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PARTIAL-BIRTH ABORTION BAN ACT OF 2003

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CONSTITUTION

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

H.R. 760

MARCH 25, 2003

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PARTIAL-BIRTH ABORTION BAN ACT OF 2003

TUESDAY, MARCH 25, 2003

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

The Subcommittee met, pursuant to call, at 2:05 p.m., in Room 2237, Rayburn House Office Building, Hon. Steve Chabot [Chairman of the Subcommittee] presiding.

Mr. CHABOT. The Committee will come to order. This is the Subcommittee on the Constitution of the Judiciary Committee.

This afternoon we will have a hearing on the Partial-Birth Abortion Ban Act, followed immediately by a markup.

We have convened this afternoon to receive testimony on H.R. 760, the "Partial-Birth Abortion Ban Act of 2003."

On February 13th, on behalf of over 100 original cosponsors, I introduced H.R. 760, the "Partial-Birth Abortion Ban Act of 2003", 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 brain 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. 760 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. On March 13, 2003 the Senate approved S.3, which is virtually identical to H.R. 760, by a 64 to 33 vote.

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 those who proclaim the medical necessity of this barbaric procedure, partial birth abortion is, in fact, a dangerous medical procedure. It can pose serious risks to the long-term health of women. As testimony received by the Subcommittee during the 107th Congress demonstrates, there is never any situation in which the procedure H.R. 760 would ban is medically necessary. In fact, 10 years after Dr. Martin Haskell presented this procedure to the mainstream abortion community, partial birth abortions have failed to become standard medical practice for any circumstance under which a woman might seek an abortion.

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. 760 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 the prohibitive procedure might be interpreted to encompass a more commonly performed late second trimester abortion procedure. As previous testimony indicates, H.R. 760 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 did not include an exception for partial birth abortions deemed necessary to preserve the "health" of the mother. The *Stenberg* court, based its conclusion on the trial courts factual findings regarding the relative health and safety benefits of the 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 regarding the safety and medical necessity of the partial birth abortion procedure - including evidence received during extensive legislative hearings during the 104th, 105th and 107th Congresses, which indicates that a partial birth abortion is never medically necessary to preserve the health of a women, poses serious risks to a woman's health, and lies outside standard medical care.

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 consistently relies upon and 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. 760 contains Congress's extensive factually 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.

H.R. 760's findings are not "false" as its opponents have charged. They are based upon the very opinions of doctors, medical associations, and a review of the practices of the medical profession as a whole. Thus, they are "legislative facts" drawn from reasonable inferences based upon substantial evidence. The fact that the abortion lobby disagrees with these inferences only demonstrates how out of step they are with public opinion and the mainstream medical community.

Despite overwhelming support from the public, past efforts to ban partial birth abortions were blocked by President Clinton. We now have a president who has promised to stand with Congress in its efforts to ban this barbaric and dangerous procedure. It is time for Congress to end the national tragedy of partial birth abortions and protect the lives of these helpless defenseless little babies. And I will, at this time, yield to the gentleman from New York, Mr. Nadler, for his opening statement.

[The prepared statement of Mr. Chabot follows in the Appendix]

Mr. NADLER. Thank you, Mr. Chairman. Today we have a very bad combination: Members of Congress who want to play doctor, and Members of Congress who want to play Supreme Court. When you put the two together you have a prescription for some very bad medicine for women and for this country.

We have been through this debate often enough to know by now that you will not find the term partial birth abortion in any medical textbook. There are procedures that you will find in medical textbooks, but apparently the authors of this legislation would prefer to use the language of propaganda rather than the language of science.

This bill, as written, fails every test the Supreme Court has laid down for what may or may not be a Constitutional regulation of abortion. It reads almost as if the authors went through the Supreme Court's recent decision in *Stenberg* v. *Carhart* and went out of their way to thumb their noses at the Supreme Court, and especially at Justice O'Connor, who is generally viewed as the swing vote on such matters, and who wrote a concurring opinion stating very specifically what exactly would be needed for her to uphold the statute.

Unless the authors think that when the Court has made repeated and clear statements over the years of what the Constitution requires in this area, they are just pulling our collective legs, this bill has to be considered facially unconstitutional.

First and foremost, it does not include a health exception, which the Court has repeatedly said is necessary, even with respect to post viability abortions. The exception for a women's life that is included in the bill is more narrowly drawn than is required by the Constitution, according to the Supreme Court, and will place doctors in the position of trying to guess just how grave a danger pregnancy is to a woman's life before they can be confident that protecting her will not result in jail time.

That is a test that doctors should not have to face. I know that some of my colleagues do not like the Constitutional rule that has been played down by the Supreme Court for 30 years, but that is the law of the land, and the supreme law of the land, and no amount of rhetoric, even if written into a piece of legislation, will change that. Even the Ashcroft Justice Department, in its brief in defending an Ohio statute now before the Court, has acknowledged that a health exception is required by law, which is not in this bill, of course.

While I may disagree with the Department's views on whether the Ohio statute adequately protects women's health so as to pass Constitutional muster, there is at least an acknowledgment that

the law requires that protection, which, again, I state is not included in the bill we are considering.

This bill is mostly findings. If there is one thing this activist court has made clear, it is that it is not very deferential to Congress's determinations of fact.

While Congress is entitled to declare anything it wants, the courts are not duty bound to accept anything we say at face value, simply because it appears in a footnote to the United States Code.

While I realize that many of the proponents of this bill view all abortion as tantamount to infanticide, that is not a mainstream view. This bill attempts to foist a marginal view on the general public by characterizing this bill as having to do only with abortions involving healthy, full-term fetuses.

If the proponents of this bill really want to deal with post-viability abortions in situations in which the woman's life and health are not in jeopardy, they should write a bill dealing with that issue. Although such a bill would be of marginal utility, since 41 States already ban post-viability abortions, except where the life or the health of the mother is in danger.

Very few people would oppose such a bill. As one of the lead sponsors of the Religious Freedom Restoration Act, which was struck down by the Supreme Court, I know what comes of Congress ignoring the will of the Supreme Court. Whatever power Congress had under section 4 of the 14th Amendment as a result of *Katzenbach* v. *Morgan*, a decision copiously cited in the bill's findings, the more recent *Boerne* decision vastly undercut those powers. Even if *Katzenbach* was still fully in force, as I wish it were, that case only empowered Congress to expand, not to curtail rights under the 14th Amendment.

This bill, of course, aims to do the exact opposite, to curtail rights under the 14th Amendment. We now have a President who has expressed a willingness to sign this bill. He may get his chance. Unfortunately there are dire consequences for American women if this legislation passes. Perhaps here the role of Congress is to help the women take a back seat to the most extreme views of the anti-choice movement. Fortunately, those dire consequences will not be enforced long, because the Constitution still serves as a bulwark against such efforts.

But the majority is not interested, the majority in this Committee and this House is clearly not interested in a bill that could pass into law and actually be enforced as not contrary to the Constitution. What they want is an inflammatory piece of rhetoric, which even if passed, would be struck down by the Supreme Court. The real purpose of this bill that we are considering is not to save babies but elections. Thank you, Mr. Chairman.

Mr. CHABOT. Thank you. If any other Members would like to make opening statements, they are free to do so. Mr. King.

Mr. KING. Thank you, Mr. Chairman. As I sit here and listen to this discussion and this issue of when life begins and the intrinsic value of human life unfolds before this Congress, again, and I reflect upon some of the history that has been brought out on this bill a bit earlier, I look down through a number of things in these opening remarks that I think are essential.

One of them is a statement that the majority wants inflammatory legislation, and is not really interested in lives so much as we are politics. I pray for nothing more than this issue would be resolved, and the deference of innocent human lives, and go away from the subject matter of the United States of America forever. That is my number one most profound belief. I will do everything in my power to save the lives of innocent babies at whatever stage of development.

So with that, Mr. Chairman, I thank you for the time. I yield back the balance.

Mr. CHABOT. Thank you very much.

Mr. Scott.

Mr. SCOTT. No, thank you.

Mr. CHABOT. Any Members of the panel? Ms. Hart. No. Mr. Feeney from Florida? No. Mr. Forbes from Virginia?

Mr. FORBES. No.

Mr. CHABOT. Thank you very much. We will move forward with the panel then at this time. We have a very distinguished panel here this afternoon. I will introduce them at this time. Our first witness will be Dr. Mark G. Neerhof who has been practicing maternal-fetal medicine for 14 years, is an associate professor of obstetrics and gynecology at Northwestern University Medical School, and an attending physician in the Department of Obstetrics and Gynecology, division of maternal-fetal medicine at Evanston, Northwestern Health Care in Evanston, Illinois.

After completing his residency in obstetrics and gynecology at Chicago Osteopathic Medical Center in 1989, Dr. Neerhof completed a fellowship in Philadelphia in 1991.

Thereafter, Dr. Neerhof joined Northwestern University Medical School. Dr. Neerhof is board certified in obstetrics and gynecology by the American College of Osteopathic Obstetricians and Gynecologist, and in maternal-fetal medicine by the American Osteopathic Board of obstetrics and gynecology.

Dr. Neerhof received his BA in Biology and Chemistry from Dordt College in Sioux Center, Iowa in 1980, and his DO from Chicago College of Osteopathic Medicine in Chicago, Illinois in 1984. And we welcome you here this afternoon, Doctor.

Our second witness will be Simon Heller. Mr. Heller, who was most recently Director of the Domestic program of the Center for Reproductive Law and Policy, now known as the Center for Reproductive Rights. He is a constitutional law expert who has been an abortion advocate for over 10 years.

Most recently, Mr. Heller argued on behalf of Dr. Leroy Carhart in *Stenberg* v. *Carhart*. In addition, he has litigated a number of other abortion-related cases throughout the country, including challenges to Medicaid funding restrictions, laws that limit the performance of an abortion to a physician, parental involvement laws and the partial birth abortion bans of Wisconsin and Virginia.

Prior to helping fund the CRLP, Mr. Heller was a staff attorney in the Reproductive Freedom Project of the American Civil Liberties Union. He also served as an assistant district attorney in Manhattan.

Mr. Heller received his juris doctor from Yale Law School in 1986, and his masters and bachelors degrees from the State Uni-

versity of New York at Stony Brook. Mr. Heller currently serves as of-counsel to the Center for Reproductive Rights. We welcome you this afternoon. Our third witness will be professor Gerard V. Bradley. Professor Bradley currently teaches constitutional theory, first amendment, trial advocacy and legal ethics at Notre Dame Law School, where he has taught since 1992.

Prior to joining the faculty at Notre Dame, Professor Bradley served as assistant professor, associate professor, and professor at University of Illinois College of Law, where he taught criminal procedure, constitutional law, religion and law, and trial advocacy.

Prior to joining the faculty at the University of Illinois, Professor Bradley spent three years as an assistant district attorney, trial division, in the New York County district attorney's office. Professor Bradley received his BA in history from Cornell University in 1976, and his juris doctor from Cornell Law School in 1980, where he graduated first in his law school class.

Mr. CHABOT. So we welcome all three of the witnesses here this afternoon, and we will begin with Dr. Neerhof. And, as you may or may not be familiar, we have a system of lights which are right there on the desk. The green light will indicate that you have five minutes to testify, yellow will mean you have a minute to wrap up, and the red light, we would appreciate if you would conclude your testimony approximately at that time. We always give a little leeway, if necessary, but we try to keep within the parameters of that, if possible.

So, Dr. Neerhof.

STATEMENT OF MARK G. NEERHOF, ASSOCIATE PROFESSOR OF OBSTETRICS AND GYNECOLOGY, NORTHWESTERN UNIVERSITY MEDICAL SCHOOL, ATTENDING PHYSICIAN DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, NORTHWESTERN HEALTH CARE

Dr. NEERHOF. Mr. Chairman and Committee Members, thank you for the opportunity to come and speak with you today. My name is Mark Neerhof. I am an associate professor of obstetrics and gynecology at Northwestern University Medical School. I am an attending physician in the Department of Obstetrics and Gynecology in the division of maternal-fetal medicine at Evanston Northwestern Health Care in Evanston, Illinois.

I have been practicing maternal-fetal medicine for 14 years. I am very familiar with fetal anomalies of all sorts, and am familiar with the options available for termination of pregnancy.

I have done many deliveries at the gestational ages where an intact D&X is performed. As a consequence, I am very familiar with the mechanism of delivery, including at these early gestational ages.

I came here today to express my support for a ban on intact D&X. I will divide my reasons into three categories; maternal, fetal, and ethical.

Maternal considerations: There exist no credible studies on intact D&X that evaluate or attest to its safety. The procedure is not recognized in medical textbooks. Intact D&X poses serious medical risks to the mother. Patients who undergo an intact D&X are at risk for the potential complications associated with any surgical

midtrimester termination which include: hemorrhage, infection, and uterine perforation.

However, intact D&X places these patients at increased risk of additional complications. 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's feet, and pulls the feet down into the cervix, thus converting the lie to a breach.

The internal version carries risks of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus. These risks have never been adequately quantified.

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 cervix by the scissors and could result in severe bleeding and the threat of shock or even maternal death. These risks have not been adequately quantified.

None of these risks are medically necessary because other procedures are available to physicians who deem it necessary to perform an abortion late in pregnancy. ASCOG policy states clearly, intact D&X is never the only procedure available.

Some clinicians have considered intact D&X necessary when hydrocephalus is present. However, a hydrocephalic fetus could be aborted by traditional means by first draining the excess fluid from the fetal skull through ultrasound guided cephalocentesis.

Some physicians who perform abortions have been concerned that a ban on late term abortions would affect their ability to provide other abortion services. Because of the proposed changes in Federal legislation, it is clear that only intact D&X would be banned.

It is my opinion that this legislation will not affect the total number of terminations done in this country. It will simply and appropriately eliminate one of the procedures by which termination can be accomplished.

Fetal considerations: Intact D&X is an extremely painful procedure for the fetus. The majority of intact D&Xs are performed on periviable fetuses. Fetuses and newborns at these gestational ages are fully capable of experiencing pain. The scientific evidence supporting this is abundant. If one still has questions in one's mind regarding this fact, in spite of the scientific evidence, one simply needs to visit a neonatal intensive care unit and your remaining doubts will be short-lived.

When infants of similar gestational ages are delivered, pain management is an important part of the care rendered to them in the intensive care nursery. However, with intact D&X, pain management is not provided for the fetus who is literally within inches of being delivered.

Forcibly incising the cranium with scissors and then suctioning out the intracranial contents is unquestionably excruciatingly painful. I happen to serve as the chairman of the Institutional Animal Care and Use Committee at my hospital. I am well aware of the Federal standards regulating the use of animals in research.

It is beyond ironic to me that the pain management practice for an intact D&X on a human fetus would not meet Federal standards for the humane care of animals used in medical research. The needlessly inhumane treatment of periviable fetuses argues against intact D&X as a means of pregnancy termination.

Ethical considerations: Intact D&X is most commonly performed between 20 and 24 weeks, and thereby raises the question of potential viability of the fetuses. Recent unpublished data from my institution indicates an 88 percent survival rate at 24 weeks gestation. These numbers will undoubtedly continue to improve over time.

Beyond the argument of potential viability, many pro- choice organizations and individuals assert that a woman should maintain control over that which is part of her own body, i.e., the autonomy argument. In this context, the physical position of the fetus with respect to the mother's body becomes relevant.

However, once the fetus is outside of the woman's body, the autonomy argument is invalid. The intact D&X procedure involves literal delivering the fetus so that only the head remains within the cervix. Based on my experience, I can tell you that if the fetal head remains in the cervix, insertion of scissors into the base of the scull is, by necessity, a blind procedure and consequently it is potentially hazardous.

If, however, as I suspect, the head is out of the cervix, and in the vagina, that fetus is essentially delivered, because there is nothing left to hold that fetal head in. At this juncture, the fetus is merely inches from being delivered and obtaining full legal rights of personhood under the U.S. Constitution.

What happens when, as must occasionally occur during the performance of an intact D&X, the fetal head inadvertently slips out of the mother, and a live infant is fully delivered? For this reason, many otherwise pro-choice individuals have found intact D&X too close to infanticide to ethically justify its continued use.

In summary, the arguments for banning this procedure are based on maternal safety, fetal pain, and ethical considerations. I regret the necessity to support the development of legislation which will regulate medical care, because in general, that is not desirable. However, in this case, it is born out of the reluctance of the medical community to stand up for what is right.

Mr. Chairman, I would like to ask that a 1998 Journal of the American Medical Association article that I authored in which I expand on the subject of my testimony in front of you today be submitted to the record.

Mr. CHABOT. Without objection.

Dr. NEERHOF. I thank you.

Mr. CHABOT. Thank you.

[The prepared statement of Dr. Neerhof follows:]

PREPARED STATEMENT OF DR. MARK G. NEERHOF

Mr. Chairman and committee members, Thank you for the opportunity to come and speak with you today.

My name is Mark Neerhof. I am an associate professor of Obstetrics and Gynecology at Northwestern University Medical School. I am an attending physician in the Department of Obstetrics and Gynecology, Division of Maternal-Fetal Medicine at Evanston Northwestern Healthcare in Evanston, Illinois. I have been practicing Maternal-Fetal Medicine for 14 years. I am very familiar with fetal anomalies of all sorts, and am familiar with the options available for termination of pregnancy. I

have done many deliveries at the gestational ages where an intact D&X is performed, and as a consequence, I am very familiar with the mechanism of delivery, including at these early gestational ages.

I came here today to express my support for a ban on intact D&X. I will divide my reasons into 3 categories: maternal, fetal, and ethical.

Maternal Considerations

There exist no credible studies on intact D&X that evaluate or attest its safety. The procedure is not recognized in medical textbooks. Intact D&X poses serious medical risks to the mother. Patients who undergo an intact D&X are at risk for the potential complications associated with any surgical mid-trimester termination, including hemorrhage, infection, and uterine perforation. However, intact D&X places these patients at increased risk of 2 additional complications. 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.

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 cervix by the scissors and could result in severe bleeding and the threat of shock or even maternal death. These risks have not been adequately quantified.

None of these risks are medically necessary because other procedures are available to physicians who deem it necessary to perform an abortion late in pregnancy. As ACOG policy states clearly, intact D&X is never the only procedure available. Some clinicians have considered intact D&X necessary when hydrocephalus is present. However, a hydrocephalic fetus could be aborted by first draining the excess fluid from the fetal skull through ultrasound-guided cephalocentesis. Some physicians who perform abortions have been concerned that a ban on late abortions would affect their ability to provide other abortion services. Because of the proposed changes in federal legislation, it is clear that only intact D&X would be banned. It is my opinion that this legislation will not affect the total number of terminations done in this country, it will simply eliminate one of the procedures by which termination can be accomplished.

Fetal Considerations

Intact D&X is an extremely painful procedure for the fetus. The majority of intact D&X are performed on periviable fetuses. Fetuses or newborns at these gestational ages are fully capable of experiencing pain. The scientific evidence supporting this is abundant. If one still has a question in one's mind regarding this fact, one simply needs to visit a Neonatal Intensive Care Unit, and your remaining doubts will be short-lived. When infants of similar gestational ages are delivered, pain management is an important part of the care rendered to them in the intensive care nursery. However, with intact D&X, pain management is not provided for the fetus, who is literally within inches of being delivered. Forcibly incising the cranium with a scissors and then suctioning out the intracranial contents is certainly excruciatingly painful. I happen to serve as chairman of the Institutional Animal Care and Use Committee at my hospital. I am well aware of the federal standard regulating the use of animals in research. It is beyond ironic that the pain management practiced for an intact D&X on a human fetus would not meet federal standards for the humane care of animals used in medical research. The needlessly inhumane treatment of periviable fetuses argues against intact D&X as a means of pregnancy termination.

Ethical Considerations

Intact D&X is most commonly performed between 20 and 24 weeks and thereby raises the question of the potential viability of the fetus. Recent unpublished data from my institution indicates an 88% survival rate at 24 weeks. These numbers will undoubtedly continue to improve over time.

Beyond the argument of potential viability, many pro-choice organizations and individuals assert that a woman should maintain control over that which is part of her own body (i.e., the autonomy argument). In this context, the physical position of the fetus with respect to the mother's body becomes relevant. However, once the fetus is outside the woman's body, the autonomy argument is invalid. The intact D&X procedure involves literally delivering the fetus so that only the head remains within the cervix. Based on my own experience, I can tell you that if the fetal head remains in the cervix, insertion of scissors into the base of the skull is, by necessity,

a blind procedure, and consequently, potentially hazardous. If, as I suspect, the head is out of the cervix and in the vagina, that fetus is essentially delivered because there is nothing left to hold the fetal head in. At this juncture, the fetus is merely inches from being delivered and obtaining full legal rights of personhood under the US Constitution. What happens when, as must occasionally occur during the performance of an intact D&X, the fetal head inadvertently slips out of the mother and a live infant is fully delivered? For this reason, many otherwise pro-choice individuals have found intact D&X too close to infanticide to ethically justify its continued use.

In summary, the arguments for banning this procedure are based on maternal safety, fetal pain, and ethical considerations. I regret the necessity to support the development of legislation which will regulate medical care because, in general, that is not desirable. However, in this case, it is born out of the reluctance of the medical community to stand up for what is right.

Thank you for the opportunity to come and speak with you today.

Mr. Chairman, I'd like to request that a 1998 Journal of the American Medical Association article that I authored, in which I expand upon the subject of my testimony in front of you today, be submitted to the record.

Mr. CHABOT. Mr. Heller, I am going to give you some additional time, because the doctor went over by about four minutes. And so it was about nine minutes all together. So I think it is fair to give you the same time, if you need it.

STATEMENT OF SIMON HELLER, DIRECTOR, CENTER FOR REPRODUCTIVE RIGHTS

Mr. HELLER. I appreciate that. Well, I want to thank the Subcommittee for inviting me here to speak. Again, this is—I believe I was here last summer. My field of expertise is Constitutional law, specifically, the jurisprudence that the United States Supreme Court has developed with respect to abortion and contraception.

Nevertheless, in the course of doing many cases involving abortion and contraception, I have become familiar with some of the medical information that exists in this area as well. From a legal standpoint, the bill you are considering today is flatly unconstitutional under a Supreme Court decision, *Stenberg* v. *Carhart* that was decided only three years ago.

There has been no change in the composition of the Supreme Court. As Mr. Nadler pointed out, Justice O'Connor, the crucial fifth vote in deciding *Stenberg* v. *Carhart*, pointed out very clearly, precisely what States or Congress must do in order for a bill regulating abortion methods to pass constitutional muster. This bill does neither of the two things she specifically directed must be done.

And I think the question one should ask oneself in considering this legislation, if one is perhaps still not decided on the question, is to imagine a Federal judge looking at this bill, and looking at the Supreme Court's decision in *Stenberg* v. *Carhart*, and deciding what the law of the land is.

And is the law of the land going to be determined in the eyes of the Federal judge, or appellate judge or Supreme Court Justice by what the Supreme Court has said, or by slightly altered legislative language with legislative findings that have—that are based not on substantial evidence, but on hardly any evidence whatsoever.

I will come back to that briefly in a moment. The reasons that the bill is unconstitutional are pretty obvious. I mean, you just

read *Stenberg* v. *Carhart*, and it applies almost word for word to the bill. It is not limited to a single procedure.

It talks about a single procedure, and Dr. Neerhof spoke about a single procedure in the beginning of the bill. But, then goes on to use different language in its operative language.

Secondly, it has no health exception. I am really going to limit most of my comments to the second flaw, the lack of a health exception, because this is where the bill goes on at length, putting forth so-called congressional findings of fact in an effort to, I suppose, displace the facts that actually exist in the real world. But, the Supreme Court has already rejected these facts once, and it will do so again. Now, I will explain that in a moment.

Much of the conversation here has been about *Stenberg* v. *Carhart*, and does this bill answer the objections the Supreme Court had? But that was not the only partial birth abortion case before the United States Supreme Court in the year 2000. In fact, there was another one from Wisconsin that was also in front of the Supreme Court.

And let me tell you a little bit about that case. In that case, a Federal district judge in Wisconsin upheld Wisconsin's partial birth abortion law. That judge said, this law is constitutional. Why did the judge do that?

Among other things, he said things like, and this was Judge Shabaz from the western district of Wisconsin, that the D&X procedure poses risks to women, he said there are no published, medically-recognized studies comparing the risks of D&E to D&X. He testified that major medical associations are reluctant to—he wrote that major medical associations are reluctant to endorse the D&X procedure.

He concluded: In light of this substantial evidence, the Court concludes that partial birth abortion is never medically necessary to preserve the life or health of a woman, and abolition of the procedure did not subject to women to materially greater health risks. Moreover, induction is safer than D&E and can be used in those rare pregnancies, et cetera. He reached the findings that this bill contains.

The 7th Circuit heard the appeal. And by a 5-to-4 vote the 7th Circuit affirmed Judge Shabaz. Judge Easterbook, a noted conservative jurist, repeated much of the district court's findings. The district court in the Wisconsin case concluded that the D&X procedure is never necessary from the perspective of the patient's health.

And Judge Easterbook said that findings is not clearly erroneous, so we have to uphold it. What did the Supreme Court do? The Supreme Court vacated the 7th Circuit's decision. The same—maybe the day after *Carhart* was decided, and on remand, the 7th Circuit unanimously, 9 to 0, said that the same Wisconsin statute they had upheld under these type of legislative—findings similar to these legislative findings was unconstitutional because it lacked a health exception and it was too broad.

In other words, all of the judges of the 7th Circuit, Judge Easterbook, Judge Posner, noted conservative judges, all agreed that under the Supreme Court's decision in *Carhart*, despite facts found by a district court to the contrary, Wisconsin's law was unconstitutional. That is because the health exception is required as

a matter of law, and because there is sufficient, I guess, disagreement about the facts that neither Congress nor the States is free to legislate in this area.

So the Supreme Court has already heard these facts. It has looked at them, and it has rejected them, despite the fact that the clearly erroneous law of course applied in the Wisconsin case as well.

There is no room for play here. The Supreme Court has rejected the old versions of this bill that were used by Congress in Congressional bills that President Clinton vetoed, and has rejected these very legislative findings that Congress is now trying to slip past the Supreme Court.

The honorable thing to do, when Congress disagrees with the Supreme Court decision, is to propose an amendment to the United States Constitution, have it passed, I believe, by a two-thirds vote of Congress, and have it ratified by three-quarters of the States. This is not that. This is, as Mr. Nadler said, thumbing its nose at the Supreme Court. It should be rejected. In fact, it was rejected by the voters of three States who were actually asked to vote on whether they wanted such a law or not, in Maine, Washington and Colorado, the voters rejected this type of statute. So the only public opinion polls that count, the ones at the ballot box, have rejected this type of legislation.

I urge the Committee to do so as well. Thank you.

Mr. CHABOT. Thank you.

[The prepared statement of Mr. Heller follows:]

PREPARED STATEMENT OF SIMON HELLER

Mr. Chairman:

Thank you for giving me the opportunity to testify this afternoon. My name is Simon Heller. I acted as the lead trial attorney in the *Stenberg* v. *Carhart* Nebraska abortion ban case and had the privilege of arguing the case before the Supreme Court in April of 2000.

I. INTRODUCTION

H.R. 760 is not a ban on one clearly defined, late-term abortion method, as its proponents deceptively claim. Instead, it is an extreme measure that sacrifices women's health to further the ideological agenda of the anti-choice movement. It is therefore unconstitutional under controlling Supreme Court precedent. Since *Roe* v. *Wade*, 410 U.S. 113 (1973), the Supreme Court has consistently held that the right to privacy under our Constitution gives primacy to the pregnant woman's health: she has the right to end a pregnancy that threatens her health, *Roe*, 410 U.S. at 164, and she has the right to the safest method of ending the pregnancy. *See Thornburgh* v. *ACOG*, 476 U.S. 747, 768-69 (1986). H.R. 760, captioned as a ban on "partial-birth abortion," is unconstitutional in that it suffers from precisely the two flaws identified by the United States Supreme Court in its recent decision striking down Nebraska's ban on "partial-birth abortion." *Stenberg* v. *Carhart*, 530 U.S. 914 (2000). In Carhart, the Court invalidated the Nebraska law for "at least two independent reasons":

> First, the law lacks any exception "'for the preservation of the . . . health of the mother." [*Planned Parenthood* v.] *Casey*, 505 U.S. [833 (2000)], at 879 (joint opinion of O'Connor, Kennedy, and Souter, JJ.). Second, it "imposes an undue burden on a woman's ability" to choose a [dilation and evacuation] abortion, thereby unduly burdening the right to choose abortion itself. *Id.*, at 874.

Carhart, 530 U.S. at 930 (parallel citations omitted). Importantly, Justice O'Connor's concurrence re-emphasized these very same constitutional infirmities. *Carhart*, 530 U.S. at 947 (O'Connor, J., concurring). The sponsors of the bill seek to evade the *Carhart* ruling in two ways. Neither is successful.

II. H.R. 760 IMPOSES AN UNDUE BURDEN ON THE RIGHT TO CHOOSE ABORTION

The Supreme Court found that the language of Nebraska's statute was broad enough to prohibit the dilation and evacuation ["D&E"] method of performing an abortion. Because D&E is the most commonly used method in the second trimester of pregnancy, a law that bans that method is tantamount to a ban on second-trimester abortions. Abortion bans have been unconstitutional since *Roe* v. *Wade* was decided nearly thirty years ago.[1]

The sponsors of H.R. 760 have altered the definition of "partial-birth abortion," which is not a medical term, but instead a propaganda term designed to inflame public opinion against all abortions. Yet this alteration still does not result in a prohibition on a narrowly circumscribed category of abortion techniques. Instead, just like the language of Nebraska's statute, it could still prohibit many pre-viability abortions using the D&E method, of which the specific technique described in the first paragraph of the bill's findings is simply one type.[2] 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. 760 § 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.

III. H.R. 760 WILL HARM WOMEN'S HEALTH

The sponsors have simply put forward the bald assertion that, contrary to the Supreme Court's holding in Carhart,[3] no health exception is necessary in their bill because the technique described in paragraph one of the bill's findings is *never* medically necessary and is actually *harmful* to women's health.[4] Both assertions are, however, false. It is thus of little moment that the sponsors seek to label these particular false statements as "Congressional findings." Whatever deference the Judiciary may owe to Congressional findings, no deference is due where the findings are demonstrably false. As Justice Thomas has written:

> 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 stat-

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[1] The Supreme Court's abortion jurisprudence has also consistently recognized that only two government interests—the interest in the potential life of the fetus and the interest in the health of the pregnant woman—can justify restrictions on abortion. Since a ban on some abortion methods simply steers women towards other abortion methods, such a ban does not serve the interest in potential life. Because the ban contained in H.R. 760 also does not promote women's health, several eminent judges have questioned whether such a ban even passes muster under the most deferential form of judicial review, often called rational basis review. For example, then Chief Judge Posner of the United States Court of Appeals for the Seventh Circuit wrote: "Even if the standard for judicial review of state abortion laws challenged under the due process clause of the Fourteenth Amendment were merely that of rational relation to a legitimate state interest, Wisconsin's partial birth statute would be in trouble. Not because states do not have legitimate interests in the regulation of abortion, especially late-term abortions, but because the Wisconsin statute does not seem rationally related to any of those interests, and in particular to the interest of preservation of fetal life " *Planned Parenthood of Wisconsin* v. *Doyle*, 162 F.3d 463, 470 (7th Cir. 1998). Similarly, Justice Stevens wrote that he could not understand "how a State has any legitimate interest in requiring a doctor to follow any procedure other than the one that he or she reasonably believes will best protect the woman in her exercise of this constitutional liberty [to choose abortion]." 530 U.S. at 946 (Stevens, J., concurring).

[2] The sponsors could have, but did not, use more specific language quoted approvingly by Justice O'Connor in her concurrence in *Carhart*, namely language used in state statutes which Justice O'Connor believed applied only to a narrowly defined abortion technique. See 530 U.S. at 950 (O'Connor, J., concurring) (quoting Kansas, Montana and Utah statutes at length). Indeed, the sponsors do not even consistently describe the same technique within the findings. *Compare* Finding ¶1 (partial-birth abortion involves delivery until "only the head remains in the womb") *with* Finding ¶14(A) (partial-birth abortion involves conversion to a footling breech presentation) *and* Finding 14(J) (partial-birth abortion involves delivery of "all but the head, out of the womb").

[3] And contrary to Justice O'Connor's concurrence: "First, the Nebraska statute is inconsistent with *Casey* because it lacks an exception for those instances when the banned procedure is necessary to preserve the health of the mother." 530 U.S. at 947.

[4] Of course, any physician who knowingly (or even negligently) performed an abortion using an *unsafe* method (e.g., using non-sterile instruments) would be both civilly liable for malpractice and subject to professional discipline in most states. Significant questions are raised under the Fifth Amendment's equal protection component by a Congressional effort to target one area of medicine, namely abortion care, for federal criminal regulation when all medical care is already extensively regulated by the States. Indeed, surgical abortion is among the safest surgical procedures performed in the United States.

> ute constitutional simply by "finding" that black is white or freedom, slavery, judicial review would be an elaborate farce. At least since *Marbury* v. *Madison*, 5 U.S. (1 Cranch) 137, 2 L.Ed. 60 (1803), that has not been the law.

Lamprecht v. *FCC*, 958 F.2d 382, 392 n.2 (D.C. Cir. 1992) (per Thomas, Circuit Justice).

"Medically necessary," in the case of abortion, has two distinct meanings: whether the *abortion itself* is medically necessary, and whether a *particular method* of abortion is medically necessary. The sponsors intentionally conflate the two meanings, even though only the latter meaning is relevant in the case of an ban on abortion methods. Thus, for example, paragraph 14(E) of the findings asserts that the physician "credited with developing the partial-birth abortion procedure" "has never encountered a situation where a partial-birth abortion was medically necessary to achieve the desired outcomee . . ." (Paragraph 14(D) similarly mischaracterizes and misconstrues Dr. Carhart's testimony.) Of course, as with other medical treatments, a pregnant woman and her physician typically choose from among a few alternative techniques to end the pregnancy. But one technique may be *the safest and most medically appropriate* technique. The bill removes the determination of which technique is the safest and most appropriate from the hands of physicians and patients and places it in the hands of federal prosecutors.

But the Supreme Court has removed this medical determination from the political arena. As the Court stated in *Carhart*, "[we have] made clear that a State may promote but not endanger a woman's health when it regulates the methods of abortion." 530 U.S. at 931 (citing *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768-69 (1986); *Colautti* v. *Franklin*, 439 U.S. 379, 400 (1979); *Planned Parenthood* v. *Danforth*, 428 U.S. 52, 76-79 (1976); *Doe* v. *Bolton*, 410 U.S. 179, 197 (1973)). The sponsors of H.R. 760 assert in their findings that the abortion techniques they are prohibiting are not only "unnecessary to preserve the health of the mother, but in fact pose[] serious risks to the long-term health of women and in some circumstances, their lives." § 2 ("Findings"), ¶2.[5] As is very clear from the factual record not only in the *Carhart* case itself, but in many other cases challenging partial-birth abortion bans, there is, at a minimum, significant evidence that no technique banned by H.R. 760 is harmful to women.

Instead, there is significant evidence that one technique banned by H.R. 760, called dilation and extraction (D&X) by the Supreme Court, *see Carhart*, 530 U.S. at 927, is in fact the safest and best abortion technique in some cases. Thus, though acknowledging the lack of statistical studies comparing the safety of the D&X technique with other abortion methods, federal judges reviewing statutes from the following states made the following factual determinations about the D&X technique based on testimony both favoring and disfavoring the D&X technique:

Arizona: The D&X method is one of several **"safe, medically acceptable abortion methods in the second-trimester."** *Planned Parenthood* v. *Woods*, 982 F. Supp. 1369, 1376 (D. Ariz. 1997) (Bilby, J., appointed by President Carter).

Illinois: **"[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 loss and less trauma for some patients and may take less operating time."** *Hope Clinic* v. *Ryan*, 995 F. Supp. 847, 852 (N.D. Ill. 1998) (Korcoras, J., appointed by President Carter).

New Jersey: **"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."** *Planned Parenthood of Central New Jer-*

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[5] The more detailed "findings" on the harm of "partial-birth abortion" to women are at best opaque, and at worst misleading and false. Paragraph 14(A) of the findings purports to list risks of "partial-birth abortion," but does not quantify those risks or compare them in any meaningful way to the risks of abortion methods (like hysterotomy which involves abdominal rather than vaginal removal of the fetus) that are clearly permitted under the bill, or to the risks of carrying a pregnancy to term. Paragraph 14(B) seems to focus on the lack of controlled studies of "partial-birth abortion," but the lack of studies does not prove that any technique is not safe, it simply leaves the question open. Paragraph 14(C) tendentiously cites an unnamed medical association's views, but fails to disclose that the medical organization specializing in reproductive health care for women, ACOG, disagrees with these views.

sey v. *Verneiro*, 41 F. Supp. 2d 478, 484-85 (D.N.J. 1998) (Thompson, C.J., appointed by President Carter) (citation to ACOG Statement on Intact D&X omitted).

Ohio: **"[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 . . ."** *Women's Medical Professional Corp.* v. *Voinovich*, 911 F. Supp. 1051, 1070 (S.D. Ohio 1995) (Rice, J., appointed by President Carter).

Rhode Island: **"Doctors have not done statistical studies as to the relative risk of a D&X, although the doctors testified that it was equal to or less than the risk of a D&E."** *Rhode Island Medical Society* v. *Whitehouse*, 66 F. Supp. 2d 288, 298 (D.R.I. 1999) (Lagueux, C.J., appointed by President Reagan).

Virginia: **"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."** *Richmond Medical Center for Women* v. *Gilmore*, 55 F. Supp. 2d 441, 491 (E.D. Va. 1999) (Payne, J., appointed by President Bush) (citations to the trial record omitted).

Wisconsin: **"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 and Gynecologists." *Planned Parenthood of Wisconsin* v. *Doyle*, 162 F.3d 463, 467-468 (7th Cir. 1998) (per Posner, C.J., appointed by President Reagan, joined by Rovner, J., appointed by President Bush) (emphasis added).

Perhaps most importantly, the Supreme Court held that the absence of medical consensus about the safety or benefits of a particular abortion technique does not authorize the government to ban the technique: "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," 530 U.S. at 937, neither Congress nor the States may ban the procedure. H.R. 760 directly contravenes this legal holding by choosing one side in the medical debate about abortion methods via the device of Congressional findings. Yet this is a debate the Supreme Court has required the government to stay out of.

IV. THE BILL THREATENS THE SEPARATION OF POWERS

The bill also presents a greater threat to our constitutional system of government. Where constitutional rights are at stake, the Judiciary conducts its own independent review of the facts. *See, e.g., Landmark Communications, Inc.* v. *Virginia,* 435 U.S. 829, 843-44 (1978). 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. *See, e.g., United States* v. *Morrison,* 529 U.S. 598, 614 (2000). 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 D&E abortions by "finding" that all D&E procedures were unsafe and that, contrary to actual fact, D&E's were rarely performed. 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.

Congressional attempts to overturn Supreme Court precedents have always failed. For example, Congress passed the Religious Freedom Restoration Act (RFRA) in response to an earlier Supreme Court decision. *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). 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." *City of Boerne* v. *Flores*, 521 U.S. 507, 519 (1997). The Court further held that "The power to interpret the Constitution in a case or controversy remains in the Judiciary," *id.* at 524, and "RFRA contradicts vital principles necessary to maintain separation of powers and the federal balance." *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.

Here, again, Congress is attempting to overturn Supreme Court constitutional precedent by enacting a law that fails to adhere to the precedent. As in these cases, Congress has overstepped its bounds - the bill does not pass constitutional muster.

V. CONCLUSION

The Supreme Court's decision in *Stenberg* v. *Carhart* is clear: even a specific, narrowly worded ban on the D&X abortion technique must contain a health exception because significant evidence supports the likelihood that the D&X technique is the safest technique in some cases. *Carhart* also re-affirms that a ban on commonly used abortion methods cannot masquerade as a prohibition on a specific technique, for such a ban imposes an undue burden. This decision is in keeping with the Supreme Court's long-held principle that the health of the pregnant woman must be protected when government regulates abortion, and that government must respect the reasonable medical judgment of physicians and their women patients. Congress would do well to heed the Supreme Court's pronouncement by rejecting this bill.

Mr. CHABOT. Professor Bradley.

STATEMENT OF GERARD V. BRADLEY, PROFESSOR OF LAW, UNIVERSITY OF NOTRE DAME

Mr. BRADLEY. I thank the Members of the Subcommittee. Thank you for this opportunity to address the constitutionality of H.R. 760, especially in light of the decision of the Court in *Stenberg* v. *Carhart*.

My written testimony addresses several issues, but in these brief opening remarks, I will limit myself to what I take to be the most important Constitutional question, the question about a health exception and medical necessity.

H.R. 760 says that medical necessity is a question of fact. H.R. 760 says that the fact is, there are no cases of medical necessity for D&X abortion, hence, there is no need for a health exception in the bill.

The *Carhart* Court also said that medical necessity is "a factual question," not a question of law, which was the matter, by the way, in the *Boerne* case, and it was the Freedom of Restoration Act that Representative Nadler referred to. There was a dispute there between Congress and the court, really about the meaning of the free exercise clause. That is not this situation.

And it was also not a case in *Stenberg* v. *Carhart* of legal characterization of facts, nor did the Court say it was a question a mix of law and fact. Now, the Supreme Court implicitly conceded, in my view, in *Carhart*, that if it is true, that there are no factual cases of medical necessity, there is no need for a health exception in the law.

So what is the problem? Well, the *Carhart* Court surely does not say, as does H.R. 760, that there are no cases of medical necessity.

On the other hand, the *Carhart* Court does not contraindicate H.R. 760.

For in my view, the *Carhart* opinion does not say, the *Carhart* majority, does not assert, that there are cases of medical necessity. But, what does the *Carhart* majority opinion say? It seems to me that the majority statements on this matter can be divided up into basically two groups, two different types, two kinds.

The first kind: The *Carhart* Court says, in so many words, the district court found that there are cases of medical necessity, and the record supports that finding. But this type of statement presents no constitutional problem, no constitutional impediment to H.R. 760. For saying that the record in a particular trial supports a verdict is not at all to say that the verdict is true, or even that a reviewing court would have reached the same verdict on the same record.

And we all know of cases of a record in a criminal trial which could well support, in fact, does well support, a judgment of conviction, even for an entirely innocent person. The fact is, an appellate court does not view the fact of the matter head on, sort of in real life in real time, without restriction, and in light of all the relevant research.

The Supreme Court in *Carhart* viewed the fact of the matter as if through a glass darkly. Appellate courts, including the Supreme Court in *Carhart*, is encumbered by the record below, and by a whole complex of assumptions, presumptions and legal rules governing the relationship between superior and inferior courts; all matters peculiar to judicial proceedings.

As the Supreme Court has often said, Congress is free of these peculiar judicial constrains, and for that reason, among others, Congress, the Supreme Court has often said, is a superior fact finder.

Now, the second type of statement in *Carhart*. Second type of statement is, in so many words, some medical authorities, the Court says substantial at one point, significant at another point, but the Court says, some medical authorities say there are cases of medical necessity and Nebraska has not demonstrated that they are wrong. Some voices say there are such cases, and the Court is unable or not in a position to say that they are wrong.

But this too is not a constitutional impediment to voting in favor of the H.R. 760. For the Court did not say that these authorities are right. The Court did not say that, in fact, there are cases of medical necessity. H.R. 760 obviously holds that these voices are mistaken, that there are no cases of medical necessity.

And what Nebraska failed to demonstrate in 1997, may well be shown to the satisfaction of Congress in 2003. The Supreme Court said that the question of medical necessity was uncertain. A confession, in my view, I think, that it just did not know what the fact of the matter truly was. But, the Court did not say that is a question that can't be answered or that is a matter to which the answer can never be known. H.R. 760 contains Congress's answer to the factual question, the factual question which I submit the Court was not in a position to answer in *Stenberg* v. *Carhart*.

Mr. CHABOT. Thank you very much.

[The prepared statement of Mr. Bradley follows:]

PREPARED STATEMENT OF GERARD V. BRADLEY

I am grateful to the Subcommittee for this opportunity to provide an opinion on the constitutionality of HR 760, especially in light of the Supreme Court's decision in *Stenberg* v. *Carhart*.

I. ENUMERATED POWERS

The first question about the Constitution and this—or any—act of Congress is not about limits, such as might be found in *Roe* v. *Wade, Casey* v. *Planned Parenthood, and Stenberg* v. *Carhart*. The first question is whether the proposed legislation is within an enumerated congressional power, powers granted by the people and listed (chiefly) in Article I of the Constitution. Our national government does not possess general, much less unlimited, lawmaking authority; in our federal system the states possess general police power, understood as an undifferentiated authority to care for the whole common good of political society. Given this federal structure, the first question is always: is this bill within the power Congress has chosen to exercise, as that power has been authoritatively interpreted by the Supreme Court?

Congress intends HR 760 to be an exercise of its power over "commerce . . . among the several states." U.S. Const, art I, sec. 8. The scope of this interstate commerce power has been reduced somewhat by recent decisions of the Supreme Court in *U.S.* v. *Lopez*, 514 U.S.549 (1995)) and *U.S.* v. *Morrison* 529 U.S. 598 (2000). But HR 760 is surely within the commerce power; this bill includes a jurisdictional element of the sort which, *Lopez* and *Morrison* suggest, satisfies constitutional requirements. *See* 529 U.S. at 613, relying upon Lopez.

An element of every prosecution (or civil suit) under HR 760 is that the partial-birth abortion be performed by a physician "in or affecting interstate or foreign commerce." In each case the federal prosecutor (or plaintiff's attorney) must establish a connection between the particular act being prosecuted (or sued upon), and interstate commerce. Proof of this element, like all the elements of a criminal offense, must satisfy a jury beyond a reasonable doubt. HR 760 wisely leaves the question of sufficient proof of this "effect" to trial courts charging juries and deciding post-verdict motions, and to appellate courts. We can speculate, though, that the element would be proved by evidence that a patient communicated from out-of-state with an abortion provider, and subsequently crossed state lines to procure the abortion.

I turn to the question of applicable limits arising from the Supreme Court's abortion cases, most pertinently *Carhart*.

II. D&E, D&X AND "UNDUE BURDEN"

The Supreme Court in *Carhart* gave two reasons for concluding that Nebraska's partial-birth abortion ban violated the Constitution. One was that the ban placed an "undue burden" upon some women's abortion liberty. Why? Because the Nebraska statute's definition covered not only the prohibited D&X procedure, but some permitted D&E procedures, too. In the Court's words: "[U]sing this law some present prosecutors and future Attorneys General may choose to pursue physicians who use D&E procedures, the most commonly used method for performing previability second trimester abortions. All those who perform abortion procedures using that method must fear prosecution, conviction, and imprisonment. The result is an undue burden upon a woman's right to make an abortion decision."

The problem in *Carhart* was shoddy legislative draftsmanship. Nebraska's drafters aimed at D&X and carelessly hit D&E too. Nowhere did the *Carhart* Court suggest that the fatal indeterminacy and overlap were features of medical reality. In reality D&X is not a vague, uncertain thing, such as (to use some standard legal examples) "unreasonable noise" or "due diligence" or "harmful effects" are vague. Those phrases may well convey a core of settled, easy applications. But they also point to gray, contested areas of uncertain application. These vague terms could be applied to many doubtful or borderline cases; persons of good faith trying to conform their conduct to law may not know which side of the line they tread. A boom box on a subway may make "unreasonable noise." Maybe not. Is it too loud on a beach? At the park? Who is to say? What is a music lover to do?

D&X is surely not an *ambiguous* term, pointing more or less equally to two separate procedures. "USC" is *ambiguous*, for it could refer to the University of Southern California, or to the University of South Carolina. D&X points to an unmistakable, distinct medical procedure.

If partial-birth abortion blended into and was often indistinguishable from D&E (or any other permitted procedure), even the best drafters might not be able to draw a line clear enough to surmount the "undue burden" hurdle of *Carhart*. But D&X is distinguishable; the definition in HR 760 reliably separates it from D&E.

The *Carhart* Court implicitly assumed that D&X is a distinct, readily identifiable procedure, distinguishable from D&E. This assumption is evident in *Carhart*'s discussion of D&X and its benefits *compared* to D&E abortions. How could Supreme Court Justices intelligently weigh the question of health risks and benefits of two medical procedures, unless the procedures were different, did not overlap, and were not confused by, or confusing to, medical practitioners and researchers? How could anyone?

In other words: no intelligent discussion of the central question before this committee—the necessity of a "health" exception to any law prohibiting D&X abortions—is *possible*, save by supposing that D&X can be reliably and systematically distinguished from other abortion procedures. One cannot debate which is the better football team—USC or UCLA—save by knowing that they are two different schools, albeit both in the California public system, and possessed of similar-sounding acronyms. Again: were not those who perform and study the effects of abortion able to *know* what is, and what is not, a D&X procedure it would be impossible to state firmly that D&X is safe, or safer, or safest, compared to other procedures. But this is precisely the position of those who oppose HR 760.

What was shoddy about the Nebraska law? Its use of the phrase *"substantial portion"* of a living unborn child. Because a D&E procedure may commonly involve pulling from the birth canal a limb or extremity—the Court referred repeatedly to "arm and a leg" and, at one telling point, "as small a portion as a foot"—Nebraska caught some (many?) D&E procedures in its D&X net.

HR 760 avoids entirely the asserted defects of the Nebraska law. This bill's definition of the prohibited procedure—most pointedly, delivery of "the entire fetal head" or, in the case of breech delivery, "any part of the fetal trunk past the naval"—overcomes the vagueness and uncertain application of the analogous Nebraska language—"substantial portion" of the unborn child. No abortion doctor could confuse what it prohibited by HR 760, and a D&E abortion.

The *Carhart* majority all but conceded that a statute drafted as is HR 760 would pass constitutional muster under the "undue burden" analysis. The Nebraska Attorney General urged the Court to read "substantial portion" to mean "the child up to the head." The Court said that such a reading—treating the statute as if it *said*, "the child up to the head"—*would reliably* distinguish D&X from D&E, where "the physician introduces into the birth canal a fetal arm or leg." But, the *Carhart* majority rejected the Attorney General's limiting instruction because it conflicted with the statutory definition—"substantial portion." The Court nonetheless said: "We are aware that adopting the Attorney General's interpretation might avoid the constitutional problem."

HR 760 actually does say, "the entire fetal head is outside the body of the mother."

III. A "HEALTH" EXCEPTION

The most controverted feature of HR 760 is the absence of a "health" exception, the second ground of the *Carhart* opinion. Since there is no doubt that Roe and succeeding cases generally require a "health" exception, the constitutionality of HR 760 depends upon its superfluity: if a D&X is never necessary to preserve a woman's health, then the absence of a "health" exception is constitutionally unobjectionable.

HR 760 recites Congress's relevant finding of fact: D&X is never necessary to preserve a woman's health.

I possess no special competence or expertise to judge the truth of this assertion. My competence permits me to address, however, a related and, I think, important constitutional question: for any member of Congress who judges the assertion to be supported by the evidence and the best conclusion available, is there some reason arising in Roe, *Carhart* or any place else in constitutional law why that member should hesitate to vote for HR 760?

My answer is no.

Effectively the same question is found paragraph (8) of the Findings part of HR 760. It says that "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 *Carhart* 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" I judge this to be an accurate statement of the law.

Since there appears to be no doubt that Congress is pursuing a legitimate interest, is basing its judgments upon substantial evidence, and that as a general matter

the Supreme Court accords great deference to Congressional fact-finding (the findings portion of HR 760 contains ample citation to the cases), I turn to what to the heart of the controversy over the proffered factual finding: whether it runs afoul of the Court's opinion in *Carhart*.

I think it does not.

The most pertinent passage of *Carhart* is this: Nebraska "fails to demonstrate that banning D&X without a health exception may not create significant health risks for women *because the record shows that significant medical authority supports the proposition that in some circumstances, D&X would be the safest procedure*." [emphasis added]

The question about HR 760 is, then, whether the proffered Congressional finding—that D&X is never medically indicated for a woman's health—is neutralized, or rendered inoperative, or is somehow in conflict with the quoted passage from *Carhart*. My answer is, again no.

Why?

My reasoning includes four important preliminary points. First. With HR 760 we are in no way talking about a Congressional power to preclude independent judicial evaluation of the facts. We are talking about the appropriate level of judicial deference to congressional fact finding, not about judicial abdication.

Second. With HR 760 we are not talking about Congress dictating to the Court what that appropriate level is, or should be. That matter is left to the Court. We are talking about the *Court's* doctrines about deference, not about a congressional *putsch*.

Third. The alleged conflict is about a question of simple fact, colored by professional medical judgment: are there cases of medical necessity? The "conflict" here is thus radically unlike the conflict in, for example, *City of Boerne* v. *Flores*, the 1995 Supreme Court decision invalidating the Religious Freedom Restoration Act. There the conflict was about the law of the Constitution, pure and simple. Congress aimed in RFRA to reverse a prior judicial interpretation of the Free Exercise Clause, namely, the holding in *Employment Division* v. *Smith*.

HR 760 is not nearly so audacious as RFRA. HR 760 rewrites no law and aims at no novel interpretation of the Constitution. A *Boerne* situation here would be if Congress asserted in HR 760 that the Court misinterpreted the Constitution in *Roe*. We would have *Boerne* here if Congress asserted, for example, that no health exception was required by the Constitution. Instead, Congress says in HR 760 that non is required by the *facts*.

HR 760 is not a case like *Brown* v. *Board of Education*, either. There is indeed a sense in which the *Brown* Court invalidated the "separate but equal" doctrine upon factual considerations, insofar as the inhibiting psychological effects of segregation upon black children's learning amount to a "fact." But *Brown* is unlike this situation for two reasons. One is that, even if the *Brown* psychological findings are "facts" which, at least in theory, Congress could have judged differently, the critical part of *Brown* was not the raw fact of the matter. It was the Court's legal characterization of those facts as unconstitutional inequality. Besides, *if* Congress could have revised *Brown* by visiting the factual question, the fault lies not with the doctrine of Congressional ascendancy over fact-finding—which is solidly supported by precedent and prudential considerations—but with the *Brown* Court, which chose to stake its holding, not on the sure high terrain of moral principle, but in the prosaic and slippery ground of psychological testing.

Fourth. Nothing in the relevant Supreme Court precedents suggests that the question at issue here—medical necessity, if any, for D&X abortion—is beyond the *ordinary* competence of Congress. Nothing in the cases suggests that the Court would, or should, deviate from its ususal standard of according great deference to a Congressional finding. The grounds for that deference were stated with unsurpassable clarity by Archibald Cox, in a classic law review article:

> The greater number of members [of a legislature] and their varied backgrounds and experience make it virtually certain that the typical legislature will command wider knowledge and keener appreciation of current social and economic conditions than will the typical court. The legislative committee, especially when armed with able counsel and the power of subpoena, is better equipped to develop the relevant data. Courts have always found it hard to develop the background facts in constitutional cases. Judicial notice often means only intuition or prejudice. Occasionally, special masters have been appointed to make elaborate studies of economic conditions, as where a particular industry has been subjected to novel legislation. A court may hear expert witnesses, but they are seldom more than special pleaders.

A. Cox, *The Role of Congress in Constitutional Determinations*, 40 U. Cinn. L. Rev. 199 (1971).

IV. CONGRESS AND COURT IN CONFLICT?

HR 760 finds that there is no medical necessity for a D&X abortion. Does this finding conflict with what the Supreme Court says in *Carhart*? There are no expressions in *Carhart* which clearly show that the Court, speaking in its own voice, evaluated the factual question head on, all things considered, and rendered a *de novo* judgment of its own. The expressions are all suggestive of a more limited, refracted and conditional judgment. Some examples: "In sum, Nebraska has not convinced us that a health exception is never necessary to preserve the health of the woman." "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. . . . " See also the expression quoted earlier in this testimony on this record Nebraska has not demonstrated the truth of its assertion that there are no cases of medical necessity.

These expressions can be read in two slightly different ways. But on neither reading does HR 760 conflict with *Carhart*.

On one reading of *Carhart*, the Supreme Court asserted no judgment of its own about medical necessity. On this first reading, the Supreme Court left undisturbed the lower court's conclusions because they were not "clearly erroneous." Findings which are not "clearly erroneous," however, could be false. On this reading the Supreme Court could actually *agree* with HR 760 that there are no cases of medical necessity. On this view, by enacting HR 760 Congress would be presenting the Supreme Court a welcome opportunity to implement its—the Court's—judgment that there are no cases of medical necessity, a judgment stifled by the incorrect though plausible findings of the District Court.

On this first reading, *Carhart* is no impediment whatsoever to Congressional fact-finding, save that which presupposes a single District Court judge can bind, for all time, the great coordinate branches of government on a question of fact. One sorely hopes that such questions cannot be settled by who wins the race to the courthouse, and on the luck of the judicial draw on race day.

The second possible reading of *Carhart* is this: the Supreme Court itself is heard to judge the record. On this reading the high Court would be saying: we (along with the District court) do not think Nebraska has made its case, as far as proof in this record goes. This reading of *Carhart* is not in conflict with HR 760.

The *Carhart* Court was inescapably limited to opining upon the record compiled below. That a judicial proceeding suffered all the limitations and comparative disadvantages identified by Archibald Cox. Cox's caution about "special pleader" experts is perhaps most noteworthy: it would be difficult to overstate the role of one man's "expert" testimony in the compilation of that record—the defendant, Dr. Leroy Carhart. The Supreme Court expressed its judgment most tellingly: "the findings and evidence support Dr. Carhart."

Those findings were, moreover, *about* Dr. Carhart: "The District Court concluded," said the Supreme Court, "that 'the evidence is both clear and convincing that *Carhart*'s D&X procedure is superior to, and safer than, the other abortion procedures used during the relevant gestational period in the 10 to 20 cases a year that present to Dr. Carhart.' The District Court made no findings, the Supreme Court added, about the procedure's "overall safety;" the record contained evidence of no "controlled studies that would help answer" the question of medical necessity.

The high Court stressed repeatedly the "uncertainty" of medical opinion about the safety of D&X, an "uncertainty" which itself *became the reason for the Court's judgment*: "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." This, I submit, is the *Carhart* Court's independent judgment about medical necessity: we simply do not know if there is a medical necessity, said the Justices. Not knowing, we choose to err on the side of safety for women, just in case Dr. Carhart is right.

The *Carhart* Court did not find facts. The *Carhart* Court *appealed* for facts. HR 760 responds to that appeal.

The record upon which the Supreme Court relied in *Carhart* was compiled in 1997–98. The record consisted of data and experiences older than that. That record indeed contained "medical authority" (which the Court described as "significant") indicating that D&X might be the safest abortion procedure in some circumstances. But the Court never said that these authorities were *right*. The Court said that the opinion expressed in those authorities—that D&X was sometimes safest—was not proved wrong by the state of Nebraska.

As anyone with courtroom experience will tel you, what is not proved wrong in a single trial might well be true.

Congress is not limited by any judicial record. Its members may rely upon the latest knowledge about D&X and medical necessity. Given the dearth of knowledge about D&X in the 1990's and the always improving levels of neo-natal and maternal medical care, what was—or may have been—not proved in 1997 might now be proven, now even clearly true.

The Findings in HR 760 assert an emergent consensus of medical and moral opinion, supported by the "great weight" of the evidence available: "partial-birth abortion is never necessary to preserve the health of a woman." Affirming this proposition does not, in my judgment, give insult to the Supreme Court, or to its decision in *Carhart*.

Mr. CHABOT. At this time, the Members of the panel will have an opportunity to ask questions of the witnesses here this afternoon. I will begin with myself, and I recognize myself for 5 minutes.

I am going to start with Dr. Neerhof. Doctor, is it possible for a physician to begin a D&E abortion or another abortion procedure and find themselves performing an abortion that would be prohibited under this bill?

Dr. NEERHOF. Whenever you ask the question, is it possible, you are using the ever's and never's and so forth. I think that the likelihood of that occurring would be extremely remote because the nature of a D&X is different than the nature of a D&E. The destructive nature of a D&E takes place in utero. A D&X, it is an intact extraction. There is no attempt to be destructive in utero.

Because of the different nature of those procedures, that would be extraordinarily unlikely.

Mr. CHABOT. Thank you. Let me follow up in another question. In your opinion, when would a physician cross the line under H.R. 760's definition of the prohibited procedures?

Dr. NEERHOF. A physician would cross the line by intentionally trying to deliver a fetus intact, with the intention of delivering all but the tip of that head before terminating that pregnancy.

Mr. CHABOT. Let me follow up again. Another question.

Many have made the claims that a partial birth abortion or a D&X abortion is just as safe as, if not safer, than a D&E abortion, or induction.

Yet, as you state, there still exists no educational materials or other clinical studies of the relative safety or medical efficacy of this procedure 10 years after Dr. Haskell's 1992 presentation.

Can you briefly describe for us what is the appropriate procedure for evaluating the safety and effectiveness of an obstetrical or gynecological medical procedure, or to ask it another way, what type of information would you and do you look for when evaluating whether to incorporate a newly developed technique or procedure into your medical practice?

Dr. NEERHOF. The appropriate way of evaluating that would be to take a group of patients who are candidates for a given procedures, or two given procedures, and to prospectively randomize in a blinded fashion, to either one of those two procedures, to have end possibilities in mind from the start that you are looking for, end points, for example, such as hemorrhage, blood loss, infection rate, uterine perforations, et cetera. From the beginning of that study, randomizing patients to either one of the two procedures,

and at the conclusion of that study, determining which of those two procedures is a safer procedure to do.

Mr. CHABOT. Thank you.

Professor Bradley, let me ask you a question. Do you believe that there is a minimal amount of evidence that must be in front of Congress before the Court will accord its legislative facts deference? Clearly, Congress can't find that the sky is red when the sky is obviously blue. So there must be some sort of reasonable basis upon which Congress can reach its conclusions.

It can't, as Mr. Heller had said, as he asserted in his written statement, we can't just find certain facts if there does not exist any evidence to support those facts. Is that correct?

Mr. BRADLEY. That is quite right. The Congress is bound to draw plausible inferences from substantial evidence. There is no question of in any sense Congress preempting or precluding the Court from finally and ultimately judging the constitutionally of this bill. We are not talking about Congress being in a position because of deference to fact finding, or displacing Supreme Court judgment.

The Court will, I suppose eventually, pass its own independent judgment upon this bill. The question is what standard of deference will the Court use when it does so? And will Congress be able to show the Court that it relied upon a substantial record.

Mr. CHABOT. Finally, let me ask you, Doctor, Brenda Pratt-Shaffer, who was a registered nurse, who had observed Dr. Haskell, the person who came up with this partial birth abortion procedure, she observed this going on at least in three different procedures.

And she testified describing a partial birth abortion that she witnessed on a baby that was 26-1/2 old as follows: "Dr. Haskell went in with forceps and grabbed the baby's leg, 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 startled reaction, like a flinch, like a baby does when he thinks he is going to fall.

The doctor opened the scissors, stuck a high-powered section 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 used. I saw the baby move in the pan. I asked another nurse, and she said it was just reflexes.

The baby boy had the most perfect angelic face I think that I have ever seen in my life", this nurse who testified that she had witnessed this particular procedure.

The procedure that I have just described, is that the procedure that we have termed partial birth abortion or D&X, that is the nature of this legislation that we are talking about today? Is that an accurate description of what we are talking about here?

Dr. NEERHOF. Yes.

Mr. CHABOT. Thank you. I will yield back the balance of my time. The gentleman from New York, Mr. Nadler, is recognized for 5 minutes.

Mr. NADLER. Thank you. Before starting my questions, I will observe that glancing out the window the sky appears gray, not blue.

Mr. Heller, in Dr. Neerhof's, I am sorry, in Professor Bradley's written testimony, he states the following: That the Nebraska law that was struck down by *Stenberg* v. *Carhart* was shoddily drafted, because it used the phrase substantial portion of a living unborn child being outside the mother.

H.R. 760 says, because the D&E procedure—the Court had said, among other things, that the law was defective because it didn't giver proper notice of what was being banned, it could be a D&E as well as a D&X, because a D&E procedure may commonly involve pulling from the birth canal a limb or extremity. The Court referred repeatedly to an arm and a leg. The one telling point, a small portion as a foot, the Nebraska court, some D&E procedures in its D&X met.

But this bill avoids entirely the asserted defects in the Nebraska law. This bill's definition of the prohibited procedure most pointedly delivery of the entire fetal head, unquote, or in the case of breech delivery, any part of the fetal trunk, overcomes the vagueness and uncertain application of the analogous Nebraska language, substantial portion of the unborn child. No abortion doctor could confuse what is prohibited by H.R. 760 in a D&E abortion.

In your opinion, does the logic of Professor Bradley here, is it persuasive? Would it be persuasive to the Supreme Court? Does it cure that defect in the Nebraska statute as found in *Stenberg*?

Mr. HELLER. It does not. Let me elaborate on that for a moment. One of the recurring themes of this debate, which has now been going on for many years, for almost 7 years, I suppose, is that new versions of so called partial birth abortion bans are proposed and modify the language previously used after courts strike that language down.

And the proponents claim, this time we have been precise. In fact, all the words that are used to describe the intact D&X procedure, whether they are the words that are used in American College of Obstetricians and Gynecologists, or the words used in the introductory section of this very bill, those words didn't occur again in the operative text.

The operative text is much broader. It talks not only about, as Dr. Neerhof said, a footling presentation, where the feet present first, but the opposite presentation.

Mr. NADLER. So in other words, the language that Professor Bradley is referring to in H.R. 760 is in the findings, but not in the operative language of the bill?

Mr. HELLER. There, in the first paragraph, I guess it is actually page 17 of the bill, there is a description of what the bill does that differs from what the actual, what the bill itself does.

Mr. NADLER. So this entire reasoning is not correct, because it doesn't refer to the proper language in the bill?

Mr. HELLER. It is not correct. Dr. Neerhof asked for an article to be put in the record that he published in the Journal of the American Medical Association. The very first page, I believe of that

article, he states, now this new 1998 version that has been proposed in Congress of a partial birth abortion bill will meet all of the objections because it is so much more precise. That is the language that the Supreme Court struck down in *Stenberg*.

Mr. NADLER. So that language was struck down in *Stenberg*. And the language that Professor Bradley cites is not the operative language of the bill?

Mr. HELLER. I believe it is not.

Mr. NADLER. Thank you. We got the gist of your answer. Dr. Neerhof. Could can you tell me whether you are aware of any medical textbook in current use in medical schools today that uses the term "partial birth abortion"?

Dr. NEERHOF. In medical schools? No.

Mr. NADLER. Secondly, Dr. Neerhof, you stated that you oppose intact D&X. But, of course, this bill doesn't talk about intact D&X. I have to conclude that you don't support the legislation as drafted, because it doesn't talk about intact D&X. It brings us back to the question of why not say in the bill what you said?

You also refer to late term abortions on viable fetuses. This bill doesn't make, of course, any references to gestational age.

Dr. NEERHOF. It does, indirectly.

Mr. NADLER. Why not do it directly?

Dr. NEERHOF. There is a gestational age category at which this procedure is done. So indirectly it does.

Mr. NADLER. Okay. Dr. Heller, would you comment on this?

Mr. HELLER. The question is, what procedure are we talking about? Are we talking about the one that Dr. Neerhof described, or that he answered from the Chairman, or are we talking about some other procedure?

Mr. NADLER. He says it indirectly refers to it.

Mr. HELLER. It doesn't refer to it at all. If a statute is to refer to post viability, it can use those words. In fact, 41 States do it. And there is no reason Congress couldn't.

Mr. CHABOT. The gentleman's time has expired. Mr. King is recognized for 5 minutes.

Mr. KING. Thank you, Mr. Chairman.

I will direct my initial question to Mr. Bradley. And, Mr. Bradley, Dr. Neerhof testified that at this juncture, the fetus is merely inches from being delivered and obtaining the full legal rights of personhood under the Constitution.

Can you give us a definition of, at that moment, when these full legal rights of personhood are achieved? How is that defined in law? Can you tell us?

Mr. BRADLEY. Well, by the best definition of when a person—a child acquires that kind of legal personality, is probably the definition that you would find in the Born Alive Infants Protection Act, passed in the last couple of years, I know I testified in the last couple of years in favor of that bill, where you find a quite precise and involved definition of that moment at which the—the child is emerged from the woman and has acquired, you might say, autonomy, or independence sufficient to be recognized as a person in his or her own rights.

So I think that bill probably has the best definition you will find.

Mr. KING. Is there constitutional protection as well, statutory?

Mr. BRADLEY. Well, at that point sure, because the Constitution protects all persons born in the United States. They are entitled at that point to the equal protection of the laws, including the laws against homicide, assault, et cetera.

Mr. KING. And the statement was made earlier at the opening of these proceedings that 41 States already ban post viability abortions. Can you advise this Committee as to whether, in fact, there are any bans on abortion in place anywhere in America today; if so, under what circumstances?

Mr. BRADLEY. Well, I don't think any State bans all abortions, even post viability. Even post viability, the Supreme Court cases made clear you have to have a life of the mother and health of the mother exception.

Mr. NADLER. Is that in this bill, this exception?

