AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

108TH CONGRESS, 1st Session | HOUSE OF REPRESENTATIVES | REPORT 108–58

PARTIAL-BIRTH ABORTION BAN ACT OF 2003

APRIL 3, 2003.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 760]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 760) to prohibit the procedure commonly known as partial-birth abortion, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

CONTENTS

	Page
Purpose and Summary	2
Background and Need for the Legislation	2
Hearings	27
Committee Consideration	27
Vote of the Committee	27
Committee Oversight Findings	32
Performance Goals and Objectives	32
New Budget Authority and Tax Expenditures	32
Congressional Budget Office Cost Estimate	33
Constitutional Authority Statement	34
Section-by-Section Analysis and Discussion	34
Changes in Existing Law Made by the Bill, as Reported	41
Markup Transcript	42
Dissenting Views	147

19–006

PURPOSE AND SUMMARY

H.R. 760, the "Partial-Birth Abortion Ban Act of 2003," bans the partial-birth abortion procedure in which an intact living fetus is partially delivered until some portion of the fetus is outside the body of the mother before the fetus is killed and the delivery completed. An abortionist who violates the ban would be subject to fines or a maximum of 2 years imprisonment, or both. The bill also establishes a civil cause of action for damages against an abortionist who violates the ban. The bill, which does not include an exception for the health of the mother, includes Congress' 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, which is identical to H.R. 4965 which passed the House during the 107th Congress by a 274–151 vote, was introduced on February 13, 2003, by Constitution Subcommittee Chairman Rep. Steve Chabot. H.R. 760 was referred to the Judiciary Committee on that same date. H.R. 760 is identical to S. 3, as it was introduced by Sen. Rick Santorum on February 14, 2003. On March 13, 2003, the Senate passed S. 3, with amendment, by a vote of 64–33.[1]

BACKGROUND AND NEED FOR THE LEGISLATION

The Procedure

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

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

---

[1] By a 52 to 46 vote, the Senate approved an amendment to S. 3 expressing the sense of the Senate that *Roe* v. *Wade* "was appropriate and secures an important constitutional right" and that the decision "should not be overturned."

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

> At this point, the right-handed surgeon slides the fingers of the left had [sic] along the back of the fetus and 'hooks' the shoulders of the fetus with the index and ring fingers (palm down).
>
> While maintaining this tension, lifting the cervix and applying traction to the shoulders with the fingers of the left hand, the surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger.
>
> [T]he surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening.
>
> The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient.[3]

This method of abortion is particularly brutal and inhuman. Brenda Pratt Shafer, a registered nurse who observed Dr. Haskell use the procedure to abort three babies in 1993, testified before the Senate Judiciary Committee in 1995 and described a partial-birth abortion she witnessed on a child of 26½ weeks as follows:

> Dr. Haskell brought the ultrasound in and hooked it up so that he could see the baby. On the ultrasound screen, I could see the heart beat. As Dr. Haskell watched the baby on the ultrasound screen, the baby's heartbeat was clearly visible on the ultrasound screen.
>
> Dr. Haskell went in with forceps and grabbed the baby's legs and pulled them down into the birth canal. Then he delivered the baby's body and the arms—everything but the head. The doctor kept the head right inside the uterus. . . .
>
> The baby's little fingers were clasping and unclasping, and his little feet were kicking. Then the doctor stuck the scissors in the back of his head, and the baby's arms jerked out, like a startle reaction, like a flinch, like a baby does when he thinks he is going to fall.
>
> The doctor opened up the scissors, stuck a high-powered suction tube into the opening, and sucked the baby's brains out. Now the baby went completely limp. . . .
>
> He cut the umbilical cord and delivered the placenta. He threw the baby in a pan, along with the placenta and the instruments he had just used. I saw the baby move in the pan. I asked another nurse, and she said it was just reflexes. . . . That baby boy had the most perfect angelic face I think I have ever seen in my life.[4]

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

---

[3] *Id.* at 27, 30–31.

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

The partial-birth abortion procedure is performed from around 20 weeks to full term.[5] It is well documented that a baby is highly sensitive to pain stimuli during this period and even earlier.[6] In fact, in a study conducted on fetuses between 20 to 34 weeks of gestation at the Institute of Obstetrics and Gynecology, Royal Postgraduate Medical School, Queen Charlotte's and Chelsea Hospital in London researchers concluded:

> Just as physicians now provide neonates with adequate analgesia, our findings suggest that those dealing with the fetus should consider making similar modifications to their practice. This applies not just to diagnostic and therapeutic procedures on the fetus, but possibly also to termination of pregnancy, especially by surgical techniques involving dismemberment.[7]

In his testimony before the Constitution Subcommittee on June 15, 1995, Professor Robert White, Director of the Division of Neurosurgery and Brain Research Laboratory at Case Western Reserve School of Medicine, stated that "[t]he fetus within this time frame of gestation, 20 weeks and beyond, is fully capable of experiencing pain."[8] After specifically analyzing the partial-birth abortion procedure, Dr. White concluded that "[w]ithout question, all of this is a dreadfully painful experience for any infant subjected to such a surgical procedure."[9]

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

Public Reaction

The partial-birth abortion procedure was brought to the attention of the nation when Minnesota Citizens Concerned for Life ran an ad in the Minneapolis Star-Tribune on May 12, 1993, containing drawings illustrating Dr. Haskell's abortion procedure with descriptive captions beneath.[10] The immediate reaction of Dr. Haskell's local community was one of outrage. According to local reports over 100 local demonstrators, including reportedly twenty-one doctors,

---

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

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

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

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

[9] *Id.*

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

protested outside of the Cincinnati abortion clinic at which Dr. Haskell performs abortions.[11]

By 1996, polls revealed that Americans, regardless of their self-identified political affiliation or position on abortion, found the procedure to be morally and ethically objectionable and thus favored criminal bans of the procedure. A 1996 Tarrance Group poll sponsored by the National Conference of Catholic Bishops found that 55 percent of Democrats and 65 percent of those identifying themselves as pro-choice supported the ban.[12] Later that year, a Gallup poll revealed that 71 percent of American voters support the ban on "a specific abortion procedure conducted in the last 6 months of pregnancy known as a 'partial-birth abortion,' except in cases necessary to save the life of the mother."[13] A 1997 survey conducted by the Pew Research Center for the People & the Press found that women supported the ban by 56 percent and Republicans, Democrats, and Independents gave their approval by 55, 54, and 56 percent, respectively.[14] Most recently, an ABC News/Washington Post survey conducted in January found that 69% of Americans believe that "late-term procedures known as dilation and extraction, or partial-birth abortions" should be illegal.[15] Similarly, a CNN/Gallup/USA Today survey conduct in January found that 70% of those surveyed favor a law that "would make it illegal to perform a specific abortion procedure conducted in the last 6 months of pregnancy known as a 'partial-birth abortion,' except in cases necessary to save the life of the mother."[16]

The most compelling proof of the public's disgust with the procedure is the speed with which the States acted to enact criminal bans on the procedure.[17] By February 2000, at least 27 state legislatures, following the democratic, political processes in their states, had enacted statutes prohibiting partial-birth abortion bans. During this same time frame, the United States Congress overwhelmingly passed a Federal ban on partial-birth abortions three times, each vote by an overwhelming majority.[18]

---

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

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

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

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

[15] *ABC News/Washington Post: Abortion Results That Both Sides Can Use,* The Hotline: National Journal's Daily Briefing on Politics, *at http://nationaljournal.com/pubs/hotline/h030122.htm* (last visited Jan. 22, 2003).

[16] *Poll Update—CNN/USA Today/Gallup: Just 18 Think Abortion Should Be Illegal in All Circumstances,* The Hotline: National Journal's Daily Briefing on Politics, *at* CNN/Gallup/USA Today, <http://nationaljournal.com/cgi-bin/ifetch4?ENG+HOTLINE+7-njindex+1055990–REVERSE+0+2+407+F+30+8003+21+abortion (last visited Feb. 5, 2003).

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

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

Continued

Stenberg *v.* Carhart *and the "Clearly Erroneous" Standard of Review*

In June 2000, the national debate regarding partial-birth abortions reached a new level when the United States Supreme Court, in *Stenberg* v. *Carhart*,[19] struck down Nebraska's partial-birth abortion ban. The Court struck down the ban concluding that it placed an undue burden on women seeking abortions because the statutory definition of a partial-birth abortion (now usually referred to as a "D & X") could also be construed to ban the most common abortion procedure used during the second trimester of pregnancy, dilation and evacuation or "D & E," and because the ban failed to include an exception for partial-birth abortions that are deemed necessary to preserve the "health" of the mother.

The Court's definitional objections have been remedied in H.R. 760 by drafting a more precise definition of the prohibited procedure. Previous versions of the bill defined a partial-birth abortion as "an abortion in which the person performing the abortion partially-vaginally delivers a living fetus before killing the fetus and completing delivery." The language the Court objected to in *Stenberg* was virtually identical. Under the current version of the ban, "partial-birth abortion" is defined as "an abortion in which—(A) the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus." This language is sufficiently precise so as to exclude the D & E abortion procedure.[20]

Addressing the Nebraska ban's failure to include a health exception, the *Stenberg* Court opined "that significant medical authority supports the proposition that in some circumstances, [partial birth abortion] would be the safest procedure" for pregnant women who wish to undergo an abortion.[21] Thus, the Court concluded that Nebraska's ban placed an undue burden on women seeking abortions because it failed to include an exception for partial-birth abortions deemed necessary to preserve the "health" of the mother. However, the great weight of evidence presented at this and other trials chal-

---

bring the differing versions to a conference since the Court issued its *Stenberg* ruling in June 2000.

[19] 530 U.S. 914 (2000). Dr. Carhart recently stated his intention to challenge H.R. 760 should it be enacted. *See* Betsy Rothstein, *Republicans push partial-birth abortion bill* The Hill, March 5, 2003, at 4.

[20] As Dr. Curtis Cook told the Subcommittee during its hearing on H.R. 4965, "I know that the concerns in the previous language had to do with this issue of 'partially vaginally delivers' and also the perceived vagueness about the overtness of the act of the killing procedure. I think from a medical standpoint, as far as looking for guidance in what things are allowed and what things aren't allowed, the two things that clarify it from a medical perspective are giving clear anatomic landmarks as far as what is a partially vaginally delivered or a majority of a partially vaginally delivered infant, by identifying the infant being delivered in a feet-first position up to the point of the umbilicus and in a head-first position being delivered up to the point of the head. So there are clear anatomic landmarks. The other thing that I think is helpful is that fact that it requires an overt act, other than completion of the delivery, as a killing process. Those two things, from a medical standpoint, clearly distinguish this procedure from other procedures." *Partial-Birth Abortion Ban Act of 2002: Hearing on H.R. 4965 Before the U.S. House of Representatives Committee on the Judiciary Subcomm. on the Constitution,* 107th Cong. (July 9, 2002) (Statement of Dr. Curtis Cook).

[21] *Id.* at 932.

lenging partial-birth abortion bans, as well as in extensive congressional hearings, supports the conclusion that partial-birth abortion is never necessary to preserve the health of a woman, is outside of the medical standard of care, and may actually pose significant health risks to a woman upon whom the procedure is performed.

Despite the *Stenberg* trial court record's dearth of evidence supporting the conclusion that a D & X abortion may be necessary to protect the health of some women, the United States Court of Appeals for the Eighth Circuit refused to set aside the district court's factual findings because, under the applicable standard of appellate review, they were not "clearly erroneous."[22] A finding of fact is clearly erroneous "when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed."[23] Under this standard, "[i]f the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently."[24]

On review from the Eighth Circuit, the Supreme Court in *Stenberg* also accepted the district court's findings and the appellate court's refusal to set them aside.[25] It was argued by at least one set of amici that the district court findings should be set aside as clearly erroneous.[26] This amicus brief, which was submitted by a number of medical organizations and doctors including the Physicians' Ad Hoc Coalition for Truth (PhACT) and the Association of American Physicians and Surgeons, asserted that the district court's findings on the D & X procedure were "self-contradictory because they simultaneously condemn the state for making illegal the most common form of second trimester abortions (D & E), while also claiming that this same method is as measured against D & X so medically deficient as to constitute a serious health risk for women."[27] In addition, they argued that the findings regarding the benefits of D & X only relied upon the testimony of Dr. Carhart, the plaintiff, and the speculation of experts, and that the record was void of any controlled study or article from a peer-reviewed journal establishing that the D & X is superior in any way to the D & E procedure.[28]

Although amici's observations were correct and were supported by Nebraska's arguments on appeal, the Supreme Court was bound by the "clearly erroneous" standard to accept the district court's findings. The Court has explained that "[d]etermining the weight and credibility of the evidence is the special province of the trier of fact."[29] Therefore, Rule 52(a) of the Federal Rules of Civil Procedure, which articulates the clearly erroneous standard necessary for setting aside a judge's factual findings, "recognizes and rests

---

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

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

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

[25] *Stenberg*, 530 U.S. at 923.

[26] *See* Brief Amici Curiae of Association of American Physicians and Surgeons et al. at 16, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448.

[27] *Id.* at 16.

[28] *Id.*

[29] *Inwood Laboratories, Inc.* v. *Ives Laboratories*, 456 U.S. 844, 856 (1982).

upon the unique opportunity afforded the trial court judge to evaluate the credibility of witnesses and to weigh the evidence."[30] Despite the fact that the Court might have found PhACT's argument to be more persuasive than the conclusions of the district court, "an appellate court cannot substitute its interpretation of the evidence for that of the trial court simply because the reviewing court 'might give the facts another construction, resolve the ambiguities differently, and find a more sinister cast to actions which the District Court apparently deemed innocent.'"[31] That is, a reviewing court must remember that when "applying the clearly erroneous standard to the findings of a district court sitting without a jury," that court's

> function is not to decide factual issues de novo. The authority of an appellate court, when reviewing the findings of a judge as well as those of jury, is circumscribed by the deference it must give to decisions of the trier of the fact, who is usually in a superior position to appraise and weigh the evidence. The question for the appellate court under Rule 52(a) is not whether it would have made the findings the trial court did, but whether "on the entire evidence (it) is left with the definite and firm conviction that a mistake has been committed."[32]

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

> The upshot is a District Court finding that D & X significantly obviates health risks in certain circumstances, a *highly plausible record-based explanation* of why that might be so, a *division of opinion among some medical experts* over whether D & X is generally safer, and an *absence of controlled medical studies* that would help to answer these medical questions. *Given these medically related evidentiary circumstances,* we believe the law requires a health exception.[33]

The *Stenberg* Court faced a situation in which "a trial judge's finding is based on his decision to credit the testimony of one of two or more witnesses, each of whom has told a coherent and facially plausible story that is not contradicted by extensive evidence."[34] The Court, in such circumstances has held that "that finding, if not internally inconsistent, can virtually never be clear error."[35]

Thus, in *Stenberg*, the Supreme Court was required to accept as true the very questionable findings issued by a single district court judge—the effect of which was to render null and void the reasoned factual findings and policy determinations of the United States Congress and at least 27 state legislatures. Whatever the cause of the lack of sufficient record evidence in *Stenberg* to contradict the view that partial-birth abortion is medically necessary and safe—be it neglect by the attorneys at the trial court, unavailability of

---

[30] *Id.* at 855

[31] *Id.* at 857.

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

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

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

[35] *Id.*

controlled tests or peer-reviewed articles—it simply cannot be the case that Congress is forever bound by the dubious factual findings of one Federal district court.

Judicial Deference to Congressional Fact-Finding

Under well-settled Supreme Court jurisprudence, the United States Congress is not bound to accept the same factual findings that the Supreme Court was bound to accept in *Stenberg* under the "clearly erroneous" standard. Rather, the United States Congress is entitled to reach its own factual findings—findings that the Supreme Court accords great deference—and to enact legislation based upon these findings so long as it seeks to pursue a legitimate interest that is within the scope of the Constitution, and draws reasonable inferences based upon substantial evidence. Thus, H.R. 760 includes extensive findings on the lack of evidence to support the medical efficacy or safety of the procedure as well as the potential dangers posed by the procedure. Under this approach Congress has expressed its disagreement with the factual conclusions of the district court in the *Stenberg* case—that a D & X abortion is in fact the safest abortion method for some women in some circumstances—without challenging the Supreme Court's authority to interpret *Roe* v. *Wade* [36] and *Planned Parenthood* v. *Casey*.[37]

The concept of Supreme Court deference to Congress' factual findings is not a new legal theory. The Court has historically been highly differential to Congress' factual determinations, regardless of the legal authority upon which Congress has sought to legislate. As Justice Rehnquist has stated, "the fact that th[e] Court is not exercising a primary judgment but sitting in judgment upon those who also have taken the oath to observe the Constitution and who have the responsibility for carrying on government," [38] compels the Court to be "particularly careful not to substitute our judgment of what is desirable for that of Congress, or our own evaluation of evidence for a reasonable evaluation by the Legislative Branch." [39]

In *Katzenbach* v. *Morgan*,[40] the Supreme Court articulated its highly deferential review of Congressional factual conclusions when it addressed the constitutionality of section 4(e) of the Voting Rights Act of 1965. That provision prohibits a state from denying the right to vote in any election to any person who has successfully completed the sixth primary grade in a public school in, or a private school accredited by, the Commonwealth of Puerto Rico where the language of instruction was other than English because of his or her inability to read or write English.[41] Section 4(e) was challenged by registered New York City voters who asserted that it prohibited the enforcement of Article II, § 1 of the New York Constitution, which required voters to be able to read and write English as a condition to voting. New York argued that section 4(e) could not be upheld as appropriate enforcement legislation under the Equal Protection Clause because the Supreme Court had already held that literacy requirements are not always unconstitu-

[36] 410 U.S. 112 (1973).
[37] 505 U.S. 833 (1992)
[38] *Rostker* v. *Goldberg*, 453 U.S. 57, 64 (1981).
[39] *Id.* at 68. *See also* K. G. Jan Pillai, *In Defense of Congressional Power and Minority Rights Under the Fourteenth Amendment* 68 Miss. L.J. 431, 509 (1998).
[40] 384 U.S. 641 (1966)
[41] *See* 42 U.S.C. sec. 1973b(e).

tional.[42] Thus, the question, as the Court saw it, was whether Congress had the authority under section 5 of the Fourteenth Amendment to enact section 4(e) even though the Court had not ruled that New York's requirement would have been unconstitutional.[43]

The Court began its analysis stating, "[w]hen we are required to pass on the constitutionality of an Act of Congress, we assume 'the gravest and most delicate duty that this Court is called on to perform.'"[44] Regarding Congress' factual determination that sec 4(e) would assist the Puerto Rican community in "gaining nondiscriminatory treatment in public services," the Court stated that it was well within congressional authority to say that this need of the Puerto Rican minority for the vote warranted Federal intrusion upon any state interest served by the English literacy requirement. *It was for Congress, as the branch that made this judgment, to assess and weigh the various conflicting considerations*—the risk or pervasiveness of the discrimination in governmental services, the effectiveness of eliminating the state restriction on the right to vote as a means of dealing with the evil, the adequacy or availability of alternative remedies, and the nature of significance of the state interests that would be affected by the nullification of the English literacy requirement as applied to residents who have successfully completed the sixth grade in a Puerto Rican school. *It is not for us to review the congressional resolution of these factors. It is enough that we be able to perceive a basis upon which the Congress might resolve the conflict as it did. There plainly was such a basis to support § 4(e) in the application in question in this case.*[45]

In *Fullilove* v. *Klutznick*,[46] the Court reviewed § 103(f)(2) of the Public Works Employment Act of 1977, otherwise known as the "minority business enterprise" provision (MBE), which stated that "no grant shall be made under this Act for any local public works project unless the applicant gives satisfactory assurance to the Secretary that at least 10 per centum of the amount of each grant shall be expended for minority business enterprises."[47] While repeatedly citing to the legislative record created by Congress, the Court upheld the MBE provision as an appropriate exercise of Congress' authority under the Spending Power, the Commerce Clause, and Section 5 of the Fourteenth Amendment.[48] Addressing the deference to be given Congress' actions the Court stated, "[h]ere we pass, not on a choice made by a single judge or a school board, but

---

[42] *See Katzenbach* v. *Morgan*, 384 U.S. 641, 648, 649 (1966).

[43] *Katzenbach,* 384 U.S. at 649.

[44] 448 U.S. 448, 472 (1980) (*citing Blodgett* v. *Holden*, 275 U.S. 142, 148 (1927).

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

[46] 448 U.S. 448 (1980)

[47] 42 U.S.C. § 6705(f)(2).

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

on a considered decision of the Congress and the President,"[49] and that "we are bound to approach our task with appropriate deference to the 'Congress, a co-equal branch.'"[50]

The Court again utilized this deferential standard in *Columbia Broadcasting System* v. *Democratic National Committee*,[51] holding that the Communications Act of 1934 and the First Amendment do not require broadcasters to accept editorial advertisements.[52] Deferring to the factual conclusions leading to the congressionally-created statutory and regulatory scheme, the Court stated that it "must afford great weight to the decisions of Congress."[53] "The judgment of the Legislative Branch," the Court continued, "cannot be ignored or undervalued simply because one segment of the broadcast constituency casts its claims under the umbrella of the First Amendment,"[54] because "when [the Court] face[s] a complex problem with many hard questions and few easy answers [it] do[es] well to pay careful attention to how the other branches of Government have addressed the same problem."[55]

In the 1990's, the Court continued its practice of deferring to congressional factual conclusions when the must-carry provisions of the Cable Television Consumer Protection and Competition Act of 1992 were challenged as a violation of the First Amendment.[56] At issue in the *Turner* cases was Congress' legislative finding that, absent mandatory carriage rules, the continued viability of local broadcast television would be "seriously jeopardized."[57] Indicating its inclination to uphold the provision, the *Turner I* Court recognized that as an institution, "Congress is far better equipped than the judiciary to 'amass and evaluate the vast amounts of data' bearing upon an issue as complex and dynamic as that presented here."[58] Although the Court recognized that in First Amendment cases "the deference afforded to legislative findings does 'not foreclose our independent judgment of the facts bearing on an issue of constitutional law," its "obligation to exercise independent judgment when First Amendment rights are implicated is not a license to reweigh the evidence *de novo*, or to replace Congress' factual predictions with our own. Rather, it is to assure that, in formu-

---

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

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

[51] 412 U.S. 94 (1973).

[52] *See id.*

[53] *Id.* at 103.

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

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

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

[57] *Turner Broadcasting System, Inc.* v. *Federal Communications Commission*, 512 U.S. 622, 665 (1994). *See also Turner,* 520 U.S. at 191 ("In explicit factual findings, Congress expressed clear concern that the 'marked shift in market share from broadcast television to cable television services,' resulting from increasing market penetration by cable services, as well as the expanding horizontal concentration and vertical integration of cable operators, combined to give cable system the incentive and ability to delete, reposition, or decline carriage to local broadcasters in an attempt to favor affiliated cable programmers. Congress predicated that 'absent the reimposition of [must-carry], additional local broadcast signals will be deleted, reposition, or not carried'; with the end result that 'the economic viability of free local broadcast television and its ability to originate quality local programming will be seriously jeopardized.").

[58] *Turner,* 512 U.S. at 665–66.

lating its judgments, Congress has drawn reasonable inferences based on substantial evidence."[59]

Three years later in *Turner II*, the Court upheld the "must-carry" provisions based upon Congress' findings, stating the Court's "sole obligation is 'to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence."[60] Citing to its ruling in *Turner I*, the *Turner II* Court reiterated, "[w]e owe Congress' findings deference in part because the institution 'is far better equipped than the judiciary to "amass and evaluate the vast amounts of data" bearing upon' legislative questions,"[61] and added that it "owe[d] Congress' findings an additional measure of deference out of respect for its authority to exercise the legislative power."[62]

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

> the government's burden of justifying its legislative enactment against a facial challenge may be carried by pointing to the enactment itself and its legislative history. These are 'legislative facts,' the substance of which cannot be trumped by the fact finding apparatus of a single court. While a party challenging an ordinance can point to other factors not considered by the legislature to demonstrate that the legislature acted irrationally, it cannot subject legislative findings themselves to judicial review under a clearly erroneous standard or otherwise. To do so would ignore the structural separation between legislative bodies and courts and would improperly subordinate one branch to another.[63]

Theses cases clearly indicate that Congress has the constitutional authority to enact a partial-birth abortion ban that does not contain a health exception, so long as in doing so Congress has drawn reasonable inferences based upon substantial evidence. "Congress ha[s] abundant evidence from which it can conclude"[64] that a ban on partial-birth abortion is not required to contain a "health" exception, as the overwhelming weight of evidence supports the conclusion that a partial-birth abortion is never medically necessary to preserve the health of a woman and it poses substantial health risks to women who undergo the procedure. Congress was informed by extensive hearings held during the 104th, 105th, and 107th Congresses and passed a ban on partial-birth abortion in the 104th, 105th, and 106th Congresses. These proceedings revealed that partial-birth abortion is never necessary to preserve the health of a woman and should, therefore, be banned.

A ban was first considered during the 104th Congress. H.R. 1833 was introduced by Rep. Charles Canady on June 14, 1995. The Subcommittee on the Constitution held a markup session on the

---

[59] *Turner,* 512 U.S. at 666.

[60] *Turner Broadcasting System, Inc.* v. *Federal Communications Commission*, 520 U.S. 180, 195 (1997).

[61] *Turner,* 520 U.S. at 195. *See also Walters* v. *National Association of Radiation Survivors*, 473 U.S. 305, 330 n.12 ("When Congress makes findings on essentially factual issues such as these, those findings are of course entitled to a great deal of deference, inasmuch as Congress is an institution better equipped to amass and evaluate the vast amounts of data bearing on such an issue.").

[62] *Turner,* 520 U.S. at 196.

[63] *Anheuser-Busch, Inc.* v. *Schmoke*, 63 F.3d 1305, 1312 (4th Cir. 1995).

[64] *Id.* at 477.

bill on June 21, 1995, and on July 12, 1995 and July 18, 1995, H.R. 1833 was marked up by the Judiciary Committee. On November 1, 1995, H.R. 1833 was considered on the floor of the House of Representatives and passed by a vote of 288 to 139. On November 17, 1995, the Senate Committee on the Judiciary held a hearing on H.R. 1833 at which it received testimony from 12 witnesses including five doctors, two nurses, and two constitutional law experts.[65] From December 5, 1995 until December 7, 1995, the Senate debated H.R. 1833 and on December 7, 1995, it passed the legislation 54 to 44. On March 21, 1996, the House Judiciary Committee's Subcommittee on the Constitution held a hearing on the "Effects of Anesthesia During A Partial-Birth Abortion."[66] Six days later on March 27, the House of Representatives, by a vote of 286 to 129, again approved the partial-birth abortion ban.[67] This bill was vetoed by then President Clinton on April 10, 1996. On September 19, 1996, the U.S. House of Representatives overrode this veto by a 285 to 137 vote. The Senate, however, failed to override the veto, its vote failing 58 to 40.

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

During the 106th Congress, Rep. Canady introduced H.R. 3660 which was identical to legislation approved by the House during the 105th Congress. It was approved by a 287 to 141 vote. On October 5, 1999, Senator Rick Santorum introduced S. 1692. It was considered on October 19, 20, and 21, 1999, and approved by a vote of 63 to 34 on October 21, 1999. Because the House and Senate versions differed from one another, S. 1692 was sent to the House for approval where it was then amended by inserting the provisions of H.R. 3660 in lieu of the Senate passed bill. This version was approved by the House on May 25, 2000.[68]

---

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

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

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

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

On June 19, 2002, Rep. Steve Chabot introduced H.R. 4965, which was the first partial-birth abortion bill after the *Stenberg* decision. The Subcommittee on the Constitution held a hearing on H.R. 4965 on July 9, 2002. The Subcommittee received testimony from Dr. Kathi Aultman, M.D., Dr. Curtis Cook, M.D., Professor Robert A. Destro, Professor of Law, Columbus School of Law at the Catholic University of America, and Simon Heller, Consulting Attorney with the Center for Reproductive Law and Policy, with additional material submitted by Dr. Kathi Aultman, M.D., Dr. Curtis Cook, M.D., and the Center for Reproductive Law and Policy. On July 11, 2002, the Subcommittee on the Constitution met in open session and ordered H.R. 4965 favorably reported by a vote of 8 to 3. On July 17, 2002, the full Judiciary Committee met in open session and ordered H.R. 4965 favorably reported without amendment by a recorded vote of 20 to 8. H.R. 4965 was passed by the House of Representatives on July 24, 2002, by a vote of 274–151. The Senate failed to take action on the bill during the 107th Congress.

On February 13, 2003, Rep. Steve Chabot introduced H.R. 760 which is identical to H.R. 4965. H.R. 760 was referred to the Judiciary Committee on that same date. On March 25, 2003, the Committee on the Judiciary's Subcommittee on the Constitution held a legislative hearing on H.R. 760 where it received testimony from Dr. Mark G. Neerhof, D.O., Mr. Simon Heller of the Center for Reproductive Rights, and Professor Gerard V. Bradley of the University of Notre Dame School of Law. On March 25, 2003, the Subcommittee reported H.R. 760 out favorably by a vote of 8 to 4. H.R. was approved by the Committee on the Judiciary by a 19 to 11 vote on March 26, 2003. Similarly, S. 3, which was identical to H.R. 760, was introduced by Sen. Rick Santorum on February 14, 2003. The Senate considered S. 3 on March 10, 11, 12, and 13, 2003, and on March 13, 2003, the Senate passed S. 3, with amendment, by a vote of 64–33.[69]

Specific Congressional Findings

The overwhelming weight of evidence compiled in a series of congressional hearings indicates that partial-birth abortions (or D & X abortions) are never necessary to preserve the health of a woman, and in fact pose substantial health risks to women undergoing the procedure. Therefore, H.R. 760 does not include a health exception.

Numerous congressional proceedings have revealed that there is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures.[70] According to the Amer-

[69] By a 52 to 46 vote, the Senate approved an amendment to S. 3 expressing the sense of the Senate that *Roe* v. *Wade* "was appropriate and secures an important constitutional right" and that the decision "should not be overturned."

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

ican Medical Association (AMA), a "D & X procedure is not even an accepted 'medical practice.'"[71] No controlled studies of partial-birth abortions have been conducted nor have any comparative studies been conducted to demonstrate its efficacy compared to other abortion methods.[72] Furthermore, there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures.[73] Indeed, unlike other more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the performance of partial-birth abortions in their curriculum.[74]

This absence of any basis upon which to conclude that partial-birth abortions are safe has not gone unnoticed by the AMA, which has stated that partial-birth abortion is "not an accepted medical practice," that it has "never been subject to even a minimal amount of the normal medical practice development," that "the relative advantages and disadvantages of the procedure in specific circumstances remain unknown," and that "there is no consensus

---

financial contributor to Planned Parenthood." Brief of Petitioner at 40, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (No. 99–830) *available at* 2000 WL 228615.

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

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

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

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

among obstetricians about its use."[75] The AMA has further noted that partial-birth abortion is broadly disfavored by both medical experts and the public, is "ethically wrong," and "is never the only appropriate procedure."[76] Thus, a select panel convened by the AMA could not find "any" identified circumstance where a partial birth abortion was "the only appropriate alternative."[77]

In order to underscore the depth of its opposition, the AMA explained that although it normally opposes criminal sanctions applied to the medical profession, "the profession has supported criminal restrictions on improper 'medical' procedures."[78] Although the AMA no longer supports the ban due to its opposition to criminal sanctions against physicians, it continues to oppose the procedure.[79] Additionally, the American College of Obstetricians and Gynecologists (ACOG), an organization which has consistently opposed legal restrictions on abortion, including partial-birth abortion bans, has reported, "A select panel convened by ACOG could identify no circumstances under which this [D & X] procedure . . . would be the only option to save the life or preserve the health of the woman."[80]

---

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

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

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

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

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

[80] Brief of Petitioner at 35, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228615. ACOG filed a brief in opposition to Nebraska's PBA ban and has consistently opposed legislation to ban the partial-birth abortion procedure. *See* Brief of Amici Curiae Amici American College of Obstetricians and Gynecologists et al., *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) available at 2000 WL 340117. ACOG later stated that "an intact D & X, however, may be the best or most appropriate procedure in a particular circumstance." *Carhart* v. *Stenberg*, 11 F. Supp.2d 1099, 1105 n.10 (D. Neb. 1998). When interviewed about the statement a D & X procedure "may" be best or most appropriate in some circumstances, ACOG President Fredric D. Frigoletto, Jr., "maintained that the [ACOG Executive] Board did not 'endorse' the procedure. 'There are no data to say that one of the procedures is safer than the other,' he said."

Neither the plaintiff in *Stenberg* v. *Carhart*, Dr. Leroy Carhart, nor the experts who testified on his behalf, have identified a *single* circumstance during which a partial-birth abortion is necessary to preserve the health of a woman. In fact, according to Dr. Carhart's testimony, when he has chosen to perform partial-birth abortions he has done so based upon the happenstance of the presentation of the unborn child, not because it was the only procedure that would have preserved the health of the mother.[81] Thus, based on Dr. Carhart's testimony, the only interest served by a partial-birth abortion is the convenience of the doctor performing the abortion and not the preservation of the health of the mother.[82] Moreover, Dr. Martin Haskell, the physician credited with developing the partial-birth abortion procedure, has testified that he has never encountered a situation where a partial-birth abortion was medically necessary to achieve the desired outcome and, thus, is never medically necessary to preserve the health of a woman.[83]

According to *The Record*, the abortion providers at the Englewood, New Jersey abortion clinic that performs 1,500 partial-birth abortions per year stated that "only a 'minuscule amount' are for medical reasons."[84] The writings of both Dr. Haskell and Dr. McMahon also indicate that partial-birth abortion is the method they prefer for all late-term abortions.[85] Dr. Haskell told the *AMNews* that the vast majority of the partial-birth abortions he performs are elective. He stated: "And I'll be quite frank: most of my abortions are elective in that 20–24 week range. . . . In my particular case, probably 20% are for genetic reasons. And the other 80% are purely elective. . . ."[86]

In 1995, Dr. McMahon reported to the Constitution Subcommittee that of over 2,000 partial-birth abortions, only 9 percent involved "maternal [health] indications," of which the most common

---

Diane M. Gianelli, *Medicine Adds to Debate on Late-Term Abortions: ACOG Draws Fire for Saying Procedure 'May' Be Best Option for Some*, 40 Amer. Med. News 1 (March 3, 1997).

