CATHERINE GLENN FOSTER, M.A., J.D.
President & CEO, Americans United for Life

Hearing of the Senate Judiciary Committee Regarding S. 160,
"The Pain-Capable Unborn Child Protection Act"

April 9, 2019, 10:00 a.m.
226 Dirksen Senate Building

April 9, 2019

Hon. Lindsey O. Graham, Chairman
Hon. Dianne Feinstein, Ranking Member
Honorable Members
United States Senate
Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, DC 20510-6275

Mr. Chairman, Ranking Member Feinstein, and Members of the Committee:

I am deeply privileged to testify today before this Committee in support of Senate Bill 160, the "Pain-Capable Unborn Child Protection Act." I serve as President and CEO of Americans United for Life (AUL), America's oldest and most active pro-life legal advocacy organization. Founded in 1971, two years before the Supreme Court's decision in *Roe v. Wade*, AUL has dedicated nearly 50 years to advocating for comprehensive legal protections for human life from conception to natural death. AUL strongly supports the Pain-Capable Act, which would protect the lives of unborn children who feel pain in late-term abortions, as well as the women who carry them, except when necessary to protect the life or physical health of the mother.

The Pain-Capable Unborn Child Protection Act restricts some—but not all—abortions after twenty weeks post-fertilization age (twenty-two weeks post LMP or "gestational age") and therefore includes abortions shortly before the current medical consensus of the viability line of about twenty-three to twenty-four weeks LMP. Later-term abortions account for a significant number of abortions, approximately 51,000 annually, with 36,000 taking place between 16 and 20 weeks, and 15,600 occurring after 20 weeks.[1] Thus, 98.5% of all abortions are done by the twentieth week, leaving only 1.5% of all abortions potentially impacted by the Pain-Capable Act.

The Pain-Capable Act is based upon congressional findings that physiological and neurological developments in the preborn infant yield substantial medical evidence that an unborn child is capable of experiencing pain at least by 20 weeks after fertilization (22 weeks LMP), if not earlier. S. 160, Sec. 2(1)-(11). S. 160 asserts a compelling governmental interest in "protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain…." S. 160, Sec. 2(12). The bill would amend Chapter 74 of title 18 of the U.S. Code to insert after the Partial-Birth Abortion Ban Act statute (18 U.S.C. § 1531) a new statutory section, 1532, relating to "Pain-capable unborn child protection." S. 160, Sec. 3(a). Section 1532 would prohibit any person from performing an abortion or attempting to do so unless they have "first ma[de] a determination of the probable post-fertilization age of the unborn child or reasonably rel[ied] upon such a determination made by another

[1] P.K. Coleman et al., *Late-Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms*, J. PREGNANCY (2010).

physician." S. 160, Sec. 3(a), § 1532(b)(1).[2] If the probable post-fertilization age is 20 weeks or greater (22 weeks LMP), the abortion shall not be attempted or performed (*id*., Sec. 3(a), § 1532(b)(2)(A)) except when the abortion "is necessary to save the life of a pregnant woman 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, but not including psychological conditions" (*id*., Sec. 3(a), § 1532(b)(2)(B)(i));[3] or when the pregnancy is the result of rape. *Id*., Sec. 3(a), § 1532(b)(2)(B)(ii)-(iii).[4] However, a physician terminating a pregnancy pursuant to these provisions must do so in the manner which provides the best opportunity for the survival of the infant. *Id*., Sec. 3(a), § 1532(b)(2)(C). The Act provides an additional exception where compliance would pose a greater risk of death or substantial and irreversible physical impairment to the maternal patient. *Id*., Sec. 3(a), § 1532(b)(2)(I).

The Pain-Capable Act provides for a criminal penalty for violations, of imprisonment for up to five years or a fine, or both, but precludes prosecution of the maternal patient. S. 160, Sec. 3(a), § 1532(c), § 1532(d). However, the maternal patient is entitled to bring a civil action against violators of the Act, as is the parent of a minor upon whom an abortion was performed in violation of the Act. *Id*., Sec. 3(a), § 1532(e).

Twenty-one states have enacted similar prohibitions on abortion after 20 weeks, and 18 of those measures are still in lawful effect: in Alabama, Arkansas, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Nebraska, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, West Virginia, and Wisconsin. Of the 21 states, Arizona, Mississippi and North Carolina's limits begin two weeks earlier at 20 weeks LMP (18 weeks post-fertilization). Mississippi's law has gone unchallenged. Arizona's 20-week LMP restriction was struck down by the Ninth Circuit Court of Appeals in *Isaacson v. Horne*, 716 F.3d 1213 (2013), *cert den*., 571 U.S. 1127 (2014), and Idaho's 20-week post-fertilization (22 weeks LMP) restriction was enjoined in *McCormack v. Herzog*, 788 F.3d 1017, 1029 (9th Cir. 2015). North Carolina's law was recently enjoined by a trial court, adopting reasoning similar to the Ninth Circuit's holding in *Isaacson* and *McCormack* that previability restrictions are "per se unconstitutional." *Bryant v. Woodall*, No. 16-1368, *slip op*. at 45 (M.Dist. NC Mar. 25, 2019). Consequently, Idaho is the only state of the 21 in which a 20-week post-fertilization law (22 weeks LMP) similar to S. 160 has been challenged in court.

