HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 321 Abortion
SPONSOR(S): Health & Human Services Quality Subcommittee; Trujillo and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee	11 Y, 3 N, As CS	Prater	Calamas
2) Judiciary Committee			
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

This bill amends chapter 390, F.S., relating to termination of pregnancies. The bill:

- Requires physicians to provide information to a woman regarding the ability of a fetus to feel pain after 22 weeks gestational age, prior to her giving informed consent for an abortion.
- Requires a physician to offer to provide anesthesia to a woman's fetus, if the fetus is 22 weeks gestational age or older, prior to performing an abortion.
- Establishes standards of legal action to be taken against any person that violates the provisions of this bill relating to the improper performance of an abortion.
- Requires AHCA to amend its rules for abortion providers that perform abortions after the first trimester.

The bill appears to have no fiscal impact.

The effective date of the bill is July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Fetal Pain

In 2008, there were 1.21 million abortions nationwide.[1] This same year, 22 percent of all pregnancies (excluding miscarriages) resulted in abortion.[2] According to the Guttmacher Institute, which surveys abortion providers, in 2008, there were 94,360 abortions in Florida[3], while there were 231,657 live births.[4] This amounts to approximately 2 abortions for every 5 births. However, the Agency for Health Care Administration (AHCA) reported 86,754 abortions, which is 7,606 less than the number reported by the Guttmacher Institute.[5]

According to AHCA, in 2009, there were 75,397 abortions performed at a gestational age of 12 weeks or younger, 6,516 at a gestational age of 13-24 weeks, and 125 at a gestational age of 25 weeks or older.[6]

Much research has been performed in recent years regarding the issue of fetal pain. Emerging scientific advances involving prenatal surgery have led to numerous medical studies regarding the ability of a fetus to feel pain, and at what stage this occurs. Research has found that pain receptors (nocieptors) are present throughout the fetuses entire body by no later than 20 weeks,[7] and that nerves link these receptors to the brain's thalalmus and subcortical plate by no later than 20 weeks.[8] By 8 weeks after fertilization, the fetus reacts to touch and after 20 weeks, the fetus reacts to stimuli that would be recognized as painful if applied to an adult human, for example, by recoiling.[9] Additionally, the application of painful stimuli to a fetus is associated with significant increases in stress hormones.[10]