Mr. BRADLEY. Certainly no health exception.

Mr. KING. However, are there any circumstances in fact where if a doctor determined that it affected the health of the mother, that at any stage of gestation, an abortion would be illegal or banned?

Mr. BRADLEY. If I understand the question, is there a case where a woman's health is in danger where a doctor is not under our law permitted to perform an abortion? I think the answer is no. And, of course, this outlaws a particular type of abortion, but it doesn't try to outlaw all abortions at a particular stage of pregnancy or when the mother's health is threatened in a particular way.

Mr. KING. And if, in fact, there were an amendment to go on this bill that would allow an exception of the health of the mother, would there be any circumstances at that point where this ban on partial-birth abortion would be in effect, or could the physician at that point determine then that any and all effect on the health of the mother was a justifiable reason to proceed?

Mr. BRADLEY. I myself have no medical competence obviously, but I understand the logic of the draftsmanship here, and that is the fear, which I think to be reasonable and well grounded, that if there is a health exception engrafted or put into this bill, then the prohibition itself would be become toothless and ineffective in light of the fact, if it is the fact, that there are no cases of genuine health necessity or medical necessity. It would seem to me that a health exception would be mischievous.

Mr. KING. And to me. Under what circumstances—I will say would the courts be bound by congressional findings, and what is your anticipation of that should this go before the Supreme Court?

Mr. BRADLEY. I don't think the Court is ever bound, strictly speaking, to a congressional fact-finding. It is a matter of greater or lesser deference. I mentioned this in passing in response to an earlier question. It is not possible for Congress to preclude the Court from looking into the fact of the matter, but given what the Court has said in prior occasions and stressed, frankly, on prior occasions, that Congress is a superior fact-finder and as a general matter the Court defers to congressional findings, so what that cashes out as in simple terms, to say that the Court defers to congressional fact-finding is to say that the Court presumes that when Congress say something is so, then it is so. That is the Court's presumption.

Mr. KING. Thank you, Mr. Bradley.

And, Dr. Neerhof, can you describe what happens when a baby is accidentally born? What would you anticipate takes place if an abortion procedure is attempted and the baby is accidentally born?

Dr. NEERHOF. I don't know, and I kind of shudder to think of it. And you know the truth of the matter is when I said in my testimony when the head is out of the cervix, there is nothing really holding that head in outside of an obstetrician. So, in effect, I would say that actually happens commonly with the intact D&X.

Mr. CHABOT. The gentleman's time has expired.

Mr. KING. Could I ask for an extra 30 seconds?

Mr. CHABOT. I ask unanimous consent that the gentleman be granted an additional 30 seconds.

Mr. KING. At that point could that baby scream for its own mercy?

Dr. NEERHOF. I am sure it could.

Mr. CHABOT. The gentleman's time has expired.

The gentleman from Virginia Mr. Scott is recognized for 5 minutes.

Mr. SCOTT. Are you familiar with the American College of Obstetricians and Gynecologists?

Dr. NEERHOF. Yes.

Mr. SCOTT. Is that a respected organization in the medical community?

Dr. NEERHOF. Yes.

Mr. SCOTT. Mr. Heller, does the Colorado *Stenberg* case require a health exception for any abortion ban?

Mr. HELLER. Yes, it does.

Mr. SCOTT. Does this bill include one?

Mr. HELLER. No, it does not.

Mr. SCOTT. Did the *Stenberg* case outline what a health exception looked like?

Mr. HELLER. It didn't have to outline it because it said it must be an exception for the woman's health and didn't specify further than that.

Mr. SCOTT. Did it say, "Necessary and appropriate medical judgment for the preservation of the life of the mother," five times both in italics and in quotation marks?

Mr. HELLER. I believe so, and that also reiterates holdings of the Supreme Court that go back as far as 1973.

Mr. SCOTT. Did you find those words in the bill?

Mr. HELLER. No. They are not in the bill.

Mr. SCOTT. Professor, did you want to say anything?

Mr. BRADLEY. No.

Mr. SCOTT. I yield back.

Mr. CHABOT. Gentleman's time has expired.

The gentleman from Indiana Mr. Hostettler is recognized for 5 minutes.

Mr. HOSTETTLER. Mr. Chairman, I wasn't here for any of your opening statements or that of the panel of the Subcommittee, but I will say for the record that there is ample evidence and history that Congress has repeatedly thumbed its nose at the United States Supreme Court. Dr. Louis Fisher of the Congressional Research Service has done an excellent paper on judicial checks on

the judiciary and also notes points in there where the executive branch likewise has disregarded the findings of the Supreme Court with regards to *Beck* v. *Communication Workers of America* and the previous Administration's executive order to lift the ban of union employees in the Federal Government from having to give union dues for political purposes. So for the record, this is not unusual what we are doing here today.

I will ask Dr. Neerhof, are you familiar with the reference book Williams Obstetrics?

Dr. NEERHOF. Yes, I am.

Mr. HOSTETTLER. I am quoting from the 20th edition, so I apologize if that is outdated. I don't know if that is the latest edition or not, but in the 20th edition, which I believe is the latest, it says, and I quote, under definition, it says, "Abortion is the termination of pregnancy by any means before the fetus is sufficiently developed to survive. In the United States, this definition is confined to the termination of pregnancy before 20 weeks based upon the day of the first day of the last normal menses." .

Now, if abortion is strictly limited in medical terms to that process by any means of terminating pregnancy before 20 weeks, what is the term for termination of pregnancy after 20 weeks?

Dr. NEERHOF. It is termination of pregnancy. You are talking about terminology as per a textbook as opposed to how it is used clinically. That prior-to-20-week cut-off just refers to how obstetricians talk about a given patient's obstetrical history; i.e., whether they delivered before 20 or after 20 weeks in any given prior pregnancy. Termination of pregnancy certainly frequently occurs before 20 weeks, but in essence, a very similar thing happens subsequent to 20 weeks. It is still termination of pregnancy.

Mr. HOSTETTLER. What if it is other means, by a spontaneous abortion?

Dr. NEERHOF. How is it termed?

Mr. HOSTETTLER. Yes.

Dr. NEERHOF. It is a good question. I guess preterm delivery.

Mr. HOSTETTLER. So a live birth and abortion—and a termination of pregnancy are both preterm births?

Dr. NEERHOF. They would be described as so because from an obstetrician's viewpoint, it is of clinical significance how far in the pregnancy that patient got. So, yes, it would be described as a preterm delivery, but not as a surviving preterm delivery.

Mr. HOSTETTLER. Not a surviving preterm delivery.

Dr. NEERHOF. Correct.

Mr. HOSTETTLER. I thank the gentleman very much.

Yield back the balance of my time.

Mr. CHABOT. Thank the gentleman for yielding back, and gentlelady from Pennsylvania is recognized for 5 minutes.

Ms. HART. I want to thank you for bringing this bill up shortly in good order since the Senate has already considered it. Professor Bradley, we have had quite a bit discussion about the findings and how the difference between the bill last session and this session is basically the findings of fact.

Mr. BRADLEY. As well as a description of the prohibited act. I think it is less vague than it has been.

Ms. HART. Right. Thank you for that.

I am interested in the reviewability or appropriateness of the review by the Court of the findings. In *Carhart*, they didn't spend much time on doing their own independent research from what we can tell. What we understand is that our review of what they did in our attempts to make sure that when we dealt with the issue this time, it would be more clear, an expansion of the findings and, as you said, the change in the description of the procedure. I am interested in what you see is the appropriateness of Congress reviewing our own work in that way as to whether that should make a difference when the Court has a chance to review it again.

Mr. BRADLEY. I am not sure if I understand the question, but I think I do. The question is the duty of Congress or the responsibility of Congress to take its own best shot at the truth of the matter?

Ms. HART. Right. It is our—legislators do this all the time. They look at what the Court does in regard to a law, and they go back and redraft it. And perhaps the Court will review it again; perhaps they won't. I mean, do you see anything wrong with that is what I am asking?

Mr. BRADLEY. I don't think there is anything wrong with it. As I read *Stenberg* v. *Carhart*, it is too strong to say that the Court is asking for help from Congress, but certainly that account is consistent with what the *Carhart* Court says. It is uncertain.

The Supreme Court does not in *Carhart* take a critical and independent attitude toward the evidence. It looks at the record and sees that there is evidence, substantial authority saying that there could be a danger to a woman's health, but the Court does not critically evaluate that, as Congress can and perhaps should; I mean, any number of situations in which one could identify credible authority holding a position which turns out to be false. And I think what Congress is thinking of doing in this situation is taking a look at the matter afresh, recognizing as the *Carhart* Court did that says there are authorities that say it is a medical necessity, but I take Congress in H.R. 760 is saying they are mistaken, their studies are not reliable, and that the truth is there aren't any cases of medical necessity. Not only do I think there is nothing is wrong with that, I think it is probably Congress's duty.

Ms. HART. From what we know in past cases that Congress has gone back and changed things that were further upheld, it has often been because of a change in societal attitude, for example, a change in this case. And a lot of this case is the change in the perception and the science around the medical necessity. And I think actually—tell me if you think I am wrong, but we actually have a stronger case than some other cases that the Court held one way and the Congress decided to do something different.

Mr. BRADLEY. I think that is true. The Supreme Court in *Carhart* is looking at a record that is limited and therefore incomplete. It expresses uncertainty on its own part as to what the truth of the matter is. But it does say there have been no studies of the overall safety of the D&X procedure. There is a great deal of textural evidence and opinion that the Court simply doesn't know, and I think that is unusual compared to other situations in which Congress has revisited a matter after a contrary Court holding. This is a case where the Court is really saying, we are not speaking in

our own voice to the truth of the matter. We don't know what the truth of the matter is, and that, I think, invites at least congressional legislation on the subject.

Ms. HART. Thank you. I think the vagueness of the concern for the, "health of the mother" is so kind of ridiculous, because any pregnancy actually can place a mother's health in danger.

So I yield back. Thank you, Mr. Chairman.

Mr. CHABOT. Thank you.

The gentleman from Florida, Mr. Feeney, is recognized for 5 minutes.

Mr. FEENEY. Thank you, Mr. Chairman.

Professor Bradley, if I could elicit some brief responses from you, because I would like to get on to Mr. Heller, and I want to take you back to con. law 101, since you have some background there. Is it a fair reading of President Johnson's position when he vetoed the second Federal banning bill on the grounds that he felt it was unconstitutional that he didn't particularly care what the U.S. Supreme Court had found in the first banning case?

Mr. BRADLEY. President Jackson, I take it?

Mr. FEENEY. Yes.

Mr. BRADLEY. I think it is fair to say.

Mr. FEENEY. When he debated Douglas, Lincoln made it clear that while he had the respect, in his opinion, of the Constitution, the decision the U.S. Supreme Court as it applied to Dred Scott, that it certainly didn't affect his thinking as to the certain liberties and rights of other African Americans in the country.

Mr. BRADLEY. I think that is correct. Lincoln's view that he had to respect Dred Scott—the decision—which meant he couldn't interfere with the execution of the judgment in that case, but Lincoln did not feel bound by the Supreme Court's interpretation of the Constitution and felt himself free to act with regard to other people, other situations, while not interfering with the execution of the judgment in the case itself.

Mr. FEENEY. Thank you. In light of that, Mr. Heller, I mean, if it has been the position of several Presidents of the United States that they have at least—and I don't want to get into a debate of *Marbury* or judicial supremacy here, although that would be fascinating, but in light of the responsibility that executives have found with respect to the importance of interpreting the United States Constitution and what it means at an equal level, perhaps as the U.S. Supreme Court, and in light of *Katzenbach*, it seems rather strange to me that the major premise of your argument, and you were intimately involved in the case, is that based on a very limited and specific set of facts, based on a very specific piece of legislation that was drafted—by the way, the only unicameral legislation in the country—and based on very specific findings by one appointed and not elected appellate court, and based on the limitations on the U.S. Supreme Court in the case that you participated in, that they are bound by the specific facts which may never be duplicated, the specific piece of legislation which isn't the same as any other in the 49 continental States, as far as I know, and the specific findings of one judge; that because they are bound by the only factual findings in front of them, that it is your position that for all times, all purposes, and all factual cases and all pieces of

legislation, that the U.S. Supreme Court's findings in that one limited case would override the fact that the United States Congress now has had the benefit of—I don't want to say benefit, actually to our detriment. We have lived through the experience of hundreds of partial-birth abortion cases. We have been advised by the American Medical Association on the question of medical necessity. We have been advised by the American College of Obstetrics and Gynecology and all sorts of fact-finding that the elected representatives of the entire populace of the United States are limited, and that our findings of fact should be—it seems to me, based on your testimony, that we are thumbing our nose, having done all this research, and that those specific facts of one case and specific pieces of legislation, and one judge ought to override the empirical evidence that we have delved into? Is that fair to describe your position?

Mr. HELLER. Not exactly. First of all, it wasn't one Federal judge in Nebraska hearing facts and conclusions about one law. There was a Federal judge in Virginia that reached the same conclusion. There was a Federal judge in West Virginia that reached the same conclusion. There was a Federal judge in Iowa that reached the same conclusion. There was a Federal judge in Illinois that reached the same conclusion. There was a Federal judge in Arizona that reached the same conclusion. There was a Federal judge in Louisiana that reached the same conclusion. There was a Federal judge in Rhode Island that reached the same conclusion. There was a Federal judge in New Jersey that reached the same conclusion. There was a Federal judge in Ohio that reached the same conclusion. There was a Federal judge in Kentucky that reached the same conclusion. There was a Federal judge in Arkansas that reached the same conclusion. There were Federal appeals court judges in the third circuit, Fourth Circuit, Fifth Circuit, Sixth Circuit, Seventh Circuit, in the Eighth Circuit, the Eleventh Circuit and the First Circuit that all reached the same conclusion based on evidence from numerous witnesses on both sides of the issue subject to cross examination that far exceeds the evidence that Congress has heard.

And let me add these States were represented by zealous advocates. They got the best witnesses they could find. The one judge who reached the opposite conclusion, reached the conclusion that is harmonious with findings in this bill, had his findings vacated by the Supreme Court of the United States. Given that, I think it is unfair to describe the Nebraska judge as the one judge viewing the unicameral law, et cetera, et cetera. This was judges across the United States at the trial court level, at the appeals court level. State judges as well in Alaska who were called upon to review Alaska's law struck it down as well because it lacked the health exception, and it was too broad. This is consensus around the legal community with the exception of one judge who was ultimately overturned by the Supreme Court.

There is far, far broader evidence that a health exception is required and that this type of statute, this one which doesn't match the language used to describe the very specific procedure, is too broad, is not written with precision. So in that sense, I disagree with your characterization.

Mr. CHABOT. By unanimous consent, the gentleman from Florida is recognized for an additional 30 seconds in order to respond.

Mr. FEENEY. Thank you, and I do appreciate your position that there are apparently a dozen cases or so where specific facts and specific pieces of interpretation have been interpreted by judges, but is it then your opinion—and perhaps maybe Professor Bradley could respond and give his—that the best place to do findings of facts about the empirical facts that affects some 280 million Americans is anecdotally and case by case a situation of what is and is not a life and what is or what isn't medically necessary, or is it appropriate for the United States Congress, the elected representatives of the people, of an issue of this high import to make the ultimate decisions? Because I think, Professor Bradley, because what the U.S. Supreme Court has done is to say that in the absence of the finding by the people who are empirical judges on a generalist proposition, we have no choice but to take specific cases.

Mr. HELLER. Actually that is not—what the Supreme Court said, in the absence of a medical consensus, not a consensus by politicians or legislators. In the absence of a medical consensus about specific procedures being safe or unsafe, this decision about how an abortion must be performed must be left to the woman and her physician. This bill intrudes into that relationship in a manner I think unprecedented in American history by telling a physician how to do surgery, by putting the woman in a position of having to sacrifice her health for the agenda of a political movement.

All that being said, I think that ultimately the Supreme Court did not say we are going to listen to what Congress says and then just do that. That is contrary to the nature of judicial review, which you said we could debate. But if judicial review is part of our democracy, and it is accepted as such——

Mr. CHABOT. The gentleman's question was also directed at Professor Bradley.

Mr. BRADLEY. I don't disagree about judicial review, although we might disagree about its precise contours and how it works. It is consistent with the warm devotion to judicial review to think that Congress is a superior fact-finder. And it would seem to me the Supreme Court is second to none at being a fan to judicial review, but yet the Supreme Court persistently recurringly says for a variety of reasons that Congress is in general the superior fact-finder.

Now, Mr. Feeney's question, going back to the original question, it is true that despite the fact that other courts have opined upon the matter, which was at the heart of *Stenberg* v. *Carhart*, the thrust of his question, I think, is sound, and that is the Supreme Court, which is the decision we are talking about, was basically hemmed in in its position; not determined, but strongly influenced by the decision of one Federal district court judge. That is the individual who helped compile the record and made the initial determination as to what the record amounted to. And the Supreme Court, as an appellate court, is bound by rules of intrasystemic deference, judicial deference to the fact-finding below.

So I do think that when you turn to Congress, you are free of these types of systemic constraints, and with the passage of 5, 6 years or 7 years, or whatever it has been since that record was put together, it seems to me that *Carhart* is not a stop sign or red light

to Congress. And I would just challenge Mr. Heller to show where the *Carhart* Court says the matter is settled.

Here is the fact of the matter, and I don't remember the *Carhart* Court saying or using the phrase "in the absence of a medical consensus that there is no case of medical necessity." I don't think the Court referred to the presence or absence of a medical consensus at all. The Court did say there is substantial authority in favor of the view that there could be a health necessity. The Court did not say those authorities were correct, and the Court itself did not say that it is true that there are cases of medical necessity.

Mr. CHABOT. The gentleman's time has expired.

The gentleman from Virginia Mr. Forbes is recognized for 5 minutes.

Mr. FORBES. Thank you, Mr. Chairman, and I want to thank the gentlemen for being here, many of you again with us. I respect the fact that reasonable people can disagree over this issue, and we certainly have opposing views.

One of the concerns I have always had has been with the pain in this procedure to the unborn fetus or the unborn child. One of the things I can't respect is, Dr. Neerhof, when you are testifying, I look out in the audience and see five or six people smiling when you are talking about that pain. And even though you can disagree on issues, that I can't respect. That I find absolutely appalling.

I want to ask you a few questions relative to the pain, and I want to tell you as I ask those, if you need to expound on them more, please feel free to put whatever you need to in the record. But I have only a few minutes to ask you the questions, so I ask that you keep them as brief as you can.

Mr. Heller, you were with us several months ago, and we appreciated you coming back. At that time you were not a licensed physician, and I take it nothing has changed in between that time?

Mr. HELLER. Not that fast, no.

Mr. FORBES. You don't have any privileges to practice medicine in any hospital?

Mr. HELLER. No.

Mr. FORBES. And you never had the right to prescribe pain killers or pain management to any patient, nor have you done that, I take it?

Mr. HELLER. No, I haven't.

Mr. FORBES. Switching to your constitutional expertise, because recognized from the medical point of view you are not trained in that area, is there any threshold of pain to an unborn child that, if established, would be so great or so horrible that it would outweigh the convenience of a partial-birth abortion no matter how trivial or small that convenience might be found to be?

Mr. HELLER. I am not sure what you mean by convenience, but I will say this. First of all, the Supreme Court has, as far as I am aware, never directly addressed the issue of fetal pain. That being said, I think prior to viability, there is no State interest, whether it be in pain or anything else, that can override the woman's interest in her own life and health and that persists even postviability under the Supreme Court.

Mr. FORBES. So your answer, and again just trying to be clear, is there would be no threshold pain.

Mr. HELLER. No. What I said was that the woman's life and health predominate over any countervailing State interest. Convenience, which is the word used—I don't even know what that means.

Mr. FORBES. The health question that you talk about, you would suggest to us today that no matter how great the pain to the unborn fetus was determined to be ultimately by a fact-finder, there would be no threshold of pain so great as to override the health concern that you would have for the mother. That would be your understanding.

Mr. HELLER. Not the health concern that I would have for the mother, but the health concern that the United States Supreme Court has for the mother—that our Constitution has for the mother.

Mr. FORBES. Let me ask you personally, is there any threshold of pain to an unborn child that if it was established that would be so great or so horrible that you think would justify—and your word earlier was doing the honorable thing—that the honorable thing for this Committee would be to try to ban partial-birth abortion?

Mr. HELLER. I think if this Committee wants to ban previability abortions for any reason without exceptions for a woman's health, it should do so by constitutional amendment.

Mr. FORBES. Could we legally require that a neurosurgeon or a neurologist be present at a partial-birth abortion?

Mr. HELLER. I am not aware of any precedent that would support that. I do know that the Supreme Court has said that the—it is sufficient for the abortion procedure that the doctor performing the abortion is present, and additional physicians are not—cannot be required prior to viability. But the precise issue of a neurosurgeon has never been tested, nor do we know.

Mr. FORBES. Dr. Neerhof, I am out of time almost, but you wrote in 1998, I believe, that there is no pain management currently given for the unborn fetus. Has anything changed in that, or is there currently?

Dr. NEERHOF. Not to my knowledge.

Mr. FORBES. You indicated that the pain standards for the human fetus in a partial-birth abortion would be less than those we require for humane care of animals used in medical research. Is that still accurate?

Dr. NEERHOF. That is correct.

Mr. FORBES. The other thing I would ask you, if it is not true that the pain suffered by an unborn fetus is actually greater than pain suffered for a similar procedure for a child that has been more fully developed than perhaps born?

Dr. NEERHOF. I am sorry. I didn't understand what you asked.

Mr. FORBES. I am out of time, and I will try to submit that in writing.

Mr. CHABOT. I will give the gentleman an additional 30 seconds.

Mr. FORBES. Some studies have indicated that actually the pain felt by an unborn fetus in a partial-birth abortion, because of the development stages of their brain, could actually be greater than a similar pain felt by a more fully developed brain in an older child or adult for the same procedure. Do you have any information to substantiate that?

Dr. NEERHOF. I do not.

Mr. CHABOT. The gentleman's time has expired.

If there are no further questions, I want to thank the panel for their testimony here this afternoon, and it has been helpful to this Committee, and at this point you are free to go.

Mr. NADLER. Mr. Chairman, may I be recognized for a unanimous consent request? Mr. Chairman, because the Minority is restricted to only one witness per hearing, we are unable to provide both legal and medical testimony. Our witness was a legal expert. I want to ensure that Congress does not consider this legislation without access to the medical facts, so I ask unanimous consent that the testimony that I have here from the Planned Parenthood Federation of America, from Felicia Stewart, M.D., from the American Medical Women's Association, from the Physicians Reproductive Choice and Health, from Anne Davis, M.D., from the American College of Obstetricians and Gynecologists, and from the University of California at San Francisco Center for Reproductive Health, Research and Policy, and from the American Association of University Women be admitted into the record.

Mr. CHABOT. Without objection.

[The information referred to follows in the Appendix]

Mr. CHABOT. I would also ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material. So ordered.

[The information referred to follows:]

Mr. CHABOT. I want to thank the panel for being here this afternoon.

[Whereupon, at 3:35 p.m., the Subcommittee proceeded to other business.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

PREPARED STATEMENT OF THE HONORABLE STEVE CHABOT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

We have convened this afternoon to receive testimony on H.R. 760, the "Partial-Birth Abortion Ban Act of 2003."

On February 13, on behalf of over 100 original co-sponsors, I introduced H.R. 760, the "Partial-Birth Abortion Ban Act of 2003" 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 dead infant. An abortionist who violates this ban would be subject to fines or a maximum of two years imprisonment, or both. H.R. 760 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. On March 13, 2003, the Senate approved S. 3, which is virtually identical to H.R. 760, by a 64 to 33 vote.

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 those who proclaim the medical necessity of this barbaric procedure, partial-birth abortion is, in fact, a dangerous medical procedure that can pose serious risks to the long-term health of women. As testimony received by the Subcommittee on during the 107th Congress demonstrates, there is never any situation in which the procedure H.R. 760 would ban is medically necessary. In fact, ten years after Dr. Martin Haskell presented this procedure to the mainstream abortion community, partial-birth abortions have failed to become the standard of medical practice for any circumstance under which a woman might seek an abortion.

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. 760 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 the prohibited procedure might be interpreted to encompass a more commonly performed late second trimester abortion procedure. As previous testimony indicates, H.R. 760 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 Court 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 regarding the safety and medical necessity of the partial-birth abortion procedure—including evidence received during extensive legislative hearings during the 104th, 105th, and 107th Congresses—which indicates that a partial-birth abortion is never medically necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care.

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 consistently relies upon and 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. 760 contains Congress's 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.

H.R. 760's findings are not "false" as its opponents have charged. They are based upon the very opinions of doctors, medical associations, and a review of the practices of the medical profession as whole. Thus they are "legislative facts" drawn from reasonable inferences based upon substantial evidence. The fact that the abortion lobby disagrees with these inferences only demonstrates how out of step they are with public opinion and the mainstream medical community.

Despite overwhelming support from the public, past efforts to ban partial-birth abortion were blocked by President Clinton. We now have a President who has promised to stand with Congress in its efforts to ban this barbaric and dangerous procedure. It is time for Congress to end the national tragedy of partial-birth abortion and protect the lives of these helpless, defenseless, little babies.

PREPARED STATEMENT OF THE HONORABLE JERROLD NADLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Thank you, Mr. Chairman. Today we have a very bad combination: Members of Congress who want to play doctor, and Members of Congress who want to play Supreme Court. When you put the two together, you have a prescription for some very bad medicine for women in this country.

We have been through this debate often enough to know that you will not find the term "partial birth abortion" in any medical text book. There are procedures that you will find in medical text books, but apparently, the authors of this legislation would prefer to use the language of propaganda rather than of science.

This bill, as written, fails every test the Supreme Court has laid down for what may or may not be a constitutional regulation on abortion. It reads almost as if the authors went through the Supreme Court's recent decision in *Stenberg* v. *Carhart* and went out of their way to thumb their noses at the Supreme Court, and especially at Justice O'Connor who is generally viewed as the swing vote on such matters, and who wrote a concurring opinion stating specifically what would be needed for her to uphold a statute. Unless the authors think that when the Court has made repeated and clear statements over the years of what the Constitution requires in this area they were just pulling our leg, this bill has to be considered facially unconstitutional.

First and foremost, it does health exception which the Court has repeatedly said is necessary even with respect to post-viability abortions. The exception for a woman's life is more narrowly drawn than is required by the Constitution, and will place doctors in the position of trying to guess just how grave a danger a pregnancy must pose to a woman before they can be confident that protecting her will not result in jail time.

I know that some of my colleagues do not like the constitutional rule that has been in place and reaffirmed by the court for thirty years, but that is the law supreme law of the land, and no amount of rhetoric, even if written into a piece of legislation, will change that. Even the Ashcroft Justice Department, in its brief defending an Ohio statute, has acknowledged that a health exception is required by law. While I may disagree with the Department's views on whether the Ohio statute adequately protects women's health, there is at least an acknowledgment that the law requires that protection.

This bill is mostly findings. If there is one thing this activist court has made clear, it is that it is not very deferential to Congress' determinations of fact. While Congress is entitled to declare anything it wants, the courts are not duty bound to accept everything we say at face value simply because it appears in a footnote in the United States Code.

While I realize that many of the proponents of this bill view all abortion as tantamount to infanticide, that is not a mainstream view. This bill attempts to foist a marginal view on the general public by characterizing this bill as having to do only with abortions involving healthy, full term fetuses. If the proponents of this bill

really want to deal with post-viability abortions, in situations in which a woman's life and health are not in jeopardy, then let them write a bill dealing with that issue, although such a bill would be of marginal utility, since 41 states already ban post-viability abortions. Very few people would oppose such a bill.

As one of the lead sponsors of the Religious Freedom Restoration Act, I know what comes of Congress ignoring the will of the Supreme Court. Whatever power Congress had under section 5 of the 14th Amendment as a result of *Katzenbach* v. *Morgan*, which is copiously cited in the bill's findings, I think the more recent Boerne decision vastly undercut those powers. Even if *Katzenbach* were still fully in force, as I wish it were, that case only empowered Congress to expand, not curtail rights under the 14th Amendment. This bill, of course, aims to do the exact opposite.

I doubt the Majority is interested in a bill that could pass into law and actually be upheld as constitutional. What they want is an inflammatory piece of rhetoric which, even if passed, would most certainly be struck down by the Supreme Court. The real purpose of this bill is not, as we have been told, to "save babies," but to save elections.

We now have a President who has expressed a willingness to sign this bill. He may in fact get his chance. Unfortunately, there are dire consequences for American women if this legislation passes. Perhaps, here in the halls of Congress, the health of women takes a back seat to the most extreme views of the anti-choice movement. Fortunately, the Constitution still serves as a bulwark against such efforts.

Thank you, Mr. Chairman.

Controversies

Rationale for Banning Abortions Late in Pregnancy

M. LeRoy Sprang, MD; Mark G. Neerhof, DO

THE ABORTION ISSUE remains in the public eye and the media headlines largely because of a single late-term abortion procedure referred to in the medical literature as intact dilation and extraction (D&X) and in the common vernacular as partial-birth abortion. This article reviews the medical and ethical aspects of this procedure and of late-term abortions in general.

Partial-Birth Abortion (Intact D&X)

Intact D&X came to the forefront of public awareness in 1995 during a congressional debate on a bill banning the procedure. During this debate, opponents of the ban asserted that the procedure was rarely performed (approximately 450-500 per year) and only used in extreme cases when a woman's life was at risk or the fetus had a condition incompatible with life.[1,2] Following President Clinton's April 1996 veto of a congressionally approved ban, conflicting information surfaced. Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, had stated in November 1995 that "women had these abortions only in the most extreme circumstances of life endangerment or fetal anomaly."[3] However, he later admitted that his own contacts with many of the physicians performing intact D&X procedures found that the vast majority were done not in response to extreme medical conditions but on healthy mothers and healthy fetuses.[3]

See also pp 724, 740, and 747.

In newspaper interviews, physicians who use the technique acknowledged performing thousands of such procedures a year. One facility reported that physicians used intact D&X on at least half of the estimated 3000 abortions they perform each year on fetuses between 20 and 24 weeks' gestation.[3] In another report, Dayton, Ohio, physician Martin Haskell, MD, who had performed more than 700 partial-birth abortions, stated that most of his abortions are elective in that 20- to 24-week range and that "probably 20% are for genetic reasons, and the other 80% are purely elective."[4] The late James T. McMahon, MD, of Los Angeles, Calif, detailed for the US Congress his experience with more than 2000 partial-birth abortion procedures. He classified only 9% of that total as involving maternal health indications (of which the most common was depression), and 56% were for "fetal flaws" that included many nonlethal disorders, some as minor as a cleft lip.[5]

These accounts indicate that the estimates of performing intact D&X have been grossly understated. The absence of accurate data is at least partly due to the erratic nature of the data collection process. The Centers for Disease Control and Prevention (CDC), Atlanta, Ga, collects annual abortion data, but these data are incomplete for several reasons. First, all states do not provide abortion-related information to the CDC. Second, data gathered vary widely from state to state, with some states lacking information on as many as 40% to 50% of abortions performed within their jurisdictions. Third, the categories CDC uses to report the method of abortion do not differentiate between dilation and evacuation (D&E) and intact D&X.[6-8]

Conflicting information about intact D&X and its frequency catalyzed prominent medical organizations to evaluate the procedure. In 1996, the American College of Obstetricians and Gynecologists (ACOG) convened a special committee to review it. According to the ACOG panel, intact D&X has been defined to consist of 4 elements[9]: (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 intercranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

An ACOG policy statement emanating from the review declared that the select panel "could identify no circumstances under which this procedure . . . would be the only option to save the life or preserve the health of the woman" and that "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."[9] However, no specific examples of circumstances under which intact D&X would be the most appropriate procedure were given.

Maternal Considerations.—There exist no credible studies on intact D&X that evaluate or attest to its safety. The procedure is not recognized in medical textbooks nor is it taught in medical schools or in obstetrics and gynecology residencies. Intact D&X poses serious medical risks to the mother. Patients who undergo an intact D&X are at risk for the potential complications associated with any surgical midtrimester termination, including hemorrhage, infection, and uterine perforation. However, intact D&X places these patients at increased risk of 2 additional complications. 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."[10]

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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 cervix by the scissors and could result in severe bleeding and the threat of shock or even maternal death. These risks have not been adequately quantified.

None of these risks are medically necessary because other procedures are available to physicians who deem it necessary to perform an abortion late in pregnancy. As ACOG policy states clearly, intact D&X is never the only procedure available. Some clinicians have considered intact D&X necessary when hydrocephalus is present. However, a hydrocephalic fetus could be aborted by first draining the excess fluid from the fetal skull through ultrasound-guided cephalocentesis. Some physicians who perform abortions have been concerned that a ban on late abortions would affect their ability to provide other abortion services. Because of the proposed changes in federal legislation, it is clear that only intact D&X would be banned.

Fetal Considerations.—The centers necessary for pain perception develop early in the second trimester.[11] Although fetal pain cannot be measured, acute stress in the fetus is indexed by blood flow redistribution to the brain, as shown by Doppler studies of human fetuses of at least 18 weeks' gestation undergoing invasive procedures that involve penetration of the fetal trunk.[12] Fetal hormonal stress response to needling of the intra-abdominal portion of the umbilical vein can be measured from as early as 23 weeks' gestation.[11]

The majority of intact D&X procedures are performed on periviable fetuses. When infants of similar gestational ages are delivered, pain management is an important part of the care rendered to them in the intensive care nursery. However, with intact D&X, pain management is not provided for the fetus, who is literally within inches of being delivered. Forcibly incising the cranium with a scissors and then suctioning out the intracranial contents is certainly excrutiatingly painful. It is beyond ironic that the pain management practiced for an intact D&X on a human fetus would not meet federal standards for the humane care of animals used in medical research.[13] The needlessly inhumane treatment of periviable fetuses argues against intact D&X as a means of pregnancy termination.

Ethical Considerations.—Intact D&X is most commonly performed between 20 and 24 weeks and thereby raises questions of the potential viability of the fetus. Information from 1988 through 1991 indicates a 15% viability rate at 23 weeks' gestation, 56% at 24 weeks, and 79% at 25 weeks.[14] Recent data from our institution indicate an 83% survival rate at 24 weeks and an 89% survival rate at 25 weeks (Evanston Northwestern Healthcare, unpublished data, 1998).

Beyond the argument of potential viability, many prochoice organizations and individuals assert that a woman should maintain control over that which is part of her own body (ie, the autonomy argument). In this context, the physical position of the fetus with respect to the mother's body becomes relevant. However, once the fetus is outside the woman's body, the autonomy argument is invalid. The intact D&X procedure involves literally delivering the fetus so that only the head remains within the cervix. At this juncture, the fetus is merely inches from being delivered and obtaining full legal rights of personhood under the US Constitution. What happens when, as must occasionally occur during the performance of an intact D&X, the fetal head inadvertently slips out of the mother and a live infant is fully delivered? For this reason, many otherwise prochoice individuals have found intact D&X too close to infanticide to ethically justify its continued use.

States With Bans on Intact Dilation and Extraction*

Partial-birth abortion bans in effect		
Indiana	South Carolina	Tennessee
Mississippi	South Dakota	Utah
Oklahoma		
Court-enjoined partial-birth abortion bans		
Alaska	Illinois	New Jersey
Arizona	Iowa	Ohio (slightly different law)
Arkansas	Louisiana	Rhode Island
Florida	Michigan	West Virginia
Idaho	Montana	Wisconsin
Enforcement limited by courts		
Georgia		
Nebraska		
Enforcement limited by order of state's attorney general		
Alabama		
Injunction overturned		
Virginia		
Bans enacted but not in effect		
Kansas		
Kentucky		

*Data are from the Center for Reproductive Law and Policy, New York, NY. Because of ongoing legislation and litigation, the status of these state laws changes frequently. This information reflects status as of August 1, 1998.

Professional, Legislative, and Public Concerns.—An extraordinary medical consensus has emerged that intact D&X is neither necessary nor the safest method for late-term abortion. In addition to American Medical Association (AMA) and ACOG policy statements, Warren Hern, MD, author of *Abortion Practice* has questioned the efficacy of intact D&X. "I have very serious reservations about this procedure. . . . You really can't defend it. . . . I would dispute any statement that this is the safest procedure to use." Hern states that turning the fetus to a breech position is "potentially dangerous."[16] In Illinois, a November 1996 survey of all physicians in Sangamon County (the city of Springfield and surrounding area) demonstrated that 91% of more than 180 respondents supported a ban of intact D&X (Perry M. Santos, MD, MS, written communication, November 5, 1996). In April 1997, more than 200 physician delegates who attended the Illinois State Medical Society annual meeting voted to support a ban on intact D&X. The AMA established its own committee to study partial-birth abortion and adopted the recommendations of that committee's report, as well as an official position of support for HR 1122, federal legislation banning partial-birth abortions that the AMA worked to improve and clarify prior to passage.[16]

Legislative bodies across the United States have decided that intact D&X is not appropriate. In fact, 28 states have approved a ban (Table), and Congress also overwhelmingly voted to ban the procedure with strong bipartisan support.[17] When Illinois' prochoice Gov Jim Edgar signed legislation enacting a ban in July 1997, he described the measure as one that "essentially prohibits a barbaric procedure that is repugnant to me and to almost all Illinoisans. I believe such a restriction is a proper, reasonable and humane public policy."[18] Public opinion surveys demonstrate wide support for banning partial-birth abortion when the procedure is described to those interviewed.[3] According to the *Chicago Tribune*, "The American people have learned enough about partial-birth abortions to know that they should be stopped."[19] New York Democratic Sen Daniel Patrick Moynihan, whose legislative record is nei-

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ther prolife nor conservative, has declared, "It [intact D&X] is as close to infanticide as anything I have come upon."[20] Former Surgeon General C. Everett Koop captured the dilemma: "... in no way can I twist my mind to see that the late-term abortion as described—you know, partial birth and then destruction of the unborn child before the head is born—is a medical necessity for the mother. It certainly can't be a necessity for the baby."[21]

Termination of Late-term Pregnancies

Many of the medical and ethical issues that pertain to intact D&X also apply to late-term pregnancy terminations, defined for the purposes of this article as termination beyond 20 weeks' gestation. Pregnancy termination at this gestational age can be accomplished either by labor induction or by D&E.

Most clinicians would argue for maintaining the option of late pregnancy termination to save the life of the mother, which is an extraordinarily rare circumstance. Maternal health factors demanding pregnancy termination in the periviable period can almost always be accommodated without sacrificing the fetus and without compromising maternal well-being. The high probability of fetal intact survival beyond the periviable period argues for ending the pregnancy through appropriate delivery. In a similar fashion, the following discussion does not apply to fetuses with anomalies incompatible with prolonged survival. When pregnancy termination is performed for these indications, it should be performed in as humane a fashion as possible. Therefore, intact D&X should not be performed even in these circumstances.

Maternal Considerations.—The risk of maternal mortality and morbidity associated with termination of pregnancy increases with advancing gestational age. Induced midtrimester abortion accounts for an estimated 10% to 20% of all abortions, and for two thirds of abortion-related major complications especially maternal mortality.[22] Women undergoing legal abortions during the first 8 weeks of gestation have the lowest risk of death (0.4 per 100 000 abortions), whereas procedures performed beyond 20 completed weeks of gestation are associated with the highest risk (10.4 per 100 000 abortions).[23] On average, the mortality from induced abortions increases 30% with each passing week of gestation.[24] At 21 weeks or more, the risk of death from abortion is 1 in 6000 and exceeds the risk of maternal death from childbirth, 1 in 13 000.[25] The risk of abortion-related maternal morbidity also increases with advancing gestational age. Among the immediate complications of abortions, the incidence of hemorrhage, laceration of the cervix, and uterine perforation is 1.2% at 8 weeks' gestation but increases to 3.6% at 15 weeks and beyond.[26] The risk of uterine perforation and resultant visceral injury also increases as gestation advances.[27] The risk of complications requiring hospital admission increases from 5.5% for abortions performed before 14 weeks' gestation to 11.2% for abortions performed subsequent to 14 weeks.[28]

Termination of pregnancy at more advanced gestational ages may predispose to infertility from endometrial scarring or adhesion formation (documented in 1 study in 23.1% of patients with induced midtrimester abortions[29]) and from pelvic infections, which occur in 2.8% to 25% of patients following midtrimester terminations.[30,31] Dilation and evacuation procedures commonly used in induced midtrimester abortion may lead to cervical incompetence, which predisposes to an increased risk of subsequent spontaneous abortion, especially in the midtrimester.[26,32,33] Cervical incompetence is more prevalent after midtrimester termination of pregnancy than first trimester termination because the cervix is dilated to a much greater degree.[34]

Considering that the risks of maternal morbidity and mortality increase substantially with advancing gestational age, elective abortions, if they are to be performed, should be performed as early as possible in gestation. Limiting late-term abortions would minimize maternal risks.

Fetal Considerations.—The fetus is capable of experiencing pain to an increasing degree as gestation advances. Prohibiting elective terminations beyond 22 weeks would minimize the fetal pain and suffering associated with termination of pregnancy. Minimizing fetal pain and suffering should also be more strongly considered in cases of late-term terminations for fetal anomalies.

Ethical Considerations.—The autonomy of the pregnant woman is increasingly counterbalanced by fetal development, the increasing tendency to attribute personhood to the fetus, and the increasing likelihood of independent fetal viability. Fetal development affects maternal autonomy on a inversely sliding scale. As a fetus evolves into an individual capable of survival independent of its mother (and thus personhood), the conditional fetal rights argument gains greater merit.

A second ethical principle concerns beneficence, ie, one individual's obligation to act for the benefit of another. As the fetus matures, the majority of individuals would extend greater and greater beneficence to the fetus. According to Stubblefield, "Inevitably, there must be a gestational age limit for abortion. I would avoid performing abortions after 22 weeks unless the mother's life were endangered or unless the fetus had major malformations so severe as to preclude prolonged survival.... When termination of pregnancy will be undertaken at or after 23 weeks because of serious risk for maternal health, the fetus should be considered as well."[27]

A third ethical principle concerns justice and denotes balancing the rights of distinct individuals. As the fetus develops, more and more people recognize that there are 2 distinct individuals involved. To take a position that would make the value of the fetus depend solely on private choice and on the individual exercise of power fails to understand the importance of communal safeguards against capricious power over life and death.[35]

Conclusions

Medical professionals have an obligation to thoughtfully consider the medical and ethical issues surrounding pregnancy termination, particularly with respect to intact D&X and late-term abortions. Having done so, we conclude the following: (1) Intact D&X (partial-birth abortion) should not be performed because it is needlessly risky, inhumane, and ethically unacceptable. This procedure is closer to infanticide than it is to abortion. (2) Abortions in the periviable period (currently 23 weeks) and beyond should be considered unethical, unless the fetus has a condition incompatible with prolonged survival or if the mother's life is endangered by the pregnancy. (3) If a maternal medical condition in the periviable period indicates pregnancy termination, the physician should wait, if the medical condition permits, until fetal survival is probable and then proceed with delivery. Such medical decisions must be individualized.

Physicians must preserve their role as healing, compassionate, caring professionals, while recognizing their ethical obligation to care for both the woman and the unborn child. In July

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1997, the ACOG Executive Board supplemented its policy on abortion toward this end, stating, "ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman."[36]

We hope that with thoughtful discussions regarding specific issues such as those considered in this article, the opposing forces in the ongoing, stagnant abortion debate will find middle ground on which most can agree. The question is often asked, "But who should decide?" Ultimately, at least in the United States, the public will decide. The results of an August 1997 national poll showed public opinion firmly in the camp of "drawing a line" on abortion rights, with 61% believing that abortion should be legal only under certain circumstances, and 22% defending the legality of abortion under any circumstances.[37] Society will not continence infanticide. According to Boston University ethicist and health law professor George Annas, JD, MPH, Americans see "a distinction between first trimester and second trimester abortions. The law doesn't, but people do. And rightfully so."[38] He explained that after approximately 20 weeks, the American public sees a baby. The American public's vision of this may be much clearer than that of some of the physicians involved.

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The Continuing Need for Late Abortions

David A. Grimes, MD

LATE ABORTION is the most controversial aspect of the most divisive social issue of our times.[1] The debate has been strident, confusing, and at times, misleading.[2] This article reviews the epidemiology of late abortion, defined herein as abortions performed 21 or more completed weeks from the beginning of last menses (this gestational age interval is the highest used in federal reports on abortion[3,4]); discusses the frequency, methods, safety, and indications of late abortions; and describes controversies concerning the upper gestational age limit and attempts to prohibit a specific abortion method.

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Epidemiology and Techniques of Late Abortion

For decades, late induced abortions have been uncommon in the United States. From 1972 through 1992, the proportion of all induced abortions that were performed at 21 or more weeks' gestation ranged from 0.8% to 1.7%.[3] The upper gestational age limit varies by state. However, the claim that many women have elective abortions in the third trimester lacks support. Most reports of abortions at 25 or more weeks' gestation are

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Recent Developments on Partial-Birth Abortion

March 24, 2003

Pro-abortion lawmakers seek cover of Hoyer-Greenwood "phony ban"

Partial-birth abortion focus turns to U.S. House, after U.S. Senate passes ban on bipartisan 64-33 vote

[For further information, contact Douglas Johnson, legislative director at the National Right to Life Committee (NRLC), at Legfederal@aol.com or 202-626-8820. Extensive documentation on this subject is posted in the Partial-Birth Abortion section of the NRLC website at www.nrlc.org/abortion/pba/index.html]

WASHINGTON (March 24, 2003) -- The Partial-Birth Abortion Ban Act -- a major pro-life federal legislative priority since 1995 -- has won approval from the U.S. Senate, and is expected to win approval from the House of Representatives later this spring.

The U.S. Senate passed its version of the ban (S. 3), sponsored by Senator Rick Santorum (R-Pa.), on March 13 by a lopsided vote of 64-33. Following Senate approval of the ban, Douglas Johnson, legislative director for the National Right to Life Committee (NRLC), commented, "**President Bush, 70 percent of the public, 64 senators, and four Supreme Court justices say there is no constitutional right to deliver most of a living baby and then puncture her head with a scissors. But five Supreme Court justices said that partial-birth abortion is protected by *Roe v. Wade*, and 33 senators agreed. We hope that by the time this ban reaches the Supreme Court, at least five justices will be willing to reject such extremism in defense of abortion.**"

Before passing the bill, the Senate voted 52-46 to add one amendment opposed by pro-life supporters of the bill: the Harkin Amendment, which endorses the Supreme Court's *Roe v. Wade* decision and urges that it not be overturned. Especially in view of the ruling by five justices that *Roe* covers even partial-birth abortion, supporters of the ban are determined to eliminate the Harkin Amendment before the bill is sent to President Bush for his signature.

The House version of the Partial-Birth Abortion Ban Act (H.R. 760) is sponsored by Congressman Steve Chabot (R-Oh.), chairman of the House Judiciary Subcommittee on the Constitution. It currently has 159 sponsors and cosponsors. It is identical to S. 3, except for the Harkin Amendment added by the Senate.

H.R. 760 is the same text as that passed by the House of Representatives on July 24, 2002, by a lopsided bipartisan vote of 274-151. But the Democratic Senate leadership, at that time holding majority control, refused to allow that bill to come up for a vote during 2002, and it died at the end of the 107th Congress. In earlier years, Congress approved national bans on partial-birth abortion twice, but they were vetoed by President Clinton. On each occasion, the House voted to override the vetoes, but supporters fell short of the necessary two-thirds majority in the Senate. [Sept. 26, 1996, and Sept. 18, 1998]

In January 22 remarks to the March for Life, President Bush said, "**My hope is that the United States Congress will pass a bill this year banning partial-birth abortion, which I will sign. Partial-birth abortion is an abhorrent procedure that offends human dignity**." The President also urged Congress to act on the bill in his January 28 State of the Union speech.

The January 2003 Gallup poll found that **70% favored** and 25% opposed "a law that would make it illegal to perform a specific abortion procedure conducted in the last six months of pregnancy known as 'partial birth abortion,' except in cases necessary to save the life of the mother." (margin of error +/- 3%)

What is a partial-birth abortion?

Supreme Court Justice Clarence Thomas accurately described the partial-birth abortion method in his dissent in *Stenberg v. Carhart* (2000): "After dilating the cervix, the physician will grab the fetus by its feet and pull the fetal body out of the uterus into the vaginal cavity. At this stage of development, the head is the largest part of the body. . . . the head will be held inside the uterus by the woman's cervix. While the fetus is stuck in this position, dangling partly out of the woman's body, and just a few inches from a completed birth, the physician uses an instrument such as a pair of scissors to tear or perforate the skull. The physician will then either crush the skull or will use a vacuum to remove the brain and other intracranial contents from the fetal skull, collapse the fetus' head, and pull the fetus from the uterus."

An eight-page instruction paper on how to perform this type of abortion, written by an abortionist in 1992, in a sense began the national debate about partial-birth abortion. It is posted on a congressional website: www.house.gov/burton/RSC/haskellinstructional.pdf.

Most partial-birth abortions are performed in the fifth and sixth months of pregnancy (20-26 weeks). At this stage, an infant who is spontaneously prematurely delivered is usually *born alive*. There is abundant medical evidence that a human

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baby at this stage is extremely sensitive to pain – whether she is inside the womb, fully born, or halfway between.

Some partial-birth abortions are performed in the seventh month and later – and not only in cases of fetal disorders or maternal distress. **It is noteworthy that in Kansas, the only state in which the law requires separate reporting of partial-birth abortions, abortionists reported in 1999 that they performed 182 partial-birth abortions on babies who were defined by the abortionists themselves as "viable," and they also reported that *all 182* of these were performed for "mental" (as opposed to "physical") health reasons.** See: www.kdhe.state.ks.us/hci/99itop1.pdf (on page 11).

Five justices said *Roe v. Wade* covers partial-birth abortions

In June 2000, the U.S. Supreme Court, in a 5-4 ruling in *Stenberg v. Carhart*, struck down a Nebraska law that was similar to the federal ban that was under consideration in Congress at that time, citing *Roe v. Wade*. In response to the *Stenberg v. Carhart* ruling, the new federal bill differs in two significant respects from the bans approved by the 104th Congress and 105th Congress (which were vetoed by President Clinton).

The five-justice majority in *Carhart* thought that Nebraska's definition of "partial-birth abortion" was vague and could be construed to cover not only abortions in which the baby is mostly delivered alive before being killed, but also the more common second-trimester "dilation and evacuation" (D&E) method. In a "D&E," a well-developed unborn child is dismembered piece by piece. (For a better understanding, see the Nucleus Medical Art image at www.nrlc.org/abortion/pba/DEabortiongraphic.html)

During a D&E, an arm or leg is sometimes pulled into the birth canal before being twisted off, while the baby is still alive in the womb, so the justices thought this might be considered a "partial-birth abortion" under the Nebraska definition. (Even after one or more limbs are twisted off, it takes a little while for the baby to bleed to death, or to be killed by the final stage, the crushing of her skull.)

In order to avoid any possibility of such confusion, the new bill defines a prohibited partial-birth abortion as one 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*," and then kills the baby. [italics added for emphasis] Some pro-abortion groups continue to assert that this definition covers abortion methods other than that depicted. (For example, in a letter published in the February 23, 2003 issue of *The New York Times*, the

chief executive of Planned Parenthood of New York City wrote that the bill "as written would outlaw some of the safest and most common methods of abortion used throughout a woman's pregnancy, as early as 10 weeks in some cases.") But they have not explained how. It appears that such advocates are counting on journalists not to demand details on how the actual language of S.3/H.R. 760 could possibly be applied to any first-trimester abortions, or to second-trimester or third-trimester dismemberment procedures.

In *Stenberg*, the five-justice majority also ruled that an abortionist must be allowed to use the partial-birth abortion method if he believes that it is the method which has the lowest risk of side effects for any particular woman seeking an abortion in the late second trimester (not only women with a "health" problem). The majority reached this result by deferring to findings of fact by the trial court, which were based on acceptance of assertions by late-term abortionist Dr. LeRoy Carhart and others that the partial-birth abortion method was sometimes the method least likely to cause side effects.

The new federal bill responds to the five-justice holding with congressional findings that partial-birth abortion is never necessary to protect the health of a woman and, indeed, exposes a woman to substantial and additional health risks. The bill concludes that, based on the extensive congressional hearing record on partial-birth abortion, "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."

Pro-abortion disinformation persists, although discredited

When legislation dealing with partial-birth abortion was first introduced in Congress in 1995, major pro-abortion groups insisted that the method was used very rarely, only a few hundred times a year, and only in cases involving acute medical crises. There was always ample documentation to the contrary; these claims were political concoctions, dictated by polling data, not facts (see, for example, the leaked memo by Democratic pollster Celinda Lake, "Positioning on so-called 'partial birth' abortion," September 16, 1996, here: http://www.nrlc.org/abortion/pba/lakememopba.pdf)

Nevertheless, these assertions were accepted and repeated incessantly as fact by many major organs of the media until at least late 1996, when several newspapers published reports based on interviews with various abortionists who acknowledged that the method was employed frequently and mostly for purely elective abortions.

5

The pro-abortion disinformation campaign suffered another blow in February 1997, when Ron Fitzsimmons, then and now the executive director of the National Coalition of Abortion Providers (NCAP), admitted that he and leaders of other pro-abortion groups knew better when they claimed that the partial-birth method was used rarely and only in extraordinary circumstances. Fitzsimmons said this was merely a "party line" adopted by the major pro-abortion advocacy groups. Regarding his own (albeit minor) role in disseminating this "party line," he said, "[I] lied through my teeth." *The New York Times* reported (Feb. 26, 1997, p. A11), **"In the vast majority of cases, the procedure is performed on a healthy mother with a healthy fetus that is 20 weeks or more along, Fitzsimmons said."** (20 weeks is the halfway point in pregnancy – 4½ months in layperson's terms.) (See this and related clippings at www.nrlc.org/abortion/pba/index.html, in the late 1996 and early 1997 archive.)

On March 4, 2003, Fitzsimmons (still head of the NCAP) confirmed that he believes that the statements quoted in that *New York Times* story are still accurate today.

A great deal of other evidence – collected by congressional committees, journalists, and other entities both before and since 1997 – supports Fitzsimmons' statements. In January 2003, even the Alan Guttmacher Institute – an affiliate of Planned Parenthood – published a survey of abortion providers that estimated that 2,200 abortions by the method were performed in the year 2000. While that figure is surely low for reasons discussed by NRLC elsewhere (www.nrlc.org/press_releases_new/release011503.html), it is *more than triple* the number that AGI estimated in its most recent previous survey (for 1996).

Despite all of that and more, some journalists and some advocates continue to disseminate the old, discredited misinformation. To cite just one example: "A so-called partial-birth abortion is defined generally as a late-term procedure in which the fetus is aborted after it is partially outside the mother's body. It is usually performed in cases when the mother's life is threatened or the fetus is deformed." (From "Anti-abortion lobby counting on victories in 108th Congress," by Pam Brogan, Gannett News Service, December 17, 2002.) Gannett has failed to provide any evidence to support its assertion that partial-birth abortion (by any name) "is usually performed in cases when the mother's life is threatened or the fetus is deformed," but also failed to inform its client papers of its error.

In another recent example, in "Senate OKs ban on a later-term form of abortion" (March 14), *Boston Globe* reporter Susan Milligan told readers that the method is used because "of fetal abnormalities or medical conditions threatening a woman" (no other reasons were mentioned in the story). The mythology ("It is generally performed late in pregnancy after discovery of damage to or abnormalities in the fetus") was also recited in a news story in the March 15 *San Francisco Chronicle*.

6

A recently published NRLC monograph, "Revival of Some Old Myths on *Roe v. Wade* and Partial-Birth Abortion," critiques some other "media myths" about partial-birth abortion and about the Supreme Court decisions that bear on the subject, including *Roe v. Wade.* You can read or download it from www.nrlc.org/abortion/pba/roevwademyths.html.

Pro-Abortion Substitute Amendments (Phony Bans)

Many lawmakers who oppose the Partial-Birth Abortion Ban Act tell their constituents that they instead favor a bill to ban "late-term" abortions with a "health" exception. These competing proposals are complete shams -- hollow bills concocted to provide political cover for lawmakers who wish to keep perfect ratings in pro-abortion "scorecards," while hoodwinking their constituents into believing that they oppose partial-birth abortions.

The leading House advocates of phony-ban legislation (H.R. 809) are Reps. Steny Hoyer (D-Md.) and Jim Greenwood (R-Pa.). Hoyer has a 100 percent voting record in NARAL scorecards, and Greenwood is co-chair of the Pro-Choice Caucus. Hoyer and Greenwood have written that this so-called "ban" actually would allow *third-trimester* abortions even for "mental health." (www.nrlc.org/abortion/pba/Phony%20ban%20on%20late-term.pdf) In a press conference on March 12, 1997, Hoyer suggested this "mental health" clause should apply when "it poses a psychological trauma to the woman to carry to term."

In the Senate, similar "phony ban" substitute bills were offered by Senator Dick Durbin (D-Il.) and by Senator Dianne Feinstein (D-Ca.); both were rejected. The Feinstein Substitute would have explicitly allowed abortions after "viability" for any "health" reason. Senator Hillary Clinton (D-NY), a backer of the amendment, took the floor to defend keeping abortions available -- after viability -- based on "mental health" justifications. (See *Congressional Record*, March 12, 2003, page S-3587.)

Resources

Additional documents on medical, legal, and legislative aspects of partial-birth abortion are posted at www.nrlc.org/abortion/pba/index.html. A good primer is the testimony NRLC presented to a joint hearing of the U.S. Senate Judiciary Committee and the U.S. House Judiciary Constitution Subcommittee in March 1997, which contains footnoted citations to some of the more thorough journalistic examinations (including interviews with partial-birth abortionists) and to primary documents: www.nrlc.org/abortion/pba/test.html.

Congress of the United States
Washington, DC 20515

HOYER-GREENWOOD LATE-TERM ABORTION RESTRICTION BILL BANS ALL PROCEDURES - NOT JUST PARTIAL BIRTH PROCEDURE

MAR 16 2000 March 16, 2000

Dear Colleague:

Last summer, we introduced H.R. 2149 - the Late Term Abortion Restriction Act of 1999 with 24 bipartisan cosponsors. The bill would prohibit all late-term abortions, regardless of procedure, with exceptions only to protect the life of the mother and to avert serious adverse health consequences.

Two critics of the bill, Rep. Hyde and Rep. Canady, claim that the legislation allows for exceptions if the mother's mental health is at stake. Indeed mental health is considered a serious and adverse consequence to the mother's health. This bill resembles existing laws, that specifically prohibit abortion after viability under specified circumstances, in **41 states**, including:

Alabama, Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin, and Wyoming.

The bill prohibiting the partial-birth procedure, introduced in the House by Rep. Canady, prohibits a particular procedure used not just during a late-term pregnancy but during the earlier stages as well. To ban a specific medical procedure, rather than all late-term abortions, does not strike at the heart of the matter: termination of a viable fetus during the late states of a pregnancy.

We urge you to cosponsor the common-sense, bi-partisan "Late-term Abortion Restriction Act." If you are interested in cosponsoring or would like additional information, please contact Bruce Marsh in Rep. Hoyer's office at 5-4131 or Joel White in Rep. Greenwood's office at 5-4276.

Thanking you for your attention to this important matter and with kindest regards, we are

Sincerely yours,

REP. STENY H. HOYER

REP. JAMES C. GREENWOOD

REP. ELLEN O. TAUSCHER

REP. NANCY L. JOHNSON

PRINTED ON RECYCLED PAPER

The Washington Post Health Section, 9/17/96
by staff writer David Brown, M.D.

Viability and the Law

The normal length of human gestation is 266 days, or 38 weeks. This is roughly 40 weeks from a woman's last menstrual period.

Pregnancy is often divided into three parts, or "trimesters." Both legally and medically, however, this division has little meaning. For one thing, there is little precise agreement about when one trimester ends and another begins. Some authorities describe the first trimester as going through the end of the 12th week of gestation. Others say the 13th week. Often the third trimester is defined as beginning after 24 weeks of fetal development.

Nevertheless, the trimester concept—and particularly the division between the second and third ones—commonly arises in discussion of late-stage abortion.

Contrary to a widely held public impression, third-trimester abortion is not outlawed in the United States. The landmark Supreme Court decisions *Roe v. Wade* and *Doe v. Bolton*, decided together in 1973, permit abortion on demand up until the time of fetal "viability." After that point, states can limit a woman's access to abortion. The court did not specify when viability begins.

In *Doe v. Bolton* the court ruled that abortion could be performed after fetal viability if the operating physician judged the procedure necessary to protect the life or health of the woman. "Health" was broadly defined.

"Medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial and the woman's age—relevant to the well-being of the patient," the court wrote. "All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment."

Because of this definition, life-threatening conditions need not exist in order for a woman to get a third-trimester abortion.

For most of the century, however, viability was confined to the third trimester because neonatal intensive-care medicine was unable to keep fetuses younger than that alive. This is no longer the case.

In an article published in the journal Pediatrics in 1991, physicians reported the experience of 1,765 infants born with a very low birth weight at seven hospitals. About 20 percent of those babies were considered to be at 25 weeks' gestation or less. Of those that had completed 23 weeks' development, 23 percent survived. At 24 weeks, 34 percent survived. None of those infants was yet in the third trimester.

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To: Editors, reporters, and other interested persons

From: Douglas Johnson, Legislative Director, National Right to Life Committee
202-626-8820, Legfederal@aol.com, www.nrlc.org

Re: Revival of some old myths about *Roe v. Wade* and partial-birth abortion

Date: February 14, 2003

Many media outlets published abortion-related stories in January, on the occasion of the 30th anniversary of the Supreme Court decision in *Roe v. Wade*. Many of those stories contained demonstrable errors, some of these apparently adopted uncritically from polemical materials issued by pro-abortion advocacy groups. This memo offers critiques of several of the most common errors. Some of these points are pertinent to anticipated upcoming coverage of debate in Congress (and in some state legislatures) on bills relating to abortion and other issues involving members of the species *Homo sapiens* prior to full live birth.

Additional documentation on current pro-life issues in Congress, including partial-birth abortion and human cloning, may be found on the National Right to Life website at www.nrlc.org under "Legislation: Current Issues," or obtained by contacting us at Legfederal@aol.com.

Counting to Nine

"What keeps Roe standing is the razor-thin five-vote majority that has stood by the decision." – *Time* magazine, Jan. 27, 2003. (Many similar examples from other major media, including the Associated Press.)

National Right to Life believes that *Roe v. Wade* should be overturned, the result of which would be to allow elected legislators to enact protective legislation to the degree desired by those who elect them. Therefore, it would be welcome news if in fact "only" five Supreme Court justices supported *Roe*. Regrettably, however, *six* current justices have voted to affirm *Roe v. Wade:* Justices Breyer, Ginsburg, Kennedy, O'Connor, Souter, and Stevens. Only three of the current justices have ever voted to overturn or substantially scale back *Roe*: Justices Rehnquist, Scalia, and Thomas.

Why the discrepancy? It seems that some pro-abortion groups think that "five to four" sounds better than "six to three," so they are counting Justice Anthony Kennedy as a *Roe* opponent. But in fact, Kennedy in the 1992 *Casey* ruling voted to reaffirm *Roe*, with the result that *Roe* was reaffirmed, 5-4, rather than being overturned. (Since then, one of the four anti-*Roe* justices, Byron White, was replaced by a pro-*Roe* justice, Ruth Bader Ginsburg.) In the 2000 *Stenberg* decision, Justice Kennedy voted to uphold Nebraska's ban on partial-birth abortion method as consistent with *Roe/Casey*.

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Will some journalists continue to count Justice Kennedy as an opponent of *Roe*, although he has voted to allow abortion for any reason until "viability," merely because he voted to permit a ban on the *method* of partial-birth abortion? If so, for the sake of consistency, it would seem that they should also report that 70% of the public must also "oppose *Roe v. Wade*," since that is the percentage that favors a ban on partial-birth abortion in both the second and third trimesters, according to the Gallup poll (Jan. 10-12, 2003).[1]

The Amazing Elastic *Roe v. Wade*

"Do you favor the Supreme Court ruling that women have the right to an abortion during the first three months of their pregnancy?" – *Time*/CNN poll question, published in *Time*, January 27, 2003. ***"The U.S. Supreme Court ruled in 1973 that a woman can have an abortion if she wants one at any time during the first three months of pregnancy. Do you favor or oppose that ruling?"*** – ABC News/*Washington Post* poll, Jan. 16-20, 2003.

"The Supreme Court voted 7-2 on Jan. 22, 1973, to legalize abortions in the first three months after conception." – *Washington Times*, Jan. 23, 2003. ***". . . the 1973 Roe v. Wade decision, which determined that a woman's constitutional privacy rights entitled her to get an abortion in the first trimester of her pregnancy."*** – from "Abortion, Cloning Are on Bush Agenda," *Washington Post*, Jan. 23, 2003 (but retracted in Jan. 24 "Corrections" column).

The notion that the "right to abortion" articulated in *Roe v. Wade* and *Doe v. Bolton* was limited in any significant way to "the first trimester" is a misconception that was repudiated by major news outlets decades ago, because it is gravely misleading and has been repeatedly rebutted by the Supreme Court itself. Yet, as the quotes above demonstrate, this hoary distortion seems to be having a resurgence lately.

In *Roe*, and in many subsequent decisions, the Court made it clear that abortion had to be allowed *for any reason whatever* through the *second* trimester. The original ruling left the door open for minor medical-practice regulations to protect women's health in the second trimester, but it was clear from the language of the decision that these regulations could not amount to much, and they never did. After months of research on the partial-birth abortion debate, *Washington Post* medical writer David Brown, M.D., accurately summarized the *Roe v. Wade* ruling in an article published Sept. 17, 1996, edition of that newspaper. Dr. Brown wrote:

> The landmark Supreme Court decisions *Roe v. Wade* and *Doe v. Bolton*, decided together in 1973, permit abortion on demand up until the time of fetal "viability."[2]

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[1] The January, 2003 Gallup poll found that 70% favored and 25% opposed "a law that would make it illegal to perform a specific abortion procedure conducted in the last six months of pregnancy known as 'partial birth abortion,' except in cases necessary to save the life of the mother." (margin of error +/- 3%)

[2] "Viability," the capacity of the baby to survive independently of the mother with technological assistance, currently is reached in the late weeks of the second trimester.

[Note: References to *Roe* are generally understood to apply to *Doe* as well, since both decisions were issued on the same day, and the Court said in *Roe*, "That opinion and this one, of course, are to be read together."]

The *Post* story went on to explain that even after "viability," the Court said that states must permit abortions sought for reasons of "health," explicitly defined to include (quoting the Court in *Doe*), "all factors -- physical, emotional, psychological, familial and the woman's age -- relevant to the well-being of the patient." Dr. Brown concluded, "Because of this definition, life-threatening conditions need not exist in order for a woman to get a third-trimester abortion."

The "first three months" formula was formally declared erroneous in the early 1980s by senior news executives of *The New York Times*, the Associated Press, and others. For example, in 1982 the national editor of *The New York Times* decreed that "brief references to the Supreme Court's 1973 decision on abortion should say simply that the court legalized abortion," because "the phrase 'in the first three months of pregnancy' might be incorrectly interpreted to mean that abortions in the last six months of pregnancy remain illegal." Associated Press Vice President and Executive Editor Louis D. Boccardi wrote in a September, 1981 directive, "The decision is often misreported, even now. . . . For summary purposes, you can say the court legalized abortion in 1973. . . . Thus, it's wrong to say only that the court approved abortion in the first three months. It did that, but more." These documents are available on request.

Anyone still laboring under the misconception that there was something different about "the first three months" was corrected again by the Supreme Court itself in the 1992 *Casey* ruling. In that ruling, the Court reaffirmed *Roe v. Wade* on a vote of 5 to 4, and held that the "abortion right" applied with equal force throughout the first and second trimesters until "viability." **The Court explicitly repudiated any distinction whatever between the first and second trimesters, writing, "We reject the trimester framework, which we do not consider to be part of the essential holding of *Roe*." Why, then, should pollsters represent that it was indeed the "essential holding of *Roe*"?**

It is also noteworthy that in the 2000 *Stenberg* ruling, the Supreme Court struck down Nebraska's ban on partial-birth abortions, a method used in the fifth month of pregnancy and later (never in the first trimester). The five-justice majority said that such a ban was inconsistent with, yes, *Roe v. Wade*.

Why, then, does the bogus "first three months" formulation keep cropping up? In some cases, it appears to reflect a desire, unconscious or otherwise, to "prettify" *Roe* – that is, to describe it in the manner least offensive to the greatest number of people.[3] Despite such cosmetic work, the

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[3] It appears that in the minds of some, *Roe* is a very elastic concept that can easily be expanded or contracted depending on which version serves a particular story line. The inconsistent treatment of *Roe* is especially evident in the January 27 edition of *Time* magazine. As quoted above, the *Time*/CNN poll asked respondents if they favored the Supreme Court decision that allowed women to obtain abortions "during the first three months of their pregnancy." If the *Time*/CNN pollster had happened to telephone Supreme Court Justice Anthony Kennedy, presumably the justice would have responded as he did in the *Casey* and *Stenberg* rulings: that the woman has a "constitutional right" to obtain an abortion for any reason she chooses not only in the first three months, but all the way up to "viability" (about 5½ months). Thus, the

Washington Post/ABC poll – which itself propagates the same error – shows public support for the ruling has dropped 11 points in ten years.[4]

Discredited Myths About Partial-Birth Abortion

A so-called partial-birth abortion is defined generally as a late-term procedure in which the fetus is aborted after it is partially outside the mother's body. It is usually performed in cases when the mother's life is threatened or the fetus is deformed. – from "Anti-abortion lobby counting on victories in 108th Congress," by Pamela Brogan, Gannett News Service, December 17, 2002. (Similar examples sighted in other media.)

