107TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
107–604

PARTIAL-BIRTH ABORTION BAN ACT OF 2002

JULY 23, 2002.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. SENSENBRENNER, from the Committee on the Judiciary, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 4965]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 4965) to prohibit the procedure commonly known as partial-birth abortion, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

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PURPOSE AND SUMMARY

H.R. 4965, the "Partial-Birth Abortion Ban Act of 2002," bans the partial-birth abortion procedure in which an intact living fetus is partially delivered until some portion of the fetus is outside the body of the mother before the fetus is killed and the delivery completed. A partial-birth abortion is defined by H.R. 4965 as an abortion in which a physician "deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus." An abortionist who violates the ban would be subject to fines or a maximum of 2 years imprisonment, or both. H.R. 4965 also establishes a civil cause of action for damages against an abortionist who violates the ban and includes an exception for those situations in which a partial-birth abortion is necessary to save the life of the mother. H.R. 4965 differs from legislation to ban partial-birth abortions approved by previous Congresses in that it contained a revised definition of the banned procedure and includes Congress's factual findings that, based upon extensive medical evidence compiled during congressional hearings, a partial-birth abortion is never necessary to preserve the health of a woman.

BACKGROUND AND NEED FOR THE LEGISLATION

BACKGROUND

The Procedure

In late 1992, Dr. Martin Haskell, an abortion provider who operates three abortion clinics, sparked a national debate over the partial-birth abortion procedure when he presented a paper entitled *Dilation and Extraction for Late Second Trimester Abortion* at the National Abortion Federation's 2-day Fall Risk Management Seminar in Dallas, Texas. In that paper, the details of which shocked the consciences of Americans all across the country, Dr. Haskell described a "quick, surgical outpatient" abortion procedure that he "routinely performs . . . on all patients 20 through 24 weeks."[1] The details of the crucial part of the procedure were described as follows:

> The surgeon introduces a large grasping forceps . . . through the vaginal and cervical canals into the corpus of the uterus. . . . When the instrument appears on the sonogram screen, the surgeon is able to open and close its jaws to firmly and reliably grasp a lower extremity [leg]. The surgeon then applies firm traction to the instrument . . . and pulls the extremity into the vagina. . . .
>
> With a lower extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and the upper extremities [arms].

[1] *See* Martin Haskell, M.D., *Dilation and Extraction for Late Second Trimester Abortions*, Presented at the National Abortion Federation Risk Management Seminar (September 13, 1992), *in* Second Trimester Abortion: From Every Angle, 1992, at 6–7.

> The skull lodges at the internal cervical os.
>
> At this point, the right-handed surgeon slides the fingers of the left had [sic] along the back of the fetus and 'hooks' the shoulders of the fetus with the index and ring fingers (palm down).
>
> While maintaining this tension, lifting the cervix and applying traction to the shoulders with the fingers of the left hand, the surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger.
>
> [T]he surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening.
>
> The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient.[2]

This method of abortion is particularly brutal and inhuman. Brenda Pratt Shafer, a registered nurse who observed Dr. Haskell use the procedure to abort three babies in 1993, testified before the Senate Judiciary Committee in 1995 and described a partial-birth abortion she witnessed on a child of 26 and a half weeks as follows:

> Dr. Haskell brought the ultrasound in and hooked it up so that he could see the baby. On the ultrasound screen, I could see the heart beat. As Dr. Haskell watched the baby on the ultrasound screen, the baby's heartbeat was clearly visible on the ultrasound screen.
>
> Dr. Haskell went in with forceps and grabbed the baby's legs and pulled them down into the birth canal. Then he delivered the baby's body and the arms—everything but the head. The doctor kept the head right inside the uterus. . . .
>
> The baby's little fingers were clasping and unclasping, and his little feet were kicking. Then the doctor stuck the scissors in the back of his head, and the baby's arms jerked out, like a startle reaction, like a flinch, like a baby does when he thinks he is going to fall.
>
> The doctor opened up the scissors, stuck a high-powered suction tube into the opening, and sucked the baby's brains out. Now the baby went completely limp. . . .
>
> He cut the umbilical cord and delivered the placenta. He threw the baby in a pan, along with the placenta and the instruments he had just used. I saw the baby move in the pan. I asked another nurse, and she said it was just reflexes. . . . That baby boy had the most perfect angelic face I think I have ever seen in my life.[3]

Clearly, the only difference between the partial-birth abortion procedure and infanticide is a mere three inches.

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[2] *Id.* at 27, 30–31.

[3] *The Partial-Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 Before the Senate Comm. on the Judiciary*, 104th Cong. 18 (Nov. 17, 1995) (statement of Brenda Pratt Shafer).

The partial-birth abortion procedure is performed from around 20 weeks to full term.[4] It is well documented that a baby is highly sensitive to pain stimuli during this period and even earlier.[5] In fact, in a study conducted on fetuses between 20 to 34 weeks of gestation at the Institute of Obstetrics and Gynaecology, Royal Postgraduate Medical School, Queen Charlotte's and Chelsea Hospital in London researchers concluded:

> Just as physicians now provide neonates with adequate analgesia, our findings suggest that those dealing with the fetus should consider making similar modifications to their practice. This applies not just to diagnostic and therapeutic procedures on the fetus, but possibly also to termination of pregnancy, especially by surgical techniques involving dismemberment.[6]

In his testimony before the Constitution Subcommittee on June 15, 1995, Professor Robert White, Director of the Division of Neurosurgery and Brain Research Laboratory at Case Western Reserve School of Medicine, stated that "[t]he fetus within this time frame of gestation, 20 weeks and beyond, is fully capable of experiencing pain."[7] After specifically analyzing the partial-birth abortion procedure, Dr. White concluded that "[w]ithout question, all of this is a dreadfully painful experience for any infant subjected to such a surgical procedure."[8]

Thus a moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion is a gruesome and inhumane procedure that is never medically necessary and, thus, should be prohibited.

Public Reaction

The partial-birth abortion procedure was brought to the attention of the nation when Minnesota Citizens Concerned for Life ran an add in the Minneapolis Star-Tribune on May 12, 1993, containing drawings illustrating Dr. Haskell's abortion procedure with descriptive captions beneath.[9] The immediate reaction of Dr. Haskell's local community was one of outrage. According to local reports over 100 local demonstrators, including reportedly twenty-one doctors,

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[4] There are several abortion techniques employed between 20 weeks and full term. The techniques fall under the general categories of partial-birth abortion, dilation and evacuation, and amnioinfusion. In the dilation and evacuation procedures the baby is dismembered and removed from the uterus in pieces. *See*, D.A. Grimes and W. Cates, Jr., *Dilation and Evacuation*, Second Trimester Abortion—Perspectives After a Decade of Experience (G.S. Berger et al. eds., 1981). Amnioinfusion requires the injection of saline or other solutions into the amniotic cavity. The solution kills the baby, and labor is induced. *See*, Warren M. Hern, M.D., M.P.H., *Abortion Practice* (1984).

[5] *See, e.g.*, K.J.S. Anand and P.R. Hickey, *Pain and Its Effects in the Human Neonate and Fetus*, 317 The New England Journal of Medicine, 1321; V. Collins et al., *Fetal Pain and Abortion: The Medical Evidence*, Studies in Law and Medicine (1984); S. Reinis and J.M. Goldman, *The Development of the Brain* (1980).

[6] Xenophon Giannakoulopoulos et al., *Fetal Plasma Cortisol and* β-Endorphin Response to Intrauterine Needling, The Lancet, July 9, 1994, at 77, 80.

[7] *Hearing on Partial-Birth Abortion Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong., 1st Sess., (1995) (testimony of Robert J. White, M.D., Ph.D.).

[8] *Id.*

[9] The adds were run in an effort to defeat the Freedom of Choice Act, S. 25, which was being debated by the United States Senate at the time. *See Shock-tactic Ads Target Late-Term Abortion Procedure: Foes Hope Campaign Will Sink Abortion Rights Legislation*, American Medical News, July 5, 1993.

protested outside of the Cincinnati abortion clinic at which Dr. Haskell performs abortions.[10]

By 1996, polls revealed that Americans, regardless of their self-identified political affiliation or position on abortion, found the procedure to be morally and ethically objectionable and thus favored criminal bans of the procedure. A 1996 Tarrance Group poll sponsored by the National Conference of Catholic Bishops found that 55 percent of Democrats and 65 percent of those identifying themselves as pro-choice supported the ban.[11] Later that year, a Gallup poll revealed that 71 percent of American voters support the ban on "a specific abortion procedure conducted in the last 6 months of pregnancy known as a 'partial-birth abortion,' except in cases necessary to save the life of the mother."[12] A 1997 survey conducted by the Pew Research Center for the People & the Press found that women supported the ban by 56 percent and Republicans, Democrats, and Independents gave their approval by 55, 54, and 56 percent, respectively.[13]

The most compelling proof of the public's disgust with the procedure is the speed with which the States acted to enact criminal bans on the procedure.[14] By February 2000, at least 27 State legislatures, following the democratic, political processes in their States, had enacted statutes prohibiting partial-birth abortions. During this same time frame, the United States Congress overwhelmingly passed a Federal ban on partial-birth abortions three times, each vote by an overwhelming majority.[15]

STENBERG V. *CARHART* AND THE "CLEARLY ERRONEOUS" STANDARD OF REVIEW

In June 2000, the national debate regarding partial-birth abortions reached a new level when the United States Supreme Court, in *Stenberg* v. *Carhart*,[16] struck down Nebraska's partial-birth abortion ban. The Court struck down the ban concluding that it placed an undue burden on women seeking abortions because the statutory definition of a partial-birth abortion (now usually referred to as a "D & X") could also be construed to ban the most common abortion procedure used during the second trimester of

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[10] *See Abortion Protesters Object to Cincinnati Doctor*, The Cincinnati Post, Oct. 27, 1993, *available at* 1993 WL 4101327.

[11] John Leo, *Anti-Abortion Viewpoints Absent From Most Media*, The Seattle Times, June 4, 1996.

[12] Barbara Vobejda and David Brown, *Harsh Details Shift Tenor of Abortion Fight; Both Sides Bend Facts on Late-Term Procedure*, The Washington Post, Sept. 17, 1996.

[13] *See Poll: Americans Against Partial Birth Abortion By Slim Majority*, Congress Daily, May 23, 1997, *available at* 1997 WL 7761974. Most recently, these numbers have remained at about 61 percent. A May 1999 CNN/USA Today/Gallup poll found that 61 percent favor a ban. *See Poll Update Poll Spotlight: Parents of Teens Should Be Accountable* The Hotline, Vol. 10, No. 9, May 5, 1999, *available at* Westlaw, 5/5/99 APN-HO 44. An April 2000 Fox News/Opinion Dynamics poll also found that 61 percent favored a ban. *Bush to Seek Ban on Late-Term Abortions: White House By Charles Hoskinson*, Agence France-Presse, Jan. 28, 2001, *available at* 2001 WL 2330777.

[14] "'The primary and most reliable indication of [a national] consensus is . . . the pattern of enacted laws.'" *Washington* v. *Glucksberg*, 521 U.S. 702, 711 (1997) (bracketed material in original) (quoting *Stanford* v. *Kentucky*, 492 U.S. 361, 373 (1989)).

[15] During the 104th and 105th Congresses, the House actually voted on each ban twice—the first to approve the legislation and the second to override President Clinton's veto. Each time, for a total of four times, the House approved the legislation with a veto proof majority. Although each chamber passed a partial-birth abortion ban during the 106th Congress, these versions were not identical. Conferees were appointed by the House but no further action was taken to bring the differing versions to a conference since the Court issued its *Stenberg* ruling in June 2000.

[16] 530 U.S. 914 (2000).

pregnancy, dilation and evacuation or "D & E," and because the ban failed to include an exception for partial-birth abortions that are deemed necessary to preserve the "health" of the mother.

The Court's definitional objections have been remedied in H.R. 4965 by drafting a more precise definition of the prohibited procedure. Previous versions of the bill defined a partial-birth abortion as "an abortion in which the person performing the abortion partially-vaginally delivers a living fetus before killing the fetus and completing delivery." The language the Court objected to in *Stenberg* was virtually identical. Under the current version of the ban, "partial-birth abortion" is defined as "an abortion in which—(A) the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus." This language is sufficiently precise so as to exclude the D & E abortion procedure.

Addressing the Nebraska ban's failure to include a health exception, the *Stenberg* Court opined "that significant medical authority supports the proposition that in some circumstances, [partial birth abortion] would be the safest procedure" for pregnant women who wish to undergo an abortion.[17] Thus, the Court concluded that Nebraska's ban placed an undue burden on women seeking abortions because it failed to include an exception for partial-birth abortions deemed necessary to preserve the "health" of the mother. However, the great weight of evidence presented at this and other trials challenging partial-birth abortion bans, as well as in extensive congressional hearings, supports the conclusion that partial-birth abortion is never necessary to preserve the health of a woman, is outside of the medical standard of care, and may actually pose significant health risks to a woman upon whom the procedure is performed.

Despite the *Stenberg* trial court record's dearth of evidence supporting the conclusion that a D & X abortion may be necessary to protect the health of some women, the United States Court of Appeals for the Eighth Circuit refused to set aside the district court's factual findings because, under the applicable standard of appellate review, they were not "clearly erroneous."[18] A finding of fact is clearly erroneous "when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed."[19] Under this standard, "[i]f the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently."[20]

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[17] *Id.* at 932.

[18] *Carhart* v. *Stenberg*, 192 F.3d 1142, 1146 (8th Cir. 1999) ("The Court's findings are not clearly erroneous, and we therefore must accept them.").

[19] *Anderson* v. *City of Bessemer City, North Carolina*, 470 U.S. 564, 573 (1985). *See also United States* v. *United States Gypsum Co.*, 333 U.S. 364 (1948).

[20] *Anderson*, 470 U.S. at 574.

On review from the Eighth Circuit, the Supreme Court in *Stenberg* also accepted the district court's findings and the appellate court's refusal to set them aside.[21] It was argued by at least one set of amici that the district court findings should be set aside as clearly erroneous.[22] This amicus brief, which was submitted by a number of medical organizations and doctors including the Physicians' Ad Hoc Coalition for Truth (PhACT) and the Association of American Physicians and Surgeons, asserted that the district court's findings on the D & X procedure were "self-contradictory because they simultaneously condemn the State for making illegal the most common form of second trimester abortions (D & E), while also claiming that this same method is as measured against D & X so medically deficient as to constitute a serious health risk for women."[23] In addition, they argued that the findings regarding the benefits of D & X only relied upon the testimony of Dr. Carhart, the plaintiff, and the speculation of experts, and that the record was void of any controlled study or article from a peer-reviewed journal establishing that the D & X is superior in any way to the D & E procedure.[24]

Although amici's observations were correct and were supported by Nebraska's arguments on appeal, the Supreme Court was bound by the "clearly erroneous" standard to accept the district court's findings. The Court has explained that "[d]etermining the weight and credibility of the evidence is the special province of the trier of fact."[25] Therefore, rule 52(a) of the Federal Rules of Civil Procedure, which articulates the clearly erroneous standard necessary for setting aside a judge's factual findings, "recognizes and rests upon the unique opportunity afforded the trial court judge to evaluate the credibility of witnesses and to weigh the evidence."[26] Despite the fact that the Court might have found PhACT's argument to be more persuasive than the conclusions of the district court, "an appellate court cannot substitute its interpretation of the evidence for that of the trial court simply because the reviewing court 'might give the facts another construction, resolve the ambiguities differently, and find a more sinister cast to actions which the District Court apparently deemed innocent.'"[27] That is, a reviewing court must remember that when "applying the clearly erroneous standard to the findings of a district court sitting without a jury," that court's

> function is not to decide factual issues de novo. The authority of an appellate court, when reviewing the findings of a judge as well as those of jury, is circumscribed by the deference it must give to decisions of the trier of the fact, who is usually in a superior position to appraise and weigh the evidence. The question for the appellate court under rule 52(a) is not whether it would have made the findings the trial court did, but wheth-

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[21] *Stenberg*, 530 U.S. at 923.
[22] *See* Brief Amici Curiae of Association of American Physicians and Surgeons et al. at 16, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448.
[23] *Id.* at 16.
[24] *Id.* at 16.
[25] *Inwood Laboratories, Inc.* v. *Ives Laboratories*, 456 U.S. 844, 856 (1982).
[26] *Id.* at 855.
[27] *Id.* at 857.

> er "on the entire evidence (it) is left with the definite and firm conviction that a mistake has been committed." [28]

In *Stenberg*, the Supreme Court described its assessment of the district court record thus:

> The upshot is a District Court finding that D & X significantly obviates health risks in certain circumstances, a *highly plausible record-based explanation* of why that might be so, a *division of opinion among some medical experts* over whether D & X is generally safer, and an *absence of controlled medical studies* that would help to answer these medical questions. *Given these medically related evidentiary circumstances*, we believe the law requires a health exception.[29]

The *Stenberg* Court faced a situation in which "a trial judge's finding is based on his decision to credit the testimony of one of two or more witnesses, each of whom has told a coherent and facially plausible story that is not contradicted by extensive evidence." [30] The Court, in such circumstances has held that "that finding, if not internally inconsistent, can virtually never be clear error." [31]

Thus, in *Stenberg*, the Supreme Court was required to accept as true the very questionable findings issued by a single district court judge—the effect of which was to render null and void the reasoned factual findings and policy determinations of the United States Congress and at least 27 State legislatures. Whatever the cause of the lack of sufficient record evidence in *Stenberg* to contradict the view that partial-birth abortion is medically necessary and safe—be it neglect by the attorneys at the trial court, unavailability of controlled tests or peer-reviewed articles—it simply is not the case that Congress is forever bound by the dubious factual findings of one Federal district court.

JUDICIAL DEFERENCE TO CONGRESSIONAL FACT-FINDING

Under well-settled Supreme Court jurisprudence, the United States Congress is not bound to accept the same factual findings that the Supreme Court was bound to accept in *Stenberg* under the "clearly erroneous" standard. Rather, the United States Congress is entitled to reach its own factual findings—findings that the Supreme Court accords great deference—and to enact legislation based upon these findings so long as it seeks to pursue a legitimate interest that is within the scope of the Constitution, and draws reasonable inferences based upon substantial evidence. Thus, H.R. 4965 includes extensive findings on the lack of evidence to support the medical efficacy or safety of the procedure as well as the potential dangers posed by the procedure. Under this approach Congress has expressed its disagreement with the factual conclusions of the district court in the *Stenberg* case—that a D & X abortion is in fact the safest abortion method for some women in some cir-

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[28] *Zenith Radio Corporation* v. *Hazeltine Research, Inc.*, 395 U.S. 100, 123 (1969). *See also Anderson* v. *City of Bessemer City, North Carolina*, 470 U.S. 564, 573 (stating that the clearly erroneous standard "plainly does not entitle a reviewing court to reverse the finding of the trier of fact simply because it is convinced that it would have decided the case differently. The reviewing court oversteps the bounds of its duty under rule 52(a) if it undertakes to duplicate the role of the lower court.").

[29] *Stenberg* v. *Carhart*, 530 U.S. 914, 936 (2000) (emphasis added).

[30] *Anderson*, 470 U.S. at 575.

[31] *Id.*

cumstances—without challenging the Supreme Court's authority to interpret *Roe* v. *Wade* [32] and *Planned Parenthood* v. *Casey*.[33]

The concept of Supreme Court deference to Congress' factual findings is not a new legal theory. The Court has historically been highly deferential to Congress' factual determinations, regardless of the legal authority upon which Congress has sought to legislate. As Justice Rehnquist has stated, "the fact that th[e] Court is not exercising a primary judgment but sitting in judgment upon those who also have taken the oath to observe the Constitution and who have the responsibility for carrying on government," [34] compels the Court to be "particularly careful not to substitute our judgment of what is desirable for that of Congress, or our own evaluation of evidence for a reasonable evaluation by the Legislative Branch." [35]

In *Katzenbach* v. *Morgan*,[36] the Supreme Court articulated its highly deferential review of Congressional factual conclusions when it addressed the constitutionality of section 4(e) of the Voting Rights Act of 1965. That provision prohibits a State from denying the right to vote in any election to any person who has successfully completed the sixth primary grade in a public school in, or a private school accredited by, the Commonwealth of Puerto Rico where the language of instruction was other than English because of his or her inability to read or write English.[37] Section 4(e) was challenged by registered New York City voters who asserted that it prohibited the enforcement of Article II, § 1 of the New York Constitution, which required voters to be able to read and write English as a condition to voting. New York argued that section 4(e) could not be upheld as appropriate enforcement legislation under the Equal Protection Clause because the Supreme Court had already held that literacy requirements are not always unconstitutional.[38] Thus, the question, as the Court saw it, was whether Congress had the authority under section 5 of the Fourteenth Amendment to enact section 4(e) even though the Court had not ruled that New York's requirement would have been unconstitutional.[39]

The Court began its analysis stating, "[w]hen we are required to pass on the constitutionality of an Act of Congress, we assume 'the gravest and most delicate duty that this Court is called on to perform.'" [40] Regarding Congress' factual determination that sec 4(e) would assist the Puerto Rican community in "gaining nondiscriminatory treatment in public services," the Court stated that it

> was well within congressional authority to say that this need of the Puerto Rican minority for the vote warranted Federal intrusion upon any State interest served by the English literacy requirement. *It was for Congress, as the branch that made this judgment, to assess and weigh the various conflicting considerations*—the risk or pervasiveness of the discrimination in governmental services, the effectiveness of eliminating the State restriction on the right to vote as a means of dealing with the

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[32] 410 U.S. 112 (1973).
[33] 505 U.S. 833 (1992).
[34] *Rostker* v. *Goldberg*, 453 U.S. 57, 64 (1981).
[35] *Id.* at 68. *See also* K. G. Jan Pillai, *In Defense of Congressional Power and Minority Rights Under the Fourteenth Amendment* 68 Miss. L.J. 431, 509 (1998).
[36] 384 U.S. 641 (1966).
[37] *See* 42 U.S.C. sec. 1973b(e).
[38] *See Katzenbach* v. *Morgan*, 384 U.S. 641, 648, 649 (1966).
[39] *Katzenbach*, 384 U.S. at 649.
[40] 448 U.S. 448, 472 (1980) (*citing Blodgett* v. *Holden*, 275 U.S. 142, 148 (1927).

> evil, the adequacy or availability of alternative remedies, and the nature of significance of the State interests that would be affected by the nullification of the English literacy requirement as applied to residents who have successfully completed the sixth grade in a Puerto Rican school. *It is not for us to review the congressional resolution of these factors. It is enough that we be able to perceive a basis upon which the Congress might resolve the conflict as it did. There plainly was such a basis to support § 4(e) in the application in question in this case.*[41]

In *Fullilove* v. *Klutznick*,[42] the Court reviewed § 103(f)(2) of the Public Works Employment Act of 1977, otherwise known as the "minority business enterprise" provision (MBE), which stated that "no grant shall be made under this Act for any local public works project unless the applicant gives satisfactory assurance to the Secretary that at least 10 per centum of the amount of each grant shall be expended for minority business enterprises."[43] While repeatedly citing to the legislative record created by Congress, the Court upheld the MBE provision as an appropriate exercise of Congress's authority under the Spending Power, the Commerce Clause, and section 5 of the Fourteenth Amendment.[44] Addressing the deference to be given Congress's actions the Court stated, "[h]ere we pass, not on a choice made by a single judge or a school board, but on a considered decision of the Congress and the President,"[45] and that "we are bound to approach our task with appropriate deference to the 'Congress, a co-equal branch.'"[46]

The Court again utilized this deferential standard in *Columbia Broadcasting System* v. *Democratic National Committee*,[47] holding that the Communications Act of 1934 and the First Amendment do not require broadcasters to accept editorial advertisements.[48] Deferring to the factual conclusions leading to the congressionally-created statutory and regulatory scheme, the Court stated that it "must afford great weight to the decisions of Congress."[49] "The judgment of the Legislative Branch," the Court continued, "cannot be ignored or undervalued simply because one segment of the broadcast constituency casts its claims under the umbrella of the

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[41] *Katzenbach*, 384 at 653 (emphasis added). *Katzenbach*'s highly deferential review of Congress's factual conclusions was relied upon by the United States District Court for the District of Columbia when it upheld the "bail-out" provisions of the Voting Rights Act of 1965, 42 U.S.C. § 1973c, stating that "*congressional fact finding, to which we are inclined to pay great deference*, strengthens the inference that, in those jurisdictions covered by the Act, State actions discriminatory in effect are discriminatory in purpose." *City of Rome, Georgia* v. *U.S.*, 472 F.Supp. 221 (D. D. Col. 1979) *aff'd City of Rome, Georgia* v. *U.S.*, 446 U.S. 156 (1980) (emphasis added). The Court recently narrowed the scope of Congress' enforcement power under the Fourteenth Amendment, but in doing so explicitly confirmed that Congress's factual conclusions are entitled great weight, stating that "[i]t is for Congress in the first instance to 'determin[e] whether and what legislation is needed to secure the guarantees of the Fourteenth Amendment,' and its conclusions are entitled to much deference." *Boerne* v. *Flores*, 521 U.S. 507, 536 (1997). The Court further stated that "[j]udicial deference, in most cases, is based not on the state of the legislative record Congress compiles but 'on due regard for the decision of the body constitutionally appointed to decide.'" *Id.* at 531.

[42] 448 U.S. 448 (1980).

[43] 42 U.S.C. § 6705(f)(2).

[44] *See Fullilove*, 448 U.S. at 474–480.

[45] *Fullilove*, 448 U.S. at 473.

[46] *Fullilove* v. *Klutznick*, 448 U.S. 448, 472 (1980). *See also Walters* v. *National Association of Radiation Survivors*, 473 U.S. 305, 319 (1985) ("we begin our analysis here with no less deference than we customarily must pay to the duly enacted and carefully considered decision of a coequal and representative branch of our Government").

[47] 412 U.S. 94 (1973).

[48] *See id.*

[49] *Id.* at 103.

First Amendment,"[50] because "when [the Court] face[s] a complex problem with many hard questions and few easy answers [it] do[es] well to pay careful attention to how the other branches of Government have addressed the same problem."[51]

In the 1990's, the Court continued its practice of deferring to congressional factual conclusions when the must-carry provisions of the Cable Television Consumer Protection and Competition Act of 1992 were challenged as a violation of the First Amendment.[52] At issue in the *Turner* cases was Congress' legislative finding that, absent mandatory carriage rules, the continued viability of local broadcast television would be "seriously jeopardized."[53] Indicating its inclination to uphold the provision, the *Turner I* Court recognized that as an institution, "Congress is far better equipped than the judiciary to 'amass and evaluate the vast amounts of data' bearing upon an issue as complex and dynamic as that presented here."[54] Although the Court recognized that in First Amendment cases "the deference afforded to legislative findings does 'not foreclose our independent judgment of the facts bearing on an issue of constitutional law," its "obligation to exercise independent judgment when First Amendment rights are implicated is not a license to reweigh the evidence *de novo*, or to replace Congress' factual predictions with our own. Rather, it is to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence."[55]

Three years later in *Turner II*, the Court upheld the "must-carry" provisions based upon Congress' findings, stating the Court's "sole obligation is 'to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.'"[56] Citing to its ruling in *Turner I*, the *Turner II* Court reiterated, "[w]e owe Congress' findings deference in part because the institution 'is far better equipped than the judiciary to "amass and evaluate the vast amounts of data" bearing upon' legislative questions,"[57] and added that it "owe[d] Congress' findings an additional measure of deference out of respect for its authority to exercise the legislative power."[58]

The United States Court of Appeals for the Fourth Circuit has described this deference to "legislative facts" as follows:

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[50] *Columbia Broadcasting System, Inc.* v. *Democratic National Committee*, 412 U.S. 94, 103 (1973).

[51] *Id.*

[52] *See Turner Broadcasting System, Inc.* v. *Federal Communications Commission*, 512 U.S. 622 (1994) *(Turner I)* and *Turner Broadcasting System, Inc.* v. *Federal Communications Commission*, 520 U.S. 180 (1997) *(Turner II)*.

[53] *Turner I*, 512 U.S. at 665. *See also Turner II*, 520 U.S. at 191 ("In explicit factual findings, Congress expressed clear concern that the 'marked shift in market share from broadcast television to cable television services,' resulting from increasing market penetration by cable services, as well as the expanding horizontal concentration and vertical integration of cable operators, combined to give cable system the incentive and ability to delete, reposition, or decline carriage to local broadcasters in an attempt to favor affiliated cable programmers. Congress predicated that 'absent the reimposition of [must-carry], additional local broadcast signals will be deleted, reposition, or not carried;' with the end result that 'the economic viability of free local broadcast television and its ability to originate quality local programming will be seriously jeopardized.'").

[54] *Turner I*, 512 U.S. at 665–66.

[55] *Turner I*, 512 U.S. at 666.

[56] *Turner II*, 520 U.S. at 195.

[57] *Id. See also Walters v. National Association of Radiation Survivors*, 473 U.S. 305, 330 n.12 (1985). ("When Congress makes findings on essentially factual issues such as these, those findings are of course entitled to a great deal of deference, inasmuch as Congress is an institution better equipped to amass and evaluate the vast amounts of data bearing on such an issue.").

[58] *Turner II*, 520 U.S. at 196.

> the government's burden of justifying its legislative enactment against a facial challenge may be carried by pointing to the enactment itself and its legislative history. These are "legislative facts," the substance of which cannot be trumped by the fact finding apparatus of a single court. While a party challenging an ordinance can point to other factors not considered by the legislature to demonstrate that the legislature acted irrationally, it cannot subject legislative findings themselves to judicial review under a clearly erroneous standard or otherwise. To do so would ignore the structural separation between legislative bodies and courts and would improperly subordinate one branch to another other.[59]

These cases clearly indicate that Congress has the constitutional authority to enact a partial-birth abortion ban that does not contain a health exception, so long as in doing so Congress has drawn reasonable inferences based upon substantial evidence. "Congress ha[s] abundant evidence from which it can conclude"[60] that a ban on partial-birth abortion is not required to contain a "health" exception, as the overwhelming weight of evidence supports the conclusion that a partial-birth abortion is never medically necessary to preserve the health of a woman and infant poses substantial health risks to women who undergo the procedure. Congress was informed by extensive hearings held during the 104th and 105th Congresses and passed a ban on partial-birth abortion in the 104th, 105th, and 106th Congresses. These proceedings revealed that partial-birth abortion is never necessary to preserve the health of a woman and should, therefore, be banned.

A ban was first considered during the 104th Congress. H.R. 1833 was introduced by Rep. Charles Canady on June 14, 1995. The Subcommittee on the Constitution held a hearing on H.R. 1833 on June 15, 1995.[61] The Subcommittee held a markup session on the bill on June 21, 1995. On July 12, 1995 and July 18, 1995, H.R. 1833 was marked up by the Judiciary Committee.[62] On November 1, 1995, H.R. 1833 was considered on the floor of the House of Representatives and passed by a vote of 288 to 139.[63] On November 17, 1995, the Senate Committee on the Judiciary held a hearing on H.R. 1833 at which it received testimony from 12 witnesses including five doctors, two nurses, and two constitutional law experts.[64] From December 5, 1995 until December 7, 1995, the Senate debated H.R. 1833 and on December 7, 1995, it passed the legislation 54 to 44.[65] On March 21, 1996, the House Judiciary Committee's Subcommittee on the Constitution held a hearing on the "Effects of Anesthesia During A Partial-Birth Abortion."[66] Six days later on March 27, the House of Representatives, by a vote of 286 to 129,

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[59] *Anheuser-Busch, Inc.* v. *Schmoke*, 63 F.3d 1305, 1312 (4th Cir. 1995).
[60] *Id.* at 477.
[61] *Partial-Birth Abortion: Hearing on H.R. 1833 Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. (1995).
[62] H.R. Rep. No. 104–267 (1995).
[63] 141 Cong. Rec. H11593–02 (1995).
[64] *See The Partial-Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 Before the Senate Comm. on the Judiciary,* 104th Cong. (Nov. 17, 1995).
[65] 141 Cong. Rec. D1430–02 (1995).
[66] *See Effects of Anesthesia During A Partial-Birth Abortion: Hearing Before the House Comm. on the Judiciary, Subcomm. on the Constitution,* 104th Cong. (March 21, 1996).

again approved the partial-birth abortion ban.[67] This bill was vetoed by then President Clinton on April 10, 1996. On September 19, 1996, the U.S. House of Representatives overrode this veto by a 285 to 137 vote.[68] The Senate, however, failed to override the veto, its vote failing 58 to 40.[69]

On March 19, 1997, the 105th Congress initiated new efforts to ban the procedure when H.R. 929 was introduced by Rep. Charles Canady on March 5, 1997. On March 11, 1997, a joint hearing before the Senate Committee on the Judiciary and the House Judiciary Committee's Subcommittee on the Constitution was held at which testimony was received from constitutional law experts, medical doctors, an official from the Center for Disease Control in charge of health statistics, abortion industry advocates, pro-life and pro-abortion advocates, and women who have undergone the procedure who were in support of and opposed to banning the partial-birth abortion procedure.[70] On March 12, 1997, the House Judiciary Committee marked-up H.R. 929.[71] On March 20, 1997, the House debated H.R. 1122, a bill virtually identical to H.R. 929, and approved H.R. 1122 by a 295 to 136 vote.[72] On May 15 and May 20, 1997, the Senate considered and approved H.R. 1122 by a 64 to 36 vote. On October 10, 1997, this bill was vetoed by then President Clinton. On July 23, 1998, the House voted to override that veto by a 296 to 132 vote. On September 18, 1998, however, the Senate, by a vote of 64 to 36, failed to override that veto.

During the 106th Congress, Rep. Canady introduced H.R. 3660 which was identical to legislation approved by the House during the 105th Congress. It was approved by a 287 to 141 vote. On October 5, 1999, Senator Rick Santorum introduced S. 1692. It was considered on October 19, 20, and 21, 1999, and approved by a vote of 63 to 34 on October 21, 1999. Because the House and Senate versions differed from one another, S. 1692 was sent to the House for approval where it was then amended by inserting the provisions of H.R. 3660 in lieu of the Senate passed bill. This version was approved by the House on May 25, 2000.[73]

SPECIFIC CONGRESSIONAL FINDINGS

The overwhelming weight of evidence compiled in a series of congressional hearings indicates that partial-birth abortions (or D & X abortions) are never necessary to preserve the health of a woman, and in fact pose substantial health risks to women undergoing the procedure. Therefore, H.R. 4965 does not include a health exception.

Numerous congressional proceedings have revealed that there is no credible medical evidence that partial-birth abortions are safe or

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[67] H.R. 1833, which was sent to the Senate after it passed the House on Nov. 1, 1995, was slightly amended when considered by the Senate. That amended version was then sent back to the House for approval which came with the March 27 vote.

[68] *See* 142 Cong. Rec. D970–01 (1996).

[69] *See* 142 Cong. Rec. D1007–02 (1996).

[70] *See Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 Before the Subcomm. on the Constitution of the House Comm. on the Judiciary and the Senate Comm. on the Judiciary*, 105th Cong. (1997).

[71] *See* H.R. Rep. No. 105–24 (1997).

[72] *See* 143 Cong. Rec. D282–01 (1997).

[73] Although conferees were appointed by the House, no further action was taken to take the differing versions to a conference since the Court issued its *Stenberg* ruling in June 2000.

are safer than other abortion procedures.[74] According to the American Medical Association (AMA), a "D & X procedure is not even an accepted 'medical practice.'"[75] No controlled studies of partial-birth abortions have been conducted nor have any comparative studies been conducted to demonstrate its efficacy compared to other abortion methods.[76] Furthermore, there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures.[77] Indeed, unlike other more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the performance of partial-birth abortions in their curriculum.[78]

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[74] For example, Dr. Nancy Romer stated that "There is simply no data anywhere in the medical literature in regards to the safety and efficacy" of partial birth abortion. *Partial-Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the United States Senate Comm. on the Judiciary*, 104th Cong. (Nov. 17, 1995) (Statement of Dr. Nancy Romer). During the *Stenberg* trial, Dr. Frank Boehm testified that he did not know of any situations "in which an intact D & X abortion procedure would be a safer abortion procedure for a woman" than an alternative procedure. Brief of Petitioner at 41–2, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228615. Dr. Boehm, the lead witness for the State of Nebraska at the trial phase of *Stenberg* v. *Carhart*, is an expert at performing abortions and his practice includes abortions that must be performed due to congenital anomalies where there are "serious malformations of the fetus." Reply Brief of Petitioner at 5, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 432363. Significantly, he identifies himself as being "pro-choice," reports that he has "not wavered in [his] advocacy of the pro-choice movement," and is a significant financial contributor to Planned Parenthood. Brief of Petitioner at 40, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (No. 99–830) *available at* 2000 WL 228615.

[75] *AMA Board of Trustees Fact Sheet on H.R. 1122,* Brief of Amici Curiae Association of American Physicians and Surgeons et al. appendix, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448. "There is no consensus among obstetricians about its use, and the Board's expert scientific report recommends against its use. It has never been subject to even a minimal amount of the normal medical practice development. It is not in the medical text books." *Id.*

[76] During the trial in *Stenberg*, Dr. Boehm testified that the safety of the D & X procedure has never been medically proven and that he is not aware of any ongoing studies in this area. Brief of Petitioner at 39 *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228615. The district court in *Stenberg* agreed with Dr. Stubblefield's statement that there are no medical studies "which compare the safety of the intact D & X to other abortion procedures or conclude that the D & X is safer than other abortion procedures." *Carhart* v. *Stenberg*, 11 F. Supp. 2d 1099, 1112 (D. Neb. 1998). Dr. Stubblefield, an expert witness who testified on behalf of Dr. Carhart at the trial phase of *Stenberg*, has performed, taught, and supervised abortions, including vacuum curettage, D & E, and labor induction, since 1973. In his position at the time of the *Stenberg* case he would perform, supervise, or assist in 10 to 20 abortions per month. When Dr. Stubblefield served as the Chief of Obstetrics and Gynecology at the Maine Medical Center from 1988 to 1994, he primarily practiced and taught the D & E procedure through 22½ weeks of gestation. *Carhart* v. *Stenberg*, 11 F. Supp. 2d 1099, 1110 (D. Neb. 1998). Dr. Stubblefield also admitted that D & X is at an "early stage" of the "progress of science in clinical medicine." Brief of Amicus Curiae State of Wisconsin at 19–20, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228491. He further testified that in order to be "really clear" about the advantages of D & X the "next step of actually comparing [D & E and D & X], preferably in a random basis in the same center" would have to be completed. *Id.* at 20. Two published articles in The Journal of American Medical Association addressing the D & X procedure have also noted the lack of credible studies regarding the safety of the procedure. *See* Janet E. Gans Epner, et al., *Late-Term Abortion*, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26, 1998) ("In the absence of controlled studies, the relative advantages and disadvantages of the procedure in specific circumstances remain unknown."); M. LeRoy Sprang & Mark G. Neerhof, *Rationale for Banning Abortions Late in Pregnancy*, 280 J. Amer. Med. Ass'n 744 (Aug. 26, 1998) ("[N]o credible studies on intact D & X that evaluate or attest to its safety.").

[77] At the *Stenberg* trial, Dr. Stubblefield acknowledged that "the safety of the intact D & X procedure" has never "been studied to the point that it has been a medically-accepted fact that it is a safer abortion procedure." Brief of Petitioner at 39, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228615. Dr. Stubblefield's testimony was consistent with the State's lead expert witness, Dr. Boehm: "There's never been to my knowledge any studies that have compared the trauma to a woman's uterus, cervix, or other vital organs with either [the D & X or D & E] technique;" "No studies have been done to show [relative safety] . . . one compared to another;" and "[N]o one has ever done any research on partial-birth abortion and compared it to other procedures." Brief of Petitioner at 40, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228615.

[78] Dr. Stubblefield, who is familiar with Ob/Gyn residency programs around the country, has testified that he is not aware of any program that is teaching D & X abortions. *See* Brief of Amicus Curiae State of Wisconsin at 21, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228491.

This absence of any basis upon which to conclude that partial-birth abortions are safe has not gone unnoticed by the AMA, which has stated that partial-birth abortion is "not an accepted medical practice," that it has "never been subject to even a minimal amount of the normal medical practice development," that "the relative advantages and disadvantages of the procedure in specific circumstances remain unknown," and that "there is no consensus among obstetricians about its use."[79] The AMA has further noted that partial-birth abortion is broadly disfavored by both medical experts and the public, is "ethically wrong," and "is never the only appropriate procedure."[80] Thus, a select panel convened by the AMA could not find "any" identified circumstance where a partial birth abortion was "the only appropriate alternative."[81]

In order to underscore the depth of its opposition, the AMA explained that although it normally opposes criminal sanctions applied to the medical profession, "the profession has supported criminal restrictions on improper 'medical' procedures."[82] Although the AMA no longer supports the ban due to its opposition to criminal sanctions against physicians, it continues to oppose the procedure.[83] Additionally, the American College of Obstetricians and Gynecologists (ACOG), an organization which has consistently opposed legal restrictions on abortion, including partial-birth abortion bans, has reported, "A select panel convened by ACOG could identify no circumstances under which this [D & X] procedure . . .

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[79] *AMA Board of Trustees Fact Sheet on H.R. 1122*, Brief of Amici Curiae Association of American Physicians and Surgeons et al. appendix, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448.

[80] The "AMA supported H.R. 1122 because, in the Board's view, 'partial birth abortion' or intact D & X is ethically wrong, and it could not otherwise be restricted. Leaders of the profession like former Surgeon General C. Everett Coop and medical ethicist Edmund Pellegrino oppose use of the procedure, as do most physicians and most members of the public. In additional, AMA's expert panel, which included an ACOG representative, could not find 'any' identified circumstance where it was 'the only appropriate alternative.'" *Id.* "The procedure is ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb. The 'partial birth' gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body." *Id.*

[81] *AMA Board of Trustees Fact Sheet on H.R. 1122*, Brief of Amici Curiae Association of American Physicians and Surgeons et al. appendix, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448.

[82] *Id.* "H.R. 1122 is now a bill which impacts only a particular and broadly disfavored—both by experts and the public—abortion procedure. It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development . . . Indeed, the procedure differs materially from other abortion procedures which remain fully available in part because it involves the partially delivered body of the fetus which is outside of the womb." Statement of Nancy W. Dickey, M.D., Chair of the AMA Board of Trustees, *AMA Supports H.R. 1122 As Amended Partial-Birth Abortion Ban Act of 1997* (May 29, 1997), Brief of Amici Curiae Association of American Physicians and Surgeons et al. appendix, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448. "Although we also believe physicians should have broad discretion in medical matters, both this procedure and assisted suicide (as well as female genital mutilation and lobotomies) can and should be regulated if the profession won't do it. And since there are safe, and indeed safer, abortion alternatives, we supported the Santorum bill as amended." Letter regarding AMA support of H.R. 1122 "Partial-Birth Abortion Ban Act of 1997" from P. John Seward, M.D., AMA Executive Vice President, to The New York Times (May 30, 1997) (on file with the Subcomm. on the Constitution).

[83] "U.S. Senator . . . Santorum . . . has reintroduced a bill that would ban intact dilation and extraction. The American Medical Association (AMA) has previously stated our opposition to this procedure. We have not changed our position regarding the use of this procedure. The AMA has asked Sen. Santorum to remove the criminal sanctions from his bill, but such a change has not been made. For this reason we do not support the bill." Statement for Response Only, American Medical Association, (Oct. 21, 1999), Brief of Amici Curiae Association of American Physicians and Surgeons et al. at 24 n.53, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448.

would be the only option to save the life or preserve the health of the woman." [84]

Neither the plaintiff in *Stenberg* v. *Carhart*, Dr. Leroy Carhart, nor the experts who testified on his behalf, have identified a single circumstance during which a partial-birth abortion is necessary to preserve the health of a woman. In fact, according to Dr. Carhart's testimony, when he has chosen to perform partial-birth abortions he has done so based upon the happenstance of the presentation of the unborn child, not because it was the only procedure that would have preserved the health of the mother.[85] Thus, based on Dr. Carhart's testimony, the only interest served by a partial-birth abortion is the convenience of the doctor performing the abortion and not the preservation of the health of the mother.[86] Moreover, Dr. Martin Haskell, the physician credited with developing the partial-birth abortion procedure, has testified that he has never encountered a situation where a partial-birth abortion was medically necessary to achieve the desired outcome and, thus, is never medically necessary to preserve the health of a woman.[87]

According to *The Record*, the abortion providers at the Englewood, New Jersey abortion clinic that performs 1,500 partial-birth abortions per year stated that "only a 'minuscule amount' are for medical reasons." [88] The writings of both Dr. Haskell and Dr. McMahon also indicate that partial-birth abortion is the method they prefer for all late-term abortions.[89] Dr. Haskell told the *AMNews* that the vast majority of the partial-birth abortions he performs are elective. He stated: "And I'll be quite frank: most of my abortions are elective in that 20–24 week range. . . . In my particular case, probably 20% are for genetic reasons. And the other 80% are purely elective. . . ." [90]

In 1995, Dr. McMahon reported to the Constitution Subcommittee that of over 2,000 partial-birth abortions, only 9 percent

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[84] Brief of Petitioner at 35, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228615. ACOG filed a brief in opposition to Nebraska's PBA ban and has consistently opposed legislation to ban the partial-birth abortion procedure. See Brief of Amici Curiae Amici American College of Obstetricians and Gynecologists et al., *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 340117. ACOG later stated that "an intact D & X, however, may be the best or most appropriate procedure in a particular circumstance." *Carhart* v. *Stenberg*, 11 F. Supp.2d 1099, 1105 n.10 (D. Neb. 1998). When interviewed about the statement a D & X procedure "may" be best or most appropriate in some circumstances , ACOG President Fredric D. Frigoletto, Jr., "maintained that the [ACOG Executive] Board did not 'endorse' the procedure. 'There are no data to say that one of the procedures is safer than the other,' he said." Diane M. Gianelli, *Medicine Adds to Debate on Late-Term Abortions: ACOG Draws Fire for Saying Procedure "May" Be Best Option for Some*, 40 Amer. Med. News 1 (March 3, 1997).

[85] "Dr. Carhart (who insists the D & X procedure is performed to benefit the mother) testified that he never bothers to convert the child to a footfirst position to facilitate use of the procedure, but rather just takes the body however it presents itself." Brief of Petitioner at 45, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228615.

