Maria Caulfield: So Professor Wyatt, welcome. Thank you so much for coming. We are running slightly behind, so please excuse us for…for being slightly behind. Just quite astonishing evidence that we're collecting in this enquiry. Could you start just by outlining your experience and your particular area of expertise for this inquiry?
Prof. Wyatt: Yes, so my background is as a neonatologist, that's a specialist in the care of newborn babies, and I've spent over 25 years of working in a big intensive care unit from…in central London and caring for a very large number of babies who go right down to the limits of viability, so I've cared for a large number of babies from 22 and 23 weeks menstrual age which is 20, 21 weeks fetal age. I also have a special interest in brain injury in newborn babies and in ways of treating and preventing brain injury, and an interest in medical ethics.
Maria Caulfield: And obviously that tie frame is very relevant to our enquiry. In your experience, in your clinical experience, do you think there is a difference between fetal awareness and fetal pain, and are the two interlinked, or can you have one without the other? What's your experience? Particularly of the 22/23 weeks that you speak of.
Prof. Wyatt: Well my experience is primarily with babies after they're born. And obviously the situation of a baby who is being born and is in the outside world is different from that of a fetus of identical maturity who's connected to a placenta and is inside the very different environment of the womb. But I think it's a natural assumption to think that at equivalent gestational ages the fundamental way that the central nervous system works, the way that the baby responds will be similar. One of the differences is that in the womb, the fetus is in a relatively sensorily deprived environment, it's dark, it's quiet. There is evidence that the fetus responds to various sensations and experiences: to any sounds coming through the mother's abdomen, like listening to her voice, light, and taste of the fluid; all these things are evidence that the fetus can respond to. Once the baby's outside, the baby's in a very different environment, and is bombarded with sensors: with light, sound, cold, and touch. My experience of caring for these babies is that they behave very much as though they were conscious, sentient, responding to their environment, that's the natural assumptions that pediatricians, neonatal nurses have when we care for these babies. Obviously they spend a lot of their time in sleep, but they have periods of wakefulness, responsiveness and the eyes open and they appear to be engaging with their environment. And when they're handled, they respond to the way they're handled, particularly if they're handled in a rough way or if they have unpleasant experiences such as, over the years I've done many painful procedures, such as inserting lines and drains and catheters and these kinds of things. And you can see the way that the baby responds to these unpleasant procedures. The response is
different from a full-term baby -- it's often slower, takes time, and that's probably to do with the maturity of the nervous system, and the speed with which nerve fibres connect…transmit impulses. The responses that you see are mainly around the face; you see the face screw up, the
brow becomes furrowed, sometimes the mouth opens, and it's often a silent cry, they can't really produce much in the way of sound. And then positively, when they're in a nice comforting environment you can see the face relax and you can see them seem to respond positively to pleasant… So I think from my observation of extremely premature babies is they are both sentient, they are conscious, and they are responsive to their environment.
Fiona Bruce: Thank you. Could you give us your opinion of the experience of a fetus

undergoing a termination procedure, the same age as some of the premature babies you care for? Prof Wyatt: Well, it's very difficult to be confident about the experience even…even of a baby,
you know, we none of us have any reliable memories from this period. So all one can do is observe the behavior and attempt to empathize with the experience, to try to imagine…to put yourself into the place of the baby.
I do think this principle… there is a difference…between the scientific approach which is to look at the hard objective empirical evidence, and only to work on the basis of what can be clearly demonstrated, versus the clinical approach, which is to play safe, in other words, I don't need to have absolutely clear objective scientific evidence that the baby is suffering in order to give pain relief, in order to give appropriate medication. Because as a doctor and as a carer my primary responsibility is to minimise suffering and adverse effects, and therefore I work on the basis of playing safe, I recognise that in many of these difficult cases it is not possible to have absolute scientific certainty. But I think if I was to apply the same principles to a baby who was undergoing procedures, any kind of procedures, I would have the same kind of approach. I think we should play safe, we should give the fetus benefit of the doubt. We should assume that it is capable of experiencing pain and unpleasant sensations, and we should then treat the baby appropriately, which would if necessary be with strong pain relief medication or with anesthesia.
Fiona Bruce: Thank you. So looking then at the 2010 RCOG guidelines on fetal awareness, I'm wondering if you could tell us how effective they are in terms of advising mothers…in terms of fetal awareness.
Can I just comment perhaps – toward the end of the document it advises consultants on how to answer frequently asked questions from mothers. The set response to "Will my baby/fetus feel pain?" is "No" then stating the reasons why. This set advice is for all fetal ages up to the point of birth. I wonder what you're thoughts are on that?...
Prof. Wyatt: Well it's very hard to justify on the basis of the available evidence, and it's got a sort of dogmatic certainty about it which I think is completely inappropriate, in terms of what we know, and I think it's distressing that a, you know, very well-known organization like the RCOG does produce evidence like this, which is hard to justify with that kind of dogmatic certainty. I have to say that my impression is that many pregnant women, if they were given that kind of evidence, would immediately question…you know "Really? Is that really the case?" I mean many people are aware of premature babies and of their responsiveness… There have been documentaries, there is a great deal of information out there for the general public. So these kind
of very clear dogmatic statements, they are reminiscent, the point has been made before, I'm sure, that as pediatricians, I was taught that, as a medical student, that newborn babies didn't experience pain.
Fiona Bruce: Yeah, I've heard that.
Prof. Wyatt: …and that the screaming reactions, and all this, this was just reflex response. And so, you know, when you look back you think, "wow, that was bizarre," you know, no mother would've said that, but this was a…a, sort of scientific response in the face of all the obvious evidence.
Fiona Bruce: Yes. Thank you. And so under those guidelines then, fetal ana…analgesia is never needed, or advised during any termination procedure during any stage of pregnancy. What is