When the federal Partial-Birth Abortion Ban Act was first introduced in mid-1995, there already was abundant evidence that some abortionists employed the partial-birth method routinely for purely elective abortions. In articles, interviews, and legislative testimony, prominent abortionists had readily admitted to using the method to perform thousands of abortions, mostly purely elective. Their printed admissions were widely circulated to the media by NRLC and other groups, and by lawmakers supporting the bill. However, many major news outlets chose to ignore this evidence and to uncritically adopt the unsupported claims of the pro-abortion lobby that the partial-birth abortion method was used only rarely and nearly always in cases involving acute medical problems with the mother or baby. [Innumerable examples of such reporting are available on request.]

However, belatedly, towards the end of 1996, some major newspapers, including the *Washington Post* and the *Record* in northern New Jersey, actually went out and investigated. They found numerous abortionists who admitted to routinely employing the method for abortions on healthy mothers with healthy babies in the fifth and sixth months of pregnancy. To cite just one example, on September 15, 1996, the *Record* (Bergen, New Jersey) published a report by staff writer Ruth Padawer, based on separate interviews with two abortionists, who independently told her that they performed **over 1,500** partial-birth abortions annually in their single facility -- which was roughly triple the *nationwide* figures then being given out by pro-abortion advocacy and industry groups and reported as fact by many journalists. As to *why* they performed these procedures:

Time pollster would have counted Justice Kennedy as among the 55% deemed to support *Roe* in that poll. Yet in the article that accompanied the published poll, Justice Kennedy was counted as an anti-*Roe* justice (to produce the "razor-thin five-vote majority"), apparently on the basis of his vote to uphold a ban on the partial-birth abortion method – a method *which is never used in the first trimester* and is used mostly in the fifth and sixth months.

[4] The *Post* reported, "A new *Washington Post*-ABC News Poll found majority support for the ruling in *Roe v. Wade* [mischaracterized as legalizing abortion "during the first three months of pregnancy"], but also showed that opposition to the decision has risen since the 20th anniversary in 1993. In the poll, 54 percent of those surveyed said they favored the Supreme Court ruling that legalized abortion, with 44 percent opposed. Ten years ago, 65 percent favored the ruling, with 33 percent opposed." "Democratic Candidates Vow To Protect Abortion Rights," by Dan Balz, *Washington Post*, Jan. 22, 2003, www.washingtonpost.com/wp-dyn/articles/A25818-2003Jan22.html

> "We have an occasional amnio abnormality, but it's a minuscule amount," said one of the doctors at Metropolitan Medical, an assessment confirmed by another doctor there. "Most are Medicaid patients, black and white, and most are for elective, not medical, reasons: people who didn't realize, or didn't care, how far along they were. Most are teenagers." (*The Record*, September 15, 1996)

The September 17, 1996 edition of the *Washington Post* contained the results of a lengthy investigation conducted by reporters Barbara Vobejda and David M. Brown, M.D., who interviewed several abortionists (*not* those in New Jersey), and concluded:

> Furthermore, in most cases where the procedure is used, the physical health of the woman whose pregnancy is being terminated is not in jeopardy.... Instead, the "typical" patients tend to be young, low-income women, often poorly educated or naive, whose reasons for waiting so long to end their pregnancies are rarely medical.

Shortly thereafter, in February 1997, the abortion industry's disinformation campaign completely exploded when Ron Fitzsimmons -- then and now the executive director of the National Coalition of Abortion Providers (an association of 150 or so abortion providers) -- gave a series of well-publicized interviews in which he acknowledged that the claim that the partial-birth abortion procedure was used rarely and mostly in acute medical situations was merely a "party line," and was false. Mr. Fitzsimmons expressed regret about his own previous (albeit minor) role in propagating that "party line," explaining, "I lied through my teeth."

The truth, Mr. Fitzsimmons said, was that "[i]n the vast majority of cases, the procedure is performed on a healthy mother with a healthy fetus" (*The New York Times*, Feb. 26, 1997). He estimated that 3,000-5,000 abortions annually are performed by the partial-birth method. Here are two examples of clear reporting on these revelations, including confirmations from other pro-abortion sources:
www.nrlc.org/abortion/pba/PBA%20NYT%20lied.pdf
and www.nrlc.org/abortion/pba/PBA%20activists%20lied.pdf

In addition, in early 1997 the PBS media criticism program *Media Matters* reviewed the history of the news media's gullible acceptance of the abortion lobby's original disinformation about partial-birth abortion, and concluded that it was a case study in bad journalism. See:
www.pbs.org/wnet/mediamatters99/transcript2.html

The *Washington Post*'s David Brown was shown on the program saying that the *Post* study found, "Cases in which the mother's life were at risk were extremely rare. . . . Most people who got this procedure were really not very different from most people who got abortions."

Is Partial-Birth Abortion Performed "Rarely"?

The *Washington Post* reported that a committee of the Virginia legislature passed a bill to ban the ***"rarely used"*** method (Jan. 28, 2003) Likewise, the Associated Press reported, ***"A bill seeking to ban a rarely performed procedure commonly referred to as 'partial-birth abortion' moved along in the [Virginia] Senate . . ."*** (Jan. 30, 2003) (Many similar sightings in other media.)

Peggy Girsham, deputy managing editor of NPR News, recently sent out a note cautioning NPR reporters, "It is not correct to call these procedures 'RARE' -- it is not known how often they are performed." However, in fact enough is known to demonstrate that it is tendentious to dismiss these brutal procedures as "rare."

Only one state (Kansas) requires reporting the partial-birth method separately from other methods used at the same stages in pregnancy.[5] As noted, in 1997, Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, estimated approximately 3,000-5,000 abortions were performed by the method annually. However, since the Supreme Court's 2000 ruling in *Stenberg v. Carhart* rendered unenforceable the bans on partial-birth abortion that had been enacted by more than half the states, the number of partial-birth abortions may have climbed since Mr. Fitzsimmons made that estimate. A voluntary survey of known abortion providers conducted by the Alan Guttmacher Institute (a special affiliate of Planned Parenthood), released in January 2003, claimed 2,200 partial-birth abortions in the year 2000 (despite a survey question so convoluted that daily practitioners of the method could have honestly answered "zero"). This was *more than triple* the absurdly low number of 650 obtained by AGI using the same question just four years earlier – yet both numbers were immediately accepted by some journalists as reliable. **So has the number of partial-birth abortions more than tripled in just four years? If so, isn't that news?**

None of these numbers justify the dismissive adjective "rare." **Rare, compared to what?** Usually, the answer is, "Rare, compared to first-trimester abortions performed by entirely different methods." But why is that the apt comparison? It is evident that a substantial fraction of the population, and many state and federal lawmakers, believe that there are some important distinctions between abortions performed by vacuum aspiration or drugs during the first three months, and abortions performed in the fifth month and later involving partial delivery while the baby is still alive.

Rare? If a virus had killed 5,000 (or 2,200) newborn premature infants in neonatal units in one year, it would be declared an epidemic and reported on the evening news -- even though that would be a "very small fraction" of all premature infants cared for in neonatal units during a year.

Resources

Additional documents on medical, legal, and legislative aspects of partial-birth abortion are posted on the NRLC website at www.nrlc.org/abortion/pba/index.html. A good primer on the issue is the testimony NRLC presented to a joint hearing of the U.S. Senate Judiciary Committee and the U.S. House Judiciary Constitution Subcommittee in March, 1997, which contains footnoted citations to some of the more thorough journalistic examinations of the issue (including interviews with partial-

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[5] In 1999, Kansas abortionists reported they performed 182 partial-birth abortions on babies who were defined by the abortionists themselves as "viable," and they also reported that all 182 of these were performed for "mental" (as opposed to "physical") health reasons. See page 11 of this document: http://www.kdhe.state.ks.us/hci/99itop1.pdf

birth abortionists) and to various primary documents. The testimony is posted here: www.nrlc.org/abortion/pba/test.html

The eight-page instruction paper on how to perform a partial-birth abortion that began the whole partial-birth abortion debate, written by an abortionist in 1992, is posted on a congressional website here: www.house.gov/burton/RSC/haskellinstructional.pdf

The New York Times

VOL. CXLVI . . . No. 50,715 WEDNESDAY, FEBRUARY 26, 1997 A11

An Abortion Rights Advocate Says He Lied About Procedure

By DAVID STOUT

WASHINGTON, Feb. 25 — A prominent member of the abortion rights movement said today that he lied in earlier statements when he said a controversial form of late-term abortion is rare and performed primarily to save the lives or fertility of women bearing severely malformed babies.

He now says the procedure is performed far more often than his colleagues have acknowledged, and on healthy women bearing healthy fetuses.

Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers, said he intentionally misled in previous remarks about the procedure, called intact dilation and evacuation by those who believe it should remain legal and "partial-birth abortion" by those who believe it should be outlawed, because he feared that the truth would damage the cause of abortion rights.

But he is now convinced, he said, that the issue of whether the procedure remains legal, like the overall debate about abortion, must be based on the truth.

In an article in American Medical News, to be published March 3, and an interview today, Mr. Fitzsimmons recalled the night in November 1995, when he appeared on "Nightline" on ABC and "lied through my teeth" when he said the procedure was used rarely and only on women whose lives were in danger or whose fetuses were damaged.

"It made me physically ill," Mr. Fitzsimmons said in an interview. "I told my wife the next day, 'I can't do this again.' "

Mr. Fitzsmmons said that after that interview he stayed on the sidelines of the debate for a while, but with growing unease. As much as he disagreed with the National Right to Life Committee and others who oppose abortion under any circumstances, he said he knew they were accurate when they said the procedure was common.

In the procedure, a fetus is partly extracted from the birth canal, feet first, and the brain is then suctioned out.

Last fall, Congress failed to override a Presidential veto of a law that would have banned the procedure, which abortion opponents insist borders on infanticide and some abortion rights advocates also believe should be outlawed as particularly gruesome. Polls have shown that such a ban has popular support.

Senator Tom Daschle of South Dakota, the Democratic leader, has suggested a compromise that would prohibit all third-trimester abortions, except in cases involving the "life of the mother and severe impairment of her health."

The Right to Life Committee and its allies have complained repeatedly that abortion-rights supporters have misled politicians, journalists and the general public about the frequency and the usual circumstances of the procedure.

"The abortion lobby manufactures disinformation," Douglas Johnson, the committee's legislative director, said today. He said Mr. Fitzsimmon's account would clarify the debate on this procedure, which is expected to be renewed in Congress.

Mr. Fitzsimmons predicted today that the controversial procedure would be considered by the courts no matter what lawmakers decide.

Last April, President Clinton vetoed a bill that would have outlawed the controversial procedure. There were enough opponents in the House to override his veto but not in the Senate. In explaining the veto, Mr. Clinton echoed the argument of Mr. Fitzsimmons and his colleagues.

"There are a few hundred women every year who have personally agonizing situations where their children are born or are about to be born with terrible deformities, which will cause them to die either just before, during or just after childbirth," the President said. "And these women, among other things, cannot preserve the ability to have further children unless the enormity — the enormous size of the baby's head — is reduced before being extracted from their bodies." A spokeswoman for Mr. Clinton said tonight that the White House knew nothing of Mr. Fitzsimmons's announcement and would not comment further.

In the vast majority of cases, the procedure is performed on a healthy mother with a healthy fetus that is 20 weeks or more along, Mr. Fitzsimmons said. "The abortion-rights folks know it, the anti-abortion folks know it, and so, probably, does everyone else," he said in the article in the Medical News, an American Medical Association publication.

Mr. Fitzsimmons, whose Alexandria, Va., coalition represents about 200 independently owned clinics, said coalition members were being notified of his announcement.

One of the facts of abortion, he said, is that women enter abortion clinics to kill their fetuses. "It is a form of killing," he said. "You're ending a life."

And while he said that troubled him, Mr. Fitzsimmons said he continued to support this procedure and abortion rights in general.

FOR A COPY OF THE AMERICAN MEDICAL NEWS ARTICLE AND OTHER DOCUMENTATION, PLEASE CALL NRLC, (202) 626-8820, fax (202) 347-3668

The Record

THURSDAY, FEBRUARY 27, 1997

ABORTION: Activists lied

Pro-choice advocates admit to deception

By RUTH PADAWER
Staff Writer

Leading abortion-rights proponents lied during the debate over "partial-birth abortions" to protect the controversial procedure against criticism, according to several abortion providers and pro-choice activists.

Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, said he "lied" in a November 1995 interview for ABC's "Nightline," when he said the procedure was rare and done only when the mother or fetus was gravely ill. It was a line passed by virtually all the top leadership of the pro-choice movement, and is still held as true by many pro-choice groups.

But Fitzsimmons now says that in the vast majority of cases, the procedure is used on a healthy mother who is five months pregnant with a healthy fetus. As news spread of his admission, abortion providers around the country agreed that the movement's claims were false.

Fitzsimmons' statement, which first appeared in an article to be published Monday in American Medical News, the American Medical Association's newsletter, marked the first time a prominent abortion-rights leader has strongly disputed the movement's claims.

"Some people wonder if I've gone off the deep end, but they're not getting it," Fitzsimmons said Wednesday. "It's a medically important procedure, and we shouldn't be afraid to speak candidly about it. We shouldn't be apologetic. We have nothing to hide."

The revelation comes one week before Congress is to consider a second attempt to ban the procedure, dubbed "partial-birth abortion" by its opponents. Congress passed a ban last year, but President Clinton vetoed it. The Senate failed to override the veto.

On Wednesday, a White House spokeswoman said Clinton opposes using the procedure on healthy women with healthy fetuses. "If this procedure is being used on an elective basis, where there's another procedure available, the president would be happy to sign legislation that would ban it," spokeswoman Mary Ellen Glynn said.

The procedure involves partial extraction of an intact fetus, feet first, with all but the head delivered. The skull is then punctured and the contents suctioned until the head collapses. Physicians call it dilation and extraction (D&X) or intact dilation and evacuation (intact D&E), because the fetus comes out whole.

Since 1993, abortion supporters and opponents have been engaged in a vicious public relations war over the procedure, with abortion foes using grisly illustrations to tap Americans' general discomfort with late abortions.

"The abortion law that currently exists in this country exists in dark part because its defenders have been able to avoid open public debate about what actually happens in an abortion," said Doug Johnson, legislative director for the National Right to Life Committee. "They have prevented the social reality from coming into sharp focus."

To a great extent, the "partial-birth" tactic worked; a July 1996 Gallup Poll found 71 percent of Americans favored banning "partial-birth" abortions.

To counter that campaign, the National Abortion Federation — the leader in the fight against a ban — produced several women who used the procedure to abort pregnancies terminated for medical reasons. Standing by Clinton as he vetoed the bill, they told anguishing tales that forced even some abortion foes to relent.

> The procedure involves partial extraction of a fetus, feet first, with all but the head delivered. The skull is then punctured and the contents suctioned until the head collapses.

The deception came when pro-choice leaders claimed that these were the typical intact D&E cases. For example, a Planned Parenthood Federation of America 1995 release said the procedure is "done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality."

Some abortion providers were uneasy at what they felt were distortions presented by their own side.

"The spin out of Washington was that it was only done for medical necessity, even though we knew it wasn't so," said Renee Chelian, president of the National Coalition of Abortion Providers and a member of the National Abortion Federation who runs three abortion clinics in the Detroit area. "I kept waiting for NAF to clarify it and they never did it. I got caught up. What do we do about this secret? Who do we tell and what happens when we tell? But frankly no one was asking me, so I didn't have to worry."

In April, at the federation's annual meeting, at least one administrator approached the group's executive director, Vicki Saporta, and urged more honesty.

"I argued from the beginning that they were taking the wrong approach," said Pam O'Leary, who runs a Toledo, Ohio, clinic that uses intact D&E in about half its post-20-week cases. "Sometimes as providers and as human beings, we all have to stop and make sure that what we're doing is what we can comfortably say we're doing. I can offer intact D&E and not be ashamed of it. I believe the work we do is honorable; it's for the health of women and society in general."

But the abortion federation and others were determined to stick with their original public claims. And when The Record and The Washington Post published articles in September reporting that the procedure was more common, and only rarely done for medical reasons, pro-choice leaders dismissed the stories. In November, the National Organization for Women issued a release saying such reports were "distorted by abortion opponents," when in fact they were true, they were based on interviews with providers who used the procedure.

Nevertheless, groups such as the abortion federation continue with their claims. On its Web page on Wednesday, the group claims that "this particular procedure is used only in about 500 cases per year, generally after 20 weeks of pregnancy, and most often when there is a severe fetal anomaly or maternal health problem detected late in pregnancy." NOW's home page makes the same claim, failing to distinguish between 2nd and 3rd trimester, and saying that fewer than 600 intact D&Es are performed annually.

To those who chafed at the false claims, this week's disclosures came as a relief.

"Anytime we collectively shy away from the hard answers, or spin something because it's more palatable instead of clarifying it, we lose credibility," said Ruth Arick, a former abortion clinic administrator who lives in Florida and now consults for clinics. "That credibility doesn't have to be lost forever; Ron is helping to rebuild it. It's a courageous step."

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March 6, 2003

Douglas Johnson
Legislative Director
National Right to Life Committee
512 10th Street NW
Washington, DC 20004

Dear Mr. Johnson:

I served as a full-time faculty member in Obstetrics and Gynecology at the University of Colorado Health Sciences Center until 1982 and thereafter at the University North Carolina until 1999. I am certified in Obstetrics and Gynecology and in Maternal-Fetal Medicine by the American Board of Obstetrics and Gynecology. My major academic interests were preterm birth, high-risk obstetrics and all aspects of labor and delivery. I am a Fellow of the American College of Obstetricians and Gynecologists, and I served on the Committee on Ethics including two years as the Chair of the committee. Currently I am Co-Editor-in-Chief of *The Obstetrical & Gynecological Survey,* a journal with wide distribution among American and foreign obstetrician/gynecologists.

I have reviewed the illustrations of the partial birth abortion procedure painted by Mrs. Tanja Bulter. Based on my 37 years of experience in clinical obstetrics, during which time I performed many deliveries of premature infants, I can testify that these illustrations accurately depict a fetus of approximately 24 weeks gestation and the anatomical and spatial relationships are accurate. Also, I believe these illustrations accurately depict the method of abortion described by Dr. Haskell in his presentation entitled "Dilatation and Extraction for Late Second Trimester Abortion," at the National Abortion Federation Risk Management Seminar in September 1992.

Sincerely,

Watson A. Bowes Jr., M.D.
Emeritus Professor of Obstetrics & Gynecology
University of North Carolina at Chapel Hill

Anthony P. Levatino, M.D., J.D.
5406 Remington Rd.
Las Cruces, N.M. 88011

March 4, 2003

Mr. Douglas Johnson
Legislative Director
National Right to Life
512-10th Street Northwest
Washington, DC 20004

Mr. Johnson:

I am a board-certified obstetrician/gynecologist and a Fellow of the American College of Obstetricians and Gynecologists. I performed both first and second trimester abortions from 1977 until 1985 including D&E abortions up to twenty-two weeks gestation. I was Assistant Professor of Obstetrics and Gynecology at Albany Medical College from June 1993 to September 2000 during which time I served as both Residency Program Director and Medical Student Education Director. I also served as the ACOG District II, Section IX Vice Chairman from 1995 until 1998. Currently I am engaged in the private practice of obstetrics and gynecology in New Mexico. My resume is attached.

The partial-birth abortion illustrations that I have forwarded to you were painted by Mrs. Tanja Butler who is currently a professor of art at Gordon College in Massachusetts. They were prepared under my supervision and, in my professional judgment, they accurately depict the D&X abortion described by Dr. Martin Haskell in his 1992 paper entitled "Dilation and Extraction for Late Second Trimester Abortion". This type of late-term abortion later came to be known by the legal term of art "partial-birth abortion" because of its similarity to full-term delivery of infants in breech position. The images are size-appropriate to a fetus of approximately 24 weeks gestation. This is a typical gestational age for partial-birth abortion although many of these procedures are performed at even later gestational ages.

Please feel free to contact me if you have any further questions.

Very truly yours,

Anthony Levatino, MD

Anthony Levatino, MD, JD

Press Release

This is a press release from the National Right to Life Committee (NRLC) in Washington, D.C., issued Tuesday, January 14, 2003, at 3:30 p.m. ET. For further information, call the NRLC Department of Media Relations at 202-626-8833, or visit the NRLC website at www.nrlc.org.

Guttmacher Survey of Abortion Providers Finds Reported Number of Partial-Birth Abortions More Than Tripled

A just-released survey of abortion providers by the Alan Guttmacher Institute (AGI) showed the reported number of partial-birth abortions more than tripling from the same organization's survey four years ago.

The AGI survey for 1996 (released in 1998) for the first time asked a question relating to partial-birth abortion (which they called "D&X"), and then estimated that "about 650" such abortions were performed annually in the U.S. Stanley Henshaw of the Alan Guttmacher Institute was quoted as saying, "The numbers aren't exact, but I'm pretty sure it's in the 500 to 1,000 range" (The New York Times, Dec. 11, 1998). Despite grave defects in the method by which that number was arrived at, and its obvious inconsistency with other evidence, the figure was immediately accepted as credible by some news media, and since has been cited by various news outlets and pro-abortion advocates.

The new survey, using the same method, estimates that 2,200 "D&X" (partial-birth) abortions were performed during 2000 -- more than tripling the 1996 figure.

"The number of partial-birth abortions reported has more than tripled in just four years," commented NRLC Legislative Director Douglas Johnson. "Either the number of partial-birth abortions is increasing rapidly, or the news media was mistaken in accepting the 1996 figure, or both. In reality, there is good evidence that even the new figure of 2,200 is much too low."

In the new study, AGI tries to minimize the significance of the 2,200 figure by saying that it amounts to only a fraction of 1% of all reported abortions. Johnson commented, "It is unbelievably callous to dismiss the killing of 2,200 mostly delivered babies as 'rare.' If a virus was killing 2,200 pre-mature infants, we'd call it an epidemic."

Johnson noted that the survey question describes the abortion method in a way that is so confused and inaccurate that even abortionists who have performed hundreds of partial-birth abortions, as legally defined, could honestly answer that they have never performed the procedure described in the question. Secondly, responses to the AGI survey are purely voluntary, and abortionists who perform large numbers of partial-birth abortions may be disinclined to feed the national controversy by voluntarily reporting.

Johnson noted that in 1997, Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers, gave a series of well-publicized interviews in which he repudiated the claim that the partial-birth abortion procedure was used rarely and mostly in acute medical situations. He said those claims were merely a "party line," and were false. The truth, Mr. Fitzsimmons said, was that "in the vast majority of cases, the procedure is performed on a healthy mother with a healthy fetus" (The New York Times, Feb. 26, 1997). He estimated that 4,000-5,000 abortions annually are performed by the partial-birth method. That is a sizable fraction of all of the abortions performed in the fifth month and later.

For more information on the number of partial-birth abortions, see:

http://www.nrlc.org/abortion/pba/PBA%20NYT%20lied.pdf

http://www.nrlc.org/abortion/pba/PBA%20activists%20lied.pdf

http://www.nrlc.org/abortion/pba/index.html

National Right to Life is the nation's largest pro-life organization, with affiliates in all 50 states and over 3,000 local chapters nationwide. National Right to Life works through legislation and education to protect those threatened by abortion, infanticide and euthanasia.

National Right to Life News, 6/19/97

Call It "Partial-Birth Abortion" — It's the Law!

By Douglas Johnson
NRLC Federal Legislative Director

WASHINGTON (June 16) - - You may have read in the paper that both houses of Congress have approved a bill "banning a medical procedure known as intact dilation and extraction," or words to that effect.

But actually, Congress never passed such a bill.

Rather, the House and Senate have given preliminary approval to a bill (HR 1122) to ban **partial-birth abortion** (unless necessary to save a mother's life). (The House must vote again on the bill to approve minor amendments made by the Senate, before it is sent to President Clinton, who says he will veto it.)

However, whenever the media uses the term chosen by Congress, **partial-birth abortion**, some opponents of the Partial-Birth Abortion Ban Act object because, they argue, "it is not a medical term."

Many journalists have been receptive to such pressure. Some recent wire service accounts of the congressional debate on the Partial-Birth Abortion Ban Act, for example, referred only to "certain late-term abortions" and contained no mention of the term "partial-birth abortion," and no description whatever of the type of abortion that would be banned by the measure.

A recent *Associated Press* dispatch, headlined "Bill Titles Can Be Distortions," claimed, "'Partial-birth' is the nonclinical name for a procedure known more scientifically as 'dilation and extraction.'"

That sort of comment is itself a distortion. When such mischaracterizations of the bill appear in the press, they should be challenged by knowledgeable pro-lifers on the grounds discussed below.

First, the term **partial-birth abortion** is now a ***legal term of art***. That is, **partial-birth abortion** has been adopted by numerous state legislative bodies as the "official" ***legal*** term to refer to a very specific and carefully defined method of killing partly born human beings. As of this writing, 13 states had enacted bills to ban **partial-birth abortion**, and it appears that several others may do so before the end of the year.

Second, the term **partial-birth abortion** is *not* equivalent to any of the terms of pseudo-medical jargon that pro-abortion groups insist are the proper "medical" or "clinical" terms.

Third, the term **partial-birth abortion** is not a "distortion" of reality, nor is the term in any way misleading. Rather, the term **partial-birth abortion** accurately conforms to terminology in related areas of law and medicine.

These points are expanded on below.

Partial-Birth Abortion: A Legal Term of Art

As of June 16, 1997, 13 states have already made it illegal to perform a **partial-birth abortion**, and three more such bills are awaiting action by governors.

In addition, lopsided majorities of both houses of Congress have voted to put the term **partial-birth abortion** into the U.S. Criminal Code.

All of these bills define **partial-birth abortion** in essentially the same way: an abortion in which the living baby is partly delivered before being killed. The proposed federal bill (HR 1122), which has served as the basic model for the state bills, would define **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 the delivery."

It is hard to see what justification journalists have for denigrating the legal terminology enacted in law by elected legislators, and substituting terms preferred by some pro-abortion advocacy groups. After all, several years ago when Congress defined certain firearms as "assault weapons," that is what they became - - in law and in the media - - even though manufacturers and users of such firearms prefer other terms.

The real reason that pro-abortion advocates dislike the term **partial-birth abortion**, of course, is that it gives the layperson a clear picture of how this type of abortion is performed. As Bear Atwood, president of the New Jersey chapter of the National Organization for Women (NOW), put it, "The whole term, 'partial-birth abortion' gives people pause." (*AP*, June 2)

Thus, pro-abortion advocates want to conceal the brutal reality behind a smokescreen of unintelligible pseudo-medical jargon.

However, the abortionists who perform partial-birth abortions, and their lobbyists, disagree among themselves as to what the "correct" jargon term should be. Indeed, various opponents of the bill have insisted on at least three *different* pseudo-"medical" terms: "intact dilation and evacuation," "dilation and extraction," and "intact dilatation and extraction."

Before Congressman Charles Canady (R-Fl.) introduced the Partial-Birth Abortion Ban Act in June, 1995, his staff researched the matter and found that none of those terms appeared in any medical dic-

tionary, nor in the Medline computer database, nor even in the standard textbook on abortion methods, *Abortion Practice* by Dr. Warren Hern.

The term "intact dilation and evacuation" (or "intact D&E") was invented by the late Dr. James McMahon, who is generally credited with developing the abortion method. But the national controversy over partial-birth abortion really began in 1993, when NRLC obtained a copy of a paper written in 1992 by Ohio abortionist Dr. Martin Haskell, in which Dr. Haskell explained step by step how to perform the procedure. In the paper, Dr. Haskell said that he had "coined" the term "dilation and extraction" or "D&X" to refer to the method.

McMahon, however, explicitly repudiated the use of the term "dilation and extraction" in a 1993 interview with *American Medical News*, saying, "I don't use the term D&X. . . . I think D&X has been defined in a way we don't want to embrace."

Besides being idiosyncratic terms, both "intact D&E" and "D&X" were very "blurry" terms. McMahon and Haskell never offered anything approximating rigid *definitions* of their coined terms. Because "intact dilation and evacuation" and "dilation and extraction" are not standard, clearly defined medical terms, Congressman Canady rejected them as useless for purposes of defining a criminal offense. A criminal statute that relied on such murky terms would be struck down by the federal courts as "void for vagueness."

[The term "*intact* dilation and evacuation" should not be confused with "dilation and evacuation" (D&E), which is a procedure commonly used to perform second-trimester abortions, involving *dismemberment* of the baby *while still in the uterus*. HR 1122 does not apply to this method at all.]

The Abortionists' Pseudo-Medical Terms Are Not Equivalent to "Partial-Birth Abortion"

It is simply ***inaccurate*** for journalists to graft abortionists' jargon terms onto the Partial-Birth Abortion Ban Act, because none of the so-called "medical" terms is equivalent to the definition of **partial-birth abortion** contained in HR 1122. The definition of **partial-birth abortion** is in some respects narrower and in some respects broader than the abortionists' terms, as explained below.

To understand these distinctions, it is first important to grasp exactly how a partial-birth abortion is typically performed. The abortionist pulls a ***living*** baby feet-first out of the womb and into the birth canal (vagina), except for the head, which the abortionist purposely keeps lodged just inside the cervix (the opening to the womb).

The abortionist then punctures the base of the skull with a surgical instrument, such as a long surgical scissors or a pointed hollow metal tube called a trochar. He then inserts a catheter (tube) into the wound, and removes the baby's brain with a powerful suction machine. This causes the skull to collapse, after which the abortionist completes the delivery of the now-dead baby.

The terms "intact dilation and evacuation" and "dilation and extraction" were sometimes used by Dr. McMahon and Dr. Haskell, respectively, to refer to certain procedures that are *not* banned by the Partial-Birth Abortion Ban Act, and shouldn't be banned. For example, both abortionists used their terms to refer to procedures in which they removed babies who had died natural deaths *in utero*. Such a procedure is not an abortion of any kind.

On the other hand, some variants of partial-birth abortions - - that is, some abortions involving the partial delivery of a living baby who is then killed - - would not have been considered "intact dilation and evacuation" procedures by Dr. McMahon or "dilation and extraction" procedures by Dr. Haskell, because they used those terms to refer to their own specific variations, and not to other specific techniques for killing partly born babies.

In other words, the McMahon and Haskell terms *overlap* with the class of abortions that would be banned by the Partial-Birth Abortion Ban Act, but the abortionists' terms are not congruent with the definition of **partial-birth abortion** in the bill.

On January 12, 1997, the executive board of the American College of Obstetricians and Gynecologists (ACOG) (an organization strongly opposed to all anti-abortion legislation), adopted a "statement of policy" which defined a procedure it called "intact dilatation and extraction" - - in effect, a hybrid term drawn from both of the McMahon and Haskell terms cited above. However, ACOG's definition does not agree with either of the other abortionists' terms, nor with the definition of **partial-birth abortion** found in the bill.

The ACOG statement defined "intact dilatation and extraction" as containing "all of" a list of "elements." Among the components of the "ACOG definition" were "*partial* evacuation of the intracranial contents of a *living* fetus to effect vaginal delivery of a dead but otherwise intact fetus." [emphasis added]

Read literally - - which is the way that criminal laws *must* be read - - this definition would not even apply to the typical partial-birth abortion described in Dr. Martin Haskell's 1992 instructional paper.

The ACOG definition covers only procedures in which the brain is "partially" removed from a "living" fetus. But medical experts agree that, in most cases, the thrust of the surgical scissors (or other instrument) into the baby's skull would kill the baby, and this occurs *before* the abortionist inserts a suction tube to remove the brain. ["When I do the instrumentation on the skull . . . it destroys the brain tissue sufficiently so that even if it (the fetus) falls out at that point, it's definitely not alive," Dr. Haskell explained in an interview with the *Dayton Daily News*, published Dec. 10, 1989.] In some cases the baby may indeed survive the skull-puncturing long enough to be killed by the brain-removal - - but it would be practically impossible for the government to prove that this had occurred in any given case, after the fact.

Moreover, typically the brain is then *entirely* removed, not "partially" removed.

Thus, most partial-birth abortions would not even be covered by the ACOG definition.

The Term "Partial-Birth Abortion" Conforms to Other Legal and Medical Usage

The term chosen by Congress, partial-birth abortion, is in no sense misleading. In sworn testimony in an Ohio lawsuit on Nov. 8, 1995, Dr. Martin Haskell - - who authored the 1992 instructional paper that touched off the national controversy over the procedure - - explained that he first learned of the method when a colleague "described very briefly over the phone to me a technique that I later learned came from Dr. McMahon where they internally grab the fetus and rotate it and accomplish - - be *somewhat equivalent to a breech type of delivery.*" [emphasis added]

However, some of those who have objected to the term "partial-birth" insist that the phrase implies that the abortion procedures at issue are usually performed at full term, or nearly full term - - which is only rarely the case. This objection confuses "full-term" with "birth," but those are two completely different things, both legally and in common parlance.

A full-term pregnancy is 40 weeks. As NRLC has emphasized since the Partial-Birth Abortion Ban Act was introduced in June, 1995, *most* partial-birth abortions are performed in the fifth and sixth months (20 to 26 weeks LMP, i.e., after the mother's last menstrual period). Generally, the partial-birth abortion method is not used before 20 weeks. A baby who is expelled alive from the womb at this stage (for example, in a spontaneous miscarriage) has indeed been legally "born." If a baby at 20 weeks or later (1) is expelled completely from the mother, and (2) shows even the briefest signs of life - - attempts to breathe, movement of voluntary muscles, etc. - - legally a *live birth* has occurred. Just about everyone will agree that such a live-born but "pre-viable" baby is protected by the Constitution and state homicide laws during her brief life outside the womb.

Obstetricians and perinatologists confirm that even during this immediate "pre-viability" range of 20 through 22 weeks, if a baby is expelled or removed completely from the uterus, she will usually gasp for breath for some time. (Thus, the victim of a partial-birth abortion is indeed only "inches from her first breath" when the surgical scissors penetrates her skull, just as NRLC has said in various literature.)

Moreover, even at 20 to 23 weeks, such a child typically will move and will have a heartbeat - - which sometimes continues for an hour or more after birth - - as the infant struggles to hold on to life.

Beginning at 23 weeks, the baby has a substantial chance for survival, which rapidly climbs to over 80% by 26 weeks (still considered the second trimester).

In summary: if a fetus/baby at (say) 21 weeks is spontaneously expelled alive, or if the head accidentally emerges during an attempted partial-birth abortion, a legal "live birth" has occurred - - even though that baby is not yet considered "viable."

Thus, there is nothing inaccurate or misleading about saying that the same living baby, entirely delivered into the birth canal *except for the head*, is "partly born." Nor is it inaccurate or misleading to call such a delivery, when performed as an abortion method, a "partial-birth abortion," which is what the various legislative bodies have done.

Moreover, large numbers of physicians are quite comfortable with the term partial-birth abortion. For example, the Physicians' Ad Hoc Coalition for Truth, a group of nearly 600 physicians (predominantly professors and other specialists in ob/gyn) embraces the term and has defended it as accurate.

President Clinton has also repeatedly used the term "partial-birth abortion."

Terminology: "Late-Term Abortions" is Murky and Misleading

Sometimes, the bill has been referred to as simply restricting "late-term abortions." This usage is murky and can be misleading. The bill does *not* contain any reference to the gestational age of the fetus/baby. From available evidence, it appears that the **partial-birth abortion** method is generally used after 20 weeks (4-1/2 months). However, there are indications that the method at times has been used somewhat earlier - - and the bill bans the practice of **partial-birth abortion** at any point in pregnancy.

When supporters of abortion such as President Clinton or NARAL say "late-term," they are using the phrase as code for "third trimester." But the vast majority of the abortion procedures prohibited by the Partial-Birth Abortion Ban Act are performed in the **fifth and sixth months** of pregnancy, *not* in the third trimester. Most of the lawmakers who oppose the Partial-Birth Abortion Ban Act tell their constituents that they generally oppose "late-term" abortions, without (in most cases) explaining that their usage of the term does not apply to the fifth and sixth months.

When the media uses the phrase "late-term" to apply, without distinction, both to bills that apply *mainly* to the fifth and sixth months and to bills that apply *not at all* in the fifth and sixth months, the media thereby obscures profound policy differences. Some pro-abortion lawmakers find such murkiness politically helpful, but when journalists engage in such unnecessary imprecision, they do a disservice to their readers or viewers.

They should just call it what the law calls it - - ***partial-birth abortion***.

(202) 626-8820

"This is not an emergency. . . . All of our procedures were considered elective."--
Claudia Crown Ades (April 12, 1996)

The Clinton Veto: Defending Euthanasia for the Partly Born?

On April 10, 1996, President Clinton vetoed the Partial-Birth Abortion Ban Act. Mr. Clinton then appeared before television cameras with five women who had received late-term abortions from the late Dr. James McMahon, including Claudia Crown Ades of Santa Monica, California. Mr. Clinton said the veto was necessary to preserve access to a "potentially life-saving-- certainly health saving" procedure. The women who were with him "never had a choice," he said.

On April 12, Ms. Ades and Douglas Johnson, legislative director for the National Right to Life Committee (NRLC), were simultaneously interviewed by telephone on "The Mike Malone Show," a live radio talk show broadcast on WNTM-AM in Mobile, Alabama. The following excerpts were carefully transcribed by NRLC from a tape recording provided by WNTM. Copies of the entire tape are available to legitimate news media from NRLC, (202) 626-8820, (301) 502-1170.

Claudia Ades: It is not a political agenda for me at all. It is simply that I want to protect women in the future that need this procedure. The procedure saved my life. [Material omitted.]

Douglas Johnson: I've heard Claudia say a couple of times that she thought this procedure saved her life. The bill explicitly permits the procedure to be done if it ever were necessary to save a woman's life.... [material omitted]

Mike Malone: Since I am a layman in all of these matters, as far as the medical end of it goes: Why would a Caesarian section not be appropriate in your case, Claudia?

Ades: Oh, well, that's very simple. There's two reasons. A Caesarian section is an emergency surgery that was designed [for] when an emergency is at hand, when the baby's life is at risk-- when the baby needs to survive, and it's an emergency situation. "A," this is not an emergency. And "B," we ***wanted*** to take our son out of torture. The

purpose of this is so that my son would not be tortured anymore. Douglas would have it that I delivered this baby and held him 'til he died, while he gasped for breath.
Malone: Douglas, is that true? What would you have told her to do?

Johnson: Well, you know, the story keeps changing here. A little while ago, it was to save her life. And now it's so that she wouldn't have to have the baby born alive...

Ades: [interrupting] No, this procedure was ***not*** performed in order to save my life. Had I carried the baby to term, and my son had died inside of me, then I would have been at risk. There's a severe risk if he had died inside of me.

Malone: Douglas, what would you have had her do?

Johnson: If a baby dies a natural death in utero-- it's a very tragic thing-- the removal of that baby is *not* an abortion. It's not a partial-birth abortion or any kind of abortion, and there's never been any kind of law against that before or after *Roe v. Wade.* It is not true...

Ades: [Interrupting] So in other words, knowing that my son was going to die, and was struggling and living a tortured life inside of me, I should have just waited for him to die-- is this what you're saying?

Johnson: Well, this is an argument [by Ms. Ades] for pre-natal euthanasia-- and we do disagree with that. But this is a far different argument than we started with, where it was asserted that this was necessary to save your life.

[material omitted]

Johnson: Every M.D. in Congress voted in favor of this bill, with one exception [the exception being Rep. Jim McDermott]. Senator Frist, a surgeon [who supported the bill], checked with the most eminent authorities in obstetrics that he could find, as he said on the Senate floor, and nobody could tell him that there was any medical justification for this procedure whatever.

You know, Dr. Martin Haskell was asked a lot of interesting questions in that tape-recorded interview with the *American Medical News.* [The interview was conducted in mid-1993; the tape-recording transcript was provided to the House Judiciary Committee by *American Medical News* on July 11, 1995.] He was asked specifically about whether he did the abortions only in these extreme cases that we're hearing about, these difficult circumstances. And this was his answer, and this is verbatim. He said, "I'll be quite

frank: Most of my abortions are elective...

Ades: [interrupting] Correct. That's correct!
Johnson: [continuing quote from Dr. Haskell transcript] ... in that 20-24 week range. In my particular case, probably 20% are for genetic reasons. And the other 80% are purely elective." [End of quote from transcript of interview with Dr. Martin Haskell.]

Ades: That's correct. My procedure was elective. That is considered an elective procedure, as were the procedures of Coreen Costello and Tammy Watts and Mary Dorothy-Line and all the other women who were at the White House yesterday. All of our procedures were considered elective.

Malone: Okay, gentleman and lady, please hang on, I am way over time here for a break.
[Material omitted]

Johnson: Where a baby has severe handicaps and disorders, it is sometimes necessary to deliver early. Most of the specialists in the country deliver babies with these disorders alive, without jeopardy to the mother. And they make the baby as comfortable as possible, give what pain relief is necessary, for whatever time that baby has allotted, in these cases. Again, the great majority of the partial-birth abortions have nothing to do with any of these [severe physical disorders of mother or baby] circumstances.

Continuation of excerpts from April 12, 1996, live radio debate between Claudia Crown Ades, who had appeared with President Clinton at the April 10 "veto ceremony," and Douglas Johnson, legislative director for the National Right to Life Committee. This transcript of the tape-recorded program was made by NRLC, (202) 626-8820.

Ades: This bill specifically is part of a political agenda.... It's the political agenda of the extreme right.

Johnson: Let's talk about that for a minute. This bill was supported by 39% of the Democrats in the House, including the leadership of the Democrats-- the leader, Dick Gephardt of Missouri, certainly no part of the 'radical right.' [Democratic whip] David Bonior...

Malone: I see Patrick Kennedy here, who supported it.

Ades: No, no! Senator Kennedy, excuse me, *Congressman* Kennedy does not support

this. *Senator* Kennedy was one of the leaders in the Senate opposing the bill.

Johnson: No, excuse me, we're talking about *Congressman* Patrick Kennedy.

Ades: Congressman Kennedy was-- along with Gephardt, along with many others-- were very, very misinformed, and very, and now, I can't guarantee you, I can't speak for them, but I can assure you, now that the President has listened to us-- and the President said to me [tangent on Clinton remarks at veto ceremony not transcribed here].

Malone: But the fact remains, does it not, that Gephardt and Representative Patrick Kennedy did support the bill?

Ades: Gephardt has stated that he was misinformed. [inaudible word] he made that statement.

Malone: Well, that's his problem, then. But did he support the bill, along with Kennedy?

Ades: Originally, yes. When it goes back to the House, I would be very surprised if you don't see a lot of those votes turn around. [material omitted]

Johnson: The question was, the 'far right." I guess that includes, then, the entire Alabama congressional delegation, of both parties, with the exception of Mr. Hilliard, and everybody out there that supports those members [of Congress], you can regard yourselves as part of 'the far right.'

A:ADESv3

MONDAY, AUGUST 17, 1998 THE WASHINGTON POST

An Unviable Abortion Bill

The so-called Late-Term Abortion Restriction Act, promoted by Reps. Steny Hoyer (D-Md.) and James Greenwood (R-Pa.), is a counterfeit designed to provide cover for politicians who oppose the Partial-Birth Abortion Ban Act [letters, July 30].

These lawmakers claim that their bill "prohibits all abortions performed after fetal viability," with a seemingly narrow exception. But in reality, it "prohibits" not a single abortion, by the partial-birth method or any other.

Most partial-birth abortions are performed in the fifth and sixth months of pregnancy. Reps. Hoyer and Greenwood do not regard these as "late-term," although the babies' lung development in these months is at most a few weeks short of the "viability" point at which they could survive independently of their mothers (at about 5½ months).

Many other victims of partial-birth abortion are certainly past that "viability" point—but whatever a baby's exact stage of lung development, he or she would find no protection in the Hoyer-Greenwood bill. First, the bill gives the abortionist authority to determine what the criteria for "viability" will be and which babies meet those criteria. Practitioners of late abortions usually insist that "viability" does not occur until well into the seventh month, and under the Hoyer-Greenwood bill, no abortionist can legally be deemed "wrong" in such a declaration.

Second, even during the final three months of pregnancy, the Hoyer-Greenwood bill would permit abortion if "in the medical judgment of the attending physician, the abortion is necessary . . . to avert serious adverse health consequences to the woman." At a March 12, 1997, press conference, Mr. Hoyer was asked what he meant by his language. Rep. Hoyer responded, "Does it include mental health? Yes, it does." He explained that this would apply in cases in which "it poses a psychological trauma to the woman to carry to term."

Thus, the Hoyer-Greenwood bill authorizes abortions of third-trimester, indisputably viable infants, whenever an abortionist decides that the abortion would preserve the mother's "mental health." Any lawmaker who is prepared to defend such a policy should co-sponsor the Hoyer-Greenwood bill.

DOUGLAS JOHNSON
Legislative Director
National Right to Life Committee
Washington

Broadcast January, 1997

Transcript

Congressional Debates | Wall Street Journal | Main Titles | Tobacco Hearings | Moving Pictures

OPEN

Hello. I'm Alex Jones, the executive editor of *Media Matters*. *Media Matters* probes that controversial, feared, even sometimes hated group known as the news media. We look at how journalists work, and how WELL they do their critically important job.

Tonight *Media Matters* presents reports by three journalists who - this time - are taking a hard look at their FELLOW journalists. Nancy Hicks Maynard, formerly of *The New York Times* and *The Oakland Tribune*, will look at the debate within the media prompted by new technology that makes it EASY to alter photographs without ANYONE being the wiser. Are news photographs NEWS . . . or are they art?

Author and journalist David Remnick of *The New Yorker* examines the powerful editorial page of The *Wall Street Journal*, whose fierce conservative voice has made it the scourge of the Clinton Administration.

But first, we take a look at how the news media covered the effort to ban intact dilation and extraction, a procedure better known as partial birth abortions. There is no more divisive or passionately argued issue than that of abortion, and reporters are not immune to those passionate convictions. According to various surveys, most journalists - like most Americans - favor abortion rights. But a journalist's job is to put personal beliefs aside when covering a story.

We're going to explore how reporters' BELIEFS concerning abortion rights may have affected coverage of this VERY sensitive issue. The effort in Congress to outlaw this abortion procedure became a battleground off opposing views. But what are the facts? Terry Eastland, editor of *Forbes' Media Critic Online*, is our reporter.

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SOUND MONTAGE OF CONGRESSIONAL DEBATES

Man
Never in my career have I heard a physician refer to any technique as a partial birth abortion. (Overlap)

TV Commentator
On Capitol Hill, abortion is re-emerging as a national election issue.

TV Commentator
(Overlap) victory for anti-abortion forces ...

(Overlapping Voices)

Woman
This is one of the most devastating (Overlap) and your child can really not(?) live.

TV Commentator
It's a very rare procedure, but it is the first time ... (Overlap)

Woman
And yet this bill would outlaw an emergency medical procedure.

Man
Why are we doing this ... to our children?

(Pause)

Man
This legislation forces us for the first time to acknowledge (Overlap)

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Terry Eastland, *Media Matters* Reporter
In June of 1995, a bill was introduced in the Congress banning a medical procedure that its sponsors called partial birth abortion ... in which the doctors who performed it refer to as intact dilation and extraction. The bill was passed by Congress and vetoed by President Clinton in April, 1996.

President Clinton
... so that we don't put these women in a position, and these families in a position, where they lose all possibility of future child bearing.

Eastland

By October, Congress had failed to override the veto and the bill was dead. Over those 15 months, the press tracked the bill's political journey and yet failed to report the substance of the story.

Karen Tumulty, *Time Magazine*
I think that the coverage of the partial birth abortion debate has been abysmal. Uh, primarily because there are facts and figures being thrown around out there where basically facts and figures do not exist.

John Leo, *U.S. News And World Report*
I can't think of a major story in the last ten years that has been distorted as fully as abortion. And the partial birth abortion was so egregiously handled that I think someone should do a great book on how the press mangled this issue.

Eastland
A little known abortion procedure pioneered by a Los Angeles doctor that is usually performed after 20 weeks of pregnancy. The physician dilates a woman's cervix in order to pull the often living fetus feet first through the birth canal before collapsing the skull in order to fully remove it.

Eastland
Diane Gianelli of the *American Medical News* became one of the first reporters to write about this procedure when anti-abortion groups began targeting it in 1993.

Diane Gianelli, *American Medical News*
The abortion debate over the years has successfully been framed as a woman's rights issue. And ... the pro-life community for years has been trying to refocus the debate to get people to look at the fetus, or the baby. And they have not been very successful at that. So, when they found Dr. Haskell's(?) printed paper describing the procedure, and they came up with line drawings ... that was their ace in the hole.

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Eastland
Anti-abortion groups created an ad featuring a graphic illustration of the abortion procedure using a description from an Ohio abortion doctor.

Douglas Johnson, National Right To Life Committee
We felt that this was one particular type of abortion on which there was really impeccable documentation. The baby, while still alive, is pulled out feet first ... everything except the head ... and then the head is punctured ... all of this while the baby is still alive. And so we thought this is something, perhaps, we can get enough support to do something about and save thousands

of lives a year.

Kate Michelman, *NARAL*
The nature of this debate really gave them, the opponents of choice, an opportunity to sensationalize, inflame and ... and really draw attention away from what I consider and most people consider to be the central question in the abortion debate which is who should decide.

Eastland
Abortion opponents claim that the procedure was used thousands of times a year ... mainly in the second trimester of pregnancy ... and mostly on the healthy fetuses of healthy mothers. Countering their campaign, abortion rights groups said that the procedure was used only several hundred times a year ... mainly in the third trimester and almost always in cases of severe fetal deformity and to protect the health or the life of the mother.

Rep. Henry Hyde, (R.) IL
You wouldn't take a coyote, a mangy raccoon and treat that animal that way because it's too cruel.

Woman
There are emergency medical procedures done in the most tragic and painful circumstances ... and yet this bill would outlaw an emergency medical procedure.

Sen. Robert Smith, (R.) NH
Why are we doing this?

Eastland
Advocates on both sides made exaggerated claims. Many opponents of the ban said that the procedure was used only in dire circumstances, while supporters asserted that healthy babies were being aborted in the final weeks of pregnancy.

Eastland
Sorting through this rhetoric, reporters faced two key questions. How many of these abortions are actually performed, and under what conditions. The absence of accurate statistics added to the difficulties in reporting this story.

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Andrew Rosenthal, *The New York Times*
With abortion, all you have are various people who gather reported abortions. There's the Guttmacher(?) Institute of people like this who collect statistics on reported abortions. Well, that could be 90 percent of them, it could be 100 percent of them, or it could be 20 percent of them. We have no idea.

Tumulty
The only people who really know how often this procedure is performed and for what reasons are the people who do it. And in trying to collect that information, you are first, you know, at the mercy of the anecdote. Uh, somebody can tell you what they do in their clinic, but that is far from an overall picture. And also you are going to have to rely on the word of people who don't want to talk about it ... and who have very good reasons not to talk about it. Doctors are harassed and stalked.

Eastland
Given the difficulties in getting reliable statistics, journalists tended to reduce the story to one of conflicting claims.

Jonathan Alter, *Newsweek*
The journalist will go to one side, and then go to the other side and think that by doing that they are reporting the story, uh, when in fact what they are doing is they are reporting on the politics of a story and the advocacy involved in a story, but not necessarily about the nub of the story itself.

Eastland
In reporting these claims, journalists tended to accept as fact assertions provided by abortion rights groups.

Tumulty
By and large most news organizations have been far more willing to accept what facts, figures and examples are offered by the ... the abortions rights side and to discount the other side's argument.

Eastland
The Washington Post reported that the procedure is believed to be used rarely, and mostly in cases when the woman's life is at risk or the fetus is seriously deformed. Citing unnamed national research groups the Los Angeles Times said that about 13,000 abortions are performed after 20 weeks gestation, and only about 500 involved the disputed procedure.

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John Leo, *U.S. News & World Report*
David Shaw(?) did this wonderful series, as you know, years ago in the Los Angeles Times ... a huge four part series for which he was nominated for a Pulitzer on how the press routinely gets the abortion story wrong. And the reason that he concluded was that the newsroom is so pro-abortion that it can't get the story straight.

Eastland
Shaw's series based on his own examination of abortion coverage and interviews with more than 100 journalists did in

fact come to the conclusion that a pro-abortion rights bias exists within the press.

Alter
Journalists are disproportionately liberal on this issue. So they're more likely to rely on either consciously or unconsciously, the information that they get from the pro-choice side.

Coreen Costello
We had one hope ... and that was that we would be able to hold our daughter (Overlap)

Eastland
Abortion rights advocates brought forth five women who had undergone the procedure for reasons of severe fetal deformity, and all in the third trimester.

Tammy Watts
I went in for a routine seven month ultrasound.

Eastland
Their cases immediately became the core of stories in print and on television programs such as NBC's Dateline and CBS's 60 Minutes.

Ed Bradley
Mickey Wilson(?) is a pediatric nurse and the mother of two children. In April of '94 she was eight months pregnant with her third child when she discovered her baby's brain was growing outside its head.

Tumulty
The piece that 60 Minutes did really fell into all the traps that this whole debate presented. They used these incredibly tragic examples, but examples that only portrayed basically one side of the debate.

Eastland
Echoing the position of abortion rights advocates, 60 Minutes focused on those abortions done by this procedure in the third trimester of pregnancy. The program made little effort to convey the view of abortion proponents that the procedure is most often used on healthy fetuses in the second trimester.

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Tumulty
These women had these unspeakable tragedies. And because those were the cases that we were able to get to immediately, and get those people on camera or into print ... those are the cases we relied on.

(Pause)

Ruth Padawer, *The Record*
Most of the stories that I read said that intact D&E(?) occurred only for fetal anomalies or tragic circumstances and that's not at all what I found.

Eastland
Ruth Patower(?), a reporter for *the Record*, a New Jersey paper was asked to research the abortion procedure. In September of 1996, some 14 months after the bill was introduced in Congress, her work led to the first independently researched article on the issue in the mainstream press.

Padawer
I was perplexed that the facts were in dispute. Uh, I had asked both sides to send me material and they both sent quite a bit of material. And ... uh, I was surprised at how far apart they were. Once I collected everything that I thought I needed from each side ... where they laid out their best cases, I decided to call physicians that I knew in New Jersey assuming that they would direct me to people in New York City or Pennsylvania. My understanding was that there were no intact D&Es in New Jersey. And in the course of our conversation the physician said, "I do them." And I was quite startled. I didn't realize that. And then he very frankly began telling me how he did them and how often he did them and what were the circumstances that brought women there.

Eastland
Through her conversations with two doctors and a clinic administrator, Patower discovered that in New Jersey alone roughly 1500 of the procedures were performed each year ... close to three times the number that abortion rights advocates had claimed for the entire country. And the procedure was mainly done in the second trimester on healthy fetuses.

Tumulty
Once the story was out they were immediately attacked and their figures were denied by the clinic involved. And they ... basically had no recourse to defend it other than to say, "We stand behind our story."

Padawer
I don't know how many abortions occur in that clinic. I am not there watching. What I do know is that two staff physicians independently told me those figures.

Eastland
Is it possible to verify Patower's reporting? In its coverage the Washington Post repeated mistakes made by many other newspapers. After complaints from anti-abortion groups, David Brown, a Post reporter and medical doctor, set out to discover

the facts for himself.

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David Brown, *The Washington Post*
I was not looking for anecdotes, I was trying to get some sense of getting the totality of these procedures ... what fraction of them involve pregnancies in which the woman's health is at risk, what fraction of them involved pregnancies in which the fetus is clearly not going to survive even if he or she is born at term ... and the only source of that information was the doctors.

Eastland
Brown's reporting resulted in two articles ... a co-authored front page story and a second, more detailed piece in the paper's health section. He drew his profile of the procedure from extensive interviews with five abortion doctors in different parts of the country.

Eastland
Can you describe for us what your reporting found?

Brown
My reporting showed that a large number, possibly even a majority of these procedures were done on normal fetuses ... most of them were done before the period of viability. Cases in which the mother's life was truly at risk were extremely rare. Most people who got this procedure were really not very different from, uh, most people who got abortions.

(Pause)

Eastland
The Washington Post and the Record were able to move beyond the rhetoric and the press releases to uncover key facts about this abortion procedure. Yet it took more than 14 months for those facts to emerge.

Alter
For news organizations to allow months to pass before they try to go out and do their own, independent assessment of the facts ... was a real problem. And they ... they let themselves substitute political reporting ... what was going on on the Hill, which is just a lot of unreliable, uh, advocates shouting at each other ... to drive out the real reporting, uh, of how many of these abortions were taking place and where, and at what time in women's pregnancies.

Eastland
And in the case of this particular story, reporters tended to accept as true the assertions of the abortion rights side ... despite evidence calling into question their claims.

Padawer
One of the unsettling things of what I found in the reporting, uh, was ... the discovery that the pro-choice side was playing fast and loose with the facts. And that that ... uh, that there's a credibility gap there that there wasn't before ... for me.

Gianelli
It's a very difficult issue to cover, uh, as a reporter because you have to ... you have to be not pro-life, not pro-choice, but pro-truth when you're writing these stories. Otherwise your stories will spin. You have to go to both sides, the primary sources, and then sit down and write it straight. And I think that's a very difficult thing to do.

Leo
It was very unfortunate. I think that the media, both TV and the print media, uh, used the arguments and often the language of the pro-choice side. They did not examine the ca... the weaknesses in their case, and I think the, uh, general coverage was ... varied from weak to openly distorted. I don't think the message was clearly brought to the American people what was at stake here.

Eastland
If a new bill banning the procedure is introduced in Congress, the press will be called upon once again. The question remains whether uncovering the divisive subject of abortion, the press can rise above the politics, and its own predilections ... to report the facts.

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PREPARED STATEMENT OF KATHI A. AULTMAN, MD

Chairman Chabot and distinguished members of the House Judiciary Subcommittee on the Constitution, Thank you for allowing me to testify before you regarding H.R.4965, the "Partial-Birth Abortion Ban Act of 2002".

My name is Kathi A. Aultman, MD. I am a board certified obstetrician gynecologist, a fellow of the American College of Obstetricians and Gynecologists (ACOG), and a member in good standing with the American Medical Association (AMA). I have been in private practice in Orange Park, Florida for 21 years. I am on the Ethics Commission of the Christian Medical and Dental Associations (CMDA) and a member of Physicians' Ad Hoc Coalition for Truth (PHACT).

I have spent my entire career as a women's advocate and have a keen interest in issues that impact women's health. I was the co-founder and co-director of the first Rape Treatment Center of Jacksonville, Florida and performed sexual assault exams as a medical examiner for Duval and Clay Counties. I also served as the Medical Director for Planned Parenthood of Jacksonville from 1981 to 1983.

After mastering first trimester and early second trimester *dilation and curettage with suction (D&C with suction)* procedures I was able to "moonlight" at an abortion clinic in Gainesville, FL. I sought out special training with a local abortionist in order to learn mid second trimester *dilation and evacuation (D&E)* procedures. Although I do not currently perform abortions, I have continued to dialogue with abortion providers regarding current practices and have studied the medical literature on abortion. I continue to perform D&C with suction and rarely D&E and *Inductions* in cases of incomplete abortion and fetal demise.

I see and treat women with medical and psychological complications from abortion and have managed and delivered women with pregnancies complicated by fetal anomalies, and medical, obstetrical, and psychological problems. I have personally had an abortion and I have a delightful adopted cousin who survived after her mother aborted her.

I have first hand knowledge and familiarity with the partial-birth abortion issue, having testified before legislative bodies in Florida and Vermont. I also testified in court as an expert witness in Arkansas and Virginia and assisted Florida and several other states in designing and/or defending their bans.

I support HR4965, the "Partial-Birth Abortion Ban Act of 2002", for the following reasons:

1) This bill clearly distinguishes Partial-Birth Abortion from other abortion procedures.
2) This bill will not endanger women's health.
3) It protects women from being subjected to a dangerous unproven experimental procedure.
4) Partial-Birth Abortion has blurred the line between abortion and infanticide.
5) It bans a procedure that is abhorrent to the vast majority of Americans.

1) HR 4965 CLEARLY DISTINGUISHES PARTIAL-BIRTH ABORTION FROM OTHER ABORTION PROCEDURES.

Partial-Birth Abortion is a legal term that covers a set of circumstances that culminate in the physician intentionally killing the fetus after it has been partially born.

As defined in the act:

> "the term "partial-birth abortion" means an abortion in which (A) the person performing the abortion deliberately and intentional 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;"

(In the rest of the text the term "partially born" will be defined as the position of the fetus as described in HR 4965.)

Partial-Birth Abortion includes but is not limited to D&X performed on live fetuses. It would also include a procedure used in China where formaldehyde is injected into the baby's brain through its fontanel (soft spot), after the head has been delivered, in order to kill it prior to completing the delivery. It does not prohibit medical abortions, D&C with suction, or D&E procedures. It would not cover Induction unless the physician intentionally intervened during the delivery portion of the procedure and killed the fetus after it had been "partially born. It would not cover a D&X on a dead fetus nor would it cover the accidental death of baby during the normal birth process. Under HR 4965 a Partial-Birth Abortion is allowed if it is "necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury.

The "Partial-Birth Abortion Ban Act of 2002" eliminates the concern that D&E is prohibited under the act by more precisely defining what is meant by a Partial Birth Abortion. According to the Supreme Court in Stenberg v Carhart, the Nebraska statute banning Partial-Birth Abortion was unconstitutional because it applied to *dilation and evacuation (D&E)* as well as to *dilation and extraction (D&X)*. The court held that the statute was unconstitutional because it imposed an undue burden on a woman's ability to choose D&E (the most common 2nd trimester abortion

procedure), thereby unduly burdening her right to choose abortion itself. The Court commented, however, that if the definition were more narrowly defined to clearly differentiate D&E, a ban might be constitutional.

Despite assertions to the contrary by some abortionists, both the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) clearly distinguish between D&X and D&E.

D&X (dilation and extraction or intact dilation and evacuation) is generally performed from about 20–22 weeks gestation and beyond and has been done as late as 40 weeks (full term). It is prohibited by HR 4965 if it is performed on a live fetus. In D&X the fetus is delivered intact except for the decompressed head. In order to accomplish this, Laminaria (dried seaweed) or a synthetic substitute, is inserted into the cervix over the course of several days. The goal is to dilate the cervix just enough to allow the body, but not the head, to be pulled through the cervix. The membranes are ruptured and the lower extremities are grasped under ultrasound guidance. If the fetus is not already breech (feet or bottom first) the baby is converted to that position using forceps. The fetus is then delivered except for its head by a method called breech extraction. The abortionist then thrusts a scissors into the base of the skull, suctions out the brains, and then completes the delivery. The placenta is then extracted using forceps and the cavity is curetted to remove any additional tissue. Prostaglandins and/or oxytocin may be used to help "ripen" the cervix and/or help the uterus contract. (There are times when the head may be pulled through the cervix as the abortionist is extracting the body. In that circumstance, if the abortionist isn't careful to hold the fetus in the vagina prior to killing it, he will be faced with the complication of an unwanted live baby.)

D&E (dilation and evacuation) is generally used from about 13–15 weeks up until 20–22 weeks and occasionally 24 weeks gestation (early to mid second trimester) and is not prohibited under HR'4965 because the fetus is removed in pieces. In D&E the cervix is dilated usually using Laminaria over the course of 1–2 days. It is dilated just enough to allow the forceps to be inserted into the uterine cavity and for body parts to be removed. The membranes are ruptured and the fluid is generally suctioned. The forceps are inserted into the uterine cavity with or without ultrasound guidance. Usually an extremity is grasped first and brought down into the vagina. The rest of the body cannot pass through the cervix so the abortionist is able to detach it by continuing to pull on it. After the smaller parts have been removed, the thorax and head would be crushed and removed from the uterine cavity. The ability to dismember the fetus is based on not over-dilating the cervix. Prostaglandins and/or oxytocin may be used to help "ripen" the cervix and/or help the uterus contract. D&E is not prohibited under the act because fetus dies as a result of being dismembered or crushed while the majority of the body is still within the uterus and not after it has been "partially born".

D&C with Suction (dilation and curettage with suction) is generally used from 6 weeks up until 14–16 weeks gestation (first and early second trimester). It is not prohibited by HR 4965. In this procedure the cervix is generally dilated with metal or plastic rods at the time of the procedure, but occasionally Laminaria are inserted the night before for the later gestations. A suction curette is then inserted and the contents of the uterus are suctioned into a bottle. The cavity is then usually checked with a sharp curette to make sure all the tissue has been removed. At times forceps are needed to remove some of the fetal parts in the later gestations. Prostaglandins and/or oxytocin may be used to help "ripen" the cervix and/or help the uterus contract. It would not be prohibited under this act because the fetus or fetal parts pass from the uterus through the suction tubing directly into a suction bottle. The fetus is therefore not intentionally killed while it is "partially born". The fetus is usually killed as it is pulled through the tip of the suction curette or on impact in the suction bottle.

Medical Induction is generally performed from 16 weeks gestation to term. This method induces labor and subsequent delivery of an intact fetus and would not be prohibited by HR 4965. Labor may be induced in several ways. The older methods are termed Instillation Methods because they involve injecting something into the uterus. Saline (a salt solution) injected into the amniotic cavity generally kills the fetus and then causes the woman to go into labor but is associated with significant risk. Urea may also be instilled and appears safer than saline but there is a higher incidence of delivering a live baby. It may also need to be augmented with prostaglandins. In another method a prostaglandin called carboprost (Hemabate) is injected into the amniotic cavity or given IM to stimulate labor but may not always kill the fetus. An intra-fetal injection of KCL or Digoxin may be necessary to prevent a live birth. (*Gynecologic and Obstetric Surgery*, Nichols 1993, 1026–1027) *Newer methods* employ the use of prostaglandins. PGE1 (misoprostol) and PGE2 are generally used vaginally, often in conjunction with oxytocin. These methods gen-

erally result in the delivery of a live baby so if an abortion is intended an intra-fetal injection of KCL or Digoxin is generally utilized. *PGE2 and oxytocin may be used in cases of previous C-section or uterine surgery.* HR 4965 would not prohibit a Medical Induction unless the abortionist purposely halted the birth process in order to intentionally kill a still living "partially born" fetus.

Some of the concerns expressed about Inductions, as opposed to surgical methods (D&E and D&X), include 1) the psychological and physical pain of labor, 2) the time involved, and 3) the fact that they are often done in a hospital and are therefore more costly. Especially if an abortion is the goal, the pain and even the memory of labor can be eliminated with medication. All three procedures generally require more than one day except perhaps in the case of an early D&E. The mean Induction time with vaginal prostaglandins is 13.4 hours and 90 % are delivered by 24 hours. All of these methods have been performed in both inpatient and outpatient settings, however, as the gestational age and therefore the risk increases, the inpatient setting generally becomes safer.

Cephalocentesis is a medical procedure during which a needle is inserted into the head of a fetus with hydrocephalus (water on the brain) in order to drain the fluid. It would not be prohibited by HR4965. This procedure can be lifesaving for the fetus and may prevent brain damage by taking pressure off the brain. The needle is usually inserted through the abdomen but may also be inserted vaginally if the fetus is in the head first position. This is done while the fetus is still inside the womb. This would not be prohibited even if the fetus had been delivered breech if were done to draw off fluid (not brain tissue) in order to shrink the head to allow delivery of an entrapped hydrocephalic head.

Death during the birth process would not be prosecuted under HR 4965, whether or not labor was induced, as long as the fetus was not intentionally killed while it was partially born.

Passage of RH 4965 will not create an undue burden on a woman seeking an abortion because its narrow definition of Partial-Birth Abortion excludes the commonly used methods of abortion which provide alternatives at every gestational level.

Some abortionists have begun to use parts of the D&X technique on earlier gestations. The mere fact that it is possible to use this procedure on pre-viable fetuses should not prevent it from being banned.

2) HR 4965 WOULD NOT ENDANGER WOMAN'S HEALTH .

Obstetricians regularly handle medical complications of pregnancy that may threaten a woman's health or life without having to resort to using a Partial-birth Abortion. When the baby is wanted and the pregnancy must be terminated after or near viability, Induction and C-section are commonly used in an attempt to save both the mother and the baby. Destructive procedures are only considered pre-viability or if the pregnancy is unwanted. Standard procedures such as D&C with suction, D&E, and Induction may be used to terminate an unwanted pregnancy. In an emergency situation, when immediate delivery is necessary D&X would not be used because of the length of time required to dilate the cervix. In it's report on Late Term Pregnancy Termination Techniques, the AMA stated, "Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery." (AMA PolicyFinder HOD, A–99, H–5.982 Late Term Pregnancy Termination Techniques).