[86] "The only interest served by the partial-birth abortion procedure is the 'convenience' of the abortionist." *The Partial-Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the Senate Comm. on the Judiciary*, 104th Cong. (Nov. 17, 1995) (statement of Dr. Pamela Smith, Director of Medical Education in the Department of Obstetrics and Gynecology at Mt. Sinai Hospital in Chicago).

[87] "Haskell, who invented the D & X pocedure, admitted that the D & X procedure is never medically necessary to . . . preserve the health of a woman" *Planned Parenthood of Wisconsin v. Doyle*, 44 F. Supp.2d 975, 980 (W.D. Wis. 1999).

[88] Ruth Padawer, *The Facts on Partial-Birth Abortion*, The Record, Sept. 15, 1996, at RO–1.

[89] *See* Martin Haskell, M.D., *Dilation and Extraction for Late Second Trimester Abortions*, Presented at the National Abortion Federation Risk Management Seminar (September 13, 1992), *in* Second Trimester Abortion: From Every Angle, 1992 at 27; Letter from James T. McMahon, M.D., to the Subcomm. on the Constitution of the House Comm. on the Judiciary (June 23, 1995) (on file with the Subcomm. on the Constitution of the House Comm. on the Judiciary).

[90] Letter from Barbara Bolsen, Editor, American Medical News, to Congressman Charles T. Canady (July 11, 1995) (on file with the Subcomm. on the Constitution of the House Comm. on the Judiciary).

involved "maternal [health] indications," of which the most common was "depression."[91] Dr. McMahon also sent the Subcommittee a graph which shows the percentage of "flawed fetuses" that he aborted using the partial-birth abortion method. The graph shows that even at 26 weeks of gestation half the babies that Dr. McMahon aborted were perfectly healthy and many of the babies he described as "flawed" had conditions that were compatible with long life, either with or without a disability. For example, Dr. McMahon listed nine partial-birth abortions performed because the baby had a cleft lip.[92]

The fact of the matter is that the mainstream medical community has rejected the partial-birth abortion procedure because of concerns about its safety.[93] Leading proponents of partial-birth abortion acknowledge that it poses additional health risks because, among other things, the procedure requires a high degree of surgical skill to pierce the infant's skull with a sharp instrument in a blind procedure. Dr. Warren Hern has testified that he had "very serious reservations about this procedure" and that "he could not imagine a circumstance in which this procedure would be safest."[94] Although he was opposed to legislation banning partial-birth abortions "because he thinks Congress has no business dabbling in the practice of medicine and because he thinks this signifies just the beginning of a series of legislative attempts to chip away at abortion rights. . . ." He also stated: "You really can't defend it. I'm not going to tell somebody else that they should not do this procedure. But I'm not going to do it."[95] He has also stated, "I would dispute any statement that this is the safest procedure to use."[96] Dr. Pamela Smith has testified that "the only interest served by the partial-birth abortion procedure is the 'convenience' of the abortionist."[97] The procedure also poses the following additional health risks to the woman: an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term;[98] an increased risk of uterine rupture, abrup-

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[91] Letter from James T. McMahon, M.D., *supra* note 80.

[92] *See id.*

[93] "In the absence of controlled studies, the relative advantages and disadvantages of the procedure in specific circumstances remain unknown." Janet E. Gans Epner et al., *Late-Term Abortion*, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26, 1998).

[94] *The Partial-Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 Before the Senate Comm. on the Judiciary,* 104th Cong. (Nov. 17, 1995) (statement of Warren Hern, M.D.). Dr. Hern is an abortionist who specializes in late-term procedures and is the author of *Abortion Practice*, the nation's most widely used textbook on abortion standards and procedures. See Diane M. Gainelli, *Outlawing Abortion Method: Veto-Proof Majority in House Votes to Prohibit Later-Term Procedure*, 38 Amer. Med. News 1 (Nov. 20, 1995).

[95] Diane M. Gainelli, *Outlawing Abortion Method: Veto-Proof Majority in House Votes to Prohibit Later-Term Procedure*, 38 Amer. Med. News 1 (Nov. 20, 1995).

[96] *Id.*

[97] *See The Partial-Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 Before the Senate Comm. on the Judiciary,* 104th Cong. (Nov. 17, 1995) (statement Dr. Pamela Smith, Dir. of Medical Education in the Department of Obstetrics and Gynecology at Mt. Sinai Hospital in Chicago).

[98] "[S]ome physicians have suggested that the procedure may increase complications, such as cervical incompetence." Janet E. Gans Epner et al., *Late-Term Abortion*, 280 J. Amer. Med. Ass'n724, 726 (Aug. 26, 1998). *See also* Brief of Amici Curiae Association of American Physicians and Surgeons et al. at 21, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448. The threat of cervical incompetence is related to the amount of cervical dilation. A. Golan, et al., *Incompetence of the Uterine Cervix*, 44 Obstet. Gynecol. Surv. 96–107 (1989). Dr. Stubblefield testified that at the same week of gestation, "the D & X requires greater dilation" than the D & E procedure which supports the conclusion that a D & X procedure brings with it the risk of cervical incompetence and an increased risk that a woman's membranes may

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tion, amniotic fluid embolus, and trauma to the uterus as a result of converting the child to a footling breech position, a procedure which, according to Williams Obstetrics, a leading obstetrics textbook, "there are very few, if any, indications for . . . other than for delivery of a second twin";[99] and a risk of iatrogenic lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death.[100] This also creates a high risk of infection should she suffer a laceration due to the non-sterile vaginal environment.[101]

Proponents of partial-birth abortion argue that, notwithstanding all of the evidence indicating that the procedure has not been proven safe, effective, or necessary, any ban on the procedure should include a health exception because it *may*, in some unidentifiable circumstance, be the safer procedure for a given women. The problem with this argument, however, is the abortionists have indicated that they will certify that *any* pregnancy poses risks to a woman's health. Dr. Warren Hern of Colorado, the author of the standard textbook on abortion procedures who also performs many third-trimester abortions has stated: "I will certify that any pregnancy is a threat to a woman's life and could cause grievous injury to her physical health."[102] Thus, including a health exception in the ban would render the ban meaningless, as it would not prohibit a *single* partial-birth abortion.

Opponents of the partial-birth abortion ban have also criticized the legislation's use of the term "partial-birth abortion," citing the absence of the term partial-birth abortion in medical literature. However, the term partial-birth abortion is a legal term defined clearly in H.R. 4965 as any abortion in which the person performing the abortion "deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal had is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus." This term is sufficiently precise to address the *Stenberg* Court's concern that the definition of the prohibited procedure clearly track the medical differences between a partial-birth abortion and other abortion procedures in which the act leading to death occurs in the uterus.

The use of this term in the legislation was necessitated by the fact that the partial-birth abortion procedure was not recognized in the medical community and has been called by various names by

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rupture. *See* Brief of Amicus Curiae State of Wisconsin at 21, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228615.

[99] Janet E. Gans Epner et al., *Late-Term Abortion*, 280 J. Amer. Med. Ass'n 724, 744–45 (Aug. 26, 1998). *See also* Diane M. Gainelli, *Outlawing Abortion Method: Veto-Proof Majority in House Votes to Prohibit Later-Term Procedure*, 38 Amer. Med. News 1 (Nov. 20, 1995) (quoting Dr. Warren Hern describing the act of turning the fetus to a breech position as being "potentially dangerous" because "[y]ou have to be concerned about causing amniotic fluid embolism or placental abruption if you do that.").

[100] Janet E. Gans Epner et al., *Late-Term Abortion*, 280 J. Amer. Med. Ass'n 724, 744–45 (Aug. 26, 1998).

[101] Brief of Amici Curiae Association of American Physicians and Surgeons et al. 25–6, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448.

[102] Ruth Padawer, *Clinton May Back Abortion Measure*, The Record, May 14, 1997.

the abortionists who invented and practice it, including "dilation and extraction," "intact dilation and evacuation," and "intrauterine cranial decompression." Just as the term partial-birth abortion was not found in medical literature, these terms were not found in medical literature because these horrific procedures were considered to be "bad medicine" by the medical community.

In fact, Dr. Pamela Smith, an obstetrician at Mt. Sinai Hospital in Chicago, testified before the Subcommittee on the Constitution that when she described the procedure to other physicians, "many of them were horrified to learn that such a procedure was even legal."[103] Dr. Smith also stated:

> [T]here is no uniformly accepted medical terminology for the method that is the subject of this legislation. Dr. McMahon does not even use the same term as Dr. Haskell, while the National Abortion Federation implausibly argues that there is nothing to distinguish this procedure from the D & E abortions. The term you have chosen, 'partial-birth abortion,' is straightforward.[104]

There are also alternative abortion procedures that are proven safer (though not necessarily safe) than partial-birth abortion. Nationwide, the testimony in partial-birth abortion cases establishes that the D & E abortion procedure is a safer alternative procedure.[105] Dr. Frank Boehm testified that banning the partial-birth abortion procedure would not enhance or increase the risk to women of amniotic fluid embolus.[106] He also testified that where an unborn child has severe hydrocephaly, which causes the head to be too large to pass through the cervix, he would use an ultrasound-guided cepholocentis procedure to "drain the ventricles of the amniotic fluid to allow the head to slip through the cervix."[107] A ban will not force a woman seeking an abortion to undergo an "alternative procedure which would create a higher risk of harm to her uterus, cervix, or internal organs" because abortionists have "been performing abortions for years on women safely with other techniques, and we don't have any data that would say that another technique such as partial-birth abortion is any safer."[108]

Those opposed to the passage of H.R. 4965 continue to assert that the government should not be in the examination room regulating physicians in the performance of their job. Yet the law follows every physician through the performance of every aspect of their job in the form of tort law. Every aspect of the practice of medicine is regulated by traditional standards of negligence that have been adapted to serve the medical profession in the form of

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[103] *Hearing on Partial-Birth Abortion Before the Subcomm. on the Constitution of the House Comm. on the Judiciary,* 104th Cong., 1st Sess., (1995) (testimony of Pamela Smith, M.D., FACOG).

[104] *Id.*

[105] *Evans* v. *Christensen*, 977 F. Supp. 1283, 1294 (E.D. Mich. 1997) (testimony by five doctors that "the D & E procedure is a safe procedure"); *Planned Parenthood of Southern Arizona Inc.* v. *Woods*, 982 F. Supp. 1369, 1376 (D. Ariz. 1997) (finding of fact by the district court that D & E is a safe, medically acceptable abortion method in the second trimester); Doyle, 9 F. Supp. At 1045 (D & E is a "safe procedure"). *See also id.* at 1376 (finding of fact that induction is safe, medically acceptable abortion method in the second trimester); *Planned Parenthood of Greater Iowa* v. *Miller*, 1 F. Supp.2d 958 (S.D. Iowa 1998) (induction is a safe, routinely performed procedure after 15 weeks).

[106] Brief of Petitioner at 37, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228615.

[107] *Id.* at 38.

[108] Dr. Frank Boem *quoted in id.* at 42.

medical malpractice. Under these rules, a "doctor must have and use the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing; and a doctor will be liable if harm results because he does not have them." [109] Thus, the law measures every aspect of a physician's medical practice against what is considered, "'good medical practice,' which is to say, what is customary and usual in the profession." [110]

Even when there is disagreement within an area of speciality as to alternative methods of acceptable treatment a physician is still required to offer the level of medical care consistent with the tenets of the school the doctor professes to follow.[111] Even this, however, does not entitle a physician to provide medical care with no proven benefits. As *Prosser and Keeton* state, "this does not mean, however, that any quack, charlatan or crackpot can set himself up as a 'school,' and so apply his individual ideas without liability. A school must be a recognized one within definite principles, and it must be the line of thought of a respectable majority of the profession." [112] Thus, a physician's medical decision-making has always been subject to legal oversight and the threat of legal liability for negligently rendered medical series is a regular aspect of the practice of medicine.

Furthermore, there are some procedures so abhorrent to society that they have been severely restricted or banned. For example, in 1996, Congress approved a ban on female genital mutilation under which anyone who "knowingly circumcises, excises, or infibulates the whole or any part of" the genitals of a woman who has not attained the age of 18 years will be fined or imprisoned not more than 5 years, or both. In 1997, the American Medical Association noted the appropriateness of this ban stating, "the profession has supported criminal restrictions on improper 'medical' procedures, such as female genital mutilation." [113]

In addition to promoting maternal health, such a prohibition will draw a bright line that clearly distinguishes abortion and infanticide, that preserves the integrity of the medical profession, and promotes respect for human life. Based upon *Roe* v. *Wade*,[114] and *Planned Parenthood* v. *Casey*,[115] the government's interest in protecting the life of a child in the process of being born arises, in part, by virtue of the fact that during a partial-birth abortion, labor is induced and the birth process has begun. This distinction was recognized in Roe when the Court noted, without comment, that the Texas parturition statute, which prohibited one from killing a child "in a state of being born and before actual birth," was not under attack.[116] This interest becomes compelling as the child emerges from the maternal body. A child that is completely born is a full, legal person entitled to constitutional protections afforded a "person" under the United States Constitution. Partial-birth abortions involve the killing of a child that is in the process, in fact

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[109] W. Page Keeton, *Prosser and Keeton on The Law of Torts* 187 (5th ed. 1984).
[110] *Id.* at 189.
[111] *See id.* at 187.
[112] *Id.*
[113] *AMA Board of Trustees Fact Sheet on H.R. 1122,* Brief of Amici Curiae association of American Physicians and Surgeons et al. appendix, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448.
[114] 410 U.S. 113 (1973).
[115] 505 U.S. 833 (1992).
[116] *Roe* v. *Wade*, 410 U.S. 113, 118 n.1 (1973).

mere inches away from, becoming a "person." While under these two rulings a pregnancy may be terminated, partial-birth abortion should not implicate this right because the pregnancy ended once the birth process began and the right to terminate one's pregnancy by aborting one's unborn child does not include an independent right to assure the death of that child regardless of its location to its mother. Thus, the government has a heightened interest in protecting the life of the partially-born child.

This, too, has not gone unnoticed by the American Medical Association which has recognized that partial-birth abortions are "ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb." Thus, the "'partial birth' gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body." [117]

Partial-birth abortion also confuses the medical, legal, and ethical duties of physicians to preserve and promote life. As a partial-birth abortion begins, a significant portion of the child's body, the lower extremities and torso except for the head, emerges from the womb, and the doctor is, by all appearances, acting as an obstetrician delivering a child. At this point, however, the physician performs an act quite contrary to the obstetrical role by stabbing the base of the skull of the living, almost-born child with a pair of scissors, spreading the scissors to enlarge the opening, inserting a suction catheter, and evacuating the contents of the almost-born, now-deceased, child. Thus, the physician acts directly against the physical life of a child, whom he or she had just delivered all but the head out of the womb, in order to end that life. Partial-birth abortion thus appropriates the terminology and techniques used by obstetricians in the delivery of living children—obstetricians who preserve and protect the life of the mother *and* the child—and instead uses those techniques to end the life of the partially-born child. Thus, by aborting a child in a manner that purposefully seeks to kill a child after he or she has begun the process of birth, partial-birth abortion undermines the public's perception of the appropriate role of a physician during the delivery process and perverts a process during which life is brought into the world in order to destroy a near-breathing child.

The gruesome and inhumane nature of the partial-birth abortion procedure and its disturbing similarity to the killing of a newborn promotes a complete disregard for infant human life that can only be countered by a prohibition of the procedure. According to Dr. Haskell, the vast majority of babies killed during a partial-birth abortion are alive until the end of the procedure.[118] It is a medical

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[117] "The procedure is ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb. The 'partial birth' gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body." *AMA Board of Trustees Fact Sheet on H.R. 1122,* Brief of Amici Curiae Association of American Physicians and Surgeons et al. appendix, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448.

[118] Responding to an interviewer's questioning, "Let's talk first about whether or not the fetus is dead beforehand . . ." Dr. Haskell responded "No it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress—intrauterine stress during, you know, the two days that the cervix is being dilated. Sometimes the membranes rupture and it takes a very small superficial infection to kill a fetus in utero when the membranes are broken. And so in my case, I would think probably about a third of those are definitely are (sic) dead before I actually start to remove the fetus. And probably the other two-thirds are not."

Continued

fact, however, that unborn infants can feel pain when subjected to painful stimuli and that their perception of this pain is more intense than that of newborn infants and older children when subjected to the same stimuli.[119] Thus, during a partial-birth abortion procedure, the child will fully experience the pain associated with piercing his or her skull and sucking out his or her brain.

Nor will a child upon whom a partial-birth abortion is being performed be significantly affected by medication administered to the mother during the performance of the procedure. As credible testimony received by the Subcommittee on the Constitution confirms, "[c]urrent methods for providing maternal anesthesia during 'partial-birth abortions' are unlikely to prevent the experience of pain and stress" that the child will feel during the procedure.[120] Thus, claims that a child is almost certain to be either dead or unconscious and near death prior to the commencement of the partial-birth are unsubstantiated.

Implicitly approving such a brutal and inhumane procedure by choosing not to prohibit it will further coarsen society to the humanity of, not only newborns, but all vulnerable and innocent human life making it increasingly difficult to protect such life. Thus, Congress has a compelling interest in acting—indeed it must act—to prohibit this inhumane procedure.

For these reasons, Congress has made its own independent findings that: partial-birth abortion is never medically indicated to preserve the life or health of the mother; is in fact unrecognized as a valid abortion procedure by the mainstream medical community; poses additional health risks to the mother; blurs the line between abortion and infanticide in the killing of a partially-born child just inches from complete birth; and confuses the role of the physician in childbirth and should, therefore, be banned.

HEARINGS

The Committee's Subcommittee on the Constitution held a hearing on H.R. 4965 on July 9, 2002. Testimony was received from four witnesses: Dr. Kathi Aultman, M.D.; Dr. Curtis Cook, M.D.; Professor Robert A. Destro, Professor of Law, Columbus School of Law at the Catholic University of America; and Simon Heller, Consulting Attorney with the Center for Reproductive Law and Policy, with additional material submitted by Dr. Kathi Aultman M.D.; Dr. Curtis Cook, M.D.; the Center for Reproductive Law and Policy; Rep. Steve Chabot; and Rep. Randy Forbes.

COMMITTEE CONSIDERATION

On July 11, 2002, the Subcommittee on the Constitution met in open session and ordered favorably reported the bill H.R. 4965, by a vote of 8 to 3, a quorum being present. On July 17, 2002, the Committee met in open session and ordered favorably reported the

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Partial-Birth Abortion: The Truth, Joint Hearing on S. 6 and H.R. 929 Before the House Comm. on the Judiciary Subcomm. on the Constitution and the Senate Comm. on the Judiciary, 105th Cong. 61 (March 11, 1997).

[119] *Effects of Anesthesia During a Partial-Birth Abortion: Hearing Before the House Comm. on the Judiciary Subcomm. on the Constitution,* 104th Cong. (March 21, 1996) (statement of Jean A. Wright).

[120] *Id.*

bill H.R. 4965 without amendment by a recorded vote of 20 to 8 a quorum being present.

VOTE OF THE COMMITTEE

The Committee considered the following amendments.

1. An amendment was offered by Ms. Baldwin and Ms. Jackson Lee to H.R. 4965 providing an exception for partial-birth abortions "performed before fetal viability, or to a partial-birth abortion performed after fetal viability where necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." The amendment was defeated by at 10–18 rollcall vote.

ROLLCALL NO. 1

	Ayes	Nays	Present
Mr. Hyde		X	
Mr. Gekas		X	
Mr. Coble			
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte			
Mr. Chabot		X	
Mr. Barr		X	
Mr. Jenkins		X	
Mr. Cannon		X	
Mr. Graham		X	
Mr. Bachus		X	
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller		X	
Mr. Issa		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence			
Mr. Forbes		X	
Mr. Conyers			
Mr. Frank	X		
Mr. Berman			
Mr. Boucher			
Mr. Nadler			
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren	X		
Ms. Jackson Lee	X		
Ms. Waters	X		
Mr. Meehan			
Mr. Delahunt			
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff	X		
Mr. Sensenbrenner, Chairman		X	
Total	10	18	

2. An amendment was offered by Mr. Hostettler to H.R. 4965 that would, pursuant Congress's power to limit appellate jurisdiction under Article III, section 2 of the United States Constitution, remove the Supreme Court's appellate jurisdiction over a case or controversy arising from this Act was. The amendment was defeated by a voice vote.

3. An amendment was offered by Mr. Frank to H.R. 4965 that would provide an exception for partial-birth abortions "performed

before viability where necessary, in appropriate medical judgment, for the preservation of the life or health of the mother, or to such a procedure performed after fetal viability if it is to protect the mother from serious, adverse physical health consequences." The amendment was defeated by a voice vote.

4. An amendment was offered by Mr. Pence to H.R. 4965 that would increase the maximum prison sentence from 2 years to 10 years. The amendment was withdrawn.

5. An amendment was offered by Ms. Jackson Lee to H.R. 4965 that would strike the civil cause of action. The amendment was defeated by a voice vote.

6. An amendment was offered by Ms. Baldwin to H.R. 4965 that would strike the congressional findings of fact. The amendment was defeated by a voice vote.

7. An amendment in the nature of a substitute was offered by Mr. Scott that would ban all post viability abortions except those abortions that in the medical judgment of the attending physician were necessary to preserve the life of the woman or to avert serious adverse health consequences to the woman. The amendment was defeated by a voice vote.

8. An amendment was offered by Ms. Jackson Lee striking the penalties for performing a partial-birth abortion. The amendment was defeated by an 8–19 rollcall vote.

ROLLCALL NO. 2

	Ayes	Nays	Present
Mr. Hyde		X	
Mr. Gekas			
Mr. Coble		X	
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte		X	
Mr. Chabot		X	
Mr. Barr		X	
Mr. Jenkins			
Mr. Cannon		X	
Mr. Graham		X	
Mr. Bachus		X	
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller		X	
Mr. Issa		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence		X	
Mr. Forbes		X	
Mr. Conyers			
Mr. Frank	X		
Mr. Berman			
Mr. Boucher			
Mr. Nadler			
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren	X		
Ms. Jackson Lee	X		
Ms. Waters	X		
Mr. Meehan			
Mr. Delahunt			
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner			

ROLLCALL NO. 2—Continued

	Ayes	Nays	Present
Mr. Schiff			
Mr. Sensenbrenner, Chairman		X	
Total	8	19	

9. Final Passage. The motion to report favorably the bill H.R. 4965 was agreed to by a rollcall vote of 20 to 8.

ROLLCALL NO. 3

	Ayes	Nays	Present
Mr. Hyde	X		
Mr. Gekas	X		
Mr. Coble	X		
Mr. Smith (Texas)	X		
Mr. Gallegly	X		
Mr. Goodlatte	X		
Mr. Chabot	X		
Mr. Barr	X		
Mr. Jenkins			
Mr. Cannon	X		
Mr. Graham	X		
Mr. Bachus	X		
Mr. Hostettler	X		
Mr. Green	X		
Mr. Keller	X		
Mr. Issa	X		
Ms. Hart	X		
Mr. Flake	X		
Mr. Pence	X		
Mr. Forbes	X		
Mr. Conyers			
Mr. Frank		X	
Mr. Berman			
Mr. Boucher			
Mr. Nadler			
Mr. Scott		X	
Mr. Watt		X	
Ms. Lofgren		X	
Ms. Jackson Lee		X	
Ms. Waters		X	
Mr. Meehan			
Mr. Delahunt			
Mr. Wexler		X	
Ms. Baldwin		X	
Mr. Weiner			
Mr. Schiff			
Mr. Sensenbrenner, Chairman	X		
Total	20	8	

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee reports that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the descriptive portions of this report.

PERFORMANCE GOALS AND OBJECTIVES

H.R. 4965 does not authorize funding. Therefore, clause 3(c) of rule XII of the Rules of the House of Representatives is inapplicable.

NEW BUDGET AUTHORITY AND TAX EXPENDITURES

Clause 3(c)(2) of House rule XIII is inapplicable because this legislation does not provide new budgetary authority or increased tax expenditures.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the Committee sets forth, with respect to the bill, H.R. 4965, the following estimate and comparison prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 19, 2002.

Hon. F. JAMES SENSENBRENNER, Jr., *Chairman,*
Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4965, the Partial-Birth Abortion Ban Act of 2002.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Mark Grabowicz (for Federal costs), who can be reached at 226–2860, and Paige Piper/Bach (for the impact on the private sector), who can be reached at 226–2940.

Sincerely,

DAN L. CRIPPEN, *Director.*

Enclosure

cc: Honorable John Conyers, Jr.
Ranking Member

H.R. 4965—Partial-Birth Abortion Ban Act of 2002.

CBO estimates that implementing H.R. 4965 would not result in any significant cost to the Federal Government. Enacting H.R. 4965 could affect direct spending and receipts; therefore, pay-as-you-go procedures would apply to the bill, but CBO estimates that any such effects would not be significant.

H.R. 4965 would ban most instances of a late-term abortion procedure known as "partial-birth abortion." Violators of the bill's provisions would be subject to a criminal fine or imprisonment. Because the bill would establish a new Federal crime, the government would be able to pursue cases it otherwise would not be able to prosecute. However, CBO expects that any increase in costs for law enforcement, court proceedings, or prison operations would not be significant because of the small number of cases likely to be affected. Any such additional costs would be subject to the availability of appropriated funds.

Because those prosecuted and convicted under H.R. 4965 could be subject to criminal fines, the Federal Government might collect additional fines if the bill is enacted. Collections of such fines are recorded in the budget as governmental receipts (revenues), which are deposited in the Crime Victims Fund and later spent. CBO expects that any additional receipts and direct spending would be negligible because of the small number of cases involved.

H.R. 4965 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on State, local, or tribal governments. H.R. 4965 would impose a private-sector mandate as defined by UMRA by prohibiting physicians from performing "partial-birth abortions," except when necessary to save the life of a mother. The direct costs of the mandate would be measured as the net income forgone by physicians and clinics. Based on information from industry sources and nongovernmental organizations, CBO expects that the direct cost of the mandate would fall below the annual threshold established by UMRA for private-sector mandates ($115 million in 2002, adjusted annually for inflation).

The CBO staff contacts for this estimate are Mark Grabowicz (for Federal costs), who can be reached at 226–2860, and Paige Piper/Bach (for the impact on the private sector), who can be reached at 226–2940. This estimate was approved by Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds the authority for this legislation in article I, section 8, clause 3 of the Constitution.

SECTION-BY-SECTION ANALYSIS AND DISCUSSION

H.R. 4965 prohibits the procedure commonly known as partial-birth abortion.

Section 1. Short Title. This section states that the short title of this bill is the "Partial-Birth Abortion Ban Act of 2002."

Section 2. Findings. In paragraph (1) Congress finds that a moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion—an abortion in which a physician delivers an unborn child's body until only the head remains inside the womb, punctures the back of the child's skull with a sharp instrument, and sucks the child's brains out before completing delivery of the dead infant—is a gruesome and inhumane procedure that is never medically necessary and should be prohibited.

In paragraph (2) Congress finds that rather than being an abortion procedure that is embraced by the medical community, particularly among physicians who routinely perform other abortion procedures, partial-birth abortion remains a disfavored procedure that is not only unnecessary to preserve the health of the mother, but in fact poses serious risks to the long-term health of women and in some circumstances, their lives. Congress also finds that as a result, at least 27 States banned the procedure as did the United States Congress which voted to ban the procedure during the 104th, 105th, and 106th Congresses.

In paragraph (3) Congress finds that in *Stenberg* v. *Carhart*,[121] the United States Supreme Court opined "that significant medical authority supports the proposition that in some circumstances, [partial birth abortion] would be the safest procedure" for pregnant women who wish to undergo an abortion. Congress also finds that as a result of having reached this conclusion the Court struck down the State of Nebraska's ban on partial-birth abortion procedures, concluding that it placed an "undue burden" on women seeking abortions because it failed to include an exception for partial-birth abortions deemed necessary to preserve the "health" of the mother.

In paragraph (4) Congress finds that in reaching this conclusion, the Court deferred to the Federal district court's factual findings that the partial-birth abortion procedure was statistically and medically as safe as, and in many circumstances safer than, alternative abortion procedures.

In paragraph (5) Congress finds that the great weight of evidence presented at the *Stenberg* trial and other trials challenging partial-birth abortion bans, as well as at extensive Congressional hearings, demonstrates that a partial-birth abortion is never necessary to preserve the health of a woman, poses significant health risks to a woman upon whom the procedure is performed, and is outside of the standard of medical care.

In paragraph (6) Congress finds that despite the dearth of evidence in the *Stenberg* trial court record supporting the district court's findings, the United States Court of Appeals for the Eighth Circuit and the Supreme Court refused to set aside the district court's factual findings because, under the applicable standard of appellate review, they were not "clearly erroneous." Congress also finds that a finding of fact is clearly erroneous "when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed."[122] Congress also finds that under this standard, "if the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently."[123]

In paragraph (7) Congress finds that in *Stenberg*, the United States Supreme Court was required to accept the very questionable findings issued by the district court judge—the effect of which was to render null and void the reasoned factual findings and policy determinations of the United States Congress and at least 27 State legislatures.

In paragraph (8) Congress finds that under well-settled Supreme Court jurisprudence, it is not bound to accept the same factual findings that the Supreme Court was bound to accept in *Stenberg* under the "clearly erroneous" standard. Congress also finds that it is entitled to reach its own factual findings—findings that the Supreme Court accords great deference—and to enact legislation based upon these findings so long as it seeks to pursue a legitimate interest that is within the scope of the Constitution, and draws reasonable inferences based upon substantial evidence.

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[121] 530 U.S. 914, 932 (2000).
[122] *Anderson v. City of Bessemer, North Carolina,* 470 U.S. 564, 573 (1985).
[123] *Id.* at 574.

In paragraph (9) Congress finds that in *Katzenbach* v. *Morgan*,[124] the Supreme Court articulated its highly deferential review of Congressional factual findings when it addressed the constitutionality of section 4(e) of the Voting Rights Act of 1965. Regarding Congress' factual determination that section 4(e) would assist the Puerto Rican community in "gaining nondiscriminatory treatment in public services," the Court stated that "[i]t was for Congress, as the branch that made this judgment, to assess and weigh the various conflicting considerations. . . . It is not for us to review the congressional resolution of these factors. It is enough that we be able to perceive a basis upon which the Congress might resolve the conflict as it did. There plainly was such a basis to support section 4(e) in the application in question in this case." [125]

In paragraph (10) Congress finds that *Katzenbach*'s highly deferential review of Congress's factual conclusions was relied upon by the United States District Court for the District of Columbia when it upheld the "bail-out" provisions of the Voting Rights Act of 1965, (42 U.S.C. 1973c), stating that "congressional fact finding, to which we are inclined to pay great deference, strengthens the inference that, in those jurisdictions covered by the Act, state actions discriminatory in effect are discriminatory in purpose." [126]

In paragraph (11) Congress finds that the Court continued its practice of deferring to congressional factual findings in reviewing the constitutionality of the must-carry provisions of the Cable Television Consumer Protection and Competition Act of 1992.[127] Congress finds that at issue in the *Turner* cases was Congress' legislative finding that, absent mandatory carriage rules, the continued viability of local broadcast television would be "seriously jeopardized." Congress finds that the *Turner I* Court recognized that as an institution, "Congress is far better equipped than the judiciary to 'amass and evaluate the vast amounts of data' bearing upon an issue as complex and dynamic as that presented here." [128] Although the Court recognized that "the deference afforded to legislative findings does 'not foreclose our independent judgment of the facts bearing on an issue of constitutional law,'" its "obligation to exercise independent judgment when First Amendment rights are implicated is not a license to reweigh the evidence de novo, or to replace Congress' factual predictions with our own. Rather, it is to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence." [129]

In paragraph (12) Congress finds that 3 years later in *Turner II*, the Court upheld the "must-carry" provisions based upon Congress' findings, stating the Court's "sole obligation is 'to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.'" [130] Congress finds that, citing its ruling in *Turner I*, the Court reiterated that "[w]e owe Congress' findings deference in part because the institution 'is far bet-

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[124] 384 U.S. 641 (1966).
[125] *Id.* at 653.
[126] *City of Rome, Georgia* v. *U.S.,* 472 F. Supp. 221 (D. D. Col. 1979) *aff'd City of Rome, Georgia* v. *U.S.*, 446 U.S. 156 (1980).
[127] *See Turner Broadcasting System, Inc.* v. *Federal Communications Commission, 512 U.S. 622 (1994) (Turner I)* and *Turner Broadcasting System, Inc.* v. *Federal Communications Commission*, 520 U.S. 180 (1997) *(Turner II)*.
[128] 512 U.S. at 665–66.
[129] *Id.* at 666.
[130] 520 U.S. at 195.

ter equipped than the judiciary to "amass and evaluate the vast amounts of data" bearing upon' legislative questions,"[131] and added that it "owe[d] Congress' findings an additional measure of deference out of respect for its authority to exercise the legislative power."[132]

In paragraph (13) Congress finds that there exists substantial record evidence upon which Congress has reached its conclusion that a ban on partial-birth abortion is not required to contain a 'health' exception, because the facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care. Congress also finds that it was informed by extensive hearings held during the 104th and 105th Congresses and passed a ban on partial-birth abortion in the 104th, 105th, and 106th Congresses. Congress finds that these findings reflect its very informed judgment that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care, and should, therefore, be banned.

In paragraph (14) Congress, pursuant to the testimony received during extensive legislative hearings during the 104th and 105th Congresses, lists its declarations regarding the relative health and safety of a partial-birth abortion:

In paragraph (14)(A) Congress declares that a partial-birth abortion poses serious risks to the health of a woman undergoing the procedure. Those risks include, among other things: an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term; an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting the child to a footling breech position, a procedure which, according to a leading obstetrics textbook, "there are very few, if any, indications for . . . other than for delivery of a second twin"; and a risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death.

In paragraph (14)(B) Congress declares that there is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures. Congress also declares that no controlled studies of partial-birth abortions have been conducted nor have any comparative studies been conducted to demonstrate its safety and efficacy compared to other abortion methods. Congress further declares that there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures. Congress also declares that unlike other more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the instruction in partial-birth abortions in their curriculum.

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[131] *Id.* at 195
[132] *Id.* at 196.

In paragraph (14)(C) Congress declares that a prominent medical association has concluded that partial-birth abortion is "not an accepted medical practice," that it has "never been subject to even a minimal amount of the normal medical practice development," that "the relative advantages and disadvantages of the procedure in specific circumstances remain unknown," and that "there is no consensus among obstetricians about its use." The association has further noted that partial-birth abortion is broadly disfavored by both medical experts and the public, is "ethically wrong," and "is never the only appropriate procedure."

In paragraph (14)(D) Congress declares that neither the plaintiff in *Stenberg* v. *Carhart*, nor the experts who testified on his behalf, have identified a single circumstance during which a partial-birth abortion was necessary to preserve the health of a woman.

In paragraph (14)(E) Congress declares that the physician credited with developing the partial-birth abortion procedure has testified that he has never encountered a situation where a partial-birth abortion was medically necessary to achieve the desired outcome and, thus, is never medically necessary to preserve the health of a woman.

In paragraph (14)(F) Congress declares that a ban on the partial-birth abortion procedure will advance the health interests of pregnant women seeking to terminate a pregnancy.

In paragraph (14)(G) Congress declares that in light of this overwhelming evidence, Congress and the States have a compelling interest in prohibiting partial-birth abortions. Congress also declares that in addition to promoting maternal health, such a prohibition will draw a bright line that clearly distinguishes abortion and infanticide, that preserves the integrity of the medical profession, and promotes respect for human life.

In paragraph (14)(H) Congress declares that based upon *Roe* v. *Wade*,[133] and *Planned Parenthood* v. *Casey*,[134] a governmental interest in protecting the life of a child during the delivery process arises, in part, by virtue of the fact that during a partial-birth abortion, labor is induced and the birth process has begun. Congress further declares that this distinction was recognized in Roe when the Court noted, without comment, that the Texas parturition statute, which prohibited one from killing a child "in a state of being born and before actual birth," was not under attack. Congress declares that this interest becomes compelling as the child emerges from the maternal body. Congress declares that a child that is completely born is a full, legal person entitled to constitutional protections afforded a "person" under the United States Constitution. Congress declares that partial-birth abortions involve the killing of a child that is in the process, in fact mere inches away from, becoming a "person." Thus, the government has a heightened interest in protecting the life of the partially-born child.

In paragraph (14)(I) Congress declares that the distinction between a partial-birth abortion and other abortion methods has been recognized by the medical community, where a prominent medical association has recognized that partial-birth abortions are "ethically different from other destructive abortion techniques because

[133] 410 U.S. 113 (1973).
[134] 505 U.S. 833 (1992).

the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb." According to this medical association, the "'partial birth' gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body."

In paragraph (14)(J) Congress declares that a partial-birth abortion also confuses the medical, legal, and ethical duties of physicians to preserve and promote life, as the physician acts directly against the physical life of a child, whom he or she had just delivered, all but the head, out of the womb, in order to end that life. Congress further declares that a partial-birth abortion thus appropriates the terminology and techniques used by obstetricians in the delivery of living children—obstetricians who preserve and protect the life of the mother and the child—and instead uses those techniques to end the life of the partially-born child.

In paragraph (14)(K) Congress declares that by aborting a child in the manner that purposefully seeks to kill the child after he or she has begun the process of birth, partial-birth abortion undermines the public's perception of the appropriate role of a physician during the delivery process, and perverts a process during which life is brought into the world, in order to destroy a partially-born child.

In paragraph (14)(L) Congress declares that the gruesome and inhumane nature of the partial-birth abortion procedure and its disturbing similarity to the killing of a newborn infant promotes a complete disregard for infant human life that can only be countered by a prohibition of the procedure.

In paragraph (14)(M) Congress declares that the vast majority of babies killed during partial-birth abortions are alive until the end of the procedure. Congress further declares that it is a medical fact, however, that unborn infants at this stage can feel pain when subjected to painful stimuli and that their perception of this pain is even more intense than that of newborn infants and older children when subjected to the same stimuli. Thus, during a partial-birth abortion procedure, the child will fully experience the pain associated with piercing his or her skull and sucking out his or her brain.

In paragraph (14)(N) Congress declares that implicitly approving such a brutal and inhumane procedure by choosing not to prohibit it will further coarsen society to the humanity of not only newborns, but all vulnerable and innocent human life, making it increasingly difficult to protect such life. Congress further declares that as a result it has a compelling interest in acting—indeed it must act—to prohibit this inhumane procedure.

In paragraph (14)(O) Congress declares that for these reasons, it finds that partial-birth abortion is never medically indicated to preserve the health of the mother; is in fact unrecognized as a valid abortion procedure by the mainstream medical community; poses additional health risks to the mother; blurs the line between abortion and infanticide in the killing of a partially-born child just inches from birth; and confuses the role of the physician in childbirth and should, therefore, be banned.

Section 3. Prohibition on Partial-Birth Abortions. This section amends title 18 of the United States Code by inserting after chapter 73 the following:

Subsection (a) prohibits any physician from, in or affecting interstate or foreign commerce, knowingly performing a partial-birth abortion and thereby killing a human fetus. A physician who does so shall be fined under this title or imprisoned not more than 2 years, or both. This paragraph does not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself. This paragraph takes effect 1 day after the enactment.

Subsection (b)(1) defines a "partial-birth abortion" as an abortion in which the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and then performs the overt act, other than completion of delivery, that kills the partially delivered living fetus.

Subsection (b)(2) defines the term "physician" as a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the doctor performs such activity, or any other individual legally authorized by the State to perform abortions: Provided, however, that any individual who is not a physician or not otherwise legally authorized by the State to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions of this section.

Subsection (c)(1) provides for a civil cause of action for the father, if married to the mother at the time she receives a partial-birth abortion procedure, and if the mother has not attained the age of 18 years at the time of the abortion, the maternal grandparents of the fetus, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

Subsection (c)(2) provides that such relief shall include money damages for all injuries, psychological and physical, occasioned by the violation of this section; and statutory damages equal to three times the cost of the partial-birth abortion.

Subsection (d)(1) allows a defendant accused of an offense under this section to seek a hearing before the State Medical Board on whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

Subsection (d)(2) provides that the findings on that issue are admissible on that issue at the trial of the defendant.

It also provides that upon a motion of the defendant, the court shall delay the beginning of the trial for not more than 30 days to permit such a hearing to take place.

Subsection (e) provides that a woman upon whom a partial-birth abortion is performed may not be prosecuted under this section, for a conspiracy to violate this section, or for an offense under section 2, 3, or 4 of this title based on a violation of this section.

Subsection (b) is a clerical amendment to insert the new chapter in the table of chapters for part I of title 18, after the item relating to chapter 73.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italics and existing law in which no change is proposed is shown in roman):

TITLE 18, UNITED STATES CODE

* * * * * * *

PART I—CRIMES

CHAPTER 74—PARTIAL-BIRTH ABORTIONS

§ 1531. Partial-birth abortions prohibited

(a) Any physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than 2 years, or both. This subsection does not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself. This subsection takes effect 1 day after the enactment.

(b) As used in this section—

(1) the term "partial-birth abortion" means an abortion in which—

(A) the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech

presentation, any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and

(B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus; and

(2) the term "physician" means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the doctor performs such activity, or any other individual legally authorized by the State to perform abortions: Provided, however, That any individual who is not a physician or not otherwise legally authorized by the State to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions of this section.

(c)(1) The father, if married to the mother at the time she receives a partial-birth abortion procedure, and if the mother has not attained the age of 18 years at the time of the abortion, the maternal grandparents of the fetus, may in a civil action obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

(2) Such relief shall include—

(A) money damages for all injuries, psychological and physical, occasioned by the violation of this section; and

(B) statutory damages equal to three times the cost of the partial-birth abortion.

(d)(1) A defendant accused of an offense under this section may seek a hearing before the State Medical Board on whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

(2) The findings on that issue are admissible on that issue at the trial of the defendant. Upon a motion of the defendant, the court shall delay the beginning of the trial for not more than 30 days to permit such a hearing to take place.

(e) A woman upon whom a partial-birth abortion is performed may not be prosecuted under this section, for a conspiracy to violate this section, or for an offense under section 2, 3, or 4 of this title based on a violation of this section.

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MARKUP TRANSCRIPT

BUSINESS MEETING

WEDNESDAY, JULY 17, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, pursuant to notice, at 10:05 a.m., in Room 2141, Rayburn House Office Building, Hon. F. James Sensenbrenner, Jr. [Chairman of the Committee] presiding.

Chairman SENSENBRENNER. The Committee will be in order.

* * * * *

The next item on the agenda is the bill H.R. 4965, the "Partial-Birth Abortion Ban Act of 2002." The Chair recognizes the gentleman from Ohio, Mr. Chabot, to make a motion.

Mr. CHABOT. Thank you, Mr. Chairman. The Subcommittee on the Constitution reports favorably the bill H.R. 4965 and moves its favorable recommendation to the full House.

Chairman SENSENBRENNER. Without objection, the bill will be considered as read and open for amendment at any point.

[The bill, H.R. 4965, follows:]

I

107TH CONGRESS
2D SESSION

H. R. 4965

To prohibit the procedure commonly known as partial-birth abortion.

IN THE HOUSE OF REPRESENTATIVES

JUNE 19, 2002

Mr. CHABOT (for himself, Mr. SENSENBRENNER, Mr. BARCIA, Mr. HYDE, Mr. HALL of Texas, Mr. SMITH of New Jersey, Mr. OBERSTAR, Mrs. MYRICK, Mr. STUPAK, Ms. HART, Mr. MOLLOHAN, Mr. PORTMAN, and Mr. RAHALL) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

To prohibit the procedure commonly known as partial-birth abortion.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Partial-Birth Abortion Ban Act of 2002''.

SEC. 2. FINDINGS.

The Congress finds and declares the following:

(1) A moral, medical, and ethical consensus exists that the practice of performing a partial-birth

abortion—an abortion in which a physician delivers an unborn child's body until only the head remains inside the womb, punctures the back of the child's skull with a sharp instrument, and sucks the child's brains out before completing delivery of the dead infant—is a gruesome and inhumane procedure that is never medically necessary and should be prohibited.

(2) Rather than being an abortion procedure that is embraced by the medical community, particularly among physicians who routinely perform other abortion procedures, partial-birth abortion remains a disfavored procedure that is not only unnecessary to preserve the health of the mother, but in fact poses serious risks to the long-term health of women and in some circumstances, their lives. As a result, at least 27 States banned the procedure as did the United States Congress which voted to ban the procedure during the 104th, 105th, and 106th Congresses.

(3) In Stenberg v. Carhart, 530 U.S. 914, 932 (2000), the United States Supreme Court opined ''that significant medical authority supports the proposition that in some circumstances, [partial birth abortion] would be the safest procedure'' for pregnant women who wish to undergo an abortion.

Thus, the Court struck down the State of Nebraska's ban on partial-birth abortion procedures, concluding that it placed an ''undue burden'' on women seeking abortions because it failed to include an exception for partial-birth abortions deemed necessary to preserve the ''health'' of the mother.

(4) In reaching this conclusion, the Court deferred to the Federal district court's factual findings that the partial-birth abortion procedure was statistically and medically as safe as, and in many circumstances safer than, alternative abortion procedures.

(5) However, the great weight of evidence presented at the Stenberg trial and other trials challenging partial-birth abortion bans, as well as at extensive Congressional hearings, demonstrates that a partial-birth abortion is never necessary to preserve the health of a woman, poses significant health risks to a woman upon whom the procedure is performed, and is outside of the standard of medical care.

(6) Despite the dearth of evidence in the Stenberg trial court record supporting the district court's findings, the United States Court of Appeals for the Eighth Circuit and the Supreme Court refused to set aside the district court's factual findings

because, under the applicable standard of appellate review, they were not ''clearly erroneous''. A finding of fact is clearly erroneous ''when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed''. Anderson v. City of Bessemer City, North Carolina, 470 U.S. 564, 573 (1985). Under this standard, ''if the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently''. Id. at 574.

(7) Thus, in Stenberg, the United States Supreme Court was required to accept the very questionable findings issued by the district court judge—the effect of which was to render null and void the reasoned factual findings and policy determinations of the United States Congress and at least 27 State legislatures.