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[2] The Act defines "fertilization" as "the fusion of human spermatozoon with a human ovum," S. 160, Sec. 3(a), § 1532(g)(5). *Cf*. TABER'S MEDICAL CYCLOPEDIA 787 (F.A. Davis 2005) ("The process that begins with the penetration of the secondary oocyte by the spermatozoon and is completed with the fusion of the male and female pronuclei."). The bases for such a determination may include inquiries of the maternal patient (e.g., regarding LMP) and medical examinations and tests relied upon by a reasonable practitioner, e.g., ultrasound measurements. S. 160, Sec. 3(a), § 1532(b)(1).

[3] This exception for the mother's "health" is consonant with the health exception upheld by the Supreme Court in *Planned Parenthood v. Casey*. Compare *Planned Parenthood of SE Pa. v. Casey*, 505 U.S. 833, at 879-80 (1992) (quoting and upholding 18 Pa.C.S.A. § 3202 (1990)), with S. 160, Sec. 3(a), § 1532(b)(2)(B)(i).

[4] In the case of rape against an adult woman, the maternal patient must have obtained counseling for the rape or medical treatment at least 48 hours prior to the abortion (S. 160, Sec. 3(a), § 1532(b)(2)(B)(ii)), provided that the abortion facility itself is not eligible to provide the counseling. S. 160, § 1532(b)(2)(I)(ii). If the pregnancy is the result of rape or incest against a minor, the Act mandates that it be reported at any time prior to the abortion to law enforcement or a governmental agency authorized to act on reports of child abuse. S. 160, Sec. 3(a), § 1532(b)(2)(B)(iii). Moreover, the abortion physician is required to comply with all applicable state laws regarding mandatory reporting of rape and incest, as well as laws protecting parental involvement in a minor's abortion. *Id*., Sec. 3(a), § 1532(b)(2)(I)(iv).

The Pain-Capable Act also includes vital protections for infants born alive in the course of an abortion, measures that give the full force and effect of federal legal protection to the most vulnerable human beings as expressed in the Born Alive Infants Protection Act, 1 U.S.C. § 8. Since its enactment, the federal Born Alive Infants Protection Act has been used as a model for similar state legislation, and now a majority of states have some form of statutory protection for infants born alive during an abortion.[5] However, the federal Born Alive Act is definitional only, and provides no penalties for persons who fail to protect infants born alive.

To effectuate the protections of the Born Alive Act, the Pain-Capable Act provides that if the pain-capable unborn child is beyond the point of viability ("has the potential to survive outside the womb"), the Act requires that a second physician trained in neonatal resuscitation be present and prepared to provide care to the child. S. 160, Sec. 3(a), § 1532(b)(2)(D). A child born alive (as defined by the federal Born Alive Infants Protection Act, 1 U.S.C. § 8) is entitled to the same degree of care and diligence to preserve his or her life as a reasonable health care provider would render to a child delivered naturally. S. 160, Sec. 3(a), § 1532(b)(2)(E)(i). Immediate transfer and admission to a hospital must follow. *Id*., Sec. 3(a), § 1532(b)(2)(E)(ii). The Act specifies documentation requirements pertaining to both the Pain-Capable and Born Alive components of the bill, *id*., Sec 3(a), § 1532(b)(2)(F), as well as informed consent requirements designed to ensure that the maternal patient is aware of the probable post-fertilization age of the baby and the exceptions to the prohibition the physician is relying on in her case. *Id*., Sec. 3(a), § 1532(b)(2)(G).

The Pain-Capable Unborn Child Protection Act Is Constitutional.

The fact that none of the 20-week post-fertilization laws that rely on fetal pain (like S. 160) have been challenged outside of the Ninth Circuit Court of Appeals is striking, especially in light of the current wave of ongoing litigation over state abortion regulations. For example, in the most recent Supreme Court decision involving abortion, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), aspects of Texas's abortion law relating to chemical abortion and to admitting privileges for doctors who perform abortion were challenged, but the concurrently enacted 20-week prohibition went unchallenged. We believe that the reason is simple: abortion advocates know that these measures are likely to withstand scrutiny by the Supreme Court.

