Abortion and the fetal pain

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Abstract

Is a fetus capable of experiencing pain ? This question is one of increasing concern, and it is not merely confined to neonatologists and experts on embryonic development. Legal or clinical mandates to prevent pain in fetuses are based on limited evidence and may put woman seeking abortion at unnecessary risk. This paper outlines neuro development in fetuses in the context of pain experience.

Thus federal government is considering legislation that will require doctors to inform women seeking abortions that “there is substantial evidence that the process of being killed in an abortion will cause the unborn child pain.” The bill mandates that a fetus of more than 22 weeks’ gestational age should receive pain reducing drugs before an abortion. Doctors who fail to comply can be fined and can lose their licence and Medicaid funding.

In the united Kingdom provocative images of the fetus generated by four dimensional ultrasonography have fuelled a reassessment of fetal capabilities along with suggestion that the fetus can respond both emotionally and cognitively.

This paper discusses whether there is sufficient evidence to support a concept of fetal pain through an examination of fetal neurobiology and the relation to experience. Important neuro biological developments occur at 7, 18 and 26 weeks’ gestation and are the proposed periods for when a fetus can feel pain. Although the developmental changes during these periods are remarkable they do not tell us whether the fetus can experience pain. The subjective experience of pain cannot be inferred from anatomical developments do not account for subjectivity and the conscious contents of pain.

KEYWORDS: Feticide, Fetal surgery, Termination of pregnancy, 26 weeks.

I. Introduction :

Being compassionate to our patients and to alleviate pain are the foremost duties of the medical profession. Compassion, in this sense, is a feeling which induces interventions to eliminate or minimize pain and suffering, and applies (but not limited) to every human being. There is an ongoing debate, started many years ago, if the unborn human (i.e., the fetus) feels pain as does the human neonate, and if yes, when exactly during intrauterine life the fetus acquires this characteristic, thus leading to the obligation to be compassionate to the fetus.

Fetal pain gained importance in recent years because interventions that might cause pain, such as fetal surgery, termination of pregnancy, and even feticide, became increasingly frequent. The American Congress passed in 2008 the "Unborn Child Pain Awareness Act" and in 2013 the "Pain-Capable Unborn Child Protection Act" to require that those who knowingly perform an abortion of a paincapable unborn child (defined as a fetus of 20 weeks or more after fertilization), to provide explicit information to the mother about the pain that the fetus may suffer and how to alleviate

it because there is "substantial evidence that the process of being killed in an abortion will cause the unborn child pain". As a result, 25 states started to discuss similar acts, and in 2010, Nebraska prohibited abortion beyond 20 weeks' gestation on the basis of potential perception of pain by the fetus. In contrast, there are many opponents to the theoretical origin of this view, providing evidence that the fetus, at least at that stage, does not feel pain.

2. Objectives of the Study

→To show how much the techniques of abortion are in-human.

→ To study wheather the fetus can experience pain during abortion.

→To study the moral obligation to provide relief of fetal pain to the same extent that we do after birth.

3.Material and Method

This is a descriptive study. A part of my doctoral thesis. Data has been collected from journals, articles, books, magazines and websites.

4.Results

In this paper I intend to show that research has clearly shown that neonates, even very pre-term newborns, develop a significant "stress reaction" to pain. it may be argued that, it is unnecessary to have a clear-cut proof that the fetus experiences pain to provide pain relief. Since it is unquestionable that the fetus exhibits protective responses to tissue injury, one may question if we have a moral obligation to provide relief of fetal pain to the same extent that we do after birth.

5.Discussion

5.1 Definition of Abortion :

The term “abortion” actually refers to any premature expulsion of a human fetus, whether naturally or spontaneously, as in a miscarriage or artificially induced, as in surgical or chemical abortion. Today the most common usage of the term “abortion” applies to artificially induced abortion, which is the subject of this thesis.

Thus ‘abortion’ may occur spontaneously or may be induced. Spontaneous abortion occur most frequently at the time when implantation takes place if the new life is to survive. For any of a number of possible reasons – such as improper hormone levels in the mother, some abnormality in the uterus caused by infection or scarred tissue, incapacity due to genetic defect of the fertilized ovum to sustain itself, incomplete process of fertilization in all such cases — abortion, usually referred to as miscarriage, are less likely to occur after the first three months of gestational development.

Abortion ends pregnancy by destroying and removing the developing fetus. Surgical abortions are usually not performed before seven weeks or forty nine days LMP. By that time, the baby has identifiable arms and legs, and displays measurable brainwaves. During the seventh through the tenth week, when the majority of abortions are performed, finger and genitals appear and the child’s face becomes recognizably human.

Now-a-days, however, the word ‘abortion’ is used mostly to refer to action aimed at intentionally bringing pregnancy to an end.