Although a Partial-Birth Abortion is never necessary to safeguard the health of the mother, HR 4965 provides an exception just in case "it is necessary to save the life of a mother whose life is endangered by a physical disorder, illness or injury." The AMA report on Late Term Pregnancy Termination Techniques states that, "According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion and ethical concerns have been raised about intact D&X." (AMA PolicyFinder HOD, A–99, H–5.982 Late Term Pregnancy Termination Techniques). Even if there were such a situation, however, the fetus could be injected with Digoxin or KCL, or the cord could be cut at the start of the procedure, in order to kill the fetus so that the procedure could be performed without risking prosecution.

In my opinion the health exception required under current case law is so broad that it basically allows elective abortion through term.

3) IT PROTECTS WOMEN FROM BEING SUBJECTED TO A DANGEROUS UNPROVEN EXPERIMENTAL PROCEDURE.

D&X is an experimental procedure that has not been adequately evaluated. There have been no peer reviewed controlled studies that have looked at the benefits and risks of D&X as compared to D&E, Induction, Delivery, or C-Section. We do not have adequate data on its mortality or morbidity. The complications of D&X include hemorrhage, infection, DIC, embolus, retained tissue, injury to the pelvic organs including the bowel and bladder, as well as an increased risk of cervical incompetence. These risks are the similar to those associated with D&E, however, these risks increase with increasing gestational age and D&X may be done at much later gestational ages. There was some suggestion in earlier studies that greater artificial cervical dilation increases the risk cervical incompetence. With D&X the cervix must be dilated significantly more than with D&E.

One of the problems in determining both the frequency and mortality and morbidity of the various abortion procedures is that the reporting of the numbers and types of abortion procedures at various gestational ages is grossly inadequate. Four states including California don't report their statistics to the CDC and many don't record the necessary details. D&X is not reported separately nor is it clear which category it should be reported under. There is also inadequate reporting of the complications of abortion.

At times I am called to see women in the ER with complications of abortions. I had always assumed that when I wrote the diagnosis on the hospital face sheet that those cases would be reported to the state. I was shocked when I found out that they aren't reported to anyone and that there is no requirement to report them. In light of that, how can we determine what the true complication rate is for any of these procedures since many never return to their abortion provider.

D&X is often done in outpatient settings. The abortionist may not have hospital privileges or know how to handle the complications of the procedure especially if he is not an OB/GYN.

Although, previous C-section has been cited as a reason why D&X might be preferred over Induction, Dr.Haskell, the originator of the procedure, excluded those cases. It is now accepted practice to use prostaglandin E2 and /or oxytocin for Induction after previous C-section.

4) PARTIAL-BIRTH ABORTION HAS BLURRED THE LINE BETWEEN ABORTION AND INFANTICIDE.

When I first heard the term I thought it strange that it would called Partial-Birth Abortion and not Partial-Birth Infanticide. I didn't understand why Drs. Haskell and McMahon weren't charged with murder, or at least lose their license to practice medicine, once they revealed what they were doing in a D&X. The fact that the babies weren't 100% born when they were killed seemed to me like an awfully flimsy technicality.

Who decided that just because a fetus was within the birth canal, the abortionist could still kill it? Does this mean that the abortionist may kill a baby that has just one foot still in the vagina? Can a woman request, even demand, that the physician attending her delivery, kill her child once it's head has been delivered if she finds it is the wrong race or has a cleft lip? Currently, her claim would be valid if she stated that the birth would damage her psychologically and might actually place her life at risk if her abusive husband found out.

We already have had cases where an infant was not treated with the same care because the mother had intended to abort it. We had several cases where teens killed their babies after delivery and we were horrified. What hypocrites we are. Had they been smart enough to leave a foot in the vagina prior to killing the baby they could only have been charged with practicing medicine without a license.

When my daughter was working on a paper on the Holocaust for school, I became particularly interested in one of her sources. It discussed the mindset of the medical community in Germany right before the holocaust. I was saddened and concerned when I considered where we are as well. Not only are we killing babies during the process of birth, but there are also those in the medical community who are advocating. euthanizing babies up to 3 months at the request of the parent. In Nazi Germany defective babies were the first to be eliminated.

In light of current case law, the passage of HR 4965 is necessary in order to reestablish a bright line between abortion and infanticide.

5) HR 4965 BANS A PROCEDURE THAT IS ABHORRENT TO THE VAST MAJORITY OF AMERICANS.

Even though I had done mid 2nd trimester D&Es, I was appalled when I heard about D&X and really didn't believe it was being done. The majority of Americans also have found Partial Birth Abortion abhorrent and have supported legislation in numerous states banning its use.

When Nebraska's Partial-birth Abortion Ban was ruled unconstitutional several things happened:

(1) The line between abortion and infanticide was blurred,

(2) The State's ability to regulate abortion at any gestation even in the case of a procedure as repugnant as PBA was effectively blocked and

(3) The State's ability to promote any interest in the potentiality of human life, even post viability, was lost.

For these reasons I feel that this committee is justified in sponsoring legislation to once again attempt ban partial-birth abortion.

Both Roe and Casey stated that the State has an interest in potential life and could even proscribe certain techniques as long as it did not create an undue burden for women obtaining abortions.

The court emphasizes that "By no means must a State grant physicians unfettered discretion in their selection of abortion methods," and yet with this decision they have done just that. The fact that a D&X can be done on a nonviable fetus does not mean that it cannot be banned as long as the prohibition does not unduly burden a woman's ability to obtain an abortion. Since there are other more acceptable procedures available this is not an issue.

As a former abortionist I can tell you that the worst complication for an abortionist is a live baby at the end of the procedure. The goal is a dead baby.

At our hospital a fetal death before 20 weeks it is considered a spontaneous abortion or miscarriage. After that time it is considered a stillbirth and a death certificate must be filled out and the baby must be sent to the funeral home. If a baby of any gestation is born alive and exhibits definite signs of life, it is considered a birth and a birth certificate is filled out.

Unlike D&E, which is limited to about 20–22 weeks by the toughness of the tissue, D&X allows a surgical delivery of the fetus through term. Unlike induction and C-section, however, the fetus has no possibility of survival with D&X.

Even ACOG, a staunch supporter of abortion rights states in its Abortion Statement of Policy, "The College continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability. *ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman.*"

When I reviewed Dr. McMahon's testimony given to the House Subcommittee on the Constitution June 23, 1995 I found that the maternal indications he listed for D&Xs he had performed were generally not serious and the vast majority were actually done for fetal indications, many of which were minor. Depression accounted for 39, Induction failure 14, Sexual Assault 19, Down's Syndrome 175, and cleft lip 9.

Dr. Haskell admitted that he did the vast majority of his D&Xs on normal fetuses and pregnancies. During the course of this debate I received a letter from an abortionist in Orlando offering termination of pregnancy up to 28 weeks for fetal indications. He went on to say that, "To obtain a pregnancy termination beyond 24 weeks gestation, Florida State Law requires that a patient receive a written statement from her personal physician indicating it would be a threat to her health to continue her pregnancy." (Letter from Dr. James S. Pendergraft dated April 14, 1999) As the court currently defines health, even continuing a normal pregnancy threatens a woman's health.

I am concerned that some of the effort to preserve this technique is being fueled by the fetal organ trade in addition to the abortion industries desire to have no restrictions on abortion.

As a moral people there are some things that just should not be allowed and the killing of an infant in the process of birth is one of them. Although the courts have given a woman the right to empty her womb they have not given her the right to a dead child. As technology and Induction techniques improve we will hopefully be able to give a woman the right to terminate her pregnancy without the necessity of terminating her child.

When Dr. McMahon first testified regarding D&X he claimed that the fetus was killed by the anesthetic given the mother. That was soundly refuted by several prominent anesthesiologists. We also now know that the fetus feels pain, which makes this procedure even more ghastly.

I have been accused of being anti-abortion because of my religious beliefs but actually I stopped doing abortions while I was an atheist.

When I started my OB/GYN Residency I was very pro-abortion. I felt no woman should have go through a pregnancy she didn't want. I felt abortion was a necessary evil and I was determined to provide women with the best abortion care possible. I perfected my D&C with suction technique and then convinced one of our local abortionists to teach me to do D&Es. I moonlighted at an abortion clinic in Gainesville as much as I could. *The only time I felt uneasy was when I was on my neonatal rotation and I realized that the babies I was trying to save were the same size as the babies I had been aborting.*

I continued to do abortions almost the entire time I was pregnant (with my eldest daughter) without it bothering me. It wasn't until I delivered my daughter and made the connection between fetus and baby that I stopped doing abortions. I found out later that few doctors are able to do abortions for very long. OB/GYNs especially, often experience a conflict of interest because they normally are concerned about the welfare of both their patients but in an abortion they are killing one of them. It's hard for most doctors to deliver babies and do abortions. It also has to do with the fact that to almost everyone else the pregnancy is just a blob of tissue, but the abortionist knows exactly what he is doing because he has to count all the parts after each abortion. I never had any doubt that I was killing little people but somehow I was able to justify and compartmentalize that.

Even though I later became a Christian, I continued to be a staunch supporter of abortion rights. I just couldn't stomach doing them myself anymore. It wasn't until I read an article that compared abortion to the Holocaust that I changed my opinion. I had always wondered how the German Doctors could do what they did to people. I realized that I was no better than they were. I had dehumanized the fetus and therefor felt no moral responsibility towards it.

I joined the fight to ban this procedure only because I felt we were no longer really dealing with abortion but rather a form of infanticide. This bill safeguards women and does not unduly interfere with their ability to obtain an abortion. It clearly does not cover D&E or other commonly performed abortion techniques. It reestablishes a bright line between abortion and infanticide and it bans a procedure that is abhorrent to most Americans.

I urge you to pass HR 4965 "The Partial-Birth Abortion Act of 2002."

Thank you.

Testimony of Kathi A. Aultman, MD before the House Judiciary Committee's Subcommittee on the Constitution at a Legislative hearing on HR 4965 the "Partial-Birth Abortion Ban Act of 2002"
Additional written testimony submitted after the Hearing on 7/9/02

I. AMA and ACOG stances

The American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) differ fundamentally in their response to Partial Birth Abortion and legislation regarding it.

The AMA's position: On May 19, 1997 John Seward, MD Executive Vice President of the AMA, wrote a letter supporting HR 1122, "The Partial Birth Abortion Ban Act of 1997" as amended. The AMA's support was based on three specific principles. "First, the bill would allow a legitimate exception where the life of the mother was endangered, thereby preserving the physician's judgment to take any medically necessary steps to save the life of the mother. Second, the bill would clearly define the prohibited procedure so that it is clear on the face of the legislation what act is to be banned. Finally, the bill would give any accused physician the right to have his or her conduct reviewed by the State Medical Board before a criminal trial commenced. In this manner, the bill would provide a formal role for valuable medical peer determination in any enforcement proceeding." (Letter to The Honorable Rick Santorum from P. John Seward, MD on May 19, 1997) Nancy W. Dickey, MD, Chair of the AMA Board of Trustees released a statement in support of HR 1122. She stated, "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, HR 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. As amended, HR 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." (Statement released by the AMA "AMA Supports HR 1122 As Amended" attributable to Nancy W. Dickey, MD) The AMA elaborated further on this issue in the "Board of Trustees Report 26 - A 97."

The AMA later withdrew their support as stated in the following response. "The House today is considering a bill that would ban intact dilatation and extraction. The American Medical Association has previously stated our opposition to this procedure. We have not changed our position regarding the use of this procedure. The AMA has asked that the criminal sanctions be removed from this bill, but such a change has not been made. For this reason we do not support the bill." (Response from the AMA April 5, 2000) Position of ACOG: ACOG released a statement July 8,2002 "The American College of Obstetricians and Gynecologists On The subject of Partial-Birth Abortion Bans." ACOG basically wants no interference by government

in medical decision making. "ACOG and AMA disagree about the Intact D&X procedure ethically being different from other abortion procedures." (AMA/ACOG Joint Statement on HR1122)

II. Comments

While neither the AMA nor ACOG want any encroachment on the practice of medicine, both have said they want to prevent late term abortions. Both ACOG and the AMA have expressed their disapproval of aborting healthy babies of healthy mothers. In medicine, the law provides the outer limits of what society allows. State licensing bodies can regulate the practice of medicine, but they must do so based on the law. Apart from a clear law protecting partially born infants, there is no way to keep unscrupulous practitioners from killing these infants. Apart from a law, ACOG and the AMA can make recommendations, but they cannot enforce anything except with their members. Hospitals can only regulate doctors with hospital privileges. Even in that case, hospitals are coming under increasing pressure to provide abortion services. Many late-term abortion providers are not board certified, nor do they have hospital privileges; therefore, they are neither regulated nor held accountable. Even the National Abortion Federation is a voluntary association. Abortion clinics are not necessarily subject to the same regulations as surgery centers. Clearly, there needs to be some standard, some limit, beyond that provided by the abortionist and the patient, both of whom may have a conflict of interest regarding the fetus. Must the right to life of the fetus, even at the extreme limits of gestation, be subjugated to the right to liberty or privacy of the mother?

The Partial-Birth Abortion Ban Act of 2002 provides desperately needed law to protect not only the nearly born infant, but also the constitutional rights of states to regulate abortion. AGOG itself admits that there is inadequate reporting of abortion numbers, methods and complications and has presented no hard data that D&X is safer for women. There are alternatives other than hysterotomy at all gestational ages and there are safety issues that are raised with Partial-Birth Abortion.

PREPARED STATEMENT OF CURTIS COOK, M.D.

My name is Dr. Curtis Cook and I am a board-certified Maternal-Fetal Medicine specialist (perinatologist) practicing and teaching in the state of Michigan. I provide care exclusively to women experiencing complicated pregnancies. These include women with preexisting medical conditions such as diabetes, hypertension and even cardiac disease and cancer. This group of complicated pregnancies also entails those with suspected fetal abnormalities including lethal fetal anomalies such as anencephaly (absent brain) and renal agenesis (absent kidneys). Additionally, this group of complicated pregnancies includes those women who have developed obstetrical complications during the course of their gestation. This would include situations such as the premature onset of labor or early leaking of the amniotic fluid.

Never in the ten years I have been providing perinatal care to women with complicated pregnancies have I ever experienced a clinical situation where the late-term abortion procedure being considered before this committee (partial-birth abortion) has ever been required or even considered as a clinically superior procedure to other well-known and readily available medical and surgical options. This includes the clinical situations where this technique has been used by some physicians, and even the theoretical situations proposed by zealous advocates of this rogue procedure. Additionally, I have queried many colleagues with decades of clinical experience and have yet to find one individual who has experienced a clinical situation that would require this procedure. This procedure has been discussed very publicly for more than five years and yet we have not seen it embraced by the medical community simply for its lack of merit in modern obstetrics.

As part of my professional responsibilities, I also teach medical students and residents the clinical management of pregnant women. This includes the various medical and surgical options for facilitating a birth or emptying a uterus in all three trimesters of pregnancy. I have never encountered teaching materials on this technique (PBA) except for the information presented by Dr. Haskell at a National Abortion Federation seminar. I am also a fellow of both the American College of Obste-

tricians and Gynecologists and the Society of Maternal-Fetal Medicine as well as a member of the Association of Professors of Gynecology and Obstetrics. I am not aware of any educational materials from any one of these groups discussing the specific technique of partial-birth abortion (or D&X/intact D&E), the appropriate clinical use of this procedure or even clinical reports of its use. This also leads me to believe this is a rogue procedure with no role in modern obstetrics.

Frankly, I am appalled that any physician is providing such "services" given the gruesome nature of this inhumane procedure. By their own admission these procedures are being performed primarily between 20–28 weeks gestation and sometimes beyond on mostly healthy mothers carrying healthy babies. The current survivability of infants born at 23 weeks is greater than 30% and at 24 weeks it is almost 70%. By 28 weeks the survival rate exceeds 95%! Many of these infants are literally inches away from enjoying the full rights afforded any American citizen including the rights to life, liberty and the pursuit of happiness.

Every argument brought forth by the zealous advocates of this procedure has been summarily dismissed in the light of the medical facts. This includes even early arguments that this procedure was never being performed. Later the argument proposed was that this procedure was rarely performed and when it was performed it was provided only to mothers or infants with severe medical problems. We know now by the independent investigations of the Washington Post, the New Jersey Bergen Record, the American Medical Association News and others that these procedures are being performed by the thousands on mostly healthy mothers carrying healthy babies as admitted to by high profile providers of this technique. It was even preposterously proclaimed that the anesthesia provided the mother during the procedure was responsible for killing the fetus rather than the act of puncturing the base of the skull and suctioning out the brain contents. This was roundly criticized by all legitimate medical bodies putting to rest the concerns of thousands of other women undergoing indicated surgical procedures during the course of their pregnancy. Indeed several pediatric pain specialists and obstetrical anesthesiologists have stated that there is good evidence to support that this procedure would generate excruciating pain for the partially born infant. In fact, this technique would not even be allowed for the purpose of euthanizing research laboratory animals.

Again I speak from the experience of providing medical and surgical care to infants at the same point in pregnancy at which these abortions are being performed. I also regularly care for women with same diagnoses as those undergoing partial-birth abortion and have been able to safely deliver these women without having to resort to these brutal techniques. This procedure does not protect the life nor preserve the health of pregnant women. It also does not enhance the ability of women to have successful pregnancies in the future and may even hinder such efforts. I am at a loss to think of any benefit of this procedure other than the guarantee of a dead baby at the time of the completed delivery.

In summary, I feel this procedure (PBA) is unnecessary, unsavory and potentially unsafe for women. Unfortunately it is still being perpetuated upon thousands of innocent partially-born children in this country every year. As I did before this committee five years ago, again I urge you to act quickly to prohibit this abomination of American medicine.

I thank you again for the opportunity to share my testimony and my deep concern for the women and children of this country.

PHACT

Physicians' Ad Hoc Coalition for Truth

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TESTIMONY OF CURTIS R. COOK, M.D.

BEFORE THE HOUSE COMMITTEE ON THE JUDICIARY SUBCOMMITTEE ON THE CONSTITUTION WITH THE SENATE COMMITTEE ON THE JUDICIARY

REGARDING THE PARTIAL-BIRTH ABORTION BAN ACT

MARCH 11, 1997

Submitted Statement

My name is Dr. Curtis Cook. I am a board-certified Obstetrician/Gynecologist and a subspecialist in Maternal-Fetal Medicine (also known as Perinatology or High Risk Obstetrics). In my practice I take care of referred complicated pregnancies because of pre-existing chronic medical conditions of the mother, or suspected abnormalities in the baby. I am also the Associate Director of our region's Maternal-Fetal Medicine division and also serve as Assistant Residency Director for our Obstetrics and Gynecology training program. I am an Assistant Clinical Professor at Michigan State University College of Human Medicine, and a member of the American College of OB/GYN, The Society of Perinatal Obstetricians, The American Medical Association, and the Association of Professors of Gynecology and Obstetrics. I am a founding member of PHACT (Physicians Ad Hoc Coalition for Truth about Partial Birth Abortion), which I helped organize after hearing the appalling medical misinformation circulated in the media regarding this procedure. PHACT includes in its membership over 400 physicians from Obstetrics, Maternal-Fetal Medicine and Pediatrics. Many of these physicians are educators or heads of departments, and also include the former Surgeon General, C. Everett Koop. All that is required of a physician for membership is an interest in maternal and child health, and a desire to educate the population on this single issue.

I must begin my statement by defining partial birth abortion as the feet first delivery of a living infant up to the level of its aftercoming head, before puncturing the base of its skull with a sharp instrument and sucking out the brain contents, thereby killing it and allowing the collapse of its skull and subsequent delivery. This description is based upon the technique of Dr. Haskell of Ohio, who has subsequently identified it as accurate. He has referred to his technique as "D & X" (Dilatation and Extraction), while Dr. McMahon of California refers to it as an "intact D & E." An ACOG ad hoc committee came up with the hybrid term "intact D & X". As you can see, many terms are used and are not clear in their description.

Partial birth abortion is mostly performed in the fifth and sixth months of pregnancy. However, these procedures have been performed up to the ninth month of pregnancy. The majority of patients undergoing this procedure do not have significant medical problems. In Dr. McMahon's series, less than ten percent were performed for maternal indications, and these included some ill-defined reasons such as depression,

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hyperemesis, drug exposed spouse, and youth. Many of the patients undergoing partial birth abortion are not even carrying babies with abnormalities. In Dr. McMahon's series, only about half of the babies were considered "flawed", and these included some easily correctable conditions like cleft lip and ventricular septal defect. Dr. Haskell claimed that eighty percent of his procedures were purely elective, and a group of New Jersey physicians claimed that only a minuscule amount of their procedures were done for genetic abnormalities or other defects. Most were performed on women of lower age, education, or socioeconomic status who either delayed or discovered late their unwanted pregnancies. It is also clear that this procedure occurs thousands of times a year, rather than a few hundred times a year, as claimed by pro-abortion advocates. This has been independently confirmed by the investigative work of The Washington Post, The New Jersey Bergen Record, and the American Medical Association News.

One of the often ignored aspects of this procedure is that it requires three days to accomplish. Before performing the actual delivery, there is a two day period of cervical dilation that involves forcing up to twenty five dilators into the cervix at one time. This can cause great cramping and nausea for the women, who are then sent to their home or to a hotel room overnight while their cervix dilates. After returning to the clinic, their bag of water is broken, the baby is forced into a feet first position by grasping the legs and pulling it down through the cervix and into the vagina. This form of internal rotation, or version, is a technique largely abandoned in modern obstetrics because of the unacceptable risk associated with it. These techniques place the women at greater risk for both immediate (bleeding) and delayed (infection) complications. In fact, there may also be longer repercussions of cervical manipulation leading to an inherent weakness of the cervix and the inability to carry pregnancies to term. We have already seen women who have had trouble maintaining pregnancies after undergoing a partial birth abortion.

There is no record of these procedures in any medical text, journals, or on-line medical service. There is no known quality assurance, credentialling, or other standard assessment usually associated with newly-described surgical techniques. Neither the CDC nor the Alan Guttmacher Institute have any data on partial birth abortion, and

certainly no basis upon which to state the claim that it is a safer or even a preferred procedure.

The bigger question then remains: Why ever do a partial birth abortion? There are and always have been safer techniques for partial birth abortion since it was first described by Dr. McMahon in 1989 and Dr. Haskell in 1992. The usual and customary (and previously studied) method of delivery at this gestation is the medical induction of labor using either intravaginal or intramuscular medications to cause contractions and expulsion of the baby. This takes about twelve hours on average, and may also include possible cervical preparation with the use of one to three cervical dilators (as opposed to the three-day partial birth abortion procedure, with up to 25 dilators in the cervix at one time). This also results in an intact baby for pathologic evaluation, without involving the other risk of internally turning the baby or forcing a large number of dilators into the cervix. The only possible "advantage" of partial birth abortion, if you can call it that, is that it guarantees a dead baby at time of delivery.

The less common situation of partial birth abortion involves an abnormal baby. These conditions do not threaten a woman over and above a normal pregnancy, and do not require the killing of the baby to preserve her health or future fertility. I have taken care of many such women with the same diagnoses as the women who provided testimony on this issue in the past. Each of these women stated that they needed to have a partial birth abortion performed in order to protect their health or future fertility. In these cases of trisomy (extra chromosomal material), hydrocephaly (water on the brain), polyhydramnios (too much amniotic fluid) and arthrogryposis (stiffened baby), there are alternatives to partial birth abortion that do not threaten a woman's ability to bear children in the future. I have personally cared for many cases of all of these disorders, and have never required any technique like partial birth abortion in order to accomplish delivery. Additionally, I have never had a colleague that I have known to have used the technique of partial birth abortion in order to accomplish delivery in this same group of patients. Moreover, there are high profile providers of third trimester abortions who likewise do not use the technique of partial birth abortion.

In the even rarer case of a severe maternal medical condition requiring early delivery, partial birth abortion is not preferred, and medical induction suffices without

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threatening future fertility. Again, the killing of the fetus is not required, only separation from the mother.

Finally, I wish to address the fetal pain issue, since it has been claimed that a fetus feels no pain at these gestational ages. This is about as ridiculous as the earlier claim that the anesthesia of partial birth abortion put the baby into a medical coma and killed it prior to the performance of the suctioning technique. This was no small claim to the many pregnant women undergoing non-obstetric surgery every day in this country. Fortunately, this was soundly denounced by both the American Society of Anesthesiologists and the Society of Obstetrical Anesthesia and Perinatology. In the course of my practice, we must occasionally perform life-saving procedures on babies while still in the uterus. I have often observed babies of five to six months gestation withdraw from needles and instruments, much like a pain response. Dr. Fisk in England has recently reported an increase in fetal pain response hormones during the course of these procedures at these same gestational ages. In addition, we frequently observe the standard grimaces and withdrawals of neonates born at six months gestation like any other pain response in a more mature infant.

While it is not my desire for legislators to enter into the realm of medical policy making, there are times when the public health risk needs to be addressed if the medical community is either unwilling or unable to address it. We have seen this precedent for female circumcision and forty-eight hour postpartum stays. I believe the unnecessary, unstudied, and potentially dangerous procedure of partial birth abortion is unworthy of continuance in modern obstetrics. It neither protects the life, the health or the future fertility of women, and certainly does not benefit the baby. For these reasons, I urge you to support the ban on partial birth abortion.

I thank you for the opportunity to share my testimony and my concern for the women and children of this country.

Respectfully submitted,

Curtis R. Cook, M.D.
Maternal-Fetal Medicine

PHACT

Physicians' Ad Hoc Coalition for Truth

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SUMMARY OF TESTIMONY
PRESENTED TO THE
HEALTH AND WELFARE COMMITTEE
RHODE ISLAND STATE SENATE
BY
WILLIAM CASHORE, M.D.
PROFESSOR OF PEDIATRICS
BROWN UNIVERSITY SCHOOL OF MEDICINE
ASSOCIATE CHIEF OF PEDIATRICS
WOMEN AND INFANTS HOSPITAL OF RHODE ISLAND

"Partial Birth" Abortion - a neonatologist's perspective

Any rational discussion about performing or limiting abortions, as with any discussion of medical treatment, needs the benefit of the best available scientific information and medical opinion. Based on my own experience and a recent review of various writings on the subject, I shall address certain questions about the surgical procedure called "partial-birth abortion."

A. When are they done?

Usually between 16-18 and 24 weeks gestation (mostly after 20 weeks). Some may be done as late as the third trimester (i.e., the last 1/3 of pregnancy, between 27 and 40 weeks).

B. How many are done?

The total number is uncertain, but probably in the thousands per year. Spokesmen for abortion providers initially told Congress and the public that this abortion procedure was rare, and was needed to deal with dire emergencies. Later statements reveal that the procedure is more common than was first claimed, and usually elective. Mr. Ron Fitzsimmons, a representative of abortion providers, now admits that he lied by deliberately underestimating the number in public statements.

C. How is it done?

1. Before surgery, the cervix is softened and dilated with medication, usually for 1-3 days as an outpatient.
2. At surgery, the softened cervix may be further dilated with blunt instruments.
3. The surgeon ruptures the membranes (bag of waters) around the fetus, reaches into the uterus, and delivers the legs and body feet first ("partial

birth").

4. The base of the skull between the neck and back of the head is pierced with a sharp instrument. A catheter is inserted and the brain is suctioned out, killing the fetus and collapsing the skull to complete the delivery.

5. The operation takes about 15 minutes. "Ripening" of the cervix with medication before surgery usually takes a day or more.

D. What are the indications?

Practically none. There is nothing in the medical literature to show that this is the necessary or best procedure for any specific indication. The 1-3 day period of cervical preparation mentioned above belies the "emergency" nature of the procedure. In 20-plus years of working with high-risk perinatal obstetricians, I have never heard this mentioned as the "best" or "only" way to terminate a pregnancy or deliver a compromised baby after 20 weeks, nor have I found any medical literature to support such a claim.

E. Is it painful?

Sedation and local anesthesia for the mother may be inadequate for the fetus, unless high levels of maternal medication cross the placenta. It is probable that an 18-20 week fetus can feel pain, and easily observed that a 22-24 week premature infant can. According to reviews and research by Dr. K.J.S. Anand of Emory University, skin receptors for touch and pain begin to appear about 7 weeks of gestation, and sensory nerve terminals in the spinal cord about 13 weeks. By about 20 weeks, pain fibers connect the spinal cord to the lower brain, and the cortical sensory areas of the upper brain are rapidly developing. It is probable that pain

perception accompanies these stages of development - that is, several weeks before an infant can adapt and survive outside the uterus. In addition, the highest density of pain endings per square inch of skin is found at about 20-22 weeks gestation. Even normal handling may traumatize the delicate skin of very premature infants, and the resulting bruises and abrasions are probably painful. Manipulation to a partial breech delivery by a gloved adult hand probably hurts the fetus before the brain is destroyed.

F. When is "viability?"

This concept is based on pediatric knowledge and experience, and has no fixed gestational age. Currently, few babies survive if born at less than 23 weeks. At 23-24 weeks, up to 25% may survive; at 24-25 weeks, 50% or more. By the end of the second trimester (middle 1/3 of pregnancy) at 26-27 weeks, 80-90% or more of premature infants can survive and recover with suitable medical support at birth.

G. What about maternal life, health, and fertility?

1. This is not an ideal procedure for an immediate threat to the mother's life, because of the time needed to dilate the cervix without damaging it.
2. In my experience, the mother's health is best served in most cases by careful medical management of both patients, the mother and fetus. The medical risk of stabilizing the mother and continuing the pregnancy may be no greater, or even smaller than, the risk of emergency anesthesia and surgery in a medically unstable patient. Occasionally, it is not possible to treat the fetus effectively, or to stabilize the mother's complications without delivery. In working with many high-risk maternal-fetal specialists, I have witnessed

that the safest approach to this problem is usually a controlled induction with vaginal delivery, rather than emergency surgery in an unstable patient.

3. CDC review of statistics indicates that the effects of mid-pregnancy terminations on subsequent fertility are minor, and similar for all techniques. There is no medical evidence that the "partial birth" procedure is better.

In summary, "partial birth" abortion lacks a clear medical justification. It is not exclusively an emergency procedure, but is more often used electively to kill fetuses at or near the time in gestation when many of them would have a reasonable chance to survive if born intact. From the viewpoint of a neonatologist, the procedure as described sounds cruel and gruesome, and it probably hurts.

1. Anand, K.J.S., and Hickey, P.R.: Pain and its effects in the human neonate and fetus. New England Journal of Medicine 317:1321, 1987.
2. Anand, K.J.S., and Carr, D.B.: Neuroanatomy, neuro-physiology, and neurochemistry of pain, stress, and analgesia in newborns and children. Pediatric Clinics of North America 36:795, 1989.

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1001 Potrero Avenue, Ward 6 3
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March 12, 2003

Senator Diane Feinstein
United States Senate Office Building
Washington DC, 50210

Dear Senator Feinstein:

I write to provide examples of the need for a "medical exemption" to the proposed restriction of use of the so-called "partial birth abortion" technique which is now before the Senate. (The medical term for the technique is "intact D&E").

I am Chief of Obstetrics and Gynecology at San Francisco General Hospital (SFGH), where my department provides about 2,000 abortions yearly to poor women from throughout Northern California. Patients who are in the second trimester and who have special medical problems are referred to SFGH for treatment because our staff has special competence in second trimester abortion and because we can provide specialized care for women who are more likely to have a complicated pregnancy termination. Although I have not reviewed medical records in order to count the number of times we have employed intact D&E, I will provide examples of cases in which the technique was critical to safe conduct of our surgery:

- A 25 year old with two previous vaginal deliveries and bleeding placenta previa and a clotting disorder at 20 weeks was referred for termination of pregnancy. After checking her coagulation parameters and making blood available for transfusion, we dilated the cervix overnight with Laminaria and planned uterine evacuation when adequate dilation was achieved or bleeding became too heavy to replace. Within 12 hours cervical dilation was 3 cm and heavy bleeding had begun. We removed the placenta quickly and used the "intac D&E" approach to complete the abortion and accomplish quick control of blood loss. The patient required a transfusion of two units of whole blood and was discharged the next day in good health.

- A 38 year old with three previous cesarean deliveries and evidence of placent accreta was referred for pregnancy termination at 22 weeks because her risk of massive hemorrhage and hysterectomy at the time of delivery was correctly estimated at about 75%. After SFGH sonographic studies confirmed placenta previa and likely accreta we undertook cervical dilation with laminaria and made blood available in case transfusion was required. To reduce the 75% probability of emergency hysterectomy in the situation of disseminated intravascular coagulation (DIC is quite likely with accreta) we decided to empty the uterus as quickly as possible with the intact D&E procedure and treat hemorrhage, if it occurred, with uterine artery embolization before our patient lost too much blood and hysterectomy was our only option. This approach succeeded and she was discharged in good health two days later.

These two patients provide examples from my memory of situations in which the "intact D&E" technique was critical to providing optimal care. I am certain that a review of our hospital records would identify cases of sever pre-eclampsia, for example, in which "intact D&E" was the safest technique of pregnancy termination, I hope the law will not deny our patients the best treatment we can provide them under life-threatening circumstances.

Sincerely,

Philip D. Darney, MD, MSc
Professor and Chief
Obstetrics, Gynecology and Reproductive Sciences
San Francisco General Hospital
University of California, San Francisco

SYNERGYMedical
EDUCATION ALLIANCE

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March 13, 2003

Hon. Rick Santorum
U.S. Senate Office Building
Washington, D.C. 50210

Dear Senator Santorum,

I am writing in response to the letter from Dr. Phillip Darney which was introduced by Senator Feinstein.

I have cared for pregnant patient patients for almost 29 years, and have worked exclusively in the field of Maternal-Fetal Medicine (high risk pregnancy) for over 15 years. I am board certified in Obstetrics & Gynecology, and also in the subspecialty of Maternal-Fetal Medicine. I am an assistant professor in Obstetrics & Gynecology for the Michigan State College of Human Medicine, and co-director of Maternal-Fetal Medicine in Saginaw Michigan.

I have never seen a situation in which a partial birth abortion was needed to save a mother's life. I have never had a maternal death, not ever.

I am familiar with Dr. Darney's letter describing two of his cases. My comments are not meant as a criticism of Dr. Darney as a person or as a physician. I have great respect for anyone in our field of medicine, which is a very rewarding specialty but which requires difficult decisions on a daily basis. We are all working to help mothers and their children make it through difficult pregnancies. Still, I do disagree with his stand that the legal freedom to do partial birth abortions is necessary for us to take good care of our patients. For example, in the second case he describes, I believe that patient could have carried the pregnancy much further, and eventually delivered a healthy child by repeat cesarean section followed by hysterectomy. Hemorrhage is always a concern with such patients, but we have many effective ways to handle this problem, which Dr. Darney knows as well as I. Blood vessels can be tied off at surgery, blood vessels can be occluded using small vascular catheters, cell-savers can be used to return the patients own blood to them, blood may be given from donors, pelvic pressure packs can be used for bleeding following hysterectomy, and other blood products (platelets, fresh frozen plasma, etc) can be given to treat coagulation abnormalities (DIC). His approach of placing laminaria to dilate the cervix in a patient with a placenta praevia is not without it's own risk.

1000 Houghton Ave • Saginaw, MI 48602 • www.synergymedical.org

Page Two

If Dr. Darney performed the partial birth abortion on this patient to keep from doing another c-section, or even to preserve her uterus, I'm hopeful he counseled the patient that if she becomes pregnant again, she will once again have a very high risk of having a placenta praevia and placenta accreta.

Lastly, I believe that for some abortionists, the real reason they wish to preserve their "right" to do partial birth abortions is that at the end of the procedure they have only a dead child to deal with. If they were to abort these women by either inducing their labor (when there is no placenta praevia present), or by doing a hysterotomy (c-section), they then need to deal with a small, living, struggling child – an uncomfortable situation for someone who's intent was to end the child's life

Sincerely,

Daniel J. Wechter, M.D.
Co-Director of Maternal-Fetal Medicine
Synergy Medical Education Alliance
Assistant Professor of Ob/Gyn
MSU College of Human Medicine

DJW/

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March 12, 2003

The Honorable Rick Santorum
United States Senate
Washing DC, 50210-3804

Re: S.3 – Partial Birth Abortion Ban Act of 2003

Dear Senator Santorum:

I have recently retired from full-time academic medicine, having served on the faculties of two major academic medical centers. I am certified in Obstetrics and Gynecology and Maternal-Fetal Medicine by the American Board of Obstetrics and Gynecology. My special interest throughout my academic career was high-risk pregnancy.

I have read the letter of this date from Dr. Philip Darney to Senator Dianne Feinstein regarding the need for a medical exemption to the proposed legislation regarding the procedure referred to as partial-birth abortion. The two examples put forth by Dr. Darney of patients whose clinical situations were regarded as requiring this particular technique to accomplish an abortion in a safe manner are, indeed, complicated pregnancies. Without challenging the clinical judgment behind the decision to recommend abortion for either of these patients, I can say, based upon my personal experience with high-risk and complicated pregnancies, knowledge of the medical literature and my discussion with colleagues who perform second trimester abortions, that the technique of abortion described in this proposed legislation is not the only option for terminating these pregnancies in the safest possible manner. Acknowledging that there can be differences of opinion on this matter, the important point is that if the technique of partial-birth abortion ("intact D&E") were not available there would be alternatives methods available to terminate the pregnancies described by Dr. Darney with comparable levels of risk to the patients.

Sincerely,

Watson A. Bowes Jr.

Watson A. Bowes Jr., M.D.
Emeritus Professor of Obstetrics & Gynecology
University of North Carolina at Chapel Hill

The Honorable Rick Santorum
United States Senate Office Building
Washington, D.C. 50210

March 13, 2003

Dear Senator Santorum,
I have reviewed the letter from Dr. Darney describing two examples of what he believes are high risk pregnancy cases that show the need for an additional "medical exemption" for partial birth abortion (also referred to as intact D&E). I am a specialist in maternal-fetal medicine with 23 years of experience in obstetrics. I teach and do research at the University of Minnesota. I am also co-chair of the Program in Human Rights in Medicine at the University. My opinion in this matter is my own.

In the rare circumstances when continuation of pregnancy is life-threatening to a mother I will end the pregnancy. If the fetus is viable (greater than 23 weeks) I will recommend a delivery method that will maximize the chance for survival of the infant, explaining all of the maternal implications of such a course. If an emergent life-threatening situation requires emptying the uterus before fetal viability then I will utilize a medically appropriate method of delivery, including intact D&E.

Though they are certainly complicated, the two cases described by Dr. Darney describe situations that were not initially emergent. This is demonstrated by the use of measures such as dilation of the cervix that required a significant period of time. In addition, the attempt to dilate the cervix with placenta previa and placenta accreta is itself risky and can lead to life-threatening hemorrhage. There may be extenuating circumstances in Dr. Darney's patients but most obstetrical physicians would not attempt dilation of the cervix in the presence of these complications. It is my understanding that the proposed partial birth abortion ban already has an exemption for situations that are a threat to the life of the mother. This would certainly allow all measures to be taken if heavy bleeding, infection, or severe preeclampsia required evacuation of the uterus.

The argument for an additional medical exemption is redundant; furthermore, its inclusion in the legislation would make the ban virtually meaningless. Most physicians and citizens recognize that in rare life-threatening situations this gruesome procedure might be necessary. But it is certainly not a procedure that should be used to accomplish abortion in any other situation.

Passage of a ban on partial birth abortion with an exemption only for life-threatening situations is reasonable and just. It is in keeping with long-standing codes of medical ethics and it is also in keeping with the provision of excellent medical care to pregnant women and their unborn children.

Sincerely, Steve Calvin MD

Steve Calvin MD.
Calvi002@umn.edu
Pager 612-654-7676

March 12, 2003

Senator Rick Santorum
United States Senate Office Building
Washington, D.C. 50210

Dear Senator Santorum,

I have read the letter from Dr. Philip Darney addressed to Senator Feinstein regarding the intact D&E (often referred to as "intact D&X" in medical terminology) procedure (partial-birth abortion) and its use in his experience.

As a board certified practicing Obstetrician/Gynecologist and Maternal-Fetal Medicine sub-specialist I have had much opportunity to deal with patients in similar situations to the patients in the anecdotes he has supplied.

In neither of the type of cases described by Dr. Darney, nor in any other that I can imagine, would an intact D&X procedure be medically necessary, nor is there any medical evidence that I am aware of to demonstrate, or even suggest, that an intact D&X is ever a safer mode of delivery for the mother than other available options.

In the first case discussed by Dr. Darney a standard D&E could have been performed without resorting to the techniques encompassed by the intact D&X procedure.

In the second case referred to it should be made clear that there is no evidence that terminating a pregnancy with placenta previa and suspected placenta accreta at 22 weeks of gestation will necessarily result in less significant blood loss or less risk to the mother than her carrying later in the pregnancy and delivering by cesarean section. There is a significant risk of maternal need for a blood transfusion, or even a hysterectomy, with either management. The good outcome described by Dr. Darney can be accomplished at a near term delivery in this kind of patient, and I have had similar cases that ended happily with a healthy mother and baby. Further a standard D&E procedure could have been performed in the manner described if termination of the pregnancy at 22 weeks was desired.

I again reiterate, and reinforce the statement made by the American Medical Association at an earlier date, that an intact D&X procedure is never *medically necessary*, that there always is another procedure available, and there is no data that an intact D&X provides any safety advantage whatsoever to the mother.

Sincerely,

Nathan Hoeldtke, MD, FACOG
Medical Director, Maternal-Fetal Medicine
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12 March 2003

The Honorable Rick Santorum
United States Senate Office Building
Washington, D.C. 50210

Dear Senator Santorum:

I am writing to contest the letter submitted to Senator Feinstein by Philip D. Darney, MD supporting the "medical exemption" to the proposed restriction of the partial birth abortion (or as abortionists call it "intact D&E").

I am a diplomate board certified by the American Board of Obstetrics and Gynecology in general Obstetrics and Gynecology and in the sub-specialty of Maternal-Fetal Medicine. I serve as a Visiting Clinical Professor in Obstetrics and Gynecology, University of Illinois at Chicago, Department of Obstetrics and Gynecology, College of Medicine at Rockford, Rockford, Illinois; as an Adjunct Professor of Obstetrics and Gynecology at Midwestern University, Chicago College of Osteopathic Medicine, Department of Obstetrics and Gynecology; and as an Adjunct Associate Professor of Obstetrics and Gynecology, Uniformed Services University of Health Sciences, F. Edward Hebert School of Medicine, Washington, D.C. I have authored over 50 peer review articles in the obstetric and gynecologic literature, presented over 100 scientific papers, and have participated in over 40 research projects,

In my over 14 years as a Maternal-Fetal Medicine specialist I have never used or needed the partial birth abortion technique to care for my complicated or life threatening conditions that require the termination of a pregnancy. Babies may need to be delivered early and die from prematurity, but there is never a medical need to perform this heinous act.

I have reviewed both cases presented by Dr Darney, and, quite frankly, do not understand why he was performing the abortions he indicates, yet alone the procedure he is using. If the young 25 year old woman had a placenta previa with a clotting disorder, the safest thing to do would be to place her in the hospital, transfuse her to a reasonable hematocrit, adjust her clotting parameters, watch her closely at bed rest, and deliver a live baby. If the patient had a placenta previa, pushing laminaria (sterile sea weed) up into her cervix, and, potentially through the previa, is contraindicated. It is no surprise to anyone that the patient went, from stable without bleeding, to heavy bleeding as they forcibly dilated her cervix to 3 centimeters with laminaria. The use of the dangerous procedure of blinding pushing scissors into the baby's skull (as part of the partial birth abortion) with significant bleeding from a previa just appears reckless and totally unnecessary.

Regarding the second case of the 38 year old woman with three cesarean sections with a possible accreta and the risk of massive hemorrhage and hysterectomy due to a placenta previa, it seems puzzling why the physician would recommend doing an abortion with a possible accreta as the indication. Many times, a placenta previa at 22 weeks will move away from the cervix so that there is no placenta previa present and no risk for accreta as the placenta moves away from the old cesarean scar. (virtually 99.5% of

time this is the case with early previas) Why the physicians did not simply take the woman to term, do a repeat cesarean section with preparations as noted for a possible hysterectomy, remains a conundrum. Dr Darney actually increased the woman's risk for bleeding, with a horrible outcome, by tearing through a placenta previa, pulling the baby down, blindly instrumenting the baby's skull, placing the lower uterine segment at risk, and then scraping a metal instrument over an area of placenta accreta. No one I know would do such a foolish procedure in the mistaken belief they would prevent an accreta with a D&E.

Therefore, neither of these cases presented convincing arguments that the partial birth abortion procedure has any legitimate role in the practice of maternal-fetal medicine or obstetrics and gynecology. Rather, they demonstrate how cavalierly abortion practices are used to treat women instead of the sound medical practices that result in a live baby and an unharmed mother.

Sincerely,

Byron C. Calhoun, MD, FACOG, FACS
Rockford Health System
Rockford, Illinois

USC
UNIVERSITY
OF SOUTHERN
CALIFORNIA

Department of
Obstetrics and
Gynecology

March 12, 2003

The Honorable Rick Santorum
United States Senate Office Building
Washington, D.C. 50210

Dear Senator Santorum,

I am writing in support of the proposed restrictions on the procedure referred to as "partial birth abortion," which the Senate is now considering.

I am chief of the Division of Maternal-Fetal Medicine in the Department of Obstetrics and Gynecology at the University of Southern California in Los Angeles. I have published more than 100 scientific papers and book chapters regarding complications of pregnancy. I direct the obstetrics service at Los Angeles County Women's and Children's Hospital, the major referral center for complicated obstetric cases among indigent and under-served women in Los Angeles.

I have had occasion to review the cases described by Dr. Philip Darney, offered in support of the position that partial birth abortion, or intact D&E, was the best care for the patient in those situations. Mindful of Dr. Darney's broad experience with surgical abortion, I nevertheless disagree strongly that the approach he describes for these two cases was best under the circumstances. Such cases are infrequent, and there is not single standard for management. However, it would certainly be considered atypical, in my experience, to wait 12 hours to dilate the cervix with laminaria while the patient was actively hemorrhaging, as was described in his first case. Similarly, the approach to presumed placenta acreta, described in the second case, is highly unusual. Although the mother survived with significant morbidity, it is not clear that the novel approach to management of these difficult cases is the safest

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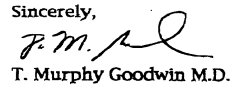
approach. It is my opinion that the vast majority of physicians confronting either of these cases would opt for careful hysterotomy as the safest means to evacuate the uterus.

Although I do not perform abortions, I have been involved in counseling many women who have considered abortion because of a medical complication of pregnancy. I have not encountered a case in which what has been described as partial birth abortion is the only choice, or even the better choice among alternatives, for managing a given complication of pregnancy.

Thank you for your consideration of this opinion.

Sincerely,



T. Murphy Goodwin M.D.
Chief, Division of Maternal-Fetal Medicine
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Susan E. Rutherford, M.D.
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Diplomate, American Board of Obstetrics & Gynecology
Board Certified, Maternal-Fetal Medicine

March 12, 2003

The Honorable Rick Santorum
United States Senate Office Building
Washington, D.C. 50210

Dear Senator Santorum,

The purpose of this letter is to counter the letter of Dr. Philip Darney, M.D. to Senator Diane Feinstein and to refute claims of a need for an exemption based on the health of the mother in the bill to restrict "partial birth abortion."

I am board certified in Maternal-Fetal Medicine as well as Obstetrics and Gynecology and have over 20 years of experience, 17 of which have been in maternal-fetal medicine. Those of us in maternal-fetal medicine are asked to provide care for complicated, high-risk pregnancies and often take care of women with medical complications and/or fetal abnormalities.

The procedure under discussion (D&X, or intact dilation and extraction) is similar to a destructive vaginal delivery. Historically such were performed due to the risk of cesarean delivery (also called hysterotomy) prior to the availability of safe anesthetic, antiseptic and antibiotic measures and frequently on a presumably dead baby. Modern medicine has progressed and now provides better medical and surgical options for the obstetrical patient.

The presence of placenta previa (placenta covering the opening of the cervix) in the two cases cited by Dr. Darney placed those mothers at extremely high risk for catastrophic life-threatening hemorrhage with any attempt at vaginal delivery. Bleeding from placenta previa is primarily maternal, not fetal. The physicians are lucky that their interventions in both these cases resulted in living healthy women. I do not agree that D&X was a necessary option. In fact, a bad outcome would have been indefensible in court. A hysterotomy (cesarean delivery) under controlled non-emergent circumstances with modern anesthesia care would be more certain to avoid disaster when placenta previa occurs in the latter second trimester.

Lastly, but most importantly, there is no excuse for performing the D&X procedure on living fetal patients. Given the time that these physicians spent preparing for their procedures, there is no reason not to have performed a lethal fetal injection which is quickly and easily performed under ultrasound guidance, similar to amniocentesis, and carries minimal maternal risk.

I understand the desire of physicians to keep all therapeutic surgical options open, particularly in life-threatening emergencies. We prefer to discuss the alternatives with our patients and jointly

with them develop a plan of care, individualizing techniques, and referring them as necessary to those who will serve the patient with the most skill. Nonetheless I know of no circumstance in my experience and know of no colleague who will state that it is necessary to perform a destructive procedure on a living second trimester fetus when the alternative of intrauterine feticide by injection is available.

Obviously none of this is pleasant. Senator Santorum, I encourage you strongly to work for passage of the bill limiting this barbaric medical procedure, performance of D&X on living fetuses.

Sincerely,

Susan Rutherford MD

Susan E. Rutherford, M.D.
Fellow, American College of Obstetricians and Gynecologists
Member, Society for Maternal-Fetal Medicine

Redmond, Washington 98052

Cc: The Honorable Patty Murray
The Honorable Maria Cantwell

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The Honorable Robert Torricelli
United States Senate
Washington, D.C. 20510

August 31, 1998

Dear Senator Torricelli,

My name is Dr. Camilla Hersh. I am a board certified Obstetrician and Gynecologist, a fellow of the American College of Obstetrics and Gynecology, in private practice, caring exclusively for the health needs of women for thirteen years. I am also a clinical assistant professor of Obstetrics and Gynecology for Georgetown University. I have been involved with teaching medical students and OBGYN residents for fourteen years at two major medical teaching centers.

I have delivered over two thousand babies. On a daily basis I treat pregnant women and their babies. In my everyday work I am privileged to participate in the joy of healthy birth and the agony and sorrow of complications in pregnancy which can lead to loss of life or heartbreaking disability.

As a member of the Physicians Ad Hoc Coalition for Truth, which now has more than 600 members, I strongly support and applaud the legislative efforts to ban the heinous Partial-Birth Abortion procedure.

Many of the members of PHACT (physicians ad hoc coalition for truth) hold teaching positions or head departments of obstetrics and gynecology or perinatology at universities and medical centers across the country. To our knowledge there are no published peer-reviewed safety data regarding the procedure in question. It is not taught as a formally recognized medical procedure.

Proponents of partial-birth abortion tout it as the safest method available. Nothing could be further from the truth. There are in fact several recognized, tested, far safer, recommended methods to empty the uterus when it is medically necessary to do so.

There is no data in the accepted standard medical literature that could possibly support any assertion of the appropriateness of this procedure.

If you ask most obstetricians or family practice physicians about partial-birth abortion , they will tell you they have never seen or heard of such a treatment for any reason in their educational training or practice.

Most physicians I have questioned are incredulous that anyone knowledgeable about Obstetrics and Gynecology would ever consider this procedure as any kind of serious suggestion, because it is so obviously dangerous. It has never been proposed or taught as the safest method to empty the uterus and end a pregnancy whether for purely elective reasons for abortion or in those grave instances when it is medically necessary to do so to save the mother's life.

Consider the grave danger involved in partial-birth abortion, which usually occurs after the fifth month of pregnancy, even into the last month of pregnancy. A woman's cervix is forcibly dilated over several days. This risks creating an incompetent cervix, a leading cause of subsequent premature delivery. It also risks serious infection, a major cause of subsequent infertility. In the event of a truly life threatening complication of pregnancy, the days of delay involved substantially add to the risk of loss of life of the mother.

The abortionist then reaches into the uterus to pull the child feet first out of the mother's body, up to the neck, but leaves the head inside. He then forces scissors through the base of the baby's skull - which remains lodged just within the opening of the forcibly dilated cervix, because the baby's head is larger and of course harder than the remainder of the soft little body.

I think it is obvious that for the baby this is a horrible way to die, brutally and painfully killed by having one's head stabbed open and one's brains suctioned out.

But for the woman this is a mortally dangerous and life threatening act.

Partial-birth abortion is a partially blind procedure, done by feel, thereby risking direct scissor injury to the mother's uterus and laceration of the cervix or lower uterine segment. Either the scissors or the bony shards or spickules of the baby's perforated and disrupted skull bones can roughly rip into the large blood vessels which supply the lower part of the lush pregnant uterus, resulting in immediate and massive bleeding and the threat of shock, immediate hysterectomy, blood transfusion, and even death to the mother.

Portions of the baby's sharp bony skull pieces can remain imbedded in the mother's cervix, setting up a complicated infection as the bony fragments decompose.

Think of the emotional agony for the woman, both immediately and for years afterward, who endures this process over a period of several days.

None of this nauseating risk is ever necessary, for any reason. Obstetrician-gynecologists like myself across the U.S. regularly treat women whose unborn children suffer the same conditions as those cited by proponents of the procedure.

Never is the partial-birth abortion procedure necessary:

not for polyhydramnios (an excess of amniotic fluid collecting around the baby),

not for trisomy (genetic abnormalities characterized by an extra chromosome),

not for anencephaly (an abnormality characterized by the absence of the top portion of the baby's brain and skull),

not for hydrocephaly (excessive cerebrospinal fluid in the head),

not for life threatening complications of pregnancy to the mother.

Sometimes, as in the case of hydrocephaly, it is first necessary to drain some of the fluid from the baby's head, with a special long needle, to allow safe vaginal delivery. In some cases, when vaginal delivery is not possible, a doctor performs a Cesarean section. But in no case is it necessary or medically advisable to partially deliver an infant through the vagina and then to cruelly kill the infant.

The legislation proposed clearly distinguishes the procedure being banned from recognized standard obstetric techniques. I must point out, even for those who support abortion for elective or medical reasons at any point in pregnancy, current recognized abortion techniques would be unaffected by the proposed ban.

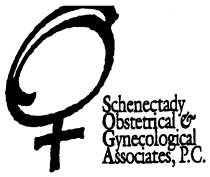
Any proponent of such a dangerous procedure is at the least seriously misinformed about medical reality or at worst so consumed by narrow minded "abortion-at-any-cost" activism, to be criminally negligent.
This procedure is blatant and cruel infanticide, and must be against the law.

Please protect women and children from this brutal procedure.

Sincerely yours,

Camilla C. Hersh, M.D.

Camilla C. Hersh, M.D., F.A.C.O.G.



Obstetrics-Gynecology-Infertility
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June 27, 1996

Honorable Members
New York State Assembly
State Capitol
Albany, NY 12248

Dear Assemblyperson:

I would like to convey to you some of my thoughts on the subject of "partial birth abortion" which is being widely discussed in state legislatures throughout the country.

Together, my partners and I represent about sixty years of OB-GYN practice .
We have had personal experience with delivering sick patients at twenty-seven to twenty-eight weeks gestation and obtaining healthy infants. With modern life preserving and sustaining capabilities, one thousand gram infants have a survival rate of approximately 90%.

Therefore, in the case where the mother is sick and the fetus healthy, a proper resolution is early delivery of an intact infant and a mother either cured of her illness, or relieved of whatever deleterious effects the pregnancy may have on that illness.

The conversion of a fetus presenting as a vertex to a breech position, as in the partial birth abortion, is capable of causing an abruption of the placenta and amniotic fluid embolism. This is a dangerous and life-threatening situation. Surely it would not benefit an already sick mother.

In the cases where a diagnosis has been made of severe deformities in the fetus, amnioinfusion of prostaglandins and induction of labor is a far safer procedure for the mother and certainly more humane for the fetus. Never, ever, in our years of practice have we seen a situation which warrants implementation of partial birth abortion. Personally, I cannot imagine why any practitioner would want to resort to such barbaric techniques when other methods are available.

I believe legislators should look very carefully at the arguments from those who would try to convince you of the need for this monstrous procedure. One of the most glaring pieces of misinformation being promoted is that if a woman has hemophilia, major surgery such as a C-section would not be an option. Please understand that partial birth abortion is major surgery, and is extremely harmful to both mother and child.

More important is the fact that hemophilia is a sex linked genetic disease which affects men. Women are only carriers.

Lewis J. Marola, M.D.

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October 28, 1995

The Honorable Charles Canady
Chairman, Subcommittee on the Constitution
House Committee on the Judiciary
1222 Longworth House Office Building
Washinton, D.C. 20515

Dear Congressman Canady:

It has recently been brought to my attention that opponents of HR 1833 have stated that this particular abortion technique should maintain its legality because it is sometimes employed by physicians in the interest of maternal health. Such an assertion not only runs contrary to facts but ignores the reality of the **risks** to maternal health that are associated with this procedure which include the following:

1. Since the procedure entails 3 days of forceful dilatation of the cervix the mother could develop cervical incompetence in subsequent pregnancies resulting in spontaneous second trimester pregnancy losses and necessitating the placement of a cerclage (stitch around the cervix) to enable her to carry a fetus to term.

2. **Uterine rupture is a well known complication associated with this procedure.** In fact, partial birth abortion is a "variant" of internal podalic version...a technique sometimes used by obstetricians in this country with the intent of delivering a live child. However, internal podalic version, in this country, has been gradually replaced by Cesarean section in the interest of **maternal** as well as fetal well being (see excerpts from the standard text Williams Obstetrics pages 520, 521, 865 and 866).

Furthermore, obstetrical emergencies(such as entrapment of the head of a hydrocephalic fetus or of a footling breech that has partially delivered on its own) are never handled by employing this abortion technique. Cephalocentesis, (drainage of fluid from the head of a hydrocephalic fetus) frequently results in the birth of a living child. Relaxing

the uterus with anesthesia, cutting the cervix (Duhrssen's incision) and Cesarean section are the standard of care for a normal, head entrapped breech fetus.

There are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the health of the mother. Partial birth abortion is a technique devised by abortionists for their own convenience...ignoring the known health risks to the mother. The health status of women in this country will thereby only be enhanced by the banning of this procedure.

Sincerely,

Pamela E. Smith MD
Director of Medical
Education
Department of Obstetrics
and Gynecology
Mt. Sinai Hospital
Chicago, Illinois

PHACT

Physicians' Ad Hoc Coalition for Truth

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CARING FOR WOMEN WITH HIGH RISK PREGNANCIES: PARTIAL-BIRTH ABORTION VS. ACCEPTED MEDICAL CARE

Throughout the national debate on partial-birth abortion, the more than 500 doctors nationwide who make up the Physicians' Ad-hoc Coalition for Truth have insisted that it is never medically necessary -- in order to protect a woman's life, health or future fertility, during the fifth or sixth month (when most partial-birth abortions take place) and after -- to partially deliver a living fetus and then destroy it. *Partial-birth abortion is never medically indicated*: the procedure is too lengthy, too risky and there are too many other alternatives.

The following analysis contrasts the partial-birth abortion method with accepted medical practice for emptying a womb in the second trimester. At this stage of a pregnancy, if it becomes necessary to empty a womb, what is required is separation of the child from the mother, not the death of the child.

Note that the standard method described below can be used safely for delivery of children with severe genetic abnormalities, including trisomy, anencephaly, omphalocele, hydrocephaly (see below) and other situations often cited to justify partial-birth abortion.

Moreover, in considering the supposed desirability of abortion in the second trimester and after, as against the medically recognized method of delivery described below, one should recognize that later term abortion is *twice as risky* for the woman's life as childbirth: the risk of maternal death is 1 in 6,000 for abortions at 21 weeks and after, and 1 in 13,000 for childbirth.

Writing in *The New England Journal of Medicine*, PHACT members John Thorp, M.D. and Watson Bowes, M.D., note: "Many experts have suggested that the cutoff point between maternal mortality from abortion and maternal mortality from continuation of pregnancy occurs at 15 to 16 weeks of gestation, with abortion being riskier beyond that point."

PARTIAL BIRTH ABORTION VS. MEDICALLY RECOGNIZED METHOD

Medically Recognized Method	Partial-Birth Abortion*
First Stage *Latent Phase:* The delivery process begins by inducing labor physiologically (as opposed to mechanically) with prostoglandins or pitocins. This produces uterine contractions that dilate the cervix. The cervix is dilated up to 4 centimeters (cm), taking between 4 to 8 hours. Medication for pain usually consists of injectable analgesics, administered by medical personnel. *Accelerated Phase:* The cervix is further dilated, traditionally to 10 cm (but this may be less in the case of very small infants), generally taking another 3 to 6 hours. Pain relief usually consists of injectable analgesics or epidural anesthesia, administered by medical personnel.	First Stage *Latent Phase:* Dilation up to about 4 cm, but taking up to 48 hours or more. The cervix is dilated mechanically (as opposed to more desirable physiological methods) with repeated insertion of laminaria into the cervix until sufficient dilation is obtained. Such mechanical dilatation exposes the woman to the risk of developing an incompetent cervix - a leading cause of future premature deliveries - thus potentially threatening her ability to have children in the future. Throughout the dilatation process, the woman is regularly in a hotel/motel room with no direct nursing or medical supervision. Pain is treated only with oral medication, administered by the patient herself. *Accelerated Phase:* Not comparable to standard delivery procedures. Cervical dilation of 4 cm is all that is done.
Second Stage: Normal expulsive efforts by the mother push the child through the completely dilated cervix , through the birth canal, and into the waiting hands of the doctor or midwife. Depending on the patient, this phase takes from 15 minutes to two hours. Throughout this entire delivery process, the mother will be in a hospital, attended by physicians and hospital staff.	Second Stage The child is manipulated into breech position by grasping a leg, usually by instrumentation through the 4 cm dilated cervix. This is a very dangerous part of the entire procedure, as it is partially or totally blind and can result in laceration of the cervix or uterus, with potentially disastrous results (e.g., massive blood loss from uterine hemorrhage, leading to shock or maternal death). *Elective* conversion to a breech position (as is done here) has been abandoned for at least 50 years because of the risks to the mother and child. *Williams Obstetrics*, a standard medical textbook, notes that the risk of "serious trauma" to both mother and child from conversion to breech is "apparent." If it is not in the mother's best interest to perform an elective breech conversion when the intent is to deliver the baby alive, and when the mother is in the hospital with trained anesthesiologists nearby, it is difficult to understand, from a medical perspective, how it should suddenly become the best, safest and least traumatic option, when the mother is in an outpatient clinic, with local anesthesia, and the intent is to deliver a dead child.

*The following information is based on Dr. Martin Haskell's paper "Second Trimester Abortion: From Every Angle," presented at the National Abortion Federation's Fall Risk Management Seminar, September 13-14, 1992, in Dallas, TX.

In cases of hydrocephaly, (an enlarged head due to excess fluid on the fetal brain), the excess fluid is drained *prior* to beginning the delivery process through a transabdominal cephalocentesis. This reduces the size of the child's head (without causing death), thus allowing the head to fit through the birth canal. If it is not possible to reduce the head size sufficiently with cephalocentesis, a standard C-Section is done.	The child is then delivered by traction on the leg or legs, pulling the body through the incompletely dilated cervix. However, the head, being the largest diameter part of the child, will not come through the cervix for delivery, because the cervix has been dilated only 4 cm. At this point, a sharp scissors is plunged through the base of the skull and the brain is sucked out through the scissors' wound. This kills the child and decompresses the skull; delivery of the now dead infant is then completed. There is danger to the mother from the relatively blind manipulation with sharp scissors to pierce the child's skull while it is still within the cervix, as well as from sharp bone shards from the infant's decompressed skull which could lacerate the cervix. Anesthesia: Varies from intravenous sedation, analgesics, paracervical block, or general anesthesia, depending on where the procedure is being done. Estimated operation time: 20 to 30 minutes.
<u>Third Stage</u> Usually 2 to 10 minutes. The uterus, now empty of the baby, contracts, shearing off the placenta which is then delivered through the cervix.	<u>Third stage</u> Placenta may deliver spontaneously, but often requires curretage of walls of uterus to assure no retained fragments remain. Estimated time: 2 to 10 minutes.

The New York Times, Thursday, September 26, 1996, A27

Why Defend Partial-Birth Abortion?

By C. Everett Koop

HANOVER, N.H.

The debate in Congress about the procedure known as partial-birth abortion reveals deep national uneasiness about abortion 23 years after the Supreme Court legalized it. As usual, each side in the debate shades the statistics and distorts the facts. But in this case, it is the abortion-rights advocates who seem inflexible and rigid.

The Senate is expected to vote today on whether to join the House in overriding President Clinton's veto of a bill last April banning partial-birth abortion. In this procedure, a doctor pulls out the baby's feet first, until the baby's head is lodged in the birth canal. Then, the doctor forces scissors through the base of the baby's skull, suctions out the brain, and crushes the skull to make extraction easier. Even some pro-choice advocates wince at this, as when Senator Daniel Patrick Moynihan termed it "close to infanticide."

The anti-abortion forces often imply that this procedure is usually performed late in the third trimester on fully developed babies. Actually, most partial-birth abortions are performed late in the second trimester, around 26 weeks. Some of these would be viable babies.

Pro-choicers twist the medical facts.

But the misinformation campaign conducted by the advocates of partial-birth abortion is much more misleading. At first, abortion-rights activists claimed this procedure hardly ever took place. When pressed for figures, several pro-abortion groups came up with 500 a year, but later investigations revealed that in New Jersey alone 1,500 partial-birth abortions are performed each year. Obviously, the national annual figure is much higher.

The primary reason given for this procedure — that it is often medically necessary to save the mother's life — is a false claim, though many people, including President Clinton, were misled into believing this. With all that modern medicine has to offer, partial-birth abortions are not needed to save the life of the mother, and the procedure's impact on a woman's cervix can put future pregnancies at risk. Recent reports have concluded that a majority of partial-birth abortions are elective, involving a healthy woman and normal fetus.

I'll admit to a personal bias: In my 30 years as a pediatric surgeon, I operated on newborns as tiny as some of these aborted babies, and we corrected congenital defects so they could live long and productive lives.

In their strident effort to protect partial-birth abortion, the pro-choice people remind me of the gun lobby. The gun lobby is so afraid of any effort to limit any guns that it opposes even a ban on assault weapons, though most gun owners think such a ban is justified.

In the same way, the pro-abortion people are so afraid of any limit on abortion that they have twisted the truth to protect partial-birth abortion, even though many pro-choice Americans find it reasonable to ban the procedure. Neither AK-47's nor partial-birth abortions have a place in civil society.

Both sides in the controversy need to straighten out their stance. The pro-life forces have done little to help prevent unwanted pregnancies, even though that is why most abortions are performed. They have also done little to provide for pregnant women in need.

On the other side, the pro-choice forces talk about medical necessity and under-represent abortion's prevalence: each year about 1.5 million babies have been aborted, very few of them for "medical necessity." The current and necessarily graphic debate about partial-birth abortion should remind all of us that what some call a choice, others call a child.

C. Everett Koop was Surgeon General from 1981 to 1989.

THE WALL STREET JOURNAL THURSDAY, SEPTEMBER 19, 1996 P. A22

Partial-Birth Abortion Is Bad Medicine

By NANCY ROMER, PAMELA SMITH, CURTIS R. COOK AND JOSEPH L. DECOOK

The House of Representatives will vote in the next few days on whether to override President Clinton's veto of the Partial Birth Abortion Ban Act. The debate on the subject has been noisy and rancorous. You've heard from the activists. You've heard from the politicians. Now may we speak?

We are the physicians who, on a daily basis, treat pregnant women and their babies. And we can no longer remain silent while abortion activists, the media and even the president of the United States continue to repeat false medical claims about partial-birth abortion. The appalling lack of medical credibility on the side of those defending this procedure has forced us—for the first time in our professional careers—to leave the sidelines in order to provide some sorely needed facts in a debate that has been dominated by anecdote, emotion and media stunts.

Since the debate on this issue began, those whose real agenda is to keep all types of abortion legal—at any stage of pregnancy, for any reason—have waged what can only be called an orchestrated misinformation campaign.

First the National Abortion Federation and other pro-abortion groups claimed the procedure didn't exist. When a paper written by the doctor who invented the procedure was produced, abortion proponents changed their story, claiming the procedure was only done when a women's life was in danger. Then the same doctor, the nation's main practitioner of the technique, was caught—on tape—admitting that 80% of his partial-birth abortions were "purely elective."

Then there was the anesthesia myth. The American public was told that it wasn't the abortion that killed the baby, but the anesthesia administered to the mother before the procedure. This claim was immediately and thoroughly denounced by the American Society of Anesthesiologists, which called the claim "entirely inaccurate." Yet Planned Parenthood and its allies continued to spread the myth, causing needless concern among our pregnant patients who heard the claims and were terrified that epidurals during labor, or anesthesia during needed surgeries, would kill their babies.