(8) However, under well-settled Supreme Court jurisprudence, the United States Congress is not bound to accept the same factual findings that the Supreme Court was bound to accept in Stenberg under the ''clearly erroneous'' standard. Rather, the

United States Congress is entitled to reach its own factual findings—findings that the Supreme Court accords great deference—and to enact legislation based upon these findings so long as it seeks to pursue a legitimate interest that is within the scope of the Constitution, and draws reasonable inferences based upon substantial evidence.

(9) In Katzenbach v. Morgan, 384 U.S. 641 (1966), the Supreme Court articulated its highly deferential review of Congressional factual findings when it addressed the constitutionality of section 4(e) of the Voting Rights Act of 1965. Regarding Congress' factual determination that section 4(e) would assist the Puerto Rican community in ''gaining nondiscriminatory treatment in public services,'' the Court stated that ''[i]t was for Congress, as the branch that made this judgment, to assess and weigh the various conflicting considerations . . . . It is not for us to review the congressional resolution of these factors. It is enough that we be able to perceive a basis upon which the Congress might resolve the conflict as it did. There plainly was such a basis to support section 4(e) in the application in question in this case.''. Id. at 653.

(10) Katzenbach's highly deferential review of Congress's factual conclusions was relied upon by the United States District Court for the District of Columbia when it upheld the ''bail-out'' provisions of the Voting Rights Act of 1965, (42 U.S.C. 1973c), stating that ''congressional fact finding, to which we are inclined to pay great deference, strengthens the inference that, in those jurisdictions covered by the Act, state actions discriminatory in effect are discriminatory in purpose''. City of Rome, Georgia v. U.S., 472 F. Supp. 221 (D. D. Col. 1979) aff'd City of Rome, Georgia v. U.S., 446 U.S. 156 (1980).

(11) The Court continued its practice of deferring to congressional factual findings in reviewing the constitutionality of the must-carry provisions of the Cable Television Consumer Protection and Competition Act of 1992. See Turner Broadcasting System, Inc. v. Federal Communications Commission, 512 U.S. 622 (1994) (Turner I) and Turner Broadcasting System, Inc. v. Federal Communications Commission, 520 U.S. 180 (1997) (Turner II). At issue in the Turner cases was Congress' legislative finding that, absent mandatory carriage rules, the continued viability of local broadcast television would be ''seriously jeopardized''. The Turner I Court rec-

ognized that as an institution, ''Congress is far better equipped than the judiciary to 'amass and evaluate the vast amounts of data' bearing upon an issue as complex and dynamic as that presented here''. 512 U.S. at 665–66. Although the Court recognized that ''the deference afforded to legislative findings does 'not foreclose our independent judgment of the facts bearing on an issue of constitutional law,' '' its ''obligation to exercise independent judgment when First Amendment rights are implicated is not a license to reweigh the evidence de novo, or to replace Congress' factual predictions with our own. Rather, it is to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.'' Id. at 666.

(12) Three years later in Turner II, the Court upheld the ''must-carry'' provisions based upon Congress' findings, stating the Court's ''sole obligation is 'to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.' '' 520 U.S. at 195. Citing its ruling in Turner I, the Court reiterated that ''[w]e owe Congress' findings deference in part because the institution 'is far better equipped than the judiciary to ''amass and evaluate the vast amounts of data''

bearing upon' legislative questions,'' id. at 195, and added that it ''owe[d] Congress' findings an additional measure of deference out of respect for its authority to exercise the legislative power.'' Id. at 196.

(13) There exists substantial record evidence upon which Congress has reached its conclusion that a ban on partial-birth abortion is not required to contain a ''health'' exception, because the facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care. Congress was informed by extensive hearings held during the 104th and 105th Congresses and passed a ban on partial-birth abortion in the 104th, 105th, and 106th Congresses. These findings reflect the very informed judgment of the Congress that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care, and should, therefore, be banned.

(14) Pursuant to the testimony received during extensive legislative hearings during the 104th and 105th Congresses, Congress finds and declares that:

(A) Partial-birth abortion poses serious risks to the health of a woman undergoing the procedure. Those risks include, among other things: an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term; an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting the child to a footling breech position, a procedure which, according to a leading obstetrics textbook, ''there are very few, if any, indications for . . . other than for delivery of a second twin''; and a risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death.

(B) There is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures. No controlled

studies of partial-birth abortions have been conducted nor have any comparative studies been conducted to demonstrate its safety and efficacy compared to other abortion methods. Furthermore, there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures. Indeed, unlike other more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the instruction in partial-birth abortions in their curriculum.

(C) A prominent medical association has concluded that partial-birth abortion is ''not an accepted medical practice,'' that it has ''never been subject to even a minimal amount of the normal medical practice development,'' that ''the relative advantages and disadvantages of the procedure in specific circumstances remain unknown,'' and that ''there is no consensus among obstetricians about its use''. The association has further noted that partial-birth abortion is broadly disfavored by both medical

experts and the public, is ''ethically wrong,'' and ''is never the only appropriate procedure''.

(D) Neither the plaintiff in Stenberg v. Carhart, nor the experts who testified on his behalf, have identified a single circumstance during which a partial-birth abortion was necessary to preserve the health of a woman.

(E) The physician credited with developing the partial-birth abortion procedure has testified that he has never encountered a situation where a partial-birth abortion was medically necessary to achieve the desired outcome and, thus, is never medically necessary to preserve the health of a woman.

(F) A ban on the partial-birth abortion procedure will therefore advance the health interests of pregnant women seeking to terminate a pregnancy.

(G) In light of this overwhelming evidence, Congress and the States have a compelling interest in prohibiting partial-birth abortions. In addition to promoting maternal health, such a prohibition will draw a bright line that clearly distinguishes abortion and infanticide, that pre-

serves the integrity of the medical profession, and promotes respect for human life.

(H) Based upon Roe v. Wade, 410 U.S. 113 (1973) and Planned Parenthood v. Casey, 505 U.S. 833 (1992), a governmental interest in protecting the life of a child during the delivery process arises by virtue of the fact that during a partial-birth abortion, labor is induced and the birth process has begun. This distinction was recognized in Roe when the Court noted, without comment, that the Texas parturition statute, which prohibited one from killing a child ''in a state of being born and before actual birth,'' was not under attack. This interest becomes compelling as the child emerges from the maternal body. A child that is completely born is a full, legal person entitled to constitutional protections afforded a ''person'' under the United States Constitution. Partial-birth abortions involve the killing of a child that is in the process, in fact mere inches away from, becoming a ''person''. Thus, the government has a heightened interest in protecting the life of the partially-born child.

(I) This, too, has not gone unnoticed in the medical community, where a prominent medical association has recognized that partial-birth abortions are ''ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb''. According to this medical association, the '' 'partial birth' gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body''.

(J) Partial-birth abortion also confuses the medical, legal, and ethical duties of physicians to preserve and promote life, as the physician acts directly against the physical life of a child, whom he or she had just delivered, all but the head, out of the womb, in order to end that life. Partial-birth abortion thus appropriates the terminology and techniques used by obstetricians in the delivery of living children—obstetricians who preserve and protect the life of the mother and the child—and instead uses those techniques to end the life of the partially-born child.

(K) Thus, by aborting a child in the manner that purposefully seeks to kill the child

after he or she has begun the process of birth, partial-birth abortion undermines the public's perception of the appropriate role of a physician during the delivery process, and perverts a process during which life is brought into the world, in order to destroy a partially-born child.

(L) The gruesome and inhumane nature of the partial-birth abortion procedure and its disturbing similarity to the killing of a newborn infant promotes a complete disregard for infant human life that can only be countered by a prohibition of the procedure.

(M) The vast majority of babies killed during partial-birth abortions are alive until the end of the procedure. It is a medical fact, however, that unborn infants at this stage can feel pain when subjected to painful stimuli and that their perception of this pain is even more intense than that of newborn infants and older children when subjected to the same stimuli. Thus, during a partial-birth abortion procedure, the child will fully experience the pain associated with piercing his or her skull and sucking out his or her brain.

(N) Implicitly approving such a brutal and inhumane procedure by choosing not to prohibit it will further coarsen society to the humanity of not only newborns, but all vulnerable and innocent human life, making it increasingly difficult to protect such life. Thus, Congress has a compelling interest in acting—indeed it must act—to prohibit this inhumane procedure.

(O) For these reasons, Congress finds that partial-birth abortion is never medically indicated to preserve the health of the mother; is in fact unrecognized as a valid abortion procedure by the mainstream medical community; poses additional health risks to the mother; blurs the line between abortion and infanticide in the killing of a partially-born child just inches from birth; and confuses the role of the physician in childbirth and should, therefore, be banned.

SEC. 3. PROHIBITION ON PARTIAL-BIRTH ABORTIONS.

(a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 73 the following:

"CHAPTER 74—PARTIAL-BIRTH ABORTIONS

"§ 1531. Partial-birth abortions prohibited

''(a) Any physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than 2 years, or both. This subsection does not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself. This subsection takes effect 1 day after the enactment.

''(b) As used in this section—

''(1) the term 'partial-birth abortion' means an abortion in which—

''(A) the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and

''(B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus; and

''(2) the term 'physician' means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the doctor performs such activity, or any other individual legally authorized by the State to perform abortions: Provided, however, That any individual who is not a physician or not otherwise legally authorized by the State to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions of this section.

''(c)(1) The father, if married to the mother at the time she receives a partial-birth abortion procedure, and if the mother has not attained the age of 18 years at the time of the abortion, the maternal grandparents of the fetus, may in a civil action obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

''(2) Such relief shall include—

''(A) money damages for all injuries, psychological and physical, occasioned by the violation of this section; and

''(B) statutory damages equal to three times the cost of the partial-birth abortion.

''(d)(1) A defendant accused of an offense under this section may seek a hearing before the State Medical Board on whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

''(2) The findings on that issue are admissible on that issue at the trial of the defendant. Upon a motion of the defendant, the court shall delay the beginning of the trial for not more than 30 days to permit such a hearing to take place.

''(e) A woman upon whom a partial-birth abortion is performed may not be prosecuted under this section, for a conspiracy to violate this section, or for an offense under section 2, 3, or 4 of this title based on a violation of this section.''.

(b) CLERICAL AMENDMENT.—The table of chapters for part I of title 18, United States Code, is amended by inserting after the item relating to chapter 73 the following new item:

''74. Partial-birth abortions ..... 1531''.

○

Chairman SENSENBRENNER. The Chair recognizes the gentleman from Ohio, Mr. Chabot, to strike the last word.

Mr. CHABOT. Thank you, Mr. Chairman.

On June 19th, on behalf of a bipartisan coalition, I introduced H.R. 4965, the "Partial-Birth Abortion Ban Act of 2002," which will ban the dangerous and inhumane procedure during which a physician delivers an unborn child's body until only the head remains inside the womb, punctures the back of the child's skull with a sharp instrument, and sucks the child's brains out before completing delivery of the now-dead infant. An abortionist who violates this ban would be subject to fines or a maximum of 2 years' imprisonment or both.

H.R. 4965 also establishes a civil cause of action for damages against an abortionist who violates the ban and includes an exception for those situations in which a partial-birth abortion is necessary to save the life of the mother.

A moral, medical, and ethical consensus exists that partial-birth abortion is an inhumane procedure that is never medically necessary and should be prohibited. Contrary to the claims of partial-birth abortion advocates, this barbaric procedure remains an untested, unproven, and potentially dangerous procedure that was never embraced by the medical profession. As a result, the United States Congress voted to ban partial-birth abortions during the 104th, 105th, and 106th Congresses, and at least 27 States enacted bans on the procedure. Unfortunately, the two Federal bans that reached President Clinton's desk were promptly vetoed.

To address the concerns raised by the majority opinion of the United States Supreme Court in *Stenberg* v. *Carhart*, H.R. 4965 differs from these previous proposals in two areas:

First, the bill contains a new, more precise definition of the prohibited procedure to address the Court's concerns that Nebraska's definition of partial-birth abortion might be interpreted to encompass a more commonly performed late-term, second-trimester abortion procedure. As last week's hearing on H.R. 4965 indicated, this bill clearly distinguishes the procedure it would ban from other abortion procedures.

The second difference addresses the majority's opinion that the Nebraska ban placed an undue burden on women seeking abortions because it failed to include an exception for partial-birth abortions deemed necessary to preserve the health of the mother. The *Stenberg* case based its conclusion on the trial court's factual findings regarding the relative health and safety benefits of partial-birth abortions, findings which were highly disputed. The Court was required to accept these findings because of the highly deferential, ″clearly erroneous″ standard that is applied to lower-court factual findings.

Those factual findings, however, are inconsistent with the overwhelming weight of authority which indicates that a partial-birth abortion is never medically necessary to preserve the health of a woman, poses serious risks to women's health, and lies outside the standard of medical care. Under well-settled Supreme Court jurisprudence, the United States Congress is entitled to reach its own factual findings, findings that the Supreme Court accords great deference, and to enact legislation based upon these findings so long as it seeks to pursue a legitimate interest that is within the

scope of the Constitution and draws reasonable inferences based upon substantial evidence.

Thus, the first section of H.R. 4965 contains Congress' extensive factual findings that, based upon extensive medical evidence compiled during congressional hearings, a partial-birth abortion is never necessary to preserve the health of a woman. The American Medical Association has concluded that partial-birth abortion is "not an accepted medical practice."

Last week our Subcommittee received additional testimony regarding the relative health and safety benefits of partial-birth abortions, including testimony from Dr. Curtis Cook, a medical expert, who labeled partial-birth abortion a "rogue procedure." The Subcommittee on the Constitution passed the ban by a 8–3 vote. Despite overwhelming support from the public, the handful of organizations that support the practice of partial-birth abortion have consistently tried to hide the truth about this gruesome procedure. Following the introduction of our bill last month, the abortion lobby swung in action once again. Press releases and statements from their leadership charged us with using inflammatory rhetoric, graphic images, and sensationalized language. They even called the effort "a political stunt" and said the legislation was "harmful."

Obviously, I disagree with this assessment of the legislation that we will consider today. In fact, I would remind everyone that it is the false rhetoric and misinformation of the abortion lobby that was exposed as blatant propaganda in 1997. You might recall that the executive director of the National Coalition of Abortion Providers admitted that, quote, he ″lied through his teeth″ when he stated that partial-birth abortions were rarely performed. He went on to say that the procedure is most often performed on healthy mothers who are about 5 months' pregnant with healthy fetuses. He acknowledged that he lied because he feared the truth would damage the abortion rights cause.

The truth today is really quite simple. Opponents of this bill—I'd ask for an additional 30 seconds to——

Chairman SENSENBRENNER. Without objection.

Mr. CHABOT. Thank you. Opponents of this bill want to hide from the facts. They do not want people to hear a legitimate description or view accurate images of this gruesome procedure. They don't want to talk about the pain inflicted on the child or how partial-birth abortion borders on infanticide. They just want to make this issue go away because it might be harmful to their cause. They are less concerned about the harm it might cause the baby or the mother.

Fortunately, I am confident that the public, a majority of the Congress, and the President all recognize the true horrors of partial-birth abortion and are committed to ending this barbaric and inhumane practice. I ask my colleagues to support our bill and help end this national tragedy.

I yield back.

Chairman SENSENBRENNER. The gentleman from Michigan, Mr. Conyers.

Mr. CONYERS. Thank you, Mr. Chairman.

My friend from Ohio may have not seen the letter that the AMA sent out in which they do not support the bill that you have before us. Did you know that?

Mr. CHABOT. Would the gentleman yield?

Mr. CONYERS. Of course.

Mr. CHABOT. I've seen letters from the AMA in favor of and against it.

Mr. CONYERS. I mean, do you know that they are against the bill, the latest one? Could I send the letter down to you? And then you read it and then you tell me what it——

Mr. CHABOT. Would the gentleman yield?

Mr. CONYERS. Of course.

Mr. CHABOT. My understanding is that their concern is about the penalties. Now, the penalties in this bill would call for 2-year imprisonment for an abortion that violates—an abortionist that violates this ban.

Mr. CONYERS. Well, then that means that you are aware that the AMA is against the bill.

Mr. CHABOT. I have already answered that question. Are you aware of how gruesome and inhumane and barbaric this procedure is?

Mr. CONYERS. Well, I would be willing to agree with you. I've never seen one or been in a hospital when it was going on. But you're not trying to evade the fact that the AMA doesn't support the bill, are you?

Mr. CHABOT. Would the gentleman yield?

Mr. CONYERS. Of course.

Mr. CHABOT. I've already indicated that the American Medical Association has supported a bill very similar to this in the past, and we have documentation of that. They've been on both sides of this issue, just as other——

Mr. CONYERS. Okay. Well, then I'll send the letter down to you, and you tell me what it means.

Now, does the gentleman from Ohio, my friend, realize that there is a health exception required in abortion laws that stem from *Roe* v. *Wade* dating from the year 1973? And I yield to him for that purpose.

Mr. CHABOT. I appreciate the gentleman yielding. That's one of the reasons that this particular legislation was so carefully crafted——

Mr. CONYERS. But, Mr. Chabot, I'm asking you if you are aware of the health exception, yes or no.

Mr. CHABOT. Would the gentleman yield?

Mr. CONYERS. If you'll answer the question.

Mr. CHABOT. I'd be happy to answer the question. I appreciate the gentleman yielding.

Mr. CONYERS. Yes or no?

Mr. CHABOT. Justice O'Connor indicated that a health exception——

Mr. CONYERS. Okay. I'm taking my time back——

Mr. CHABOT.—was something that had to be considered by this Committee——

Mr. CONYERS. Sir, you just lost the right to discuss with me on my time. The fact that there is a health exception that has continually made these bills like yours unconstitutional, according to the United States Supreme Court, not only in *Roe* but in *Casey* and in the *Carhart* bill, the Nebraska case, that also held for the same

reason the State law was unconstitutional. There's got to be a health exception.

Now, I didn't create that, nor did you, but it's—but the Supreme Court has repeatedly held it. Now, why would you keep bringing a bill before us with all the work we've got to do in the last 26 legislative days and tell us that this is—give us all this great argument, even if the bill passed, Mr. Chabot, even if the bill passed the House and the Senate, the Supreme Court would again hold it unconstitutional. Don't you get it?

Mr. CHABOT. I don't know whether to ask you to yield or not because you said you wouldn't yield, but would the gentleman yield?

Mr. CONYERS. Ask me to yield. No thanks.

Mr. CHABOT. Okay. Well, thank you.

Mr. CONYERS. You're welcome.

So, I mean, if this is a—if this is a cause that you are trying to promote in the general public, fine. But you're a lawyer, and you're a Member of the Judiciary Committee. We are the ones that pass on Supreme Court decisions. We are the place that constitutional amendments are sent.

Now, if you don't understand this, we're in bad shape, sir. So I would now yield to the gentleman from Ohio for all the time I have remaining.

Mr. CHABOT. Well, I thank the gentleman for yielding. The gentleman has called me a lawyer. I might ask that his words be taken down. But, in any event, the—— [Laughter.]

Mr. CHABOT. The health exception—the health exception issue is an issue that we've dealt with in this bill. The Supreme Court based their decision on the factual findings of the trial court, and the lack of findings in previous bills was the problem. Under this bill, there are about 15 pages of factual findings that were based on medical evidence and testimony that was taken in Committees in several past Congresses, and in addition to that, to this Congress, and we believe that we have met any concerns that the Supreme Court had relative to a health exception.

Mr. CONYERS. And I'm sorry that you are a lawyer because you seem to be ashamed of it.

Chairman SENSENBRENNER. The gentleman's time has expired. Without——

Mr. CHABOT. I'm a recovering lawyer.

Chairman SENSENBRENNER. Without objection, all Members may insert opening statements in the record at this point.

Are there amendments?

Ms. BALDWIN. Mr. Chairman?

Chairman SENSENBRENNER. Does the gentlewoman from Wisconsin have an amendment?

Ms. BALDWIN. Yes. I have the Baldwin-Jackson Lee amendment at the desk.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 4965, offered by Ms. Baldwin and Ms. Jackson Lee, page 16, beginning on line 7, strike "that is necessary"——

Ms. BALDWIN. Mr. Chairman, I ask that the amendment be considered as read.

Chairman SENSENBRENNER. Without objection, so ordered.

[The amendment follows:]

AMENDMENT TO H.R. 4965

OFFERED BY Ms. Baldwin and Ms. Jackson-Lee

Page 16, beginning in line 7, strike "that is necessary" and all that follows through the period in line 11 and insert "performed before fetal viability, or to a partial-birth abortion performed after fetal viability where necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.".

Chairman SENSENBRENNER. And the gentlewoman from Texas—or from Wisconsin is recognized for 5 minutes.

Ms. BALDWIN. Thank you, Mr. Chairman.

This amendment is very straightforward. It adds a health exception to this measure. Forty-one States, including my home State of Wisconsin, already have passed laws banning post-viability abortions, except when necessary to save the life or the health of the mother. And while this—these bills vary from State to State, most prohibit all post-viability abortion procedures, not just this procedure, again, except when necessary to save the life or health of the mother.

The Supreme Court's ruling in *Stenberg* v. *Carhart* held that the Nebraska statute was unconstitutional not only because the definition of the procedure was too broad and placed an undue burden on the right to obtain an abortion, but also because there was no health exception for the mother as required by *Planned Parenthood* v. *Casey*.

The Supreme Court's *Stenberg* decision also noted that after the fetus has become viable, States may substantially regulate and even proscribe abortion, but any such regulation or proscription must contain exceptions for instances where necessary in appropriate medical judgment for the preservation of the life or health of the mother.

Because this bill does not make a clear exception for the life and health of the mother as required by the Supreme Court, it remains unconstitutional. Women should decide when or whether to carry a child. A woman should not have to sacrifice her life or her health in the tragic event of a crisis pregnancy. These decisions should be made between a woman, her doctor, her family, and whoever else she chooses to consult.

The real life stories of the families who have needed this procedure either to save the life or the health of the mother should be heard in this debate today. The women that I have heard from and met wanted nothing more than to have a child, and each was devastated to learn that her baby could not live outside the womb. They made excruciating and difficult decisions with their doctors and their families to terminate the pregnancy to preserve their own health and in many cases to preserve their ability to try again to have another child.

They were able to make these decisions because *Roe* v. *Wade* protects their constitutional right and says that the health of the woman matters. If a woman chooses to assume a risk during her pregnancy and to carry a baby to term, that is her decision, and we should all respect it. But no one should force a woman to assume that health risk.

I urge my colleagues to support this amendment.

Mr. CHABOT. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from Ohio, Mr. Chabot.

Mr. CHABOT. Thank you, Mr. Chairman. I move the strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. CHABOT. Mr. Chairman, this amendment should be opposed for several reasons.

First, limiting the prohibition to only viable fetuses would exempt the vast majority of partial-birth abortions because most partial-birth abortions are performed on babies during their fifth and sixth months of pregnancy, and most of the babies born during that period are not viable.

Second, the notion that only viable infants are entitled to the protections of the law is misguided. Premature infants who are born pre-viability with little or no chance of survival are fully entitled to the protections of the law while they are alive. You could not, for example, just walk into a neonatal intensive care unit and kill an infant who was born 22 weeks into the pregnancy and is an incubator struggling to survive. That child's ultimate viability has no bearing on whether he or she is entitled to protections of the law.

In the same way, partially born children with little or no chance of survival outside of the womb are entitled to the protections of the law while they are alive. Viability is simply not a prerequisite for legal protection of born or partially born children.

This amendment should also be opposed because it would allow partial-birth abortions allegedly necessary to preserve the health of the mother. The overwhelming weight of evidence compiled in a series of congressional hearings indicates that partial-birth abortions are never necessary to preserve the health of the woman and, in fact, pose substantial health risks to women undergoing the procedure. Leading proponents of partial-birth abortion acknowledge that it poses additional health risks because, among other things, the procedure requires a high degree of surgical skill to pierce the infant's skull with a sharp instrument in a blind procedure. Dr. Warren Hern has testified that he had, quote, very serious reserva-

tions about this procedure and that he could not imagine a circumstance in which this procedure would be safest, unquote.

Although he was opposed to legislation banning partial-birth abortions, he also stated, "You really can't defend it. I'm not going to tell you somebody"—"I'm not going to tell somebody else that they should not do this procedure, but I'm not going to do it."

He has also stated, "I would dispute any statement that this is the safest procedure to use."

A health exception, no matter how narrowly drafted, gives the abortionist unfettered discretion in determining when a partial-birth abortion may be performed, and abortionists have demonstrated that they can justify any abortion on any ground.

Dr. Warren Hern of Colorado, the author of a standard textbook on abortion procedures, who also performs many third-trimester abortions, has stated, "I will certify that any pregnancy is a threat to a woman's life and could cause grievous injury to her physical health." I mean, listen to that: "I will certify that any pregnancy is a threat to a woman's life and could cause grievous injury to her physical health." That's what the health exception is all about.

Ruth Padawer, "Clinton may back abortion measure," The Record, May 14, 1997. It's unlikely then that a law that includes such an exception would ban a single partial-birth abortion or any other late-term abortion.

I yield back the balance of my time.

Chairman SENSENBRENNER. For what purpose does the gentlewomen from California, Ms. Waters, seek recognition?

Ms. WATERS. To strike the last word.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

Ms. WATERS. I rise in support of this amendment, and I had not intended to get into this debate one more time. But it seems to me every election year we have those who would take up some form of preventing women from having a choice about whether or not they wish to carry a child to term. And it seems to me that we keep see it coming time and time again, and as it was mentioned by the Ranking Member, this issue has been debated ad nauseam and the courts have ruled.

Now, the audacity of any man to say that a woman's health is never to be considered important in making this decision is simply outrageous. I am offended by the fact that the author of this bill has the audacity, again, to sit in this Committee and disregard a woman's health and to say to this Committee under no circumstances is a woman at risk and should have the ability to make this decision. I don't know if the gentleman has ever heard of toxemia. I don't know if he's ever heard of placenta previa. I don't know if he heard of hydatidiform mole. I'm sure he has not because he would not take the time to learn about this—these very, very difficult and complicated situations that women find themselves in and sometimes would have to make a decision about whether or not they're willing to die or maybe stay alive so that they can raise the other children in the family.

For the gentleman to say that women should not have the right to make that decision, that never, ever, ever should any other complications of pregnancy be considered as at-risk situations for a woman is outrageous and just plain unacceptable. And I would

think that every man who cares about his wife, his daughters, and women would not want to take this position that they know better, that no matter what the doctors say, that no matter what a woman says, they know better. It's unacceptable, and I would ask the Members of this Committee, and particularly the men, to reject this kind of thinking. It is not only unacceptable, it is surprising that it could be put forth in this day and age.

Ms. LOFGREN. Would the gentlelady yield?

Ms. WATERS. I will yield.

Ms. LOFGREN. I thank the gentlelady.

I would just like to add that, like she, I had not planned to speak because this is obviously a politicized effort to create a 30-second ad. But I think it's worth pointing out that the gentlelady's amendment—Ms. Jackson Lee and Ms. Baldwin—actually would make this bill constitutional. I think it's worth noting that I am willing—I am pro-choice. I am willing to support this amendment because I think we could get consensus that this procedure, although sometimes necessary to save the life or health of a woman, is a procedure that we can agree should not be an elective procedure. And that's essentially what the gentlelady's amendment would do, and I can support—we could have that consensus. But, instead, we're going to have a political battlefield instead of reaching a conclusion that would be fair and just and also respect the health and life of women who need this procedure.

I thank the gentlelady for yielding me these few minutes and very much appreciate her comments and her willingness to allow me this brief time. Thank you.

Ms. JACKSON LEE. Mr. Chairman?

Chairman SENSENBRENNER. Does the gentlewoman yield back?

Ms. WATERS. I yield back.

Mr. GOODLATTE. Mr. Chairman?

Chairman SENSENBRENNER. For what purpose does the gentleman from Virginia seek recognition?

Mr. GOODLATTE. Move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. GOODLATTE. Thank you, Mr. Chairman.

Mr. Chairman, I speak in strong opposition to this amendment, and I take strong exception to the remarks from the gentlewoman from California to suggest that husbands and fathers and men in general do not care about the lives of children. We haven't heard one word from her about the health of the child involved in this process. Not one word. Why? Of course, we won't hear anything, because the process presumes the child is going to die.

Now, when you weigh the balance of the life of the mother against the life of the child, that's a moral choice in which the parties should have input, including the doctor. But when you weigh the indefinable term "health" against the life of the child, in my opinion, there is only one choice and that is to oppose this amendment.

I yield to gentleman from Ohio.

Mr. CHABOT. I thank the gentleman very much for yielding. I'll be brief.

The gentlelady has raised issues and alleged that there's a lack of concern for women's health with respect to this legislation. I

would argue to the contrary, that we have the utmost concern about women's health, and we had extensive testimony that this particular gruesome procedure causes serious risk to women's health, and I'll just mention a couple of examples.

According to the medical testimony, it causes an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation, making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term; an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting the child to foot breech position, a procedure which, according to Williams Obstetrics, a leading obstetrics textbook, there are very few if any indications for, other than for delivery of a second twin.

Mr. WEINER. Would the gentleman yield on that?

Mr. CHABOT. It's not my time, but—it's the gentleman from Virginia's time, but I'd like to complete my statement here. And a risk of iatrogenic lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal—that means mother's—death. This also created a high risk of infection should she suffer a laceration due to the non-sterile vaginal environment.

And I thank the gentleman very much for yielding. Again, we are very concerned about not only the health of that innocent unborn human being that the mother's carrying, but we're also very concerned about the mother's health.

Mr. GOODLATTE. Mr. Chairman, I yield back my time.

Ms. JACKSON LEE. Mr. Chairman? Mr. Chairman?

Ms. LOFGREN. Mr. Chairman?

Chairman SENSENBRENNER. The gentlewoman from California, Ms. Lofgren.

Ms. LOFGREN. Thank you, Mr. Chairman.

I want to just speak briefly on one of the findings on page 3, line 13—actually, line 17, indicating this procedure is never necessary to preserve the health of a woman. And that's simply not the case.

You know, there are times when we're here in the Congress and I think, you know, I was somehow sent here by God to be able to tell a story, and the story I can tell to Members of this Committee has to do with a person who I know quite well, and that is the story of Vickie Wilson. As a matter of fact, her mother-in-law, Suzie Wilson, and I served together on the Board of Supervisors in Santa Clara County for 12 years. And I remember very well when Vickie became pregnant with their third child and Suzie was so excited because they had done the amniocentesis and it was going to be a girl and it was going to be Suzie's first granddaughter. They had a name picked out. And in the eighth month, Suzie called me and Dianne McKenna, the other woman on the board, and was in tears because they had discovered at the eighth month of pregnancy that Abigail—they had picked a name for the child—that Abigail's brains had formed almost entirely out of the cranium. And I saw the ultrasound picture. It looked like this child had two heads. And the only question—I mean, this was not a viable child. This could—Abigail could not live. And the only question was:

Would Vickie live? Would Vickie be so injured that she would not be able to care for her other two children?

Now, Vickie's own mother was so devastated, she was having trouble going down to be with Vickie. And so Suzie went down. Suzie Wilson went down to Los Angeles where Vickie was with her husband. And the doctor decided that the safest thing for Vickie was the dilation and extraction procedure. And that is what they did, and it was a very devastating experience to lose that wanted child and to go through this procedure, and yet it was what was necessary. And afterwards, I remember, I spoke to Vickie's doctor and obviously to her and to my friend, Suzie, and then I got elected to Congress. And the first time I heard about this so-called partial-birth procedure, I called my Ob-Gyn, I said, What is it? He said there is no such thing, there is no such medical terminology. And I was trying to figure out what it was, and all of a sudden I realized it was the procedure that Vickie Wilson had had. And she actually came here, and she believed that when she stood up and told her story that the Members of the Committee would say, oh, we understand now. And, instead, Members of this Committee, especially a Member who's no longer with us, called her a murderer in a public hearing.

I couldn't believe that they would attack this woman who had been through this trauma and who was willing to tell her personal story.

So I know firsthand that this is a procedure that is sometimes medically necessary. I am not—I am going to vote for the amendment before us, but I'm not going to offer any further amendments because I know this is a political endeavor. This isn't about women's health. This isn't about complying with the Supreme Court decision, which I would willingly do. This is about creating a 30-second ad opportunity for the November elections.

I think it's wrong to do that, but I recognize the Committee is going to do that. The only comfort I take in that the Supreme Court, if this bill ever becomes law, will strike this down, too, because it's unconstitutional. And that is small comfort for women who, like Vickie, may need this procedure under very trying circumstances in the interim. But all I can do is have faith in our Supreme Court and faith in the voters that they will see through this shameful political exercise that is so dismissive of women who are suffering traumatic circumstances in their lives, along with their husbands and their fathers and their sons.

And I yield back the balance of my time.

Chairman SENSENBRENNER. For what purpose does the gentleman from Illinois seek recognition?

Mr. HYDE. To strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. HYDE. Mr. Chairman, in 28 years in this body—excuse me—I've made a strenuous effort not to personalize debate, not to question people's motives, because I lack the power to look into their hearts and their minds. I assume at face value people are sincere when they advocate protecting the unborn. And so to call this a political gesture, to imply insincerity and hypocrisy on the part of its advocates, I think is a very unfortunate attitude to take on something that is very near and dear to the hearts of many of us, and

that is protecting the totally defenseless, powerless, vulnerable unborn. We talk about the woman, and rightly so. But not a word, as Mr. Goodlatte said, about the tiny little defenseless life.

The choice that you have—and we use the word "choice" as a euphemism, because somehow "abortion" is a little abrasive. So no doctor says he's an abortionist. He specializes in reproductive health. The baby is referred to as the products of conception, and when you kill it, it undergoes demise.

The marvelous euphemisms that cover up the grotesque, sordid fact that you're exterminating a human life at bottom is part of their arsenal.

Now, Senator Moynihan of New York, who never voted with us in his whole political career, looked at this and said, my God, this is infanticide. Partial-birth abortion where the baby is almost totally extracted from the birth canal, if you can't value that, what can you value?

This is a macabre process, and you can be for abortion, you can be for choice, as you euphemistically call it—there's only one choice, by the way, a dead baby or a live baby. That's the choice. But it certainly doesn't mean we're insensitive to a woman's health.

Now, that's an interesting aspect of this debate. The word "health" has been defined by the Supreme Court in the case of *Doe* v. *Bolton* as a state of emotional well-being. See, that's the problem. You're taking a life and you're going to justify killing that baby, in the womb or out of the womb, because the woman's health is affected otherwise, and that means her state of well-being; it means the economic situation of the woman, psychological situation. And these, in my judgment, in my hierarchy of values, are of lesser consideration than the very life—the very life of the baby.

Now, that little baby is not a diseased appendix. It's not a pair of infected tonsils. It is a tiny little member of the human family needing only time and nourishment to be as big and as healthy and as attractive as you are.

No, we respect women. We respect women. We genuflect before their ability to carry children to term, but we respect the little baby in the womb, something that you somehow choose to overlook.

This is not a good amendment. This process of partial birth abortion may be convenient for the abortionist, but it's fatal to the baby. I'm for babies. I'm for women. I'm for life. I yield back.

Chairman SENSENBRENNER. The question is on—what purpose the gentlewoman from Texas, Ms. Jackson Lee seek recognition?

Ms. JACKSON LEE. To strike the last word.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

Ms. JACKSON LEE. I think the Chairman very much, and I respect my colleagues, particularly those of us who have seen this debate go on and on, for their sensitivity to offering what may be potentially futile amendments, and I thank them for supporting the amendment offered by Ms. Baldwin and myself on this issue.

I would take issue with—or maybe I would—I will take issue with my good friend from Virginia to suggest that their concern—or there is concern for all of the parties involved, the physicians, the spiritual leaders of respective women, the mothers, and of course this unborn that they are speaking of, because if it was, we would find a way to resolve this matter in the best possible direc-

tion, recognizing and respecting the diverse viewpoints about whether life can be saved and the life of the mother, and whether the health of the mother is impacted.

I'm reminded of my colleague and friend, Pat Schroder, who tells a story that when she came to this body, she and Ron Dellums, another great and outstanding Member of Congress and not in this body any longer, tried to be seated in the Armed Services Committee. It was a time of sexism and racism in this body, very blatant and open. And the Chairman at that time did not have a seat, suggested that the two of them could sit in one seat together. They were denigrated and denied the ability to sit——

Chairman SENSENBRENNER. Would the gentlewoman yield?

Ms. JACKSON LEE. I am having a discussion, Mr. Chairman, I would be happy to yield.

Chairman SENSENBRENNER. Wasn't that during the 40 years of Democrat control that that happened?

Ms. JACKSON LEE. Mr. Chairman, you're so very kind. It was a time of sexism and racism in this Nation and in this body.

Chairman SENSENBRENNER. Is that currently—will the gentlewoman yield further?

Ms. JACKSON LEE. I'd like to reclaim my time, Mr. Chairman. I thank you for your kindness.

In any event, they were not allowed to sit at the seat of power. We welcome change in whatever way it comes, and we now come to a time where we're being denied again the opportunity for voices to be heard on this issue. I might offer to say that the *Stenberg* decision clearly acknowledges that the legislation presently before us is going to be held unconstitutional. Sandra Day O'Connor is still on the bench. The decision is such that we believe the decision or the review of this legislation will be the same. Why are we trying to push forward legislation that smacks in the face of medical opinion and as well the Supreme Court decision. The only thing this amendment does is to try to address the concerns and the viewpoints and the clear letter of the law on the viability of the unborn. It clearly suggests that there needs to be some leeway for viability questions to be made by the woman, her family, spiritual adviser and the physician.

And let me just say the American College of Obstetricians and Gynecologists simply say the potential exists that legislation prohibiting specific medical practices such as intact D&X may outlaw techniques that are critical to the lives and health of American women. The intervention of legislative bodies into medical decision making is inappropriate, ill-advised and dangerous. The California Medical Association in particular says that it believes that the D&E may provide a substantial medical benefits, and that procedure is safer in several respects than the alternatives. Thus, the California Medical Association has stated that there are numerous reasons why the intact D&E procedure may be medically appropriate in a particular case and there is virtually no scientific evidence supporting its ban on its use.

To my friends who have had hearings, you can call any number of medical professionals to argue your point. The question is, do you talk to the millions of women yet to have to make this decision that my colleague from California enunciated, that we saw in this room time after time while women cried because they did not want

to have the procedure, but their life and their health was in jeopardy. Do we foolishly go forward?

With all due respect to my good friend from Illinois, knowing his passion and interfering in these decisions made by individuals who have prayed to their gods, asking for either direction or guidance, why are we being God in this room and not allowing the God of all of us to pray with us, to guide us, and to allow us to make these decisions? We come again to the same issue. I don't denigrate your beliefs, your leader's beliefs, but you are attacking mine. You're not allowing me to pray and to counsel and to make these decisions?

Chairman SENSENBRENNER. Time, gentlewoman——

Ms. JACKSON LEE. It is political, it is wrong. I ask my colleagues to vote for this amendment.

Chairman SENSENBRENNER. For what purpose does the gentleman from Indiana seek recognition?

Mr. PENCE. Move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. PENCE. Mr. Chairman, I'm a new Member of Congress. I'm pro-life. I don't apologize for it, and in many ways I feel that I came to Congress to fight to make abortion less legal, less available, and less acceptable in America.

It's hard for me to describe, Mr. Chairman, what a privilege I felt to be sitting on the Judiciary Committee to enjoy the remarks of the former Chairman of this Committee, Henry Hyde. Flanked by his own portrait on the wall, I will always count it a privilege to have sat here and heard him make a clarion defense for life.

But let me speak to this amendment, the Baldwin and Jackson Lee Amendment in the specific, because I think, in fairness to our colleagues on the other side of the aisle, this amendment in particular is about the interests of women, and I'm a little bit befuddled. I want to concede to the Ranking Member if he's with us in any way, that I am an attorney and I'm properly confused by that training. And I also am a Member of Congress, which means that I'm pretty far out of touch with reality most of the time. But I'm trying to put my mind, Mr. Chairman, around this simple reality. We've heard one of my colleagues on the other side of this panel quote a great number of medical procedures, long names that my wife the valedictorian could pronounce, I probably couldn't.

But there is one medical procedure that has been around since the time of its namesake. It is called the Caesarian procedure, named after Julius Caeser, if my history serves, and it is the opening of the uterus through the abdomen and the nonviolent removal of the unborn child, not utilizing the God-given birth canal in that process. The process of the baby passing through the birth canal, having been present for the birth of all 3 of my children, is a very violent, very painful process. The Caesarian section spares, as it did my wife, that entire ordeal. And so I arrive at a rhetorical question of my colleagues on the other side of the aisle, and that is, if a partial birth abortion, as defined in this act, is an abortion in which a physician delivers an unborn child's body into the birth canal until only the head remains inside the womb, holding the squirming child—that's my language added—while the doctor punctures the back of the child's skull with a sharp instrument and

sucks the child's brains out before complete delivery of the dead infant, how could this ever be in the interest of the health——

Ms. LOFGREN. Will the gentleman yield?

Mr. PENCE. I will yield in just a moment.

How could this ever possibly be more conducive to the health of the mother than a procedure that has been available to physicians for 2,000 years and does not involve the birth canal and the endangerment, and as the Chairman of the Subcommittee eloquently stated, the potential harm that happens in the vaginal area, the potential ensuing infection? I'm just—I will be happy to yield to my friend on this point, but would ask if she might specific—addressing the definition of the procedure that we are attempting to outlaw here, how could this ever possibly be an appropriate medical judgment or appropriate to the health of the mother when Caesarian section is available.

Mr. WEINER. Would the gentleman—would the gentleman——

Ms. LOFGREN. If the gentleman would yield, I've had a Caesarian section. My first child was delivered by C-section, and to describe that as not a violent procedure does not comport with my personal experience. [Laughter.]

Ms. LOFGREN. Number one. Number two, there are the health issues and sometimes life-threatening issues of a C-section are rather large. There is a significant mortality rate to C-sections. And in my own case, I mean, we had a C-section because my daughter was showing fetal distress and that's what we did, and I'm glad we did. She's 20 years old. It was a great success story. But there are times, and I'll tell you the case of Vickie because I did have his discussion only with her and with her doctor. They were concerned that there could be a uterine rupture in that case, and that's why—I mean they had two heads essentially to deliver and that was—the reason why they used this procedure was they couldn't deliver two heads and they were concerned about the ruptured uterus on a C-section, and that's why they——

Mr. PENCE. Reclaiming my time, I yield back.

Chairman SENSENBRENNER. The time of the gentleman from Indiana has expired.

For what purpose does the gentleman from Virginia, Mr Scott, seek recognition?

Mr. SCOTT. Move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. SCOTT. Mr. Chairman, I think just about everybody on the Committee came to the Committee with a preconceived notion on the issue of abortion, so I think it would be instructive to get away from opinion and just read some of what the Supreme Court said about partial-birth abortion. In the *Stenberg* case the court said, "Three established principles determine the issue before us. First, before viability, the woman has the right—has a right to choose to terminate her pregnancy. Second, the law designed to further the State's interest in fetal life, which imposes an undue burden on the woman's decision before fetal viability is unconstitutional. And third, subsequent to viability, the State, in promoting an interest in the potentiality of human life may if it chooses regulate and even prescribe abortion, except where it is necessary in appropriate

medical judgment for the preservation of life or health of the mother."

The case goes on for four pages talking about the medical situation involved, the pros and cons and all that, and then says, "The question before us is whether Nebraska statute making criminal the performance of a partial-birth abortion violates the Constitution as interpreted in *Planned Parenthood of Southeast Pennsylvania* v. *Casey* and *Roe* v. *Wade*." We conclude that it does for at least two independent reasons. First, the law lacks an exception, quote, "for the preservation of the health of the mother;" and second, it imposes an undue burden on a woman's ability to choose a D&E abortion, thereby unduly burdening the right to choose abortion itself. "The *Casey* joint opinion"—and I'm still reading—"the *Casey* joint opinion reiterated that what the Court held in *Roe*, that subsequent to viability, the State, in promoting its interest in the potentiality of human life, may if it chooses regulate and even prescribe an abortion, except where it is necessary in appropriate medical judgment for the preservation of life or health of the mother."

It goes on to say that, "Consequently the governing standard requires an exception 'where it is necessary in the appropriate medical judgment for the preservation of the life or health of the mother.'"

Then it says, Justice Thomas said that in cases just cited, limit this principle to situations where the pregnancy itself creates a threat to health, he is wrong. Our cases have repeatedly invalidated statutes that in the process of regulating the methods of abortion impose significant health risks. They make it clear that a risk to a woman's health is the same whether it happens to arise from regulating a particular method of abortion or from barring the abortion entirely.

And finally, Mr. Chairman, it says that in sum, Nebraska has not convinced us that a health exception is "never necessary to preserve the health of woman"—reply brief for petitioners, and that's in the reply brief—"rather a statute that altogether forbids D&X, creates a significant health risk. The statute subsequently must contain a health exception." It goes on to say that, "By no means must a State grant physicians 'unfettered discretion' in their selection of abortion methods, but where substantial medical authority supports the proposition that banning a particular abortion procedure could endanger a woman's health, *Casey* requires the statute to include a health exception when the procedure is 'necessary in appropriate medical judgment for the preservation of life or health of the mother.' Requiring such an exception in this case is no departure from *Casey*, but simply a straightforward application of its holding."

It then goes on to show how the lack of the health exception places an undue burden on the mother.

Mr. Chairman, I guess we could—if we don't adopt this amendment, it is clear from this decision that the court will rule it unconstitutional. Five judges signed this opinion. All five are still on the Supreme Court.

Now, whatever our views on the underlying issue of abortion, we ought to read the decision and apply the law.

Mr. CHABOT. Would the gentleman yield?

Mr. SCOTT. I yield.

Mr. CHABOT. The Supreme Court's case was based upon the trial court's factual findings that partial-birth abortions are safe. And the fact, the overwhelming weight of the evidence that we had in testimony from medical experts in our hearings, is that they are never medically necessary, they pose severe health risk, potential health risk to the woman, and they're outside the standard of standard medical care in this country.

So for those reasons there are findings based upon evidence here in Congress that that—the trial court was in error. We expect the Supreme Court to uphold——

Chairman SENSENBRENNER. The gentleman's time has expired.

Mr. FORBES. Mr. Chairman?

Mr. SCOTT. May I have 30 additional seconds, Mr. Chairman?

Chairman SENSENBRENNER. Without objection.