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

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

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

[84] Ruth Padawer, *The facts on partial-birth abortion*, The Record, Sept. 15, 1996, at RO–1.

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

[86] Letter from Barbara Bolsen, Editor, American Medical News, to Congressman Charles T. Canady (July 11, 1995) (on file with the Subcomm. on the Constitution of the House Comm. on the Judiciary). The experiences of the state of Kansas, the only state to require physicians to report the performance of partial-birth abortions, are instructive on this point. Under its mandatory reporting scheme for partial-birth abortions, in 1998 fifty-eight partial-birth abortions were performed, all of which were on viable babies and all of which were "necessary to prevent substantial and irreversible impairment of a major bodily function," which was an "impairment of the patient's mental function." Similarly, in 1999, one hundred eighty-two such procedures were performed all for the same reason and again all on viable babies. Center for Health and Environmental Statistics, Kansas Dept. of Health and Environment, *Abortions in Kansas 1998–2001: Preliminary Report, available at* <http://www.kdhe.state.ks.us/hci/99itop1.pdf>(last visited Feb. 25, 2003).

was "depression."[87] Dr. McMahon also sent the Subcommittee a graph which shows the percentage of "flawed fetuses" that he aborted using the partial-birth abortion method. The graph shows that even at 26 weeks of gestation half the babies that Dr. McMahon aborted were perfectly healthy and many of the babies he described as "flawed" had conditions that were compatible with long life, either with or without a disability. For example, Dr. McMahon listed nine partial-birth abortions performed because the baby had a cleft lip.[88]

The fact of the matter is that the mainstream medical community has rejected the partial-birth abortion procedure because of concerns about its safety.[89] Leading proponents of partial-birth abortion acknowledge that it poses additional health risks because, among other things, the procedure requires a high degree of surgical skill to pierce the infant's skull with a sharp instrument in a blind procedure. Dr. Warren Hern has testified that he had "very serious reservations about this procedure and that "he could not imagine a circumstance in which this procedure would be safest."[90] Although he was opposed to legislation banning partial-birth abortions "because he thinks Congress has no business dabbling in the practice of medicine and because he thinks this signifies just the beginning of a series of legislative attempts to chip away at abortion rights," he also states, "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."[91] He has also stated, "I would dispute any statement that this is the safest procedure to use."[92] Dr. Pamela Smith has testified that "the only interest served by the partial-birth abortion procedure is the 'convenience' of the abortionist."[93] The procedure also poses the following additional health risks to the woman: an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term[94]; an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting

---

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

[88] *See id.*

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

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

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

[92] *Id.*

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

[94] "[S]ome physicians have suggested that the procedure may increase complications, such as cervical incompetence." Janet E. Gans Epner et al., *Late-Term Abortion*, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26, 1998). *See also* Brief of Amici Curiae Association of American Physicians and Surgeons et al. at 21, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228448. The threat of cervical incompetence is related to the amount of cervical dilation. A. Golan, et al., *Incompetence of the Uterine Cervix*, 44 Obstet. Gynecol. Surv. 96–107 (1989). Dr. Stubblefield testified that at the same week of gestation, "the D & X requires greater dilation" than the D & E procedure which supports the conclusion that a D & X procedure brings with it the risk of cervical incompetence and an increased risk that a woman's membranes may rupture. *See* Brief of Amicus Curiae State of Wisconsin at 21, *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (99–830) *available at* 2000 WL 228615.

the child to a footling breech position, a procedure which, according to Williams Obstetrics, a leading obstetrics textbook, "there are very few, if any, indications for . . . other than for delivery of a second twin"[95]; and a risk of iatrogenic lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death.[96] This also creates a high risk of infection should she suffer a laceration due to the non-sterile vaginal environment.[97]

Proponents of partial-birth abortion argue that, notwithstanding all of the evidence indicating that the procedure has not been proven safe, effective, or necessary, any ban on the procedure should include a health exception because it *may*, in some unidentifiable circumstance, be the safer procedure for a given women. The problem with this argument, however, is the abortionists have indicated that they will certify that any pregnancy poses risks to a woman's health. Dr. Warren Hern of Colorado, the author of the standard textbook on abortion procedures who also performs many third-trimester abortions has stated: "I will certify that any pregnancy is a threat to a woman's life and could cause grievous injury to her physical health."[98] Thus, including a health exception in the ban would render the ban meaningless, as it would not prohibit a single partial-birth abortion.

Opponents of the partial-birth abortion ban have also criticized the legislation's use of the term "partial-birth abortion," citing the absence of the term partial-birth abortion in medical literature. However, the term partial-birth abortion is a legal term defined clearly in H.R. 760 as any abortion in which the person performing the abortion "deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal 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." This term is sufficiently precise to address the *Stenberg* Court's concern that the definition of the prohibited procedure clearly track the medical differences between a partial-birth abortion and other abortion procedures in which the act leading to death occurs in the uterus.

The use of this term in the legislation was necessitated by the fact that the partial-birth abortion procedure was not recognized in the medical community and has been called by various names by the abortionists who invented and practice it, including "dilation and extraction," "intact dilation and evacuation," and "intrauterine

---

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

[96] Janet E. Gans Epner et al., *Late-Term Abortion*, 280 J. Amer. Med. Ass'n724, 744–45 (Aug. 26, 1998).

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

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

cranial decompression." Just as the term partial-birth abortion was not found in medical literature, these terms were not found in medical literature because these horrific procedures were considered to be "bad medicine" by the medical community.

In fact, Dr. Pamela Smith, an obstetrician at Mt. Sinai Hospital in Chicago, testified before the Subcommittee on the Constitution that when she described the procedure to other physicians, "many of them were horrified to learn that such a procedure was even legal."[99] Dr. Smith also stated:

> [T]here is no uniformly accepted medical terminology for the method that is the subject of this legislation. Dr. McMahon does not even use the same term as Dr. Haskell, while the National Abortion Federation implausibly argues that there is nothing to distinguish this procedure from the D & E abortions. The term you have chosen, 'partial-birth abortion,' is straightforward.[100]

There are also alternative abortion procedures that are proven safer (though not necessarily safe) than partial-birth abortion. Nationwide, the testimony in partial-birth abortion cases establishes that the D & E abortion procedure is a safer alternative procedure.[101] Dr. Frank Boehm testified that banning the partial-birth abortion procedure would not enhance or increase the risk to women of amniotic fluid embolus.[102] He also testified that where an unborn child has severe hydrocephaly, which causes the head to be too large to pass through the cervix, he would use an ultrasound-guided cepholocentis procedure to "drain the ventricles of the amniotic fluid to allow the head to slip through the cervix."[103] A ban will not force a woman seeking an abortion to undergo an "alternative procedure which would create a higher risk of harm to her uterus, cervix, or internal organs" because abortionists have "been performing abortions for years on women safely with other techniques, and we don't have any data that would say that another technique such as partial-birth abortion is any safer."[104]

Those opposed to the passage of H.R. 760 continue to assert that the government should not be in the examination room regulating physicians in the performance of their job. Yet the law follows every physician through the performance of every aspect of their job in the form of tort law. Every aspect of the practice of medicine is regulated by traditional standards of negligence that have been adapted to serve the medical profession in the form of medical malpractice. Under these rules, a "doctor must have and use the knowledge, skill and care ordinarily possessed and employed by

---

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

[100] *Id.*

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

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

[103] *Id.* at 38.

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

members of the profession in good standing; and a doctor will be liable if harm results because he does not have them."[105] Thus, the law measures every aspect of a physician's medical practice against what is considered, "'good medical practice,' which is to say, what is customary and usual in the profession." *Id.* at 189.

Even when there is disagreement within an area of speciality as to alternative methods of acceptable treatment a physician is still required to offer the level of medical care consistent with the tenets of the school the doctor professes to follow. *See id.* at 187. Even this, however, does not entitle a physician to provide medical care with no proven benefits. As *Prosser and Keeton* state, "this does not mean, however, that any quack, charlatan or crackpot can set himself up as a 'school,' and so apply his individual ideas without liability. A school must be a recognized one within definite principles, and it must be the line of thought of a respectable majority of the profession." *Id.* Thus, a physician's medical decision-making has always been subject to legal oversight and the threat of legal liability for negligently rendered medical series is a regular aspect of the practice of medicine.

Furthermore, there are some procedures so abhorrent to society that they have been severely restricted or banned. For example, in 1996, Congress approved a ban on female genital mutilation under which anyone who "knowingly circumcises, excises, or infibulates the whole or any part of" the genitals of a woman who has not attained the age of 18 years will be fined or imprisoned not more than 5 years, or both. In 1997, the American Medical Association noted the appropriateness of this ban stating, "the profession has supported criminal restrictions on improper 'medical' procedures, such as female genital mutilation."[106]

In addition to promoting maternal health, such a prohibition will draw a bright line that clearly distinguishes abortion and infanticide, that preserves the integrity of the medical profession, and promotes respect for human life. Based upon *Roe* v. *Wade*,[107] and *Planned Parenthood* v. *Casey*,[108] the government's interest in protecting the life of a child in the process of being born arises, in part, by virtue of the fact that during a partial-birth abortion, labor is induced and the birth process has begun. This distinction was recognized in *Roe* when the Court noted, without comment, that the Texas parturition statute, which prohibited one from killing a child "in a state of being born and before actual birth," was not under attack.[109] This interest becomes compelling as the child emerges from the maternal body. A child that is completely born is a full, legal person entitled to constitutional protections afforded a "person" under the United States Constitution. Partial-birth abortions involve the killing of a child that is in the process, in fact mere inches away from, becoming a "person." While under these two rulings a pregnancy may be terminated, partial-birth abortion should not implicate this right because the pregnancy ended once the birth process began and the right to terminate one's pregnancy

[105] W. Page Keeton, *Prosser and Keeton on The Law of Torts* 187 (5th ed. 1984).

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

[107] 410 U.S. 113 (1973).

[108] 505 U.S. 833 (1992).

[109] *Roe* v. *Wade*, 410 U.S. 113, 118 n.1 (1973).

by aborting one's unborn child does not include an independent right to assure the death of that child regardless of its location to its mother. Thus, the government has a heightened interest in protecting the life of the partially-born child.

This, too, has not gone unnoticed by the American Medical Association which has recognized that partial-birth abortions are "ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb." Thus, the "'partial birth' gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body."[110]

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

The gruesome and inhumane nature of the partial-birth abortion procedure and its disturbing similarity to the killing of a newborn promotes a complete disregard for infant human life that can only be countered by a prohibition of the procedure. According to Dr. Haskell, the vast majority of babies killed during a partial-birth abortion are alive until the end of the procedure.[111] It is a medical fact, however, that unborn infants can feel pain when subjected to painful stimuli and that their perception of this pain is more intense than that of newborn infants and older children when sub-

---

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

[111] Responding to an interviewer's questioning, "Let's talk first about whether or not the fetus is dead beforehand . . ." Dr. Haskell responded "No it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress—intrauterine stress during, you know, the 2 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." *Partial-Birth Abortion: The Truth, Joint Hearing on S. 6 and H.R. 929 Before the House Comm. on the Judiciary Subcomm. on the Constitution and the Senate Comm. on the Judiciary,* 105th Cong. 61 (March 11, 1997).

jected to the same stimuli.[112] Thus, during a partial-birth abortion procedure, the child will fully experience the pain associated with piercing his or her skull and sucking out his or her brain.

Nor will a child upon whom a partial-birth abortion is being performed be significantly affected by medication administered to the mother during the performance of the procedure. As credible testimony received by the Subcommittee on the Constitution confirms, "[c]urrent methods for providing maternal anesthesia during 'partial-birth abortions' are unlikely to prevent the experience of pain and stress" that the child will feel during the procedure.[113] Thus, claims that a child is almost certain to be either dead or unconscious and near death prior to the commencement of the partial-birth are unsubstantiated.

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

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

Constitutional Authority

Congress derives its constitutional authority to enact H.R. 760 from the Commerce Clause which provides Congress with the authority to "regulate Commerce with Foreign Nations, and among the several States."[114]

The provision of abortion services, including partial-birth abortions, is clearly commerce. As former Attorney General Janet Reno testified during consideration of the Freedom of Access to Clinic Entrances Act[115] in 1993,

> The provision of abortions services is commerce. The entities that provide these services, including clinics, physicians' offices, and hospitals, purchase or lease facilities, purchase and sell equipment, goods, and services, employ people, and generate income. Not only do their activities have an effect on interstate commerce, but they engage directly in interstate commerce. It should be easy to document that they purchase medicine, medical supplies, surgical instruments, and other supplies produced in other States. Moreover, it is well-established that many serve significant number of patients from other states. For example, in *Bray v. Alexandria Women's Health Clinic*, 113 S.Ct. at 762, the Supreme Court accepted

[112] *Effects of Anesthesia During a Partial-Birth Abortion: Hearing Before the House Comm. on the Judiciary Subcomm. on the Constitution,* 104th Cong. (March 21, 1996) (statement of Jean A. Wright).
[113] *Id.*
[114] U.S. Const. Art. I, § 8, cl. 3.
[115] 18 U.S.C. § 248.

> the district court's finding that substantial numbers of patients at abortion clinics in the Washington, D.C., area traveled interstate to obtain the services of the clinics. In Wichita, KS, the Federal district court found that some 44 percent of the patents at one clinic came from out of State. *See New York State NOW* v. *Terry*, 886 F. 2d at 1360 (many women travel from out-of-State to New York clinics).[116]

Congress received similar testimony when Professor David Smolin appeared before the Judiciary Committee's Subcommittee on the Constitution,

> Abortion services would generally be classed within the broader category of medical and health care services, for purposes of commerce clause analysis. Health care constitutes, as the Congress well knows, a large and significant portion of the national economy, and it would seem absurd to hold that an industry comprising one-seventh of the national economy could not be regulated under the commerce clause.[117]

It is also clear that women travel between the states in order to obtain abortions. In 1999, according to the Centers for Disease Control and Prevention, 54.9 percent of abortions performed in the District of Columbia were on out-of-State residents, 34.8 percent of those performed in Delaware were on out-of-State residents, and 48.6 percent of those performed in Kansas were on out-of-State residents.[118]

A review of the performance of partial-birth abortions indicates that in the process of providing partial-birth abortions, abortionists engage in interstate commerce. First, the performance of a partial-birth abortion, as with the performance of any abortion, is an economic transaction in which a service is performed for a fee. Second, because so few abortionists perform partial-birth abortions, women seeking to obtain a partial-birth abortion are more likely to have to travel out-of-State to find an abortionist willing to perform the procedure. As Professor David Smolin testified in front of the Judiciary Committee's Subcommittee on the Constitution,

> The relatively few number of abortion providers who perform partial-birth abortions appear particularly likely to be involved in serving out-of-State patients, given the relatively specialized nature of the services they provide. Some providers of abortion services do not perform abortions in the second half of pregnancy, during the period for which partial-birth abortions were designed; thus, those abortion providers who provide late term abortions are even more likely to receive referrals, and patients, from outside of their immediate geographical area.[119]

---

[116] *Hearing on S. 636, the Freedom of Access to Clinic Entrances Act of 1993 Before the Senate Comm. on Labor and Human Resources,* 103rd Cong. 16 (May 12, 1993)(Statement of Attorney General Janet Reno). All circuits to have addressed the question have concluded that the Freedom of Access to Clinic Entrances Act was a valid use of Congress' Commerce Clause authority. *See Norton* v. *Ashcroft*, 298 F.3d 547, 555 (6th Cir. 2002).

[117] *Partial-Birth Abortions: Hearing before the Comm. on the Judiciary Subcomm. on the Constitution,* 105th Cong. (June 15, 1995) (Statement of David M. Smolin).

[118] *See* Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report: Abortion Surveillance—United States, 1999*, 14 (2002). *See also* H.R. Rep. No. 103–306 at 6 (1993) ("women travel interstate to obtain reproductive health services").

[119] *Partial-Birth Abortions: Hearing before the Comm. on the Judiciary Subcomm. on the Constitution,* 105th Cong. (June 15, 1995) (Statement of David M. Smolin).

Third, partial-birth abortions are usually performed in an outpatient clinic or facility which is likely to "purchase medicine, medical supplies, surgical instruments, and other supplies produced in other States."[120] Finally, abortionists who perform partial-birth abortions advertise their services across state lines and women travel across state lines in order to obtain partial-birth abortions. A review of the practices of the state of Kansas bears this out. Since 1998, abortionists in Kansas have been required to report the performance of partial-birth abortions.[121] In 1998, all 58 partial-birth abortions performed in Kansas were performed on out-of-State residents.[122] Similarly, in 1999, 175 of the 182 partial-birth abortions performed were performed on out-of-State residents.[123] The practices of Dr. Haskell are instructive on this issue as well. Dr. Haskell himself advertises to out-of-State women as evidenced by his website and an Indianapolis, Indiana phone book. On his website Dr. Haskell states,

> Indiana limits abortion access beyond the first trimester of pregnancy. Indiana law requires second trimester procedures to be performed in a hospital or licensed surgical center. This makes terminations beyond the first trimester unnecessarily expensive. As a result most Indiana women choosing to terminate after the first trimester travel to either Dayton or Cincinnati, Ohio where hospitalization is not required."[124]

He continues, "Our Ohio Centers in Cincinnati, Dayton and Akron provide second trimester services to many out of state women."[125]

In 1995 the Court limited Congress' authority under the Commerce Clause when, in *U.S.* v. *Lopez*,[126] it held that Congress exceeded its Commerce Clause authority by enacting the Gun-Free School Zones Act which prohibited the possession of a gun on or near the grounds of a school.[127] However, *Lopez* turned on the fact that it proscribed noncommercial activity, the mere possession of a gun on or near school grounds. Indeed, Chief Justice Rehnquist, writing for the majority, highlighted this key point in the first paragraph of his opinion when he stated that, "[t]he Act neither

---

[120] *Hearing on S. 636, the Freedom of Access to Clinic Entrances Act of 1993 Before the Senate Comm. on Labor and Human Resources,* 103rd Cong. 16 (May 12, 1993)(Statement of Attorney General Janet Reno).

[121] Under Kansas law physicians electing to perform a partial-birth abortion procedure are required to "report such determination and the reasons for such determination in writing to the medical care facility in which the abortion is performed for inclusion in the report of the medical care facility to the secretary of health and environment . . ." K.S.A. § 65–6721 (c). A partial-birth abortion is defined as "an abortion procedure which includes the deliberate and intentional evacuation of all or a part of the intracranial contents of a viable fetus prior to removal of such otherwise intact fetus from the body of the pregnant woman." K.S.A. § 65–6721 (b).

[122] Center for Health and Environmental Statistics, Kansas Department of Health and Environmental Statistics, Kansas, Abortions in Kansas 1998: Preliminary Report 10 (1999).

[123] Center for Health and Environmental Statistics, Kansas Department of Health and Environmental Statistics, *Kansas, Abortions in Kansas 1999: Preliminary Report* 10 (2000). No partial-birth abortions have been performed in Kansas since October 1999. *See* Center for Health and Environmental Statistics, Kansas Department of Health and Environmental Statistics, *Kansas, Abortions in Kansas, 2001: Preliminary Report* 10 (2002).

[124] *www.womensmedcenter.com/laws/indiana.asp,* last visited July 19, 2002.

[125] *Id.* Although Dr. Haskell does not state that he performs partial-birth abortions on his website it is a fact that he does perform the procedure since he has stated that he "routinely performs [a partial-birth abortion] . . . on all patients 20 through 24 weeks." Martin Haskell, M.D., *Dilation and Extraction for Late Second Trimester Abortions*, Presented at the National Abortion Federation Risk Management Seminar (September 13, 1992), *in* Second Trimester Abortion: From Every Angle, 1992, at 6–7. Thus the advertisement of abortion services through the 24 week of pregnancy should be considered as an advertisement for partial-birth abortions.

[126] 514 U.S. 549 (1995) (emphasis added).

[127] 18 U.S.C. §922(q)(1)(A) (1998 ed., Supp. V).

regulates a commercial activity nor contains a requirement that the possession be connected in any way to interstate commerce" and thus concluded that the law "exceed[ed] the authority of Congress '[t]o regulate Commerce . . . among the several States.'"[128]

Citing to the Court's opinion in *Wickard* v. *Filburn*,[129] which upheld the application of the Agricultural Adjustment Act of 1938 to the production and consumption of homegrown wheat, Chief Justice Rehnquist stated, "[e]ven *Wickard*, which is perhaps the most far reaching example of Commerce Clause authority over intrastate activity, involved economic activity in a way that the possession of a gun in a school zone does not." The Chief Justice went on to reason that the activity at issue in *Wickard*, the growing of wheat mostly for one's own consumption and use, could be regulated by Congress under the Commerce Clause because the regulation was "an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated" whereas the Gun-Free School Zones Act was "a criminal statute that by its terms has nothing to do with 'commerce' or any sort of economic enterprise, however broadly one might define those terms."[130] It is thus argued by some that the regulation of partial-birth abortions is not "an essential part of a large regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." This analysis, however, is flawed because the business of performing partial-birth abortions involves interstate commercial activity in a manner in which the mere possession of a gun on or near a school simply does not. Thus it's unnecessary to even consider whether the performance of partial-birth abortions "arise out of or are connected with a commercial transaction, which viewed in the aggregate, substantially affects interstate commerce."[131] In other words, the fact that abortion services and the performance of partial-birth abortions are commerce "sufficiently distinguishes the proposed ban from *Lopez*, which concerned an attempted regulation of noncommercial activity."[132]

Furthermore, H.R. 760 also contains a jurisdictional requirement, "[a]ny physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion . . . ," which will "ensure, through case-by-case inquiry, that" the partial-birth abortion "in question affects interstate commerce."[133]

For these reasons, enactment of H.R. 760 is an appropriate and constitutional use of Congress' authority under the Commerce Clause.

---

[128] *Lopez,* 514 U.S. at 551.

[129] 317 U.S. 111 (1942).

[130] *Lopez,* 514 U.S. at 561.

[131] *Lopez,* 514 U.S. at 561. The testimony of Professor Smolin is, again, instructive on this point,

> The Supreme Court's recent decision in *United States* v. *Lopez*, 115 S.Ct. 1624 (1005), does not alter the conclusion that Congress possesses the authority to enact the proposed ban on partial-birth abortions. *Lopez* concerned the proscription of a noncommercial activity: the possession of a firearm in a school zone. The United States argued unsuccessfully that this noncommercial activity substantially affected interstate commerce because of its negative impact upon education. The Court rejected the dissent's view that schools (including public schools) are commercial. 115 S.Ct. at 1633.

Partial-Birth Abortions: Hearing before the Comm. on the Judiciary Subcomm. on the Constitution, 105th Cong. (June 15, 1995) (Statement of David M. Smolin).

[132] *Partial-Birth Abortions: Hearing before the Comm. on the Judiciary Subcomm. on the Constitution,* 105th Cong. (June 15, 1995) (Statement of David M. Smolin).

[133] *U.S.* v. *Lopez*, 514 U.S. 549, 561 (1995).

HEARINGS

The Committee's Subcommittee on the Constitution held 1 day of hearings on H.R. 760 on March 25, 2003. Testimony was received from Dr. Mark G. Neerhof, D.O., Mr. Simon Heller, Of Counsel to the Center for Reproductive Rights, and Professor Gerard V. Bradley of the University of Notre Dame Law School. Additional material was submitted by Constitution Subcommittee Chairman Rep. Steve Chabot and Rep. Jerrold Nadler.

COMMITTEE CONSIDERATION

On March 25, 2003, the Subcommittee on the Constitution met in open session and ordered favorably reported the bill H.R. 760 by a vote of 8 to 4, a quorum being present. On March 26, 2003, the Committee met in open session and ordered favorably reported the bill H.R. 760 without amendment by a recorded vote of 19 to 11, a quorum being present.

VOTE OF THE COMMITTEE

1. An amendment was offered by Mr. Scott, Ms. Baldwin and Ms. Jackson Lee to add an exception for partial-birth abortions performed to preserve the health of the mother and to replace the H.R. 760's exception for the life of the mother. The amendment was defeated by a rollcall vote of 7 yeas to 15 nays.

ROLLCALL NO. 1

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble		X	
Mr. Smith		X	
Mr. Gallegly			
Mr. Goodlatte			
Mr. Chabot		X	
Mr. Jenkins			
Mr. Cannon		X	
Mr. Bachus		X	
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake			
Mr. Pence			
Mr. Forbes		X	
Mr. King		X	
Mr. Carter		X	
Mr. Feeney		X	
Mrs. Blackburn		X	
Mr. Conyers			
Mr. Berman			
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt			
Ms. Lofgren			
Ms. Jackson Lee			
Ms. Waters			
Mr. Meehan			
Mr. Delahunt			
Mr. Wexler	X		
Ms. Baldwin	X		

ROLLCALL NO. 1—Continued

	Ayes	Nays	Present
Mr. Weiner	X		
Mr. Schiff	X		
Ms. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	7	15	

2. An amendment was offered by Mr. Nadler that would strike the civil cause of action. The amendment was defeated by a rollcall vote of 11 yeas to 15 nays.

ROLLCALL NO. 2

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble		X	
Mr. Smith		X	
Mr. Gallegly		X	
Mr. Goodlatte			
Mr. Chabot		X	
Mr. Jenkins		X	
Mr. Cannon		X	
Mr. Bachus			
Mr. Hostettler		X	
Mr. Green			
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake			
Mr. Pence			
Mr. Forbes		X	
Mr. King		X	
Mr. Carter		X	
Mr. Feeney		X	
Mrs. Blackburn		X	
Mr. Conyers	X		
Mr. Berman			
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren	X		
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan			
Mr. Delahunt			
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff	X		
Ms. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	11	15	

3. An amendment was offered by Ms. Baldwin to remove the criminal sanctions. The amendment was defeated by a rollcall vote of 8 yeas to 15 nays.

ROLLCALL NO. 3

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble		X	
Mr. Smith		X	
Mr. Gallegly		X	
Mr. Goodlatte			
Mr. Chabot		X	
Mr. Jenkins		X	
Mr. Cannon		X	
Mr. Bachus		X	
Mr. Hostettler		X	
Mr. Green			
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake			
Mr. Pence			
Mr. Forbes		X	
Mr. King		X	
Mr. Carter		X	
Mr. Feeney		X	
Mrs. Blackburn			
Mr. Conyers			
Mr. Berman			
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren			
Ms. Jackson Lee			
Ms. Waters			
Mr. Meehan			
Mr. Delahunt			
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff	X		
Ms. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	8	15	

4. An amendment was offered by Ms. Baldwin that would strike the congressional findings of fact. The amendment was defeated by a rollcall vote of 10 yeas to 18 nays.

ROLLCALL NO. 4

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble		X	
Mr. Smith		X	
Mr. Gallegly		X	
Mr. Goodlatte			
Mr. Chabot		X	
Mr. Jenkins		X	
Mr. Cannon		X	
Mr. Bachus		X	
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence		X	
Mr. Forbes		X	

ROLLCALL NO. 4—Continued

	Ayes	Nays	Present
Mr. King		X	
Mr. Carter		X	
Mr. Feeney		X	
Mrs. Blackburn			
Mr. Conyers			
Mr. Berman			
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren			
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan	X		
Mr. Delahunt			
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff	X		
Ms. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	10	18	

5. An amendment was offered by Ms. Jackson Lee that would change the name of H.R. 760 to the "Safe Abortion Procedures Ban Act of 2003." The amendment was defeated by a rollcall vote of 8 yeas to 19 nays.

ROLLCALL NO. 5

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble		X	
Mr. Smith		X	
Mr. Gallegly		X	
Mr. Goodlatte			
Mr. Chabot		X	
Mr. Jenkins		X	
Mr. Cannon		X	
Mr. Bachus		X	
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence		X	
Mr. Forbes		X	
Mr. King		X	
Mr. Carter		X	
Mr. Feeney		X	
Mrs. Blackburn		X	
Mr. Conyers			
Mr. Berman			
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt			
Ms. Lofgren			
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan	X		
Mr. Delahunt			

ROLLCALL NO. 5—Continued

	Ayes	Nays	Present
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff			
Ms. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	8	19	

6. An amendment was offered by Ms. Baldwin to insert additional findings regarding the U.S. Supreme Court's holding in *Stenberg* v. *Carhart*, 914 U.S. 914 (2000). The amendment was rejected by a rollcall vote of 10 yeas to 16 nays.

ROLLCALL NO. 6

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble		X	
Mr. Smith		X	
Mr. Gallegly		X	
Mr. Goodlatte			
Mr. Chabot		X	
Mr. Jenkins		X	
Mr. Cannon		X	
Mr. Bachus			
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller			
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence			
Mr. Forbes		X	
Mr. King		X	
Mr. Carter		X	
Mr. Feeney		X	
Mrs. Blackburn		X	
Mr. Conyers			
Mr. Berman			
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren	X		
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan	X		
Mr. Delahunt			
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff			
Ms. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	10	16	

7. Final Passage. The motion to report favorably the bill H.R. 760 was agreed to by a rollcall vote of 19 to 11.

ROLLCALL NO. 7

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble	X		
Mr. Smith	X		
Mr. Gallegly	X		
Mr. Goodlatte	X		
Mr. Chabot	X		
Mr. Jenkins	X		
Mr. Cannon	X		
Mr. Bachus	X		
Mr. Hostettler	X		
Mr. Green	X		
Mr. Keller	X		
Ms. Hart	X		
Mr. Flake	X		
Mr. Pence			
Mr. Forbes	X		
Mr. King	X		
Mr. Carter	X		
Mr. Feeney	X		
Mrs. Blackburn	X		
Mr. Conyers			
Mr. Berman			
Mr. Boucher			
Mr. Nadler		X	
Mr. Scott		X	
Mr. Watt		X	
Ms. Lofgren		X	
Ms. Jackson Lee		X	
Ms. Waters		X	
Mr. Meehan		X	
Mr. Delahunt			
Mr. Wexler		X	
Ms. Baldwin		X	
Mr. Weiner		X	
Mr. Schiff			
Ms. Sánchez		X	
Mr. Sensenbrenner, Chairman	X		
Total	19	11	

Committee Oversight Findings

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

Performance Goals and Objectives

H.R. 760 does not authorize funding. Therefore, clause 3(c) of rule XII of the Rules of the House of Representatives is inapplicable.

New Budget Authority and Tax Expenditures

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

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

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

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 28, 2003.

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

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 760, the Partial-Birth Abortion Ban Act of 2003.

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

Sincerely,

DOUGLAS HOLTZ-EAKIN.

Enclosure

cc: Honorable John Conyers, Jr.
Ranking Member

H.R. 760—Partial-Birth Abortion Ban Act of 2003.

CBO estimates that implementing H.R. 760 would not result in any significant cost to the Federal Government. Enacting H.R. 760 could affect direct spending and receipts, but CBO estimates that any such effects would not be significant.

H.R. 760 would ban most instances of a late-term abortion procedure known as "partial-birth abortion." Violators of the bill's provisions would be subject to a criminal fine or imprisonment. Because the bill would establish a new Federal crime, the government would be able to pursue cases it otherwise would not be able to prosecute. However, CBO expects that any increase in costs for law enforcement, court proceedings, or prison operations would not be significant because of the small number of cases likely to be affected. Any such additional costs would be subject to the availability of appropriated funds.

Because those prosecuted and convicted under H.R. 760 could be subject to criminal fines, the Federal Government might collect additional fines if the bill is enacted. Collections of such fines are recorded in the budget as governmental receipts (revenues), which are deposited in the Crime Victims Fund and later spent. CBO expects that any additional receipts and direct spending would be negligible because of the small number of cases involved.

H.R. 760 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on State, local, or tribal governments. H.R. 760 would impose a private-sector mandate as defined by UMRA by prohibiting physicians from performing "partial-birth abortions," as defined in the

bill, except when necessary to save the life of a mother. The direct costs of the mandate would be measured as the net income forgone by physicians and clinics. Based on information from industry sources and nongovernmental organizations, CBO expects that the direct cost of the mandate would fall below the annual threshold established by UMRA for private-sector mandates ($117 million in 2003, adjusted annually for inflation).

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

CONSTITUTIONAL AUTHORITY STATEMENT

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

SECTION-BY-SECTION ANALYSIS AND DISCUSSION

H.R. 760 prohibits the procedure commonly known as partial-birth abortion.

Section 1. Short Title

This section states that the short title of this bill is the "Partial-Birth Abortion Ban Act of 2003."

Section 2. Findings

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

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

In paragraph (3) Congress finds that in *Stenberg* v. *Carhart*,[134] the United States Supreme Court opined "that significant medical authority supports the proposition that in some circumstances, [partial birth abortion] would be the safest procedure" for pregnant women who wish to undergo an abortion. Congress also finds that as a result of having reached this conclusion the Court struck down the State of Nebraska's ban on partial-birth abortion procedures,

[134] 530 U.S. 914, 932 (2000).

concluding that it placed an "undue burden" on women seeking abortions because it failed to include an exception for partial-birth abortions deemed necessary to preserve the "health" of the mother.