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[1] The Guttmacher Institute, Abortion Incidence and Access to Services in the United States, 2008.
[2] *Id.*
[3] The Guttmacher Institute, Abortion Incidence and Access to Services in the United States, 2008.
[4] Florida Department of Health, Department of Vital Statistics, 2008.
[5] The Guttmacher Institute, Abortion Incidence and Access to Services in the United States, 2008.
[6] Agency for Health Care Administration, Reported Induced Terminations of Pregnancy by Reason, 2009.
[7] Myers LB, Bulich LA, Hess, P, Miller, NM. Fetal endoscopic surgery: indications and anaesthetic management. *Best Practice & Research Clinical Anaesthesiology* 18:2 (2004) 231-258; Derbyshire SW, Foetal pain? *Best Practice & Research Clinical Obstetrics and Gynaecology* 24:5 (2010) 647-655; Annand KJS, Hickey PR. Pain and its effects in the human neonate and fetus. New England Journal of Medicine 317:21 (1987) 1321-1329; Vanhalto S, van Nieuwenhuizen O. Fetal Pain? *Brain & Development*. 22 (2000) 145-150; Brusseau R. Developmental Perpectives: is the Fetus Conscious? *International Anesthesiology Clinics.* 46:3 (2008) 11-23.
[8] Van Scheltema PNA, Bakker S, Vandenbussche FPHA, Oepkes, D. Fetal Pain. *Fetal and Maternal Medicine Review*. 19:4 (2008) 311-324; Glover V. Fetal pain: implications for research and practice. *British Journal of Obstetrics and Gynaecology.* 106 (1999) 881-886; Lee SJ, Ralston HJP, Drey EA, Partridge, JC, Rosen, MA. A Systematic Multidisciplinary Review of the Evidence. *Journal of the American Medical Association.* 294:8 (2005) 947-954; Gupta R, Kilby M, Cooper G. Fetal surgery and anaesthetic implications. *Continuing Education in Anaesthesia, Critical Care & Pain.* 8:2 (2008) 71-75.
[9] Gupta R, Kilby M, Cooper G. Fetal surgery and anaesthetic implications. *Continuing Education in Anaesthesia, Critical Care & Pain.* 8:2 (2008) 71-75; Glover V. The fetus may feel pain from 20 weeks; The Fetal Pain Controversy. *Conscience.* 25:3 (2004) 35-37; Myers LB, Bulich LA, Hess, P, Miller, NM. Fetal endoscopic surgery: indications and anaesthetic management. *Best Practice & Research Clinical Anaesthesiology.* 18:2 (2004) 231-258; Derbyshire SW. Fetal Pain: Do We Know Enough to Do the Right Thing? *Reproductive Health Matters*. 16: 31Supp. (2008) 117-126; Giannakoulopoulos X, Sepulveda W, Kourtis P, Glover V, Fisk NM. Fetal plasma cortisol and β-endorphin response to intrauterine needling. *Lancet.* 344 (1994) 77-81; Lowery CL, Hardman MP, Manning N, Clancy B, Hall RW, Anand KJS. Neurodevelopmental Changes of Fetal Pain. *Seminars in Pernatology.* 31 (2007) 275-282; Mellor DJ, Diesch TJ, Gunn AJ, Bennet L. The importance of „awareness" for understanding fetal pain. *Brain Research Reviews*. 49 (2005) 455-471.
[10] Tran, KM. Anesthesia for fetal surgery. *Seminars in Fetal & Neonatal Medicine.* 15 (2010) 40-45; Myers LB, Bulich LA, Hess, P, Miller, NM. Fetal endoscopic surgery: indications and anaesthetic management. *Best Practice & Research Clinical Anaesthesiology.* 18:2 (2004) 231-258; Derbyshire SW. Fetal Pain: Do We Know Enough to Do the Right Thing? *Reproductive Health Matters*. 16: 31Supp. (2008) 117-126; Gupta R, Kilby M, Cooper G. Fetal surgery and anaesthetic implications. *Continuing Education in Anaesthesia, Critical Care & Pain.* 8:2 (2008) 71-75; Fisk NM, Gitau R, Teixeira MD, Giannakoulopoulos, X, Cameron, AD, Glover

Fetal anesthesia is routinely administered on fetuses undergoing surgery, and fetuses that receive the anesthesia show a decrease in stress hormones compared to those that do not.[11] Some medical experts assert that the fetus is incapable of experiencing pain until a point later in pregnancy than 20 weeks because the ability to experience pain depends on the cerebral cortex and requires nerve connections between the thalamus and the cortex.[12] However, recent medical research since 2007, provides strong evidence that a functioning cortex is not necessary to experience pain.[13] Lastly, there is documented evidence to show a fetuses reaction to painful stimuli and fetal surgeons have found it necessary to sedate the fetus with anesthesia to prevent the fetus from thrashing about in reaction to invasive surgery.[14]

Ten states currently provide either written or verbal information regarding fetal pain to women seeking an abortion (Alaska, Arkansas, Georgia, Louisiana, Minnesota, Missouri, Oklahoma, South Dakota, Texas, and Utah).

Fetal Anesthesia

Fetal anesthesia is administered routinely to unborn children that are undergoing fetal surgery[15]. There are 3 anesthetic techniques used for fetal surgery, and the technique used depends upon the type of

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VA. Effect of Direct Fetal Opioid Analgesia on Fetal Hormonal and Hemodynamic Stress Response to Intrauterine Needling. *Anesthesiology*. 95 (2001) 828-835.