Mr. SCOTT. Mr. Chairman, I would just point out that the Supreme Court went through the evidence presented in court for four pages, analyzing that information, and I think any court would view that kind of analysis more heavily than a hearing where one side gets to pick what witnesses it wants without a reasonable chance of a really full finding of the facts.

The Court went through all of this for four pages, and I think it's clear that there is substantial medical testimony to support this procedure, and that's why they will again just like they did before.

Thank you, Mr. Chairman.

Chairman SENSENBRENNER. For what purpose the gentleman from Virginia, Mr. Forbes, seek recognition?

Mr. FORBES. Mr. Chairman, I move to strike the last word.

Chairman SENSENBRENNER. The gentleman's recognized for 5 minutes.

Mr. FORBES. Mr. Chairman, I'm like my good friend from Indiana in that I am new to this debating, congress, not new to the issues, but one of the things that amazed me, first of all, I hope we'll have an opportunity to discuss the Supreme Court case with the gentleman from Virginia a little bit later.

But one of the things that really amaze me is when you oftentimes listen to the debate on the floor and the Committee, there is a huge disconnect with the bill that is actually before us, and oftentimes I'll listen to the debate, and I say, "What in the world are we talking about in the debate, because it's not what's in the bill?" And I think if you look at this bill, Mr. Chairman, this bill is clearly not about choice. This bill is about preventing egregious and unnecessary pain to a newborn child or if you want to pick a different nomenclature, a fetus. The overwhelming testimony is that that unborn child, that fetus, experiences more pain at this particular juncture than it does even after it's born.

This bill is not about having an abortion. It's about whether or not you can have a partial-birth abortion. And some of the individuals that have spoken today talk about the AMA. They want to use the AMA position when it favors them. They want to reject it when it doesn't. But the bottom line is, the AMA does not favor this position. What the AMA is against are the penalties in this provision, and I would suggest to the Members of this Committee that over the next several weeks we're going to discuss a lot of corporate activity in America. You're going to see CEOs that are going to come in here, and none of them are going to object to the practices as

being improper, but where they're going to have a problem is when you start to say there are penalties for those particular practices.

And I would suggest to you that if you look at the testimony, the Chairman of this Subcommittee is absolutely right, the overwhelming testimony is that it is never necessary, necessary, to protect the health of the mother to have a partial-birth abortion. The whole purpose of this amendment is to make sure that you never ban partial-birth abortions, because to allow the doctor that's performing the abortion, who has a financial interest in doing that abortion, to determine whether or not he should have it, is exactly like having an accounting firm who is doing the work for a corporation also do the compliance audits, just doesn't work. You know, there is no checks and balances there.

And Mr. Chairman, I believe this issue comes down to one simple question. Is there no limit? Is there no amount of pain? Is there no procedure that is so extreme that we can apply to this unborn child or this fetus that we are willing as a country to say that just goes too far, we can't allow that to happen, and that's what partial-birth abortion does. That's why it's so important that we reject this amendment. That's why it's so important that we pass this bill. And, Mr. Chairman, I hope we will do those things.

Chairman SENSENBRENNER. What purpose does the gentleman from Massachusetts seek recognition?

Mr. FRANK. Strike the last word, Mr. Chairman.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. FRANK. Mr. Chairman, I do want to note what I thought was an important point made by the Chairman of the Subcommittee. He appeared to me to be acknowledging that this would be held unconstitutional unless the Supreme Court were prepared to accept a different view of the facts than governed last time.

Now, procedurally, the gentleman says, the Supreme Court felt governed by the factual findings of the trial court, and then the issue is, will the Supreme Court be sufficiently impressed by the different findings of this Committee and of the Congress if it passes the bill, so as to do a different factual basis, but I think it is important to note that the Chairman apparently acknowledges that unless they are prepared to reverse their factual findings, they would find this unconstitutional.

Mr. CHABOT. Would the gentleman yield?

Mr. FRANK. I'll yield the gentleman, but I just stated——

Mr. CHABOT. When the gentleman refers to the findings of the Subcommittee, it's the evidentiary hearing that was held by the Congress and that was based upon medical testimony.

Mr. FRANK. But it wasn't held by the Congress. At least I didn't see Senators there. I mean I think it was held by the Subcommittee. I don't understand why the gentleman——

Mr. CHABOT. Right. We're obviously——

Mr. FRANK. Right. And the question then would be whether the Congress adopts the findings, but I take it by what the gentleman didn't say, that he agrees, that we have a bill that was held unconstitutional by the Supreme Court, and the hope is that they will accept contrary findings as a result of a hearing and change their opinion.

I must say, as I have viewed this current Supreme Court majority, that has not been their pattern. They rejected very extensive findings with regard to the prevalence of disability and employment. They're rejected findings with regard to gun control.

Mr. HOSTETTLER. Would the gentleman yield?

Mr. FRANK. Yes.

Mr. HOSTETTLER. I thank the gentleman for yielding. Again, this was a Nebraska case that the Federal Court reviewed. They never actually reversed the Congress's——

Mr. FRANK. No, but the gentleman just ignored my point, which is right there in the First Amendment. You can ignore any point you want, but it seems to me odd that you would ask me to yield to rebut a point that you plan to ignore.

My point was that in similar cases where the Congress has tried to establish findings, the Supreme Court has totally and completely ignored them. They ignored the findings when they held part of the American with Disabilities Act not applicable against states. They have ignored some of the findings, repudiated them, with regard to the drug-free or gun-free schools.

So I think the argument that, yes, the Supreme Court did find something like this unconstitutional but we're going to find their mind with new factual findings, is a bit strained.

The other thing I would note—and this was clear in what the gentleman from Virginia just said, and I appreciate his forthrightness in this regard—the gentleman from Illinois, the former Chairman, with the passion and eloquence that he has brought to this subject as a matter of deep conscience for him, for his entire congressional career, once again articulated the position that abortion is wrong. Anyone who has served with him has enormous respect for the integrity and energy with which he has defended that, but we should note that this is not a bill, which even if it were passed and upheld by the Supreme Court, that would prevent any abortions.

As the gentleman from Virginia pointed out, this is over the method of abortion. This bill does not prevent any of the issues—or does not prevent the central issue that the gentleman from Illinois addressed. It does not stop abortions, it does not prevent abortions. It simply says to the doctors, if you're going to have—if you're going to perform an abortion, you must do other procedures, not this procedure. So we should be clear about this, that this is not anything that will interfere with abortions.

And that's relevant because I understand the deep feeling—and this is one of the most troubling issues I think for many of us, the question of abortion, including many of us who come down on the side of saying this should be a choice that a woman ultimately makes herself as long as she's the one who is pregnant and carrying. But part of the argument for legislative restriction, part of the argument for challenging a United States Supreme Court decision in the hope that they will reverse factual findings or accept factual findings and reverse themselves, is the desire to prevent abortions. And this bill does not do that, by its sponsor's acknowledgement. This is not a bill that will stop one abortion, that will prevent one abortion. It will change the method by which we have abortion. And given that, it seems to me that the case for chal-

lenging a Supreme Court decision in this way is not made. So I would hope that the amendment was adopted.

Mr. HOSTETTLER. Would the gentleman yield?

Ms. JACKSON LEE. Would the gentleman yield?

Mr. FRANK. Who asked me to yield? Well, the gentleman from Indiana asked me to yield first.

Mr. HOSTETTLER. I thank the gentleman for yielding. If this bill will not stop a single abortion from taking place, why do you think a significant portion of your colleagues on your side——

Mr. FRANK. Oh, very simple. First of all, it's not a question of "if." I mean everybody acknowledges that, because we do not consider ourselves to be the super medical board of America, because we do not believe, I certainly don't believe, that it's up to me to tell a physician what to do or what not to do in a medical procedure.

Chairman SENSENBRENNER. The gentleman's time has expired. The question is——

Mr. SCHIFF. Mr. Chairman?

Mr. WATT. Mr. Chairman?

Chairman SENSENBRENNER. For what purpose the gentleman from California, Mr. Schiff, seek recognition?

Mr. SCHIFF. Move to strike the last word.

Chairman SENSENBRENNER. The gentleman's recognized for 5 minutes.

Mr. SCHIFF. I thank the Chairman for yielding.

I wanted to really echo some of the remarks the gentleman from Massachusetts and the gentleman from North Carolina have made, and that is that I found on the subject of abortion this is one uniquely ill-suited to persuasion. I have never seen someone pro-choice persuade someone who is pro-life to be pro-choice or vice versa, and I don't expect we're going to break that precedent here today.

I do think that we've heard some of the most articulate formulations of the respective positions. The gentleman from Illinois's comments I think were among the most articulate I've ever heard in defense of his position, and likewise my colleagues on the other side of the issue.

There is I think an aspect of this we can discuss, and that is whether the Congress, by virtue of articulating findings, can compel the Supreme Court to reach a different conclusion than it has on several occasions. Can we find, as the bill sets out, that there is a medical consensus that partial-birth abortion is never medically necessary? Can the Congress simply declare that and expect that the court will adopt that finding when there is ample evidence to the contrary, that there is in fact no medical consensus, that is never medically necessary, when you have organizations like the American College of Obstetricians and Gynecologists, the American Public Health Association, the American Nurses Association, the American Medical Women's Association, the California Medical Association, the Physicians for Reproductive Choice and Health, and many other organizations taking a contrary view, can Congress simply declare that there is a medical consensus when there is none and expect the Supreme Court to adopt that as fact.

I don't think we can. And so in the absence of this amendment, the likelihood of the Supreme Court deferring to Congress to that degree is extraordinarily unlikely.

Findings alone are not sufficient to make an unconstitutional act constitutional. That is I think the bottom line, and so we have an opportunity to make this act constitutional with an amendment or we have the opportunity to send the bill to the Supreme Court, knowing in all probability it will simply be struck down as others have before it. And so we, I think, have a choice today of whether we legislate in this area or whether we make a symbolic act that may be consistent with the philosophical views of some of the Members of this Committee. But if that is what we're going to do we should be at least candid about what we're doing.

Ms. JACKSON LEE. Gentleman yield?

Mr. SCHIFF. I would yield to the gentlewoman from Texas.

Ms. JACKSON LEE. I thank the gentleman. Let me just follow up on the gentleman's reasoning as well as the gentleman from Massachusetts in the *Stenberg* case and the two grounds on which the Supreme Court ruled against the Nebraska ban on partial-birth abortion. The bans failed to include a health exception, impermissibly threatened women's health and then the undue burden on a woman's right to choose.

A few days ago the parent of John Lindh Walker compared him to Nelson Mandela. John Lindh Walker is no Nelson Mandela, and of course this bill before us has nothing to do with the issues of banning abortion. It has to do with medical procedures of which physicians have to make determinations in an emergency, when a woman comes and she is in an emergency dealing with her life or her health. And the one thing that we've not mentioned in this room is the ability of the woman to procreate in the future. And we had testimony years ago which the Supreme Court, on the basis of looking at legislative history, would look at, which showed that one of the reasons physicians would make the decision was to allow that woman to procreate again, because if she did not have the procedure she would be denied her right to give birth prospectively and her family's right to give birth prospectively because she would not, because of not having the procedure, be able to do so. So I think that we are, one, flying in the face of the evident Supreme Court law, and might I says, though we do not speak of the other body, clearly, the other body will not accept this legislation and will not accept the legislative history that we put forward, because you can find a myriad of opinions on whether or not this is a right procedure, the American Medical Association, my good friend from California listed a number of them. What is the answer, my friends on the other side, about this procedure helping a woman be able to procreate as she desires, because if she does not have it, her health is undermined, her life is in jeopardy, and therefore denying her that right. I would hope my colleagues would look at this legislation for what it is——

Chairman SENSENBRENNER. The gentleman's time has expired.

Ms. JACKSON LEE.—choices to be made by a woman and her family.

Chairman SENSENBRENNER. For what purpose does the gentlewoman from Pennsylvania seek recognition?

Ms. HART. Strike the last word, Mr. Chairman.

Chairman SENSENBRENNER. The gentlewoman's recognized for 5 minutes.

Ms. HART. Thank you, Mr. Chairman.

In response to the gentleman from California who said that he's not seen anyone be converted from an opinion as pro-choice or pro-life to the other side. I can assure him I've seen a number of people who were converted from the position of pro-choice to the position of pro life once they have understood the facts, especially the facts of this procedure. In fact my U.S. Senator counts as one of them.

This procedure again is the issue. It is not the issue of whether we will have abortion be legal in this country. The concern of this amendment is specifically that for some—in some way this procedure can protect the health of the mother, but in fact, Dr. Leroy Carhart, the *Carhart* in *Stenberg* v. *Carhart*, has testified—and those who have testified on his behalf, have not identified a single circumstance during which a partial-birth abortion is necessary to preserve, as they stated, the health of a woman. In fact, according to Dr. Carhart's testimony, when he has chosen to perform a partial-birth abortion, he has done so based upon, as he presented it, the happenstance of the presentation of an unborn child, not because it was the only procedure that would have preserved the health of the mother.

Also, Dr. Martin Haskell, who is the physician who is, unfortunately, credited with developing the partial-birth abortion procedure, he has testified that he has never encountered a situation where a partial-birth abortion was medically necessary to even achieve the desired outcome of aborting the child.

Those are some fairly extreme positions of physicians as we sit here as a bunch of lawyers and non-lawyers discussing this case, I think it's important especially to bring them to our attention because they were those who supported this particular procedure. They did not, however, support this procedure as necessary to preserve the health of a woman.

Obviously, I rise encouraging my colleagues to reject this amendment, not only because of the issues that were very clearly discussed about the facts of the procedure, but also the requirement that this amendment makes, that is necessary to preserve the health of a woman——

Mr. WEINER. Would the gentlelady yield on that point?

Ms. HART. It simply is not. I will not. And I will yield back my time.

Mr. WATT. Mr. Chairman?

Mr. WEINER. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from North Carolina, Mr. Watt?

Mr. WATT. I move to strike the last word.

Chairman SENSENBRENNER. Before recognizing you, let me say that is the Chair's intent to vote on this amendment and then to dispose of the amendment that the gentleman from Indiana, Mr. Hostettler, intends to offer, and then we can break for lunch.

The gentleman is recognized for 5 minutes.

Mr. WATT. Thank you, Mr. Chairman.

I yield to Mr. Scott from Virginia.

Mr. SCOTT. Thank you.

And just very briefly, Mr. Chairman, we've had arguments about the medical issues, and I think it's important to put those in context by reading the decision itself.

It says, "The word 'necessary' in *Casey*'s phrase, 'necessary in appropriate medical judgment for the preservation of the life or health of the mother,' cannot refer to an absolute necessity or absolute proof. Medical treatments and procedures are often considered appropriate or inappropriate in light of estimated comparable health risks and health benefits in particular cases. Neither can the phrase 'require unanimity of medical opinion.' Doctors often differ in their estimation of comparable health risk and appropriate treatment. In *Casey*'s words, 'Appropriate medical judgment must embody the judicial need to tolerate responsible differences of medical opinion,' differences of the sort that the American Medical Association and the American College of Obstetricians and Gynecologists' statements together indicate are present here, where a significant body of medical opinion believes a procedure may bring it greater safety for some patients, and explains the medical reasons supporting the view, we cannot say that the presence of a differing view by itself proves the contrary."

And it goes on to say that where the substantial medical authority supports the proposition that banning a particular abortion procedure could endanger women's health, *Casey* requires the statute to include a health exception where the procedure is, and for many times they've cited, necessary in the appropriate medical judgment for the preservation of the life or health of the mother.

Mr. Chairman, that's what the Supreme Court, five judges. They're still there. And I think we need—that's why we need this amendment.

And I yield back.

Mr. WATT. I'd yield to Mr. Wiener.

Mr. WEINER. I just want to briefly say it is—it's interesting to me the level to which proponents of the bill adhere to the medical testimony before the Subcommittee, and yet are so fearful of language that says "in appropriate medical judgment" in the bill. I mean it seems like both sides—although sometimes I wonder—both sides are conceding that we are not physicians here, that we are not qualified to make these decisions individually. Yet, there appears to be reluctance on those that are opposed to this amendment, just to leave the medical judgment, the appropriate medical judgment as sufficient language to protect the idea that we don't know enough.

And I would say something also, because this has now come up I guess a couple of times, you know, from the gentleman from Indiana, gentleman from Virginia. It reminds me of that Phil Hartman character on Saturday Night Live, Caveman, you know, talking about the mysterious ways here in Congress. I'm a Caveman Congressman waking up from a deep slumber.

You know, this isn't that—this isn't that mysterious. This is simply kind of, I would argue, a fairly basic question about whether or not you're conservative, because conservatives, I have always been told, believe that Government should be involved in people's individual lives and choices as infrequently as absolutely possible. And yet in this case, I guess these newer Members or some more senior Members, who claim to be conservative, throw away that instinct when it comes to this issue.

This isn't that mysterious. It's simply a matter of, "A", whether you want the bill to pass, and we've had an enormous amount of

discussion about how to make it comply with the constitutional prescriptions as outlined by the Supreme Court. We have safeguards to ensure that if our judgment is wrong, meaning that we're not physicians, and I think that some of my colleagues have said, well, maybe they're not qualified because they're not lawyers. You're also not qualified because you're men who aren't doctors.

So all of these things seem to be protected by supporting the amendment here, and I yield back.

Ms. WATERS. Would you yield—would the gentleman yield to——

Mr. WATT. I will yield to the gentlelady from California.

Ms. WATERS. Thank you very much.

Mr. Chairman and Members, I was just sitting here feeling so uncomfortable in all of this discussion, and wondering why I'm allowing this to bother me so much. And to tell you the truth, my response to all of this is really in defense of womanhood, and defense of our right to be respected, in defense of our right not to be talked down to, have ignorant people talk to us about our bodies. I am offended by the fact that the gentleman, the author of this bill, had the audacity to talk to us about our cervix and our uterus and lacerations and hemorrhaging and shock and infection.

I want you to know that we live all of our lives protecting our bodies and paying attention to our bodies, and most of what he refers to we will experience many times in our lives, and we have learned how to take care of ourselves. And I don't like the fact that any man would dare to dispassionately discuss what is very private and precious to a woman, and I wish you would knock it off, and I wish you would stop it, because it is disrespectful, and when you disrespect me and the woman of this Committee and the women in this room, you indeed disrespect your wives and your daughters.

Chairman SENSENBRENNER. The time of the gentleman has expired.

The question is on agreeing to the amendment offered by the gentlewoman from Wisconsin, Ms. Baldwin. Those in favor will say aye.

Opposed, no.

Ms. BALDWIN. rollcall.

Chairman SENSENBRENNER. The noes appear to have it. The rollcall is requested. Those in favor of the Baldwin Amendment will as your names are called answer aye, those opposed, no, and the clerk will call the roll.

The CLERK. Mr. Hyde?

Mr. HYDE. No.

The CLERK. Mr. Hyde, no. Mr. Gekas?

Mr. GEKAS. No.

The CLERK. Mr. Gekas, no. Mr. Coble?

[No response.]

The CLERK. Mr. Smith?

Mr. SMITH. No.

The CLERK. Mr. Smith, no. Mr. Gallegly?

Mr. GALLEGLY. No.

The CLERK. Mr. Gallegly, no. Mr. Goodlatte?

[No response.]

The CLERK. Mr. Chabot?

Mr. CHABOT. No.

The CLERK. Mr. Chabot, no. Mr. Barr?

Mr. BARR. No.
The CLERK. Mr. Barr, no. Mr. Jenkins?
Mr. JENKINS. No.
The CLERK. Mr. Jenkins, no. Mr. Cannon?
Mr. CANNON. No.
The CLERK. Mr. Cannon, no. Mr. Graham?
Mr. GRAHAM. No.
The CLERK. Mr. Graham, no. Mr. Bachus?
Mr. BACHUS. No.
The CLERK. Mr. Bachus, no. Mr. Hostettler?
Mr. HOSTETTLER. No.
The CLERK. Mr. Hostettler, no. Mr. Green?
[No response.]
The CLERK. Mr. Keller?
Mr. KELLER. No.
The CLERK. Mr. Keller, no. Mr. Issa?
Mr. ISSA. No.
The CLERK. Mr. Issa, no. Ms. Hart?
Ms. HART. No.
The CLERK. Ms. Hart, no. Mr. Flake?
Mr. FLAKE. No.
The CLERK. Mr. Flake, no. Mr. Pence?
[No response.]
The CLERK. Mr. Forbes.
Mr. FORBES. No.
The CLERK. Mr. Forbes, no. Mr. Conyers?
[No response.]
The CLERK. Mr. Frank?
Mr. FRANK. Aye.
The CLERK. Mr. Frank, aye. Mr. Berman?
[No response.]
The CLERK. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
[No response.]
The CLERK. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
Mr. WATT. Aye.
The CLERK. Mr. Watt, aye. Ms. Lofgren?
Ms. LOFGREN. Aye.
The CLERK. Ms. Lofgren, aye. Ms. Jackson Lee?
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee, aye. Ms. Waters?
Ms. WATERS. Aye.
The CLERK. Ms. Waters, aye. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
Mr. WEINER. Aye.

The CLERK. Mr. Weiner, aye. Mr. Schiff?

Mr. SCHIFF. Aye.

The CLERK. Mr. Schiff, aye. Mr. Chairman?

Chairman SENSENBRENNER. No.

The CLERK. Mr. Chairman, no.

Chairman SENSENBRENNER. Are there Members in the chamber that wish to cast or change their votes? If none, the clerk will report.

The gentleman from Wisconsin, Mr. Green?

Mr. GREEN. How am I recorded as voting?

The CLERK. Mr. Green, you are not recorded.

Mr. GREEN. Vote no.

The CLERK. Mr. Green, no.

Chairman SENSENBRENNER. Further Members who wish to cast or change their votes? If not, the clerk will try again to report.

The CLERK. Mr. Chairman, there are 10 ayes and 18 nays.

Chairman SENSENBRENNER. And the amendment is not agreed to.

Are there further amendments? For what purpose the gentleman from Indiana seek recognition?

Mr. HOSTETTLER. Mr. Chairman, I have an amendment at the desk.

Chairman SENSENBRENNER. The Clerk will report the amendment.

The CLERK. Amendment to H.R. 4865 offered by Mr. Hostettler. Add at the end the following: Sec. Limitation on Judicial Review. In accordance with Congress' power to limit appellate jurisdiction under article III, section 2 of the Constitution of the United States——

Chairman SENSENBRENNER. Without objection, the amendment is considered as read, and the gentleman from Indiana is recognized for 5 minutes.

[The amendment follows:]

AMENDMENT TO H.R. 4965

OFFERED BY MR. HOSTETTLER

Add at the end the following:

SEC. . LIMITATION ON JUDICIAL REVIEW.

In accordance with Congress' power to limit appellate jurisdiction under article III, section 2 of the Constitution of the United States, the Supreme Court of the United States shall have no appellate jurisdiction over a case or controversy arising from this Act.

Mr. HOSTETTLER. I thank the Chairman. Mr. Chairman, on May 15, 1997, Lino A. Graglia, the A. Dalton Cross Professor of Law at the University of Texas School of Law stated before the Subcommittee on Courts and Intellectual Property the following, "The first and most important thing to know about constitutional law is that it has virtually nothing to do with the Constitution."

Mr. Chairman, not being an attorney myself, and that discussion was had frequently today, I have not studied constitutional law and so I will resort to the actual Constitution itself for the basis of my amendment.

Congress has the power to limit the Supreme Court's appellate jurisdiction in article III, section 2 of the Constitution. The section states, "In all the other cases before mentioned the Supreme Court shall have appellate jurisdiction both as to law and fact, with such exceptions and under such regulations as the Congress shall make."

I believe we should take this step to limit the Supreme Court's jurisdiction on this issue, because I believe the Supreme Court has gotten this wrong. In *Stenberg* v. *Carhart*, Justice Breyer equated partial-birth abortion with a treatment for a rare disease. He also quoted the trial court rulings that said, "Because the fetus is larger at this stage of gestation, particularly the head, and because bones are more rigid, dismemberment or other destructive procedures are more likely to be required than at earlier gestational ages to remove fetal and placental tissue."

And he also described the D&X procedure in this way, following, "It begins with induced dilation of the cervix. The procedure then involves removing the fetus from the uterus through the cervix intact, i.e., in one pass rather than in several passes. If the fetus presents head first, the doctor collapses the skull, and the doctor then

extracts the entire fetus through the cervix. If the fetus presents with feet first, the doctor pulls the fetal body through the cervix."

Later he described how, "The D&X procedure may create special risks, including cervical incompetence, caused by over dilation, injury caused by conversion of the fetal presentation, and dangers arising from the so-called blind use of instrumentation to pierce the fetal skull while lodged in the birth canal."

Now, Justice Breyer had no problem about ruling in favor of partial-birth abortion even after describing these heinous procedures. Do we really want these people to in effect continue legislating to the entire United States? As elected legislators we must ask ourselves by what standard shall we make public policy? We have been elected by our constituents to make principled responsible decisions. We should not relinquish our legislative power to as few as five un-elected unaccountable officials. Instead the Judiciary should rightly apply the law as given by elected, accountable legislators. We can see, Mr. Chairman, that the framers of the Constitution were wise by granting the Judiciary so little power. In effect, once again as little as five un-elected people should not impose their standards on the entire country.

Mr. Chairman, in conclusion, I would simply say that while there's going to be a health discussion on whether we should do this or not, it is encouraging to me that the framers of the Constitution, in article III, established the procedure to allow us to do it, and so while we'll talk a lot about whether we should, we do know that we can.

Ms. JACKSON LEE. Would the gentleman yield?

Mr. CANNON. Would the gentleman yield, Mr. Hostettler?

Mr. HOSTETTLER. I'll yield first to the lady from Texas.

Ms. JACKSON LEE. Let me just say to the distinguished gentleman, I respect every Member's right to bring forward a discussion such as this. In fact, I think it's worthy of a lively discussion. And might I correct for the record, I think I called the Supreme Court case Sternberg, it's *Stenberg*. I needed my reading glasses.

But in any event, I would only say to you I have difficulty in the way courts render decisions regarding the death penalty, and what you are suggesting to me then is that in any instance where we have difficult with the higher body's decision, then we can put forward these particular proposals or amendments, and I can rely upon the Ninth Circuit or maybe even the Second Circuit, which is more favorable to my perspective.

I respect the gentleman. I think—I love a constitutional discussion, but I simply say to you that we must be very cautious in overturning 200 years of constitutional theory and law and standards.

And I yield back to the gentleman, thank him for his kindness.

Mr. HOSTETTLER. Thank you. And not only do I believe we can do that, but the majority of delegates who ratified the Constitution believe so as well.

And in that, I yield to the gentleman from Utah if he desires.

Mr. CANNON. Thank you. Would there be time for one question?

Chairman SENSENBRENNER. The gentleman's time is expired and the Chair recognizes himself for 5 minutes in opposition to the amendment.

First of all, I don't think it's settled law that Congress can take away the jurisdiction of the Supreme Court in the manner in which

is proposed in this amendment. Assuming, however, for the sake of argument, that the amendment is constitutional and the Supreme Court would so hold it, the amendment does not take away the jurisdiction of the lower Federal courts to deal with the issue of the constitutionality of the partial-birth abortion statute that is under consideration here. And I would assume that the Ninth and the Second Circuits would decide this issue one way, and the Fifth Circuit might decide this issue, and the Fourth Circuit would decide the issue another way, and that way you would have a different interpretation of the Constitution between circuits that the Supreme Court could not review and establish a uniform constitutional interpretation of the question.

One of the things that the Supreme Court always grants certiorari on is when different circuits reach opposite conclusions, so that there can be settled law throughout the country. And I do not agree with the Court's decision in the *Stenberg* case and am a principal co-sponsor of this bill and strongly support it. But I don't think this amendment does this debate any favors, and will result in an even more confusing state of the law should this amendment be approved, the bill be enacted into law, and the Supreme Court decline to extend its jurisdiction over reviewing the decisions of the various United States Courts of Appeals that would come on up on certiorari.

I yield to the gentleman from Illinois.

Mr. HYDE. Would the gentleman yield?

Chairman SENSENBRENNER. I yield.

Mr. HYDE. Thank you.

The remedy of court stripping, which is what this is called, is very extreme. It can hardly get more extreme, and I would respectfully suggest to the gentleman from Indiana that if you're going to go in that direction, it seems overkill to take away from the Court any jurisdiction over partial-birth abortion, one procedure in a whole array of procedures involving abortion. It would seem to me if you're in for a penny, be in for a pound and take the subject of abortion away from the Court. You're just taking away partial-birth abortion.

So it just seems to me overkill. I certainly sympathize with what the gentleman is trying to do. I note that the *Carhart* decision was 5 to 4, which means one Justice changing his or her mind, you'd have had an entirely different result and you wouldn't have heard any citations of the Supreme Court from the other side. But taking a subject away from the Court, which is very radical, has not been done really. It seems to me you're using a blunderbuss on a—well, I don't want to say a gnat, but on a less significant issue, and I would ask the gentleman if he might reconsider offering this, and we'll have a seminar sometime on appropriate subjects to strip from the Court.

Mr. HOSTETTLER. Mr. Chairman, will the Chairman yield?

Chairman SENSENBRENNER. I yield.

Mr. HOSTETTLER. I appreciate the use of the term "overkill" when dealing with the issue of partial-birth abortion, but I would suggest that extreme measures call for extreme remedies, and that's my desire in this amendment. Yield back.

Mr. FRANK. Mr. Chairman

Chairman SENSENBRENNER. For what purpose does the gentlemen from Massachusetts seek recognition?

Mr. FRANK. To strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized.

Mr. FRANK. Let me say, Mr. Chairman, I want to congratulate my California colleagues in particular. There are a number of Members on this side of the aisle from California, because I think the notion of setting the precedent that the Ninth Circuit could have the last word on constitutional issues has some appeal to them, and there might be——

Ms. JACKSON LEE. And me too from Texas.

Mr. HOSTETTLER. Would the gentleman yield?

Mr. FRANK. And we might be tempted to vote aye, but I do believe in the interest of the Constitution and lunch, they're probably going to do that, and I would yield back the—I yield to the gentleman from Indiana if he wishes me to.

Mr. HOSTETTLER. Well, given recent precedent, I think that the Court could find upon itself to overturn itself and block its own decision, so I'm not as concerned about the Ninth Circuit Court, given what they've done regarding the Pledge of Allegiance as some conservatives may be. Yield back.

Chairman SENSENBRENNER. The question is on agreeing to the amendment offered by the gentleman from Indiana, Mr. Hostettler. Those in favor will say aye.

Opposed, no.

The noes appear to have it. The noes have it. The amendment is not agreed to.

The Chair is prepared to recess the Committee until 2:00 p.m. Should there be a vote at 2:00 p.m., we will reconvene immediately after that vote. The Committee is recessed.

[Recess at 12:46 p.m.]

AFTERNOON SESSION

Chairman SENSENBRENNER. The Committee will be in order.

When the Committee recessed, pending was a motion to report the bill H.R. 4965 to the House favorably. By unanimous consent——

Ms. JACKSON LEE. I had amendments. That wasn't pending.

Chairman SENSENBRENNER. By unanimous consent, the bill had been considered as read and open for amendment at any point.

Are there further amendments?

Ms. JACKSON LEE. I have an amendment at the desk, Jackson Lee.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 4965, offered by Ms. Jackson Lee. Page 17, strike line 13 and all that follows through line 25.

[The amendment follows:]

AMENDMENT TO H.R. 4965

OFFERED BY ~~Mr. Nadler~~

Ms Jackson Lee

Page 17, strike line 13 and all that follows through line 25.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

Ms. JACKSON LEE. I will not take up all of the time, Mr. Chairman. Let me just simply say that we have debated this. This bill unfairly and harshly penalizes physicians, medical practitioners, who simply are responding to the emergency medical need of the patient.

This is an issue that should be, again, as I said, between patient, family, spiritual leader, and certainly on the basis of saving the life or the health of the mother. And so I don't think that this should be a criminal proceeding, where physicians who have taken a Hippocratic Oath to save lives should be penalized criminally. And this language removes the criminal penalties against physicians.

And I would like to submit into the record a letter from the American Medical Association, dated October 21, 1999. "The AMA has asked Senator Santorum to remove the criminal sanctions from his bill, but such a change has not been made. For this reason, we do not support the bill."

Chairman SENSENBRENNER. Without objection, the letter will be included in the record.

[The information follows:]

American Medical Association
Physicians dedicated to the health of America

Statement

For Response Only **October 21, 1999**

"U.S. Senator Rick Santorum (R-PA) has reintroduced a bill that would ban intact dilatation and extraction. The American Medical Association (AMA) has previously stated our opposition to this procedure. We have not changed our position regarding the use of this procedure.

"The AMA has asked Sen. Santorum to remove the criminal sanctions from his bill, but such a change has not been made. For this reason we do not support the bill."

[The prepared statement of Ms. Jackson Lee follows:]

Amendment .003

Mr. Chairman, I have an amendment at the desk, number .003.

Mr. Chairman, I ask unanimous consent that the amendment be considered as read.

Mr. Chairman, this amendment would do away with the language in the bill that would allow a birth father, if the parents are married, or the birth mother's parents, if she is under 18 years of age, to sue the woman or her doctor. This is an outrageous intrusion into a woman's right to choose and will have absurd and disgraceful consequences.

It would allow a birth father, who has abandoned his pregnant wife, to sue her for having an abortion, even if it was to preserve her health of the woman, because there is no health exception in this bill. He would be able to sue her and her doctor even if he abused her before abandoning her. I am not sure how this is either a pro-family or a pro-life position. It is certainly pro-plaintiffs' lawyer, and would provide a windfall for the worst sorts of individuals.

A doctor, before preforming a medical procedure, would have to do some investigative work on his patient to determine if there was perhaps a separated spouse out there somewhere who might want to make a little money. How much investigation does a doctor have to do? Do a records search to see if the woman has ever been married? Or if she has ever used any aliases? Of to demand a copy of a divorce certificate before performing a medical procedure that may be required by the woman's health – again, there is no health exception in this bill although one is

required by the Supreme Court.

It is certainly not clear why the authors of this bill are insisting on placing this legal sword of Damocles over the head of women and their doctors, except, perhaps, to make some mischief. That is really a disgraceful burden on a woman's right to choose.

I urge its adoption.

Ms. JACKSON LEE. And so I would argue vigorously that this is wrong-directed, misdirected. Again, this does nothing to stop abortions. And so if we are to be even levelheaded, putting aside fair-minded, certainly the criminal penalties against physicians who are, in essence——

Mr. CHABOT. Would the gentlelady yield?

Ms. JACKSON LEE.—operating under their——

Mr. CHABOT. Would the gentlelady yield?

Ms. JACKSON LEE. I'd be happy to yield.

Mr. CHABOT. I believe the gentlelady has two different amendments, one to remove the civil and one to remove the criminal. And I think you may be arguing the wrong one. I would advise you just to take a look at it, or staff to check it out.

Ms. JACKSON LEE. Well, whatever it is—let me pull up the amendment dealing with the physicians, please.

Chairman SENSENBRENNER. Does the gentlewoman——

Ms. JACKSON LEE. Withdraw this amendment.

Chairman SENSENBRENNER. Does the gentlewoman anticipate reintroducing this amendment, because we can save a little bit of time if you'll just change your argument rather than saying it over again?

Ms. JACKSON LEE. Well, Mr. Chairman, if you would be kind enough to allow me to do that, I would be happy to do so. And I will just end on simply saying whatever this——

Chairman SENSENBRENNER. The Chair will restart the clock for the gentlewoman from Texas so that she now can describe the right amendment.

Ms. JACKSON LEE. And I guess it's the redundancy of this argument, Mr. Chairman. I apologize to my colleagues. And in fact, this is Mr. Nadler's amendment that I'm now offering as my amendment. So I won't prolong it, other than to say that is strikes out——

Mr. SCOTT. Point of order, Mr. Chairman. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman will state his point of order.

Mr. SCOTT. Could we report the amendment we're discussing?

Chairman SENSENBRENNER. We already have reported the amendment that we're discussing.

Ms. JACKSON LEE. This strikes the language that you have noted, from Mr. Scott's viewpoint, on page 12, dealing with—17, dealing with, reading, "The father, if married to the mother at the time she

receives a partial-birth abortion procedure, and if the mother has not obtained the age of 18 years of age at the time of the abortion, the maternal grandparents of the fetus may in a civil action obtain appropriate relief, unless the pregnancy resulted in"—we've asked that this amendment be deleted because it would allow a birth father who has abandoned his pregnant mother to sue her for having an abortion, even if it was to preserve the health of the woman, because there is no health exception in this bill. He'd be able to sue her and her doctor, even if he abused her before abandoning her.

And so we'd ask that this language be deleted.

I yield back.

Chairman SENSENBRENNER. The gentleman from Ohio, Mr. Chabot.

Mr. CHABOT. Thank you. Move to strike the last word, Mr. Chairman.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. CHABOT. Thank you, Mr. Chairman. I'll be brief.

I rise in opposition to this amendment. The amendment should be opposed because the civil enforcement provisions of the law are necessary to ensure that there are effective deterrents in place to keep physicians from performing partial-birth abortions, which will be banned by this particular legislation.

The civil action provision is also drafted to ensure that individuals do not profit from their own misconduct. The provision excludes plaintiffs who consented to the abortion or whose criminal conduct caused the pregnancy.

With that, I would urge my colleagues to oppose this amendment. And I yield back the balance of my time.

Chairman SENSENBRENNER. Does the gentleman yield back?

Mr. CHABOT. I yield back.

Chairman SENSENBRENNER. The question is on the amendment offered by the gentlewoman from California, Ms. Jackson Lee.

Those in favor will say aye.

Excuse me, Texas.

Those in favor say aye.

Opposed, no.

The noes appear to have it. The noes have it, and the amendment is not agreed to.

Are there further amendments?

Ms. BALDWIN. Mr. Chairman? Mr. Chairman?

Ms. JACKSON LEE. I have an amendment.

Chairman SENSENBRENNER. For what purpose does the gentleman from Massachusetts, Mr. Frank, seek recognition?

Mr. FRANK. I have an amendment at the desk.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 4965, offered by Mr. Frank——

Mr. FRANK. I ask unanimous consent it be considered—well, I'll wait if the Chairman wants me to withhold——

Chairman SENSENBRENNER. The clerk will continue to read.

The CLERK. Page 16, beginning in line 7, strike "that is necessary" and all that follows through——

Chairman SENSENBRENNER. Without objection, the amendment is considered as read.

[The amendment follows:]

Amendment to H.R. 4965
Offered by Mr. Frank

Page 16, beginning in line 7, strike "that is necessary" and all that follows through the period in line 11 and insert "performed before fetal viability where necessary, in appropirate medical judgment, for the preservation of the life or health of the mother, or to such a procedure performed after fetal viability if it is to protect the mother from serious, adverse physical health consequences.".

Chairman SENSENBRENNER. And the gentleman from Massachusetts is recognized for 5 minutes.

Mr. FRANK. Mr. Chairman, this really is a variant, to some extent, on the lengthy debate we already had, so I don't think there's need for a long debate.

The preference of many on this side was for a health exception throughout, with regard to the bill. We lost on that. This is a modified version. It calls for a health exception unrestricted before viability, which we believe is constitutionally called for. Post-viability, recognizing that the Supreme Court has conceded to Congress some additional power post-viability, although its extent is yet to be fully delineated, it would grant a more limited health exception. It would say, post-viability, you could perform such a procedure, the procedure proscribed by the bill, to protect the mother from serious adverse physical health consequences.

I note "physical." The gentleman from Illinois has frequently stressed that his opposition of a health exception is partly motivated by the fact that, as interpreted, it includes mental health as well as physical health. Again, we believe that in the pre-viability period, that's constitutionally compelled. Post-viability, it may not be. And in the interest of trying to move this forward, I offer this amendment.

I would say this: The mental health reasons are more likely, which I think are valid ones, to come earlier in the pregnancy. If we are talking about very late in the pregnancy and the post-viability period, I can see your argument that the mental health reasons may not have—that there's some skepticism that they arose later. I don't agree with that, but I understand it.

What this says is that if, in the appropriate medical judgment, this procedure that is proscribed, forbidden by the bill, is necessary to protect the mother from serious adverse physical health consequences, it ought to go forward. Now, I know Members have said, "Well, that will never be the case." But the bill does say that the prohibited procedure may be performed to save the life of the mother.

I am not a doctor, and unlike a substantial number of my colleagues, I do not aspire, this late in my life, to become one. So I am not prepared to engage, as some of my colleagues are, in the

practice of medicine. But I would be confident as to this: Doctors cannot be certain that there is a procedure that's necessary to save someone's life but it would not implicate serious physical health consequences.

In other words, I think, to my colleagues in the majority, you have conceded the point. When you put in the bill that there must be an exception if it is deemed to be necessary to save a life, then you must contemplate that it might also sometimes be necessary to avoid serious physical health consequences.

Again, none of us can think of any situation in which it is clear that it will be either life or death but, if it's not death, then there are no consequences. So I am really just trying to build on what you've done.

It is less than many of us would like. I will be honest—let me anticipate the question we often ask each other in this case—I will vote against the bill even if my amendment is adopted. But it does seem to me to deal with the situation that we heard from several of our colleagues. And to say that, again, we will make an exception if the life of the mother is at stake, but we will not make an exception to avoid serious adverse physical health consequences, clearly, once you have conceded that it may be necessary to save life, you've conceded that it may be necessary to prevent adverse physical health consequences.

We are again talking, as I noted before, not about preventing abortions. We're talking only about which method. And to acknowledge that an abortion can be performed, but to forbid a particular method if the doctor thinks this might, in this particular circumstance, avoid serious adverse physical consequences, it seems to be in error. So that's why I offer this amendment.

Mr. CHABOT. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from Ohio.

Mr. CHABOT. Thank you, Mr. Chairman. I move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. CHABOT. Thank you, Mr. Chairman. Again, I will be brief.

I would urge my colleagues to oppose this particular amendment. I do agree with one aspect of what Mr. Frank said, and that's that this is very similar to the Baldwin-Jackson Lee amendment, which we already debated at some length on both sides and really aired a lot of the basic arguments for and against this particular piece of legislation.

And so I will, rather than extend the debate further, I would just, again, urge my colleagues to oppose this amendment, and yield back the balance of my time.

Chairman SENSENBRENNER. The question is on the amendment offered by the gentleman from Massachusetts, Mr. Frank.

Those in favor will say aye.

Opposed, no.

The noes appear to have it. The noes have it, and the amendment is not agreed to.

Are there further amendments?

Ms. BALDWIN. Mr. Chairman?

Mr. PENCE. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from Indiana, Mr. Pence.

Mr. PENCE. I have an amendment at the desk.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 4965, offered by Mr. Pence. Page 16, line 5, strike "2 years" and insert "10 years."

[The amendment follows:]

AMENDMENT TO H.R. 4965

OFFERED BY MR. PENCE

Page 16, line 5, strike ''2 years'' and insert ''10 years''.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. PENCE. Thank you, Mr. Chairman.

As I mentioned earlier on this panel, I'm pro-life. I don't apologize for it. I recognize, as we've heard on this panel today, in evidence, that our country has a broad disagreement on this issue. The question of abortion, or to use the former Chairman's term, the question of what—abortion is called reproductive rights.

But let me suggest that as we consider this very excellent bill, H.R. 4965, the "Partial-Birth Abortion Ban Act of 2002," it is not about abortion, that we contend today. I would offer, rather, that it is, if I may put it plainly, it is about the proper response in society to the shedding of innocent blood. I believe, Mr. Chairman, that a society is rightly judged by how it deals with the most defenseless in that society and also how it confronts those who would prey upon the most defenseless in a society.

As has been said before, former Senator Daniel Patrick Moynihan has accurately described the procedure known as partial-birth abortion, the procedure described in the Partial-Birth Abortion Ban Act of 2002, as near-infanticide. And I would read into the record again that of which we are speaking today. This is not an abortion; this is something much more heinous and much worse. And it's the basis upon which I would offer an amendment today that the penalties be stronger against medical professionals who perform this act.

A partial-birth abortion in the act is defined as "an abortion in which a physician delivers an unborn child's body until only the head remains inside the womb, punctures the back of the child's skull with a sharp instrument, and sucks the child's brains out before completing delivery of the dead infant."

Mr. Chairman, I submit to you that this is not an abortion; this is a horrific practice that is utterly unconscionable. And for that reason, I offer the amendment today that 2 years in Federal prison is not an adequate punishment for this type of barbaric ending of an innocent and defenseless human life. I believe that we should change the punishment for performing a partial-birth abortion from

a maximum sentence of 2 years to a maximum sentence of 10 years.

And I would also point out to my colleagues, who might think 2 years is sufficient, what some of the corollaries in Federal law are for penalties of this nature. You can serve 6 months in Federal prison for using the character or name of Smokey Bear without authorization. Also, using the character or name of Woodsy Owl or the slogan "Give a hoot, don't pollute" will get you 6 months. Putting a penny on a railroad track will get you 5 years in America. Anyone who takes or steals any newspaper can get up to 1 year in Federal prison. Mailing lottery tickets illegally can get you 5 years in the hoosegow. And on and on, the list, it goes. Misrepresentation of citizenship will get you 3 years in prison.

And yet, what we described today as the barbaric ending of an innocent and defenseless human life only draws 2 years in Federal prison. I think the message here is very plain, Mr. Chairman, that the punishment should fit the crime, and that this, I believe, is a time for moral clarity. We are not about the business today of paying politics. We ought to be about the business of doing nothing less than justice, to creating new barriers in the laws of this country against violent acts against our citizens, even our nascent and newborn citizens. And only by raising the penalties beyond—with 15 percent of time off for good behavior in the Federal prison system for time served, a person could use this procedure to barbarically end an innocent, defenseless human life and serve less than a year on average in Federal prison for having done that.

I understand, Mr. Chairman, that there are concerns about this amendment, that there is a larger issue of trying to bring, with the new findings of fact, trying to bring this bill that the Subcommittee Chairman has done in such a workman-like way to the floor in similar fashion as the past. So with that, I would respectfully ask unanimous consent to withdraw this amendment.

Chairman SENSENBRENNER. The amendment is withdrawn.

Are there further amendments?

Ms. BALDWIN. Mr. Chairman?

Chairman SENSENBRENNER. The gentlewoman from Wisconsin.

Ms. BALDWIN. Mr. Chairman, I have an amendment at the desk.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 4965, offered by Ms. Baldwin. Strike section 2.