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

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

In paragraph (6) Congress finds that despite the dearth of evidence in the *Stenberg* trial court record supporting the district court's findings, the United States Court of Appeals for the Eighth Circuit and the Supreme Court refused to set aside the district court's factual findings because, under the applicable standard of appellate review, they were not "clearly erroneous." Congress also finds that a finding of fact is clearly erroneous "when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed."[135] Congress also finds that under this standard, "if the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently."[136]

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

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

In paragraph (9) Congress finds that in *Katzenbach* v. *Morgan*,[137] the Supreme Court articulated its highly deferential review of Congressional factual findings when it addressed the constitutionality of section 4(e) of the Voting Rights Act of 1965. Regarding Congress' factual determination that section 4(e) would assist the Puerto Rican community in "gaining nondiscriminatory treatment in public services," the Court stated that "[i]t was for Congress, as the branch that made this judgment, to assess and weigh the var-

[135] *Anderson v.* City of Bessemer, North Carolina, 470 U.S. 564, 573 (1985).
[136] *Id.* at 574.
[137] 384 U.S. 641 (1966).

ious conflicting considerations . . . . It is not for us to review the congressional resolution of these factors. It is enough that we be able to perceive a basis upon which the Congress might resolve the conflict as it did. There plainly was such a basis to support section 4(e) in the application in question in this case." [138]

In paragraph (10) Congress finds that *Katzenbach*'s highly deferential review of Congress' factual conclusions was relied upon by the United States District Court for the District of Columbia when it upheld the "bail-out" provisions of the Voting Rights Act of 1965, (42 U.S.C. 1973c), stating that "congressional fact finding, to which we are inclined to pay great deference, strengthens the inference that, in those jurisdictions covered by the Act, state actions discriminatory in effect are discriminatory in purpose." [139]

In paragraph (11) Congress finds that the Court continued its practice of deferring to congressional factual findings in reviewing the constitutionality of the must-carry provisions of the Cable Television Consumer Protection and Competition Act of 1992.[140] Congress finds that at issue in the *Turner* cases was Congress' legislative finding that, absent mandatory carriage rules, the continued viability of local broadcast television would be "seriously jeopardized." Congress finds that the *Turner I* Court recognized that as an institution, "Congress is far better equipped than the judiciary to 'amass and evaluate the vast amounts of data' bearing upon an issue as complex and dynamic as that presented here." [141] Although the Court recognized that "the deference afforded to legislative findings does 'not foreclose our independent judgment of the facts bearing on an issue of constitutional law,'" its "obligation to exercise independent judgment when First Amendment rights are implicated is not a license to reweigh the evidence de novo, or to replace Congress' factual predictions with our own. Rather, it is to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence." [142]

In paragraph (12) Congress finds that 3 years later in *Turner II*, the Court upheld the "must-carry" provisions based upon Congress' findings, stating the Court's "sole obligation is 'to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.'" [143] Congress finds that, citing its ruling in *Turner I*, the Court reiterated that "[w]e owe Congress' findings deference in part because the institution 'is far better equipped than the judiciary to "amass and evaluate the vast amounts of data" bearing upon' legislative questions," [144] and added that it "owe[d] Congress' findings an additional measure of deference out of respect for its authority to exercise the legislative power." [145]

In paragraph (13) Congress finds that there exists substantial record evidence upon which Congress has reached its conclusion

---

[138] *Id.* at 653.

[139] *City of Rome, Georgia* v. *U.S.,* 472 F. Supp. 221 (D. D. Col. 1979) *aff'd City of Rome, Georgia* v. *U.S.*, 446 U.S. 156 (1980).

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

[141] 512 U.S. at 665–66.

[142] *Id.* at 666.

[143] 520 U.S. at 195.

[144] *Id.* at 195

[145] *Id.* at 196.

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

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

> In paragraph (14)(A) Congress declares that a partial-birth abortion poses serious risks to the health of a woman undergoing the procedure. Those risks include, among other things: an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term; an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting the child to a footling breech position, a procedure which, according to a leading obstetrics textbook, 'there are very few, if any, indications for . . . other than for delivery of a second twin'; and a risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death.
>
> In paragraph (14)(B) Congress declares that there is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures. Congress also declares that no controlled studies of partial-birth abortions have been conducted nor have any comparative studies been conducted to demonstrate its safety and efficacy compared to other abortion methods. Congress further declares that there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures. Congress also declares that unlike other more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the instruction in partial-birth abortions in their curriculum.
>
> In paragraph (14)(C) Congress declares that a prominent medical association has concluded that partial-birth abortion is "not an accepted medical practice," that it has "never been subject to even a minimal amount of the normal medical practice development," that "the relative advantages and disadvantages of the procedure in specific circumstances remain unknown," and that "there is no consensus among obstetricians about its use." The association has further noted that partial-birth abor-

tion is broadly disfavored by both medical experts and the public, is "ethically wrong," and "is never the only appropriate procedure."

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

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

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

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

In paragraph (14)(H) Congress declares that based upon *Roe* v. *Wade*,[146] and *Planned Parenthood* v. *Casey*,[147] a governmental interest in protecting the life of a child during the delivery process arises, in part, by virtue of the fact that during a partial-birth abortion, labor is induced and the birth process has begun. Congress further declares that this distinction was recognized in *Roe* when the Court noted, without comment, that the Texas parturition statute, which prohibited one from killing a child "in a state of being born and before actual birth," was not under attack. Congress declares that this interest becomes compelling as the child emerges from the maternal body. Congress declares that a child that is completely born is a full, legal person entitled to constitutional protections afforded a "person" under the United States Constitution. Congress declares that partial-birth abortions involve the killing of a child that is in the process, in fact mere inches away from, becoming a "person." Thus, the government has a heightened interest in protecting the life of the partially-born child.

In paragraph (14)(I) Congress declares that the distinction between a partial-birth abortion and other abortion methods has been recognized by the medical community, where a prominent medical association has recognized that partial-birth abortions are "ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb." According to this medical association, the "'partial birth' gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body."

[146] 410 U.S. 113 (1973).
[147] 505 U.S. 833 (1992).

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

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

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

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

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

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

Section 3. Prohibition on Partial-Birth Abortions

This section amends Title 18 of the United States Code by inserting after chapter 73 the following:

CHAPTER 74—PARTIAL-BIRTH ABORTIONS

Section 1531. Partial-Birth Abortions Prohibited

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

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

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

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

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

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

Subsection (d)(2) provides that the findings on that issue are admissible on that issue at the trial of the defendant. It also provides that upon a motion of the defendant, the court shall

delay the beginning of the trial for not more than 30 days to permit such a hearing to take place.

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

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

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

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

TITLE 18, UNITED STATES CODE

* * * * * * *

PART I—CRIMES

Chap.		Sec.
1.	**General provisions**	**1**
	* * * * * * *	
74.	***Partial-birth abortions***	***1531***
	* * * * * * *	

CHAPTER 74—PARTIAL-BIRTH ABORTIONS

Sec.
1531. Partial-birth abortions prohibited.

§ 1531. Partial-birth abortions prohibited

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

(b) As used in this section—

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

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

outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and

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

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

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

(2) Such relief shall include—

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

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

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

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

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

* * * * * * *

MARKUP TRANSCRIPT

BUSINESS MEETING

WEDNESDAY, MARCH 26, 2003

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

The Committee met, pursuant to notice, at 10:04 a.m., in Room 2141, Rayburn House Office Building, Hon. F. James Sensenbrenner, Jr. [Chairman of the Committee] presiding.

Chairman SENSENBRENNER. The Committee will be in order. A working quorum is present.

* * * * * * *

Now, pursuant to notice, the next item on the agenda is the adoption of H.R. 760, the "Partial-Birth Abortion Ban Act of 2003."

The Chair recognizes the gentleman from Ohio, Mr. Chabot, Chairman of the Subcommittee on the Constitution, for a motion.

Mr. CHABOT. Mr. Chairman, the Subcommittee on the Constitution reports favorably the bill H.R. 760 and moves its favorable recommendation to the full House.

Chairman SENSENBRENNER. Without objection, H.R. 760 will be considered as read and open for amendment at any point.

[The bill, H.R. 760, follows:]

I

108TH CONGRESS
1ST SESSION

H. R. 760

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

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 13, 2003

Mr. CHABOT (for himself, Mr. SENSENBRENNER, Mr. KING of Iowa, Mr. KENNEDY of Minnesota, Mr. BACHUS, Mr. BRADY of Texas, Mr. CANNON, Mr. CANTOR, Mr. CUNNINGHAM, Mr. ENGLISH, Mr. GREEN of Wisconsin, Ms. HART, Mr. HAYES, Mr. HEFLEY, Mr. HOEKSTRA, Mr. HUNTER, Mr. JENKINS, Mr. KINGSTON, Mr. MILLER of Florida, Mrs. MYRICK, Mr. NEY, Mr. PENCE, Mr. PETERSON of Pennsylvania, Mr. PITTS, Mr. TOOMEY, Mr. WELDON of Pennsylvania, Mr. PICKERING, Mr. OXLEY, Mr. CRANE, Mr. DEMINT, Mr. SCHROCK, Mr. TANCREDO, Mr. ADERHOLT, Mr. TIAHRT, Mr. NORWOOD, Mr. SHADEGG, Mr. BURTON of Indiana, Mr. DOOLITTLE, Mr. EHLERS, Mr. ROGERS of Michigan, Mr. BAKER, Mr. MOLLOHAN, Mr. BALLENGER, Mr. MCCRERY, Mr. RENZI, Mr. FLETCHER, Mr. TIBERI, Mr. AKIN, Mr. COLLINS, Mr. JOHN, Mr. RYUN of Kansas, Mr. HOSTETTLER, Mr. VITTER, Mr. MCCOTTER, Mr. PORTMAN, Mr. SESSIONS, Mr. SOUDER, Mr. SHUSTER, Mr. WOLF, Mr. POMBO, Mr. DELAY, Mr. CAMP, Mr. BARTON of Texas, Mr. COSTELLO, Mr. BISHOP of Utah, Mr. TAYLOR of Mississippi, Mr. EVERETT, Mr. BLUNT, Mr. TERRY, Mrs. CUBIN, Mr. OBERSTAR, Mr. GRAVES, Mr. WHITFIELD, Mr. ISSA, Mr. FEENEY, Mr. STENHOLM, Mr. GOSS, Mr. SMITH of New Jersey, Mr. HYDE, Mr. WILSON of South Carolina, Mr. GUTKNECHT, Mr. PETRI, Mr. LINDER, Mr. COBLE, Mr. HAYWORTH, Mr. FRANKS of Arizona, Mr. BURGESS, Mr. STEARNS, Mr. BEAUPREZ, Mr. HULSHOF, Mr. ROGERS of Alabama, Mr. BURNS, Mr. PLATTS, Mr. BROWN of South Carolina, Mr. REHBERG, Mrs. EMERSON, Mr. KLINE, Mr. LAHOOD, Mr. MORAN of Kansas, Mr. TOM DAVIS of Virginia, Mr. BOOZMAN, Mr. OSBORNE, Mr. LEWIS of Kentucky, Mr. MURPHY, Mr. SIMPSON, Mr. RAHALL, Mr. TAYLOR of North Carolina, Mrs. JO ANN DAVIS of Virginia, Mr. WAMP, Mr. GOODE, Mr. CHOCOLA, Mrs. NORTHUP, Mr. FORBES, Mr. SULLIVAN, Mr. GOODLATTE, Mr. PUTNAM, Mrs. BLACKBURN, Mr. TURNER of Ohio, Mr. PEARCE, Mrs. MILLER of Michigan, Ms. GRANGER, Mr. GINGREY, Mr. MANZULLO, Mr. COLE, Mr. FERGUSON, Mr. CALVERT, Mr. SMITH of Texas, Mr. GARRETT of New Jersey, Mr. STUPAK, Mr. BURR, Mr. RYAN of Wisconsin, Mr. JONES of North Carolina, Mrs. MUSGRAVE, Mr. CULBERSON, Mr. LATOURETTE, Mr. BOEHNER, Mr. BARRETT of South Carolina, and Mr. HENSARLING)

introduced the following bill; which was referred to the Committee on the Judiciary

---

A BILL

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

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Partial-Birth Abortion Ban Act of 2003''.

SEC. 2. FINDINGS.

The Congress finds and declares the following:

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

(2) Rather than being an abortion procedure that is embraced by the medical community, particularly among physicians who routinely perform other

abortion procedures, partial-birth abortion remains a disfavored procedure that is not only unnecessary to preserve the health of the mother, but in fact poses serious risks to the long-term health of women and in some circumstances, their lives. As a result, at least 27 States banned the procedure as did the United States Congress which voted to ban the procedure during the 104th, 105th, and 106th Congresses.

(3) In Stenberg v. Carhart, 530 U.S. 914, 932 (2000), the United States Supreme Court opined "that significant medical authority supports the proposition that in some circumstances, [partial birth abortion] would be the safest procedure" for pregnant women who wish to undergo an abortion. Thus, the Court struck down the State of Nebraska's ban on partial-birth abortion procedures, concluding that it placed an "undue burden" on women seeking abortions because it failed to include an exception for partial-birth abortions deemed necessary to preserve the "health" of the mother.

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

cumstances safer than, alternative abortion procedures.

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

(6) Despite the dearth of evidence in the Stenberg trial court record supporting the district court's findings, the United States Court of Appeals for the Eighth Circuit and the Supreme Court refused to set aside the district court's factual findings because, under the applicable standard of appellate review, they were not ''clearly erroneous''. A finding of fact is clearly erroneous ''when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed''. Anderson v. City of Bessemer City, North Carolina, 470 U.S. 564, 573 (1985). Under this standard, ''if the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court

of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently''. Id. at 574.

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

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

(9) In Katzenbach v. Morgan, 384 U.S. 641 (1966), the Supreme Court articulated its highly deferential review of Congressional factual findings

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

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

U.S., 472 F. Supp. 221 (D. D. Col. 1979) aff'd City of Rome, Georgia v. U.S., 446 U.S. 156 (1980).

(11) The Court continued its practice of deferring to congressional factual findings in reviewing the constitutionality of the must-carry provisions of the Cable Television Consumer Protection and Competition Act of 1992. See Turner Broadcasting System, Inc. v. Federal Communications Commission, 512 U.S. 622 (1994) (Turner I) and Turner Broadcasting System, Inc. v. Federal Communications Commission, 520 U.S. 180 (1997) (Turner II). At issue in the Turner cases was Congress' legislative finding that, absent mandatory carriage rules, the continued viability of local broadcast television would be ''seriously jeopardized''. The Turner I Court recognized that as an institution, ''Congress is far better equipped than the judiciary to 'amass and evaluate the vast amounts of data' bearing upon an issue as complex and dynamic as that presented here''. 512 U.S. at 665–66. Although the Court recognized that ''the deference afforded to legislative findings does 'not foreclose our independent judgment of the facts bearing on an issue of constitutional law,' '' its ''obligation to exercise independent judgment when First Amendment rights are implicated is not a li-

cense to reweigh the evidence de novo, or to replace Congress' factual predictions with our own. Rather, it is to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.'' Id. at 666.

(12) Three years later in Turner II, the Court upheld the ''must-carry'' provisions based upon Congress' findings, stating the Court's ''sole obligation is 'to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.' '' 520 U.S. at 195. Citing its ruling in Turner I, the Court reiterated that ''[w]e owe Congress' findings deference in part because the institution 'is far better equipped than the judiciary to ''amass and evaluate the vast amounts of data'' bearing upon' legislative questions,'' id. at 195, and added that it ''owe[d] Congress' findings an additional measure of deference out of respect for its authority to exercise the legislative power.'' Id. at 196.

(13) There exists substantial record evidence upon which Congress has reached its conclusion that a ban on partial-birth abortion is not required to contain a ''health'' exception, because the facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious

risks to a woman's health, and lies outside the standard of medical care. Congress was informed by extensive hearings held during the 104th, 105th, and 107th Congresses and passed a ban on partial-birth abortion in the 104th, 105th, and 106th Congresses. These findings reflect the very informed judgment of the Congress that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care, and should, therefore, be banned.

(14) Pursuant to the testimony received during extensive legislative hearings during the 104th, 105th, and 107th Congresses, Congress finds and declares that:

(A) Partial-birth abortion poses serious risks to the health of a woman undergoing the procedure. Those risks include, among other things: an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term; an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of

converting the child to a footling breech position, a procedure which, according to a leading obstetrics textbook, ''there are very few, if any, indications for . . . other than for delivery of a second twin''; and a risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death.

(B) There is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures. No controlled studies of partial-birth abortions have been conducted nor have any comparative studies been conducted to demonstrate its safety and efficacy compared to other abortion methods. Furthermore, there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures. Indeed, unlike other more commonly used abortion procedures, there are currently no medical schools that pro-

vide instruction on abortions that include the instruction in partial-birth abortions in their curriculum.

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

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

(E) The physician credited with developing the partial-birth abortion procedure has testified that he has never encountered a situation where a partial-birth abortion was medically

1 necessary to achieve the desired outcome and,
2 thus, is never medically necessary to preserve
3 the health of a woman.
4 (F) A ban on the partial-birth abortion
5 procedure will therefore advance the health in-
6 terests of pregnant women seeking to terminate
7 a pregnancy.
8 (G) In light of this overwhelming evidence,
9 Congress and the States have a compelling in-
10 terest in prohibiting partial-birth abortions. In
11 addition to promoting maternal health, such a
12 prohibition will draw a bright line that clearly
13 distinguishes abortion and infanticide, that pre-
14 serves the integrity of the medical profession,
15 and promotes respect for human life.
16 (H) Based upon Roe v. Wade, 410 U.S.
17 113 (1973) and Planned Parenthood v. Casey,
18 505 U.S. 833 (1992), a governmental interest
19 in protecting the life of a child during the deliv-
20 ery process arises by virtue of the fact that dur-
21 ing a partial-birth abortion, labor is induced
22 and the birth process has begun. This distinc-
23 tion was recognized in Roe when the Court
24 noted, without comment, that the Texas partu-
25 rition statute, which prohibited one from killing

a child ''in a state of being born and before actual birth,'' was not under attack. This interest becomes compelling as the child emerges from the maternal body. A child that is completely born is a full, legal person entitled to constitutional protections afforded a ''person'' under the United States Constitution. Partial-birth abortions involve the killing of a child that is in the process, in fact mere inches away from, becoming a ''person''. Thus, the government has a heightened interest in protecting the life of the partially-born child.

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

(J) Partial-birth abortion also confuses the medical, legal, and ethical duties of physicians

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

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

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

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

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

(O) For these reasons, Congress finds that partial-birth abortion is never medically indicated to preserve the health of the mother; is in fact unrecognized as a valid abortion procedure by the mainstream medical community; poses

additional health risks to the mother; blurs the line between abortion and infanticide in the killing of a partially-born child just inches from birth; and confuses the role of the physician in childbirth and should, therefore, be banned.

SEC. 3. PROHIBITION ON PARTIAL-BIRTH ABORTIONS.

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

"CHAPTER 74—PARTIAL-BIRTH ABORTIONS

"Sec.
"1531. Partial-birth abortions prohibited.

"§ 1531. Partial-birth abortions prohibited

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

"(b) As used in this section—

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

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

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

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

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

"(2) Such relief shall include—

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

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

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

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

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

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

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

○

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

Mr. CHABOT. Thank you, Mr. Chairman.

On February 13, 2003, on behalf of a bipartisan coalition numbering over 100 Members, 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 now-dead infant. An abortionist who violates this ban would be subject to fines or a maximum of 2-year 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.

A moral, medical, and ethical consensus exists that partial-birth abortions are inhumane procedures that are never medically necessary and should be prohibited. Contrary to the claims of partial-birth abortion advocates, this barbaric procedure remains an untested, unproven, and potentially dangerous procedure that has never been embraced by the medical profession.

As a result, the United States Congress voted to ban partial-birth abortions during the 104th, 105th, 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 yesterday's hearing on H.R. 760 indicated, this bill clearly distinguishes the procedure it would ban from other abortion procedures.

The second difference addresses the majority's opinion that the Nebraska ban placed an undue burden on women seeking abortions because it 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 court's factual findings regarding the relative health and safety benefits of partial-birth abortions, findings which were highly disputed.

The Court was required to accept these findings because of the highly deferential, "clearly erroneous" standard that is applied to lower-court factual findings. Those factual findings, however, are inconsistent with the overwhelming weight of authority, which indicates that a partial-birth abortion is never medically necessary to preserve the health of a woman, poses serious risks to the woman's health, and lies outside standard medical care.

Under well-settled Supreme Court jurisprudence, the United States Congress is entitled to reach its own factual findings, findings that the Supreme Court accords great deference, and to enact legislation based upon these findings, so long as it seeks to pursue

a legitimate interest that is within the scope of the Constitution and draws reasonable inferences based upon substantial evidence.

Thus, the first section of H.R. 760 contains Congress' extensive factual findings that, based upon extensive medical evidence compiled during congressional hearings, a partial-birth abortion is never necessary to preserve the health of a woman.

The American Medical Association has concluded that partial-birth abortion is, quote, "not an accepted medical practice," unquote. Yesterday, our Subcommittee received additional testimony regarding the relative health and safety benefits of partial-birth abortion. The Subcommittee on the Constitution passed the ban by an 8–4 vote. Despite overwhelming support from the public, the handful of organizations that support the practice of partial-birth abortion have consistently tried to hide the truth about this gruesome procedure.

Following the introduction of our bill, the abortion lobby swung into action just as it did when virtually identical legislation, H.R. 4965, was introduced and approved by the 107th Congress. Statements from those opposed to H.R. 760 continue to charge us with using inflammatory rhetoric, characterize this bill as "deceptive" and efforts to pass it as "mere politics," and said the legislation would hurt women.

Obviously, I strongly disagree with this assessment of the legislation that we will consider today. In fact, I would remind everyone that it is the false rhetoric and misinformation of the abortion lobby that was exposed as blatant propaganda in 1997. You might recall that the executive director of the National Coalition of Abortion Providers admitted that he, quote, lied through his teeth, unquote, when he stated that partial-birth abortions were rarely performed. He went on to say that the procedure is—Mr. Chairman, could I have one additional minute?

Chairman SENSENBRENNER. Without objection.

Mr. CHABOT. Thank you. He went on to say that the procedure is most often performed on healthy mothers who are about 5 months pregnant with healthy fetuses. He acknowledged that he lied because he feared the truth would damage the abortion rights cause.

The truth today is really quite simple. Opponents of this bill want to hide from the facts. They do not want people to hear a legitimate description or view accurate images of this procedure. They don't want to talk about the pain inflicted on the child or how partial-birth abortions border on infanticide. They just want to make the issue go away because it might be harmful to their cause. They are less concerned about the harm it may cause the baby or the mother.

Fortunately, I am confident that the public, a majority of the Congress, and the President all recognize the true horrors of partial-birth abortion and are committed to ending this barbaric and inhuman practice.

On March 13, 2003, the Senate passed virtually identical legislation, S. 3, by a 64–33 vote.

Chairman SENSENBRENNER. The gentleman's time has once again expired.

Mr. CHABOT. I ask my colleagues to pass this legislation.

Chairman SENSENBRENNER. The gentleman from Virginia, Mr. Scott?

Mr. SCOTT. Mr. Chairman, this bill is unconstitutional and everybody knows it. The Constitution in the *Stenberg* case lets everybody know that a health exception is required. I'll have an amendment in due course to apply a health exception and will make a more extensive statement at that time.

I yield back.

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

PREPARED STATEMENT OF THE HONORABLE SHEILA JACKSON LEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. Chairman, once again we are considering legislation that is unconstitutional, and once again I oppose this legislation.

We recently honored the 30th anniversary of the landmark *Roe* v. *Wade* decision. This decision reaffirmed a woman's right to choose. H.R. 760 is not only unconstitutional but it is yet another attempt to ban so-called "partial birth abortions." This is a non-medical term. The U.S. Supreme Court struck down a similar statute in *Stenberg* v. *Carhart.* The Court invalidated a Nebraska statute banning so-called "partial birth abortions. So, this legislation is at odds with the court's ruling. In *Roe* v. *Wade*, the court held that women had a privacy interest in electing to have an abortion, based on the 5th and 14th Amendments' concept of personal liberty.

Despite the fact that the Supreme Court struck down legislation virtually identical to H.R. 760 in the year 2000, anti-choice Members of Congress sacrifice women's health by promoting this legislation to advance their long-term goal of eliminating a woman's right to choose.

H.R. 760 is unconstitutional for the same two reasons the Supreme Court found other statutes attempting to ban partial birth abortions unconstitutional.

First, H.R. 760 lacks a health exception, which the Supreme Court unequivocally said was a fatal flaw in any restriction on abortion.

Second, the non-medical term "partial birth abortion" is overly broad and would include a ban of safe, pre-viability abortions. Banning the safest abortion option imposes an undue burden on a woman's ability to choose.

H.R. 760 would improperly put the government in the physician's office. Allowing physicians to exercise their medical judgment is not only good policy—it is also the law. In *Stenberg* v. *Carhart*, 530 U.S. 914 (2000), the Supreme Court ruled that all abortion legislation must allow the physician to exercise reasonable medical judgment, even where medical opinions differ. The Court made clear that exceptions to an abortion ban cannot be limited to situations where the health risk is an "absolute necessity," nor can the law require unanimity of medical opinion as to the need for a particular abortion method.

H.R. 760'S FINDINGS ARE INCORRECT

- The findings to H.R. 760 attempt to justify the fact that the bill directly conflicts with *Carhart* by suggesting that the Supreme Court must defer to Congressional fact-finding, even if Congress's so-called "facts" conflict with the preponderance of evidence in litigation before the Court. But the drafters of H.R. 760 are wrong. *First,* a fundamental tenet of our constitutional structure, which establishes three separate branches of the federal government, is that Congress can enact laws, but it cannot decide whether those laws are constitutional. The power to decide what laws are constitutional is exclusively the Supreme Court's role. *Second,* the Supreme Court is not required to defer to Congressional fact-finding. Rather, the Court has the power and the duty to independently assess the evidence that is presented to it, as it did in *Carhart*, and has no obligation to defer to Congressional findings on "partial-birth abortion."
- The drafters of H.R. 760 are clearly wrong in asserting that they can overrule *Carhart* through legislation. Prior attempts by Congress to undo disfavored Supreme Court rulings (such as Congress's attempt to legislatively overturn *Miranda* v. *Arizona*, 384 U.S. 436 (1966), and *Employment Division, Dep't of Human Resources of regon* v. *Smith*, 494 U.S. 872 (1990)) have been soundly rejected by the Supreme Court. Given the utter absence of legal support for this bill, it must be seen as a purely political gesture, not as a serious attempt at legislation.

Most importantly, the medical community does not support banning these partial birth abortions.

- The American College of Obstetricians and Gynecologists (ACOG), whose more than 44,000 members represent approximately 95% of all board-certified obstetricians and gynecologists practicing in the United States, opposes abortion ban legislation and has stated that ". . . [t]he intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous."
- Moreover, ACOG has concluded that intact dilation and extraction ("intact D&E" or "D&X") is a safe procedure and may be the safest option for some women.
- In addition to ACOG, other medical groups have opposed attempts by Congress to enact abortion ban legislation, including:
- The American Public Health Association, the American Nurses Association, the American Medical Women's Association, the California Medical Association, Physicians for Reproductive Choice and Health, the American College of Nurse Practitioners, the American Medical Student Association, the Association of Reproductive Health Professionals, the Association of Schools of Public Health, the Association of Women Psychiatrists, the National Asian Woman's Health Organization, the National Association of Nurse Practitioners in Reproductive Health, the National Black Women's Health Project, the National Latina Institute for Reproductive Health, the National Women's Health Network, and the Rhode Island Medical Society.

I urge my colleagues to oppose this measure both for constitutional and health reasons.

Are there amendments? The gentleman from Virginia?

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

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment offered by Mr. Scott, Ms. Baldwin, and Ms. Jackson Lee to H.R. 760, the "Partial-Birth Abortion Ban Act of 2003." On page 16, on line——

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

[The amendment follows:]

Amendment #1 offered by Mr. Scott, Ms. Baldwin, and Ms. Jackson-Lee
to HR 760, the "Partial-Birth Abortion Ban Act of 2003"

On Page 16, on line 17, after the word "abortion" strike all that follows through the period following the word "itself" on Page 16, line 21, and insert:

" that is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."

Chairman SENSENBRENNER. The gentleman from Virginia is recognized for 5 minutes.

Mr. SCOTT. Thank you, Mr. Chairman.

As I said, the bill in its present form without this amendment is clearly unconstitutional. The bill before us will not prohibit any abortions. It claims to prohibit a procedure, but even if it does, the abortion will take—still take place using another procedure. And I will not inflame the debate by describing in detail the alternative procedures that may be used, but I would point out that Nebraska had a law banning this procedure, the so-called partial-birth abor-

tion, and nearly 3 years ago, the United States Supreme Court held in *Stenberg*—in the *Stenberg* case that that law was unconstitutional.

The Supreme Court said five times in its majority opinion and other times in concurring opinions that in order to make a partial-birth abortion ban constitutional, the law must contain a health exception to allow the procedure when it is, quote, "necessary in the appropriate medical judgment for the preservation of the life or health of the mother." This is what five Supreme Court Justices said is necessary to make the bill constitutional, and all five are still on the Supreme Court.

In the *Stenberg* case, the Court said, "The question before us is whether Nebraska's statute making criminal the performance of a partial-birth abortion violates the Federal Constitution as interpreted in the *Casey* case. We conclude that it does for at least two independent reasons," and they said the first reason was that the law lacks an exception for the preservation of the health of the mother. The *Stenberg* case reminded us what a long line of cases has held, that, quote, "subsequent to viability, the State, in promoting its interest in the potentiality of human life, may, if it chooses, regulate and even proscribe abortion, except"—and they put this in italics—"when it is necessary and appropriate medical judgment for the preservation of the life or health of the mother."

It goes on to say, in quotes, in case we didn't understand the italics, that "The governing standard requires an exception where it is necessary in the appropriate medical judgment for the preservation of the life or health of the mother."

We didn't get—if we didn't get that, the Court stated again, "By no means must a State grant physicians unfettered discretion in their selection of abortion methods, but where substantial medical authority supports the proposition that banning a particular abortion procedure could endanger a woman's health, *Casey* requires the statute to include an exception where the procedure is necessary in the appropriate medical judgment for the preservation of the life and the health of the mother. Requiring such an exception in this case is no departure from *Casey*, but simply a straightforward application of its holding."

Mr. Chairman, whatever your views are on the underlying issue of abortion, we ought to read the decision and apply the law. The Supreme Court in one opinion said at least five times that a health exception must be included for the statute to be constitutional. Furthermore, they put "necessary in the appropriate medical judgment for the preservation of the life or health of the mother" in italics and in quotation marks. We now consider a bill without this health exception.

Now, the bill tries to evade the *Stenberg* ruling by making a finding that a partial-birth abortion is never necessary. Unfortunately, the hearing record reflects that this conclusion is contradicted by rulings in at least seven courts and the American College of Obstetricians and Gynecologists, who said that it is sometimes necessary to save the life or health of the mother.

Now, since the Court has made it clear that such a health exception is required, any bill that passes without such a health exception will be found unconstitutional. I, therefore, urge my colleagues

to vote for the amendment to make the bill constitutional, and I yield back the balance of my time.

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

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

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. CHABOT. Mr. Chairman, I oppose this amendment. This amendment should be opposed for a number of reasons.

The overwhelming weight of the evidence compiled in a series of congressional hearings indicates that partial-birth abortions are never necessary to preserve the health of a woman and, in fact, pose substantial health risks to women who undergo this procedure. No controlled studies of partial-birth abortions have been conducted, nor have any comparative studies been conducted to demonstrate its safety or efficacy compared to other abortion methods.

There have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures. Neither the plaintiff in *Stenberg* v. *Carhart,* Dr. Leroy Carhart, nor the experts who testified on his behalf have identified a single circumstance during which a partial-birth abortion is necessary to preserve the health of the woman. In fact, according to Dr. Carhart's own testimony, when he was chosen to perform—when he has chosen to perform partial-birth abortions, he has done so based upon the happenstance of the presentation of the unborn child, not because it was the only procedure that would have preserved the health of the mother.

Dr. Martin Haskell, the physician credited with developing the partial-birth abortion procedure, has testified that he has never encountered a situation where a partial-birth abortion was medically necessary to achieve the desired outcome.

Leading proponents of partial-birth abortions acknowledge that it poses additional health risks because, among other things, the procedure requires a high degree of surgical skill to pierce the infant's skull with a sharp instrument in a blind procedure.

Dr. Warren Hearn has testified that he had, quote, very serious reservations about this procedure, and that he could not imagine a circumstance in which this procedure would be safest. Although he was opposed to legislation banning partial-birth abortions, he also stated, "You really can't defend it. I'm not going to tell somebody else that they should not do this procedure, but I'm not going to do it."

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

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

and a risk of iatrogenic lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in serious bleeding, brings with it the threat of shock, and could ultimately result in maternal death. This also creates a high risk of infection should she suffer a laceration.

Finally, a health exception, no matter how narrowly drafted, gives the abortionist unfettered discretion in determining when a partial-birth abortion may be performed. And abortionists have demonstrated that they can justify any abortion on this ground. Dr. Warren Hearn of Colorado, the author of the standard textbook on abortion procedures, who also performs many third-trimester abortions, has stated, "I will certify that any pregnancy is a threat to a woman's life and could cause grievous injury to her physical health."

It is unlikely then that a law that includes such an exception as being proposed would ban a single partial-birth abortion or any other late-term abortion.

I yield back the balance of my time.

Chairman SENSENBRENNER. The question is on the——

Ms. BALDWIN. Mr. Chairman?

[Intervening business.]

Chairman SENSENBRENNER. The gentlewoman from Wisconsin?

Ms. BALDWIN. Mr. Chairman, I move to strike the last word.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

Ms. BALDWIN. Thank you, Mr. Chairman.

I am offering this amendment today with my colleagues from Virginia, Mr. Scott, and Texas, Ms. Jackson Lee. this amendment would provide an exception in order to protect the health of the mother.

The families that are affected by this bill are dealing with the tragic circumstances of crisis pregnancies. In most cases, they have just learned that their babies will not survive. They are then confronted by choices that none of us would wish on any human being. This is the context in which these circumstances under which this legislation comes into play. And any suggestion to the contrary deceives the American public about the realities of this issue.

The experiences that families face with crisis pregnancies are real. Their stories demonstrate the need for this exception to protect the health of the mother. Kathy and Chris from Wisconsin were married and were excited when they found out that Kathy was pregnant 6 years ago. They received the best prenatal care for their baby, and the pregnancy seemed to be going just fine. She was over 6 months along when they went to their doctor to have an ultrasound and discovered that their baby was developing with no brain. There was a tumor in the baby's brain cavity and other factors that would compromise and jeopardize Kathy's health. Her doctor recommended that she have an abortion.

Imagine the pain of these parents who so much wanted to have this, their first child. Tragically, their doctor could not locate a provider in Wisconsin, and so they had to travel over a thousand miles away.

After extensive tests, another doctor determined that this procedure, the one being banned under this bill, was medically necessary to protect Kathy's health. Because of the stigma associated with this procedure, neither Chris nor Kathy even told their parents that they had to have this procedure. But now Kathy is speaking out because she believes that women must know that when they are faced with an extremely dangerous pregnancy, they deserve the right to protect their own health.

Typically, women who must face this decision want nothing more than to have a child and are devastated to learn that their baby would not survive outside the womb. In consultation with their doctors and families, they make difficult decisions to terminate pregnancies to preserve their own health and in many cases to preserve their ability to have children in the future.