[11] Van de Velde M, Van Schoubroeck DV, Lewi LE, Marcus MAE, Jani JC, Missant C, Teunkens A, Deprest J. Remifentanil for Fetal Immobilization and Maternal Sedation During Fetoscopic Surgery: A Randomized, Double-Blind Comparison with Diazepam. *Anesthesia & Analgesia*. 101 (2005) 251-258; Myers LB, Bulich LA, Hess, P, Miller, NM. Fetal endoscopic surgery: indications and anaesthetic management. *Best Practice & Research Clinical Anaesthesiology.* 18:2 (2004) 231-258; Gupta R, Kilby M, Cooper G. Fetal surgery and anaesthetic implications. *Continuing Education in Anaesthesia, Critical Care & Pain.* 8:2 (2008) 71-75; Giannakoulopoulos X, Sepulveda W, Kourtis P, Glover V, Fisk NM. Fetal plasma cortisol and β-endorphin response to intrauterine needling. *Lancet.* 344 (1994) 77-81; Van Scheltema PNA, Bakker S, Vandenbussche FPHA, Oepkes, D. Fetal Pain. *Fetal and Maternal Medicine Review*. 19:4 (2008) 311-324; Fisk NM, Gitau R, Teixeira MD, Giannakoulopoulos, X, Cameron, AD, Glover VA. Effect of Direct Fetal Opioid Analgesia on Fetal Hormonal and Hemodynamic Stress Response to Intrauterine Needling. *Anesthesiology*. 95 (2001) 828-835; De Buck F, Deprest J, Van de Velde M. Anesthesia for fetal surgery. *Current Opinion in Anaesthesiology.* 21 (2008) 293-297; Derbyshire SW. Fetal Pain: Do We Know Enough to Do the Right Thing? *Reproductive Health Matters*. 16: 31Supp. (2008) 117-126.

[12] Lee SJ, Ralston HJP, Drey EA, Partridge JC, Rosen MA. Fetal Pain: a systematic multidisciplinary review of the evidence. JAMA. 2005;294(8):947-954, at 949.

[13] Anand KJS. Fetal Pain? *Pain: Clinical Updates.* 14:2 (2006) 1-4; Fetal Awareness: Review of Research and Recommendations for Practice. Report of a Working Party. *Royal College of Obstetricians and Gynecologists.* March 2010; Lee SJ, Ralston HJP, Drey EA, Partridge, JC, Rosen, MA. A Systematic Multidisciplinary Review of the Evidence. *Journal of the American Medical Association.* 294:8 (2005) 947-954; Brusseau R, Myers L. Developing consciousness: fetal anesthesia and analgesia. *Seminars in Anesthesia, Perioperative Medicine and Pain.* 25 (2006) 189-195; Mellor DJ, Diesch TJ, Gunn AJ, Bennet L. The importance of „awareness" for understanding fetal pain. *Brain Research Reviews*. 49 (2005) 455-471; Derbyshire SWG. Can fetuses feel pain? *British Medical Journal*. 332 (2006) 909-912; Merker B. Consciousness without a cerebral cortex: A challenge for neuroscience and medicine. *Behavioral and Brain Sciences.* 30 (2007) 63-81; Anand KJS. Consciousness, cortical function, and pain perception in nonverbal humans. *Behavioral and Brain Sciences*. 30:1 (2007) 82-83; Brusseau R. Developmental Perpectives: is the Fetus Conscious? *International Anesthesiology Clinics.* 46:3 (2008) 11-23.

[14] Van de Velde M, Van Schoubroeck DV, Lewi LE, Marcus MAE, Jani JC, Missant C, Teunkens A, Deprest J. Remifentanil for Fetal Immobilization and Maternal Sedation During Fetoscopic Surgery: A Randomized, Double-Blind Comparison with Diazepam. *Anesthesia & Analgesia*. 101 (2005) 251-258; Giannakoulopoulos X, Sepulveda W, Kourtis P, Glover V, Fisk NM. Fetal plasma cortisol and β-endorphin response to intrauterine needling. *Lancet.* 344 (1994) 77-81; Lee SJ, Ralston HJP, Drey EA, Partridge, JC, Rosen, MA. A Systematic Multidisciplinary Review of the Evidence. *Journal of the American Medical Association.* 294:8 (2005) 947-954; Van Scheltema PNA, Bakker S, Vandenbussche FPHA, Oepkes, D. Fetal Pain. *Fetal and Maternal Medicine Review*. 19:4 (2008) 311-324.