The latest baseless statement was made by President Clinton himself when he said that if the mothers who opted for partial-birth abortions had delivered their children naturally, the women's bodies would have been "eviscerated" or "ripped to shreds" and they "could never have another baby."

That claim is totally and completely false. Contrary to what abortion activists would have us believe, partial-birth abortion is *never* medically indicated to protect a woman's health or her fertility. In fact, the opposite is true: The procedure can pose a significant and immediate threat to both the pregnant woman's health and her fertility. It seems to have escaped anyone's attention that one of the five women who appeared at Mr. Clinton's veto ceremony had five miscarriages after her partial-birth abortion.

Consider the dangers inherent in partial-birth abortion, which usually occurs after the fifth month of pregnancy. A woman's cervix is forcibly dilated over several days, which risks creating an "incompetent cervix," the leading cause of premature deliveries. It is also an invitation to infection, a major cause of infertility. The abortionist then reaches into the womb to pull a child feet first out of the mother (internal podalic version), but leaves the head inside. Under normal circumstances, physicians avoid breech births whenever possible; in this case, the doctor intentionally causes one—and risks tearing the uterus in the process. He then forces scissors through the base of the baby's skull—which remains lodged just within the birth canal. This is a partially "blind" procedure, done by feel, risking direct scissor injury to the uterus and laceration of the cervix or lower uterine segment, resulting in immediate and massive bleeding and the threat of shock or even death to the mother.

None of this risk is ever necessary for any reason. We and many other doctors across the U.S. regularly treat women whose unborn children suffer the same conditions as those cited by the women who appeared at Mr. Clinton's veto ceremony. Never is the partial-birth procedure necessary. Not for hydrocephaly (excessive cerebrospinal fluid in the head), not for polyhydramnios (an excess of amniotic fluid collecting in the women) and not for trisomy (genetic abnormalities characterized by an extra chromosome). Sometimes, as in the case of hydrocephaly, it is first necessary to drain some of the fluid from the baby's head. And in some cases, when vaginal delivery is not possible, a doctor performs a Caesarean section. But in no case is it necessary to partially deliver an infant through the vagina and then kill the infant.

How telling it is that although Mr. Clinton met with women who claimed to have needed partial-birth abortions on account of these conditions, he has flat-out refused to meet with women who delivered babies with these same conditions, with no damage whatsoever to their health or future fertility!

Former Surgeon General C. Everett Koop was recently asked whether he'd ever operated on children who had any of the disabilities described in this debate. Indeed he had. In fact, one of his patients—"with a huge omphalocele (a sac containing the baby's organs) much bigger than her head"—went on to become the head nurse in his intensive care unit many years later.

Mr. Koop's reaction to the president's veto? "I believe that Mr. Clinton was misled by his medical advisers on what is fact and what is fiction" on the matter, he said. Such a procedure, he added, cannot truthfully be called medically necessary for either the mother or—he scarcely need point out—for the baby.

Considering these medical realities, one can only conclude that the women who thought they underwent partial-birth abortions for "medical" reasons were tragically misled. And those who purport to speak for women don't seem to care.

So whom are you going to believe? The activist-extremists who refuse to allow a little truth to get in the way of their agenda? The politicians who benefit from the activists' political action committees? Or doctors who have the facts?

Dr. Romer is clinical professor of obstetrics and gynecology at Wright State University and chairman of obstetrics and gynecology at Miami Valley Hospital in Ohio. Dr. Smith is director of medical education in the department of obstetrics and gynecology at Chicago's Mt. Sinai Medical Center. Dr. Cook is a specialist in maternal fetal medicine at Butterworth Hospital, Michigan State College of Human Medicine. Dr. DeCook is a fellow of the American College of Obstetricians and Gynecologists. The authors are founding members of the Physicians' Ad Hoc Coalition for Truth, which now has more than 300 members.

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FOR IMMEDIATE RELEASE
September 16, 1998

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WHY NOT PERINATAL HOSPICE?
Partial-Birth abortion for fetal anomalies is not medically necessary and can put women's mental health at risk

A recent article in *Issues in Law and Medicine* by PHACT members Byron Calhoun, M.D., James Reitman, M.D., and Nathan Hoeldtke, M.D. cites evidence that late-term abortion upon a diagnosis of fetal anomalies, while performed under the guise of reducing emotional suffering, actually threatens the best interests of the mother.

A consensus has emerged within the medical community that partial-birth abortion is never medically necessary or indicated to protect the life, health or future fertility of the mother, including in cases of fetal abnormalities. In fact, partial-birth abortion poses its own set of risks to a woman's health.

In their article Drs. Calhoun, Reitman and Hoeldtke cite studies that show abortion for fetal-anomalies appears to put the mother's* mental *well being at increased risk. These studies show that:

- ***A disproportionate number of the psychological complications which arise two years after an abortion are related to abortions for fetal abnormalities;***
- ***Psychological stress is significantly greater three months out for women who aborted disabled children between 24 and 34 weeks than for those who delivered such children after 34 weeks.***

Perinatal hospice programs are an emerging form of care for women facing such tragically sick children. They are an option to women considering recourse to partial-birth abortion. Such programs coordinate the combined efforts of obstetricians, maternal-fetal medicine physicians, neonatologists, anesthesia providers, labor and delivery nurses, neonatal and intensive care nurses, chaplains/pastors, and social workers. Working together, they assist these women to carry their children to term, offering them a far preferable way to cope with their tragedy than condemning their child to a partial-birth abortion.

The physical health risks to women from partial-birth abortion have already been attested to by doctors nationwide. An article in the current issue of the *Journal of the American Medical Society (JAMA)*, cites such health risks as "uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus," as well as "laceration of the uterus or cervix" that could result in "severe bleeding and the threat of shock or even maternal death." Dr. Warren Hearn, a specialist in late-term abortion and author of the standard textbook on late abortion procedures, has said of partial-birth abortion "You really can't defend it...I would dispute any statement that this is the safest procedure to use."

— #### —

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THE CASE OF COREEN COSTELLO

Partial-birth abortion was* not a medical necessity *for the most visible "personal case" proponent of procedure.

Coreen Costello is one of five women who appeared with President Clinton when he vetoed the Partial-Birth Abortion Ban Act (4/10/96). She has probably been the most active and the most visible of those women who have chosen to share with the public the very tragic circumstances of their pregnancies which, they say, made the partial-birth abortion procedure their only medical option to protect their health and future fertility.

But based on what Ms. Costello has publicly said so far, her abortion was not, in fact, medically necessary.

In addition to appearing with the President at the veto ceremony, Ms. Costello has twice recounted her story in testimony before both the House and Senate; the *New York Times* published an op-ed by Ms. Costello based on this testimony; she was featured in a full page ad in the *Washington Post* sponsored by several abortion advocacy groups; and, most recently (7/29/96) she has recounted her story for a "Dear Colleague" letter being circulated to House members by Rep. Peter Deutsch (FL).

Unless she were to decide otherwise, Ms. Costello's full medical records remain, of course, unavailable to the public, being a matter between her and her doctors. However, Ms. Costello has voluntarily chosen to share significant parts of her very tragic story with the general public and in very highly visible venues. Based on what Ms. Costello *has* revealed of her medical history -- of her own accord and for the stated purpose of defeating the Partial-Birth Abortion Ban Act -- doctors with PHACT can only conclude that Ms. Costello and others who have publicly acknowledged undergoing this procedure "are honest women who were sadly misinformed and whose decision to have a partial-birth abortion was based on a great deal of misinformation" (Dr. Joseph DeCook, Ob/Gyn, PHACT Congressional Briefing, 7/24/96). Ms. Costello's experience does not change the reality that a partial birth abortion is never medically indicated -- in fact, there are available several alternative, *standard* medical procedures to treat women confronting unfortunate situations like Ms. Costello had to face.

The following analysis is based on Ms. Costello's public statements regarding events leading up to her abortion performed by the late Dr. James McMahon. This analysis was done by Dr. Curtis Cook, a perinatologist with the Michigan State College of Human Medicine and member of PHACT:

"Ms. Costello's child suffered from at least two conditions: 'polyhydramnios secondary to abnormal fetal swallowing,' and 'hydrocephalus'. In the first, the child could not swallow the amniotic fluid, and an excess of the fluid therefore collected in the mother's uterus. The second condition, hydrocephalus, is one that causes an excessive amount of fluid to accumulate in the fetal head. Because of the swallowing defect, the child's lungs were not properly stimulated, and an underdevelopment of the lungs would likely be the cause of death if abortion had not intervened. The child had no significant chance of survival, but also would not likely die as soon as the umbilical cord was cut.

The usual treatment for removing the large amount of fluid in the uterus is a procedure called amniocentesis. The usual treatment for draining excess fluid from the fetal head is a procedure called cephalocentesis. In both cases the excess fluid is drained by using a thin needle that can be placed inside the womb through the abdomen ("transabdominally"–the preferred route) or through the vagina ("transvaginally.") The transvaginal approach however, as performed by Dr. McMahon on Ms. Costello, puts the woman at an increased risk of infection because of the non-sterile environment of he vagina. Dr. McMahon used this approach most likely because he had no significant expertise in obstetrics and gynecology. In other words, he may not have been able to do it well transabdominally -- the standard method used by ob/gyns -- because that takes a degree of expertise he did not possess. After the fluid has been drained, and the head decreased in size, labor would be induced and attempts made to deliver the child vaginally.

Ms. Costello's statement that she was unable to have a vaginal delivery, or, as she called it, 'natural birth or an induced labor,' is contradicted by the fact that she did indeed have a vaginal delivery, conducted by Dr. McMahon. What Ms. Costello had was a breech vaginal delivery for purposes of aborting the child, however, as opposed to a vaginal delivery intended to result in a live birth. A cesarean section in this case would not be medically indicated -- not because of any inherent danger -- but because the baby could be safely delivered vaginally."

Given these medical realities, the partial-birth abortion procedure can in no way be considered the standard, medically necessary or appropriate procedure appropriate to address the medical complications described by Ms. Costello or any of the other women who were tragically misled into believing they had no other options."

****

The Physicians' Ad-hoc Coalition for Truth (PHACT), with over three hundred members drawn from the medical community nationwide, exists to bring the medical facts to bear on the public policy debate regarding partial birth abortions. Members of the coalition are available to speak to public policy makers and the media. If you would like to speak with a member of PHACT, please contact Gene Tarne or Michelle Powers at 703-684-8352.

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PHACT

Physicians' Ad Hoc Coalition for Truth

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Communications Counsel:
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September 23, 1996

Dear Member of Congress:

My name is Dr. Pamela E. Smith. I am a founding member of PHACT (Physicians' Ad-hoc Coalition for Truth). This coalition of over three hundred medical providers nationwide (which is open to everyone, irrespective of their political stance on abortion) was specifically formed to educate the public, as well as those involved in government, in regards to disseminating **medical facts** as they relate to the Partial-Birth Abortion procedure.

In this regard, it has come to my attention that an individual (Ms. Vicki Stella, a diabetic) who underwent this procedure, who is **not** medically trained, has appeared on television and in *Roll Call* proclaiming that it was necessary for her to have this particular form of abortion to enable her to bear children in the future. In response to these claims I would invite you to note the following:

1. Although Ms. Stella proclaims this procedure was the only thing that could be done to preserve her fertility, the fact of the matter is that the standard of care that is used by medical personnel to terminate a pregnancy in its later stages **does not** include partial-birth abortion. Cesarean section, inducing labor with pitocin or protoglandins, or (if the baby has excess fluid in the head as I believe was the case with Ms. Stella) draining the fluid from the baby's head to allow a normal delivery are all techniques taught and used by obstetrical providers throughout this country. These are techniques for which we have safety statistics in regards to their impact on the health of both the woman and the child. In contrast, there are no safety statistics on partial-birth abortion, no reference of this technique in the national library of medicine database, and no long term studies published that prove it does not negatively affect a woman's capability of successfully carrying a pregnancy to term in the future. Ms. Stella may have been told this procedure was necessary and safe, but she was sorely misinformed.

2. Diabetes is a chronic medical condition that tends to get worse over time and that predisposes individuals to infections that can be harder to treat. If Ms. Stella was advised to have an abortion most likely this was secondary to the fact that her child was diagnosed with conditions that were incompatible with life. The fact that Ms. Stella is a diabetic, coupled with the fact that diabetics are prone to infection and the partial-birth abortion procedure requires manipulating a normally contaminated vagina over a course of three days (a technique that **invites infection**) medically I would contend of all the abortion techniques currently available to her this was the worse one that could have been recommended for her. The others are quicker, cheaper and do not place a diabetic at such extreme risks for life-threatening infections.

3. Partial-birth abortion is, in fact, a public health hazard in regards to women's health in that one employs techniques that have been **demonstrated in the scientific literature** to place women at increased

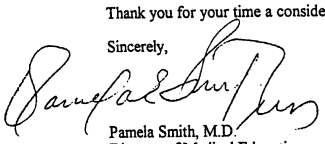
risks for uterine rupture, infection, hemorrhage, inability to carry pregnancies to term in the future and maternal death. Such risks have even been acknowledged by abortion providers such as Dr. Warren Hern.

4. Dr. C. Everett Koop, the former Surgeon General, recently stated in the *AMA News* that he believes that people, including the President, have been misled as to "fact and fiction" in regards to third trimester pregnancy terminations. He said, and I quote, "in no way can I twist my mind to see that the late term abortion described...is a medical necessity for the mother...I am opposed to partial-birth abortions." He later went on to describe a baby that he operated on who had some of the anomalies that babies of women who had partial-birth abortions had. His particular patient, however, went on to become the head nurse in his intensive care unit years later!

I realize that abortion continues to be an extremely divisive issue in our society. However, when considering public policy on such a matter that indeed has medical dimensions, it is of the utmost importance that decisions are based on facts as well as emotions and feelings. Banning this dangerous technique will not infringe on a woman's ability to obtain an abortion in the early stage of pregnancy or if a pregnancy truly needs to be ended to preserve the life or health of the mother. What a ban *will do* is insure that women will not have their lives jeopardized when they seek an abortion procedure.

Thank you for your time a consideration.

Sincerely,



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September 18, 1996

Dear Member of Congress:

We write to you as founding members of the Physicians' Ad-hoc Coalition for Truth (PHACT), an organization of over three hundred members drawn from the medical community nationwide -- most ob/gyns, perinatologist and pediatricians -- concerned and disturbed over the medical misinformation driving the partial-birth abortion debate. As doctors, we cannot remember another issue of public policy so directly related to the medical community that has been subject to such distortions and outright falsehoods.

The most damaging piece of medical disinformation that seems to be driving this debate is that the partial-birth abortion procedure may be necessary to protect the lives, health and future fertility of women. You have heard this claim most dramatically not from doctors, but from a handful of women who chose to have a partial-birth abortion when their children were diagnosed with some form of fetal abnormality.

As physicians who specialize in the care of pregnant women and their children, we have all treated women confronting the same tragic circumstances as the women who have publicly shared their experiences to justify this abortion procedure. So as doctors intimately familiar with such cases, let us be very clear: *the partial-birth abortion procedure, as described by Dr. Martin Haskell (the nation's leading practitioner of the procedure) and defined in the Partial-Birth Abortion Ban Act, is never medically indicated and can itself pose serious risks to the health and future fertility of women.*

There are simply no obstetrical situations encountered in this country which require a partially-delivered human fetus to be destroyed to preserve the life, health or future fertility of the mother. Not for hydrocephaly (excessive cerebrospinal fluid in the head); not for polyhydramnios (an excess of amniotic fluid collecting in the woman); and not for trisomy (genetic abnormalities characterized by an extra chromosome).

Our members concur with former Surgeon General C. Everett Koop's recent statement that "in no way can I twist my mind to see that [partial-birth abortion] is a medical necessity for the mother."

As case in point would be that of Ms. Coreen Costello, who has appeared several times before Congress to recount her personal experience in defense of this procedure. Her unborn child suffered from at least two conditions: "polyhydramnios secondary to abnormal fetal swallowing," which causes amniotic fluid to collect in the uterus, and "hydrocephalus", a condition that causes an excessive amount of fluid to accumulate in the fetal head.

The usual treatment for removing the large amount of fluid in the uterus is a procedure called amniocentesis. The usual treatment for draining excess fluid from the fetal head is a procedure called cephalocentesis. In both cases the excess fluid is drained by using a thin needle that can be placed inside the womb through the abdomen ("transabdominally"--the preferred route) or through the vagina ("transvaginally.") The transvaginal approach however, as performed by Dr. McMahon on Ms. Costello, puts the woman at an increased risk of infection because of the non-sterile environment of

the vagina. Dr. McMahon used this approach most likely because he had no significant expertise in obstetrics and gynecology. After the fluid has been drained, and the head decreased in size, labor would be induced and attempts made to deliver the child vaginally. Given these medical realities, the partial-birth abortion procedure can in no way be considered the standard, medically necessary or appropriate procedure appropriate to address the medical complications described by Ms. Costello or any of the other women who were tragically misled into believing they had no other options.

Indeed, the partial-birth abortion procedure *itself* can pose both an immediate and significant risk to a woman's health and future fertility. To take just one example, to forcibly dilate a woman's cervix over the course of several days, as this procedure requires, risks creating an "incompetent cervix," a leading cause of future premature deliveries. It seems to have escaped anyone's attention that one of the five women who appeared at President Clinton's veto ceremony who had a partial-birth abortion subsequently had five miscarriages.

The medical evidence is clear and argues overwhelmingly against the partial-birth abortion procedure. Given the medical realities, a truly pro-woman vote would be to end the availability of a procedure that is so potentially dangerous to women. The health status of women and children in this country can only be enhanced by your unequivocal support of H.R. 1833.

Thank you for your consideration.

Sincerely,

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What about the small minority of cases that do involve "serious fetal deformity"?

It is true that some partial-birth abortions -- a small minority -- involve babies who have grave disorders that will result in death soon after birth. But these unfortunate members of the human family deserve compassion and the best comfort-care that medical science can offer-- not a scissors in the back of the head. In some such situations there are good medical reasons to deliver such a child early, after which natural death will follow quickly. Dr. Harlan Giles, a professor of "high-risk" obstetrics and perinatology at the Medical College of Pennsylvania, performs abortions by a variety of procedures up until "viability." However, in sworn testimony in the U.S. Federal District Court for the Southern District of Ohio (Nov. 13, 1995), Prof. Giles said:

> [After 23 weeks] I do not think there are any maternal conditions that I'm aware of that mandate ending the pregnancy that also require that the fetus be dead or that the fetal life be terminated. In my experience for 20 years, one can deliver these fetuses either vaginally, or by Cesarean section for that matter, depending on the choice of the parents with informed consent. . . But there's no reason these fetuses cannot be delivered intact vaginally after a miniature labor, if you will, and be at least assessed at birth and given the benefit of the doubt. [transcript, page 240]

In a partial-birth abortion, the abortionist dilates a woman's cervix for three days, until it is open enough to deliver the entire baby breech, except for the head. When American Medical News asked Dr. Martin Haskell why he could not simply dilate the woman a little more and remove the baby without killing him, Dr. Haskell responded:

> The point here is you're attempting to do an abortion... not to see how do I manipulate the situation so that I get a live birth instead. [*American Medical News* transcript]

Under closer examination, it becomes clear that in some cases, the primary reason for performing the procedure is not concern that the baby will die in utero, but rather, that he/she will be *born alive*, either with disorders incompatible with sustained life outside the womb, *or* with a *non-lethal disability*. (Again, in Dr. McMahon's table of partial-birth abortions performed for "fetal indications," the largest category was for Down Syndrome.)

Viki Wilson, whose daughter Abigail died at the hands of Dr. McMahon at *38 weeks*, said:

> I knew that I could go ahead and carry the baby until full term, but knowing, you know, that this was futile, you know, that she was going to die... I felt like I needed to be a little more in control in terms of her life and my life, instead of just sort of leaving it up to nature, because look where nature had gotten me up to this point. [NAF video transcript, page 4.]

Tammy Watts, whose baby was aborted by Dr. McMahon in the 7th month, said:

> I had a choice. I could have carried this pregnancy to term, knowing everything that was wrong. [Testimony before Senate Judiciary Committee, Nov. 17. 1995]

Claudia Crown Ades, who appeared with President Clinton at the April 10 veto, said:

> My procedure was elective. That is considered an elective procedure, as were the procedures of Coreen Costello and Tammy Watts and Mary Dorothy-Line and all the other women who were at

> the White House yesterday. All of our procedures were considered elective. [Quotes from taped appearance on WNTM, April 12, 1996]

In a letter opposing HR 1833, one of Dr. McMahon's colleagues at Cedar-Sinai Medical Center, Dr. Jeffrey S. Greenspoon, wrote:

> As a volunteer speaker to the National Spina Bifida Association of America and the Canadian National Spina Bifida Organization, I am familiar with the burden of raising a significantly handicapped child. . . . The burden of raising one or two abnormal children is realistically unbearable. [Letter to Rep. Hyde, July 19, 1995]

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Partial Birth Abortion ≠ Standard Medical Practice

Apologists for procedure create confusion with recognized medical practices where none exists

The following analysis was done by PHACT founding member Pamela Smith, M.D.:

There have also been numerous attempts by abortion advocates to confuse a well recognized and utilized obstetrical technique called **cephalocentesis** with partial birth abortion. One such account was printed in the Chicago Sun Times on Monday April 8, 1996 and was authored by Ms. Mary-Dorothy Line. The most recent attempts have been made by Ms. Collen Costello and has been reprinted and circulated to members of Congress. The fact of the matter is, if the accounts of Ms. Costello and Ms. Line are as they state neither one of them had a partial birth abortion. The differences between partial birth abortion and cephalocentesis can be summarized as follows:

CEPHALOCENTESIS	PARTIAL BIRTH ABORTION
1. A small bore needle is used to remove fluid	1. A large bore needle is used to remove brain tissue
2. The intent is allow a normal delivery by either the vaginal or C/S route. If the baby survives the procedure the intent is never to kill him/her	2. The intent is to kill the baby and avoid the "dreaded complication" of a live birth
3. The baby may be head or feet first alive or dead	3. The baby is **alive** and is intentionally pulled out feet first by the practitioner even if this means flipping him/her around in the womb This obstetrical maneuver has known, serious, health risk for the mother.
4. This procedure can be found in standard textbooks and has known safety statistics	4. No reference of this procedure in the medical or abortion textbooks. No safety statistics
5. Performed primarily by obgyns who have special training in high risk pregnancies	5. Performed primarily by two family practitioners who only do abortions for a living and have no training in in high risk obstetrics

In both the cases of Ms. Costello and Ms. Line they state their babies were dead prior to extraction. This fact

alone disqualifies their procedure as being classified as a partial birth abortion in that the ban specifically states that **a living fetus** is partially delivered with only the head remaining inside when the suction catheter is inserted, the brains removed, and the delivery taken to completion.

We might also add that the technique used to perform the cephalocentesis on Ms. Costello, when reviewed by a perinatologist, was questionable in regards to safety. Removing the fluid by passing a thin needle through the mother's abdomen is safer than doing this through the vagina which normally is inhabited by bacteria. But of course, the person performing the procedure had no training in high risk obstetrics and perhaps was unaware of this factor.

In summary, there are absolutely no obstetrical situations in this country which require this abortion technique. The cases of Ms. Costello and Ms. Line are not examples of partial birth abortions and even if these individuals, for whatever reasons, had decided to terminate their pregnancies there are too many other quicker, safer and reliable means to do so. Partial birth abortion is a public health hazard to women. The status of maternal and child health in this country can only be improved by the banning of this abortion technique.

NANCY G. ROMER, M.D.
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Douglas Johnson
National Right to Life

May 28, 1996

Dear Mr. Johnson,

This is in reference to our conversation in regards to the 60 Minutes program on late term abortions. Lisa Binns of 60 Minutes called me on Friday April 26 and we spoke for approximately 45 minutes. I made several points in regard to late term abortions:

1. A handicapped fetus is not a threat to the mother's life. Ms. Binns suggested that a fetus with anencephaly has a higher risk of intrauterine death and this presents a risk to the mother. I told her that intrauterine fetal death under any circumstances is not a medical emergency and can be treated in a few days. Once the fetus dies partial birth abortion ban does not apply.

2. If a mother has a serious medical condition what is required is separation of the fetus from the mother not fetal death. This can be accomplished in several ways, either through induction of labor or cesarean section.

3. There are safe alternatives to partial birth abortion. I FAXed her a copy of Dr. Warren Hearn's article where he described his method of second trimester terminations. He injects the fetal heart with digoxin on day two to allow fetal death. On day three he documents fetal death and again now that the fetus is dead the law no longer applies. I can fax this article to you if you do not have it.

While I was out of the country May 1-10 Ms. Binns called to speak to me. I returned her call on May 14. She said she had a quick question. "Do you personally know of any physicians who would electively terminate a healthy fetus in a healthy mother past viability." I answered yes that I personally had a patient that Dr. Haskell had done an abortion on at 26 weeks. She argued that was not really viable and we debated viability. She then asked "Do you personally know of any physician who terminated a healthy fetus in a healthy mother at term?" I said Dr. McMahon had reported terminating babies with cleft lip and cleft palate. She suggested these were not healthy. I said they were not PERFECT but arguably healthy. Then I said " So what your asking is do I personally know of

any physician who has terminated a PERFECT baby in a PERFECT mother at term? The answer is no."

I hope this is of some help to you and apologize for taking so long to respond. If I can be of further help or answer any questions please don't hesitate to call.

Sincerely,

Nancy G. Romer, M.D.

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ACOG: MEDICALLY SOUND OR POLITICALLY CORRECT?

"An intact D&X (sic), however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman..."

--- Statement of Policy, American College of Obstetricians and Gynecologists (ACOG), 1/12/97

"On what possible basis does ACOG make this rather astounding assertion? To our knowledge, there are no published peer-reviewed safety data regarding the procedure in question. It is not taught as a formally recognized medical procedure. We can think of no data that could possibly support such an assertion...your claim that a totally unrecognized, non-standard procedure, for which no peer-reviewed data exist, can nonetheless be the safest and most appropriate in certain situations, simply defies understanding. If ACOG is truly committed to standing by this claim, then it would appear to be violating its own standards by recommending the use of a procedure for which no peer reviewed studies or safety data exist."

--- Denis Cavanaugh, M.D. (FL); Curtis Cook, M.D. (MI); Don Gambrell, M.D. (GA); Joseph DeCook, M.D. (MI); Pamela Smith M.D. (IL); Hans Geisler, M.D. (IN); Nancy Romer, M.D. (OH); William Stalter,M.D. (OH); Stephen H. Cruikshank, M.D. (OH), on behalf of the more than 450 members of PHACT.

"I am appalled at the lack of intellectual honesty displayed by the ACOG executive board in releasing this statement. To endorse a procedure that has not shown peer review journal efficacy, clearly lacks intellectual honesty...In view of the fact that most 'intact D&X's' are done for social convenience, the risks of the mother and benefit of the procedure must be greatly questioned ...To endorse it without this study, has the flavor of one pursuing a political agenda as opposed to being an honest advocate for health care of the female patient."

--- John G. Hartmann, M.D. (Michigan)

...[T]his statement from ACOG has been released with little or no input from the membership at large...There is absolutely no scientific medical evidence to support their position and it is interesting to note that they do not give any grounds or reasons for their position. As a Board Eligible/Certified Obstetrician Gynecologist for the last ten years, I can tell you with great assurance that there is no medical reason to ever perform this procedure and that it is never of any physical health benefit to the mother....Please know that this statement does not represent the feelings of the majority of Obstetricians/Gynecologists in this country, who are by-and-large opposed to this brutal and inhumane procedure."

--- Jeffrey A Keenan, M.D. (Tennessee)

"I am a former abortion provider and I would like to take issue with the 'Statement' for a number of reasons...I, too, resent the intrusion of government into so many aspects of my personal and professional life. However, one of our government's primary responsibilities is protection of her citizens. Purposeful killing of a healthy infant who would be viable outside the womb should be called what it truly is -- *infanticide* or *murder*, and the legislature has every right to step in. Finally, I'm sure there are many ACOG members who join me in reminding you that your stand on this issue, published as an official policy statement, does not reflect the views of many, if not most, ACOG members. However, the perception of the general public is that you speak for all of us. Please recognize that you have a responsibility to all members of ACOG if not to stay neutral in sensitive areas such as this, to at least issue a disclaimer on such a statement that the opinions of the ACOG Executive Committee do not reflect those of its members."

--- Steven Hammond, M.D. (Tennessee)

"I have been a member of the American College of Ob Gyn since 1987. I am appalled by the politically motivated, medically unsound statement that the Executive Committee is attempting to pass off as representative of the feelings of the membership at large. Please do not be misled by these untruths...[The statement] is simply not true. This procedure is *never* the best or most appropriate procedure. There are *always* other options which would achieve the same goal for the patient and the doctor without resorting to a procedure in which the babies brains are sucked out of its head just moments before birth. The ACOG Statement does not attempt to justify its statement because no such justification exists...Please do not accept [ACOG's] biased misrepresentations as truth...Your conscience tells you this is wrong. Do not allow a professional organization lead you to a different conclusion with lies and misrepresentations of the truth."

--- Stephen R. Belton, M.D. (California)

"The American College of OB/GYN issued a policy statement dated January 12, 1997 with which I strongly disagree...The leadership of our national organization exceeded their authority and violated member trust when they issued this statement. I agree that it is a dangerous precedent to allow Congress to legislate for or against medical procedures, but partial-birth abortion is not a medical procedure that a morally responsible nation can allow to continue...Partial birth abortion is both a dangerous and unnecessary procedure.

--- J. Peter Forney, M.D. (Texas)

To intimate that this procedure is done with any degree of frequency to "save the life and conserve the health of a woman" is the epitomy of hypocrisy...When medicine, and in particular, our specialty, can police itself no better than this, then unfortunately, relief must be sought through legislative efforts to curb this travesty."

--- James M. Anderson, M.D. (California)

NOTE: All of the doctors quoted above are Fellows of the American College of Obstetricians and Gynecologists (FACOG) as well as members of PHACT.

PHACT

Physicians' Ad Hoc Coalition for Truth

FOUNDING MEMBERS

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Family Practitioner, Obstetrician
Member, U.S. House of Representatives (OK-2)

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Fellow, American College of Obstetricians & Gynecologists
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Communications Consult:
Gene Tarne, Michelle Powers

January 29, 1997

Fredric D. Frigoletto, Jr. M.D.
President of the Executive Board
American College of Obstetricians and Gynecologists

Dear Dr. Frigoletto:

We write to you on behalf of the hundreds of doctors nationwide who are members of the Physicians' Ad hoc Coalition for Truth (PHACT). PHACT was formed to address expertly one issue: partial-birth abortion. While the coalition includes physicians from all medical specialties, the vast majority of its members are obstetricians and gynecologists. Of these, a sizeable number are also Fellows of the American College of Obstetricians and Gynecologists (ACOG).

With this in mind, we are writing to express our surprise and concern over a recent statement issued by ACOG, dated January 12, 1997, on the subject of partial-birth abortion. Surprise, because those of us who are fellows were never informed that ACOG was even investigating this subject, with the goal of issuing a public statement, presumably on behalf of us and the others within ACOG's membership. And concern, because the statement that was issued, by endorsing a practice for which no recognized research data exist, would seem to be violating ACOG's own standards.

Let us address the latter concern -- content -- first.

The statement correctly notes at the outset that the procedure in question is not recognized in the medical literature. The same, it should be noted, can be said of the name you have chosen to call it -- "Intact Dilatation and Extraction," or "Intact D&X" -- and all the other names proponents of this procedure have concocted for it. We have closely followed the issue of partial-birth abortion -- again, it is the *only* issue PHACT addresses -- and the term Intact Dilatation and Extraction is new to us and would appear to be unique to you. The late Dr. James McMahon, until his death a leading provider of partial-birth abortions, called them "Intact Dilation and Evacuation (Intact D&E)" while another provider, Dr. Martin Haskell of Ohio, calls them "Dilation and Extraction (D&X)." Planned Parenthood, for example, calls them D&X abortions, while the National Abortion Federation prefers Intact D&E, so there is no agreement, even among proponents of this procedure, as to what to call it. Indeed, in its January, 1996 newsletter, ACOG then referred to it as "intact dialation (sic) and evacuation." Your new coinage would seem to be a combination of these various "names" floating about, but to what end is not clear. What is clear is that none of these terms, including your own "Intact D&X" can be found in any of the standard medical textbooks or databases.

It is wrong to say, as your statement does, that descriptions, at least the description in last year's Partial-Birth Abortion Ban Act, are "vague" and "could be interpreted to include elements of many recognized" medical techniques. The description in the federal legislation is very precise as to what is being proscribed and is based on Dr. Haskell's own descriptions. Moreover, the legislation is so worded as to clearly distinguish the procedure being banned from recognized obstetric techniques, and recognized abortion techniques, such as D&E, which would be unaffected by the proposed ban.

By far, however, the most disturbing part of ACOG's statement is the assertion that "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 the mother."

On what possible basis does ACOG make this rather astounding assertion?

Many of our members hold teaching positions or head departments of obstetrics and gynecology or perinatology at universities and medical centers. To our knowledge there are no published peer-*reviewed* safety data regarding the procedure in question. It is not taught as a formally recognized medical procedure. We can think of no data that could possibly support such an assertion. If ACOG or its "select panel" has such data, we would, as teachers and practicing ob/gyns, certainly like to review it.

The best that your statement does to back this claim is the very vague assertion that "other data show that second trimester transvaginal instrumental abortion is a safe procedure." While this may be true, it is, as surely you must be aware, totally beside the point. Such data may exist regarding, e.g., second trimester D&E abortion, but this is irrelevant to the fact that no similar data, at least to our knowledge, exists with respect to partial-birth abortion (or, as you prefer, "intact D&X" or whatever other medical-sounding coinage supporters of this procedure may use). To include such an assertion that can only refer to second trimester abortion procedures *other* than partial-birth is deceptive and misleading at best.

ACOG clearly recognizes that in no circumstances is partial-birth abortion the only option for women. In other words, ACOG agrees that there are other, *medically recognized*, and standard procedures available to women other than partial-birth abortion. Given ACOG's acceptance of this medical fact, your claim that a totally unrecognized, non-standard procedure, for which no peer-reviewed data exist, can nonetheless be the safest and most appropriate in certain situations, simply defies understanding.

If ACOG is truly committed to standing by this claim, then it would appear to be violating its own standards by recommending the use of a procedure for which no peer-reviewed studies or safety data exist.

In contrast, our research of the subject leads us to conclude that there are no obstetrical situations that would necessitate or even favor the medically unrecognized partial-birth abortion procedure as the safest or most appropriate option. Indeed, we have concerns that this procedure may itself pose serious health risks for women.

Ordinarily, we would agree that the intervention of legislative bodies into medical decision making is usually inappropriate. However, when the medical decision making *itself* is inappropriate, and may be putting women at risk by subjecting them to medically unrecognized procedures, then the intervention of a legislative body, such as the U.S. Congress, may be the only way to protect mothers and infants threatened by the partial-birth abortion procedure.

In addition to these concerns over the content of the statement, we are also concerned as to the procedure by which it came to be issued.

As mentioned, the vast majority of PHACT members are specialists and sub-specialists (i.e. perinatologists) in obstetrics and gynecology, and many of these are also fellows of ACOG. After them, our membership consists largely of family practitioners and pediatricians. Former Surgeon General C. Everett Koop, perhaps the nation's leading pediatric surgeon, has been associated with PHACT and his public statements on partial-birth abortion are in agreement with PHACT. Our membership is open to any doctor, regardless of his or her political views on the larger question of abortion rights, precisely because our focus is strictly on the medical realities that relate to this procedure. (In fact, doctors who are pro-choice have publicly stated their opposition, on medical grounds, to the use of this abortion method).

We cannot recall receiving any notification whatsoever that the American College of Obstetricians and Gynecologists was even reviewing the issue of partial-birth abortion toward the end of issuing a statement of policy. We cannot recall ever being informed that ACOG was going to convene a "select panel" to accomplish this. We find 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. Those of us who are fellows of ACOG were kept completely in the dark as to what ACOG's leadership was doing in regard to this issue.

In truth, this statement is the product of a panel -- whose membership ACOG has not made public -- that was working behind closed doors and with no real participation from ACOG's membership itself. In crafting this statement, ACOG simply ignored its own members. There is the danger that in issuing this statement, ACOG is giving the larger public the impression that the statement somehow represents the thinking of its members on this subject. It does not. ACOG members had no knowledge of this statement until it was issued as a *fait accompli*.

In conclusion, 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 the partial-birth abortion method. We ask you to provide the medical data, research and all other relevant materials which could possibly have led to such an assertion. We ask that you also make available the names of those on the select panel who arrived at such a conclusion. We would also ask that the leadership of ACOG officially withdraw this statement until the matter at issue -- partial-birth abortion -- has been subject to a thorough and open discussion among the members of ACOG and those doctors in related specialties who have significant knowledge regarding this issue. We look forward to your response.

Sincerely:

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Director, Division of Ob/Gyn
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College of Medicine
FACOG

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February 6, 1997

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Dear Fellows:

Thank you for writing to me regarding ACOG's Intact D & X statement. I appreciate hearing the views of our fellows. Differences with regard to the substance of what ACOG states in any document can occur. I regret that you have differences with our statement, but it remains ACOG's statement.

I am concerned about your allegations about being excluded from the ACOG process. You specifically cite the lack of consultation in the development of this statement. I am unclear as to whether you are asserting this as individual members of the College or on behalf of PHACT, so I will respond to each. With regard to PHACT as an organization, I am personally unaware of any attempt by PHACT prior to this letter to communicate with the College on the issue of Intact D and X. If I am in error and there have been other communications, I would appreciate receiving copies of such communications. However, I do have some awareness of your organization through information provided by Congressional sources.

The views of individual fellows are critical to me and to ACOG. I welcome you to write or call at any time to share your views. On the other hand, in developing policy ACOG relies upon selected groups -- committees, task forces, etc. -- to provide both medical and policy expertise. Ultimately, the Board adopts policy. The Board is composed of the elected representatives of the College; these members act on Fellows' behalf.

In the case of the "Intact D & X" statement, the Board, at my request, formally agreed at one of its meetings that I could appoint a task force to look into this issue. Since that time, I made it a specific point to inform attendees at ACOG District meetings and other College forums at which I spoke of the work of the task force. Members of the public did in fact contact ACOG about the task force during this period. Upon completion of the task force's work, the Board reviewed its recommended statement and amended and approved it at its January 1997 meeting. The statement was unanimously approved.

As stated previously, I believe the process for the development of this statement was a sound one and I, and the ACOG Board, stand firmly behind ACOG's policy. Clearly, our organizations do not agree on the content of the statement. I hope that we can respect these differences.

Respectfully Yours,

Fredric D. Frigoletto, Jr., MD
President
American College of Obstetricians andGynecologists

American Medical Association
Physicians dedicated to the health of America

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.

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] suffice[d]*" 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 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" 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 Dilatation and Extraction (Intact D&X)." ACOG Factsheet, April 14, 1997 (emphasis added).

American Medical Association
Physicians dedicated to the health of America

P. John Seward, MD
Executive Vice President

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464 4184 Fax

May 19, 1997

The Honorable Rick Santorum
United States Senate
120 Russell Senate Office Bldg.
Washington, DC 20510

Dear Senator Santorum:

The American Medical Association (AMA) is writing to support HR 1122, "The Partial-Birth Abortion Ban Act of 1997," as amended. Although our general policy is to oppose legislation criminalizing medical practice or procedure, the AMA has supported such legislation where the procedure was narrowly defined and not medically indicated. HR 1122 now meets both those tests.

Our support of this legislation is based on three specific principles. First, the bill would allow a legitimate exception where the life of the mother was endangered, thereby preserving the physician's judgment to take any medically necessary steps to save the life of the mother. Second, the bill would clearly define the prohibited procedure so that it is clear on the face of the legislation what act is to be banned. Finally, the bill would give any accused physician the right to have his or her conduct reviewed by the State Medical Board before a criminal trial commenced. In this manner, the bill would provide a formal role for valuable medical peer determination in any enforcement proceeding.

The AMA believes that with these changes, physicians will be on notice as to the exact nature of the prohibited conduct.

Thank you for the opportunity to work with you towards restricting a procedure we all agree is not good medicine.

Sincerely,

P. John Seward, M.D

P. John Seward, MD

150 Years of Caring for the Country
1847 • 1997

THE NEW YORK TIMES
MAY 26, 1997

A.M.A. SUPPORT

To the Editor:

You are wrong in your speculation about the American Medical Association's support for the "partial-birth" abortion legislation. You are also wrong about the bill (editorial, May 21). Our reasons for supporting the bill are simple: the partial delivery of a living fetus for the purpose of killing it outside the womb is ethically offensive to most Americans and physicians. Our panel could not find any identified circumstance in which the procedure was the only safe and effective abortion method. Finally, the bill's sponsors changed the bill for the safety of our patients so that no accepted abortion technique is covered and so that physicians have full discretion to use even the partial-birth technique in the course of a delivery in unforeseen circumstances.

The bill is not inconsistent with Roe v. Wade, as you suggest. No procedure necessary to preserve the life or the health of the woman will be denied - it just won't be done in this particular rare and inappropriate way.

We would have preferred for this issue to be handled within the profession, and we attempted to build a consensus necessary to do that. But dozens of state legislatures are considering broader legislation modeled on the original, flawed House bill. The amendments we obtained, while not everything we wanted, will improve the laws in those states.

DANIEL H. JOHNSON, JR. M.D.
President, American Medical Assn.
Chicago, May 22, 1997

American Medical Association
Physicians dedicated to the health of America

Statement

AMA Supports HR 1122 As Amended

Statement attributable to: Nancy W. Dickey, MD
Chair

The American Medical Association Board of Trustees has determined to support HR 1122 because it has now been significantly changed to substantially meet the criteria which the Board established for any abortion legislation. (The document containing that criteria, made public and forwarded to our House of Delegates early last week, is attached.)

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, HR 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.

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, HR 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.

HR 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.

For more information, please contact: James Stacey 202/789-7419
Brenda Craine 202/789-7447

1101 Vermont Avenue, NW
Washington, DC 20005
202 789-7400

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 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 anti-tobacco agenda, or (c) delivered on May 21 a letter to Representatives Kildee and Stark supporting ERISA reform which the Republicans generally oppose, or engaged in countless other activities that defy partisan identification.

Sincerely,

P. John Seward, MD

AMA Press Releases: AMA Supports H.R. 1122 As Amended

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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."

PHACT

Physicians' Ad Hoc Coalition for Truth

For Immediate Release
May 13, 1997

Contact: Gene Tarne, Michelle Powers
703/684-8352

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Family Practitioner, Obstetrician
Member, U.S. House of Representatives (OK-2)

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PARTIAL-BIRTH ABORTION: THE NAME GAME

"The author has coined the term Dilation and Extraction or D&X to distinguish it from dismemberment-type D&E's."
–Dr. Martin Haskell, *"Dilation and Extraction in Late Second Trimester Abortion,"* 9/13/92

"[Dr. James] McMahon has developed his own method that he calls intrauterine cranial decompression."
– *Los Angeles Times Magazine*, 1/7/90

"Only Dr. Haskell, James T. McMahon and a handful of other doctors perform the D&X procedure, which Dr. McMahon refers to as 'intact D&E.'"
– *The American Medical News*, 7/5/93

"Intact D&E (dilation and evacuation) is a medical procedure that would be outlawed by H.R. 1833, the so-called 'Partial-Birth Abortion Ban' Act."
–National Abortion Federation information sheet, 2/96

"The attempt to ban dilation and extraction (D&X), a late abortion procedure that is used very rarely and in the most tragic circumstances..."
– Planned Parenthood information sheet, 3/21/96

"The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as 'Intact Dilatation and Extraction' (Intact D&X)."
– ACOG Statement of Policy, 1/12/97

"The U.S. House of Representatives and Senate recently passed legislation that would criminalize intact dialation (sic) and evacuation, which the bill describes as 'partial-birth abortion.'"
– Newsletter of the American College of Obstetricians and Gynecologists (ACOG), 1/96

"Eleven states have enacted bans on the procedure, know medically as 'intact dilation and evacuation.'"
– *New York Times* reporter Katharine Q. Seeyle, "As Federal Ban Faces A Veto, States Outlaw Late Abortion," 5/5/97.

"...in anticipation of next week's vote on a proposed ban on the procedure, known medically as intact dilation and extraction or evacuation."
– *New York Times* reporter Katharine Q. Seeyle, "Democratic Leader Proposes Measure to Limit Abortion," 5/9/97.

Supporters of the Partial-Birth Abortion Ban have been consistent in referring to the procedure by one term alone: Partial-Birth Abortion. Congress intends this term to be a legal one, not medical. On the other hand, advocates for the continued use of partial-birth abortion have coined any number of names for the procedure, claiming each new coinage is a proper medical term. As the above quotes show, they cannot agree even among themselves as to just what the "proper medical name" for the procedure is.

There is a reason for this: *there is no proper medical name for partial-birth abortion*, only medically sounding ones. What all these names share in common is that none of them can be found in any of the standard medical textbooks or databases. Indeed, the procedure itself is not recognized by the medical community, nor is it taught as a formally recognized medical procedure.

The term partial-birth abortion, on the other hand, according to maternal-fetal specialist and PHACT member Watson Bowes, M.D. "is accurate as applied to the procedure described by Dr. Martin Haskell in his 1992 paper entitled 'Dilation and Extraction For Late Second Trimester Abortion,' distributed by the National Abortion Federation." Dr. Pamela Smith, a founding member of PHACT and former director of medical education, ob/gyn at Mt. Sinai Hospital in Chicago, calls both the name partial-birth abortion and its legal definition "straightforward" and notes that "this definition covers this procedure and no other."

The very variety of names that have been coined for it are proof that there is no single, standard, medical term for partial-birth abortion. Claims that there is such a medically recognized name are false. The only purpose for medically-sounding coinages is to give the general public the impression that the partial-birth abortion procedure possesses a degree of medical legitimacy, which it does not.

ON SOCIETY

BY JOHN LEO

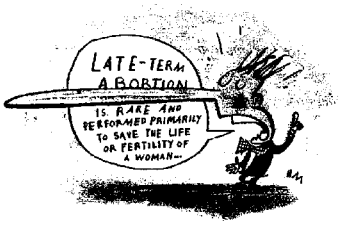
The first crack in the wall

So Ron Fitzsimmons can't stand it anymore. He wants us to know that he can't live with the untruths he told for the abortion cause. He's the executive director of the National Coalition of Abortion Providers, now saying he "lied through my teeth" on *Nightline* in November '95, when he "just went out there and spouted the party line" about how partial-birth abortions are rare and confined to serious threats to mother and fetus.

Oddly, Fitzsimmons is expressing moral anguish over quotes that hadn't reached the American people—his *Nightline* lies wound up on the cutting-room floor. But his statement makes it clear that he is really troubled by his participation in the broader campaign of untruths by defenders of partial-birth abortion.

"When . . . the leaders of your movement appear before Congress and go on network news and say these procedures are done in only the most tragic of circumstances, how do you think it makes you feel?" he asks, then answers: "Like a dirty little abortionist with a dirty little secret."

Along the way, Fitzsimmons paid tribute to my good friend Richard Cohen, the *Washington Post* columnist who retracted a column broadly defending partial-birth abortion, writing that he was wrong to take at face value the misinformation supplied by abortion groups. This is an example of how one honest man, an abortion-rights supporter, encouraged honesty in another, thus providing the first crack in the stone wall of movement propaganda.



'It's a dishonest campaign aimed at keeping the truth from the American people.'

Brutal candor. Astonishingly, most of the misinformation was an attempt to deny facts already put on the record by the two doctors best known for performing partial-birth abortions: Dr. Martin Haskell, owner of two Ohio abortion clinics, and the late Dr. James McMahon of Los Angeles.

In the early days of the controversy, both spoke with almost brutal candor about what they were doing. Haskell provided a vivid and detailed description of the operation, which became the basis of the now famous drawings of a baby halfway down the birth canal being stabbed in the skull with surgical scissors. Haskell said these drawings were accurate "from a technical point of view." But they were later repeatedly attacked by abortion activists as misleading.

McMahon said he had moral compunctions about the operation and considered the fetus to be a child at 20 weeks. In papers given to Congress, he made clear that he performed partial-birth procedures during all 40 weeks of pregnancy for a long litany of reasons, including cleft lip, maternal depression, and what he called "pediatric indications," which, he explained to a congressional aide, meant that the mother-to-be was very young. Haskell, too, acknowledged that most of his partial-birth abortions were elective and that he stopped doing them at about 25 weeks. In a taped interview, Haskell told the *American Medical News* that the fetus was usually alive when the stabbing and brain suction took place. (Q: Let's talk first about whether or not the fetus is dead beforehand. Haskell: No, it's not. No, it's really not.)

Then, McMahon died, Haskell went into seclusion, and the abortion activists circled the wagons. Though the McMahon-Haskell testimony showed a great many procedures done on healthy mothers with healthy fetuses, the chorus of activists said otherwise. "It's not only a myth, it's a lie" that these abortions were done for minor defects such as cleft palates, said Kate Michelman of the National Abortion and Reproductive Rights Action League. Planned Parenthood said the procedure "is extremely rare and done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality." Michelman made similar statements over and over, and much of the media fell into line. National Public Radio announced, for instance, that "Doctors resort to this rare procedure only for late-term abortions if the fetuses have severe abnormalities and no chance of survival." All untrue and well known inside the movement.

Activists began to insist that the fetus can't feel pain because anesthesia kills it peacefully. (Anesthesia "causes fetal demise," said Michelman. "The fetus dies of an overdose of anesthesia given to the mother intravenously," said Planned Parenthood.) But the American Society of Anesthesiologists debunked this claim as "entirely inaccurate."

Standards dipped so low that doctors started to deny quotes that reporters had on tape. Dr. Warren Hern, a Colorado specialist in late abortions, told Diane Gianelli of *American Medical News* that he "would dispute that [partial-birth abortion] is the safest procedure to use." Then, he went on *60 Minutes* and vehemently denied the quote, though Gianelli has a tape. Another Gianelli article quoted Haskell saying that 80 percent of his partial-birth abortions are elective. He wrote a letter strongly implying he was misquoted, but again Gianelli had a tape showing that he wasn't.

Fitzsimmons is right to separate himself from all this. It's a dishonest campaign aimed at keeping the truth from the American people. ■

ILLUSTRATION BY HAL MAYFORTH FOR USN&WR

NEW YORK POST, FRIDAY, MARCH 22, 1996

Leading doc tells Congress pro-choicers 'misinformed'

Anesthesia information

By MARILYN RAUBER
Post Correspondent

WASHINGTON — The head of the American Society of Anesthesiologists yesterday accused abortion-rights activists of spreading medical "misinformation" and scaring moms-to-be.

The furor erupted during a testy House hearing on late-term "partial birth" abortion — and recent claims by pro-choicers that anesthesia given to the patient kills the fetus before the controversial procedure does.

ASA President Norig Ellison blasted that claim as an "entirely inaccurate" myth provoking "fear" in some pregnant patients who need surgery.

"Pregnant women are routinely heavily sedated . . . for a variety of necessary surgical procedures with absolutely no adverse effect on the fetus, let alone death," Ellison told the panel.

The hearing, with graphic drawings of the gruesome abortion procedure on display, was held days before the House is scheduled to vote on a Senate-backed bill banning the rarely-used procedure except to save the mother's life.

During the procedure, the fetus' brains are removed by suction through an incision in the neck.

Pro-choice activists didn't produce any medical experts to support the claim that the fetus is killed by anesthesia — instead, pro-choice Rep. Patricia Schroeder (D-Colo.) dismissed the hearing as "political theater."

"This is a distraction . . . This is a new American witchcraft trial," said Schroeder, adding that the real issue is "a bill that would take away doctors' choices" to save women's lives and preserve their fertility.

But David Birnbach, head of obstetric anesthesiology at New York's St. Luke's-Roosevelt Hospital Center, warned the misinformation "may cause some to unnecessarily delay emergency surgery . . . Pregnant women *must* get the message that should they need anesthesia, they may do so without worrying."

GOP House members specifically rebuked National Abortion Rights Action League President Kate Michelman for publicly claiming "the anesthesia that they give the woman already causes the demise of the fetus" before the brain suctioning.

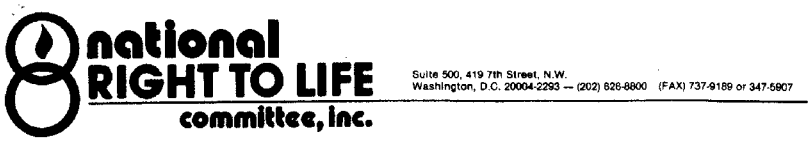
"If it was a mistake, say it was a mistake . . . that would be the responsible thing to do," fumed panel chairman Charles Canady (R-Fla.).

NARAL political director, Jo Blum, told The Post her organization "relied on credible medical testimony" from doctors who performed the procedure.

When asked if NARAL still stood by its original position, she said, "there is clearly a difference of opinion" among doctors.

In moving testimony, two California women who underwent the unusual abortion procedure after discovering they were carrying babies with fatal deformities, pleaded with House members not to ban the procedure.

They argued it was a safe method that didn't risk infertility. Both are now pregnant again.



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Members of Congress
Propagate the "Anesthesia Myth"

Senator Carol Moseley-Braun (D-Il.) said during U.S. Senate floor debate on the bill (Nov. 8), "The fetus dies during the first dose of anesthesia."

Congresswoman Sheila Jackson-Lee (D-Tx.) said during U.S. House floor debate on the bill (Nov. 1), "This debate has injected an ugly picture of incorrect representation about this medical procedure simply to inflame your emotions. The fetus is already deceased based on an excessive amount of anesthesia."

Congressman Sam Gedjenson (D-Ct.) said in letters to constituents, "Particularly in cases of severe fetal abnormality, it is misleading to imply that the fetus is alive or experiencing sensation during the abortion, because neurological fetal demise (brain death) is confirmed before the procedure begins."

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ONE HUNDRED FOURTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON THE JUDICIARY

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March 19, 1996

The Honorable Barney Frank
Ranking Member
Subcommittee on the Constitution
2210 Rayburn H.O.B.
Washington, D.C. 20515

Dear Barney:

My staff has just informed me that the minority has not requested that any medical experts be invited to testify on the effects of anesthesia during a partial-birth abortion, the subject of Thursday's hearing before the Subcommittee on the Constitution.

As you know, the claim that anesthesia administered to a mother kills her unborn child before a partial-birth abortion has begun has been disseminated throughout the country by Kate Michelman of the National Abortion Rights Action League, Dr. Mary Campbell of Planned Parenthood, and the National Abortion Federation. Planned Parenthood and the National Abortion Federation represent hundreds of abortion providers. Surely one of their experts is willing to defend their claims. I find it disturbing that there is not a single medical expert to defend this claim which has been so prominent in the attacks on H.R. 1833.

In accordance with Committee procedures, I expect that I will receive the testimony of the minority's witnesses today. If you are able to find a witness with medical credentials, I would be happy to extend the deadline for that witness's testimony to 10:00 a.m. tomorrow.

Sincerely yours,

Chas.

Charles T. Canady
Chairman
Subcommittee on the Constitution

NARAL Promoting Reproductive Choices

March 15, 1996

The Honorable Henry J. Hyde
Chairman
Committee on the Judiciary
2138 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Hyde:

Thank you for offering me the opportunity to testify on March 21, 1996 before the Subcommittee on the Constitution.

I regret that I will be unable to testify before the Subcommittee due to a previous commitment located outside of the District of Columbia.

Sincerely,

Kate Michelman

Kate Michelman

cc: The Honorable Barney Frank

National Abortion
and Reproductive Rights
Action League

1156 15th Street, NW
Suite 700
Washington, DC 20005

Phone (202) 973-3000
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SUBCOMMITTEE ON THE CONSTITUTION
Committee on the Judiciary
U.S. House of Representatives

Oversight Hearing: "Fetal Death" or Dangerous Deception?
The Effects Of Anesthesia During A Partial-Birth Abortion
2141 Rayburn House Office Building
Thursday, March 21, 1996
9:00 a.m.

WITNESS LIST

PANEL I:

Honorable Tom A. Coburn, M.D.
U.S. House of Representatives, Oklahoma/2nd District

PANEL II:

Norig Ellison, M.D.
President, American Society of Anesthesiologists
Clinical Director, Department of Anesthesia, University of Pennsylvania Hospital
Professor and Vice Chair, Department of Anesthesia, University of Pennsylvania School of Medicine

David J. Birnbach, M.D.
President-Elect, Society for Obstetric Anesthesia and Perinatology
Director of Obstetric Anesthesiology, St. Luke's-Roosevelt Hospital Center, Columbia University

David Hill Chestnut, M.D.
Chairman, Department of Anesthesiology, University of Alabama, Birmingham Hospital
Professor, Department of Obstetrics and Gynecology and Department of Anesthesiology
University of Alabama, Birmingham School of Medicine
Editor, Obstetric Anesthesia: Principles and Practice, 1994

Jean A. Wright, M.D., M.B.A.
Medical Director, Egleston Children's Hospital, Emory University
Associate Professor, Department of Pediatrics and Anesthesiology, Emory University

PANEL III

Brenda Pratt Shafer, R.N.
Franklin, Ohio

Coreen Costello
Agoura, California

Mary-Dorothy Line
Marina del Ray, California

Helen M. Alvare
Director of Planning and Information, Secretariat for Pro-Life Activities, National Conference of Catholic Bishops

STATEMENT OF NORIG ELLISON, M.D., PRESIDENT
AMERICAN SOCIETY OF ANESTHESIOLOGISTS
Before the
Subcommittee on the Constitution
U.S. House of Representatives
March 21, 1996

Chairman Canady, members of the Subcommittee. My name is Norig Ellison, M.D., I am the President of the American Society of Anesthesiologists (ASA), a national professional society consisting of over 34,000 anesthesiologists and other scientists engaged or specially interested in the medical practice of anesthesiology. I am also Professor and Vice-Chair of the Department of Anesthesiology at the University of Pennsylvania School of Medicine in Philadelphia and a staff anesthesiologist at the Hospital of the University of Pennsylvania.

I appear here today for one purpose, and one purpose only: to take issue with the testimony of James T. McMahon, M.D., before this Subcommittee last June. According to his written testimony, of which I have a copy, Dr. McMahon stated that anesthesia given to the mother as part of dilation and extraction abortion procedure eliminates any pain to the fetus and that a medical coma is induced in the fetus, causing a "neurological fetal demise", or --in lay terms -- "brain death".

I believe this statement to be entirely inaccurate. I am deeply concerned, moreover, that the widespread publicity given to Dr. McMahon's testimony may cause pregnant women to delay necessary, even life-saving, medical procedures, totally unrelated to the birthing process, due to misinformation regarding the effect of anesthetics on the fetus. Annually over 50,000 pregnant women are anesthetized for such necessary procedures.

Although it is certainly true that some general analgesic medications given to the mother will reach the fetus and perhaps provide some pain relief, it is equally true that pregnant women are routinely heavily sedated during the second or third trimester for the performance of a variety of necessary surgical procedures with absolutely no adverse effect on the fetus, let alone death or "brain death". In my medical judgment, it would be necessary -- in order to achieve "neurological demise" of the fetus in a "partial birth" abortion -- to anesthetize the mother to such a degree as to place her own health in serious jeopardy.

As you are aware, Mr. Chairman, I gave the same testimony to a Senate committee four months ago. That testimony received wide circulation in anesthesiology circles and to a lesser extent in the lay press. You may be interested in the fact that since my appearance, not one single anesthesiologist or other physician has contacted me to dispute my stated conclusions. Indeed, two eminent obstetric anesthesiologists appear with me today, testifying on their own behalf and not as ASA representatives. I am pleased to note that their testimony reaches the same conclusions that I have expressed.

Thank you for your attention. I am happy to respond to your questions.

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STATEMENT OF DAVID J. BIRNBACH, M.D.
before the
SUBCOMMITTEE ON THE CONSTITUTION
COMMITTEE ON THE JUDICIARY
U.S. HOUSE OF REPRESENTATIVES
March 21, 1996

Mr. Chairman, Members of the Subcommittee:

My name is David Birnbach, M.D. and I am presently the Director of Obstetric Anesthesiology at St. Luke's-Roosevelt Hospital Center, a teaching hospital of Columbia University College of Physicians and Surgeons in New York City. I am also president-elect of the Society for Obstetric Anesthesia and Perinatology, the society which represents my subspecialty.

I am here today to take issue with the previous testimony before committees of the Congress that suggests that anesthesia causes fetal demise. I believe that I am qualified to address this issue because I am a practicing obstetric anesthesiologist. Since completing my anesthesiology and obstetric anesthesiology training at Harvard University, I have administered analgesia to more than five thousand women in labor and anesthesia to over a thousand women undergoing cesarean section. Although the majority of these cases were at full term gestation, I have provided anesthesia to approximately 200 patients who were carrying fetuses of less than 30 weeks gestation and who needed emergency non-obstetric surgery during pregnancy. These operations have included appendectomies, gall bladder surgeries, numerous orthopedic procedures such as fractured ankles, uterine and ovarian procedures (including malignant tumor removal), breast surgery, neurosurgery, and cardiac surgery.

The anesthetics which I have administered have included general, epidural, spinal and local. The patients have included healthy as well as very sick pregnant patients. Although I often use spinal and epidural anesthesia in pregnant patients, I also administer general anesthesia to these patients and, on occasion, have needed to administer huge doses of general anesthesia in order to allow surgeons to perform cardiac surgery or neurosurgery.

In addition, I believe that I am also especially qualified to discuss the effect of maternally-administered anesthesia on the fetus, because I am one of only a handful of anesthesiologists who has administered anesthesia to a pregnant patient undergoing in-utero fetal surgery, thus allowing me to watch the fetus as I administered general anesthesia to the mother. A review of the experiences that my associates and I had while administering general anesthesia to a mother while a surgeon operated on her unborn fetus was published in the Journal of Clinical Anesthesia vol.1, 1989, pp363-367. In this paper, we suggested that general

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anesthesia provides several advantages to the fetus who will undergo surgery and then be replaced in the womb to continue to grow until mature enough to be delivered. Safe doses of anesthesia to the mother most certainly did not cause fetal demise when used for these operations.

Despite my extensive experience with providing anesthesia to the pregnant patient, I have never witnessed a case of fetal demise that could be attributed to an anesthetic. Although some drugs which we administer to the mother may cross the placenta and affect the fetus, in my medical judgment fetal demise is definitely not a consequence of a properly administered anesthetic. In order to cause fetal demise it would be necessary to give the mother dangerous and life-threatening doses of anesthetics. This is not the way we practice anesthesiology in the United States.

Mr. Chairman, I am deeply concerned that the previous congressional testimony and the widespread publicity that has been given this issue will cause unnecessary fear and anxiety in pregnant patients and may cause some to unnecessarily delay emergency surgery. As an example, several newspapers across the US have stated that anesthesia causes fetal demise. Because this issue has been allowed to become a "controversy" several of my patients have recently expressed concerns about anesthesia, having seen newspaper or heard radio or television coverage of this issue. Evidence that patients are still receiving misinformation regarding the fetal effects of maternally administered anesthesia can be seen by review of an article that a pregnant patient recently brought with her to the labor and delivery floor. In last month's edition of Marie Claire, a magazine which many of my pregnant patients read, an article about partial birth abortion states "The mother is put under general anesthetic, which reaches the fetus through her bloodstream. By the time the cervix is sufficiently dilated, the fetus has overdosed on the anesthetic and is brain-dead." These incorrect statements continue to find their way into newspapers and magazines around the country. Despite the previous testimony of Dr. Ellison, I have yet to see an article that states, in no uncertain terms, that anesthesia when used properly does not harm the fetus. This supposed controversy regarding the effects of anesthesia on the fetus must be finally and definitively put to rest.

In order to address this complex issue, I believe that it is necessary to comment on three of the statements which have recently been made to the Congress.

I) Dr. James McMahon, now deceased, testified that anesthesia causes neurologic fetal demise.

II) Dr. Lewis Koplick supported Dr. McMahon and stated "I am certain that anyone who would call Dr. McMahon a liar is speaking from ignorance of abortions in late pregnancy and of Dr. McMahon's technique and integrity."

3

III) Dr. Mary Campbell of Planned Parenthood has addressed this issue by writing the following: "Though these doses are high, the incremental administration of the drugs minimizes the probability of negative outcomes for the mother. In the fetus, these dosage levels may lead to fetal demise (death) in a fetus weakened by its own developmental anomalies."

My responses to these statements are as follows:

1. There is absolutely no scientific or clinical evidence that a properly administered maternal anesthetic causes fetal demise. To the contrary, there are hundreds of scientific articles which demonstrate the fetal safety of currently used anesthetics.

2. Dr. Koplick has stated that the "massive" doses used by Dr. McMahon are responsible for fetal demise. This again, is incorrect and there is no scientific or clinical data to support this allegation. I have personally administered "massive" doses of narcotics to intubated critically ill pregnant patients who were being treated in an intensive care unit. I am pleased to say that the fetuses were born alive and did well.

3. Dr. Campbell has described the narcotic protocol which Dr. McMahon had used during his D & X procedures: it includes the administration of Midazolam(10-40 mg) and Fentanyl (900-2500 μg). Although there is no evidence that this massive dose will cause fetal demise, there is clear evidence that this excessive dose could cause maternal death. These doses are far in excess of any anesthetic that would be used by an anesthesiologist and even if they were incrementally given over a two to three hour period these doses would in all probability cause enough respiratory depression of the mother, to necessitate intubation and/or assisted respiration. Since Dr. McMahon can not be questioned regarding his "heavy handed" anesthetic practice, I am unable to explain why he would willingly administer such huge amounts of drugs. If he did indeed administer 2500 μg of fentanyl and 40 mg of midazolam to a patient in a clinic, without an anesthesiologist present, he was definitely placing the mother's life at great risk.

In conclusion, I would like to say that I believe that I have a responsibility as a practicing obstetric anesthesiologist to refute any and all testimony that suggests that maternally administered anesthesia causes fetal demise. It is my opinion that in order to achieve that goal one would need to administer such huge doses of anesthetic to the mother as to place her life at jeopardy. Pregnant women must get the message that should they need anesthesia for surgery or analgesia for labor, they may do so without worrying about the effects on their unborn child.

Thank you for your attention. I am happy to respond to your questions.

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Egleston Children's Hospital at Emory University
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Statement of Jean A. Wright, M.D., M.B.A
Associate Professor of Pediatrics and Anesthesia

Division Director, Pediatric Critical Care & Emergency Medicine
Emory University School of Medicine

before the

Subcommittee on the Constitution
Oversight Hearing

Chairman Canady, and members of the Subcommittee. My name is Jean A. Wright, MD., MBA. I am an Associate Professor of Pediatrics and Anesthesia at Emory University School of Medicine in Atlanta. I am also an Associate Professor at the Emory Center for Clinical Evaluation Sciences. I am board certified in Pediatrics, Anesthesia, and in both sub-boards of Critical Care Medicine. I have been a faculty member and a practicing physician since 1983.

I appreciate the invitation to testify before the Committee on the topic of the effects of anesthesia administered to a mother during a partial birth abortion. I understand that this committee was considering legislation which would ban 'partial birth abortions', and that this is the second hearing on this topic. I will focus my testimony on the **ability of the fetus to feel and respond to pain during this procedure**, and on the effects of the anesthetic upon the fetus while administered to the mother.

My testimony will be divided into three parts. 1) The developmental aspects of pain in the fetus; 2) The increased sensitivity of preterm infants to pain compared to term or older infants; and 3) the effects of maternally administered anesthetics to blunt or alter the effect of this pain.

1. Development of the pain system in the human fetus and neonate:

Very preterm neonates have the **neuroanatomic substrate** and functional physiologic and chemical processes in the brain responsible for mediating pain or noxious stimuli (known as nociception). [Fitzgerald and Anand]. [See Chart from Anand & Hickey, NEJM, 1987]. **Anatomic studies** have shown that the density of the skin pain fibers (cutaneous nociceptive nerve endings) in the late fetus and newborn infant may **equal or exceed** that of adult skin. Early studies by Hooker showed that cutaneous sensory perception appears around the mouth of the human fetus in the **seventh week of gestation** and gradually spreads to **all** skin and mucous surfaces by 20 weeks.

Traditionally, lack of myelination (or the layer around the nerve fibers) has been proposed as an index of immaturity in the neonatal nervous system and used frequently to support the argument that neonates and infants are not capable of pain perception. However, pain (nociceptive) impulses in adults are conducted by unmyelinated or thinly myelinated fibers. Furthermore, Gilles has shown that nerve tracts associated with pain in the spinal cord and brain stem are completely myelinated (up to the thalamus) by 30 weeks of gestation.

Several types of observations speak for the **functional maturity** of the brain (cerebral cortex) in the fetus and neonate. First are reports of **fetal and neonatal EEG patterns**, including cortical components of visual and auditory evoked potentials, that have been recorded in preterm babies of less than 28 weeks gestation. Cortical evoked potentials to somatosensory stimuli (touch, pain, heat, cold) were also recently documented in preterm neonates from 26 weeks gestation. Well defined periods of sleep and wakefulness are present in utero from 28 weeks gestation onward.

