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Abortion Partial Birth - Legal

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COMMISSION FOR WOMEN'S EQUALITY

April 2, 1997

MEMORANDUM

To: Regional Directors CWE Members

From: Lois Waldman

Re: **Lobbying Against Bill Regulating Intact Dilation and Extraction Procedure ("Partial Birth Abortion")**

INTRODUCTION

On March 20, the United States House of Representatives voted for the fourth time to ban an abortion procedure described by gynecologists as "intact dilation and extraction" and by abortion opponents as "partial birth" abortion. The issue now goes to the Senate. Senator Trent Lott, the Republican leader and abortion opponent, has announced that the measure will not be taken up until after the Congressional recess, which ends April 6, and perhaps not until late April so as to give, in Lott's words, time for a "little steam to build up." The Senate is still about seven votes shy of being able to override a Presidential veto. However, since the President's veto last session, there have been statements by a lobbyist for the National Coalition of Abortion Providers that he lied about the number of the D&E abortions and the circumstances under which they were performed.[1] These statements have played into the hands of anti-choice politicians, demonized this specific procedure and assisted the right-to-life forces in their effort to blur the distinction between pre- and post-viability abortions. In the House, for example, five legislators changed their votes this time, including some who were formerly considered firmly pro-choice, like Sue Kelly of New York and Christopher Shays of Connecticut. Further, the composition of the Senate has changed. It is vital that Senators be shored up to support the presidential veto that has been promised. A list of particular Senators who need our efforts is available on request. It is also important that efforts to enact similar bills in the various states be turned back. Currently, bills are pending in many states, including New York,

Arkansas, Illinois, Montana, Oklahoma and South Carolina, and prohibitions have already been enacted in Michigan, Mississippi, South Dakota, Alaska and Georgia.

In order to effectively argue against these bills with our legislators, we must understand both the medical and legal implications. The following is an attempt to set forth the medical and legal facts and to respond to the most commonly asked questions on the issue.

MEDICAL FACTS

Because doctors who perform abortions are reluctant to call attention to themselves or their procedures, information about the medical aspects of the procedures has not been readily available in the media. Recently, both in an article in *The New York Times* and in depositions in a case challenging the Michigan law on intact D&Es, doctors have spoken about the procedures used in late term abortions. The following facts have been set forth:

(1) Approximately 90% of abortions occur during the first trimester of pregnancy--that is, before the first 12 or 13 weeks. For these early abortions, physicians typically use suction curettage. In this procedure, the physician dilates the cervix and then removes the embryo or fetus and the other products of conception with a tube inserted into the uterus. The tube is attached to a vacuum generator.

(2) After the first trimester, when the fetus is often too large to remove simply by means of suction, physicians generally use one of two methods: D&E, which accounts for 95% of post-first trimester abortions, or induction, which accounts for 5% of such abortions.

(3) Late abortions are rare in and of themselves. Approximately 5% of abortions occur after 16 weeks. Only 1% or 15,000 of the 1.5 million abortions a year take place after 20 weeks of gestation. Most late abortions occur between 20 and 24 weeks. The rarity of these abortions give the lie to the impression created by the anti-choice forces that most abortions involve mature fetuses akin to born babies. These advanced pregnancies are ended by one of three basic methods.

(4) After fourteen weeks and throughout the early part of the second trimester, most physicians use a D&E procedure. At the outset of a D&E procedure, the physician dilates the cervix, typically over twelve to thirty-six hours, with multiple intracervical osmotic dilators made of either laminaria (seaweed) or a synthetic agent. When the cervix is sufficiently dilated, the physician, using a combination of forceps, suction curettage, and sharp curettage, disjoins and removes the fetus. Typically, the calvarium (skull) is too large to pass through the cervix whole, and so must be compressed. Sometimes, the physician uses suction to remove the contents of the calvarium before compressing it.

(5) For procedures later in the second trimester, some physicians use a variant of D&E, known as intact D&E or dilation and extraction (D&X). In the intact D&E, the physician dilates

the cervix and then removes the fetus from the uterus intact. To do so, the physician extracts the fetal body intact, feet first, until the cervix is obstructed by the aftercoming head, which is too large to pass through the cervix. Then, using a sharp instrument, the physician creates a small opening at the base of the fetal skull and evacuates the contents, allowing the skull to pass through the cervical opening.