[15] Van de Velde M, Van Schoubroeck DV, Lewi LE, Marcus MAE, Jani JC, Missant C, Teunkens A, Deprest J. Remifentanil for Fetal Immobilization and Maternal Sedation During Fetoscopic Surgery: A Randomized, Double-Blind Comparison with Diazepam. *Anesthesia & Analgesia*. 101 (2005) 251-258; Myers LB, Bulich LA, Hess, P, Miller, NM. Fetal endoscopic surgery: indications and anaesthetic management. *Best Practice & Research Clinical Anaesthesiology.* 18:2 (2004) 231-258; Gupta R, Kilby M, Cooper G. Fetal surgery and anaesthetic implications. *Continuing Education in Anaesthesia, Critical Care & Pain.* 8:2 (2008) 71-75; Giannakoulopoulos X, Sepulveda W, Kourtis P, Glover V, Fisk NM. Fetal plasma cortisol and β-endorphin response to intrauterine needling. *Lancet.* 344 (1994) 77-81; Van Scheltema PNA, Bakker S, Vandenbussche FPHA, Oepkes, D. Fetal Pain. *Fetal and Maternal Medicine Review*. 19:4 (2008) 311-324; Fisk NM, Gitau R, Teixeira MD, Giannakoulopoulos, X, Cameron, AD, Glover VA.

surgery being performed.[16] For an open fetal surgery, general anesthesia is provided to the mother, which is then transferred to the fetus through placental passage, which typically takes an hour. The fetus is then given an anesthetic such as fentanyl, intramuscularly[17] to supplement the anesthesia.[18] For fetoscopic[19] surgery, epidural anesthesia is used most commonly.[20] However, in some circumstances it is necessary to supplement the epidural with a balanced inhalation-opioid anesthetic.[21] Each anesthetic technique has advantages and disadvantages. Epidural anesthesia has the advantage of having minimal effects on fetal heart rate, uteroplacental blood flow, and postoperative uterine activity.[22] The disadvantages to this technique include: lack of uterine relaxation, lack of fetal anesthesia, and difficulty manipulating the uterus and umbilical cord while the fetus may be moving.[23] A balanced inhalation-opioid anesthetic has the advantage of allowing uterine manipulation with an immobile-anesthetized fetus yet should have less fetal cardiovascular depression that deep inhalation anesthesia.[24] The disadvantage to this technique is an inability to fully relax the uterus to access difficult umbilical cord positions.[25] Lastly, deep inhalation anesthesia has the advantage of profound uterine relaxation, while having the disadvantage of fetal cardiovascular depression and decreased uteroplacental blood flow.[26]

Caselaw Related to Abortion

The Viability Standard

In the seminal case regarding abortion, *Roe v. Wade*, the United States Supreme Court established a rigid trimester framework dictating how, if at all, states can regulate abortion.[27] One of the primary holdings in the case was that, in the third trimester, when the fetus is considered viable, states can prohibit abortions as long as the life or health of the mother is not at risk.[28]

Recognizing that medical advancements in neonatal care can advance viability to a point somewhat earlier than that of the third trimester, in *Planned Parenthood v. Casey*[29] the United States Supreme Court rejected the trimester framework in favor of limiting the states' ability to regulate abortion pre-viability.[30]

Thus, while upholding the underlying holding in *Roe* that states can "[r]egulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life

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[16] Seminars in Pediatric Surgery, Vol 12, No 3 (August), 2003: pp196-201 by Uwe Schwarz and Jeffrey Galinkin, MD. From the Department of Anesthesiology and Critical Care Medcine, The Children's Hospital of Philadelphia, University of Pennsylvania.
[17] Intramuscular is defined as: situated in, occurring in, or administered by entering a muscle. *See* http://www.merriam-webster.com/dictionary/intramuscularly (last viewed on March 29, 2011).
[18] Seminars in Pediatric Surgery, Vol 12, No 3 (August), 2003: pp196-201 by Uwe Schwarz and Jeffrey Galinkin, MD. From the Department of Anesthesiology and Critical Care Medcine, The Children's Hospital of Philadelphia, University of Pennsylvania.
[19] Fetoscopy is a procedure that utilizes an instrument called a fetoscope to evaluate or treat the fetus during pregnancy. *See* http://www.surgeryencyclopedia.com/Ce-Fi/Fetoscopy.html (last viewed on March 29, 2011).
[20] Seminars in Pediatric Surgery, Vol 12, No 3 (August), 2003: pp196-201 by Uwe Schwarz and Jeffrey Galinkin, MD. From the Department of Anesthesiology and Critical Care Medcine, The Children's Hospital of Philadelphia, University of Pennsylvania.
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] 410 U.S. 113 (1973).
[28] *Id.* at 164-165.
[29] 505 U.S. 833 (1992).
[30] The standard developed in the Casey case was the "undue burden" standard, which provides that a state regulation cannot impose an undue burden on, meaning it cannot place a substantial obstacle in the path of, the woman's right to choose. *Id.* at 876-79.