This was the case for Kathy and Chris, who, because they took steps to terminate her first pregnancy, now have a beautiful 5-year-old son, Frederick. How can we look a woman like Kathy in the eyes and tell her that she cannot have a safe procedure that would preserve her health and give her the best chance to have children in the future?

Our compassion alone should justify a health exception. But if you need more than that, the U.S. Supreme Court has made it clear that such an exemption is constitutionally required. In *Stenberg* v. *Carhart,* the Court, in striking down a Nebraska statute, held that it was unconstitutional because there was no health exception for the mother. The language in this amendment is taken directly from that Supreme Court's ruling.

Denying a maternal health exception is wrong and it is unconstitutional. If this bill passes today without the adoption of this amendment, women who are already dealing with the tragic consequences of a crisis pregnancy will have their health put in serious danger.

I urge Members to support this amendment on behalf of Kathy and on behalf of all women who have faced this most difficult decision, and on behalf of Frederick and all the children who have been brought into the world because their mothers had access to safe abortions, including this procedure, and were able to have children again.

I yield back.

Chairman SENSENBRENNER. The question is on the amendment offered by the gentleman from——

Mr. SCHIFF. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from California, Mr. Schiff.

Mr. SCHIFF. Move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. SCHIFF. Mr. Chairman, I'd yield the balance of my time to the gentleman from Virginia.

Mr. SCOTT. Thank you, and I thank the gentleman for yielding.

In response to one of the things that the gentleman from Ohio said, he mentioned the words "unfettered discretion," which are mentioned in a dissent but are dealt with in the majority opinion, which says—this is the majority opinion, five Justices, "By no means must a State grant physicians unfettered discretion in their

selection of abortion methods, but where substantial medical authority supports the proposition that banning a particular abortion procedure could endanger a woman's health, *Casey* requires the statute to include a health exception when the procedure is necessary in the appropriate medical judgment for the preservation of the life or health of the mother."

Regarding such an exception in this case is no departure from *Casey*, but simply a straightforward application of its holding. And we have substantial medical authority that this procedure could be necessary to save a woman's health or life.

Thank you, and I thank the gentleman for yielding, and I yield back to the gentleman from California. Adam?

Chairman SENSENBRENNER. The gentleman from California yield back?

Mr. SCHIFF. Yes, I yield back, Mr. Chairman.

Chairman SENSENBRENNER. The question is on the amendment offered by the gentleman from Virginia, Mr. Scott. Those in favor will say aye? Opposed, no.

The noes appear to have it—a rollcall will be ordered. Those in favor of the Scott amendment will, as your names are called, answer aye, those opposed, no, and the clerk will call the roll.

The CLERK. Mr. Hyde?

[No response.]

The CLERK. Mr. Coble?

Mr. COBLE. No.

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

Mr. SMITH. No.

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

[No response.]

The CLERK. Mr. Goodlatte?

[No response.]

The CLERK. Mr. Chabot?

Mr. CHABOT. No.

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

[No response.]

The CLERK. Mr. Cannon?

Mr. CANNON. No.

The CLERK. Mr. Cannon, no. Mr. Bachus?

[No response.]

The CLERK. Mr. Hostettler?

Mr. HOSTETTLER. No.

The CLERK. Mr. Hostettler, no. Mr. Green?

[No response.]

The CLERK. Mr. Keller?

Mr. KELLER. No.

The CLERK. Mr. Keller, no. Ms. Hart?

[No response.]

The CLERK. Mr. Flake?

[No response.]

The CLERK. Mr. Pence?

[No response.]

The CLERK. Mr. Forbes?

Mr. FORBES. No.

The CLERK. Mr. Forbes, no. Mr. King?

Mr. KING. No.

The CLERK. Mr. King, no. Mr. Carter?
Mr. CARTER. No.
The CLERK. Mr. Carter, no. Mr. Feeney?
Mr. FEENEY. No.
The CLERK. Mr. Feeney, no. Mrs. Blackburn?
Mrs. BLACKBURN. No.
The CLERK. Mrs. Blackburn, no. Mr. Conyers?
[No response.]
The CLERK. Mr. Berman?
[No response.]
The CLERK. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
[No response.]
The CLERK. Ms. Lofgren?
[No response.]
The CLERK. Ms. Jackson Lee?
[No response.]
The CLERK. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
Mr. WEINER. Aye.
The CLERK. Mr. Weiner, aye. Mr. Schiff?
Mr. SCHIFF. Aye.
The CLERK. Mr. Schiff, aye. Ms. Sánchez?
Ms. SÁNCHEZ. Aye.
The CLERK. Ms. Sánchez, aye. Mr. Chairman?
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.
Chairman SENSENBRENNER. Members in the chamber who wish to cast or change their vote? The gentleman from Alabama, Mr. Bachus?
Mr. BACHUS. No.
The CLERK. Mr. Bachus, no.
Chairman SENSENBRENNER. The gentleman from Wisconsin, Mr. Green?
Mr. GREEN. No.
The CLERK. Mr. Green, no.
Chairman SENSENBRENNER. The gentlewoman from Pennsylvania, Ms. Hart?
Ms. HART. No.
The CLERK. Ms. Hart, no.

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

The CLERK. Mr. Chairman, there are 7 ayes and 15 noes.

Chairman SENSENBRENNER. And the amendment is not agreed to.

Are there further amendments?

Mr. NADLER. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from New York, Mr. Nadler?

Mr. NADLER. Mr. Chairman, I was delayed in getting here because of a Democratic caucus on the subject of Iraq, and I request permission to read my opening statement now.

Chairman SENSENBRENNER. Opening statements will be put into the record.

Mr. NADLER. I'd like to read the opening statement.

Chairman SENSENBRENNER. Well, the——

Mr. NADLER. I was delayed because of a caucus on Iraq. Our troops are in the field, and I think there should be a little flexibility because of that fact.

Chairman SENSENBRENNER. Well, it has been the policy of the Committee to have one opening statement on each side. The gentleman from Virginia gave the Democrats' opening statement, and the Chair asked for and received unanimous consent that all Members place opening statements into the record.

Mr. NADLER. Mr. Chairman, I ask unanimous consent—I'm the Ranking Member on the Subcommittee that considered this bill, and as—that considered this bill and reported it yesterday. And as I said, if it weren't for the caucus on Iraq, I would have been here. I would have given the Democratic opening statement. And I think——

Chairman SENSENBRENNER. For what purpose does the gentleman ask unanimous consent for?

Mr. NADLER. To strike the last word so that I may read the opening statement.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes—for what purpose does the gentleman from Alabama seek recognition?

Mr. NADLER. I think, Mr. Chairman, we'd have no objection if one other opening statement on the Republican side were read.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

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 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 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 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 a swing vote on such matters and who wrote a concurring opinion stating specifically what 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 were just pulling our collective legs, this bill has to be considered facially unconstitutional.

First and foremost, it does not contain the 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 30 years, but that is 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 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, which is not in this bill.

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 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 a woman's life and health are not in jeopardy, then 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. 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 that Congress—what comes of Congress ignoring the will of the Supreme Court. Whenever Congress—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 to 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 candidates.

We now have a President who has expressed a willingness to sign this bill. He may get his chance. Unfortunate, there will be 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. And we know what the Constitution requires. If people are serious about enacting a piece of legislation that will be enforced by the courts, then they will put a health exception into this bill. They will talk about post-viability abortions. They will stop trying to define a procedure which is not recognized by the medical books, and they would have a constitutional bill.

But apparently the proponents of this bill are not interested in saving babies; they're interested in saving elections.

Thank you, Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from Virginia.

Mr. FORBES. Mr. Chairman, every time this bill comes up, it reminds me of a Casablanca movie, because instead of rounding up the usual suspects, what we do is round up the same old arguments, even though they are tired and worn out. And we need to understand that this piece of legislation is not about abortion really. It's not about choice. What this legislation is about, is about banning one horrific procedure. And the part of this procedure that's always struck me kind of supersedes all the constitutional arguments and all of the theories and the philosophies that we here flown back and forth in Subcommittee and full Committee, but it comes down to this, that this unborn baby, if it's my semantics or fetus if it's others, is subjected to an incredible amount of pain during this procedure. All of the testimony that we've had, which has been unrefuted, suggests that this unborn child or fetus has a developed brain that senses pain even more so than a more developed child or an adult.

And, Mr. Chairman, I can't believe it when I hear folks who are supporting this procedure, who testify, as they did in our Subcommittee, that there is no threshold, no level of pain that could be inflicted on an unborn child or an unborn fetus that would be great enough that they would be willing to ban this procedure.

Mr. Chairman, everybody needs to know that when this invasive procedure takes place on the brain of this unborn child, there is no, no pain management given, there is no neurologist that is there present, as it would otherwise take place. And Mr. Chairman, the thing that appalls me most is when you talk about this pain to some people who support this procedure, instead of being concerned about it, they sit there and smile with almost a lack of concern, and we need to understand that the pain that we inflict on this unborn child or fetus would not even be legal or allowed to be inflicted upon an animal.

And, Mr. Chairman, that's why I think it's so vitally important that this Committee do everything we possibly can to get rid of this abhorrent, cruel procedure, and I hope that we'll support this bill and pass it on to the House.

Chairman SENSENBRENNER. The gentleman yield back?

Mr. FORBES. I yield.

Chairman SENSENBRENNER. Other further amendments? The gentleman from New York.

Mr. NADLER. Thank you, Mr. Chairman. I offer an amendment that's styled No. 2.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 760 offered by Mr. Nadler. Page 18, strike line 1 and all that follows——

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

[The amendment follows:]

AMENDMENT #2 OFFERED BY MR. NADLER TO H.R. 760

Page 18, strike line 1 and all that follows through the end of line 13 (and make such technical and conforming changes as may be necessary).

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

The bill, as drafted, would allow a birth father who has abandoned his pregnant wife to sue her for having an abortion even if it was to preserve her health because there is no health exception in this bill. He would be able to sue her and her doctor even if he abused her before abandoning her. I'm not sure that this is either a pro-family or a pro-life position. It is certainly pro plaintiff's lawyer, which is an appalling turnaround for Members who just recently voted to limit the compensation due to women who have been horribly mutilated by negligent medical treatment. This bill, however, would provide a windfall for the worst sorts of individuals.

A doctor, before performing a medical procedure, would have to do some investigative work on his patient to determine if there was perhaps a separate spouse out there somewhere who might want to make a little money. How much investigation does a doctor have to do? Do a record search to see if the woman has ever been married, or if she has ever used any aliases, or to demand a copy of a divorce certificate before performing a medical procedure that may be required by the woman's health?

Again, I remind you there's no health exception in this bill, although one is required by the Supreme Court.

It is certainly not clear why the authors of this bill are insisting on placing a legal sword of Damocles over the heads of women and their doctors, except perhaps to make some mischief. This is really a disgraceful burden on a woman's right to choose, and I urge the Members to support this amendment to remove this language al-

lowing such lawsuits against a woman and her doctor. I thank you and I yield back.

Chairman SENSENBRENNER. Gentleman from Ohio.

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

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

Mr. CHABOT. Mr. Chairman, I rise in opposition to this amendment. This amendment should be opposed because the civil enforcement provisions of the law are necessary to ensure that there are effective deterrents in place to keep physicians from performing partial-birth abortions, which will be banned, of course, when this becomes law. The civil action provision is also drafted to ensure that individuals do not profit from their own misconduct. The provision excludes, of course, plaintiffs who consented to the abortion, or whose criminal conduct caused the pregnancy.

For those and other reasons, I strongly oppose this amendment, and would ask my colleagues to oppose.

Chairman SENSENBRENNER. The question is on the Nadler amendment. Those in favor will say aye.

Opposed, no.

The noes appear to have it. Noes have it.

Mr. NADLER. I say aye. Can we have a record vote?

Chairman SENSENBRENNER. Okay, the Chair is always willing to accommodate the gentleman from New York. Those in favor of the Nadler amendment will, as your names are called, answer aye, those opposed no, and the clerk will call the roll.

The CLERK. Mr. Hyde?

[No response.]

The CLERK. Mr. Coble?

[No response.]

The CLERK. Mr. Smith?

Mr. SMITH. No.

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

Mr. GALLEGLY. No.

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

[No response.]

The CLERK. Mr. Chabot?

Mr. CHABOT. No.

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

[No response.]

The CLERK. Mr. Cannon?

[No response.]

The CLERK. Mr. Bachus?

[No response.]

The CLERK. Mr. Hostettler?

[No response.]

The CLERK. Mr. Green?

[No response.]

The CLERK. Mr. Keller?

Mr. KELLER. No.

The CLERK. Mr. Keller, no. Ms. Hart?

Ms. HART. No.

The CLERK. Ms. Hart, no. Mr. Flake?

[No response.]

The CLERK. Mr. Pence?
[No response.]
The CLERK. Mr. Forbes?
Mr. FORBES. No.
The CLERK. Mr. Forbes, no. Mr. King?
Mr. KING. No.
The CLERK. Mr. King, no. Mr. Carter?
Mr. CARTER. No.
The CLERK. Mr. Carter, no. Mr. Feeney?
Mr. FEENEY. No.
The CLERK. Mr. Feeney, no. Mrs. Blackburn?
Mrs. BLACKBURN. No.
The CLERK. Mrs. Blackburn, no. Mr. Conyers?
Mr. CONYERS. Aye.
The CLERK. Mr. Conyers, aye. Mr. Berman?
[No response.]
The CLERK. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
[No response.]
The CLERK. Ms. Lofgren?
[No response.]
The CLERK. Ms. Jackson Lee?
Ms. JACKSON LEE. Pass.
The CLERK. Ms. Jackson Lee, pass. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
Mr. WEINER. Aye.
The CLERK. Mr. Weiner, aye. Mr. Schiff?
Mr. SCHIFF. Aye.
The CLERK. Mr. Schiff, aye. Ms. Sánchez?
Ms. SÁNCHEZ. Aye.
The CLERK. Ms. Sánchez, aye. Mr. Chairman?
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.
Chairman SENSENBRENNER. The Members in the chamber wish to cast or change their votes? Gentleman from North Carolina, Mr. Coble.
Mr. COBLE. No.
The CLERK. Mr. Coble, no.
Chairman SENSENBRENNER. The gentleman from Utah, Mr. Cannon?
Mr. CANNON. No.

The CLERK. Mr. Cannon, no.

Chairman SENSENBRENNER. The gentleman from Indiana, Mr. Hostettler?

Mr. HOSTETTLER. No.

The CLERK. Mr. Hostettler, no.

Chairman SENSENBRENNER. Gentleman from Tennessee, Mr. Jenkins?

Mr. JENKINS. No.

The CLERK. Mr. Jenkins, no.

Chairman SENSENBRENNER. Further Members who wish to—gentlewoman from California, Ms. Lofgren?

Ms. LOFGREN. Aye.

The CLERK. Ms. Lofgren, aye.

Chairman SENSENBRENNER. Gentleman from North Carolina, Mr. Watt?

Mr. WATT. Aye.

The CLERK. Mr. Watt, aye.

Chairman SENSENBRENNER. Gentlewoman from Texas, Ms. Jackson Lee?

Ms. JACKSON LEE. Aye.

The CLERK. Ms. Jackson Lee, aye.

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

The CLERK. Mr. Chairman, there are 11 ayes and 15 nays.

Chairman SENSENBRENNER. And the amendment is not agreed to. Are there further amendments?

Ms. BALDWIN. Mr. Chairman?

Chairman SENSENBRENNER. Gentlewoman from Wisconsin.

Ms. BALDWIN. Mr. Chairman, I have an amendment at the desk, Baldwin Amendment No. 2.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 760 offered by Ms. Baldwin. Page 16, beginning in line 15, strike "or imprisoned" and all that follows through "both" in line 16.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

[The amendment follows:]

AMENDMENT TO H.R. 760
OFFERED BY MS. BALDWIN #2

Page 16, beginning in line 15, strike "or imprisoned" and all that follows through "both" in line 16.

Ms. BALDWIN. Thank you, Mr. Chairman. This amendment is also quite simple. It would strike the provision that subjects doctors to imprisonment for up to 2 years for performing any procedure proscribed by this legislation.

Mr. Chairman, when making a decision to terminate a pregnancy, the doctor, in consultation with the patient, chooses the safest, most effective procedure based on the specific circumstances present. Physicians use their best medical judgment to make these very difficult decisions. Under this legislation Congress is taking

away the decision making from doctors and their patients. Congress should not be involved in banning specific medical procedures.

This legislation is overly vague. It is unclear exactly which procedures we would ban. The term "partial-birth abortion" has no legal or medical meaning. It is a term invented for political purposes. The findings and actual operative clauses of the bill are inconsistent in their definitions, and in both cases are overly vague.

Medical experts testified just yesterday before the Constitution Subcommittee that the definition in the bill could easily be construed to ban the most commonly used second trimester abortion procedure.

My point with this amendment is not to try to fix these flawed definitions. As I said, I believe it is wrong to ban medical procedures. But the flawed definition in this legislation is combined with criminal penalties of up to 2 years in prison for physicians. We should not be inserting lawyers into the doctor's office to help them decide which procedure to use. They should be making these decisions based on medical judgment and safety.

Mr. Chairman, the American Medical Association does not support this legislation because of these criminal sanctions. Dr. Ann Davis, Assistant Professor in Clinical Obstetrics and Gynecology at Columbia University testified yesterday that the risk of a particular abortion procedure varies in each 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 and others that I didn't list, it is essential that a physician be able to choose from the full array of safe techniques. Having the physician add a legal review to these decisions because they are worried about criminal penalties due to a vague law is wrong. With this legislation before us, we in essence have Congress practicing medicine and doctors practicing law.

I urge my colleagues to support this amendment and strike the criminal penalties on doctors.

Chairman SENSENBRENNER. Gentleman from Ohio.

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

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. CHABOT. Mr. Chairman, this amendment should be rejected. I think it's important that we not lose sight of what we're really dealing with, what this procedure is all about.

Brenda Pratt Schaefer was a registered nurse, and she observed Dr. Haskell use the partial-birth abortion procedure on at least three different babies, and she testified before the Senate Judiciary Committee and described a partial-birth abortion that she personally witnessed on a child who was 26½ weeks along. And here's what she saw. She said, "Dr. Haskell went in with forceps and grabbed the baby's legs and pulled them down into the birth canal. Then he delivered together baby's body and the arms, everything but the head. The doctor kept the head right inside the uterus. The baby's little fingers were clasping and unclasping and his little feet were kicking. Then the doctor stuck the scissors in the back of his head and the baby's arms jerked out like a startle reaction, like a

flinch, like a baby does when he thinks he is going to fall. The doctor opened up the scissors, stuck a high-powered suction tube into the opening and sucked the baby's brains out. Now the baby went completely limp. He cut the umbilical cord and delivered the placenta. He threw the baby in a pan, along with the placenta and the instruments he had just used. I saw the baby move in the pan. I asked another nurse and she said it was just reflexes. That baby boy had the most perfect angelic face I think I've ever seen in my life."

And that's what Brenda Pratt Schaefer saw, what she witnessed with her own eyes.

There are some medical procedures that are so abhorrent to society that they justify a criminal prohibition. The purpose of the criminal prohibitions are to ensure that physicians are significantly deterred from performing this otherwise improper procedure. In 1997 the American Medical Association noted the appropriateness of the partial-birth abortion bans penalty, stating, quote, "The profession has supported criminal restrictions on improper medical procedures such as female genital mutilation, for example."

I mean there are just some procedures which are too abhorrent for a civilized society. This is one of those, and therefore, these criminal procedures need to stay in place. I encourage my colleagues to oppose this amendment and yield back the balance.

Chairman SENSENBRENNER. The question is on the Baldwin amendment. Those in favor will say aye.

Ms. BALDWIN. I ask for a recorded vote.

Chairman SENSENBRENNER. Those opposed, no.

Noes appear to have it.

Ms. BALDWIN. Ask for a recorded vote.

Chairman SENSENBRENNER. Recorded vote is ordered. Those in favor of the Baldwin amendment will, as your names are called, answer aye, those opposed no, and the clerk will call the roll.

The CLERK. Mr. Hyde?

[No response.]

The CLERK. Mr. Coble?

[No response.]

The CLERK. Mr. Smith?

Mr. SMITH. No.

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

Mr. GALLEGLY. No.

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

[No response.]

The CLERK. Mr. Chabot?

Mr. CHABOT. No.

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

[No response.]

The CLERK. Mr. Cannon?

[No response.]

The CLERK. Mr. Bachus?

Mr. BACHUS. No.

The CLERK. Mr. Bachus, no. Mr. Hostettler?

Mr. HOSTETTLER. No.

The CLERK. Mr. Hostettler, no. Mr. Green?

[No response.]

The CLERK. Mr. Keller?

Mr. KELLER. No.
The CLERK. Mr. Keller, no. Ms. Hart?
Ms. HART. No.
The CLERK. Ms. Hart, no. Mr. Flake?
[No response.]
The CLERK. Mr. Pence?
[No response.]
The CLERK. Mr. Forbes?
Mr. FORBES. No.
The CLERK. Mr. Forbes, no. Mr. King?
Mr. KING. No.
The CLERK. Mr. King, no. Mr. Carter?
Mr. CARTER. No.
The CLERK. Mr. Carter, no. Mr. Feeney?
Mr. FEENEY. No.
The CLERK. Mr. Feeney, no. Mrs. Blackburn?
[No response.]
The CLERK. Mr. Conyers?
[No response.]
The CLERK. Mr. Berman?
[No response.]
The CLERK. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
Mr. WATT. Aye.
The CLERK. Mr. Watt, aye. Ms. Lofgren?
[No response.]
The CLERK. Ms. Jackson Lee?
[No response.]
The CLERK. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
Mr. WEINER. Aye.
The CLERK. Mr. Weiner, aye. Mr. Schiff?
Mr. SCHIFF. Aye.
The CLERK. Mr. Schiff, aye. Ms. Sánchez?
Ms. SÁNCHEZ. Aye.
The CLERK. Ms. Sánchez, aye. Mr. Chairman?
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.

Chairman SENSENBRENNER. Members in the room who wish to cast or change their vote? Gentleman from North Carolina, Mr. Coble?

Mr. COBLE. Nay.

The CLERK. Mr. Coble, no.

Chairman SENSENBRENNER. Gentleman from Utah, Mr. Cannon?

Mr. CANNON. No.

The CLERK. Mr. Cannon, no.

Chairman SENSENBRENNER. Further Members in the chamber who wish to case or change their vote? The gentleman from Tennessee, Mr. Jenkins?

Mr. JENKINS. No.

The CLERK. Mr. Jenkins, no.

Chairman SENSENBRENNER. Other Members who wish to cast or change their votes?

If not, the clerk will report.

The CLERK. Mr. Chairman, there are 8 ayes and 15 noes.

Chairman SENSENBRENNER. And the amendment is not agreed to. Are there further amendments?

Ms. BALDWIN. Mr. Chairman?

Chairman SENSENBRENNER. Gentlewoman from Wisconsin.

Ms. BALDWIN. Mr. Chairman, I have an amendment at the desk, Baldwin Amendment No. 1.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 760 offered by Mrs. Baldwin. Strike Section 2.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

[The amendment follows:]

AMENDMENT TO H.R. 760
OFFERED BY MS. BALDWIN #1

Strike section 2.

Ms. BALDWIN. Thank you, Mr. Chairman. This amendment is very straightforward. It strikes the findings from the bill. There are several good reasons to remove the findings from this bill.

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

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

The findings in this bill simply ignore the significant evidence of medical experts and the reasoned judgment of the Supreme Court.

The second reason to remove these findings is that they are not supported by any sort of legislative record. These findings, which are identical to last year's bill, were drafted and introduced before the Constitution Subcommittee even had a legislative hearing to establish any case to justify the bill. Talk about putting the cart before the horse. I always thought that fact finding came before legislating, especially if the majority wants to create a legislative record that will be considered and respected by the court. This Committee has failed to produce any such record and the court will rightly disregard these inaccurate and unsupported findings.

The third reason to strike the findings in this bill is that they are unlikely to have any impact on the Supreme Court's judgment as to the constitutionality of this legislation. Federal courts have rejected our fact finding in the past. They have clearly stated that findings are subject to judicial review and independent judgment by the court. As Members of this Committee know well, the legislative record established for the Violence Against Women Act was one of the most extensive ever assembled by Congress. Four years of hearing on the Violence Against Women Act produced significant evidence, supported the findings that domestic violence impacted interstate commerce. Yet the court struck down the Violence Against Women Act's civil remedy in the *Morrison* decision, disregarding our very well documented findings.

Mr. Chairman, these findings are not supported by the evidence. They're not supported by our Committee record, and they are not going to have any impact on the court's actions. I urge my colleagues to support this amendment.

Chairman SENSENBRENNER. Gentleman from Ohio, Mr. Chabot.

Mr. CHABOT. Move to strike the last word.

Chairman SENSENBRENNER. Gentleman's recognized for 5 minutes.

Mr. CHABOT. Thank you, Mr. Chairman. This amendment should be rejected. H.R. 760's findings are necessary statements of Congress' factual conclusions regarding the relative health and safety of a partial-birth abortion. The extensive findings make it clear that substantial evidence exists upon which Congress can conclude that a partial-birth abortion is not medically necessary to preserve the health of a women. Despite the claims of H.R. 760's opponents, the Supreme Court does not consider congressional findings irrelevant. Quite to the contrary. The court consistently reviews and discerns Congress' intentions based upon the findings. To remove the findings would remove the basis upon which the court could determine whether the legislative facts which support H.R. 760 are based upon reasonable inferences made from substantial evidence. The congressional findings are a critically important part of this bill, and therefore should remain. Thus I oppose this amendment.

Yield back the balance of my time.

Chairman SENSENBRENNER. The question is on the Baldwin amendment.

Mr. SCOTT. Mr. Chairman, move to strike the last word?

Chairman SENSENBRENNER. The gentleman from Virginia is recognized for 5 minutes.

Mr. SCOTT. Mr. Chairman, I agree with the gentleman from Ohio, that you need these findings to make the bill constitutional. The only problem is they're not supported by the evidence. I forgot

who it was that said facts are stubborn things, but the former President kind of changed that around a little bit, and said facts are stupid things. The fact is that the American College of Obstetricians and Gynecologists have said that, "ACOG has concluded that 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 women." That's an unfortunate stubborn fact that we have to deal with. The finding is in disagreement with that, and I think they all ought to be struck because they're inconsistent with the record.

And appreciate the gentlelady's amendment. Yield back.

Chairman SENSENBRENNER. Gentleman from North Carolina, Mr. Watt.

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

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. WATT. Thank you, Mr. Chairman. I won't take 5 minutes. I can agree with Mr. Scott on this issue. I think I understand why the majority is attempting to make a bunch of findings to try to legitimize the conclusion that they reach. Unfortunately, while there is probably information in the hearing record to support a set of findings that is here, there's also substantial information in the hearing record that supports the exact opposite conclusions, and it's not as if the Members who are supporting this legislation are not aware of that. They are aware of that. I mean we just heard this testimony yesterday. This became a part of the record. It's been over and over and over again made a part of the record. This is the American College of Obstetricians and Gynecologists, who is the organization that is the group that is an organization of people who are in this profession. And yet, somehow or another, you seem to want to disregard what they are saying, which seems to me to have as much or greater weight than all of the testimony that other people have given. I mean you can't just be selective about it. There has to be some equity here.

And I just don't think these findings that are in this bill are supported by the record. I mean I have been here over and over and over again for hearings, and on every single panel of witnesses that we have heard, we have heard doctors or organizational representatives say that this procedure, in some limited number of cases, is the best and safest procedure that's available. And I don't know how we can just cavalierly disregard that unless we think we are somehow supposed to be not only the legislators here, but we decided we're going to be the doctors here.

So I just don't—I can't subscribe to and support a set of findings that is just contrary in many respects to the evidence that I have sat in the room and heard with my own ears, and these people seem to me to be absolutely credible witnesses, and I don't know. Maybe they're wrong, maybe they're right. But I can't reject what they're saying and accept an opposite set of findings.

I'll yield to Mr. Scott.

Mr. SCOTT. Thank you, and I thank the gentleman for yielding.

I just want to remind the Committee of a statement I've made at least twice during this hearing, and this is right out of the majority opinion, where the court says, "Where substantial medical authority," doesn't say "majority medical authority," but certainly

"substantial medical authority supports the proposition that banning a particular abortion procedure could"—doesn't say "would"—"could endanger a woman's health." *Casey* requires the statute to include a health exception.

Mr. WATT. I yield back, Mr. Chairman.

Chairman SENSENBRENNER. The question is on the Baldwin amendment.

Mr. BACHUS. Mr. Chairman?

Chairman SENSENBRENNER. Gentleman from Alabama.

Mr. BACHUS. I have a question for the sponsor of the amendment. The gentlelady from Wisconsin, do you believe in criminal penalties for child abuse? Do you support those?

Ms. BALDWIN. Yes.

Mr. BACHUS. You're saying yes? So you do support criminal penalties for child abuse?

Ms. BALDWIN. Yes.

Mr. BACHUS. All right, thank you.

Chairman SENSENBRENNER. The gentleman yield back the balance of his time?

Mr. NADLER. Mr. Chairman?

Chairman SENSENBRENNER. The gentlemen from New York, Mr. Nadler.

Mr. NADLER. Mr. Chairman, I simply want to point out that it is not child abuse to pursue—to perform or to execute a legal abortion which the Supreme Court has declared is a legal abortion.

I want to say something else too, because it really pervades this whole discussion. You can—and you know, this whole bill, to make a particular abortion procedure illegal is in one sense dishonest and in one sense honest. It is dishonest in that it purports to talk about late term abortions, whereas these procedures may in fact be late term or less than late term. Late term abortions, no one really supports. They are already illegal in 41 States. And if the majority here really wanted a late term abortion bill, they would write a late term abortion bill, and as I said before, there would be very little opposition so long as you said after 24 weeks or 26 weeks, or whatever you've chosen along those lines, you can't perform the abortion except to save the life or health of the mother, which is the two requirements the Supreme Court says you must do. And if we had such a bill then all the talk about babies being inches from birth, et cetera would be taken care of, postviability. But that's not what this bill is really about.

The other debate about this bill is a more honest debate, and it says, look, let's be squeamish. We can describe in gruesome terms the actual procedure by which a fetus is aborted, and it sounds terrible, and it's only inches from delivery, so let's, because it sounds terrible, let's outlaw it. But the fact is, and the opponents of abortion say this constantly too, you can probably describe other abortion procedures and make them sound terrible. But the fact is that if they're previability, then you can't legislate against them, period. The Supreme Court says so. If they're postviability you can legislate against them as long as you put in a life and health exception for the mother.

So if you want to be honest, you put in a late term abortion bill that would pass, and would pass constitutional muster. If you want to be dishonest and just play to the political galleries but accom-

plish nothing, then you put in this bill, which is unconstitutional on its face, despite all the facile and nonsensical discussions that we're having here. Everybody knows the Supreme Court's going to throw it out. Despite any denials of that, it's obvious. Everybody knows that. It's facially unconstitutional. But it makes for good election headlines.

Mr. CHABOT. Would the gentleman yield? Would the gentleman yield?

Mr. NADLER. Yes.

Mr. CHABOT. I can guarantee you that not everybody accepts that the Supreme Court is going to throw this out.

Mr. NADLER. Reclaiming my time. Everybody knowledgeable and not fooling themselves knows that the Supreme Court is going to throw it out unless there are some new appointments to the Supreme Court before it gets there. Then who knows?

But the fact of the matter is, any competent scholar of constitutional who reads that knows exactly what the current Supreme Court would do. And the point is, again, if you want to ban a late term abortion, we should have a bill to do that. A constitutional ban, all it had to say is after 26 weeks, life and health exception, it would be constitutional. You wouldn't get too much exception. So let's stop talking about late term abortions, because that's easy to do if people really wanted to do it.

What this bill does is something that it can't do and shouldn't do, which is to ban a particular form of abortion, previability as well as postviability. If it's postviability you can do it without even mentioning a particular procedure. If it's previability you can't do it in any event. So while we have all this discussion, it's just a lot of political nonsense not aimed at a real bill or at accomplishing anything real. I yield.

Mr. WATT. Would the gentleman yield?

Mr. NADLER. I'll yield to the gentleman.

Mr. WATT. Let me just respond to Mr. Bachus's concern. We do think that criminal penalty is appropriate. The problem here is that these findings just simply are absolutely inconsistent with anything that is in the record, and it's not about child abuse. This would be a very close issue in any event because you are really put to the—even if you assume what you were underlying for the last few years, to put us to a choice where we've got to select between the health—the life of a baby or the life of the mother, which is what the evidence that's in the record suggests we would be doing, for me is at odds with any kind of——

Chairman SENSENBRENNER. Time of the gentleman has expired.

Mr. NADLER. I ask unanimous consent to 30 seconds.

Chairman SENSENBRENNER. The gentleman from New York is recognized for another 30 seconds.

Mr. WATT. Would the gentleman yield?

Mr. NADLER. I yield.

Mr. WATT. The very first finding says that there's a moral and ethical consensus that this procedure is never medically necessary. That is just absolutely inconsistent with the testimony that we have heard. It is not consistent with what the people have testified.

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

Mr. HOSTETTLER. Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from Indiana, Mr. Hostettler. Let me point out that there are votes scheduled at about 11:30. If we're not done with this bill by then, we will be back this afternoon.

The gentleman from Indiana.

Mr. HOSTETTLER. Move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. HOSTETTLER. I yield to the gentleman from Alabama.

Mr. BACHUS. Mr. Chairman, I'll be very brief.

But I would like to respond first to the gentleman from North Carolina. He says that you're asking us to choose between the life of the mother and the baby, and we're not going to make that choice. I submit to you that, first of all, the mother's life, according to all the medical testimony that we've heard, is not endangered. The life of the baby is certainly——

Mr. WATT. Would the gentleman yield?

Mr. BACHUS. And you are, in fact, choosing to kill that baby, which is an innocent baby.

Now, we've had debates in this body about capital punishment, and some of the same people that are going to vote to take the life of this baby, which I think we all agree is innocent, have said that you oppose capital punishment—and you have two reasons. One is that you're taking innocent life, and one is that you're simply taking life, and that you don't believe in taking the life of anyone. But, in fact, by allowing this procedure to continue, you're doing that.