Ultrasonographic findings report **specific fetal movements in response to needle punctures *in utero*** (Robinson & Smotherman, 1992; Sival 1993). Moreover, a controlled study of intrauterine blood sampling and blood transfusions in fetuses between 20 and 34 weeks of gestation showed that hormonal responses that were consistent with fetal perception of pain, and were correlated with the duration of the painful stimulus (Giannakoulopuolos et al, 1994). Preterm neonates born at 23 weeks gestation show **highly specific and well-coordinated physiologic and behavioral responses to pain**, similar to those seen in full-term neonates, older infants, and small children (summarized in *"Pain in Neonates"*, Anand & McGrath, 1993).

2. Increased sensitivity to pain in preterm infants.

Contrary to previous teaching, current data indicate that preterm neonates have greater pain sensitivity than term neonates or older age groups. Several lines of scientific evidence support this concept. I will review these from the most basic science, to that which reflects clinical practice.

1. **Studies of reflex responses:**

The Cutaneous Flexor Reflex - has a lower threshold in preterm neonates than in term neonates or adults [Fitzgerald; Woolf]. The study of this reflex has been used to establish when connections between the skin and the spinal cord are first made in the fetus, and they have Been used to study the maturation of ascending motor pathways. This reflex has been shown in man to **parallel pain perception exactly** in terms of threshold, peak intensity, and sensitivity to analgesics.

2. **Studies of neurotransmitting substances in the spinal cord:**

   Neurotransmitter development in the dorsal horn of the spinal cord has demonstrated the early and abundant expression of the neurotransmitters mediating pain (e.g. substance P, L-glutamate, VIP, CGRP), and increased somatosensory excitability in the premature spinal cord. In contrast, the neurotransmitters contained in descending inhibitory fibers from supraspinal centers (5-HT, Norepi, Dopamine) were expressed postnatally, [Anand & Carr, 1989] implying **poorly developed gate control mechanisms for pain in preterm infants.**

3. **Receptors for pain in the fetal brain:**

   Opioid receptor labeling in the brain stem of fetuses 19-21 weeks gestation demonstrated very high densities in supraspinal centers associated with sensory perception [Kinney et al, 1990]. (These inhibitory Opioid receptors may protect developing neuronal systems from constant over stimulation, given the underdeveloped gate control mechanism in the dorsal horn of the spinal cord.)

4. **Pain and stress are reflected in the hormones produced by the fetus.**

   Pain in the fetus and neonate can be measured in two dimensions. Pain and surgical stress are demonstrated by a coordinated outpouring of pituitary, adrenal, and pancreatic hormones. Secondly, cardiovascular responses, such as increases in blood pressure, heart rate, dysrhythmias, or poor cardiac output may signal pain. The magnitude of hormonal (endocrine-metabolic) and other stress responses to invasive procedures or surgical operations was **much greater in neonates** as compared to adults; with neonatal catacholamine and metabolic responses up 3 - 5 times those of adult patients undergoing similar types of surgery [Anand].

5. **Pain felt as a fetus or neonate has a long term effect on the child's well-being:**

The effects of anesthesia on the neonatal stress responses are important and may contribute to the effects of stress suppression on postoperative clinical outcome. In a randomized controlled trial, preterm babies undergoing ligation of the patient ductus arteriosus were given nitrous oxide and curare, with or without the addition of intravenous fentanyl. The hormonal responses of neonates receiving nitrous oxide alone were associated with significant increases in blood glucose, lactate, and pyruvate; these were prevented in neonates given therapeutic doses of fentanyl. This study went on to show that **aggressive anesthesia not only decreased the stress responses of neonates undergoing surgery but also improved their postoperative clinical outcome**. Similarly, neonatal intensive care patients who are exposed to a single (circumcision) or repeated painful events (heelsticks) have been shown to have procedural memory for the event, and may have long term effects, even into adulthood.

6. **The amount of medicine needed to achieve a desired effect:**

   Pharmacokinetic studies of anesthetic drugs have shown **higher plasma concentrations were required to maintain effective surgical anesthesia in preterm neonates** as compared to old age groups [Yaster; Greeley & de Bruijn].

Developmental changes occur in the expression of pain which differentiate preterm from term or older infants; however, these findings illustrate a **communicational specificity** and **not changes in pain threshold during development** [Johnston]. The studies cited above indicate a lower pain threshold in preterm neonates, and the occurrence of further decreases in pain threshold following exposure to a painful stimulus or experience [Fitzgerald].

3. Effects of Anesthesia on the fetus

Obstetrical anesthesia has become a very safe practice, with many women a year receiving an anesthetic during the time of their pregnancy. These women are in addition to those who receive an anesthetic at the time of delivery. It is from this patient population that the effects of anesthesia on the fetus can be derived.

Local anesthetics rarely have any affect on the fetus. By their nature, their affect is to numb the nerves and tissues around the injection site, and only minuscule amounts of drug enter the mother's circulation, and even less reach the fetus.

The administration of intravenous sedation/anesthesia has minimal effects on the unborn due to two mechanisms: 1) The mother's liver clears much of the drug, and 2) the drug must cross from the mother's blood stream into the placenta before reaching the fetus.

Since the fetus has a much higher density of Opioid (pain) receptors, **scientific reasoning postulates that higher doses of Opioids will be required to saturate the increased number of receptors, and achieve a therapeutic response.**

Preliminary evidence for this therapeutic response is obtained from the decreased levels of steroid stress hormones in the amniotic fluid of fetuses whose mothers had received anesthesia as compared to the those that did not receive anesthesia in response to fetoscopy performed at 16-21 weeks gestation (Partsch et al, 1991). The mothers who had received anesthesia had a infant that was less stressed by the procedure.

CONCLUSIONS

The scientific literature reviewed above and my clinical experience in the delivery of general anesthesia, systemic analgesia, conscious sedation, local and regional anesthesia to a wide variety of patients lead me to believe that:

1. The anatomical and functional processes responsible for the perception of pain have developed in human fetuses that may be considered for 'partial birth abortions'. (At this stage of neurologic development, human fetuses respond to the pain caused by needle puncture *in utero* in a similar manner as older children or adults, within the limits of their behavioral repertoire).

2. It is likely that the **threshold for such pain perception is lower** than that of older preterm newborns, full-term newborns, and older age groups. Thus, the pain experienced during 'partial birth abortions' by the human fetus would have **a much greater intensity than any similar procedures performed in older age groups**.

3. Current methods for providing maternal anesthesia during 'partial birth abortions' are unlikely to prevent the experience of pain and stress in the human fetuses before their death occurs after partial delivery.

After Dr. Norig Ellison presented his prepared testimony at the Nov. 17 public hearing before the Senate Judiciary Committee, the following exchange occurred among Senator Spence Abraham (R-Mi.); Dr. Mary Campbell, medical director of Planned Parenthood of Metropolitan Washington; and Dr. Ellison.

SEN. ABRAHAM [to Dr. Campbell]: Would you make the statement then that the fetus dies due to the anesthesia? Is that your position?

DR. CAMPBELL (Medical Director, Planned Parenthood of Metropolitan Washington): I think the fetus has no pain because of the anesthesia. I do not...

SEN. ABRAHAM: No, I'm asking you whether you think that's what causes the fetus to die?

DR. CAMPBELL: I do not know what causes the fetus to die. The fetuses are dead when delivered.

SEN. ABRAHAM: Well, let me just direct you, if I could -- I have here a factsheet that indicates it was prepared by you which relates to the House legislation in which...

> ***[Sen. Abraham was referring to "H.R. 1833, Medical Questions and Answers," which contains the caption, "Fact Sheet Prepared by Mary Campbell, M.D." This document was circulated to members of the House of Representatives in October, before HR 1833 came to a vote in that house. This document contains the following passage:***
>
> ***"Q: When does the fetus die?***
>
> ***"A: The fetus dies of an overdose of anesthesia given to the mother intravenously. A dose is calculated for the mother's weight which is 50 to 100 times the weight of the fetus. The mother gets the anesthesia for each insertion of the dilators, twice a day. This induces brain death in a fetus in a matter of minutes. Fetal demise therefore occurs at the beginning of the procedure while the fetus is still in the womb."]***

DR. CAMPBELL: I was quoting Dr. McMahon at that time. [EDITOR'S NOTE: There is no reference to Dr. McMahon anywhere in Dr. Campbell's five-page factsheet.] On thinking it over in more depth, I believe because there are no EEG studies available...

SEN. ABRAHAM: So you no longer adhere to the position that you say in here, "the fetus dies of an overdose of anesthesia given to the mother intravenously." That is no longer your position?

DR. CAMPBELL: I believe that is true.

SEN. ABRAHAM: You believe that is true?

DR. CAMPBELL: I believe that is true.

SEN. ABRAHAM: Dr. Ellison, would you like to comment on that?

DR. ELLISON (President, American Society of Anesthesiologists): There is absolutely no basis in scientific fact for that statement. There is -- I can present you a study in the American Journal of Obstetrics and Gynecology, 1989, by [names inaudible] et al, of 5,400 cases of women having surgery having general anesthesia or regional anesthesia in which the fetus did not suffer demise. I think the suggestion that the anesthesia given to the mother, be it regional or general, is going to cause brain death of the fetus is without basis of fact.

DR. CAMPBELL: I have not said brain death. I'm saying no spontaneous respirations, no movement.

SEN. ABRAHAM: Well, that's what you are saying today, but in this fact sheet, which you prepared I believe fairly recently, it says, "The fetus dies"-- there's no qualifying regarding breathing or anything else-- "of an overdose of anesthesia." I mean, that is a very clear statement assertion.

DR. CAMPBELL: [Pause] I simplified that for Congress. [Outburst of laughter from audience.] I do not actually believe that you want a full discussion of when death occurs.

SEN. ABRAHAM: Well, we are forced to make those decisions, and I guess my question is that how many other things would you say in the fact sheet or in your statements today have been likewise simplified in this dramatic fashion?

DR. CAMPBELL: Since I have over 28 years of education and experience in medicine, I would say that is a great deal less and a great deal more simple than what I know.

SEN. ABRAHAM: Well, it seems to me that there's a rather substantial disparity between what Dr. Ellison says and what you are both saying now and have certainly written here. I just am wondering how that bears on other comments that have been made.

****

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Barbara Bolsen, Editor

July 11, 1995

The Hon. Charles T. Canady
Chairman, Subcommittee on the Constitution
Committee on the Judiciary
U.S. House of Representatives
2138 Rayburn House Office Bldg.
Washington, D.C. 20515-6216

Dear Representative Canady:

We have received your July 7 letter outlining allegations of inaccuracies in a July 5, 1993, story in American Medical News, "Shock-tactic ads target late-term abortion procedure."

You noted that in public testimony before your committee, AMNews is alleged to have quoted physicians out of context. You also noted that one such physician submitted testimony contending that AMNews misrepresented his statements. We appreciate your offer of the opportunity to respond to these accusations, which now are part of the permanent subcommittee record.

AMNews stands behind the accuracy of the report cited in the testimony. The report was complete, fair, and balanced. The comments and positions expressed by those interviewed and quoted were reported accurately and in-context. The report was based on extensive research and interviews with experts on both sides of the abortion debate, including interviews with two physicians who perform the procedure in question.

We have full documentation of these interviews, including tape recordings and transcripts. Enclosed is a transcript of the contested quotes that relate to the allegations of inaccuracies made against AMNews.

Let me also note that in the two years since publication of our story, neither the organization nor the physician who complained about the report in testimony to your committee has contacted the reporter or any editor at AMNews to complain about it. AMNews has a longstanding reputation for balance, fairness and accuracy in reporting, including reporting on abortion, an issue that is as divisive within medicine as it is within society in general. We believe that the story in question comports entirely with that reputation.

Thank you for your letter and the opportunity to clarify this matter.

Respectfully yours,

Barbara Bolsen

Barbara Bolsen
Editor

Attachment

American Medical News transcript - page 1

Relevant portions of recorded interview with Martin Haskell, MD:

AMN: Let's talk first about whether or not the fetus is dead beforehand...

Haskell: 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.

AMN: Is the skull procedure also done to make sure that the fetus is dead so you're not going to have the problem of a live birth?

Haskell: It's immaterial. If you can't get it out, you can't get it out.

AMN: I mean, you couldn't dilate further? Or is that riskier?

Haskell: Well, you could dilate further over a period of days.

AMN: Would that just make it... would it go from a 3-day procedure to a 4- or a 5-?

Haskell: Exactly. The point here is to effect a safe legal abortion. I mean, you could say the same thing about the D&E procedure. You know, why do you do the D&E procedure? Why do you crush the fetus up inside the womb? To kill it before you take it out?

Well, that happens, yes. But that's not why you do it. You do it to get it out. I could do the same thing with a D&E procedure. I could put dilapan in for four or five days and say I'm doing a D&E procedure and the fetus could just fall out. But that's not really the point. The point here is you're attempting to do an abortion. And that's the goal of your work, is to complete an abortion. Not to see how do I manipulate the situation so that I get a live birth instead.

AMN, wrapping up the interview: I wanted to make sure I have both you and (Dr.) McMahon saying 'No' then. That this is misinformation, these letters to the editor saying it's only done when the baby's already dead, in case of fetal demise and you have to do an autopsy. But some of them are saying they're getting that information from NAF. Have you talked to Barbara Radford or anyone over there? I called Barbara and she called back, but I haven't gotten back to her.

Haskell: Well, I had heard that they were giving that information, somebody over there might be giving information like that out. The people that staff the NAF office are not medical people. And many of them when I gave my paper, many of them came in, I learned later, to watch my paper because many of them have never seen an abortion performed of any kind.

AMN: Did you also show a video when you did that?

American Medical News transcript - page 2

Haskell: Yeah. I taped a procedure a couple of years ago, a very brief video, that simply showed the technique. The old story about a picture's worth a thousand words.

AMN: As National Right to Life will tell you.

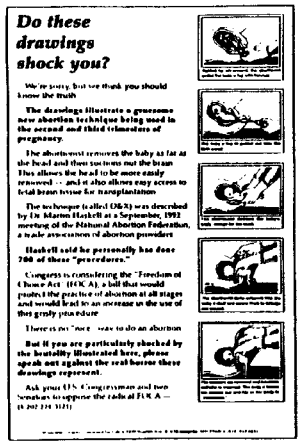
Haskell: Afterwards they were just amazed. They just had no idea. And here they're rabid supporters of abortion. They work in the office there. And...some of them have never seen one performed...

Comments on elective vs. non-elective abortions:

Haskell: 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...

American Medical
NEWS
AMERICAN MEDICAL ASSOCIATION JULY 5, 1993

Shock-tactic ads target late-term abortion procedure



Do these drawings shock you?

We're sorry, but we think you should know the truth

The drawings illustrate a gruesome new abortion technique being used in the second and third trimesters of pregnancy.

The abortionist removes the baby as far as the head and then sucks out the brain. This allows the head to be more easily removed — and it also allows easy access to fetal brain tissue for transplantation.

The technique is called D&X; was described by Dr. Martin Haskell at a September, 1992 meeting of the National Abortion Federation, a trade association of abortion providers.

Haskell said he personally has done 700 of these "procedures."

Congress is considering the "Freedom of Choice Act" (FOCA), a bill that would protect the practice of abortion at all stages and would lead to an increase in the use of this grisly procedure.

There is no "nice" way to do an abortion.

But if you are particularly shocked by the brutality illustrated here, please speak out against the real horror these drawings represent.

Ask your US Congressman and two Senators to oppose the radical FOCA — (202) 224-3121

Abortion opponents hope this ad and a similar brochure will sway Congress against the "Freedom of Choice Act."

Foes hope campaign will sink federal abortion rights legislation

By Diane M. Gianelli
AMNEWS STAFF

WASHINGTON — In an attempt to derail an abortion-rights bill maneuvering toward a congressional showdown, opponents have launched a full-scale campaign against late-term abortions.

The centerpieces of the effort are newspaper advertisements and brochures that graphically illustrate a technique used in some second- and third-trimester abortions. A handful of newspapers have run the ads so far, and the National Right to Life Committee has distributed 4 million of the brochures, which were inserted into about a dozen other papers.

By depicting a procedure expected to make most readers squeamish, campaign sponsors hope to convince voters and elected officials that a proposed federal abortion-rights bill is so extreme that states would have no authority to limit abortions — even on potentially viable fetuses.

According to the Alan Guttmacher Institute, a research group affiliated with Planned Parenthood, about 10% of the estimated 1.6 million abortions done each year are in the second and third trimesters.

Barbara Radford of the National Abortion Federation denounced the ad campaign as disingenuous, saying its "real agenda is to outlaw virtually all abortions, not just late-term ones." But she acknowledged it is having an impact, reporting scores of calls from congressional staffers and others who have seen the ads and brochures and are asking pointed questions about the procedure depicted.

Abortion rights forces call the campaign a 'disingenuous' effort to outlaw all abortions.

The *Minneapolis Star-Tribune* ran the ad May 12, on its op-ed page. The anti-abortion group Minnesota Citizens Concerned for Life paid for it.

In a series of drawings, the ad illustrates a procedure called "dilation and extraction," or D&X, in which forceps are used to remove second- and third-trimester fetuses from the uterus intact, with only the head remaining inside the uterus.

The surgeon is then shown jamming scissors into the skull. The ad says this is done to create an opening large enough to insert a catheter that suctions the brain, while at the same time making the skull small enough to pull through the cervix.

"Do these drawings shock you?" the ad reads. "We're sorry, but we think you should know the truth."

The ad quotes Martin Haskell, MD, who described the procedure at a September 1992 abortion federation meeting, as saying he personally has performed 700 of them. It then states that the proposed "Freedom of Choice Act" now moving through Congress would "protect the practice of abortion at all stages and would lead to an increase in the use of this grisly procedure."

Accuracy questioned

Some abortion rights advocates have questioned the ad's accuracy.

See ABORTION, page 21

Abortion

Continued from page 3

A letter to the *Star-Tribune* said the procedure shown "is only performed after fetal death when an autopsy is necessary or to save the life of the mother." And the Morrisville, Vt., *Transcript*, which said in an editorial that it allowed the brochure to be inserted in its paper only because it feared legal action if it refused, quoted the abortion federation as providing similar information. "The fetus is dead 24 hours before the pictured procedure is undertaken," the editorial stated.

But Dr. Haskell and another doctor who routinely use the procedure for late-term abortions told *AMNews* that the majority of fetuses aborted this way are alive until the end of the procedure.

Dr. Haskell said the drawings were accurate "from a technical point of view." But he took issue with the implication that the fetuses were "aware and resisting."

Radford also acknowledged that the information her group was quoted as providing was inaccurate. She has since sent a letter to federation members, outlining guidelines for discussing the matter. Among the points:

- Don't apologize: this is a legal procedure.
- No abortion method is acceptable to abortion opponents.
- The language and graphics in the ads are disturbing to some readers. "Much of the negative reaction, however, is the same reaction that might be invoked if one were to listen to a surgeon describing step-by-step almost any other surgical procedure involving blood, human tissue, etc."

Late-abortion specialists

Only Dr. Haskell, James T. McMahon, MD, of Los Angeles, and a handful of other doctors perform the D&X procedure, which Dr. McMahon refers to as "intact D&E." The more common late-term abortion methods are the classic D&E and induction, which usually involves injecting digoxin or another substance into the fetal heart to kill it, then dilating the cervix and inducing labor.

Dr. Haskell, who owns abortion clinics in Cincinnati and Dayton, said he started performing D&Es for late abortions out of necessity. Local hospitals did not allow inductions past 18 weeks, and he had no place to keep patients overnight while doing the procedure.

But the classic D&E, in which the fetus is broken apart inside the womb, carries the risk of perforation, tearing and hemorrhaging, he said. So he turned to the D&X, which he says is far less risky to the mother.

Dr. McMahon acknowledged that the procedure he, Dr. Haskell and a handful of other doctors use makes some people queasy. But he defends it. "Once you decide the uterus must be emptied, you then have to have 100% allegiance to maternal risk. There's no justification to doing a more dangerous procedure because somehow this doesn't offend your sensibilities as much."

Brochure cites N.Y. case

The four-page anti-abortion brochures also include a graphic depiction of the D&X procedure. But the cover features a photograph of 16-month-old Ana Rosa Rodriquez, whose right arm was severed during an abortion attempt when her mother was 7 months pregnant.

The child was born two days later, at 32 to 34 weeks' gestation. Abu Hayat, MD, of New York, was convicted of assault and performing an illegal abortion. He was sentenced to up to 29 years in prison for this and another related offense.

New York law bans abortions after 24 weeks, except to save the mother's life. The brochure states that Dr. Hayat never would have been prosecuted if the federal "Freedom of Choice Act" were in effect, because the act would invalidate the New York statute.

The proposed law would allow abortion for any reason until viability. But it would leave it up to individual practitioners — not the state — to define that point. Postviability abortions, however, could not be restricted if done to save a woman's life or health, including emotional health.

The abortion federation's Radford called the Hayat case "an aberration" and stressed that the vast majority of abortions occur within the first trimester. She also said that later abortions usually are done for reasons of fetal abnormality or maternal health.

But Douglas Johnson of the National Right to Life Committee called that suggestion "blatantly false."

"The abortion practitioners themselves will admit the majority of their late-term abortions are elective," he said. "People like Dr. Haskell are just trying to teach others how to do it more efficiently."

Numbers game

Accurate figures on second- and third-trimester abortions are elusive because a number of states don't require doctors to report abortion statistics. For example, one-third of all abortions are said to occur in California, but the state has no reporting requirements. The Guttmacher Institute estimates there were nearly 168,000 second- and third-trimester abortions in 1988, the last year for which figures are available.

About 60,000 of those occurred in the 16- to 20-week period, with 10,660

See ABORTION, next page

Abortion

Continued from preceding page

at week 21 and beyond, the institute says. Estimates were based on actual gestational age, as opposed to last menstrual period.

There is particular debate over the number of third-trimester abortions. Former Surgeon General C. Everett Koop, MD, estimated in 1984 that 4,000 are performed annually. The abortion federation puts the number at 300 to 500. Dr. Haskell says that "probably Koop's numbers are more correct."

Dr. Haskell said he performs abortions "up until about 25 weeks" gestation, most of them elective. Dr. McMahon does abortions through all 40 weeks of pregnancy, but said he won't do an elective procedure after 26 weeks. About 80% of those he does after 21 weeks are nonelective, he said.

Mixed feelings

Dr. McMahon admits having mixed feelings about the procedure in which he has chosen to specialize.

"I have two positions that may be internally inconsistent, and that's probably why I fight with this all the time," he said.

"I do have moral compunctions. And if I see a case that's later, like after 20 weeks where it frankly is a child to me, I really agonize over it because the potential is so imminently there. I think, 'Gee, it's too bad that this child couldn't be adopted.'

"On the other hand, I have another position, which I think is superior in the hierarchy of questions, and that is: 'Who owns the child?' It's got to be the mother."

Dr. McMahon says he doesn't want to "hold patients hostage to my technical skill. I can say, 'No, I won't do that,' and then they're stuck with either some criminal solution or some other desperate maneuver."

Dr. Haskell, however, says whatever qualms he has about third-trimester abortions are "only for technical reasons, not for emotional reasons of fetal development."

"I think it's important to distinguish the two," he says, adding that his cutoff point is within the viability threshold noted in *Roe v. Wade*, the Supreme Court decision that legalized abortion. The decision said that point usually occurred at 28 weeks "but may occur earlier, even at 24 weeks."

Viability is generally accepted to be "somewhere between 25 and 26 weeks," said Dr. Haskell. "It just depends on who you talk to.

"We don't have a viability law in Ohio. In New York they have a 24-week limitation. That's how Dr. Hayat got in trouble. If somebody tells me I have to use 22 weeks, that's fine. . . . I'm not a trailblazer or activist trying to constantly press the limits."

Campaign's impact debated

Whether the ad and brochures will have the full impact abortion opponents intend is yet to be seen.

Congress has yet to schedule a final showdown on the bill. Although it has already passed through the necessary committees, supporters are reluctant to move it for a full House and Senate vote until they are sure they can win.

In fact, House Speaker Tom Foley (D, Wash.) has said he wants to bring the bill for a vote under a "closed rule" procedure, which would prohibit consideration of amendments.

But opponents are lobbying heavily against Foley's plan. Among the amendments they wish to offer is one that would allow, but not require, states to restrict abortion — except to save the mother's life — after 24 weeks.

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 "pro-choice" 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 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.

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.

Opponents: Congress has no business legislating medical standards and procedures; bill begins erosion of abortion rights.

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 about causing amniotic fluid embolism or placental abruption if you do that."

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.

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Abortion

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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 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 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 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

Continued from preceding page

Carolina, Chapel Hill, said in a letter 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 anesthesized 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.

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.

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."

2nd trimester ABORTION

An interview with W. Martin Haskell, MD

Last summer, *American Medical News* ran a story on abortion specialists. Included was W. Martin Haskell, MD, a Cincinnati physician who introduced the D & X procedure for second trimester abortions. The Academy received several calls requesting information about D & X. The following interview provides an overview.

Q: What motivated you to become an abortion specialist?

A: I stumbled into it by accident. I did an internship in anesthesia. I worked for a year in general practice in Alabama. I did two years in general surgery, then switched into family practice to get board certified. My intentions at that time were to go into emergency medicine. I enjoyed surgery, but I realized there was an abundance of really good surgeons here in Cincinnati. I didn't feel I'd make much of a contribution. I'd be just another good surgeon. While I was in family practice, I got a part-time job in the Women's Center. Over the course of several months, I recognized things there could be run a lot better, with a much more professional level of service—not necessarily in terms of medical care—in terms of counseling, the physical facility, patient flow, and in the quality of people who provided support services. The typical abortion patient spends less than ten minutes with the physician who performs the surgery. Yet, that patient might be in the facility for three hours. When I talked to other physicians whose patients were referred here, I saw problems that could be easily corrected. I realized there was an opportunity to improve overall quality of care, and make a contribution. I own the center now.

Q: Back in 1979 when you were making these decisions, did you consider yourself pro-choice?

A: I've never been an activist. I've always felt that no matter what the issue, you prove your convictions by your hard work—not by yelling and screaming.

Q: Have there been threats against you?

A: Not directly. Pro-life activist Randall Terry recently said to me that he was going to do everything within his power to have me tried like a Nazi war criminal.

Q: A recent American Medical News article stated that the medical community hadn't really established a point of fetal viability. Why not?

A: Probably because it can't be established with uniform certainty. Biological systems are highly variable. The generally accepted point of fetal viability is around 24-26 weeks. But you can't take a given point in fetal development and apply that 100 percent of the time. It just doesn't happen that way. If you look at premature deliveries and survival percentages at different weeks of gestation, you'll get 24-week fetuses with some survival rate. The fact that you get some survivors demonstrates the difficulty in defining a point.

Q: Most women who get abortions end pregnancies during the first trimester. Who is the typical second-trimester patient?

A: I don't know that there is a typical second-trimester abortion. But if you look at the spectrum of abortions (most women are between the ages of 19 and 29) they tend to be younger. Some are older. The typical thing that happens with older women is that they never realized they were pregnant because they were continuing to bleed during the pregnancy. The other thing we see with older women is fetal malformations or Down's Syndrome. These are being diagnosed much earlier now than they used to be. We're seeing a lot of genetic diagnoses with ultrasound and amniocentesis at 17-18 weeks instead of 22-24 weeks. With the teenagers, anybody who has ever worked with or had teenagers can appreciate how unpredictable they can be at times. They have adult bodies, but a lot of times they don't have adult minds. So their reaction to problems tends to be much more emotional than an adult's might be. It's a question of maturity. So even though they may have been educated about all kinds of issues in reproductive health, when a teenager becomes pregnant, depending upon her relationship with her family, the amount of peer support she has—every one is a highly-individual case—sometimes they delay until they can no longer contain their problem and it finally comes out. Sometimes it's money. It takes them a while to get the money. Sometimes it's just denial.

Q: Do you think more information on abstinence and contraceptives would decrease the number of teenage pregnancies?

A: I grew up in the sixties and nobody talked about contraception with teenagers in the sixties. But today, though it may be controversial in some areas, there's a lot being taught about reproductive health in the high school curricula. I think a lot more is being done, but the bottom line is we're all still just human—with human emotions, and particularly with teenagers, a sense of invulnerability; it can't happen to me. So education helps a lot, but it's not going to eliminate the problem. You can teach a person the skills, but you can't make them use them.

Q: Does it bother you that a second trimester fetus so closely resembles a baby?

A: I really don't think about it. I don't have a problem with believing the fetus is a fertilized egg. Sure it becomes more physically developed but it lacks emotional development. It doesn't have the mental capacity for self-awareness. It's never been an ethical dilemma for me. For people for whom that is an ethical dilemma, this certainly wouldn't be a field they'd want to go into. Many of our patients have ethical dilemmas about abortion. I don't feel it's my role as a physician to tell her she should not have an abortion because of her ethical feelings. As individuals grow and mature, learn more, feel more, experience more, their perspective about themselves and life, morality and ethics change. Facing the situation of abortion is a part of that passage through life for some women—how they resolve that is their decision. I can be their advisor much as a lawyer can be; he can tell you your options, but he can't make you file a suit or tell you not to file a suit. My role is to provide a service and, to a limited degree, help women understand themselves when they make their decision. I'm not to tell them what's right or wrong.

Q: Do your patients ever reconsider?

A: Between our two centers, that happens maybe once a week. There's a patient who changes her mind or becomes truly ambivalent and goes home to reconsider, then might come back a week or two later. I feel that's one of the strengths of how we approach things here. We try not to create pressure to have an abortion. Our view has always been that there are enough women who want abortions that we don't have to coerce anyone to have one. We've always been strongly against pressure on our patients to go ahead with an abortion.

Q: How expensive is a second trimester abortion?

A: Fees range from $1,200-1,600 depending on length of pregnancy. More insurance companies cover abortion than don't cover it. About 15 percent of our patients won't use insurance because they want to maintain privacy. About 10-20 percent use insurance. The rest pay out of pocket.

Q: What led you to develop D & X?

A: D & E's, the procedure typically used for later abortions, have always been somewhat problematic because of the toughness and development of the fetal tissues. Most physicians do terminations after 20 weeks by saline infusion or prosteglandin induction, which terminates the fetus and allows tissue to soften. Here in Cincinnati, I never really explored it, but I didn't think I had that option. There certainly weren't hospitals willing to allow inductions past 18 weeks—even Jewish, when they did abortions, their limit was 18 weeks. I don't know about University. What I saw here in my practice, because we did D & Es, was that we had patients who needed terminations at a later date. So we learned the skills. The later we did them, the more we saw patients who needed them still later. But I just kept doing D & Es because that was what I was comfortable with, up until 24 weeks. But they were very tough. Sometimes it was a 45-minute operation. I noticed that some of the later D & Es were very, very easy. So I asked myself why can't they all happen this way. You see the easy ones would have a foot length presentation, you'd reach up and grab the foot of the fetus, pull the fetus down and the head would hang up and then you would collapse the head and take it out. It was easy. At first, I would reach around trying to identify a lower extremity blindly with the tip of my instrument. I'd get it right about 30-50 percent of the time. Then I said, 'Well gee, if I just put the ultrasound up there I could see it all and I wouldn't have to feel around for it.' I did that and sure enough, I found it 99 percent of the time. Kind of serendipity.

Q: Does the fetus feel pain?

A: Neurological pain and perception of pain are not the same. Abortion stimulates fibers, but the perception of pain, the memory of pain that we fear and dread are not there. I'm not an expert, but my understanding is that fetal development is insufficient for consciousness. It's a lot like pets. We like to think they think like we do. We ascribe human-like feelings to them, but they are not capable of the same self-awareness we are. It's the same with fetuses. It's natural to project what we feel for babies to a 24-week old fetus.❑

The D & X Procedure—Dilation and Extraction (D & X), a method for second trimester abortion up to 26 weeks, was developed in 1992 by Cincinnati physician W. Martin Haskell, MD. It is a modification of Dismemberment and Extraction (D & E) which has been used in the US since the 1970s. Haskell has performed more than 700 D & X procedures in his office.

Step One—The patient's cervix is dilated to 9-11 mm. over a period of two days using Dilapan hydroscopic dilators. The patient remains at home during the dilation period.

Step Two—In the operating room, patients are given Valium, the Dilapan are removed and the cervix is scrubbed, anesthetized and grasped with a tenaculum. Membranes are ruptured.

Step Three—The surgical assistant scans the fetus with ultrasound, locating the lower extremities.

Step Four—Using a large forceps, the surgeon opens and closes its jaws to firmly grasp a lower extremity. The surgeon turns the fetus if necessary and pulls the extremity into the vagina.

Step Five—The surgeon uses his fingers to deliver the opposite lower extremity, then the torso, shoulders, and upper extremities.

Step Six—The skull lodges at the internal cervical os. Usually there is not enough dilation for it to pass through. The fetus is spine up.

Step Seven—A right-handed surgeon slides the fingers of his left hand along the back of the fetus and hooks the shoulders of the fetus with the index and ring fingers (palm down). He slides the tip of his middle finger along the spine towards the skull while applying traction to the shoulder and lower extremities. The middle finger lifts and pushes the anterior cervical lip out of the way.

Step Eight—While maintaining this tension, the surgeon takes a pair of blunt curved scissors in the right hand. He 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. The surgeon forces the scissors into the base of the skull and spreads the scissors to enlarge the opening.

Step Nine—The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents.

Step Ten—With the catheter still in place, he applies traction to the fetus, removing it completely from the patient, then removes the placenta.

CINCINNATI MEDICINE FALL 1993

(202) 626-8820, www.nrlc.org

Key Facts on Partial-Birth Abortion

February 14, 2003

For further information, contact the Federal Legislation Department at the National Right to Life Committee (NRLC) at Legfederal@aol.com or 202-626-8820, and visit the Partial-Birth Abortion section of the National Right to Life website at www.nrlc.org/abortion/pba/index.html, especially www.nrlc.org/abortion/pba/test.html.

- The Partial-Birth Abortion Ban Act (H.R. 760, S. 3) would ban performance of a partial-birth abortion except if it were necessary to the save a mother's life. The bill defines 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," and then kills the baby. The bill would permit use of the procedure if "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."

- In a partial-birth abortion, the abortionist pulls a living baby feet-first out of the womb and into the birth canal (vagina), except for the head, which the abortionist purposely keeps lodged just inside the cervix (the opening to the womb). The abortionist punctures the base of the baby's skull with a surgical instrument, such as a long surgical scissors or a pointed hollow metal tube called a trochar. He then inserts a catheter (tube) into the wound, and removes the baby's brain with a powerful suction machine. This causes the skull to collapse, after which the abortionist completes the delivery of the now-dead baby. (See www.house.gov/burton/RSC/haskellinstructional.pdf)

- The January 2003 Gallup poll found that 70% favored and 25% opposed "a law that would make it illegal to perform a specific abortion procedure conducted in the last six months of pregnancy known as 'partial birth abortion,' except in cases necessary to save the life of the mother." (margin of error +/- 3%)

- The term "partial-birth" is perfectly accurate. Under both federal law and most state laws, a "live birth" occurs when a baby is entirely expelled from the mother and shows any signs of life, however briefly -- regardless of whether the baby is "viable," i.e., developed

enough to be sustained outside the womb with neo-natal medical assistance. Even at 4½ months (20 weeks), perinatologists say that if a baby is expelled or removed completely from the uterus, she will usually gasp for breath and sometimes survive for hours, even though lung development is usually insufficient to permit successful sustained respiration until 23 weeks.

- Some prominent defenders of partial-birth abortions, such as NARAL's Kate Michelman and syndicated columnist Ellen Goodman, insisted that anesthesia kills the babies before they are removed from the womb. This myth has been refuted by professional societies of anesthesiologists. In reality, the babies *are alive and experience great pain* when subjected to a partial-birth abortion. [Documentation on request.]

- Partial-birth abortions are performed thousands of times annually on healthy babies of healthy mothers. In 1997, Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers (1997), estimated that the method was used 3,000 to 5,000 times annually. "In the vast majority of cases, the procedure is performed on a healthy mother with a healthy fetus that is 20 weeks or more along, Fitzsimmons said." (*The New York Times*, Feb. 26, 1997, p. A11.) (See clippings at www.nrlc.org/abortion/pba/index.html, in the late 1996 and early 1997 archive.) In January 2003, even the Alan Guttmacher Institute – an affiliate of Planned Parenthood – published a survey of abortion providers that estimated that 2,200 abortions were performed by the method in the year 2000. While that figure is surely low (see www.nrlc.org/press_releases_new/release011503.html), it is *more than triple* the number that AGI estimated in its most recent previous survey (for 1996).

- In January 1997, the PBS program *Media Matters* showed that in 1995-96, the news media largely swallowed a pro-abortion "party line" that partial-birth abortions are performed rarely and only in extreme medical circumstances -- claims later discredited. (See www.pbs.org/wnet/mediamatters99/transcript2.html)

- "Phony ban" counterproposals advanced by Reps. Steny Hoyer (D-Md.) and Jim Greenwood (R-Pa.) would place no limits on partial-birth abortions in the fifth and sixth months of pregnancy, when the vast majority of partial-birth abortions occur. Furthermore, these "phony bans" would allow an abortion even in the seventh month and later if an abortionist asserts that a baby is not "viable" or that an abortion is required to preserve "health." Reps. Hoyer and Greenwood admitted that their proposal would allow third-trimester abortions even for (in their words) "mental health" reasons. (www.nrlc.org/abortion/pba/Phony%20ban%20on%20late-term.pdf)

- Another "phony ban" substitute amendment proposed in the past by Senator Tom Daschle (D-SD) and Richard Durbin (D-Il.) would not affect the typical partial-birth abortions performed in the late second trimester. Even in the seventh month and later, the

substitute would permit abortions based on any degree of "risk" of "grievous injury to her physical health." Dr. Warren Hern, a leading practitioner of very late abortions who wrote the textbook *Abortion Practice*, commented on the Daschle amendment, "I say every pregnancy carries a risk of death," and therefore, "I will certify that any pregnancy is a threat to a woman's life and could cause 'grievous injury' to her 'physical health.'" (in *USA Today* and *Washington Times*, both May 15, 1997) In other words, under the Daschle-Durbin amendment, any pregnant woman would qualify for an abortion even in the seventh month and later.

- Although usually used in the fifth and sixth months, the partial-birth abortion method is also used to perform abortions in the third trimester -- that is, the seventh month and later. In Kansas, the only state in which the law requires separate reporting of partial-birth abortions, abortionists reported in 1999 they had performed 182 partial-birth abortions on babies who were defined by the abortionists themselves as "viable," and they also reported that all 182 of these were performed for "mental" (as opposed to "physical") health reasons. See page 11 of this state report: www.kdhe.state.ks.us/hci/99itop1.pdf

- In a written submission to the House Judiciary Committee in June, 1995, the late Dr. James McMahon – who is considered to be the developer of the method – explicitly acknowledged that he performed such abortions on babies with no "flaw" whatever, even in the third trimester, for such reasons as mere youth of the mother or for "psychiatric" difficulties. Indeed, even at 29 weeks -- well into the seventh month -- one-fourth of the babies that McMahon aborted had no "flaw," however minor. Moreover, McMahon's submission showed that in a "series" of about 2,000 such abortions that he performed, only 9% were performed for "maternal [health] indications," and of that group, the most common reason was "depression."

- The Physicians' Ad Hoc Coalition for Truth (PHACT) -- a group of over 600 physician-specialists (mostly in obstetrics, perinatology, and related disciplines) -- has spoken out to dispute claims that some women need partial-birth abortions to avoid serious physical injury. PHACT said: "We, and many other doctors across the United States, regularly treat women whose unborn children suffer these and other serious conditions. Never is the partial-birth procedure medically indicated. Rather, such infants are regularly and safely delivered live, vaginally, with no threat to the mother's health or fertility." In September, 1996, former Surgeon General C. Everett Koop and other PHACT members said that "partial-birth abortion is never medically necessary to protect a mother's health or her future fertility. On the contrary, this procedure can pose a significant threat to both."

- In May, 1997, the Partial-Birth Abortion Ban Act (then H.R. 1122) was endorsed by the American Medical Association. In a letter to Senator Rick Santorum (R-Pa.), AMA Executive Vice President P. John Seward, M.D., wrote, "Thank you for the opportunity to work with you towards restricting a procedure we all agree is not good medicine."

DOCUMENTS SUNBMITTED BY REPRESENTATIVE JERROLD NADLER

PREPARED STATEMENT OF VANESSA CULLINS

I am Vanessa Cullins, M.D., M.P.H., M.B.A. I am a board-certified obstetrician-gynecologist with Masters degrees in both Public Health and Business Administration. I currently serve as the Vice President of Medical Affairs for Planned Parenthood Federation of America (PPFA), the nation's largest and most trusted provider of reproductive health care and education. Each year, nearly five million women, men, and teenagers receive reproductive health services at the 875 centers operated by the Planned Parenthood network of 125 affiliates, serving communities in 49 states and the District of Columbia.

I received my medical training (medical school, internship, and residency) from the Johns Hopkins University School of Medicine/Johns Hopkins Hospital. I received my Public Health degree from Johns Hopkins University School of Hygiene and Public Health, and my M.B.A. degree from the Wharton School, University of Pennsylvania. I am currently a member of the National Medical Association (NMA), the American Medical Association (AMA), and the American College of Obstetricians & Gynecologists (ACOG).

Among other professional positions I held before beginning work for PPFA, I served as an assistant professor at Johns Hopkins University School of Medicine, and was an attending physician in the obstetrics and gynecology department at Johns Hopkins Bayview Medical Center. In addition, I have published extensively and made numerous presentations in the area of obstetrics and gynecology.

I submit this testimony in opposition to H.R. 760, the so-called "Partial-Birth Abortion Ban Act of 2003" (the "2003 Abortion Ban Bill"). Based on my extensive training and clinical experience in the provision of health care for women, including abortion, it is my medical judgment that the 2003 Abortion Ban Bill would harm the health of many women in this country.

A. THE BILL PREVENTS DOCTORS FROM EXERCISING NECESSARY DISCRETION

Central to women's ability to protect their health in the context of abortion (or any other medical matter) is the ability of their physician to exercise appropriate medical judgment. The physician's main goal in performing any abortion is to terminate the pregnancy by the method that is safest for the patient. A physician, in consultation with his or her patient, chooses the most appropriate and safest procedure for that patient based on a variety of factors, including the patient's overall medical condition; the physician's training in the procedure; 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.[1]

The risk of a particular abortion procedure varies in every case, depending on the individual woman's health, the skill of the physician, the medical facilities available, and how the selected procedure proceeds. With any abortion procedure, several factors determine how the procedure will proceed—including the size and orientation of the fetus, the amount of dilation, the condition of the cervix and uterus, and the patient's overall health and medical condition. The physician must adapt his or her technique as the surgery proceeds in light of the individual patient's needs. It is, therefore, essential that in providing care, physicians have discretion to consider the full panoply of safe methods and techniques of abortion and to proceed in the way most appropriate for each patient.

By attempting to legislate which abortion procedures are permitted, and which banned, this legislation takes away from physicians the full armamentarium of techniques that may be necessary in any particular case to provide an abortion in the safest possible manner for each patient. It thus denies physicians the necessary discretion to provide medical care with the safety and health of their patients as their foremost concern. If this bill were to become law and the physician continued to adhere to the medically and ethically appropriate course of treatment, he or she would risk criminal prosecution and imprisonment, as well as civil lawsuits. And if the physician strictly followed H.R. 760's prescriptions, the inevitable result would be to force some women to undergo less safe procedures than their physician would otherwise perform. This is unacceptable.

For this reason, I fully endorse the conclusion of ACOG that "[t]he 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

[1] *See* KENNETH E. NISWANDER & ARTHUR T. EVANS, MANUAL OF OBSTETRICS 15 (5th ed. 1996).

intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous."[2]

B. THE SCOPE OF THE BAN IS UNCLEAR, BUT EVEN IF IT BANNED ONLY D&X ABORTIONS IT WOULD DEPRIVE WOMEN OF A SAFE ABORTION OPTION

Although the findings to the 2003 Abortion Ban Bill suggest that the sponsors intend to ban only the abortion procedure known (interchangeably) as intact dilation and extraction or dilation and extraction ("intact D&E" or "D&X") (see Finding Number 1), the operative language of the bill, however, is not so limited. Indeed, as I read the language of the bill itself (proposed 18 U.S.C. § 1531(b)), it would ban not only the D&X procedure, as ACOG defines it, but also dilation and evacuation (D&E) and induction abortions. D&E is the most commonly performed second-trimester abortion procedure. Together, D&E and D&X abortions comprise approximately 96% of all second-trimester abortions performed in this country.[3] Induction abortions account for most of the remaining 4% of second-trimester abortions.[4] Induction abortions require hospitalization and are more expensive than D&E or D&X abortion. While induction is a safe procedure, for some women, it poses unacceptable risks.[5]

Given that almost all second-trimester abortions in this country are performed using the D&E or D&X methods or by induction, a ban on these methods would constitute a virtual ban on previability second-trimester abortions in this country. Therefore, if this bill became law, physicians in this country would be forced either: (1) to perform virtually all second-trimester abortions under threat of criminal and civil prosecution; (2) to alter their medical practices in ways that threaten maternal health and increase the cost and burden of the abortion procedure, or (3) to cease providing second-trimester abortions altogether. This would turn back the clock and lower the standards of obstetrical and gynecological care in this country to a level not seen since before abortion was legalized.

Even if the 2003 Abortion Ban Bill were limited to banning the D&X procedure, it would nonetheless pose significant health risks for some women. I strongly disagree with the statements in the bill's Findings that D&X is outside the standard of medical care and poses serious risks to a woman's health. (Findings Numbers 1, 13.) In fact, based on my clinical experience and observations, and my discussions with other physicians, it is my professional opinion that D&X is within the accepted standard of care and is not only safe, but for some women may be safer than other abortion methods. As the Supreme Court explained in *Stenberg* v. *Carhart*, "the record shows that significant medical authority supports the proposition that in some circumstances, D&X would be the safest procedure."[6] Indeed, the Court concluded that "a statute that altogether forbids D&X creates a significant health risk."[7]

D&X abortions offer a variety of potential safety advantages over other procedures used during the same gestational period.

First, compared to D&E abortions, D&X involves less risk of uterine perforation or cervical laceration because it requires fewer passes into the uterus with sharp instruments.

Second, there is considerable evidence that D&X reduces the risk of retained fetal tissue, a serious complication that can cause maternal death or injury.

Third, D&X may be safer than available alternatives for women with particular health conditions. As ACOG has concluded, 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."[8] D&X may also be the most appropriate method in the presence of certain fetal indications. For example, D&X "may be especially useful in the pres-

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[2] ACOG's Statement of Policy, *Statement on Intact Dilatation and Extraction* (Jan. 1997) ("ACOG *Statement*"), at 2 (emphasis in original omitted); *see also* ACOG's Statement on So-Called "Partial Birth Abortion" Laws (Feb. 2002).

[3] Joy Herndon *et al., Abortion Surveillance—United States, 1998*, in *CDC Surveillance Summaries*, 51 MMWR (No. SS–3) 32 (Table 18) (Centers for Disease Control, June 7, 2002).

[4] *Id.*

[5] In an induction, the physician uses one of several substances and methods to induce preterm labor. ACOG, Practice Bulletin No. 10, *Induction of Labor* at 1 (Nov. 1999). Some medical authorities indicate that induction often is unsuccessful prior to approximately 16 weeks from the woman's last menstrual period ("LMP") because the uterus is less responsive to the inducing agents. *See* EUGENE GLICK, SURGICAL ABORTION at 46–48 (1998). In the case of an incomplete or unsuccessful induction, a subsequent surgical abortion procedure is necessary. *See* A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION at 125 (Maureen Paul et al. eds., 1999).

[6] 530 U.S. 914, 932 (2000).

[7] *Id.* at 938.

[8] ACOG *Statement* at 2.

ence 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."[9] In addition, "intactness allows unhampered evaluation of structural abnormalities" in the fetus and can thus aid in diagnosing fetal anomalies. Finally, an intact fetus can "aid . . . patients grieving a wanted pregnancy by providing the opportunity for a final act of bonding."[10]

Fourth, D&X procedures usually take less time than other abortion methods used at a comparable stage of pregnancy, which can have significant health advantages.

Based on my clinical experience and knowledge of this field, there is no reliable medical evidence to support the claim in H.R. 760's Findings that D&X endangers maternal health. (Finding Number 14(A).) The Findings claim that the amount of cervical dilatation involved in D&X procedures heightens the risk of cervical incompetence or cervical trauma. Many D&E procedures, however, involve similar amounts of dilatation, and of course childbirth involves even more dilatation. The concern stated in the Findings about the risks posed by the physician repositioning the fetus into a footling breech, is similarly misplaced. Some clinicians recommend repositioning the fetus in some D&Es, depending on how the fetus initially presents. Moreover, the Findings suggest that the use of sharp instruments to collapse the head in a D&X is more dangerous than repeated instrument passes into the uterus in a D&E. But the physician can visualize and feel the surgical field during a D&X and therefore the instrument can be carefully guided, thus minimizing risk to the woman.

Finally, H.R. 760's sponsors attempt to rely on the lack of comparative studies or peer-reviewed articles relating to the D&X procedure. (Finding Number 14(B).) However, the development and medical acceptance of safe surgical procedures is not always achieved by orderly and controlled testing. For example, the most common abortion procedures used today were all developed years ago by physicians who slightly varied their technique to achieve greater safety for their patients, found that the variation did improve the safety, and then taught the new technique to their colleagues. Similarly, open heart surgery (as an example) was not tested in a randomized, controlled way. Rather, physicians figured out how to perform the surgery, and did so. As patients lived, physicians kept doing it, and got better at it.

Moreover, given the security concerns that are ever-present for doctors who perform abortions, physicians who use the D&X procedure may be understandably reluctant to publicly acknowledge that they use this procedure, and may be even more reluctant to participate in a study and then publish the results. Therefore, the dearth of peer-reviewed studies of D&X (described in Finding Number 14(B)), is not surprising and does not indicate anything negative about the safety of D&X procedures.

C. H.R. 760 WILL HARM WOMEN'S HEALTH

The bill's ban on safe abortion procedures that are within the standard of care strips physicians of the discretion they need to make critical medical judgments. This will result in an unacceptable risk to women's health. Given the safety advantages of D&E, D&X and induction procedures over other abortion procedures, banning these procedures will necessarily harm women and deprive them of optimal care. As a physician and a woman, I consider this result unacceptable.

It is unconscionable that Congress is attempting to legislatively ban safe and necessary medical procedures, and thereby to deny patients optimal medical care. The practice of medicine must be left to doctors and medical professionals.

I strongly urge this Subcommittee to stop trying to practice medicine and to reject H.R. 760.

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[9] David A. Grimes, *The Continuing Need for Late Abortions*, 280 JAMA 747, 748 (Aug. 26, 1998).

[10] *Id.*

March 5, 2003

The Honorable Barbara Boxer
United States Senate
112 Hart
Washington, D.C. 20510

Dear Senator Boxer:

I understand that your will be considering Senate S. 3, the ban on abortion procedures, soon and would like to offer some medical information that may assist you in your efforts. Important stakes for women's health are involved: if Congress enacts such a sweeping ban, the result could effectively ban safe and common, pre-viability abortion procedures.

By way of background, I am an adjunct professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco, where I co-direct the Center for Reproductive Health Research and Policy. Formerly, I directed the Reproductive Health program for the Henry J. Kaiser Family Foundation and served as Deputy Assistant Secretary for Population Affairs for the United States Department of Health and Human Services. I represented the United States at the International Conference on Population and Development (ICPD) in Cairo, Egypt, and currently serve on a number of Boards for organizations that promote emergency contraception and new contraceptive technologies, and support reducing teen pregnancy. My medical and policy areas of expertise are in the family planning and reproductive health, prevention of sexually transmitted infections including HIV/AIDS, and enhancing international and family planning.

The proposed ban on abortion procedures criminalizes abortions in which the provider "deliberately and intentionally vaginally delivers a living fetus . . . for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus. . . ." The criminal ban being considered is flawed in a number of respects:

- it fails to protect women's health by omitting an exception for women's health;
- it menaces medical practice with the threat of criminal prosecution;
- it encompasses a range of abortion procedures; and
- it leaves women in need of second trimester abortions with far less safe medical options: hysterotomy (similar to a cesarean section) and hysterectomy.

The proposed ban would potentially encompass several abortion methods, including dilation and extraction (d&x, sometimes referred to as "intact d&e), dilation and

evacuation (d&e), the most common second-trimester procedure. In addition, such a ban could also apply to induction methods. Even if a physician is using induction as the primary method for abortion, he or she may not be able to assure that the procedure could be effected without running afoul of the proposed ban. A likely outcome if this legislation is enacted and enforced is that physicians will fear criminal prosecution for any second trimester abortion - and women will have no choice but to carry pregnancies to term despite the risks to their health. It would be a sad day for medicine if Congress decides that hysterotomy, hysterectomy, or unsafe continuation of pregnancy are women's only available options. *Williams Obstetrics*, one of the leading medical texts in Obstetrics and Gynecology, has this to say about the hysterotomy "option" that the bill leaves open:

> **Nottage and Liston (1975), based on a review of 700 hysterotomies, rightfully concluded that the operation is outdated as a routine method for terminating pregnancy.** (original in bold). Cunningham and McDonald, et al, *Williams Obstetrics,* 19th ed., (1993), p. *683.*

Obviously, allowing women to have a hysterectomy means that Congress is authorizing women to have an abortion at the price of their future fertility, and with the added risks and costs of major surgery. In sum, the options left open are less safe for women who need an abortion after the first trimester of pregnancy.

I'd like to focus my attention on that subset of the women affected by this bill who face grievous underlying medical conditions. To be sure, these are not the majority of women who will be affected by this legislation, but the grave health conditions that could be worsened by this bill illustrate how sweeping the legislation is.

Take for instance women who face hypertensive disorders such as eclampsia - convulsions precipitated by pregnancy-induced or aggravated hypertension (high blood pressure). This, along with infection and and hemorrhage, is one of the most common causes of maternal death. With eclampsia, the kidneys and liver may be affected, and in some cases, if the woman is not provided an abortion, her liver could rupture, she could suffer a stroke, brain damage, or coma. Hypertensive disorders are conditions that can develop over time or spiral out of control in short order, and doctors must be given the latitude to terminate a pregnancy if necessary in the safest possible manner.

If the safest medical procedures are not available to terminate a pregnancy, severe adverse health consequences are possible for some women who have underlying medical conditions necessitating a termination of their pregnancies, including:

- death (risk of death higher with less safe abortion methods)
- infertility
- paralysis

- coma
- stroke
- hemorrhage
- brain damage
- infection
- liver damage
- kidney damage

Legislation forcing doctors to forego medically indicated abortions or to use less safe but politically-palatable procedures is simply unacceptable for women's health.

Thank you very much, Senator, for your efforts to educate your colleagues about the implications of the proposed ban on abortion procedures.

Sincerely,

Felicia H. Stewart, M.D.

PREPARED STATEMENT OF ANNE R. DAVIS

I am a physician licensed to practice medicine in New York and am board-certified in obstetrics and gynecology. I received my medical degree at Columbia University College of Physicians and Surgeons and completed my residency in Obstetrics and Gynecology at the University of Washington in Seattle. Since 1997, I have

been an Assistant Professor in Clinical Obstetrics and Gynecology at Columbia University. In addition to my teaching responsibilities, I provide direct patient care.

I am a Fellow of the American College of Obstetricians and Gynecologists, and also am a member of, among other organizations, the American Medical Women's Association, Physicians for Reproductive Choice and Health, and the Association of Reproductive Health Professionals. As detailed on my Curriculum Vitae, a copy of which is attached, I have published and lectured in the area of obstetrics and gynecology.

I submit this testimony in opposition to H.R. 760, the so-called "Partial-Birth Abortion Ban Act of 2003." Based on my training and professional experience in the field of women's health care, it is my medical judgment that H.R. 760 would pose a serious threat to women's health.

H.R. 760 will severely limit physicians' ability to provide the best medical care to their patients. Because the bill is confusing and contradictory, it will be difficult for physicians to interpret. However, the operative language of the bill appears to ban safe and common abortion procedures used well before fetal viability, including the most common methods of abortion used in the second-trimester, which starts at approximately thirteen weeks of pregnancy. H.R. 760 is all the more harmful because it contains no exception for those instances when a procedure is necessary to preserve a woman's health, and includes only a dangerously inadequate exception for those instances when a procedure is necessary to save a woman's life.

H.R. 760, therefore, leaves physicians with the untenable choice of either performing procedures under threat of criminal prosecution or ceasing to provide the medical care that we deem most appropriate for a particular patient. Either choice poses grave risks to patient care.

I. BACKGROUND ON ABORTIONS IN THE UNITED STATES

In the United States, almost 90% of abortions take place during the first trimester of pregnancy.[1] Less than 2% of abortions in the United States take place at or after twenty-one weeks measured from the date of the woman's last menstrual period (LMP).[2]

There are a variety of complicated circumstances that prompt women to terminate pregnancies. Many women end unplanned pregnancies for a wide range of reasons including their age, their family situation, and their personal circumstances. Some women who seek abortions are pregnant as a result of rape or incest.

Still other women are forced to terminate wanted pregnancies. These include women who learn that their fetuses have severe, potentially fatal, anomalies. Some anomalies are sure to be fatal within days, if not minutes, of birth. Trisomy 13 and trisomy 18, for example, cause severe malformations and usually lead to death within twenty-four hours of birth. Anencephaly—a condition characterized by markedly defective development of the brain and skull—results in death before birth or soon after. Other conditions might permit survival but cause severe, life-long impairment. For example, Tay-Sachs disease usually results in death at three or four years of age. Women carrying fetuses with such conditions often choose to terminate their pregnancies due to the very poor prognosis.

Some women require abortions because their pregnancies compromise their health. In some instances, the patient has a preexisting medical condition that is exacerbated by her pregnancy. For example, women with certain kinds of heart disease are at increased risk during pregnancy, with the risk of maternal and fetal death as high as fifty percent. Women who develop peripartum cardiomyopathy, a condition in which the heart muscle does not pump blood sufficiently, are at serious risk of cardiac failure. Women with conditions such as renal (kidney) and liver disease may experience exacerbation of those diseases as a result of the pregnancy.

Some women who have cancer learn that they are pregnant. In these cases, although the pregnancy does not threaten the patient's life, she may require treatment with chemotheraphy or radiation, which is inconsistent with carrying a pregnancy to term.

Even for women without preexisting medical problems, dangerous conditions may develop during pregnancy. One such condiction is pre-eclampsia, a pregnancy-induced hypertension that can result in cerebral hemorrhage, as well as liver dysfunction or failure, kidney failure, temporary or permanent visual disturbances or vision

[1] Laurie D. Elam-Evans *et al., Abortion Surveillance—United States, 1999*, in *CDC Surveillance Summaries*, 51 *MMWR* (No. SS–9) 4, 5, 12, 18 (Table 1, 6) (Centers for Disease Control, Nov. 29, 2002).

[2] *Id.*

loss, and coma. In these situations, abortion may be indicated to preserve the patient's health or life.

Although only 10% of abortions in this country take place in the second trimester of pregnancy, these post-first-trimester abortions may take place because of the circumstances I have just described. This is because it is often not possible to diagnose fetal abnormalities before the second trimester because the tests used to detect these conditions are not accurate until later in pregnancy. And, the maternal health conditions that necessitate abortion often worsen in the second trimester, requiring women to seek abortions at this stage.

Physicians generally use two different techniques to perform abortions after the first trimester: dilation and evacuation (D&E) and induction. In a D&E, the physician dilates the cervix and evacuates the uterus using a combination of forceps (a grasping instrument), suction curettage, and sharp curettage (the use of an instrument with a sharp edge to ensure that the uterus is entirely empty). In a variation of D&E called intact D&E (or dilation and extraction (D&X)), the physician maximizes the chances of an intact or relatively intact delivery in order to minimize risk to the woman. In an induction procedure, one of several medications is used to induce premature labor.

D&E is the most commonly performed second-trimester abortion procedure. D&E, including its intact variation, comprises approximately 96% of all second-trimester abortions performed in this country.[3] Induction abortions account for most of the remaining 4% of second-trimester abortions.[4] Induction requires hospitalization and is a more lengthy process than D&E. For most women, inductions are safe procedures. Inductions may involve complications and physiological stress associated with labor and delivery at term, including contractions that last from four to thirty hours or more. That alone often makes induction contraindicated for women with certain medical conditions, including cardiac disease or a prior hysterotomy or prior "classical" (high) cesarean section. Induction abortion can also be contraindicated when the fetus has certain anomalies.

II. H.R. 760 BANS AN ARRAY OF SAFE AND COMMON ABORTION PROCEDURES.

The language of H.R. 760 is confusing and contradictory. It is therefore unclear precisely what it prohibits. It refers to "partial-birth abortion," a term that is not used by doctors. I am aware, however, that many courts have concluded that this term can refer to a variety of abortion methods. Moreover, there is no correlation between the definition of banned abortions in the bill's operative language and the description of procedures included in the bill's Findings. For example, the bill's Findings refer to "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." H.R. 760, Sec. 2(1). The Findings also refer to "cervical dilation" and "converting the child to a footling breech position." H.R. 760, Sec. 2(14)(A). Yet the language in the actual ban does not mention any of those steps. In addition, the Findings refer to procedures performed at or after twenty weeks LMP, see H.R. 760, sec. 2(14)(I), but the ban contains no such limit. The language in the ban is thus unrelated to, and much broader than, the description contained in the bill's Findings.

I understand that proponents of this bill have contended that it is intended to ban only the abortion procedure known as intact D&E or D&X. H.R. 760 reaches those procedures. But its terms would reach D&Es and inductions, as well. H.R. 760 therefore would ban every safe and common option for second-trimester pregnancy termination.

H.R. 760 defines the banned procedures as any one in which: The 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; and performs the overt act, other than completion of delivery, that kills the partially delivered living fetus." H.R. 760, Sec.3(a). These words describe what happens in many D&E procedures.

H.R. 760 would ban D&Es as they proceed in any number of ways. Each D&E is different, and the physician adapts his or her surgical technique based on the individual patient and on how the particular case progresses. The physician cannot predict which steps will be safest during a D&E until the surgery has begun. But

[3] Joy Herndon *et al., Abortion Surveillance—United States, 1998*, in *CDC Surveillance Summaries*, 51 MMWR (No. SS–3) 32 (Table 18) (Centers for Disease Control, June 7, 2002).

[4] *Id.*

in every D&E, each time the physician inserts instruments into the uterus, the physician then deliberately and intentionally delivers as much of the fetus as possible, which can mean that "the entire fetal head is outside the body of the mother" or that "any part of the fetal trunk past the navel is outside the body of the mother"; the physician does so for the purpose of evacuating the uterus as safely as possible for the woman; and the physician knows that evacuating the uterus as safely as possible may entail "an overt act, other than the completion of delivery" that will cause fetal demise. Any D&E can entail these steps. Thus, any doctor performing a D&E is at risk of falling under the ban.

Any doctor performing an induction abortion would also be at risk under H.R. 760. After preterm labor is induced, a variety of complications may develop that will necessitate taking the very steps used commonly in D&Es. Because any induction can progress in this way, a physician starting any induction will know that the safest way to proceed could turn out to involve using techniques that H.R. 760 prohibits.

H.R. 760 thus subjects any physician to the risk of prosecution for using any safe and common second-trimester abortion method. This poses an intolerable threat to women's health. The only procedures a physician can safely perform without risk of prosecution are hysterotomy or hysterectomy. Both of these procedures pose such serious health risks that they have been all but abandoned as methods of pregnancy termination.[5] Thus, H.R. 760 seriously jeopardizes women's health.

III. EVEN IF IT BANNED ONLY D&X PROCEDURES, H.R. 760 WOULD THREATEN WOMEN'S HEALTH.

Even if it were true, as some proponents of H.R. 760 claim, that the bill covers only a single variation of abortion known as intact D&E or D&X, it 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 are some women for whom the banned procedure will be the safest.

In my medical judgment and in the judgment of many experienced physicians, there is no question that intact D&E is a safe abortion procedure that may well be the safest procedure for some women in certain circumstances. The American College of Obstetricians and Gynecologists ("ACOG"), of which I am a member, has articulated its safety advantages. According to ACOG, intact D&Es provide the following potential advantages: First and most important, intact D&E has the potential to greatly reduce the risk of uterine perforation or cervical laceration by reducing the number of times the physician must insert instruments through the cervix and into the uterus. Second, intact D&E also reduces the risk of perforation and laceration from sharp fetal parts. Third, intact D&E minimizes the risk of retained fetal tissue in the uterus. Finally, intact D&E reduces blood loss, trauma, and operating time (and thus anesthesia exposure) for many patients. Based on my experience, I wholly agree with these conclusions.

I have read the discussion of the alleged safety risks of elements of certain intact D&Es in the Findings section of H.R. 760. Based on my experience, these claims are unfounded. There are no data supporting the assertion that the gradual and gentle dilation involved in an intact D&E causes cervical incompetence, and, based on my experience, I do not believe that it does. There is likewise no support for the assertion that converting the pre-viable fetus to a breech presentation is dangerous. Moreover, such conversion may occur in D&Es generally and does not always occur in an intact D&E. Similarly, the risk of laceration and of damage from blind insertion of instruments is decreased—not increased—by removing the fetus intact. Because of these safety advantages, ACOG has stated that intact 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." ACOG, Statement of Policy, *Abortion Policy* at 3 (Sept. 2000).

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[5] Hysterotomy and hysterectomy are generally justified as abortion methods only when the woman has some medical condition that independently requires such surgery. Hysterotomy is a preterm cesarean section, in which an incision made in the uterine wall through which the physician removes the fetus. Hysterotomy in the second trimester is significantly more dangerous than a cesarean section at term because it involves cutting through the uterine wall when it is much thicker. During any future pregnancy—even before labor—a prior hysterotomy can cause uterine rupture and catastrophic bleeding. Hysterectomy is the removal of the uterus, which results in complete loss of fertility. Hysterectomy and hysterotomy thus entail significantly higher rates of morbidity and mortality than are associated with either D&E or induction.

IV. H.R. 760 LACKS NECESSARY EXCEPTIONS TO PROTECT WOMEN'S HEALTH AND LIVES.

In addition to the problems outlined above, H.R. 760 poses grave risks to women by failing to include any exception for cases in which a banned procedure may be needed to preserve a woman's health. Women with the kind of medical complications I have described above will suffer serious harm if H.R. 760 prevents their physician from choosing the safest and most appropriate abortion procedure for their particular health circumstances. It is simply not true, as the Findings in the bill contend, that the procedures banned by this bill will never be necessary to preserve a woman's health.

The life exception in H.R. 760 is also dangerously inadequate. It applies only when the abortion procedures otherwise banned by the bill are "necessary to save the life of the mother whose life is endangered by a physical disorder, a physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." Rather than provide an exception to be used *whenever* a woman's life is at stake, *this* exception applies only when a banned procedure is "necessary" to save a woman's life. But in almost every case, other procedures that are not banned, such as hysterotomy or hysterectomy, would likely save the woman's life, even though they pose far greater risks and can have irreversible medical consequences for the woman. H.R. 760 thus forces women from safer to riskier procedures.

V. H.R. 760 UNDERMINES PHYSICIANS' ABILITY TO USE THEIR BEST MEDICAL JUDGMENT IN CARING FOR PATIENTS.

A crucial component of effective health care is a physician's ability to rely on his or her best medical judgment in determining the appropriate treatment for a particular patient. H.R. 760 undermines patient care by preventing physicians from relying on their best medical judgment in providing abortions. The risk of a particular abortion procedure varies in every case depending on a variety of factors including, the individual woman's health, the skill of the physician, the medical facilities available, and how the selected procedure progresses in a particular case. Given these many variables, it is essential that a physician be able to choose from the full array of safe techniques in providing abortions—or in providing any other medical treatment.

I urge this Subcommittee to leave decisions about the best surgical techniques for women in the hands of doctors and patients. I urge you to reject H.R. 760.

Oppose the So-Called Partial-Birth Abortion Ban Act of 2003

AMERICAN ASSOCIATION OF UNIVERSITY WOMEN

March 24, 2003

Dear Representative Nadler:

On behalf of the over 100,000 bipartisan members of the American Association of University Women (AAUW), we urge you to oppose the so-called Partial-Birth Abortion Ban Act of 2003 (HR 760) during the Constitution subcommittee of the Judiciary Committee markup of the bill. HR 760 would endanger women's health and would violate the constitutional underpinnings of *Roe v. Wade*. A woman's right to safe, accessible, and comprehensive reproductive health care remains an integral part of the effort to gain equity for women.

The U.S. Supreme Court decision in *Roe v. Wade* struck a careful balance between the right of a woman to choose abortion in the early stages of pregnancy and the states' interest in protecting potential life after viability. The Court held that prior to fetal viability, the decision to have an abortion must reside with the woman in consultation with her doctor and within the context of her own religious and moral beliefs. After fetal viability, *Roe* allows states to ban abortion as long as the woman's life and health are protected. The Court explicitly affirmed this principle in *Planned Parenthood v. Casey* (1992).