or health of the mother[,]"[31] the Court determined that the line for this authority should be drawn at "viability," because "[T]o be sure, as we have said, there may be some medical developments that affect the precise point of viability…but this is an imprecision with tolerable limits given that the medical community and all those who must apply its discoveries will continue to explore the matter."[32] Furthermore, the Court recognized that "In some broad sense, it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child."[33]

The Medical Emergency Exception

In *Doe v. Bolton*, an early United States Supreme Court decision decided around the time of *Roe*, the Supreme Court was faced with determining, among other things, whether a Georgia statute criminalizing abortions (pre- and post-viability) except when determined to be necessary based upon a physician's "best clinical judgment" was unconstitutionally void for vagueness for inadequately warning a physician under what circumstances an abortion could be performed.[34]

In its reasoning, the Court agreed with the District Court decision that the exception was not unconstitutionally vague, by recognizing that:

> [t]he medical judgment may be exercised in the light of all factors-physical, emotional, psychological, familial, and the woman's age-relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment.

This broad determination of what constituted a medical emergency was later tested in the *Casey case*, albeit in a different context. One question before the Supreme Court in *Casey* was whether the medical emergency exception to a 24-hour waiting period for an abortion was too narrow in that there were some potentially significant health risks that would not be considered "immediate."[35] The exception in question provided that a medical emergency is:

> [t]hat condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert death or for which delay will create serious risk of substantial and irreversible impairment of a major bodily function.[36]

In evaluating the more objective standard under which the physician is to determine the existence of a medical emergency, the Court in *Casey* determined that the exception would not significantly threaten the life and health of a woman and imposed no undue burden on the woman's right to choose.[37]

Since *Casey*, the scope of the medical emergency exception, particularly whether the broader requirement in *Doe* that the woman's mental health should be considered, is not entirely settled. For example, in 1997, the Sixth Circuit Court of Appeal, which is not binding on Florida, affirmed a United States District Court case wherein the trial court determined an Ohio statute restricting post-viability

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[31] *See Roe*, 410 U.S. at 164-65.
[32] *See Casey, 505 U.S.* at 870.
[33] *Id*.
[34] 410 U.S. 179 (1973) Other exceptions, such as in cases of rape and when, "The fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect." *Id.* at 183. *See also, U.S. v. Vuitich*, 402 U.S. 62, 71-72 (1971)(determining that a medical emergency exception to a criminal statute banning abortions would include consideration of the mental health of the pregnant woman).
[35] *Id.* at 880. The Court also considered a medical emergency exception related to informed consent requirements in pre-viability cases. Some courts have construed the Court's reasoning in *Casey* to require a mental health component to the medical emergency exception for obtaining informed consent because the Court recognized that psychological well-being is a facet of health and it is important that a woman comprehend the full consequences of her decision so as to reduce the risk that the woman will later discover that the decision was not fully informed, which could cause significant psychological consequences. *Id.* at 881-885.
[36] *Id.* at 879.
[37] *Id.* at 880.

abortions was unconstitutional for, among other reasons, failure to include a medical emergency exception that incorporates the mental health of the mother.[38]

The United States Supreme Court denied the petition for writ of certiorari[39] on March 23, 1998;[40] however, Justice Thomas, with whom Justices Scalia and the Chief Justice joined, wrote a strong dissenting opinion within which Justice Thomas claimed that the 6th Circuit Court of Appeal, "[w]renched this Court's prior statements out of context in finding the statute's mental health exception constitutionally infirm." Justice Thomas recognized that the 6th Circuit used dicta within the *Doe v. Bolton*[41] opinion to stand for the proposition a similar medical emergency exception approved in the later decided *Casey case* requires a mental health exception.