(6) Aside from D&E, the other common method of post-first-trimester abortion is induction, which entails using medications to induce premature labor. There are several ways of inducing labor. One is to inject an agent such as oxytocin intravenously, continuously over many hours. A second method--instillation--nvolves injecting agents such as prostaglandins, prostaglandins and urea, or hypertonic saline into the amniotic sac. A third method involves introducing prostaglandins into the vagina or cervix. A fourth method entails intramuscular injection of prostaglandins.

(7) Inductions are not generally done before 16 weeks. Before that point, the uterus is relatively less responsive to labor-inducing medications, and any instillation procedure is technically more difficult and less successful.

D&E is said to be safer than induction, which involves the same complications as labor and delivery and is physiologically stressful to the woman, particularly for women with certain medical conditions such as cardiac ailments and active pelvic infections. D&E is said to entail lower rates of maternal health complications, including fever, endometritis, retained products of conception, hemorrhage and cervical injury. It also can be performed earlier, which, in view of the fact that delay increases abortion risks, is an advantage.

Intact D&E has certain advantages over standard D&E. For example, intact D&E may reduce the risk of uterine perforation because it dramatically reduces the insertion of sharp instruments into the uterus, and because the fetus passes through the birth canal intact. In a standard D&E, in which the physician disjoins the fetus, sharp instruments and sharp fetal fragments may damage the woman's tissues. An intact D&E reduces those risks. An intact D&E may also result in less blood loss and less trauma for some patients, and may take less operating time, thus reducing anesthesia needs. Intact D&E may also have some advantages when a physician needs an intact fetus for an autopsy to assess the risk of fetal anomaly.

It may be difficult for a physician to predict with certainty that an intact method will be most appropriate in a particular procedure. If, for example, the physician grabs the fetal foot first, and the fetus starts to pass intact, it may be safer and quicker to do an intact procedure.

Because an intact D&E may be the most appropriate method for some patients, the American College of Obstetricians and Gynecologists has taken the position that the physician's best medical judgment must govern the decision of which method to use, and that the state should not ban specific methods, including intact D&E.

Although the epidemiological and medical data bear on the assessment of the safety of various methods of pregnancy termination, the procedure that is generally statistically safest may not be the best procedure for a particular woman in light of her circumstances. When performing an abortion, the physician determines the most appropriate method for a particular patient based on many variables: any underlying health conditions the patient may have; the exact stage of pregnancy; the condition of the fetus; the position of the fetus; the skill and training of the physician; and the facilities available. For abortion to remain safe, the physician must retain the discretion to make this judgment.

LEGAL SITUATION

Under *Roe* v. *Wade* and the subsequent *People* v. *Casey*, which reaffirmed a woman's fundamental right to reproductive choice, the Supreme Court has held that states may outlaw abortions only after fetal viability, that is, when the fetus is capable of survival outside the womb. Even as to these post viability abortions, states must allow exceptions to protect the life and health of the mother. Health has been held to include psychological health. Though viability varies and it is to be decided by physicians, not the legislature, it becomes more common after 24 weeks.

Thus, with respect to the 500 or so intact D&E procedures performed after 24 weeks, if performed on a viable fetus and not to protect the life or health of the mother, such abortions are already illegal. Forty one states and the District of Columbia have passed laws banning abortion after viability.[1] Thus, the intact D&E prohibition is not needed. And to the extent that the proposed prohibition does not permit exceptions for the health of the mother, it would be unconstitutional.