In June 2000, the Supreme Court handed down *Stenberg v. Carhart,* striking down a Nebraska law banning so-called partial-birth abortion. The Nebraska law was nearly identical to the federal bans passed by the 105th and 106th Congress, and by the House of Representatives in the 107th Congress. The Court gave the following reasons for striking the Nebraska ban: first, the legislation was unconstitutionally vague because it did not rely on a medical definition of what is prohibited; second, the Nebraska law did not provide an exception to protect women's health; and, finally, it violated the *Roe* decision by banning procedures regardless of the viability of the fetus. HR 760 violates both the *Roe* and *Stenberg* decisions.

The so-called Partial-Birth Abortion Ban Act also unduly interferes with doctor-patient relationships by giving Congress the ability to punish physicians and put patients at risk. Moreover, while proponents of this legislation claim it would ban just one abortion procedure, the bill's language is so vague and broad that it could prohibit virtually all surgical abortion procedures throughout pregnancy.

HR 760 is part of an ongoing anti-choice strategy to undermine a woman's right to choose. This extreme, deceptive, and unconstitutional legislation would endanger women's health and violate the core principles of *Roe v. Wade*. HR 760 bans a variety of safe and common abortion procedures both before and after viability, therefore imposing an undue burden on women seeking access to abortion services.

Once again, we urge you to oppose HR 760, the so-called Partial-Birth Abortion Ban Act of 2003. Instead of making abortion more difficult and dangerous for women, we urge you to promote policies that prevent unintended pregnancy and reduce the need for abortion. If you have any questions, please contact Lisa Maatz, Director of Public Policy Government Relations, at 202/785-7793, or Jamie Fasteau, Senior Lobbyist/Government Relations Manager, at 202/785-7730.

Sincerely,

Nancy Rustad
President

Jacqueline Woods
Executive Director

1111 SIXTEENTH ST. NW, WASHINGTON, DC 20036 202/785-7700 FAX 202/872-1425
email: info@aauw.org http://www.aauw.org

The American College of Obstetricians and Gynecologists On The Subject Of "Partial-Birth Abortion" Bans

The American College of Obstetricians and Gynecologists (ACOG), an organization of 44,000 physicians dedicated to women's health care, continues to oppose Federal legislation known as "partial birth abortion" bans.

ACOG has concluded there are circumstances under which this type of procedure would be the most appropriate and safest procedure to save the life or health of a woman. Only the doctor, in consultation with the patient, based upon the woman's particular circumstances, can make this decision.

This bill violates a fundamental principle at the very heart of the doctor-patient relationship: that the doctor, in consultation with the patient, based on that patient's individual circumstances, must choose the most appropriate method of care for the patient. This bill removes decision-making about medical appropriateness from the physician and the patient. ACOG's 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 in providing care for each patient.

ACOG opposes legislation such as HR 4965 as an inappropriate, ill-advised and dangerous intervention into medical decision making. HR 4965 is vague and broad, with the potential to restrict other techniques in obstetrics and gynecology. It fails to use recognized medical terminology and fails to define explicitly the prohibited medical techniques it criminalizes. ACOG notes particularly that imposing criminal penalties for use of a procedure that includes elements of recognized gynecologic and obstetric techniques could outlaw use of those techniques in both abortion and non-abortion circumstances. Some of these techniques can be critical to the lives and health of American women.

ACOG's opposition to this particular legislation must be viewed in the larger context of its overall position on abortion and family planning. ACOG advocates the need to reduce the number of abortions in the United States. As recently as the 2000 reaffirmed Policy Statement on Abortion, ACOG said:

> "The need for abortions, other than those indicated by serious fetal anomalies or conditions which threaten maternal welfare, represents failures in the social environment and the educational system. [...] The most effective way to reduce the number of abortions is to prevent unwanted and unintended pregnancies."

ACOG believes preventing unwanted and unintended pregnancies – not legislative intervention into private, protected medical decisions – is the best means for reaching a shared national goal of reducing abortion.

July 8, 2002

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS
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ACOG *Statement of Policy*

As issued by the ACOG Executive Board

ABORTION POLICY

The following statement is the American College of Obstetricians and Gynecologists' (ACOG) general policy related to abortion, with specific reference to the procedure referred to as "intact dilatation and extraction" (intact D & X).

1. The abortion debate in this country is marked by serious moral pluralism. Different positions in the debate represent different but important values. The diversity of beliefs should be respected.

2. ACOG recognizes that the issue of support of or opposition to abortion is a matter of profound moral conviction to its members. ACOG, therefore, respects the need and responsibility of its members to determine their individual positions based on personal values or beliefs.

3. Termination of pregnancy before viability is a medical matter between the patient and physician, subject to the physician's clinical judgment, the patient's informed consent and the availability of appropriate facilities.

4. The need for abortions, other than those indicated by serious fetal anomalies or conditions which threaten maternal welfare, represents failures in the social environment and the educational system.

The most effective way to reduce the number of abortions is to prevent unwanted and unintended pregnancies. This can be accomplished by open and honest education, beginning in the home, religious institutions and the primary schools. This education should stress the biology of reproduction and the responsibilities involved by boys, girls, men and women in creating life and the desirability of delaying pregnancies until circumstances are appropriate and pregnancies are planned.

In addition, everyone should be made aware of the dangers of sexually transmitted diseases and the means of protecting each other from their transmission. To accomplish these aims, support of the community and the school system is essential.

The medical curriculum should be expanded to include a focus on the components of reproductive biology which pertain to conception control. Physicians should be encouraged to apply these principles in their own practices and to support them at the community level.

Society also has a responsibility to support research leading to improved methods of contraception for men and women.

The American College of Obstetricians and Gynecologists
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5. Informed consent is an expression of respect for the patient as a person; it particularly respects a patient's moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities, and to the support of the patient's freedom within caring relationships.

   A pregnant woman should be fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption, and abortion. The information conveyed should be appropriate to the duration of the pregnancy. The professional should make every effort to avoid introducing personal bias.

6. ACOG supports access to care for all individuals, irrespective of financial status, and supports the availability of all reproductive options. ACOG opposes unnecessary regulations that limit or delay access to care.

7. If abortion is to be performed, it should be performed safely and as early as possible.

8. ACOG opposes the harassment of abortion providers and patients.

9. ACOG strongly supports those activities which prevent unintended pregnancy.

The College continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability. ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman. Viability is the capacity of the fetus to survive outside the mother's uterus. Whether or not this capacity exists is a medical determination, may vary with each pregnancy and is a matter for the judgment of the responsible attending physician.

Intact Dilatation and Extraction

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

ACOG believes the intent of such legislative proposals is to prohibit a procedure referred to as "intact dilatation and extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation 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.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X. Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy.

ABORTION POLICY
Page 3

The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother.

Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, 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. 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.**

Approval by the Executive Board
General policy: January 1993
Reaffirmed and revised July 1997
Intact D & X statement: January 1997
Combined: and reaffirmed September 2000

American
Medical
Women's
Association, Inc.

Lynn C. Epstein, MD, *President*
Linda D. Hallman, *Executive Director*

March 25, 2003

The Honorable Jerrold Nadler
House of Representatives
Washington, DC 20515

Dear Congressman Nadler:

The American Medical Women's Association (AMWA) strongly opposes HR 760, the "Partial-Birth Abortion Ban Act of 2003." While the Association has high respect for each member and their right to hold whatever moral, religious and philosophical beliefs his or her conscience dictates, as an organization of 10,000 women physicians and medical students dedicated to promoting women's health and advancing women in medicine, we believe HR 760 is unconscionable.

AMWA has long been an advocate for women's access to reproductive health care. As such, we recognize this legislation as an attempt to ban a procedure that in some circumstances is the safest and most appropriate alternative available to save the life and health of the woman. Furthermore, this bill violates the privilege of a patient in consultation with her physician to make the most appropriate decision regarding her specific health circumstances.

AMWA opposes legislation such as HR 760 as inappropriate intervention in the decision-making relationship between physician and patient. The definition of the bill is too imprecise and it includes non-medical terminology for a procedure that may ultimately undermine the legality of other techniques in obstetrics and gynecology used in both abortion and non-abortion situations. At times, the use of these techniques is essential to the lives and health of women. The potential of this ban to criminalize certain obstetrics and gynecology techniques ultimately interferes with the quality of health and lives of women. Furthermore, the current ban fails to meet the provisions set forth by the Supreme Court in *Stenberg v. Carhart,* a ruling that overturned a Nebraska statute banning abortion because it contained no life and health exception for the mother.

AMWA's position on this bill corresponds to the position statement of the organization on abortion and reproductive health services to women and their families. AMWA believes that the prevention of unintended pregnancies through access to contraception and education is the best option available for reducing the abortion rate in the United States. Legislative bans for procedures that use recognized obstetrics and gynecological techniques fails to protect the health and safety of women and their children, nor will it improve the lives of women and their families. If you have any questions please contact Meghan Kissell, at 703-838-0500.

Sincerely,

Lynn C. Epstein MD

Lynn Epstein, MD

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Jodi Magee
Executive Director

March 25, 2003

The Honorable Jerrold Nadler
United States House of Representatives
Washington, DC 20515

Dear Congressman Nadler:

We are writing to urge you to stand in defense of women's reproductive health and vote against H.R. 760, legislation regarding so-called "partial birth" abortion.

We are practicing family physicians; obstetrician-gynecologists; academics in obstetrics, gynecology and women's health; and a variety of other specialties in medicine. We believe it is imperative that those who perform terminations and manage the pre- and post-operative care of women receiving abortions are given a voice in a debate that has largely ignored the two groups whose lives would be most affected by this legislation: physicians and patients.

It is misguided and unprincipled for lawmakers to legislate decision-making in medicine. We all want safe and effective medical procedures for women; on that there is no dispute. However, the business of medicine is not always palatable to those who do not practice it on a regular basis. The description of a number of procedures - from liposuction to cardiac surgery - may seem distasteful to some, and even repugnant to others. When physicians analyze and refine surgical techniques, it is always for the best interest of the patient. The risk of death associated with childbirth is about 11 times as high as that associated with abortion. Abortion is proven to be one of the safest procedures in medicine, significantly safer than childbirth, and in fact saves women's lives.

While we can argue as to why this legislation is dangerous, deceptive and unconstitutional - and it is - the fact of the matter is that the text of the bill is so vague and misleading that there is a great need to correct the misconceptions around abortion safety and technique. It is wrong to assume that a specific procedure is never needed; what is required is the safest option for the patient, and that varies from case to case.

THE FACTS

1) So-called "partial birth" abortion does not exist.

There is no mention of the term "partial birth" abortion in any medical literature. Physicians are never taught a technique called "partial birth" abortion and therefore are unable to medically define the procedure.

What is described in the legislation, however, could ban all abortions. "What this bill describes, albeit in non-medical terms, can be interpreted as any abortion," stated one of our physician members. "Medicine is an art as much as it is a science; although there is a standard of care, each procedure-and indeed each woman-is different. The wording here could apply to any abortion patient." The bill's language is too vague to be useful; in fact, it is so vague as to be harmful. It is intentionally unclear and deceptive.

2) <u>Physicians need to have all medical options available in order to provide the best medical care possible</u>.
Tying the hands of physicians endangers the health of patients. It is unethical and dangerous for legislators to dictate the details of specific surgical procedures. Until a surgeon examines the patient, she does not necessarily know which technique or procedure would be in the patient's best interest. Banning procedures puts women's health at risk.

3) <u>Politicians should not legislate medical decision-making</u>.
To do so would violate the sanctity and legality of the physician-patient relationship. The right to have an abortion is constitutionally-protected. To falsify scientific evidence in an attempt to deny women that right is unconscionable and dangerous.

> *The American College of Obstetricians and Gynecologists, representing 45,000 ob-gyns, agrees: "The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous."*
>
> *The American Medical Women's Association, representing 10,000 female physicians, is opposed to an abortion ban because it "represents a serious impingement on the rights of physicians to determine appropriate medical management for individual patients."*

THE SCIENCE
We know that there is no such technique as "partial birth" abortion, and we believe this legislation is a thinly-veiled attempt to outlaw <u>all</u> abortions. Those supporting this legislation seem to want to confuse both legislators and the public about which abortion procedures are actually used. Since the greatest confusion seems to center around techniques that are used after the first trimester, we will address those: dilation and evacuation (D&E), dilation and extraction (D&X), instillation, hysterectomy and hysterotomy (commonly known as a c-section).

Dilation and evacuation (D&E) is the standard approach for second-trimester abortions. The D&E is similar to first-trimester vacuum aspiration except that the cervix must be further dilated because surgical instruments are used. Morbidity and mortality studies indicate D&E is preferable to labor induction methods (instillation), hysterotomy and hysterectomy because of issues regarding complications and safety.

From the years 1972-76, labor induction procedures carried a maternal mortality rate of 16.5 (*note: all numbers listed are out of 100,000*); the corresponding rate for D&E was 10.4. From 1977-82, labor induction fell to 6.8, but D&E dropped to 3.3. From 1983-87, induction methods had a 3.5 mortality rate, while D&E fell to 2.9. Although the difference between the methods shrank by the mid-1980s, the use of D&E had already quickly outpaced induction.

Morbidity trends indicate that dilation and evacuation is much safer than labor induction procedures and for women with certain medical conditions, labor induction can pose serious risks. Rates of major complications from labor induction, including bleeding, infections, and unnecessary surgery, were at least twice as high as those from D&E. There are instances of women who, after having failed inductions, acquired infections necessitating emergency

D&Es as a last resort. Hysterotomy and hysterectomy, moreover, carry a mortality rate seven times that of induction techniques and ten times that of D&E.

There is a psychological component which makes D&E preferable to labor induction; undergoing difficult, expensive and painful labor for up to two days can be extremely emotionally and psychologically difficult, much more so than a surgical procedure that can be done in less than an hour under general or local anesthesia. Furthermore, labor induction does not always work: Between 15 and 30 percent or more of cases require surgery to complete the procedure. There is no question that D&E is the safest method of second-trimester abortion.

There is also a technique known as dilation and extraction (D&X). There is a limited medical literature on D&X because it is an uncommonly used variant of D&E. However, it is sometimes a physician's preferred method of termination for a number of reasons: It offers a woman the chance to see the intact outcome of a desired pregnancy, to speed up the grieving process; it provides a greater chance of acquiring valuable information regarding hereditary illness or fetal anomaly; and D&E provides a decreased risk of injury to the woman, as the procedure is quicker than induction and involves less use of sharp instruments in the uterus, providing a decreased chance of uterine perforations or tears and cervical lacerations. The American College of Obstetricians and Gynecologists addressed this in their statement in opposition to so-called "partial birth" abortion when they said 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, and only the doctor, in consultation with the patient, based on the woman's particular circumstances, can make this decision."

It is important to note that these procedures are used at varying gestational ages. Both D&E and D&X are options for surgical abortion prior to viability. D&E and D&X are used solely based on the size of the fetus, the health of the woman, and the physician's judgment, and the decision regarding which procedure to use is done on a case-by-case basis.

THE LEGISLATION

Because this legislation is so vague, it would outlaw D&E and D&X (and arguably techniques used in the first-trimester). Indeed, the Congressional findings - which go into detail, albeit in non-medical terms - do not remotely correlate with the language of the bill. This legislation is reckless. The outcome of its passage would undoubtedly be countless deaths and irreversible damage to thousands of women and families. We can safely assert that without D&E and D&X, that is, an enactment of H.R. 760, we will be returning to the days when an unwanted pregnancy led women to death through illegal and unsafe procedures, self-inflicted abortions, uncontrollable infections and suicide.

The cadre of physicians who provide abortions should be honored, not vilified. They are heroes to millions of women, offering the opportunity of choice and freedom. We urge you to consider scientific data rather than partisan rhetoric when voting on such far-reaching public health legislation. <u>We strongly oppose legislation intended to ban so-called "partial birth" abortion</u>.

Sincerely,

Nassim Assefi, MD
Attending, Women's Clinic and Adult Medicine
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Jonathan D. Berman, M.D.
Columbia River Mental Health Services
Vancouver, WA

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Beverly Winikoff, MD, MPH
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Gynuity Health Projects
New York, NY

And the board of *Physicians for Reproductive Choice and Health®*

March 24, 2003

Dear Representative:

On behalf of the National Women's Law Center, we are writing to urge you to oppose H.R. 760, the so-called "Partial-Birth Abortion Ban Act of 2003" introduced by Representative Chabot. H.R. 760 suffers from the exact same fundamental flaws as Nebraska's abortion ban, which the U.S. Supreme Court in Stenberg v. Carhart (2000) found was inconsistent with the right to choose guaranteed by Roe v. Wade and therefore unconstitutional.

H.R. 760, like Nebraska's abortion ban, would make it a criminal offense to perform what the bill terms a "partial-birth abortion" at any point in the pregnancy and without any exception to protect a woman where her health would be endangered by carrying the pregnancy to term. In all of the 21 states where medical providers have challenged similar bans, courts have completely or partially blocked their enforcement as unconstitutional.

Like the Nebraska ban, H.R. 760 is so vague in its definition of which procedure is banned that it would impose an unconstitutional undue burden on the right of American women to have a safe abortion. The U.S. Supreme Court in Stenberg found that, although the ban was allegedly designed to apply to one specific abortion procedure, Nebraska's definition of the procedure applied to numerous safe abortion procedures, including the most common second-trimester abortion method, D&E. Similarly, H.R. 760's definition of "partial-birth abortion" is vague and fails to exclude the D&E procedure from its prohibitions.

The term "partial-birth abortion" does not exist in any medical literature. The term, and the definition provided in the legislation, has no basis in medicine whatsoever. As a result, there are no accepted medical or legal guidelines to help doctors determine whether any procedures they perform may fall within the prohibition of this bill. This means, inevitably, that if this legislation is enacted, some doctors will not risk performing safe and legal abortions for fear that they could be considered "partial-birth abortions" and expose the physician to criminal liability.

Like Nebraska's ban, H.R. 760's ban contains no mention of viability and hence applies even before fetal viability, putting it in clear conflict with Roe v. Wade. In Stenberg, the Court reaffirmed the essential holding of Roe v. Wade that before fetal viability a woman has the right to choose to terminate her pregnancy without undue interference by the state. As an absolute ban on at least one, and possibly other,

abortion procedures before fetal viability, H.R. 760, like the Nebraska ban, fails to meet clearly established constitutional standards.

Like the Nebraska ban, H.R. 760 fails to make any exception for risks to the woman's health. In Stenberg, the Court reaffirmed that even after viability, the government may restrict a woman's right to choose only if the law contains exceptions for pregnancies that, if carried to term, would endanger the woman's life or health. H.R. 760, like the Nebraska ban, contains absolutely no exception for cases where the woman's health is at risk and thus is also unconstitutional on this ground.

By including the same constitutional flaws as the Nebraska abortion ban, H.R. 760 rejects the U.S. Supreme Court's holding in Stenberg. We urge you not to ignore this landmark decision and put the lives and health of pregnant women at risk. Please oppose H.R. 760. It will result in bad medicine and bad law.

Sincerely,

Marcia D. Greenberger
Co-President

DOCUMENTS SUBMITTED BY REPRESENTATIVE JOHN CONYERS

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."

Report of Ad Hoc Committee on Structure, Governance, and Operations of the AMA (I-98)

Memo to: Delegates, Alternate Delegates
Executive Directors
State Medical Associations
National Medical Specialty Societies

From: Ad Hoc Committee on Structure, Governance and Operations

Audrey M. Nelson, MD, Chair
Billy Ben Baumann, MD
S. William Clark, III, MD
T. Reginald Harris, MD
David R. Holley, MD
Don Q. Mitchell, MD
Nancy H. Nielsen, MD, PhD
Francis X. Van Houten, MD
Robert Wah, MD
Cecil B. Wilson, MD

Date: November 9, 1998

At the 1997 Interim Meeting, the Speaker of the House of Delegates appointed the Ad Hoc Committee on Structure, Governance and Operations. The Committee has completed its work and submits the attached report for consideration by the House of Delegates at the 1998 Interim Meeting.

Because your committee believes it is important to provide you with the data that formed the basis for our findings and conclusions, two appendices are enclosed:

- Volume I contains the complete, final report of our consultants, Booz-Allen & Hamilton.
- Volume II contains the appendices to Booz-Allen's final report.

The committee particularly calls to your attention the two case studies (Partial Birth Abortion Ban Act of 1997 and the E & M Services Documentation Guidelines) located in appendix D and appendix E of Volume II. These studies examine the decision-making processes of our Association and present important findings that served as the basis of many of our conclusions.

Please note that, due to the interest in this report, the Speaker has arranged for it to be presented to Reference Committee F at a time when no other business is scheduled. This report will be the first item considered by Reference Committee F at 1:00 PM on Sunday, December 6.

REPORT OF THE AD HOC COMMITTEE ON STRUCTURE, GOVERNANCE, AND OPERATIONS

(I-98)

Subject: Final Report
(Resolutions 604, I-97 and 4, 9, & 610, A-98)

Presented by: Audrey M. Nelson, MD, Chair

Referred to: Reference Committee F
(James G. Hoehn, MD, Chair)

INTRODUCTION

At the 1997 Interim Meeting, the House of Delegates adopted as amended Resolution 605, introduced by the New Jersey Delegation, which states:

> "Resolved that the Speaker of the House of Delegates appoint an ad hoc committee on structure, governance, and operations to study the function and operation of the House of Delegates and Board of Trustees, to recommend structural and procedural changes to policies, procedures, and/or Constitution and Bylaws that assure propriety, efficiency, and accountability in the development of Association programs and the conduct of all activities; and be it further

The Georgia Delegation introduced the following amendment, which was also adopted as part of the action on this issue:

> "Resolved, that this committee utilize the services of an independent management firm to perform a management audit to evaluate the internal decision-making process as it relates to staff-board relationships and policy implementation of the AMA."

The House of Delegates referred Resolution 604 (I-97) to the ad hoc committee. This resolution, also introduced by the New Jersey Delegation, states:

> "Resolved, that votes of the American Medical Board of Trustees on policy matters be recorded by name and distributed with the minutes of each Trustees meeting."

At the 1998 Annual Meeting, the House referred the following observations and suggestions from the report of the Ad Hoc Committee to Study the Sunbeam Matter to be addressed by this committee in the course of its work:

- The Board, through its Chair, should be actively involved in the process of developing its agendas and prioritizing its activities and the use of its time, all within the framework of the AMA's vision.

- The role of the Board Chair is critical to the smooth functioning of the organization. The role of the Chair should be clearly defined. Board chairs should receive formal training for this role, especially related to communication and coordination with the Executive Vice President, so that appropriate Board fiduciary responsibility is exercised while at the same time avoiding wasteful micro-management of staff activities.
- Directives to staff should be communicated by the Board Chair through the Executive Vice President. Individual trustees should coordinate their communication with AMA staff through the Board Chair in order to decrease the possibility of misinterpretation, provide for clear avenues of accountability, and eliminate situations that may undermine the role of the Executive Vice President.
- The Board should empower its Executive Committee to function much more actively on behalf of the Board and should make better use of committees to accomplish the routine and preliminary work of the Board so that general Board sessions can focus on critical decision making.
- The Board should reconsider the role of Board members in performing representative and ambassadorial work. Much of this work should be done by others whose responsibilities are less critical to the assurance of the fiduciary soundness and integrity of the organization.
- The roles of the AMA President and the Chair of the Board of Trustees should be more distinctly differentiated. A "two-track system" should be explored in which individuals aspiring to AMA officer positions would select one or the other but not both.

At the 1998 Annual Meeting, the House also referred Resolutions 4, 9 and 610.

~~Resolution 4 (A-98), sponsored by the New Jersey Delegation, states:~~

> "Resolved, That Section 5.404 of the Bylaws be amended by addition of the following language:
>
> 'No general officer of the corporation as specified in Article VII of the Constitution shall be eligible to serve as Executive Vice President within five years of leaving their most recent general office.'"

Resolution 9 (A-98), introduced by Joseph M. Heyman, MD, Delegate, Massachusetts, states:

> "Resolved, That the American Medical Association Bylaws be amended so as to state that recommendations from the Board of Trustees regarding reports of the Councils may be considered by the Councils, and may be either accepted or rejected by the Councils before submission to the House of Delegates; and be it further
>
> Resolved, That the American Medical Association Bylaws be amended so as to state that all final Council reports shall be submitted to the House of Delegates without modification or delay by the Board of Trustees."

Resolution 610 (A-98), sponsored by the Illinois Delegation, states:

> "Resolved, That our American Medical Association open all Board, Council, committee, advisory committee, and subcommittee meetings to American Medical Association members, and to representatives of the various organizations of the members."

The Speaker appointed the following delegates to serve on the Ad Hoc Committee on Structure, Governance, and Operations:

Audrey M. Nelson, MD, Chair	Don Q. Mitchell, MD
Billy Ben Baumann, MD	Nancy H. Nielsen, MD, PhD
S. William Clark, III, MD	Francis X. Van Houten, MD
T. Reginald Harris, MD	Robert M. Wah, MD
David R. Holley, MD	Cecil B. Wilson, MD

The committee set about its work immediately. Even though the creation of the ad hoc committee was triggered by the Sunbeam crisis, the committee did not directly address this issue. The Sunbeam crisis is just one of several events that points to serious flaws in AMA's decision-making processes. And, even though there is the sense that many AMA members are unhappy with the AMA and that there is much that is not right in the way the Federation is organized, the committee has not tried to address sweeping broad-based problems with the organization of the Federation.

It is not the intent of the committee to fix blame on individuals or elements of the Association. The Board of Trustees, the House of Delegates, the Councils, and the Executive Staff are men and women of good will who want to do what is right for the Association. The AMA has many "star performers," which calls for a strong structure of control to reach concerted action. The committee acknowledges, however, that there is a disturbing element of distrust among the House, Councils, Board and staff. Each of these governance groups has an important role. If the AMA is to survive, the governance components must work together and make decisions for the overall good of the organization. Breakdowns in this complex decision-making process result in serious and visible failures, with national implications, that detract from the national standing and effectiveness of the organization. When one element of the governance process is out of sync with the others, the system of checks and balances does not work, and, as we have seen, the results can be disastrous for our organization.

Since January 1998, the committee has met seven times and held four lengthy conference calls. Much of the committee's work has involved gathering and analyzing scores of documents. Particular attention has been given to an analysis of the survey of the members of the House of Delegates at the 1998 Annual Meeting. Six hundred twenty-three out of a possible 968 surveys were received (64 percent), which is sufficient to ensure 97 percent confidence in the findings. The confidential interviews with the Board of Trustees, Council Chairs, past AMA officers, and members of all levels of AMA staff gave the committee insights into the internal operations of the organization. Everyone has been cooperative and helpful. The committee received everything it requested. Nothing appeared to be concealed.

Everyone spoke frankly and honestly, and the committee believes that the AMA is blessed with many intelligent and talented individuals sincerely concerned about the future of the organization and the American medical profession.

As directed by action of the House of Delegates, the committee's work has been aided immeasurably by an independent management consulting firm. As reported at the 1998 Annual Meeting, the committee hired Booz-Allen & Hamilton, Inc., McLean Virginia. The firm's consultants, led by Partner Joyce Doria, operated under the direct supervision of the committee. They met and exceeded the committee's expectations in their professionalism, organizational knowledge, and adherence to a rigorous and demanding work plan and timetable.

Booz-Allen consultants conducted extensive research that serves to support the committee's recommendations. The committee decided to share this valuable and illuminating information with members of the House of Delegates. The following background materials are contained in Volume II, which is enclosed with this report:

- "Document Inventory for the American Medical Association." This is a list of the scores of documents read and analyzed by the consultants during the course of this study.
- "Interview and Follow-up Questionnaire." This document outlines the findings resulting from the 53 Booz-Allen interviews with the current and former Board members, Council Chairs, and key staff to explore governance and decision-making issues at the AMA.
- "House of Delegates Survey." This document presents the results of the survey of delegates and alternate delegates conducted at the 1998 Annual Meeting.
- "Case Study: Decision-Making Processes on the American Medical Association's Support of 'The Partial-Birth Abortion Ban Act of 1997.'
- "Case Study: Decision-Making Processes on the Development of the 1997 Evaluation and Management (E&M) Services Documentation Guidelines"
- "Comparative Analysis" This document provides a comparative analysis of a range of other associations to identify patterns of and options for association governance.
- "Process Flow Diagrams" This document summarizes various AMA processes, including Board of Trustees Meeting Agenda Setting, Board of Trustees Meeting Activities, Board Report Development, Council Report Development, AMA Planning, and AMA Policymaking Process.

In addition, the committee is providing the full text of Booz-Allen's final report (enclosed Volume I) so that the delegates will have the full benefit of the information and advice received by this committee. The delegates will notice that in some instances the committee's recommendations are different from our consultant's recommendations. Sometimes the committee chose not to make a recommendation at all, either because it disagreed with the recommendations or the committee believed that the timing is not yet right. Even when we did not agree with our consultants, we found their observations intriguing and worthy of further discussion. Particular attention should be given to the two case studies on the Partial Birth Abortion Ban Act of 1997 and the E & M Services Documentation Guidelines, because these reports served to shape many of the committee's

recommendations. The Booz-Allen report also details the objectives and scope of analysis and the methodology employed by the consultants in the conduct of this management audit. In the interest of brevity, this report will not repeat that information; but the committee urges that delegates take time to review it.

This report first presents findings and conclusions for "overarching issues" or those that cut across several governance groups and are crucial for the proper functioning of each governance group examined. The report will then present findings and conclusions for the Board of Trustees, the House of Delegates, the AMA Presidents (President, President-Elect, and Immediate Past President), the Councils, and the Corporate Staff and Executive Vice President. These findings and conclusions serve as the basis for the recommendations at the end of this report.

FINDINGS AND CONCLUSIONS

Overarching Issues

1. **Roles and Responsibilities**
2. **Strategic Planning**
3. **Risk Management**
4. **Stakeholder Involvement**
5. **Communications**

Introduction: The AMA is governed by a loose confederation of entities sometimes distracted by their own interests rather than focused on those of the organization as a whole.

A. The governing entities – the Board of Trustees, the House of Delegates, and the Councils – operate independently rather than as an integrated system, with loosely defined and overlapping roles and responsibilities.

B. The AMA culture, as described in the interviews, is one of power and control, where political considerations often take precedence over the profession's needs. Individual ambitions sometimes override organizational priorities.

C. These problems are exacerbated by—

- An information overload (as seen in the four-day agendas for Board meetings), which indicates competing priorities
- Inadequate communication among the House of Delegates, the Board of Trustees, AMA members, senior staff, and outside stakeholders.
- An insular perspective that fails to sufficiently recognize the influence of the external environment on the AMA's success.
- An unfocused internal environment which reduces the effectiveness of AMA governance and decision making, and that engenders a set of overarching issues that negatively affect the AMA overall.

1. Roles and Responsibilities

Insufficient definition and separation of roles have clouded the AMA's decision-making effectiveness.

Fundamentally, key governing and leadership roles of the various bodies, as defined by the AMA Bylaws, lack sufficient detail; further, where descriptions do exist, they create significant overlap among positions, diffusing responsibility and accountability. For example, although the House of Delegates is the policy-making body, some interpretation and policy setting are the responsibility of the Board of Trustees in "urgent situations."

Current operating policies and procedures exacerbate the problem. For example, because the President and the Chair of the Board have unclear and sometimes overlapping responsibilities, political influence and individual personalities have become significant factors in decision-making. The Report of the Ad Hoc Committee to Study the Sunbeam Matter (A-98) noted that – "This organizational confusion over the different roles of the President and the Chair may have contributed to the Sunbeam matter."

The case study on the partial birth abortion ban reveals a Board very much engaged in traditional staff matters of managing and lobbying rather than developing the strategy to achieve legislative goals consistent with existing House policy, monitoring events, and approving any mid-course corrections.

The E&M Guidelines case study demonstrates how various panels, advisory groups, and task forces developing the guidelines operated without sufficient clarity of roles and responsibility for a highly visible and highly sensitive endeavor. Absent such guidance from the governing bodies, they defaulted to the reporting and decision-making arrangements used for the development of the related but far less controversial CPT codes.

2. Strategic Planning

The AMA's governing bodies need to operate with stronger strategic focus.

The Board, with support of the Council on Long Range Planning and Development, developed this year's Statement of Strategic Directions (1998). As the centerpiece of AMA's Strategic Plan, it lays out four objectives. The AMA should become –

- The world's leading information provider on health and medical practice
- The acknowledged leader in medical standards setting
- The most authoritative and influential advocate for physicians and patients
- A growth-oriented, fiscally sound organization, benefiting members and employees.

Within each objective, the plan provides several key strategies – 16 in all – intended to demonstrate how these objectives would be accomplished. These objectives and strategies contain several weaknesses:

- They lack sufficient detail to develop feasible action plans that can assist in achieving one or more of the four objectives.
- No time frame exists indicating whether the objectives and their key strategies should be accomplished in one or more years.
- No measures are described to evaluate the programs that emerge from these key strategies.

The current strategic plan does not define AMA activities and does not have a limited number of accomplishments to be achieved at year-end. The plan is not integrated with what the AMA does on a daily basis and there is no consistency of activities among the various AMA governance entities. For the AMA to survive as a viable organization, the strategic plan should not be just a list of goals and activities, but should be a driving force in everything that the AMA does throughout the year.

The AMA leadership has allowed too much of the organization's focus to drift into short-term, time-sensitive issues, neglecting longer-term needs.

The Sunbeam matter has served as the catalytic event through which the AMA's leadership has begun to question its focus and role in relation to the mission of "acting in the best interest of the physician, the patient, and the AMA." The AMA developed a new planning process, first presented at the 1998 Annual Meeting. The environmental analysis is now a focused element of the planning process and is intended to incorporate external factors into the development of annual strategies. Member and stakeholder opinion and issues are not explicitly, but should become, key elements in this development process.

Despite these attempts to improve the planning process, it is apparent that the AMA does not have a focused strategic plan to implement on an annual basis. Rather, the AMA operates in an ad hoc fashion, reacting to problems and issues as they surface. An integrated strategic plan, identifying the priorities upon which the Association should focus for the coming year, is crucial to the success of the organization. That plan will serve as a disciplinary process for the governance groups. The Board, the Councils, and the staff should execute against the plan, and provide an annual report to the House of Delegates identifying how well the organization met its objectives.

3. Risk Management

AMA does not have in place an effective risk management plan, early warning systems, or adequate crisis response plans.

In the absence of a risk management process, the AMA has been forced to react to several unanticipated and potentially avoidable negative events and outcomes in the recent past, most recently the Sunbeam matter, physician reaction to the E&M Guidelines, and negative response to the AMA position on the Partial Birth Abortion Ban Act of 1997. These events have damaged the reputation and effectiveness of the AMA. The committee believes this is due to a structural problem that transcends the most recent events.

Multiple data sources, both Booz-Allen analyses and AMA documentation, confirm that the AMA lacks a capability to identify situations of risk and respond to them effectively. Lack of clarity between policy and operational decisions, as well as an apparently unclear chain of command, contributes to these risks to financial strength, the membership base, and/or public image.

Staff responses in interviews indicated that they confront "gray area" decisions that do not fall neatly into either the staff's purview of operational matters or into the realm of higher visibility and higher risk policy matters, which are the responsibility of the House and/or the Board. Furthermore, staff reported that there are no guidelines or mechanisms to help them make a judgment regarding the proper decision-maker and then convey the matter to the responsible individual or entity.

The case study on E&M Service Documentation Guidelines highlighted this confusion. The findings revealed that a profound change occurred in the regulatory environment when the Health Care Financing Administration (HCFA) initiated fraud and abuse procedures that would use E&M Guidelines to detect physician abuse. Assigning the CPT codes was an AMA staff responsibility, and consequently, the AMA leadership assumed that developing the E&M Guidelines should be largely a staff responsibility. The Board did not recognize the new implications for policy affecting AMA members and did not step in to exercise its oversight responsibility until a full-blown crisis had developed.

Conversely, the case study on the Partial Birth Abortion Ban Act of 1997 (i.e. H.R. 1122) revealed no clear trigger for the Board decision that establishing an AMA position on the legislation was an "urgent situation" and required action before the House of Delegates meeting the following month. The Board contended that because the U.S. Senate was slated to vote on the bill, the matter was "urgent," compelling the Board to establish the AMA position without waiting for the House of Delegates meeting. Many argued that existing policies, plus the precedent of remaining neutral, should have prevailed. It was inappropriate for Board members to act as lobbyists and negotiate directly with members of Congress; these activities placed the AMA at significant risk.

The Sunbeam matter illustrated the financial and ethical risks resulting from lack of internal controls of the negotiation and contracting process and lack of adequate supervision of senior level managers. Although investigations revealed that the AMA did have policies and procedures that could have obviated the crisis, the Report of the Ad Hoc Committee to Study the Sunbeam Matter (A-98) noted that staff "failed to understand, acknowledge, or follow" these controls, and that "...[no] crisis management plan appears to have been in effect prior to its immediate need."

The range of potential risks to the AMA's well being, reputation, and achievement of its objectives have not been defined. The AMA has neither placed sufficient emphasis on the importance of following existing policies and procedures, nor has it defined and communicated the sanctions for not knowing or not observing them. Finally, the AMA does not have an established general risk management plan or adequate crisis response plan.

A review of best practices indicates that responsibility for risk management should rest with the board of directors, with oversight typically assigned to an audit committee. In order to protect the Association, a new unit—risk management—must be established and staffed. This unit should seek input from all stakeholders and should report to the Executive Vice President, who should report to the Audit Committee of the Board of Trustees on risk management matters. The Board should ensure that risk assessment becomes standard operating procedure during the review of every issue and that all organizational components (Board, Councils, staff) are involved in this process.

4. Stakeholder Involvement

The AMA does not engage its stakeholders in an effective, regular, and timely manner, resulting in a number of negative effects on decision-making.

The AMA does not have a unified view of its "stakeholders." In the interviews conducted by Booz-Allen, respondents referred to stakeholders variously as the House of Delegates, specialty societies, members, physicians, students, patients, staff, and/or the larger medical community (more typically defined as constituents).

According to Philip Kotler's Marketing for Non-Profit Organizations, *stakeholders* are "publics [which are] distinct group[s] of people and/or organizations that have an actual or potential interest and/or impact on the organization."

For the AMA there are two basic types of stakeholders:

1. Internal stakeholders or constituents are those within the organization. For the AMA, they include members, the House, the Board, Council members, national specialty societies, state and county medical societie medical executives, staff, and volunteers.
2. External stakeholders are interested parties outside of an association and its membership; for the AMA, external stakeholders include, among others, patients and patient organizations, non-member physicians, other national health-related organizations, industry suppliers, medical schools, hospitals, clinics, networks, pharmaceutical companies, insurance companies, national health care regulatory and accreditation organizations, and the government.

Seeking AMA stakeholder input should be an integral part of everything the governance groups do. For the AMA and the Federation to survive, it is very important that the Board, Councils, and staff make a concerted effort to weave stakeholder involvement into the day-to-day work of the Association.

These stakeholders are not always supporters, but they care about what the AMA does. The organization cannot survive without developing ongoing relationships with its stakeholders, and yet the committee has seen instances of disregard for stakeholder input, including our own grassroots AMA members.

The committee found that the AMA has no planned strategy for seeking stakeholder input on a routine basis by using conventional marketing tools such as member satisfaction surveys, issue polling, or coalition building. Neither does the AMA sufficiently disseminate information and decisions for the benefit of its stakeholders and other interested parties. Finally, it would serve the AMA well to increase the frequency with which we seek to engage stakeholder organizations to gain support for AMA positions or to build coalitions to assist the AMA in the achievement of its goals as outlined in the strategic plan.

Interview and survey analyses confirmed that inadequate stakeholder input is an issue:

- Sixty-one percent of the interview questionnaire respondents believed that input is not sought from stakeholders before decisions are made. About half of those respondents qualified this response, adding, "stakeholders are not directly contacted for their input."
- The majority of the respondents to the House of Delegates survey believed that the AMA does not adequately share the decisions the AMA has made with interested parties.
- The case study on the development of the E&M Code Guidelines is illustrative of the AMA's lack of awareness of or responsiveness to stakeholder concerns; both member physicians and chief executive officers of national medical societies raised objections to the Guidelines following their initial circulation.

The committee believes that lack of stakeholder involvement in the AMA decision-making process is a major failing of the leadership, which has diminished the effectiveness of our national association and the development of an effective Federation. The committee believes that this problem should be remedied quickly.

5. Communications

Inadequate and fragmented communication weakens AMA's decision-making and image.

Interview responses from the Board, Council Chairs, and staff identify four types of communication flow problems:

1. Internally between the Board and the staff
2. Internally among the staff
3. Externally between AMA and its constituents
4. Externally between the AMA and its stakeholders

The AMA internal decision-making processes operate in an information-rich environment largely attributed to a diligent staff, skilled at gathering and processing information. However, not all appropriate information sources may be considered in framing an issue, examining options, and ultimately reaching a decision.

The case study on E&M Guidelines illustrates issues with internal staff communication. The Booz-Allen report found no coordinating mechanisms for the

non-senior staff working on various aspects of the guidelines to discuss issues of mutual importance, or triggers to identify policy issues and develop strategies for addressing these issues. Staff operates in an insular fashion with little cross-communication between units. This same study also highlights inadequate communication between the Board and the staff. Although the Board and senior staff were periodically briefed, neither group remained sufficiently involved or informed to make connections between the E&M Services Guidelines and growing physician concerns about the fraud and abuse function the Guidelines now served for the federal government.

The committee finds that AMA's communication with external parties is fragmented and then usually only one way--from the AMA. The AMA leadership frequently fails to listen to its stakeholders and does not foster productive two-way communication. Multiple parties, including the President, Board members, and various staff have conveyed inconsistent messages. The E&M Services Guidelines case study also illustrates poor communication efforts with AMA membership, which led to unfounded negative impressions of AMA actions. Furthermore, research confirmed that the AMA does not communicate effectively with stakeholders during critical decision-making cycles. This was illustrated graphically in the Partial Birth Abortion Ban case study. This case study found that the Board of Trustees had not adequately or consistently consulted with or brought into the decision-making process other physician groups, such as ACOG and AMWA, that had a stake in the outcome of negotiations with members of the U.S. Congress.

The House of Delegates recognizes the need for better and more consistent external communication. Open-ended responses on the June 1998 House of Delegates survey indicated that delegates wanted improvements in communication, especially with grassroots membership, other physicians, and the general public. At the 1998 Annual meeting, the House adopted Resolution 615, "Increasing Member Input." This resolution asks the AMA to "...continue to study ways to expand physician participation in the AMA and to get input from members who currently do not participate." The resolution recommends the use of surveys in AMA publications and on the AMA website.

Board of Trustees

Roles and Responsibilities. The AMA Constitution and Bylaws define the official roles and responsibilities and basic organization of the Board of Trustees. The Bylaws include 12 clauses that, with varying degrees of specificity, define the roles, responsibilities, and organization of the Board. They define governance roles, fiduciary responsibilities, and organizational mandates. To supplement the Bylaws, the House has enacted various policies and directives affecting the Board's roles, responsibilities, and structure. The AMA Policy Compendium includes policies that elaborate on or modify the Bylaws with respect to policy making, advocacy, fiduciary responsibility, and communication. These policies are detailed in the Booz-Allen final report.

The Board is also guided by a set of "standing rules" that it establishes for itself. [illegible] rules consist of two documents, one relating to the composition and

functioning of the Board, and the second covering travel and expenses of General Officers. These rules are intended to foster good governance and management of the Board of Trustees.

Board Meetings. Six formal Board meetings are held each year. The Board's agenda is established primarily by the Chair, with assistance of the staff, according to a specific process. That process, however, is not apparent to other Trustees and is the source of some confusion on the Board. Before Board meetings, all Trustees are provided with extensive materials prepared by the staff. Both the quantity and quality of the materials presented to the Board require a great deal of staff resources. Typically, a 2-4 day Board meeting covers from 30 to 60 topics and the material that staff prepares in advance often exceeds 500 pages. The Booz-Allen team examined the agendas and minutes for four formal Board meetings. The team identified nine broad topic areas and categorized the Board's actions. About 30% of the Board's time was spent making decisions, and about the same amount time (31.4%) was spent receiving information. Decisions were generally made by consensus with no reported formal vote at any of these meetings.

Activities of Board Members. Board members engage in a very broad array of activities. These include Board events, AMA events, federation events, health-related events, civic/government events, media events, and others. Only nine percent of the events that the Chair participated in during calendar year 1997 were Board events and only 19 percent of the events other Trustees participated in were Board events. Many of the events in which the Chair and other Trustees participated were tied to the AMA's appearance program.

This examination of the current practices of the Board of Trustees surfaced several issues that deeply concern the committee.

Roles and Responsibilities of the Board and the Executive Vice President. Although the roles and responsibilities of the Board are spelled out in 12 provisions of the Bylaws, only one refers to the Executive Vice President. In addition, the 1998 AMA Policy Compendium contains no reference to the roles and responsibilities of the Executive Vice President. Without a clear definition of roles and responsibilities, the Board may find itself too deeply involved in the day-to-day operational matters normally reserved for the Executive Vice President and his or her staff.

Fiduciary Responsibility of the Board. The primary focus of the Board should be its fiduciary responsibilities, commonly assumed to encompass financial and legal responsibilities, but which by definition means to entrust in another the authority to act on one's behalf. Fiduciary responsibilities of the Board should also include the following:

- Ensuring that an effective strategic planning process is in place, and that resources are properly prioritized and allocated to accomplish the mission, goals and objectives of the AMA.
- Monitoring progress in achieving these objectives through an effective performance measurement and tracking system.

- Requiring that risks (ethical, financial, legal, image, membership, etc.) to the AMA are systematically assessed as new initiatives and major ongoing activities are being considered.
- Ensuring that the AMA has the capacity and a strategically aligned agenda to serve as an effective advocate for physicians and patients.
- Insisting that external and internal stakeholder input is solicited and considered during deliberations over key policy or strategic issues.

Although the Board's responsibilities are spelled out in the Bylaws, the results of the interviews and surveys indicate that responsibilities are not clear in practice. Overlapping responsibilities, particularly with regard to legislative activities and planning, might cause confusion. Furthermore, the Board often focuses on inappropriate issues, and no priorities are established for determining which issues the Board should address. The Board believes that because of its fiduciary responsibility, it must address all issues that are raised.

The Appearance Program and Compensation Plan for the Trustees. The appearance program for the Trustees remains a source of continuing controversy. Although Trustees are firmly committed to an active appearance program, the House of Delegates feels that the responsibilities of the Board, as defined in the Bylaws, are much more important than the appearance program. Indeed more than two-thirds of the delegates surveyed believed that Trustees should spend no more than 40 percent of their time making appearances on behalf of the AMA. The Board in general opposes changes to the appearance program, but a majority of the House of Delegates believes that some of the appearances could be handled by senior staff or others with expert knowledge in a particular area.

Support of Board activities consumes about $4 million of AMA's resources annually. The honoraria and per diem paid to the Board members exceeds $2.3 million annually ($1.4 million honoraria, $932,000 per diem). Travel expenses for Board members and their spouses exceed $1 million annually, with $836,000 attributable to the appearance program. In addition, there are 11 full-time staff members whose sole responsibility is to facilitate Board appearances; their combined salaries total $478,020. Speechwriters, field representatives and other professional staff are assigned to provide support to the traveling Trustee. The Board's current compensation plan, developed and approved by the Board itself, is without parallel in any other national professional association. There is an inherent conflict of interest in having this or any board set its own compensation without review or approval by any other body.

The Board appearance program and the Board's compensation plan have been the subject of much discussion. The appearance program is very expensive and diverts the Trustees from their fiduciary responsibilities. This program places the Board in a vulnerable position for criticism, because the program's value has not been proven. More importantly, the program is not tied in a meaningful way to the Association's strategic plan. The committee makes the following observations and will submit a recommendation to significantly modify this program:

1. Members of the House of Delegates indicated in the survey that they want members of the Board of Trustees to bring the perspective of practicing (working) physicians to the Board.
2. Members of the House of Delegates indicated in the survey that they do not want the position of Trustee to be, in effect, a full time job nor the primary or sole source of income.
3. Delegates surveyed indicate that they expected Trustees to spend less than 40 percent of their time making appearances on behalf of the AMA.
4. The Report of the Ad Hoc Committee to Study the Sunbeam Matter (A-98) states that, "The Board should reconsider the role of Board members in performing representational and ambassadorial work. Much of this work should be done by others whose responsibilities are less critical to the assurance of the fiduciary soundness and integrity of the organization."
5. The Skoglund Report (Report of the Special Committee to Study the Board of Trustees, I-96) envisioned an AMA Board that delegates substantial responsibility for representing the AMA to AMA Councils, delegates, sections, staff and others.
6. Each Trustee presently spends an average of 112 days per year on AMA business. This time commitment makes it very difficult for most Trustees to effectively maintain another occupation.
7. Of the average number of days per Trustee, 19 percent are Board events and 32 percent are AMA events (committee and Council meetings and other AMA sponsored meetings and conferences). The remaining 49 percent are for assignments which are federation related (15%), health organization related (10%), JCAHO participation (10%) and civic/government/media representation (14%).
8. The assignments represented by the 49 percent as well as the category of AMA events can and are performed well by AMA Trustees; but some could also be performed by other representatives of the AMA.

The Chair Succeeding to the Position of President-Elect. It is common AMA practice for the Chair to be elected as President-Elect immediately following his or her term as Chair. Usually this election is uncontested. Continuing this practice has little support in the House (i.e., only 13 percent either agree or strongly agree with this practice). Individual political aspirations may be in conflict with the Chair's fiduciary responsibility to the AMA. Furthermore, this practice appears to be unique to the AMA. The Booz-Allen report found no evidence in the examination of the practices of other associations that they have similar succession practices.

Effective Use of Executive Committee and Intra-Board Committees. The Board does not appropriately use its Executive Committee and other Board committees to assist in its oversight responsibility. The committees should be empowered to provide essential services to the full Board's broader mission and help in the creation of a long term agenda around the integrated strategic plan. These Board committees should actively bring issues to the Board of Trustees. The Executive Committee should be used on an ad hoc basis, as needed, and at the specific direction of the full Board of Trustees. There should not be duplicated or competing agendas between the Executive Committee and the full Board, and most of the activities of the Executive Committee should be handled by conference calls.

Self-Evaluation Program for the Board of Trustees. As an important part of the Board's development process, the Board should establish a self-evaluation program tied to annual goals and known criteria. The Board should obtain outside help in the design of the instrument or process. Also involvement and approval by the House of Delegates should be sought, not from mistrust, but from a need for collaboration and agreement on roles and achievements. The goal of the self-evaluation program would be educational and constructive improvement and would not assess the suitability for re-election. The members of the Board would have the assurance that their performance is in line with the will of the House. This process should include feedback on performance from other parts of the organization. The results would be private and confidential, but the Board should provide an annual report to the House on its accomplishments for the year.

One of the reasons for instituting a self-evaluation process is to restore trust between the Board and the AMA membership. Such a program will also ensure the membership that the Board is concerned that every Board member is doing what they should be doing and doing it well. The current lack of trust is a driving factor in the strong feelings among delegates that Board meetings should be open and votes should be recorded. Our consultants recommended that Board meetings not be open and votes not be recorded, and the Committee supports this recommendation. Your committee found no evidence that publicizing recorded Trustee votes and conducting more open Board meetings would improve the effectiveness of the Board. In addition, the Committee believes such changes would disrupt the Board's consensus approach to decision-making and to its efforts to engage in open and frank deliberations. It is current policy that AMA members who wish to attend a regular meeting of the Board may submit their request to the Chair or the Executive Vice President. Instituting the self-evaluation program will help restore trust in the Board while preserving efforts to encourage more deliberation among the Trustees over critical and often divisive issues.

In the course of its deliberations, the committee looked at other aspects of the Board. It is the committee's opinion that the size and composition of the Board is adequate and does not need to be changed at this time.
The consultants report that internal boards, like the AMA's, are more likely to be politicized than external boards; therefore, our systematic checks and balances are more crucial to the integrity of our Association. The Board is, however, too politicized, with each Trustee planning his or her political future almost immediately after election. This is exemplified by the current need to position oneself to "get in line" early on to move to the Executive Committee and, in succession, become an at-large member, Secretary, Vice Chair, Chair. For years it has been a common practice to designate seating at the Board table based on office held, seniority, and number of votes received in the House election. This practice is antithetical to collegiality and may influence the performance of the Board in carrying out its oversight responsibilities.

The consultants recommended, and the committee considered, the concept of adding a public member to the Board of Trustees. However, the committee questions the timing of such a change and believes it should be formally studied by the Council on Long Range Planning and Development.

The Board needs to focus its time and attention and effectively organize itself to successfully fulfill its mission. It needs to acquire the necessary skills to properly oversee a large membership association. There needs to be a regular program for Board development that educates the members of the Board on how to perform their duties and gives them the needed tools for carrying out their fiduciary responsibilities.

House of Delegates

The roles, responsibilities, and organization of the House of Delegates are defined by ten clauses in the Bylaws, the Constitution, and the AMA Policy Compendium. There is a clearly defined and structured process through which the House sets the AMA's official position on issues. Each delegate has the opportunity to influence policy-making at multiple entry points in the process, including submission of resolutions, open hearings and discussion in Reference Committees, and floor debate.

Staff conducts research and prepares background material for each resolution and briefs Reference Committee Chairs and Trustees assigned to each Reference Committee. Staff also prepares cost estimates for each resolution having a potential financial impact on the AMA. The House may refer items that cannot be resolved by the House to the Board of Trustees for decision or further study. The staff, through the Executive Vice President, under the direction and supervision of the Board, is responsible for implementing policies.

The AMA House of Delegates is a very democratic institution. Any delegate may submit a resolution to be considered by the House of Delegates at its semiannual meeting. The House must consider and discuss all resolutions. Resolutions submitted to the House of Delegates receive only a legal review; no process exists to evaluate the resolutions from the perspective of relevance to the Strategic Plan. The Board of Trustees and the organization as a whole must later address all issues referred to it by the House.

Another issue is the voluminous amount of information processed by the House of Delegates at every meeting. This is largely because the House wants to give every member the opportunity to raise issues for consideration. At the 1998 Annual Meeting, 341 reports and resolutions were considered by the House of Delegates. The Council on Long Range Planning and Development (CLRPD) proposed that the process for handling reports and resolutions be reevaluated because it represents a major expense to the AMA. The House however, is caught in the dilemma of trying to enhance its representativeness by giving any and all members an opportunity to submit resolutions or proposals for discussion and review while assuring that this approach is cost effective in contributing to the policy-making process.

Some issues with respect to the House of Delegates have been brought to the attention of the committee. One is the question of term limits for members of the House to generate more turnover in the delegate population to help assure accurate representation of the constituency. This is an issue that is raised periodically, and

some state medical associations have adopted term limit provisions. Your committee believes that this issue should continue to be handled locally.

While the delegates have every opportunity to shape Association policy, once the meeting concludes the delegates have no defined obligation to advocate the AMA's positions to their constituents. The delegates should take more responsibility for ensuring that policies adopted by the House become known and adhered to by their constituents. Under the present arrangement there is little accountability on the part of delegates to communicate with their constituents and encourage them to embrace policies adopted by the House. The delegates should be more engaged in AMA activities throughout the year, especially those considered strategic imperatives by the AMA. The delegates should also recognize a responsibility to determine what their constituents are thinking and bring those views to the House meetings.

Through the years the House has made a number of procedural changes that are designed to handle an increasing volume of material without diminishing the important democratic tradition enjoyed by the Delegates. Considering the volume of business, the efficiency of the House is most impressive. However, the House must find some way to focus its agenda to become more effective in moving the Association toward achievement of the goals of its Strategic Plan. Some specific topics that need to be addressed are: an examination of the referral process of reports and resolutions to the Board and Councils; whether informational reports can be handled by the House outside the semi-annual meeting; and how resolutions could be encouraged to adhere to an integrated strategic plan before submission to the House for action.

~~The Presidents (President, President-Elect, Immediate Past President)~~

The Constitution and Bylaws vest in the President the following six responsibilities:

1. Serve as the official spokesperson in enunciating and advocating the official policies and positions of the AMA
2. Serve ex-officio as a member of the Board of Trustees
3. When emergency conditions warrant, nominate committees requested by Councils
4. Participate ex-officio, without the right to vote, in sessions of the House of Delegates
5. Address the opening sessions of the annual and interim meetings of the House of Delegates
6. Deliver an inaugural address

In addition, the Rules of the Board authorize the President to serve as the official liaison with other officers of the federation and other organizations. The results of the House survey indicate that delegates believe the President's most important responsibility is to serve as the principal AMA spokesperson. However, Board members expressed support during interviews for engaging the entire Board in active representational roles in the Association's various appearance and meeting opportunities. The committee has concluded that the diversity of issues, coupled

with the volume of official appearances and policy pronouncements, represents a challenge to identify the most appropriate Association spokesperson for each venue. That challenge can only be met if the first selection criterion is expertise in the relevant field. The Association would also be well served by expansion of the spokesperson pool to include Council members, delegates and alternates, section representatives and staff.

The role of the President as chief spokesperson for the AMA is consistent with the practice of most other organizations analyzed in this study. Indeed, in some organizations the President also chairs the Board.

In looking at the role of the President, it is apparent that this valuable resource has not been used to its fullest potential. The AMA President should be a key participant in an energetic communications program and should have additional responsibilities and a broader role in this crucial activity. This increased responsibility and authority requires a vigorous level of understanding of current issues, including regular communications with the Chair of the Board and the Executive Vice President.

A number of important issues regarding the AMA President require the attention of the House of Delegates:

- Although the President should be the principal spokesperson, many others also serve as spokespersons for the AMA. During 1997, the three Presidents (President, Immediate Past President, President-Elect) accounted for only 25 percent of appearances, while the remaining 75% were handled by the Chair and other Trustees. The proper roles of the President and Board Chair require better definition.
- The large number of officers and others representing the AMA, coupled with the heavy volume of appearances, complicates efforts to deliver a consistent, unified message on AMA policy. The case study on the Partial Birth Abortion Ban Act of 1997 noted that the AMA had several spokespersons offering inconsistent and sometimes contradictory statements on the reason for the organization's changed position. AMA's preference to involve all Trustees complicates the organization's efforts to deliver a unified and consistent message to its constituents and stakeholders.
- The election process for the AMA President does not offer adequate assurance that the most suitable candidates are considered for this crucial leadership position. For the most part, officer elections are uncontested, with the Chair or Speaker of the House traditionally chosen to succeed to President-Elect when his/her terms expire. This is inconsistent with the succession practices of other professional membership organizations. Various special AMA committees and Councils examining AMA governance have noted that effective service as either the Chair or the President requires a different set of skills. Although prior Board service is a desirable asset, the succession practice of Chair or Speaker to President-Elect limits the field of candidates for consideration. This automatic succession pattern does not vet candidates against suitable selection criteria to ensure the best-qualified individuals are given the opportunity to serve.

The Councils

The AMA Bylaws describe the functions and membership criteria for seven permanent Councils that advise and recommend on issues and topics considered germane to each Council's specific mission. The Councils are a key element of the governance process. Their reports (in response to a referred resolution, at the Board's request, or self-initiated) often deal with the most substantive and far-reaching policy matters before the House. Council reports are presently submitted to the Board for transmission to the House. Although there is no officially described mechanism for the Board to return, withhold, or alter a Council report, there have been occasions when the Board has assumed this role. Revising the Bylaws to authorize Councils to submit their reports directly to the House, rather than through the Board as currently structured, would enhance the House's deliberative process by removing an unnecessary filter between the Councils and the House. The Board should provide non-binding input to the Councils on their reports.

Councils need to be an integral part of the planning process, with the Board serving as the principal planning agent. There needs to be a formalized and substantive process for providing Council input into the AMA's strategic plan. Councils also need to seek stakeholder input as they set out their own agendas and accomplish their work.

At the 1998 Board of Trustees/All Council meeting, Council representatives conveyed concern about the sheer volume of items referred from the House to the Councils. There are significant resources expended in addressing referred resolutions. Council agendas are packed with referred items, leaving little time, in the view of some, for the discussion of emerging issues. Currently there is no mechanism for Councils to prioritize referred items, as all must be dealt with. The desire for an unlimited participatory democracy needs to be viewed in the light of available resources, time and the organization's strategic priorities.

Corporate Staff and Executive Vice President

The AMA's governance documents and policies provide for an Executive Vice President and generally define the Executive Vice President's role. The Executive Vice President oversees a diverse staff of more than 1200, located in three areas of the United States. The Chicago office houses more than 1000 employees. The Washington office, which is charged with conducting AMA federal and political affairs, has a staff close to 100. In addition, small offices of about 20 employees are located in New Jersey and New York to handle some communications and advertising sales for AMA publications.

The roles and responsibilities of the AMA's Executive Vice President are comparable to the roles and responsibilities of executive directors of similar organizations. The Executive Vice President is charged with "...managing and directing the activities of the Association and performing the duties commonly required of the chief executive officer of a corporation" under the Bylaws of the AMA. The Executive Vice President is a registered lobbyist in Washington, DC.

The AMA staff provides critical support to all facets of AMA governance and decision-making, including the budget and planning cycle. Staff also serves as the "institutional memory" of the AMA to ensure continuity in management and administrative actions aligned with the policies and directives of the House and Board. They provide the critical links between the various governing bodies to ensure coordinated attention to the AMA's principal functions.

The governing leadership views the AMA staff as a valuable asset to the association. The House of Delegates survey shows that the professional staff are regarded as knowledgeable and highly capable. Fifty-nine percent of respondents to the House survey indicated that the appearance program should use expert staff in the future as appropriate for speaking engagements. Sixty-three percent supported having the staff serve on expert panels of non-AMA organizations.

The follow-up questionnaires to formal interviews showed that 70 percent of current and former Trustees believe that staff adequately prepares the Board for its meetings. Many of the staff have been with the AMA for several years; these staff have a detailed understanding of how the AMA processes work.

The staff is also involved in the decision process. Few procedures are in place, however, to help managers and staff distinguish between routine, operational decisions and the more far-reaching policy decisions, or to determine when one type of decision is transitioning to the other. This can result in the wrong expertise being applied to an issue at the wrong time, and may result in an individual not recognizing when an issue should be elevated to more senior management. The case study on E&M Services Guidelines, for instance, revealed how low-profile, low-risk operational decisions of a clinical nature can evolve into high-profile, high-risk policy decisions with significant legal and financial ramifications for virtually all physicians.

With no viable strategic plan in place, staff activities are unfocused, which leads to overload and staff burnout. Multiple groups, organizations, and staff often have similar overlapping responsibilities for issues and activities, resulting in blurred roles and responsibilities. The staff tends to view issues in an insular manner with little cross-communication. The staff needs a better and broader view and to be better informed about activities in other areas. Unclear and/or fragmented lines of authority and accountability increase the risk that important decisions reached without sufficient oversight could severely damage the AMA's reputation and finances.

Two significant issues related to the staff emerged in this study:

- Significant differences exist between the Board leadership and staff perceptions of how effectively the AMA governs itself. Interviews with trustees and key staff and follow up questionnaires revealed widely divergent assessments of AMA Board meeting effectiveness. According to questionnaire data, Board members and staff members disagree whether Board meetings are effective. The interview questionnaire data also show that the staff members believe that long-range objectives at the AMA are often sacrificed because of an over-emphasis

on short-term results. It is interesting to note that the Council Chairs share the viewpoints of the staff more often than that of the Board.

- The staff indicates that communication is a major source of problems at the AMA. Interviews and follow-up questionnaires show that Board, Council Chairs, and staff agree that communication problems exist. According to the questionnaire data, 58 percent of the staff indicate that the Board and staff do not communicate well with one another. Only 26 percent of respondents overall indicate that Board-staff communication is good. The E&M Case Study illustrates communications problems that led to a major crisis for the AMA.

RECOMMENDATIONS

The Ad Hoc Committee on Structure, Governance, and Operations recommends that the following recommendations be adopted in lieu of Resolution 604 (I-97) and Resolutions 4, 9, and 610 (A-98) and that the remainder of the report be filed:

Strategic Plan

1. That the AMA adopt an integrated strategic planning process led by the Board and the Executive Vice President to include the following elements:

- Input of all organizational components (House of Delegates, Councils, Board of Trustees, Executive Vice President, staff).
- A five-year plan identifying the most critical strategic issues for the organization
- The critical success factors for each issue
- An annual work plan with measurable performance objectives, tasks and timelines, assignments for implementation, and expected outcomes. For example, What are five things that the AMA wants to accomplish in a one-year period?

2. That the Board of Trustees ensure that adequate resources – staff, funding, and material – are available for developing the integrated strategic plan.

3. That the AMA integrated planning process consist of the following multi-step, 18-month process, requiring the participation of the House and its Councils, the Board and its committees, and the Executive Vice President and AMA staff:

Step 1: The Council on Long Range Planning and Development should develop a detailed, integrated process for determining the AMA's strategic priorities. The Council should (a) gather and analyze input from other Councils, the House of Delegates, and other appropriate internal and external sources on the AMA's near- and long-term strategic issues, (b) begin the prioritization process, and (c) forward these to the Board of Trustees between the Annual and Interim Meetings.

Step 2: Based on the input and analysis from the CLRPD, the Board of Trustees establishes strategic priorities and forwards them to the House for approval.

Step 3: At its Interim Meeting, the House approves strategic priorities for the AMA and directs the Board to provide a strategic plan.

Step 4: Based on direction from the Board, the Executive Vice President with assistance from the staff should prepare the Strategic Plan and submit it to the Board.

Step 5: During its annual planning retreat, the Board should evaluate the Strategic Plan.

Step 6: The Board should approve the Strategic Plan and forward it to Reference Committee F of the House for comment and recommendations.

Step 7: The House should approve the Strategic Plan at its Annual Meeting.

Step 8: The Executive Vice President, with assistance from the staff, should develop the annual work plan and the budget.

Step 9: The Board should approve the budget.

Step 10: The Executive Vice President, with assistance from the staff, should drive the execution of the work plan and the budget.

Step 11: The Board, as part of its fiduciary responsibilities, should monitor and track progress against the Strategic Plan and report such to the House of Delegates for evaluation.

In addition, the goals of the Strategic Plan should become an overarching part of all Board and Council meetings. All ongoing initiatives and new undertakings must be regularly measured against the Plan, and emerging issues that impact the Plan should be identified.

Risk Management

4. That the Board of Trustees and the Executive Vice President develop and implement a risk management program that will position the association to prevent crises and to respond effectively when needed. The Board of Trustees will have responsibility for risk management, with its Audit Committee driving and exercising oversight over the risk management function. The Executive Vice President should create a staff risk management unit and hire a risk management manager who reports directly to the Executive Vice President. The Executive Vice President in turn reports to the Audit Committee on risk management issues. The risk management capability should (a) involve the continuous assessment of environmental and internal risk factors by the Board of Trustees and its committees, the Councils and staff; (b) establish a common understanding of what issues should be brought to the Board; and (c) provide for appropriate risk management training of the staff.

Board of Trustees

5. That the Board of Trustees, with the concurrence of the House, better define its role using an agreed-upon set of fiduciary priorities in an effective oversight mode. In addition to the financial and legal responsibilities typically assumed by a Board, the House should prescribe the following additional fiduciary responsibilities to the Board: risk management, policy integration, stakeholder involvement, advocacy, communications, strategic planning,

6. That the Board of Trustees, through revision of its Standing Rules, redefine the mission, composition, and responsibilities of its standing committees so that they can execute against the integrated strategic plan and provide appropriate Board oversight of AMA activities. Specifically, the committees should become especially active in areas of substantial risk (i.e., ethical, financial, legal, image, membership, etc.) to the Association.

7. That the Board of Trustees expand the charge to its Audit Committee to accurately reflect the committee's appropriate role, including such duties as (a) responsibility for monitoring the financial, economic, legal, and operating risk characteristics of the AMA, (b) conducting the Board's annual self-evaluation program, and (c) evaluating the quality of the internal control structure by having the internal auditors report directly to the Audit Committee.

8. That a new process be established, through the Audit Committee, to provide for the ongoing and regular review of Board expenses by the external auditor reporting directly to the Audit Committee.

9. That the Executive Committee of the Board become a more active body, addressing issues that arise between regularly scheduled Board meetings. The Standing Rules should be amended (a) to define the Executive Committee as serving on an ad hoc basis at the specific direction of the full Board of Trustees, and (b) to indicate that Executive Committee meetings should generally be held by conference call.

10. That the Board of Trustees develop its own annual plan to guide its agenda-setting process to include the following key elements:

- The agenda should span multiple meetings to ensure that the various phases of planning, implementation, and mid-course correction receive appropriate attention for those initiatives considered vital to the Board's strategic priorities.
- The Board should actively seek input from AMA internal stakeholders, such as other medical organizations considered part of the federation of medicine, in defining the Board's longer-range agenda.
- The Board should develop its own annual work plan during its yearly planning retreat and should consider revisions to that plan during each subsequent Board meeting.
- All Board members should have the opportunity to participate in the agenda-setting process.