First, because the Pain-Capable Act regulates commerce that impacts economic activity among the several states, it is clearly within the constitutional authority of the federal legislature pursuant to the Commerce Clause, U.S. CONST. Art. I, Sec. 8, cl. 3. See *United States v. Lopez*, 514 U.S. 549, 559 (1995) ("[W]e have upheld a wide variety of congressional Acts regulating interstate economic activity where we have concluded that the activity substantially affected interstate commerce."). The commercial activity of performing late-term abortions clearly substantially impacts interstate commerce. *United States v. Morrison*, 529 U.S. 598, 611 (2000) ("[I]n those cases where we have sustained federal regulation of intrastate activity based upon the activity's substantial effects on interstate commerce, the activity in question has been some sort of economic endeavor."). The federal Partial-Birth Abortion Ban Act is

[5] *See, e.g*., Ala. Code § 26-22-3(c)(5); Ariz. Rev. Stat. Ann. § 36-2301; Ark. Code Ann. § 20-16-604; Cal. Health & Safety Code § 123435; Del. Code Ann. § 1795; Fla. Stat. § 390.0111; 720 Ill. Comp. Stat. § 510/6(2)(b); Ind. Code § 16-34-2-3; La. Rev. Stat. Ann. § 40:1061.12; Me. Rev. Stat. tit. 22 § 1594; Mich. Comp. Laws § 333.1073; Minn. Stat. § 145.423; Miss. Code Ann. § 97-3-4; Mo. Rev. Stat. § 565.300; Mont. Code Ann. § 50-20-108; Neb. Rev. Stat. § 28-331; Nev. Rev. Stat. § 442.270; N.D. Cent. Code § 14-02.1-08; Okla. Stat. tit. 59 § 524; 18 Pa. Cons. Stat. § 3212; R.I. Gen. Laws § 11-9-18; S.C. Code Ann. § 2-7-30; S.D. Codified Laws § 34-23A-16.1; Tenn. Code Ann. § 39-15-206; Tex. Fam. Code § 151.002; Va. Code Ann. 18.2-71.1; Wash. Rev. Code § 18.71.240; Wis. Stat. § 990.001(17)(b); Wyo. Stat. Ann. § 35-6-104.

likewise based upon Commerce Clause authority. *See* 18 U.S.C. § 1531(a) ("Any physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than 2 years, or both."). In upholding the Partial-Birth Abortion Ban Act, the Supreme Court did not question Congress's authority to enact the law. See generally *Gonzales v. Carhart*, 550 U.S. 124 (2007) (upholding Partial-Birth Abortion Ban Act as a constitutional exercise of Congress's authority).

Second, the late-term abortion restriction contemplated by the Pain-Capable Act falls well within existing Supreme Court abortion jurisprudence. The notion indulged by a small number of courts reviewing 20-week limits that abortion regulations that operate prior to viability are *per se* unconstitutional is fallacious. In *Gonzales v. Carhart*, this Court upheld a prohibition on partial-birth abortion that operated throughout pregnancy, pre- as well as postviability, in deference to Congress's legislative findings that the prohibition protected against fetal pain and upheld the integrity of the medical profession by drawing a bright line between abortion and infanticide. 550 U.S. at 158. The Court held that in the rare event a serious fetal anomaly was diagnosed after the 20-week mark that might lead a woman to consider an abortion, an as-applied challenge to the law could be entertained at that time. *Id*. at 168.

Moreover, as Justice Kennedy has noted, *Planned Parenthood v. Casey* held that it is "inappropriate for the Judicial Branch to provide an exhaustive list of state interests implicated by abortion." *Stenberg v. Carhart*, 530 U.S. 914, 961 (2000) (Kennedy, J., dissenting) (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, at 877 (1992). Changes in the public's factual understanding may better inform the Court's perception of governmental interests. One such change of fact in *Gonzales* was the gruesomeness of the partial-birth abortion procedure. Crediting Congress's policy judgment that "the practice of performing a partial-birth abortion . . . is a gruesome and inhumane procedure that is never medically necessary and should be prohibited," the Court upheld a complete ban on partial-birth abortions, except where "necessary to save the life of the mother." 550 U.S. at 141, 142, 158. The ban applied "both previability and postviability because, by common understanding and scientific terminology," the Court noted, "a fetus is a living organism while within the womb, whether or not it is viable outside the womb." 550 U.S. at 147; see also *id*., at 156 (concluding the Act did not impose a "substantial obstacle to late-term, but previability, abortions"). And Justice Ginsburg expressly acknowledged in her dissent that the majority decision in *Gonzales* had "blur[red] the line" between "previability and postviability abortions." *Id*., at 171, 186 (Ginsburg, J., dissenting).[6]

Gonzales, then, establishes that factors other than viability matter to the Court's abortion jurisprudence. As with the federal Partial-Birth Abortion Ban Act upheld in *Gonzales*, the Pain-Capable Act does not ban all previability abortions. It continues to allow them prior to 20 weeks of fetal age (22 weeks gestational age) when, as even abortion proponents acknowledge, the overwhelmingly large majority of second-trimester abortions are performed. The Act would also continue to allow abortions even after the 20-wee mark when terminating the pregnancy is necessary to avert death or serious health risk to the mother. But responding to current medical understanding, the Act proposes limitations on abortions after the twenty-week mark in order to protect against fetal pain and a significantly increased risk to maternal health. These are the very kinds of state interests based on evolving medical evidence that are not captured by the viability line, but that the Court credited in *Gonzales*.