With respect to abortion after 20 weeks but before viability, *Roe* v. *Wade* and *People v. Casey* hold that the state may regulate to protect maternal health and to promote its interest in the potential life of fetus. However it may not impose an undue burden on a woman seeking such an abortion. That is, the state may only impose restrictions which do not have the "purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion." In prior cases the Supreme Court has held that a woman and her physician--and not the government--must be able to determine the course of her medical treatment. In *Colautti v. Franklin*, the Justices found unconstitutional a state statute that required physicians performing abortions when a fetus is or may be viable to use the techniques most likely to

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1 Ban opponents in the House used the key concept of viability to unsuccessfully push an alternative measure that would have banned all post viability abortions except those needed to save a woman's life and health, but allow any procedure before viability. Senator Daschle is working on a similar compromise in the Senate.

result in a live birth. In rejecting the measure, the High Court explicitly recognized the "central role of the physician," both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out.

Similarly, efforts to ban a specific abortion method, whether before or after viability, have been found to impermissibly restrict a physician's ability to use the procedure that best suits the particular medical needs and circumstances of a patient. Both the Supreme Court and lower federal courts have invalidated state laws that prevented a woman and her physician from determining the method of abortion to be used. In *Planned Parenthood of Central Missouri v. Danforth*, the Justices struck down a ban on the use of saline amniocentesis after the first 12 weeks of pregnancy, in part because "it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed."

Even when the government exercises its authority to ban abortions after viability, the Supreme Court has made clear that the state may not make its interest in the fetus paramount to women's health or require a "trade-off" between a woman's health and fetal survival. In *Thornburgh v. American College of Obstetricians and Gynecologists*, the Justices invalidated a law requiring a physician performing a post-viability abortion to employ the abortion technique "which would provide the best opportunity for the unborn child to be aborted alive unless ... that technique would present a significantly greater medical risk to the life or health of the pregnant woman."

If it can be established, as the depositions by physicians in the Michigan case seek to do, that induction is not an equally safe alternative and thus there are no equally safe and available alternative methods of abortion in particular cases to the intact D&E and standard D&E procedures, then the Court would have to find that the prohibition on intact D&E was unconstitutional.

In fact, the only Federal case to consider a constitutional challenge to a state prohibition on intact D&E procedure enjoined the ban. It found that the procedure not only "appears to have the potential of being a safer procedure than other available abortion procedures" after the 19th week of pregnancy. *Women's Medical Professional Corp.* v. *Voinovich*, 911 F.Supp. 1051, 1070 (S.D. Ohio 1995). The court compared the D&X procedure to induction, hysterotomy and hysterectomy and found it safer.

The court in this case also found that the use of D&X in the late second trimester "appears to pose less risk to maternal health" than D&E "because it is less invasive--that is, it does not require sharp instruments to be inserted into the uterus with the same degree of risk of uterine and cervical lacerations.

However, although the current bills for the reasons listed above seem patently unconstitutional, we cannot rely on the long and arduous court procedures to eliminate the

threat to abortion rights. Difficult though it may be, these bans must be fought in the legislature.

STRATEGY AND COUNTER STRATEGY

The very effective strategy of the antiabortion forces has been to single out this particularly "unattractive procedure" and to suggest falsely that it is performed on fetuses at a very late stage and thus to spread the view that abortion is akin to "infanticide." The facts as we have shown are otherwise. By blurring the distinction between viable and pre-viable fetus they seek to move the legal prohibition backward in time and thus effectively undermine *Roe* and change the current law so as to ban almost all abortions after 20 weeks.

Pro-choice advocates recognize that not only are intact D&E procedures performed very late in pregnancy in cases of severe fetal anomalies or where the health of the mother is at risk but also on a substantial number of nonviable fetuses carried by often healthy women. However, the answer to this situation is not to ban this procedure but to recognize that most of these late term abortions involve teenagers who deny their pregnancies, victims of incest, drug users, women who are menopausal or have irregular periods and women who because of poverty or personal disorganization are unable to obtain an early abortion. The solution to these problems is improved contraception and, as one editorial writer has argued, to remove the barriers that keep women from getting early abortions--parental notification laws and lack of Medicaid funding--and to encourage access to promising new drugs that induce abortion very early in pregnancy.

While acknowledging that the procedure sought to be banned is gruesome, pro-choice advocates must argue that many medical procedures--open heart surgery, amputation, heart and liver transplants, etc.--may seem gruesome to the lay person, but for those whose lives and health are saved by it, "gruesome" is not the issue. Rather, the determination of which abortion procedure is best for a particular woman in a particular circumstance should not be determined by which procedure is aesthetically pleasing (no abortion procedure is that) but is best left to medical professionals in consultation with the patient and her family.