Even more recently, in *Gonzales v. Carhart*,[42] the United States Supreme Court upheld a federal law banning partial birth abortions which did not include a medical emergency exception. Justice Kennedy's opinion for the Court acknowledged that, "The law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community."[43]

The United States Supreme Court has not yet had a case regarding regulation of abortion in consideration of fetal pain; however, in *Gonzalez v. Carhart*, the Supreme Court recognized that, "The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty."[44]

Applicable Florida Caselaw

Article I, Section 23 of the Florida Constitution provides an express right to privacy. The Florida Supreme Court has recognized the Florida's constitutional right to privacy "is clearly implicated in a woman's decision whether or not to continue her pregnancy."[45]

In *In re T.W.* the Florida Supreme Court, determined that

> [p]rior to the end of the first trimester, the abortion decision must be left to the woman and may not be significantly restricted by the state. Following this point, the state may impose significant restrictions only in the least intrusive manner designed to safeguard the health of the mother. Insignificant burdens during either period must substantially further important state interests….Under our Florida Constitution, the state's interest becomes compelling upon viability….Viability under Florida law occurs at that point in time when the fetus becomes capable of meaningful life outside the womb through standard medical procedures.[46]

The court recognized that after viability, the state can regulate abortion in the interest of the unborn so long as the mother's health is not in jeopardy.[47]

In *Womancare of Orlando v. Agwunobi,*[48] an almost identical medical emergency exception to that in the *Casey* case was upheld when Florida's parental notification statute was challenged.[49] Florida's

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[38] *See Voinovich v. Women's Medical Professional Corporation*, 130 F.3d 187 (6th Cir. 1997).
[39] Which means that the Court declined to take up the issue on appeal.
[40] *See Voinovich v. Women's Medical Professional Corporation*, 523 U.S. 1036 (1998).
[41] 410 U.S. 179 (1973).
[42] 550 U.S. 124 (2007).
[43] *Id.* at 163.
[44] *Id.* (*Citations Omitted*).
[45] *See In re T.W.*, 551 So.2d 1186, 1192 (Fla. 1989)(holding that a parental consent statute was unconstitutional because it intrudes on a minor's right to privacy).
[46] *Id.* at 1193-94.
[47] *Id.* at 1194.
[48] 448 F.Supp. 2d 1293, 1301 N.D. Fla. (2005).

parental notification statute, s. 390.01114, F.S., defines medical emergency as, "a condition that, on the basis of a physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death, or for which a delay in the termination of her pregnancy will create serious risk of substantial and irreversible impairment of a major bodily function."

Informed Consent Requirements

The Woman's Right to Know Act (Act) is Florida's informed consent law related to abortion procedures and was enacted by the Legislature in 1997.[50] The Act requires that, a patient be provided with the following information in person prior to obtaining an abortion:

- The nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a knowing and willful decision of whether to terminate a pregnancy;
- The probable gestational age of the fetus at the time the procedure is to be performed; and
- The medical risks to the patient and fetus of carrying the pregnancy to term.[51]

The patient must also be provided printed materials that include a description of the fetus, a list of agencies that offer alternatives to abortion, and detailed information about the availability of medical assistance benefits for prenatal care, childbirth and neonatal care. The written materials must be prepared and provided by the Department of Health (department) and the patient has the option to view the materials provided.[52]

The patient must acknowledge in writing that this information has been provided to her before she gives informed consent for an abortion.[53] This information is not required to be provided if the abortion is being performed because of a medical emergency.[54] The method of determining the probable gestational, age as required above, is not specified in current law. Physicians who fail to inform the patient of the provisions described above are subject to disciplinary action.[55]

For any abortion performed later than the first trimester, the physician who is to perform the abortion is required to estimate the gestational age based on an ultrasound.[56] Failure to meet this requirement can result in a fine imposed by AHCA and other administrative penalties, as defined in s. 408.831, F.S.[57]

Abortion Clinic Regulations

Abortion clinics and physicians that perform abortions are subject to various laws and regulations. Some violations of these laws and regulations may result in criminal penalties, while others may result in licensure actions or administrative fines. Additionally, some laws and regulations that apply to clinics that perform abortions for one or more patients in their second trimester of pregnancy do not apply to clinics that only provide abortions to patients in their first trimester.