[The amendment follows:]

AMENDMENT TO H.R. 4965

OFFERED BY Ms. Baldwin

Strike section 2.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

Ms. BALDWIN. Thank you, Mr. Chairman.

This amendment is very simple. It strikes the findings from the bill. There are several good reasons to remove the findings from this bill.

First, many of these findings are incorrect and inaccurate. As we've already discussed, the majority of medical evidence indicates that the intact D&E or D&X procedure is a safe abortion procedure and may be the safest option for some women. The American College of Obstetricians and Gynecologists, otherwise known as ACOG, the leading professional association of doctors specializing in women's health care, has stated that D&X, and I quote, "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman."

Mr. Chairman, I ask unanimous consent to enter the ACOG amicus brief in the case of *Stenberg* v. *Carhart* before the United States Supreme Court into the record.

Chairman SENSENBRENNER. Without objection.

[The information follows:]

DON STENBERG, Attorney General of the State of Nebraska, et al., Petitioners, v. LEROY CARHART, M.D., Respondent.

No. 99-830

1999 U.S. Briefs 830

March 29, 2000

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit.

BRIEF OF AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL WOMEN'S ASSOCIATION, NATIONAL ABORTION FEDERATION, PHYSICIANS FOR REPRODUCTIVE CHOICE AND HEALTH, AND AMERICAN NURSES ASSOCIATION IN SUPPORT OF RESPONDENT

A. STEPHEN HUT, JR., MATTHEW A. BRILL, KIMBERLY A. PARKER, MATTHEW P. PREVIN, WILMER, CUTLER & PICKERING, 2445 M Street, N.W., Washington, D.C. 20037, (202) 663-6000.
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Counsel for Amici Curiae. **[*i]**

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[*1] STATEMENT OF INTEREST OF AMICI CURIAE

The American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Women's Association ("AMWA"), the National Abortion Federation ("NAF"), Physicians for Reproductive Choice and Health ("PRCH"), and the American Nurses Association ("ANA") submit this brief amici curiae in support of Respondent. n1

n1 Pursuant to Rule 37.6, amici state that no counsel for a party authored any portion of this brief, and no person other than amici and their counsel made any monetary contribution to the preparation or submission of this brief. Letters of consent to the filing of this brief have been lodged with the Clerk of the Court pursuant to Rule 37.3.

ACOG, a non-profit educational and professional organization founded in 1951, is the leading professional association of physicians who specialize in the health care of women. Its more than 40,000 members represent approximately 90% of all board-certified obstetricians and gynecologists practicing in the United States, and it is the body representing the vast majority of physicians affected by Nebraska's ban on "partial-birth abortion" (the "Act"). Its members, whatever their beliefs about abortion, share an interest in opposing laws that interfere with a physician's ability to exercise his or her best medical judgment to determine the appropriate care for each patient, and they believe that physicians must be able to use new techniques or vary recognized techniques in order to advance the development of safe, effective medical procedures. ACOG has appeared as amicus in seven other cases involving laws similar to the Act.

AMWA is a national organization of 10,000 women physicians and physicians-in-training, dedicated to promoting women's health and fostering the woman physician. Founded in 1915, AMWA has physician chapters in 35 states, including Nebraska, and student chapters in nearly all of the nation's 144 medical schools. AMWA **[*2]** strongly opposes legislation banning any method of abortion or other interference with decision-making appropriately left to the woman and her physician.

NAF, a private, non-profit organization founded in 1977, is the professional association of abortion providers in the United States and Canada. NAF's mission is to promote and enhance the quality of abortion services, ensuring that abortion remains safe, legal, and accessible. NAF publishes clinical practice guidelines for abortion, publishes a leading textbook on abortion practice, and sponsors accredited continuing medical education programs for abortion providers. Its members include over 350 non-profit and private clinics, women's health centers, Planned Parenthood facilities and private physicians' offices in 46 states. NAF's members provide over half of the abortions performed in the United States each year and will thus be directly affected by the Act and similar laws in other states.

PRCH is a national, physician-led, non-profit organization founded in 1992. PRCH represents more than 3,500 physicians of various disciplines, and non-physician supporters. PRCH's mission is to enable concerned physicians to take a more active and visible role in support of voluntary universal reproductive healthcare. PRCH is committed to ensuring that all people have the knowledge, equal access to quality services, and freedom of choice to make their own reproductive health care decisions.

ANA is the only full-service professional organization representing the nation's 2.6 million registered nurses through its 53 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, and projecting a positive and realistic view of nursing. ANA is committed to ensuring the ready availability and accessibility of health **[*3]** care services and has long supported freedom of choice and equitable access for all women to basic health services, including reproductive health care.

STATEMENT OF MEDICAL FACTS

The physician's main goal in performing any abortion is to terminate the pregnancy by the method safest for the woman.

1. First-Trimester Abortions n2

n2 This discussion does not include early "medical" abortions--those performed by administering drugs (such as RU 486) to a pregnant woman to induce a miscarriage--which would not be banned by the Act. However, in the approximately 5% of cases in which a medical abortion fails, the pregnant woman would have to undergo a vacuum aspiration procedure.

The overwhelming majority of abortions in Nebraska--and nationwide--are performed in the first trimester of pregnancy. n3 In 1996, almost 90% of abortions occurred before 13 weeks LMP. n4 Virtually all first-trimester abortions are performed using a method known as vacuum aspiration (sometimes called suction curettage). n5 Vacuum aspiration is the safest surgical abortion procedure practiced **[*4]** today. n6 It is generally used for abortions up to 14 weeks LMP. n7

n3 See, e.g., Lisa M. Koonin et al., Abortion Surveillance--United States, 1996, in CDC Surveillance Summaries, 48 MORBIDITY AND MORTALITY WEEKLY REPORT (No. SS-4) 1, 25-26, 29 (Tables 6 & 8) (CDC, July 30, 1999).

n4 Id. Measuring the pregnancy in terms of "LMP" dates the length of the pregnancy from the first day of the woman's last menstrual period before she became pregnant. Fetal age measured by LMP is on average two weeks greater than if measured from the estimated date of conception.

n5 Koonin at 6; see A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION 107, 108 (Maureen Paul, et al. eds., 1999) ("CLINICIAN'S GUIDE"); Phillip G. Stubblefield, First and Second Trimester Abortion, in GYNECOLOGIC, OBSTETRIC, AND RELATED SURGERY 1033, 1033 (David H. Nichols & Daniel L. Clarke-Pearson eds., 2d ed. 2000).

n6 See CLINICIAN'S GUIDE at 108-09; Herschel W. Lawson et al., Abortion Mortality, United States, 1972 Through 1987, 171 AM. J. OBSTETRICS & GYNECOLOGY 1365, 1367-68 (Tables II & III) (1994); Willard Cates, Jr. & David A. Grimes, Morbidity and Mortality of Abortion in the United States, in

ABORTION AND STERILIZATION: MEDICAL AND SOCIAL ASPECTS 155, 161 (Jane E. Hodgson ed., 1981).

n7 See generally Pak Chung Ho, Termination of Pregnancy Between 9 and 14 Weeks, in MODERN METHODS OF INDUCING ABORTION 54, 56-57 (1995); CLINICIAN'S GUIDE at 109.

In a vacuum aspiration procedure, the physician dilates the cervix and inserts a small tube called a cannula through the vagina and cervix and into the uterus. Once the cannula is in the uterus, the physician creates negative pressure and delivers the products of conception. A single pass or several passes of the cannula through the uterus may be required before all the products of conception have been removed. The embryo or fetus may come through the cannula intact or disarticulated, and a portion of the fetus may enter the vagina while the fetus is still alive. Later in the first trimester, if the physician cannot complete the procedure with the cannula, rigid curettage or forceps may be necessary to remove the products of conception completely. n8

n8 See PHILIP D. DARNEY ET AL., PROTOCOLS FOR OFFICE GYNECOLOGICAL SURGERY 169-74 (1996); CLINICIAN'S GUIDE at 111-12; Stubblefield at 1035-37.

2. Post-First-Trimester Abortions

In the second trimester of pregnancy (roughly 13-26 weeks LMP), when vacuum aspiration is no longer effective, dilatation and evacuation ("D&E"), and induction to a much lesser extent, are the most commonly used abortion procedures. n9

n9 ACOG, Technical Bulletin 109, Methods of Midtrimester Abortion (1987); see generally Stubblefield at 1042-45; CLINICIAN'S GUIDE at 123.

[*5] Dilatation and Evacuation. D&E now accounts for over 90% of post-first-trimester abortions performed in the United States. See Koonin at 41 (Table 18). Although every physician's technique varies somewhat, in general the physician begins by dilating the cervix with laminaria, which slowly expand by absorbing moisture from the woman's cervix and thus increase the circumference of its opening (or os). Laminaria are inserted hours to days prior to the evacuation portion of the procedure. The amount of time required for adequate dilatation varies based on a number of factors including the gestational age of the fetus and the number of prior vaginal deliveries.

After the cervix is sufficiently dilated, the patient returns to the physician to undergo the evacuation procedure, which lasts 10 to 30 minutes. n10 The physician begins by rupturing the membranes and suctioning out the amniotic fluid. Then a clamp or forceps is inserted through the dilated cervix. Using the instrument, the physician reaches into the uterus, grasps the fetus and attempts extraction. The physician does this by pulling the fetal part he or she has grasped in the instrument through the cervical os and into the vagina. At this point the fetus is usually intact. Often, especially earlier in the second trimester, disarticulation occurs after a fetal part has been brought into the vagina--as it does in Dr. Carhart's practice, *Carhart v. Stenberg, 11 F. Supp. 2d 1099, 1103 (D. Neb. 1998),* aff'd, *192 F.3d 1142 (8th Cir. 1999)*--due to the counterpressure exerted as the rest of the fetus lodges against the uterine wall. Continuing disarticulation of fetal parts eventually kills the fetus. In some D&Es, little or no disarticulation occurs, and the physician removes the fetus relatively intact.

n10 For a more extensive description of the evacuation process, see generally EUGENE GLICK, SURGICAL ABORTION 48-57 (1998); DARNEY at 198-207; Stubblefield at 1042-44; CLINICIAN'S GUIDE at 127-36.

Especially later in the second trimester, the head of the fetus, its largest part, will generally be too big to fit **[*6]** through the cervix because cervical dilatation is only about 20% of that achieved at term. In that case, the skull must be compressed to allow it to pass through the cervix. There are several ways to accomplish this, including using forceps or evacuating the contents with suction.

Intact D&E. Later in the second trimester, some physicians perform D&Es in which the fetus is delivered intact (known as "intact D&E"). In one variant, the physician brings the fetus through the cervix intact in a breech (feet- or buttocks-first) position up to the head and, if the head lodges in the uterus, collapses it to complete extraction. ACOG has referred to this procedure as intact dilatation and extraction ("intact D&X" or

"D&X"). n11 In another variant of intact D&E, the physician begins by collapsing the skull of a fetus that is presenting head-down and then delivers the fetus intact. Regardless of the presentation, such intact extractions constitute intact D&E procedures. Intact D&E, including D&X, is a minor--and often safer--variant of the "traditional" non-intact D&E. n12 It makes no medical difference whether any portion of the fetus is delivered before fetal demise. n13 An intact D&X may be the best or most appropriate procedure for a particular patient in a particular **[*7]** circumstance. n14 Only the physician, in consultation with the patient and based on her circumstances, can make this decision.

n11 ACOG's description of this procedure is set forth in its Statement on Intact Dilatation and Extraction (Jan. 12, 1997) ("ACOG Statement"). ACOG attempted to define the procedure that was being discussed at the time in the highly charged political debate, congressional testimony, and in other publications. There is no medical or medical-ethical reason to distinguish among any of the variants of D&E.

n12 See generally National Abortion Federation, Second Trimester Abortion From Every Angle: Presentations, Bibliography & Related Materials (1992) ("NAF Bibliography"); Stubblefield at 1043 (describing intact D&E as a "variation of D&E" and referring to "the breech extraction variation of intact D&E").

n13 See CLINICIAN'S GUIDE at 136-37; Stubblefield at 1043; Janet E. Gans Epner et al., Late-term Abortion, *280 JAMA 724, 726* (Aug. 26, 1998).

n14 See Part II.B.1, infra. At least five federal courts have found that this procedure may be the safest one for women in the later part of the second trimester. See *Planned Parenthood v. Doyle, 162 F.3d 463, 467-68 (7th Cir. 1998); Carhart, 11 F. Supp. 2d at 1107-08; Hope Clinic v. Ryan, 995 F. Supp. 847, 852 (N.D. Ill. 1998),* rev'd on other grounds, *195 F.3d 857 (7th Cir. 1999); Women's Med. Prof'l Corp. v. Voinovich, 911 F. Supp. 1051, 1070 (S.D. Ohio 1995),* aff'd on other grounds, *130 F.3d 187 (6th Cir. 1997),* cert. denied, *118 S. Ct. 1347 (1998); Evans v. Kelley, 977 F. Supp. 1296, 1316 (E.D. Mich. 1997).*

Induction. Induction, or induced preterm labor, consists of "stimulating uterine contractions before the spontaneous onset of labor." ACOG, Practice Bulletin No. 10, Induction of Labor 1 (Nov. 1999) ("Induction of Labor"). This method accounts for only about 5% of post-first-trimester procedures nationally. Koonin at 41 (Table 18). The physician uses one of several substances and methods to induce labor, for example, prostaglandin in the form of vaginal suppositories or intramuscular injections; oxytocin as an intravenous injection; or some combination of saline, urea, and prostaglandin injected into the amniotic cavity. Although some of these substances may cause the death of the fetus, others do not. Rather, they initiate labor, which can last more than 24 hours and which usually, but not always, causes the death of a nonviable fetus. n15 In some cases in which the induction results in a breech delivery, the fetal skull may be too large to fit through the partially dilated cervix, in which case the physician generally collapses the skull (sometimes while the fetus still has a heartbeat) in order to complete the delivery. In other inductions, the umbilical cord may become entangled after the (still living) **[*8]** fetus has been delivered into the vagina, requiring the physician to cut the cord (which kills the fetus) to complete the delivery.

n15 F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 599-600 (20th ed. 1997); Induction of Labor at 1; JAMES R. WOODS, JR. & JENNIFER L. ESPOSITO, PREGNANCY LOSS 59-61 (1987); CLINICIAN'S GUIDE at 139, 143 (Table 11-2).

Because induction requires around-the-clock medical attention, inductions take place in hospitals or hospitallevel settings, thus greatly increasing expense and limiting accessibility. See Stubblefield at 1046; CLINICIAN'S GUIDE at 125. Some medical authorities indicate that induction often is unsuccessful prior to approximately 16 weeks LMP because the uterus is less responsive to the inducing agents. See PREGNANCY LOSS at 59; Methods of Midtrimester Abortion at 3; GLICK at 46-48. In the case of an incomplete or unsuccessful induction, a subsequent surgical abortion procedure is necessary. CLINICIAN'S GUIDE at 125. Induction poses risks to some women and may be absolutely contraindicated for others. n16

n16 For example, prostaglandins are contraindicated in patients with sepsis (blood infection), hypertension (high blood pressure), coronary artery disease, and, in some cases, asthma. CLINICIAN'S GUIDE at 125.

Women with certain heart defects, such as defective heart valve, may not survive prolonged labor. Id. Inductions are also contraindicated for women who have had a previous hysterotomy or cesarean section with classical (vertical) scar because it can lead to uterine rupture, hemorrhage, and even death. See P. Boulout et al., Late Vaginal Induced Abortion after a Previous Cesarean Birth: Potential for Uterine Rupture, 36 GYNECOLOGIC & ORSTETRIC INVESTIGATION 87, 88 (1993); Methods of Midtrimester Abortion at 2.

Hysterotomy and Hysterectomy. Hysterotomy--a preterm cesarean section--is a radical procedure to terminate a pregnancy, WILLIAMS OBSTETRICS at 684-85; Methods of Midtrimester Abortion at 2, that was deemed "out of date" as an abortion technique fully 19 years ago. n17 Hysterotomy, a major surgical procedure, has all the risks of such surgery and is considerably riskier than either induction or D&E. See, e.g., Gans Epner at 727 & Table **[*9]** 4. It is significantly more dangerous than a cesarean section done at term, because the uterine wall is thicker and tends to bleed more. It may also cause uterine rupture in subsequent pregnancies and may require the woman to have any subsequent delivery by cesarean section. Diggory at 317.

n17 P. Diggory, Hysterotomy and Hysterectomy as Abortion Techniques, in ABORTION AND STERILIZATION: MEDICAL AND SOCIAL ASPECTS 317, 331 (Jane E. Hodgson ed., 1981).

Hysterectomy, or the removal of the uterus, is not an appropriate method of abortion under any but the rarest circumstances. See Cates & Grimes at 161; Diggory at 321-24, 331. Hysterectomy leaves the woman sterile and has the potential to result in blood clots, severe infection, bleeding, or even death. ACOG, Patient Education Pamphlet, Gynecologic Problems: Understanding Hysterectomy (1995).

SUMMARY OF ARGUMENT

The Act--and others like it enacted throughout the country--is so hopelessly vague that the physicians subject to its terms cannot know what it prohibits. Reasonably read, it bans virtually all abortions in Nebraska, imperiling the public health by deterring physicians from providing their patients with medically appropriate and necessary care and imposing an unconstitutional burden on a woman's right to terminate her pregnancy.

Even if read to ban only intact D&X procedures, the Act cannot stand because it precludes some Nebraska women from obtaining the most medically appropriate abortion procedure for their particular health circumstances, and it thwarts medical advancement. The Act also lacks constitutionally compelled exceptions to protect women's health and lives.

ARGUMENT

I. THE ACT IS UNCONSTITUTIONALLY VAGUE.

Nebraska's ban on "partial-birth abortion" is hopelessly vague and therefore violates the due process rights of Dr. Carhart and his patients. See, e.g., *Colautti v. Franklin,* **[*10]** *439 U.S. 379, 391 (1979).* The Act's imprecise terms make it impossible for Dr. Carhart and similarly situated physicians to know which abortion procedures fall within the statutory ban. Contrary to the State's assertion that "no reasonable person" could interpret the Act as applying to D&E in addition to D&X (Brief of Petitioners ("Pet. Br.") 15), four reasonable federal judges--the District Court and the unanimous Court of Appeals--determined that the Act unambiguously bans *D&E. Carhart, 11 F. Supp. 2d at 1120-21; 192 F.3d at 1146.* At the very least, therefore, the Act is impermissibly vague because persons "of common intelligence must necessarily guess at its meaning and differ as to its application." *Smith v. Goguen, 415 U.S. 566, 572 n.8 (1974)* (citations omitted).

A. The Terms of the Act Are Hopelessly Ambiguous.

Neither the term "partial-birth abortion" nor the words used to define it provide meaningful guidance to physicians who must comply with the Act under the threat of felony prosecution and forfeiture of their medical licenses. The Act conditions liability on the performance of an abortion in which the physician "partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery." Neb. Rev. Stat. § 28-326(9). The Act then defines the phrase "partially delivers vaginally a living unborn child before

killing the unborn child" to mean "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." Id.

This definition, however, could easily encompass virtually every safe and common abortion procedure. The phrase "partially delivers vaginally," for example, applies both when the physician partially delivers an intact fetus **[*11]** into the vagina and when the physician delivers a portion of the fetus that is severed from the remainder, see, e.g., *Planned Parenthood v. Miller, 30 F. Supp. 2d 1157, 1165 (S.D. Iowa 1998),* because "deliver" is a medical term of art meaning to remove the fetus, the placenta, or part of the fetus from the uterus.

The phrase "substantial portion" introduces still more vagueness. As the District Court properly found, based on the testimony of "every doctor who testified," this term "could be interpreted in vastly different ways by fair-minded people." *Carhart, 11 F. Supp. 2d at 1131* (emphasis added). Dr. Carhart understood "substantial portion" to refer to "any identifiable part of the fetus," including an extremity or a portion of the skull. *Id. at 1118.* Dr. Stubblefield testified that he had no idea how much of a fetus was a "substantial portion." Id. As for the State's experts, while Dr. Riegel surmised that "substantial portion . . . probably [referred to] over 50%" of the fetus, he readily conceded that "it's a vague term." Id. Likewise, while Dr. Boehm interpreted the phrase as referring to "more than a hand or a leg," he acknowledged that "some people might consider a hand or a leg to be a substantial portion," and noted that his "own personal view" would not necessarily match that of "someone who wants to prosecute this letter of the law." *Id. at 1119.* As the District Court recognized, that is precisely why the statute is impermissibly vague. *Id. at 1132,* n18

n18 See also *Richmond Med. Ctr. for Women v. Gilmore, 183 F.3d 303, 305-06 (4th Cir. 1998)* (Murnaghan, J., dissenting from order denying motion to vacate stay) ("'substantial portion' [could] mean 'a portion of the trunk,' one-third of the fetus by volume, 'well into the thorax,' twenty-five percent, thirty-five percent, or a portion that is 'not insubstantial'"); *Rhode Island Med. Soc'y v. Whitehouse, 66 F. Supp. 2d 288, 311 (D.R.I. 1999).*

Finally, the Act's use of the phrase "living unborn child" further muddies the waters. "It is not clear whether 'living [unborn child]' refers only to an intact fetus with **[*12]** a heartbeat or some other form of 'life,' or to a disarticulated fetus with a heartbeat or some other sign of 'life.'" *Miller, 30 F. Supp. 2d at 1165.* The fact that the moment at which fetal demise occurs is "'extremely variable,'" *Carhart, 11 F. Supp. 2d at 1118* (quoting testimony of Dr. Hodgson), further compromises a physician's ability to conform his or her conduct to the requirements of the Act.

B. The Act Potentially Reaches All Safe and Common Abortion Procedures and Is Not Readily Susceptible to the State's Proffered Narrowing Constructions.

The upshot of the Act's profound ambiguity is that D&E and other safe and common abortion procedures appear to fit within the statutory ban. The ban contains three essential elements: A physician must (1) deliberately and intentionally deliver into the vagina a living fetus or a substantial portion thereof (2) for the purpose of performing a procedure that the physician knows will kill the fetus and does kill the fetus (3) before completing the delivery. See Neb. Rev. Stat. § 28-326(9). These elements cannot be confined to the D&X procedure, as the State claims.

1. The Act Reaches D&E and Other Safe and Common Abortion Procedures.

As both the District Court and Court of Appeals recognized, the Act, reasonably interpreted, applies to D&E abortions. See *Carhart, 11 F. Supp. 2d at 1128; 192 F.3d at 1150.* In a D&E, as in any abortion procedure (other than a hysterotomy or a hysterectomy), the physician deliberately and intentionally "delivers" the (usually living) fetus or "a substantial portion thereof"--such as an arm or leg, see *Carhart, 192 F.3d at 1150*--into the vagina. See Methods of Midtrimester Abortion; see also *Planned Parenthood v. Woods, 982 F. Supp. 1369, 1372 (D. Ariz. 1997).* The physician generally delivers a presenting **[*13]** part of an intact fetus through the cervical os before any disarticulation occurs. n19

n19 See *Carhart, 11 F. Supp. 2d at 1104* ("the dismemberment occurs after [Dr. Carhart] pull[s] a part of the fetus through the cervix"); *id. at 1128 & n.42; Carhart, 192 F.3d at 1147.* In fact, disarticulation may not occur at all. When the physician pulls a substantial portion of the fetus through the cervical os, the fetus usually disarticulates as a result of traction at the cervix, but sometimes it does not. See *Carhart, 11 F. Supp. 2d at 1107 & n.12.* Indeed, it is sometimes predictable--given the amount of cervical dilatation and the position and gestational age of the fetus--that no disarticulation will occur. Thus, a physician doing a D&E may intentionally perform a procedure indistinguishable from a D&X. Ignoring this reality of abortion practice, the State proffers the mistaken theory that a bright line separates D&E from D&X. (See Pet. Br. 15-18.)

D&Es also satisfy the second element of the statutory ban because the physician delivers a "substantial portion" of the fetus "for the purpose of performing a procedure that the physician knows will kill the fetus and does kill the fetus." By its nature, a D&E, like any abortion, is a procedure that the physician knows will kill the fetus and that contains intermediate steps that do kill the fetus. Thus, having delivered a "substantial portion" of a living fetus, the physician performing a D&E will then cause the death of the fetus--by disarticulating it, for example, or by collapsing its skull. A physician performing a D&E invariably satisfies the third element of the ban by then "completing the delivery." n20 Therefore, as the District Court and Court of Appeals held, D&E involves each **[*14]** of the required elements of a "partial-birth abortion." *Carhart, 11 F. Supp. 2d at 1128-29; 192 F.3d at 1150.* n21

n20 The District Court found that "the fetus is 'invariably' alive" when Dr. Carhart begins performing a D&E, and Dr. Carhart "has observed fetal heart activity with 'extensive parts of the fetus removed.'" *Carhart, 11 F. Supp. 2d at 1105.* And while the moment at which fetal demise occurs during the performance of the D&E varies, *id. at 1118,* fetal demise generally occurs before the physician completes the delivery of the fetus. See *Carhart, 192 F.3d at 1150.* Dr. Carhart's D&E practice is fully consistent with the procedure described in medical texts. See CLINICIAN'S GUIDE at 135-37; Stubblefield at 1043.

n21 The Act's text also encompasses some induction and vacuum aspiration procedures. Inductions may entail partial delivery of a living fetus because "a portion of the fetus may come through the cervical os and into the vaginal cavity while the fetal heart is still beating." *Woods, 982 F. Supp. at 1872;* see also *Hope Clinic, 995 F. Supp. at 857.* In some inductions, such as those in which the fetal head becomes lodged in the woman's cervix or the umbilical cord becomes entangled, the physician takes steps after partial delivery that he or she knows will cause the death of the (then still-living) fetus before completion of the delivery. See *Hope Clinic, 995 F. Supp. at 852.* Likewise, in a vacuum aspiration procedure, a substantial portion of a living fetus--either intact or disarticulated--will be delivered into the cannula in the vagina. See *Carhart, 11 F. Supp. 2d at 1103.* The separation of the fetus from the placenta or disarticulation will cause its death shortly after it is brought into the vagina and before completion of the delivery. See *id. at 1110.* In these circumstances, the physician apparently will have performed a "partial-birth abortion." See, e.g., *Miller, 30 F. Supp. 2d at 1165.*

2. Nothing in the Act's Text or Legislative History Supports the Limiting Constructions Advanced by the State and Its Amici.

A court cannot reshape the Nebraska ban into something that applies only to D&X in order to save it, because the Act is not "'readily susceptible' to such a construction." *Reno v. ACLU, 521 U.S. 844, 884 (1997)* (quoting *Virginia v. American Booksellers Ass'n, 484 U.S. 383, 397 (1988)).* A statute is not "readily susceptible" to a narrowing construction unless its "text or other source of [legislative] intent identifie[s] a clear line" for a court to draw. *Reno, 521 U.S. at 884.* As was true of the statute at issue in Reno, the Nebraska ban has "many ambiguities," *id. at 870,* and thus "provides no guidance whatever for limiting its coverage." *Id. at 884.* n22

n22 See *American Booksellers, 484 U.S. at 397* (court "will not rewrite a . . . law to conform it to constitutional requirements"). The notion that Nebraska's or any other "partial-birth abortion" ban applies only to the delivery of an "intact" fetus, see, e.g., *Richmond Med. Ctr. for Women v. Gilmore, 144 F.3d 326, 328 (4th Cir. 1998)* (Luttig, J., as single Circuit Judge), is without basis. Neither the Nebraska Act nor any similar legislation includes that term. In any event, as shown above (Part I.B.1, supra), the Act would still reach D&Es

even if read to apply only to the delivery of a substantial portion of an intact fetus: In Dr. Carhart's practice and in general, D&Es regularly involve delivery of a substantial part of an intact living fetus into the vagina before any disarticulation occurs.

[*15] Contrary to the State's assertion (see Pet. Br. 27-28), the Act's "scienter" requirement does not create a safe harbor for D&E. Under Nebraska law, a person intends the natural and probable consequences of his actions. See, e.g., *State v. McDaniels, 16 N.W.2d 164, 168 (Neb. 1944)*. It is a natural and probable consequence of performing a D&E that the physician will deliver a substantial portion of an intact fetus and then cause its death by disarticulating it or collapsing its skull. The physician will thus "deliberately and intentionally" have violated the Act. n23

n23 See *Carhart, 11 F. Supp. 2d at 1129* ("a surgeon performing a routine D&E deliberately intends to do exactly what defendants admit is prohibited"); see also *Carhart, 192 F.3d at 1150.*

The State further distorts the Act in claiming that its text limits the ban to D&X abortions by requiring that the physician deliver a substantial portion of the fetus into the vagina for the purpose of performing a "separate, death-causing procedure." (Pet. Br. 14 (emphasis added).) This phrase appears nowhere in the Act. Contrary to the State's assertion that the "procedure" mentioned in the second sentence of the Act (the physician must perform "a procedure that [he] knows will kill the unborn child") must be "separate and distinct" from the "procedure" mentioned in the first sentence (see id. at 17), the word "procedure" appears to refer to the same thing--an abortion--in each sentence. See *Gustafson v. Alloyd Co., 513 U.S. 561, 570 (1995)* ("identical words used in different **[*16]** parts of the same act are intended to have the same meaning") (internal quotation marks and citation omitted). n24

n24 Nor is there any basis for the State's assertion that the Act focuses on "where the killing act occurs." (Pet. Br. 17 (emphasis added).) Indeed, contrary to the State's suggestion that fetal death must occur in the vagina to come within the ban (id.), the fact that only a "substantial portion" of the fetus need enter the vagina--rather than the whole or even the bulk of the fetus--demonstrates that fetal death can just as readily occur in the uterus during a banned procedure (to the extent that it makes any sense at all to say death occurs either in the uterus or the vagina when a fetus is in both places at once). Even with a D&X, which the State asserts to be the sole object of the ban, fetal death does not "occur" in the vagina, because the decompression of the fetal skull--what the State identifies as the "death-causing" act (id. at 18)--takes place in the uterus.

Even if the Act could be rewritten to include "separate" and "death-causing" before "procedure" in the second sentence of the Act, that construction would only compound the vagueness of the ban. There is no rational way to distinguish the "death-causing" portion of a D&X (the use of an instrument to decompress the fetal skull) from the "death-causing" portion of a non-intact D&E (the use of an instrument to disarticulate the fetus or collapse its skull, as is often necessary in a non-intact D&E). If the "death-causing" portion of the D&X is an independent "procedure," so too is the "death-causing" portion of the D&E; in each case the physician performs a distinct act that kills the fetus before completing the delivery. n25 **[*17]** Conversely, if the death-producing step within a D&E were seen as indivisible from the rest of that procedure (see Pet. Br. 17), then there is no reason why the death-producing step in a D&X should be seen as any more distinguishable from the balance of that procedure. These opposing applications of the State's logic--neither of which is any more compelling than the other--demonstrate that the Act as the State would rewrite it is no clearer than the version that appears in the statute books.

n25 Some induction and vacuum aspiration abortions also appear to be covered by the Act even if a requirement that the physician perform a separate, death-producing act is read into the statute. If the fetal head becomes lodged at the cervix or the umbilical cord becomes entangled during induction, the physician may be required to take a step that causes fetal demise, thus bringing the procedure within the Act's ban. See, e.g., *Planned Parenthood v. Verniero, 41 F. Supp. 2d 478, 485 (D.N.J. 1988); Hope Clinic, 995 F. Supp. at 852.* In a vacuum aspiration procedure, the cannula may become clogged by an intact fetus; the physician then must remove the suction tube, which will cause the uterus to expel its contents into the vaginal cavity and, inevitably, result in fetal demise. See *Carhart, 11 F. Supp. 2d at 1103, 1110;* CLINICIAN'S GUIDE at 112. This separate and deliberate act therefore would appear to violate the Act.

Nor does the Act's muddled legislative history support the proffered narrowing constructions. That the leading sponsor of the bill could not articulate a meaningful (much less a limiting) definition of "substantial portion"--and indeed opined that delivery of a foot would be covered by the Act--vividly illustrates the Act's vagueness. See *Carhart, 11 F. Supp. 2d at 1131*. Moreover, if the legislature really had intended to ban D&X but not D&E generally, it easily could have included some language to that effect in the Act. Indeed, the thrust of the amici curiae brief filed by medical professionals supporting the State is that D&X is widely recognized as a distinct medical procedure. See Brief of Association of American Physicians and Surgeons, et al. ("AAPS Br.") 5-12. The purported distinctness of the D&X procedure only underscores the significance of the State's failure to make any reference to it in the Act, whether by name or by reference to its well-established components. n26 Because the legislative history at best sends "inconsistent signals as to where the new line **[*18]** or lines should be drawn," accepting the State's narrowing construction would constitute "a serious invasion of the legislative domain." *Reno, 521 U.S. at 544* (internal quotation marks and citation omitted).

n26 In light of this complete failure to make reference to D&X, and the strong evidence that the ban covers D&E, the Seventh Circuit's admittedly "brute force" effort "to assimilate the statutory definitions [of "partial-birth abortion"] to the medical definition of D&X," *Hope Clinic, 195 F.3d at 865*, in this case would constitute an unreasonable departure from the text of the Act and its underlying purpose.

II. THE ACT IMPOSES AN UNDUE BURDEN ON A WOMAN'S RIGHT TO SEEK AN ABORTION.

To the extent that the Act can be understood by physicians who perform abortions, its language, on its face, criminalizes safe and common abortion procedures used throughout pregnancy. It thus imposes an impermissible undue burden on a woman's right to terminate her pregnancy in violation of this Court's decision in *Planned Parenthood v. Casey, 505 U.S. 833 (1992)*. By precluding a woman, in consultation with her physician, from choosing the most appropriate abortion procedure for her particular health circumstances, the Act places a substantial--and thus unconstitutional--obstacle in the path of a woman seeking an abortion.

A. The Act Prevents Women From Obtaining the Safest and Most Common Abortion Procedures Used Before Fetal Viability.

Whether read on its face or with the linguistic glosses urged by the State and the amici supporting it, the Act is so broad that it bans D&Es of all varieties, which account for more than 90% of post-first-trimester abortions performed in the United States, Koonin at 41 (Table 18), and 100% of Dr. Carhart's second-trimester practice, *Carhart, 11 F. Supp. 2d at 1108-09*. Because Dr. Carhart is the only provider of elective abortions after 16 weeks LMP in Nebraska, *id. at 1102*, D&Es account for nearly all abortions in the state performed between 16 and approximately 22 weeks LMP. Plainly, as the State implicitly concedes (Pet. Br. 23-28), a ban on D&Es constitutes an undue burden. Cf. *Planned Parenthood v. Danforth, 428 U.S. 52, 79 (1976)* (holding unconstitutional **[*19]** a ban on intra-uterine saline instillation, then the most common method of post-first-trimester abortion). n27

n27 Forcing Dr. Carhart in all cases either to modify his current, safe D&E technique to avoid the reach of the Act by causing fetal demise in utero or to resort to induction abortions, a procedure that he does not now perform, would impose unacceptable health risks on his patients. See *Carhart, 11 F. Supp. 2d at 1105-07;* see also Stubblefield at 1046. Medical texts indicate that induction abortions are generally unavailable until 16 weeks LMP. See PREGNANCY LOSS at 59; Methods of Midtrimester Abortion at 3. The delay entailed in an across-the-board switch to induction would alone significantly and needlessly increase the health risks associated with the abortion. See Lawson at 1367 (Table II) (risks associated with abortion increase as gestation advances). Moreover, inductions are absolutely contraindicated for some women and relatively contraindicated for others. See note 16, supra.

Where, as here, the ban could prohibit not only D&Es, but also vacuum aspiration and induction procedures, see Part I.B.2, supra, the burden imposed by the Act is even more clearly undue. Because vacuum aspiration, induction, and D&E together account for more than 99% of abortions performed in Nebraska and in

the United States, see Koonin at 29-30, 41 (Tables 8 & 18), such a ban is nearly absolute and unquestionably unconstitutional.

B. Even if Limited to the D&X Procedure, the Act Creates an Undue Burden Because It Unconstitutionally Forces Women From Safer to Riskier Abortion Procedures.

Even if the Act were somehow construed to proscribe only D&X, it would not pass constitutional muster. The unbroken tie that binds this Court's abortion cases is the preeminence accorded to women's health, which derives from the inescapable fact that pregnancy is fraught with health risks--including a risk of death, see Stubblefield at 1033--that the woman alone must bear. See *Casey, 505 U.S. at 852.* Thus, Danforth invalidated a ban on saline instillation abortions (which at the time left physicians with few alternatives other than hysterotomy and hysterectomy) **[*20]** because "as a practical matter, it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." *428 U.S. at 78-79.* Colautti again underscored the primacy of women's health by holding that a restriction on a physician's choice of abortion method that does not "clearly specify . . . that the woman's life and health must always prevail over the fetus' life and health when they conflict" raises "serious ethical and constitutional difficulties." *439 U.S. at 400.* And Thornburgh made clear that the state may not regulate abortion, including restricting a physician's choice of method, if it "fail[s] to require that maternal health be the physician's paramount consideration." *Thornburgh v. ACOG, 476 U.S. 747, 768-69 (1986).*

Casey did nothing to alter the weight this Court has always placed on maternal health in its analysis. Rather, Casey reaffirmed Roe's essential holding that--both pre-and post-viability--a state may not "interfere with a woman's choice to undergo an abortion procedure if continuing a pregnancy would constitute a threat to her health." *505 U.S. at 880, 846.* A corollary to this holding is the principle that the state may not force a woman to terminate a pregnancy by a method less medically appropriate for her and may not deprive a woman of her right to choose among medically sound alternative methods of pregnancy termination. This, however, is precisely what the Act requires--even if read to ban only D&X.

1. D&X Is a Safe Procedure, Within the Standard of Care, That Will Be the Most Medically Appropriate Procedure for Some Patients.

Central to women's ability to protect their health interests is the ability of their physicians to exercise appropriate medical judgment. See *City of Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416, 427 (1982).* "The choice of an appropriate abortion technique . . . is a complex medical judgment . . . ." *Colautti, 439 U.S. at 401.* On the basis of various factors--including the patient's **[*21]** overall medical condition; the gestational age, size, and presentation of the fetus; the extent of dilatation of the cervix; the existence of fetal abnormalities; and a patient's desire, for example, to avoid prolonged labor and hospitalization--a physician, in consultation with his or her patient, chooses the most appropriate and safest abortion procedure for that particular patient at the time. See KENNETH E. NISWANDER & ARTHUR T. EVANS, MANUAL OF OBSTETRICS 15 (5th ed. 1996). The risk of a particular abortion procedure varies in every case, depending on the individual woman's health, the skill of the physician performing the procedure, the medical facilities available, and how the selected procedure proceeds on a given day. See CLINICIAN'S GUIDE at 125-26.

Depending on the physician's skill and experience, the D&X procedure can be the most appropriate abortion procedure for some women in some circumstances. n28 D&X presents a variety of potential safety advantages over other abortion procedures used during the same gestational period. Compared to D&Es involving dismemberment, D&X involves less risk of uterine perforation or cervical laceration because it requires the physician to make fewer passes into the uterus with sharp instruments and reduces the presence of sharp fetal bone fragments that can injure the uterus and cervix. n29 There is also considerable evidence **[*22]** that D&X reduces the risk of retained fetal tissue, a serious abortion complication that can cause maternal death, and that D&X reduces the incidence of a "free-floating" fetal head that can be difficult for a physician to grasp and remove and can thus cause maternal injury. n30 That D&X procedures usually take less time than other abortion methods used at a comparable stage of pregnancy can also have health advantages. The shorter

the procedure, the less blood loss, trauma, and exposure to anesthesia. n31 The intuitive safety advantages of intact D&E are supported by clinical experience. See CLINICIAN'S GUIDE at 137-38.

n28 For example, as the District Court found, there are at least 10 to 20 Nebraska women each year for whom a D&X is the most appropriate procedure. See *Carhart, 11 F. Supp. 2d at 1106, 1121-22, 1127.*

n29 See CLINICIAN'S GUIDE at 135 ("When possible, intact delivery in pregnancies over 18 weeks reduces the number of instrument passes necessary for extraction."); id. at 136 ("The aim of intact D&E is to minimize instrumentation within the uterine cavity. . . ."). The testimony of experts on abortion practice overwhelmingly confirms this view. See *Evans, 977 F. Supp. at 1296* (recounting testimony of six medical experts); *Voinovich, 911 F. Supp. at 1069* (D&X "causes less trauma to the maternal tissues (by avoiding the break up of bones, and the possible laceration caused by their raw edges)"); see also *Carhart, 11 F. Supp. 2d at 1107; Whitehouse, 66 F. Supp. 2d at 314; Richmond Med. Ctr. for Women v. Gilmore, 55 F. Supp. 2d 441, 455, 490 (E.D. Va. 1999); Verniero, 41 F. Supp. 2d at 485; Miller, 30 F. Supp. 2d at 1161; Hope Clinic, 995 F. Supp. at 851.*

n30 See *Carhart, 11 F. Supp. 2d at 1107, 1123.* Practitioners and medical experts confirm these potential advantages. See *Evans, 977 F. Supp. at 1296; Hope Clinic, 995 F. Supp. at 851.*

n31 See *Richmond Med. Ctr., 55 F. Supp. 2d at 491; Hope Clinic, 995 F. Supp. at 852; Voinovich, 911 F. Supp. at 1069.*

Especially for women with particular health conditions, there is medical evidence that D&X may be safer than available alternatives. A select panel convened by ACOG concluded that D&X may be "the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman." n32 D&X may also be **[*23]** the most appropriate abortion method in the presence of certain fetal indications. For example, D&X "may be especially useful in the presence of fetal abnormalities, such as hydrocephalus" because it entails reducing the size of the fetal skull "to allow a smaller diameter to pass through the cervix, thus reducing risk of cervical injury." David A. Grimes, The Continuing Need for Late Abortions, *280 JAMA 747, 748* (Aug. 26, 1998). In addition, "intactness allows unhampered evaluation of structural abnormalities" in the fetus and can thus aid in diagnosing fetal anomalies. CLINICIAN'S GUIDE at 136. Finally, an intact fetus can "aid . . . patients grieving a wanted pregnancy by providing the opportunity for a final act of bonding." Id. n33

n32 ACOG Statement at 2; see also *Voinovich, 911 F. Supp. at 1067* (D&X may be most medically appropriate for women with prior uterine scar); *Evans, 977 F. Supp. at 1296* (D&X is especially appropriate for women for whom induction is contraindicated). That ACOG "could identify no circumstances under which this procedure . . . would be the only option to save the life or preserve the health of the woman," see ACOG Statement at 2, is in no way inconsistent with the proposition that D&X may be the best or most appropriate procedure in certain circumstances. A single abortion procedure will virtually never be the only option to save the life or preserve the health of a woman, but it may be the best option.

n33 Some physicians also believe intact D&E is an easier procedure for physicians to master because it involves techniques that are more familiar to physicians than those involved in non-intact D&E. See generally NAF Bibliography; CLINICIAN'S GUIDE at 136.

No reliable medical evidence supports the claims of the State's amici physicians that D&X endangers maternal health. These doctors claim (AAPS Br. 21-22) that the amount of cervical dilatation involved in D&X procedures can cause cervical incompetence. Many D&E procedures, however, involve similar amounts of dilatation--sometimes over a several-day period, see CLINICIAN'S GUIDE at 128; GLICK at 49--and of course childbirth involves even greater cervical dilatation. Their concern about the risks posed by internal podalic version, in which the physician repositions the fetus into a footling breech (AAPS Br. 22), is similiarly misplaced. Dr. Carhart "does not perform instrumental conversion of the fetus . . . but [rather] removes the fetus headfirst or feet first, depending on how the fetus is positioned." *Carhart, 11 F. Supp. 2d at 1105.* n34 Moreover, some clinicians recommend repositioning **[*24]** the fetus in some D&Es depending on how the fetus initially presents. See CLINICIAN'S GUIDE at 135. The "blind" procedure (piercing the fetal skull) that

the amici physicians warn is so dangerous in a D&X (AAPS Br. 22-23) is arguably less blind than the continued use of sharp instruments in the uterine cavity that characterizes D&Es. n35 The State's (and its amici physicians') attempt to justify a ban on D&X as a protection of maternal health is clearly pretextual: The Act permits precisely the same procedure (with the same alleged risks to the woman) so long as the physician effects fetal demise in utero before any portion of the fetus is vaginally delivered. n36

n34 There is nothing "self-contradictory" (AAPS Br. 16-17) about Dr. Carhart's belief that intact extraction is safer than dismemberment on the one hand, and his unwillingness to convert the fetus in order to perform a D&X on the other hand. First, the charge of inconsistency fails to recognize that Dr. Carhart performs intact D&Es, and thus realizes the safety advantages of intact extraction, when the fetus presents head-down, without the need for conversion. See *Carhart. 11 F. Supp. 2d at 1105.* Second, it is perfectly consistent for Dr. Carhart to conclude, given his assessment of his own skills and the relative risks involved, that the potential safety advantages of D&X are reduced (and even outweighed) when he must convert the fetus from a transverse or compound presentation. That conclusion, however, in no way undermines the determination that D&X is the safest procedure for Dr. Carhart's patients when he can perform it. Likewise, the relative infrequency of D&X in Dr. Carhart's practice in no way refutes its safety advantages or argues against attempting it where appropriate.

n35 See CLINICIAN'S GUIDE at 133. Uterine perforation, which can require a bowel resection, colostomy, or hysterectomy, is the most serious complication of D&E and can be fatal. See, e.g., Edward Trott et al., Major Complications Associated with Termination of a Second Trimester Pregnancy: A Case Report, 67 DEL. MED. J. 294, 296 (1995).

n36 The State's and its amici physicians' objection to D&X on the ground that it "blurs the line . . . between abortion and infanticide," by using obstetrical techniques to "perform[] an act quite contrary to the obstetrical role" (AAPS Br. 27; see also Pet. Br. 29), is equally misplaced. All abortion procedures use obstetrical techniques. Induction abortions in particular contain almost every element of delivery at term. See Induction of Labor. There is nothing unethical or medically inappropriate in employing obstetrical and gynecological techniques to terminate pregnancy in the manner safest for the patient and in keeping with the physician's role as a provider of comprehensive reproductive health services.

[*25] 2. A Ban Solely on D&X Cannot Withstand Constitutional Scrutiny.