your view on that, and at what age would you advise that?
Prof. Wyatt: Well I have to say it really is outside my professional expertise. I do understand that when …I mean fetal surgery is now becoming more common, and in those situations I understand that it's quite commonplace for anesthetists to ensure that the fetus is anesthetized. And that would seem to me entirely appropriate, and I would've thought that the same kind of guidelines which apply to fetal surgery could well be applied to any kind of invasive procedure...
Maria Caulfield: So in terms of your thoughts that if it's a fetal surgery the analgesia is given but if it's a termination it's not, if we wanted to level the playing field there, how would that happen, you know, how is it, how could it be…would it be legislation, would it be clinical practice, what would it take to level that playing field so that fetal analgesia is given to any procedure?
Prof. Wyatt: Again, I have to say that it's rather outside my expertise as a pediatrician, because it
would really be a question for obstetricians and gynecologists, and fetal medicine specialists, I mean this is their area of expertise. Perhaps one of the problems is that in order to become a fetal
medicine specialist these days you have to be prepared to, I understand, train in these procedures
– late feticides and all the rest – and therefore you've already taken a sort of position, and my perspective a s a pediatrician, is therefore, rather different. I don't know…again, I'm not an expert in legislation, I think certainly clinical guidelines. There are, for instance, quite specific guidelines about pain relief in newborn babies, and I think it would be quite possible to have similar clinical guidelines mandating this kind of pain relief in …prior to certainly late abortions.
MP: Do you think it would be possible…think it would be preferable…?
Prof. Wyatt: Well to be honest, from an ethical point of view, the primary issue is about the destruction of the human life, it's not
MP: Yes!
Prof. Wyatt: whether you anesthetise them before execution, you know, and, you know, the primary issue seems to me about whether the intentional destruction of another human life is appropriate. And you know it's a slightly strange thing, you know, we're going to execute all these people so at least we might be doing it humanely. It's not the primary issue at stake I think. But I can understand, just from a sort of common humanity, that we should protect the fetus at every possibility.
Lord Alton: Sorry to interrupt, we are running pretty low on time…

Maria Caulfield: We were really talking about, you know, we probably got to question 6, and then slightly gone off on a tangent…
Lord Alton: Professor, would it be alright if we emailed?
Prof. Wyatt: Yes, of course…absolutely.
…
Fiona Bruce: No, no, we're grateful to have your expert advice, for counsel on this whole enquiry
Maria Caulfield: Thank you very much for being very very helpful and we will send you…questions that we've not been able to fit it, because I think just having your expertise and knowledge is just so helpful for the enquiry, particularly around…I am particularly…the point

about analgesia for procedures. But I think just, you know, getting that evidence, that, you know, the potential for fetal pain, and ethically, you know, we need to be mindful of that.
Fiona Bruce: That's right, and any recommendations on how…could be improved.
Prof Wyatt: Could be improved, yep.
Fiona Bruce: That was going to be my next question.
Maria Caulfield: Thank you very much
Prof. Wyatt: Thank you very much for having me