All abortion clinics and physicians performing abortions are subject to the following requirements:

- An abortion can only be performed in a validly licensed hospital, abortion clinic, or in a physician's office.[58]

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[49] One of the underlying issues in the case was whether the parenting notice statute was unconstitutionally vague in that it allegedly failed to give physicians adequate guidance about when the medical emergency provision applies. It was this question for which the court determined that the medical emergency definition was sufficient. The medical emergency provision applies as an exception to obtaining parental notice.
[50] S. 390.0111(3), F.S.
[51] *Id.*
[52] *Id*
[53] S. 390.0111(3)3., F.S.
[54] S. 390.0111(3)(a), F.S.
[55] A violation of this is subject to disciplinary action under s. 458.0331 or s. 459.015, F.S.
[56] 390.012(3)(d)5., F.S.
[57] S. 390.018, F.S.
[58] s. 797.03 (1), F.S.

- An abortion clinic must be operated by a person with a valid and current license.[59]
- Any third trimester abortion procedure must only be performed in a hospital.[60]
- No abortion shall be performed in the third trimester of pregnancy, unless medically necessary.[61]
- An abortion must be performed by a physician as defined in s. 390.011, F.S.[62]
- Proper medical care must be given and used for a fetus for abortions performed during viability.[63]
- Experimentation on a fetus is prohibited.[64]
- No hospital or person can be forced to participate in an abortion procedure.[65]
- Except when there is a medical emergency, an abortion may only be performed after a patient has given voluntary and written informed consent.[66]
- Fetal remains shall be disposed of in a sanitary and appropriate manner.[67]
- Parental notice must be given 48 hours before performing an abortion on a minor,[68] unless waived by a parent or otherwise ordered by a judge.

Abortion clinics that perform abortions after the first trimester are subject to additional laws and regulations which are enforced by AHCA. AHCA can impose fines for violations. For example, pursuant to s. 390.0112, F.S., such clinics are required to have proper dressing rooms, hand-washing areas, and proper exam tables; proper clinical supplies and equipment such as sterilized instruments, medication and ultrasound equipment; meet certain personnel requirements, such as having a designated medical director who has hospital privileges, surgical staff trained in counseling, and trained volunteers; provide for medical screening such as checking medical history, certain blood tests, performing an ultrasound, and performing physical examinations; have certain protocols in place, such as the use of anesthesia, intravenous access, and monitoring vital signs; and post certain protocols for patients to see, such as the required length of stay, post abortion medical instructions, and follow up visits.

Effect of Proposed Changes

The bill provides an additional requirement to the informed consent law relating to abortion procedures for any woman who is obtaining an abortion after the fetus has reached 22 weeks gestational age. For such abortions, the woman must be informed, in person, by the physician who is to perform the abortion, or a referring physician of the ability of the fetus to feel pain. The information must include but need not be limited to the following:

- By at least 22 weeks gestational age, a fetus possesses all the anatomical structures, including pain receptors, spinal cord, nerve tracts, thalamus, and cortex, that are necessary in order to feel pain.
- A description of the actual steps in the abortion procedure to be performed or induced, and at which steps the abortion procedure could be painful to the fetus.
- There is evidence that by 22 weeks of gestational age, fetuses seek to evade certain stimuli in a manner that in an infant or adult would be interpreted as a response to pain.
- Anesthesia is given to fetuses who are 22 weeks or more gestational age who undergo prenatal surgery.

[59] s. 797.03 (2), F.S.
[60] s. 797.03(3), F.S. The violation of any of these provisions results in a second degree misdemeanor.
[61] s. 390.0111(1), F.S.
[62] s. 390.0111(2), F.S.
[63] s. 390.0111(4), F.S.
[64] s. 390.0111(6), F.S.
[65] s. 390.0111(8), F.S. Any person that performs or participates in an abortion that violates any of these provisions commits a third degree felony. Any person that performs or participates in an abortion that violates any of these provisions and results in the death of a woman commits a second degree felony.
[66] s. 390.0111(3), F.S. A physician violating this provision is subject to disciplinary action.
[67] s. 390.0111(8), F.S. A person who improperly disposes of fetal remains commits a second degree misdemeanor.
[68] s. 390.01114(3), F.S. A physician who violates this provision is subject to disciplinary action.