This Court has invalidated choice-of-method statutes that remove physician discretion and force women to resort to abortion procedures that are less safe or less appropriate for their particular health circumstances. See *Danforth. 428 U.S. at 75-79; Thornburgh. 476 U.S. at 766-69.* Underlying these holdings is the recognition that a constitutionally impermissible threat to women's health always results when the state removes a safe medical procedure from the physician's array of options. That other safe abortion procedures may remain available (Pet. Br. 33) does not eliminate the constitutional problem. Because the banned procedure will always be the safest for some (if not most) women, an absolute prohibition on a safe method of abortion will impermissibly increase the health risks of abortion for some women in some circumstances. The unbroken emphasis on maternal health in this Court's abortion jurisprudence precludes the state from restricting abortion in a manner that imposes such increased health risks. See *Casey. 505 U.S. at 880.*

The suggestion that a state may ban a safe abortion procedure so long as that procedure is not needed by a large number of women, see *Hope Clinic. 195 F.3d at 871-74.* betrays a misunderstanding of this Court's precedents. Rather, from this Court's command that women's health remain "paramount," *Thornburgh. 476 U.S. at 769.* and that every abortion restriction contain an exception to permit a woman to obtain an immediate abortion if continuing her pregnancy would constitute a threat to her health, *Casey. 505 U.S. at 846, 880.* it follows that a safe procedure that is within the standard of care must remain available for each and every woman for whom that procedure would be the most appropriate. **[*26]** As the District Court found, even if the Act affected only the 10 to 20 women per year for whom Dr. Carhart performs a D&X, it would violate the constitutional rights of these women. See *Carhart. 11 F. Supp. 2d at 1121-22. 1127;* see also *Hope Clinic. 195 F.3d at 884* (Posner, C.J., dissenting) ("It is slight consolation to be told that while the state has forbidden the

optimal treatment of your medical problem, that problem happily is rare."). Banning a procedure that may be the most appropriate even for a small fraction of women impermissibly endangers their health. n37

n37 Consider, for example, a ban on hysterotomies. Despite data indicating that hysterotomies are significantly more dangerous than every common method of abortion except hysterectomy, see Lawson at 1367 (Table II), a small number of abortions continue to be performed by hysterotomy each year because physicians resort to this procedure in specific and serious health situations. See CLINICIAN'S GUIDE at 126 (hysterotomy indicated for "life threatening medical crises such as unremitting hemorrhage associated with placenta accreta, massive disseminated intravascular coagulation (DIC), or severe forms of preeclampsia"); Koonin at 41 (Table 18) (36 reported abortions in 1996 were performed by hysterotomy or hysterectomy). It would be medically inappropriate to ban hysterotomy because, for a small number of women each year, that procedure was the safest in their particular health circumstances. A ban on D&X--even if D&X is the safest option for only a handful of women--is similarly medically inappropriate and unconstitutional.

III. THE ACT THREATENS WOMEN'S HEALTH BY HINDERING MEDICAL ADVANCEMENT.

The Act also endangers women's health by impeding physicians from developing new, and potentially safer, surgical techniques. This Court has long recognized that "present medical knowledge" changes, see *Akron, 462 U.S. at 437,* and that bans on abortion methods threaten to stymie medical advancement. Thus, in Danforth, the Court invalidated a broad ban on saline instillation because it threatened to preclude "methods that may be developed in the future and that may prove highly effective and completely safe." *428 U.S. at 78.* The Act at **[*27]** issue here also fails to leave room for medical evolution and thus violates a guiding principle of this Court's prior abortion rulings.

The most common abortion procedures used today were all developed by physicians seeking safer procedures. For example, vacuum aspiration developed as a safer alternative to dilatation and curettage ("D&C"), which was slower, less thorough, and caused many more complications. See Pak at 54. Although vacuum methods for uterine evacuation were known as early as 1872, see CLINICIAN'S GUIDE at 107, it was only after abortion became legal nationwide in 1973 that physicians were free to develop the vacuum aspiration technique to the point where it has replaced D&C as the preferred method of first-trimester abortion. n38

n38 See CLINICIAN'S GUIDE at 107-08; Jane E. Hodgson, Abortion by Vacuum Aspirator, in ABORTION AND STERILIZATION: MEDICAL AND SOCIAL ASPECTS 225, 225-26, 234-39 (Jane E. Hodgson ed., 1981); Pak at 54.

Likewise, D&E was developed in the early 1970s in response to the shortcomings of inductions (see Part B.2.b., supra) and the lack of an effective procedure between 12 and 16 weeks LMP, when inductions often cannot reliably be performed. For several years, physicians labored alone to develop a surgical procedure; finally, in 1975, D&E techniques began to be shared among physicians. D&E has become the most common and safest post-first-trimester abortion method in large part due to the ingenuity of physicians looking for better options for their patients. See GLICK at 46-48; see also *Akron, 462 U.S. at 435-37.* One of the reasons D&E safety has itself improved so markedly is that physicians have experimented with slightly varying techniques in performing it, and have taught the different techniques to colleagues. See, e.g., GLICK at 47.

[*28] The variation of D&E techniques among physicians arises from innovation during surgical procedures, either in response to some unforeseen circumstance or as a result of an observation made by the physician in the course of the procedure. D&X thus arose as a minor variant of D&E. See, e.g., CLINICIAN'S GUIDE at 136. As discussed above, D&X may offer a variety of safety advantages over D&E and induction methods. Permitted to evolve, D&X could well turn out to improve abortion safety markedly or lead to the discovery of one or more other techniques that would effect such improvement. Nebraska's "partial-birth abortion" ban and others like it, if permitted to stand, would ensure that this potential will never be realized. n39

n39 There will be no opportunity for the safety and benefits of D&X to be recognized in peer-reviewed studies--the lack of which both the State and its amici use to condemn the technique (Pet. Br. 39; AAPS Br. 14-15)--if there is a criminal prohibition on its use.

IV. THE ACT LACKS CONSTITUTIONALLY COMPELLED EXCEPTIONS TO PROTECT A WOMAN'S HEALTH AND TO SAVE HER LIFE.

The Act also is unconstitutional because it fails to exclude from its ban situations in which a woman's health or life is at risk. Casey made clear that any regulation of abortion must contain an exception "for pregnancies which endanger the woman's life or health." *Casey, 505 U.S. at 846.* In contravention of this command, the Act lacks any health exception whatsoever, and contains a constitutionally inadequate life exception.

As Casey recognized, pregnancy can often place a woman's life or health in jeopardy. In such circumstances, a physician must be permitted not only to provide an abortion, but also to use the method he or she determines to be most medically appropriate: In a medical emergency requiring quick response to rapidly changing circumstances, permitting a physician the discretion to **[*29]** use the full range of treatment options is particularly crucial. Given the Act's breadth, its omission of a health exception is clearly unconstitutional. Because D&X is the most medically appropriate abortion method in some situations, however, the lack of a health exception would condemn the Act even if it could be construed to target only D&X. The Act would force a woman whose health is threatened by pregnancy to choose between undergoing an abortion procedure more dangerous to her health than D&X and continuing her pregnancy in the face of potentially serious health risks. This Casey clearly forbids. *505 U.S. at 846, 879-80.*

The State's suggestion that the absence of a health exception is constitutionally permissible because such an exception is not "necessary in all circumstances or even in a large fraction of circumstances" (Pet. Br. 31) misconstrues this Court's precedent. Casey held that the State can never interfere with "a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." *505 U.S. at 880* (emphasis added). The requirement of a health exception continues throughout pregnancy and applies even after fetal viability when the state is otherwise free to ban abortion. *Id. at 877-78.* There is no need to show that the health of "a large fraction" of women needing an abortion (or specifically, a D&X) will be jeopardized by the Act. The "large fraction" test simply does not apply where a woman's health is at risk. If, as here, an abortion restriction will endanger the health of any woman, the restriction must contain a health exception.

The Act's narrow and wholly inadequate life exception also contravenes Casey and jeopardizes women's health. The Act permits a physician to perform a "partial-birth abortion" only if the banned procedure is "necessary to save the life of the mother." Neb. Rev. Stat. § 28-328(1). If a hysterotomy or hysterectomy would save a woman's **[*30]** life, the Act requires the physician to resort to those procedures even though they present far greater risks to the woman's health and future fertility than any of the banned procedures. The Act's life exception is further deficient because it is limited to situations in which the woman's life is threatened by a "physical disorder, physical illness, or physical injury." Id. Such a limitation violates Casey's command that abortion restrictions contain an exception for any threat to a woman's life. See *Casey, 505 U.S. at 879.* Finally, the Act does not clearly permit physicians to rely on their own best medical judgment in determining whether a banned procedure is necessary to save a woman's life. See *Colautti, 439 U.S. at 395-96, 401.* Even physicians who act in good faith in a medical emergency risk imprisonment and loss of license if their decisions are later second-guessed. The Act therefore hinders a physician's ability to provide his or her patients with the best medical care.

CONCLUSION

For the reasons set forth above, the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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March 29, 2000

Ms. BALDWIN. Thank you, Mr. Chairman.

It's not just these medical experts who believe that D&X is a safe and effective procedure that is most appropriate in certain, very rare cases. The United States Supreme Court came to the same decision in *Stenberg* v. *Carhart*. The Court concluded that the record shows that significant medical authority supports the proposition that, in some circumstances, D&X would be the safest procedure, and the findings in this bill simply ignore the significant evidence of medical experts and the reasoned judgment of the Court.

Mr. Chairman, the Supreme Court benefited from far more expert advice than this Committee has, and so I would also like to enter other amicus briefs into our record today. Mr. Chairman, I ask unanimous consent to enter the following briefs from the

Stenberg case: brief of the respondent, LeRoy Carhart, M.D.; brief of the United States; brief of NARAL, the National Women's Law Center, People for the American Way, and the National Partnership for Women and Families; brief of the Religious Coalition for Reproductive Choice and 53 other religious organizations; brief of Women's Law Project and 74 other organizations; the brief of 124 Members of Congress; the brief of physicians and clinics providing services in several States, represented by the ACLU; the brief of Planned Parenthood of Wisconsin; and, finally, the briefs of the States of New York, Maine, Oregon, and Vermont.

Chairman SENSENBRENNER. Does the gentlewoman intend to have all of these briefs reprinted in the Committee report, at great expense to the taxpayer?

Ms. BALDWIN. Here's the issue: We have—the supporters of this bill are pinning a lot of their hopes of the constitutionality of this on Committee hearing records and the findings that they've added to this bill. My point is, they're not supported in the scientific evidence, and I believe they're properly made a part of the record.

Chairman SENSENBRENNER. Without objection, the amicus briefs will be included in the record.

Ms. BALDWIN. Thank you, Mr. Chairman.

The second reason to remove these inaccurate findings is that they were drafted before establishing any sort of legislative record attempting to justify them. The bill was introduced with these findings before the Constitution Subcommittee had a legislative hearing to establish any case to justify this bill. Talk about putting the cart before the horse, I always thought that fact-finding came before legislating, especially if the supporters of this bill want to create a legislative record that will be considered and respected by the Court.

The third reason to strike the findings is that they are unlikely to have any impact on the Supreme Court's judgment as to the constitutionality of this legislation. Federal courts have rejected our fact-finding in the past. They have clearly stated that findings are subject to judicial review and independent judgment by the court.

As Members of this Committee, we know well the legislative record established for the Violence Against Women Act was one of the most extensive ever assembled by Congress. Four years of hearings on the Violence Against Women Act produced significant evidence supporting a finding that domestic violence impacted interstate commerce. Yet, the Court struck down the Violence Against Women Act civil remedy in the Morrison decision last term, disregarding our well-documented finding.

Mr. Chairman, these findings are not supported by the evidence, they're not supported by the Committee record, and they're not going to have any impact on the Court's action. And I urge my colleagues to support this amendment.

Chairman SENSENBRENNER. Mr. Chairman, I move to strike the last word and speak in opposition to the amendment.

I just want to say that even though all of the amicus briefs have been included in the record, should the Committee report the bill out, and should the House of Representatives pass the bill with the findings in it, in the opinion of the Chair, this constitutes a rejection of the arguments advanced in the amicus briefs that the gentlewoman from Wisconsin has included in the record.

I now yield to the gentleman from Ohio.

Mr. CHABOT. I thank the gentleman for yielding. I move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. CHABOT. Thank you. Mr. Chairman, before I get into my argument, in light of the gentlelady's request about the amicus briefs, I would just ask that the Chair consider the briefs on both sides being included. We have several days to make the determination on that, but——

Chairman SENSENBRENNER. Without objection, the amicus briefs on the other side of the issue will be included in the record as well, with the same disclaimer on those briefs as I have made in respect to the briefs referred to by the gentlewoman from Wisconsin.

[The information follows:]

DON STENBERG, ATTORNEY GENERAL OF THE STATE OF NEBRASKA, et al., Petitioners, v. LEROY CARHART, M.D., Respondent.

No. 99-830

1999 U.S. Briefs 830

February 28, 2000

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit.

BRIEF AMICI CURIAE of Association of American Physicians and Surgeons, Illinois State Medical Society, Physicians' Ad hoc Coalition for Truth, Christian Medical and Dental Society, Catholic Medical Association, Physicians Resource Council of Focus on the Family, Pennsylvania Physicians Resource Council, Physicians Research Council of the Indiana Family Institute, New Jersey Physicians Resource Council, Oklahoma Physicians Resource Council, Texas Physicians Resource Council, Wisconsin Physicians Resource Council, Drs. Kathi A. Aultman, Gerard Black, Watson A. Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Peter R. DeMarco, Fred de Miranda, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Joseph R. McCaslin, Phillip McNeeley, Phillip Metz, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, Dennis D. Weisenburger, and Joseph R. Zanga, IN SUPPORT OF PETITIONERS

This amici curiae brief is respectfully submitted on behalf of the Association of American Physicians and Surgeons, Illinois State Medical Society, Physicians' Ad hoc Coalition for Truth, Christian Medical and Dental Society, Catholic Medical Association, Physicians Resource Council of Focus on the Family, Pennsylvania Physicians Resource Council, Physicians Research Council of the Indiana Family Institute, New Jersey Physicians Resource Council, Oklahoma Physicians Resource Council, Texas Physicians Resource Council, Wisconsin Physicians Resource Council, Drs. Gerard Black, Watson Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Phillip McNeeley, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, and Joseph R. Zanga, MD, in support of Petitioners and in favor of reversal of the judgment of the United States Court of Appeals for the Eighth Circuit entered on September 24, 1999. n1

n1 Pursuant to Rule 37.3 of the Rules of this Court, Amici have obtained and file herewith the written consent of each of the parties to the filing of this brief. Counsel for a party did not author this brief in whole or in part. No person or entity, other than the Amici Curiae, its members, or its counsel made monetary contribution to the preparation and submission of this brief.

TERESA STANTON COLLETT, Counsel of Record, 1303 San Jacinto, Houston, Texas 77002-7000, (713) 646-1834.
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[*1] INTEREST OF THE AMICI CURIAE

Amicus Curiae The Association of American Physicians & Surgeons, Inc. ("AAPS") is a nonprofit organization dedicated to defending the practice of private medicine. Founded in 1943, AAPS has thousands of members nationwide in all specialties. AAPS frequently participates in litigation in defense of the practice of medicine in accordance with the Oath of Hippocrates. Central to **[*2]** the interest of AAPS are procedures which, like the one at issue here, are not designed to promote and protect the health of the patient.

Amicus Curiae Illinois State Medical Society ("ISMS") is a nonprofit professional organization with membership of over 16,000 licensed physicians, medical residents and medical students. ISMS policy specifically states:

ISMS opposes all intact dilation and extraction procedures (Partial-Birth Abortion). (1997 Annual meeting)

ISMS participation is limited to the purposes of this Brief to establish the medical realities surrounding intact dilation and extraction and not the penalties provided in the Nebraska statute.

Amicus Curiae The Physicians' Ad Hoc Coalition for Truth is an organization of more than 600 physicians from around the nation - most specializing in the fields of obstetrics and gynecology, perinatology or pediatrics - that have united to effectively express their opinion that the procedure known as partial-birth abortion is never medically necessary, and often may be contraindicated. This organization takes no position on the ultimate question of whether the current legal protections of abortion should be continued.

Amicus Curiae The Christian Medical & Dental Society (CMDS) was founded in 1941 and today represents over 14,000 members - primarily practicing physicians representing the entire range of medical specialties. This organization views principles of biblical faith as essential to protecting the lives and best interests of patients, the conscientious practice of medicine according to long-standing Hippocratic and religious principles, and to preserving the public respect accorded to physicians as guardians of health and life.

Amicus Curiae Catholic Medical Association ("CMA") is an association of physicians who seek to integrate their understanding of the teachings of the Roman Catholic Church into their professional lives. CMA believes that partial-birth abortion is never medically necessary.

[*3] Amicus Curiae Pennsylvania Physicians Resource Council ("PPFC") is an association of physicians concerned for the health and well-being of women and preborn children. PPFC has 250 members and concurs that intact D & X is not recognized as the preferred medical treatment at any stage of pregnancy, nor for any particular condition experienced in pregnancy.

Amicus Curiae Indiana Physicians Research Council ("IPRC") is an association of physicians and part of the Indiana Family Institute. IPRC was instrumental in the passage of a partial birth abortion ban that was enacted by the Indiana General Assembly in 1997.

Amicus Curiae Texas Physicians Resource Council ("TPRC") is a subsidiary of Free Market Foundation of Texas. TPRC represents approximately 500 physicians. TPRC recognizes that the United States Supreme Court's decision in this case will impact medical practice in Texas and endorses the ban on partial birth abortion.

Amicus Curiae New Jersey Physicians Resource Council ("NJPRC") is an association of 45 New Jersey physicians which provides insight on medical, ethical and social issues for policymakers, medical professionals and the public. NJPRC does not believe that partial birth abortion is ever medically indicated to save the life of the mother or to protect her future fertility.

Amicus Curiae Oklahoma Physicians Resource Council ("OPRC") is a multi-specialty organization of Oklahoma physicians. OPRC is associated with Oklahoma Family Policy Council, a nonprofit research and educational organization. OPRC and the physicians associated with it believe that bans against the medical performance of partial-birth abortion procedures are legitimate, moral and ethical public policy positions for states to hold.

Amicus Curiae Physicians Resource Council ("PRC") of Focus on the Family, a California non-profit religious corporation, is an advisory organization that helps identify critical, medically related issues and to form national task forces to develop and implement strategies and objectives to preserve traditional family values. The PRC **[*4]** is comprised of 22 physicians and oversees the publication of Physician Magazine which is received by approximately 74,000 physicians.

Amicus Curiae Wisconsin Physicians Resource Council (WPRC) operates in concert with The Family Research Institute of Wisconsin, Inc. (FRI), which is a charitable and educational organization. The partial-birth abortion issue in this case will impact medical practice in Wisconsin since Wisconsin passed a similar ban in 1998.

Amici curiae Gerard Black, Watson Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Phillip McNeeley, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, and Joseph R. Zanga, are physicians, many of whom have testified before Congress or their state legislatures regarding the medical necessity of the procedure known as "partial-birth abortion."

SUMMARY OF ARGUMENT

Amici offer this brief for the limited purpose of establishing the medical realities surrounding the procedure known as "partial birth abortion," "intact dilation and extraction," or "intact dilation and evacuation." Amici believe it is both desirable and constitutional to restrict the use of this procedure as Nebraska has done in this case. On this issue amici echo the sentiments expressed by a representative of the American Medical Association ("AMA"):

This issue is whether the partial delivery of a living fetus for the purpose of killing it outside of the womb ought to be severely restricted. We believe, as a matter of ethical principle, it should rarely if ever be done. And although we also believe physicians should have broad discretion in medical matters, both this procedure and **[*5]** assisted suicide (as well as female genital mutilation and lobotomies) can and should be regulated if the profession won't do it.

Letter to the New York Times, dated May 30, 1997 by P. John Seward, M.D. in his capacity as AMA Executive Vice President (emphasis added). n2

n2 Reproduced at App. 7-9 for the convenience of the Court.

As a legitimate health regulation the Nebraska statute succeeds in limiting the use of an unproven and ethically questionable practice, while insuring that safe and effective procedures remain available for women seeking to obtain abortions. While the autonomy of the medical profession is an important and valuable component of the success American medicine has experienced in the attempt to provide the highest quality of care in the world, this interest does not require the profession or the state to disregard practices that erode the public's under-standing of and confidence in the physician's role in assisting pregnant women. Dilation and extraction is such a practice, and thus should be prohibited.

ARGUMENT

I. D&X IS GENERALLY RECOGNIZED AS A DISTINCTIVE TECHNIQUE

A. THE FINDINGS OF THE DISTRICT COURT BELOW INDICATE THAT DILATION AND EXTRACTION IS A DISTINCTIVE TECHNIQUE CLEARLY DISTINGUISHABLE FROM DILATION AND EVACUATION AND OTHER ABORTION TECHNIQUES

The legal theories and factual findings by which the district court invalidated Nebraska's Partial-Birth Abortion Prohibitions are in tension with one another. On the one hand, the claim is made that the prohibitions are vague or constitute an undue burden because they **[*6]** encompass not only intact dilation and extraction ("D&X"), n3 but also dilation and evacuation ("D&E") abortion, the latter method being the most common method of second trimester abortion. n4 In accordance with this legal theory, the district court attempted to blur the line between D&X and other methods. n5

n3 This is the term applied to the procedure by its originator when it was first formally discussed among abortion providers. See Martin Haskell, Dilation and Extraction for Late Second Trimester Abortion (presented at the National Abortion Federation Risk Management Seminar, Sept. 13, 1992), published in The Partial-Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the Senate Comm. On the Judiciary, 104th Cong., 1st Sess. 3 (Nov. 17, 1995).

n4 See, e.g., *Carhart v. Stenberg, 11 F. Supp. 2d 1099, 1127-32 (D. Neb. 1998); 192 F.3d 1142, 49-50 (8th Cir. 1999).*

n5 See, e.g., *Carhart v. Stenberg, 972 F. Supp. 507, 525 (D.Neb. 1997)* (D&X is a variant of D&E and the difference between the two procedures is not a medical issue, but merely political). *11 F. Supp. 2d at 1106* (claiming that Carhart "intends to remove fetus intact" for all post-fifteen week abortions, although only successful in five to ten percent of such abortions).

On the other hand, the claim is made that D&X is a distinctive method with health benefits for women beyond that of other methods, including D&E. n6 For this purpose, of course, the district court drew a sharp distinction between D&X and other methods, in order to make comparative claims or findings about the supposed medical superiority of D&X over D&E and other methods. n7

n6 See, e.g., *Carhart, 972 F. Supp. at 525-27; 11 F. Supp. 2d at 1122-23.*

n7 See id.

Obviously, when the district court finds that the D&X procedure is medically superior to other methods, it is implicitly acknowledging that D&X is a distinctive technique, clearly distinguishable from, for example, D&E abortion. Other sections of this brief will take issue with **[*7]** the district court findings on the supposed benefits of D&X, and will demonstrate that the statutory definition of "partial-birth abortion" sufficiently distinguishes intact D&X from standard D&E. At the outset, however, it should be recognized that the district court findings themselves presuppose that the D&X procedure is indeed a distinctive method, clearly distinguishable from D&E abortion and other methods.

B. MEDICAL SOURCES INDICATE THAT INTACT D&X IS A DISTINCT TECHNIQUE

The term "D&X" abortion appears to have been introduced by Dr. Martin Haskell in a paper presented at a 1992 National Abortion Federation Conference. n8 The district court below specifically described the "Haskell D&X" as follows:

On the first and second days of the procedure, Dr. Haskell inserts dilators into the patient's cervix. On the third day, the dilators are removed and the patient's membranes are ruptured. Then, with the guidance of ultra-sound, Haskell inserts forceps into the uterus, grasps a lower extremity, and pulls it into the vagina. With his fingers, Haskell then delivers the other lower extremity, the torso, shoulders, and the upper extremities. The skull, which is too big to be delivered, lodges in the internal cervical os. Haskell uses his fingers to push the anterior cervical lip out of the way, then presses a pair of scissors against the base of the fetal skull. He then forces the scissors into the base of the skull, spreads them to enlarge the opening, removes the scissors, inserts a suction catheter, and evacuates the skull contents. With the head decompressed, he then removes the fetus completely from the patient.

[*8] *972 F. Supp. at 516* (quoting *Women's Med. Prof'l Corp. v. Voinovich, 911 F. Supp. 1051 (S.D. Ohio 1995)).*

n8 See Haskell, supra.

Dr. Haskell's 1992 paper explains the distinction between D&X and other methods as follows:

The surgical method described in this paper differs from classic D&E in that it does not rely upon dismemberment to remove the fetus. Nor are inductions or infusions used to expel the intact fetus.

Rather, the surgeon grasps and removes a nearly intact fetus through an adequately dilated cervix. The author has coined the term Dilation and Extraction or D&X to distinguish it from dismemberment-type D&E's.

. . . .

Classic D&E is accomplished by dismembering the fetus inside the uterus with instruments and removing the pieces through an adequately dilated cervix. n9

n9 See Haskell, supra.

As the district court found, Dr. Haskell employed his new method for pregnancies that had progressed to twenty weeks or beyond. n10 Dr. Haskell's 1992 paper explained that classic D&E dismemberment became difficult beginning at twenty weeks due to "the toughness of fetal tissues at this stage of development." Alternative D&E methods involved causing fetal death by various methods prior to surgery, to produce softening of fetal tissues. Late second trimester abortions could also be performed by induction methods. Dr. Haskell's D&X method was a new procedure that resolved the problem of fetal tissue toughness post-twenty weeks by providing a non-induction, non-dismemberment technique. n11 Instead of either dismembering the fetus piece by piece **[*9]** through the cervix or inducing labor, Dr. Haskell provided extensive dilation in a three-day procedure, then delivered all but the head of the fetus into the vagina, followed by reduction of the head size through evacuation of the skull contents, allowing complete delivery of the fetus.

n10 *972 F. Supp. at 516.*

n11 See id.

There has been a certain amount of confusion over the correct term for this distinctive procedure. At the time that Dr. Haskell presented his paper there were no references to this procedure in any medical textbooks, dictionaries, or journals. Even standard texts on abortion, such as Warren Hern, Abortion Practice (1990 reprint), did not name or describe the procedure. Dr. Haskell claimed to have "coined the term Dilation and Extraction or D&X". n12 However, another physician employing the method, Dr. James T. McMahon, chose the slightly different name "intact dilation and evacuation (intact D&E)." n13 Subsequently, abortion rights proponents such as the National Abortion Federation and Planned Parenthood divided over the right terminology, the former adopting Haskell's terminology, n14 the latter McMahon's. n15 Both organizations claimed their term the proper "medical" one, in supposed contrast to the term "partial-birth abortion," which was derided by advocates of the procedure as a non-medical term. n16 In the absence of any published descriptions of **[*10]** the term in medical textbooks, dictionaries, or standard medical journals, and amidst political controversy over proposed bans on partial-birth abortion which were aimed at prohibiting the new Haskell/McMahon procedure, it was difficult to standardize precise medical terminology for the new procedure.

n12 Haskell, supra.

n13 See James Bopp & Curtis R. Cook, Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence, *14 Issues L. & Med. 3, 20 (1998).*

n14 Planned Parenthood Federation of America, Fact Sheet: Why Abortion Bans are Unconstitutional (visited February 22, 2000) <http://www.plannedparenthood.org/library/ ABORTION/abortban___fact.html.>

n15 National Abortion Federation, NAF's Response to "Partial-Birth Abortion" Ban (visited February 22, 2000) <http:// www.prochoice.org/issues/ban.htm.>

n16 See id.

Subsequently the American College of Obstetricians and Gynecologists ("ACOG") issued a January 1997 statement adopting a hybrid term "intact dilation and extraction" or "intact D&X," combining the Haskell/McMahon definitions. The American Medical Association relied upon this report in issuing its own policy declarations. Therefore, the term "intact dilation and extraction" or "intact D&X" - which is sometimes shortened simply to "D&X" - appears to have become the most common appellations for the procedure in question. n17

n17 See *11 F. Supp. 2d at 1105 & n.10.* Amici do not suggest that unanimity has emerged on the proper name of this procedure, even at this time.

ACOG states that intact D&X has been described as including the following four elements:

(1) the deliberate dilation of the cervix, usually over a sequence of days;

(2) instrumental conversion of the fetus to a footling breech;

(3) breech extraction of the body, excepting the head; and

(4) partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

11 F. Supp. 2d at 1105.

The ACOG acceptance of this description indicates once again that D&X is medically understood as a distinctive technique, different from classic D&E abortion, even if it is sometimes denominated as a variant form of D&E. This four-part description is useful so long as it is not **[*11]** taken too literally. For example, dilation is "usually over a sequence of days" post twenty weeks, but prior to twenty weeks instrumental dilation not requiring this extended time frame may be employed. n18 (This is significant to the present case, as the Respondent Dr. Carhart testified that he only performed D&X from 16 to 20 weeks.) n19 Secondly, as Dr. Frank Boehm, professor of obstetrics and gynecology at the Vanderbilt University School of Medicine and Director of Obstetrics for the hospital, noted in testimony before the district court, version (or purposeful manipulation) is only needed when the fetus does not present in breech. n20 In the present case Dr. Carhart testified that he only chose to perform a D &X when the fetus presented in breech or where repositioning the fetus from a side presentation resulted in a breech presentation. n21

n18 "For procedures at up to 16 weeks' gestation, placing the dilators 4-8 hours prior to surgery may suffice. Beyond 16 weeks it is common practice to allow overnight dilation, and some mid to late second trimester protocols call for a second insertion in 16-24 hours." W. Martin Haskell et al., Surgical Abortion After the First Trimester in A Clinician's Guide to Medical and Surgical Abortion (Maureen Paul, et al., 1999) at 128.

n19 *972 F. Supp. 507 at 514-15.*

n20 Ex. 32, Videotaped Dep. of Dr. Boehm at 31:23-32:6. This point was first noted by Dr. Haskell in his 1992 paper presented at the National Abortion Federation Fall Risk Management Seminar. See Haskell, Dilation and Extraction, supra ("Version (as needed)").

n21 *972 F. Supp. at 522 n.20.*

The medical literature on D&X, although severely limited, takes into account these slight variations in technique. For example, in an article based on the AMA Board of Trustees 1997 Report, which was approved by the AMA House of Delegates in June 1997, the authors quote the ACOG description of intact D&X, then note "However, there may be variations of D&X that depart from this protocol, such as when an identical procedure is **[*12]** performed without converting the fetus to a footling breech or using decompression without suction evacuation of the cranial contents." n22

n22 Janet E. Gans Epner, et al., Late-Term Abortion, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26, 1998). See also W. Martin Haskell, et al., Surgical Abortion After the First Trimester 136-7 in A Clinician's Guide to Medical and Surgical Abortion (Maureen Paul, et al. eds., 1999) (discussing variations in procedure for breech and vertex position).

The Nebraska statute takes account of these variations, and other variations which at this point are not seriously proposed by any medical professional (e.g., intentionally delivering a live fetus head-first in order to kill it before completed delivery). A more detailed medical definition could invite practitioners to evade the law by modifying other minor details of the procedure. What remains the same throughout these variations and distinguishes the D&X procedure from other abortion techniques is: (1) Deliberate dilation of the cervix, technique and duration variable depending on stage of pregnancy and other factors; (2) Instrumental or manual conversion of the fetus to a footling breech where necessary; (3) Breech extraction of the body except the head; and (4) Reduction of the head size of a living fetus through methods such as decompression or evacuation of the intracranial contents to effect vaginal delivery of a dead, but otherwise intact, fetus.

II. INTACT D&X IS NOT RECOGNIZED WITHIN THE MEDICAL PROFESSION AS THE PRIMARY INDICATED TECHNIQUE OR STANDARD OF CARE AT ANY STAGE OF PREGNANCY OR FOR ANY PREGNANCY, AND THEREFORE CANNOT BE CONSIDERED MEDICALLY SUPERIOR TO THE STANDARD METHODS OF SECOND TRIMESTER ABORTION, SUCH AS D&E.

[*13] A. THE DISTRICT COURT ISSUED CONTRADICTORY FINDINGS OF FACT REGARDING THE SUPPOSED SUPERIORITY OF INTACT D&X WHICH MUST BE REGARDED AS CLEARLY ERRONEOUS

The district court correctly found, and the court of appeals agreed, that standard D&E abortion is the most common abortion method during the relevant gestational period. n23 This finding is supported by the practice of Respondent Dr. Carhart, who was found to perform standard D&E abortion rather than intact D&X in approximately ninety percent of his post-fifteen week abortions. n24 Although Dr. Haskell designed the D&X originally for the post-twenty-week period, the district court found that Respondent Dr. Carhart chose not to perform a D&X post-twenty weeks, but instead "induces fetal death by injection." n25 During the period from sixteen to twenty weeks Dr. Carhart only performs the D&X procedure when he finds the fetus in breech (or sometimes transverse, or side) presentation. Thus he employs D&X in approximately ten to twenty abortions out of the 190 sixteen-to-twenty-week abortions he performs annually. n26 The district court also recorded Dr. Carhart's procedure if he found the fetus presenting in transverse (sideways) position:

Carhart grasps whatever portion of the fetus he can in order to turn it so that part of the body will pass through the cervix. He performs this procedure because "you can't bring the fetus out sideways." If he can grasp the fetus "feet first" **[*14]** he will, but Carhart does not "intentionally spend a lot of time doing that."

972 F. Supp. at 521 n.20 (quoting portions of Dr. Carhart's testimony).

n23 *11 F. Supp. 2d at 1127-30; 192 F.2d at 1149-51* (D&E most common abortion method for second trimester abortions).

n24 See *972 F. Supp. at 520-22.*

n25 See *972 F. Supp. at 522.*

n26 *972 F. Supp. at 511, 520, 521 & n.20.*

Finally, the district court found that Dr. Carhart was, so far as he knew, the only provider of post-sixteen-week abortions in Nebraska, and therefore the only physician in the state who performed the D&X procedure. n27

n27 *972 F. Supp. at 511.*

The district court in summary found: (1) Standard D&E abortion is the most common method used during the relevant gestational period; (2) Respondent, the only provider of abortions during the relevant gestational period, chooses D&E over D&X approximately ninety percent of the time; and (3) Respondent allowed the presentation of the fetus during the period from sixteen to twenty weeks to determine which method he employed, and cared so little which technique he used that, when faced with a transverse lie, he did not "intentionally" spend "a lot of time" seeking to grasp the feet so that he could perform a D&X rather than D&E.

Directly contradictory to these findings, the district court also found that "medical evidence established that the D&X procedure is appreciably safer for women than the D&E procedure." n28 The district court relied on claims that D&X was superior to D&E because of (1) less chance of trauma to the cervix and uterus from bony fragments; (2) less instrumentation in the uterus, lessening the risk of complications from tearing or perforating the uterus; (3) prevention of disseminated intravascular coagulopathy and amniotic fluid embolus; (4) reduced chance of retained fetal parts; (5) reduced risk of free floating head; and (6) shorter operating time, reducing the amount of bleeding and the risks of hemorrhage and infection. n29 The only evidence offered to support the existence of these **[*15]** benefits was the testimony of the Respondent and the speculation of experts. The record is void of any controlled study or article from a peer-reviewed journal establishing that the D&X procedure is superior in any way to the D&E procedure most commonly employed in second and third trimester abortions. n30

n28 *972 F. Supp. at 525.*

n29 See *id. at 526-27.*

n30 The only generally available medical publication to make similar claims on behalf of the procedure is a recently published medical text, A Clinician's Guide to Medical and Surgical Abortion (Maureen Paul, et al. eds.) (1999). Based exclusively upon the self-reporting of the deceased Dr. James T. McMahon, one of the originators of the D&X procedure, the text states "This major complication rate is virtually identical to that of an earlier series of nonintact D&E's reported by Hern (3.07 [per] 1000 cases) despite the fact that nearly one-fourth of the cases in McMahon's series exceeded Hern's 25-week gestational limit." W. Martin Haskell, et al., Surgical Abortion After the First Trimester, in A Clinician's Guide to Medical and Surgical Abortion, supra at 137. This information was available at the time of trial, yet in the absence of any external review or indicia of reliability, none of the Respondent's experts or the district judge considered it relevant. Even taken at face value this statement provides little support for the finding of the district court that D&X is superior to D&E.

The chapter goes on to assert "Haskell [the other originator of D&X and co-author of the chapter] has performed more than 1500 intact D&E's at 20-26 weeks' gestation without a serious event." Id. No information is provided regarding the methodology of follow-up to obtain information about delayed complications, nor is there an adequate explanation of Haskell's or McMahon's definition of what constitutes a complication.

All the reasons given by the district court for finding intact D&X "appreciably safer for women" than D&E, if valid, would apply to the ninety percent of abortions for which Respondent Carhart chose not to perform a D&X. Moreover, the district court opinions fail to list any potential negative effects of the D&X procedure. Therefore, the findings of the district court suggest that Respondent Carhart, and indeed the vast majority of **[*16]** second-trimester abortion providers, are guilty of deliberately failing to choose an "appreciably safer" method of abortion, D&X.

The district court findings are self-contradictory. They simultaneously condemn the State of Nebraska for allegedly making illegal the most common form of second trimester abortion (D&E), while also claiming that this same method is, as measured against D&X, so medically deficient as to constitute a serious health risk for women.

The district court findings on the safety of D&X, in short, cannot be taken seriously as "findings of fact," but instead should be read merely as alternative legal theories. Alternative legal theories or alternative rationales, even where offered by a district court, cannot however, be accorded the same weight as findings of

fact. Surely a single district judge lacks the authority to condemn as medically deficient and unsafe a procedure - D&E abortion - which is clearly within the current standard of care for second trimester abortion. n31

n31 Paul D. Blumenthal, et al., Abortion by Labor Induction, in A Clinician's Guide to Medical and Surgical Abortion, supra at 139 ("Compared to induction abortion, dilation and evacuation (D&E) has generally been recognized as the safest and most expeditious means of pregnancy termination for similar gestational ages, specially prior to 20 weeks").

Ironically, the district court condemned as "irrelevant" "political rhetoric" prior statements issued by the AMA supporting the proposed Partial-Birth Abortion Ban Act of 1997, H.R. 1122. n32 To disregard the predominant practice of substantially all physicians, including the Respondent, and condemn the statements of the largest organized group of physicians in the country as merely "political" fuels the public perception in some quarters that abortion jurisprudence is driven by the personal or political preferences of the judiciary, rather than reasoned **[*17]** interpretation of medical facts and constitutional limitations. In light of the common practice of all physicians testifying in this case, and the statements of the larger medical community that no circumstances necessitate the use of intact D&X, the findings of the district court on the supposed medical superiority of intact D&X abortion must be set aside as clearly erroneous.

n32 *972 F. Supp. at 525 n.27.*

B. MEDICAL SOURCES INDICATE THAT INTACT D&X IS NOT THE STANDARD OF CARE OR PREFERRED METHOD AT ANY STAGE OF PREGNANCY OR FOR ANY PREGNANCY, AND MAY HAVE SIGNIFICANT MATERNAL HEALTH RISKS THAT WERE NOT CONSIDERED BY THE DISTRICT COURT

The varied statements by ACOG and the AMA reflect professional organizations caught between two impulses. On the one hand, it is clear, as reflected for example by amici, that there are significant numbers of physicians and health care providers who hold that intact D&X is both medically and ethically objectionable. n33 Further, D&X is not the standard of care or preferred **[*18]** method at any stage of pregnancy or for any pregnancy, according to current medical literature and standards. On the other hand, professional organizations such as ACOG and the AMA have an understandable tendency to resist governmental regulation of medical procedures and medical providers, particularly when regulation may involve criminal sanctions.

n33 " 'I have very serious reservations about this procedure,' " said Colorado physician Warren Hern, M.D. The author of Abortion Practice, the nation's most widely used textbook on abortion standards and procedures, Dr. Hern specializes in late-term procedures . . . of the procedure in question he says, " 'You really can't defend it.' " Diane M. Gainelli, Outlawing abortion method: Veto-proof majority in House votes to prohibit late-term procedure," 38 Amer. Med. News 1 (Nov. 20, 1995) (reproduced at App. 11-20 for the convenience of the Court); M. LeRoy Sprang & Mark G. Neerhof, Rationale for Banning Abortions Late in Pregnancy, 280 J. Amer. Med. Ass'n 744 (Aug. 26, 1998); and Janet E. Gans Epner, et al., Late-term Abortion, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26, 1998) ("in the absence of controlled studies, the relative advantages and disadvantages of the procedure in specific circumstances remain unknown").

These conflicting impulses are well illustrated by the ACOG and AMA literature pertaining to intact D&X/ partial-birth abortion. A January 1997 ACOG statement, after describing the intact D&X procedure, stated:

A select panel convened by the ACOG could identify no circumstances under which this procedure [intact D&X] . . . would be the only option to save the life or preserve the health of the woman. An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision.

See *11 F. Supp. 2d at 1105 n.10.*

The first sentence of the ACOG statement reflects the failure of medical experts to identify any stage of pregnancy or particular circumstance in which intact D&X abortion represents the standard of care, or would be medically necessary to protect the life or health of women. In direct opposition to the clearly erroneous finding of the district court that intact D&X was generally and appreciably safer than the predominant D&E, the ACOG's panel of experts could not identify a single circumstance where D&X is medically superior. A subsequent policy statement by the AMA agreed, finding that "there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion." AMA Policy H-5.982, quoted in *Hope Clinic v. Ryan, 195 F.3d 857, 872 (7th Cir. 1999)* (en banc).

[*19] These expert findings of ACOG and the AMA were employed by the AMA when it issued statements in support of the Partial-Birth Abortion Ban of 1997, which is quite similar to the Nebraska law at issue herein. The AMA Board of Trustees Press Release and Fact Sheet took the position that the federal bill did not prohibit D&E, but only prohibited intact D&X. The AMA press release described that procedure as "broadly disfavored - both by experts and the public. . . . It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development." n34 The AMA Board of Trustees Fact Sheet on HR 1122 stated that "Intact D&X is not an accepted 'medical practice'. . . . the Board's expert scientific report recommends against its use." n35

n34 American Medical Association, AMA Press Releases: AMA Supports H.R. 1122 As Amended, Statement by Nancy W. Dickey, MD, Chair of the AMA Board of Trustees (reproduced at App. 5-6 for the convenience of the Court).

n35 American Medical Association, AMA Board of Trustees FACT SHEET on HR 1112 (June 1997) (reproduced at App. 1-4 for the convenience of the Court).

While ACOG has consistently opposed legal prohibition of intact D&X/partial birth abortion, and the AMA has taken varying positions regarding such legislation, neither organization has yet offered any specific circumstances in which the procedure is believed to be medically necessary. ACOG's statement that there "may" be such circumstances is clearly just another way of expressing generalized opposition to legislative regulation of physicians. Indeed, when interviewed by American Medical News about this statement, ACOG President Fredric D. Frigoletto, Jr., "maintained that the [ACOG Executive] Board did not 'endorse' the procedure. 'There are no data to say that one of the procedures is safer than the other,' he said. When asked why the statement said the procedure 'may be the best' in some cases, Dr. Frigoletto **[*20]** answered, 'or it may not be.' " n36 Such reference to the bare possibility of health risks by a professional organization opposed in principle to legislative regulation of abortion cannot constitute an "undue burden," if the undue burden test is to play its role of distinguishing between permissible and impermissible governmental regulation.

n36 Diane M. Gianelli, Medicine adds to debate on late-term abortions: ACOG draws fire for saying procedure 'may' be best option for some, 40 Amer. Med. News 1 (March 3, 1997) (reproduced at App. 21-27 for the convenience of the Court).

The district court below acknowledged as correct the statement of its most favored expert, Dr. Stubblefield, n37 that there are no medical studies "which compare the safety of the intact D&X to other abortion procedures or conclude that the D&X is safer than other abortion procedures." n38 Two published articles in The Journal of the American Medical Association relating to the D&X procedure have also noted the lack of credible studies on safety. n39

n37 See *11 F. Supp. 2d at 1116* (Dr. Stubblefield most persuasive and helpful expert).

n38 *11 F. Supp. 2d at 1112.*

n39 See Janet E. Gans Epner, et al., Late-term Abortion, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26 1998) ("in the absence of controlled studies, the relative advantages and disadvantages of the procedure in specific circumstances remain unknown"); M. LeRoy Sprang & Mark G. Neerhof, Rationale for Banning Abortions Late in Pregnancy, 280 J. Amer. Med. Ass'n 744 (Aug. 26, 1998) ("no credible studies on intact D&X that evaluate or attest to its safety").

The district court, not fearing to tread beyond the confines of published studies and the expert panels of ACOG and the AMA, dismissed the lack of published studies as unimportant. n40 The district court relied largely upon Dr. Stubblefield, "a teacher and user of the D&E **[*21]** procedure," n41 to buttress claims that the D&X procedure was medically superior to D&E abortion, despite the fact that Dr. Stubblefield "has not performed this procedure himself, nor has he viewed anyone else perform it." n42 The court never appears to have wondered why Dr. Stubblefield, its favored expert, had never used or taught the intact D&X procedure if he believed it to be superior to D&E. Nor was the district court deterred by Dr. Stubblefield's testimony that characterized the possible health benefits of D&X as mere theory which should be regarded as uncertain pending data. n43 Similarly, Respondent's other expert, Dr. Hodgson, who had "performed or supervised at least 30,000 abortions," n44 and yet had never intentionally performed an intact D&X, n45 was relied upon to buttress claims of D&X as a "technological advance." n46 Such appearance of a "courtroom conversion" by Respondent's experts, who adhere to the D&E in their medical practice while opining about the supposed superiority of the D&X inside the courtroom, undermines any support for the findings of the district court.

n40 See, e.g., *11 F. Supp. 2d at 1124.*

n41 *11 F. Supp. 2d at 1125 n.35.*

n42 *11 F. Supp. 2d at 1112.*

n43 See *11 F. Supp. 2d at 1111* ("theoretically, would be safer. It would be a while before we have the data to compare. . . .")

n44 *11 F. Supp. 2d at 1105.*

n45 See *11 F.2d at 1105, 972 F. Supp. at 516.*

n46 See *972 F. Supp. at 516.*

The district court's speculations on why D&X is superior to D&E failed to mention or take account of the special risks that may be associated with D&X. First, "some physicians have suggested that the procedure may increase complications, such as cervical incompetence." n47 The threat of cervical incompetence is related to the **[*22]** amount of cervical dilation. n48 Cervical incompetence consequent to intact D&X may make it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term.

n47 280 J. Amer. Med. Ass'n at 726 (footnote omitted).

n48 A. Golan, et al., Incompetence of the Uterine Cervix, 44 Obstet. Gynecol. Surv. 96-107 (1989).