[6] Significantly, the District Court decision that *Gonzales* reversed was based on the same viability line treated as dispositive by the Ninth Circuit in *Isaacson*. *See Carhart v. Ashcroft*, 331 F.Supp.2d 805, 1048 (D. Neb. 2004)).

The Pain-Capable Act Protects Human Life in the Womb.

Human life in the womb is recognized and protected in federal law and by the laws of most states against crimes of violence.[7] The Unborn Victims of Violence Act makes it a federal crime to kill or cause bodily injury to an unborn human in utero. 18 U.S.C. § 1841(a)(1). Thirty-eight states currently treat the killing of an preborn human as homicide, with at least twenty-eight of those states criminalizing the act from conception.[8] Nearly all fifty states, as well as the District of Columbia, have wrongful death statues, allowing recovery for the death of an unborn human or the subsequent death of an infant born alive who was injured while in utero.[9] Outside of the context of elective abortion, the medical profession recognizes

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[7] *See* Unborn Victims of Violence Act of 2004 (Public Law 108-212), at 18 U.S.C. § 1841 and 22 U.S.C. § 919a (UNIFORM CODE OF MILITARY JUSTICE, Art. 119a). The Unborn Victims of Violence Act defines "unborn child" as a "child in utero," which means "a member of the species homo sapiens, at any stage of development, who is carried in the womb." 18 U.S.C. § 1841(d). Many state laws either mirror this definition or adopt a version of their own. *See, e.g*., Alaska Stat. § 11.81.900(b)(64); Ark. Code Ann. § 5-1- 102(13); Fl. Stat. § 775.021(5); Ga. Code Ann. § 52-7-12.3(a); 720 Ill. Comp. Stat. § 5/9-2.1(d); Kan. Stat. Ann. § 21-5419; Ky. Rev. Stat. Ann. § 507A.010; La. Rev. Stat. Ann. §§ 14:2(7), (11); Minn. Stat. § 145.4241; Miss. Code Ann. § 97-3-37; N.C. Gen. Stat. § 14-23.1; Okla. Stat. tit. 21, § 691; S.C. Code Ann. § 16-3-1083; Wis. Stat. § 939.75(1).

[8] *See, e.g*., Ala. Code § 13A-6-1; Alaska Stat. § 11.41.150; Ariz. Rev. Stat. Ann. § 13-1102; Ark. Code Ann. § 5-1-102(13); Cal. Penal Code § 187(a); Fla. Stat. § 775.021(5); Ga. Code Ann. § 16- 5-80; Idaho Code Ann. § 18-4001; 720 Ill. Comp. Stat. 5/9-1.2; Ind. Code § 35-42-1-1; Kan. Stat. Ann. § 21-5419; Ky. Rev. Stat. Ann. § 507A.020; La. Rev. Stat. Ann. § 14:32.5; Md. Code Ann., Crim. Law § 2-103; Mass. Gen. Laws ch. 90, § 24G (as interpreted by Commonwealth v. Cass, 467 N.E.2d 1324 (Mass. 1984)); Mich. Comp. Laws § 750.322; Minn. Stat. § 609.2114; Miss. Code Ann. § 97-3-19; Mo. Rev. Stat. § 565.020 (as defined by id. § 1.205); Mont. Code Ann. § 45-5-102; Neb. Rev. Stat. § 28-389; Nev. Rev. Stat. § 200.210; N.H. Rev. Stat. Ann. § 630:1-a; N.C. Gen. Stat. § 14-23.2; N.D. Cent. Code § 12.1-17.1-02; Ohio Rev. Code Ann. § 2903.01; Okla. Stat. tit. 21, § 691; 18 Pa. Cons. Stat. § 106; R.I. Gen. Laws § 11-23-5; S.C. Code Ann. § 16-3-1083; S.D. Codified Laws § 22-16-1.1; Tenn. Code Ann. § 39-13-214; Tex. Penal Code Ann. § 19.02 (as defined by id. § 1.07); Utah Code Ann. § 76-5- 201; Va. Code Ann. § 18.2-32.2; Wash. Rev. Code § 9A.32.060; W. Va. Code § 61-2-30; Wis. Stat. § 940.04.