5.2 Abortion Techniques :

There are different technique of abortion and some of them are mentioned here –

a) Suction Aspiration, in which a powerful suction tube with a sharp cutting edge is inserted into the womb through the dilated cervix. The suction then dismembers the body of the developing fetus and tears the placenta from the wall of the uterus, sucking blood, amniotic fluid, placental tissue, and fetal parts into a collection bottle.

b) Dilation and curettage, in this technique, the cervix is dilated or stretched to permit the insertion of a loop shaped steel knife. The body of the baby is cut into pieces and removed and the placenta is scraped off the uterine wall.

c) Amniocentesis is a technique in which amniotic fluid is withdrawn from the amniotic sac by means of a needle inserted through the abdominal wall of the matter.

d) Dilation and Evacuation, involve the injection of drugs or chemicals through the abdomen or cervix into the amniotic sac to cause the death of the fetus and its expulsion from the uterus.

e) 'Salt poisoning' otherwise known as 'Salt amniocentesis' is used after sixteen weeks of pregnancy. A needle is inserted through the mother's abdomen and 50-250 ml of amniotic fluid is withdrawn and replaced with a solution of concentrated salt. The fetus breathes in, swallowing the salt, and is poisoned. The chemical solution also causes painful burning and deterioration of baby's skin. Usually, after about an hour, the fetus dies. The mother after thirty three to thirty five hour delivers a dead, burned and shrivelled baby.

f) Partial-birth abortion is a procedure which is used about twenty to thirty two weeks or even later to pregnant women. Guided by ultrasound, the abortionist reaches into the uterus, grasps the unborn baby's leg with forceps and pulls the baby into the birth canal, except for the head, which is deliberately kept just inside the womb. Then the abortionist jams scissors into the back of the baby's skull and spreads the tip of the scissors apart to enlarge the wound. After removing the scissors, a suction catheter is inserted into the skull and the baby's brain is sncked out. The collapsed head is then removed from the uterus.

5.3. Medical consequences of abortion :

After the first trimester induced abortions are more difficult and less safe for the mother. [Dilation and extraction may be used which requires dilating the cervix, inserting a forcep to dismember and remove the fetus, followed by dilation and curettage (D &C) to ensure that the uterus is emptied]. A different method known as saline abortion is also used for second trimester abortion. A needle is inserted through the woman's abdomen and the amniotic fluid is drawn off and replaced with a concentrated salt solution. This poisoned solution asphyxiates the fetus. Normally the mother then goes into labour and delivers a (usually) dead fetus. A more recent version of a similar method involves the injection of prostaglandins, which also induce labour and delivery. This method is considerably more likely than the saline method to result in the delivery of a living child.

An induced abortion beyond the second trimester will often require a surgical procedure called hysterectomy.

Late term abortion occurs during the third trimester of pregnancy around the twenty seventh week of gestation. Two different techniques are used for this abortion procedure. Infact Dilation and Extraction (partial birth) removes the fetus from the uterus through the vaginal canal and creates a suction to remove the brain and spiral fluid from the skull (as stated above). The American Medical Association recommends that intact dilation and extraction procedure not be used unless alternative procedures posed a greater risk to the woman and further that, abortions should not be performed in the third trimester in cases of serious fetal anomalies incompatible with life.[1]

Dilation and Extraction (D&E) is another late-term method. The Doctor dismembers the fetal part that has been brought out of the vagina and removes it. The rest of the fetus remains in the uterus while dismemberment occurs. There is wide disagreement with the medical community, and still controversies range whether the procedure (D&E) is safer than others or even whether it should be performed.

Bleeding, reactions to anaesthesia, and cervical injuries are all risks that must be considered with these abortion procedures. Abortion related mortality statistics show 16.7 deaths per 100,000 procedures. Hence this procedure raises serious legal and moral questions about the physician's responsibility, not just of the mother but of the possibly viable infant.

5.4. Does A fetus feel pain?

The evaluation of pain in the human fetus is difficult because pain is generally defined as a subjective phenomenon. Early studies of neurologic development concluded that fetus's responses to painful stimuli were decorticate in nature and that perception or localization of pain was not present. Furthermore, since fetus may not have memories of painful experiences, they were not thought capable of interpreting pain in a manner similar to that of adults on a theoretical basis. It was also argued that a high threshold of painful stimuli may be adaptive in protecting infants from pain during birth. These traditional views have led to a widespread belief in the medical community that the fetus may not be capable of experiencing pain.

In general, proponents of moderate views believe that consciousness and the ability to feel pain develop after about six months. In about five weeks, the smooth brain begins to fold into familiar surface convolutions that ingeniously add surface area for more brain cells. But the first brain activities are discernable after the seventh week so that it is possible to conclude that the fetus may feel pain after this date. In this respect, the ability to suffer is delusive for acknowledging a morally significant break. One may object to this claim that the proponents of this view redefine the empirical feature of 'the ability to suffer' as a normative feature. It is logically unsound to conclude from the bare fact that the fetus feels pain, hence it is morally reprehensible or morally prohibited to abort fetus.

By the ninth week the fetus reacts to noises and can suck its thumb. Premature newborns can clearly hear, and the babies still in the womb in the late second and third trimesters, have been shown to recognize and prefer their mother's voice.