Secondly, I would address the gentleman from New York. You said let's be honest here. But then you said this procedure is not child abuse. I just want to read two paragraphs and close with this. Every Member of this body can decide whether this is child abuse or not. I think this is the ultimate child abuse. This is what was read earlier.

"Dr. Haskell went in with forceps and grabbed the baby's legs and pulled them down into the birth canal. Then he delivered the baby's body and the arms, everything but the head. The doctor kept the head right inside the uterus." This is testimony before the Senate Judiciary Committee.

"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's going to fall."

"The doctor opened up the scissors, stuck a high-powered suction tube into the opening, and sucked the baby's brains out. Now the baby went completely limp."

Mr. NADLER. Would the gentleman yield, since he misquoted me?

Mr. BACHUS. Let's be perfectly honest. Is that child abuse?

Mr. NADLER. Would the gentleman yield, since he misquoted me?

Chairman SENSENBRENNER. The time belongs to the gentleman from Indiana.

Mr. NADLER. Would the gentleman yield?

Mr. HOSTETTLER. I yield to the gentleman from New York.

Mr. NADLER. Thank you.

What I said was that that procedure for abortion, as well as other procedures for abortion, which aren't being made illegal in

this bill, could be made to sound very gruesome, but that if we really wanted to deal with that, we would do a late term abortion bill with the constitutional exceptions for the life and health of the mother and that would take care of that.

Mr. BACHUS. You do agree that what I just read is child abuse?

Mr. NADLER. No, I will not agree. But I'm saying, if we really wanted to deal with that, we could deal with it, but not with this bill, which won't deal with it.

Mr. BACHUS. Do you consider that child abuse or not, to do that?

Chairman SENSENBRENNER. The time is controlled by the gentleman from Indiana, who yielded to the gentleman——

Mr. HOSTETTLER. I take back the balance of my time.

Chairman SENSENBRENNER. The question is on the Baldwin amendment. Those in favor will say aye. Opposed, no. The noes appear to have it.

Ms. BALDWIN. A rollcall is requested.

Chairman SENSENBRENNER. rollcall will be ordered, The question is on agreeing to the Baldwin amendment. Those in favor will say aye as your names are called; those opposed, no. The Clerk will call the roll.

The CLERK. My. Hyde?

[No response.]

The CLERK. Mr. Coble?

[No response.]

The CLERK. Mr. Smith.

Mr. SMITH. No.

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

Mr. GALLEGLY. No.

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

[No response.]

The CLERK. Mr. Chabot?

Mr. CHABOT. No.

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

[No response.]

The CLERK. Mr. Cannon?

[No response.]

The CLERK. Mr. Bachus?

Mr. BACHUS. No.

The CLERK. Mr. Bachus, no. Mr. Hostettler?

Mr. HOSTETTLER. No.

The CLERK. Mr. Hostettler, no. Mr. Green?

Mr. GREEN. No.

The CLERK. Mr. Green, no. Mr. Keller?

Mr. KELLER. No.

The CLERK. Mr. Keller, no. Ms. Hart?

Ms. HART. No.

The CLERK. Ms. Hart, no. Mr. Flake?

Mr. FLAKE. No.

The CLERK. Mr. Flake, no. Mr. Pence?

Mr. PENCE. No.

The CLERK. Mr. Pence, no. Mr. Forbes?

Mr. FORBES. No.

The CLERK. Mr. Forbes, no. Mr. King?

Mr. KING. No.

The CLERK. Mr. King, no. Mr. Carter?

Mr. CARTER. No.
The CLERK. Mr. Carter, no. Mr. Feeney?
Mr. FEENEY. No.
The CLERK. Mr. Feeney, no. Mrs. Blackburn?
[No response.]
The CLERK. Mr. Conyers?
[No response.]
The CLERK. Mr. Berman?
[No response.]
The CLERK. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
Mr. WATT. Aye.
The CLERK. Mr. Watt, aye. Ms. Lofgren?
[No response.]
The CLERK. Ms. Jackson Lee?
[No response.]
The CLERK. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan?
Mr. MEEHAN. Aye.
The CLERK. Mr. Meehan, aye. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
Mr. WEINER. Aye.
The CLERK. Mr. Weiner, aye. Mr. Schiff?
Mr. SCHIFF. Aye.
The CLERK. Mr. Schiff, aye. Ms. Sánchez?
Ms. SÁNCHEZ. Ms. Sánchez, aye. Mr. Chairman?
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.

Chairman SENSENBRENNER. Are there Members in the chamber who wish to cast or change their vote? The gentleman from North Carolina, Mr. Coble.

Mr. COBLE. No.
The CLERK. Mr. Coble, no.

Chairman SENSENBRENNER. The gentleman from Tennessee, Mr. Jenkins.

Mr. JENKINS. No.
The CLERK. Mr. Jenkins, no.

Chairman SENSENBRENNER. The gentlewoman from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee, aye.

Chairman SENSENBRENNER. The gentleman from Utah, Mr. Cannon.

Mr. CANNON. No.

The CLERK. Mr. Cannon, no.

Chairman SENSENBRENNER. Are there further Members in the chamber who wish to cast or charge their vote? If not, the Clerk will report.

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

Chairman SENSENBRENNER. And the amendment is not agreed to.

Are there further amendments?

Ms. JACKSON LEE. Mr. Chairman.

Chairman SENSENBRENNER. The gentlewoman from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. I have an amendment at the desk.

Mr. CLERK. Amendment to H.R. 760, offered by Ms. Jackson Lee of Texas. Section 1, amend the text to read as follows: "This Act may be cited as the 'Safe Abortion Procedures Ban Act of 2003'.".

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

[The amendment follows:]

AMENDMENT TO H.R. 760

OFFERED BY MS. JACKSON-LEE OF TEXAS

Section 1, amend the text to read as follows: "This Act may be cited as the 'Safe Abortion Procedures Ban Act of 2003'.".

Chairman SENSENBRENNER. The Clerk will report the amendment.

Ms. JACKSON LEE. Thank you very much, Mr. Chairman.

Needless to say, this has been a debate that many of us have encountered for a number of sessions. I think it is important, Mr. Chairman, to note as well that I have not, in the course of the debate, from my colleagues who support this legislation and those who are opposed to this legislation, any lack of humanity and recognition of the preciousness of the opportunity to any family, any couple, any individual, to be able to successfully, with love and affection, bring into this world an opportunity for a life to thrive in a peaceful existence.

Many of us come to this perspective from our different faiths and regional backgrounds. Some have a more unique perspective maybe than others. I don't offer these words in condemnation. But it is difficult sometimes to be able to capture the intensity and the emotion that a woman experiences in her attempt to procreate with a loved one.

There are those of us who could go on record having personally experienced the joys and the tragedies of birth. There will be many

of you who would argue that that's not the place, or this is not the place, for such discussion. But having lived through this for a number of terms, I am reminded of a witness from California who argued or presented to us how long she tried to give birth, and how broken they were as a couple when they were advised that they had a pregnancy, and in order to ensure the life of the mother and the health of the mother in particular, and the ability to give birth in the future, they had to make a decision between their God, their family, and their physician.

We now come full circle, 2 years, 4 years, 6 years, 8 years later, and I've heard the voices describing this procedure, well-known to be a very unique procedure and, as well, rarely used.

We have before us legislation that will criminalize the physician, legislation that will criminalize the mother, legislation that will destroy already a broken family, and certainly legislation that many believe will uphold their values and their faith.

But I think the Constitution has spoken, or the Supreme Court has spoken, on this issue. Frankly, I believe we should label this bill what it is, "The Partial-Birth Abortion Ban Act of 2003," to the "Safe Abortion Procedures Ban Act." Because my legislation tells the truth, that if you go to a physician and not a back ally, if the physician advises you, for your health and your life, you are still a criminal in the eyes of the law that is now being presented to us today. This is clearly a safe abortion procedures ban act of 2003.

The Supreme Court made it clear, first of all, that there is a right to privacy, and *Roe* v. *Wade* has made it clear. And my good friends and colleagues, based upon their conscience, have tried every manner of way, every tactic, to undermine *Roe* v. *Wade*. Why don't we make and allow these decisions to be decisions that are privately made by the woman, her family, her God, and the physician? Why don't we trust the same doctors, which we held on a pedestal just a few weeks ago, when we were rushing out the door for medical malpractice and citing them as gods, no matter how many people they injured, why can't we put them as gods today, that they make the right decision because they've taken an oath to save lives. Why are we putting them in this position that we will criminalize these individuals?

The Court has spoken. They have acknowledged that this is a viable procedure.

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

PREPARED STATEMENT OF THE HONORABLE SHEILA JACKSON LEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

I. INTRODUCTION

On February 13, 2003, Representative Steve Chabot introduced H.R. 760, the "Partial-Birth Abortion Ban Act of 2003." On March 26, 2003 the full Judiciary Committee convened to debate Amendments to H.R. 760. The Democratic members of the Committee proposed seven amendments to H.R. 760. I proposed an Amendment that read as follows:

> Section 1, amend the text to read as follows: "This Act may be cited as the 'Safe Abortion Procedures Ban Act of 2003'.".

I proposed this Amendment to change the title of the bill because the title as written is medically inaccurate, and is so vague that it includes procedures that are beneficial to women's health. The abortion procedure the sponsors of the bill inaccurately call "partial birth abortions" (intact dilation and extraction, or D&X procedures) are safe abortion procedure. In fact, many physicians and federal appellate

courts have considered this issue carefully and concluded that in some cases so-called "partial birth abortions are the safest available procedure.

II. PHYSICIANS AND FEDERAL COURTS HAVE CONCLUDED D&X IS SAFE

The American College of Obstetricians and Gynecologists (ACOG) has members who are experts on the subject of women's reproductive health. They have extensive experience with all abortion procedures including the D&X procedure. The ACOG has concluded that for some women the D&X procedure is a safer abortion option than other available abortion procedures. The ACOG has explained, "Compared to [non-intact] D&Es, D&X involves less risk of uterine perforation or cervical laceration because it requires the physician to make fewer passes into the uterus with sharp instruments." ACOG also concluded that D&X may be the best and most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman.

There is also considerable evidence comparing the D&E and D&X procedures that concludes the D&X procedure reduces the risk of retained fetal tissue, a serious abortion complication that can result in the death of the mother. Moreover, the D&X procedure takes less time than other abortion procedures and, therefore, reduces the risk of blood loss, trauma, and exposure to anesthesia.

Federal courts across the country, including the United States Supreme Court, have heard testimony and considered evidence on the safety of the D&X procedure. After hearing the evidence, the vast majority of federal courts concluded that the D&X procedure is a safe procedure, and for some women in certain circumstances, it is the safest procedure. In reviewing the record in *Stenberg* v. *Carhart*, a case considering the validity of a Nebraska statute nearly identical in scope to H.R. 760, the Supreme Court found, "the record shows that significant medical authority supports the proposition that in some circumstances, D&X would be the safest procedure."

Every federal appellate court in the country, except one, ruled that the D&X procedure may be safer for some women in certain circumstances. Notably, in the *Carhart* case the Supreme Court overruled the one court that found the D&X procedure unsafe, Nebraska's federal court. The prevailing view, among federal judges in courts in Arizona, Illinois, New Jersey, Ohio, Rhode Island, Virginia, and Wisconsin is that the D&X procedure is safer for women in some circumstances. For example, a Federal District Court in Ohio considered evidence for and against the D&X procedure and stated, "After viewing all of the evidence, and hearing all of the testimony, this 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 and does not pose the same degree of risk of uterine and cervical lacerations. . ."

III. THE "FINDINGS" OF H.R. 760 GROSSLY MISCHARACTERIZE THE FACTS

The Republican's "findings" that the D&X procedure is unsafe are baseless. The Supreme Court heard and rejected the identical "findings" in the *Carhart* case. The Court concluded that D&X is a safe procedure. The Court also found the procedure does not create risks of cervical incompetence and lacerations, risks from blind instrumentation, or risks of conversion of the fetus to a breech position. H.R. 760 also makes the baseless claim that the dilation required in a D&X abortion increases a woman's risk of cervical incompetence. On the contrary the ACOG concluded, "many D&E procedures involve similar amounts of dilation—sometimes over a several-day period." Plus, according to ACOG, the dilation in D&X is less than that involved in childbirth.

IV. H.R. 760 BANS SEVERAL ABORTION PROCEDURES, NOT JUST ONE

H.R. 760 is flawed not only because it inaccurately labels the D&X procedure unsafe. It is also flawed because the non-medical term "partial birth abortion" is imprecise. The term partial birth abortion does not apply to a single abortion procedure, but to multiple abortion procedures. The bill's prohibitions, as presently written, would ban procedures performed pre-viability and post-viability. The drafters of H.R. 706 deliberately omitted any mention that the ban applies only to post-viability abortions, and deliberately omitted any mention of a specific, medically defined, procedure. This bill is an obvious attempt by anti-choice advocates to advance their efforts to ban all abortions.

V. H.R. 760 CONTRADICTS SUPREME COURT PRECEDENT

The Court in *Stenberg* concluded, "a statute that altogether forbids D&X creates a significant health risk." In *Stenberg*, the Court reaffirmed that women's health must always be protected. The Court said if a procedure may be safer for some women in certain circumstances, then it cannot be banned. The Supreme Court con-

cluded in several cases that a woman's health must be the physicians primary concern and that a physician must be given the discretion to determine the best course of treatment to protect women's lives and health. H.R. 760 ignores all of the Supreme Court's mandates. It flatly bans the D&X procedure and well as other procedures. It bans procedures that may be safer for some women, and it denies many physicians the discretion to determine the best course of treatment.

VI. THIS AMENDMENT IS NOT FRIVOLOUS

The proponents of H.R. 760 have argued that my Amendment to change the title of the bill from "The Partial Birth Abortion Ban Act of 2003" to the "Safe Abortion Procedures Ban Act of 2003" is frivolous. I strongly believe that any debate about the issue of abortion is a debate about life and death. Likewise, any debate about abortion inherently concerns women's reproductive health. The issues of women's reproductive health, and life and death, are never frivolous. H.R. 760 bans safe abortion procedures, and jeopardizes women's health. The title of the bill should reflect that unfortunate reality.

Chairman SENSENBRENNER. The gentlewoman's time has expired. The gentleman from Ohio, Mr. Chabot.

Mr. JACKSON LEE. I would ask my colleagues to support the amendment.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. CHABOT. Mr. Chairman, this is truly a frivolous amendment and I would urge my colleagues to vote against it.

I yield back the balance of my time.

Mr. NADLER. Mr. Chairman, Mr. Chairman——

Chairman SENSENBRENNER. The vote is on the Jackson Lee amendment. Those in favor——

Mr. NADLER. Mr. Chairman, I was requesting——

Chairman SENSENBRENNER. Those in favor will say aye, opposed will say no. The noes appear to have it. The noes have it.

The rollcall will be ordered. Those in favor of the Jackson Lee amendment will, as your names are called, answer aye. Those opposed, no. The Clerk will call the roll.

The CLERK. Mr. Hyde?

[No response.]

The CLERK. Mr. Coble?

[No response.]

The CLERK. Mr. Smith?

Mr. SMITH. No.

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

Mr. GALLEGLY. No.

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

[No response.]

The CLERK. Mr. Chabot?

Mr. CHABOT. No.

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

[No response.]

The CLERK. Mr. Cannon?

[No response.]

The CLERK. Mr. Bachus?

Mr. BACHUS. No.

The CLERK. Mr. Bachus, no. Mr. Hostettler?

Mr. HOSTETTLER. No.

The CLERK. Mr. Hostettler, no. Mr. Green?

Mr. GREEN. No.

The CLERK. Mr. Green, no. Mr. Keller?

Mr. KELLER. No.

The CLERK. Mr. Keller, no. Ms. Hart?
Ms. HART. No.
The CLERK. Ms. Hart, no. Mr. Flake?
Mr. FLAKE. No.
The CLERK. Mr. Flake, no. Mr. Pence?
Mr. PENCE. No.
The CLERK. Mr. Pence, no. Mr. Forbes?
Mr. FORBES. No.
The CLERK. Mr. Forbes, no. Mr. King?
Mr. KING. No.
The CLERK. Mr. King, no. Mr. Carter?
Mr. CARTER. No.
The CLERK. Mr. Carter, no. Mr. Feeney?
Mr. FEENEY. No.
The CLERK. Mr. Feeney, no. Mrs. Blackburn?
Mrs. BLACKBURN. No.
The CLERK. Mrs. Blackburn, no. Mr. Conyers?
[No response.]
The CLERK. Mr. Berman?
[No response.]
The CLERK. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
[No response.]
The CLERK. Ms. Lofgren?
[No response.]
The CLERK. Ms. Jackson Lee?
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee, aye. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan?
Mr. MEEHAN. Aye.
The CLERK. Mr. Meehan, aye. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler.
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
Mr. WEINER. Aye.
The CLERK. Mr. Weiner, aye. Mr. Schiff?
[No response.]
The CLERK. Ms. Sánchez?
Ms. SÁNCHEZ. Aye.
The CLERK. Ms. Sánchez, aye. Mr. Chairman?
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.

Chairman SENSENBRENNER. Members in the chamber who wish to cast or change their vote? The gentleman from Tennessee, Mr. Jenkins.

Mr. JENKINS. No.

The CLERK. Mr. Jenkins, no.

Chairman SENSENBRENNER. The gentleman from Utah, Mr. Cannon.

Mr. CANNON. No.

The CLERK. Mr. Cannon, no.

Chairman SENSENBRENNER. The gentleman from North Carolina, Mr. Coble.

Mr. COBLE. No.

The CLERK. Mr. Coble, no.

Chairman SENSENBRENNER. Any Members who wish to cast or change their vote? If not, the Clerk will report.

The CLERK. Mr. Chairman, there are 8 ayes and 19 noes.

Chairman SENSENBRENNER. Then the amendment is not agreed to.

Are there further amendments?

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

Chairman SENSENBRENNER. The gentlewoman from Wisconsin. The Clerk will report the amendment.

The CLERK. Amendment to H.R. 760 offered by Ms. Baldwin. On page 15, after line 5——

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

Chairman SENSENBRENNER. Without objection, so ordered. The gentlewoman is recognized for 5 minutes.

[The amendment follows:]

AMENDMENT TO H.R. 760
OFFERED BY MS. BALDWIN #3

On page 15, after line 5, insert the following:

"(15) In *Stenberg v. Carhart*, 530 U.S. 914, 938 (2000), the Supreme Court had before it the same evidence available to this Congress."

"(16) The Supreme Court found based on the same evidence available to this Congress, 'substantial medical authority' supports the conclusion that a statute that forbids the D&X procedure 'creates a significant health risk' to women. *Stenberg*, 530 U.S. at 938."

"(17) The Supreme Court recognized a select panel of the American College of Obstetricians and Gynecologists, the leading professional association of physicians who specialize in the health care of women, have concluded that the D&X procedure may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman. *Stenberg*, 530 U.S. at 932."

"(18) The Supreme Court recognized that all but one federal trial court to hear expert evidence on the safety of the D&X procedure found that it may be the best or most appropriate procedure to preserve a woman's health. *Stenberg*, 530 U.S. at 932-33."

Ms. BALDWIN. Thank you, Mr. Chairman.

Since the Committee earlier choose not to strike the inaccurate findings in this bill, maybe we can correct the record by adding in some accurate findings. That's what this amendment would do. It would add to the findings the conclusions of the United States Supreme Court in the *Stenberg* case, that the D&X procedure in safe and is often most appropriate as a procedure in a particular circumstance to save the life or preserve the health of a woman.

We discussed earlier but it bears repeating, that the majority of medical evidence indicates that the intact D&E or D&X procedures are safe abortion procedures and may be the safest option for some women. Under some circumstances——

Chairman SENSENBRENNER. The gentlewoman will suspend. The Committee is recessed until one o'clock.

[Recess.]

Chairman SENSENBRENNER. The Committee will be in order. A working quorum is present.

When the Committee recessed for the votes and for lunch, pending was an amendment that was offered by the gentlewoman from Wisconsin, Ms. Baldwin, to the bill H.R. 760.

The chair recognizes the gentlewoman from Wisconsin for 5 minutes.

Ms. BALDWIN. Thank you, Mr. Chairman.

Since the Committee earlier this morning chose not to strike inaccurate findings contained in this bill, we certainly can correct this record by adding some findings that are accurate. That's what this amendment would do. I would add to the findings the conclusions of the United States Supreme Court in the *Stenberg* case, that the D&X procedure is safe and is often the most appropriate procedure in a particular circumstance to save the life or to preserve the health of a woman.

We discussed earlier, but it bears repeating, that the majority of medical evidence indicates that the intact D&E or D&X procedures are safe abortion procedures that may be the safest option for some women under some circumstances.

Mr. Chairman, the brief of the American College of Obstetricians and Gynecologists in the *Stenberg* case provides significant evidence of the safety and need for these procedures, and I ask unanimous consent to enter the American College of Obstetricians and Gynecologists brief into the record.

Chairman SENSENBRENNER. Without objection.

[The information follows:]

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

No. 99-830

1999 U.S. Briefs 830

March 29, 2000

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

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

A. STEPHEN HUT, JR., MATTHEW A. BRILL, KIMBERLY A. PARKER, MATTHEW P. PREVIN, WILMER, CUTLER & PICKERING, 2445 M Street, N.W., Washington, D.C. 20037, (202) 663-6000.
ADAM L. FRANK Counsel of Record, SCHULTE ROTH & ZABEL LLP, 900 Third Avenue, New York, N.Y. 10022, (212) 756-2000.
Counsel for Amici Curiae. **[*i]**

View Table of Contents

View Table of Authorities

[*1] STATEMENT OF INTEREST OF AMICI CURIAE

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

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

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

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

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

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

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

STATEMENT OF MEDICAL FACTS

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

1. First-Trimester Abortions n2

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

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

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

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

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

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

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

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

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

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

2. Post-First-Trimester Abortions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUMMARY OF ARGUMENT

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

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

ARGUMENT

I. THE ACT IS UNCONSTITUTIONALLY VAGUE.

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

A. The Terms of the Act Are Hopelessly Ambiguous.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

Respectfully submitted,

A. STEPHEN HUT, JR., MATTHEW A. BRILL, KIMBERLY A. PARKER, MATTHEW P. PREVIN, WILMER, CUTLER & PICKERING, 2445 M Street, N.W., Washington, D.C. 20037, (202) 663-6000

ADAM L. FRANK, Counsel of Record, SCHULTE ROTH & ZABEL LLP, 900 Third Avenue, New York, N.Y. 10022, (212) 756-2000

Counsel for Amici Curiae
March 29, 2000

Ms. BALDWIN. Thank you, Mr. Chairman.

Of those courts that heard expert evidence on the safety of these procedures, the Supreme Court and all but one Federal trial court found that this procedure was necessary under some circumstances to save the life and preserve the health of a woman.

The California Medical Association has said that it believes that the intact D&E procedure may provide substantial medical benefits, and that procedure is safer in several respects than the alternatives. Physicians for Reproductive Choice and Health has stated that banning D&X will force competent physicians to choose riskier medical options that increase danger to patients.

Mr. Chairman, last year during the markup of this legislation, I brought with me all the briefs filed in the *Stenberg* case, so that they could be included in the Committee's report. The purpose of that act was to demonstrate that the evidence in these briefs far outweighs the lack of foundations for the bill's findings. These many briefs provide real and significant evidence about the safety of these procedures.

I will not ask to enter them into the record today. I would like to read the list of briefs, and I encourage American citizens who are interested in some factual findings to read them.

First and foremost, I recommend the excellent brief filed by the American College of Obstetricians and Gynecologists. Other briefs include the Respondent Leroy Carhart, M.D.; brief of the United States; brief of NARAL; National Women's Law Center; People for the American Way; and the National Partnership for Women and Families. The brief of the Religious Coalition for Reproductive Choice, and 93 other religious organizations. The brief of the Women's Law Project and 74 other organizations. The brief of 124 Members of Congress; brief of physicians and clinics providing services in several States, represented by the American Civil Liberties Union; the brief of Planned Parenthood of Wisconsin, and the brief of the States of New York, Maine, Oregon and Vermont.

Mr. Chairman, the Supreme Court has found that substantial medical authority supports the conclusion that a statute that bans the D&X procedure creates significant health risk. The Supreme Court has recognized the conclusions of the American College of Obstetricians and Gynecologists, that this procedure is safe and may be appropriate in particular circumstances. These new findings are accurate, they are truthful, and they are critically important and we should include them in this legislation.

I yield back.

Chairman SENSENBRENNER. The gentleman from Ohio.

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

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. CHABOT. Thank you.

This amendment should be rejected because it attempts to bind Congress to the findings of fact reached in the *Stenberg* case. 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, except in *Stenberg,* under the clearly erroneous standard. Rather, the United States Congress is entitled to reach its own factual findings, findings that the Supreme Court

accords great deference, and to enact legislation based upon those findings, so long as it seeks to pursue a legitimate interest that is within the scope of the Constitution and draws reasonable inferences based upon substantial evidence.

Thus, H.R. 760 includes extensive findings on the lack of evidence to support the medical efficacy or safety of the procedure that is in question here today, which is, of course, partial-birth abortion, as well as the potential dangers posed by this particular procedure.

The concept of Supreme Court deference to Congress' factual findings is not a new legal theory. The Court has historically been highly deferential to Congress' factual determinations, regardless of the legal authority upon which Congress has sought to legislate.

As Justice Rehnquist has stated, "The fact that the Court is not exercising a primary judgement but sitting in judgement upon those who also have taken the oath to observe the Constitution, and who have the responsibility for carrying on Government, compels the Court to be particularly careful not to substitute our judgement—" meaning the Court's judgement "—of what is desirable for that of Congress, or our own evaluation of evidence for a reasonable evaluation by the Legislative branch." In other words, us.

Although the Supreme Court in *Stenberg* was obligated to accept the District Court's findings regarding the relative health and safety benefits of a partial-birth abortion due to the applicable standard of appellate review, Congress possesses an independent constitutional authority upon which it may reach findings of fact that contradict those of the trial court. Under well-settled Supreme Court jurisprudence, these congressional findings will be entitled to great deference by the Federal Judiciary in ruling on the constitutionality of a partial-birth abortion ban.

Thus, the first section of the Partial-Birth Abortion Ban Act of 2003 contains Congress' 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.

For these reasons, and a number of others, I oppose the gentlelady from Wisconsin's amendment and I ask my colleagues to do the same.

Ms. JACKSON LEE. Mr. Chairman.

Chairman SENSENBRENNER. The gentlewoman from Texas.

Ms. JACKSON LEE. Mr. Chairman, I rise to strike the last word.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

Ms. JACKSON LEE. Thank you very much, Mr. Chairman.

I rise to support the distinguished gentlelady's amendment. I do want to express my appreciation for the tone that amendments have been offered.

I want to draw my colleagues' attention that some years ago in this Committee there was legislation dealing with the Child Predators Act, and one of the successful amendments that was offered by myself was to remove the term "predator" from the title of the bill to not compare children to predators. That was a successful turning of the tone and the thrust of that legislation.

I think it is important, when we're debating such important issues, that we maintain the same civility that amendments that

discuss the opposition of Members to legislation before us, that may mischaracterize positions of many constituents, but more importantly, mischaracterize the role of Congress and as well the rule we have juxtaposed the Supreme Court are not to be labeled as frivolous. So I think it's important that we're having this markup, and we're here listening to a number of amendments.

What the gentlelady's amendment does is clearly speak to *Stenberg* v. *Carhart.* The drafters of H.R. 760 are clearly wrong in asserting that they can overrule the *Carhart* decision through legislation. Prior attempts by Congress to undo disfavored Supreme Court rulings, such as Congress' attempt to legislatively overturn *Miranda* and to legislatively overturn *Employment Division, Department of Human Resources of Oregon* v. *Smith,* have been soundly rejected by the Supreme Court. Given the utter absence of legal support for this bill, it must be seen as well as questionable as to whether or not the legislation can overturn the Supreme Court's position, both in *Roe* v. *Wade* and the *Stenberg*—excuse me—case.

So I believe the gentlelady is simply trying to restate what—I hesitate to say what is obvious, but certainly also to protect a legitimate medical procedure, and that is the D&X. Clearly, as she has indicated in her amendment, the Supreme Court recognized that—all but one Federal trial court—to hear expert evidence on the safety of the D&X procedure found that it may be the best or the most appropriate procedures to preserve a woman's health. So I think that the amendment clearly would enhance this legislation by restating what the Supreme Court has found and, as well, what the Supreme Court has stated in this case, that is still law. *Stenberg* is still law.

I would ask my colleagues that, if we are to view the role that we play in this room to be a role that allows us to have some consensus, even as we disagree, that the gentlelady's amendment is appropriate and that in the spirit of which we are presenting this, that no amendment be characterized as being frivolous because we're all here trying to seriously represent our constituents as well as our interpretation of the laws that are presented before this particular body. I would ask my colleagues to support the amendment.

Chairman SENSENBRENNER. The gentleman from Iowa.

Mr. KING. Thank you, Mr. Chairman. I may be out of order, but I would point out there were a number of briefs that were submitted in opposition to this procedure, and I would ask that the amicus briefs submitted by a number of medical doctors opposed to this procedure be admitted as well.

Chairman SENSENBRENNER. If the gentleman from Iowa would yield, the gentlewoman from Wisconsin did not ask that the briefs she referred to be reprinted in the record at public expense. She listed names of organizations that submitted amicus briefs. In trying to—Are you asking for one or are you asking for more than one?

Mr. KING. I would ask simply for an equal number, should they be admitted into the record.

Chairman SENSENBRENNER. Well, she—did the gentlewoman from Wisconsin get one brief admitted, and you're asking for one?

Mr. KING. Yes.

Chairman SENSENBRENNER. Without objection, it's a deal.

Mr. KING. Thank you, Mr. Chairman.
[The information follows:]

DON STENBERG, ATTORNEY GENERAL OF THE STATE OF NEBRASKA, et al., Petitioners, v. LEROY CARHART, M.D., Respondent.

No. 99-830

1999 U.S. Briefs 830

February 28, 2000

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit.

BRIEF AMICI CURIAE of Association of American Physicians and Surgeons, Illinois State Medical Society, Physicians' Ad hoc Coalition for Truth, Christian Medical and Dental Society, Catholic Medical Association, Physicians Resource Council of Focus on the Family, Pennsylvania Physicians Resource Council, Physicians Research Council of the Indiana Family Institute, New Jersey Physicians Resource Council, Oklahoma Physicians Resource Council, Texas Physicians Resource Council, Wisconsin Physicians Resource Council, Drs. Kathi A. Aultman, Gerard Black, Watson A. Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Peter R. DeMarco, Fred de Miranda, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Joseph R. McCaslin, Phillip McNeeley, Phillip Metz, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, Dennis D. Weisenburger, and Joseph R. Zanga, IN SUPPORT OF PETITIONERS

This amici curiae brief is respectfully submitted on behalf of the Association of American Physicians and Surgeons, Illinois State Medical Society, Physicians' Ad hoc Coalition for Truth, Christian Medical and Dental Society, Catholic Medical Association, Physicians Resource Council of Focus on the Family, Pennsylvania Physicians Resource Council, Physicians Research Council of the Indiana Family Institute, New Jersey Physicians Resource Council, Oklahoma Physicians Resource Council, Texas Physicians Resource Council, Wisconsin Physicians Resource Council, Drs. Gerard Black, Watson Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Phillip McNeeley, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, and Joseph R. Zanga, MD, in support of Petitioners and in favor of reversal of the judgment of the United States Court of Appeals for the Eighth Circuit entered on September 24, 1999. n1

n1 Pursuant to Rule 37.3 of the Rules of this Court, Amici have obtained and file herewith the written consent of each of the parties to the filing of this brief. Counsel for a party did not author this brief in whole or in part. No person or entity, other than the Amici Curiae, its members, or its counsel made monetary contribution to the preparation and submission of this brief.

TERESA STANTON COLLETT, Counsel of Record, 1303 San Jacinto, Houston, Texas 77002-7000, (713) 646-1834.
DAVID M. SMOLIN, Professor of Law, Cumberland Law School, Samford University, Birmingham, Alabama 35229, (205) 726-2418. **[*i]**

View Table of Contents

View Table of Authorities

[*1] INTEREST OF THE AMICI CURIAE

Amicus Curiae The Association of American Physicians & Surgeons, Inc. ("AAPS") is a nonprofit organization dedicated to defending the practice of private medicine. Founded in 1943, AAPS has thousands of members nationwide in all specialties. AAPS frequently participates in litigation in defense of the practice of medicine in accordance with the Oath of Hippocrates. Central to **[*2]** the interest of AAPS are procedures which, like the one at issue here, are not designed to promote and protect the health of the patient.

Amicus Curiae Illinois State Medical Society ("ISMS") is a nonprofit professional organization with membership of over 16,000 licensed physicians, medical residents and medical students. ISMS policy specifically states:

ISMS opposes all intact dilation and extraction procedures (Partial-Birth Abortion). (1997 Annual meeting)

ISMS participation is limited to the purposes of this Brief to establish the medical realities surrounding intact dilation and extraction and not the penalties provided in the Nebraska statute.

Amicus Curiae The Physicians' Ad Hoc Coalition for Truth is an organization of more than 600 physicians from around the nation - most specializing in the fields of obstetrics and gynecology, perinatology or pediatrics - that have united to effectively express their opinion that the procedure known as partial-birth abortion is never medically necessary, and often may be contraindicated. This organization takes no position on the ultimate question of whether the current legal protections of abortion should be continued.

Amicus Curiae The Christian Medical & Dental Society (CMDS) was founded in 1941 and today represents over 14,000 members - primarily practicing physicians representing the entire range of medical specialties. This organization views principles of biblical faith as essential to protecting the lives and best interests of patients, the conscientious practice of medicine according to long-standing Hippocratic and religious principles, and to preserving the public respect accorded to physicians as guardians of health and life.

Amicus Curiae Catholic Medical Association ("CMA") is an association of physicians who seek to integrate their understanding of the teachings of the Roman Catholic Church into their professional lives. CMA believes that partial-birth abortion is never medically necessary.

[*3] Amicus Curiae Pennsylvania Physicians Resource Council ("PPFC") is an association of physicians concerned for the health and well-being of women and preborn children. PPFC has 250 members and concurs that intact D & X is not recognized as the preferred medical treatment at any stage of pregnancy, nor for any particular condition experienced in pregnancy.