Further risks peculiar to intact D&X are described as follows:

First, the risk of uterine rupture may be increased. An integral part of the D&X procedure is an internal podalic version, during which the physician instrumentally reaches into the uterus, grasps the fetus' feet, and pulls the feet down into the cervix, thus converting the lie to a footling breech. The internal version carries risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus. According to Williams Obstetrics, "there are very few, if any, indications for internal podalic version other than for delivery of a second twin." n49

The risk of podalic version (repositioning the fetus) referred to in Williams Obstetrics involves manual internal version (repositioning by hand within the woman's body) to deliver a fetus in the third trimester. While this differs somewhat from version (repositioning) of the fetus with an instrument as described by Haskell in the D&X procedure, the risks of Haskell's procedure are unknown, and can only be the subject of speculation based upon the risks of similar, but not identical procedures.

The second potential complication of intact D&X is the risk of iatrogenic laceration and secondary hemorrhage. Following internal version and partial breech extraction, scissors are forced into the base of the fetal skull while it is lodged in the birth canal. This blind procedure risks maternal injury from laceration of the uterus or **[*23]** cervix by the scissors and could result in severe bleeding and the threat of shock or even maternal death. n50

All of these risks, if realized, have significant import for maternal health.

n49 280 J. Amer. Med. Ass'n at 744-45 (footnote omitted).

n50 Id. (footnotes omitted).

The district court's failure to take account of the negative risks associated with D&X in its supposed findings on the comparative superiority of intact D&X, alone renders those findings clearly erroneous. Any comparative analysis of the various techniques applicable to a specific stage of pregnancy or circumstance must obviously take account of the relative risks of both procedures to be valid. Simply listing the risks associated with second trimester D&E abortion, as the court did, n51 fails utterly to constitute findings of fact on the comparative risks of D&E and D&X.

n51 See *11 F. Supp. 2d at 1123.*

Amici believe that the nearly eight years that have passed since Dr. Haskell's 1992 paper on intact D&X have demonstrated that the procedure is never medically necessary, and remains generally inferior, in terms of maternal health, to existing abortion methods. Although abortion rights orientated experts are clearly willing to go into federal court and testify as to the efficacy of the D&X, physicians have retained their preference, in actual practice, for various forms of D&E and induction methods. n52 Professional organizations with strong interests in professional autonomy and maternal health have been unable to identify any particular circumstances where there is a need for the procedure. While the AMA **[*24]** no longer supports the federal ban on partial-birth abortion due to its overall opposition to criminal sanctions against physicians, the AMA continues to oppose this procedure. n53 Rather than being a new method on the rise, D&X remains after almost eight years an aberrant curiosity, a medically needless flashpoint of deeply-felt division.

n52 See, e.g., David A. Grimes, The Continuing Need for Late Abortions, 280 J. Amer. Med. Ass'n 747, 748 (Aug. 26, 1998) ("only a small number of physicians nationwide" perform intact dilation and extraction).

n53 An October 21, 1999 "Statement For Response Only" issued by the AMA states:

U.S. Senator . . . Santorum . . . has reintroduced a bill that would ban intact dilation and extraction. The American Medical Association (AMA) has previously stated our opposition to this procedure. We have not changed our position regarding the use of this procedure.

The AMA has asked Sen. Santorum to remove the criminal sanctions from his bill, but such a change has not been made. For this reason we do not support the bill.

American Medical Association, Statement for Response Only (Oct. 21, 1999) (reproduced at App. 10 for the convenience of the Court).

The weakness of the record in the instant case contrasts strangely with the supposed findings of the district court. None of the experts in the instant case had ever performed a D&X procedure. Even Respondent Carhart performed the D&X procedure in only about ten percent of his post-fifteen week abortions. Moreover, Carhart did not identify particular circumstances that necessitated use of D&X, but instead chose the procedure based on the happenstance of the presentation of the fetus, failing even in transverse presentations to make sustained efforts to effect a D&X procedure. The actions of the Respondent and his experts undercut any claims or finding of medical necessity for this procedure.

[*25] C. THERE ARE NO SPECIAL MEDICAL OR HEALTH INDICATIONS FOR D&X

The district court's over-reaching, clearly erroneous "finding" that the D&X procedure is generally superior to the more common and generally accepted methods, in combination with the fact that Respondent Carhart chose D&X based on the happenstance of fetal position, rather than special maternal indications, makes this case a particularly poor candidate for exploring whether there may be rare cases where D&X is necessary to maternal health. Neither the district court nor the appellate court below relied to a significant degree on such a

claimed need for D&X in specialized or extreme medical circumstances. Nonetheless, amici, having extensive experience with a wide variety of difficult medical circumstances related to maternal-fetal health, wish to emphasize that speculations on a supposed need for the D&X procedure in particular circumstances are groundless. This fact is not changed by the invocation of the emotionally charged circumstances surrounding tragic fetal abnormalities.

1. INTACT D&X ABORTION IS NOT INDICATED FOR HYDROCEPHALUS

Hydrocephalus, or excessive fluid accumulated in the fetal head, has sometimes been offered as a condition necessitating intact D&X, due to the impossibility of normally delivering the enlarged head. Of course, as ACOG and the AMA have noted, D&X has never been identified as the standard of care or indicated treatment for any particular circumstances. In fact, the usual treatment for hydrocephalus is transabdominal cephalocentesis, whereby the excess fluid in the fetal skull is drained through the use of a thin needle placed inside the womb through the woman's abdomen. n54 By contrast, proceeding transvaginally with scissors - the very crude method **[*26]** adopted by Haskell - or even a needle places the woman at an increased risk of infection because of the non-sterile vaginal environment.

n54 See, e.g., 280 J. Amer. Med. Ass'n at 745.

2. INTACT D&X IS NOT INDICATED OR NECESSARY IN ORDER TO DIAGNOSE FETAL ABNORMALITIES

It has sometimes been stated that it is useful to have an intact fetus in order to confirm abnormal prenatal diagnoses. n55 However, "a study involving 60 patients who underwent D&E at 14 to 22 weeks of gestation after fetal abnormalities were detected found that D&E successfully and consistently confirmed abnormal prenatal diagnoses." n56 Notwithstanding the results of these studies, to the extent that intact fetal salvage is desirable, this can be achieved through labor induction abortion. n57 Again, intact D&X upon examination has failed to become the standard of care for any particular circumstance, as there are always medically-sound alternatives.

n55 See W. Martin Haskell, et al., Surgical Abortion After the First Trimester in A Clinician's Guide to Medical and Surgical Abortion (Maureen Paul, et al. eds., 1999) at 136.

n56 280 J. Amer. Med. Ass'n at 727 (footnote number omitted) (citing L.P. Shulman, et al., Dilation and evacuation for second-trimester genetic pregnancy termination, 75 Obstet. Gynecol. 1037-40 (1990); see also W. Hern, et al., Outpatient abortion for fetal anomaly and fetal death from 15-34 menstrual weeks' gestation: Techniques and clinical management 81 Obstet Gynecol 301-06 (1993)).

n57 W. Martin Haskell, et al., Surgical Abortion After the First Trimester in A Clinician's Guide to Medical and Surgical Abortion (Maureen Paul, et al. eds., 1999) at 125.

III. INTACT D&X CONFUSES THE DISPARATE ROLES OF A PHYSICIAN IN CHILDBIRTH AND ABORTION IN A WAY THAT BLURS THE LINE BETWEEN INFANTICIDE AND ABORTION AND [*27] UNDERMINES THE PUBLIC INTEGRITY OF THE MEDICAL PROFESSION

Even abortion rights proponents have frequently expressed a particularly negative reaction to intact D&X, otherwise known as partial-birth abortion. This negative reaction is frequently shared by medical providers who are well acquainted with the relative gruesomeness of surgery and particular methods of abortion. There is something particularly shocking and aberrant about this particular procedure beyond, or different from, the difficult issues raised by abortion itself.

Intact D&X is aberrant and troubling because the technique confuses the disparate roles of a physician in childbirth and abortion in such a way as to blur the medical, legal, and ethical line between infanticide and abortion. When the physician performs (as necessary) instrumental version of the live fetus to a footling breech - using terminology (footling breech) and techniques borrowed from past and current obstetrics - she appears

initially to be assisting live delivery. As the physician manually performs breech extraction of the body of a live fetus, excepting the head, she continues in the apparent role of an obstetrician delivering a child. At this point of the procedure it is possible for all of the fetus' body, except for the head, to be outside of the woman's body, and the physician is holding the fetus' live body in one of her hands. The techniques used to this point of the procedure appear to be clear adaptations of the role of a physician acting with a duty of care to both fetus and woman, and the fetus is remarkably close - whether viable or not - to achieving live delivery.

Suddenly, the physician appears to switch roles and performs an act quite contrary to the obstetrical role: stabbing the base of the skull of the living fetus with a pair of scissors, spreading the scissors to enlarge the opening, inserting a suction catheter, and evacuating the skull contents. The physician acts directly against the physical life of a fetus who she has previously delivered, all but the head, out of the uterus. Even when the method **[*28]** is altered somewhat to involve other means of "evacuating" or "decompressing" the fetal skull, this portion of the intact D&X dramatically shifts the technique and role of the physician from delivery of a live fetus out of the womb to destroyer of a fetus almost entirely outside the uterus.

Even abortion rights proponents recognize that post-fifteen-week abortions are difficult and troubling for all involved. n58 However, the reason that Congress and thirty state legislatures have, usually by wide margins, passed bans on intact D&X abortion amounts to more than a negative response to second and third trimester abortion, and more than discomfort with the raw gruesomeness of surgery or late-term abortion. Rather, in a society that, due to this Court's precedents, must permit elective previability abortion and health-indicated post-viability abortion, there is a medical, legal, and ethical imperative to draw a bright, unblurred line between infanticide and abortion. Intact D&X threatens this bright line between infanticide and abortion in a way that undermines both the public integrity of the medical profession and society's interest in protecting human life.

n58 David A. Grimes and Willard Cates, Jr., "Dilation & Evacuation" in Second Trimester Abortion: Perspectives After a Decade of Experience (Gary S. Berger, et al. eds., 1981) at p. 130.

IV. NEBRASKA'S USE OF THE TERM "PARTIALBIRTH ABORTION" AND ACCOMPANYING DEFINITIONS FAIRLY DISTINGUISH INTACT D&X FROM STANDARD D&E ABORTION WHILE EXPRESSING THE STATE INTEREST IN DRAWING A BRIGHT LINE BETWEEN INFANTICIDE AND ABORTION

Even today, there is no fixed medical term for the procedure at issue herein. While ACOG and the AMA appear generally to use the term "intact dilation and extraction," as late as August 1998 the well-known **[*29]** reproductive health expert David A. Grimes used the term "intact D&E." n59 The district court below seemed somewhat challenged by the medical terminology, referring to the procedure alternatively as "intact dilation and evacuation," "intact D&X," "intact D&E," and "intact dilation and extraction." n60 Yet it also used one of these terms (intact D&E) for a different procedure in which the fetus is entirely within the uterus - and in one instance already dead - when the fetal skull size is reduced. n61 Moreover, despite claims that the term "intact dilation and extraction" is a medical term, the district court referred to this term as emanating from "the popular press." n62

n59 David A. Grimes, The Continuing Need for Late Abortions, 280 J. Amer. Med. Ass'n 747, 748 (Aug. 26, 1998).

n60 See, e.g., *11 F. Supp. 2d at 1105.*

n61 See *11 F. Supp. 2d at 1111-12.*

n62 *11 F. Supp. 2d at 1105.*

Under these circumstances, the Nebraska legislature, acting in 1997, cannot be fairly criticized for failing to use a medical term, as medical terminology has been evolving and uncertain. Moreover, the medical terminology fails to express the state's interests in drawing a clear line between infanticide and abortion which safeguards the public integrity of the medical profession. The term "partial-birth abortion" expresses reasonably well the gravamen of the objection to this procedure, which is that the procedure confuses the role of physician

in childbirth and physician in abortion, blurs the line between infanticide and abortion, and undermines the public integrity of the medical profession. "The 'partial birth abortion' legislation is by its very name aimed exclusively at the procedure by which a 'living fetus' is 'intentionally and **[*30]** deliberately' given 'partial birth' and 'delivered' for 'for the purpose of' killing it." n63

n63 American Medical Association, AMA Board of Trustees FACT SHEET on HR 1122 (June 1997) (reproduced at App. 1-4 for the convenience of the Court).

In their statutory construction the courts below have failed to interpret the statute in accord with its clearly expressed purpose. It is perverse to focus exclusively on the term "substantial portion," apart from the purposes of the act and important statutory terms such as "partial-birth abortion," "delivers," "delivers vaginally a living unborn child before killing the unborn child." Properly interpreting the various terms of the statute in light of the statute's purpose, the definition of partial-birth abortion clearly excludes the dismemberment of the fetus as is common with D&E abortion. There is certainly nothing resembling a "partial birth" in classic Dilation and Evacuation (D&E) abortion, nor does a D&E resemble intentional "delivery" of a living fetus into the birth canal.

CONCLUSION

For the foregoing reasons, we respectfully request that this Court reverse the judgments of the district court and Court of Appeals.

Respectfully submitted,

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[*App.] 1 American Medical Association
Physicians dedicated to the health of America

[LOGO]

AMA Board of Trustees FACT SHEET on HR 1122

1. Why did AMA support HR 1122?

AMA supported HR 1122 because, in the Board's view, "partial birth abortion" or intact D&X is ethically wrong, and it could not otherwise be restricted. Leaders of the profession, like former Surgeon General C. Everett Koop and medical ethicist Edmund Pellegrino oppose use of the procedure, as do most physicians and most members of the public.

In addition, AMA's expert panel, which included an ACOG representative, could not find "any" identified circumstance where it was "the only appropriate alternative."

Finally, by giving its support in exchange for changes in the legislation, AMA was able to substantially improve the Federal law and the law in the many states which are using, and passing, the Federal model.

2. Why is Intact D&X ethically wrong? How is it different from other destructive abortion procedures?

The procedure is ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb. The "partial birth" gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body.

[*App.] 2 **3. Does the Board endorse criminalization of "medical practice" by supporting HR 1122?**

In the Board's view, Intact D&X is not an accepted "medical practice," so the answer is no. There is no consensus among obstetricians about its use, and the Board's expert scientific report recommends against its use. It has never been subject to even a minimal amount of the normal medical practice development. It is not in the medical text books.

The AMA policy opposing the criminalization of medical practice is aimed primarily at preventing the prosecution (as recently occurred in New York) of physicians who have made serious, unintentional errors. In contrast, society has a long tradition of legislating, and criminalizing, certain abortion procedures, e.g., elective third trimester abortions. The profession has, in general, not opposed those efforts and the profession has supported criminal restrictions on improper "medical" procedures, such as female genital mutilation.

4. What changes were made in HR 1122?

The amendments obtained by the AMA were substantial and they were the maximum changes that could be obtained. Without the changes:

(a) a physician doing an Intact D&X because he or she believes there may be a risk to the mother's life would have to show that "no other procedure would [have] sufficed" to protect the mother, a difficult burden under any circumstance. The AMA changes entirely deleted the "no other procedure would suffice" requirement. When a woman is endangered by her pregnancy, her physician retains the discretion to **[*App.]** 3 choose this procedure over other procedures that might also be available.

(b) a physician would not have had the right to halt any prosecution in order to obtain review by an independent medical practice board of the appropriateness of the physician's conduct. That right is now guaranteed by AMA's changes.

(c) a physician intending to do a delivery who encountered emergency circumstances that in his or her judgment required use of the procedure would have been subject to the law. He or she now has complete discretion to do whatever is necessary for the life or health of the woman without any concern for the statute. It does not apply.

(d) a physician doing certain other kinds of abortion procedures might have been concerned about the legislation. It is clear beyond question as a result of AMA's changes that the legislation covers only Intact D&X.

5. Can the legislation be read as covering other abortion techniques?

The "partial birth abortion" legislation is by its very name aimed exclusively at a procedure by which a "living fetus" is "intentionally and deliberately" given "partial birth" and "delivered" "for the purpose of" killing it. There is no other abortion procedure which could be confused with that description.

Throughout the debate over the bill in Congress, and in the press, only the procedure known as Intact D&X was described as being covered by the bill. Any extension of the bill would be patently unconstitutional. Notwithstanding ACOG's objection to the use of non "medical" **[*App.]** 4 terms, ACOG has conceded that the sponsors' intent is clear and limited: "However, based on legislative testimony, ACOG believes the intent of the Federal ban is to criminalize an abortion technique . . . which some practitioners have termed Intact Dilation and Extraction (Intact D&X)." ACOG Factsheeet, April 14, 1997 (emphasis added).

June 1997

[*App.] 5 **Advocacy & Communications:**

AMA Supports H.R. 1122 As Amended

"Partial-Birth Abortion Ban Act of 1997"

(Washington - May 20) - Nancy W. Dickey, MD, Chair of the AMA Board of Trustees issued the following statement:

The American Medical Association Board of Trustees has determined to support H.R. 1122 because it has now been significantly changed to substantially meet the criteria which the Board established for any abortion legislation.

Consistent with an expert report requested by AMA's House of Delegates last December and also forwarded to the AMA House last week for consideration at its June meeting, H.R. 1122 now narrowly defines the procedure to be restricted - a procedure for which AMA's expert panel could not find "any identified situation" in which it was "the only appropriate procedure to induce abortion" - and it broadens the exceptions.

The changed language in the bill now: (a) makes it clear beyond any question that the accepted abortion procedure known as dilation and evacuation (also referred to as "D&E") is not covered by the bill, (b) permits the procedure to save the life of the mother without any obligation to show that "no other procedure would suffice," and (c) does not restrict use of the procedure for physicians intending a delivery at the outset, i.e., it can be done as necessary in their best medical judgment.

[*App.] 6 In addition, as also required by our legislative criteria letter, a physician will be entitled to stay any criminal proceeding in order to obtain expert review by the state medical board of any questioned conduct under the bill for use at trial.

As amended, H.R. 1122 is now a bill which impacts only a particular and broadly disfavored - both by experts and the public - abortion procedure. It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development. The bill has no impact on a woman's right to choose an abortion consistent with Roe v. Wade. Indeed, the procedure differs materially from other abortion procedures which remain fully available in part because it involves the partially delivered body of the fetus which is outside of the womb.

H.R. 1122 is serving as a model for many state legislatures and it is vitally important that the improvements which have been made become a part of the broader legislative process.

[*App.] 7 **Advocacy & Communications**

Letter to The New York Times
regarding AMA support of H.R. 1122

"Partial-Birth Abortion Ban Act of 1997"

The following letter from AMA Executive Vice President P. John Seward, MD was sent to The New York Times:

May 30, 1997

Letters to the Editor, The New York Times, 229 W. 43rd Street, New York, NY 10036, Via Fax: 212-556-3622

Dear Editor:

There is no civility and very little truth in abortion politics. At the extreme ends of both sides - like the Frank Rich column about the AMA (Op. Ed. May 29, 1997) - there is only hysterical distortion designed to distract from the real issue.

The issue is not the AMA - which has been described by David Kessler as a "hero" of the anti-tobacco movement and whose Medicare policy was recently applauded in an editorial by this newspaper. The issue is whether the partial delivery of a living fetus for the purpose of killing it outside of the womb ought to be severely restricted. We believe, as a matter of ethical principle, it should rarely if ever be done. And although we also believe physicians should have broad discretion in medical matters, both this procedure and assisted suicide (as **[*App.]** 8 well as female genital mutilation and lobotomies) can and should be regulated if the profession won't do it. And since there are safe, and indeed safer, abortion alternatives, we supported the Santorum bill as amended.

AMA's congressional advocacy is derived exclusively from the profession's values, especially the patient-physician relationship. But we cannot control the timing of the Congressional agenda. Our letters on abortion and Medicare - both public documents - went the same day because the Santorum bill ultimately came up the day that Congress had asked everyone - doctors, hospitals, home health care providers, insurance companies - to deliver their views on Medicare legislation. The Medicare letter went to 125 Congressional leaders, including Democratic leaders. It is similar to dozens of letters received on or about that same day from the other interested groups. Frank Rich could not be more wrong.

If it is just the Republicans we are trying to persuade we certainly would not have (a) delivered one day later a letter to Senator Kennedy supporting his efforts to expand access to care for children through an increased tobacco tax that the Republican leadership vigorously opposed, (b) stood one month earlier on the steps of the Capitol with Henry Waxman, demanding that Congress enact a lengthy antitobacco agenda, or (c) delivered on May 21 a letter to Representatives Kildee and Stark supporting ERISA reform which the Republicans **[*App.]** 9 generally oppose, or engaged in countless other activities that defy partisan identification.

Sincerely,

P. John Seward, MD

[*App.] 10 **American Medical Association Physicians dedicated to the health of America**

[LOGO]

Statement

For Response Only October 21, 1999

"U.S. Senator Rick Santorum (R-PA) has reintroduced a bill that would ban intact dilation and extraction. The American Medical Association (AMA) has previously stated our opposition to this procedure. We have not changed our position regarding the use of this procedure.

"The AMA has asked Sen. Santorum to remove the criminal sanctions from his bill, but such a change has not been made. For this reason we do not support the bill."

[*App.] 11 **American Medical**

NEWS

AMERICAN MEDICAL ASSOCIATION

NOVEMBER 20, 1995

VOLUME 38 - NUMBER 43

Outlawing abortion method

Veto-proof majority in House votes to prohibit late-term procedure

By Diane M. Gianelli
AMNEWS STAFF

WASHINGTON - His strategy was simple: Find an abortion procedure that almost anyone would describe as "gruesome," and force the opposition to defend it.

When Rep. Charles T. Canady (R. Fla.) learned about "partial birth" abortions, he was set.

He and other anti-abortion lawmakers launched a congressional campaign to outlaw the procedure.

Following a contentious and emotional debate, the bill passed by an overwhelming - and veto-proof - margin: 288-139. It marks the first time the House of Representatives has voted to forbid a method of abortion. And although the November elections yielded a "pro-life" infusion in both the House and the Senate, massive crossover voting occurred with a significant number of "prochoice" representatives voting to pass the measure.

The controversial procedure, done in second and third-trimester pregnancies, involves an abortion in which the provider, according to the bill, "partially **[*App.]** 12 vaginally delivers a living fetus before killing the fetus and completing the delivery."

"Partial birth" abortions, also called "intact D&E" (for dilation and evacuation), or "D&X" (dilation and extraction) are done by only a handful of U.S. physicians, including Martin Haskell, MD, of Dayton, Ohio, and, until his recent death, James T. McMahon, MD, of the Los Angeles area. Dr. McMahon said in a 1993 AMNews interview that he had trained about a half-dozen physicians to do the procedure.

The procedure usually involves the extraction of an intact fetus, feet first, through the birth canal, with all but the head delivered. The surgeon forces scissors into the base of the skull, spreads them to enlarge the opening, and uses suction to remove the brain.

The procedure gained notoriety two years ago, when abortion opponents started running newspaper ads that described and illustrated the method. Their goal was to defeat an abortion rights bill then before Congress on grounds it was so extreme that states would have no ability to restrict even late-term abortions on viable fetuses. The bill went nowhere but strong reaction to the campaign prompted anti-abortion activists to use it again.

They drafted a bill that would ban the procedure, after considering a number of other options. An Ohio law passed earlier this year, for instance, bans "brain suction" abortions, except when all other methods would pose a greater risk to the pregnant woman. It has been enjoined pending a challenge.

[*App.] 13 **Mixed feelings in medicine**

The procedure is controversial in the medical community. On the one hand, organized medicine bristles at the notion of Congress attempting to ban or regulate any procedures or practices. On the other hand, even some in the abortion provider community find the procedure difficult to defend.

"I have very serious reservations about this procedure," said Colorado physician Warren Hern, MD. The author of Abortion Practice, the nation's most widely used textbook on abortion standards and procedures. Dr. Hern specializes in late-term procedures.

He opposes the bill, he said, because he thinks Congress has no business dabbling in the practice of medicine and because he thinks this signifies just the beginning of a series of legislative attempts to chip away at abortion rights. But of the procedure in question he says, "You really can't defend it. I'm not going to tell somebody else that they should not do this procedure. But I'm not going to do it."

Dr. Hern's concerns center on claims that the procedure in late-term pregnancy can be safest for the pregnant women, and that without this procedure women would have died. "I would dispute any statement that this is the safest procedure to use," he said.

Turning the fetus to a breech position is "potentially dangerous," he added. "You have to be concerned abut causing amniotic fluid embolism or placental abruption if you do that."

[*App.] 14 Pamela Smith, MD, director of medical education, Dept. of Ob-Gyn at Mt. Sinai Hospital in Chicago, added two more concerns: cervical incompetence in subsequent pregnancies caused by three days of forceful dilation of the cervix and uterine rupture caused by rotating the fetus within the womb.

"There are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the life of the mother," Dr. Smith wrote in a letter to Canady.

Partial-Birth Abortion
Ban Act of 1995

The bill: HR 1833

Summary: Bans abortions in which provider 'partially vaginally delivers a living fetus before killing the fetus and completing the delivery.'

Exceptions: 'Life of mother' and physician belief that no other procedure would suffice as "affirmative defense" to prosecution or civil action.

Penalties: Possibility of suits, fines and/or imprisonment of up to two years.

Proponents: Procedure is medically and morally indefensible.

Opposition: Congress has no business legislating medical standards and procedures; bill begins erosion of abortion rights.

[*App.] 15 **Abortion**

The procedure also has its defenders. The procedure is a "well-recognized and safe technique by those who provide abortion care," Lewis H. Koplik, MD, an Albuquerque, N.M., abortion provider, said in a statement that appeared in the Congressional Record.

"The risk of severe cervical laceration and the possibility of damage to the uterine artery by a sharp fragment of calvarium is virtually eliminated. Without the release of thromboplastic material from the fetal central nervous system into the maternal circulation, the risk of coagulation problems, DIC [disseminated intravascular coagulation], does not occur. In skilled hands, uterine perforation is almost unknown," Dr. Koplik said.

Bruce Ferguson, MD, another Albuquerque abortion provider, said in a letter released to Congress that the ban could impact physicians performing late-term abortions by other techniques. He noted that there were "many abortions in which a portion of the fetus may pass into the vaginal canal and there is no clarification of what is meant by 'a living fetus.' Does the doctor have to do some kind of electrocardiogram and brain wave test to be able to prove their fetus was not living before he allows a foot or hand to pass through the cervix?"

Apart from medical and legal concerns, the bill's focus on late-term abortion also raises troubling ethical issues. In fact, the whole strategy, according to Rep. Chris Smith (R. N.J.), is to force citizens and elected officials to move beyond a philosophical discussion of "a woman's **[*App.]** 16 right to choose," and focus on the reality of abortion. And, he said, to expose those who support "abortion on demand" as "the real extremists."

Another point of contention is the reason the procedure is performed. During the Nov. 1 debate before the House, opponents of the bill repeatedly stated that the procedure was used only to save the life of the mother or when the fetus had serious anomalies.

Rep. Vic Fazio (D. Calif.) said, "Despite the other side's spin doctors - real doctors know that the late-term abortions this bill seeks to ban are rare and they're done only when there is no better alternative to save the woman, and, if possible, preserve her ability to have children."

Dr. Hern said he could not imagine a circumstance in which this procedure would be safest. He did acknowledge that some doctors use skull-decompression techniques, but he added that in those cases fetal death has been induced and the fetus would not purposely be rotated into a breech position.

Even some physicians who specialize in this procedure do not claim the majority are performed to save the life of the pregnant woman.

In his 1993 interview with AMNews, Dr. Haskell conceded that 80% of his late-term abortions were elective. Dr. McMahon said he would not do an elective abortion after 26 weeks. But in a chart he released to the House Judiciary Committee, "depression" was listed most often as the reason for late-term nonelective abortions with **[*App.]** 17 maternal indications. "Cleft lip" was listed nine times under fetal indications.

The accuracy of the article was challenged, two years after publication, by Dr. Haskell and the National Abortion Federation, who told Congress the doctors were quoted "out of context," AMNews Editor Barbara Bolsen defended the article, saying AMNews "had full documentation of the interviews, including tape recordings and transcripts."

Bolsen gave the committee a transcript of the contested quotes, including the following, in which Dr. Haskell was asked if the fetus was dead before the end of the procedure.

"No it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress - intrauterine stress during, you know, the two days that the cervix is being dilated. Sometimes the membranes rupture and it takes a very small superficial infection to kill a fetus in utero when the membranes are broken.

"So in my case, I would say probably about a third of those are definitely are [sic] dead before I actually start to remove the fetus. And probably the other two-thirds are not," said Dr. Haskell.

In a letter to Congress before his death, Dr. McMahon stated that medications given to the mother induce "a medical coma" in the fetus, and "there is neurological fetal demise."

But Watson Bowes, MD, a maternal-fetal specialist at University of North Carolina, Chapel Hill, said in a letter **[*App.]** 18 to Canady that Dr. McMahon's statement "suggests a lack of understanding of maternal-fetal pharmacology. . . . Having cared for pregnant women who for one reason or another required surgical procedures in the second trimester, I know they were often heavily sedated or anesthetized for the procedures, and the fetuses did not die."

Next move in the Senate

At AMNews press time, the Senate was scheduled to debate the bill. Opponents were lining up to tack on amendments, hoping to gut the measure or send it back to a committee where it could be watered down or rejected.

In a statement about the bill, President Clinton did not use the word "veto." But he said he "cannot support" a bill that did not provide an exception to protect the life and health of the mother. Senate opponents of the bill say they will focus on the fact that it does not provide such an exception.

The bill does provide an affirmative defense to a physician who provides this type of abortion if he or she reasonably believes the procedure was necessary to save the life of the mother and no other method would suffice.

But Rep. Patricia Schroeder (D. Colo.) says that's not sufficient. "This means that it is available to the doctor after the handcuffs have snapped around his or her wrists, bond has been posted, and the criminal trial is under way," she said during the House debate.

[*App.] 19 Canady disagrees. "No physician is going to be prosecuted and convicted under this law if he or she reasonably believes the procedure is necessary to save the life of the mother."

Organized medicine positions vary

The physician community is split on the bill. The California Medical Assn., which says it does not advocate elective abortions in later pregnancy, opposes it as "an unwarranted intrusion into the physician-patient relationship." The American College of Obstetricians and Gynecologists also opposes it on grounds it would "supersede the medical judgment of trained physicians and . . . would criminalize medical procedures that may be necessary to save the life of a woman," said spokeswoman Alice Kirkman.

The AMA has chosen to take no position on the bill, although its Council on Legislation unanimously recommended support. AMA Trustee Nancy W. Dickey, MD, noted that although the board considered seriously the council's recommendations, it ultimately decided to take no position, because it had concerns about some of the bill's language and about Congress legislating medical procedures.

Meanwhile, each side in the abortion debate is calling news conferences to announce how necessary or how ominous the bill is. Opponents highlight poignant stories of women who have elected to terminate wanted pregnancies because of major fetal anomalies.

[*App.] 20 Rep. Nita Lowey (D. N.Y.) told the story of Claudia Ames, a Santa Monica woman who said the procedure had saved her life and saved her family.

Ames told Lowey that six months into her pregnancy, she discovered the child suffered from severe anomalies that made its survival impossible and placed Ames' life at risk.

The bill's backers were "attempting to exploit one of the greatest tragedies any family can ever face by using graphic pictures and sensationalized language and distortions," Ames said.

Proponents focus on the procedure's cruelty. Frequently quoted is testimony of a nurse. Brenda Shafer, RN, who witnessed three of these procedures in Dr. Haskell's clinic and called it "the most horrifying experience of my life.

"The baby's body was moving. His little fingers were clasping together. He was kicking his feet." Afterwards, she said, "he threw the baby in a pan." She said she saw the baby move. "I still have nightmares about what I saw."

Dr. Hern says if the bill becomes law, he expects it to have "virtually no significance" clinically. But on a political level, "it is very, very significant."

"This bill's about politics," he said, "it's not about medicine."

[*App.] 21 **American Medical**

NEWS

AMERICAN MEDICAL ASSOCIATION .

MARCH 3, 1997

. VOLUME 48 . NUMBER 9

Medicine adds to debate on late-term abortion

ACOG draws fire for saying procedure 'may' be best option for some

By Diane M. Gianelli AMNEWS STAFF

WASHINGTON - As Congress and state legislatures consider banning a procedure opponents call "partial birth" abortion, the medical community is conducting its own appraisal of this controversial late-term abortion procedure.

The American College of Obstetricians and Gynecologists weighed in with an opinion from its Executive Board in January, saying it could identify "no circumstances under which this procedure would be the only option to save the life of the mother or preserve the health of the woman."

It added, however, that the procedure, which ACOG called intact dilation and extraction (D&X) and others call intact dilation and evacuation (D&E), "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances, can make this decision."

[*App.] 22 **Opinion comes under fire**

ACOG was immediately taken to task by a group of physicians who oppose the procedure.

By endorsing a practice "for which no peer-reviewed or safety data exist," ACOG appears to be violating its own standards, said members of PHACT (Physicians Ad Hoc Coalition for Truth), a group of about 400 physicians, many of whom are also ACOG members.

This statement "clearly does not represent a consensus among the nation's obstetricians and gynecologists as to the safety or appropriateness, under any circumstances, of partial birth abortion," the PHACT letter said. It added that it found it "unusual that PHACT, a coalition of doctors formed for no other reason than to investigate medical claims made about partial-birth abortion, was not invited to participate in these deliberations."

ACOG President Fredric D. Frigoletto, MD, in an interview, maintained that the board did not "endorse" the procedure. "There are no data to say that one of the procedures is safer than the other," he said. When asked why the statement said the procedure "may be the best" in some cases, Dr. Frigoletto answered, "or it may not be."

William Stalter, MD, an Ohio ob-gyn, said he feels let down by his professional organization.

ACOG, he said, "is supposed to be our standard-bearer for high-quality care in obstetrics and gynecology. And it's supposed to be the watchdog [against] procedures that are poorly conceived or unproven. Yet here **[*App.]** 23 they're defending a procedure that is virtually unstudied," said Dr. Stalter, a professor of obstetrics and gynecology at Wright State University in Dayton.

Dr. Frigoletto, in a letter responding to PHACT's complaints, said a task force drafted the policy statement that was amended and unanimously adopted by ACOG's executive board in January. "Clearly our organizations do not agree on the content of the statement," he wrote. "I hope we can respect these differences."

Meanwhile, the American Medical Association is also looking at the issue. Although it opted not to take a position when a federal bill to ban the procedure was considered last year, several members of the AMA House of Delegates pressed for a change in that position in the AMA's Interim Meeting in December. The house voted to have the AMA study the issue and evaluate the medical evidence before determining whether the practice conformed to the standards of good medical practice.

The AMA board discussed the issue at its February meeting, said AMA Trustee John C. Nelson, MD, a Salt Lake City ob-gyn. But it came to no conclusions.

"I'm not sure exactly what we'll say," he said. "If the medical literature or our colleagues cannot justify this procedure, we'll say we shouldn't do it. If in fact we can justify it, we'll say we could do it."

What medical groups have in common when viewing a potential ban on the procedure is a reluctance to allow Congress to meddle in medical matters. But this stance invites criticism from those who point out that

many medical groups supported congressional efforts to pass [*App.] 24 laws requiring insurers to cover minimum stays for child-birth deliveries and banning another controversial procedure called female circumcision or genital mutilation.

Looking for the science

The late-term abortion procedure is difficult to study, Dr. Nelson said, because there are no published reports on it. "We want to have the information so we can come up with a considered and reasoned viewpoint," Dr. Nelson said. He added that the AMA "will have a board report on the issue in June."

Without published data and peer-reviewed studies on the procedure, it's hard to reach clear findings about it. Now that Congress is taking a second look at a bill to ban the procedure and at least 25 states have introduced similar legislation, safety questions are once again being raised. The bill to ban it passed in both the Senate and the House last year, but it was vetoed by President Clinton.

Those who perform the procedure say it is safer for the woman and more convenient for the surgeon. Although the whole procedure takes three days, to allow for the women to come in for frequent laminaria insertions to dilate her cervix, the actual operation is scheduled on an outpatient basis and takes only five to 15 minutes.

Some providers say this method is safer than the classic D&E procedure in which the fetus is dismembered in the womb, leaving the mother at greater risk for internal perforations caused by either the slip of the surgeon's [*App.] 25 instruments or bones from the fetus broken inside her body.

They claim that the intact D&E, because it avoids much of the sharp instrumentation and bone tears, is the procedure of choice for late-term abortions to preserve the woman's future fertility.

At a news conference this fall, the president spoke movingly of the women who chose this method to end their wanted pregnancies because of unexpected fetal anomalies. This procedure, he said, allowed them the chance to have another baby.

Opponents of the procedure assert, however, that the claim is without medical merit, and note that one of the five women at Clinton's veto ceremony had five miscarriages after her intact D&E. The procedure, opponents say, is potentially risky and actually contraindicated for fertility enhancement.

Late-term abortion options

A better option, they maintain, is to deliver the fetus by induction, using prostaglandin or pitocin to ripen the cervix and induce labor. Fetus demise can be induced beforehand.

Some also question the necessity of killing the fetus through brain suction or any other method if it has a condition incompatible with life and suggest it is "more humane" to have the physician induce labor and let the child die naturally.

[*App.] 26 Critics also say turning the fetus to a breech position can cause amniotic fluid embolism, placental abruption or uterine rupture.

And they maintain that the forcible dilation necessary to prepare the women's cervix for the procedure risks creating an "incompetent cervix," which could prevent a woman from carrying future pregnancies to term.

Diana Grossheim, from Huntington Beach, Calif., may be one of those women. Grossheim had an intact D&E in 1995. She now has an incompetent cervix.

When Grossheim's almost 21-week-old fetus died in utero, she said her physician told her she had two choices: labor, which was described as up to 48 hours of torture, or intact D&E, which her doctor described as "more merciful."

Grossheim said the procedure was "three days of pure hell" - both physical and mental.

She had to stay in a hotel and go back and forth to the clinic for laminaria changes. She was afraid she might deliver the baby in the hotel. On her second night, the pain was terrible - she was vomiting, cramping and screaming all night.

When her daughter was finally delivered, Grossheim said she and her husband didn't understand why she had such a flat head. If they were told about the brain suction procedure, it wasn't in terms she could understand, said the high school math teacher.

When Grossheim became pregnant again, she was told during a routine ultrasound in her 23rd week that she had an incompetent cervix and had to go on bed rest **[*App.]** 27 for the remainder of her pregnancy. She delivered a healthy boy at 37 weeks, but still remembers the second half of her pregnancy as uncomfortable and frightening - thinking the baby would come any time and would die, too. She was heavily medicated and having contractions around the clock.

She's now 35 years old and would like to get pregnant again. But she can't afford to hire someone to watch her child while she spends her next pregnancy in bed. And she fears her chances of carrying to term are slim.

In retrospect, Grossheim wishes she had chosen the labor option. She would have felt safer in the hospital, where her pain could have been controlled and her fear of delivering alone eliminated. And she doesn't see any justification for the intact D&E procedure.

"Now that I've been through actual labor and delivery," she said, "I think it was much easier than what I went through."

Mr. CHABOT. Thank you, Mr. Chairman.

And I rise in very strong opposition to this amendment. This amendment should be rejected for a number of reasons. H.R. 4965's findings are necessary statements of Congress's factual conclusions regarding the relative health and safety of partial-birth abortions. The extensive findings make it clear that substantial evidence exists upon which Congress can conclude that a partial-birth abortion is not medically necessary to preserve the health of a woman.

Despite the claims of H.R. 4965's opponents, the Supreme Court does not consider congressional findings irrelevant. Quite to the contrary, the Court consistently reviews and discerns Congress's intentions based upon them. To remove the findings would remove the only basis upon which the Court could determine whether the

legislative facts which support H.R. 4965 are based upon reasonable inferences made upon substantial evidence.

For that reason, I strongly urge my colleagues to oppose this amendment. And I yield back the balance of my time.

Mr. SCOTT. Mr. Chairman?

Mr. FRANK. Mr. Chairman?

Chairman SENSENBRENNER. The Committee will be in recess until the end of the three votes that we have. Members will come back promptly, because the Chair believes this to be the last amendment, and we can——

Ms. JACKSON LEE. No——

Chairman SENSENBRENNER. There are additional amendments. Well, please be back promptly, so we can continue debating this bill and the amendments.

The Committee stands in recess.

[Recess.]

Chairman SENSENBRENNER. The Committee will be in order.

When the Committee recessed, the bill H.R. 4965 was pending. The gentleman from Ohio, Mr. Chabot, had made a motion to report the bill favorably with——

Ms. JACKSON LEE. I have a——

Chairman SENSENBRENNER. Will the gentlewoman from Texas give me the courtesy of stating where we are at before interrupting?

Ms. JACKSON LEE. Be delighted to do that. I just want to make sure we——

Chairman SENSENBRENNER. This is about the third time you've done it today.

Ms. JACKSON LEE. I am—that's correct——

Chairman SENSENBRENNER. The bill 4965——

Ms. JACKSON LEE.—because I know what happens in this Committee. But I thank the Chairman.

Chairman SENSENBRENNER. The bill 4965—a motion by the gentleman from Ohio to report the bill favorably was pending. Without objection, the bill was considered as read and open for amendment at any point. Pending was the amendment by the gentlewoman from Wisconsin, Ms. Baldwin, to strike section 2.

Mr. FRANK. Mr. Chairman?

Chairman SENSENBRENNER. I believe the gentleman from Massachusetts has already been recognized on the amendment.

Mr. FRANK. Not on the findings amendment.

Chairman SENSENBRENNER. On the Baldwin amendment?

Mr. FRANK. Not on this Baldwin amendment.

Chairman SENSENBRENNER. Does the gentleman move to strike the last word?

Mr. FRANK. I do, Mr. Chairman.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. FRANK. Thank you, Mr. Chairman.

I did want to stress what seems to be an inconsistency here with regard to the language in the bill that makes an exception, it says as follows: The defendant may seek a hearing before the State medical board on whether the physician's conduct was, "necessary to save the life of the mother whose life was endangered by a physical disorder, physical illness, or physical injury."

In other words, the bill contemplates that there could be a physical problem for the mother, requiring this procedure. But then the findings categorically announce that there is no possibility of there being a health problem.

Now, it simply is not logical to argue that there could be a situation in which a physical disorder or physical illness or physical injury endangered the life of the mother and, therefore, there could be an exception to the prohibition, and then there's a flat statement that says, on line 11 in the findings, page 11, finding D: Neither the plaintiff nor the experts have identified a single circumstance during which a partial-birth abortion was necessary to preserve the health of a woman.

The findings say it's never relevant to health; the bill says, well, if it's necessary because of a physical disorder.

Now, I know there's an old saying that says whatever doesn't kill me makes me stronger. I have always thought that, frankly, to be particularly stupid—— [Laughter.]

—since a severely broken arm neither kills you nor makes you stronger, in my experience. A lot of old sayings are stupid; that's not our problem here.

But it does seem to be adopted by this bill. The notion is that either something is going to kill you or, at the very least, have no adverse effect on your health.

That's the logical inconsistency in this. On the one hand, you want findings that say there can never be a health problem. On the other hand, you make an exception for a health problem that will endanger the life. And it simply could not be argued logically that there could be a circumstance in which the woman's life was in endangered, but there was zero chance that she would have any negative physical consequences short of losing her life.

So in part for that reason, and because I think this shows that these are not scientific findings—they are arguments which we are entitled to make, but I do not think it is accurate to call them findings. And I think we ought to adopt the amendment.

Chairman SENSENBRENNER. The gentleman from Virginia, Mr. Scott, was he recognized on this amendment earlier?

Mr. SCOTT. No, Mr. Chairman.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. Chairman, it seems to me that, without this amendment—I don't know what significance the findings would be anyway. I mean, how do you get them into evidence? You're challenging the constitutionality of the legislation. You come in and put on your medical evidence. What does the defense do, come in and wave, "Well, this is what Congress found," and expect the trial court to consider that as evidence?

I don't know, but I do know what Justice Thomas wrote in 1992. He was a sitting member of the Supreme Court but had heard the argument in this case and was sitting as a member of the D.C. Circuit. And he wrote, at that time: We know of no support for the proposition that if the constitutionality of a statute depends in part on the existence of certain facts, a court may not review Congress's judgment that the facts exist. If Congress "could make a statute constitutional simply by 'finding' that black is white or freedom,

slavery, judicial review would be an elaborate farce. At least since *Marbury* v. *Madison*, that has not been the law."

I think this bill, the merits of the bill, out to stand on their own, without these findings that have no significance. And I would hope that the amendment would be adopted.

Chairman SENSENBRENNER. The question is on the Baldwin amendment.

Those in favor will say aye.

Opposed, no.

The noes appear to have it. The noes have it, and the amendment is not agreed to.

Are there further amendments?

The gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Mr. Chairman, I have an amendment at the desk.

Chairman SENSENBRENNER. The clerk will report the amendment.

Mr. SCOTT. I have two amendments; this is number 1.

Chairman SENSENBRENNER. The clerk will report Scott 1.

The CLERK. Amendment in the nature of a substitute to H.R. 4965, offered by Mr. Scott of Virginia. Strike all after the enacting clause and insert the following——

[The amendment follows:]

AMENDMENT IN THE NATURE OF A SUBSTITUTE

TO H.R. 4965

OFFERED BY MR. SCOTT OF VIRGINIA

Strike all after the enacting clause and insert the following:

SECTION 1. PROHIBITION ON CERTAIN ABORTIONS.

(a) IN GENERAL.—It shall be unlawful, in or affecting interstate or foreign commerce, knowingly to perform an abortion after the fetus has become viable.

(b) EXCEPTION.—This section does not prohibit any abortion if, in the medical judgment of the attending physician, the abortion is necessary to preserve the life of the woman or to avert serious adverse health consequences to the woman.

(c) CIVIL PENALTY.—A physician who violates this section shall be subject to a civil penalty not to exceed $10,000. The civil penalty provided by this subsection is the exclusive remedy for a violation of this section.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. Chairman, I oppose the bill in its present form. The amendment before us is a substitution of the bill of another piece of legislation that was introduced by the gentleman from Maryland, Mr. Hoyer, and the gentleman from Pennsylvania, Mr. Greenwood.