Until women have improved means to control their fertility, and this requires greater investment in contraceptive research, women must continue to argue that abortion must remain an option if women are to achieve true parity and participate equally in the economic and social life of the nation. And so long as abortion is legal, physicians must be permitted to use their best judgment in deciding the abortion method that is safest for the woman in a particular situation. In this connection, it must be noted that no major medical organization has supported legislation to ban the D&X procedure. In fact, numerous medical organizations--including the American College of Obstetricians and Gynecologists, the American Public Health Association,

and the American Medical Women's Association--oppose any such legislation. (I am enclosing one of their statements.)

Moreover, a lack of consensus in the medical community is not grounds for the legislature to step in and decide the issue. In such circumstances, individual trained and licensed doctors, not legislators, should be left to determine what medical procedures are appropriate.

drs

Abortion - partial birth - legal

Memorandum

Subject	Date
S.6, Banning "Partial-Birth" Abortions	March 11, 1997

To	From
Andrew Fois Assistant Attorney General Office of Legislative Affairs	Richard L. Shiffrin Deputy Assistant Attorney General Office of Legal Counsel

This memorandum sets forth the comments of the Office of Legal Counsel on the "Partial-Birth Abortion Ban Act of 1997," S.6, which would ban a particular method of performing an abortion.[1] The bill would criminalize performance of the procedure except where the procedure is "necessary to save the life of a mother" and "no other medical procedure would suffice for that purpose."

In our view, the bill, as currently drafted, suffers from at least two flaws, each of which is sufficient to render the bill unconstitutional. First, with regard to post-viability abortions, the bill does not contain an exception for performance of the procedure in order to preserve the woman's health. Second, with regard to pre-viability abortions, the bill is likely to impose a substantial obstacle to a woman's constitutional right to choose an abortion.

In Planned Parenthood v. Casey, 505 U.S. 833, 846 (1992), the Supreme Court "confirm[ed] . . . the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health." See also id. at 879 (plurality) ("'subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.'") (quoting Roe v. Wade, 410 U.S. 113, 164-65 (1973)). This means, first, that the government may not deny access to an abortion where necessary to preserve the life

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[1] The procedure described by the bill appears to be a form of "dilation and extraction" abortion, sometimes abbreviated as "D&X." See Women's Medical Professional Corp. v. Voinovich, 911 F. Supp. 1051, 1065-67 (S.D. Ohio 1995).

of the woman or to preserve the health of the woman. It also means that the government may not regulate access to abortions in a manner that effectively "'require[s] the mother to bear an increased medical risk'" in order to serve a state interest. Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 768-69 (1986) (citation omitted) (invalidating requirement that doctor use abortion procedure most protective of fetal life "unless . . . [that procedure] would present a significantly greater medical risk to the life or health of the pregnant woman" because that would require some degree of "trade-off" between woman's health and fetal survival). See also Jane L. v. Bangerter, 61 F.3d 1493, 1502-04 (10th Cir. 1995) (striking down provision that physician use abortion method that "'will give the unborn child the best chance of survival' unless that method would cause 'grave damage to the woman's medical health,'" because "Thornburgh's admonition that a woman's health must be the paramount concern remains vital in the wake of Casey") (citations omitted), sum. rev'd in part on other grounds sub nom. Leavitt v. Jane L., 116 S. Ct. 2068 (per curiam), and judgment reinstated in relevant part on remand, 102 F.3d 1112, 1114 n.1 (10th Cir. 1996). In short, even where survival of a viable fetus is at stake, the government may neither prohibit abortions without a health exception nor make them more dangerous to a woman's health.

The government's ability to regulate abortions in the pre-viability context is far more circumscribed. The Supreme Court held in Casey that government regulation before the fetus becomes viable is unconstitutional if it imposes an "undue burden" on a woman's ability to obtain an abortion. See, e.g., Casey, 505 U.S. at 895; id. at 877 (plurality). "Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure." Id. at 846.[2] Under the approach taken in Casey, a regulation is unconstitutional on its face whenever, "in a large fraction of the cases in which [it] is

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[2] As the plurality explained:

> A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. A statute with this purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it. And a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends.