[9] *See, e.g*., Ala. Code § 6-5-410 (as interpreted by *Mack v. Carmack*, 79 So.3d 597 (Ala. 2011)); Alaska Stat. § 09.55.585; Ariz. Rev. Stat. Ann. § 12-611 (as interpreted by *Summerfield v. Superior Court*, 698 P.2d 712 (Ariz. 1985)); Ark. Code Ann. § 16- 62-102; Colo. Rev. Stat. § 13-21-202 (as interpreted by *Espadero v. Feld*, 649 F. Supp. 1480 (D. Colo. 1986)); Conn. Gen. Stat. § 52- 555 (as interpreted by *Florence v. Town of Plainfield*, 849 A.2d 7 (Conn. Super. Ct. 2004)); Del. Code Ann. tit. 10, § 3724 (as interpreted by *Worgan v. Greggo & Ferrara, Inc*., 128 A.2d 557 (Del. Super. Ct. 1956)); D.C. Code § 12-101 (as interpreted by *Greater Se. Cmty. Hosp. v. Williams*, 482 A.2d 394 (D.C. 1984)); Fla. Stat. § 768.19 (as interpreted by *Stern v. Miller*, 348 So.2d 303 (Fla. 1977)); Ga. Code Ann. § 19-7-1 (as interpreted by *Porter v. Lassiter*, 87 S.E.2d 100 (Ga. Ct. App. 1955)); Haw. Rev. Stat. § 663-3 (as interpreted by *Wade v. United States*, 745 F. Supp. 1573 (Dist. Haw. 1990)); Idaho Code Ann. § 5-310 (as interpreted by *Volk v. Baldazo*, 651 P.2d 11 (Idaho 1982)); 740 Ill. Comp. Stat. § 180/2 (as interpreted by *Chrisafogeorgis v. Brandenberg*, 304 N.E.2d 88 (Ill. 1973)); Ind. Code § 34-23-2-1; Kan. Stat. Ann. § 60-1901; Ky. Rev. Stat. Ann. § 411.130 (as interpreted by *Mitchell v. Couch*, 285 S.W.2d 901 (Ky. 1955)); La. Civ. Code Ann. art. 2315.2 (as defined by id. art. 26); Me. Rev. Stat. tit. 18-A, § 2- 804; (as interpreted by *Milton v. Cary Med. Ctr.*, 538 A.2d 252 (Me. 1988)); Md. Code Ann., Cts. & Jud. Proc. § 3-904 (as interpreted by *State ex. rel. Odham v. Sherman*, 198 A.2d 71 (Md. 1964)); Mass. Gen. Laws ch. 229, § 2 (as interpreted by *Mone v. Greyhound Lines, Inc.*, 331 N.E.2d 916 (Mass. 1975)); Mich. Comp. Laws § 600.2922a; Minn. Stat. § 573.02 (as interpreted by *Verkennes v. Corniea*, 38 N.W.2d 838 (Minn. 1949)); Miss. Code Ann. §11-7-13; Mo. Rev. Stat. §537.080 (as defined by id. § 1.205.2); Mont. Code Ann. § 27-1-513 (as interpreted by *Strzelczyk v. Jett*, 870 P.2d 730 (Mont. 1994)); Neb. Rev. Stat. § 30-809; Nev. Rev. Stat. § 41.085 (as interpreted by *White v. Yup*, 485 P.2d 617 (Nev. 1969)); N.H. Rev. Stat. Ann. § 556:7 (as interpreted by *Poliquin v. MacDonald*, 135 A.2d 249 (N.H. 1957)); N.J. Stat. Ann. § 2A:31-1 (as interpreted by *Graf v. Taggert*, 204 A.2d 140 (N.J. 1964)); N.M. Stat. Ann. § 41-2-1 (as interpreted by *Salazar v. St. Vincent Hosp*., 619 P.2d 826 (N.M. 1980)); N.C. Gen. Stat. § 28A-18-2 (as

that a physician treating a pregnant mother has two patients, the maternal patient and the fetal patient, and owes duties of care to each.[10]

The regulation of abortion after twenty weeks simply recognizes that there is substantial medical evidence that the preborn child feels pain by that point.[11] However, the question of *when* a fetus can experience pain has been the subject of some debate over the last two decades.[12] There is research to show that the sensory connections for feeling pain are present by 20 weeks gestation.[13] In fact, there is a steadily increasing body of medical evidence and literature supporting the conclusion that a fetus may feel pain from around 11 to 13 weeks, or even as early as 5.5 weeks.[14] Indeed, there is some evidence that fetal

