it raises some of these concerns in a vivid (but ultimately limited) manner. The fear of the pro-lifer is that recognition of fetal suffering will result in an ethic premised on the notion that abortion is permissible as long as it is as painless as possible. The fear of the pro-choicer is that legislative acknowledgment of fetal pain will eventually result in restrictions on abortion that are unconnected to such pain.

Confronting the suffering of sentient beings has produced reforms in other areas of the law. As Judge Noonan has observed, "[t]he best indication that attention to the pain of the unborn may have social consequences is afforded by the example of humanitarian activity on behalf of animals." Legal protections for animals have evolved over the past few centuries in England and the United States, supplanting
a common law baseline in which animals were a species of property with very little protection against cruelty:96

[Today,] mere neglect of animal welfare counts as a criminal violation, and people are under an affirmative obligation to expend resources for the care and protection of animals. In many states, a failure to feed or shelter an animal can amount to a violation of that animal’s rights. The AWA [Animal Welfare Act] creates national rights to food, shelter, medical care, and even adequate ventilation. Indeed, animals have, under current law, a remarkable set of legal entitlements, including property rights of various sorts, and they enjoy these rights against their owners.97

Confrontation with suffering has also prompted legal changes in the administration of the death penalty. Many states have reformed their capital punishment laws to eliminate some of the more painful methods of execution.98 As this example illustrates, “reform” can be double-edged, seemingly useful in the short term but potentially counterproductive in the long term. From the perspective of those who oppose capital punishment, changing the method of execution may prop up an unacceptable legal practice by sanitizing it and making it less distasteful.99

The expansion of animal cruelty legislation supports pro-choicers’ fears that fetal pain legislation could expand into more restrictive abortion regulation, and the sanitization of the death penalty supports pro-lifers’ fears that fetal pain legislation could legitimize a practice they find fundamentally objectionable for reasons other than physical pain to the fetus. Though it is far from clear whether fetal pain legislation ultimately would lead to the realization of the fears of pro-choicers or pro-lifers, debate over such legislation is certain to turn on each “side’s” assessment of the constitutive effects of such legislation on popular conceptions of the appropriate legal status of the human fetus.

This legal status is an essentially contested concept in areas not directly related to abortion. The House of Representatives in 2001 passed the Unborn Victims of Violence Act, declaring that an unborn

96 Sunstein, supra note 81, at 1337.
97 Id. at 1363 (footnote omitted).
child injured or killed in the commission of a federal crime is a victim of that crime.\textsuperscript{100} Many states have enacted similar laws.\textsuperscript{101} The Department of Health and Human Services has issued a proposed regulation that permits states to define the fetus as a child when implementing the federal Children's Health Insurance Program (CHIP) at the state level.\textsuperscript{102} While Bush Administration officials and pro-lifers attempted to deflect attention from this definition's implications for abortion, the dismay of abortion supporters over the regulation was apparent. One told a reporter, "I just have to believe their hidden agenda is to extend personhood to a fetus."\textsuperscript{103}

In this environment of competing understandings, the constitutive effects of fetal pain legislation may be profound. The issue of fetal pain has particular salience because of the individualized nature of pain experiences. Because pain is experienced internally as a subjective experience, legal recognition of fetal pain distinct from maternal pain implies legal recognition of the fetus as a \textit{subject} distinct from the mother.

Awakened empathy is a powerful social force, and the legal recognition of fetal pain has consequences. Fetal pain legislation may have a significant effect on the way in which our society deals with abortion and other social problems, for "[i]n the long run, the way in which we name things and imagine them may be decisive for the way we feel and act with respect to them, and for the kind of people we ourselves become."\textsuperscript{104} Such legislation may be desirable for precisely this reason.

\textsuperscript{100} Unborn Victims of Violence Act of 2001, H.R. 503, 107th Cong. (2001) (passed by the House of Representatives on April 26, 2001, and awaiting action in the Senate as of April 2002). More closely related to abortion, the House of Representatives in March 2002 passed the Born-Alive Infants Protection Act. H.R. 2175, 107th Cong. (2002) (defining the words "person," "human being," "child," and "individual" to include "every infant member of the species homo sapiens who is born alive at any stage of development").

\textsuperscript{101} See JEAN REITH SCHROEDEL, IS THE FETUS A PERSON? A COMPARISON OF POLICIES ACROSS THE FIFTY STATES 126-32 (2000) (identifying, as of January 1998, twenty-three states with "statutes making it a crime for a third party (not while performing an abortion) to kill a fetus").


\textsuperscript{104} GLENDON, \textit{supra} note 92, at 62. Recognizing that the law has constitutive effects on culture and urging legislators to shape the law in light of such effects should not mislead legislators into assuming that enlisting the \textit{coercive} power of the law is invariably the best way to change the underlying culture. \textit{See generally} M. Cathleen Kaveny, \textit{The Limits of Ordinary Virtue: The Limits of the Criminal Law in Implementing Evangelium Vitae, in Choosing Life: A Dialogue on Evangelium Vitae} 132, 133 (Kevin Wm. Wildes, S.J. & Alan C. Mitchell eds., 1997) (observing that "[t]he task of a legislator ... involves a complex and morally precarious balancing act" that requires the legislator to "distinguish between censurable acquiescence in the culture of death and clear-eyed realism about concrete possibilities for legislative advancement of a culture of life").