Amicus Curiae Indiana Physicians Research Council ("IPRC") is an association of physicians and part of the Indiana Family Institute. IPRC was instrumental in the passage of a partial birth abortion ban that was enacted by the Indiana General Assembly in 1997.

Amicus Curiae Texas Physicians Resource Council ("TPRC") is a subsidiary of Free Market Foundation of Texas. TPRC represents approximately 500 physicians. TPRC recognizes that the United States Supreme Court's decision in this case will impact medical practice in Texas and endorses the ban on partial birth abortion.

Amicus Curiae New Jersey Physicians Resource Council ("NJPRC") is an association of 45 New Jersey physicians which provides insight on medical, ethical and social issues for policymakers, medical professionals and the public. NJPRC does not believe that partial birth abortion is ever medically indicated to save the life of the mother or to protect her future fertility.

Amicus Curiae Oklahoma Physicians Resource Council ("OPRC") is a multi-specialty organization of Oklahoma physicians. OPRC is associated with Oklahoma Family Policy Council, a nonprofit research and educational organization. OPRC and the physicians associated with it believe that bans against the medical performance of partial-birth abortion procedures are legitimate, moral and ethical public policy positions for states to hold.

Amicus Curiae Physicians Resource Council ("PRC") of Focus on the Family, a California non-profit religious corporation, is an advisory organization that helps identify critical, medically related issues and to form national task forces to develop and implement strategies and objectives to preserve traditional family values. The PRC **[*4]** is comprised of 22 physicians and oversees the publication of Physician Magazine which is received by approximately 74,000 physicians.

Amicus Curiae Wisconsin Physicians Resource Council (WPRC) operates in concert with The Family Research Institute of Wisconsin, Inc. (FRI), which is a charitable and educational organization. The partial-birth abortion issue in this case will impact medical practice in Wisconsin since Wisconsin passed a similar ban in 1998.

Amici curiae Gerard Black, Watson Bowes, Joseph M. Casey, Byron Calhoun, Steven Calvin, William F. Colliton, Jr., Curtis Cook, Eugene F. Diamond, Timothy Fisher, Don Gambrell, Phillip McNeeley, Robert Orr, Edmund Pellegrino, Nancy Romer, Pamela Smith, LeRoy Sprang, and Joseph R. Zanga, are physicians, many of whom have testified before Congress or their state legislatures regarding the medical necessity of the procedure known as "partial-birth abortion."

SUMMARY OF ARGUMENT

Amici offer this brief for the limited purpose of establishing the medical realities surrounding the procedure known as "partial birth abortion," "intact dilation and extraction," or "intact dilation and evacuation." Amici believe it is both desirable and constitutional to restrict the use of this procedure as Nebraska has done in this case. On this issue amici echo the sentiments expressed by a representative of the American Medical Association ("AMA"):

This issue is whether the partial delivery of a living fetus for the purpose of killing it outside of the womb ought to be severely restricted. We believe, as a matter of ethical principle, it should rarely if ever be done. And although we also believe physicians should have broad discretion in medical matters, both this procedure and **[*5]** assisted suicide (as well as female genital mutilation and lobotomies) can and should be regulated if the profession won't do it.

Letter to the New York Times, dated May 30, 1997 by P. John Seward, M.D. in his capacity as AMA Executive Vice President (emphasis added). n2

n2 Reproduced at App. 7-9 for the convenience of the Court.

As a legitimate health regulation the Nebraska statute succeeds in limiting the use of an unproven and ethically questionable practice, while insuring that safe and effective procedures remain available for women seeking to obtain abortions. While the autonomy of the medical profession is an important and valuable component of the success American medicine has experienced in the attempt to provide the highest quality of care in the world, this interest does not require the profession or the state to disregard practices that erode the public's under-standing of and confidence in the physician's role in assisting pregnant women. Dilation and extraction is such a practice, and thus should be prohibited.

ARGUMENT

I. D&X IS GENERALLY RECOGNIZED AS A DISTINCTIVE TECHNIQUE

A. THE FINDINGS OF THE DISTRICT COURT BELOW INDICATE THAT DILATION AND EXTRACTION IS A DISTINCTIVE TECHNIQUE CLEARLY DISTINGUISHABLE FROM DILATION AND EVACUATION AND OTHER ABORTION TECHNIQUES

The legal theories and factual findings by which the district court invalidated Nebraska's Partial-Birth Abortion Prohibitions are in tension with one another. On the one hand, the claim is made that the prohibitions are vague or constitute an undue burden because they **[*6]** encompass not only intact dilation and extraction ("D&X"), n3 but also dilation and evacuation ("D&E") abortion, the latter method being the most common method of second trimester abortion. n4 In accordance with this legal theory, the district court attempted to blur the line between D&X and other methods. n5

n3 This is the term applied to the procedure by its originator when it was first formally discussed among abortion providers. See Martin Haskell, Dilation and Extraction for Late Second Trimester Abortion (presented at the National Abortion Federation Risk Management Seminar, Sept. 13, 1992), published in The Partial-Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the Senate Comm. On the Judiciary, 104th Cong., 1st Sess. 3 (Nov. 17, 1995).

n4 See, e.g., *Carhart v. Stenberg, 11 F. Supp. 2d 1099, 1127-32 (D. Neb. 1998); 192 F.3d 1142, 49-50 (8th Cir. 1999).*

n5 See, e.g., *Carhart v. Stenberg, 972 F. Supp. 507, 525 (D.Neb. 1997)* (D&X is a variant of D&E and the difference between the two procedures is not a medical issue, but merely political). *11 F. Supp. 2d at 1106* (claiming that Carhart "intends to remove fetus intact" for all post-fifteen week abortions, although only successful in five to ten percent of such abortions).

On the other hand, the claim is made that D&X is a distinctive method with health benefits for women beyond that of other methods, including D&E. n6 For this purpose, of course, the district court drew a sharp distinction between D&X and other methods, in order to make comparative claims or findings about the supposed medical superiority of D&X over D&E and other methods. n7

n6 See, e.g., *Carhart, 972 F. Supp. at 525-27; 11 F. Supp. 2d at 1122-23.*

n7 See id.

Obviously, when the district court finds that the D&X procedure is medically superior to other methods, it is implicitly acknowledging that D&X is a distinctive technique, clearly distinguishable from, for example, D&E abortion. Other sections of this brief will take issue with **[*7]** the district court findings on the supposed benefits of D&X, and will demonstrate that the statutory definition of "partial-birth abortion" sufficiently distinguishes intact D&X from standard D&E. At the outset, however, it should be recognized that the district court findings themselves presuppose that the D&X procedure is indeed a distinctive method, clearly distinguishable from D&E abortion and other methods.

B. MEDICAL SOURCES INDICATE THAT INTACT D&X IS A DISTINCT TECHNIQUE

The term "D&X" abortion appears to have been introduced by Dr. Martin Haskell in a paper presented at a 1992 National Abortion Federation Conference. n8 The district court below specifically described the "Haskell D&X" as follows:

On the first and second days of the procedure, Dr. Haskell inserts dilators into the patient's cervix. On the third day, the dilators are removed and the patient's membranes are ruptured. Then, with the guidance of ultra-sound, Haskell inserts forceps into the uterus, grasps a lower extremity, and pulls it into the vagina. With his fingers, Haskell then delivers the other lower extremity, the torso, shoulders, and the upper extremities. The skull, which is too big to be delivered, lodges in the internal cervical os. Haskell uses his fingers to push the anterior cervical lip out of the way, then presses a pair of scissors against the base of the fetal skull. He then forces the scissors into the base of the skull, spreads them to enlarge the opening, removes the scissors, inserts a suction catheter, and evacuates the skull contents. With the head decompressed, he then removes the fetus completely from the patient.

[*8] *972 F. Supp. at 516* (quoting *Women's Med. Prof'l Corp. v. Voinovich, 911 F. Supp. 1051 (S.D. Ohio 1995)).*

n8 See Haskell, supra.

Dr. Haskell's 1992 paper explains the distinction between D&X and other methods as follows:

The surgical method described in this paper differs from classic D&E in that it does not rely upon dismemberment to remove the fetus. Nor are inductions or infusions used to expel the intact fetus.

Rather, the surgeon grasps and removes a nearly intact fetus through an adequately dilated cervix. The author has coined the term Dilation and Extraction or D&X to distinguish it from dismemberment-type D&E's.

. . . .

Classic D&E is accomplished by dismembering the fetus inside the uterus with instruments and removing the pieces through an adequately dilated cervix. n9

n9 See Haskell, supra.

As the district court found, Dr. Haskell employed his new method for pregnancies that had progressed to twenty weeks or beyond. n10 Dr. Haskell's 1992 paper explained that classic D&E dismemberment became difficult beginning at twenty weeks due to "the toughness of fetal tissues at this stage of development." Alternative D&E methods involved causing fetal death by various methods prior to surgery, to produce softening of fetal tissues. Late second trimester abortions could also be performed by induction methods. Dr. Haskell's D&X method was a new procedure that resolved the problem of fetal tissue toughness post-twenty weeks by providing a non-induction, non-dismemberment technique. n11 Instead of either dismembering the fetus piece by piece **[*9]** through the cervix or inducing labor, Dr. Haskell provided extensive dilation in a three-day procedure, then delivered all but the head of the fetus into the vagina, followed by reduction of the head size through evacuation of the skull contents, allowing complete delivery of the fetus.

n10 *972 F. Supp. at 516.*

n11 See id.

There has been a certain amount of confusion over the correct term for this distinctive procedure. At the time that Dr. Haskell presented his paper there were no references to this procedure in any medical textbooks, dictionaries, or journals. Even standard texts on abortion, such as Warren Hern, Abortion Practice (1990 reprint), did not name or describe the procedure. Dr. Haskell claimed to have "coined the term Dilation and Extraction or D&X". n12 However, another physician employing the method, Dr. James T. McMahon, chose the slightly different name "intact dilation and evacuation (intact D&E)." n13 Subsequently, abortion rights proponents such as the National Abortion Federation and Planned Parenthood divided over the right terminology, the former adopting Haskell's terminology, n14 the latter McMahon's. n15 Both organizations claimed their term the proper "medical" one, in supposed contrast to the term "partial-birth abortion," which was derided by advocates of the procedure as a non-medical term. n16 In the absence of any published descriptions of **[*10]** the term in medical textbooks, dictionaries, or standard medical journals, and amidst political controversy over proposed bans on partial-birth abortion which were aimed at prohibiting the new Haskell/McMahon procedure, it was difficult to standardize precise medical terminology for the new procedure.

n12 Haskell, supra.

n13 See James Bopp & Curtis R. Cook, Partial-Birth Abortion: The Final Frontier of Abortion Jurisprudence, *14 Issues L. & Med. 3, 20 (1998).*

n14 Planned Parenthood Federation of America, Fact Sheet: Why Abortion Bans are Unconstitutional (visited February 22, 2000) <http://www.plannedparenthood.org/library/ ABORTION/abortban___fact.html.>

n15 National Abortion Federation, NAF's Response to "Partial-Birth Abortion" Ban (visited February 22, 2000) <http:// www.prochoice.org/issues/ban.htm.>

n16 See id.

Subsequently the American College of Obstetricians and Gynecologists ("ACOG") issued a January 1997 statement adopting a hybrid term "intact dilation and extraction" or "intact D&X," combining the Haskell/McMahon definitions. The American Medical Association relied upon this report in issuing its own policy declarations. Therefore, the term "intact dilation and extraction" or "intact D&X" - which is sometimes shortened simply to "D&X" - appears to have become the most common appellations for the procedure in question. n17

n17 See *11 F. Supp. 2d at 1105 & n.10.* Amici do not suggest that unanimity has emerged on the proper name of this procedure, even at this time.

ACOG states that intact D&X has been described as including the following four elements:

(1) the deliberate dilation of the cervix, usually over a sequence of days;

(2) instrumental conversion of the fetus to a footling breech;

(3) breech extraction of the body, excepting the head; and

(4) partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

11 F. Supp. 2d at 1105.

The ACOG acceptance of this description indicates once again that D&X is medically understood as a distinctive technique, different from classic D&E abortion, even if it is sometimes denominated as a variant form of D&E. This four-part description is useful so long as it is not **[*11]** taken too literally. For example, dilation is "usually over a sequence of days" post twenty weeks, but prior to twenty weeks instrumental dilation not requiring this extended time frame may be employed. n18 (This is significant to the present case, as the Respondent Dr. Carhart testified that he only performed D&X from 16 to 20 weeks.) n19 Secondly, as Dr. Frank Boehm, professor of obstetrics and gynecology at the Vanderbilt University School of Medicine and Director of Obstetrics for the hospital, noted in testimony before the district court, version (or purposeful manipulation) is only needed when the fetus does not present in breech. n20 In the present case Dr. Carhart testified that he only chose to perform a D &X when the fetus presented in breech or where repositioning the fetus from a side presentation resulted in a breech presentation. n21

n18 "For procedures at up to 16 weeks' gestation, placing the dilators 4-8 hours prior to surgery may suffice. Beyond 16 weeks it is common practice to allow overnight dilation, and some mid to late second trimester protocols call for a second insertion in 16-24 hours." W. Martin Haskell et al., Surgical Abortion After the First Trimester in A Clinician's Guide to Medical and Surgical Abortion (Maureen Paul, et al., 1999) at 128.

n19 *972 F. Supp. 507 at 514-15.*

n20 Ex. 32, Videotaped Dep. of Dr. Boehm at 31:23-32:6. This point was first noted by Dr. Haskell in his 1992 paper presented at the National Abortion Federation Fall Risk Management Seminar. See Haskell, Dilation and Extraction, supra ("Version (as needed)").

n21 *972 F. Supp. at 522 n.20.*

The medical literature on D&X, although severely limited, takes into account these slight variations in technique. For example, in an article based on the AMA Board of Trustees 1997 Report, which was approved by the AMA House of Delegates in June 1997, the authors quote the ACOG description of intact D&X, then note "However, there may be variations of D&X that depart from this protocol, such as when an identical procedure is **[*12]** performed without converting the fetus to a footling breech or using decompression without suction evacuation of the cranial contents." n22

n22 Janet E. Gans Epner, et al., Late-Term Abortion, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26, 1998). See also W. Martin Haskell, et al., Surgical Abortion After the First Trimester 136-7 in A Clinician's Guide to Medical and Surgical Abortion (Maureen Paul, et al. eds., 1999) (discussing variations in procedure for breech and vertex position).

The Nebraska statute takes account of these variations, and other variations which at this point are not seriously proposed by any medical professional (e.g., intentionally delivering a live fetus head-first in order to kill it before completed delivery). A more detailed medical definition could invite practitioners to evade the law by modifying other minor details of the procedure. What remains the same throughout these variations and distinguishes the D&X procedure from other abortion techniques is: (1) Deliberate dilation of the cervix, technique and duration variable depending on stage of pregnancy and other factors; (2) Instrumental or manual conversion of the fetus to a footling breech where necessary; (3) Breech extraction of the body except the head; and (4) Reduction of the head size of a living fetus through methods such as decompression or evacuation of the intracranial contents to effect vaginal delivery of a dead, but otherwise intact, fetus.

II. INTACT D&X IS NOT RECOGNIZED WITHIN THE MEDICAL PROFESSION AS THE PRIMARY INDICATED TECHNIQUE OR STANDARD OF CARE AT ANY STAGE OF PREGNANCY OR FOR ANY PREGNANCY, AND THEREFORE CANNOT BE CONSIDERED MEDICALLY SUPERIOR TO THE STANDARD METHODS OF SECOND TRIMESTER ABORTION, SUCH AS D&E.

[*13] A. THE DISTRICT COURT ISSUED CONTRADICTORY FINDINGS OF FACT REGARDING THE SUPPOSED SUPERIORITY OF INTACT D&X WHICH MUST BE REGARDED AS CLEARLY ERRONEOUS

The district court correctly found, and the court of appeals agreed, that standard D&E abortion is the most common abortion method during the relevant gestational period. n23 This finding is supported by the practice of Respondent Dr. Carhart, who was found to perform standard D&E abortion rather than intact D&X in approximately ninety percent of his post-fifteen week abortions. n24 Although Dr. Haskell designed the D&X originally for the post-twenty-week period, the district court found that Respondent Dr. Carhart chose not to perform a D&X post-twenty weeks, but instead "induces fetal death by injection." n25 During the period from sixteen to twenty weeks Dr. Carhart only performs the D&X procedure when he finds the fetus in breech (or sometimes transverse, or side) presentation. Thus he employs D&X in approximately ten to twenty abortions out of the 190 sixteen-to-twenty-week abortions he performs annually. n26 The district court also recorded Dr. Carhart's procedure if he found the fetus presenting in transverse (sideways) position:

Carhart grasps whatever portion of the fetus he can in order to turn it so that part of the body will pass through the cervix. He performs this procedure because "you can't bring the fetus out sideways." If he can grasp the fetus "feet first" **[*14]** he will, but Carhart does not "intentionally spend a lot of time doing that."

972 F. Supp. at 521 n.20 (quoting portions of Dr. Carhart's testimony).

n23 *11 F. Supp. 2d at 1127-30; 192 F.2d at 1149-51* (D&E most common abortion method for second trimester abortions).

n24 See *972 F. Supp. at 520-22.*

n25 See *972 F. Supp. at 522.*

n26 *972 F. Supp. at 511, 520, 521 & n.20.*

Finally, the district court found that Dr. Carhart was, so far as he knew, the only provider of post-sixteen-week abortions in Nebraska, and therefore the only physician in the state who performed the D&X procedure. n27

n27 *972 F. Supp. at 511.*

The district court in summary found: (1) Standard D&E abortion is the most common method used during the relevant gestational period; (2) Respondent, the only provider of abortions during the relevant gestational period, chooses D&E over D&X approximately ninety percent of the time; and (3) Respondent allowed the presentation of the fetus during the period from sixteen to twenty weeks to determine which method he employed, and cared so little which technique he used that, when faced with a transverse lie, he did not "intentionally" spend "a lot of time" seeking to grasp the feet so that he could perform a D&X rather than D&E.

Directly contradictory to these findings, the district court also found that "medical evidence established that the D&X procedure is appreciably safer for women than the D&E procedure." n28 The district court relied on claims that D&X was superior to D&E because of (1) less chance of trauma to the cervix and uterus from bony fragments; (2) less instrumentation in the uterus, lessening the risk of complications from tearing or perforating the uterus; (3) prevention of disseminated intravascular coagulopathy and amniotic fluid embolus; (4) reduced chance of retained fetal parts; (5) reduced risk of free floating head; and (6) shorter operating time, reducing the amount of bleeding and the risks of hemorrhage and infection. n29 The only evidence offered to support the existence of these **[*15]** benefits was the testimony of the Respondent and the speculation of experts. The record is void of any controlled study or article from a peer-reviewed journal establishing that the D&X procedure is superior in any way to the D&E procedure most commonly employed in second and third trimester abortions. n30

n28 *972 F. Supp. at 525.*

n29 See *id. at 526-27.*

n30 The only generally available medical publication to make similar claims on behalf of the procedure is a recently published medical text, A Clinician's Guide to Medical and Surgical Abortion (Maureen Paul, et al. eds.) (1999). Based exclusively upon the self-reporting of the deceased Dr. James T. McMahon, one of the originators of the D&X procedure, the text states "This major complication rate is virtually identical to that of an earlier series of nonintact D&E's reported by Hern (3.07 [per] 1000 cases) despite the fact that nearly one-fourth of the cases in McMahon's series exceeded Hern's 25-week gestational limit." W. Martin Haskell, et al., Surgical Abortion After the First Trimester, in A Clinician's Guide to Medical and Surgical Abortion, supra at 137. This information was available at the time of trial, yet in the absence of any external review or indicia of reliability, none of the Respondent's experts or the district judge considered it relevant. Even taken at face value this statement provides little support for the finding of the district court that D&X is superior to D&E.

The chapter goes on to assert "Haskell [the other originator of D&X and co-author of the chapter] has performed more than 1500 intact D&E's at 20-26 weeks' gestation without a serious event." Id. No information is provided regarding the methodology of follow-up to obtain information about delayed complications, nor is there an adequate explanation of Haskell's or McMahon's definition of what constitutes a complication.

All the reasons given by the district court for finding intact D&X "appreciably safer for women" than D&E, if valid, would apply to the ninety percent of abortions for which Respondent Carhart chose not to perform a D&X. Moreover, the district court opinions fail to list any potential negative effects of the D&X procedure. Therefore, the findings of the district court suggest that Respondent Carhart, and indeed the vast majority of **[*16]** second-trimester abortion providers, are guilty of deliberately failing to choose an "appreciably safer" method of abortion, D&X.

The district court findings are self-contradictory. They simultaneously condemn the State of Nebraska for allegedly making illegal the most common form of second trimester abortion (D&E), while also claiming that this same method is, as measured against D&X, so medically deficient as to constitute a serious health risk for women.

The district court findings on the safety of D&X, in short, cannot be taken seriously as "findings of fact," but instead should be read merely as alternative legal theories. Alternative legal theories or alternative rationales, even where offered by a district court, cannot however, be accorded the same weight as findings of

fact. Surely a single district judge lacks the authority to condemn as medically deficient and unsafe a procedure - D&E abortion - which is clearly within the current standard of care for second trimester abortion. n31

n31 Paul D. Blumenthal, et al., Abortion by Labor Induction, in A Clinician's Guide to Medical and Surgical Abortion, supra at 139 ("Compared to induction abortion, dilation and evacuation (D&E) has generally been recognized as the safest and most expeditious means of pregnancy termination for similar gestational ages, specially prior to 20 weeks").

Ironically, the district court condemned as "irrelevant" "political rhetoric" prior statements issued by the AMA supporting the proposed Partial-Birth Abortion Ban Act of 1997, H.R. 1122. n32 To disregard the predominant practice of substantially all physicians, including the Respondent, and condemn the statements of the largest organized group of physicians in the country as merely "political" fuels the public perception in some quarters that abortion jurisprudence is driven by the personal or political preferences of the judiciary, rather than reasoned **[*17]** interpretation of medical facts and constitutional limitations. In light of the common practice of all physicians testifying in this case, and the statements of the larger medical community that no circumstances necessitate the use of intact D&X, the findings of the district court on the supposed medical superiority of intact D&X abortion must be set aside as clearly erroneous.

n32 *972 F. Supp. at 525 n.27.*

B. MEDICAL SOURCES INDICATE THAT INTACT D&X IS NOT THE STANDARD OF CARE OR PREFERRED METHOD AT ANY STAGE OF PREGNANCY OR FOR ANY PREGNANCY, AND MAY HAVE SIGNIFICANT MATERNAL HEALTH RISKS THAT WERE NOT CONSIDERED BY THE DISTRICT COURT

The varied statements by ACOG and the AMA reflect professional organizations caught between two impulses. On the one hand, it is clear, as reflected for example by amici, that there are significant numbers of physicians and health care providers who hold that intact D&X is both medically and ethically objectionable. n33 Further, D&X is not the standard of care or preferred **[*18]** method at any stage of pregnancy or for any pregnancy, according to current medical literature and standards. On the other hand, professional organizations such as ACOG and the AMA have an understandable tendency to resist governmental regulation of medical procedures and medical providers, particularly when regulation may involve criminal sanctions.

n33 " 'I have very serious reservations about this procedure,' " said Colorado physician Warren Hern, M.D. The author of Abortion Practice, the nation's most widely used textbook on abortion standards and procedures, Dr. Hern specializes in late-term procedures . . . of the procedure in question he says, " 'You really can't defend it.' " Diane M. Gainelli, Outlawing abortion method: Veto-proof majority in House votes to prohibit late-term procedure," 38 Amer. Med. News 1 (Nov. 20, 1995) (reproduced at App. 11-20 for the convenience of the Court); M. LeRoy Sprang & Mark G. Neerhof, Rationale for Banning Abortions Late in Pregnancy, 280 J. Amer. Med. Ass'n 744 (Aug. 26, 1998); and Janet E. Gans Epner, et al., Late-term Abortion, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26, 1998) ("in the absence of controlled studies, the relative advantages and disadvantages of the procedure in specific circumstances remain unknown").

These conflicting impulses are well illustrated by the ACOG and AMA literature pertaining to intact D&X/ partial-birth abortion. A January 1997 ACOG statement, after describing the intact D&X procedure, stated:

A select panel convened by the ACOG could identify no circumstances under which this procedure [intact D&X] . . . would be the only option to save the life or preserve the health of the woman. An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision.

See *11 F. Supp. 2d at 1105 n.10.*

The first sentence of the ACOG statement reflects the failure of medical experts to identify any stage of pregnancy or particular circumstance in which intact D&X abortion represents the standard of care, or would be medically necessary to protect the life or health of women. In direct opposition to the clearly erroneous finding of the district court that intact D&X was generally and appreciably safer than the predominant D&E, the ACOG's panel of experts could not identify a single circumstance where D&X is medically superior. A subsequent policy statement by the AMA agreed, finding that "there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion." AMA Policy H-5.982, quoted in *Hope Clinic v. Ryan. 195 F.3d 857, 872 (7th Cir. 1999)* (en banc).

[*19] These expert findings of ACOG and the AMA were employed by the AMA when it issued statements in support of the Partial-Birth Abortion Ban of 1997, which is quite similar to the Nebraska law at issue herein. The AMA Board of Trustees Press Release and Fact Sheet took the position that the federal bill did not prohibit D&E, but only prohibited intact D&X. The AMA press release described that procedure as "broadly disfavored - both by experts and the public. . . . It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development." n34 The AMA Board of Trustees Fact Sheet on HR 1122 stated that "Intact D&X is not an accepted 'medical practice'. . . . the Board's expert scientific report recommends against its use." n35

n34 American Medical Association, AMA Press Releases: AMA Supports H.R. 1122 As Amended, Statement by Nancy W. Dickey, MD, Chair of the AMA Board of Trustees (reproduced at App. 5-6 for the convenience of the Court).

n35 American Medical Association, AMA Board of Trustees FACT SHEET on HR 1112 (June 1997) (reproduced at App. 1-4 for the convenience of the Court).

While ACOG has consistently opposed legal prohibition of intact D&X/partial birth abortion, and the AMA has taken varying positions regarding such legislation, neither organization has yet offered any specific circumstances in which the procedure is believed to be medically necessary. ACOG's statement that there "may" be such circumstances is clearly just another way of expressing generalized opposition to legislative regulation of physicians. Indeed, when interviewed by American Medical News about this statement, ACOG President Fredric D. Frigoletto, Jr., "maintained that the [ACOG Executive] Board did not 'endorse' the procedure. 'There are no data to say that one of the procedures is safer than the other,' he said. When asked why the statement said the procedure 'may be the best' in some cases, Dr. Frigoletto **[*20]** answered, 'or it may not be.' " n36 Such reference to the bare possibility of health risks by a professional organization opposed in principle to legislative regulation of abortion cannot constitute an "undue burden," if the undue burden test is to play its role of distinguishing between permissible and impermissible governmental regulation.

n36 Diane M. Gianelli, Medicine adds to debate on late-term abortions: ACOG draws fire for saying procedure 'may' be best option for some, 40 Amer. Med. News 1 (March 3, 1997) (reproduced at App. 21-27 for the convenience of the Court).

The district court below acknowledged as correct the statement of its most favored expert, Dr. Stubblefield, n37 that there are no medical studies "which compare the safety of the intact D&X to other abortion procedures or conclude that the D&X is safer than other abortion procedures." n38 Two published articles in The Journal of the American Medical Association relating to the D&X procedure have also noted the lack of credible studies on safety. n39

n37 See *11 F. Supp. 2d at 1116* (Dr. Stubblefield most persuasive and helpful expert).

n38 *11 F. Supp. 2d at 1112.*

n39 See Janet E. Gans Epner, et al., Late-term Abortion, 280 J. Amer. Med. Ass'n 724, 726 (Aug. 26 1998) ("in the absence of controlled studies, the relative advantages and disadvantages of the procedure in specific circumstances remain unknown"); M. LeRoy Sprang & Mark G. Neerhof, Rationale for Banning Abortions Late in Pregnancy, 280 J. Amer. Med. Ass'n 744 (Aug. 26, 1998) ("no credible studies on intact D&X that evaluate or attest to its safety").

The district court, not fearing to tread beyond the confines of published studies and the expert panels of ACOG and the AMA, dismissed the lack of published studies as unimportant. n40 The district court relied largely upon Dr. Stubblefield, "a teacher and user of the D&E **[*21]** procedure," n41 to buttress claims that the D&X procedure was medically superior to D&E abortion, despite the fact that Dr. Stubblefield "has not performed this procedure himself, nor has he viewed anyone else perform it." n42 The court never appears to have wondered why Dr. Stubblefield, its favored expert, had never used or taught the intact D&X procedure if he believed it to be superior to D&E. Nor was the district court deterred by Dr. Stubblefield's testimony that characterized the possible health benefits of D&X as mere theory which should be regarded as uncertain pending data. n43 Similarly, Respondent's other expert, Dr. Hodgson, who had "performed or supervised at least 30,000 abortions," n44 and yet had never intentionally performed an intact D&X, n45 was relied upon to buttress claims of D&X as a "technological advance." n46 Such appearance of a "courtroom conversion" by Respondent's experts, who adhere to the D&E in their medical practice while opining about the supposed superiority of the D&X inside the courtroom, undermines any support for the findings of the district court.

n40 See, e.g., *11 F. Supp. 2d at 1124.*

n41 *11 F. Supp. 2d at 1125 n.35.*

n42 *11 F. Supp. 2d at 1112.*

n43 See *11 F. Supp. 2d at 1111* ("theoretically, would be safer. It would be a while before we have the data to compare. . . .")

n44 *11 F. Supp. 2d at 1105.*

n45 See *11 F.2d at 1105, 972 F. Supp. at 516.*

n46 See *972 F. Supp. at 516.*

The district court's speculations on why D&X is superior to D&E failed to mention or take account of the special risks that may be associated with D&X. First, "some physicians have suggested that the procedure may increase complications, such as cervical incompetence." n47 The threat of cervical incompetence is related to the **[*22]** amount of cervical dilation. n48 Cervical incompetence consequent to intact D&X may make it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term.

n47 280 J. Amer. Med. Ass'n at 726 (footnote omitted).

n48 A. Golan, et al., Incompetence of the Uterine Cervix, 44 Obstet. Gynecol. Surv. 96-107 (1989).

Further risks peculiar to intact D&X are described as follows:

First, the risk of uterine rupture may be increased. An integral part of the D&X procedure is an internal podalic version, during which the physician instrumentally reaches into the uterus, grasps the fetus' feet, and pulls the feet down into the cervix, thus converting the lie to a footling breech. The internal version carries risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus. According to Williams Obstetrics, "there are very few, if any, indications for internal podalic version other than for delivery of a second twin." n49

The risk of podalic version (repositioning the fetus) referred to in Williams Obstetrics involves manual internal version (repositioning by hand within the woman's body) to deliver a fetus in the third trimester. While this differs somewhat from version (repositioning) of the fetus with an instrument as described by Haskell in the D&X procedure, the risks of Haskell's procedure are unknown, and can only be the subject of speculation based upon the risks of similar, but not identical procedures.

The second potential complication of intact D&X is the risk of iatrogenic laceration and secondary hemorrhage. Following internal version and partial breech extraction, scissors are forced into the base of the fetal skull while it is lodged in the birth canal. This blind procedure risks maternal injury from laceration of the uterus or **[*23]** cervix by the scissors and could result in severe bleeding and the threat of shock or even maternal death. n50

All of these risks, if realized, have significant import for maternal health.

n49 280 J. Amer. Med. Ass'n at 744-45 (footnote omitted).

n50 Id. (footnotes omitted).

The district court's failure to take account of the negative risks associated with D&X in its supposed findings on the comparative superiority of intact D&X, alone renders those findings clearly erroneous. Any comparative analysis of the various techniques applicable to a specific stage of pregnancy or circumstance must obviously take account of the relative risks of both procedures to be valid. Simply listing the risks associated with second trimester D&E abortion, as the court did, n51 fails utterly to constitute findings of fact on the comparative risks of D&E and D&X.

n51 See *11 F. Supp. 2d at 1123.*

Amici believe that the nearly eight years that have passed since Dr. Haskell's 1992 paper on intact D&X have demonstrated that the procedure is never medically necessary, and remains generally inferior, in terms of maternal health, to existing abortion methods. Although abortion rights orientated experts are clearly willing to go into federal court and testify as to the efficacy of the D&X, physicians have retained their preference, in actual practice, for various forms of D&E and induction methods. n52 Professional organizations with strong interests in professional autonomy and maternal health have been unable to identify any particular circumstances where there is a need for the procedure. While the AMA **[*24]** no longer supports the federal ban on partial-birth abortion due to its overall opposition to criminal sanctions against physicians, the AMA continues to oppose this procedure. n53 Rather than being a new method on the rise, D&X remains after almost eight years an aberrant curiosity, a medically needless flashpoint of deeply-felt division.

n52 See, e.g., David A. Grimes, The Continuing Need for Late Abortions, 280 J. Amer. Med. Ass'n 747, 748 (Aug. 26, 1998) ("only a small number of physicians nationwide" perform intact dilation and extraction).

n53 An October 21, 1999 "Statement For Response Only" issued by the AMA states:

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

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

American Medical Association, Statement for Response Only (Oct. 21, 1999) (reproduced at App. 10 for the convenience of the Court).

The weakness of the record in the instant case contrasts strangely with the supposed findings of the district court. None of the experts in the instant case had ever performed a D&X procedure. Even Respondent Carhart performed the D&X procedure in only about ten percent of his post-fifteen week abortions. Moreover, Carhart did not identify particular circumstances that necessitated use of D&X, but instead chose the procedure based on the happenstance of the presentation of the fetus, failing even in transverse presentations to make sustained efforts to effect a D&X procedure. The actions of the Respondent and his experts undercut any claims or finding of medical necessity for this procedure.

[*25] C. THERE ARE NO SPECIAL MEDICAL OR HEALTH INDICATIONS FOR D&X

The district court's over-reaching, clearly erroneous "finding" that the D&X procedure is generally superior to the more common and generally accepted methods, in combination with the fact that Respondent Carhart chose D&X based on the happenstance of fetal position, rather than special maternal indications, makes this case a particularly poor candidate for exploring whether there may be rare cases where D&X is necessary to maternal health. Neither the district court nor the appellate court below relied to a significant degree on such a

claimed need for D&X in specialized or extreme medical circumstances. Nonetheless, amici, having extensive experience with a wide variety of difficult medical circumstances related to maternal-fetal health, wish to emphasize that speculations on a supposed need for the D&X procedure in particular circumstances are groundless. This fact is not changed by the invocation of the emotionally charged circumstances surrounding tragic fetal abnormalities.