John Hopkins researcher Janet Di Pietro has shown evidence that fetal temperament can predict a baby's behaviour after birth. In 1988, Di Pietro observed that, "birth is a trivial event in development — nothing neurologically interesting happens."

A backhanded compliment to the complex early development of the unborn brain was provided, ironically, by fetal transplant researchers throughout the 1990's. They proposed reversing the brain degeneration of patients with Parkinson's disease,

with a chemical whose absence is thought to cause Parkinson's—and then transplanting these cells deep into the Parkinson patient's brains.

The experiments not only failed, as such unnatural ventures are prone to do, but they ultimately caused ghastly and uncontrollable movement and side effects. Nevertheless, the scientists were right about one thing. The tiny unborn brain of eight weeks already contains midbrain cells that are able to produce the chemical dopamine, which is responsible for some of the more refined, sophisticated forms of adult voluntary movement.

Elevated stress hormones, the same as those released by adults in pain— are found to be massively elevated when a painful blood extraction procedure is performed on unborn babies as early as eighteen weeks. An automatic protective response to pain occurs in fetal brain circulation at just sixteen weeks gestation. More alarmingly newly discovered brain chemicals devoted to pain perception have now been detected of the fetal brain as early as eleven to thirteen weeks.

Since premature newborns of twenty-three to twenty four weeks have been observed to feel pain, even more strongly than full-term newborn, this is clearly the outside limit of when an unborn baby can detect pain. That is why, the gynaecologists who accepted the fetal pain findings, did not conclude that unborn babies should be spared an unimaginably painful (elective) death. Rather, they called for doomed second-trimester infants to receive anaesthesia before being executed. While abortion supporters have their stalwarts who would not be shaken by such a concept, we can just feel the movement of opinion among a huge segment of middle group people, whose thread bare tolerance for unrestrained abortion would be reaching its limit.

5.5. Fetal behavior :

Not before long, it was believed that neonates do not feel pain. Research has clearly shown that neonates, even very pre-term newborns, develop a significant "stress reaction" to pain. Thus adequate analgesia during surgery might reduce mortality rates. Eventually, neonatal anesthesia became standard of care. Neonatal reaction to pain (e.g., heel prick) is self-evident both by facial expression and by crying. Interestingly, neonatal reaction to pain somewhat depends on when during the sleep-wake cycle the prick was done. This suggests that an inborn behavioral conditioning might exist before the neonate had a chance to acquire this reaction in early extra-uterine life. This well-known observation was just a step away from similar observation of fetal facial expression. Indeed, Reissland et al. sought to identify intra-uterine facial expressions of pain and suffering with the advent of 4-D ultrasound. The authors found increasing complexity of expressions, including those of pain and suffering, with advancing gestational age. The authors suggested that the development of fetal facial expression has a role postpartum, and that facial expressions in-utero may help to differentiate between normal and abnormal fetal development. Of importance is the fact that the startle response to external stimuli so vividly seen in the neonate was also observed in anencephalic fetuses, implying that this reaction is present at a sub-cortical level. Obviously, fetal crying vividly seen with 4-D ultrasound as early as 20 weeks' gestation involves not only activation of a complex motor sequence (coordinated breathing movements, jaw opening, mouthing, chin quiver, tongue extension, and swallowing) but also an association with a stimulus of negative connotation. Also, the recognition of this stimulus as potentially harmful implies integration of brain sites that mediate affect with a proper motor response. Together with the fact that we may hear the crying sound of extremely premature

babies these observations suggest that the fetus is capable of expressing coordinated facial movements that mimic extrauterine cry.

6. Conclusion :

It follows that since it is unquestionable that the fetus exhibits protective responses to tissue injury, one may question if we have a moral obligation to provide relief of fetal pain to the same extent that we do after birth. If the reply to this question is positive, then a secondary question would be when this obligation starts.

But it may be argued that, it is unnecessary to have a clear-cut proof that the fetus experiences pain to provide pain relief. It was argued that indirect evidence is sufficient to raise a reasonable doubt that pain is indeed felt by the fetus. There is a difference between a reasonable doubt and ethical uncertainty and it appears that uncertainty works as a restrictive rather than a permissive argument. For example, a reasonable doubt will not allow a hunter to shoot into the bush if unsure whether it is a deer stirring in the bush. This approach toward pain management of the fetus was adopted by the Society of Family Planning. In simple words, even a reasonable doubt about fetal pain is a strong enough argument that calls for fetal pain management. The motto of the concept of the 'fetus as a patient' maintains that "being a patient means that one is presented to the physician and there exist clinical interventions that are reliably expected to result in a greater balance of clinical benefits over harm". Whereas ethicists suggest that the 'fetus becomes a patient' at viability (roughly around 24 weeks' gestation), it appears that the medical duty to alleviate fetal pain begins at least 4 weeks earlier. Because respect for autonomy and the concept of autonomy-based rights therefore do not apply to the fetus, it is unclear whether the approach to fetal pain should alleviate pain and suffering from the unborn child. This quantum of solace may start as early as 18 weeks' gestation.

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