- Anesthesia is given to premature children who are 22 weeks or more gestational age who undergo surgery.
- Anesthesia or analgesics are available in order to minimize or alleviate the pain to the fetus.
- The medical risks associated with the particular anesthetic or analgesic.

In the case of a medical emergency[69], a woman is not required give informed consent before an abortion procedure.[70]

The bill requires a physician to offer to administer anesthesia or an analgesic[71] to the fetus prior to performing an abortion at 22 weeks or more gestational age, unless in the case of a medical emergency.[72] The physician is required to document in the patient's medical history file whether the patient has accepted or declined fetal anesthetic or analgesic.

The bill creates for a cause of action for negligence which may be brought by the patient or the father of the fetus upon whom an abortion was performed in violation of these requirements. The bill provides for fees, costs and damages in such cases. Plaintiffs are entitled to recover reasonable attorneys' fees, costs of the action, and damages, unless the plaintiff has acted in bad faith or with malicious purpose or that there was a complete absence of a justiciable issue of either law or fact. Prevailing defendants are entitled to recover reasonable attorney's fees under s. 57.105, F.S. That section requires a court finding that the plaintiff or plaintiff's attorney knew or should have known that a claim or defense was not supported by the material facts necessary to establish the claim or defense, or would not be supported by the application of then-existing law to those material facts. The bill provides that these remedies are in addition to other legal and administrative remedies available to the woman or the father. The bill provides that any action brought pursuant to these provisions is not a claim for medical malpractice, and sets the statute of limitations for pursuing the cause of action pursuant to s. 95.11(3), F.S., which is 4 years.

Finally, the bill requires AHCA to amend its rules for abortion clinics that perform abortions after the first trimester to require such clinics to provide appropriate use of general and local anesthesia or analgesia for fetuses.

B. SECTION DIRECTORY:

Section 1: Amends s. 390.0111, F.S., relating to termination of pregnancies.

Section 2: Amends s. 390.012, F.S., relating to Powers of agency; rules; disposal of fetal remains.

Section 3: Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[69] S. 390.01114(2)(d), F.S., defines "medical emergency" as a condition that, on the basis of a physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death, or for which a delay in the termination of her pregnancy will create serious risk of substantial and irreversible impairment of a major bodily function.

[70] S. 390.0111(3)(a), F.S.

[71] Analgesia is simply the loss of one's ability to feel pain. Sensations of touch, pressure and the ability to move generally remain intact. The patient also remains awake. Accordingly, laboring patients with epidural analgesia feel pressure and have muscle strength to push when the time comes. Anesthesia is loss of all sensation. It includes loss of touch, loss of certain reflexes and loss of one's ability to move. With general anesthesia the patient is also asleep. Anesthesia is primarily used for surgery. *See* http://www.cedars-sinai.edu/Patients/Programs-and-Services/Obstetrics-and-Gynecology/Frequently-Asked-Questions/Questions-about-Childbirth-Pain.aspx (last viewed on March 29, 2011).

[72] S. 390.01114(2)(d), F.S.

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

It is possible that this bill may be challenged under Art. I, Section 23, of the Florida Constitution, which provides for an express right to privacy. While the Florida Supreme Court recognized the State's compelling interest in regulating abortion post-viability in *In re T.W.*, 551 So.2d 1186 (1989), the issue of regulating abortions in consideration of fetal pain has not been before the Florida Supreme Court or the United States Supreme Court. Furthermore, other court decisions that have construed the medical health exception to include the "mental health" of the woman may be persuasive.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 29, 2011, the Health and Human Services Quality Subcommittee adopted a strike-all amendment to HB 321. The amendment:

- Added a requirement to the informed consent law for abortion procedures after the fetus has reached 22 weeks gestational age – the physician must inform the woman of several specified points related to fetal pain.
- Requires a physician to offer to administer anesthesia or an analgesic to the fetus prior to performing an abortion at is 22 weeks or more gestational age, unless in the case of a medical emergency.
- Provides for a cause of action for negligence to be taken by a woman or the father of the fetus upon whom an abortion was performed in violation of these requirements.
- Requires AHCA to amend its rules for abortion providers that perform abortions after the first trimester to require such clinics to provide appropriate use of general and local anesthesia or analgesia for fetuses.

The bill was reported favorable as a Committee Substitute. The analysis reflects the Committee Substitute.