Id. at 877.

relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." Id. at 895. This means that the constitutionality of a prohibition must be judged "by reference to those for whom it is an actual rather than an irrelevant restriction." Id. at 894-95.[3] Applying that test here, the relevant group of cases should be limited to women who would have had their physicians perform the procedure at issue but for the prohibition in S.6. If, in a large fraction of these cases, the prohibition on the use of the procedure poses a substantial obstacle to the woman's election of an abortion, the prohibition is rendered unconstitutional.

Under S.6, physicians would face criminal prosecution for using this method of abortion even when they believed it was the safest procedure to use for a particular woman or [when it was the only procedure available in the woman's geographical area.[4]] The women for whom S.6 operates as a relevant prohibition, then, would be prevented from using this procedure where they would otherwise have chosen it, presumably, in consultation with their physicians as [the most medically appropriate method] for their situation. Therefore, it would appear that the bill is likely to impose an undue burden on not just a "large fraction" but most, if not all, women upon whom it operates as a relevant restriction.

ever true??

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[3] Casey considered, among other things, the constitutionality of a provision allowing married women to obtain abortions only if their husbands had been notified, with certain exceptions, such as when, for example, the husband could not be located. The Court rejected the State's argument that the provision was not invalid on its face because only "one percent of the women seeking abortions who are married would choose not to notify their husbands of their plans." 505 U.S. at 894. The Court explained that the State had selected the wrong "controlling class" based on which to measure the impact of the restriction. The "real target is narrower . . . : it is married women seeking abortions who do not wish to notify their husbands of their intentions and who do not qualify for one of the statutory exceptions to the notice requirement." Id. at 895. Because for a "large fraction of the[se] cases" the notification requirement imposed a "substantial obstacle" to choosing an abortion, the Court held that it was facially invalid. Id.

[4] In Women's Medical Professional Corp., the District Court concluded, after receiving sworn testimony from several physicians, that physicians were performing D&X abortions because this method appeared to pose less of a risk to a woman's health than any alternative procedure. 911 F. Supp. at 1070.

Abortion - partial birth - legal

NATIONAL WOMEN'S LAW CENTER

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QUICK FAX MESSAGE:

As we discussed.

Draft

Language:

An abortion would be unlawful "when in the medical judgment of the attending physician the fetus is viable, unless it is necessary to save the life or of prevent serious bodily injury to the woman, where serious bodily injury involves: (a) a substantial risk of death or (b) protracted loss or impairment of the function of a bodily member or organ [or system] [or mental faculty]."

Problems:

If "mental faculty" is deleted, it guarantees that a court will read that deletion as reflecting a clear Congressional intent to exclude mental health concerns, because the language on which this is modeled -- numerous federal statutes that have this definition of "serious bodily injury," or something very close to it -- invariably includes "mental faculty." See, e.g., 21 USC 802; 18 USC 1365; 18 USC 247; 18 USC 831; 33 USC 1319; 42 USC 6928; 18 USC 2246; plus many others that cross reference 18 USC 1365, such as 18 USC 43. See attached list.

Even if impairment of a "mental faculty" is included, this language could be read very narrowly. First, it could be read only to cover mental health effects when they accompany physical health effects. Because the "mental faculty" language appears in the context of "serious bodily injury" ("where serious bodily injury involves . . . protracted loss or impairment of the function of a . . . mental faculty") it could be read to cover impairment of a mental faculty only when there is a "bodily" (i.e., physical) injury that also "involves" mental injury.