1. INTACT D&X ABORTION IS NOT INDICATED FOR HYDROCEPHALUS

Hydrocephalus, or excessive fluid accumulated in the fetal head, has sometimes been offered as a condition necessitating intact D&X, due to the impossibility of normally delivering the enlarged head. Of course, as ACOG and the AMA have noted, D&X has never been identified as the standard of care or indicated treatment for any particular circumstances. In fact, the usual treatment for hydrocephalus is transabdominal cephalocentesis, whereby the excess fluid in the fetal skull is drained through the use of a thin needle placed inside the womb through the woman's abdomen. n54 By contrast, proceeding transvaginally with scissors - the very crude method **[*26]** adopted by Haskell - or even a needle places the woman at an increased risk of infection because of the non-sterile vaginal environment.

n54 See, e.g., 280 J. Amer. Med. Ass'n at 745.

2. INTACT D&X IS NOT INDICATED OR NECESSARY IN ORDER TO DIAGNOSE FETAL ABNORMALITIES

It has sometimes been stated that it is useful to have an intact fetus in order to confirm abnormal prenatal diagnoses. n55 However, "a study involving 60 patients who underwent D&E at 14 to 22 weeks of gestation after fetal abnormalities were detected found that D&E successfully and consistently confirmed abnormal prenatal diagnoses." n56 Notwithstanding the results of these studies, to the extent that intact fetal salvage is desirable, this can be achieved through labor induction abortion. n57 Again, intact D&X upon examination has failed to become the standard of care for any particular circumstance, as there are always medically-sound alternatives.

n55 See W. Martin Haskell, et al., Surgical Abortion After the First Trimester in A Clinician's Guide to Medical and Surgical Abortion (Maureen Paul, et al. eds., 1999) at 136.

n56 280 J. Amer. Med. Ass'n at 727 (footnote number omitted) (citing L.P. Shulman, et al., Dilation and evacuation for second-trimester genetic pregnancy termination, 75 Obstet. Gynecol. 1037-40 (1990); see also W. Hern, et al., Outpatient abortion for fetal anomaly and fetal death from 15-34 menstrual weeks' gestation: Techniques and clinical management 81 Obstet Gynecol 301-06 (1993)).

n57 W. Martin Haskell, et al., Surgical Abortion After the First Trimester in A Clinician's Guide to Medical and Surgical Abortion (Maureen Paul, et al. eds., 1999) at 125.

III. INTACT D&X CONFUSES THE DISPARATE ROLES OF A PHYSICIAN IN CHILDBIRTH AND ABORTION IN A WAY THAT BLURS THE LINE BETWEEN INFANTICIDE AND ABORTION AND [*27] UNDERMINES THE PUBLIC INTEGRITY OF THE MEDICAL PROFESSION

Even abortion rights proponents have frequently expressed a particularly negative reaction to intact D&X, otherwise known as partial-birth abortion. This negative reaction is frequently shared by medical providers who are well acquainted with the relative gruesomeness of surgery and particular methods of abortion. There is something particularly shocking and aberrant about this particular procedure beyond, or different from, the difficult issues raised by abortion itself.

Intact D&X is aberrant and troubling because the technique confuses the disparate roles of a physician in childbirth and abortion in such a way as to blur the medical, legal, and ethical line between infanticide and abortion. When the physician performs (as necessary) instrumental version of the live fetus to a footling breech - using terminology (footling breech) and techniques borrowed from past and current obstetrics - she appears

initially to be assisting live delivery. As the physician manually performs breech extraction of the body of a live fetus, excepting the head, she continues in the apparent role of an obstetrician delivering a child. At this point of the procedure it is possible for all of the fetus' body, except for the head, to be outside of the woman's body, and the physician is holding the fetus' live body in one of her hands. The techniques used to this point of the procedure appear to be clear adaptations of the role of a physician acting with a duty of care to both fetus and woman, and the fetus is remarkably close - whether viable or not - to achieving live delivery.

Suddenly, the physician appears to switch roles and performs an act quite contrary to the obstetrical role: stabbing the base of the skull of the living fetus with a pair of scissors, spreading the scissors to enlarge the opening, inserting a suction catheter, and evacuating the skull contents. The physician acts directly against the physical life of a fetus who she has previously delivered, all but the head, out of the uterus. Even when the method **[*28]** is altered somewhat to involve other means of "evacuating" or "decompressing" the fetal skull, this portion of the intact D&X dramatically shifts the technique and role of the physician from delivery of a live fetus out of the womb to destroyer of a fetus almost entirely outside the uterus.

Even abortion rights proponents recognize that post-fifteen-week abortions are difficult and troubling for all involved. n58 However, the reason that Congress and thirty state legislatures have, usually by wide margins, passed bans on intact D&X abortion amounts to more than a negative response to second and third trimester abortion, and more than discomfort with the raw gruesomeness of surgery or late-term abortion. Rather, in a society that, due to this Court's precedents, must permit elective previability abortion and health-indicated post-viability abortion, there is a medical, legal, and ethical imperative to draw a bright, unblurred line between infanticide and abortion. Intact D&X threatens this bright line between infanticide and abortion in a way that undermines both the public integrity of the medical profession and society's interest in protecting human life.

n58 David A. Grimes and Willard Cates, Jr., "Dilation & Evacuation" in Second Trimester Abortion: Perspectives After a Decade of Experience (Gary S. Berger, et al. eds., 1981) at p. 130.

IV. NEBRASKA'S USE OF THE TERM "PARTIALBIRTH ABORTION" AND ACCOMPANYING DEFINITIONS FAIRLY DISTINGUISH INTACT D&X FROM STANDARD D&E ABORTION WHILE EXPRESSING THE STATE INTEREST IN DRAWING A BRIGHT LINE BETWEEN INFANTICIDE AND ABORTION

Even today, there is no fixed medical term for the procedure at issue herein. While ACOG and the AMA appear generally to use the term "intact dilation and extraction," as late as August 1998 the well-known **[*29]** reproductive health expert David A. Grimes used the term "intact D&E." n59 The district court below seemed somewhat challenged by the medical terminology, referring to the procedure alternatively as "intact dilation and evacuation," "intact D&X," "intact D&E," and "intact dilation and extraction." n60 Yet it also used one of these terms (intact D&E) for a different procedure in which the fetus is entirely within the uterus - and in one instance already dead - when the fetal skull size is reduced. n61 Moreover, despite claims that the term "intact dilation and extraction" is a medical term, the district court referred to this term as emanating from "the popular press." n62

n59 David A. Grimes, The Continuing Need for Late Abortions, 280 J. Amer. Med. Ass'n 747, 748 (Aug. 26, 1998).

n60 See, e.g., *11 F. Supp. 2d at 1105.*

n61 See *11 F. Supp. 2d at 1111-12.*

n62 *11 F. Supp. 2d at 1105.*

Under these circumstances, the Nebraska legislature, acting in 1997, cannot be fairly criticized for failing to use a medical term, as medical terminology has been evolving and uncertain. Moreover, the medical terminology fails to express the state's interests in drawing a clear line between infanticide and abortion which safeguards the public integrity of the medical profession. The term "partial-birth abortion" expresses reasonably well the gravamen of the objection to this procedure, which is that the procedure confuses the role of physician

in childbirth and physician in abortion, blurs the line between infanticide and abortion, and undermines the public integrity of the medical profession. "The 'partial birth abortion' legislation is by its very name aimed exclusively at the procedure by which a 'living fetus' is 'intentionally and **[*30]** deliberately' given 'partial birth' and 'delivered' for 'for the purpose of' killing it." n63

n63 American Medical Association, AMA Board of Trustees FACT SHEET on HR 1122 (June 1997) (reproduced at App. 1-4 for the convenience of the Court).

In their statutory construction the courts below have failed to interpret the statute in accord with its clearly expressed purpose. It is perverse to focus exclusively on the term "substantial portion," apart from the purposes of the act and important statutory terms such as "partial-birth abortion," "delivers," "delivers vaginally a living unborn child before killing the unborn child." Properly interpreting the various terms of the statute in light of the statute's purpose, the definition of partial-birth abortion clearly excludes the dismemberment of the fetus as is common with D&E abortion. There is certainly nothing resembling a "partial birth" in classic Dilation and Evacuation (D&E) abortion, nor does a D&E resemble intentional "delivery" of a living fetus into the birth canal.

CONCLUSION

For the foregoing reasons, we respectfully request that this Court reverse the judgments of the district court and Court of Appeals.

Respectfully submitted,

TERESA STANTON COLLETT Counsel of Record, 1303 San Jacinto, Houston, Texas 77002-7000, (713) 646-1834

DAVID M. SMOLIN, Professor of Law, Cumberland Law School, Samford University, Birmingham, Alabama 35229, (205) 726-2418

[*App.] 1 American Medical Association
Physicians dedicated to the health of America

[LOGO]

AMA Board of Trustees FACT SHEET on HR 1122

1. Why did AMA support HR 1122?

AMA supported HR 1122 because, in the Board's view, "partial birth abortion" or intact D&X is ethically wrong, and it could not otherwise be restricted. Leaders of the profession, like former Surgeon General C. Everett Koop and medical ethicist Edmund Pellegrino oppose use of the procedure, as do most physicians and most members of the public.

In addition, AMA's expert panel, which included an ACOG representative, could not find "any" identified circumstance where it was "the only appropriate alternative."

Finally, by giving its support in exchange for changes in the legislation, AMA was able to substantially improve the Federal law and the law in the many states which are using, and passing, the Federal model.

2. Why is Intact D&X ethically wrong? How is it different from other destructive abortion procedures?

The procedure is ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb. The "partial birth" gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body.

[*App.] 2 **3. Does the Board endorse criminalization of "medical practice" by supporting HR 1122?**

In the Board's view, Intact D&X is not an accepted "medical practice," so the answer is no. There is no consensus among obstetricians about its use, and the Board's expert scientific report recommends against its use. It has never been subject to even a minimal amount of the normal medical practice development. It is not in the medical text books.

The AMA policy opposing the criminalization of medical practice is aimed primarily at preventing the prosecution (as recently occurred in New York) of physicians who have made serious, unintentional errors. In contrast, society has a long tradition of legislating, and criminalizing, certain abortion procedures, e.g., elective third trimester abortions. The profession has, in general, not opposed those efforts and the profession has supported criminal restrictions on improper "medical" procedures, such as female genital mutilation.

4. What changes were made in HR 1122?

The amendments obtained by the AMA were substantial and they were the maximum changes that could be obtained. Without the changes:

(a) a physician doing an Intact D&X because he or she believes there may be a risk to the mother's life would have to show that "no other procedure would [have] sufficed" to protect the mother, a difficult burden under any circumstance. The AMA changes entirely deleted the "no other procedure would suffice" requirement. When a woman is endangered by her pregnancy, her physician retains the discretion to **[*App.]** 3 choose this procedure over other procedures that might also be available.

(b) a physician would not have had the right to halt any prosecution in order to obtain review by an independent medical practice board of the appropriateness of the physician's conduct. That right is now guaranteed by AMA's changes.

(c) a physician intending to do a delivery who encountered emergency circumstances that in his or her judgment required use of the procedure would have been subject to the law. He or she now has complete discretion to do whatever is necessary for the life or health of the woman without any concern for the statute. It does not apply.

(d) a physician doing certain other kinds of abortion procedures might have been concerned about the legislation. It is clear beyond question as a result of AMA's changes that the legislation covers only Intact D&X.

5. Can the legislation be read as covering other abortion techniques?

The "partial birth abortion" legislation is by its very name aimed exclusively at a procedure by which a "living fetus" is "intentionally and deliberately" given "partial birth" and "delivered" "for the purpose of" killing it. There is no other abortion procedure which could be confused with that description.

Throughout the debate over the bill in Congress, and in the press, only the procedure known as Intact D&X was described as being covered by the bill. Any extension of the bill would be patently unconstitutional. Notwithstanding ACOG's objection to the use of non "medical" **[*App.]** 4 terms, ACOG has conceded that the sponsors' intent is clear and limited: "However, based on legislative testimony, ACOG believes the intent of the Federal ban is to criminalize an abortion technique . . . which some practitioners have termed Intact Dilation and Extraction (Intact D&X)." ACOG Factsheeet, April 14, 1997 (emphasis added).

June 1997

[*App.] 5 **Advocacy & Communications:**

AMA Supports H.R. 1122 As Amended

"Partial-Birth Abortion Ban Act of 1997"

(Washington - May 20) - Nancy W. Dickey, MD, Chair of the AMA Board of Trustees issued the following statement:

The American Medical Association Board of Trustees has determined to support H.R. 1122 because it has now been significantly changed to substantially meet the criteria which the Board established for any abortion legislation.

Consistent with an expert report requested by AMA's House of Delegates last December and also forwarded to the AMA House last week for consideration at its June meeting, H.R. 1122 now narrowly defines the procedure to be restricted - a procedure for which AMA's expert panel could not find "any identified situation" in which it was "the only appropriate procedure to induce abortion" - and it broadens the exceptions.

The changed language in the bill now: (a) makes it clear beyond any question that the accepted abortion procedure known as dilation and evacuation (also referred to as "D&E") is not covered by the bill, (b) permits the procedure to save the life of the mother without any obligation to show that "no other procedure would suffice," and (c) does not restrict use of the procedure for physicians intending a delivery at the outset, i.e., it can be done as necessary in their best medical judgment.

[*App.] 6 In addition, as also required by our legislative criteria letter, a physician will be entitled to stay any criminal proceeding in order to obtain expert review by the state medical board of any questioned conduct under the bill for use at trial.

As amended, H.R. 1122 is now a bill which impacts only a particular and broadly disfavored - both by experts and the public - abortion procedure. It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development. The bill has no impact on a woman's right to choose an abortion consistent with Roe v. Wade. Indeed, the procedure differs materially from other abortion procedures which remain fully available in part because it involves the partially delivered body of the fetus which is outside of the womb.

H.R. 1122 is serving as a model for many state legislatures and it is vitally important that the improvements which have been made become a part of the broader legislative process.

[*App.] 7 **Advocacy & Communications**

Letter to The New York Times
regarding AMA support of H.R. 1122

"Partial-Birth Abortion Ban Act of 1997"

The following letter from AMA Executive Vice President P. John Seward, MD was sent to The New York Times:

May 30, 1997

Letters to the Editor, The New York Times, 229 W. 43rd Street, New York, NY 10036, Via Fax: 212-556-3622

Dear Editor:

There is no civility and very little truth in abortion politics. At the extreme ends of both sides - like the Frank Rich column about the AMA (Op. Ed. May 29, 1997) - there is only hysterical distortion designed to distract from the real issue.

The issue is not the AMA - which has been described by David Kessler as a "hero" of the anti-tobacco movement and whose Medicare policy was recently applauded in an editorial by this newspaper. The issue is whether the partial delivery of a living fetus for the purpose of killing it outside of the womb ought to be severely restricted. We believe, as a matter of ethical principle, it should rarely if ever be done. And although we also believe physicians should have broad discretion in medical matters, both this procedure and assisted suicide (as **[*App.]** 8 well as female genital mutilation and lobotomies) can and should be regulated if the profession won't do it. And since there are safe, and indeed safer, abortion alternatives, we supported the Santorum bill as amended.

AMA's congressional advocacy is derived exclusively from the profession's values, especially the patient-physician relationship. But we cannot control the timing of the Congressional agenda. Our letters on abortion and Medicare - both public documents - went the same day because the Santorum bill ultimately came up the day that Congress had asked everyone - doctors, hospitals, home health care providers, insurance companies - to deliver their views on Medicare legislation. The Medicare letter went to 125 Congressional leaders, including Democratic leaders. It is similar to dozens of letters received on or about that same day from the other interested groups. Frank Rich could not be more wrong.

If it is just the Republicans we are trying to persuade we certainly would not have (a) delivered one day later a letter to Senator Kennedy supporting his efforts to expand access to care for children through an increased tobacco tax that the Republican leadership vigorously opposed, (b) stood one month earlier on the steps of the Capitol with Henry Waxman, demanding that Congress enact a lengthy antitobacco agenda, or (c) delivered on May 21 a letter to Representatives Kildee and Stark supporting ERISA reform which the Republicans **[*App.]** 9 generally oppose, or engaged in countless other activities that defy partisan identification.

Sincerely,

P. John Seward, MD

[*App.] 10 **American Medical Association Physicians dedicated to the health of America**

[LOGO]

Statement

For Response Only October 21, 1999

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

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

[*App.] 11 **American Medical**

NEWS

AMERICAN MEDICAL ASSOCIATION

NOVEMBER 20, 1995

VOLUME 38 - NUMBER 43

Outlawing abortion method

Veto-proof majority in House votes to prohibit late-term procedure

By Diane M. Gianelli
AMNEWS STAFF

WASHINGTON - His strategy was simple: Find an abortion procedure that almost anyone would describe as "gruesome," and force the opposition to defend it.

When Rep. Charles T. Canady (R. Fla.) learned about "partial birth" abortions, he was set.

He and other anti-abortion lawmakers launched a congressional campaign to outlaw the procedure.

Following a contentious and emotional debate, the bill passed by an overwhelming - and veto-proof - margin: 288-139. It marks the first time the House of Representatives has voted to forbid a method of abortion. And although the November elections yielded a "pro-life" infusion in both the House and the Senate, massive crossover voting occurred with a significant number of "prochoice" representatives voting to pass the measure.

The controversial procedure, done in second and third-trimester pregnancies, involves an abortion in which the provider, according to the bill, "partially **[*App.]** 12 vaginally delivers a living fetus before killing the fetus and completing the delivery."

"Partial birth" abortions, also called "intact D&E" (for dilation and evacuation), or "D&X" (dilation and extraction) are done by only a handful of U.S. physicians, including Martin Haskell, MD, of Dayton, Ohio, and, until his recent death, James T. McMahon, MD, of the Los Angeles area. Dr. McMahon said in a 1993 AMNews interview that he had trained about a half-dozen physicians to do the procedure.

The procedure usually involves the extraction of an intact fetus, feet first, through the birth canal, with all but the head delivered. The surgeon forces scissors into the base of the skull, spreads them to enlarge the opening, and uses suction to remove the brain.

The procedure gained notoriety two years ago, when abortion opponents started running newspaper ads that described and illustrated the method. Their goal was to defeat an abortion rights bill then before Congress on grounds it was so extreme that states would have no ability to restrict even late-term abortions on viable fetuses. The bill went nowhere but strong reaction to the campaign prompted anti-abortion activists to use it again.

They drafted a bill that would ban the procedure, after considering a number of other options. An Ohio law passed earlier this year, for instance, bans "brain suction" abortions, except when all other methods would pose a greater risk to the pregnant woman. It has been enjoined pending a challenge.

[*App.] 13 **Mixed feelings in medicine**

The procedure is controversial in the medical community. On the one hand, organized medicine bristles at the notion of Congress attempting to ban or regulate any procedures or practices. On the other hand, even some in the abortion provider community find the procedure difficult to defend.

"I have very serious reservations about this procedure," said Colorado physician Warren Hern, MD. The author of Abortion Practice, the nation's most widely used textbook on abortion standards and procedures. Dr. Hern specializes in late-term procedures.

He opposes the bill, he said, because he thinks Congress has no business dabbling in the practice of medicine and because he thinks this signifies just the beginning of a series of legislative attempts to chip away at abortion rights. But of the procedure in question he says, "You really can't defend it. I'm not going to tell somebody else that they should not do this procedure. But I'm not going to do it."

Dr. Hern's concerns center on claims that the procedure in late-term pregnancy can be safest for the pregnant women, and that without this procedure women would have died. "I would dispute any statement that this is the safest procedure to use," he said.

Turning the fetus to a breech position is "potentially dangerous," he added. "You have to be concerned abut causing amniotic fluid embolism or placental abruption if you do that."

[*App.] 14 Pamela Smith, MD, director of medical education, Dept. of Ob-Gyn at Mt. Sinai Hospital in Chicago, added two more concerns: cervical incompetence in subsequent pregnancies caused by three days of forceful dilation of the cervix and uterine rupture caused by rotating the fetus within the womb.

"There are absolutely no obstetrical situations encountered in this country which require a partially delivered human fetus to be destroyed to preserve the life of the mother," Dr. Smith wrote in a letter to Canady.

Partial-Birth Abortion
Ban Act of 1995

The bill: HR 1833

Summary: Bans abortions in which provider 'partially vaginally delivers a living fetus before killing the fetus and completing the delivery.'

Exceptions: 'Life of mother' and physician belief that no other procedure would suffice as "affirmative defense" to prosecution or civil action.

Penalties: Possibility of suits, fines and/or imprisonment of up to two years.

Proponents: Procedure is medically and morally indefensible.

Opposition: Congress has no business legislating medical standards and procedures; bill begins erosion of abortion rights.

[*App.] 15 **Abortion**

The procedure also has its defenders. The procedure is a "well-recognized and safe technique by those who provide abortion care," Lewis H. Koplik, MD, an Albuquerque, N.M., abortion provider, said in a statement that appeared in the Congressional Record.

"The risk of severe cervical laceration and the possibility of damage to the uterine artery by a sharp fragment of calvarium is virtually eliminated. Without the release of thromboplastic material from the fetal central nervous system into the maternal circulation, the risk of coagulation problems, DIC [disseminated intravascular coagulation], does not occur. In skilled hands, uterine perforation is almost unknown," Dr. Koplik said.

Bruce Ferguson, MD, another Albuquerque abortion provider, said in a letter released to Congress that the ban could impact physicians performing late-term abortions by other techniques. He noted that there were "many abortions in which a portion of the fetus may pass into the vaginal canal and there is no clarification of what is meant by 'a living fetus.' Does the doctor have to do some kind of electrocardiogram and brain wave test to be able to prove their fetus was not living before he allows a foot or hand to pass through the cervix?"

Apart from medical and legal concerns, the bill's focus on late-term abortion also raises troubling ethical issues. In fact, the whole strategy, according to Rep. Chris Smith (R. N.J.), is to force citizens and elected officials to move beyond a philosophical discussion of "a woman's **[*App.]** 16 right to choose," and focus on the reality of abortion. And, he said, to expose those who support "abortion on demand" as "the real extremists."

Another point of contention is the reason the procedure is performed. During the Nov. 1 debate before the House, opponents of the bill repeatedly stated that the procedure was used only to save the life of the mother or when the fetus had serious anomalies.

Rep. Vic Fazio (D. Calif.) said, "Despite the other side's spin doctors - real doctors know that the late-term abortions this bill seeks to ban are rare and they're done only when there is no better alternative to save the woman, and, if possible, preserve her ability to have children."

Dr. Hern said he could not imagine a circumstance in which this procedure would be safest. He did acknowledge that some doctors use skull-decompression techniques, but he added that in those cases fetal death has been induced and the fetus would not purposely be rotated into a breech position.

Even some physicians who specialize in this procedure do not claim the majority are performed to save the life of the pregnant woman.

In his 1993 interview with AMNews, Dr. Haskell conceded that 80% of his late-term abortions were elective. Dr. McMahon said he would not do an elective abortion after 26 weeks. But in a chart he released to the House Judiciary Committee, "depression" was listed most often as the reason for late-term nonelective abortions with **[*App.]** 17 maternal indications. "Cleft lip" was listed nine times under fetal indications.

The accuracy of the article was challenged, two years after publication, by Dr. Haskell and the National Abortion Federation, who told Congress the doctors were quoted "out of context," AMNews Editor Barbara Bolsen defended the article, saying AMNews "had full documentation of the interviews, including tape recordings and transcripts."

Bolsen gave the committee a transcript of the contested quotes, including the following, in which Dr. Haskell was asked if the fetus was dead before the end of the procedure.

"No it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress - intrauterine stress during, you know, the two days that the cervix is being dilated. Sometimes the membranes rupture and it takes a very small superficial infection to kill a fetus in utero when the membranes are broken.

"So in my case, I would say probably about a third of those are definitely are [sic] dead before I actually start to remove the fetus. And probably the other two-thirds are not," said Dr. Haskell.

In a letter to Congress before his death, Dr. McMahon stated that medications given to the mother induce "a medical coma" in the fetus, and "there is neurological fetal demise."

But Watson Bowes, MD, a maternal-fetal specialist at University of North Carolina, Chapel Hill, said in a letter **[*App.]** 18 to Canady that Dr. McMahon's statement "suggests a lack of understanding of maternal-fetal pharmacology. . . . Having cared for pregnant women who for one reason or another required surgical procedures in the second trimester, I know they were often heavily sedated or anesthetized for the procedures, and the fetuses did not die."

Next move in the Senate

At AMNews press time, the Senate was scheduled to debate the bill. Opponents were lining up to tack on amendments, hoping to gut the measure or send it back to a committee where it could be watered down or rejected.

In a statement about the bill, President Clinton did not use the word "veto." But he said he "cannot support" a bill that did not provide an exception to protect the life and health of the mother. Senate opponents of the bill say they will focus on the fact that it does not provide such an exception.

The bill does provide an affirmative defense to a physician who provides this type of abortion if he or she reasonably believes the procedure was necessary to save the life of the mother and no other method would suffice.

But Rep. Patricia Schroeder (D. Colo.) says that's not sufficient. "This means that it is available to the doctor after the handcuffs have snapped around his or her wrists, bond has been posted, and the criminal trial is under way," she said during the House debate.

[*App.] 19 Canady disagrees. "No physician is going to be prosecuted and convicted under this law if he or she reasonably believes the procedure is necessary to save the life of the mother."

Organized medicine positions vary

The physician community is split on the bill. The California Medical Assn., which says it does not advocate elective abortions in later pregnancy, opposes it as "an unwarranted intrusion into the physician-patient relationship." The American College of Obstetricians and Gynecologists also opposes it on grounds it would "supersede the medical judgment of trained physicians and . . . would criminalize medical procedures that may be necessary to save the life of a woman," said spokeswoman Alice Kirkman.

The AMA has chosen to take no position on the bill, although its Council on Legislation unanimously recommended support. AMA Trustee Nancy W. Dickey, MD, noted that although the board considered seriously the council's recommendations, it ultimately decided to take no position, because it had concerns about some of the bill's language and about Congress legislating medical procedures.

Meanwhile, each side in the abortion debate is calling news conferences to announce how necessary or how ominous the bill is. Opponents highlight poignant stories of women who have elected to terminate wanted pregnancies because of major fetal anomalies.

[*App.] 20 Rep. Nita Lowey (D. N.Y.) told the story of Claudia Ames, a Santa Monica woman who said the procedure had saved her life and saved her family.

Ames told Lowey that six months into her pregnancy, she discovered the child suffered from severe anomalies that made its survival impossible and placed Ames' life at risk.

The bill's backers were "attempting to exploit one of the greatest tragedies any family can ever face by using graphic pictures and sensationalized language and distortions," Ames said.

Proponents focus on the procedure's cruelty. Frequently quoted is testimony of a nurse. Brenda Shafer, RN, who witnessed three of these procedures in Dr. Haskell's clinic and called it "the most horrifying experience of my life.

"The baby's body was moving. His little fingers were clasping together. He was kicking his feet." Afterwards, she said, "he threw the baby in a pan." She said she saw the baby move. "I still have nightmares about what I saw."

Dr. Hern says if the bill becomes law, he expects it to have "virtually no significance" clinically. But on a political level, "it is very, very significant."

"This bill's about politics," he said, "it's not about medicine."

[*App.] 21 **American Medical**

NEWS

AMERICAN MEDICAL ASSOCIATION .

MARCH 3, 1997

. VOLUME 48 . NUMBER 9

Medicine adds to debate on late-term abortion

ACOG draws fire for saying procedure 'may' be best option for some

By Diane M. Gianelli AMNEWS STAFF

WASHINGTON - As Congress and state legislatures consider banning a procedure opponents call "partial birth" abortion, the medical community is conducting its own appraisal of this controversial late-term abortion procedure.

The American College of Obstetricians and Gynecologists weighed in with an opinion from its Executive Board in January, saying it could identify "no circumstances under which this procedure would be the only option to save the life of the mother or preserve the health of the woman."

It added, however, that the procedure, which ACOG called intact dilation and extraction (D&X) and others call intact dilation and evacuation (D&E), "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances, can make this decision."

[*App.] 22 **Opinion comes under fire**

ACOG was immediately taken to task by a group of physicians who oppose the procedure.

By endorsing a practice "for which no peer-reviewed or safety data exist," ACOG appears to be violating its own standards, said members of PHACT (Physicians Ad Hoc Coalition for Truth), a group of about 400 physicians, many of whom are also ACOG members.

This statement "clearly does not represent a consensus among the nation's obstetricians and gynecologists as to the safety or appropriateness, under any circumstances, of partial birth abortion," the PHACT letter said. It added that it found it "unusual that PHACT, a coalition of doctors formed for no other reason than to investigate medical claims made about partial-birth abortion, was not invited to participate in these deliberations."

ACOG President Fredric D. Frigoletto, MD, in an interview, maintained that the board did not "endorse" the procedure. "There are no data to say that one of the procedures is safer than the other," he said. When asked why the statement said the procedure "may be the best" in some cases, Dr. Frigoletto answered, "or it may not be."

William Stalter, MD, an Ohio ob-gyn, said he feels let down by his professional organization.

ACOG, he said, "is supposed to be our standard-bearer for high-quality care in obstetrics and gynecology. And it's supposed to be the watchdog [against] procedures that are poorly conceived or unproven. Yet here **[*App.]** 23 they're defending a procedure that is virtually unstudied," said Dr. Stalter, a professor of obstetrics and gynecology at Wright State University in Dayton.

Dr. Frigoletto, in a letter responding to PHACT's complaints, said a task force drafted the policy statement that was amended and unanimously adopted by ACOG's executive board in January. "Clearly our organizations do not agree on the content of the statement," he wrote. "I hope we can respect these differences."

Meanwhile, the American Medical Association is also looking at the issue. Although it opted not to take a position when a federal bill to ban the procedure was considered last year, several members of the AMA House of Delegates pressed for a change in that position in the AMA's Interim Meeting in December. The house voted to have the AMA study the issue and evaluate the medical evidence before determining whether the practice conformed to the standards of good medical practice.

The AMA board discussed the issue at its February meeting, said AMA Trustee John C. Nelson, MD, a Salt Lake City ob-gyn. But it came to no conclusions.

"I'm not sure exactly what we'll say," he said. "If the medical literature or our colleagues cannot justify this procedure, we'll say we shouldn't do it. If in fact we can justify it, we'll say we could do it."

What medical groups have in common when viewing a potential ban on the procedure is a reluctance to allow Congress to meddle in medical matters. But this stance invites criticism from those who point out that

many medical groups supported congressional efforts to pass **[*App.]** 24 laws requiring insurers to cover minimum stays for child-birth deliveries and banning another controversial procedure called female circumcision or genital mutilation.

Looking for the science

The late-term abortion procedure is difficult to study, Dr. Nelson said, because there are no published reports on it. "We want to have the information so we can come up with a considered and reasoned viewpoint," Dr. Nelson said. He added that the AMA "will have a board report on the issue in June."

Without published data and peer-reviewed studies on the procedure, it's hard to reach clear findings about it. Now that Congress is taking a second look at a bill to ban the procedure and at least 25 states have introduced similar legislation, safety questions are once again being raised. The bill to ban it passed in both the Senate and the House last year, but it was vetoed by President Clinton.

Those who perform the procedure say it is safer for the woman and more convenient for the surgeon. Although the whole procedure takes three days, to allow for the women to come in for frequent laminaria insertions to dilate her cervix, the actual operation is scheduled on an outpatient basis and takes only five to 15 minutes.

Some providers say this method is safer than the classic D&E procedure in which the fetus is dismembered in the womb, leaving the mother at greater risk for internal perforations caused by either the slip of the surgeon's **[*App.]** 25 instruments or bones from the fetus broken inside her body.

They claim that the intact D&E, because it avoids much of the sharp instrumentation and bone tears, is the procedure of choice for late-term abortions to preserve the woman's future fertility.

At a news conference this fall, the president spoke movingly of the women who chose this method to end their wanted pregnancies because of unexpected fetal anomalies. This procedure, he said, allowed them the chance to have another baby.

Opponents of the procedure assert, however, that the claim is without medical merit, and note that one of the five women at Clinton's veto ceremony had five miscarriages after her intact D&E. The procedure, opponents say, is potentially risky and actually contraindicated for fertility enhancement.

Late-term abortion options

A better option, they maintain, is to deliver the fetus by induction, using prostaglandin or pitocin to ripen the cervix and induce labor. Fetus demise can be induced beforehand.

Some also question the necessity of killing the fetus through brain suction or any other method if it has a condition incompatible with life and suggest it is "more humane" to have the physician induce labor and let the child die naturally.

[*App.] 26 Critics also say turning the fetus to a breech position can cause amniotic fluid embolism, placental abruption or uterine rupture.

And they maintain that the forcible dilation necessary to prepare the women's cervix for the procedure risks creating an "incompetent cervix," which could prevent a woman from carrying future pregnancies to term.

Diana Grossheim, from Huntington Beach, Calif., may be one of those women. Grossheim had an intact D&E in 1995. She now has an incompetent cervix.

When Grossheim's almost 21-week-old fetus died in utero, she said her physician told her she had two choices: labor, which was described as up to 48 hours of torture, or intact D&E, which her doctor described as "more merciful."

Grossheim said the procedure was "three days of pure hell" - both physical and mental.

She had to stay in a hotel and go back and forth to the clinic for laminaria changes. She was afraid she might deliver the baby in the hotel. On her second night, the pain was terrible - she was vomiting, cramping and screaming all night.

When her daughter was finally delivered, Grossheim said she and her husband didn't understand why she had such a flat head. If they were told about the brain suction procedure, it wasn't in terms she could understand, said the high school math teacher.

When Grossheim became pregnant again, she was told during a routine ultrasound in her 23rd week that she had an incompetent cervix and had to go on bed rest **[*App.]** 27 for the remainder of her pregnancy. She delivered a healthy boy at 37 weeks, but still remembers the second half of her pregnancy as uncomfortable and frightening - thinking the baby would come any time and would die, too. She was heavily medicated and having contractions around the clock.

She's now 35 years old and would like to get pregnant again. But she can't afford to hire someone to watch her child while she spends her next pregnancy in bed. And she fears her chances of carrying to term are slim.