Nearly 2 years ago, the United States Supreme Court held in *Stenberg* v. *Carhart* the Nebraska law proscribing so-called partial-birth abortions was unconstitutional for two reasons. First, it lacked the health exception, and second, it had the undue burden—placed an undue burden on a woman's right to choose.

In light of this, I urge my colleagues to give this amendment consideration. This is actually a truth-in-advertising amendment. This would in fact restrict all late-term abortions that are permissible to be restricted according to Supreme Court guidelines. It makes it unlawful to knowingly perform an abortion after the fetus becomes viable unless, in the medical judgment of the attending physician, it is necessary to preserve the life of the woman or avoid serious adverse health consequences.

Now, that last phrase, "avoid serious adverse health consequences," is actually a stretch on the Supreme Court language that says "health consequences," not "serious." But we're stretching as far as we can, to the extent that—the underlying bill does not eliminate any abortions; it just eliminates a procedure. This amendment would actually eliminate every late-term abortion possible under the Supreme Court guidelines. That is what the rhetoric of the underlying legislation has said, so this amendment would conform the legislation to the rhetoric.

I would hope that we would agree to the amendment, Mr. Chairman, because I think, with this language, we could get a consensus on the legislation.

Mr. CHABOT. Mr. Chairman?

Mr. SCOTT. I yield back, Mr. Chairman.

Chairman SENSENBRENNER. The gentleman Ohio, Mr. Chabot.

Mr. CHABOT. Thank you, Mr. Chairman. I move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized 5 minutes.

Mr. CHABOT. Thank you, Mr. Chairman.

I would urge my colleagues to oppose this amendment for a number of reasons.

The first one being, it offers protection only to viable infants, and the majority of partial-birth abortions are performed on babies during their fifth and sixth months of pregnancy. Most of the infants aborted during this period, obviously, are not viable. The substitute would thus have no impact on the vast majority of partial-birth abortions, and that's the whole purpose of this legislation. It's to ban this horrendous, barbaric practice in this country.

Second, the exemption for post-viability abortions that are necessary to preserve the health of the mother gives the abortionist unfettered discretion in determining when a partial-birth abortion may be performed. And abortionists have demonstrated that they can justify any abortion on this ground. Again, Dr. Warren Hern of Colorado, the author of the standard textbook on abortion procedures, who also performs many third-trimester abortions, stated, and this is a quote, "I will certify that any pregnancy is a threat to a woman's life and could cause grievous injury to her physical health."

And the third reason I would oppose this amendment is that the substitute appears to be based on the notion that viability is prerequisite for giving any legal protection to a child. But this notion is misguided. Premature infants who are born pre-viability with little or no chance of survival are fully entitled to the protections of the law while they are alive.

As I had mentioned earlier, you could not, for example, just walk into a neonatal intensive care unit and kill an infant who was born

22 weeks, for example, into the pregnancy and is in an incubator, literally struggling to survive. That child's ultimate viability has no bearing whatsoever on whether he or she is entitled to the protections of the law, in the same way partially born children, with little or no chance of survival outside the womb, are entitled to the protections of the law while they are alive. Viability is simply not a prerequisite for legal protection of born or partially born children.

And for all three of those reasons, I would strongly oppose this amendment, and I yield back the balance of my time.

Ms. JACKSON LEE. Mr. Chairman?

Mr. WEINER. Mr. Chairman?

Chairman SENSENBRENNER. The gentlewoman from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. I thank the Chairman very much. And I appreciate the work that we have to do in this Committee. I noticed that we can just drone on about rules and regulations.

But I really would like to support this amendment on the practicality and the common sense that this amendment presents, and the opportunity to be as—to find a consensus.

I think it's important to note that this partial-birth abortion is done post-viability. These are babies that are wanted. And before they get to the point of this enormous decision, these women have gone to their physicians. They've gone to geneticists. As I've indicated, I keep saying over and over again, they have convened a family meeting. They have sought their spiritual leader's guidance.

They are pregnant, and this is not an abortion—this is abortion legislation. This legislation is actually interfering with a medical procedure, a health procedure, a procedure—I listened to one of my good friends and colleagues describe the heinousness of the procedure. Well, have you ever looked at open-heart surgery? They crack you open. So do you want laws to make illegal open-heart surgeries? Crack you open, rip your chest open, and maybe sometimes have people pulling back—it is a horrific-looking sight to save life.

Mr. CHABOT. Will the gentlelady yield?

Ms. JACKSON LEE. In just a moment.

And, therefore, here is an opportunity, offered by Mr. Scott, that has had in the past Republican and Democratic support, that indicates that it is a medical judgment that is made. And for the life of me, I cannot understand why my good friends could not see the value in this.

You keep equating the partial-birth abortion with an abortion. It has that name in it because you gave it that name. It never had such a name 10 years ago. Physicians with expertise were being sought to save lives and to allow a mother to procreate.

This is a very valid amendment, if we are serious about doing what we are supposed to be doing. And I haven't seen a pretty surgery yet.

And for those of us who have offered our personal stories, I do think there's a distinction, my friends, for those of us or those women who have been in C-section, that's not pretty either. But they do it to save lives.

I yield to the gentleman for a moment.

Mr. CHABOT. I thank the gentlelady for yielding.

The gentlelady compares open-heart surgery and a partial-birth abortion. I would just remind the gentlelady that the purpose of

open-heart surgery is to save the life of that patient. The purpose of a partial-birth abortion is to destroy that innocent human life.

Ms. JACKSON LEE. Reclaiming my time, and I thank the gentleman. I knew that he was going to make that point. And I'm going to yield to Mr. Scott.

Let me just make a point to say that we disagree, we differ. And I think you'll find an enormous amount of medical science that suggests that this procedure, the medical judgment of making this decision after a mother has gone everywhere to save that life, after that, that is to save a life. And it is not a pretty procedure.

So I know that the gentleman and I disagree. I'd be happy to yield to the distinguished gentleman from Virginia.

Mr. SCOTT. Thank you. And I thank the gentlelady for yielding.

I think that we have to remind ourselves that the underlying bill does not prevent a single abortion; it just makes sure that it is not done with one procedure. It will be done with another procedure. And I'm not going to insult everybody's intelligence or sensibilities by trying to describe what those alternatives are. Perhaps the gentleman from Ohio can describe the procedure that would be used if this procedure cannot be used.

And I yield back.

Ms. JACKSON LEE. I thank the gentleman. As I heard his description of it, that is exactly right. And I would simply argue vigorously that this is a common-sense amendment in the nature of a substitute. It, again, reinforces the point that we've been trying to make over and over again.

I wish we could have videotaped the—it seems like hundreds of hours of hearings that I sat through, where I actually listened to women who had to receive or seek these particular procedures, and see the pain that was exhibited by these individuals, and maybe have that videotape part of the record. I think, then, my colleagues who are new to this—some of you are new to this debate, some newer than others. I know Mr. Chabot is not. But the point is that——

Chairman SENSENBRENNER. The time of the gentlewoman has expired.

Ms. JACKSON LEE.—Mr. Chairman, this amendment should be supported. I yield back. Thank you.

Chairman SENSENBRENNER. The question is on the amendment offered by the gentleman from Virginia, Mr. Scott.

Those in favor will say aye.

Opposed, no.

The noes appear to have it. The noes have it, and the amendment is not is agreed to.

Are there further amendments?

Ms. JACKSON LEE. I have an amendment at the desk. It is now 004, Mr. Chairman.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 4965, offered by Ms. Jackson Lee. Page 16, beginning on line 5, strike——

[The amendment follows:]

AMENDMENT TO H.R. 4965

OFFERED BY Ms. Jackson Lee

Page 16, beginning in line 5, strike "or imprisoned"

and all that follows through "both" in line 6.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

Ms. JACKSON LEE. I thank the Chairman.

The argument preceded me, as I was presenting another amendment using the argument. But this, in essence, is an amendment that strikes the language that would incarcerate physicians. Noted that has already been submitted into the record, and the Chairman graciously accepted it, was a 1999 letter from the American Medical Association that has begged this Congress to void the language that deals with imprisonment.

Again, these procedures are not done in backroom alleys. They are procedures that husband and wife, wife, or—excuse me—woman and family, mother and family, go to a physician after no other options can be pursued.

The physician does it in the light of day. I asked whether there had been testimony in the hearings of this most recent effort to suggest that these are fly-by-night procedures, and whether people are advertising in the Yellow Pages and standing in line to get them. I don't think there's any data that suggests that we stand up voluntarily and say, "I'd like to have this procedure post-viability."

And, therefore, for a physician who has taken an oath to be imprisoned is really taking us back to the medieval Dark Ages and leaving out the Renaissance period. Clearly, this is detrimental to our science, the medicine, what we teach our physicians in schools, in medical schools, and the freedom that we give medical practitioners, to a certain extent, to be able to save a life.

And to the distinguished gentleman from Ohio, let me simply say, there's an argument that I can probably document for you that these procedures have saved a life, and so you can't negate that. You may argue with me on the life, what your viewpoint is. But I can assure you, we have medical documentation that a woman's life has been saved by this particular legislation. And as it has been saved, she has been left here, since medical science has not designated the male species to procreate—albeit, it may be on the horizon. I would venture to say, you would not be successful; you can't stand pain.

But the point is that the issue is that this stands ready to allow a woman to procreate again with this procedure. And to imprison a physician I think is a shame.

I'd ask my colleagues to support this amendment.

Mr. CHABOT. Mr. Chairman?

Mr. HYDE. Would the gentlelady yield?

Ms. JACKSON LEE. I'd be happy to yield the time to the distinguished gentleman.

Mr. HYDE. The gentlelady said that men can't stand pain; I would like the record to show I have listened to every word the gentlelady has uttered. [Laughter.]

Chairman SENSENBRENNER. And the record will so state.

Does the gentlelady yield back the balance——

Ms. JACKSON LEE. Reclaiming my time, Mr. Hyde, you are right, you have listened, and it is painful. I agree with you. But it will never reach that degree of pain which we as women have experienced, and we do it all the time.

I thank you very much, Mr. Hyde.

Chairman SENSENBRENNER. Does the gentlewoman yield back now?

Ms. JACKSON LEE. I am willing to yield back as long as the reporter has captured that refrain. Thank you.

Chairman SENSENBRENNER. The Chair will state that the reporter does a very good job of capturing everything.

Ms. JACKSON LEE. I know she does. Thank you, Madam Reporter.

Chairman SENSENBRENNER. The gentleman from Ohio.

Mr. CHABOT. Thank you, Mr. Chairman. I move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. CHABOT. Thank you, Mr. Chairman.

And I rise in opposition to the amendment. Such an amendment clearly should be rejected. There are some medical problems that are just so abhorrent to society that they justify a criminal prohibition. The purpose of the criminal prohibitions are to ensure that physicians are significantly deterred from performing this otherwise improper procedure. In 1997, for example, the American Medical Association noted the appropriateness of the partial-birth abortion ban's penalty, stating, "The profession has supported criminal restrictions on improper medical procedures, such as female genital mutilation, for example."

Thus, I strongly oppose this particular amendment.

And just, not to digress, but several points that were made on the other side, the gentleman from Virginia talked about, well, if we ban this particular type of abortion, there are others that are particularly gruesome and grotesque and brutal. And I would agree that those other types of abortion are horrendous as well. But there is a consensus in this country, even many folks who would consider themselves to be pro-choice, after looking at this particular procedure and studying it and reading about it, have come to the conclusion that this does cross a line. And that's why many of our colleagues that are pro-choice under most circumstances voted to ban this on the floor of the House in the past, Democrats as well as Republicans. And as the former Chairman of this Committee, Mr. Hyde, said, in referring to Senator Moynihan, even Senator Moynihan referred to this procedure as infanticide.

And the gentlelady, again, referred before to the open-heart surgery and compared that to partial-birth abortion. My friend and colleague from Virginia reminded me that there's also another difference between the two, and that's that when one has open-heart

surgery, anesthesia is provided to subdue and eliminate pain. But when a partial-birth abortion occurs, there's absolutely nothing given to that innocent human little life there that's growing, and the pain is indescribable. But it happens. And that's another reason——

Mr. SCOTT. Would the gentleman yield?

Mr. CHABOT. I would yield.

Mr. SCOTT. Thank you.

I would again ask, what alternative does have a consensus? And after that, even if there is a consensus, what difference does it make if the Supreme Court has specifically ruled that consensus unconstitutional?

Mr. CHABOT. Reclaiming my time, and we've been through this quite a number of times, it's our position that after extensive evidentiary hearings, that there is substantial medical evidence which establishes that this is a procedure that's never medically necessary, that poses severe risks of health dangers to the woman, and is not standard medical practice. So there are many reasons to oppose, so we oppose this amendment.

Chairman SENSENBRENNER. Does the gentleman yield back?

Mr. CHABOT. I yield back.

Chairman SENSENBRENNER. The question is on the Jackson Lee amendment.

Those in favor will say aye.

No?

The noes appear to have it. The noes——

Ms. JACKSON LEE. rollcall.

Chairman SENSENBRENNER. rollcall is demanded.

Those in favor of the Jackson Lee amendment will, as your name is called, answer aye.

Those opposed, no. And the clerk will call the roll.

The CLERK. Mr. Hyde?

Mr. HYDE. No.

The CLERK. Mr. Hyde, no. Mr. Gekas?

[No response.]

The CLERK. Mr. Coble?

[No response.]

The CLERK. Mr. Smith?

Mr. SMITH. No.

The CLERK. Mr. Smith, no. Mr. Gallegly?

Mr. GALLEGLY. No.

The CLERK. Mr. Gallegly, no. Mr. Goodlatte?

[No response.]

The CLERK. Mr. Chabot?

Mr. CHABOT. No.

The CLERK. Mr. Chabot, no. Mr. Barr?

Mr. BARR. No.

The CLERK. Mr. Barr, no. Mr. Jenkins?

[No response.]

The CLERK. Mr. Cannon?

Mr. CANNON. No.

The CLERK. Mr. Cannon, no. Mr. Graham?

[No response.]

The CLERK. Mr. Bachus?

Mr. BACHUS. No.

The CLERK. Mr. Bachus, no. Mr. Hostettler?
Mr. HOSTETTLER. No.
The CLERK. Mr. Hostettler, no. Mr. Green?
Mr. GREEN. No.
The CLERK. Mr. Green, no. Mr. Keller?
Mr. KELLER. No.
The CLERK. Mr. Keller, no. Mr. Issa?
Mr. ISSA. No.
The CLERK. Mr. Issa, no. Ms. Hart?
Ms. HART. No.
The CLERK. Ms. Hart, no. Mr. Flake?
Mr. FLAKE. No.
The CLERK. Mr. Flake, no. Mr. Pence?
[No response.]
The CLERK. Mr. Forbes?
Mr. FORBES. No.
The CLERK. Mr. Forbes, no. Mr. Conyers?
[No response.]
The CLERK. Mr. Frank?
Mr. FRANK. Aye.
The CLERK. Mr. Frank, aye. Mr. Berman?
[No response.]
The CLERK. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
[No response.]
The CLERK. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
Mr. WATT. Aye.
The CLERK. Mr. Watt, aye. Ms. Lofgren?
Ms. LOFGREN. Aye.
The CLERK. Ms. Lofgren, aye. Ms. Jackson Lee?
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee, aye. Ms. Waters?
Ms. WATERS. Aye.
The CLERK. Ms. Waters, aye. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
[No response.]
The CLERK. Mr. Schiff?
[No response.]
The CLERK. Mr. Chairman?
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.
Chairman SENSENBRENNER. Are there Members in the chamber who wish to cast or change their vote?
The gentleman from North Carolina, Mr. Coble?
Mr. COBLE. No.

The CLERK. Mr. Coble, no.

Chairman SENSENBRENNER. The gentleman from Virginia, Mr. Goodlatte?

Mr. GOODLATTE. No.

The CLERK. Mr. Goodlatte, no.

Chairman SENSENBRENNER. The gentleman from South Carolina, Mr. Graham?

Mr. GRAHAM. No.

The CLERK. Mr. Graham, no.

Chairman SENSENBRENNER. The gentleman from Indiana, Mr. Pence?

Mr. PENCE. No.

The CLERK. Mr. Pence, no.

Chairman SENSENBRENNER. Further Members who wish to cast or change their votes?

If not, the clerk will report.

The CLERK. Mr. Chairman, there are eight ayes and 19 nays.

Chairman SENSENBRENNER. The amendment is not agreed to.

There has been an agreement reached relative to the printing of Supreme Court amicus briefs in the *Stenberg* case in this Committee record. Without objection, the PHACT and ACOG briefs will be printed in full, and the other briefs referred to by the gentlewoman from Wisconsin, Ms. Baldwin, and the gentleman from Ohio, Mr. Chabot, earlier today will be referenced in the record.

Hearing none, so ordered.

Are there further amendments? If not, the Chair notes the presence of a reporting quorum. The question is on reporting the bill H.R. 4965 favorably.

Those in favor will say aye.

Opposed, no.

The ayes appear to have it.

Mr. CHABOT. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from Ohio.

Mr. CHABOT. I ask for a recorded vote.

Chairman SENSENBRENNER. A rollcall will be ordered.

Those in favor of reporting the bill H.R. 4965 favorably will, as your names are called, answer aye. Those opposed, no. And the clerk will call the roll.

The CLERK. Mr. Hyde?

Mr. HYDE. Aye.

The CLERK. Mr. Hyde, aye. Mr. Gekas?

Mr. GEKAS. Aye.

The CLERK. Mr. Gekas, aye. Mr. Coble?

Mr. COBLE. Aye.

The CLERK. Mr. Coble, aye. Mr. Smith?

Mr. SMITH. Aye.

The CLERK. Mr. Smith, aye. Mr. Gallegly?

Mr. GALLEGLY. Aye.

The CLERK. Mr. Gallegly, aye. Mr. Goodlatte?

Mr. GOODLATTE. Aye.

The CLERK. Mr. Goodlatte, aye. Mr. Chabot?

Mr. CHABOT. Aye.

The CLERK. Mr. Chabot, aye. Mr. Barr?

Mr. BARR. Aye.

The CLERK. Mr. Barr, aye. Mr. Jenkins?

[No response.]
The CLERK. Mr. Cannon?
Mr. CANNON. Aye.
The CLERK. Mr. Cannon, aye. Mr. Graham?
Mr. GRAHAM. Aye.
The CLERK. Mr. Graham, aye. Mr. Bachus?
Mr. BACHUS. Aye.
The CLERK. Mr. Bachus, aye. Mr. Hostettler?
Mr. HOSTETTLER. Aye.
The CLERK. Mr. Hostettler, aye. Mr. Green?
Mr. GREEN. Aye.
The CLERK. Mr. Green, aye. Mr. Keller?
Mr. KELLER. Aye.
The CLERK. Mr. Keller, aye. Mr. Issa?
Mr. ISSA. Aye.
The CLERK. Mr. Issa, aye. Ms. Hart?
Ms. HART. Aye.
The CLERK. Ms. Hart, aye. Mr. Flake?
Mr. FLAKE. Aye.
The CLERK. Mr. Flake, aye. Mr. Pence?
Mr. PENCE. Aye.
The CLERK. Mr. Pence, aye. Mr. Forbes?
Mr. FORBES. Aye.
The CLERK. Mr. Forbes, aye. Mr. Conyers?
[No response.]
The CLERK. Mr. Frank?
Mr. FRANK. Nay.
The CLERK. Mr. Frank, nay. Mr. Berman?
[No response.]
The CLERK. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
[No response.]
The CLERK. Mr. Scott?
Mr. SCOTT. No.
The CLERK. Mr. Scott, no. Mr. Watt?
Mr. WATT. No.
The CLERK. Mr. Watt, no. Ms. Lofgren?
Ms. LOFGREN. No.
The CLERK. Ms. Lofgren, no. Ms. Jackson Lee?
Ms. JACKSON LEE. No.
The CLERK. Ms. Jackson Lee, no. Ms. Waters?
Ms. WATERS. No.
The CLERK. Ms. Waters, no. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. No.
The CLERK. Mr. Wexler, no. Mr. Weiner?
[No response.]
The CLERK. Ms. Baldwin?
Ms. BALDWIN. No.
The CLERK. Ms. Baldwin, no. Mr. Weiner?
[No response.]

The CLERK. Mr. Schiff?

[No response.]

The CLERK. Mr. Chairman?

Chairman SENSENBRENNER. Aye.

The CLERK. Mr. Chairman, aye.

Chairman SENSENBRENNER. Are there Members in the chamber who wish to cast or change their votes?

If there are none, the clerk will report.

The CLERK. Mr. Chairman, there are 20 ayes and eight nays.

Chairman SENSENBRENNER. And the motion to report favorably is agreed to.

Without objection, the Chairman is authorized to move to go to conference pursuant to House rules. Without objection, the staff is directed to make any technical and conforming changes. And all Members will be given 2 days, as provided by the House rules, in which to submit additional, dissenting, supplemental, or minority views.

This concludes the business before the Committee. The Committee stands adjourned.

[Whereupon, at 3:51 p.m., the Committee was adjourned.]

DISSENTING VIEWS

H.R. 4965, the "Partial-Birth Abortion Ban Act of 2002," was introduced in response to the Supreme Court's ruling in *Stenberg* v. *Carhart*,[1] in which the Supreme Court held unconstitutional a Nebraska statute banning so-called "partial-birth" abortions. We oppose H.R. 4965 because it flies in the face of *Stenberg* with the same unconstitutional flaws for which the Court invalidated the Nebraska statute; because the bill is dangerous to women; and because private medical decisions should be made by women and their families, in consultation with their doctors—not politicians.

Fifteen of the eighteen pages of H.R. 4965 contain "findings" on matters the Court reviewed in *Stenberg*.[2] In its three pages of operative legislative language, the bill makes it illegal for a physician knowingly to perform a so-called "partial-birth" abortion unless it is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury.[3] A physician who violates the law is subject to a fine and up to 2 years imprisonment.[4]

Rather than complying with the constitutional requirements in *Stenberg*, the drafters of H.R. 4965 have created a propaganda piece intended to demonize abortion and abortion providers. As a result, the bill is an unconstitutional attempt to regulate abortion, and is detrimental to women's health.

H.R. 4653 IS UNCONSTITUTIONAL FOR THE SAME REASONS THE SUPREME COURT STRUCK DOWN A SIMILAR "PARTIAL-BIRTH" ABORTION BAN IN *STENBERG* V. *CARHART*

The caselaw on abortion is clear. In *Planned Parenthood* v. *Casey*,[5] the Court articulated the three principles that govern abortion jurisprudence: (1) a woman has the right to choose to termi-

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[1] 530 U.S. 914 (2000).

[2] The "findings" in the bill include misstatements of both the facts and the law, including, among others: the partial birth abortion procedure is "never medically necessary," Sec. 2, ¶1; the procedure is "outside of the standard of medical care," Sec. 2, ¶5; the Supreme Court was "required to accept the very questionable findings issued by the district court," Sec. 2, ¶7; "Partial-birth abortion poses serious risks to the health of a woman undergoing the procedure," Sec. 2, ¶14(A); and "There is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures," Sec. 2, ¶14(B).

[3] The term "partial-birth abortion" is not a medical term. The bill defines it as, "an abortion in which—

> (A) the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of a breech presentation, any part of the fetal trunk past the naval is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and
>
> (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus."

H.R. 4965, Sec. 3, ¶(b).

[4] H.R. 4965, Sec. 3, ¶(a).

[5] 505 U.S. 833 (1992).

nate her pregnancy prior to "viability;"[6] (2) a law designed to further the State's interest in fetal life, but which imposes an "undue burden" on the woman's decision before fetal viability is unconstitutional;[7] and (3) after viability, a State may regulate or proscribe abortion except "where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."[8]

In 2000, the Supreme Court applied these principles to a Nebraska ban on partial-birth abortions, and found the statute unconstitutional on two grounds: it did not include an exception to protect the health of the woman, and it posed an undue burden on the right to obtain an abortion.[9] Because H.R. 4965 suffers from these same defects, it is likewise unconstitutional.

H.R. 4653 Unconstitutionally Omits an Exception to Protect Maternal Health

Both pre- and post-viability restrictions on abortion must contain an exception "where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."[10] Furthermore, such an exception must not only protect women from health risks created by the pregnancy, itself, but also from health risks caused by a regulation that forces women to choose a less medically appropriate abortion procedure.[11]

Even the Ashcroft Department of Justice recognizes that, in order for any abortion regulation to be constitutional, it must contain an exception to protect the woman's life *and health*. The Department of Justice has stated, "After fetal viability, States may ban abortion altogether, *so long as they allow abortions necessary to safeguard the woman's life or health*."[12]

There is no question that H.R. 4965 does not contain an exception to protect maternal health. For this reason, alone, the bill is unconstitutional.[13]

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[6] *Stenberg* v. *Carhart* 530 U.S. at 921. "Viability" of the fetus differs from woman to woman. A woman's doctor determines the point of viability, but it typically occurs between 24 to 28 weeks after gestation.

[7] *Id.* An "undue burden is . . . 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." *Id.* (quoting *Casey*, 505 U.S. at 877).

[8] *Id.* (quoting *Casey*, 505 U.S. at 879). Indeed, the conservative jurist, Richard Posner, has suggested that partial-birth abortion bans such as H.R. 4965 do not even meet the extremely deferential standard of having a "rational relation to a legitimate State interest" because they do not preserve fetal life, but rather, simply shift the method of abortion to a more dangerous procedure. *Planned Parenthood of Wisconsin* v. *Doyle*, 162 F.3d 463, 470–71 (7th Cir. 1998) ("The singling out of the D & X procedure for anathematization seems arbitrary to the point of irrationality. Annexing the penalty of life imprisonment to a medical procedure that may be the safest alternative for women who have chosen abortion because of the risk that childbirth would pose to their health adds a note of the macabre to the Wisconsin statute, especially when we consider that physicians can insulate themselves from all legal risk by killing the fetus *in utero*." *Id.* at 471.) *See also Stenberg*, 530 U.S. at 946, 951 (Stevens, J. and Ginsberg, J., concurring).

[9] *Stenberg*, 530 U.S. at 930.

[10] *Stenberg*, 530 U.S. at 930 (quoting Roe, at 164–64 (emphasis omitted)) ("Since the law requires a health exception in order to validate even a postviability abortion regulation, it at a minimum requires the same in respect to previability regulation.").

[11] *Id.* at 934–38 (comparing the relative safety of different abortion procedures and concluding that "a statute that altogether forbids D & X creates a significant health risk").

[12] Brief for the United States of America as Amicus Curiae Supporting Reversal at 7, *Women's Medical Professional Corp.* v. *Taft*, (6th Cir.) (No. 01–4124) (emphasis added).

[13] Representatives Baldwin and Jackson Lee offered an amendment that would have added a post-viability health exception, in conformance with *Stenberg*, which was defeated 18–10 in a party-line vote. Representative Frank offered another amendment that would have created an exception after viability to protect the mother from "serious, adverse, physical health consequences," and even this—arguably unconstitutional—exception was defeated in a party-line voice vote. Likewise, an amendment by Rep. Scott that would have limited late-term abortions,

The Supreme Court Will Not Defer to Erroneous Factual and Legal Conclusions Masked as Congressional "Findings"

The drafters of H.R. 4965 attempt to justify the lack of a health exception in the bill's "findings," which summarily assert that the banned procedure is "never medically necessary to preserve the health of a woman."[14] They argue that, because the *Stenberg* decision was based on "very questionable findings,"[15] Congress is better equipped to assess the evidence after holding "extensive" hearings on the subject.[16] Claiming that congressional findings demonstrate that a health exception is unnecessary, they argue that the Supreme Court is bound to accord "great deference" to these findings.

The mere statement of "findings" does nothing to rehabilitate the bill's unconstitutionality. There have been several instances in the past in which Congressional attempts to overturn Supreme Court precedents have failed. For example, Congress passed the Religious Freedom Restoration Act ("RFRA") in response to an earlier Supreme Court decision.[17] As in this case, Congress held separate hearings to assess the issues and made independent findings, prior to enacting the law. In striking down RFRA, the Supreme Court held that Congress "has been given the power 'to enforce,' not the power to determine what constitutes a constitutional violation."[18] The Court further held that "[t]he power to interpret the Constitution in a case or controversy remains in the Judiciary"[19] and "RFRA contradicts vital principles necessary to maintain separation of powers and the Federal balance."[20]

With H.R. 4965, the sponsors are attempting to overturn Supreme Court constitutional precedent by enacting a law that fails

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but contained an exception to "avert serious adverse health consequences" was also defeated in a party-line vote.

[14] H.R. 4965, Sec. 2, ¶14(E). We wonder: if the procedure is *never necessary* to protect the mother's health, why the proponents of the bill admit that the procedure may be necessary to protect a mother "whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." Sec. 3, ¶(d)(1). Are not these situations in which the mother's health is also at risk?

[15] H.R. 4965 Sec. 2, ¶7. Far from being "questionable," the trial court's findings in *Stenberg* were based on consideration of evidence from experts on both sides of the issue, including evidence from *the congressional hearings* themselves. *Stenberg*, 530 U.S. at 929, 935. Nor was there a "dearth of evidence" in the trial court supporting the findings. *See Stenberg* v. *Carhart*, 11 F. Supp. 2d 1099, 1110–18 (D. Neb. 1998). Additionally, in reviewing the evidence, the Supreme Court acknowledged many of the points raised by the sponsors, such as the "division of medical opinion," the risks of different abortion procedures, and the lack of medical studies establishing the safety of "partial- birth abortion/D&X." *Stenberg*, 530 U.S. at 926, 937. After reviewing all this evidence the Court found: "Where a significant body of medical opinion believes a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view, we cannot say that the presence of a different view by itself proves the contrary. Rather, the uncertainty means a significant likelihood that those who believe that D&X is a safer abortion method in certain circumstances may turn out to be right." 530 U.S. at 937.

[16] *Id.* at Sec. 2, ¶¶9, 10, 11, 12, citing *Katzenbach* v. *Morgan*, 384 U.S. 641 (1966), *Turner Broadcasting System Inc.* v. *F.C.C.*, 512 U.S. 622 (1994) *("Turner 1"), Turner Broadcasting System Inc.* v. *F.C.C.*, 520 U.S. 180 (1997) *("Turner II")*, and *City of Rome, Georgia* v. *United States*, 472 F. Supp. 221 (D. Colo. 1979), *aff'd*, 446 U.S. 156 (1980).

[17] *Employment Div., Dept. of Human Resources of Oregon* v. *Smith*, 494 U.S. 872 (1990) (holding that neutral, generally applicable laws may be applied to religious practices even when not supported by a compelling State interest).

[18] *City of Boerne* v. *Flores*, 521 U.S. 507, 519 (1997).

[19] *Id.* at 524.

[20] *Id.* at 536. Similarly, Congress attempted to overturn the Supreme Court's *Miranda* requirements by enacting a new "voluntariness" standard in their place. In *Dickerson* v. *United States*, 530 U.S. 428, 435–36 (2000), the Supreme Court reviewed the law, and in striking it down held that "*Miranda*, being a constitutional decision of this Court, may not be in effect overruled by an Act of Congress," *id.* at 432, and "Congress may not legislatively supersede our decisions interpreting and applying the Constitution." *Id.* at 437.

to adhere to the precedent. This attempt will fail and the bill will be declared unconstitutional.

The Bill Threatens the Separation of Powers

The bill also presents a threat to our constitutional system of government and separation of powers. Where constitutional rights are at stake, the Judiciary conducts its own independent review of the facts.[21] Even where constitutional rights are not at stake, the Court has recently viewed with skepticism Congressional findings purportedly supporting its exercise of powers under article I or section 5 of the Fourteenth Amendment.[22]

Here, the sponsors assert that factual findings made by the Judiciary can be, in essence, set aside by contrary Congressional findings. Under this novel regime, Congress could have overturned *Brown* v. *Board of Education* by "finding" that racially separate schools were, in fact "equal," or could, in line with this bill's approach, ban *all* abortions by "finding" that all procedures were unsafe. Ultimately, Congressional findings that seek to defy the Supreme Court and the function of the Federal courts as triers of facts will not only threaten the independence of the Judiciary, but undermine the value of Congressional findings in other contexts where such findings may, unlike in this bill, actually be a legitimate and appropriate exercise of Congressional power.

H.R. 4965 Is Overbroad and Places an Undue Burden on a Woman's Right to Obtain an Abortion

Like the law struck down by the *Stenberg* court, H.R. 4965 is also overbroad and places an undue burden on a woman's constitutional right to choose to have an abortion. The Supreme Court has made clear that the State has a different interest in regulating abortion prior to- and post-viability. Before viability, the woman has a right to choose to terminate her pregnancy, and a law must not impose an "undue burden" on this decision.[23]

H.R. 4965 is not limited to post-viability abortions.[24] Nor is it limited to one clearly-defined "late-term" abortion procedure. To the contrary, the bill's definition of "partial-birth abortion" is, vague,[25] overbroad, and covers the most common type of 2nd-trimester abortion procedure.[26] In fact, the term "partial-birth abor-

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[21] *See, e.g., Landmark Communications, Inc.* v. *Virginia*, 435 U.S. 829, 843–44 (1978).

[22] *See, e.g., United States* v. *Morrison*, 529 U.S. 598, 614 (2000).

[23] *Stenberg*, 530 U.S. at 921 (citing Casey, 505 U.S. at 870, 877).

[24] The bill's sponsor, Rep. Chabot, admitted this at the Judiciary Committee hearing when he spoke regarding an amendment offered by Rep. Scott, which would have banned abortions on viable fetuses, with certain exceptions. Representative Chabot stated,

> [The amendment] offers protection only to viable infants, and the majority of partial-birth abortions are performed on babies during their fifth and sixth months of pregnancy. Most of the infants aborted during this period, obviously, are not viable. The substitute would thus have no impact on the vast majority of partial-birth abortions, and that's the whole purpose of this legislation.

Statement of Rep. Chabot, Markup of H.R. 4965, "The Partial-Birth Abortion Ban Act of 2002," Committee on the Judiciary, 107th Cong., July 17, 2002, at 148–149.

[25] Indeed, H.R. 4965 does not even consistently describe the same technique within the findings. *Compare* H.R. 4965, Sec. 2, ¶1 (partial-birth abortion involves delivery until "only the head remains inside the womb"); Sec. 2, ¶14(A) (partial-birth abortion involves conversion to a footling breech presentation); Sec. 2, ¶14(J) (partial-birth abortion involves delivery of "all but the head, out of the womb").

[26] Approximately 10% of all abortions are performed during the second trimester of pregnancy (12 to 24 weeks). The most commonly used procedure during this period is called "dilation and evacuation" or "D & E". That procedure accounts for about 95% of all abortions performed from

tion" is not a medical term, but a political one intended to inflame public opinion and shift the focus from the fact that private medical decisions should be made by women and their families, in consultation with their doctors—not politicians.

As Simon Heller testified before the Subcommittee on the Constitution,

> [J]ust like the language of Nebraska's statute, [H.R. 4965] could still prohibit many pre-viability abortions using the D&E [dilation and evacuation] method, of which the specific technique described the first paragraph of the bill's findings is simply one type. In fact, the prohibitory language of the bill is quite plainly broader than the abortion technique described in paragraph one of the bill's "findings." Compare H.R. 4965 § 2, ¶ 1 (describing breech presentation technique) *with* § 3, ch. 74 § 1531(b)(1)(A) (prohibiting both breech and cephalic presentation techniques). The bill perpetuates the problem of Nebraska's law: it uses language which sweeps more broadly than the single technique described in the "findings" by the sponsors.[27]

Because the bill is not limited to a single, late-term abortion procedure but, instead, also prohibits the most common 2nd-trimester abortion method, the bill imposes an undue burden on a woman's right to obtain an abortion and is unconstitutional for this reason, as well.

H.R. 4965 ENDANGERS WOMEN'S HEALTH BY BANNING SAFE ABORTION PROCEDURES

Even if H.R. 4965 covered only a single, late-term abortion procedure (known medically as "intact D & E," "dilation and extraction," or "D & X")—which it does not—the bill would still endanger women's health. A threat to women's health always results when a safe medical procedure is removed from the physician's array of options, as there will always be some woman for whom the banned procedure would be the safest.

Contrary to the contentions in the findings of H.R. 4965, the conclusion that D & X is a safe procedure is not the view of a single trial judge to whose factual findings the Supreme Court deferred. Rather, after hearing extensive expert medical testimony, every court in the country to reach the question but one has agreed that D & X is a safe procedure that may well be the safest for some women in certain circumstances.[28]

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12 to 20 weeks of gestational age. *Stenberg*, 530 U.S. at 924. The drafters of the bill could have chosen to use more specific language and exclude the D & E method of abortion, but chose not to. *See id.* at 950 (O'Connor, J., concurring) (recognizing that "unlike Nebraska, some other States have enacted statutes more narrowly tailored to proscribing the D & X ['dilation and extraction'] procedure alone. Some of those statutes have done so by specifically excluding from their coverage the most common methods of abortion, such as the D & E and vacuum aspiration procedures," and citing the Kansas, Utah, and Montana statutes approvingly).

[27] Testimony of Simon Heller, Esq. *before the* Committee on the Judiciary, Subcommittee on the Constitution, Hearing on H.R. 4965, July 9, 2002.

[28] *See, e.g., Planned Parenthood of Wisconsin* v. *Doyle*, 162 F.3d 463, 467–468 (7th Cir. 1998) ("The D & X procedure is a variant of D & E designed to avoid both labor and the occasional failures of induction as a method of aborting the fetus, while also avoiding the potential complications of a D & E. For some women, it may be the safest procedure. So at least the plaintiff physicians believe, and these beliefs are detailed in affidavits submitted in the district court. *This is also the opinion of the most reputable medical authorities in the United States to have addressed the issue: the American Medical Association and the American College of Obstetricians*

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These rulings were based on a wealth of credible medical evidence. Indeed, the American College of Obstetricians and Gynecologists ("ACOG"), the leading professional association of physicians who specialize in the health care of women, has concluded that D & X is a safe procedure and may be the safest option for some women. ACOG has explained that "[i]ntact D & E, including D & X, is a minor—and often safer—variant of the 'traditional' non-intact D & E."[29] ACOG has also stated that D & X "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman."[30] "Only the physician, in consultation with the patient and based on her circumstances, can make this decision."[31]

Relying on such medical evidence, the Supreme Court concluded in *Stenberg* that "significant medical authority supports the proposition that in some circumstances, D & X would be the safest procedure."[32] Indeed, the Court concluded that "a statute that altogether forbids D & X creates a significant health risk."[33]

This is why, in addition to ACOG, numerous other medical groups have publicly opposed attempts by Congress to pass abortion ban legislation, including the American Public Health Association, American Nurses Association, American Medical Women's Association, California Medical Association, Physicians for Reproduc-

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and Gynecologists." (emphasis added)); *Women's Med. Prof'l Corp.* v. *Taft*, 162 F. Supp. 2d 929, 942 (S.D. Ohio 2001) ("The safety advantages of the D & X over other methods of abortion are both intuitive and well supported by the record."); *Rhode Island Med. Soc'y* v. *Whitehouse*, 66 F. Supp. 2d 288, 314 (D.R.I. 1999), *aff'd*, 239 F.3d 104 (1st Cir. 2001) ("Defendants claim that a D & X could never be necessary to save a woman's health, but the evidence at trial failed to support that contention. . . . Therefore, this Court finds that the D & X could be used to preserve a woman's health and must be available to physicians and women who want to rely upon it."); *Richmond Medical Center for Women* v. *Gilmore*, 55 F. Supp. 2d 441, 491 (E.D. Va. 1999) ("When the relative safety of the D&E is compared to the D&X, there is evidence that the D&X (which is but a type of D&E . . .) has many advantages from a safety perspective. . . . For some women, then, the D&X may be the safest procedure." (citations to the trial record omitted)); *Planned Parenthood of Central New Jersey* v. *Verneiro*, 41 F. Supp. 2d 478, 484–85 (D.N.J. 1998) ("The intact dilatation and extraction, or intact D&X, has not been the subject of clinical trials or peer-reviewed studies and, as a result, there are no valid statistics on its safety. As its 'elements are part of established obstetric techniques,' the procedure may be presumed to pose similar risks of cervical laceration and uterine perforation. However, because the procedure requires less instrumentation, it may pose a lesser risk. Moreover, the intact D&X may be particularly helpful where an intact fetus is desirable for diagnostic purposes." (citation to ACOG Statement on Intact D&X omitted)); *Richmond Med. Ctr. for Women* v. *Gilmore*, 11 F. Supp. 2d 795, 827 n.40 (E.D. Va. 1998), *aff'd*, 224 F.3d 337 (4th Cir. 2000); *Hope Clinic* v. *Ryan*, 995 F. Supp. 847, 852 (N.D. Ill. 1998) (Korcoras, J., appointed by President Carter) ("[T]he record here contains significant evidence that the D&X procedure is often far safer than other D&E procedures."); "[D&X] reduces the risk of retained tissue and reduces the risk of uterine perforation and cervical laceration because the procedure requires less instrumentation in the uterus. [It] may also result in less blood take less operating time."); *Planned Parenthood* v. *Woods*, 982 F. Supp. 1369, 1376 (D. Ariz. 1997) (The D&X method is one of several "safe, medically acceptable abortion methods in the second-trimester."); *Women's Medical Professional Corp.* v. *Voinovich*, 911 F. Supp. 1051, 1070 (S.D. Ohio 1995) ("[T]his Court finds that use of the D&X procedure in the late second trimester appears to pose less of a risk to maternal health than does the D&E procedure, because it is less invasive—that is, it does not require sharp instruments to be inserted into the uterus with the same frequency or extent—and does not pose the same degree of risk of uterine and cervical lacerations . . . [T]he D&X procedure appears to have the potential of being a safer procedure than all other available abortion procedures . . .").

[29] Brief of *Amici Curiae* American College of Obstetricians and Gynecologists, et al., in Support of Respondent at 6, filed in *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (No. 99–830) (*hereinafter* "ACOG Brief").

[30] ACOG, Statement of Policy, *Abortion Policy* at 3 (Sept. 2000).

[31] ACOG Brief at 7.

[32] *Stenberg*, 530 U.S. at 932.

[33] *Id.* at 938. In addition, the Supreme Court squarely rejected the very same claims made in H.R. 4965's "findings" that D & X is somehow unsafe because it allegedly creates risks of cervical incompetence and lacerations or risks from blind instrumentation and conversion of the fetus to a breech position. *Stenberg*, 530 U.S. at 933–38. Medical evidence fails to support any of these claims.

tive Choice and Health, American College of Nurse Practitioners, American Medical Student Association, Association of Reproductive Health Professionals, Association of Schools of Public Health, Association of Women Psychiatrists, National Asian Woman's Health Organization, National Association of Nurse Practitioners in Reproductive Health, National Black Women's Health Project, National Latina Institute for Reproductive Health, and Rhode Island Medical Society. Moreover, contrary to the claims of the sponsors of H.R. 4965, the American Medical Association does not support any criminal abortion ban legislation.[34]

H.R. 4965 CRIMINALIZES DOCTORS AND ENCOURAGES WOMEN TO BE SUED BY THEIR HUSBANDS AND PARENTS

H.R. 4965 would turn doctors into criminals and put them in jail for performing a safe medical procedure.[35] The civil sanctions and criminal remedies, along with previous references by legislative proponents to medical professionals as "assassins," "exterminators" and "murderers," have been said to be part of a design to intimidate medical professionals from performing abortions generally. Similarly, put in the context of abortion clinic demonstrations and bombings, it seems that many in the anti-abortion movement have an agenda of banning all abortions.

The provisions in the legislation imposing criminal sanctions—including imprisonment—appear to be drafted to put physicians in a position where they will be chilled from performing many of the most common abortion procedures. For example, doctors may well choose not to perform any abortion for fear that they will be unable to afford the costs of establishing that the method of abortion chosen wasn't the only one available to save the woman's life. Given the vague and overbroad language of the bill, doctors can reasonably fear prosecution for using the safest and most common second-trimester abortion methods. For this reason, the American Medical Association does not support the bill.[36]

Further, the bill allows a woman to be sued by her husband or parents if she receives a partial-birth abortion.[37] As the Supreme Court has held, a husband cannot have veto power over his wife's decision to have an abortion.[38] Allowing a husband to sue his wife, or threaten to sue his wife, is merely a back-door attempt to avoid yet another Supreme Court holding. In addition, this provision allows an abusive husband or a husband who has abandoned his wife to sue or threaten his wife with a lawsuit if she obtained the procedure to protect her health and future fertility. This is an extremely anti-family provision that encourages litigation over a personal, medical decision.

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[34] American Medical Association Statement, Oct. 21, 1999 (because abortion ban bill contained criminal sanctions, "[f]or this reason we do not support the bill").

[35] H.R. 4965, Sec. 3, ¶a. Representative Jackson Lee offered an amendment to eliminate the criminal penalties, which was defeated in a 19–8 party-line vote.

[36] American Medical Association Statement, Oct. 21, 1999.

[37] Although the bill exempts women from criminal prosecution, Sec. 3, ¶(e), they are not exempt from the bill's imposition of civil liability: "The father, if married to the mother at the time she receives a partial-birth abortion procedure, and if the mother has not attained the age of 18 years at the time of the abortion, the maternal grandparents of the fetus, may in a civil action obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion." Sec. 3, ¶(c)(1).

[38] *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 70 (1976).

CONCLUSION

H.R. 4965 is a facially unconstitutional attempt to roll back a woman's right to choose. The bill suffers from the same two flaws that led the Supreme Court to declare a similar Nebraska statute unconstitutional: it fails to include an exception to protect maternal health, and it places an undue burden on a woman's right to obtain an abortion prior to viability by banning the most common 2nd-trimester abortion procedure. Fifteen pages of "findings" do nothing to remedy this unconstitutionally flawed bill.

Further, even if the bill were limited to one, specific abortion method—which it is not—it would still endanger women's health by prohibiting a procedure that the American College of Obstetricians and Gynecologists and other respected medical groups say may be the best or most appropriate procedure to save the life or preserve the health of a woman. In addition, the bill is part of a political scheme to sensationalize the abortion debate through heated rhetoric and to shift the focus from the fact that women and their doctors—not the government—should decide matters of their own health care. Finally, the bill criminalizes the practice of medicine and subjects women to lawsuits by their husbands and parents. For all of these reasons, we dissent.

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