Second, there is caselaw construing "impairment of a mental faculty" very narrowly, under the statutes that include that language. See, e.g., United States v. Vasquez Rivera, 83 F.3d 542 (1st Cir. 1996) (rape victim who suffered extreme mental trauma from an ordeal that "had a devastating effect on her life" was held not to have suffered "protracted loss or impairment of the function of a . . . mental faculty" as required by 18 USC 1365); United States v. Yankton, 986 F.2d 1225 (8th Cir. 1993) (woman who endured a rape-induced pregnancy of twins, one of which died in utero and the other of which died three weeks after birth, was held not to have suffered "impairment of a function of a . . . mental faculty" under the federal Sentencing Guidelines even though her trauma had "life altering consequences"). There is thus no assurance that the mental trauma and life altering consequences of carrying an unwanted pregnancy to term and delivering a baby incompatible with sustained or cognitive life would be held to qualify as "impairment of a mental faculty" under the language under consideration.

This language does not include "extreme physical pain" as another category of "serious bodily injury," even though many of the statutory models cited above do include this category. See, e.g., 18 USC 1365; 18 USC 247; 18 USC 831. See attached.

The omission of this category will be construed as a deliberate decision by Congress to exclude it.

The language doesn't make clear that it applies when it is necessary in the judgment of the attending physician to save the woman's life or prevent serious bodily injury to her. Compare last year's Boxer amendment, which said "where, in the medical judgment of the attending physician, the abortion is necessary to preserve the life or avert serious adverse health consequences . . . ."

The following federal statutes include the "mental faculty" language in their definitions of "serious bodily injury" like said definition in section 802 of the Drug Abuse Prevention and Control Act:

1. 18 USC §1365: Criminal Code: Tampering with Consumer Products:

(3)[T]he term "serious bodily injury" means bodily injury which involves--

(A) a substantial risk of death;
(B) extreme physical pain;
(C) protracted and obvious disfigurement; or
(D) protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

18 USC §1365(g)(3).

2. The above definition of "serious bodily injury" which includes the "mental faculty" language has been incorporated by reference throughout the United States Criminal Code, Title 18 USC. Examples include:

a. 8 USC §1324: Immigration and Nationality Deportation: Bringing in and Harboring Certain Aliens

b. 18 USC §37: Aircraft and Motor Vehicles: Violence at International Airports

c. 18 USC §43: Animal Enterprise Protection Act of 1992

d. 18 USC §113: Assault with Maritime and Territorial Jurisdiction

e. 18 USC §831: Prohibited Transactions Involving Nuclear Materials

f. 18 USC §1153 Offense Committed with Indian Country

g. 18 USC §1347 Mail Fraud: Health Care Fraud

h. 18 USC §2119: Robbery and Burglary: Motor Vehicles

i. 18 USC §2261A: Domestic Violence and Stalking: Interstate Stalking

j. 18 USC §2332b: Terrorism: Acts of Terrorism Transcending National Boundaries

3. 18 USC §247: Civil Rights: Damage to Religious Property

[T]he term "serious bodily injury" means bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious

disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

4. 18 USC §1864: Hazardous or Injurious Devices on Federal Lands

(1)[T]he term "serious bodily injury" means bodily injury which involves--

(A) a substantial risk of death;
(B) extreme physical pain;
(C) protracted and obvious disfigurement; and
(D) protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

5. 18 USC §2246: Sexual Abuse

(4)[T]he term "serious bodily injury" means bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

18 USC §2246(4).

6. 18 USC Appx 1B1.1: Sentencing Guidelines for the United States Courts: Application Instructions

(j) "Serious bodily injury: means injury involving extreme physical pain or the impairment of a function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery. hospitalization. or physical rehabilitation.

7. 33 USC §1319: Water Pollution Prevention and Control: Enforcement

[T]he term "serious bodily injury" means bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

8. 42 USC §5106a: Child Abuse Prevention and Treatment and Adoption Reform: Grants for States

[T]he term "serious bodily injury" means bodily injury which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

9. 42 USC §6928: Solid Waste Disposal: Federal Enforcement

The term "serious bodily injury" means--

(A) bodily injury which involves a substantial risk of death;
(B) unconsciousness;
(C) extreme physical pain;
(D) protracted and obvious disfigurement; or
(E) protracted loss or impairment of the function of a bodily member, organ or mental faculty.

10. 42 USC §7413: Air Pollution Prevention and Control: Federal Enforcement

The term "serious bodily injury" means bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.