In retrospect, Grossheim wishes she had chosen the labor option. She would have felt safer in the hospital, where her pain could have been controlled and her fear of delivering alone eliminated. And she doesn't see any justification for the intact D&E procedure.

"Now that I've been through actual labor and delivery," she said, "I think it was much easier than what I went through."

Chairman SENSENBRENNER. The gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. SCOTT. Mr. Chairman, it's one thing to reach findings, but it's another thing to just make up findings. The record reflects that, as these findings say, that all but one court to hear this case ruled on the safety, that the D&X procedure may be the best and most appropriate procedure to preserve a woman's health.

The record from the hearing yesterday says even that one was subsequently overturned by an appellate court. We have the record from ACOG, the American College of Obstetricians and Gynecologists; we have the language from the case which says, where substantial medical authorities support the proposition that banning the particular abortion procedure "could" endanger a woman's health—I mean, these are facts. As the gentlelady from Wisconsin said, these are facts. I would hope that we would allow the introduction of these facts into the bill, rather than the speculation that's in there now.

I yield back.

Chairman SENSENBRENNER. The question is on the Baldwin amendment. Those in favor will say aye. Opposed, no. The noes appear to have it.

A recorded vote is ordered. Those in favor of the Baldwin amendment will, as your name is called, answer aye; those opposed, no. The Clerk will call the roll.

The CLERK. Mr. Hyde?

[No response.]

The CLERK. Mr. Coble?

[No response.]

The CLERK. Mr. Smith?

Mr. SMITH. No.

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

Mr. GALLEGLY. No.

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

[No response.]

The CLERK. Mr. Chabot?

Mr. CHABOT. No.

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

[No response.]

The CLERK. Mr. Cannon?

Mr. CANNON. No.

The CLERK. Mr. Cannon, no. Mr. Bachus?

[No response.]

The CLERK. Mr. Hostettler?

Mr. HOSTETTLER. No.

The CLERK. Mr. Hostettler, no. Mr. Green?

[No response.]

The CLERK. Mr. Keller?

[No response.]

The CLERK. Ms. Hart?

Ms. HART. No.

The CLERK. Ms. Hart, no. Mr. Flake?

Mr. FLAKE. No.

The CLERK. Mr. Flake, no. Mr. Pence?
[No response.]
The CLERK. Mr. Forbes?
Mr. FORBES. No.
The CLERK. Mr. Forbes, no. Mr. King?
Mr. KING. No.
The CLERK. Mr. King, no. Mr. Carter?
Mr. CARTER. No.
The CLERK. Mr. Carter, no. Mr. Feeney?
Mr. FEENEY. No.
The CLERK. Mr. Feeney, no. Mrs. Blackburn?
Mrs. BLACKBURN. No.
The CLERK. Mrs. Blackburn, no. Mr. Conyers?
[No response.]
The CLERK. Mr. Berman?
[No response.]
The CLERK. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
Mr. WATT. Aye.
The CLERK. Mr. Watt, aye. Ms. Lofgren?
Ms. LOFGREN. Aye.
The CLERK. Ms. Lofgren, aye. Ms. Jackson Lee?
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee, aye. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan.
Mr. MEEHAN. Aye.
The CLERK. Mr. Meehan, aye. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
Mr. WEINER. Aye.
The CLERK. Mr. Weiner, aye. Mr. Schiff?
[No response.]
The CLERK. Ms. Sánchez?
Ms. SÁNCHEZ. Aye.
The CLERK. Ms. Sánchez, aye. Mr. Chairman?
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.

Chairman SENSENBRENNER. Members in the chamber who wish to cast or change their votes? The gentleman from North Carolina. Mr. Coble.

Mr. COBLE. No.
The CLERK. Mr. Coble, no.

Chairman SENSENBRENNER. The gentleman from Tennessee, Mr. Jenkins.

Mr. JENKINS. No.

The CLERK. Mr. Jenkins, no.

Chairman SENSENBRENNER. The gentleman from Wisconsin, Mr. Green.

Mr. GREEN. No.

The CLERK. Mr. Green, no.

Chairman SENSENBRENNER. Are there further Members who wish to cast or change their vote? If not, the Clerk will report.

The CLERK. Mr. Chairman, there are 10 ayes and 16 noes.

Chairman SENSENBRENNER. And the amendment is not agreed to.

Are there further amendments? If there are no further amendments, the chair notes the presence of a reporting quorum. The question occurs on the motion to report the bill favorably. Those in favor will say aye. Opposed, no. The ayes appear to have it.

A rollcall will be ordered. The question is on the motion to report the bill favorably. Those in favor will, as your name is called, answer aye, those opposed, no, and the Clerk will call the roll.

The CLERK. Mr. Hyde?

[No response.]

The CLERK. Mr. Coble?

Mr. COBLE. Aye.

The CLERK. Mr. Coble, aye. Mr. Smith?

Mr. SMITH. Aye.

The CLERK. Mr. Smith, aye. Mr. Gallegly?

Mr. GALLEGLY. Aye.

The CLERK. Mr. Gallegly, aye. Mr. Goodlatte?

[No response.]

The CLERK. Mr. Chabot?

Mr. CHABOT. Aye.

The CLERK. Mr. Chabot, aye. Mr. Jenkins?

Mr. JENKINS. Aye.

The CLERK. Mr. Jenkins, aye. Mr. Cannon?

Mr. CANNON. Aye.

The CLERK. Mr. Cannon, aye. Mr. Bachus?

[No response.]

The CLERK. Mr. Hostettler?

Mr. HOSTETTLER. Aye.

The CLERK. Mr. Hostettler, aye. Mr. Green?

Mr. GREEN. Aye.

The CLERK. Mr. Green, aye. Mr. Keller?

Mr. KELLER. Aye.

The CLERK. Mr. Keller, aye. Ms. Hart?

Ms. HART. Aye.

The CLERK. Ms. Hart, aye. Mr. Flake?

Mr. FLAKE. Aye.

The CLERK. Mr. Flake, aye. Mr. Pence?

[No response.]

The CLERK. Mr. Forbes?

Mr. FORBES. Aye.

The CLERK. Mr. Forbes, aye. Mr. King?

Mr. KING. Aye.

The CLERK. Mr. King, aye. Mr. Carter?

Mr. CARTER. Aye.

The CLERK. Mr. Carter, aye. Mr. Feeney?

Mr. FEENEY. Aye.

The CLERK. Mr. Feeney, aye. Mrs. Blackburn?
[No response.]
The CLERK. Mr. Conyers?
[No response.]
The CLERK. Mr. Berman?
[No response.]
The CLERK. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
Mr. NADLER. No.
The CLERK. Mr. Nadler, no. Mr. Scott?
Mr. SCOTT. No.
The CLERK. Mr. Scott, no. Mr. Watt?
[No response.]
The CLERK. Ms. Lofgren?
Ms. LOFGREN. No.
The CLERK. Ms. Lofgren, no. Ms. Jackson Lee?
Ms. JACKSON LEE. No.
The CLERK. Ms. Jackson Lee, no. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan?
Mr. MEEHAN. No.
The CLERK. Mr. Meehan, no. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. No.
The CLERK. Mr. Wexler, no. Ms. Baldwin?
Ms. BALDWIN. No.
The CLERK. Ms. Baldwin, no. Mr. Weiner?
Mr. WEINER. No.
The CLERK. Mr. Weiner, no. Mr. Schiff?
[No response.]
The CLERK. Ms. Sánchez?
Ms. SÁNCHEZ. No.
The CLERK. Ms. Sánchez, no. Mr. Chairman?
Chairman SENSENBRENNER. Aye.
The CLERK. Mr. Chairman, aye.
Chairman SENSENBRENNER. Members in the chamber wish to cast or change their vote? The gentleman from Alabama, Mr. Bachus.
Mr. BACHUS. Aye.
The CLERK. Mr. Bachus, aye.
Chairman SENSENBRENNER. The gentleman from Virginia, Mr. Goodlatte.
Mr. GOODLATTE. Aye.
The CLERK. Mr. Goodlatte, aye.
Chairman SENSENBRENNER. The gentlewoman from Tennessee, Mrs. Blackburn.
Mrs. BLACKBURN. Aye.
The CLERK. Mrs. Blackburn, aye.
Chairman SENSENBRENNER. The gentleman from North Carolina, Mr. Watt.
Mr. WATT. No.
The CLERK. Mr. Watt, no.

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

Ms. WATERS. No.

The CLERK. Ms. Waters, no.

Chairman SENSENBRENNER. Are there further Members in the chamber who wish to cast or change their votes? If not, the Clerk will report.

The CLERK. Mr. Chairman, there are 19 ayes and 11 noes.

Chairman SENSENBRENNER. And the motion to report favorably is agreed to.

Without objection, the Chairman is authorized to move to go to conference pursuant to House Rules. Without objection, the staff is directed to make any technical and conforming changes, and all Members will be given 2 days as provided by House Rules in which to submit additional dissenting supplemental or minority views.

The Chair thanks the Members for their diligence today. The business of the Committee having been concluded, the Committee stands adjourned.

[Whereupon, at 1:18 p.m., the Committee adjourned.]

DISSENTING VIEWS

H.R. 760, the "Partial-Birth Abortion Ban Act of 2003," was introduced in response to the Supreme Court's ruling in *Stenberg* v. *Carhart*,[1] in which the Supreme Court held unconstitutional a Nebraska statute banning so-called "partial-birth" abortions. We oppose H.R. 760 because it flies in the face of *Stenberg* with the same unconstitutional flaws for which the Court invalidated the Nebraska statute; because the bill is dangerous to women; and because private medical decisions should be made by women and their families, in consultation with their doctors—not politicians.

Sixteen of the nineteen pages of H.R. 760 contain "findings" on matters the Court reviewed in *Stenberg*.[2] In its three pages of operative legislative language, the bill makes it illegal for a physician knowingly to perform a so-called "partial-birth" abortion unless it is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury.[3] A physician who violates the law is subject to a fine and up to 2 years imprisonment.[4]

Rather than complying with the constitutional requirements in *Stenberg*, the drafters of H.R. 760 have created a propaganda piece intended to demonize abortion and abortion providers. As a result, the bill is an unconstitutional attempt to regulate abortion, and is detrimental to women's health.

H.R. 760 IS UNCONSTITUTIONAL FOR THE SAME REASONS THE SUPREME COURT STRUCK DOWN A SIMILAR "PARTIAL-BIRTH" ABORTION BAN IN *STENBERG* V. *CARHART*

The caselaw on abortion is clear. In *Planned Parenthood* v. *Casey*,[5] the Court articulated the three principles that govern abortion jurisprudence: (1) a woman has the right to choose to termi-

---

[1] 530 U.S. 914 (2000).

[2] The "findings" in the bill include misstatements of both the facts and the law, including, among others: the partial birth abortion procedure is "never medically necessary," Sec. 2, ¶1; the procedure is "outside of the standard of medical care," Sec. 2, ¶5; the Supreme Court was "required to accept the very questionable findings issued by the district court," Sec. 2, ¶7; "Partial-birth abortion poses serious risks to the health of a woman undergoing the procedure," Sec. 2, ¶14(A); and "There is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures," Sec. 2, ¶14(B).

[3] The term "partial-birth abortion" is not a medical term. The bill defines it as,

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

H.R. 760, Sec. 3, ¶(b).

[4] H.R. 760, Sec. 3, ¶(a).

[5] 505 U.S. 833 (1992).

nate her pregnancy prior to "viability;[6]" (2) a law designed to further the State's interest in fetal life, but which imposes an "undue burden" on the woman's decision before fetal viability is unconstitutional;[7] and (3) after viability, a State may regulate or proscribe abortion except "where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."[8]

In 2000, the Supreme Court applied these principles to a Nebraska ban on partial-birth abortions, and found the statute unconstitutional on two grounds: it did not include an exception to protect the health of the woman, and it posed an undue burden on the right to obtain an abortion.[9] Because H.R. 760 suffers from these same defects, it is likewise unconstitutional.

H.R. 760 Unconstitutionally Omits an Exception to Protect Maternal Health

Both pre- and post-viability restrictions on abortion must contain an exception "where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.[10]" Furthermore, such an exception must not only protect women from health risks created by the pregnancy, itself, but also from health risks caused by a regulation that forces women to choose a less medically appropriate abortion procedure.[11]

Even the Ashcroft Department of Justice recognizes that, in order for any abortion regulation to be constitutional, it must contain an exception to protect the woman's life *and health*. The Department of Justice has stated, "After fetal viability, States may ban abortion altogether, *so long as they allow abortions necessary to safeguard the woman's life or health*."[12]

There is no question that H.R. 760 does not contain an exception to protect maternal health. For this reason, alone, the bill is unconstitutional.[13]

---

[6] *Stenberg* v. *Carhart* 530 U.S. at 921. "Viability" of the fetus differs from woman to woman. A woman's doctor determines the point of viability, but it typically occurs between 24 to 28 weeks after gestation.

[7] *Id.* An "'undue burden is . . . shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.'" *Id.* (quoting *Casey*, 505 U.S. at 877).

[8] *Id.* (quoting *Casey*, 505 U.S. at 879). Indeed, the conservative jurist, Richard Posner, has suggested that partial-birth abortion bans such as H.R. 760 do not even meet the extremely deferential standard of having a "rational relation to a legitimate state interest" because they do not preserve fetal life, but rather, simply shift the method of abortion to a more dangerous procedure. *Planned Parenthood of Wisconsin* v. *Doyle*, 162 F.3d 463, 470–71 (7th Cir. 1998) ("The singling out of the D & X procedure for anathematization seems arbitrary to the point of irrationality. Annexing the penalty of life imprisonment to a medical procedure that may be the safest alternative for women who have chosen abortion because of the risk that childbirth would pose to their health adds a note of the macabre to the Wisconsin statute, especially when we consider that physicians can insulate themselves from all legal risk by killing the fetus *in utero*." *Id.* at 471.) *See also Stenberg,* 530 U.S. at 946, 951 (Stevens, J. and Ginsberg, J., concurring).

[9] *Stenberg*, 530 U.S. at 930.

[10] *Stenberg*, 530 U.S. at 930 (quoting *Roe, at 164–64 (emphasis omitted)) ("Since the law requires a health exception in order to validate even a postviability abortion regulation, it at a minimum requires the same in respect to previability regulation.").*

[11] *Id.* at 934–38 (comparing the relative safety of different abortion procedures and concluding that "a statute that altogether forbids D & X creates a significant health risk").

[12] Brief for the United States of America as Amicus Curiae Supporting Reversal at 7, *Women's Medical Professional Corp.* v. *Taft*, (6th Cir.) (No. 01–4124) (emphasis added).

[13] Representatives Scott, Baldwin, and Jackson Lee offered an amendment that would have added a health exception, in conformance with *Stenberg*, which was defeated in a party-line vote.

The Supreme Court Will Not Defer to Erroneous Factual and Legal Conclusions Masked as Congressional "Findings"

The drafters of H.R. 760 attempt to justify the lack of a health exception in the bill's "findings," which summarily assert that the banned procedure is "never medically necessary to preserve the health of a woman.[14]" They argue that, because the *Stenberg* decision was based on "very questionable findings,"[15] Congress is better equipped to assess the evidence after holding "extensive" hearings on the subject.[16] Claiming that congressional findings demonstrate that a health exception is unnecessary, they argue that the Supreme Court is bound to accord "great deference" to these findings.

The mere statement of "findings" does nothing to rehabilitate the bill's unconstitutionality. There have been several instances in the past in which congressional attempts to overturn Supreme Court precedents have failed. For example, Congress passed the Religious Freedom Restoration Act ("RFRA") in response to an earlier Supreme Court decision.[17] As in this case, Congress held separate hearings to assess the issues and made independent findings, prior to enacting the law. In striking down RFRA, the Supreme Court held that Congress "has been given the power 'to enforce,' not the power to determine what constitutes a constitutional violation."[18] The Court further held that "[t]he power to interpret the Constitution in a case or controversy remains in the Judiciary"[19] and "RFRA contradicts vital principles necessary to maintain separation of powers and the Federal balance."[20]

With H.R. 760, the sponsors are attempting to overturn Supreme Court constitutional precedent by enacting a law that fails to ad-

---

[14] H.R. 760, Sec. 2, ¶14(E). We wonder: if the procedure is *never necessary* to protect the woman's health, why the proponents of the bill admit that the procedure may be necessary to protect a mother "whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." Sec. 3, ¶(d)(1). Are not these situations in which the mother's health is also at risk?

[15] H.R. 760 Sec. 2, ¶7. Far from being "questionable," the trial court's findings in *Stenberg* were based on consideration of evidence from experts on both sides of the issue, including evidence from *the congressional hearings* themselves. *Stenberg*, 530 U.S. at 929, 935. Nor was there a "dearth of evidence" in the trial court supporting the findings. *See Stenberg* v. *Carhart*, 11 F. Supp. 2d 1099, 1110–18 (D. Neb. 1998). Additionally, in reviewing the evidence, the Supreme Court acknowledged many of the points raised by the sponsors, such as the "division of medical opinion," the risks of different abortion procedures, and the lack of medical studies establishing the safety of "partial-birth abortion/D&X." *Stenberg*, 530 U.S. at 926, 937. After reviewing all this evidence the Court found: "Where a significant body of medical opinion believes a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view, we cannot say that the presence of a different view by itself proves the contrary. Rather, the uncertainty means a significant likelihood that those who believe that D&X is a safer abortion method in certain circumstances may turn out to be right." 530 U.S. at 937.

[16] *Id.* at Sec. 2, ¶¶9, 10, 11, 12, citing *Katzenbach* v. *Morgan*, 384 U.S. 641 (1966), *Turner Broadcasting System Inc.* v. *F.C.C.*, 512 U.S. 622 (1994) *("Turner I"), Turner Broadcasting System Inc.* v. *F.C.C.*, 520 U.S. 180 (1997) *("Turner II")*, and *City of Rome, Georgia* v. *United States*, 472 F. Supp. 221 (D. Colo. 1979), *aff'd*, 446 U.S. 156 (1980).

[17] *Employment Div., Dept. of Human Resources of Oregon* v. *Smith*, 494 U.S. 872 (1990) (holding that neutral, generally applicable laws may be applied to religious practices even when not supported by a compelling state interest).

[18] *City of Boerne* v. *Flores*, 521 U.S. 507, 519 (1997).

[19] *Id.* at 524.

[20] *Id.* at 536. Similarly, Congress attempted to overturn the Supreme Court's *Miranda* requirements by enacting a new "voluntariness" standard in their place. In *Dickerson* v. *United States*, 530 U.S. 428, 435–36 (2000), the Supreme Court reviewed the law, and in striking it down held that "*Miranda*, being a constitutional decision of this Court, may not be in effect overruled by an Act of Congress," *id.* at 432, and "Congress may not legislatively supersede our decisions interpreting and applying the Constitution." *Id.* at 437.

here to the precedent. This attempt will fail and the bill will be declared unconstitutional.

The Bill Threatens the Separation of Powers

The bill also presents a threat to our constitutional system of government and separation of powers. Where constitutional rights are at stake, the Judiciary conducts its own independent review of the facts.[21] Even where constitutional rights are not at stake, the Court has recently viewed with skepticism Congressional findings purportedly supporting its exercise of powers under Article I or Section 5 of the Fourteenth Amendment.[22]

Here, the sponsors assert that factual findings made by the Judiciary can be, in essence, set aside by contrary Congressional findings. Under this novel regime, Congress could have overturned *Brown* v. *Board of Education* by "finding" that racially separate schools were, in fact "equal," or could, in line with this bill's approach, ban *all* abortions by "finding" that all procedures were unsafe. Ultimately, Congressional findings that seek to defy the Supreme Court and the function of the Federal courts as triers of facts will not only threaten the independence of the Judiciary, but undermine the value of Congressional findings in other contexts where such findings may, unlike in this bill, actually be a legitimate and appropriate exercise of Congressional power.

H.R. 760 Is Overbroad and Places an Undue Burden on a Woman's Right to Obtain an Abortion

Like the law struck down by the *Stenberg* court, H.R. 760 is also overbroad and places an undue burden on a woman's constitutional right to choose to have an abortion. The Supreme Court has made clear that the State has a different interest in regulating abortion prior to- and post-viability. Before viability, the woman has a right to choose to terminate her pregnancy, and a law must not impose an "undue burden" on this decision.[23]

H.R. 760 is not limited to post-viability abortions.[24] Nor is it limited to one clearly-defined "late-term" abortion procedure. To the contrary, the bill's definition of "partial-birth abortion" is, vague,[25] overbroad, and covers the most common type of 2nd-trimester abortion procedure.[26] In fact, the term "partial-birth abortion" is not a

---

[21] *See, e.g., Landmark Communications, Inc.* v. *Virginia*, 435 U.S. 829, 843–44 (1978).

[22] *See, e.g., United States* v. *Morrison*, 529 U.S. 598, 614 (2000).

[23] *Stenberg*, 530 U.S. at 921 (citing *Casey*, 505 U.S. at 870, 877).

[24] During the debate of an identical bill in the 107th Congress, the bill's sponsor, Rep. Chabot, admitted this at the Judiciary Committee markup when he spoke regarding an amendment offered by Rep. Scott, which would have banned abortions on viable fetuses, with certain exceptions. Representative Chabot stated,

> [The amendment] offers protection only to viable infants, and the majority of partial-birth abortions are performed on babies during their fifth and sixth months of pregnancy. Most of the infants aborted during this period, obviously, are not viable. The substitute would thus have no impact on the vast majority of partial-birth abortions, and that's the whole purpose of this legislation.

Statement of Rep. Chabot, Markup of H.R. 760, "The Partial-Birth Abortion Ban Act of 2002," Committee on the Judiciary, 107th Cong., July 17, 2002, at 148–149.

[25] Indeed, H.R. 760 does not even consistently describe the same technique within the findings. *Compare* H.R. 760, Sec. 2, ¶1 (partial-birth abortion involves delivery until "only the head remains inside the womb"); Sec. 2, ¶14(A) (partial-birth abortion involves conversion to a footling breech presentation); Sec. 2, ¶14(J) (partial-birth abortion involves delivery of "all but the head, out of the womb").

[26] Approximately 10% of all abortions are performed during the second trimester of pregnancy (12 to 24 weeks). The most commonly used procedure during this period is called "dilation and

medical term, but a political one intended to inflame public opinion and shift the focus from the fact that private medical decisions should be made by women and their families, in consultation with their doctors—not politicians.

As Simon Heller testified before the Subcommittee on the Constitution,

> [J]ust like the language of Nebraska's statute, [H.R. 760] could still prohibit many pre-viability abortions using the D&E [dilation and evacuation] method, of which the specific technique described the first paragraph of the bill's findings is simply one type. In fact, the prohibitory language of the bill is quite plainly broader than the abortion technique described in paragraph one of the bill's "findings." *Compare* H.R. 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.[27]

Because the bill is not limited to a single, late-term abortion procedure but, instead, also prohibits the most common 2nd-trimester abortion method, the bill imposes an undue burden on a woman's right to obtain an abortion and is unconstitutional for this reason, as well.

H.R. 760 ENDANGERS WOMEN'S HEALTH BY BANNING SAFE ABORTION PROCEDURES

Even if H.R. 760 covered only a single, late-term abortion procedure (known medically as "intact D & E," "dilation and extraction," or "D & X")—which it does not—the bill would still endanger women's health. A threat to women's health always results when a safe medical procedure is removed from the physician's array of options, as there will always be some woman for whom the banned procedure would be the safest.

Contrary to the contentions in the findings of H.R. 760, the conclusion that D & X is a safe procedure is not the view of a single trial judge to whose factual findings the Supreme Court deferred. Rather, after hearing extensive expert medical testimony, every court in the country to reach the question but one has agreed that D & X is a safe procedure that may well be the safest for some women in certain circumstances.[28]

---

evacuation" or "D & E." That procedure accounts for about 95% of all abortions performed from 12 to 20 weeks of gestational age. *Stenberg*, 530 U.S. at 924. The drafters of the bill could have chosen to use more specific language and exclude the D & E method of abortion, but chose not to. *See id.* at 950 (O'Connor, J., concurring) (recognizing that "unlike Nebraska, some other States have enacted statutes more narrowly tailored to proscribing the D & X ["dilation and extraction"] procedure alone. Some of those statutes have done so by specifically excluding from their coverage the most common methods of abortion, such as the D & E and vacuum aspiration procedures," and citing the Kansas, Utah, and Montana statutes approvingly).

[27] Testimony of Simon Heller, Esq. *before the* Committee on the Judiciary, Subcommittee on the Constitution, Hearing on H.R. 760, March 25, 2003.

[28] *See, e.g., Planned Parenthood of Wisconsin* v. *Doyle*, 162 F.3d 463, 467–468 (7th Cir. 1998) ("The D & X procedure is a variant of D & E designed to avoid both labor and the occasional failures of induction as a method of aborting the fetus, while also avoiding the potential complications of a D & E. For some women, it may be the safest procedure. So at least the plaintiff physicians believe, and these beliefs are detailed in affidavits submitted in the district court. *This is also the opinion of the most reputable medical authorities in the United States to have*

Continued

These rulings were based on a wealth of credible medical evidence. Indeed, the American College of Obstetricians and Gynecologists ("ACOG"), the leading professional association of physicians who specialize in the health care of women, has concluded that D & X is a safe procedure and may be the safest option for some women. ACOG has explained that "[i]ntact D & E, including D & X, is a minor—and often safer—variant of the 'traditional' non-intact D & E.[29]" ACOG has also stated that D & X "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman.[30]" "Only the physician, in consultation with the patient and based on her circumstances, can make this decision."[31]

Relying on such medical evidence, the Supreme Court concluded in *Stenberg* that "significant medical authority supports the proposition that in some circumstances, D & X would be the safest procedure.[32]" Indeed, the Court concluded that "a statute that altogether forbids D & X creates a significant health risk."[33]

This is why, in addition to ACOG, numerous other medical groups have publicly opposed attempts by Congress to pass abortion ban legislation, including the American Public Health Association, American Nurses Association, American Medical Women's As-

---

addressed the issue: the American Medical Association and the American College of Obstetricians and Gynecologists." (emphasis added)); *Women's Med. Prof'l Corp.* v. *Taft*, 162 F. Supp. 2d 929, 942 (S.D. Ohio 2001) ("The safety advantages of the D & X over other methods of abortion are both intuitive and well supported by the record."); *Rhode Island Med. Soc'y* v. *Whitehouse*, 66 F. Supp. 2d 288, 314 (D.R.I. 1999), *aff'd*, 239 F.3d 104 (1st Cir. 2001) ("Defendants claim that a D & X could never be necessary to save a woman's health, but the evidence at trial failed to support that contention. . . . Therefore, this Court finds that the D & X could be used to preserve a woman's health and must be available to physicians and women who want to rely upon it."); *Richmond Medical Center for Women* v. *Gilmore*, 55 F. Supp. 2d 441, 491 (E.D. Va. 1999) ("When the relative safety of the D&E is compared to the D&X, there is evidence that the D&X (which is but a type of D&E . . .) has many advantages from a safety perspective. . . . For some women, then, the D&X may be the safest procedure." (citations to the trial record omitted)); *Planned Parenthood of Central New Jersey* v. *Verneiro*, 41 F. Supp. 2d 478, 484–85 (D.N.J. 1998) ("The intact dilatation and extraction, or intact D&X, has not been the subject of clinical trials or peer-reviewed studies and, as a result, there are no valid statistics on its safety. As its 'elements are part of established obstetric techniques,' the procedure may be presumed to pose similar risks of cervical laceration and uterine perforation. However, because the procedure requires less instrumentation, it may pose a lesser risk. Moreover, the intact D&X may be particularly helpful where an intact fetus is desirable for diagnostic purposes." (citation to ACOG Statement on Intact D&X omitted)); *Richmond Med. Ctr. for Women* v. *Gilmore*, 11 F. Supp. 2d 795, 827 n.40 (E.D. Va. 1998), *aff'd*, 224 F.3d 337 (4th Cir. 2000); *Hope Clinic* v. *Ryan*, 995 F. Supp. 847, 852 (N.D. Ill. 1998) (Korcoras, J., appointed by President Carter) ("[T]he record here contains significant evidence that the D&X procedure is often far safer than other D&E procedures."); "[D&X] reduces the risk of retained tissue and reduces the risk of uterine perforation and cervical laceration because the procedure requires less instrumentation in the uterus. [It] may also result in less blood take less operating time."); *Planned Parenthood* v. *Woods*, 982 F. Supp. 1369, 1376 (D. Ariz. 1997) (The D&X method is one of several "safe, medically acceptable abortion methods in the second-trimester."); *Women's Medical Professional Corp.* v. *Voinovich*, 911 F. Supp. 1051, 1070 (S.D. Ohio 1995) ("[T]his Court finds that use of the D&X procedure in the late second trimester appears to pose less of a risk to maternal health than does the D&E procedure, because it is less invasive—that is, it does not require sharp instruments to be inserted into the uterus with the same frequency or extent—and does not pose the same degree of risk of uterine and cervical lacerations . . . [T]he D&X procedure appears to have the potential of being a safer procedure than all other available abortion procedures . . .").

[29] Brief of *Amici Curiae* American College of Obstetricians and Gynecologists, et al., in Support of Respondent at 6, filed in *Stenberg* v. *Carhart*, 530 U.S. 914 (2000) (No. 99–830) (*hereinafter* "ACOG Brief").

[30] ACOG, Statement of Policy, *Abortion Policy* at 3 (Sept. 2000).

[31] ACOG Brief at 7.

[32] *Stenberg*, 530 U.S. at 932.

[33] *Id.* at 938. In addition, the Supreme Court squarely rejected the very same claims made in H.R. 760's "findings" that D & X is somehow unsafe because it allegedly creates risks of cervical incompetence and lacerations or risks from blind instrumentation and conversion of the fetus to a breech position. *Stenberg*, 530 U.S. at 933–38. Medical evidence fails to support any of these claims.

sociation, California Medical Association, Physicians for Reproductive Choice and Health, American College of Nurse Practitioners, American Medical Student Association, Association of Reproductive Health Professionals, Association of Schools of Public Health, Association of Women Psychiatrists, National Asian Woman's Health Organization, National Association of Nurse Practitioners in Reproductive Health, National Black Women's Health Project, National Latina Institute for Reproductive Health, and Rhode Island Medical Society. Moreover, contrary to the claims of the sponsors of H.R. 760, the American Medical Association does not support any criminal abortion ban legislation.[34]

H.R. 760 CRIMINALIZES DOCTORS AND ENCOURAGES WOMEN TO BE SUED BY THEIR HUSBANDS AND PARENTS

H.R. 760 would turn doctors into criminals and put them in jail for performing a safe medical procedure.[35] The civil sanctions and criminal remedies, along with previous references by legislative proponents to medical professionals as "assassins," "exterminators" and "murderers," have been said to be part of a design to intimidate medical professionals from performing abortions generally. Similarly, put in the context of abortion clinic demonstrations and bombings, it seems that many in the anti-abortion movement have an agenda of banning all abortions.

The provisions in the legislation imposing criminal sanctions—including imprisonment—appear to be drafted to put physicians in a position where they will be chilled from performing many of the most common abortion procedures. For example, doctors may well choose not to perform any abortion for fear that they will be unable to afford the costs of establishing that the method of abortion chosen wasn't the only one available to save the woman's life. Given the vague and overbroad language of the bill, doctors can reasonably fear prosecution for using the safest and most common second-trimester abortion methods. For this reason, the American Medical Association does not support the bill.[36]

Further, the bill allows a woman to be sued by her husband or parents if she receives a partial-birth abortion.[37] As the Supreme Court has held, a husband cannot have veto power over his wife's decision to have an abortion.[38] Allowing a husband to sue his wife, or threaten to sue his wife, is merely a back-door attempt to avoid yet another Supreme Court holding. In addition, this provision allows an abusive husband or a husband who has abandoned his wife to sue or threaten his wife with a lawsuit if she obtained the procedure to protect her health and future fertility. This is an extremely

[34] American Medical Association Statement, Oct. 21, 1999 (because abortion ban bill contained criminal sanctions, "[f]or this reason we do not support the bill").

[35] H.R. 760, Sec. 3, ¶a. Representative Baldwin offered an amendment to eliminate the criminal penalties, which was defeated in a party-line vote.

[36] American Medical Association Statement, Oct. 21, 1999.

[37] Although the bill exempts women from criminal prosecution, Sec. 3, ¶(e), they are not exempt from the bill's imposition of civil liability: "The father, if married to the mother at the time she receives a partial-birth abortion procedure, and if the mother has not attained the age of 18 years at the time of the abortion, the maternal grandparents of the fetus, may in a civil action obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion." Sec. 3, ¶(c)(1).

[38] *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 70 (1976).

anti-family provision that encourages litigation over a personal, medical decision.[39]

CONCLUSION

H.R. 760 is a facially unconstitutional attempt to roll back a woman's right to choose. The bill suffers from the same two flaws that led the Supreme Court to declare a similar Nebraska statute unconstitutional: it fails to include an exception to protect maternal health, and it places an undue burden on a woman's right to obtain an abortion prior to viability by banning the most common 2nd-trimester abortion procedure. Fifteen pages of "findings" do nothing to remedy this unconstitutionally flawed bill.

Further, even if the bill were limited to one, specific abortion method—which it is not—it would still endanger women's health by prohibiting a procedure that the American College of Obstetricians and Gynecologists and other respected medical groups say may be the best or most appropriate procedure to save the life or preserve the health of a woman. In addition, the bill is part of a political scheme to sensationalize the abortion debate through heated rhetoric and to shift the focus from the fact that women and their doctors—not the government—should decide matters of their own health care. Finally, the bill criminalizes the practice of medicine and subjects women to lawsuits by their husbands and parents. For all of these reasons, we dissent.

JOHN CONYERS, JR.
HOWARD L. BERMAN.
RICK BOUCHER.
JERROLD NADLER.
ROBERT C. SCOTT.
MELVIN L. WATT.
ZOE LOFGREN.
SHEILA JACKSON LEE.
MAXINE WATERS.
WILLIAM D. DELAHUNT.
ROBERT WEXLER.
TAMMY BALDWIN.
ANTHONY D. WEINER.
LINDA T. SÁNCHEZ.

○

[39] Representative Nadler offered an amendment that would have eliminated the civil cause of action against the woman, but it was defeated in a party-line vote.