- The material supplied to the Board during meetings must explicitly show how these matters relate to the strategic imperatives of the AMA
- Each standing committee of the Board should develop its annual plan with progress presentations as standard items for the Board agenda/meetings.
- The Board should submit an annual report to the House of Delegates on its accomplishments.

11. That the Board of Trustees obtain external expert advice and input from others in the organization (Council Chairs, Delegates, Executive Vice President) to assist in the design of a self-evaluation instrument to annually measure the Board's effectiveness and to encourage more accountability. Recognizing that the primary purpose of these evaluations is to help the Board and its members improve their performance, this self-evaluation instrument should include the following elements:

- These self-evaluations should be for the Board as a whole and then individually for each Trustee.
- To maintain control and confidentiality, the Audit Committee of the Board should conduct the evaluations.
- An assessment of how well the Board and its members accomplished the initiatives stated in their own annual work plan
- An assessment of the extent to which the Board and its members exerted a positive influence on the key measures of success that should be defined in the AMA's strategic plan
- An assessment of the effectiveness of the Board and its members' approach to governance and decision making.
- The design of the self-evaluation should be approved by the House.
- The House should receive regular reports of the nature and frequency of these self-evaluations, but the results should be held confidentially by the Board to encourage more accurate responses by the participants.
- In conducting these self-evaluations the Board should seek feedback from the AMA's internal stakeholders and other elements of the organization, including staff.
- Where the evaluation identifies individual performance deficits, the Board should initiate follow-up training tailored to specific needs.

12. That the Board of Trustees commit itself to an ongoing Board Development Program, specifically tailored to the AMA's needs, to provide continuing education in the skills and knowledge essential for successfully meeting its fiduciary responsibilities.

13. That the Speaker and the President immediately establish a committee of the House of Delegates to evaluate the structure and amount of compensation for the Board of Trustees. This committee will act in lieu of the Board Compensation Committee and will make recommendations on an annual basis for approval by the House of Delegates.

14. That the Bylaws be amended to clarify the Board's responsibility as one of oversight, with the Board referring all operational business matters (employee issues, contracting, facility issues, internal communications, etc.) of the AMA to the

Executive Vice President. The Standing Rules of the Board, as well as the Chair's leadership, should also reflect the Board's principal role as one of oversight and not day-to-day management of the AMA's affairs. In addition to financial oversight, the Board's oversight role should include:

- Ensuring that an effective strategic planning process is in place, and that resources are properly prioritized and allocated to accomplish the mission, goals and objectives of the AMA
- Monitoring progress in achieving these objectives through an effective performance measurement and tracking system
- Requiring that risks (ethical, financial, legal, image, membership, etc.) to the AMA are systematically assessed for both major ongoing activities as well as new initiatives under consideration
- Ensuring that the AMA has the capacity and a strategically aligned agenda to serve as an effective advocate for physicians and patients
- Insisting that external and internal stakeholder input is solicited and considered during deliberations over key policy or strategic issues.

15. That the Bylaws be amended to include a Chair and Chair-elect as officers of the Board. Each would be limited to a single one-year term, with the Chair-elect automatically succeeding to Chair upon completion of his or her Chair-elect term.

16. That the Bylaws be amended to preclude the Chair of the Board of Trustees from immediately succeeding to the position of President-Elect.

17. That the Bylaws be amended to provide that no AMA Officer or Trustee shall be eligible to serve as Executive Vice President within three years of leaving office.

18. That the AMA President be included in an established process of regular consultation with the Chair of the Board of Trustees and the Executive Vice President regarding ongoing activities of the Association.

19. That the majority of appearances be undertaken by the Presidents (President, Immediate Past President, President-Elect) as the Association's primary spokespersons.

20. That the Board of Trustees change its Appearance Program so that control over appearances by Trustees and other officers is transferred to the President (in his or her role as the Association's primary spokesperson) who shall have the following specific responsibilities:

- Assigning Trustees to appearances. However, the authority to appoint Board members to standing Board assignments (e.g. JCAHO Commissioners, Advisory Council of the National Business Coalition on Health, National Committee on Quality Assurance, National Patient Safety Foundation, etc.) shall remain with the Chair of the Board.
- Obtaining external independent expertise in determining the value of the appearance program and in establishing criteria for assessing the value of an

appearance relative to achievement of objectives identified in the AMA strategic plan.

- Reducing the average number of days worked by Trustees, Speaker and Vice Speaker for the AMA by 40 percent over the next four years (at least 10% a year) to make it more likely that Trustees can preserve their primary occupation, continue to work as physicians, and, therefore, continue to bring that perspective to the deliberations of the Board.
- Accomplishing the reduction of the average number of days worked by Trustees by recruiting other representatives of the AMA (Council members, corporate staff, and others as appropriate) to represent the Association.
- Reporting annually to the House the status of progress toward this goal.
- Presenting a report to the House, at the 2002 Interim Meeting, assessing the impact of this initiative.

House of Delegates

21. That the Speaker of the House of Delegates initiate an evaluation of the functioning of the House of Delegates and make recommendations for improvement, particularly in handling the large volume of business before the House and focusing the agenda of the House to allow it to be more effective in integrating its work with the AMA's strategic plan.

22. That the House of Delegates hold the Board of Trustees accountable for the proper oversight of the AMA, but not through (a) the recording and publication of individual votes on matters before the Board, or (b) open meetings because neither will enhance the Board's deliberations and may hinder the Board's decision-making process.

23. That the Board of Trustees and Executive Vice President be evaluated against how well they performed based on the AMA Strategic Plan.

24. That members of the House of Delegates recognize a responsibility to communicate with their constituents and solicit their views on the important issues affecting the medical profession.

Councils

25. That the Bylaws be amended to provide that Council reports are submitted directly to the House, and that Board comments regarding Council reports should be considered by the Councils, but are not binding.

26. That the Councils actively seek stakeholder input into all items of business.

27. That the Councils provide input, in the areas of their specific expertise, into the Board's strategic planning process.

28. That a mechanism be crafted by the Council on Long Range Planning and Development, and be presented for consideration, that would allow prioritization of

items referred by the House of Delegates consistent with the strategic priorities of the AMA and mindful of available resources.

Communications

29. That the Board of Trustees direct the Executive Vice President to conduct a comprehensive communications review and develop a communications plan to identify strategies and systems to support the AMA vision and strategic plan. The following issues must be addressed:

- Analyzing internal and external communications processes; horizontal and vertical communication processes; and uni-directional and bi-directional communications processes
- Reviewing the operations of the division of communication, its management, and the mechanisms it employs for communication
- Evaluating the effectiveness of communication among staff units
- Evaluating the effectiveness of current communication vehicles (website, American Medical News, internal newsletters, etc.) for conveying the AMA message
- Enhancing our current communication vehicles to (a) solicit stakeholder feedback about the AMA and its activities and (b) obtain constituent feedback on satisfaction with the AMA, its mission and strategy, and performance against that strategy.
- Defining specific strategies to emphasize the needs, opinions, and interests of the AMA's stakeholders in order to create coalitions for the AMA.
- Designating a single individual to communicate with external stakeholders on any given issue. This person should be the AMA President as often as possible, supported by a designated staff member.

Corporate Staff and Executive Vice President

30. That the Executive Vice President clearly define and regularly evaluate roles and accountability of the corporate staff in adhering to clear guidelines on the limits of their decision-making authority and where to turn when confronted with issues beyond their scope of action:

- The Executive Vice President should work with staff, the Board and the House to establish guidelines that differentiate between operational and policy issues, and identify to whom the staff should turn when they believe they are confronting an issue with policy implications.
- These guidelines should be included both in the employee manual and a Board of Trustees Handbook
- These guidelines should be annually reviewed and updated, with the Executive Vice President leading the revision process
- Objectives in the performance appraisals of senior managers should be refocused to align with the AMA vision and bonus criteria should also be linked to the vision and the strategic plan.
- Managers need to supervise work groups by establishing clear, measurable performance objectives and tasks for all staff and hold staff accountable.

31. That the Board of Trustees require the Executive Vice President to evaluate staff structure and to audit resources to ensure that the AMA is supported efficiently and effectively consistent with the Strategic Plan approved by the House of Delegates. As part of the evaluation of staff structure, the Executive Vice President should examine the AMA's member services strategy to ensure that the structure facilitates responsive and accurate responses to member queries.

32. That the AMA take better advantage of its staff capabilities to include staff participation in the appearance program, serving on non-AMA panels, and fostering cooperative working relationships with other organizations that share common objectives.

33. That the Bylaws be amended (a) to clearly describe the roles and responsibilities of the Executive Vice President as well as his or her reporting arrangement, (b) to explicitly charge the Executive Vice President with managing the AMA staff, not just AMA activities, (c) to charge the Executive Vice President with being an active leader in Washington for legislative activities, and (d) to clarify that these are not responsibilities of the Board or the Chair of the Board.

Other

34. That the Council on Constitution and Bylaws and the Council on Long Range Planning and Development comprehensively review the Bylaws and other policies and procedures and make recommendations in a joint report, which would provide clearer and more distinct descriptions of various governing bodies and roles of AMA officers.

35. That the Council on Long Range Planning and Development study the issue of whether adding a public member to the Board of Trustees would be beneficial to the governance of the AMA.

36. That the Board of Trustees provide a separate section for governance policies in the AMA Policy Compendium.

CONCLUDING COMMENTS

The Ad Hoc Committee on Structure, Governance and Operations thanks all who participated in this far-reaching study. From its first meeting, your committee observed that the AMA's recent events provided an opportunity to re-evaluate some of the basic premises of the organization and operations of AMA's governing bodies. Your committee hopes that its findings and recommendations will give the House of Delegates some practical strategies toward remodeling the American Medical Association into a more vibrant, focused and effective organization that is valued by its members and the American public. The committee also thanks the Speaker and the House for the opportunity to serve the Association in this way.

Booz-Allen & Hamilton, Management Audit of the American Medical Association Decision-Making Processes

Prepared for Ad Hoc Committee on Structure, Governance, and Operations, Final Report Vol. II, App. D (Case Study: Decision-Making Processes on The American Medical Association's Support of "The Partial-Birth Abortion Ban Act of 1997")

Oct. 13, 1998

FINAL REPORT
VOLUME II
Appendixes

Prepared for
Ad Hoc Committee on Structure,
Governance, and Operations

Management Audit
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Management Audit of the
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CASE STUDY: DECISION-MAKING PROCESSES ON THE AMERICAN MEDICAL ASSOCIATION'S SUPPORT OF "THE PARTIAL-BIRTH ABORTION BAN ACT OF 1997"

Foreword

On May 19, 1997, the American Medical Association unexpectedly announced its support of H.R. 1122, the "Partial-Birth Abortion Ban Act of 1997." This decision was made just one month before the AMA House of Delegates was to convene for its annual meeting. In its decision to support the ban, the AMA took its first position on an abortion bill.[1] Furthermore, the AMA's support of the bill represented only the second time that the AMA had supported legislation that would criminalize a medical procedure.[2] By announcing its position, the AMA broke ranks with other professional medical societies. The American College of Obstetricians and Gynecologists, the American Medical Women's Association, and the American Nurses Association all opposed the ban.

Almost immediately, congressional watchdogs and journalists criticized the AMA and claimed that the AMA's decision was mired in Medicare politics. On the same the day that the AMA announced its support of the ban, the AMA sent Congress a letter detailing its position on anticipated Medicare budget cuts. In its published response to the *New York Times*, dated May 30, 1997, the AMA countered these criticisms stating, "AMA's congressional advocacy is derived exclusively from the profession's values, especially the patient-physician relationship."[3]

Soon thereafter, President Clinton vetoed the bill, and the Senate was unable to garner enough votes to override the veto. As a result, this highly controversial issue was relegated to the back burner.

The following case study examines the decision-making processes surrounding the AMA's decision to announce its support of H.R. 1122. It discusses the history of the AMA's position on abortion legislation, the internal and external environments, and the events leading up to the AMA's announcement in May 1997. The case will focus on the role of policies and procedures in guiding decision-making, especially as they pertain to roles and responsibilities, structure and governance, accountability, stakeholder input, and communication.

Background

For years, the AMA maintained a position of neutrality on the issue of abortion, stating, "The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures."[4] The AMA's original 1977 stance on this issue was: "The Principles of Medical Ethics of the AMA do

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1 Although the AMA had taken positions that included language related to abortion, for example, on cutting Medicaid coverage of abortions; however, this was the first time that the AMA took a position directly in support of or in opposition to abortion itself.

2 The AMA had taken a position to oppose "genital mutilation" of women.

3 "Partial Birth Abortion Ban Act of 1997" (letter from P. John Seward, Executive Vice President, American Medical Association, to the New York Times, regarding AMA support of H.R. 1122).

4 "Policy on Abortion," H-5.990.

not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law."[5]

During the late 1980s and early 1990s, the AMA consistently supported patient-physician rights regarding the abortion issue. In 1989, the AMA stated, "...The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities."[6] In 1991, the AMA voiced strong objections to the so-called "Gag Rule," which would have prohibited medical professionals at Title X clinics from counseling, advising, or providing information about abortion and from referring women to health care facilities that offered abortion counseling or services. In its response to the "Gag Rule," the AMA House stated, "It is the policy of the AMA to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient."[7] In 1992, the AMA opposed mandatory parental consent to abortion, stating, "The patient—even an adolescent—generally must decide whether, on balance, parental involvement is appropriate."[8]

Partial Birth Abortion Legislation

During the mid-1990s, the AMA House of Delegates voted to reaffirm many of its positions on abortion. Meanwhile, there was a resurgence of attention on the abortion issue at the national level. In 1995, the debate focused on a rarely used procedure sometimes referred to as "partial birth abortion." The Republican-controlled U.S. House of Representatives had developed legislation, H.R. 1833, to ban the procedure. The "Partial-Birth Abortion Ban Act of 1995," which had been introduced by Representative Charles Canady (R-FL), defined the "partial birth abortion" procedure as "an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery." The bill would have made it a felony for any physician to perform the procedure. A physician performing the procedure would had been subject to criminal fines and up to 2 years in prison. In addition, the father, and if the mother was a minor, the maternal grandparents, would have been able to sue the physician for civil monetary and statutory damages. The only exception to the ban would have been "when such an abortion is necessary to save the life of a mother endangered by a physical disorder, illness, or injury, provided that no other medical procedure would suffice."[9]

By September 1995, the AMA's Washington Office had flagged the partial birth abortion issue and asked the AMA's Council on Legislation to review Representative Canady's bill. The Council on Legislation, deliberated on the issue in September. In its attempt to "review

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5 "Abortion," E-2.01.

6 "Right to Privacy in Termination of Pregnancy," H-5.993.

7 "Freedom of Communication Between Physicians and Patients," H-5.989.

8 "Mandatory Parental Consent to Abortion," H-5.984.

9 H.R. 1833, U.S. House of Representatives

proposed federal legislation and recommend appropriate action" in accordance with AMA policy,[10] the Council submitted the following statement and recommendation to the Board in October.

> "The Council had an extensive discussion about this bill and agreed that this was an extremely rare and controversial procedure that should not be condoned if performed as defined in the bill... The Council is cognizant of concerns that passage of this bill could be considered as legislative interference with the practice of medicine and be used as a way of limiting the right of abortion. However, as long as the legislation is crafted as a narrow mechanism to deter a single procedure that is so far afield from what is acceptable medical practice, the Council agreed to support H.R. 1833. However, any attempt to expand criminalization of abortions or other medical procedures beyond this particular procedure would not be acceptable and the Council would recommend opposition to any such expansion." [11]

Through means that are not clearly understood, a copy of the Council report was leaked to the public before the AMA Board had an opportunity to review and deliberate on it. As a result, AMA's official position was prejudged by the public and medical community as supporting H.R. 1833. A public letter writing campaign, both in favor of and in opposition to the AMA's position, ensued. When the Board did deliberate on the report, in October 1995, the AMA Board of Trustees voted to retain the AMA's stance of neutrality and decided to neither support nor oppose H.R. 1833.

On November 1, 1995, H.R. 1833 was passed in the U.S. House of Representatives by a vote of 288-139. Later that month, the American College of Obstetricians and Gynecologists (ACOG) became the first medical society to oppose the legislation. In its announcement, ACOG condemned Congress, saying, "The College finds it very disturbing that any action by Congress [that] would supersede the medical judgment of trained physicians and [that] would criminalize medical procedures that may be necessary to save the life of a woman. Moreover, in defining what medical procedures doctors may or may not perform, the bill employs terminology that is not even recognized in the medical community—demonstrating why Congressional opinion should never be substituted for professional medical judgement."[12]

On December 7, an amended version of the bill was passed in the Senate by a vote of 54-44. Though these votes represented a victory of sorts to the "pro-life" forces in Congress, those sponsoring the "Partial-Birth Abortion Ban Act of 1995" in the Senate were unable to garner the two-thirds majority required to override a presidential veto. President Clinton had warned the Congress that he intended to veto the measure unless it included a provision that would permit the "partial birth abortion" to protect the *health* of the woman. On April 19, 1996, President Clinton vetoed the bill as promised.

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10 AMA Bylaws B-6.6011 on the Council on Legislation.

11 "Supplemental Report of the Council on Legislation Meeting of September 22-24, 1995," (memorandum from Roy Skoglund to the AMA Board of Trustees, October 1995).

12 American College of Obstetricians and Gynecologists, Statement on HR 1833, November 1, 1995.

During the December 1996 AMA House of Delegates Interim Meeting, the House reaffirmed a number of its positions on abortion, including its policies on "Policy on Abortion," "Right to Privacy in Termination of Pregnancy," and "Abortion." The House also referred the matter to the AMA Board of Trustees, requesting it to undertake a "study of late-term pregnancy termination techniques and circumstances to ensure that they conform to the standards of good medical practice." Furthermore, the House resolved that the AMA would work with pertinent medical specialty organizations to develop clinical practice guidelines appropriate for late-term pregnancy termination.[13]

In response to that request, the AMA convened a study group comprised of one representative from each of the following physician groups: the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Family Physicians (AAFP), the American Academy of Pediatricians (AAP), the AMA Council on Scientific Affairs, the AMA Council on Legislation, the AMA Council on Medical Education, and the AMA Council on Ethical and Judicial Affairs. In addition, a representative from the Illinois State Medical Society, which introduced the original Resolution 225, and from the Pennsylvania Medical Society, which introduced the original Resolution 208, participated in the study group.

The report that emerged from this study group, *Report 26 of the Board of Trustees (A-97) on Late-Term Pregnancy Termination Techniques*, was written primarily by three AMA staff members. The Board of Trustees decided that the principal author on the report would be from AMA's science area. Therefore, a staff representative from the Office of Scientific Affairs wrote the bulk of the report, while representatives from the Offices of Legislative Affairs and the Council on Ethics and Judiciary Affairs made significant contributions in their respective areas of expertise. The report contained six sections.

- A review of the data available on abortion and later-term abortion.
- ~~Definitions of the types of abortions performed at different stages of~~ pregnancy.
- A review of complications and sequelae related to abortion.
- A discussion of the legal context of medical decision-making regarding abortion.
- A description of policies of major medical societies on late-term abortion.
- An overview of ethical considerations related to abortion, in general, and with respect to gestational age, specifically.

The scientific section of the report consisted of sections 1-3 and 5. The report pointed out the lack of clarity in the House of Delegate's Substitute Resolution 208. Specifically, the report asked whether the term that the House used, "late-term pregnancy termination techniques," was intended to include only third trimester procedures or any post-viability procedures in the study.

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13 Sub. Res. 208 (I-96).

The report's most salient points of the scientific sections of the report included the following:

- There is an overall lack of useful data on later-term abortion and related maternal morbidity.
- Some procedures used to induce abortion prior to viability are the same or similar to procedures used to induce abortion after the fetus has become viable.
- "Viability," defined by the U.S. Supreme Court as "the capacity for meaningful life outside the womb, albeit with artificial aid," varies by individual fetus.
- Before 20 weeks of age, the fetus is not viable. After 27 weeks of age, the fetus is viable. The period between 20 and 27 weeks constitutes a "gray zone."
- "Dilatation and evacuation" (D&E) and "dilatation and extraction" (D&X) are two similar labor induction methods that are used during second- and third-trimester of pregnancy.[14]
- The distinction between the two procedures has not been recognized universally. In fact, the organization collecting the most reliable information on abortion classifies both types of abortion as D&E.
- There are no disaggregated data on the prevalence or maternal morbidity rate of D&X.
- Risk of complications is correlated with the abortion method used.
- Risk of complications associated with D&E procedures was lower than those associated with other procedures used to induce abortion during the mid-second and third trimesters of pregnancy.[15]

14 "Dilatation and evacuation" refers generically to transcervical procedures performed at 13 weeks gestation or later. D&E is similar to vacuum aspiration (the most common procedure used to induce abortion in the first trimester) except that the cervix must be dilated more widely because surgical instruments are used to remove larger pieces of tissue. When used as a mid-second-trimester or third-trimester procedure, D&E may require dismemberment. Some physicians use intrafetal potassium chloride or digoxin to induce fetal demise prior to a late D&E, to facilitate evacuation. The walls of the uterus are scraped with a curette to ensure that no tissue remains. (Source: Board of Trustees Report 26-A-97) According to the American College of Obstetricians and Gynecologists, "dilatation and extraction" refers to a specific procedure that contains the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus. (Source: Board of Trustees Report 26-A-97, which sites American College of Obstetricians and Gynecologists, Statement on Intact Dilatation and Extraction, January 1997.)

15 "Late-Term Pregnancy Termination Techniques," Board of Trustees Report 26-A-97.

At the February 1997 Board meeting in Arizona, the Board voted to convene a smaller study group to review the report and make suggestions on the content. At this point, the report did not include any recommendations. The small (second) study group consisted of representatives from the ACOG, AAP, the delegation from Pennsylvania, the delegation from Illinois, the Board of Trustees, the Council on Legislation, and the Office of Scientific Affairs.

In the meantime, Representative Canady (R-FL) reintroduced the bill as H.R. 1122. H.R. 1122 was nearly identical to the original 1995 bill. On March 20, 1997, the measure passed the House by a vote of 295-136 and was placed on the Senate Legislative Calendar.

This AMA Board appointed study group met on April 6, 1997 in Chicago to discuss the draft report on late-term pregnancy termination techniques. The group decided to accept the science component in its entirety and request revisions for the component on ethics. One member of the group drafted an initial set of recommendations, which became the foundation for the final recommendations. Ultimately, the report included the following recommendations:

- The American Medical Association reaffirms current policy regarding abortion.
- The term, "partial birth abortion" is not a medical term. Therefore, it will not be used by the AMA.
- According to the scientific literature, there does not appear to be any identifiable situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment.
- ~~It is the physician who should determine the viability of a specific fetus.~~
- In recognition of the constitutional principles articulated in *Roe v. Wade*, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life.
- The AMA will work with the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics to develop clinical guidelines for induced abortion after the 22nd week of gestation. The guidelines should be evidence-based and patient-focused.
- The American Medical Association urges the Centers for Disease Control and Prevention as well as state health department officials to develop expanded, ongoing surveillance systems of induced labor. This would include but not be limited to a more detailed breakdown of:

  1) the prevalence of abortion by gestational age,
  2) the type of procedure used to induce abortion at each gestational age,
  3) maternal and fetal indications for the procedure,
  4) abortion-related maternal morbidity and mortality statistics, and
  5) type and severity of both short-and long-term complications.

- The AMA will work with appropriate medical specialty societies, government agencies, private foundations, and other interested groups to educate the public regarding pregnancy prevention strategies, with special attention to at-risk populations, which would minimize or preclude the need for abortions.[16]

During its April 14-17, 1997 Board meeting, the Board reviewed the proposed report on late term pregnancy termination. During this meeting, the Board voted to pursue two tracks. On one track, the Board approved the written report (Report 26 of the Board of Trustees (A-97)) and agreed that it would be submitted to the House of Delegates for consideration during the June House of Delegates Annual Meeting. On the other track, the Board decided to form a subcommittee comprised of representatives from the Board, the Council on Legislation, and staff. The subcommittee would be charged with reviewing all of the information available related to H.R. 1122 so that the AMA could "reevaluate" the report and develop a response to the pending partial abortion legislation. The Board agreed to follow up on the issue via telephone conference following the subcommittee's deliberations.[17]

The Board's authority to take a position on H.R. 1122 was sanctioned by H-535.995, *AMA Policy Actions*, which states,

> "In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy."[18]

The policy further states, "Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation."[19]

From late April to late May 1997, the partial birth abortion issue became the most urgent issue on the Board's agenda, calling for a flurry of communications including six morning telephone conferences and numerous other phone conversations among and between Board members, AMA staff, and senior Republican U.S. Congressmen.

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16 "Late-Term Pregnancy Termination Techniques," Report of the Board of Trustees, 26-A-97. For a complete text of the recommendations, see Appendix D.

17 Minutes from the AMA Board of Trustees Meeting (April 14-17, 1997).

18 BOT Rep. FF, A-79; Reaffirmed: CLRPD Rep. B, I-89; CLRPD Rep. I-93-2.

19 *Ibid.*

On Friday, April 25, the AMA Board and senior AMA staff engaged in the first telephone conference meeting on the partial birth abortion issue. During the April 25 meeting, the subcommittee reported that it had engaged in a number of conference calls, and during one of those calls, it had given the ACOG an opportunity to present its views on the legislation. The general consensus among Board members was that the pending legislation (H.R. 1122) was poorly written; the bill's vague language made it unclear what procedure the bill addressed. Moreover, Board members expressed concern about components of the bill that would incriminate physicians and undermine physicians' medical judgment. Prior to the meeting, the subcommittee, with help from the AMA Council on Legislation, had drafted suggested amendments to H.R. 1122 and criteria that the bill would have to meet in order to be acceptable to the AMA. These comments were circulated to members of the Board prior to the meeting. The subcommittee noted the following specific problems with the bill and proffered the following recommendations:

- The bill would place adjudication and enforcement within the criminal justice system, undermining the medical judgment required to evaluate circumstances surrounding the performance of the procedure. Therefore, the subcommittee recommended that oversight and enforcement be established through the state medical licensing boards.
- The term, "partial birth abortion," used in the bill to define the prohibited conduct, is not a recognized medical term and is not sufficiently defined to avoid confusion with other procedures.
- The bill prohibits the act without regard to whether it relates to induced or spontaneous abortions.
- The bill does not recognize that the physician must retain the discretion to make the judgment in the best interests of the patient.[20]

At the close of the April 25 meeting, the Board voted to oppose H.R. 1122 as drafted, but to retain its public stance of neutrality by stating that the AMA was still reviewing and considering the language of the bill. The Board also voted to "advise the Senate sponsors that, in order for the AMA to not publicly oppose H.R. 1122, modifications in the bill related to the four problem areas must be made."[21]

Originally, the AMA intended to give Senator Santorum and the congressional leadership one week to respond to the AMA's letter. However, one week passed, and the congressmen did not respond. Throughout the remainder of the negotiation process, the AMA continued to communicate with its contacts in Congress and request a response within a week; however, the congressmen rarely responded within the desired time frame.

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20 Minutes from the AMA Board of Trustees Telephone Conference (April 25, 1997).
21 *Ibid.*

On May 2, 1997, the Board and senior AMA staff reconvened for a second 9:00 a.m. telephone conference call. During this meeting, the Board focused two issues that they perceived to be the major problems with the bill: poor definitions and the criminalization of physicians. During this meeting, the Board also heard a report from the AMA Washington Office on activities related to H.R. 1122. The Washington Office informed the Board that there might be a window of opportunity within the following days to effect changes in the bill's language. To take advantage of this opportunity, the Board voted to authorize two of its members to negotiate directly with "the H.R. sponsors and Congressional leadership on language according to Board consensus which is that the AMA could support the prohibition on "partial birth abortion" if it is defined as intact dilitation (*sic.*) and extraction or D&X and if a medical board plays a significant role in the penalty process."[22] The decision to authorize two Board members to negotiate directly with members of Congress was unusual; however, the decision was in accordance with AMA policy. According to AMA Bylaw B5.4, the Board is authorized to "perform all acts and transact all business for or in behalf of the Association."[23]

The following week, the designated AMA Board member negotiators and the AMA Executive Vice President held a conference call with Representative Canady and Senator Santorum to lobby for changes to the bill's language. The congressmen indicated that the bill would probably not come to the Senate floor until the following week, and they agreed to take the AMA's message back to congressional leaders. Finally, the congressmen requested to view a copy of the AMA's "scientific report" on late term-pregnancy termination techniques. Although the AMA representatives were willing to share the report with the congressmen, they did not believe that it was appropriate for the report to be shared with the congressmen before it was transmitted to the AMA House of Delegates.

The following Friday, on May 9, the entire Board met for a third telephone conference call on H.R. 1122. During that meeting, the Board voted "to mail the delegates and alternative delegates ~~a copy of the report, 'Late-Term Pregnancy Termination Techniques' with communication from~~ the Speaker and a memo from the Board Chair outlining the criteria being used by the Board for AMA support of any legislation impacting medical decision-making."[24] During the telephone conference, the Board also decided to fax communications to the Federation leadership the following Monday and provide copies to the press as well as to Congress.

On Thursday, May 15, the Executive Committee of the Board and five members of senior AMA staff convened for a fourth morning telephone conference call on H.R. 1122. The Executive Vice President reported that the Board Chair had been engaged in 11th hour negotiations with congressional leaders on H.R. 1122. During the meeting, the Executive Committee members were informed that the Senate was in the process of debating the Feinstein Amendment and the Daschle Bill; however, the Board did not devote much time discussing these other pieces of proposed legislation related to the issue of partial birth abortion.

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22 Minutes from the AMA Board of Trustees Telephone Conference (April 25, 1997).

23 AMA Bylaws, B-5.40 on Duties and Privileges of the Board of Trustees.

24 Minutes from the AMA Board of Trustees Telephone Conference (May 9, 1997).

The Board meeting attendees noted that there had been "enormous improvement in the language of H.R. 1122, including: (1) deletion of no other procedure language, covering the life of the mother, and (2) inclusion of the state medical board making an expert decision as to whether the physician made the best judgment."[25] Interestingly, the latter change in the bill's language did not actually meet the criteria established by the subcommittee prior to the April 25 meeting. The bill's language permitted an indicted physician to stand before a state medical board; however, a criminal court would still make the final determination of guilt or innocence. Moreover, the Congressional leaders and sponsors of the bill were unwilling to accept a third item requested by the Board—the use of the medically-accepted term, "dilatation and extraction." To address the AMA's third bulleted point, the Executive Committee considered the following sentence, which the AMA proposed to be added to the existing bill. The proposed sentence stated, "As used in this section, the term 'vaginally delivers a living fetus before killing the fetus' means 'deliberately and intentionally delivers into the vagina a living fetus or substantial portion thereof for the purpose of performing a procedure with the intent to kill the fetus and then to complete the act of killing the fetus.' "[26] The Executive Committee voted to authorize the AMA Washington staff to forward the proposed language change to the bill sponsors and congressional leaders. Notably, there is no record in the meeting minutes that the Executive Committee discussed the AMA's fourth bulleted point, that "the physician must retain the discretion to make the judgment in the best interests of the patient."

That same day in the Senate, Senator Tom Daschle (D-SD) proposed Amendment SP 289, the "Daschle Substitute," which would make it "unlawful to abort a viable fetus unless the physician certifies that continuation of the pregnancy would threaten the mother's life or risk grievous injury to her physical health..."[27] The bill was defeated by a vote of 64-36.

The following day, the full Board and senior AMA staff convened for a fifth telephone conference call. During this conference call, the Board Chair updated the Board on the previous day's Executive Committee conference call meeting. The Chair reported that there had been multiple calls between the Board and Senator Santorum, and there remained a chasm between the changes in the legislative language that the AMA demanded and the changes that the congressmen were willing to make.

The AMA Washington Office reported that the Senate would vote on the measure the following Tuesday, May 20. It also reported that Senator Santorum and the congressional leadership had returned to the AMA that morning. The Washington Office reported that while the congressmen were not willing to adopt the language proposed by the AMA, they did review the AMA's proposed language and had introduced their own modifications to the bill's language. The

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25 Minutes from the Executive Committee of the AMA Board of Trustees Telephone Conference (May 15, 1997). Note that the revised bill contained the phrase, "The Partial Birth Abortion Ban Act of 1997—Amends the Federal criminal code to prohibit any physician from knowingly performing a partial birth abortion in or affecting interstate or foreign commerce, unless it is necessary to save the life of the mother..." The previous version of the bill included an additional clause, "...and provided that no other medical procedure would suffice." This clause was deleted from the revised version of the bill.

26 Minutes from the Executive Committee of the AMA Board of Trustees Telephone Conference (May 15, 1997).

27 "Post-Viability Abortion Prevention Act," introduced by Tom Daschle, May 15, 1997.

Washington Office representative indicated that the revisions in the language appeared to be acceptable based on what he understood from his telephone conversation with the congressmen. The Washington Office representative stressed that the Board should agree to support H.R. 1122, as modified, because the bill met the criteria that had been established. The Board agreed that the modified language would be faxed to the Board and that a conference call would be scheduled the next day to vote on the matter.[28]

The following morning, the Board of Trustees convened to vote on H.R. 1122. Notably, six voting members, including the Board Chair and the other Board member who originally had been authorized to negotiate with congressional leaders, were absent. The Board received for consideration the most recently drafted revisions to H.R. 1122 along with the revisions deemed necessary by the Executive Committee. The Board decided that the proposed new language was basically identical to that which the Committee had recommended. The Board voted to "support the H.R. 1122, 'partial birth abortion' legislation if amended consistent with the AMA's concerns as outlined in the attachment to these minutes."[29]

Much of the remaining Board discussion focused on how the AMA would communicate its position to the general public. The Board decided that there would be no announcement until the bill had been amended. The Board also decided that the AMA would not be proactive about its support for the bill. Furthermore, the Board decided to issue a statement explaining that the AMA supported the bill because it had been changed significantly to "substantially meet the criteria which the Board established for any abortion legislation and narrowly defines the procedure to be restricted."[30] The AMA claimed that the amended language:

- Makes it clear beyond any question that the accepted abortion procedure known as dilation (*sic.*) and evacuation is not covered by the bill,
- Permits the procedure to save the life of the mother without any obligation to show that "no other procedure would suffice,"
- Does not restrict use of the procedure for physicians intending a live delivery at the outset, i.e., it can be done as necessary in their best medical judgment,
- Entitles a charged physician to stay any criminal proceeding in order to obtain expert review by the state medical licensing board of any questioned conduct under the bill for use at trial.[31]

Finally, the Board suggested that the state medical associations and the national medical specialty societies, as well as those who had been sent a copy of the AMA's scientific report, "Late-Term Pregnancy Termination Techniques," receive a copy of the statement.

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28 Minutes from the AMA Board of Trustees Telephone Conference (May 16, 1997).

29 Minutes from the AMA Board of Trustees Telephone Conference (May 19, 1997).

30 Minutes from the AMA Board of Trustees Telephone Conference (May 19, 1997).

31 *Ibid.*

During the period of time that the AMA Board spent negotiating with the U.S. Congressmen on the bill's language, the AMA had not engaged in communications with the American College of Obstetricians and Gynecologists or any other specialty societies. The absence of communication during this time period was ironic in light of the AMA's effort to bring together—through better collaboration and communication—the professional associations that represent the professional associations. The keystone of this effort was the AMA's leadership in assembling the "Federation of Medicine," a loosely structured coalition of national and state medical associations. During the period of time that the Board was deliberating on the partial birth abortion legislation, other areas of the AMA were drafting the AMA's "Statement of Collaborative Intent," which would be unveiled at the June 1997 Annual Meeting. The "Statement of Collaborative Intent," included the following principles:

- Organizations of the Federation should collaborate in the development of joint programs and services that benefit patients and member patients
- Organizations in the Federation should seek ways to enhance communications among physicians, between physicians and medical associations, and among organizations in the Federation.
- Organizations in the Federation should support, whenever possible, the policies, advocacy positions, and strategies established by the Federation of Medicine.
- Organizations in the Federation should inform other organizations in the Federation in a timely manner whenever their major policies, positions, strategies, or public statements may be in conflict.

The day after the AMA Board voted to support H.R. 1122, the Senate approved H.R. 1122 but fell three votes short of the two-thirds majority needed to override President Clinton's promised veto. In the days that followed, many doctors were outraged that the Board of Trustees had endorsed a legal ban on an abortion procedure after the Association, itself, had voted to remain neutral at its most recent meeting in December 1996.

Furthermore, the AMA was criticized in the press by journalists and pro-choice leaders. In a story that broke in *Modern Healthcare* magazine, Jonathan Gardner reported that on the same day that the AMA announced its support of the partial birth abortion ban, the AMA's executive vice president had sent an eight page letter to Newt Gingrich delineating the AMA's requests regarding the upcoming budget battles on Medicare. [32] Furthermore, the AMA was criticized for appearing to contradict the recommendations of the report that it had disseminated only one week before. In the report that the AMA had issued, "Late-Term Pregnancy Termination Techniques," the AMA stated that abortion is "a medical matter between the patient and physician, subject to the physician's clinical judgment."

"The AMA clearly cares more about moving their political agenda through a Republican-controlled 'anti-choice' Congress than they do about women's health or protecting women's

32 Rich, Frank, "Hypocritic Oath," The New York Times, May 29, 1997, Section A, p. 21.

constitutional liberties," said Kate Michelman, President of the National Abortion and Reproductive Rights Action League.[33] The Wall Street Journal's Albert Hunt wrote, "The American Medical Association became steeped in politics this week when it surprisingly endorsed the [partial birth abortion] ban; there are credible reports the doctor's lobby secretly struck a deal with GOP leaders over Medicare reimbursement in return for the endorsement..."[34]

AMA's executive vice president defended the AMA's decision saying, "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 principal, 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 can and should be regulated if the profession won't do it...AMA's congressional advocacy is derived exclusively from the profession's values, especially the patient-physician relationship."[35]

Contradicting the Executive Vice President's statement, the Chair of the AMA Board of Trustees spoke up a month later and claimed that the AMA would not have wanted any legislation on partial birth abortion. The Chair explained the AMA's apparent change of heart as a strategic necessity. Since 1995, 35 states had tried to pass laws banning the procedure, some with more sweeping language than the federal bill. The AMA Board Chair said that the question was not how to preserve physician autonomy, but how to prevent the most restrictive proposals from getting passed into law. "In an ideal world, there would have been no legislation. That was our preference. Unfortunately, it's not an ideal world."[36]

In June 24, 1997, at its Annual Meeting, the AMA House of Delegates deliberated on the Board's earlier endorsement of H.R. 1122. During the debate, delegates voiced strong concerns about the criminalization components in the law. But others argued that by not supporting the Board's action, the AMA would seriously undermine its own credibility and jeopardize the AMA's power to negotiate with Congress. Such action would be particularly detrimental to the AMA at a time when Congress was considering matters related to Medicare, managed care, and malpractice laws. After five hours of official debate and three days of hallway conversations, the House overwhelmingly supported a compromise measure that supported the Board's action. But the House added a caveat that AMA policy "strongly condemn any interference by the government or other third parties," and that the AMA would work with the ban's sponsors in Congress and in various states to eliminate criminal penalties.[37]

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33 Seelye, Katherine, "AMA Votes to Support a Ban on Late Abortion Procedure," The New York Times, May 20, 1997, Section A, p.1.

34 Hunt, Albert, "Politics and People: Daschle Charts Common Ground on Abortion," The Wall Street Journal, May 22, 1997, Section A, p. 15.

35 "Partial Birth Abortion Ban Act of 1997" (letter from P. John Seward, Executive Vice President, American Medical Association, to the New York Times, regarding AMA support of H.R. 1122).

36 Trafford, Abigail, "The Doctors Invite Congress In," Washington Post, June 30, 1997, Section A, p. 19.

37 Seelye, Katherine, "AMA Ratifies Leaders' Call for a Late-Term Abortion Ban," The New York Times, June 25, 1997, Section A, p. 11; Trafford, Abigail, "The Doctors Invite Congress In," Washington Post, June 30, 1997, Section A, p. 19.

Since that time, there has not been a lot of attention surrounding the AMA's decision, primarily because the issue at the national level has been quiet. On October 8, 1997, the U.S. House of Representatives agreed to amendments made by the Senate. The measure was signed in the House and the Senate and presented to President Clinton the following day. On October 10, 1997, the President vetoed the "Partial-Birth Birth Abortion Ban Act of 1997."

Costs to the AMA

Due to the fact that H.R. 1122 was vetoed by President Clinton and the U.S. Senate was unable to override the veto, the Partial-Birth Abortion Ban Act of 1997 was never passed. Still, it is likely that the AMA's decision to take a position supporting the bill one-month before the House of Delegates meeting did have an impact on the relationships between:

- the Board of Trustees and the House of Delegates,
- the Board of Trustees and staff,
- the AMA and members,
- the AMA and non-member physicians,
- the AMA and the American College of Obstetricians and Gynecologists (ACOG), and
- the AMA and other specialty societies.

In the absence of polls or surveys, however, it is impossible to assess the manner in which and the degree to which the Board's decision to support H.R. 1122 affected these relationships. The Board's decision to support H.R. 1122 may also have had ramifications in two other important areas: the AMA's reputation with the general public and the AMA's decision-making process.

The AMA's decision to support H.R. 1122 received a substantial amount of national press. Some of this press applauded the AMA's decision; however, the bulk of the media reports castigated the AMA's decision. Among other things, they suggested that the AMA supported the Republican bill to win Republican support of Medicare legislation that was sympathetic to physicians' financial interests. There is no evidence proving this to be true. Nonetheless, the AMA worked with the Republican leadership and submitted AMA recommendations on Medicare legislation on the same day that the AMA announced its support of H.R. 1122. Through its actions, the AMA gave the public the impression that the AMA had calculated the timing of its endorsement of H.R. 1122 to appeal to Republican politicians. As a result, the AMA painted a picture of itself as (1) primarily concerned about protecting the financial interests of physicians and (2) aligned with the conservative Republicans.

The Board of Trustees' actions were sanctioned by AMA policy (which permits the Board to determine AMA policy in "urgent situations"). However, this crisis mode of policy-setting was perhaps the least preferable mode of establishing policy because it did not employ the mechanisms established to ensure that important policy decisions were developed through thoughtful, deliberative, and democratic processes. Therefore, the Board's actions may have taken a toll on the decision-making process at the AMA, setting a less-than-ideal precedent for decision-making in "urgent situations."

its decision to support H.R. 1122, the Board's actions:

- Circumvented the policy-setting mechanism of the House of Delegates.
- Assigned non-professional negotiators to the task of engaging in high-stakes negotiations.
- Allowed the decision-making of controversial policies to be made by relatively few individuals, without many key individuals present when final decisions were made.

Analysis of the Process

Over a year has passed since the AMA Board of Trustees engaged in the flurry of phone conference calls on the partial birth abortion issue and subsequently announced the AMA's support for H.R. 1122. It cannot be determined whether the AMA's action resulted in substantial damage or benefit to the AMA or whether the Board of Trustees should have or should not have taken the action supporting H.R. 1122. To this day, individuals at the AMA will argue for both sides of this contentious issue. In spite of these divergent opinions, many individuals familiar with the decision to support H.R. 1122 would agree that the decision-making process was less than ideal.

The decision-making process used to address the issue of H.R. 1122 was in stark contrast to the democratic framework for decision-making that the AMA employed under ordinary circumstances. The most prominent problems with the decision-making process on H.R. 1122 were that individual actors played too influential a role in framing the issues and that external politics greatly swayed the decision-making process. Moreover, when the decision to support H.R. 1122 was finally made and journalists asked the AMA why it had decided to support the ban, the AMA lacked a consistent, convincing, and coherent response.

Historically, the AMA had managed to address the issue of abortion without muddling in the politics of abortion. It avoided controversy by consistently emphasizing established AMA policies that focused on the sanctity of the physician-patient relationship and the physician's judgment in medical matters.

When the AMA first became involved in the issue of partial birth abortion, the Board of Trustees was conscientious about drawing from existing AMA policies to develop its position. For example, after the Council on Legislation submitted its October 1995 recommendation in favor of supporting H.R. 1833, the Board of Trustees voted to remain neutral on the bill.[38] A review of legislative debate in the U.S. Congress during the Fall of 1995 revealed frequent reference to

[38] The Council on Legislation's position to support H.R. 1833 in late 1995 turned primarily on a clinical determination of the acceptability of a certain late-term pregnancy termination procedure—Intact Dilatation and Extraction (D&X). This clinical determination should have been the responsibility of the Council on Scientific Affairs, but there is no indication that the views of this or any other AMA Council was solicited or considered by the Council on Legislation. Moreover, the COL's position to support a Federal ban on a medical procedure contradicted long-standing AMA policy.

the AMA Council's position on H.R. 1833, and the fact that the AMA Board took no position on the bill. While the Board took a position minimally consistent with AMA policy, its failure to oppose H.R. 1883—and thereby directly challenge the position of the COL—may have persuaded some in Congress to support the Bill, thus contributing to its passage in the House and Senate. Although the President vetoed the Bill, and Congress failed to override it, the Board may have been mindful of its last skirmish over the partial birth abortion issue when it decided to act more forcefully when the bill reappeared as H.R. 1122 during a subsequent Congress.

More than a year later, when the House referred the matter of late-term pregnancy termination techniques to the Board, the Board initially remained mindful about confining its work to the parameters defined by the House. In an attempt to center the issue on factual rather than emotional or political issues, the Board assigned primary authorship of the study of late-term pregnancy termination techniques to a representative from the AMA's science area.

Soon thereafter, however, internal politics began to seep into the decision-making process. For example, while the report was being drafted, individuals who personally supported H.R. 1122 began to try to sway the decision-making process by attempting to influence the content of the written scientific report. Over time, individual influences played an increasing role in framing the final decision-making process. The politicization of the issue became a *fait accompli* in the early spring of 1997 when the AMA began to negotiate on the bill language with a handful of Republican congressmen. There is no evidence that the AMA ever embarked on discussions with sponsors of other congressional bills on partial birth abortion issues. This may be because H.R. 1122 was the most visible of the partial birth abortion bills being debated in Congress. Furthermore, it was the one being sponsored by the Republican leadership and therefore the one most likely to actually pass both the House and the Senate. It is likely that the AMA felt that it needed to take a position on the most visible and contested of the partial birth abortion bills.

~~Indeed, the AMA appeared to get swept up by the high-profile nature of the issue.~~ The AMA became less focused on interpreting AMA policy and lost sight of their option to not take a position on the partial birth abortion legislation. They became more focused on their negotiations with the congressmen and determined to walk away from the negotiating table with an agreement in hand.

As the AMA became determined to cut a deal with the congressmen, the decision-making process began to reel out of the control of the AMA and into the control of the congressmen on the other side of the negotiating table. The congressmen had three major advantages to leverage their positions. First, the congressmen were seasoned, adept negotiators. Meanwhile, the Board of Trustee members were not trained negotiators. Second, the congressmen were accustomed to operating under intense pressure in time-sensitive situations and using time constraints to their own advantage. The AMA, on the other hand, was not accustomed to operating under such high-pressure conditions. Third, the congressmen had power to influence other pieces of legislation that would have an impact on the AMA and its members. Although it is unlikely that any conversation of a *quid pro quo* ever transpired, both sides were keenly aware of Congress' power to either greatly help or greatly hinder the medical profession through its influence on other pieces of legislation.

its determination to engage in successful negotiations with the congressmen, the AMA policy makers gradually abandoned a number of the conditions that they had originally established for arriving at an agreement with the congressmen. An analysis of recommendations and criteria set by the Board over time reveals a gradual ratcheting down of the AMA's standards. In fact, only one out of four of the original recommendations for bill language changes were actually made in the final version of the bill that the AMA endorsed.[39] When the AMA announced its support for H.R. 1122, the AMA issued a statement explaining that the changes in the bill's language met the Board's criteria. It is more accurate to suggest, however, that the Board's criteria shifted to meet the bill's (slightly modified) language.

The involvement of the U.S. congressmen—along with internal pressures from AMA staff who supported of H.R. 1122—also gave the AMA's policy decision an unusual sense of urgency and perhaps an over-inflated sense of importance. As a result, the AMA decision-makers became convinced that it was imperative that the AMA take a position on the Partial-Birth Abortion Ban Act rather than wait for the House of Delegates to deliberate on the issue.

The Board's decision to take a position on the abortion legislation—that some would argue was, in many ways, in opposition to the House's previous positions—placed the House of Delegates in a difficult position. The House could reverse the Board's decision, thereby undermining the Board, jeopardizing the AMA's negotiating power with Congress, and embarrassing the organization as a whole. Or the House could endorse the Board's decision even though the Board's position contradicted a number of the policies that the House had voted to reaffirm just six months prior. In the end, the House made the best decision it could and took the middle ground, reaffirming the Board's decision but adding caveats regarding the AMA's opposition to government interference into the practice of medicine and the criminalization of the procedure.

Those handling the AMA's communications with the public were not so adept at reconciling seemingly contradictory statements and/or actions. First, the AMA's announcement of its support for H.R. 1122 came about a week after it had mailed copies of its scientific report on late-term pregnancy termination techniques. The AMA's announcement appeared to contradict parts of the written report that indicated that the AMA's policies supported the physician-patient relationship and the physician's judgment in medical matters. Second, the AMA had the misfortunate of poor timing—it submitted its position letter on Medicare legislation on the same day that it announced its support of the partial abortion ban. By sending these two documents at the same time, the AMA set itself up for accusations of playing politics with the Republicans over Medicare legislation. Then, AMA spokespersons proceeded to deny a *quid pro quo* arrangement with the Republican congressmen, and they rationalized the AMA's decision to support H.R. 1122 using different explanations that appeared to contradict each other.

During its final telephone conference meeting on the issue on May 19, the Board had delineated the AMA's public explanation for its support of H.R. 1122. However, this public statement failed to explain why the AMA decided that it needed to take a position at all and why the

[39] The recommendations were: (1) oversight and enforcement established through the state medical licensing boards, (2) discontinued use of the non-medical term, "partial birth abortion," (3) an allowance for spontaneous abortions, and (4) ultimate discretion made by the physician.

AMA's action seemed to conflict with the recommendations of that the AMA had disseminated one week prior through its report on late-term abortion. Because the AMA's official announcement did not address these issues, AMA spokespersons developed different public responses to these questions.

The AMA's executive vice president claimed that legislative intervention on partial birth abortion was necessary. Furthermore, the EVP claimed that ethical principles and the profession's value of the patient-physician relationship were the only factors driving the AMA's decision to support H.R. 1122.

Meanwhile, the Chair of the Board claimed that the AMA had wanted to avoid legislation but felt obliged to take a position in order to prevent more restrictive state proposals from being passed into law. As the principal explanation for the Board's action, this explanation was not convincing. At the time when Congress was discussing H.R. 1122, Congress was also discussing two other partial birth abortion bills (the Feinstein bill and the Daschle Amendment) that were less stringent than H.R. 1122, left more discretion to the physician, and were introduced by Democrats. These bills were barely mentioned during the Board's telephone conference calls, and the Board never considered supporting either of these alternative pieces of partial birth abortion legislation.

By providing different explanations for the AMA's decision and providing explanations that were not supported by the evidence, the AMA risked giving the appearance of being dishonest about its motives. In the end, the image of dishonesty was worse for the AMA than the image of fighting to protect physicians' financial interests. In the aftermath of the AMA's decision to support H.R. 1122, the AMA contended with both of these images.

~~FINDINGS~~

Issue: Policy Setting and Accountability

Finding 1: The Board of Trustees failed to draw upon existing policy statements established by the House of Delegates.

During the late 1980s and early 1990s, the AMA maintained a position of neutrality on the issue of abortion. The House of Delegates had, however, established a number of AMA policies on specific aspects of the abortion issue. The AMA's "Policy on Abortion" and its policy on the "Right to Privacy in Termination of Pregnancy" clearly advocated protection of the right to an abortion. Furthermore, H-5.990 stated that "the AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures. Resolution H-5.993 stated that "the AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities." Resolution H-5.998, "Public Funding of Abortion Services," stated that "the AMA reaffirms its opposition to legislative proposals that utilize

federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population."

With a number of policy precedents in place on abortion, the AMA Board's support of H.R. 1122 reflects an independence of judgment and action from the House of Delegate's policies which exceeds its responsibilities for interpreting House policies. Support of H.R.1122 was rationalized by a decision that dilatation and extraction was not an established or scientifically accepted medical procedure because it was not specifically addressed in medical journals. Furthermore, it was argued that because much of the public was opposed to the procedure, D&X was not generally accepted. Nonetheless, in light of the AMA's other policies on abortion, it is debatable whether the Board's actions on H.R. 1122 were justified.

Issue: Roles and Responsibilities

Finding 2: The AMA Board members displayed a lack of understanding of their roles and responsibilities as a Board of Trustees as well as in relationship to the House of Delegates, management and staff.

According to the AMA's Constitution, Article VI, "The legislative and policy-making body of the Association is the House of Delegates..." At the same time, H-535.995 gave the Board of Trustees the authority "in the absence of specifically applicable current statements of policy [to determine] what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter." The previous finding illustrates how these overlapping responsibilities have the potential to cause confusion in policy-setting roles and responsibilities.

This overlapping pattern is exaggerated by the fact that the policy gave the Board the authority, during times of urgency, to determine AMA policy "in the best interests of physicians, patients, and the AMA." The Board's decision raises two key issues regarding its interpretation of its authority. First, there is no evidence as to how the Board determined that this was an "urgent situation" which caused them to act without waiting a month for the House of Delegates' meeting. The Board argued that, because the U.S. Senate was slated to vote on the Partial-Birth Abortion Ban Act of 1997, the issue was "urgent" and the Board was compelled to establish the AMA's position on H.R. 1122 without waiting for the House of Delegates' meeting. Others argued that the Board did not have to act when it did—it could have remained neutral and waited for the House of Delegates to deliberate on the issue.

Second, there were many examples of actions which indicated that the Board confused its legitimate role to act "in the best interest of the patient, physician and the AMA" with the operational responsibilities of management to execute the AMA's vision. With the exception of some allusions to the Washington office staff, the Board members were described as playing a major role in negotiating directly with Congressional sponsors -- functions for which they were ill-prepared, as well as inappropriate.

The Board indicated that it did not accurately understand its role in establishing and supporting the vision and values of the AMA. Rather than focusing on its role as "steward" for the

profession and the public health, the Board got enmeshed in operational issues of lobbying, and lost sight of its responsibility for making decisions which, first and foremost, benefit the patient; and protect the physician-patient relationship.

Issue: Strategic Focus and Stakeholder Input

Finding 3: The AMA lacked an ongoing strategy and mechanisms for surveying its members and its stakeholders to ensure that the AMA represented their views.

According to H-535.995, the Board was to determine policy that best represented "the interests of patients, physicians, and the AMA." However, there were no market research efforts to gather information about member's and non-member physician's abortion beliefs. Furthermore, there were no ongoing market research efforts that polled members about how policy positions that the AMA was considering would affect members' decisions to continue or discontinue their AMA memberships.

In the absence of an ongoing outreach strategy and mechanisms including polling or surveying of members, non-member physicians, and/or patients, it was impossible to provide concrete evidence that the AMA's actions were in the best interests of any of these stakeholder groups. In general, the AMA appeared to rely on a general sense, based on national polls, that the American public was opposed to the partial birth abortion procedure. It is questionable whether the opinion of the general public could serve as a proxy for the "best interest of patients and physicians."

Issue: Communication

Finding 4: Lack of a communications strategy to assure a unified, consistent AMA message

~~One of the most troubling aspects of the AMA's decision to support H.R. 1122 was the~~ inconsistency of its messages to the public. First, the AMA's decision to support H.R. 1122 appeared to contradict the recommendation of its report on late term pregnancy termination techniques. Then, after the AMA announced its support of H.R. 1122, AMA spokespersons seemed to contradict each other's statements. One spokesperson claimed that, based on ethical principles, the procedure had to be legislated. The other spokesperson indicated that the AMA had wanted to avoid legislating the procedure but was compelled to take a position in order to "prevent the most restrictive proposals from getting passed into law."

These contradictions occurred because the AMA lacked an organized strategy for effectively communicating its position on this (or other) issues. First, there were several spokespersons, rather than one individual designated as "liaison" to the public. Second, inconsistent and sometimes contradictory messages created a "credibility gap" for the association and reflected negatively on the medical community. Finally, since the Board's actions were not well-grounded in existing policy and inadequately supported by evidence of solidarity with other groups (inside and outside the AMA), the Board members and staff who participated in these actions may have jeopardized the AMA's ability to negotiate on other significant policy issues in the future.

Conclusion

Most of the individuals familiar with the decision-making process that took place during the spring of 1997 would agree that they are grateful that the issue has moved out of the limelight. This sentiment may have been spawned by the awkward nature of the decision-making process itself. The AMA Board of Trustees' decision to support H.R. 1122 was made in a cloud of ambiguity over roles and authority and without clear leadership. The Board's decision-making process gave many a feeling of discomfort, especially since the poorly-guided decisions were intended to determine official AMA policy on a deeply controversial and emotional issue.

In general, the AMA had gone to great lengths to ensure that AMA policies were products of a slow, well-thought-out, deliberative, and democratic process. For "urgent situations," however, AMA policy allowed the Board to bypass AMA's normal channels of democratic deliberation and voting. By authorizing the Board to take policy actions "in urgent situations," the AMA's Bylaws allow a haphazard system for AMA policy making during critical periods.

Ironically, the combined effect of AMA policies was to allow the most critical, controversial, and high-visibility policy issues to be addressed using the least democratic, least researched, and least systematic decision-making process. If the AMA had more explicit policies about how to define "urgent situations," the AMA might have emerged from the debate about the Partial Birth Abortion Ban Act of 1997 with a consistent, clinically-based message that reaffirmed the AMA's influence in the health policy arena. Instead, the AMA blundered. In the process, the AMA risked its reputation and emerged from this decision-making process appearing to its stakeholders and the public as a poorly managed organization on the wrong side of the issue.

Annex A

Timeline of Events Related to the Decision to Support H.R. 1122, the Partial-Birth Abortion Ban Act of 1997

1995	H.R. 1833, the "Partial-Birth Abortion Ban Act of 1995" was passed by the U.S. House of Representatives and the U.S. Senate
Sept. 1995	The AMA Washington Office asked the AMA's Council on Legislation to review H.R. 1833
Oct. 1995	The AMA's Council on Legislation submitted its recommendation to the Board of Trustees to support H.R. 1833. The Board votes to remain neutral.
April 1996	President Clinton vetoed H.R. 1833, the first so-called "Partial Birth Abortion Ban Act."
Dec. 1996	During its December meeting, the AMA House of Delegates reaffirmed its "Policy on Abortion," "Right to Privacy in Termination of Pregnancy," and "Abortion."
	The AMA Board convened a group of experts consisting of members from pertinent AMA Councils and medical specialty societies to study the issue of late-term pregnancy termination techniques.
Jan. 1997	American College of Obstetricians and Gynecologists' (ACOG's) Executive Board issued a statement saying it could identify "no circumstances under which this procedure [intact dilation and extraction (D&X)] would be the only option to save the life of the mother or preserve the health of the woman." ACOG's statement further said 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, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances, can make this decision."
Feb. 1997	The group studying late-term pregnancy termination techniques submitted its report to the Board of Trustees.
Feb. 1997	The AMA Board of Trustees discussed the partial birth abortion issue at its February meeting and voted to convene a smaller group to make suggestions on the content of the late-term pregnancy termination techniques report.
March 1997	Rep. Charles Canady (R, FL) reintroduced legislation, H.R. 1122, which was identical to H.R. 1833 introduced a year earlier, the "Partial Birth Abortion Ban Act."

April 14, 1997 The Board of Trustees began a series of meetings on the partial birth abortion issue. They decided to develop two tracks. One track would submit the late-term pregnancy termination techniques report to the House of Delegates, and the other track would develop a policy position on H.R. 1122.

April 25, 1997 The Board of Trustees convened for a conference call meeting. The small study group outlined 4 major problems with the language of H.R. 1122 and offered recommendations for changes. The Board voted to oppose H.R. 1122.

May 2, 1997 The Board of Trustees convened for a conference call meeting. The Board voted to authorize two individuals to negotiate directly with congressmen.

May 19, 1997 The Board of Trustees convened for a conference call meeting. The Board voted to support H.R. 1122.

May 20, 1997 The AMA announced its support of H.R. 1122, as amended.

ex B

Relevant AMA Policies

Abortion Issues

H-5.990 Policy on Abortion. The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures. (Res. 158, A-90; Reaffirmed by Sub. Res. 208, I-96)

H-5.993 Right to Privacy in Termination of Pregnancy. "...The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgement, the patient's informed consent, and the availability of appropriate facilities. (Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96)

H-5.998 Public Funding of Abortion Services. The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population. (Sub. Res. 89, I-83; Reaffirmed: CLRPD Rep. I-93-1)

Governance Issues

H-535.995 AMA Policy Actions. Except as noted herein, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation. (BOT Rep. FF, A-79; Reaffirmed: CLRPD Rep. B, I-89; CLRPD Rep. I-93-2)

Annex C
Drafts of Legislation

The Partial Birth Abortion Ban Act of 1995, As amended by the Senate, December 7, 1995

Partial-Birth Abortion Ban Act of 1995—Subjects any physician who knowingly performs a partial-birth abortion in or affecting interstate or foreign commerce to a fine or imprisonment for not more than two years or both, except where such an abortion is necessary to save the life of a mother endangered by a physical disorder, illness, or injury, provided that no other medical procedure would suffice.

Defines: (1) "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 the delivery; and (2) "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.

Permits 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 at the time of the abortion) the maternal grandparents to obtain, through a civil action, relief which would include money damages for all psychological and physical injuries and statutory damages equal to three times the cost of the partial-birth abortion, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

The Partial Birth Abortion Ban Act of 1997,
As amended by the Senate, May 20, 1997

Partial-Birth Abortion Ban Act of 1997—Amends the Federal criminal code to prohibit any physician from knowingly performing a partial-birth abortion in or affecting interstate or foreign commerce, unless it is necessary to save the life of the mother. Prescribes penalties.

Defines a "partial birth abortion" as an abortion in which a person, deliberately and intentionally, partially vaginally delivers a living fetus before killing the fetus and completing the delivery.

Authorizes the father, if married to the mother at the time of the abortion, and the maternal grandparents of the fetus, if the mother is under 18 years of age, to obtain specified relief in a civil action, unless the pregnancy resulted form the plaintiff's criminal conduct or the plaintiff consented to the abortion.

Authorizes a defendant accused of an offense under this Act to seek a hearing before the State Medical Board on whether the physician's conduct was necessary to save the life of the mother.

Prohibits the prosecution of a woman upon whom a partial-birth abortion is performed for conspiracy to violate this Act or under provisions regarding punishment as a principal or an accessory or for concealment of a felony.

The Daschle Substitute, Amendment SP 289,
"Post-Viability Abortion Prevention Act,"
not agreed by a vote of 36-64, on May 15, 1997

1531 Prohibition.

(a) It shall be unlawful to perform an abortion when, in the medical judgment of the attending physician, the fetus is viable, except that an abortion after viability shall be permitted if the attending physician certifies that, in his or her medical judgment, the continuation of the pregnancy would threaten the mother's life or endanger her health.

(b) Endangering of health—For purposes of subsection (a), the health of a mother would be endangered if, in the medical judgment of the attending physician, the continuation of the pregnancy would risk serious injury or harm to the mother.

(c) Definition—As used in this section, the term "serious injury or harm" means—
(1) the onset of a debilitating illness or disease;
(2) the inability to provide necessary treatment for a life-threatening condition; or
(3) the loss or protracted impairment of a bodily organ or system.
Such term does not include any condition that is not medically diagnosable.

1532 Penalties.

(a) Action by Attorney General—The Attorney General may commence a civil action under this chapter in any appropriate United States district court to enforce the provisions of this chapter.

(b) Relief—
(1) First offense—Upon a finding by the court that the respondent in an action commenced under subsection (a) has violated a provision of this chapter, the court shall order the suspension or revocation of the respondent's medical license, certificate, or permit, or shall assess a civil penalty against the respondent in an amount not exceeding $100,000, or both.
(2) Second offense—If a respondent in an action commenced under subsection (a) has been found to have violated a provision of this chapter on a prior occasion, the court shall order the revocation of the respondent's medical license, certificate, or permit, or shall assess a civil penalty against the respondent in an amount not exceeding $250,000, or both.

(c) Certification requirements—

(1) In general—At the time of the commencement of an action under subsection (a), the Attorney General shall certify to the court involved that, at least 30 calendar days prior to the filing of such action, the Attorney General—

(A) has provided notice of the alleged violation of this section, in writing, to the Governor or chief legal officer or the State or political subdivision involved; and

(B) believes that such an action by the United States is in the public interest and necessary to secure substantial justice.

(2) Limitation—No woman who has had an abortion after fetal viability may be prosecuted under this chapter for a conspiracy to violate this chapter or for an offense under section 1531.

1533 State Regulations. Each state shall establish regulations—

(1) for—

(A) the certification by an attending physician that a post-viability abortion has been performed and was necessary based upon the best medical judgment of the physician to preserve the life or avoid the risk serious injury or harm to the woman involved;

(B) the imposition of appropriate penalties for the falsification of information under a certification; and

(C) the enforcement of the penalties associated with the suspension or revocation of a respondent's medical license, certificate, or permit under section 1532; and

(2) to ensure the confidentiality of all information submitted pursuant to a certification by a physician under paragraph (1).

1534 Nonpreemption Provision. "The provisions of this chapter shall not be construed to preempt any State law that prohibits the abortion of a viable fetus."

Appendix D

Full Text of Recommendations of Report 26 of the Board of Trustees (A-97)

- The American Medical Association reaffirms current policy regarding abortion, specifically policies 5.990, 5.993, and 5.995. In summary:
  - the early termination of pregnancy is a medical matter between the patient and physician subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities;
  - abortion is a medical procedure and should be performed by a physician in conformance with standards of good medical practice;
  - support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures;
  - neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles.

- The term, "partial birth abortion" is not a medical term. The American Medical Association will use the term "intact dilatation and extraction" (or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because "partial birth abortion" is not a medical term it will not be used by the AMA.

- According to the scientific literature, there does not appear to be any identifiable situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

- The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second-trimester when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.

- In recognition of the constitutional principles regarding the right to an abortion articulate by the Supreme Court in Roe v. Wade, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.

- The AMA will work with the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics to develop clinical guidelines for induced abortion after the 22nd week of gestation. The guidelines will address indications and contra-indications for such procedures, identify techniques which conform to standards of good medical practice and, whenever possible, should be evidence-based and patient-focused.

- The American Medical Association urges the Centers for Disease Control and Prevention as well as state health department officials to develop expanded, ongoing surveillance systems of induced labor. This would include but not be limited to: a more detailed breakdown of the prevalence of abortion by gestational age as well as the type of procedure used to induce abortion at each gestational age, and maternal and fetal indications for the procedure. Abortion-related maternal morbidity and mortality statistics should include reports on the type and severity of both short-and long-term complications, type of procedure, gestational age, maternal age, and type of facility. Data collection procedures should ensure the anonymity of the physician, the facility, and the patient.

- The AMA will work with appropriate medical specialty societies, government agencies, private foundations, and other interested groups to educate the public regarding pregnancy prevention strategies, with special attention to at-risk populations, which would minimize or preclude the need for abortions. The demand for abortions, with the exception of those indicated by serious fetal anomalies or conditions which threaten the life or health of the pregnant woman, represent failures in the social environment and education. Such measures should help women who elect to terminate a pregnancy through induced abortion to receive those services at the earliest possible stage of gestation.[40]

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40 "Late-Term Pregnancy Termination Techniques," Report of the Board of Trustees, 26-A-97.

Process Diagrams

1) AMA Washington Office flagged legislation (H.R. 1833) and asked Council on Legislative Affairs to look into issue
2) Council on Legislative Affairs studies H.R. 1833 and writes recommendation to Board of Trustees
3) Board of Trustees deliberates on issue and votes to remain neutral
4) Issue lays to rest temporarily
5) House Delegates submit resolutions to take positions on late term pregnancy termination
6) House of Delegates refers issue of late term pregnancy termination techniques to Board of Trustees
7) Board delegates task force with representation from AMA Councils, specialty societies, and state medical associations to develop report on late term pregnancy termination techniques
8) Task force submits report, without recommendations, to Board
9) Board votes to convene smaller group to review report and develop recommendations
10) Smaller group convenes and develops recommendations
11) During regularly-scheduled meeting, Board reviews report and decides to (a) submit report to House of Delegates and (b) study H.R. 1122 and determine whether the AMA should take a position on the pending legislation
12) Board begins to convene for series of telephone conference call meetings on H.R. 1122.
13) During second conference call meeting, Board votes to authorize two of its members to negotiate directly with U.S. Congressmen
14) During series of conference calls, Executive Committee of the Board meets on H.R. 1122 and asks the Washington Office to forward AMA's suggested bill language changes to U.S. Congressmen.
15) During fifth conference call meeting, Washington Office reports to Board on the status of bill language changes.
16) During final (sixth) conference call Board meeting, the Board voted to support H.R. 1122.

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