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interpreted by *DiDonato v. Wortman*, 358 S.E.2d 489 (N.C. 1987)); N.D. Cent. Code § 32-21- 01 (as defined by id. § 14-10-15); Ohio Rev. Code Ann. § 2125.01 (as interpreted by *Werling v. Sandy*, 476 N.E.2d 1053 (Ohio 1985)); Okla. Stat. tit. 12, § 1053; Or. Rev. Stat. § 30.020 (as interpreted by *Libbee v. Permanente Clinic*, 518 P.2d 636 (Or. 1974)); 42 Pa. Const. Stat. § 8301 (as interpreted by *Amadio v. Levin*, 501 A.2d 1085 (Pa. 1985)); R.I. Gen. Laws § 10-7-1 (as interpreted by *Presley v. Newport Hosp*., 365 A.2d 748 (R.I. 1976)); S.C. Code Ann. § 15-51-10 (as interpreted by *Fowler v. Woodward*, 138 S.E.2d 42 (S.C. 1964)); S.D. Codified Laws § 21- 5-1; Tenn. Code Ann. § 20-5-106; Tex. Civ. Prac. & Rem. Code Ann. §§ 71.001, 71.002; Vt. Stat. Ann. tit. 14, §§ 1491, 1492 (as interpreted by *Vaillancourt v. Med. Ctr. Hosp. of Vt., Inc*., 425 A.2d 92 (Vt. 1980)); Va. Code Ann. § 8.01-50; Wash. Rev. Code § 4.24.010 (as interpreted by *Moen v. Hanson*, 537 P.2d 266 (Wash. 1975)); W. Va. Code § 55-7-5 (as interpreted by *Baldwin v. Butcher*, 184 S.E.2d 428 (W. Va. 1971)); Wis. Stat. § 895.03 (as interpreted by *Kwaterski v. State Farm Mut. Auto Ins. Co*., 148 N.W.2d 107 (Wis. 1967)).

[10] L.B. McCullough and F.A. Chervenak, ETHICS IN OBSTETRICS AND GYNECOLOGY (Oxford University Press New York 1994); D.W. Bianchi, et al., FETOLOGY: DIAGNOSIS AND MANAGEMENT OF THE FETAL PATIENT (McGraw Hill New York 2000).

[11] K. J. Anand & P. R. Hickey, *Pain and Its Effects in the Human Neonate and Fetus*, 317 New Eng. J. Med. 1321 (1987); Antony Kolenc, *Easing Abortion's Pain: Can Fetal Pain Legislation Survive the New Judicial Scrutiny of Legislative Fact-Finding?*, 10 Tex. Rev. of Law & Politics 171 (2005); Teresa Collett, *Fetal Pain Legislation: Is It Viable?*, 30 Pepp. L. Rev. 161 (2003).

[12] *See, e.g.* Corke B., Seals J., ANESTHETIC & OBSTETRIC MANAGEMENT OF HIGH RISK PREGNANCY, ed. Datta S. (Harvard Medical School: Boston, 1996).

[13] Roland Brusseau, *Developmental Perspectives: Is the Fetus Conscious?,* INT'L ANESTHESIOLOGY CLINICS, (2008) citing Sinno H.P. Simons & Dick Tibboel, *Pain Perception Development and Maturation*, 11 SEMINARS ON FETAL AND NEONATAL MEDICINE 227 (2006) ("The first essential requirement for nociception is the presence of sensory receptors, which develop first in the perioral area at around 7 weeks gestation. From here, they develop in the rest of the face and in the palmar surfaces of the hands and soles of the feet from 11 weeks. By 20 weeks, they are present throughout all of the skin and mucosal surfaces"); Van Scheltema, et al., "Fetal Pain," in 19 FETAL AND MATERNAL MEDICINE REVIEW 311-324 (2008) ("The connection between the spinal cord and the thalamus (an obligatory station through which nearly all sensory information must pass before reaching the cortex) starts to develop from 14 weeks onwards and is finished at 20 weeks"); Marc Van de Velde & Frederik De Buck, *Fetal and Maternal Analgesia/Anesthesia for Fetal Procedures*, 31 FETAL DIAGN. THER. 201-9 (2012) ("To experience pain an intact system of pain transmission from the peripheral receptor to the cerebral cortex must be available. Peripheral receptors develop from the seventh gestational week. From 20 weeks' gestation [= 20 weeks post-fertilization] peripheral receptors are present on the whole body. From 13 weeks' gestation the afferent system located in the substantia gelatinosa of the dorsal horn of the spinal cord starts developing. Development of afferent fibers connecting peripheral receptors with the dorsal horn starts at 8 weeks' gestation. Spinothalamic connections start to develop from 14 weeks' and are complete at 20 weeks' gestation, whilst thalamocortical connections are present from 17 weeks' and completely developed at 26–30 weeks' gestation. From 16 weeks' gestation pain transmission from a peripheral receptor to the cortex is possible and completely developed from 26 weeks' gestation.").

[14] Commission of Inquiry into Fetal Sentience, *Human sentience before birth; Rawlinson repor,*. London: HMSO (1996). *See also* T.S. Collett, *Fetal Pain Legislation,* 30 Pepp. L. Rev. at 169; Slobodan Sekulic et al., *Appearance of Fetal Pain Could Be Associated With Maturation of the Mesodiencephalic Structures*, 9 J. PAIN RES. 1031 (2016); MARK D. ROLLINS & MARK A. ROSEN, Anesthesia for Fetal Intervention and Surgery, GREGORY'S PEDIATRIC ANESTHESIA 5TH ED. (2011) ("Immature skin nociceptors are probably present by 10 weeks and definitely present

suffering may actually be more intense due to the uneven maturation of fetal neurophysiology.[15] A British survey of neuroscientists showed that 80% of the neuroscientists participating in the survey felt that pain relief should be given to a fetus for abortions after 11 weeks gestation.[16]

Moreover, medical information on fetal neurological development and a child's consequent ability to feel pain in the womb is a concern of women considering abortion,[17] and therefore providing this information is relevant for a woman to make a fully-informed choice on whether or not to obtain an abortion. In light of this, six states have laws requiring abortion facilities to give women information on fetal pain. Arkansas, Kansas, Louisiana, Minnesota, Missouri, and Oklahoma require physicians to inform women of the possibility of fetal pain at 20 weeks gestation. Additionally, Georgia requires abortion facilities to inform women orally prior to an abortion that fetal pain information is available on a state-sponsored website.[18]

Insofar as the existence of pain in the preborn infant at or before 20 weeks is firmly established in the congressional findings of S. 160, and reflects a reasonable reliance by Congress on current medical science, protecting infants in the womb from intense pain felt during an abortion is an appropriate and constitutional state interest in restricting abortion beyond this time frame. *Gonzales*, 550 U.S. at 163 ("The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty.").

The Pain-Capable Act Protects Women from the Serious Risks of Late-Term Abortion.

From its inception in *Roe v. Wade*, the abortion right has been explicitly qualified. In *Roe*, while the Court found a constitutional right to abortion, it simultaneously expressed that "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that [ensure] maximum safety for the patient."[19] Affirming what is considered the essential holding of *Roe*, the Supreme Court in *Casey* nonetheless asserted that "The woman's liberty [to terminate her pregnancy] is not so unlimited, however, that from the outset [of pregnancy] the State cannot show its concern."[20] In both *Casey* and later in *Gonzales v. Carhart*, the Court continued to affirm its "essential holding" that states have "legitimate interests from the outset of the pregnancy in protecting the health of

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by 17 weeks. Nociceptors develop slightly later in internal organs. Peripheral nerve fibers that control movement first grow into the spinal cord at about 8 weeks of gestation").

[15] Sekulic, et al., *Appearance of Fetal Pain*, *supra* n. 14 at 1035-36; *see also* Sezgi Goksan, *fMRI Reveals Neural Activity Overlap Between Adult and Infant Pain*, ELIFE, (2015) (In 2015, a study was run using functional magnetic resonance imaging (fMRI) to compare the pain response between newborns and adults. The researchers found that "the infant pain experience closely resemble[d] that seen in adults" which suggested infants experience "increased sensitivity" compared to adults).

[16] *Id.*; *see also* Sekulic, et al., *Appearance of Fetal Pain*, *supra* n.14 at 1036 ("[T]he fetus is extremely sensitive to painful stimuli, and that this fact should be taken into account when performing invasive medical procedures on the fetus. It is necessary to apply adequate analgesia to prevent the suffering of the fetus").

[17] T.S. Collett, *Fetal Pain Legislation,* 30 Pepp. L. Rev. at 102.

[18] Ark. Code Ann. § 20-16-1703 (physician offers info); Ga. Code Ann. § 31-9A-3 (physician informs fetal pain info is on website); Kan. Stat. Ann. § 65-6710 (printed information); La. Rev. Stat. Ann. § 40:1061.17 (website); Minn. Stat. § 145.4242 (physician information); Mo. Rev. Stat. § 188.027 (printed information); Okla. Stat. tit. 63 § 1-738.8 (printed information).

[19] *Roe v. Wade*, 410 U.S. 113 at 150 (1973). Later, in both *Casey* and *Gonzales v. Carhart*, the Supreme Court affirmed "the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman." *Gonzales*, 550 U.S. at 145, quoting *Casey*, 505 U.S. at 846 (citing *Roe*, 410 U.S. 113).

[20] *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. at 869.

the woman."[21] This means the states can enact regulations aimed at protecting the health of the mother from the earliest stages of pregnancy.

In 1973, the Supreme Court enshrined abortion as a constitutional "right" without any real consideration of the impact of abortion on maternal health. No medical data was entered into the legal record. Yet *Roe* rested in part on the medical assumption that abortion is safer than childbirth.[22] Indeed, *Roe* specifically deferred to "present medical knowledge" at that time when it held that the State's interest in protecting maternal health becomes "compelling" "at approximately the end of the first trimester," "because of the now-established medical fact . . . that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth."[23]

In fact, when *Roe* was decided nearly five decades ago, there were few, if any, peer-reviewed studies related to the risks of abortion.[24] We now know that the risk of harm increases substantially with gestational age. Abortion carries a higher medical risk when performed later in pregnancy. Gestational age is the strongest risk factor for abortion-related mortality, and the incidence of major complications is significantly higher after 20 weeks gestation.[25] For example, compared to an abortion at 8 weeks gestation, the relative risk of mortality increases exponentially - by 38 percent for each additional week - at higher gestations.[26] Specifically, the risk of death at 8 weeks is reported to be one death per one million abortions; at 16 to 20 weeks, that risk rises to 1 per every 29,000 abortions; and at 21 weeks or more, the risk of death is 1 per every 11,000 abortions.[27] In other words, a woman seeking an abortion at 20 weeks is 35 times more likely to die from the abortion than she was in the first trimester. And at 21 weeks or more, she is 91 times more likely to die from the abortion than she was in the first trimester.[28] Further, researchers have concluded that it may not be possible to reduce the risk of death in later-term abortions because of the "inherently greater technical complexity of later abortions."[29] This is because in later-term abortions there is a greater degree of cervical dilation needed, the increased blood flow predisposes to hemorrhage, and the myometrium is relaxed and more subject to perforation. Thus, even if we set aside the debate over

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[21] *Id.* at 846; *see also Gonzales v. Carhart*, 550 U.S. at 145.
[22] 410 U.S. at 149, 165.
[23] 410 U.S. at 162-63.
[24] *See* Clarke D. Forsythe, ABUSE OF DISCRETION: THE INSIDE STORY OF THE SUPREME COURT'S CREATION OF THE RIGHT TO ABORTION (2013) (Providing information on the legal and medical landscape in 1973.). The undisputed risks of immediate medical complications from abortion include blood clots, hemorrhage, incomplete abortion, infection, and injury to the cervix and other organs. These risks are acknowledged by abortion businesses. *See, e.g.*, Planned Parenthood, "How safe is an in-clinic abortion?" (2017), available at https://www.plannedparenthood.org/learn/abortion/in-clinic-abortion-procedures/how-safe-is-an-in-clinic-abortion (last visited Apr. 8, 2019).
[25] L.A. Bartlett et al., *Risk Factors for Legal Induced Abortion—Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 731 (2004); J.P. Pregler & A.H. DeCherney, WOMEN'S HEALTH: PRINCIPLES AND CLINICAL PRACTICE 232 (2002).
[26] Bartlett, *supra*, n. 25.
[27] *Id*.
[28] Even Planned Parenthood, the largest abortion chain in the United States, agrees that abortion becomes riskier later in pregnancy. On its national website, Planned Parenthood states: "The chances of problems gets higher the later you get the abortion, and if you have sedation or general anesthesia . . . ," which would be necessary for an abortion at or after 20 weeks of gestation." *See* Planned Parenthood, *How Safe Is An In-Clinic Abortion?*, https://www.plannedparenthood.org/learn/abortion/in-clinic-abortion-procedures/how-safe-is-an-in-clinic-abortion (last visited Apr. 5, 2019).
[29] Bartlett, *supra* n. 25 at 735.

whether abortion at early gestational ages is relatively safe,[30] its risks at 20 weeks and beyond put the lie to *Roe*'s assumptions that access to the procedure must be guaranteed for virtually any reason. Protecting women from a highly risky, elective medical procedure is surely a "compelling interest" that passes muster under *Roe* and *Casey*.

As a post-abortive woman myself, I can assure you that what the Supreme Court said about abortion is true – that "some women come to regret their choice to abort the infant life they once created and sustained." *Gonzales*, 550 U.S. at 159. Without question, it is a decision "fraught with emotional consequence," as Justice Kennedy recognized. *Id*. I have endured nearly twenty years of regret since my own abortion, and not a day goes by that I do not think of my child, with all the milestones and daily moments she has missed due to my decision. With each passing year, more and more women like me emerge from the silence after abortion. They are wounded and speak out in anguish on the physical, emotional, spiritual, and psychological harm they have suffered and still suffer as a direct result of their abortions. Our experiences reflect the fact that abortion businesses, like the one I went to, often fail to provide adequate and accurate medical information to women considering abortions. The abortion facility I went to did not provide me with the information I sought in making my decision, and so I was unable to give true informed consent to the procedure. Over the years, through my work advocating for women who have been harmed by their abortion decisions, I have heard and tried to console many other women with similar stories.

Today, I strongly urge this Committee to protect maternal health and preborn children who feel pain and pass S. 160. It is constitutionally sound and will protect women from the harms inherent in later-term abortions, including the increased risk of death. It will also respect the humanity and lives of preborn children capable of feeling pain. Thank you.

Sincerely,

Catherine Glenn Foster
President and CEO
AMERICANS UNITED FOR LIFE

[30] It is impossible to definitively state how safe abortion is in the United States, when only 27 states require abortion businesses to report injuries and complications from abortion. Guttmacher Institute, *Abortion Reporting Requirements* (2017), available at https://www.guttmacher.org/state-policy/explore/abortion-reporting-requirements (last visited Apr. 8, 2019). Moreover, abortion is predominantly practiced by contract physicians, who are often unavailable for followup; abortion complications consequently are usually treated in hospital emergency departments, where they are not reflected in complications data.